National Preventive Mechanism

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

Annual Report 2017

PARLIAMENTARY OMBUDSMAN OF FINLAND

The Finnish National Preventive Mechanism against Torture

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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) since 7 November 2014. Separate sections on these activities have been included in the Parliamentary Ombudsman's annual reports for 2015, 2016 and 2017. In addition, a more extensive English-language publication was prepared on the 2016 operations.

It is not possible to detail all the findings and recommendations made by the NPM in the Parliamentary Ombudsman's Annual Report. Therefore, this more expensive report on the activities of the NPM has been prepared and published on the Ombudsman's website in Finnish, Swedish and English.

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 been 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.

Overall, it can be said that the Ombudsman's opinions and recommendations are complied with fairly well. Non-compliance is usually explained by a lack of resources or shortcomings in legislation.

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OPCAT Coordinator, Senior Legal Advisor

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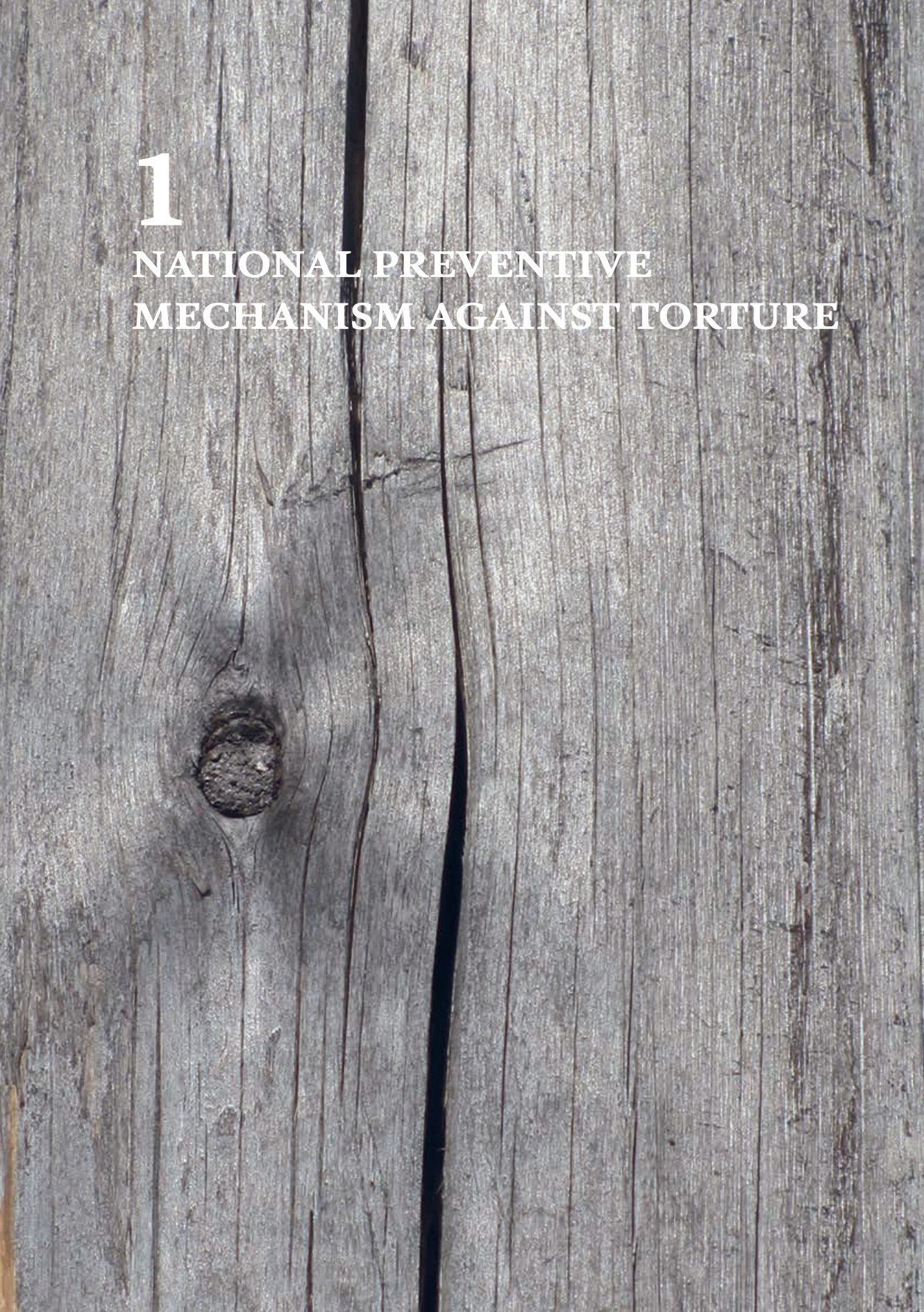


1
NATIONAL PREVENTIVE MECHANISM AGAINST TORTURE

1.1 The Ombudsman's task as a National Preventive Mechanism

On 7 November 2014, the Parliamentary Ombudsman was designated as 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 a set of international standards known as the 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 thousands of facilities in total. In practice, the NPM makes visits to, for example, care homes for elderly people with memory disorders, with the objective of preventing 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 conduct-

ed 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's personnel whose area of responsibility covers facilities 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, 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 allocated for the Ombudsman to perform its duties as 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 significantly increase 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 its recommendations issued in December 2016 on the basis of Finland's seventh periodic report, the UN Committee against Torture (CAT) expressed its concern about the Ombudsman having insufficient financial or human resources to fulfil the mandate of the NPM. The CAT recommended that the State strengthen the NPM by providing it with sufficient resources to fulfil its mandate independently and efficiently. The CAT also recommended that Finland should consider the possibility of establishing the NPM as a separate entity under the Parliamentary Ombudsman. The State has been requested to respond to the recommendations by 7 December 2017.

The Ombudsman submitted his statement on the matter to the Ministry for Foreign Affairs on 13 October 2017. In giving his opinion, the Ombudsman states that the Office has so far received no additional human resources to fulfil its remit as the NPM, although such increases were included in the 2014 and 2016 budget proposals. In line with the parliamentary guidance restricting the creation of new government posts, the Ombudsman did not include additional human resources in the 2017 budget proposal. Instead, the Ombudsman proposed an increase in financial resourcing to allow, for example, the consultation of external experts. The Ombudsman also states that its duties included visits to closed institutions and monitoring of the treatment of persons deprived of their liberty long before its designation as the NPM. The Ombudsman therefore had the resources required for these operations before it assumed the duties of the NPM. However, more resources are required for the development of the operations. With internal organisational changes and the reallocation of resources from other oversight activities, the Office of the Parliamentary Ombudsman has been able to appoint one full-time legal adviser to coordinate the NPM's operations. A further two new posts, a coordinator and an assistant, are still needed.

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. The Ombudsman has assigned two public servants at the Office to coordinate the NPM duties for a fixed term in addition to their other duties. The coordinators are responsible for the international relations of the NPM and internal coordination within the Office. This arrangement was in force until the end of 2017. To improve coordination within the NPM, the Ombudsman decided to assign one legal adviser exclusively to the role of coordinator. This was achieved through the reorganisation of duties, as no new personnel resources were gained. At the beginning of 2018, the role of principal legal adviser and full-time coordinator for the NPM was assumed by Senior Legal Adviser Iisa Suhonen. She is supported by Principal Legal Adviser Jari Pirjola and on-duty lawyer Pia Wirta, who coordinate the NPM's activities alongside their other duties, as of 1 January 2018 until further notice.

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 referred to in the OPCAT. The team has nine members and is led by the head coordinator of the NPM. During 2017, the OPCAT team formulated strategies by collating working methods and goals for the administrative sectors, as they realised the methods and goals in their capacity as the NPM. The strategy work is ongoing and will form the basis for the NPM's overall strategy.

In 2016 and 2017, the NPM provided induction training for external experts regarding the related visits. The NPM currently uses the services of eight external medical experts: three psychiatrists (one of whom also specialises in adolescent psychiatry), one specialist in forensic psychiatry, two specialists in geriatrics, one specialist in intellectual disabilities and one psychiatric nurse. The NMP also employs three trained experts by experience, whose expertise will be used during visits to closed social welfare institutions for children and adolescents. The two other experts by experience represent the Disability Section of the Human Rights Centre, and their expertise will be used on visits conducted by the NPM to units where the rights of disabled people are being restricted.

During the visits conducted by the NPM, efforts have been made to engage more frequently in constructive dialogue with staff, regarding good practices and procedures. Feedback on observations as well as guidance and recommendations may also be given to the supervised entity during the visit. At the same time, it has been possible to engage in amiable discussions of how the facility might, 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 of any measures taken in response. After that, the facility may also be requested to notify, by a given deadline, of any measures it will take in relation to those observations that have not yet been dealt with. If, during an inspection visit, something has arisen that needed investigating, the Ombudsman has taken up the investigation of the matter on his own initiative, and the issue has not been dealt with further in the report.

Information activities

A brochure on the NPM activities has been published and is currently available in Finnish, Swedish, English, Estonian and Russian. It will also 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. It has been agreed at the Office of the Parliamentary Ombudsman that as of 2018, all reports will be published in full, excluding details that must remain confidential. This objective will also be included in the strategy of the NPM.

The new content on the public website of the Office of the Parliamentary Ombudsman will be made available by the end of 2018. The project also includes the launch of the NPM's own website. Another objective is to communicate about the visits and related themes more actively on social media.

Education and training on fundamental and human rights

The Ombudsman and the Human Rights Centre started a joint project in 2017, to promote human rights education and training. The project is particularly targeted at the educational sector. Officials from the Office of the Parliamentary Ombudsman and experts from the Human Rights Centre toured schools throughout Finland. The goal of the project and the inspection visits is to assess and promote education and training on basic and human rights at all levels of school life. Based on the experiences gained during the visits, the project team produced a training package for municipal directors of education and headmasters. The plan is to launch similar collaboration on human rights education between the NPM and the Human Rights Centre.

1.2 Cooperation

Cooperation with other operators

In the ADMINISTRATIVE BRANCH OF POLICING, police prisons and inspection visits to them are regularly discussed at meetings of the National Police Board and the network for the oversight of legality within the police force. Summaries of all decisions on actions regarding the police – including those on police prisons – are sent to the National Police Board (which further distributes them among departments), the National Bureau of Investigations, and the Police University College of Finland. Reports on visits to police prisons are always submitted to the National Police Board and the police department in question and, when necessary, directly to the police prison. 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 the police prisons in their respective territories. Each year, the National Police Board provides the Parliamentary Ombudsman with a report on the oversight of legality within its area of responsibility.

The DEFENCE FORCES and the FINNISH BORDER GUARD also submit annual reports to the Parliamentary Ombudsman on their internal oversight of legality.

In the field of CRIMINAL SANCTIONS, reports on inspection visits are sent for information to the Central Administration of the Criminal Sanctions Agency, the management of the criminal sanctions region in question, and the Department of Criminal Policy at the Ministry of Justice. In addition, the central and regional administrations are often requested to report measures taken as a result of the observations. The Parliamentary Ombudsman receives reports on the facilities visited, drawn up for the internal oversight of legality in the criminal sanctions field. Furthermore, each month, the Criminal Sanctions Agency provides the Ombudsman with its statistics on the number of prisoners and amount of prison leave. Among other things, the prisoner statistics indicate the number of remand prisoners, male and female prisoners, and prisoners under the age of 21. The statistics on prison leave give an indication of the processing practices concerning leave applications in each prison, or in other words, how many prisoners apply for leave and how often, and how much leave is granted. The visits also draw attention to the processing of prison leave applications, emphasising the importance of taking the related decisions individually, based on the law and reasonable grounds.

In 2017, the Criminal Sanctions Agency lawyers in charge of legal oversight were invited to the Office of the Parliamentary Ombudsman to discuss collaboration and problems identified during legality oversight. The closing discussion on the visit was attended by two representatives of the Criminal Sanctions Region of Southern Finland.

Representatives of the national association for prisoners' families (Vankien Omaiset ry) were invited to the Office of the Parliamentary Ombudsman in December 2017 to introduce the association and its work, as well as their experiences of the operations of the Criminal Sanctions Agency from the family perspective. The Ombudsman also continues its collaboration and exchange of information with Kriminaalihuollon tukisäätiö (KRITS), a nationwide non-governmental non-profit aftercare organisation for released prisoners. Krits makes visits to ten prisons annually, and therefore holds a wealth of in-

formation on the treatment, living conditions and health care of prisoners. Krits provides valuable knowledge about the problems of which it is informed by prisoners and their families.

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, as a rule the competent regional state administrative agency is contacted in order to gain information on its observations about the facility in question. Other third-party operators, such as local associations for the families of psychiatric patients, may also be contacted prior to visits. The Ombudsman and the senior management of Valvira held a collaboration meeting in September 2017.

The Ombudsman also receives AVI Northern Finland's supervision plans for the Prisoners' Health Care Unit, and guidance and assessment reports following its visits. As part of this collaboration, the Ombudsman sends its own supervision plans and reports, for information, to Valvira and the Regional State Administrative Agency. The Ombudsman, Valvira and AVI Northern Finland also hold regular meetings on issues in the field of prisoner health care.

In the field of SOCIAL WELFARE, reports on visits are generally sent to the relevant Regional State Administrative Agency for information. In 2016, Valvira published the results of the survey on the mistreatment of customers in elderly care, which it conducted in 2016 among employees at full-time care facilities for older people. The survey revealed widespread problems among elderly care units in areas such as self-monitoring, identifying mistreatment, and intervening in cases of mistreatment. Valvira has initiated reactive supervision in units where, on the basis of the survey, it considers it necessary to investigate whether the safety of customers has been severely compromised. The survey results will also be of use to the NPM when selecting sites for inspection visits.

Valvira published a similar survey on the actualisation of self-determination within residential and institutional services for the intellectually disabled. Data on the use of restriction measures and decision-making processes is essential to the NPM in its work.

International cooperation

The UN Subcommittee on Prevention of Torture

The NPM's report on 2016 was submitted for information to the UN Subcommittee on Prevention of Torture (SPT). The SPT presented a number of comments and questions to the NPM on the annual report, which were addressed by the OPCAT team.

In October 2017, the NPM, headed by the Ombudsman, met SPT member Mari Amos, who is the subcommittee's rapporteur for Finland. Among other things, the parties discussed the resources of the NPM, touched upon some of the issues that the SPT had raised regarding the latest report, and prepared for the next meeting alongside the SPT.

The delegation of the Ombudsman met with SPT representatives again in November 2017, at the SPT annual meeting in Geneva. Prior to the meeting, the NPM had provided the SPT with a completed Assessment Matrix for NPMs, which was based on the "Analytical assessment tool for national preventive mechanisms" created by the STP for the use of NPMs. After the meeting, SPT provided feedback and asked some further questions. The Ombudsman gave his response to the feedback in April 2018.

Nordic cooperation

The Nordic NPMs meet regularly twice a year. The Finnish NPM hosted the January 2017 meeting in Helsinki. In addition to Finnish representatives, the meeting was attended by representatives of the Swedish, Norwegian and Danish NPMs. For the first time, a representative of the Parliamentary Ombudsman of Iceland also participated in the meeting. The topic of the meetings was inspection methods, interviewing techniques and the use of external experts. The meeting was paired with a training day on interviewing methods and using external experts. The speaker at the meeting was Dr. Clive Meux from the Institute of Psychiatry in London, UK.

The subsequent meeting was held in Oslo in August 2017, hosted by the Norwegian NPM. The topic of the August meeting was inspection visits made to units housing minors. A special theme discussed was the use of coercion and restrictive measures on minors during transport to or between institutions. The speaker at the meeting was Kirsten Sandberg, Professor of Law at the University of Oslo and a member of the UN Committee on the Rights of the Child, who gave a talk on "The best interest of the child and reflections on the NPM work".

NPM collaboration between EU Member States

The coordinator of the NPM attended a two-day meeting in Strasbourg in April 2017, on the launch of collaboration between the NPMs of the EU Member States (EU NPM Network).

Other cooperation

In March 2017, the Ombudsman played host to a representative of the European Ombudsman, who came to find out about the work of the Ombudsman. During the visit, the representative was also introduced to the operations of the NPM.

The delegation of the Ombudsman of Montenegro paid a two-day visit to the Office of the Parliamentary Ombudsman in September 2017. One of the objectives of the visit was to learn about the practices of the Finnish NPM, including inspection visits made to closed institutions and psychiatric units in particular.

In the same month, four representatives of the Estonian NPM joined the Finnish NPM on a two-day inspection visit to the psychiatric care facilities run by the Päijät-Häme Joint Authority for Health and Wellbeing. During the same visit, the Estonian guests had the opportunity to visit a residential social welfare unit for people with memory disorders.

Training

The NPM organised a training event for office staff and external experts on interview methods and the use of external experts for inspection visits.

The on-duty lawyer of the Office of the Parliamentary Ombudsman participated in a seminar series in January and February 2017 on the mental well-being of refugees, which focused on the recognition of mental health problems in refugees and the treatment offered to refugees who have experienced severe trauma. The seminar was organised by the National Institute of Health and Welfare (THL), HUH Psychiatry, and the Finnish Association for Mental Health.

The revised Standard Minimum Rules for the Treatment of Prisoners, known as the Nelson Mandela Rules, were adopted by the UN General Assembly in December 2015. The rules are recommendations intended to ensure that all prisoners in the world are treated humanely and in accordance with generally accepted principles and practices. The Finnish translation of the rules and the introduction were published in February 2017. The publication seminar of the Finnish edition was attended by several legal advisers from the Office of the Parliamentary Ombudsman. The UN representative attending the seminar was Mr Philipp Meissner, Crime Prevention and Criminal Justice Officer.

In March 2017, the Office of the Parliamentary Ombudsman organised internal training on the removal of foreign nationals from the country and return flights. The trainers were representatives of the Helsinki Police Department and the Office of the Non-Discrimination Ombudsman. Another training event held in May focused on human trafficking, with trainers from the Office of the Non-Discrimination Ombudsman and Victim Support Finland.

One of the on-duty lawyers of the Office of the Parliamentary Ombudsman participated in a seminar in Copenhagen in April 2017 entitled "The Use of Solitary Confinement as a Disciplinary Measure", which was organised by Dignity – Danish Institute Against Torture. The other on-duty lawyer attended the four-day training course "Detention monitoring applying the UN Nelson Mandela Rules", held in Bristol in August 2017.

In 2017, two officials from the Office of the Parliamentary Ombudsman attended a three-day training event in Vienna, jointly organised for NPMs by the Austria NPM, IOI (International Ombudsman Institute) and APT (Association for the Prevention of Torture). The training event was a continuation of similar sessions held in previous years in Riga and Vilnius. The theme of this year's training was "Communications skills and techniques".

Three legal advisers attended the criminal sanctions field seminar on the theme of appeals, organised by the Criminal Sanctions Agency and the Department of Criminal Policy at the Ministry of Justice in October 2017. The target group of the meeting and training event were lawyers from the Criminal Sanctions Agency and the administrative courts, and its focus was on prisoners' right of appeal.

In November 2017, the on-duty lawyer at the Office of the Parliamentary Ombudsman attended a training course on the self-determination of the intellectually disabled and the use of restrictive measures, organised by Valvira and the Regional State Administrative Agencies.

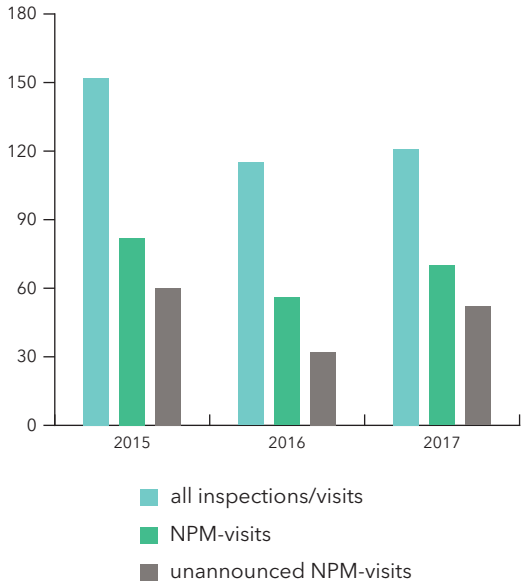
In addition, the Office of the Parliamentary Ombudsman held several information events during 2017, aimed at the entire staff and communicating the main content of the above training events and meetings. Whenever necessary, the OPCAT coordinator also provides training for new staff members at the Office on the duties of the NPM.


2
VISITS

2.1 NPM visits

Fulfilling the role of an NPM requires regular visits to sites. In some administrative branches, such as the police and criminal sanctions, site visits can be made. However, in the case of social services and health care, the number of units is so large that sites must be selected for visits on the basis of certain priorities. In 2017, the number of follow-up visits was increased in order to determine how the recommendations of the NPM had been implemented in practice. The implementation of recommendations is also monitored through notifications submitted to the Ombudsman by the visited units or other authorities, regarding any changes and improvements made in their operations.

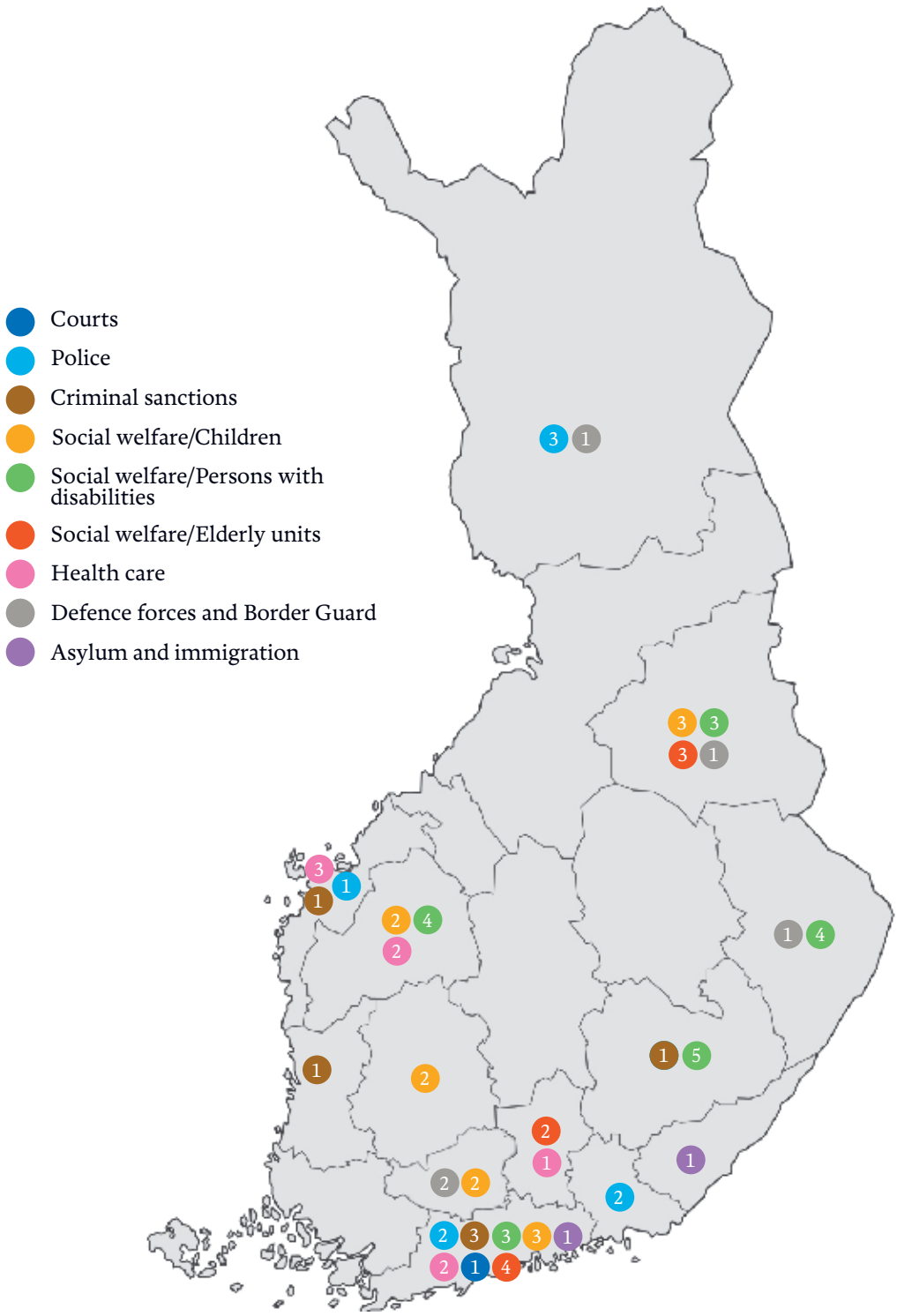
The NPM made a total of 70 visits during 2017. Of these, 52 where made unannounced. Use of external experts has become an established practice in certain administrative branches. However, the practice of using external experts during inspection visits is still taking shape. In 2017, external experts where involved in 19 visits. In the field of social welfare, a visit to a youth home for residents with special needs was attended by an expert by experience. In addition, a doctor specialising in intellectual disabilities and an expert by experience participated in five visits made to residential care units for intellectually disabled people.



Visits in 2015–2017.

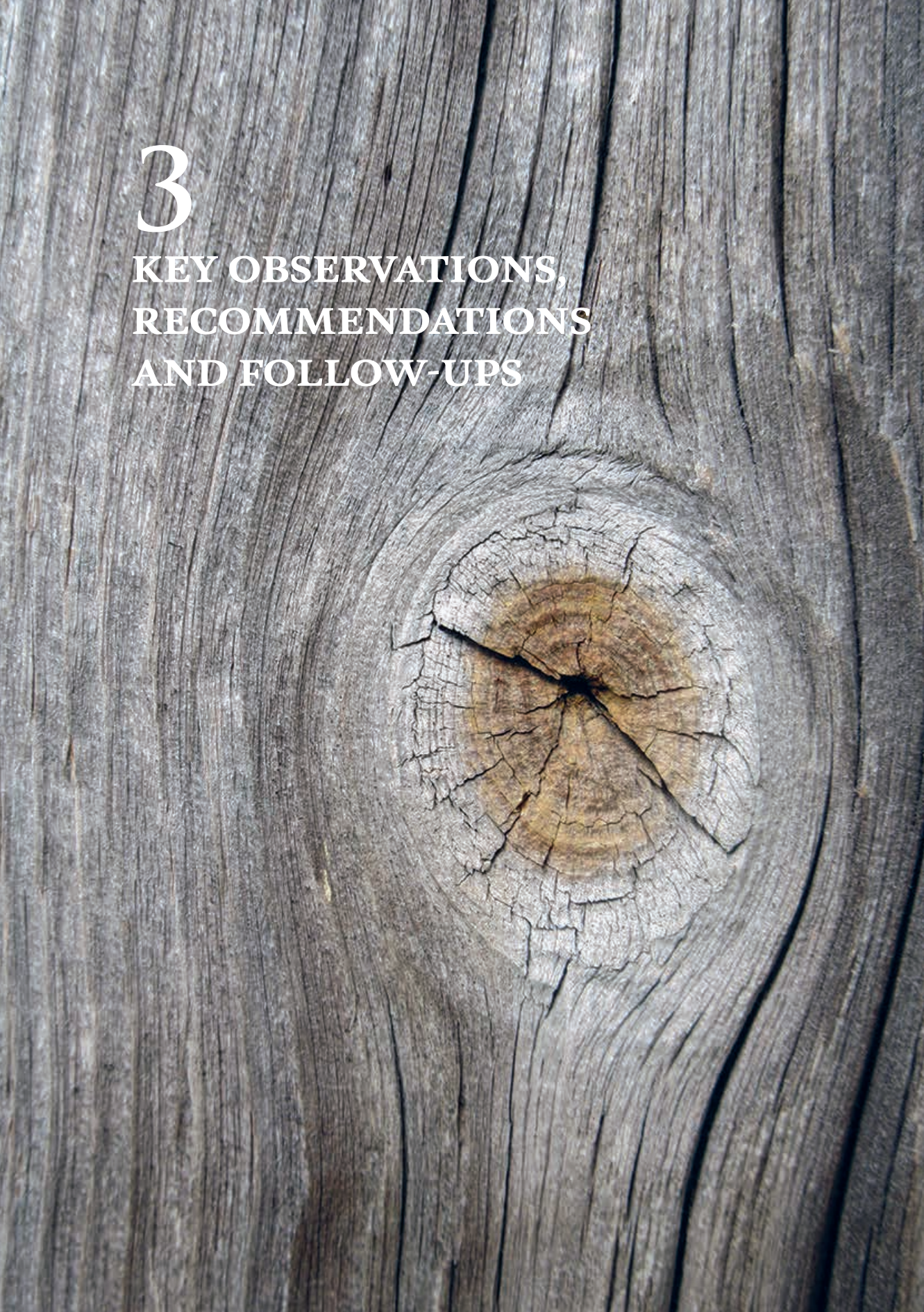
Since the establishment of the NPM, it has been increasingly focused on interviewing persons who have been deprived of their liberty. On site, the NPM has sought to interview those in the most vulnerable position, such as foreign nationals. This has meant an increase in the use of interpreter services. Interpreters have been used on visits to prisons and detention units for foreign nationals in particular. The aim has been to create a designated "interpreter pool" for NPM visits, consisting of interpreters that are familiar with the environment and professional vocabulary used. This helps to improve the quality of the interviews.

One of the key themes for the Office of the Parliamentary Ombudsman for 2017 was efficient legal remedies. A focus area during the visits was paying attention to how well clients and their families can access the legal remedies to which they are entitled, such as complaints and appeals. The Ombudsman has not yet set a specific theme for the visits made by the NPM. However, the various visits may have focused on specific issues, or certain groups of vulnerable people.



NPM visits 2017. Most of the population and the sites visited are located in Southern and Western Finland A full list of all visits and inspections is provided in Appendix 2.

3
KEY OBSERVATIONS, RECOMMENDATIONS AND FOLLOW-UPS



3.1 Police detention facilities

It is the duty of the police to arrange for the detention of persons deprived of their liberty not only in connection with police matters, but also as part of the activities of Customs and the Border Guard. Most apprehensions, over 60,000 every year, are due to intoxication. The second largest group is formed by persons 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 50 police prisons in Finland, and their size and occupancy rates vary widely. The largest police departments are currently undergoing a renovation programme.

In addition to the Ombudsman, on numerous occasions international supervisory bodies have criticised the holding of remand prisoners on police premises, in particular, as they are not fit for long-term accommodation. In recent years, fewer than one hundred remand prisoners have been held on police premises on a daily basis. The Remand Imprisonment Act has been amended so that remand prisoners may not be kept in a police detention facility for longer than seven days without an exceptionally weighty reason considered by a court. Furthermore, provisions on an enhanced travel ban and house arrest during investigations have been added as alternatives to remanding prisoners in custody under the Coercive Measures Act. The amendments will enter into force on 1 January 2019.

The rationale presented in the government proposal (HE 252/2016 vp) also refers to the opinions expressed by the CPT and the Ombudsman, that police facilities are unfit for accommodating remand prisoners. The long-term goal must therefore be to gradually abandon the practice of holding remand prisoners at police facilities. In 2017, the Deputy-Ombudsman recommended that four police prisons (Vaasa, Porvoo, Kotka and Kouvola) discontinue the practice of holding remand prisoners on their premises. In connection with two police prisons (Inari and Sodankylä), the Deputy-Ombudsman has further stated that their premises and security arrangements are suitable for short-term accommodation only.

The Act on the Treatment of Persons in Police Custody is also currently under review. Following the Act's amendment, the National Police Board will update its own guidelines on the treatment of persons in police custody, and determine any general matters possibly provided for in the rules on custody facilities (a rules template). In practice, this will mean that police departments must review and update the rules for police prisons. In anticipation of this process, the Deputy-Ombudsman has recommended that police departments familiarise themselves with his decision of September 2017 (1154/2/16), detailing the matters that should be considered when drawing up rules for a detention facility. The decision can be read on the Ombudsman's website www.oikeusasiamies.fi in Finnish.

The NPM aims to make regular visits to at least the police prisons of the largest police departments. Every inspection to a police department by the Deputy-Ombudsman will also include an inspection to the police prison. In addition, the Deputy-Ombudsman will perform extended NPM visit tours of a number of police prisons. The themes of the visits are partly determined by the topics of complaints received, but a special focus will be given to the most vulnerable groups, such as foreign nationals and minors.

Based on the visit reports submitted, the National Police Board completed a list of development needs and distributed the list among all police departments during November 2017. Overall, follow ups on recommendations have shown that the issues raised by the NPM have been taken seriously and addressed accordingly. The letter sent by the National Police Board to police departments also indicates that it is assuming its expected active role in the supervision of police prisons. Collaboration between the National Police Board and its legality oversight is described in detail in section 1.2.

In 2017, eight inspection visits were made to police prisons. In addition, the visit to Espoo police prison included a visit to the sobering-up station; the findings of this visit are explained under the section on visits to health-care facilities.

The police prisons visited by the NPM in 2017 were:
- Espoo police prison (42 cells), Western Uusimaa Police Department
- Vaasa police prison (32 cells), Ostrobothnia Police Department
- Porvoo police prison (22 cells), Eastern Uusimaa Police Department
- Kotka police prison (25 cells), Southeastern Finland Police Department
- Kouvola police prison (25 cells), Southeastern Finland Police Department
- Rovaniemi police prison (22 cells), Lapland Police Department
- Sodankylä police prison (7 cells), Lapland Police Department
- Inari police prison (4 cells), Lapland Police Department

Three of the visits were made to sites where the previous visit had been made within a year and where one of the aims was to follow-up on the practical implementation of the Deputy-Ombudsman's recommendations (Espoo, Vaasa and Porvoo).

Visits to police prisons are usually made unannounced. In 2017, two of the visits were pre-announced (Sodankylä and Inari). This was necessary in order to ensure that someone would be on duty to receive the NPM. As a rule, the detention facilities are empty, and therefore no officers are on site. An external expert on forensic psychiatry was involved in the visits to the Espoo police prison and the City of Espoo sobering-up station. These visits were made during the evening.

The key findings and recommendations regarding the visits:

Human resources

- In two police prisons, police officers were required to serve in guard duties on a weekly basis. In two other police prisons, the police officers were solely responsible for guard duties.

The Deputy-Ombudsman referred to the statement by the Police University College in which it was clarified that the basic police training provides the readiness to assist an experienced prison officer in police detention facilities but not to serve independently as a guard. In the Deputy-Ombudsman's view, this fact should be taken into account in the guarding arrangements in police prisons. The question is about the safety and the rights of the detainees, as well as the legal rights of

those standing in as prison guards. The Deputy-Ombudsman recommended that the police officers in guard duties receive sufficient further training. This means, for example, that the medicine distribution training for prison officers in spring 2018 should also include police officers participating in guard duties.

The treatment of a detained minor

- During the visit, a minor who had been apprehended by the police was brought to the police prison and was subsequently detained in a cell, awaiting the arrival of social service officers.

It remained unclear to the NPM on what grounds the minor was detained in a cell and whether the appropriate records were made of the apprehension, and whether the apprehended person was informed of their rights and obligations, and how the person's young age was taken into consideration in their treatment. The Deputy-Ombudsman decided to investigate the matter on his own initiative.

The detention of remand prisoners in a police prison

- It was noted during the visits to four police prisons that remand prisoners had no access to activities outside their cells, apart from outdoor time, and that the outdoor area at the police prison was not suitable for any type of exercise. Remand prisoners were forced to spend time in their cells with very few stimuli to keep them occupied.

The Deputy-Ombudsman stated that, at the time of the visits, the period of detention for remand prisoners did not exceed the maximum of four weeks, as provided in the Remand Imprisonment Act. However, he did find that, owing to the conditions at the police prisons, the detention of remand prisoners in them should be discontinued at the earliest opportunity.

Follow-up:
The National Police Board reported to the Deputy-Ombudsman in December 2017 that it was not in the interest of the police to detain remand prisoners in police prisons any longer than the ongoing investigation necessitates. With the amended legislation entering into force on 1 January 2019, the detention period in police prisons is likely to be further reduced. The aim is also to pay attention to remand prisoners' access to activities by building activity rooms as part of the prison renovation projects. During the renovations, remand prisoners' access to television and radio has been improved by installing power and antenna sockets in cells. However, the limited guard resources in police prisons make it difficult to organise activities outside cells, as the resources only allow for the most imperative activities.

The participation of criminal investigators in detention duties

- The police prison had a small number of books and magazines on offer and persons deprived of their liberty had no access to a canteen. The NPM were told that criminal investigators could bring newspapers and magazines for those deprived of their liberty and could shop for items outside the police prison on their behalf, and they were also partly in charge of organising prison visits for them.

The Deputy-Ombudsman referred to the CPT report on Finland, which had drawn attention to the point that the responsibility for the detention of those deprived of their liberty and that for the criminal investigation should be strictly separated. According to the CPT, overlaps in criminal investigation and detention duties would present a risk of misconduct. The Deputy-Ombudsman found it problematic that the police officer investigating the matter concerning a person deprived of their liberty participated in the detention duties of the latter at the police prison.

The Deputy-Ombudsman made the recommendation to police departments that the investigation of a criminal case and the detention of a person deprived of their liberty be kept strictly separate. The Deputy-Ombudsman noted that while there were no signs of misconduct, the risk alone of such misconduct is unacceptable.

Follow-up:

At the request of the police department, guidelines clarifying and limiting the duties related to the detention of a person deprived of their liberty and criminal investigations were issued in October 2017. The guidelines make clear, for example, that the persons investigating the matter concerning the person deprived of their liberty may not be involved in the daily activities of the latter any more than is necessary for the purpose of the investigation. If requests are made to the officer involved in the investigation that are not relevant to the matter under investigation, the officer shall pass the request on to a competent guard.

One of the police prisons reported that it has insufficient staff to make sure that only staff members working at the detention facility purchased items on behalf of the persons deprived of their liberty.

Another police department, also with a limited number of officers, had adopted a practice by which duties in the detention of persons deprived of their liberty were only carried out by police prison guards. Criminal investigators may assist guards by providing magazines, cigarettes, and other personal items for persons deprived of their liberty, but the decision to hand them over to the remanded person is made by the guard.

- A person deprived of their liberty had a television in their cell; according to the police prison personnel, the decision to allow a television for a remanded person is made by the officer investigating the matter.

The Deputy-Ombudsman emphasised the decision to withhold the personal property of a person deprived of their liberty under the Act on the Treatment of Persons in Police Custody is made by the police officer or a guard. The Deputy-Ombudsman also emphasised that persons in charge of the investigation do not make decisions concerning the conditions of a person deprived of their liberty while at a police prison, other than is specifically provided in law. The Deputy-Ombudsman suggested that it would be logical if the decision to allow a television in a cell were made by the police prison staff.

Follow-up:
The police department responded that the staff of the police department and the police prison would be further instructed on the decision making regarding the personal property of persons deprived of their liberty.

- It was unclear who in the police prison was authorised to make the decision on handing over personal property: according to the guard, decisions on which items can be handed over were made by the investigators, whereas according to the police prison rules and regulations, these decisions should be made by the guards.

The Deputy-Ombudsman drew attention to the police prison personnel's obligation to be informed about statutory decision-making and appeal procedures.

Information about rights and conditions at the detention unit

- Based on the interviews with persons deprived of their liberty, it would appear that some had not been informed about the conditions and practices of the detention facility on arrival.

The Deputy-Ombudsman recommended that, in addition to written information, the staff should proactively inform persons deprived of their liberty about the mealtimes, outdoor times, shower arrangements, and use of the telephone, on arrival.

Follow-up:
The police department responded that it had taken a more active role in informing detained persons of the rules and conditions at the detention facility. The police prison staff have also been instructed to give basic information orally to detained persons about the conditions and rules of the detention facility on their arrival.

- All information was available in Finnish only.

  The Deputy-Ombudsman stated that since there might be persons detained at the facility who did not speak Finnish, the information should be translated into languages that are frequently needed.

  Follow-up:
  The police department responded that the daily programme at the detention facility, including information on shower arrangements and outdoor times, had been posted in a visible place at the detention facility. The daily programme will also be provided in the most common foreign languages needed (Swedish, English, Russian).

- It has also been noted during the visits that the personnel at police prisons (including physicians visiting the police prison) are not aware of the right of persons deprived of their liberty to receive medical care at the detention unit according to permission by the physician provided by the police and at their own expense. Therefore, persons deprived of their liberty may not be informed about this right.

  The Deputy-Ombudsman has required that all persons deprived of their liberty must be informed of their right to receive medical care at detention facilities at their own expense.

  Follow-up:
  The National Police Board has instructed police departments that each person deprived of their liberty should be informed on arrival of their right to receive medical treatment at the detention facility according to permission by the physician provided by the police and at their own expense.

- Police prisons do not, as a rule, provide written information about the authorities who supervise their operations to give to the detained persons.

  The Deputy-Ombudsman has noted that the police prisons are not obliged under the Act on the Treatment of Persons in Police Custody to provide such information. However, under the Remand Imprisonment Decree, a list of authorities overseeing the operations of police prisons must be provided. The Deputy-Ombudsman finds it a reasonable requirement that all persons deprived of their liberty have access to a list of authorities overseeing the operations of police prisons while at the police detention facilities.

  Follow-up:
  The National Police Board instructed police departments to provide, in police prisons, a written list of the main authorities overseeing the operations of police prisons. The list can be given to a person deprived of their liberty if necessary. The list was appended to the circular.

Preparing and training for the appeals process

- It has been noted during visits that police prisons are not prepared for the application of the regulations regarding appeals under the Act on the Treatment of Persons in Police Custody, which concern, for example, the possession of personal property. No forms required for decision-making or instituting an appeals process were available at the detention facilities.

The Deputy-Ombudsman has recommended that training on the appeals process and the availability of forms used in the appeals process be improved.

Follow-up:
The Deputy-Ombudsman drew attention to the police prison personnel's obligation to be informed about statutory decision-making and appeals processes. Moreover, forms required in the appeals process should be made available at police prisons. A template of this form was appended to the circular.

Protection of privacy / confidentiality

- The security camera did not respect the right to use the toilet in privacy.

The Deputy-Ombudsman stated that privacy when using the toilet was an issue that had drawn attention during legality oversight, and that the National Police Board has also demanded that this privacy be respected. The Deputy-Ombudsman recommended that security cameras be positioned so that the toilet can be used in privacy. At the same time, however, care must be taken not to compromise security and to make sure that the guards are able to monitor the detained person.

Follow up:
The National Police Board has instructed police departments on the use of camera surveillance so that the cameras must be positioned in the detention facilities so that persons deprived of their liberty may use the toilet in privacy.

- The confdentiality of information was compromised in a number of police prisons in a situation in which a person deprived of their liberty was obliged to speak with their legal counsel over the phone so that the guard was able to overhear at least the detained person's side of the conversation.

The Deputy-Ombudsman stressed that under the Act on the Treatment of Persons in Police Custody, phone calls between a legal counsel and their client may not be listened to. The conditions must be arranged so that the confidentiality of phone calls between a legal counsel and their client can be guaranteed.

Follow-up:
According to the instructions of the National Police Board, phone calls between persons deprived of their liberty and their legal counsel must be arranged so that the confidentiality of the phone calls can be guaranteed with certainty by using, for example, a Bluetooth headset.

- A health-care professional had not been provided with a consultation room to meet with a person deprived of their liberty. Usually the consultation takes place in the cell of the person deprived of their liberty, and the health-care professional is accompanied by a guard for security.

The Deputy-Ombudsman recommended that the guards at the police prison pay particular attention to a person's right to privacy when receiving medical care or an examination. This right should be respected without the person deprived of their liberty having to ask to see a health-care professional without the guard present. When security concerns require the presence of a guard, the situation should be arranged in collaboration with the care staff so that the right to privacy of the person deprived of their liberty is compromised as little as possible. The Deputy-Ombudsman recommended that when planning the future renovation of a detention facility, the question of providing a consultation room for health-care professionals be resolved so that they could consult with their patients outside the cells.

Follow-up:
The police department responded that a separate consultation room would be added in conjunction with the next major renovation. The police department will also instruct the police prison staff to pay special attention to detained persons' right to privacy when receiving medical care.

Restrictions on communication

- It became apparent on reviewing the documentation in many of the police prisons that the grounds for the restriction of communication imposed by the police were often insufficient or nonexistent.

The Deputy-Ombudsman stressed that when imposing restrictions on communication, the specific grounds for the restrictions must be documented.

Follow-up:
The police department responded that the decision on the restriction of communication is made by a police officer authorised to make arrests. The police department had urged heads of investigations and general managers to be more accurate and specific and to make sure that the grounds for a decision are correctly and fully recorded on the coercive measures form. The implementation of training and guidelines in practice will be monitored through line manager supervision and inspections carried out by the legal unit of the police department.

Outdoor exercise and outdoor facilities

- The outdoor facilities in police prisons are often very modest and sometimes unsuitable for outdoor activities. In one of the police prisons visited in 2017, the exercise yard was an unfurnished concrete-based space with only a sliver of sky visible at the top. The exercise yard in another, renovated police prison that was visited during the year was a small cage next to the ramp leading up to the police prison. Physical exercise was not possible in the yard and the police prison had no other sports or activity facilities. One of the police prisons visited had no outdoor space at all.

The Deputy-Ombudsman stressed that the requirement under the Act on the Treatment of Persons in Police Custody to provide access to outdoor exercise is non-negotiable and the fact that a police prison does not have an exercise yard does not justify a deviation from the rule of one hour of outdoor time.

Alarm systems in cells

- A police prison had two temporary confined cell-type spaces, neither of which were equipped with an alarm system and one of which did not have camera surveillance. Based on the information obtained and observations made during the visit, the monitoring of the persons deprived of their liberty who were placed in the space without camera surveillance was not systematic or coordinated.

The Deputy-Ombudsman stated that both spaces failed to comply with the non-negotiable requirement of the Act on the Treatment of Persons in Police Custody for an alarm system that a person deprived of their liberty may use to contact staff.

Follow-up:
The police department responded that the plan was to equip the temporary detention spaces with alarm systems in conjunction with the upcoming renovation of the police prison. Owing to delays in the renovation, the police department had prioritised more urgent and pressing alterations, which were scheduled to be completed by the end of 2017. Alarm devices are among these alterations. Prior to such installation, the staff are instructed to place persons deprived of their liberty in other spaces. If this is not possible, the monitoring of the persons detained in these spaces must be regular and systematic.

Treatment and conditions

- It was brought to the attention of the NPM during interviews with persons deprived of their liberty that the lights in their cells had not been switched off for the night despite their requests. According to police prison rules, lights must be out during the night unless security reasons necessitate that they are kept switched on or the person detained requests otherwise. In another police prison, the security cameras had been fitted with motion detectors during the prison renovation, and cameras would operate even if the room was dark. Usually, however, in these cells, which were mainly used for intoxicated persons, lights were kept at least on low during the night.

- Interviewed persons who were deprived of their liberty said they were allowed to shower approximately three times a week, while in another police prison the detained persons were able to shower once a week, and in another police prison only on request.

  ↳ The Deputy-Ombudsman stated that, in line with the principle of normality, persons deprived of their liberty should, as a rule, be able to shower once a day. He found it reasonable that persons deprived of their liberty are offered the opportunity to shower every day.

  Follow-up:
  The National Police Board has instructed police departments to aim to arrange the opportunity for detained persons to shower daily.

- Persons deprived of their liberty were given breakfast items the previous evening, although the breakfast included perishable food.

  ↳ The Deputy-Ombudsman recommended that breakfast be served in a manner that is compliant with the food legislation.

  Follow-up:
  The National Police Board has instructed police departments that they should organise the serving of breakfast and the evening snack so that any perishable products can be kept in the fridge until they are consumed. Breakfast that includes perishable foods cannot therefore be distributed to the cells the day before, for example, when serving dinner.

- The NPM noted that one of the cells was untidy and, in particular, that the person deprived of their liberty was keeping food on the floor, even next to the toilet seat.

  ↳ The Deputy-Ombudsman regarded the way the food was stored as unacceptable.

  Follow-up:
  The police department responded that the daily routines in the police prison have been changed so that persons detained in the prison are urged to tidy up their cells daily. The cells of long-term detainees are cleaned by a professional cleaner.

- Remand prisoners are provided with fabric bedlinen, but it was noticed during a visit that a remand prisoner who had been detained at the police prison for more than a week was still using disposable bedlinen, and he also said that his cell was cold. The NPM raised the issue during the visit with a guard, who provided a duvet and fabric bedlinen. In another police prison, a remand prisoner had no sheets and the guard was asked to provide him with sheets. In the same police prison, the pillows, mattresses, and blankets were discovered to be extremely dirty.

The Deputy-Ombudsman stated that dignified treatment and the principle of normality require that mattresses, pillows, and blanket must be clean and that persons deprived of their liberty need not sleep without clean bedclothes or with bedclothes used by the previous detainee. The Deputy-Ombudsman recommended that the police department ensure that all persons deprived of their liberty are provided with clean bedlinen.

Follow-up:
The police department responded that the dirty bedclothes had been disposed of. Furthermore, the practices in the prison had been changed so that disposable paper sheets are no longer used as a rule, since they are found to protect the bedding poorly. In the new practice, persons deprived of their liberty are provided with fabric sheets on arrival.

According to the National Police Board guidelines, changing the sheets should not be left to the remand prisoner's own initiative. The guards should proactively ensure that remand prisoners and other persons deprived of their liberty have clean and undamaged bedclothes to use, and that the sheets are regularly changed.

Health care

- Only a few police prisons have their health-care personnel on site, which is why NPM have repeatedly drawn attention during its visits to the standard of training given to the guards in the distribution of medicines. The general observation is that guards are not trained in or introduced to this duty.

The Deputy-Ombudsman has considered the prevailing situation problematic and has stressed that the matter is not only relevant for patient safety but also for the employee's legal protection and occupational health and safety, as the person participating in the administration of a pharmaceutical substance is always personally responsible for their actions. It is the responsibility of the employer to ensure that their staff is appropriately trained in their duties.

Follow-up:
The National Police Board has informed police departments that all guards serving at police departments will undergo obligatory medicine distribution training during spring 2018.

- Observations have also been made during visits on the storage of medicines, and it has been noted that the practices vary.

The Deputy-Ombudsman recommends that police prisons comply with the principles laid down in the relevant guidelines of the National Institute for Health and Welfare (THL) concerning safe medication practices.

Follow-up:
The National Police Board has instructed police departments to store the medicines for persons deprived of their liberty in a locked cabinet or locker so that they cannot be accessed by unauthorised persons.

- The standard of record-keeping on the storage and distribution of medicines also varies between police prisons.

The Deputy-Ombudsman has recommended that appropriate notes are taken on all handling of medicines.

Follow up:
The National Police Board has instructed police departments to keep a medicine log sheet or diary near the medicine storage cabinet so that appropriate notes are made of all actions related to the storage and distribution of medicines.

- None of the police prisons conduct health checks on persons deprived of their liberty on arrival, and their health is examined during detention on request only.

The Deputy-Ombudsman has recommended that police prisons should aim to arrange for all those who are detained for longer than 24 hours to see a health-care professional.

Follow-up:
The National Police Board has not given instructions to police departments on this matter as it is not a legal requirement, and has stated that police departments may continue providing health care services as necessary on a case-by-case basis.

3.2 Defence Forces detention facilities

In 2017, the NPM conducted four visits to the detention facilities of the Finnish Defence Forces. All of the visits were made unannounced. The visits were made to the facilities of the Armoured Brigade in Hämeenlinna and Riihimäki, the Kainuu Brigade and the Sodankylä facility of the Jaeger Brigade. At the time of the visits, no persons deprived of their liberty were being held in the detention facilities. In general, the detention facilities are rarely used: in the last six months, only one person had been detained in the Riihimäki facility; the highest number of detainees was in the Kainuu Brigade, where 13 persons had been detained in the previous 10 months. The most common grounds for detention were intoxication and desertion.

The treatment of person deprived of their liberty in Defence Forces facilities is governed by the Act on the Treatment of Persons in Police Custody. During these visits, attention was paid to the conditions and treatment of those deprived of their liberty, their access to information, and their security.

Each detained person undergoes an inspection on arrival, which includes taking notes on any illnesses and injuries. The withheld personal effects and the medicines of detained persons were kept in a separate box or a locked cabinet at all sites visited.

All visited sites had a policy of ensuring that the persons deprived of their liberty were provided with a compilation of relevant rules and regulations. The persons deprived of their liberty were allowed to take a copy of this information into their cells.

All detention facilities operated camera surveillance, in addition to which the status of the detained person was regularly checked in person by a member of staff. The interval between checks depended on the individual, ranging from every 10 minutes to every 30 minutes. All detention rooms had alarm devices, which were tested during some of the visits. Notes on the monitoring or measures taken during detention were entered into a guard report or similar log.

Some detention rooms have no windows and the level of their furnishing in general could vary, depending on whether the room was intended to be occupied by someone detained on the grounds of intoxication or criminal offence. The detention rooms included either a toilet or the person deprived of their liberty had access to one by pushing a call button.

Follow-up:
Following the Ombudsman's most recent visit, the Kainuu Brigade has addressed the issue of privacy when using the toilet.

None of the sites visited had separate outdoor areas for persons deprived of their liberty, and outdoor time was spent within the closed garrison compound. Access to the outdoors was typically arranged on request but, as a rule, all detained persons had the opportunity to spend one hour outdoors.

In 2017, no specific recommendations were issued regarding detention facilities. During the previous year's visit to the Karelian Brigade, however, it was noted that the facilities lacked the alarm device required by law that would enable a person deprived of their liberty to contact staff if necessary.

Follow-up:
According to the response of Defence Command Finland, the detention facilities at the Karelian Brigade have since been fitted with an alarm system.

3.3 Border Guard and Customs detention facilities

The Finnish Border Guard currently uses 15 closed spaces for the detention of persons deprived of their liberty. The facilities are typically shared by the Border Guard and Customs. Customs also has facilities for its exclusive use in three locations. These detention facilities are used for short-term detention before transferring detainees to a police prison, detention unit, or reception centre. The treatment of persons deprived of their liberty at Customs or Border Guard facilities is governed by the Act on the Treatment of Persons in Police Custody. The duration of detention in these facilities varies from one to several hours. The maximum detention time is 12 hours in all cases. The locations, standard and furnishing of the facilities vary. The Border Guard Headquarters have approved the rules for Border Guard's detention facilities and issued regulations for detention facilities. Similarly, Customs has approved of the detention facilities used by it and issued its own rules for its detention facilities. The scope of the Customs rules for detention facilities has been under an own-initiative investigation by the Ombudsman.

The NPM made a pre-announced visit to the detention facilities at the Niirala border-crossing point run by the North Karelia Border Guard District. The facilities are shared with Customs, in such a manner that one of the detention rooms is primarily reserved for persons detained by Customs. The Customs detention facilities did not, however, fulfil the regulations at the time of the visit, and all persons detained by Customs were taken to the detention facilities of the police. The plan was to renovate the facilities to meet the regulations and serve Customs by December 2017, when the rules for the detention facility and material for persons in custody were scheduled for publication. The idea is that, from that point onwards, Customs will be responsible for the supervision of detained persons deprived of their liberty in matters falling under the jurisdiction of Customs.

At the time of the visits, no persons deprived of their liberty were being held in the detention facilities. The detention room has rarely been used. In 2016, only one person, and in early 2017 one other person, had been detained by the Border Guard. The rules of the detention facility are available in Swedish, English, Russian, and Arabic. The rules include separate sections on those detained on the grounds of the Aliens Act and their rights. The persons deprived of their liberty are informed about their rights and obligations on arrival, and they are provided with a copy of the detention facility rules, listing the key legal provisions applicable.

As part of the security and arrival check, notes are also made of the person's possible illnesses and injuries. The withheld personal effects are placed in a locked cabinet.

The persons deprived of their liberty are monitored in the detention rooms with a recording security camera. The detained persons are also monitored in person in the detention room and through the hatch on the detention room door. The detention rooms are equipped with an alarm button that the persons deprived of their liberty can use to alert staff. The detention rooms have no windows and they are furnished with a bed. The rooms are fitted with fire alarms. There are toilets near the detention rooms that the persons deprived of their liberty may use. However, the facility has no shower facilities and the detained persons may use the showers in the staff facilities instead.

The outdoor area is at the front of the administrative building, and it is not protected or fenced off against outsiders. The persons deprived of their liberty have access to outdoors on request. The NPM was informed that, as a rule, everyone detained at the facility has the opportunity to spend time outdoors under supervision, but owing to the short duration of the detention, this possibility has not been used.

3.4 Criminal sanctions

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 operates 26 prisons. Prisoners serve their sentences in either 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 mainly focus on closed prisons. The average number of prisoners in 2017 was approximately 3,000.

Six prison visits were made in 2017, of which one was made to an open prison (Kerava). The visit to Mikkeli Prison was a follow-up of the visit of November 2016, during which grave legal violations had been observed. The Vantaa Prison visit included an accessibility assessment and a visit to the Vantaa unit of the Health Care Services for Prisoners (VTH). All of the visits were pre-announced, except for one.

The visited prisons and their capacity:
- Vantaa Prison (232 places)
- Kerava Prison (94 places)
- Vaasa Prison (59 places; 3 for women and 12 in men's open prison)
- Mikkeli Prison (110 places)
- Satakunta Prison, Köyliö Unit (76 places)
- Vantaa Prison (183 places)

In addition, unannounced visit was made of the detention facilities for persons deprived of their liberty and of their transportation at the Helsinki District Court.

Presented in the following are some of the observations made during inspection visits at prisons, and statements and recommendations based on them. Some of the observations and recommendations were not commented on by the visited institutions:

The treatment of prisoners and the general atmosphere in the prison

- Based on the observations made during the visit, the relationship and communication between the staff and the prisoners was good and unstrained. The atmosphere at the prison was calm. There were no signs of the mistreatment of prisoners or that they were not treated in a dignified manner. During the visit, the prisoners volunteered their opinion that the conduct of the staff was appropriate.

- In another prison, some of the foreign national prisoners felt that Finnish prisoners took a hostile attitude towards them, which restricted their interaction with the prison community. The NPM got the impression that if a foreign national prisoner wished to isolate themselves because of the nature of their crime or cultural factors, they may do so without much intervention from staff.

The Deputy-Ombudsman recommended that the lack of security that some foreign national prisoners experienced in prison should be addressed and that practices be adopted to intervene in a discriminatory atmosphere.

- When interviewed in private, both staff members and prisoners drew attention to the fact that preventing substance abuse in prison was difficult.

The Deputy-Ombudsman expressed his concern about the level of substance abuse in the prison. He pointed out that substance abuse by prisoners forms a risk for the security of enforcement and makes the situation difficult for prisoners who are attempting to lead a substance-free lifestyle. The Deputy-Ombudsman considers it essential for the Criminal Sanctions Agency to carry out a closer evaluation of the situation and take the necessary action. He finds it particularly pressing to assess the grounds on which prisoners are placed in a particular prison, the compartmentalisation of the prison, and the staffing. The Deputy-Ombudsman also emphasised that the measures taken to improve prisoner safety should not lead to a deterioration in the prisoner's living conditions, such as the possibility to spend time outside their cell.

Information given to prisoners

- The prisoners should be aware of the authorities who oversee the operations of prisons. The Central Administration Unit of the Criminal Sanctions Agency has drawn up a list of the relevant authorities and sent it to all prisons, to be posted on a noticeboard in prison wards or in another visible location.

In the case of two prisons, the Deputy-Ombudsman recommended that the prisons make sure the contact details of supervisory authorities are updated.

Follow-up:
The prison reported that new lists of the contact details of supervisory authorities and the authorities supervising prisoners' health care services had been provided in Finnish, Swedish, and English on the noticeboards in each ward.

- Prisoners must have access to legal provisions relevant to imprisonment, as well as information about the activities and practices in the prison, to ensure their awareness of all relevant information.

The Deputy-Ombudsman found in the case of two prisons that neither the prisoners nor the prison officers were aware of where the provisions could be accessed. In addition, the prisoners should be handed a guide for new prisoners, the prison rules, and the daily programme of the ward on their arrival. The best way for prisoners to be aware of relevant information is to have their personal copies of the necessary documents. The Deputy-Ombudsman recommended that the prison properly establishes who is responsible for the guidance of new prisoners and provides them with the necessary documents.

Follow-up:
The prison responded that there were now folders in each ward containing the regulations and house rules relevant to the prisoners, as well as a list of guidelines and regulations issued by the Criminal Sanctions Agency and a note that all the materials were available in personal copies. The guide for new prisoners was being updated, and in the future it will be handed out to all new prisoners on arrival. In addition, it will be verified that each new prisoner is given an entrance interview and induction.

The position of female remand prisoners

- A prison had reserved places in the closed ward for three female remand prisoners in two cells; one of the cells could be shared by two remand prisoners, if necessary. The cell for two prisoners was found to be quite confined even for single occupancy, and there was no door between the room and the toilet in the cell. Furthermore, the women had no separate outdoor area designated specifically for them. In the dialogue between the NPM and the prison director it was agreed that, in practice, the detention of female remand prisoners was identical to isolation.

The Deputy-Ombudsman stated that the Remand Imprisonment Act requires that remand prisoners are treated with dignity. Staying confined in a small space for nearly 24 hours a day together with another person does not meet the criteria of dignified treatment. The appropriate treatment in prison also includes the right to use the toilet in privacy. The Deputy-Ombudsman recommended that the toilet be separated from the rest of the room by a door or a screen. In the view of the Deputy-Ombudsman, the cells reserved for female remand prisoners should be used for single occupancy only.

Follow-up:
The prison responded that the Criminal Sanctions Agency had taken the decision to allocate only two female prisoners to the unit in the future. Currently, each cell has only one bed. According to the prison, the toilet doors were being painted and repaired at the time of the visit, and they had since been reinstalled.

The Deputy-Ombudsman found that placing female remand prisoners in facilities such as these was unacceptable and should be discontinued. If the purpose is to provide places for female remand prisoners

in the prison in the future, their living conditions, opportunities to spend time with other female remand prisoners, and access to free-time and other activities should be appropriately arranged in equal measure to male prisoners. The Deputy-Ombudsman noted that the prison's resources to address the matter were small. Ultimately, the question concerns the allocation of prisoners and remand prisoners, which falls under the remit of the Criminal Sanctions Agency and the Ministry of Justice, respectively.

Follow-up:
The prison responded that the Criminal Sanctions Region would be putting forward a proposal that the prison no longer be used for holding female remand prisoners.

Based on the report by the Central Administration Unit of the Criminal Sanctions Agency, the placement of remand prisoners in institutions is currently under wider assessment, since the legislative amendment entering into force on 1 January 2019 will significantly reduce the period for which a remand prisoner may be detained in police custody. The implementation of the law is being prepared by a taskforce whose responsibilities include establishing which prisons and regions are likely to receive higher numbers of remand prisoners and ensuring sufficient capacity. The taskforce is looking to identify means by which the conditions and legal protection of remand prisoners could be improved while acknowledging the requirements of successful police investigations.

The position of minor prisoners

- At the time of the visit, the prison did not hold minor prisoners, but the NPM were informed that it would be impossible to keep minors separate from adult prisoners. Under the Imprisonment Act and the Remand Imprisonment Act, prisoners/remand prisoners under the age of 18 must be kept separate from adult prisoners/remand prisoners unless some other arrangement is in the minor's best interest.

According to the established legal praxis of the Ombudsman, the reason for placing minor prisoners separately from adult prisoners is to ensure their safety and protection. The possibility to deviate from this rule should be interpreted only very narrowly. Placing minor and adult prisoners together cannot be an established practice or the only option available. Minors should be provided with separate accommodation units with no access by adult prisoners. However, arranging for separate accommodation for a minor must not mean that the minor is placed in isolation. If minor prisoners participate in activities outside the cell together with adult prisoners, it is imperative that the activities are sufficiently supervised.

The Deputy-Ombudsman stressed that the placement of minor prisoners should be brought in line with what is required by law and international recommendations. Compliance with these regulations and recommendations appears to be very difficult, if not impossible, for prisons. The Deputy-Ombudsman found that it was also the duty of the Criminal Sanctions Regions and the Central Administration unit of the Criminal Sanctions Agency to take measures to address the problem.

The position of foreign national prisoners

- The prison was known to be a pilot institution for digital applications and the prisoners had, for example, the opportunity to make Skype calls. However, some of the foreign national prisoners were not aware of this possibility, nor do they have any other means of communicating with their families abroad. Based on the observations made during the visit, it appeared that some of the foreign national prisoners had not been adequately informed about the practices in the institution.

The Deputy-Ombudsman stressed that the right of foreign national prisoners to information should be respected in prison, including through interpreting services if necessary.

Follow-up:
The prison responded that all foreign national prisoners would be informed in the future about the possibility to make phone calls abroad, including via Skype. The prison will increase the use of interpretation services in the introduction of prison rules and practices.

- In another prison, it seemed that some of the foreign national prisoners had not received proper induction into the practices of the ward, which was partly due to a lack of interpreters in the induction situations.

The Deputy-Ombudsman recommended that the prison review the induction practices for foreign national prisoners and create routines to ensure that all prisoners receive sufficient induction.

Separating remand prisoners from other prisoners

- A remand prisoner unit had been established at the prison in spring 2017 with capacity for 8–10 remand prisoners. However, the actual number of remand prisoners ranged between 15 and 45 at any given time. Remand prisoners may, in certain circumstances, be placed in the same unit as convicted prisoners, provided that the conditions prescribed by law are fulfilled. It appeared that, even after the new unit was opened, the principle of arranging separate accommodation for remand prisoners was challenging to comply with.

The Deputy-Ombudsman stated that separating remand prisoners from other prisoners is a principle clearly prescribed by national legislation and international recommendations. It is integrally linked to the principle of the presumption of innocence. The Deputy-Ombudsman stressed that the law must be complied with in all operations, including these. The problem cannot be resolved by the prison alone, however, and collaboration with the Region Centre and Assessment Centre of the Criminal Sanctions Region, as well as the Central Administration Unit of the Criminal Sanctions Agency, will be necessary.

Accessibility in prison

- None of the facilities in the prison (e.g. visitor premises) had been installed with induction loops for persons with hearing impairment and there was no portable induction loop available.
- The special unit was virtually completely inaccessible for persons who use assistive mobility equipment.
- The prison had three cells designated for persons with restricted mobility or those using assistive mobility equipment Two of these cells were inspected and they were identical in furnishings and floor area. The cell and the toilet and shower room were more spacious than in a normal cell. However, the facilities were found to be lacking in several aspects and required improvement. For example, the call button to alert the guard was too high for anyone in a wheelchair. It was also stated that, for prisoners with restricted mobility, an alarm button on the wall is not sufficient, as they must be able to call for assistance in situations when they are unable to access the alarm button (e.g. using a handheld alarm device). The handheld hose on the bidet shower was too short to reach the toilet seat, and it was cumbersome to use as the tap and the basin were far from the toilet seat. The call button in the toilet and shower room was on the rear wall and it could not be reached from the toilet seat.

The Deputy-Ombudsman recommended that the Central Administration Unit of the Criminal Sanctions Agency should consider the observations made by the NPM when designing and renovating prisons.

The isolation cell at Vantaa Prison is not suited to those with severe disabilities and using physical aids (left). The cells for persons with disabilities are spacious but the alarm button in the toilet was out of reach.

Conditions in isolation premises

- The isolation cell of the prison was unfurnished, with only a thin mattress on the floor. The isolation cell was also used for the enforcement of the disciplinary measure of solitary confinement. According to law, solitary confinement should not involve any tougher living conditions than normal imprisonment, such as an unfurnished cell in which the prisoner is obliged to sleep on the floor and is not able to

eat while seated at the table. In another prison, there was a specific cell for solitary confinement, with a concrete bed, chair, and table, in addition to an isolation cell with no furnishings. It appeared that the prison had no fixed policy on which of the cells was used for solitary confinement. One foreign national prisoner who had been placed in isolation because of the risk of self-harm told the NPM that he had refused food because he did not want to eat from the floor.

The Deputy-Ombudsman found that solitary confinement must not be enforced in conditions similar to an isolation cell. Similarly, while a prisoner is segregated for the purpose of investigating a breach of prison rules, holding the person in isolation cell conditions is not appropriate unless the prisoner's behaviour exceptionally merits this. The Deputy-Ombudsman also stated that, as a rule, there are no grounds for not providing any furnishings in the cell, including fixed furniture, even from the perspective of isolation under observation or observation. The Deputy-Ombudsman stated that the isolation cell should not be used in any other situation than those in which the lack of furnishings is clearly justified.

Follow-up:
The prison responded that the place where disciplinary punishments are enforced had been changed and the punishment is now carried out in a normal cell from which the television has been removed. In the future, prisoners will be held in isolation cells only if their behaviour calls for isolation cell conditions. According to the prison, the isolation cell is not used for observation under isolation, as there is another cell for this purpose, which is equipped with a fixed bed.

- The isolation cell was equipped for camera surveillance and the prisoner was informed that when the red light on the camera was lit, the camera was in operation.

The Deputy-Ombudsman stated that camera surveillance in a cell violated the prisoner's right to privacy, and therefore its use is possible only under circumstances specifically referred to in law. Camera surveillance in a cell occupied by a prisoner is possible only as a safety measure. A person in solitary confinement cannot be monitored through a security camera. The Deputy-Ombudsman commended the fact that the prisoners were able to see for themselves whether or not they were under camera surveillance. The Deputy-Ombudsman recommended, however, that the use of the cell for disciplinary purposes be discontinued, because the presence of the camera alone was likely to create distrust in prisoners.

Follow-up:
The prison responded that the unfurnished cell with a security camera was used only when there were good reasons for it. In these cases, the prisoner is informed that they will be able to see when the camera is operating. Camera surveillance is not used any more than is necessary.

- The security camera had a direct view of the toilet seat in the isolation cell.

The Deputy-Ombudsman stated that it is not acceptable, even in situations where the camera surveillance of a prisoner is legal, to subject a person to surveillance while using the toilet. This is acceptable only when a prisoner is placed in isolation under observation, or in other words, when there is reason to suspect that the prisoner has prohibited substances or items in his body. In these cases, the aim must be to allow at least some privacy when the prisoner is using the toilet. In many prisons, the security camera view of the toilet seat is blurred to allow privacy. The Deputy-Ombudsman recommended that the prison impose similar restrictions in their camera surveillance practices.

Segregated accommodation at the prisoner's own request

- The prison had made no documented decisions on a prisoner's segregation on their own request, although it became apparent that prisoners had been placed in the isolation cell of their own will. The placements had lasted a maximum of four days.

The Deputy-Ombudsman stated that, under the Prison Sentences Act and the Remand Imprisonment Act, a prisoner must be given the opportunity to live entirely or partially in segregation from other prisoners, if he or she has a well-founded reason to believe his or her personal safety is otherwise at risk. The rights of the prisoner may not be restricted any more than what inevitably follows from segregation. However, the law does not recognise isolation that takes place at a person's own request. The Deputy-Ombudsman noted that the due decisions had not been made in the prison to keep prisoners of different status separate. The Deputy-Ombudsman emphasised that the isolation unit was not intended for long-term accommodation and that segregation at the prisoner's own request did not mean that the prisoner may be placed in an isolation unit.

Temporary cells

A temporary cell is intended only for the short-term accommodation of prisoners arriving in or departing a prison. Temporary cells are also used on overnight trips to court proceedings or during transfer to another prison.

- The prison had three cells for temporary accommodation (so-called "travelling cells") with 4–6 beds in each. These cells appeared quite small, considering the number of beds, and did not comply with the regulations laid down by the Central Administration Unit of the Criminal Sanctions Agency (5.5 square metres per individual). According to the regulations, temporary cells are not considered as accommodation spaces and they may not be used for permanent accommodation. In reality,

however, prisoners are accommodated in them for long periods of time. According to the prison officers, the temporary cells are used for accommodation because the units are full.

The Deputy-Ombudsman stated that all spaces used for accommodation must be sufficiently spacious. The temporary cells were not suitable for long-term accommodation at their full capacity. The Deputy-Ombudsman stressed that the space requirements were particularly pressing in the case of temporary cells since the prisoners in the temporary cell unit were usually not allowed to spend time outside the cells. Temporary cells should not be used for managing the shortage of beds in the other units. Temporary cells can be used only for short-term placement if necessary, such as when a prisoner arrives in the prison or is preparing to leave.

Follow-up:
The prison responded that the unit is nearly always overcrowded. The prison and the Assessment Centre are unable to keep the numbers within the official limits, which inevitably affects the allocation of prisoners within the unit.

- The temporary cells in another prison were in poor repair. Drawings and writing on the walls added to the untidy appearance. In one piece of writing, a named prisoner was called a "snitch".

The Deputy-Ombudsman recommended that efforts should be made to keep the walls of the cells clean by, for example, painting them over more frequently. Writing mentioning prisoners' real names should be immediately removed.

- During a visit, the NPM interviewed a foreign national prisoner who had been accommodated in a temporary cell for nearly two months. The prisoner said he had asked on a daily basis to be moved to the other unit. The NPM was told that the reason for the arrangement was the fact that the prisoner did not smoke and there were currently no non-smoking cells free on the other units. On the basis of what the prison officers said, no information came up that would justify the accommodation of the prisoner in a temporary cell for such a lengthy period of time. The deputy director of the prison was notified of the matter, and he reported back during the visit that the prisoner had been moved to an other unit. As a result of this observation, further inquiries were made into the reasons for and the lengths of accommodation in the temporary cell.

The Deputy-Ombudsman noted that prisoners were not transferred from the temporary cells to the prison unit swiftly enough. The Deputy-Ombudsman stressed that the prison must organise the units so that the placement of prisoners is reassessed daily to avoid situations in which a prisoner spends a considerable length of time in a temporary cell.

Visitors

- The duration of supervised visits in the prison was 30 minutes, whereas in other prisons the duration varies from 40 to 60 minutes. According to the prison director, the duration of visits could not be prolonged.

  The Deputy-Ombudsman noted that visitors arriving to see a prisoner may be travelling far, so the duration of the visit was obviously of great importance. The visits cannot be too short, although there are no regulations on the minimum length of a visit. According to the report received from the prison following the inspection visit, the utilisation rate of the visitor centre varied so that there were often free slots during the morning visiting hours. In the Deputy-Ombudsman's view, this should give the prison the flexibility to prolong visiting hours where possible. The Deputy-Ombudsman stated that there were no grounds for the exceptionally short visiting times adopted in the prison, especially since the practice differed from that of any other prison.

Facilities for child visitors

- The room for supervised visits was long and narrow, with a long table divided by plexiglass in the middle and chairs as the only furnishings. There was also a small cabinet with children's toys, but otherwise child visitors were not catered for in the furnishings. Under the Imprisonment Act and the Remand Imprisonment Act, the supervised visits of a child must be organised in rooms intended for the purpose, and suitable facilities for the visits must be provided in closed prisons.

According to the Deputy-Ombudsman, the room for supervised visits did not meet the criteria laid down in the law regarding visitor facilities for child visitors. The Deputy-Ombudsman recommended that a more comfortable room that resembles a normal room be provided for child visitors.

Follow-up:
The prison responded that the visitor room had been repainted and fitted with sound insulation panels. More suitable furniture has also been ordered for the room.

- In another prison, the room used for child visitors had been furnished with children's needs in mind. The prison had also produced a picture book for visitors, especially children, so that the prisoner could talk about life in prison and explain the conditions they were in, which may help alleviate their family members' concerns and worries about the situation their loved one is in.

The Deputy-Ombudsman highly commended the picture book idea and hoped that this initiative would be adopted in all prisons.

The picture book was authored by two remand prisoners together with the prison psychologist and social worker.

Exercise yards and access to the outdoors

- The exercise yards of the prison had no rain shelters.

The Ombudsman has frequently raised the issue of the lack of rain shelters in prison exercise yards. The Deputy-Ombudsman stressed that the prison should encourage prisoners to spend time outdoors regardless of the weather, and that prisoners should have shelter against adverse weather. The Deputy-Ombudsman recommended that rain shelters are installed in outdoor areas or that the prison provides the prisoners with weatherproof clothing.

Follow-up:
The prison responded that the plans and cost estimates for building a rain shelter had already been made. The project had received funding and will be completed according to the agreed schedule.

- The prison was allocated a high number of remand prisoners, who were segregated pending criminal investigations. Arranging outdoor time for the prisoners was a challenge. There were only two time windows for outdoor exercise per day, one hour each, which seemed little compared to the number of prisoners (47 prisoners). Some of the prisoners used the exercise yard on the roof of the building. The exercise yard did not lend itself to any sports activities and was mainly used for standing and sitting outside.

The Deputy-Ombudsman stated that, in this case, it remained unclear why there were only two time windows for spending time outside and whether it had been considered how the outdoor times for prisoners could be increased. The lack of outdoor time also raised the question of how communication restrictions ordered by the court could be implemented in practice with such limited outdoor times. The Deputy-Ombudsman also noted that it would be reasonable and important to arrange the opportunity for those spending their outdoor time on the roof to occasionally visit the outdoor area in the yard reserved for prisoners in segregation.

Prisoner transport conditions

- A prison had acquired two new compartmented prison transportation vehicles, in which prisoners were placed in different compartments separate from other prisoners and officers. According to the prison officers, since the acquisition of the new vehicles, there had been no further need to restrain prisoners during transportation to and from the court.

The Deputy-Ombudsman stated that, under the Imprisonment Act and the Remand Imprisonment Act, restraining prisoners is possible only in individual cases based on consideration. The systematic policy of restraining prisoners without individual consideration when transporting prisoners from the prison in question to the court has long been raised as a problematic issue, and the policy has been found to be illegal. The Deputy-Ombudsman stated that with the new vehicles, the matter has finally been resolved in a satisfactory manner.

The participation of prison officers in the distribution of medicines

- Prison officers participated in the medical treatment of prisoners by distributing medicines. During the weekends, opioid substitution treatment medicines were distributed by criminal sanctions supervisors. Prison officers have received two different types of training in medicine distribution. The new prison officer training curriculum includes a separate module on medicine distribution, which corresponds to the training prescribed in the THL guidelines on safe medication practices in cases when medicines are dispensed by a person other than a health-care professional. Those who have not been trained under the new curriculum can complete an online training module on medicine distribution, but the module does not, in all respects, meet the criteria laid down in the THL guidelines. It also became apparent during the visit that there were prison officers working at the prison who had undergone neither of the training courses.

The Deputy-Ombudsman stressed that the training and guidance on medicine distribution is not only necessary for patient safety but also for the employee's legal protection and occupational health and safety. Every member of staff participating in the provision of medical treatment is always personally liable for their actions, even if the overall responsibility for a patient is with the attending physician.

The Deputy-Ombudsman stated that it was not possible, even following additional clarification, to determine whether or not the medicine distribution training for criminal sanctions supervisors meets the criteria for the training required for opioid substitution treatment, according to the THL guidelines on safe medication practices. Information obtained during the visits, and from incident reports illustrating how the guards distribute medicines in practice, left the impression that more attention should be paid to medicine distribution guidelines and training. The Deputy-Ombudsman stressed that the shortcomings in the training were, however, such that they do not only concern the prison in question, but probably the majority of prisons in Finland.

Mikkeli Prison

- *The follow-up visit to Mikkeli Prison* was conducted in order to review the measures taken to implement the Deputy-Ombudsman's recommendations and to identify areas that require further development. During the visit, the operations of the Criminal Sanctions Regional Centre for Eastern and Northern Finland were reviewed from the perspective of legality oversight.

The Deputy Ombudsman stated that the Regional Centre had neglected its duty to oversee the legality of the prison operations. The Deputy Ombudsman stressed that the Regional Centre must step up its legality oversight activities and provide the legal guidance and support required by the prison management.

Key changes observed during the visit

- A prison had made considerable changes to improve the availability of activities and to extend the time that the cells are kept open; these adjustments have changed the nature of the prison into a more open one. Relations between the prisoners and the staff appeared to have improved and the general atmosphere was calm.
- Remand prisoners had been allocated separate units and there was no further criticism to be made on their placement.
- The possession of trial documents was no longer restricted and the prisoners had the necessary opportunities to prepare themselves for their trial.
- The prisoners had at their disposal the provisions and regulations relevant to their situation, and these were also available in the most commonly used foreign languages.
- The prison had begun issuing administrative decisions, complete with instructions on how to appeal.
- The prison rules and practices regarding leave, disciplinary measures, and visitors were now similar to those of other prisons.
- Prisoners' access to the outdoors and sports activities, as well as to the library, had been improved.

Development areas

- Some deficiencies in decision-making regarding the possession of personal property were still identified.
- The operations of the reception ward still had room for improvement regarding the policy on the possession of personal property.
- There are no proper gym facilities.

Measures taken based on the recommendations issued after the follow-up visit

- The Criminal Sanctions Regional Centre has organised a training event for prison personnel on the appeals process and acceptable grounds for decisions on the possession of personal property.
- Prison officers had participated in the training organised by the Criminal Sanctions Regional Centre for personnel at reception unit. The operations of the reception unit have been reorganised.
- Attention has been paid to the educational background of new Senior Criminal Sanctions Officials to ensure that they have the necessary readiness to perform the administrative duties included in their managerial role.

- The staff attend workshops on prisoner induction.
- Arrangements for unsupervised visits have been improved by changing the booking process, and the cancellation rate of visits is also actively monitored.
- Access to exercise and the use of the gym has been increased and new exercise equipment has been purchased. A new, permanent role has been established for managing the prisoners' exercise activities.
- Guidelines have been issued on the use of isolation cells.

The detention and transportation facilities of persons deprived of their liberty at Helsinki District Court

- Attention was drawn to drawings on the cell walls, which gave the space an unkempt feel, as well as the persistent smell of cigarettes.

The Deputy-Ombudsman found that the cells should be kept in better repair by, for example, more frequent repainting. He also suggested, for consideration, that at least one cell be reserved for non-smokers, in which smoking is prohibited.

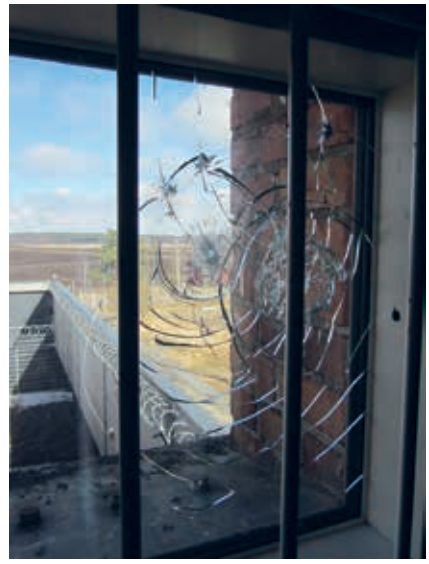
- There were additional smaller holding cells on different floors, which were used only when the cell unit were full. These back-up cells did not have alarm systems and at least one did not have a working light.

The Deputy-Ombudsman stated that these back-up cells were very small, even when taking into account that the persons deprived of their liberty would stay in these cells for short periods of time only, and they were used only occasionally. He stressed that it is always necessary to have an alarm system in all cells, including those intended for short-term accommodation, and even if the person deprived of their liberty is monitored from outside the cell. The lights in reserve cells should also be in working order.

- The room reserved for detainees and their legal counsel was divided into two with a partition, the upper half of which was made of plexiglass.

According to the Deputy-Ombudsman, meetings between a detainee and their legal counsel should, as a rule, be arranged in rooms where they are not separated by plexiglass. The Deputy-Ombudsman found it problematic that there was only one room for the meetings. He also found that it was unclear regarding the facilities at the District Court, whether they were governed by the criteria laid down in the Imprisonment Act and the Remand Imprisonment Act on the conditions and supervision of meetings with the legal counsel.

3.5 Alien affairs



There were approximately 13,500 asylum seekers in Finland at the end of 2017; they were housed in 56 reception centres. Under section 121 of the Aliens Act, an asylum seeker may be held in detention for reasons such as establishing his or her identity or enforcing a decision on removing him or her from the country. There are two detention units for foreign nationals in Finland, one in Joutseno and one in Metsälä, Helsinki. The detention unit at the Joutseno Reception Centre operates under the Finnish Immigration Service. The Joutseno Reception Centre had 30 places at the beginning of 2017, and by the end of 2017, 38 new places had been added. The most recent new places were added in January 2018. The Metsälä Detention Unit was operated by the City of Helsinki up to the end of 2017. On 1 January 2018, the Unit was transferred under the management of the Finnish Immigration Service. The Metsälä Detention Unit has 40 places; following the renovation of the unit, which was still ongoing at the end of 2017, its capacity was reduced by 30 places.

The reception centres have not been considered part of the remit of NPM supervision, and visits to the sites have been made under the mandate of the Ombudsman. However, the situation may change as a result of the amended Aliens Act. Regulations on the residence requirement and new protection measures related to the residence requirement applicable to children entered into force at the beginning of February 2017. A foreign national who has sought international asylum may be ordered to live at a specific reception centre and to report to the reception centre from one to four times a day. The criteria for placing an adult under a residence requirement are less strict than those for detention. Furthermore, a child must remain within the area of the reception centre in question. The criteria for placing a child under the residence requirement are the same as for the detention of a child, which makes the procedure an alternative to detention.

The Ombudsman does not oversee return flights in its role as the NPM, although this would fall under its jurisdiction. This is because the Non-Discrimination Ombudsman has been assigned the special duty of overseeing the removal of foreign nationals from the country. However, the Ombudsman has received complaints, such as the conduct of the police, regarding issues related to return flights for asylum seekers.

Some residents in reception centres and detention units may be victims of human trafficking, and recognising such residents is a challenge. A system of assistance for victims of human trafficking operates in connection with Joutseno Reception Centre. According to a press release by the Finnish Immigration Services, 127 new customers, representing 31 nationalities, were accepted by the system of assistance in 2017. Fourteen of the customers were minors. The number of customers of the assistance system grew by more than in any previous year. In total, the assistance system had 322 customers at the end of 2017.

The aim is to make regular visits to both detention units. The NPM visited the Joutseno Detention Unit in February 2017 and the Metsälä Detention Unit in December 2017. In addition, the Deputy-Ombudsman made an unannounced visit to the residential unit for unaccompanied minors in Kajaani.

Joutseno Detention Unit

The two-day visit to the Joutseno Detention Unit was pre-announced. An external expert in forensic psychiatry participated in the visit. During the visit, detained residents were interviewed with the assistance of Russian, Arabic, Turkish and Dari interpreters. The visit also included an introduction to the assistance system for victims of human trafficking.

Since the previous visit, the situation at the centre had changed in that it was now continuously at full capacity. Some foreign nationals were therefore being held in the detention facilities of the police. Another noteworthy observation was that an increasing number of the detained foreign nationals had arrived straight from prison. In many cases, the process of removing the person from the country had not been initiated while they were serving their sentence, but only after their release. This is not an acceptable practice, as it prolongs the actual period of detention. Presented in the following are some of the observations made during visits, and statements and recommendations based on them:

The exercise yard at Joutseno Detention Unit was relatively spacious and included activities for children.

Atmosphere

- Many of the detainees interviewed commended the conduct of the personnel and their treatment at the Detention Unit. One of the interviewees reported feeling unsafe, as there were detainees in the same unit who were guilty of serious criminal offences. NPM also witnessed the impact on the atmosphere of the increasing number of detainees being transferred to the unit directly from prison.

Uncertainty about legal status and dissatisfaction with the legal aid provided

- Nearly all interviewees had not been kept updated on the progress of the process of removing them from the country. Many were unaware of the grounds on which they had been detained and their legal status, as well as their future. One detainee mentioned that they had had no legal counsel at any point during the processing of their asylum and residence permit application. Many also said they had not understood the grounds of the negative decision they had received and only understood that their applications had been rejected. One of the interviewees had had a particularly bad experience with their legal counsel. The Detention Unit did not organise general legal advice for detainees.

The Ombudsman found that detainees who had been detained awaiting their removal from the country may require legal advice and assistance in matters related to asylum and residence permits. The Ombudsman stated that it was possible that an increasing proportion

of detainees have not been provided with legal advice during their process, or their vulnerable position has not been recognised. If the time between the decision and the enforcement has been prolonged, the situation or legal practices in the applicant's home country may have changed in a way that could be relevant to their case.

Follow-up:
According to the Finnish Immigration Service, the personnel at the Detention Unit had regularly organised general legal advice on different processes. Advice had been provided on request or if it had become apparent that a detainee was in need of legal advice. Furthermore, the introductory information given to all new detainees included specific sections on the detainees' right to legal aid and right to appeal, as well as the practical arrangements for legal aid. In the view of the Finnish Immigration Service, the general legal advice provided at the Detention Unit meets the legal criteria.

Camera surveillance in the seclusion room

- The NPM drew attention during its visit to the security camera in the shower space in the seclusion room. The bare upper part of the body of a person showering was visible in the camera view. The necessity of having a security camera in the shower room was discussed with the personnel.

Follow-up:
The Finnish Immigration Service responded that the camera angle in the shower room had been changed so that the upper part of the person showering is not visible. In addition, the shower room has a sign on the wall explaining what parts of the body are not visible in the camera. Having a security camera in the shower room is considered necessary for the safety of detainees presenting with thoughts of self-harm and to prevent vandalism.

The arrival medical examination and consent form

- The arrival medical examinations were routinely carried out but were not based on a standard questionnaire. The NPM introduced the arrival health-check forms that were in use in prison health care in different language versions. The health-care in the Detention Unit had introduced a form in which the detainee gives written consent to disclose certain personal medical data to the officers at the Detention Unit. The form was available in Finnish only.

The Ombudsman recommended that the arrival medical examination is carried out as soon as possible on the arrival of the detainee. In addition, any observations of signs that may be the result of physical or mental abuse should also be recorded, and the detainees should also be asked about the possible use of violence during their apprehension or transportation. It would be important to raise the issue of potential experiences of torture or other cruel or degrading treatment during the arrival interview.

The Ombudsman found the use of a consent form to be a good practice. He suggested that it be translated into several languages. This would guarantee that all detainees would genuinely understand – with the help of an interpreter, if necessary – what they are consenting to.

Follow-up:
The Finnish Immigration Service responded that the arrival medical examination is usually carried out at the Detention Unit within 24 hours of the detainee's arrival. With the existing resources, however, these arrival health checks cannot be conducted at weekends, as the health-care personnel are on duty on weekdays only. Furthermore, the majority of detentions are enforced during weekdays. If a detainee arrives at the Detention Unit during the weekend and presents with physical or psychological symptoms, medical care will be arranged by the duty personnel.

The new arrival interview form for the Detention Unit will be introduced in autumn 2017. Language versions of the consent form will be produced in conjunction with it.

Acknowledging "quiet customers" in health care

- Being detained inevitably causes increased anxiety in a person. This matter was raised on several occasions during the NPM visit, including the interviews with the detainees. It was also suggested that health-care providers, in particular, should pay attention to this issue, and that they should proactively maintain contacts with those who have been detained for a long period of time to monitor their health, even if they themselves are not seeking medical help.

Metsälä Detention Unit

The visit to the Metsälä Detention Unit was made unannounced. The focus of the visit was two-fold. Firstly, the visit was a follow-up on the previous visit of December 2016. The City of Helsinki Social Services and Health Care Division had reported to the Ombudsman in May 2017 on the measures raised in connection with the initial visit. On this occasion, the aim was to observe how well the Ombudsman's recommendations had been implemented in practice. The second main focus of the visit was to inspect health care provision. As a general observation, the detained persons interviewed by the NPM said that they were treated well at the detention unit.

Presented in the following are some of the observations made during the visits, and statements and recommendations based on them:

Uncertainty about legal status and dissatisfaction with the legal aid provided

- The City of Helsinki Department of Social Services and Health Care and the public legal aid of the City of Helsinki Legal Aid Office agreed at a cooperation meeting in summer 2017 to seek new ways of improving the provision of advice and information about detainees' legal status. The detainees reported during the visits that they continued to live in uncertainty about their legal status and that they were unsatisfied with the legal assistance they received. Based on the information received from the detainees, some had been provided with information on their rights and

obligation on arrival. However, none had signed any confirmation of receipt of this information, as required under the Act on Treatment of Detained Foreigners and the Detention Facility.

The Ombudsman recommended that the provision of effective, high-standard legal assistance at the Detention Centre be further developed. The Ombudsman also drew attention to the duty to inform newly arrived detainees of their rights and obligations, as well as of the rules and regulations at the Detention Centre. The information must be provided in writing, if possible, and in the person's native language or a language they understand. The information may also be provided orally. The detainee must confirm receipt of the information with their signature.

The standard of outdoor areas and suspected poor indoor air quality

- Since the previous visit of the NPM, an indoor air quality survey had been conducted at the detention centre. During the present visit, the facilities were undergoing refurbishment.

Follow-up:
According to the City of Helsinki, the potential and need for structural renovation of the outdoor spaces would be left for the Finnish Immigration Service to consider after the management of the centre is handed over to the state authorities in 2018.

Disruptions in the operation of security cameras

- The City of Helsinki agreed that deficiencies in the functioning of the security technology presented a major safety risk. The Finnish Immigration Service informed the City of Helsinki in autumn 2016 that it would take over the security arrangements at the detention centre. The plan was to upgrade the security camera systems during the refurbishment ongoing during the visit.

Activities supporting the life-management skills of detainees

- The City of Helsinki admitted that the staffing at the detention centre was no longer adequate for the provision of activities supporting the detainees' life-management skills, although this is required by the law. However, the average duration of detention has become substantially shorter over time, so there may be less need for such activities. The aim is to look into ways of increasing the provision of life-management activities through volunteer resources. The City of Helsinki responded that it would propose the Finnish Immigration Service carry out a thorough reassessment of the staffing requirements. The NPM learnt during the visit that the unit had organised some activities with the detainees, such as food-themed events.

Health care

- With regard to health care, the NPM was left with the impression that the staff were strongly committed to their care work and were keen to develop their practices, but that this was not possible owing to the shortage of resources.

The Ombudsman emphasised the particular role of health-care professionals in the prevention of ill treatment.

- According to the City of Helsinki, the implementation of requirements concerning the arrival medical examination and the daily consultations with a customer held in segregation with one duty nurse is a challenge. This aspect of staffing requires reconsideration when the Detention unit is handed over to the state administration. It became apparent during the visit that the arrival medical examination is still not automatically carried out on all detainees and, instead, the need for a check is assessed on a case-by-case basis. If a newly arriving detainee seems to be in poor health, they may be referred directly to a physician. Otherwise the medical examination is carried out within 3 to 4 days. The nurse interviewed during the visit was aware of the Ombudsman's recommendation, but because of the staff resources the medical examination for all new arrivals could not be carried out within the recommended 24 hours.

The Ombudsman reiterated his earlier recommendation on the medical examination. A health-care professional should meet all new arrivals at the detention centre and carry out a medical examination, subject to their consent. Examination should be carried out as soon as possible and always within 24 hours of arrival. This would also allow for the documentation of any signs of violence that a detainee may present. According to the Ombudsman, the Finnish Immigration Service will, in the future, be responsible for ensuring adequate staffing for the health-care services at the Metsälä Detention Unit.

- The identification and referral to treatment of victims of torture or other cruel or degrading treatment

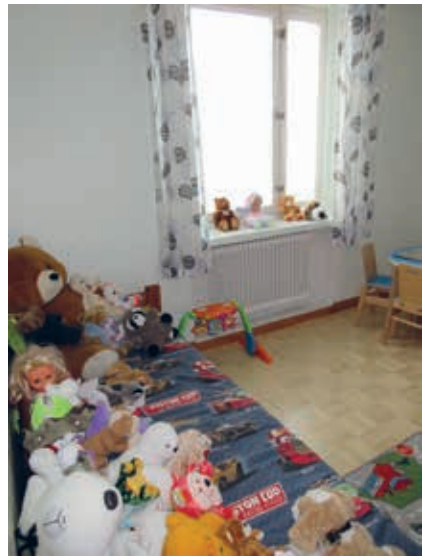
The Ombudsman recommended that, after the nurse has made a record of the injuries and a report from the detained person on how they sustained the injuries, the detained person is referred to a physician for immediate examination of the injuries and more detailed documentation.

The Ombudsman recommended that the arrival medical examination be based on a standard form or other template to ensure the consistency of interview outcomes. The Ombudsman recommended that the form contain a separate section for notes on signs of violence and questions presented to the interviewee on possible violence during their transportation or apprehension. It would be important to ask the interviewees at the arrival interview about their possible experiences of torture or other cruel and degrading treatment.

- The detention unit did not have psychiatric/psychological services available, and these services were outsourced. The Ombudsman had no statistics on how many detainees required services that the detention unit was obliged to provide.

The Ombudsman recommended that, if the demand for the services of psychiatrists or psychologists is constantly high, providing these services at the detention unit should be considered, as was recommended by the CPT following its 2014 visit to the Metsälä Detention Unit.

3.6
Social welfare / children's units



Foster care referred to in the Child Welfare Act is organised for children who have been taken into care, placed as an emergency measure, or placed under a temporary court order (children aged 0–17 years) in institutions, in family homes operating under a statutory licence, or in foster care. According to statistics compiled by THL, 6,300 children (mainly those taken into care) had been placed in institutions or similar places in 2016, 2,000 children had been placed in professional foster care, and 7,000 had been placed in foster family care. Under the Child Welfare Act, only children placed in an institution or similar place (including emergency placement) may be subjected to the restrictive measures referred to in legislation. Foster care may be provided by units owned by municipalities, or the municipality responsible for the placement may buy foster care services from units maintained by private service providers. Valvira only holds records on private providers of foster care. The total number of such units is 110 (69 service providers).

Visits by the NPM have been made exclusively to institutions or similar units. However, restrictive measures as referred to in the Child Welfare Act are also probably used in foster care within foster families. The situation regarding the supervision of foster family care under the mandates of the NPM or Ombudsman is unclear, as this would require inspections of private households. No such visits have been made so far, but the Ombudsman does have the opportunity to oversee foster care providers through the processing of complaints. All other supervision of foster families falls under the remit of local authorities, whose social service workers have the right to visit private homes.

As a rule, during visits to child welfare institutions the aim is to hear resident children before interviewing the personnel of the unit. The children interviewed are assured that they can contact the inspectors if they are subjected to disciplinary or other similar measures following the visit. The personnel are also reminded that any retaliative measures against the children are prohibited.

The visits are, as a rule, unannounced and usually last one day. The inspectors typically spend 10–11 hours on site. If the institution is paired with a school or if any issues arising during the visit so demand, the visit lasts two days, with the second day of inspection taking place within a week. The second day of inspection is pre-announced, with the children who have been interviewed also being notified. This has proved a useful practice, as by the second day, the children are more familiar with the inspectors and may encourage children who were unwilling or unable to speak to the inspectors on the first day to agree to be interviewed. The additional, second-day visits are regarded as part of the inspection and are not recorded as separate visits.

The visits focus on any restrictive measures to which the children may be subjected and the related decision-making process – including hearing the child and justifying the decision to use restrictions. In particular, the boundary between the restriction on movement and the right or restriction of communication seems unclear for many

within the field of institutional foster care. Nearly all institutions have had problems in communicating their decisions to children. There is also a lack of awareness of the difference between restrictive measures and acceptable childrearing methods. Restrictions may be imposed on the children as part of their normal upbringing, but most such restrictions require an administrative decision. During visits, it has been noted that arrangements for the psychiatric care of a child and collaboration between the institution, social services and health care are not always made in a manner that would be in the best interests of the child. Attention is also paid to the children's school attendance and the interest taken by local authorities in the tuition provided at the institution.

All the NPM visit reports are sent to the visited unit and the local Regional State Administrative Agency (AVI), which is responsible for the regional guidance and supervision of social services. The report is also occasionally sent to the National Supervisory Authority for Welfare and Health (Valvira), which is responsible for the national guidance and supervision of social services. A copy is always sent to the local authorities in the municipality responsible for the placement of the child. The Deputy-Ombudsman had also found it necessary to inform the social workers in charge of the placed children of the observations and recommendations made as a result of the visit. In addition, the Deputy-Ombudsman has required that social workers discuss the content of the report with the placed child.

The institutions tend to have a constructive attitude to the Deputy-Ombudsman's opinions and comply with the recommendations given. In most cases, they react to the observations and recommendations promptly, either while the visit is ongoing or upon receiving a draft copy of the inspection report. One example of this is an institution where the documentation of restrictive measures was incomplete or nonexistent. The director of the unit reported that documentation and its importance had been discussed with the staff immediately after the visit and the making of administrative decisions on restriction had been practiced. Staff will receive regular training in the future, to ensure that similar shortcomings in documentation can be avoided.

The NPM made 12 visits to child welfare units in 2017. In the case of one of the institutions, the initial visit was followed by a repeat visit after a couple months. All of the visits were made unannounced. The follow-up visit was pre-announced. Owing to the nature of the institutions, visits were also made outside office hours, for example on a Sunday. An external expert (a specialist in adolescent psychiatry) participated in one of the visits, which was made to a child welfare unit for children and adolescents suffering from neuropsychiatric disorders. In addition, one of the visits to a youth home for residents with special needs was attended by an expert by experience.

Children's and youth home Kimppa in Paltamo has a hobby space for a wide range of activities and some of the residents also attend hobbies outside the home.

The sites visited were:
- Peiponpesä, Hyvinkää (21 places, private services provider)
- Outamo children's home, Lohja (37 places, run by local authorities)
- Lukkarila children's home, Peräseinäjoki (7 places, private service provider)
- Nummela youth home, Lapua (4 places, private service provider)
- Harjulakoti, Kajaani (7 places, private service provider)
- Salmila children's home, Kajaani (14 places, run by local authorities)
- Kimppa children's and youth home, Paltamo (7 places, private service provider)
- Villa Junior, Ylöjärvi (7 places, private service provider)
- Honkalyhty, child welfare unit for children with special needs, Kangasala (7 places, private service provider)
- Varatie Tervakoski, Janakkala (16 places, private service provider)
- Tukikoti Tasapaino, Forssa (7 places, private service provider)

Presented in the following are some of the observations made during the visits, and statements and recommendations based on them:

Resources / responsibility for arrangements and costs

- The Deputy-Ombudsman pointed out that many of the deficiencies observed in the operations of the unit appeared to be the result of inadequate staffing.

The Deputy-Ombudsman took the initiative to investigate the personnel resourcing in relation to the children's care needs.

Atmosphere / treatment

- Each placed child interviewed during the visit conveyed a sense of satisfaction with the conditions, atmosphere, and staff at the unit. The children said they were happy at the unit, which was supported by the observations made during the visit.

The Deputy-Ombudsman stated that it is an elemental part of the standard of care that the children themselves find the atmosphere at the institution positive and that the staff members are able to build good, supportive relationships with the children.

The Deputy-Ombudsman drew specific attention to the vital obligation to provide appropriate, high-standard treatment of the children placed in the institution's care. Any poor, degrading or invalidating treatment or attitude shown by the staff towards a child merits immediate intervention through the means available to the management. The Deputy-Ombudsman also emphasised the importance of using appropriate language when conversing with a child or discussing their case.

The Deputy-Ombudsman stressed that children must be treated as equal individuals and that they must be addressed in a respectful manner.

Communicating information / decisions to children

- The inspectors were given the impression that some of the children were unaware of their rights, the rights and obligations of the institution, or the duties and responsibilities of their designated social worker.

According to the Deputy-Ombudsman, a child has the right, regardless of their age, to information on what the rights and obligations of the authorities or the place of foster care are, and, more importantly, what the rights of the child are. The Deputy-Ombudsman took the initiative to investigate how the children's right to meet their designated social worker and the children's right to information is honoured.

- Notifications of decisions on restrictive measures had been forwarded to the child's social worker and guardians, but it was not mentioned in any of the decisions whether the information had also been officially communicated to the child.

The Deputy-Ombudsman stated that the children themselves should also receive information on the decision on restrictive measures in the original or as a copy, and proof of receipt should be indicated on the documents. A child has the right to be informed in sufficient detail of the reasons leading to the restrictive measure, the purpose and the duration of the measure, and the practical implications of the decision in their particular case. They should also be advised on the possible filing of an appeal or obtaining appropriate legal advice.

Restrictive measures / disciplinary measures

- As one form of disciplinary measure used at the unit, the children were ordered to stay in their rooms, a method to which the inspectors of the municipality of residence had drawn attention on their visit; the punishment practices should be reviewed to ascertain that punishments are reasonable regardless of the ward or the staff on duty. The primary intervention is a discussion with the child.

The Deputy-Ombudsman drew attention to the importance of continuous assessment of the child's situation and the appropriateness of the nature and proportion of any disciplinary and educational measures adopted.

- The unit had the policy of imposing a 24-hour restriction of movement automatically for any unauthorised absences; the restrictions of movement were understood as educational restrictions at the unit.

The Deputy-Ombudsman noted that the grounds for the restriction of movement and its extent and duration must always be considered individually, and that a blanket decision on a day-long disciplinary restriction of movement is comparable to punishment. The Deputy-Ombudsman pointed out that the educational methods adopted must always be selected and scaled on an individual basis and that educational restrictive measures should never be used as a form of punishment or as a consequence of a child's behaviour.

The Deputy-Ombudsman stated that if the restriction of movement in practice means the restriction of communication, a separate decision on the restriction of communication must be issued.

- The unit had adopted a policy according to which a child could not attend school while under restriction of movement.

According to the Deputy-Ombudsman, such as policy is not based on the law and, as a rule, children should be given the opportunity to learn and participate in leisure activities as normal. The arrangements must always be based on individual consideration and the child's circumstances, while taking into account the grounds for the decision on the restriction of movement. The Deputy-Ombudsman took the initiative to investigate the decision-making procedures adopted at the unit for restrictions of movement.

The role of social workers

- It became apparent during the visit that some of the children's designated social workers met with their clients only rarely or never met with them one-to-one. Contact requests made by children are not always even responded to.

The Deputy-Ombudsman investigated on her own initiative in what ways the right of the children placed in the unit to private conversations and confidential meetings with their social workers, as required in the Child Welfare Act, is honoured in practice. The Deputy-Ombudsman took the initiative to investigate the manner in which social workers responded to contact requests and other messages sent by the children in their care.

- During an interview with a child who had been taken into care, it came to the attention of the interviewers that the child had been without a named designated social worker for months and that the child had not been allowed home for visits in nearly four months, owing to the lack of an up-to-date care plan.

The Deputy-Ombudsman took the initiative to investigate why the social services of the customer municipality had not ensured that the child had a designated social worker at all times. The Deputy-Ombudsman also decided to carry out a more general review of how the municipality in question ensured that the rights of the children in foster care were honoured and safeguarded.

The Deputy-Ombudsman found that, to better comply with and promote the rights of the child, both the institution and the social worker should preferably make a record on the documents concerning the child of when and how meetings with the child have taken place and whether the child was met one-to-one.

- Some of the social workers failed to submit the updated customer care plan to the institution in a timely manner at the beginning of the placement. As a result of such delays, some of the children were not able to leave for their home visits as had been previously agreed.

The Deputy-Ombudsman stressed that customer care plans should be shared with relevant institutions in a timely manner to ensure the appropriate arrangement of foster care. Delays in drawing up a care plan must not compromise contact and communication with the child.

Health care/right to privacy

- According to a psychologist at the unit, the pressing problems at the unit were the lack of children's rehabilitation assessment and that the local authorities did not provide the neuropsychological services that the children needed, as required by the Child Welfare Act. Yet nearly all of the children residing at the unit had some degree of an attention disorder or difficulty in language or learning.

The Deputy-Ombudsman took the initiative to investigate the adequacy and arrangements of neuropsychological services for children placed at the institution.

- Children placed in the unit were required to tell a staff member the reason for making a doctor's appointment, although this is a personal matter that the children have the right to decide on by themselves and that does not fall under the remit of foster care. In addition, the supervisor was often present during the appointment.

The Deputy-Ombudsman drew specific attention to the importance of respecting children's right to self-determination when receiving medical treatment.

The handling of the child's money

- According to the rules and practices adopted at the institution, children hand over their money to the institution for safekeeping, but the institution had no bookkeeping system or records on the use of the children's money.

The Deputy-Ombudsman drew attention to the importance of prompt and accurate procedures and documentation when handling children's money and requested the competent Regional State Administrative Agency to establish the use of the children's money in collaboration with the institution.

3.7 Social welfare services / units for older people

The goal is that older people can live at home with the support of the appropriate home-care services. When this is no longer possible, the elderly person moves into an institution or full-time care or residential unit, where they receive care round the clock, including terminal care. There are some 2,000 care units providing full-time care for older people in Finland. Visits are primarily made to closed units providing full-time care for people with memory disorders, and to psycho-geriatric units, where restrictive measures, such as locking the doors, using "back-zip" overalls, and chemical and other forms of restraint, may be used. The aim is to visit care units run by both private and public service providers within a given municipality. This allows for detecting any differences in the standard of care.

Social welfare and health care units, including services for older people, are under a statutory obligation to produce a self-monitoring plan. Such a plan includes all key measures taken by the service provider to monitor their operative units, the performance of their staff and the quality of the services they provide. Staff members have a statutory obligation to report any deficiencies in the care provided. The self-monitoring plan prohibits all retaliatory measures against whistle-blowers.

Visits to care units for older people always focus on the use of restrictive measures and their duration, documentation and the related decision-making. Another central theme involves ascertaining whether the care and treatment received by customers are respectful of their dignity. This aspect is particularly relevant when assessing the level of personal hygiene and arrangements for end-of-life care.

The purpose of the visits is to assess the level of health care and pain management, as well as physiotherapy/rehabilitation, oral hygiene and health care, nutrition and hydration, personal hygiene and the amount of outdoor exercise received by customers. The number of staff and the suitability of the facilities are also assessed. In addition, the inspectors examine how the customers' right to self-determination and privacy are guaranteed. Attention is also paid to the general appearance and atmosphere of the unit, the quality of indoor air, accessibility, and the availability of suitable stimuli. The inspectors review the training of the staff and the validity of fire safety and rescue plans.

The tone of the reports on the visits is qualitative, because the units are homes for their residents, who may be spending the final years of their lives in them. All reports are published on the website of the Ombudsman. The purpose of the publication is to inform the general public that the operations of a certain unit are being monitored. The reports also provide residents, family members and staff with important information on the observations made during the visit. It may also be requested that the inspection report be made available to the public on the noticeboard of the unit for a period of one month. The aim is that residents, family members, and other stakeholders are able to

draw attention to any shortcomings that have been overlooked, and to report these to the authorities.

The NPM has noticed a positive development trend in the standard of treatment and living conditions of the elderly. For example, the protection of privacy has improved: most residents in care homes for older people now have private rooms and bathrooms. The standard of care has improved, and less medication is used. The quality of food, the cleanliness of the facilities and the quality of indoor air have also improved. The most common deficiencies observed during visits involve lack of outdoor exercise, poor oral health, and lack of rehabilitation and activities. There have also been deficiencies in end-of-life care.

All visits made to care units for the elderly in 2017 were made under the NPM mandate. A total of 9 visits were made in 2017. All visits were made unannounced. Five of the units were run by private service providers.

The sites visited were:
- Viherlaakso service centre, Espoo (48 long-term residents, run by local authorities)
- Taavin muistipalvelukeskus, Espoo (46 residents, run by local authorities)
- Antinkoti, Helsinki (94 residents, run by a foundation)
- Kannelkoti, Helsinki (93 residents, run by a foundation)
- Arvola-koti, Kajaani (54 residents, run by an association)
- Menninkäinen care home, Kajaani (30 residents, run by a private family business)
- Aamurusko care home, Suomussalmi (14 residents, run by a foundation)
- Marttila serviced housing, Orimattila (45 residents, run by a joint authority)
- Timontalo serviced housing, Nastola (24 residents, run by a joint authority)

The recommendations presented in the reports are usually promptly implemented. Some key observations and recommendations made by the Deputy-Ombudsman based on the visits are presented in the following:

Atmosphere/treatment

- The relationship between the care personnel and the residents seemed close and the personnel were mindful of the residents' needs.

- As a positive observation, it was noted that the care plan included the resident's own views on the care and other services they received.

Restrictive measures

- It was considered a positive initiative that the use of back-zip overalls was going to be reviewed so that the use of restrictive clothing would always require a physician's decision in the future.

- When a person is subject to restrictive measures (e.g. bedrails, back-zip overalls), a documented decision on the measure must be made and the need for the continuation of the measure must be systematically reviewed. Restrictive measures must be discontinued immediately when there is no longer reason for them.

End of life care / privacy

- The patient's right to privacy and dignified end-of-life care was not implemented in rooms with four beds.
- It was problematic from the perspective of patient privacy that the doors had windows and that there was an unrestricted view into the rooms from the corridor.
- It was considered important that the unit be allocated additional resources for the night shift, since a nurse who is alone on duty is not able to provide high-quality end-of-life care.

Follow-up:
The social welfare boards report having taken measures to improve the protection of privacy or increase the number of staff in terminal care.

The use of toilets

- According to the nursing staff, the quality of adult diapers had deteriorated following the competitive tendering of suppliers.
- It was recommended that the residents are assisted to the toilets proactively on the nursing staff's initiative, to help maintain the functional capacity of the residents.

Oral health

- The care plans should have daily records of oral and dental hygiene, taking into account the importance of oral health to the general health of an elderly person.
- A dental hygienist should visit the unit to review the residents' oral health and provide training for the staff on appropriate oral hygiene.

Outdoor time

- There were no records of the time the residents had access to the outdoors, although the self-monitoring plan stresses the importance of outdoor activities in an elderly person's quality of life.

Antinkoti offers residential care with round the clock services for customers with memory disorders. Pictured is a spacious balcony with its many plants at Antinkoti.

- The unit did not organise daily outdoor time and none of the residents were able to go outdoors independently.
- The unit had allocated more resources to outdoor time year-round, and the implementation of the plan was monitored.

Accessibility / facilities

- The steep incline of the ramp at the entrance required action: especially in the winter, the ramp was difficult to negotiate for anyone using a walking frame.
- The safety and comfort of the staff, as well as the residents, requires adequate lighting on the premises.
- Accessibility extends to the use of websites. The joint authority for primary care should make it a requirement that the websites of serviced accommodation are more accessible, easier to use, and more informative.

Rehabilitation / activities

- Physiotherapy services for persons with memory disorders should be more frequent, to prevent the stiffening caused by memory disorders and to improve the persons' quality of life.
- The unit could offer more physical exercises to maintain and improve the functional capacity of the residents.
- As a positive observation, the unit employed two in-house physiotherapists, one of whom concentrated on serving the staff to counteract the physical strain of their occupation.

Viherlaakso service centre has a lumious fitness area.

- The NPM also commended the rehabilitative approach to care work and that regular activities and exercise were organised for the residents.
- The care of the residents focused heavily on medical aspects, which might lead to a situation in which there is insufficient time allocated to social interaction and stimulating activities.

Physician's services

- The attending physician visited the patients once a month, which must be considered inadequate considering the number of residents under intensified support (34 customer places).
- The doctor visited the care home only 4–5 times per year. This was considered a clear shortcoming, especially since these were the only opportunities to review the need for restrictive measures.

3.8
Visits to other social welfare units

The Ombudsman also makes visits to services centres and other centres for homeless substance abusers and mental health patients. The customers of these units form an exceptionally vulnerable group, which is why the Ombudsman finds it essential to review the conditions in which these persons live, what services they are offered, and how they are treated. The visits were made under the mandate of the Ombudsman because, as a rule, the residents of the units may not be subjected to restrictive measures.

The units visited during 2017 were all run by the City of Helsinki:
- The Hietaniemenkatu services centre (60 places),
- The Kulosaari support facility (22 places), and
- The Pakila support facility (28 places).

All visits were made unannounced. The visits did not lead to the taking of any action. Regarding the Hietaniemi Service Centre, however, the Deputy-Ombudsman stated that, when emergency accommodation is being arranged, those requiring and using the service should be provided with an appropriate place to sleep. The services provided (sleeping in dormitories, sometimes on a mattress) were suitable for accommodation only in exceptional circumstances, when other spaces were unavailable.

Pictures of the Kulosaari support facility.

3.9 Residential units for persons with intellectual and other disabilities

According to a goal of the 2012 government resolution on individual housing and services for persons with intellectual disabilities, no person with a disability should be living in an institution after 2020. It has been estimated that there are some 40,000 persons with intellectual disabilities in Finland. According to a statistical report compiled by THL (42/2017), there were 920 intellectually disabled residents in institutional care (191 of whom were minors). The number of long-term residents was 795 (131 of whom were minors). Long-term residents refers to clients for whom a decision has been made on long-term care or who have been in care for more than 90 days. The total number of units falling under the remit of the NPM – units where residents may be subjected to restrictive measures – is 856. Of these, 830 units offer full-time care (397 are run by private service and 433 by public service providers). In addition, 920 persons live in 26 units.

On visits to units providing institutional care and housing services for persons with disabilities, special attention is paid to the use of restrictive measures and the relevant documentation, decision-making, and appeals procedures under the provisions of the Act on Special Care for Mentally Handicapped Persons, which entered into force on 10 June 2016. According to the preliminary work on the Act, the restrictions must be highly exceptional and used only as a measure of last resort. If a person in special care repeatedly requires restrictive measures, it should be assessed whether the unit they are currently residing in is suitable and appropriate for their needs. The practices of the unit should always be assessed as a whole. Restrictive measures should only be resorted to when this is necessary in order to protect another basic right that takes precedence over the basic right subject to restriction. It follows from this principle that restrictive measures should never be used for disciplinary or educational purposes. The purpose of the visits is to assess the use of restrictive measures, as well as the living conditions and the accessibility and feasibility of the facilities, while appraising the attainment of the disabled residents' right to self-determination and the availability of adequate care and treatment.

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. For this reason, the Ombudsman also paid attention to the implementation of the rights specified in the Convention on his visits.

The number of residential units of intellectually and physically disabled persons visited in 2017 was 19. One of the units was a full-time residential unit for disabled persons. The other sites were units for intellectually disabled people. There were disabled residents under involuntary special care in three of the units visited. Most of the visits (11) were made unannounced. Three of the units were run by private service providers. One of the visits was made during the evening.

The sites visited were:
- Sirkunkuja residential unit (14 places), Kainuu social welfare and health care joint authority, Kajaani
- Leivola serviced housing (13 places), Kainuu social welfare and health care joint authority, Kajaani
- Pikkupihlaja institutional care unit (6 places), Eskoo social welfare joint authority, Seinäjoki
- Kotomarkki and Helakoti residential service units for intellectually disabled (20 and 21 places), Eskoo social welfare joint authority, Seinäjoki
- Tuulentupa and Neliapila institutional care units (19 and 20 places), Eskoo social welfare joint authority, Seinäjoki
- Vanamo children's and youth home (12 places), Eskoo social welfare joint authority, Seinäjoki
- Aurinkolahti group home (13 places), City of Helsinki Social Services and Health Care Division, Helsinki
- Turva, psychiatric examination and rehabilitation unit for intellectually disabled people (8 places), Rinnekoti Foundation, Espoo
- Annala group home for intellectually disabled children (10 places), Rinnekoti Foundation, Espoo
- Koivukaarre residential unit for disabled people (8 places), Betania children's home foundation, Suomussalmi
- Honkatähti intensified support unit (20 places), North Karelia social welfare and health care joint authority (Siun Sote), Joensuu
- Tuulikello inpatient services for disabled people (11 places), North Karelia social welfare and health care joint authority (Siun Sote), Joensuu
- Inpatient services for disabled people, Muksula – Pauliina – Majakka (16 places), North Karelia social welfare and health care joint authority (Siun Sote), Joensuu
- Leppälä residential unit (20 places), North Karelia social welfare and health care joint authority (Siun Sote)
- Luotain rehabilitation unit for adolescents (9 places), Vaalijala joint authority, Pieksämäki
- Jolla, residential unit for children with special needs (6 places), Vaalijala Joint Authority, Pieksämäki
- Satama rehabilitation unit for adults (20 places), Vaalijala joint authority, Pieksämäki
- Reimari rehabilitation unit for adults (10 places), Vaalijala joint authority, Pieksämäki
- Kaisla examination and rehabilitation unit for adults and a terraced house unit (10 and 3 places), Vaalijala joint authority, Pieksämäki

A physician specialising in intellectual disabilities participated in nine of the visits as an external expert. A specialist in intellectual disabilities and an expert by experience participated in five of the visits. An expert from the Human Rights Centre also participated in some of the visits.

Presented in the following are some of the observations made during the visits, and statements and recommendations based on them:

Atmosphere

- One of the units in the residential institution had an ongoing problem with violent altercations. During the visit, one of the residents exhibited restless behaviour. It was unclear how a single staff member could be expected to look after all five residents in the unit in such a challenging situation.

  The Ombudsman stated that, on the whole, special care units must be staffed by a sufficient number of social and health-care professionals and other personnel, regarding the nature of the unit's operations and the special needs of the persons in special care. The Ombudsman emphasised the employer's responsibility to ensure that restrictive measures are carried out only by personnel who have the necessary professional qualifications. The Ombudsman also stressed the employer's responsibility to provide suitable staff training so that staff are able to anticipate situations and avoid the use of restrictive measures.

- The atmosphere in the unit was calm and relaxed and no imminent threat of violent behaviour was present.

- The NPM noted that the operations and organisation of the unit had institutional features, although attempts had been made to make the unit home-like, with toys and wall paintings. However, all staff members, who were referred to as nurses, were dressed in nursing outfits.

  The Ombudsman noted that the unit requires active development to remove institutional practices and structures.

The relaxation lounge at the student hall of residence Luotain at Vaalijala competence and support centre.

Intervention in mistreatment

- The staff had a channel for anonymous feedback and suggestions in use, through which they could suggest improvements to the technical or visual features at the unit. A postbox had been provided for this purpose at the unit.

  The Ombudsman found this to be a good practice and recommended that the unit introduce a similar whistle-blowing system for suspected mistreatment of residents. The Ombudsman considered it essential that the management communicate to all employees that any incidence of poor treatment must be immediately reported to the management.

- It was stated in the self-monitoring plan that inappropriate treatment will be intervened in, following the procedures adopted by the joint authority, but no details of these procedures were provided.

  The Ombudsman stressed that the self-monitoring plan should include instruction for social services on the correct procedure if they detect or become aware of inappropriate treatment.

- As a positive observation, it was noted that the noticeboard of the unit provided instructions by the joint authority on the duty of social services to report any shortcomings or risk of shortcomings that they become aware of in the course of duty.

Restrictive measures and the use of restrictive equipment

- The residential unit used various devices (e.g. wristbands) to keep track of the movements of residents with memory disorders. The benefit of this equipment is that the movements of other residents need not be restricted and the doors of the unit need not be locked from the inside.

- A resident was restrained by his hands to a bed or wheelchair nearly round the clock, as he otherwise harmed himself by tearing and scratching at his ears and eyes. At meal times, the restraints were removed, but the resident's legs were restrained with Velcro® straps to prevent kicking, and he wore a helmet. As an alternative to restraint, the external expert of the NPM mentioned special observation, in which the resident is continuously accompanied by a nurse, and the use of weighted blankets when nurses are not available for special observation.

  The Ombudsman drew attention to the provisions of the Act on Special Care for Persons with Intellectual Disabilities, under which a person can be restrained only if other measures prove inadequate. A person may be physically restrained for the necessary period of time only, and for no longer than eight hours in total, continuously or repeatedly, during which time the physician in charge must reassess the criterias for physical restraint at least every two hours. In addition,

when a person is restrained, his or her condition must constantly be monitored so that a health-care professional is in visual or aural contact with the restrained person.

The Ombudsman also pointed out that the decision on the repeated use of restrictive instruments or clothing in serious dangerous situations must include a record of the maximum period of time restrictive instruments or clothing can be applied at one time. Moreover, the decision must include the reasons why other available methods are not appropriate or sufficient in the given situation. The application of restraint must also be reported to the Regional State Administration Agency within two weeks.

The Ombudsman considered it important that the residential unit immediately take measures to bring the treatment of the resident into compliance with the law. The unit should consider without delay the reasons that have led to the use of restrictive measures and examine methods by which the long-standing policy of regular restraining of residents could be discontinued. The Ombudsman requested that the competent Regional State Administration Agency continue the investigation.

- The review of documentation revealed that the doors of a resident's room had been kept locked on several nights for approximately 12 hours.

The Ombudsman stressed that the Act on Special Care for Persons with Intellectual Disabilities allows the locking of a person's own room for the night for a maximum of eight hours.

- One unit providing institutional care and two residential units providing intensified support used cage beds for some residents with intellectual disabilities. The residents in the institutional unit were minors.

The final statement and recommendation of the Ombudsman regarding the cage bed remains pending. The CPT categorically objects to the use of a cage bed, regardless of the length of time for which it is used.

The cage bed that was in use in the inspected unit.

Isolation facilities and their furnishings

- The residential unit had no separate secure or seclusion room Challenging and physically violent situations are resolved through other methods.

- The NPM drew attention to the furnishings of the secure room in the group home and the mattress on the floor, which was protected by a rescue sheet that had been attached with duct tape. The secure room had no direct access to the toilet or shower facilities.

The Ombudsman stated that dignified treatment and a good standard of care require that a person held in isolation must always have access to a toilet, and they should be proactively offered the possibility to use the toilet without having to ask. For this reason alone, a person should be able to contact a member of staff without delay. In addition, the seclusion room should have a clock so that the person in seclusion can keep track of time.

Follow-up:
Following the Ombudsman's visit, the unit reported that the secure room had been fitted with a mattress that meets the safety requirements.

Decision-making

- The NPM visited the unit run by a private service provider and noted that no appealable decisions had been documented, as required by the Act on Special Care for Persons with Intellectual Disabilities, although there had been situations in which it had been necessary to restrict the residents' right to self-determination. Based on the report provided by the unit, no expert assessments on the necessity and application of restrictive measures had been made, as required by the law, although the unit had applied restrictive measures since early 2016.

The Ombudsman observed that there were substantial shortcomings and deficiencies in the decision-making procedures of the unit and the prompt provision of expert assessments, which required immediate remedy. The Ombudsman drew specific attention to the documented cases of negligence and decided to conduct, on his own initiative, an investigation into the decision-making process for the use of restrictive measures in the unit.

Standard of accommodation

- Each resident had their own room, but the toilets were located along the ward corridor.

The Ombudsman found it a deficiency that the rooms did not have bathrooms and toilets.

Right to self-determination/opportunities for participation/access to adequate assistance and care

- The municipal social services operate a resident council, the aim of which is to improve communication between residents, families, and the staff at residential units. Each residential unit is represented in the council and the members include persons with intellectual disabilities and their family members.
- The residential units regularly collect feedback from the residents and their families. Development areas are selected based on the feedback.
- The weekly programme includes outdoor time every day, and records are made of time spent outside.
- Arrangements for year-round outdoor time for the residents are inadequate.

The Ombudsman stressed the importance of daily outdoor time and that adequate access to the outdoors was part of good basic care, as well as dignified treatment. The Ombudsman recommended that outdoor time is included in the residents' care and service plan.

Protection of privacy

- A residential unit has a recording security camera in the common facilities.

The Ombudsman drew the unit's attention to the fact that although the residential unit was fitted with security cameras, using them in an open-care residential facility was not necessary and might even be questionable from the perspective of the residents' right to privacy.

- A unit offering long-term institutional care for ageing persons with intellectual disabilities had allocated all patients to single-occupancy rooms, with the exception of one room that had two occupants.

The Ombudsman drew attention to the lack of privacy in double-occupancy room.

- Visits by the family and friends of the residents were organised outside the unit to protect the other residents' privacy.

- The separate building, which formed a part of the unit, had a non-recording security camera. Two cameras were installed in the common living and dining room so that no blind angles remained. In bedrooms, the camera view extended approximately one metre inside the room, and the bed area was not in view.

The Ombudsman drew attention to the Supreme Administrative Court decision (KHO 2017:132), according to which it is not permitted, under the Act on Special Care for Persons with Intellectual Disabilities , to use camera surveillance in a room for personal use by a person with intellectual disabilities, or in toilets.

3.10 Health care

In the health care sector, an accurate number of health-care units that fall under the NPM's mandate is unavailable. Information has been requested from the Ministry of Social Affairs and Health (1164/2/2016). According to the response, there are 50 psychiatric units in which coercion is used. One indication of this is provided by the statistics of the National Institute for Health and Welfare, according to which there were 26,561 patients in specialised psychiatric care in Finland in 2013, with a total of 38,000 inpatient stays. In addition, there are health-care units other than those providing specialised psychiatric care where coercive measures may be used (emergency care units of somatic hospitals), or where persons deprived of liberty are treated (health care services for prisoners). The NPM also made a visit to the sobering-up station, which was linked to the practice of using personnel from the sobering-up station in the care of persons deprived of freedom and detained in the police prison.

Owing to the large number sites to be visited, certain prioritisations must be made with regard to the allocation of resources. The NPM has therefore mainly elected to visit the units where most coercive measures are taken, and where the patient material is most challenging. These include the State psychiatric hospitals (Niuvanniemi and the Old Vaasa Hospital) and other units providing forensic psychiatric care. The aim is the make regular visits to these units, which in practice means a visit every couple of years. State psychiatric hospitals provide treatment for most forensic psychiatric cases in Finland, in addition to whom the units treat difficult-to-manage patients transferred from other psychiatric units. The terms of treatment of forensic and difficult-to-manage psychiatric patients are longer. The aim is also to make regular visits to units that care for difficult-to-manage minors (units in Tampere and Kuopio). Otherwise, the selection of sites will depend on when the place was previously visited and the number of complaints made about the unit.

As a rule, visits to units providing health-care services are always attended by an external medical expert. Of the 2017 visits, only the one to the Vantaa health-care clinic was made without a medical expert present. Involving a medical expert in the visits has made it possible for inspectors to address the use of restrictive measures from a variety of angles and to explore ways of preventing their use. As in the case of social services, the intention is to carry out visits to health-care units in 2018 accompanied by experts with experience.

The NPM made a total of eight visits to health-care units in 2017. In addition, as part of the preparation for visits in Ostobothnia, the NPM paid a visit to the social welfare and health-care division of AVI Western and Inland Finland. Only the visit to Päijät-Häme Joint Authority for Health and Wellbeing was pre-announced. This decision was made because the inspection team included a delegation from the Estonian NPM, which required some special arrangements from the unit as well. Otherwise, the visits were made either completely unannounced or the unit was given prior notice of the NPM's arriving within a certain period of time, but not the exact date.

The units visited by the NPM were:
- Old Vaasa Hospital (155 beds)
- The psychiatric ward of Vaasa Central Hospital (68 beds)
- Psychiatric unit for the Southern Ostrobothnia Hospital District (88 beds)
- Psychiatric wards of Päijät-Häme Joint Authority for Health and Wellbeing (72 beds)
- The Vantaa clinic of the VTH
- Emergency care unit at Vaasa Central Hospital
- Emergency care unit at Seinäjoki Central Hospital
- City of Espoo sobering-up station

Presented in the following are some of the observations made during visits, and statements and recommendations based on them. Some of the observations and recommendations were pending response from the visited institution:

Atmosphere/treatment

- The general impression given by the visit was that the wards at the hospital had a calm and professional atmosphere, with "patients first" as the general principle.

- There were no signs of tension in the relationship between the staff and the patients. The patients did not mention any demeaning or undignified treatment, and they felt they were receiving appropriate care.

- There were no signs that the patients were mistreated in any way or that the patients felt unsafe. However, the hospital had no specific whistle-blowing policy in place should mistreatment be detected or suspected.

In the Ombudsman's opinion, the staff must have instructions to follow on how to proceed in a situation in which they observe mistreatment, and how to intervene. This also requires that mistreatment is correctly identified and defined, and that a clear position is taken by the management that mistreatment is unacceptable and will always lead to consequences. The patients and their families should also have instructions on how to report mistreatment.

Seclusion facilities

- The seclusion room was furnished only with a thin, yellow plastic mattress, and there was no drain in the room. In addition, the room was hot and stuffy.

The Ombudsman noted in general that having appropriate equipment in the seclusion room is of major importance when assessing whether 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 referred to in the Act on the Status and Rights of Patients. The Ombudsman found the conditions in the seclusion room to be unacceptable.



- The conditions in the seclusion room were closer to a police jail than a seclusion room in a psychiatric hospital.

  ↳ The Ombudsman stated that while the seclusion room is rarely used, it must be safe and appropriately furnished. The Ombudsman found it humiliating for the patient to have to eat either standing up or sitting on the floor on a thin mattress. The Ombudsman noted that at mealtimes, the patient could be provided with a stand for their tray, if it is not possible to bring the patient out of the seclusion room to eat. The Ombudsman recommended that the mealtimes of a secluded patient be arranged on the basis of separate instructions.

  ↳ The Ombudsman also recommended that more attention should be paid to the quality of the fittings and furnishings in isolation facilities and that, when new facilities are designed, consideration is given to the safety and furnishings of the rooms, to ensure more dignified treatment of patients placed in isolation.

- The seclusion room had no night light, so the room had lights on during the night for the purpose of security monitoring.

  ↳ The Ombudsman considered it unacceptable that the lighting in the room could not be adjusted for the night, and that the patient is compelled to sleep with the lights on for the purpose of supervision.

- According to the hospital rules, secluded patients are escorted to the toilet when necessary and, if required, handheld urinals and bedpans are used.

  ↳ The Ombudsman stated that the dignified treatment of a secluded patient, as well as good health-care standards, requires that the patient has access to a toilet. The Ombudsman recommended that the code of conduct at the hospital be updated to include more specific instructions for the staff to proactively ensure that all secluded patients have the opportunity to use the toilet.

- The seclusion facilities lacked an alarm button, a security camera, and means for the patient and staff to communicate. In the concluding discussion, the hospital staff pointed out that they considered special observation to be a more effective alternative than camera observation. The staff saw the patient every 30 minutes.

The Ombudsman referred to the THL (the National Institute for Health and Welfare) guidelines to reduce the use of coercive measures, citing, for example, that the monitoring space for seclusion rooms must be one from where there is uninterrupted visual and audio contact with the patient. The Ombudsman noted that security cameras can never replace personal communication, but can be a welcome additional device adding to patient safety. According to Valvira (the National Supervisory Authority for Welfare and Health), it is not good practice to arrange monitoring exclusively by means of security cameras without the possibility for the patient to speak to the staff in person.

The Ombudsman recommended that all seclusion facilities are immediately fitted with an alarm bell or a similar system so that the patients can contact a staff member without delay. The Ombudsman recommended that the seclusion facilities be furnished with fixtures that the patients cannot use to harm themselves.

Follow-up:
The hospital reported that it had acquired a bed-like mattress for the seclusion rooms on two wards, which already had a table and a stool. Technical communication systems will be installed in 2017. The hospital also responded that the new hospital currently under construction would have special architectural features that promote the reduction of seclusion as a care method.

Other facilities

- Some of the patients shared their room with one or two other patients.

The Ombudsman stated that, when taking into consideration the long treatment periods of forensic psychiatric patients (average time 8 years 17 days), it should be the general goal to allocate patients to single-occupancy rooms.

- Patient in a rehabilitation and acute ward were allocated to double-occupancy rooms as a rule.

The Ombudsman referred to the Valvira statement, according to which it had been shown that allocating psychiatric patients to single-occupancy rooms reduced the occurrence of altercations and the use of restrictive measures, and speeded up recovery. The Ombudsman recommended that the general objective of the Valvira statement to allocate patients to single-occupancy rooms be observed in the design of the new premises.

- It was considered a positive development that there was a separate room for visits by family and friends. However, on the negative side, the patients were forced to share their rooms with one or several other patients, and the hospital could not provide a fenced outdoor area for patients who require special observation.

Follow-up:
The hospital responded after the visit that the new hospital will have single rooms for all patients. However, the modern and patient-driven care concept does not support the use of fenced-off outdoor spaces. Adequate outdoor time will be enabled for all patients by means of adequate staffing and designated carers.

Outdoor time

- A hospital had no separate outdoor area or fenced-off yard in which patients under special observation could spend time outdoors. The wards seemed to abide by varying practices in regard to outdoor time, and it did not become clear during the visit how outdoor time was organised in practice for patients of different status, or whether patients in voluntary care were able to go out as and when they wished to do so. On several wards, outdoor time was not routinely included in the weekly programme.

The outdoor area for psychiatric patients at Päijät-Häme Joint Authority for Health and Wellbeing.

The Ombudsman stated that outdoor time is part of good care, and the staff should encourage patients to spend time outdoors. The Ombudsman stressed the importance of monitoring actual outdoor time and including outdoor time in the patients' care plans. The Ombudsman stressed that access to outdoors may not be restricted simply because the outdoor areas are not suitable for patients under restriction of movement or because there are not enough staff to supervise

outdoor time. This also concerns patients placed under observation and secluded patients, when their health permits outdoor time.

The Ombudsman recommended that the hospital pay more attention to its outdoor time policy and ensure that patients' access to the outdoors is not limited any more than is necessary. The Ombudsman also recommended that the hospital adopt a policy of monitoring the patients' outdoor time, especially in the case of patients who are not able to go out independently.

- At the geriatric psychiatric ward, the daily programme included 45 minutes of outdoor time six days per week, while at the youth psychiatric ward, the daily outdoor time was 15 minutes.

The Ombudsman emphasised that all patients should be given the opportunity to spend at least an hour outdoors every day, their health permitting.

Follow-up:
The hospital reported that it had changed its practices following the visit and had increased opportunities for outdoor time.

- In reviews of patient documentation, the NPM noted that a patient who had been under long-term seclusion had been able to go outdoors only once a month on average over the past three years.

The Ombudsman stressed the importance of daily outdoor time as part of high-quality care. According to the Ombudsman, patients should have the opportunity to spend at least one hour per day outdoors, unless their health or a special, particularly grave reason related to order and safety at the hospital prevents this. The Ombudsman recommended that outdoor time should be included in the patients' care plans. The Ombudsman took the initiative to investigate the conditions of a person who had been in seclusion for a prolonged period of time.

Reduction of restrictive measures

- The information obtained from the hospital showed that coercive and restrictive measures were used in the hospital relatively rarely. It was, however, difficult to form an overall picture of how this information was utilised in practice, other than as a summary in the hospital's annual report.

The Ombudsman referred to the CPT standards, according to which each psychiatric unit should adopt a plan to minimise the use of coercive measures. The Ombudsman recommended that the hospital continually monitor the implementation of measures and draw up a plan to reduce the use of coercive measures.

Follow-up:
The hospital reported on measures that the hospital had taken to reduce the use of coercive measures. These included staff training on encountering aggressive behav-

iour, debriefing with the patient following seclusion or restraint, and the adoption of the Safewards model. In addition, the hospital's own guidelines on the application of restrictive measures, Handbook on the options and coercive and restrictive measures under the Mental Health Act were, in the hospital's opinion, compliant with the CPT recommendations.

Guidelines and agreement on the use of restrictive measures

- A hospital ward had adopted guidelines and practices that restricted the patients' rights more than the law prescribes. As an example, the patients could be subjected to bodily searches and required to give blood or urine samples.

The Ombudsman stressed that a patient's rights cannot be restricted by a ward's individual instructions, as any restrictions must be based on law, and they must be used on the basis of individual consideration.

- The hospital aims to reach an agreement with the patient on their care, instead of resorting to restrictions on self-determination.

The Ombudsman explained in his statement the general rules for consensual restriction of basic rights and what is required of the person giving consent. The Ombudsman stressed that any intervention in the physical integrity of a patient, or other care measures, must always be subject to voluntary and informed consent given by the patient. The patient must also have the right to withdraw his or her consent at any time. The Ombudsman stated that, for example, metal detectors can be used if the patient consents to the practice. Otherwise, the patient can be subjected to a bodily search if the criteria provided in the Mental Health Act are met.

- A patient in involuntary treatment had given their consent on the care agreement form used by the hospital district on the restriction of their basic rights on entering a substance-free treatment period.

The Ombudsman recommended that on the care agreement form, a section should be added in which the patient can cancel the agreement at their own discretion, including information on what the consequences of such cancellation may be.

- A patient who was in involuntary care told the NPM that food that she had purchased was placed in a locked fridge in the ward and that she had access to it only on request.

The Ombudsman stated that patients under involuntary treatment can also agree on the safekeeping of their personal belongings during treatment, in which case the safekeeping does not constitute the possession of personal property referred to in the Mental Health Act. The

patient must be clearly informed, however, that they have the right to receive an appealable decision on the possession of the personal property, if they object to the policy adopted by the ward. In unclear situations, the patient must be asked whether he or she would like to request an official decision. The Ombudsman recommended that the guidelines on restrictive measures should include instructions on the matter.

Procedure in admitting patients for observation

- On reviewing the patient documents, it became apparent that the decisions to admit patients for observation did not contain assessments on whether or not the conditions for ordering the patient to treatment had been met.

The Ombudsman stressed that admitting a person for observation means deprivation from liberty for no longer than four days. The patient cannot appeal the decision, unless they are ordered into involuntary care. It is essential from the perspective of patients' legal rights that the legality of the observation decision can be demonstrated afterwards. The Ombudsman stated that there is no specific form for admitting a person for observation, but according to the Mental Health Act, the physician deciding on the measure must assess whether or not the conditions for ordering the patient to treatment are likely to be met.

The Ombudsman recommended that, in the future, in each individual case, decisions on admitting a person for observation include records of the physician's evaluation of the probable fulfilment of the criteria laid down in the Mental Health Act.

Follow-up:
The hospital reported that it would expect its physicians to comply with the Ombudsman's recommendation.

Involuntary medication

- Shortcomings were detected in the documentation of involuntary medication, as well as in the establishment of justified grounds for the practice.

The Ombudsman stated that a physician may decide on the involuntary medication for a period of time specified in advance, but such a decision may be made for one day only, and the physician must, in the same juncture, decide on the specific nature of restrictive measures to be used during the administration.

- The ward had resorted to involuntary medication in acute situations on a patient's arrival or in a more systematic manner, when a patient had been in treatment for a longer period of time and was refusing medication.

The Ombudsman stressed that a patient in involuntary care or under observation may be administered medication against their will only if the failure to provide medication seriously endangers the health and safety of themselves or others. The Ombudsman referred to the guidelines issued by THL on reducing the use of coercion. According to the guidelines, involuntary medication refers to medication (injection, tablet, oral solution, etc.) that the patient refuses to take, as well as a situation in which the patient is told that if they refuse to take medication orally, they will be administered the medicine involuntarily by injection.

Restrictive measures aimed at a child

- Children were mainly in voluntary care in the paediatric psychiatric unit, and when the children exhibited aggressive behaviour, they would be manually restrained (forcible holding).

The Ombudsman referred to his previous praxis and stated that the Mental Health Act is applicable in the case of manual restraint of a patient under inpatient care. However, the restrictions provided for in the Mental Health Act, such as manual restraint, cannot be applied to children in voluntary care. The Ombudsman recognises that the violent behaviour of a child requires intervention using appropriate means, to prevent them from harming themselves and others. In an emergency situation, means that are in proportion to the behaviour of the child can be used. If the child is held tightly for the purpose of calming them down, the conduct must be considered as a method of upbringing and nurturing, and not as a restrictive measure.

The Ombudsman considered it necessary that guidelines for restraining situations should be drawn up to make sure that staff have a clear understanding of the limits of competence.

Restrictive measures with no basis in the Mental Health Act

- Several wards in a hospital had a policy of preventing patients from accessing their rooms in the morning and afternoon by locking the doors.

The Ombudsman took the initiative to investigate the appropriateness of the method.

- It appeared that the hospital was adequately staffed to allow for the use of 100% special observation (so-called "rooming-in care") as the main method of restriction, which allowed the nursing staff to concentrate on providing care to the patient under observation, as they remained next to the patient or at least within eye contact of the patient at all times.

The Ombudsman found that the method of 100% observation was often used in a situation in which the other alternative would have been the seclusion of the patient. It was also evident from the list of restrictive measures that the adoption of 100% observation was successful in reducing the need for seclusion, which the Ombudsman found to be a highly satisfactory outcome. The Ombudsman further stated that this type of observation was not included in the restrictive measures referred to in the Mental Health Act, but considered it prudent that its use should be documented and transparent, and that its use should be documented in the record of restrictive measures if the patient objects to it.

- One of the wards had a restrictive vest in use for aggressive patients, so that the patient did not need to be secluded. The geriatric psychiatric ward had back-zip overalls in use, albeit rarely. There were no guidelines on the use of restrictive clothing.

The Ombudsman stated that if a hospital is using restrictive clothing, there must be guidelines, and the use of the garment must be duly recorded in the list of restrictive measures used. The Ombudsman encouraged the institution to consider completely discontinuing the use of restrictive garments, as they were rarely used.

- A hospital had adopted the use of chest and crotch straps for various situations, and separate guidelines for their use had been provided.

The Ombudsman pointed out that there are no provisions in the Mental Health Act that are directly applicable to the use of chest or crotch restraints, and restraining as it is understood in the law refers exclusively to the use of conventional bed restraints. Usually this type of restraint is used for patients who are not in involuntary treatment but whose movements need to be controlled for the sake of their own safety. The Ombudsman referred to the Valvira guidelines on the use of restrictive safety equipment and the principles on the restriction of movement of a person in voluntary care. The Ombudsman emphasised that a separate assessment should be made of the use of restrictive equipment, and alternative applicable safety measures should be considered.

The Ombudsman recommended that the hospital review its guidelines regarding the use of chest or crotch restraints for patients in involuntary care. The Ombudsman also recommended that the guidelines include principles on the restriction of movement applied to patients in voluntary care, as based on Valvira guidelines, unless the matter is not governed by law.

Debriefing on the use of restrictive measures with the patient

- According to the hospital guidelines, patients are offered the opportunity for debriefing following seclusion or restraint, and this is entered into the patient's records.

The ombudsman stated that patients should be given the right to debriefing following other restrictive measures as well.

Protection of privacy

- A hospital had security cameras in patients' rooms on certain wards.

The Ombudsman noted that camera observation is always an intrusion into a patient's privacy, but that there was no legal provision on the use of security cameras in psychiatric hospitals. The Ombudsman decided to take the own initiative to investigate the room-monitoring practices and request the hospital to detail their room-monitoring policies and the grounds for them.

- The doors of the patients' rooms had a window with a direct view of the room and the bed.

The Ombudsman found this unacceptable from the perspective of privacy and observed that the patient should have the possibility to cover the window as they wished.

- A hospital ward had a security camera in the common spaces, but the camera had been positioned next to a patient's room so that the patient felt their right to privacy was being violated.

Follow-up:
The NPM was told during the visit that the positioning of the camera would be changed immediately.

Information for patients and their families

- A hospital had produced informative guides, but these guides failed to explain clearly that different patient groups had different status.

The Ombudsman noted that guides are important for the patients' legal protection and recommended that separate guides should be produced for patients remanded for a mental health examination and other patient groups, depending on their legal status. The Ombudsman also stated that the guide aimed at families should have updated information on the restrictions on patients' basic rights.

- The different wards of a hospital offered a varying amount of information about the rights and position of the patients, as well as the legal remedies at their disposal.

The Ombudsman found that, to guarantee patients' rights, it is essential that patients and their next of kin are aware of patients' rights and the legal remedies available to them (objection, complaint, and notice of patient injury). The Ombudsman recommended that patients on all wards, and their families, should be provided on arrival with clear and simple information on the rights and obligations of the patients, both orally and in writing. The staff should also familiarise themselves with the material so that they can tell patients and their families of the patients' rights in clear and understandable terms.

Prioritising the best interests of a child

- The paediatric psychiatric ward was open only on weekdays, and the children usually spent the weekends at home. If a child was unable to go home, they were transferred to the paediatric psychiatric ward of the university hospital.

The Ombudsman referred to the UN Convention on the Rights of the Child, according to which the best interests of the child must be taken into consideration in all measures taken by the authorities. The Ombudsman pointed out that this arrangement meant that the child would have to travel more than 300 km to an unfamiliar environment, and that the parents would not necessarily be able to visit the child.

Follow-up:
The hospital responded that this arrangement was used only very rarely. Regardless of this, the hospital will no longer systematically refer children to the university hospital and, instead, will attempt to find a solution that is in the best interests of each individual child. One option could be the adolescent psychiatric ward of a more nearby hospital.

Arrival examinations

- The patients arriving at a geriatric psychiatric ward also underwent an examination for somatic health. The ward also had guidelines for identifying signs of domestic abuse and used the Mini Nutritional Assessment.

  The Ombudsman found the holistic approach to the care of patients adopted at the ward to be highly commendable. The Ombudsman also referred to the importance of the nutritional assessment of the elderly patients and encouraged the hospital to investigate any causes of poor nutritional status.

- A ward did not conduct routine somatic examinations on patients on arrival.

  The Ombudsman stated that it is a widely accepted view that persons with mental health disorders also have more somatic illnesses than the average population, which is why it is important that the somatic conditions are also recorded and treated appropriately. The Ombudsman recommended that the patients receive a somatic health examination on arrival.

- A ward did not examine patients on arrival for signs of injuries from violence.

  The Ombudsman noted that some of the patients arrived escorted by the police and that the patients may have been subject to the use of force during transportation, causing physical injuries. The CPT has also drawn attention, during their visit to Finland, to deficiencies in the practice of recording injuries allegedly resulting from abuse. The Ombudsman recommended that injuries and other signs of abuse detected on arrival be documented as soon as possible, the patient's health permitting.

Rehabilitation

- A hospital had introduced dog-assisted occupational therapy as a new form of therapy. The therapy is used for learning interactional skills and developing tactile tolerance, as well as cognitive skills. Patients, including some in isolation facilities, have received visits from dog-assisted therapists.

  The Ombudsman found it to be a positive development that the hospital had increased the use of occupational rehabilitation techniques following the statements issued by the CPT.

Secure rooms in emergency care units

As in previous years, the Ombudsman felt it was important to visit the emergency care units of somatic hospitals, which use secure rooms for the seclusion of patients brought to emergency care services who, for example because they are aggressive or confused, cannot be placed with other emergency patients. This situation is a problem because there is no legislation on seclusion in somatic health care.

However, secluding a patient may sometimes be justified under emergency or self-defence provisions. Such situations tend to involve an emergency, during which it is necessary to restrict the patient's freedom in order to protect either his or her own health or safety, or those of other persons. The Ombudsman has required in his legal practice that the legal provisions and ethical norms governing the actions of doctors and other health care professionals must also be taken into account in these situations, and, as a result, the application of two parallel sets of standards. Furthermore, the procedure may not violate the patient's human dignity. Having appropriate equipment in the seclusion room is of major importance when assessing whether 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.

The criteria laid down in the Mental Health Act for the seclusion of a psychiatric patient are also applicable as minimum requirements for secure rooms in somatic hospitals. A patient placed in a secure room must be continuously monitored. 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. Appropriate records must be kept of the monitoring at all times.

The different emergency care units have numerous security rooms, which are regularly used. Regardless of this, patients rarely complain to the Ombudsman about their placement in a secure room, or their treatment while in seclusion. Attention is also paid to the privacy of the patient in urgent-care facilities. The Ombudsman has stressed the importance of ensuring, by various means including spatial design, that patients' details are not disclosed to third parties in the hectic environment of an emergency room. The Ombudsman finds it important that the protection of privacy is raised as a topic in staff training and that due attention is paid to the matter in the execution of daily duties.

The NPM visited the urgent care unit of two central hospitals in 2017. All visits were made unannounced and during the evening. An external expert participated in the visits.

Prisoners' health care

Health care for prisoners was transferred to the administrative branch of the Ministry of Social Affairs and Health at the beginning of 2016. Health Care Services for Prisoners (VTH) 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 cover the prisoners' health care organisation. In practice, the supervision has been centralised in 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, 13 of these units had been visited. The objective is that AVI will have visited all of the VTH units by the end of 2018.

The NPM visited the Vantaa unit of VTH in 2017. Because the visit was combined with the inspection visit to Vantaa Prison, the inspection team had the opportunity, before inspecting the clinic, to interview prisoners on the health care they had received. In

addition, the Ombudsman headed the resource management audit of the VTH during the year under review. The Ombudsman pointed out, for example, that a person who has been placed under observation due to suicidal thoughts should undergo a medical examination as soon as possible, even if the prisoner was met only briefly before being placed under observation.

Sobering-up stations

In 2017, the NPM also visited a sobering-up station run by the local authorities. The visit was combined with the visit to Espoo police prison, as detailed in the section above on visits to police prisons. The visit was made in the evening, with the participation of an external expert. The visit mainly focused on the role played by sobering-up station staff when managing persons deprived of their liberty and held in the police detention facilities. The NPM was particularly interested in their role in situations where the staff at the police prison used the restraining bed. The police prison discontinued the use of the restraining bed after receiving the Deputy-Ombudsman's opinion, due to which the Ombudsman no longer had any reason to evaluate practices related to the use of the bed. Instead, the Ombudsman made the following statements and recommendations:

- The Ombudsman drew attention to the protection of the privacy of those deprived of their liberty held in police prisons, when they are seen by the nurse from the sobering-up facility. The Ombudsman finds it essential that the safety and security of health-care professionals is guaranteed at all times. The need for the presence of a guard must be separately assessed in each individual case and the arrangements should be such that the violation of privacy is as minor as possible.

- The Ombudsman recommended that in all cases where the personnel at sobering-up stations are made aware of injuries sustained by a person who is in police custody, they should make a note in the patient's records of the injuries and of the account of the person deprived of their liberty on how these injuries were sustained. After this, the person deprived of their liberty should immediately be referred to a physician for the examination and detailed documentation of their injuries. The Ombudsman stressed that the injuries need not be serious enough to require treatment, and the matter is primarily one of appropriate documentation.

- The Ombudsman stressed that it was unacceptable that customers of the sobering-up station were unaware of their legal status, and that they were free to leave at their own discretion. The Ombudsman pointed out that staff members at the sobering-up station are obliged to inform customers that they are not in police custody while they are staying at sobering-up station.

4
OTHER ACTIVITIES

4.1 Statements and Own-initiatives

Statements issued

Criminal sanctions sector

In the criminal sanctions sector, statements were issued during the reporting year to the Legal Affairs Committee and the Constitutional Law Committee on the government proposal on the amendment of the Imprisonment Act, the Remand Imprisonment Act, and the Act on Enforcement of Community-Based Sanctions (HE 263/2016 vp), and on the government proposal on the Act on Enforcement of Combined Sentences of Imprisonment (HE 268/2016 vp).

Own-initiative investigations

Suicide committed by a prisoner

During a visit to Vantaa Prison, it came to the attention of the NPM that a prisoner had taken his own life a few weeks earlier. The prisoner had arrived from Mikkeli Prison by train and was awaiting further transportation to the Psychiatric prison hospital in Turku. The Deputy-Ombudsman decided to subject the matter to a separate investigation.

Prisoner subjected to a body search at a private health clinic

As part of a complaint, it was brought to the Ombudsman's attention that a prisoner had been subjected to a body search at a private health clinic. The Ombudsman launched a general own-initiative investigation to establish whether a body search constitutes an exercise of public authority that must be carried out by a physician in a public-service employment relationship, or whether it may be carried out by a private practitioner.

Outsourced medical services in health care services for prisoners

During an inspection visit to the resource planning unit of Health Care Services for Prisoners (VTH), it came to the attention of the NPM that approximately half of the physicians' services in outpatient care for prisoners were provided by outsourced services. The Ombudsman found it problematic that, in health care services for prisoners, there was such heavy and consistent demand for the medical services of private agencies. As a result, the Ombudsman launched an own-initiative investigation on the use of outsourced medical services in health care services for prisoners.

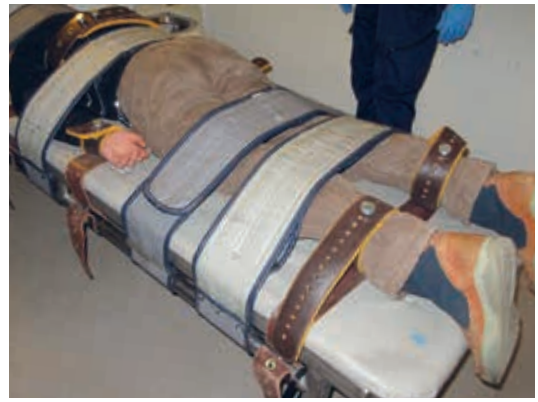
Private transport services providers in child welfare services

In the processing of complaints and during inspection visits, it emerged that a private company was providing transportation services under very challenging circumstances for children and adolescents placed in care, usually in a situation where the child or adolescent had absconded from a place of foster care. This gave rise to the suspicion that the same operator may continue operating independently in some situations, without the social services. On some occasions, children had also been transported by private security firms. Valvira has been requested to establish to what extent private companies are used as part of foster care service provision, how these companies operate, under what circumstances the services may be used and how the operations are supervised.

Decision issued on own-initiative investigations

The use of a restraining bed at Espoo Police Prison

Based on an observation during a visit to Espoo Police Prison, it was discovered that a restraining bed was in use, on which a person may be restrained, while face down, by the arms and legs. The person may also be restrained by handcuffs and leg cuffs whilst strapped to the bed. The bed has an opening through which the restrained person can vomit. The person may additionally be restrained by straps fastened across their body, including the head, so that the person lies completely immobilised.



During the visit to the Espoo Police Prison, the inspectors learnt about the restraining bed and how it is used. One of the experts agreed to be restained on the bed during the visit.

The Deputy-Ombudsman finds that the current legislation does not allow for the use of such means of restraint in a police prison. If such restraint beds were to be used in police prisons in the future, the practice should be governed by legal provisions similar to those of the Mental Health Act. Moreover, even under such legislation, the bed should be similar to those used in medical treatment in psychiatric care, and not the type used at Espoo Police Prison. In general, the Deputy-Ombudsman did not find any just cause for the use of a restraining bed in police prisons and concurs with the opinion of the CPT that restraining beds should no longer be used in police prisons. Restraining measures should be strictly based on a physician's assessment and carried out by health-care professionals.

Follow-up:
The National Police Board reported that it had sent a communication to all police departments with instructions to stop using restraining beds in police prisons. The Western Uusimaa Police Department had already stopped the use of the restraining bed prior to the communication. According to the National Police Board, restraining beds are no longer used in any police prisons. According to the Ministry of the Interior, there are no plans to reintroduce restraining beds as a means of restraint in police prisons.

Lack of safety belts in police vans

The Deputy-Ombudsman found that, while the regulations do not, in principle, require the fitting of safety belts in the hold of a police van, the practice is unsatisfactory as passengers transported in the hold may sustain injuries in accidents and during abrupt breaking or steering, as they are not protected by seatbelts. Furthermore, passengers are often in an unfit state to control their movements.

Follow-up:
The National Police Board reported that, during the next round of competitive tendering on the acquisition of new police patrol vans, which will be held in 2018, the specifications for the hold would include the option of fitting safety belts.

Prison Rules at the Eastern Uusimaa Police Department police prison

Among other issues, the Deputy-Ombudsman found that when the prison rules had been drawn up, inadequate consideration had been given to what types of orders may be given in prison rules. As a result, some of the rules are in violation of the law. Furthermore, insufficient attention has been paid to the fact that the Prison Rules form a self-standing regulation, not a collection of regulations. The issue of what types of matters may be regulated by prison rules, and what types of orders may be given on such matters, is not necessarily self-evident. The Deputy-Ombudsman therefore finds it crucial and necessary that the formulation of prison rules be placed under national guidance, rather than police departments attempting to resolve these regulatory problems on their own.

Follow-up:
The matter was discussed during a visit to the National Police Board. The National Police Board will issue instructions on the content of prison rules as soon as the amendments to the Act on the Treatment of Persons in the Custody of the Police has been approved.

The treatment of a prisoner who had stayed in the isolation unit for more than two years

The Deputy-Ombudsman found no sufficient or lawful reasons to segregate a person, who at his own request had lived for nearly two years and three months in the isolation unit, from other prisoners. More effective intervention should have been made in the situation, in which the prisoner was afraid of other prisoners. Unlike the ordinary prison rooms, the isolation unit and adjacent exercise yard were unsuitable for long-term accommodation and the decision to place the person in segregation had not been made through due process. An own-initiative investigation was launched based on an observation made during a prison visit.

Time spent outside cells

The basic principle behind regulations and international recommendations regarding prisoners is rehabilitation and the treatment that enables their social reintegration once released. Prisoners and remand prisoners should therefore be allowed to spend a reasonable amount of time, at least eight hours per day, outside their cells. During that time, they should be able to engage in rewarding and stimulating activities, such as work, training and exercise. During a visit to Riihimäki Prison, it was noted that, in certain wards, prisoners had few opportunities to spend time outside their cells in a meaningful way. The prison has since made efforts to address the situation. The Deputy-Ombudsman has since drawn the prison's attention to the fact that, during weekends, prisoners have limited opportunities to spend time outside their cells. The Deputy-Ombudsman also pointed out that prisoners who did not participate in activities should also be offered the opportunity to spend time outside their cells.

Equitable treatment of prisoners

The possibility of prisoners to purchase vitamins and nutritional supplements, and the right to possess them, varies between prisons. The Deputy-Ombudsman stated that the harmonisation of prison rules was necessary in this respect.

Follow-up:
The Central Administration of the Criminal Sanctions Agency reported that it was planning to establish a prison rules working group. The prison rules working group may consider the varying practices regarding the possession, purchase, and storage of vitamins and nutritional supplements. The Central Administration of the Criminal Sanctions Agency appointed the Prison Rules Working Group in December 2017, and it was tasked with preparing for the harmonisation of rules and practices with the aim of ensuring the equitable treatment of prisoners.

Failures in decision-making required by the Act on Special Care for Mentally Handicapped Persons

During a visit to the Kuusanmäki Service Centre, it was noted that the unit had not made statutory decisions on matters such as restrictive equipment and clothing or supervised movement, as required by the Act on Special Care for Mentally Handicapped Persons. The Ombudsman found that the service centre had neglected its statutory duty to base the use of restrictive measures on a proper decision. Negligence in proper decision-making was prevalent throughout the Kainuu social welfare and health care district. The Ombudsman stated that, as in the case of AVI Northern Finland, the practical implementation of statutory practices laid down in law had been overlooked and under-resourced. There were also shortcomings in communications. The Ombudsman issued a reprimand to the Kainuu social welfare and health care joint authority and Kuusanmäki Service Centre for unlawful conduct.

4.2 Legislative proposals and proposals on recompense

Legislative proposals

Detention facilities at courts of law

In conjunction with a visit to the holding facilities at the Helsinki District Court for persons deprived of their liberty, the Deputy-Ombudsman stated that there are no legal provisions regulating holding facilities at courts of law in Finland. The 2010 government proposal for an act on prisoner transport has lapsed and no similar proposal has been made since. The Deputy-Ombudsman found this problematic and expressed this opinion to the Ministry of Justice.

Patient transport

The Mental Health Act includes no provisions on executive assistance during patient transport to destinations aside from health-care service units, or on the treatment and conditions of the patient during transport. Furthermore, the law has no provisions on the use of coercive measures by care personnel to restrict a patient's freedom of movement outside a hospital area, or in order to bring a patient to hospital from outside the hospital area. Care personnel are currently allowed to use coercive measures during transport, mainly in self-defence or as an act of necessity under the Criminal Code.

It is the opinion of the Ombudsman that the transport of a patient, their treatment and conditions during transport, and the competencies of the accompanying personnel should be specifically provided for by law. Since problems are continually arising due to the lack of applicable legislation and possible emergency situations, the Ombudsman has called for the amendment of the related legislation as a matter of urgency. The Ombudsman has therefore made a proposal to the Ministry of Social Affairs and Health that the legislation be clarified in this respect. The Ombudsman reiterated this proposal in his decision on a complaint, in which a hospital was found responsible for misconduct after contracting a private security firm to manage the security of patient transport without applying the necessary legal provisions.

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 led to a positive outcome in most cases. Below are some examples of proposals on recompense made in 2017, associated with violations against persons deprived of their liberty or with their treatment.

The Deputy-Ombudsman proposed that the State pay compensation to a prisoner for inappropriate treatment that violated his dignity. The prisoner had been made to stay in an isolation cell naked and without a cover while under observation. Such conduct is particularly reprehensible due to its duration, the fact that the prisoner was held naked for five hours, and that the events took place under camera observation. Moreover, restraining and attaching the prisoner to the bars of the isolation cell by his arms and legs was illegal.

Follow-up:
In July 2017, the State Treasury decided to pay the prisoner compensation of EUR 2,500 for the violation of basic rights and EUR 1,000 for pain and suffering and other temporary disability.

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.

Visits

#) = unannounced visit

Courts

- 26 September Detention facilities for persons deprived of their liberty in District Court of Helsinki#) (5560/2017)

Police administration

- 14 March Espoo Central Police Station, Police prison#) (1382/2017)
- 21 May Vaasa Central Police Station, Police prison#) (3243/2017)
- 4 July Porvoo Police Station, Police prison#) (3854/2017)
- 4 July Kotka Police Station, Police prison#) (3855/2017)
- 4 July Kouvola Central Police Station, Police prison#) (3856/2017)
- 14 November Helsinki Police Department, Legal Unit (6470/2017)
- 12 December Rovaniemi Central Police Station, Police prison#) (6794/2017)
- 12 December Sodankylä Police Station, Police prison (6795/2017)
- 13 December Inari Police Station, Police prison, Ivalo (6796/2017)

Defence Forces and Border Guard

- 28 March North Karelia Border Guard District, Detention facilities at Niirala Border Crossing Point for persons deprived of their liberty (2213/2017)
- 27 June Armoured Brigade, Detention facilities in Hämeenlinna Unit for persons deprived of their liberty#) (4034/2017)
- 27 June Armoured Brigade, Detention facilities in Riihimäki Unit for persons deprived of their liberty#) (4128/2017)
- 25 October Kainuu Brigade, detention facilities for persons deprived of their liberty#), Kajaani (6306/2017)
- 12 December Jaeger Brigade, Detention facilities in Sodankylä Unit for persons deprived of their liberty#) (7119/2017)

Criminal sanctions

- 22 March Helsinki Prison (2052/2017)
- 4 April Kerava Prison (2359/2017)
- 22 May Vaasa Prison (2705/2017)
- 29–30 May Mikkeli Prison (3005/2017*)
- 7 September Satakunta Prison, Köyliö Unit#) (3733/2017)
- 28 and 30 November Vantaa Prison (6206/2017)

Aliens affairs

- 5–6 April Joutseno Reception Centre, Detention Unit (1868/2017)
- 14 December City of Helsinki, Metsälä Reception Centre, Detention Unit[#)], Helsinki (6966/2017)

Social welfare / children

- 8 March Familar Oy, Peiponpesä[#)] (private home for children requiring demanding psychiatric care), Hyvinkää (619/2017)
- 20 September City of Helsinki, Outamo children's home[#)] (child welfare unit), Lohja (5500/2017)
- 15 October Vaahteramäki Oy, youth home Lukkarila[#)] (private child welfare unit), Peräseinäjoki (5727/2017)
- 16 October Familar Oy, youth home Nummela[#)] (private special youth home), Lapua (5681/2017)
- 24 October Save the Children Finland, Children's home Harjula[#)], Kajaani (6182/2017)
- 24 October Kainuu Social Welfare and Health Care Joint Authority (Kainuun sote), Children's home Salmila – Salmijärvi child welfare unit[#)], Kajaani (6184/2017)
- 25 October Children's and youth home Kimppa[#)] (private child welfare unit), Paltamo (6183/2017)
- 8 November City of Helsinki, Outamo children's home (child welfare unit), Lohja (5500/2017)
- 21 November Nauha ry, Villa Junior[#)] (child welfare unit for adolescents aged 15–17), Ylöjärvi (6545/2017)
- 22 November Special child welfare unit Honkalyhty[#)] (private child welfare unit), Kangasala (6546/2017)
- 14 December Familar Oy, Varatie Tervakoski[#)] (private children's welfare institution for children with neuropsychiatric symptoms), Tervakoski (7024/2017)
- 19 December Tukikoti Tasapaino[#)] (neuropsychiatric child welfare unit for children and adolescents), Forssa (7015/2017)

Social welfare / persons with disabilities

- 3 March Kainuu Social Welfare and Health Care Joint Authority, Sirkunkuja residential Unit[#)], Kajaani (assisted living for people with intellectual disabilities) (1191/2017)
- 3 March Kainuu Social Welfare and Health Care Joint Authority, Leivolan asunnot[#)], (assisted living for people with intellectual disabilities), Kajaani (1193/2017)
- 5 April Eskoo Social Welfare Joint Authority, Tuulentupa and Neliapila (Institutional care for people with intellectual disabilities), Seinäjoki (2398/2017)
- 5 April Eskoo Social Welfare Joint Authority, Pikkupihlaja[#)] (institutional care for children with intellectual disabilities), Seinäjoki (2413/2017)
- 5 April Eskoo Social Welfare Joint Authority, children's and youth home Vanamo (child welfare unit), Seinäjoki (2526/2017)
- 5 April Eskoo Social Welfare Joint Authority, Kotomarkki (services housing for adults with intellectual disabilities) and Helakoti (residential services for young adults with intellectual disabilities), Seinäjoki (628/2017)
- 13 July City of Helsinki, Aurinkolahti group home[#)] (intensified support unit for people with intellectual disabilities) (4378/2017)
- 10 October Rinnekoti Foundation examination and rehabilitation Unit Turva[#)] (psychiatric institutional care for people with intellectual disabilities), Espoo (5794/2017)

- 10 October Rinnekoti Foundation Annala[#)] (small group home for children with intellectual disabilities), Espoo (6006/2017)
- 25 October Betanian lastenkodin säätiö, Koivukaarre[#)] (assisted living for people with disabilities), Suomussalmi (6295/2017)
- 26 October North Karelia Social Welfare and Health Care Joint Authority (Siun sote), Honkatähti[#)] (intensified support unit for people with intellectual disabilities), Liperi (5920/2017)
- 26 October North Karelia Social Welfare and Health Care Joint Authority (Siun sote), Leppälä[#)] (intensified support unit for people with intellectual disabilities), Liperi (6670/2017)
- 26 October North Karelia Social Welfare and Health Care Joint Authority (Siun sote), Tuulikello[#)] (institutional care for people with disabilities), Liperi (5922/2017)
- 26 October North Karelia Social Welfare and Health Care Joint Authority (Siun sote), Muksula, Pauliina and Majakka Units[#)] (institutional care for children and adolescents with disabilities), Liperi (6311/2017)
- 22 November Vaalijala Joint Authority, Residential Unit Luotain (psychiatric and psycho-social rehabilitation unit for adolescents aged 12–18), Pieksämäki (5662/2017)
- 22 November Vaalijala Joint Authority, Residential Unit Jolla (psychiatric rehabilitation unit for children and adolescents), Pieksämäki (6421/2017)
- 22 November Vaalijala Joint Authority, Satama (adult psychiatric crisis and rehabilitation service) and Luoto Unit (a closed unit for adults requiring special psycho-social and psychiatric support), Pieksämäki (7007/2017)
- 23 November Vaalijala Joint Authority, Kaisla (psychiatric and psycho-social rehabilitation and examination unit for adults), Pieksämäki (6800/2017)
- 23 November Vaalijala Joint Authority, Reimari (adult psychiatric and psycho-social rehabilitation centre), Pieksämäki (7006/2017)

Social welfare / elderly units

- 30 March City of Espoo Taavi Service Centre[#)] (intensified support unit for people with memory disorders), Espoo (2066/2017)
- 30 March City of Espoo Viherlaakso Service Centre[#)] (intensified support unit for people with memory disorders), Espoo (2065/2017)
- 4 July Helsinki Seniorisäätiö's Antinkoti[#)] (nursing home for people with memory loss) (4210/2017)
- 4 July Helsinki Seniorisäätiö's Kannelkoti[#)] (home for the elderly) (4211/2017)
- 24 October Serviced housing Arvola-home[#)] (private housing services for the elderly) , Kajaani (6198/2017)
- 24 October Care home Menninkäinen[#)] (private housing services for the elderly), Kajaani (6199/2017)
- 25 October Betanian lastenkodin säätiö, Serviced housing Aamurusko[#)] (assisted living for the elderly), Suomussalmi (6185/2017)
- 28 November Päijät-Häme Joint Authority for Health and Wellbeing, Marttila serviced housing, group home Päivänsini[#)] (intensified support unit for people with memory disorders), Orimattila (6712/2017)
- 28 November Päijät-Häme Joint Authority for Health and Wellbeing, Timontalo serviced housing[#)] (intensified support unit for people with memory disorders), Nastola (6713/2017)

Health care

- 14 March City of Espoo, Sobering-up station[#)] (1606/2017)
- 25–26 April Vanha Vaasa Hospital[#)], Vaasa (forensic psyciatric hospital) (2147/2017)
- 27 April Emergency Care Unit at Vaasa Central Hospital[#)] (2149/2017)
- 27–28 April Psychiatric Unit at Vaasa Central Hospital[#)] (2148/2017)
- 6 June Emergency Care Unit at Seinäjoki Central Hospital[#)] (2151/2017)
- 6–7 June The Hospital District of South Ostrobothnia, Psyciatry[#)], Seinäjoki (2150/2017)
- 19–20 September Päijät-Häme Joint Authority for Health and Wellbeing, Central Hospital, Psychiatric wards (5338/2017)
- 29 November Health Care Services for Prisoners, Outpatient clinic in Vantaa Prison (6454/2017)