



PARLIAMENTARY OMBUDSMAN OF FINLAND

SUMMARY
OF THE ANNUAL REPORT
2018

National Preventive Mechanism
against Torture

Contents

3.5 National Preventive Mechanism against Torture	72
3.5.1 The Ombudsman’s task as a National Preventive Mechanism	72
3.5.2 Operating model	73
3.5.3 Information activities	74
3.5.4 Education and training on fundamental and human rights	74
3.5.5 Training	74
3.5.6 Nordic and international cooperation	75
3.5.7 Visits	75
3.5.8 Police	77
Inspection visits require up-to-date information on the detention facilities in use	79
Compliance with the National Police Board’s circular in police prisons	79
Shortcomings in outdoor exercise areas	79
Distribution of medicines	80
Separation of investigation and detention responsibilities	80
Information about rights	81
Catering	81
Detention of a suspect in the drunk tank	82
Positive observations	82
3.5.9 The Finnish Defence Forces	83
3.5.10 The Finnish Border Guard and Customs	83
3.5.11 The Criminal Sanctions field	83
Conditions in solitary confinement	85
Placement of remand prisoners	86
Time spent outside the cell	87
Smoking ban	87
Impact of health care resources on prison activities	88
Treatment of foreign prisoners	88
Prisoner transport by train	89

Consideration of prisoners in need of special support	91
Positive observations and good practices	92
3.5.12 Alien affairs	92
Protection of privacy in the shower facilities of the isolation premises	93
Conditions in isolation premises	94
Identification of suicidal tendencies and suicide prevention	94
3.5.13 Units for children and adolescents in the social welfare services	95
Restrictive measures and setting limits are two different things	96
Decision-making on restrictive measures	97
Isolation	97
Restrictions on communication	98
Restricting the freedom of movement	98
Physical examinations and bodily searches	99
Room and mail searches	99
Punitive restrictions	100
Disciplinary measures provided for in the basic education act	100
Children's right to express their opinion and influence their everyday lives	101
The right to meet social workers	101
Employee behaviour	102
3.5.14 Social welfare units for older people	102
Restrictive measures used in units for older people	103
The safety of residents at night	105
End-of-life care	106
Outdoor time	106
The right to sufficient health care services	108
3.5.15 Residential units for persons with intellectual and developmental disabilities	110
Use of cage beds	112
Sufficiency of human resources	113
The realisation of privacy in housing services	113
Right to self-determination and opportunities for participation	113
Use of secure room	114
Outdoor time	115
Interviewing clients and their families	115
Use of security guards	115

3.5.16 Health care	116
Prevention of the mistreatment of patients	117
Seclusion premises	118
Treatment of patients in seclusion	119
The Deputy-Ombudsman recommended the patient to be compensated for their treatment while in seclusion	120
Decreasing the use of coercive measures	120
Use of mechanical restraints	120
Involuntary medication	121
Quality of care and care culture	122
Work for decreasing the use of coercion in a state forensic psychiatric hospital	122
Emergency units	124
Supervision of health care for prisoners	125

3.5

National Preventive Mechanism against Torture

3.5.1 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 application of the OPCAT has been intentionally made as broad as possible. It includes 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.

In the case of the Parliamentary Ombudsman's Office, however, it has been deemed more appropriate to integrate its operations as a supervisory body with those 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. Therefore, the number of visits conducted would remain considerably smaller. Participation in the visits and the other tasks of the Ombudsman, especially the handling of complaints, are mutually supportive activities.

The information obtained and experience gained during visits can be utilised in the handling of complaints, and vice versa. For this reason, too, it is important that those members of the Office'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, nearly 30 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. In its recommendations issued 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 Ombudsman submitted his statement on the matter to the Ministry for Foreign Affairs on 13 October 2017. The Ombudsman states that the Office has so far received no additional human resources to fulfil its remit as the NPM, although such increases have been proposed. The Office of the Parliamentary Ombudsman's operating and financial plan for 2019–2022 states that allowances should be made for increasing the human resources in the NPM's area of responsibility in the planning period. In the Office's estimate, two additional posts would be required in addition to the current legal adviser coordinating the duties of the NPM, obtained through internal organisational changes. The required additional officials would be a coordinator and assistant. In the budget proposal for 2018, the Ombudsman did not propose an appropriation for the new posts. This is partly due to the fact that the results of the report on the

division of duties between the Parliamentary Ombudsman and Chancellor of Justice have not been yet decided.

3.5.2 OPERATING MODEL

The tasks of the National Preventive Mechanism have been organised without setting up a separate NPM unit in the Office of the Parliamentary Ombudsman. 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 ten members and it is led by the head coordinator of the NPM.

The NPM has provides induction training for external experts regarding the related visits. The NPM currently has nine external health care specialists available from the fields of psychiatry, youth psychiatry, geriatric psychiatry, forensic psychiatry, geriatrics and intellectual disability medicine. Four other external experts represent the Disability Section of the Human Rights Centre, and their expertise will be used on visits to units where the rights of disabled people are being restricted. The NPM also employs five experts by experience. Three of them have experience of closed social welfare institutions for children and adolescents, while the expertise of the other two is used in health care visits.

During its visits the NPM strives 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.

3.5.3 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.

The reports on the inspection visits conducted by the NPM have been published on the Ombudsman's external website since the beginning of 2018. The NPM has enhanced its communications on visits and related matters in the social media.

3.5.4 EDUCATION AND TRAINING ON FUNDAMENTAL AND HUMAN RIGHTS

In order to promote human rights education and training, The Ombudsman and the Human Rights Centre started a joint project in 2017. The project is particularly targeted at the educational sector. 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. In 2018, the NPM initiated a joint project with the Human Rights Centre on the realisation of fundamental and human rights in housing services for the disabled. In preparation for the project, experts employed by the Human Rights Centre have participated in visits of service units for disabled people.

3.5.5 TRAINING

The Office of the Parliamentary Ombudsman provided training related to the duties of the NPM as follows:

- National patient ombudsman days / NPM inspection visits of health care units. Cooperation with patient ombudsmen during visits
- Training on the right to self-determination for special care districts / The Ombudsman's task as a national preventive mechanism
- Forty years of research into intellectual disabilities conference / The Ombudsman's inspection visits of institutions and housing services for the intellectually disabled
- The seminar organised by the Finnish Association on Intellectual and Developmental Disabilities / Human rights and housing
 - the perspective of the overseer of legality
- Costs and impact of foster care in child welfare services training day / What are the obligations and restrictions imposed by the law?
- Police criminal investigation seminar / Presentation of the Ombudsman's recent decisions concerning the police

The Office of the Parliamentary Ombudsman participated in training related to the duties of the NPM as follows:

- "Abuse and neglect. What has happened to the nurse's ethic?" / Finnish Nursing Congress and Exhibition
- The prisoner's social rights seminar, with topics such as "How are the fundamental rights of prisoners being realised? What is the significance of sentence planning for the implementation of imprisonment?" / The Training Institute for Prison and Probation Services
- Foreigners as perpetrators / The Training Institute for Prison and Probation Services The seminar was opened by Deputy-Ombudsman Pölonen
- Substance addiction as a disease and its treatment - is the Finnish model working? / Parliamentary Committee for the promotion of health and well-being

- The Mental Health Congress seminar, with topics such as “Psychosis patients in prison”
- Seminar on the oversight of legality in the criminal sanctions services. The topics included “How is the principle of legality fulfilled in the criminal sanctions service and especially in the implementation of imprisonment?” The presentations included recent decisions and policy guidelines issued by the overseers of legality, along with experiences from the field. Deputy-Ombudsman Pölönen gave a talk at the seminar

Two Office representatives also participated in an international training event held in Copenhagen on 3 and 4 January (“IOI Workshop for NPMs”). The topic was “Strengthening the follow-up to NPM recommendations” and the event was organised by the Danish Parliamentary Ombudsman, the IOI (International Ombudsman Institute) and the APT (Association for the Prevention of Torture).

The NPM organised an internal workshop whose content was “Restraint measures and involuntary treatment in mental health care settings” in May 2018. The workshop was conducted by Professor Georg Hoyer, Doctor of Philosophy and Emeritus Professor of Social Medicine at the University of Tromsø. Since 2010, Professor Hoyer is representing Norway at the CPT. He is Chairman of the Norwegian Research Network on the use of coercion in psychiatry. In addition to the Office’s representatives, external experts participated in Professor Hoyer’s workshop.

3.5.6 NORDIC AND INTERNATIONAL COOPERATION

The Nordic NPMs meet regularly twice a year. The Danish NPM organised a cooperation meeting in Copenhagen in January 2018. The theme of the meeting was solitary confinement in prisons and remand prisons, the various types of isolation and how they are addressed during visits. The “*de facto*” isolation of prisoners, i.e. the fact that, in practice, prisoners and remand prisoners are also

isolated in situations that have no basis in law, was the topic of much discussion at the meeting. The meeting also included a visit to a prison in which the majority of inmates were remand prisoners.

In August 2018, the Swedish NPM hosted a cooperation meeting in Lund. The subject of the meeting was the treatment of intoxicated persons and addicts by various authorities. The participants were given a tour of a treatment and rehabilitation unit for people with addictions.

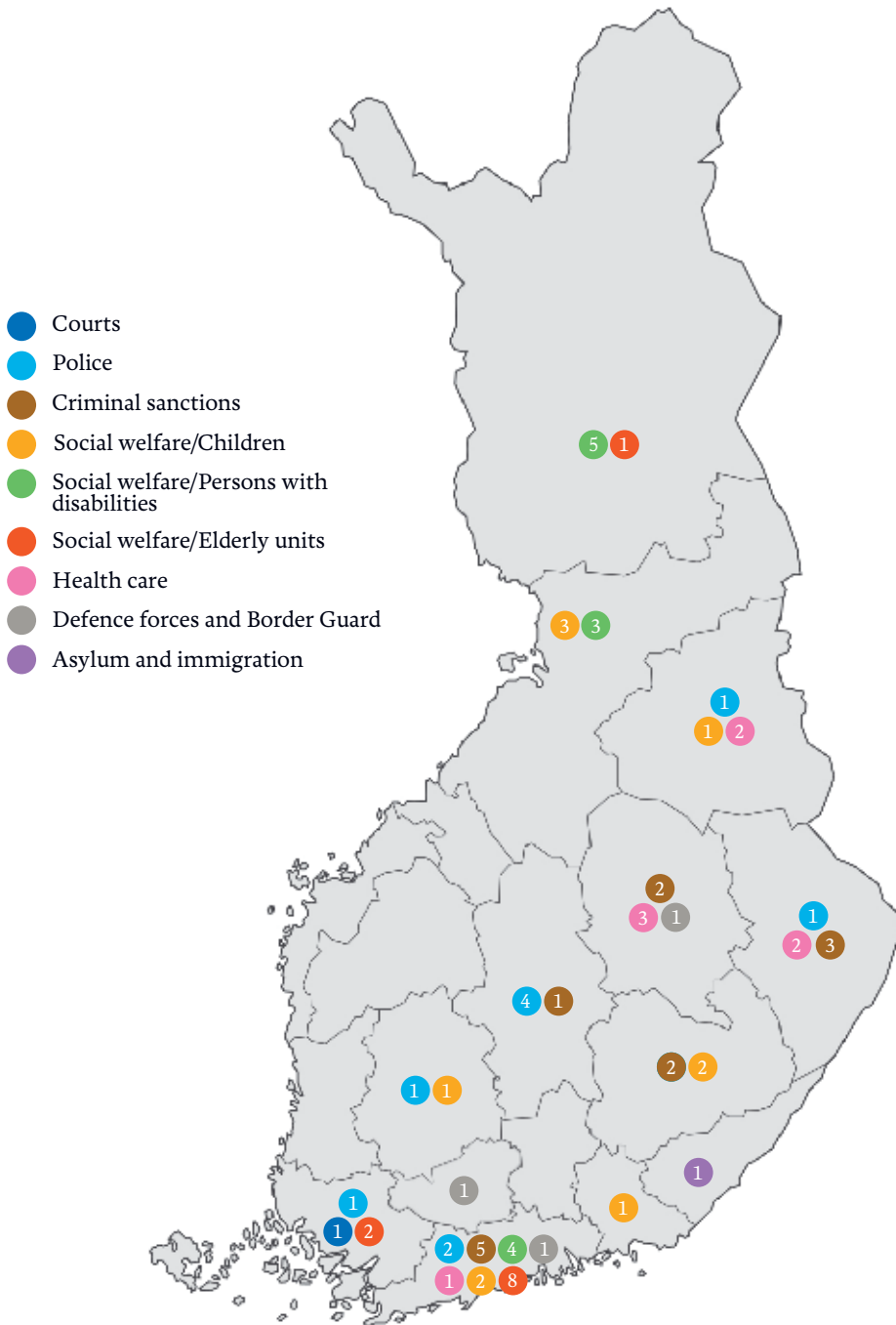
In November 2018, representatives of the Swedish Parliamentary Ombudsman visited the Office of the Parliamentary Ombudsman of Finland with the intent of studying the work methods and special tasks of the Ombudsman. During the visit, the guests were also introduced to the operations of the Finnish NPM.

Representatives of the Parliamentary Ombudsman of Georgia visited the Office of the Parliamentary Ombudsman of Finland in November 2018. They were interested in the operations of the Finnish NPM and, in particular, inspection visits of asylum seeker reception centres and detention centres for foreigners.

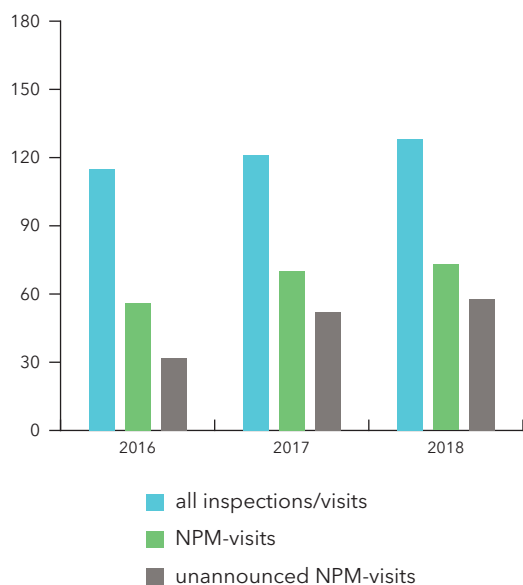
3.5.7 VISITS

Fulfilling the role of an NPM requires regular visits to sites. In some administrative branches, such as the police and criminal sanctions, such visits are also possible in practice. 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 2018, follow-up visits were made 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.

In 2018, the NPM conducted a total of 73 visits (out of 122 conducted by the Office as a whole). Most of the visits were made unannounced. Use of external experts has become an established



NPM visits by region in 2018. A full list of all visits and inspections is provided in Appendix 5.



Visits in 2016–2018.

practice in certain administrative branches. In 2018, external experts were involved in 19 visits. On four visits, the medical expert was supplemented by an expert by experience. The NPM intends to further increase the use of external experts.

Out of the other visits conducted by the Ombudsman, 5 were related to the duties of the NPM, such as visits to the National Police Board and the Central Administration Unit of the Criminal Sanctions Agency.

Since its establishment the NPM has 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.

One of the key themes for the Office of the Parliamentary Ombudsman for 2018 was the right to privacy. Further details on the theme of fundamental and human rights are provided in section 3.8.

In addition to the key theme, the special duties of the Ombudsman, i.e. the rights of children, the elderly and the disabled, are taken into account on each visit. The visits also involve the “oversight of oversight”, i.e. the realisation of the NPM’s duty to oversee the activities of other supervisory authorities.

3.5.8 POLICE

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. The greatest number of people, over 60,000 every year, are apprehended due to intoxication. The second largest group consists of persons suspected of an offence. A small number of people detained under the Aliens Act are also held in police prisons.

From 1 January 2019, the detention of remand prisoners in a police detention facility for longer than seven days has been prohibited without an exceptionally weighty reason considered by a court. The rationale presented in the government proposal (HE 252/2016 vp) also refers to the opinions expressed by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) and the Ombudsman, that police facilities are unfit for the accommodation of remand prisoners. The long-term goal must therefore be to gradually abandon the practice of holding remand prisoners at police facilities.

The Act on the Treatment of Persons in Police Custody (Police Custody Act) 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 facility-specific rules on custody (a rules template).

The reports on the Ombudsman’s visits are always sent to the National Police Board and the visited facility. 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 police operates 42 police prisons. Nine of the prisons are only intended for short-term custody. Police buildings are quite old, with the majority having been built in the 1960s to 1980s. Many of the buildings are at or near the end of their service lives. A national renovation plan for police prisons has been drawn up, but its implementation has been slow. The old buildings also afford limited potential for modification. In addition, visits have shown that the temporary solutions adopted for the duration of renovations can be quite unsatisfactory. Renovations can also radically increase the transport needs of persons deprived of their liberty.

In 2018, 13 inspection visits were made to police prisons. The visit to Pasila police prison also included a visit of health care at the prison. Visits are also made to the Ministry of the Interior's Police Department and the National Police Board each year. The NPM is in regular contact with the units responsible for the oversight of legality within the police force over matters such as the themes and targets of visits and recent decisions on complaints.

The sites visited were:

- Pasila police prison, 7 March 2018 and 22 March 2018, 94 cells, (849/2018)
- Pasila police prison health care, 7 March 2018 (1488/2018)
- Turku police prison, 17 April 2018, 71 cells, only some of which are in use due to a renovation (1963/2018)
- Kajaani police prison, 28 May 2018, 12 cells (2485/2018)
- Iisalmi police prison, 29 May 2018, 19 cells (2486/2018)
- Kuopio police prison, 29 May 2018, 31 cells (2487/2018)
- Varkaus police prison, 30 May 2018, 16 cells (2489/2018)



A cell at the Pasila Police Prison.

- Joensuu police prison, 30 May 2018, 48 cells (2490/2018)
- Lahti police prison, 3 July 2018, 48 cells (3332/2018)
- Jämsä police prison, 2 September 2018, 12 cells (4390/2018)
- Saarijärvi police prison, 3 September 2018, 8 cells (4391/2018)
- Jyväskylä police prison, 3 September 2018, 8 cells in temporary facilities (4392/2018)
- Mänttä-Vilppula police prison, 4 September 2018, not in use (4393/2018)
- Tampere police prison, 4 September 2018, 62 cells, only some of which are in use due to a renovation (4394/2018)

All visits of police detention facilities were unannounced. One visit (health care in Pasila police prison) was attended by an external expert (specialist in forensic psychiatry). The visit to Jämsä police prison took place on a Sunday, but the others were made on business days.

INSPECTION VISITS REQUIRE UP-TO-DATE INFORMATION ON THE DETENTION FACILITIES IN USE

Upon arrival at the site, it became apparent that the police prison had not been in use since 2014 at the latest. The visit had been planned on the basis of a list of police prisons in use, obtained from the National Police Board in November 2017. According to the list, the police prison contained seven cells for persons deprived of their liberty by virtue of an offence. The Ombudsman noted that the availability of reliable and up-to-date information on police detention facilities is crucial to the successful investigation of police activities. As a rule, visits to detention facilities are made unannounced, so checking in advance whether the detention facilities are in operation is not feasible. The list provided to the Ombudsman contained other errors as well. The Ombudsman requested the National Police Board to deliver an up-to-date report on the detention facilities used by the police (4393/2018).

COMPLIANCE WITH THE NATIONAL POLICE BOARD'S CIRCULAR IN POLICE PRISONS

In November 2017, the National Police Board issued a circular on matters that should be taken into account in police detention facilities. The circular contained 17 rectification requests, mostly based on observations made by the Ombudsman and the legality oversight unit of the National Police Board.

The visits showed that the implementation of the rectifications required by the circular varied between police prisons. The NPM noted shortcomings in areas such as the storage of medicines, safeguarding the confidentiality of telephone calls with legal representatives as well as knowledge of the provisions concerning appeal in the Police Custody Act. After the visits, the police departments were requested to indicate how they had taken each item of the circular into account.



The outdoor exercise area at the Kajaani Police Prison.

SHORTCOMINGS IN OUTDOOR EXERCISE AREAS

Not all police prisons have adequate outdoor exercise yards, and some are lacking them altogether. The acceptability of temporary solutions made during renovations also requires attention. Even temporary solutions are required to comply with the minimum requirements stipulated by law.

A temporary outdoor exercise area had been constructed for a police prison. The area was a small and dim veneer enclosure with direct access from the detention area. This exercise area was not fit for purpose (4394/2018).

The NPM noted a strong smell of tobacco in an outdoor exercise area of a police prison opened in May 2018. The Deputy-Ombudsman noted that the prison should consider how prisoners could be afforded the opportunity to take exercise in fresh air. The cleaning of outdoor exercise areas also requires more attention (3332/2018).

The Häme Police Department reported that there are only two outdoor exercise areas, one of which is mainly reserved for smokers deprived of their liberty. The other exercise area is only available to smokers when the police prison is so full that

equal access to outdoor exercise requires such a measure. However, a clear majority of persons deprived of their liberty are regular smokers. Particular attention has been paid to the daily cleaning of cigarette butts from the exercise area.

The police prison's exercise area was not fit for purpose. The area had next to no ventilation and was poorly cleaned (4391/2018).

DISTRIBUTION OF MEDICINES

The intention was to provide training in the distribution of medicines to all police department guards during 2018. This has not happened, however. The training programme was begun in November 2018, with the objective that all guards should have passed the course and examination by June 2019.



Storage of medication at the Joensuu Police Prison.

SEPARATION OF INVESTIGATION AND DETENTION RESPONSIBILITIES

In the context of the oversight of legality, it has frequently been noted that the responsibilities for investigating an offence and holding a suspect should be kept separate, administratively and in practice. If investigation and detention are left "in the same hands", there is a risk of detention conditions and the treatment of remand prison-

ers becoming dependent on the progress of the investigation and the remand prisoner's attitude towards it. Even though no such cases have been observed, the mere possibility gives cause for criticism. In this regard, practices such as the investigating officer managing the prisoner's meetings with family members are problematic. The police department should conduct a thorough assessment of the separation of investigation and detention responsibilities. This observation and opinion applied to nearly all visited police prisons.

According to the Deputy-Ombudsman, police prisons should have clear and uniform rules for obtaining a television, which should not be left to the decision of the investigating officer. Rather, the decision should be made by police prison staff according to these predefined criteria (849/2018).

According to the Helsinki Police Department, the police prison is equipped with 20 televisions, and access to them is subject to the discretion of the police prison staff. A specific guideline has been drawn up on the remand prisoners' right to obtain a television.

If no restrictions on communication have been imposed on a person, neither can the investigating officer impose such restrictions. In general, the interviews of remand prisoners indicated that the handling of the affairs of persons deprived of their liberty could be much delayed when they were referred to the investigating officer (849/2018).

According to the Helsinki Police Department, the intention was not to create artificial restrictions on communication, and the cases mainly involved the practical arrangements of meetings. The Act on the Treatment of Persons in Police Custody entering into force at the beginning of 2019 will change the visitation practices of all police prisons so that the practical arrangements will fall under the responsibility of police prison staff. Partly due to the increased resource need caused by this, the police department is recruiting new guards. Upon the entry into force of the Act on the Treatment of Persons in Police Custody at the latest, the police department will change its visitation practices so that police prison staff will be responsible for all practical arrangements of visits.

The visit arrangements and handling the affairs of all persons deprived of their liberty must be subject to the same criteria (2485/2018).

According to the Oulu Police Department, investigation and detention responsibilities have been separated in all of its police prisons both administratively and in practice.

INFORMATION ABOUT RIGHTS

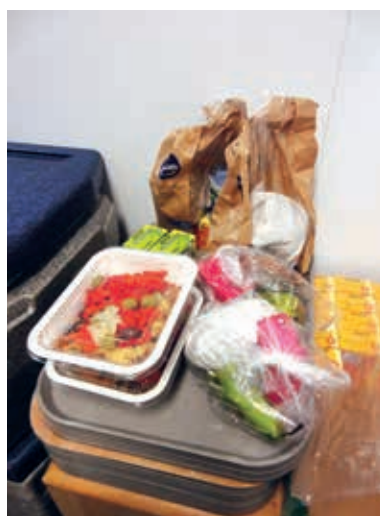
In accordance with the National Police Board guideline, persons deprived of liberty must be informed of their rights as well as of the daily routine in the detention facilities. Fulfilling this obligation must be recorded in the data system. The NPM noted that the police prison had not in all cases been recorded this information. Additionally, the police prison's compliance with another guideline issued by the National Police Board requires further information. According to this guideline, persons deprived of liberty (regardless of the grounds) must immediately upon arrival in the detention facility be provided with a form stating their rights and duties, the police prison's disciplinary regulations as well as the above-mentioned National Police Board guideline (4390/2018).

On visits to police prisons in Lapland in 2017, the Deputy-Ombudsman noted that the document describing the rights and duties of persons deprived of their liberty was available in several languages, some of them quite rare, but not in Sámi. Taking the provisions of the Sámi Language Act into account, the Deputy-Ombudsman considered it justified to have the document translated to all three Sámi languages (6796/2017).

The National Police Board reported having drawn up "Rights and obligations of persons deprived of their liberty" forms in Sámi.

CATERING

The Act on the Treatment of Persons in Police Custody specifies that meals must be organised for persons deprived of their liberty, ensuring that they receive healthy, versatile and adequate nutrition. More detailed provisions on catering are provided in a Decree of the Ministry of the Interior specifying that persons deprived of their liberty for a continuous period of more than 12 hours are entitled to two meals per day. At least one of these meals must be hot. Other nourishment appropriate with regard to the time and duration of detention can also be arranged for persons deprived of their liberty.



Catering at the Kuopio Police Prison.

Among other things, the catering at police prisons was investigated during the NPM's visits. The results have shown practices to vary considerably between police prisons and, for example, weekdays and weekends. In some situations, prisoners can be required to go without nourishment for too long. The Deputy-Ombudsman has taken the matter under investigation on his own initiative and requested the Ministry of the Interior to assess whether the prevailing practices and regulations in force secure the provision of the healthy, diverse and sufficient nourishment afforded by

law to persons deprived of their liberty in all situations (4488/2017).

The visits have also raised the question of how catering at police prisons should be assessed from the perspective of food legislation. The Deputy-Ombudsman has decided to investigate the matter. He found a joint investigation by the National Police Board and the Finnish Food Safety Authority Evira (the Finnish Food Authority from 1 January 2019) of the requirements imposed by food legislation on catering in police prisons, both as a whole and taking into account the various local arrangements, to be justified. The Deputy-Ombudsman also noted that the matters described in the report should also be taken into account in future amendments to the Police Custody Act and the decrees and regulations issued by virtue of the Act. The National Police Board was requested to report on the measures it had taken on the matter (59/2018).

As its position, the National Police Board stated that food safety was not completely realised in all police prisons. The Board indicated that it would continue investigating the matter in cooperation with Evira.

The NPM noted that the hot meal was offered quite early in the afternoon. The interval to the morning meal is long, even taking the light evening meal into account. The Deputy-Ombudsman noted that, if changing these meal times is not possible, particular attention should be paid to the diet and meal rhythm of those persons deprived of their liberty whose health requires such considerations, such as persons with diabetes (849/2018).

The National Police Board noted that the canteen delivers extra evening meal bags to the police prison each evening, which can then be distributed to persons who, on account of their health or other equivalent reasons, require more nourishment or meals at shorter intervals.

In his decision on the complaint, the Deputy-Ombudsman recommended the police to compensate the complainants for the harm suffered by them due to the police's serious neglect of its duty to arrange meals in the police prison by virtue of the Police Act. Four persons taken into custody by virtue of the Police Act were deprived of their liberty for 19 hours. They were served no food during this time (5304/2017).

The police reported that it had reached an agreement with the complainants for the compensation of the harm caused to them, and EUR 150 was paid in compensation to each complainant.

DETENTION OF A SUSPECT IN THE DRUNK TANK

Use of a police prison's detention facilities was banned due to indoor air problems. The temporary detention facilities were primarily reserved for persons detained by virtue of the Police Act, i.e. mostly intoxicated persons. Regardless of this, the documents and accounts of the guards seemed to indicate that persons taken into custody due to suspected offences were held there quite often. The criteria for this measure remained unclear, as there were no cells intended for such detainees in the facilities. A separate investigation of the matter was launched under the Ombudsman's initiative (4392/2018).

POSITIVE OBSERVATIONS

The circular sent by the National Police Board to police departments indicates that it is assuming the active role in the supervision of police prisons expected of it.

The Police University College has started again to hold guard courses every autumn and senior guard courses at somewhat longer intervals as of 2019.

3.5.9 THE FINNISH DEFENCE FORCES

In 2018, the NPM conducted three visits to the detention facilities of the Finnish Defence Forces. All of the visits were made unannounced.

The sites visited were:

- The detention facilities for persons deprived of their liberty of the Armoured Brigade's Riihimäki unit, 7 June 2018, two detention rooms (3117/2018)
- The detention facilities for persons deprived of their liberty of Karelian Air Command, 20 November 2018, three detention rooms (6084/2018)
- The detention facilities for persons deprived of their liberty of Guards Jaeger Regiment, 10 December 2018, three detention rooms capable of accommodating 12 persons (6511/2018)

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, the NPM paid attention to the conditions and treatment of those deprived of their liberty, their access to information, and their security.

3.5.10 THE FINNISH BORDER GUARD AND CUSTOMS

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 maxi-

mum 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 (6194/2017).

No visits to the Border Guard's or Customs' detention facilities were made in the reporting year.

3.5.11 THE CRIMINAL SANCTIONS FIELD

The Criminal Sanctions Agency operates under the Ministry of Justice and is responsible for the enforcement of sentences to imprisonment and community sanctions. The Criminal Sanctions Agency runs 26 prisons. Prisoners serve their sentences either in a closed prison or an open institution. Of Finnish prisons, 15 are closed and 11 open institutions. In addition, certain closed prisons also include open units. Visits mainly focus on closed prisons. The average number of prisoners has remained stable at around 3,000 prisoners for several years now.

There are major construction projects related to prisons currently under way in the criminal sanctions field. The greatest international attention has been focused on the prisons of Helsinki and Hämeenlinna, which have used "bucket cells", i.e. cells without a flush toilet in them. This has no longer been the case in Helsinki Prison after the completion of the renovation in the spring of 2017. The replacement of Hämeenlinna Prison with a new facility has been planned, with the new prison slated for completion in the autumn of 2020. Indoor air problems were discovered in the current facilities, however, and use of the prison building was discontinued immediately in December 2018.



A renovated cell hallway at the Helsinki Prison.

In the reporting year, the Deputy-Ombudsman issued one statement to the Legal Affairs Committee of Parliament on a government proposal related to prisoners (4724/2018). The proposal suggested a new, discretionary basis for imposing supervision on prisoners released to probationary freedom. The proposed basis for supervision was a high risk of repeating a violent or sex offence. In 2018, the NPM also gave two statements to the Department of Criminal Policy at the Ministry of Justice and made 10 proposals, most of which involved legislation or drawing up internal guidelines for the administrative branch.

The Deputy-Ombudsman proposed the payment of compensation in one decision concerning a complaint made by a prisoner. The prison had charged the prisoner's bank account as compensation for a broken item without the prisoner's consent. The Deputy-Ombudsman stated that the prison did not have the right to do this without

the prisoners consent and was therefore required to return the funds to the prisoner. If an agreement cannot be reached on the matter, the prison should file an action for damages in the court (3721/2017).

The prison reported that it had returned the money to the prisoner's account

In the field of criminal sanctions, visit reports are sent for information to the Central Administration of the Criminal Sanctions Agency, the management of the criminal sanctions region in question and the 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 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 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.

Visits to the Central Administration Unit of the Criminal Sanctions Agency and Department of Criminal Policy at the Ministry of Justice were also made in the reporting year.

The NPM made a total of 13 inspection visits were made in the field of criminal sanctions. Six of these visits involved the whole facility.

The visited facilities were:

- Kerava Prison, 30 January 2018, 94 places (448/2018)
- Laukaa Prison, 23 May 2018, 59 places (2337/2018)
- Kuopio Prison, 23 May 2018, specific theme (2338/2018)
- Sulkava Prison, 3 May 2018, 48 places (2339/2018)

- Mikkeli Prison, 24 May 2018, specific theme (2340/2018)
- Prisoner transport by train, 29 May 2018 (2648/2018)
- Accessibility in Jokela Prison, 20 June 2018 (3183/2018)
- Juuka Prison, 9 October 2018, 40 places (4652/2018)
- Pyhäselkä Prison, 9–10 October 2018, 87 places (4653/2018)
- Accessibility in Pyhäselkä Prison, 10 October 2018 (5322/2018)
- Helsinki prison, 27 and 29 November 2018, 312 places (5563/2018)
- Visiting area premises of Kuopio Prison, 20 November 2018 (6085/2018)
- Accessibility in Helsinki Prison, 27 November 2018 (6148/2018)

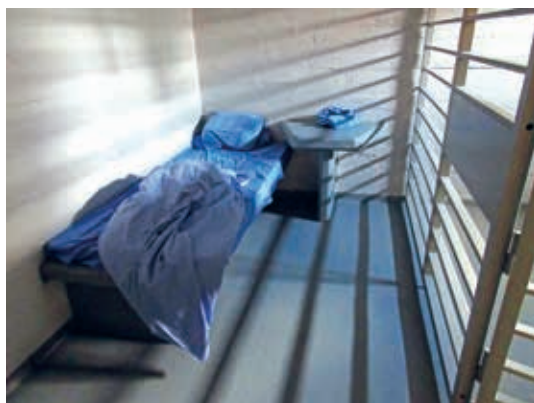
The inspection visits were announced with the exception of the visits of the prisoner transport, Mikkeli Prison, Jokela Prison and the visiting premises of Kuopio Prison. The visit to Mikkeli Prison was mainly a follow-up to the visits conducted in 2016 and 2017.

The observations made during the prison accessibility inspection visits are also reported in Section 3.4 (Rights of persons with disabilities).

The Kerava, Pyhäselkä and Helsinki outpatient clinics of Health Care Services for Prisoners were visited in addition to the above. These visits are described in the health care section.

CONDITIONS IN SOLITARY CONFINEMENT

Provisions on the conditions of observation were added to the Imprisonment Decree in 2015. Among other things, these provisions state that a prisoner's rights may only be restricted if it is necessary in order to fulfil the purpose of observation. The grounds for placing the prisoner under observation must be taken into consideration in restricting the prisoner's rights. In other words, being placed under observation should not automatically mean that, for example, the prisoner would have to eat on the floor.



Seclusion facilities at Juuka Prison.

In his decision issued on 23 February 2018, the Deputy-Ombudsman commented on the furnishings of isolation cells and observation cells. He considered it problematic that all cells in the isolation unit of Riihimäki Prison were unfurnished. The only piece of furniture was a mattress on the floor. Unfurnished isolation cells were also discovered in other prisons. Prisoners are placed in isolation cells on various grounds, for example as a disciplinary punishment or safety measure. For this reason, the type of cell and conditions that each prisoner should be placed in must be considered on a case-by-case basis. According to the Deputy-Ombudsman, it cannot be a general principle that a prisoner can be placed in an unfurnished cell in all situations. He also noted that the prisons should acquire furniture that they could issue to prisoners for their cells. Making prisoners eat on the floor is not acceptable with regard to their human dignity. Different prisons have different practices in the above-mentioned matters. The Deputy-Ombudsman considered it to be justified and important that the Central Administration Unit of the Criminal Sanctions Agency would issue guidelines to prisons on how and in what conditions placement in an isolation unit should be implemented (1276/2017*).

The Criminal Sanctions Agency reported that it will issue guidelines on how and in what conditions solitary confinement should be implemented. The

Central Administration Unit will review the furniture of each unit, taking into account the requirements specified in the Ombudsman's decision.

The only furniture in the isolation cells consisted of a toilet seat and a mattress on the floor (4653/2018).

According to the prison, four table cubes had already been purchased and installed.

The Imprisonment Act requires cells to be equipped with alarm devices that can be used to contact prison staff immediately. Using the alarm button to contact prison staff required the person placed in the cell to go down on their knees and lie down on their stomach to reach the button. This could put the person's life in danger in the event of, for example, a seizure. From the perspective of the persons deprived of their liberty, the location of the button could be seen as extremely humiliating (2338/2018).

The Criminal Sanctions Region of Eastern and Northern Finland reported that the old buttons in Kuopio Prison had been decommissioned, and new buttons were located at door handle height from the floor. Photographs of the new button locations were enclosed with the report.



Deputy-Ombudsman Pölönen is trying out the accessibility of the alarm button.

The NPM recommended the prison to issue drinking water to prisoners in plastic bottles until working water taps could be installed in the cells. The prison took measures to purchase plastic bottles immediately during the visit (2340/2018).

The NPM found that the lights of one of the isolation cells did not work at all. After the visit, the facility reported that the fault in the lights had been repaired and they were once again operational. According to prison management, the isolation cell had been last used in June 2018. The bed in the cell was still unmade (in October). After the visit, the prison reported that the used bed linen had been removed and the cell cleaned (4652/2018).

The isolation cell was equipped with a toilet but no water fixture. There was a pallet in the cell, but no proper bed. The footage from the surveillance camera could be viewed in the control room. It was impossible to tell from the camera in the cell when it was on. The cell's toilet seat was visible in the camera view on the screen. Therefore, when the camera was on, a prisoner placed in the cell could not go to the toilet without being surveilled by a camera. During the visit, the prison was made aware that camera surveillance of a prisoner placed in an isolation cell was only permitted under the Imprisonment Act if the prisoner had been placed in the cell for observation or isolation under observation (4652/2018).

PLACEMENT OF REMAND PRISONERS

The Remand Imprisonment Act requires separate units for remand prisoners and convicted prisoners. Remand prisoners may only be placed in the same unit as convicted prisoners when the specific conditions provided for by law are met.

It was an established practice in the prison to place convicted prisoners and remand prisoners in the same units. This had already been pointed out to the prison during an inspection made by the Ombudsman in 2007. At the time of the visit, the prison was nearly fully occupied and the numbers of remand prisoners varied a great deal. There were also relatively few units in the prison. These factors presented understandable difficulties in

the housing of remand prisoners. However, separating remand prisoners from other prisoners is a principle clearly prescribed by national legislation and international recommendations, which is based on the presumption of innocence. The Deputy-Ombudsman noted that the placement of remand prisoners had not been done according to the law, or even according to the prison's own placement instructions or the unit division specified in the daily schedule. In the case of female remand prisoners, a further error had been committed in placing them in the same cells with convicted prisoners (4653/2018).

TIME SPENT OUTSIDE THE CELL

The Ombudsman's decisions and international recommendations have for a long time been based on the premise that prisoners should be permitted to spend a reasonable amount of time, and no less than eight hours per day, outside their cells. During that time, they should be able to engage in meaningful and stimulating activities, such as work, rehabilitation, training and exercise.

After the visit, the NPM asked the prison to provide a report on how many hours of activities the prisoners had attended in a certain week. The situation appeared to be quite good on weekdays, when the majority of prisoners spent more than eight hours per day out of their cells. In the weekends, however, the situation was clearly worse. In addition, the female prisoners' extremely poor ability to function set limits on their placement in activities. The Deputy-Ombudsman noted that open units were difficult to achieve merely by increasing the amount of activities. The Deputy-Ombudsman did not see why cell doors could not be open also when there was no organised or supervised activity going on in the unit (4653/2018).

Depending on the unit, the prisoners had the opportunity to spend from three to five hours out of their cells each day. In addition, the prisoners of two units were not permitted to visit the prison shop, but had to order the products they wanted (5563/2018).

A default prisoner is a person serving a conversion sentence in lieu of an unpaid fine. A conversion sentence is passed for a person sentenced to a fine if efforts to collect the fine have been unsuccessful. The placement of default prisoners is subject to the same provisions as that of convicted prisoners, and they have equal rights to participate in activities. Not a single default prisoner had been placed in an activity, however. The unit was the most closed in the prison, and no activities had apparently been arranged for the prisoners (5563/2018).

SMOKING BAN

The Imprisonment Act permits smoking to be banned in the accommodation premises of prisoners. If smoking is prohibited in cells, prisoners must be provided with the opportunity to smoke in a designated space or in other ways. The Central Administration Unit of the Criminal Sanctions Agency decides on the prohibition of smoking in prisons. It also issues more detailed regulations on smoking arrangements. On 15 June 2018, the Central Administration Unit issued a regulation stipulating that prisoners were to be allowed to smoke for a minimum of three times a day at regular intervals, such as in the morning, afternoon and evening. Helsinki Prison is the first prison to ban smoking in its residential premises. The smoking ban entered into force on 1 August 2018.

Regarding the smoking ban, the NPM focused on the prison's practical smoking arrangements as well as the prisoners' attitude toward it. The Ombudsman had received several complaints regarding the smoking ban, so the visit did not address the actual prohibition of smoking. The prisoners did not have many complaints about not being able to smoke in the residential quarters anymore. Instead, they criticised the decisions and practices related to the prohibition of smoking. Due to the limited amount of storage space in the units, the purchase of tobacco products had been limited to three packs of cigarettes per week by decision of the prison director. Neither were the prisoners allowed to roll their own cigarettes anymore,

which is cheaper. Giving one's cigarette to another prisoner during outdoor exercise was forbidden. The NPM was told that only prisoners who took their own cigarettes (a maximum of two) with them were allowed to go outside to smoke. Thus, prisoners who did not smoke could potentially spend less time out of their cells than smokers. The NPM also heard that prisoners who were caught smoking elsewhere than in the smoking yard would face a two-week ban on buying cigarettes (5563/2018).

IMPACT OF HEALTH CARE RESOURCES ON PRISON ACTIVITIES

During the visits made to Kerava Prison and VTH Kerava outpatient clinic, the NPM observed that a lack of personnel at the clinic limited the number of prisoners undergoing opioid substitution treatment that could be admitted into the prison. The Deputy-Ombudsman found it a cause for concern that a transfer to an open institution could be prevented by a lack of health care resources (448/2018). The same issue was discovered on a visit to Sulkaiva Prison in May 2018 (2339/2018).

The Deputy-Ombudsman noted that the co-operation between the Criminal Sanctions Agency and Health Care Services for Prisoners (VTH) was not optimal with regard to taking the prisoners' need for health care services and the availability of health care personnel resources into account in the placement of prisoners. As key players in the process, the assessment centres should be aware of the facilities' capacity for meeting the health care needs of prisoners placed in them. VTH's treatment guidelines require multidisciplinary co-operation in the implementation of substitution treatments. The team includes a drug and alcohol counsellor employed by the prison. In accordance with the guidelines, a drug and alcohol counsellor's duty is to take care of the psychosocial rehabilitation of prisoners receiving substitution treatment. The guidelines also specify minimum requirements for the presence of a nurse and physician in the prison before substitution treatment can be implemented in the first place. It seemed

that these requirements were not being met in all open institutions. The Deputy-Ombudsman recommended that the prisoner's state of health should always be taken into account in the prisoner's placement when it is known that the prisoner will have a greater than average need for health care services. At the very least, this applies to prisoners with disabilities and prisoners receiving substitution treatment.

TREATMENT OF FOREIGN PRISONERS

The proportion of foreign prisoners in Finland's prisons has grown. At present, roughly 18 per cent of all prisoners are foreign nationals. The NPM seeks to take these prisoners into account during visits, for example by interviewing them with the help of an interpreter. In these interviews, the NPM seeks to determine whether the prisoners have been informed of their rights and duties, for example.

Prisons still do not employ adequate interpretation services when dealing with foreign prisoners (2339/2018).

The prison reported that it had requested a quotation for interpretation services in order to provide the service in the prison. The working groups will discuss uniform practices for the use of interpretation services.

Even though the guide for new prisoners may have been translated into several languages, the translations are not always actively offered to foreign prisoners arriving at the prison. The availability of books and magazines in other languages also varies between prisons. In particular, foreign prisoners would like to have access to foreign TV and radio channels (5563/2018). The Deputy-Ombudsman has begun an investigation into the opportunities of foreign prisoners to watch television.

In connection with a visit to the Department of Criminal Policy at the Ministry of Justice, the Deputy-Ombudsman expressed the opinion that the Imprisonment Act and Remand Imprison-

ment Act should be translated into English for distribution to prisoners.

According to information received from the Ministry of Justice, the translations have been completed and are available in Finlex. The Criminal Sanctions Agency has been requested to ensure that foreign prisoners are informed of their rights through the translations.

When interviewed, foreign prisoners describe similar issues as other prisoners, i.e. that visiting rights are not fulfilled or that living in a closed unit causes anxiety. On the other hand, fewer foreign prisoners have complaints about the behaviour of prison officers.

In 2018, the Criminal Sanctions Agency announced on its website that it has published multi-lingual orientation materials. In connection with this, a video guide for new prisoners was published in five languages. The objective is for the video to provide prisoners with sufficient basic information on their rights and term of sentence and the operation of a closed institution in their own language. Helsinki Prison was not aware of these materials at the time of the NPM's visit in November, so the NPM did not have the opportunity to investigate the prisoners' experiences of the video guide.

PRISONER TRANSPORT BY TRAIN

The prisoner transport route starts in Helsinki and ends in Oulu. The duration of the trip is nearly nine hours. In addition to this, prisoners joining the transport at the station of departure are brought into the train approximately one hour before its departure, so prisoners can spend up to ten hours on the train. The NPM travelled on the train for approximately one hour, from Helsinki to Lahti. Four prisoners were interviewed during the inspection visit. At that time, the total number of prisoners being transported was five.

The information on the potability of the water drawn from cell taps was contradictory. The Deputy-Ombudsman found cause to investigate the potability of the water drawn from cell taps. If nothing else, the quality of the water should be investi-

gated for the reason that the cars have been in use for approximately 35 years. According to the Deputy-Ombudsman, the cells should have notices for the prisoners on the potability of the tap water.

Furthermore, the Deputy-Ombudsman stated that the prisoners must absolutely be informed of the availability of drinking water, whether from the tap or a bottle. In any event, the prisoners' access to drinking water during the trip must be rectified immediately, if necessary by purchasing bottled water. This must be communicated clearly enough and also with due consideration of prisoners who do not speak and/or understand Finnish.

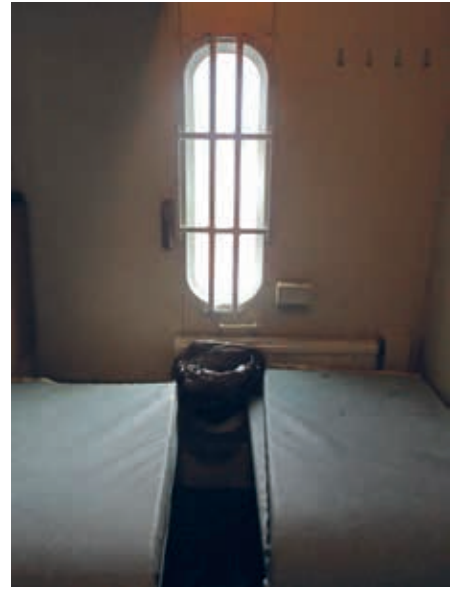
The Criminal Sanctions Agency reported that bottled water had been acquired for the prisoners as a stop-gap measure and a notice on the matter was being drawn up. The notice also states that the tap water should not be drunk as its potability is under investigation. This notice for prisoner car passengers will be drawn up in eight languages.

The Deputy-Ombudsman found the practice that prisoners had to use the toilets in the presence of other prisoners to be degrading of their human dignity. The practice is also a serious violation of the prisoners' right to privacy. In addition to the prisoner using the toilet, the practice is demeaning for the other prisoners in the cell, taking into account the cramped conditions and poor ventilation. The screen envisioned in the Criminal Sanctions Agency's statement does not change these circumstances. The Deputy-Ombudsman found no cause to doubt the guards' account of prisoners being permitted to use the toilet in private upon request. However, a situation in which the prisoners are not aware of this possibility is equivalent to a situation in which the possibility does not exist. The opportunity must be communicated clearly enough and also with due consideration of prisoners who do not speak and/or understand Finnish.

The Criminal Sanctions Agency stated that it had begun drawing up a notice to be posted on the wall of the prisoner car, indicating that prisoners could ask the guards to be permitted to go to the toilet privately. In the future, this information will also be communicated verbally to all prisoners being transported.



A prisoner carriage at the departure train station in Helsinki and photographs from inside the carriage cells.



On the left, a photograph of a toilet in a cell. Above, a photograph of the tanks for drinking water in a prison carriage.

The Deputy-Ombudsman considered it necessary to inspect the operability of the car's alarm and other technical devices regularly, preferably after every transport. The cleanliness of the cell and, for example, the condition of the mattresses also requires better care. The Deputy-Ombudsman exhorted the Criminal Sanctions Agency to investigate whether anything could be done about the heat in the cells. The need to clean the ventilation ducts should also be determined.

The Criminal Sanctions Agency reported that, in the future, the operability of the toilet and guard call buttons would be checked on a regular basis. The Railway Company (VR) had contacted the company responsible for cleaning the prisoner car in order to improve the level of cleanliness. The walls were cleaned as an immediate measure. VR notified the Ombudsman that it would replace the mattresses in the prisoner cars and have the ventilation ducts cleaned on a regular basis. Other measures for alleviating the heat were also being looked into.

Non-smoking prisoners should not be placed in the same cell with smokers against their will. The prisoners' must be asked about their opinion in this.

One of the targets set in the Criminal Sanctions Agency's strategy is making the Criminal Sanctions Agency smoke-free by 2020. According to the Criminal Sanctions Agency, the conditions of the prisoner car will also be taken into account in this project.

The Deputy-Ombudsman suggested that the Agency should review the quality and quantity of the prisoners' packed lunch for the trip. Particular attention should be paid to the needs of prisoners whose health requires the observance of a special diet (such as diabetics).

The Criminal Sanctions Agency reported that an overall reform of catering was being planned, and the issues noted in the NPM report would be taken into account in it. The contents of the packed lunches will be updated, and the new lunches will be available from the start of 2020.



The Deputy-Ombudsman did not approve of the use of the prisoner transport car to carry prisoners with conditions that require special health monitoring and involve the risk of a seizure. Assessing the health risk of prisoners is not the duty of the guards responsible for the transport, but belongs to health care professionals.

CONSIDERATION OF PRISONERS IN NEED OF SPECIAL SUPPORT

The prison is not always aware of prisoners' disabilities or conditions impairing their ability to function, such as minor intellectual disabilities or autistic disorders such as Asperger's or ADHD, if this information is not provided by the prisoners themselves. However, such information and the ways in which the disabilities or disorders affect the lives of the prisoners are crucial for setting the prisoner's targets in the sentence plan and defining the methods for achieving such targets. The investigators were unable to determine to what extent Health Care Services for Prisoners is involved in drawing up and monitoring the sentence plans of prisoners in need of special support (5322/2018).

The cell for disabled prisoners was located in the unit for new arrivals. There were no common recreational areas in the unit, and the cell doors were kept closed. All prisoners placed in the unit's cells – including the prisoner in the cell for the disabled – had their meals in their cells. The possibility for daily outdoor exercise was provided in the unit. The Deputy-Ombudsman noted that, since the cell for disabled prisoners was located in the arrivals unit, this meant that, in practice, prisoners with impaired mobility had to be placed in a closed unit even if they would otherwise have been eligible for placement in an open unit. This practice for the placement of prisoners with impaired mobility was not in compliance with the Imprisonment Act (5322/2018).

POSITIVE OBSERVATIONS AND GOOD PRACTICES

Everyone had the opportunity to use the prison shop. Even prisoners in solitary confinement were given the opportunity to go shopping once a week. No-one was required to make their purchases by filling in an order coupon (4653/2018).

In connection with a visit to Vantaa Prison in late 2017, the Deputy-Ombudsman was shown a picture book titled “Welcome to Vantaa Prison”, drawn up for visitors and especially children. From the book, visitors got a better idea of the conditions in which their family members were imprisoned, which helps to alleviate their concerns about the situations of their loved ones. The Deputy-Ombudsman commended the picture book idea highly and hoped that this initiative would be adopted in all prisons (6206/2017).

Vantaa Prison had also drawn up a cookbook, which instructs the prisoners in cooking with the products available in the prison shop. Several prisoners participated in writing the book, and all recipes were tested by the head cook. Cooking is a life management skill. The Deputy-Ombudsman found the guide to be a highly commendable idea and hoped that other prisons would also introduce the guide or draw up similar guides of their own (6206/2017).

3.5.12 ALIEN AFFAIRS

There were approximately 10,700 asylum seekers in Finland at the end of 2018, the majority of them housed in 43 reception centres. In addition to the reception centres, there were six units for children who had entered the country alone. Some asylum seekers are also housed in private accommodations. 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. Both currently operate under

the Finnish Immigration Service, as the Metsälä detention unit was transferred from the City of Helsinki to the Finnish Immigration Service on 1 January 2018. The Joutseno detention unit has 68 places and the Metsälä unit 40 places.

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 release published by the Finnish Immigration Service, 163 new clients were registered in the assistance system in 2018, and 52 of them were thought to be victims of abuse pointing to human trafficking in Finland. In total, the assistance system had 455 clients at the end of 2018.

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. The immigration police of Helsinki Police Department was the subject of an inspection in the reporting year (1658/2018).

Until now, inspections to reception centres have been made under the jurisdiction of the Parliamentary Ombudsman. An example would be the unannounced inspection of Lahti Reception Centre, an enhanced support unit maintained by the Finnish Red Cross with 20 places. The unit is intended for adult asylum seekers suffering from mental health or substance abuse problems.

The aim is to make regular visits to both detention units. The NPM visited the Metsälä Detention Unit in December 2017 (6966/2017) and the Joutseno Detention Unit in November 2018 (5145/2018). The following opinions and recommendations concern the Joutseno Detention Unit.



The photos are taken at Joutseno detention unit. On the left, a place for washing feet. On the right, a new indoor football court.

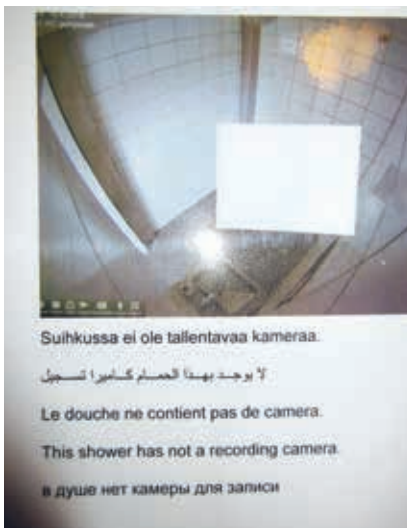
PROTECTION OF PRIVACY IN THE SHOWER FACILITIES OF THE ISOLATION PREMISES

On the previous inspection visit, the NPM had pointed out that the isolation room's surveillance camera had been installed in a manner that permitted viewing the torso of the person in the shower. The Ombudsman was not convinced that a surveillance camera was necessary in the shower room. According to the Finnish Immigration Service, the surveillance camera was necessary, especially due to the safety of suicidal clients. The prevention of vandalism was cited as another important reason for surveillance. After the Ombudsman gave his opinion, the camera surveillance of the shower facilities was nevertheless changed to exclude the torso of the person using the shower from the picture. In addition, a sign explaining what parts of the body are not visible in the camera was posted on the wall of the shower room. The surveillance camera in the shower premises was non-recording.

The Ombudsman noted that, by virtue of the Detention Act, all premises in the detention unit could be placed under camera surveillance. Recording surveillance cameras are not allowed in certain premises of detention units – such as the

accommodation, toilet and shower areas. The only exception to this are facilities in which persons are kept in isolation – such facilities are not considered as accommodation space and the use of recording camera surveillance is allowed in them. The Ombudsman noted that no other administrative branch that has premises for keeping persons deprived of their liberty has a statutory right to use surveillance technology in the scope permitted in alien detention units. This is true for psychiatric hospitals, prisons and police detention facilities alike. Suicidal persons and persons with a risk of causing property damage are also placed in isolation in these facilities.

The Ombudsman was not convinced of the necessity of camera surveillance in the isolation area's shower room. If an individual case requires a person to be under constant supervision due to a risk of self-harm, the Ombudsman considered having someone monitor them in person when they take a shower would be a better alternative. The Ombudsman found the situation to be particularly problematic with regard to the right to privacy of foreign persons placed in the detention unit. The toilets and shower rooms in facilities for keeping persons in isolation are for both male and female detainees placed in isolation. The surveil-



Camera surveillance in the shower facilities of the seclusion premises.

lance personnel also contains members of both sexes. The supervised person is not aware of who is watching them and cannot know whether there is more than one person in the control room. Being aware of being watched while taking a shower may affect a person's willingness to wash themselves at all. Neither was the Ombudsman convinced of the adequacy of the present changes to the shower room's camera surveillance in safeguarding the privacy of its users. It is apparent from the surveillance monitor that the person can be watched right until the moment they are standing under the shower.

CONDITIONS IN ISOLATION PREMISES

The isolation premises were renovated and clean, but very ascetic and cell-like. The Ombudsman recommended the detention unit to take measures to ensure the appropriate and dignified treatment of detainees held in the current isolation premises. The room should have at least some type of level surface for eating. The thin mattress used as a bed should be replaced with a thicker, bed-like mattress. The Ombudsman also recommended the

purchase of clocks for the isolation premises so that a person would have the opportunity to keep track of time.

The detention unit reported that it had purchased 30 cm high safety beds and cube tables for the isolation rooms. Clocks would also be purchased for the premises.

IDENTIFICATION OF SUICIDAL TENDENCIES AND SUICIDE PREVENTION

Several cases involving suicidal tendencies and one suicide had occurred in the detention unit during the year. During the visit, the management of the detention unit was provided with information on the Criminal Sanctions Agency's training materials for suicide-prevention and the assessment of the need for urgent care. The NPM had the impression that the detention unit was not aware of the Finnish Immigration Service's instructions concerning these matters.

The Ombudsman recommended that the Finnish Immigration Service should review its guidelines concerning suicides in order to assess whether they contain enough information on

the identification of suicide risks and the actions, responsibilities and communication of employees for the prevention of suicides. The staff's awareness of the guidelines and training in the prevention of suicides should also be increased.

3.5.13 UNITS FOR CHILDREN AND ADOLESCENTS IN THE SOCIAL WELFARE SERVICES

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. There are roughly 770 units providing foster care services in Finland, out of which some 670 are run by private service providers.

Visits by the NPM have been made exclusively to institutions or similar units. As many children as possible, i.e. everyone who will talk to the NPM, are interviewed during child welfare visits. The children interviewed are assured that they can contact the NPM if they are subjected to disciplinary or other similar measures following the visit. The personnel are also reminded that any retaliatory measures against the children are prohibited. This is also mentioned in every visit report.

The visits are, as a rule, unannounced and usually last one or two days. The visits focus on any restrictive measures to which the children may be subjected and the related decision-making process: whether a decision on restrictive measures has been made or not, and has the child been heard regarding the decision. Shortcomings have also been detected in notifying the children of decisions. There is also a lack of awareness of the difference between restrictive measures and acceptable child-rearing methods. Restrictions may be imposed on the children as part of their normal upbringing, but most such restrictions require an administrative decision.

The Deputy-Ombudsman has considered it necessary that the authorities charged with the supervision of foster care react when they notice such issues or deficiencies in foster care that could affect the treatment or care of the child. The authorities should notify the municipality of placement, State Regional Administrative Agency (AVI) and any other municipalities that are known to have placed children in the same place of foster care of such situations without delay. The State Regional Administrative Agency responsible for the regional steering and supervision of social welfare services should also communicate any shortcomings, especially to the municipalities responsible for the placements.

All visit reports are sent to the unit which has been visited and to the local AVI. Some reports are also 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. The Deputy-Ombudsman has required that social workers discuss the content of the report with the placed child.

Institutions usually take 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 visit report. In the reporting year, however, the Deputy-Ombudsman was exceptionally forced to strictly remind one institution of its obligation to comply with the opinions of the authority charged with the oversight of legality. The Deputy-Ombudsman also drew the institution's attention to the Parliamentary Ombudsman's and NPM's right to receive information. The Deputy-Ombudsman was forced to emphasise that the child welfare institutions have the obligation to cooperate with the Parliamentary Ombudsman or other overseers of legality in order to provide them with all of the information required to perform the inspection

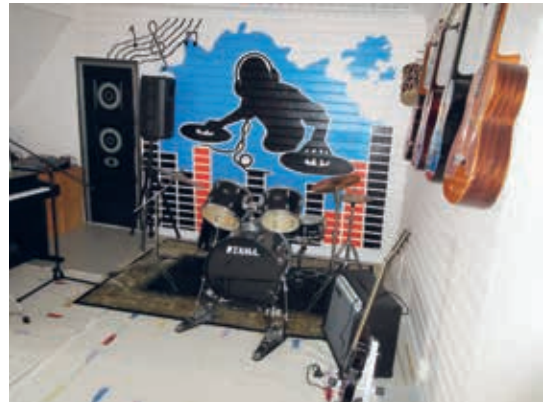
visit and effectively fulfil the children's right to be heard during the visit (1353/2018).

There has also been cause to stress the reasons for and significance of the prohibition against retaliation. The dialogue with the child welfare institution revealed that the unit's employees had not comprehended the contents of the UN Convention against Torture in this regard and experienced the prohibition against retaliatory measures, noted in the visit report, as insulting. The Deputy-Ombudsman noted that it is ultimately the responsibility of the institution's management to ensure that the institution's employees are familiar with the peremptory legislation related to their work and the duties, activities and jurisdictions of the various supervisory authorities, including the right to make unannounced inspection visits to the institution, during which the NPM have the right to interview the persons placed in the institution. The Deputy-Ombudsman has required the institution to arrange training on these matters for its employees (4099/2018).

The NPM made 10 visits to child welfare units in 2018. Two of these were follow-up visits. All visits, with the exception of one follow-up visit, were unannounced. Two of the visits were attended by an expert by experience.

The sites visited were:

- Vuorela Residential School, Nummela, 24 January 2018, 26 placed children, state-run (356/2018)
- Follow-up visit to Vuorela Residential School, 31 January 2018 (846/2018)
- Children's home Sutelakoti, Anttola, 27 March 2018, 5 places, private service provider (1605/2018)
- Children's home Rivakka, 28 March 2018, Hirvensalmi, 12 places, private service provider (1606/2018)
- Pohjola Residential School, Muhos, 17-18 April 2018, 35 placed children, run by a private association (1353/2018)
- Child Welfare Unit Sassikoti, Sastamala, 3 May 2018, 6 places, private service provider (2248/2018)



A music room in the special child welfare unit Loikala kartano.

- Follow-up visit to Children's home Salmila, Kajaani, 19 March 2018, 14 places, run by the municipality (1455/2018)
- Child Welfare Unit Jussin Kodit, Haukipudas, 20-21 November 2018, 16 placed children, private service provider (4099/2018*)
- Special child welfare unit Loikala Kartano, Mankala, 23 October 2018, 14 places, private service provider (5377/2018*)
- Family Home Ojantakanen, Pulkkila, 20-21 November 2018, 16 placed children, private service provider (5916/2018)

The inspection visit to Pohjola Residential School led the Deputy-Ombudsman to order a pre-trial investigation. The observations made during the visit also led to an urgent amendment to the Child Welfare Act (HE 237/2018 vp).

RESTRICTIVE MEASURES AND SETTING LIMITS ARE TWO DIFFERENT THINGS

Restrictive measures always involve restricting some fundamental right of the individual. They are intended to safeguard the fulfilment of the purpose of placement into care and protect the child or another individual. The use of restrictive measures always requires a case-by-case assessment of the extent to which the child's fundamen-

tal rights must be restricted. Restrictive measures may only be employed in the situations and subject to the conditions provided for in the Child Welfare Act. Restrictive procedures may not be employed systematically as an educational remedy to be applied to all children placed in the institution. Neither may restrictive measures be used as a means of punishment.

The measure that least restricts the child's right to self-determination or other fundamental right must always be chosen from those available. If less drastic means are sufficient, restrictive measures may not be employed at all. The measures must always be implemented as safely as possible and with respect for the child's human dignity.

Setting boundaries is a part of the care and upbringing of a child. Such boundaries must be kept distinct from the restrictive measures referred to in the Child Welfare Act. Restrictions of a disciplinary nature are not used to impinge on a child's fundamental and human rights, but to arrange a child's day-to-day custody and care and to support his or her growth and development. The purpose, duration and intensity of educational methods may not be equivalent to those of the restrictive measures provided for in the Child Welfare Act.

DECISION-MAKING ON RESTRICTIVE MEASURES

The use of restrictive measures always requires an individual decision in which the fulfilment of the conditions provided for in the law is evaluated on a case-by-case basis. The place of foster care must ensure that these conditions are met in the case of each restrictive measure employed.

The Deputy-Ombudsman drew the residential school's attention to the fact that restrictive measures may not be used as a means for implementing another restrictive measure. For example, the bodily search of a child cannot be implemented by physically restraining the child. The recording of restrictive measures was also stressed (1353/2018).

The Deputy-Ombudsman considered it important for the place of foster care to draw up a specific plan for supporting the realisation of the child's right to self-determination and promote good

treatment. The plan could include an explanation of what the legal restrictions mean for the unit in practice, a description of the practical implementation of the restrictions and methods for decreasing the use of restrictions. In part, the purpose of such plans would be to reduce the need for employing restrictive measures. The plan could also increase the staff's and child's awareness of legal and acceptable practices (4099/2018*).

ISOLATION

It is not permitted to isolate a child as punishment for his or her behaviour. Isolation may only be used when strictly necessary, and it must be ended immediately when it is not necessary anymore (1353 and 4099/2018).

The forced undressing or dressing of a child is not permitted by the Child Welfare Act. The Deputy-Ombudsman required the residential school to abandon the practice of undressing the children when they were taken to the isolation room. In the future, isolation and any bodily search related to it must be conducted with respect for the child's human dignity and in a manner that permits the child to cover his or her body during the search. A decision to isolate a child must clearly indicate the situation and behaviour that led to the isolation, the implementation method of the isolation, the assessment of the grounds for continuing the isolation, and the grounds for ending the isolation. If the isolation of the child involves holding the child in place or a bodily search or physical examination, the individual records required by law must be drawn up for these. In addition, the names of all employees participating in the isolation must be recorded in the isolation decision. It was the duty of the residential school to ensure that outside persons do not "threaten" the children with illegal measures or restrictive measures that they did not have the jurisdiction to implement in the first place (1353/2018).

The Deputy-Ombudsman required the residential school to abandon all practices reminiscent of isolation. These included shutting the children in their own rooms while doing written assignments given by the instructions, the unjustified severing

of the children's social relations and punishments in the form of segregated dining (1353/2018).

The residential school was required to ensure that the social worker in charge of the child's affairs will always be notified of the child's isolation without delay (1353/2018).

The Deputy-Ombudsman recommended installing a clock in the isolation room of one unit so that the child would have the opportunity to keep track of the time. He also suggested purchasing a thicker, more bed-like mattress for the isolation room (1353/2018).

In the interview of one child, it turned out that the child had been forced to sleep in a bare isolation room resembling a jail cell for three nights after the end of the child's isolation. The Deputy-Ombudsman found the practice to be degrading and strictly reminded the residential school of its duty to arrange safe foster care for the children (356/2018).

The child welfare unit was required to make sure that no outside persons participate in the isolation of children. The Deputy-Ombudsman recommended the unit to take urgent measures to move the isolation room to more suitable premises (4099/2018*).

RESTRICTIONS ON COMMUNICATION

The Child Welfare Act states that foster care must safeguard the continuous and safe relationships that are important for the child's development. If an agreement on communication cannot be reached, communication between the child and the people close to the child can only be restricted on grounds specifically provided for in the Child Welfare Act. The authority to make such decisions lies with the social worker – not the place of foster care. The restriction of communication always requires a decision subject to appeal.

In her opinions, the Deputy-Ombudsman has stressed that, if a child's freedom of movement has been restricted in a manner that also restricts the child's right to previously agreed-upon contact – such as a scheduled home visit – each such situation requires a specific assessment of whether



Seclusion facilities in the Pohjolakoti Residential School.

the legal grounds for making a decision to restrict communications are in place (356 and 1353/2018).

The child's mobile phone cannot be confiscated by the institution as a precautionary or punitive measure. The Child Welfare Act does not give the director of the institution the jurisdiction to make decisions on continuing the restriction of communications (1353/2018).

The children's agreed-upon home visits cannot be cancelled with a simple verbal announcement. A decision to move or cancel a home visit always requires consulting the social worker in charge of the child's affairs (4099/2018*).

RESTRICTING THE FREEDOM OF MOVEMENT

A child's freedom of movement is being restricted if, in addition to generally acceptable boundaries related to normal upbringing, the child is prevented from leaving the institution or deprived of the

opportunity to participate in hobbies or other normal activities in or outside the institution. Only permitting the child to move in the company of an employee is also considered a restriction of the child's freedom of movement. Restricting the freedom of movement always requires a written decision subject to appeal.

The children's movement had been limited to either a short period of independent outdoor exercise or leaving the unit only in the company of an adult. Every unit of the residential school restricted the children's freedom of movement without a decision. Children could lose their rights to take walks, or the walks could be shortened as punishment for their behaviour. The arbitrariness of the rules concerning movement was underlined by the fact that several children placed into the institution whose freedom of movement was severely restricted while in the institution were nevertheless permitted to travel independently to home visits in the weekends. The Deputy-Ombudsman stressed that restricting a child's freedom of movement may not be used as a punishment for the child's behaviour. She considered that the residential school's rules restricting the children's freedom of movement had no basis in law (1353/2018).

The movement of the children in their free time had been severely limited without individual decisions on the matter. The children were not permitted to leave the exercise area defined by the institution and their movement outside the institution was supervised. It is possible that the restrictions on the children's movement constituted restrictions on the freedom of movement provided for by law, in which case they would have required individual decisions for each child (356/2018).

In the Deputy-Ombudsman's opinion, the child welfare unit's rules restricting the children's freedom of movement – such as only taking outdoor exercise alone and the related severing of social relationships – had no basis in law. The children's opportunity to go to school must also be specifically secured during any restrictions on the freedom of movement. If this is not possible, the decision must provide specific justifications for such restrictions (4099/2018*).

PHYSICAL EXAMINATIONS AND BODILY SEARCHES

The "justified reason to suspect" justifying a physical examination or bodily search must be recorded in the child's documents. Such reasons are always individual and must be evaluated individually for each child. The child's documents must also describe the practical implementation of the bodily search and physical examination.

The Deputy-Ombudsman has required personnel conducting bodily searches and physical examinations to take the child's age, sex, level of development, individual attributes, religion and cultural background into account. Such searches and examinations must be implemented in the manner that causes the least harm to the child (1353 and 4099/2018*).

The residential school must make sure that no unauthorised external persons participate in the bodily searches or physical examinations of children. With regard to the child's legal protection, the Deputy-Ombudsman considered it essential that the samples of children who give a positive screening test result and deny the use of the substance be always sent to a laboratory for examination (1353/2018).

ROOM AND MAIL SEARCHES

The Deputy-Ombudsman has specified that a search of a child's mail or room must always have a legal basis, which must be assessed individually and recorded appropriately in the child's documents. Regular searches of a child's mail without a concrete suspicion of substances or items referred to in the Child Welfare Act are not permitted.

The Deputy-Ombudsman pointed out that the child has the right to know the reason for the search and be present during the search (1353 and 4099/2018*).

PUNITIVE RESTRICTIONS

The Deputy-Ombudsman considered “*early retirement to your room*” to be punitive when applied as a systematic consequence for minor negligence or other behaviour on the part of the child. On the other hand, the educational objectives of the practice were understandable. Rules and restrictions must nevertheless be proportionate to their objectives. Among other things, this means that disciplinary rules and restrictions imposed on a child must not go further or last longer than is necessary to fulfil the acceptable objectives of such rules or restrictions. Neither may disciplinary rules be arbitrary or excessive. The child’s age, level of development and other individual needs and circumstances must always be taken into account in their application (356/2018).

The Deputy-Ombudsman found the residential school’s practices for employing and implementing *physical restraint* to be illegal. A child cannot be restrained physically due to disobedience or passive resistance. The use of physical restraint must be necessary in each individual case and may never be used as a punishment. The Deputy-Ombudsman required the residential school to pay particular attention to the operating cultures of its various units (1353/2018).

The Deputy-Ombudsman required the units to immediately abandon their *degrading and humiliating practices* in the use of written assignments. If the children are given written assignments, they must always have an educational objective and purpose and must be genuinely useful for the child. Doing assignments must never cause harm to the child or his or her development (1353/2018).

Consequences for all of the children – “*collective punishments*” – are not acceptable upbringing methods. The Deputy-Ombudsman required the residential school to abandon all collective punishments (1353/2018).

The Deputy-Ombudsman required the residential school to give up *degrading and humiliating rules and punishments* for the children. Placement into care and foster care is not a punishment for the child. The purpose of child welfare services is to protect the child and provide him or her with the most normal childhood and youth possible (1353/2018).

The Deputy-Ombudsman required that, in the future, the *children’s possessions would only be confiscated* when the legal requirements were met and after making the decisions required by law. Confiscation must never be used as a punishment (1353 and 4099/2018*).

DISCIPLINARY MEASURES PROVIDED FOR IN THE BASIC EDUCATION ACT

The Deputy-Ombudsman pointed out to the residential school that it is subject to the Basic Education Act. This means that only the disciplinary measures provided for in the Basic Education Act are permitted during the school day (1353/2018).

The pupils were regularly searched for items falling outside the scope of section 29 of the Basic Education Act. The Deputy-Ombudsman also considered it problematic that the grounds for the searches were not recorded in the pupil’s or school’s documents in any way. In the absence of such entries, the justification and methods of the searches was impossible to determine in retrospect. The Deputy-Ombudsman considered it necessary for pupils to be informed of the reasons for searches in the manner specifically provided for in the Basic Education Act. The school also searched a child who was not placed in the residential school but came from outside to study. The searches were conducted every morning before the start of the school day. However, the Basic Education Act requires “*evident*” reasons for conducting a search (356/2018).

Consent for the morning searches had been obtained from the pupil’s parents and social worker. The Deputy-Ombudsman considers it problematic that there are views or practices according to which it is possible to infringe on a child’s protected rights based on a consent of the child or the child’s custodian. This applies also to a social worker. Guaranteeing the genuine voluntariness of consent is always problematic in the case of minors. For example, children can be afraid of being subjected to restrictive measures in the child welfare unit if they do not voluntarily consent to the restriction of their rights. Therefore, a negative stance must be taken to conducting such searches



The school at the Ojantakanen Family Home provides teaching in small groups.

– and extending them to find, e.g. snuff – on the basis of consent alone (356/2018).

In general, the Deputy-Ombudsman drew the State Regional Administrative Agency's (AVI) attention to the fact that, according to section 80 of the Child Welfare Act, it is the special duty of AVIs to monitor the use of restrictive measures in child welfare institutions. The Deputy-Ombudsman also requested the AVIs to take note of the possibility of affording children the opportunity for confidential discussions with AVI representatives as provided for in the Act. On his own initiative, the Deputy-Ombudsman decided to investigate which measures the National Institute for Health and Welfare, in its capacity as the supervisory authority for state-run residential schools, and the National Board of Education with regard to basic education, were going to take on the basis of the observations and opinions presented in the visit report (356/2018).

The Deputy-Ombudsman noted that a practice in which events during school affect the child's free time in foster care has no basis in the Basic Education Act. She decided to request a report on the matter from the residential school (356/2018).

CHILDREN'S RIGHT TO EXPRESS THEIR OPINION AND INFLUENCE THEIR EVERYDAY LIVES

The Deputy-Ombudsman required the residential school to provide the placed children with the opportunity to influence and participate in the affairs that concern them. The child's own opinion must be determined and taken genuinely into account in both administrative decisions and the daily implementation of foster care. Children must not suffer consequences from expressing their opinions. The child's place of foster care must be capable of creating a home-like atmosphere in which the child feels safe and is able to discuss to have confidential discussions with the adults participating in the everyday operations of the place of foster care without fear of repercussions (1353 and 4099/2018*).

In the Deputy-Ombudsman's opinion, the children's client documents and accounts paint a particularly concerning picture, in which the children's attempts to influence their everyday lives are considered unwanted behaviour since the unit's adults make all the decisions and define what children are permitted to do and how they are permitted to behave in each situation. Children should have the opportunity to influence their everyday routines and discuss them with their carers. The Deputy-Ombudsman pointed out that children have the right to take part in activities. It is the institution's obligation to support and encourage the children's participation in activities and make practical arrangements permitting the children to participate in them (1353/2018).

THE RIGHT TO MEET SOCIAL WORKERS

A child placed in a child welfare institution has an unconditional right to have confidential discussions with his or her social worker. The Deputy-Ombudsman required the institution to cease limiting the children's right to consult with their social workers and to respect the confidentiality of such discussions in the future. The practice of having the institution and social worker record the date, time and practical arrangements of the meeting between the child and social worker in

the child's documents is a commendable practice that fulfils and promotes the rights of the child. It should also be recorded whether the meeting was private. The Deputy-Ombudsman recommended the residential school to develop practices for ensuring the children's opportunity to express their opinions of the foster care arrangements to their social workers every month (1353/2018).

The Deputy-Ombudsman decided to ask the municipalities that had placed children in the child welfare unit to report on how the social workers in charge of the children's affairs were actually able to perform their statutory duties. In addition, the Deputy-Ombudsman requested every social worker who had placed children in their charge in the unit to meet with the placed children and explain the contents and meaning of the visit report to them. The social worker must give the child an opportunity to discuss the matter in private. The afore-mentioned report must also indicate when and how the visit report was discussed with the child (4099/2018*).

EMPLOYEE BEHAVIOUR

Due to the issues reported by the children in their interviews, the residential school was reminded of the appropriate behaviour of employees. The Deputy-Ombudsman noted that employees commissioned by an authority, such as the staff of a private child welfare institution, are also required to behave appropriately and use acceptable language and expressions that demonstrate respect for the child. The educational work of the child welfare institution staff gives the children a model of how adults behave in various situations. For this reason, the persons responsible for the care provided by the institution and those working in the institution must behave in a manner that permits the children placed in the institution to learn appropriate behaviours and good manners (1353/2018).

3.5.14 SOCIAL WELFARE 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 care and residential unit, where they receive care round the clock, including end-of-life care if necessary. There are some 2,200 care units providing full-time care for older people in Finland. Today, no-one is cared for by any unit solely on the basis of old age. Caring for elderly people with multiple conditions consists of health care and nursing in either a social welfare or health care unit. Visits are primarily made to closed units providing full-time care for people with memory disorders, and to psycho-geriatric units, where restrictive measures are 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. In 2018, the focus of visits was on units operated directly by the municipalities.

Social welfare and health care units, including units providing services for older people, are required to draw up a self-monitoring plan. Such a plan includes the key measures taken by the service provider to monitor their operative units, the



Taasiakoti offers intensified assisted living services for the elderly. The home also houses two cats.

performance of their staff and the quality of the services they provide. Staff members have in social welfare a statutory obligation to report any deficiencies in the care provided. Persons voicing concerns may not be subjected to negative consequences of any kind.

Visits to care units for older people pay special attention to the use of restrictive measures. The use of such measures is made problematic for the fact that there is still no legislation on imposing restrictive measures on older people with memory disorders. According to the Constitution, however, such measures would have to be based on law. The Ombudsman has issued several opinions in which he has demanded legislation to be passed on the matter. It is the opinion of the Ombudsman that, even though there is no legislation on restrictive measures yet, their use should be transparent and consistent with human dignity. The provisions of the Mental Health Act on the use of restrictive measures on individuals in involuntary care should be applied as a minimum requirement. On its visits, the NPM paid attention to matters such as the duration and recording of restrictive measures and deciding on them.

All visit 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 visit report be made available to the public on the noticeboard of the unit for a period of three months. The aim is for residents, family members and other stakeholders to report any shortcomings that have been overlooked to the supervisory authorities.

All visits made to care units for the elderly in 2018 were made under the NPM mandate. Eleven such visits were made in 2018, one of them to a unit operated by a private service provider. All of the visits were made unannounced. One visit was a follow-up visit conducted in the evening.

The sites visited were:

- intensive service unit Portsakoti, Turku, 26 January 2018, 23 places (383/2018)

- group home Elsekoti, Turku, 26 January 2018, 12 places (384/2018)
- intensive service unit Taasiakoti, Loviisa, 8 February 2018, 36 places in total (657/2018)
- intensive service unit Emil-koti, Loviisa, 8 February 2018, 9 places (659/2018)
- Näsmäkieppi serviced housing, Rovaniemi, 21 March 2018, 35 places in total (1212/2018)
- Lohja service centre for the elderly/Alatupa, Lohja, 25 April 2018, 11 places (2114/2018)
- Lohja service centre for the elderly/Kultakoti, Lohja, 25 April 2018, 9 places (2217/2018)
- Lohja service centre for the elderly/Kultakarantano, Lohja, 25 April 2018, 18 places (2218/2018)
- Follow-up visit to Lohja service centre for the elderly, 18 June 2018 (3082/2018)
- intensive service unit Riihikoto/Tammikoto, Tuusula, 28 June 2018, 24 places (3290/2018)
- Attendo Linnanharju nursing home, Helsinki, 4 July 2018, 61 places (3367/2018)

RESTRICTIVE MEASURES USED IN UNITS FOR OLDER PEOPLE

It is an established practice in the legality oversight of service units for the elderly that the use of any kind of restrictive measures on residents requires the decision of a physician. The physician should also monitor that the restrictive measures are not used to a greater extent or time than necessary. The use of restrictive measures must be stopped immediately when they are no longer necessary. These measures should be discussed with the resident's next of kin or family members before their adoption. The necessity of such a measure must also be explained to them. The decision-making on the use of restrictive measures and their duration may be jeopardised if the physician does not visit the unit often or meet the residents during such visits.

A care plan drawn up in an assisted living unit with intensified support specified that the movement of the resident was restricted. According to the entries, this had been authorised by the resident, who suffered from a memory disorder, and the resident's next of kin. The entries did not

indicate that a physician would have decided on the restriction. The Deputy-Ombudsman did not deem it acceptable to employ restrictive measures on the basis of a permission given by an individual suffering from a memory disorder, who may not have understood the matter. The use of restrictive care measures must always be based on a physician's assessment and decision. In addition, the necessity of such measures must be evaluated on a regular basis (383/2018).

The majority of the residents of a unit offering round-the-clock assisted living with intensified support suffered from memory loss disease. The outer doors of the unit were locked. They could be opened with a numeric code. The gate of the fenced yard was also locked. As a further restrictive measure, the beds were equipped with bedrails to prevent their occupants from falling out of them. The patients' families had agreed on the matter with a physician. The NPM stressed that the use of restrictive measures was only permitted by decision of a physician. Furthermore, the use of restrictive measures must be monitored to ensure that they are only used when and for as long as necessary. For this reason as well, the physician should visit the unit sufficiently often and meet all of the residents. It is also the nurses' duty to discuss the restrictive measures and their grounds with the residents' next of kin or family members (659/2018).

A unit for persons suffering from serious memory loss symptoms sought to organise its operations at the terms of the residents. This meant that the residents were allowed to decide when they woke up or ate. If they did not feel sleepy at night, they were allowed to stay up and walk in the hallways, provided that they did not disturb the other residents. The use of restrictive measures was decided by a physician. These measures included raised bedrails, various belts and back-zip overalls. Back-zip overall, also known as patient overall, is a garment preventing for example persons with dementia from undressing themselves in public. The necessity of continuing the restrictive measures was monitored on a daily basis. The unit was even equipped with restraints. However, the NPM



The furnishings in the service centre for the elderly was modest and worn-out.

were told that the restraints had not been needed for years, since the nurses had learned to work on the terms of the residents and calm them down in other ways. Sedatives had to be given to the residents at times. It was also necessary to lock the rooms of residents every now and then to prevent restless residents from wandering into the rooms of others. In the Deputy-Ombudsman's opinion, locking the doors of residents at night for reasons of client and patient safety was problematic with regard to fire safety and the right to self-determination of the elderly people suffering from memory disorders. The fact that the solution was temporary had no bearing on the matter (2217/2018).

The report given by the city stated that locking the rooms was an extreme measure intended to ensure the safety of the group home's residents.

Nurses at a group home for individuals with severe memory loss symptoms felt that meal times took excessively long. All residents had to be assisted and monitored while they were eating. Some of the residents were so restless that they

had to be restrained to the chair with a belt for the duration of the meal to keep them still. The Deputy-Ombudsman noted that tying a resident down is always a restrictive measure. In addition, such restraints can cause anxiety and aggression. The Deputy-Ombudsman requested the city to report on what basis the resident was tied to the chair for the duration of the meal. The Deputy-Ombudsman also wanted to know why the resident was not allowed to leave the table and later directed back to continue the meal – several times if necessary. Furthermore, the Deputy-Ombudsman asked the city to determine who made the decision to tie the resident to the chair and whether, as part of the decision-making process, the matter had been discussed with the resident's next of kin or family members (2217/2018).

According to the report provided by the city, the decision to restrict the right of self-determination, such as using restraints, is always made by the physician in charge of the patient. The decision on the restrictive measure and its start and end times are recorded in the patient data system. Restrictions are discussed with the residents' next of kin and family members, but their wishes must sometimes be ignored to permit the resident more freedom of movement instead of, e.g., being tied to a wheelchair for the whole day.

In the report, it was stated that people with memory loss disease do not always recognise the feeling of hunger, so they must be provided with relaxed and frequent opportunities to eat. The mobility of the residents must sometimes be restricted during meals to secure their nourishment and safeguard the other residents' right to a peaceful meal. Only those residents who compulsively and repeatedly rise from the table and wander around the dining area and ward hallways are restrained. Such behaviour has a corresponding effect on others who are having their meal, preventing anyone from eating in peace and repeatedly interrupting the meal. The eating and condition of residents tied to their chairs is monitored continuously, and residents who appear anxious are released.

An evening follow-up visit was made to the unit. The NPM noted that at least two residents were wearing back-zip overalls – also at night. Back-zip

overalls are a restrictive measure on which there are no regulations. The Deputy-Ombudsman noted that the use of a back-zip overall infringes on the patient's right to self-determination. The use of an overall must always be based on physician's decision and the use must be stopped immediately when it is no longer necessary (3082/2018).

THE SAFETY OF RESIDENTS AT NIGHT

On the basis of observations made during a visit to a unit offering round-the-clock assisted living, the Deputy-Ombudsman noted that conditions in the unit were not safe for the residents at night. The Ombudsman had already drawn attention to the matter on an inspection in 2007. The situation had deteriorated since then, as the number of residents in the unit had grown and the night nurse was also responsible for the residents of the serviced flats. The nurses hoped that two nurses could work the night shift or that the city's mobile night-time service team could take care of the night-time alarms of the serviced housing residents. The nurses did not know the people living in the serviced flats or their illnesses, so the night shifts felt unreasonably stressful to them. The Deputy-Ombudsman requested the city to report on the sufficiency of night-time care and the safety of the residents at night (657/2018).

The city reported that two practical nurses would be hired for the nursing home with fixed-term employment contracts beginning on 1 May 2018. That will enable assigning two nurses to the night shift. In addition, the home care night nurses will answer the night-time alerts made by the residents of the serviced flats around the nursing home from 1 March 2018. The nursing home's nurse will no longer be required to care for the residents of the service flats.

Only one nurse worked the night shift of a nursing home close to the one described above and assisted the night nurse of that care home every night in addition to her own work. For this reason, the doors of the residents had been equipped with alarms so the night nurse would know to return to her post in the nursing home if the residents

left their rooms. This arrangement was not safe for the residents of the nursing home, since the distance between the two buildings was approximately 200 metres. The situation in the other nursing home could have prevented the night nurse from leaving immediately. This matter had also been addressed in connection with the visit made by the Ombudsman in 2007. The Deputy-Ombudsman noted that night-time care must be organised in a manner that does not leave residents without supervision. The Deputy-Ombudsman requested the city to notify him of the measures it had taken (659/2018).

According to the city, the night nurse does not have to leave the unit during the shift anymore, because night care in the other nursing home will be arranged differently from 1 May 2018.

END-OF-LIFE CARE

The NPM discovered no significant shortcomings in the field of end-of-life care in the visited units in 2018. According to the nurses, some units were prepared to hire additional employees for the duration of end-of-life care, and the nursing staff felt sufficiently trained in end-of-life care (657, 659, 1212 and 2218/2018). The organisation of end-of-life care in some units gave the Deputy-Ombudsman cause to issue the following opinions.

One nursing home stated that the number of nursing staff was not increased for the duration of end-of-life care. In addition, the representative of the company providing the nursing home services stated that the nurses could freshen up their end-of-life care skills by watching a video on the company's intranet. In the opinion of the Deputy-Ombudsman, appropriate and competent end-of-life care is the fundamental right of every older person, and every nurse must be familiar with it. Therefore, she suggested considering ways to provide the staff with further training in end-of-life care. The Deputy-Ombudsman did not consider it sufficient that nurses who felt that they required additional instruction on the issue would watch the instructions independently on the intranet. In addition, the city and service provider needed

to resolve who was responsible for organising the training (3367/2018).

The report by the city that purchased the care service noted that, according to the outsourced service agreement, the service provider shall have quantitatively and structurally sufficient staff for the service being provided. The unit personnel must have the expertise, competence and motivation required by their duties. This also applies to competence in end-of-life care. The service provider must see to the further training of its personnel. The service provider shall thus arrange training for its personnel, and the city will provide further training if necessary. According to the report, end-of-life care training will be provided to the nursing home's personnel in late 2018. The key themes of end-of-life care will be reviewed through training materials, discussions and the sharing of experiences.

The nursing home strived to provide high-quality end-of-life care. However, the nurses expressed a wish for further training in the area. The Deputy-Ombudsman requested the municipality to report on its measures in the matter (3290/2018).

The municipality reported that its end-of-life care guidelines had been reviewed in the group homes. In addition, the group home nurse who is a member of the municipal end-of-life care team participated in dedicated end-of-life care training. The written feedback on the training was reviewed in the group home. When the unit has a resident in need of end-of-life care, the staff will hold regular and in-depth discussions on the resident's situation, the measures required, how to care for and support the resident, and how to take the resident's next of kin into account and support them.

OUTDOOR TIME

The importance of spending time outdoors every day for the quality of care was emphasised in connection with the visits made to the service units for older people. Providing sufficient time outside is a part of caring for the residents' basic needs and, thus, respecting their human dignity. The Deputy-Ombudsman has recommended including outdoor time in the residents' care and service

plan. Taking the residents outdoors should not be left to the next of kin and volunteers. During the visits, it was noted that daily outdoors time is not provided in several units or is impossible to verify due to deficient records.

The staff of the assisted living unit with intensified support told the NPM that they did not have time to take the residents outside. The visit conducted in March did not reveal how the residents' access to the outdoors had been arranged or whether the residents had the opportunity to go outside. According to the report received after the visit, the residents' next of kin saw to taking them outdoors. The report indicated that volunteers visited the nursing unit to take the residents for outings such as rickshaw rides once per week if the weather was good (1212/2018).

The Deputy-Ombudsman considered it important that people suffering from memory loss disease, who are often still quite capable physically, should have the opportunity for regular outings. According to the resident records obtained, this had either not been realised particularly well or the records were incomplete. For example, one outing had been recorded for one resident for a two-week period, while another had no recorded outings. The unit's self-monitoring plan nevertheless required targets related to daily exercise, time spent outdoors and rehabilitation to be recorded in the resident's care and service plan. The realisation of these targets should be followed on a daily basis. On the basis of the care plan records of two residents, this was not the case. The Deputy-Ombudsman pointed out that resident records should correspond to the guidelines provided in the self-monitoring plan (2217/2018).

According to the city's report, efforts are made to provide the residents with as much time outdoors as possible. Volunteers take the residents on outings every week if the weather is good. In the summer, the city hires young people to help with taking the residents outside. In addition, the unit has several individuals in rehabilitative work activities, whose duties also include taking the residents for outings. The city indicated that it would pay attention to recording the time spent outdoors. Advanced memory loss disease can prevent residents from going out-

side safely, so the situation needs to be considered individually for each resident. The group home has a spacious balcony where the residents can spend time safely.

During a visit to a group home for people with memory disorders, the NPM were told that the residents had the right to sufficient outdoors time. On the basis of the records inspected after the visit, however, it was impossible to verify that the resident had actually spent time outside. The Deputy-Ombudsman noted that the records must indicate the actual events in the resident's day, not just the basics of nursing and care. If a resident takes assisted outdoor exercise or participates in activities, it must be recorded in the documents. Otherwise, it will be impossible to determine whether the service plan is also being realised with regard to outings and recreation. The Deputy-Ombudsman reminded the unit's staff of keeping sufficient records, which indicate the actual quality and diversity of service in addition to basic care (3290/2018).

The municipality reported that, in the future, the group home staff would record outings, participation in stimulating activities, etc. in the patient information system. Particular attention will be paid to recording activities performed with the assistance of other professions and individuals (summer workers, students, assistants, next of kin, etc.). Instructions concerning this were issued in autumn 2018. Furthermore, to secure sufficient access to the outdoors, at least one employee will take residents outside every day.

The time spent outdoors by residents was monitored with lists. In the opinion of the NPM, the realisation of sufficient access to the outdoors should also be monitored in the care and service plans. The Deputy-Ombudsman considered it important that residents should also be provided with the opportunity to leave the balcony and yard if permitted by their condition (3367/2018).

The report of the city that purchased the care service notes that the city requires the client's wishes and willingness to spend time outside to be recorded in the client's care plan, along with targets for the amount of time spent outdoors and the ways of

spending that time. The realisation of the plan should also be evaluated at three-month intervals and when the client's circumstances change. According to the director of the nursing home, residents are also taken outside the yard when their condition permits. They also go on outings outside the unit.

During the inspection visits, some observations were also made on the possibility of round-the-clock assisted living units for ensuring the residents' daily outdoor exercise in a pleasant environment (657, 659 and 2218/2018).

THE RIGHT TO SUFFICIENT HEALTH CARE SERVICES

The adequacy of physician's services varied

The Deputy-Ombudsman commended the weekly visits made by physicians (383 and 384/2018).

A municipal geriatrist visited the group home once per week and also met with the residents. The geriatrist could be called when necessary (3290/2018).

Previously, a physician from the health centre had visited the nursing home once per month. The physician mostly dealt with the nurse, but would also visit the residents if necessary. Now, the physician had last visited the unit three months ago. The intent was to return to the monthly schedule. The physician was easy to reach by telephone. However, the frequency of the physician's visits should be based on the needs of the residents. Increasing the interval between visits was problematic as the unit did not employ a full-time nurse. The Deputy-Ombudsman deemed the physician's services available in the unit to be insufficient if a physician or other health care professional is not available when needed. The Deputy-Ombudsman requested the city to report on the measures taken in this nursing home and another home run by the city (659 and 657/2018).

The municipality reported that the provision of physician's services in the nursing homes would continue according to the current plan.



Notary Kaisu Lehtikangas displaying a rickshaw bicycle in the serviced housing Nämänkieppi. Volunteers take the residents in the serviced housing on rickshaw rides once a week, if weather permits.

A physician visited the serviced housing unit once per week, focusing on alternate floors on each visit, but also taking care of any acute situations on the other floor. The physician was available by telephone on weekdays, and the geriatric emergency service responded to situations on the weekends. On the rounds during the visit, the physician met with residents according to the needs assessment conducted by the unit's staff (1212/2018).

The representatives of the company providing the nursing services were sorry that the city had put the physician's services out to tender, as they had been satisfied with the long-term, successful cooperation with the physician. Now, a physician only visited the unit once every two months, which the unit felt to be quite a long interval. The physician was easy to reach by telephone, however. The Deputy-Ombudsman requested the city to give a report on the sufficiency of physician's services (3367/2018).

According to the report provided by the city that purchased the nursing services, it invites tenders for outsourced nursing and physician's services at regular intervals, which can lead to changes in service providers. The frequency of physician's visits is

proportionate to the size of the unit, with the maximum interval between physician's rounds being two calendar months. Otherwise, the affairs of patients are taken care of through weekly telephone consultations. In addition to making their regular rounds, the physicians must be available by telephone during business hours on weekdays. The physician is also obligated to visit the unit between rounds if a patient's condition demands it.

Oral health care

A dental hygienist visited the unit once a year to check the patients' teeth. Dentist's appointments were implemented at the health centre, where the resident was accompanied by a nurse (657 and 659/2018).

According to the reports received, patients who still had their own teeth visited a nearby dental clinic annually for check-ups and the required treatment. A dental technician inspected the residents' dentures in case of any problems. Instead of regular visits, the dental hygienist visited the unit when required. The Deputy-Ombudsman commended the regular visits to a dentist (1212/2018).

The nurses tried to see whether the resident's teeth were painful in connection with brushing their teeth every day. The municipal dentist visited the group home to examine and treat the patient's teeth when necessary. A dentist and dental hygienist also visited the unit once per year to examine and care for the residents' teeth (3290/2018).

The staff sought to look after the residents' oral hygiene and health, but problems were caused by the fact that many of the residents refused to open their mouths. According to the nurse, no one had their teeth brushed by force, however. The nurses tried to see whether any of the residents had oral pains. A dental hygienist from the health centre visited the unit once per year to care for the residents' teeth and assess the treatment needs of residents who the nurses thought to be suffering from tooth aches. Residents were escorted to the health centre's dentist on the basis of these assessments or as otherwise required (3367/2018).

Maintaining the ability to function

The observations made during the visits indicated that some nursing homes had invested in maintaining the residents' ability to function. However, there was room for improvement.

The Deputy-Ombudsman considered it positive that the serviced housing unit had its own physiotherapist who was able to provide individual physiotherapy to the residents (383/2018).

The municipal physiotherapist visited the nursing home once per week. The unit also employed a physiotherapy nurse (657/2018).

The Deputy-Ombudsman considered it insufficient for a service centre for older people to only employ one physiotherapist who worked mostly with home care residents (2218/2018).

The group home for the elderly did not have a dedicated physiotherapist or physiotherapy nurse. Some residents purchased physiotherapy services, and the physician could refer residents to a physiotherapist. The unit had designated employees responsible for ergonomics, but their job description did not include physiotherapy. Therefore, the residents' physical exercise was largely left to the nurses' rehabilitative working methods. The Deputy-Ombudsman considered it to constitute a shortcoming that a unit with 88 places did not have access to physiotherapy services, which are essential to the care of people with memory disorders in maintaining their ability to function. The Deputy-Ombudsman asked the municipality to consider ways of providing such services in the future (3290/2018).

The municipality reported that it had arranged municipal physiotherapy services and instruction in the use of mobility aids for residents who required them and were referred by a physician. Physiotherapy is not part of the concept of assisted living with intensified support. Rather, the residents acquire the services as any other people living at home. The residents have the opportunity to use the gym equipment in the adjacent building free of charge on certain days of the week. The staff support the residents' everyday mobility with rehabilitative work practices and try to spend as much time as possible outdoors with those residents who wish.

The nursing service unit did not have a dedicated physiotherapist or physiotherapy nurse. One practical nurse was responsible for the rehabilitation of the residents, which was not equivalent to the services of a physiotherapist according to the nurse employed by the nursing home. Neither did the elderly residents purchase any physiotherapy services, so their physical exercise was largely dependent on the rehabilitative work practices of the nurses. Taking the unit's large number of residents into account, the Deputy-Ombudsman considers it important to have a professional physiotherapist in charge of maintaining the residents' ability to function (3367/2018).

The report of the city that purchased the nursing services states that the nursing home has rehabilitation-oriented nurses who instruct the other nurses in rehabilitation and actively take part in the rehabilitation of the residents. Residents have the opportunity to purchase additional services at their own expense, including physiotherapy services.

3.5.15 RESIDENTIAL UNITS FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

A goal set in the 2012 Government Resolution on the independent living and services for persons with intellectual disabilities is that no disabled person will be living in an institution after 2020. The Finnish Association on Intellectual and Developmental Disabilities reports that the client volumes of housing with round-the-clock support, or assisted housing services, and supported housing services in particular have been growing. Correspondingly, the number of long-term residents in institutions for the intellectually disabled has decreased. Even though the trend is positive, it appears that giving up institutional housing by the deadline will not be successful. According to information from various sources, there are slightly less than 1,000 intensified support units for people with intellectual and developmental disabilities in Finland, and approximately 400 of these are run by private service providers. There are 26 institutional care units, of which 11 are run

by private service providers. The majority of these units employ restrictive measures.

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 Persons with Intellectual Disabilities, 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 persons in special care repeatedly require 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 opportunities for participation, along with the availability of adequate care and treatment.

With the ratification of the UN Convention on the Rights of Persons with Disabilities (10 June 2016), 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. This special duty of the Ombudsman, as well as observations on accessibility, are discussed in more detail in section 3.4.

The number of residential units of intellectually and physically disabled persons visited in 2018 was 12. Two of the units were full-time residential units for disabled persons. One of these was intended for persons with significant functional limitations due to substance addiction and/or mental health disorders, social problems and impaired cognitive abilities. The other was for people under that age of 65 with physical and/or mental

limitations on their ability to function. The other sites visited were units for intellectually disabled people. There were disabled residents under involuntary special care in three of the units visited. Most of the visits (7) were made unannounced. Four of the units were run by private service providers.

The sites visited were:

- Esperi Hoitokoti Narikka, Järvenpää, 19 March 2018, 24 places, private service provider (1376/2018)
- Lintukorven Validia-talo, Espoo, 25 April 2018, 21 places, private service provider (1871/2018)
- Attendo Valkamahovi serviced housing, Helsinki, 4 July 2018, a total of 45 residents in three group homes, private service provider (3351/2018)
- Kolpene service centre joint municipal authority / Palvelukoti Metsärinne, Rovaniemi, 20 September 2018, 17 places, municipal (3375/2018)
- The Rinnekoti Foundation's Pipolakoti housing units, Karjalohja, 6 July 2018, 20 places, private service provider (3524/2018)
- Northern Ostrobothnia Hospital District, Care of the developmentally disabled / Adult rehabilitation unit, Oulu, 11–12 December 2018, 12 places, municipal (4639/2018)
- Kuumaniemi group home, Kemijärvi, 20 September 2018, 12 places, run by the city (4665/2018)
- Kolpene service centre joint municipal authority / Housing services, Rovaniemi, 21 September 2018, 9 group flats and 4 flats, municipal (4701/2018)
- Kolpene service centre joint municipal authority / Mäntyrinne and Mustikkarinne, Rovaniemi, 20–21 September 2018, a total of 26 places, municipal (4880/2018)
- Kolpene service centre joint municipal authority / Kuntoutuskeskus Vuoma, Rovaniemi, 21 September 2018, 15 places, municipal (5028/2018)
- Northern Ostrobothnia Hospital District, Care of the developmentally disabled / Children and youth unit, Oulu, 11–12 December 2018, Oulu, 10 places, municipal (6388/2018)



Sound-insulated chairs at the Kolpene Service Centre joint municipal authority.

- Northern Ostrobothnia Hospital District, Care of the developmentally disabled / Lounastuuli, Oulu, 11–12 December 2018, 8 places, municipal (6389/2018)

A physician specialising in intellectual disabilities participated in six of the visits as an external expert. An expert from VIOK took part in one visit as an external expert. Experts from the Human Rights Centre also participated in some of the visits. Some of the key opinions and recommendations issued on the basis of the visits are presented below. Certain remarks relate to visits made in 2017, but with opinions issued in 2018.

USE OF CAGE BEDS

In connection with a visit to institutional care and housing units for the intellectually and developmentally disabled, it was noted that cage beds were used in one ward. This was the first time such beds were observed during a visit made by the Parliamentary Ombudsman or NPM.

For one child under the age of 10, the bed was used to prevent the child from falling out of the bed during epileptic seizures. The bed was not a normal cot for small children (0–3 years), but a larger metal cage bed with a roof. The bed had been made by a local workshop. A cage bed was also used for another child in the same ward. The restrictive measure decisions required by the Act

on intellectual disabilities had been made for the use of the beds.

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has stated that the use of cage beds can be considered to offend human dignity and must therefore be stopped immediately. In its report (StVM 4/2016 vp), the Social Affairs and Health Committee of Parliament has stated that other means shall always be used in preference to restrictive equipment when possible. Instead of a restrictive measure, it can be possible to use a wide and low bed, or a bed whose height can be electronically adjusted according to the situation.

The Ombudsman urged that the use of cage beds be discontinued and that alternative solutions be found instead. The legality of restrictive measures used in the care of the intellectually disabled can be referred to a court for evaluation. The court will make the final decision on whether the restrictive measure or piece of equipment can be considered legal in each specific case. The Ombudsman also highlighted that restrictive equipment must comply with the requirements of the Act on Health Care Devices and Equipment. Such equipment can include hospital beds with bedrails (visits to the North Karelia social welfare and health care joint authority's (Siun Sote) care units for the intellectually disabled, 6311* and 5920/2017*).

The joint authority reported that it would look for replacement beds compliant with the requirements of the Act on Health Care Devices and Equipment, without endangering the health and safety of the residents.



A metal cage bed with a ceiling.

SUFFICIENCY OF HUMAN RESOURCES

The Deputy-Ombudsman drew the care home's attention to the fact that, among other things, the Act on Intellectual Disabilities requires special care units to 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 commended the fact that the city monitored the operations of the private housing units in its area and their fulfilment of the minimum staffing requirements (1376/2018).

The unit's staff turnover was considerable. The situation was perhaps affected by the challenging nature of the work and a shortage of employees. The NPM got the impression that the staff was in need of more supervision. A chronic personnel shortage was also described in the interviews conducted during the visit. The Ombudsman pointed out that care units must be staffed by a sufficient number of personnel with regard to their operations (1871/2018).

The documentation indicated that the unit had also counted students in its staff numbers. On a general level, the Ombudsman pointed out that students are not yet social welfare or health care professionals. The employer is responsible for ensuring that restrictive measures are carried out only by personnel who have the necessary professional qualifications. Whether a student possesses the required professional competence for participating in a restrictive measure requires careful assessment. Students cannot be responsible for the use of restrictive measures, but require guidance and supervision from professionals. The Ombudsman reminded that students temporarily performing the duties of a social welfare or health care professional are subject to the regulations applied to such professionals, and can thus potentially suffer consequences for errors made in the course of their work (visit to the adult rehabilitation unit of Vaalijala joint authority, 7007/2017).

The rehabilitation unit reported that only students hired by the organisation for an apprenticeship were counted in the unit's staffing numbers. The apprenticeship trainees do not participate in the use of restrictive measures.

THE REALISATION OF PRIVACY IN HOUSING SERVICES

The Ombudsman has proposed that every disabled person living in a housing service unit should have a private room equipped with sanitary facilities.

From the perspective of arranging home-like accommodation and guaranteeing the protection of privacy, the NPM found it to be a shortcoming that not all of the residents had their own toilet and shower facilities in their apartment (room) (1376/2018).

The unit had installed camera surveillance in the common areas, isolation area and hallways. The Ombudsman noted that camera surveillance is always an infringement on privacy and may only be used when necessary. The use of camera surveillance cannot be justified by a shortage of staff in the unit, and its necessity must be regularly evaluated against the individual needs of the residents (7007/2017).

RIGHT TO SELF-DETERMINATION AND OPPORTUNITIES FOR PARTICIPATION

The individual's right to self-determination is one of the guiding principles of the UN Convention on the Rights of Persons with Disabilities. According to the Act on Intellectual Disabilities, the rights of persons in special care to participate in and influence their own affairs must safeguarded.

According to the Ombudsman, children should generally be permitted to use their own telephones according to their age and level of development in the same way as children who are not in rehabilitation in a residential unit. Confiscating a child's technical devices for an individual disciplinary reason, such as for the night, requires a specific reason related to the individual child. Such reasons could include an inability to stop using the telephone or that the telephone disturbs the child's sleep. The Ombudsman stressed that disciplinary rules related to upbringing may not be excessively strict, and the child's age, level of development and other individual needs and cir-

cumstances must be taken into consideration in applying them (Oppilaskoti Jolla, Vaalijala joint authority, 6421/2017).

Disabled persons have the right to be informed of their rights and the rights and obligations of the rehabilitation unit with regard to the arrangement of rehabilitation and care. The Ombudsman considered it important that the rehabilitation unit should increase the clients' awareness of their right to self-determination and other rights (7007/2017).

The rehabilitation unit reported that, after the visit, the unit had started informing its clients of their right to self-determination and their other rights. Clients are free to ask questions and present ideas to the organisation's experts on the right of self-determination.

USE OF SECURE ROOMS

A secure room can be used to calm a person in special care for the intellectually disabled, if an individual behaving problematically would otherwise be likely to endanger the person's own health or safety, the health or safety of others or cause significant property damage. The use of a secure room requires the conditions specified in the Act

on Intellectual Disabilities for short-term isolation of up to two hours to be met. A secure room could also be used in cases in which shutting the person in their own room would cause a negative emotional experience connected to the room, which should be a safe and pleasant place for the person. On the other hand, if isolation in the person's own room is considered to have a soothing effect on the person, it should be preferred to the secure room.

During the visit, it turned out that use of the unit's secure room had decreased significantly from 2016. This was found to be connected to the amendments to the Act on Intellectual Disabilities that entered into force on 10 June 2016. The maximum duration of short-term isolation is two hours, and the preparatory documents for the Act note that isolating the client in his or her own room is to be preferred if it would have a soothing effect on the client. The rehabilitation unit had set the target of being able to handle challenging situations without recourse to the secure room. When isolation has been required, it has usually been ended in 1–2 hours. The achievement of this

On the right a view to a security room which has a separate wc. Below a peephole of a door to a security room.



target has been promoted by making consultation visits to other units and proactively increasing resources for potential crises (7007/2017).

OUTDOOR TIME

Taking care of the basic needs of an individual with intellectual disabilities includes ensuring a sufficient amount of exercise and outdoor time.

The interviews of clients and their next of kin indicated that the time spent outside by the clients was not always recorded in the daily logs. The NPM also discovered that outdoor time could be systematically restricted at the beginning of the examination or rehabilitation period. The Ombudsman stressed the significance of spending time outdoors on a daily basis for the high-quality care referred to in the Act on the Status and Rights of Social Welfare Clients. Providing sufficient time outside is a part of caring for the residents' basic needs and, thus, respecting their human dignity. The Ombudsman recommended including the time spent outdoors in the resident's care and service plan and recording its daily realisation in the customer's documentation (7007/2017).

The joint authority reported that, in the future, the time spent outdoors by the clients would be recorded in their personal rehabilitation plans. The clients' outdoor time and possible refusal to go outside will be clearly recorded in the daily logs. Opportunities to spend time outdoors will be offered on a daily basis.

INTERVIEWING CLIENTS AND THEIR FAMILIES

The interviews of the clients' families indicated that the families were not always satisfied with how the residential unit staff had consulted them on matters related to the client's care. Furthermore, the discussions revealed a general uncertainty regarding the practices in the residential unit and the practical contents of the child's rehabilitation. In the Ombudsman's assessment, the cooperation between the residential unit and the

families of its residents had not been realised in the best manner possible. The Ombudsman recommended that the residential unit should pay more attention to this aspect in the future (6421/2017).

After the visit, a family member of a client sent a letter to the Ombudsman, expressing shortcomings experienced by the family member. The rehabilitation unit was notified of the contents of the letter for the purposes of the evaluation and development of its operations. Development of the client feedback system was an item in the development plan included in the unit's self-monitoring plan. The Ombudsman encouraged the unit to develop its client feedback system further (7007/2017).

After the visit, the unit submitted a report stating that the organisation had developed a uniform feedback system. The unit gathers continuous feedback from clients and their families into a feedback log, which is reviewed at the workplace meeting on a weekly basis and taken into account in operations. Feedback is also collected with a dedicated form. Stakeholders and the people close to the residents are encouraged to give feedback.

USE OF SECURITY GUARDS

The residential service unit of a private service provider employed a round-the-clock security guard service. According to the staff, the guard could be called if a client behaved in an inappropriate or threatening manner, e.g. due to intoxication, and would not leave the common area when requested. The staff stated that the guard could use physical force to take the client to his or her own flat, for example. If illegal intoxicants, such as drugs, are found on the resident, the police is called. The report provided after the visit specified that the guard service had been acquired for the safety of the staff. The guards could assist in calming clients down by their presence. However, they were not entitled to use physical force to guide clients to their flats. The unit's service manager indicated that the purpose and authorities of the guard service would be reviewed with the staff.

In the Ombudsman's opinion, it is possible to employ security guards for duties permitted by the legislation on private security services in the common areas of serviced housing units. The issue is with the tasks appointed to the security guards or stewards and whether they have the required authority to perform the services ordered by the serviced housing unit. The Ombudsman has stressed that private guards may not take part in measures related to the client's care, which have been appointed to the nursing staff by law. Measures that restrict the client's right to self-determination must be deemed to constitute care-related tasks in which security guards cannot, as a rule, participate. On the other hand, security guards may, within the limits of their authority, secure the nursing staff's physical integrity and the safety of their work (1871/2018).

3.5.16 HEALTH CARE

In the health care sector, an accurate number of health-care units that fall under the NPM's mandate is unavailable. According to information received from the Ministry of Social Affairs and Health, there are approximately 50 psychiatric units that employ coercive measures. 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).

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. In recent years, it has also been customary to invite the Regional State Senior Medical Officer of the competent AVI to the visit debriefing. The final visit report is also delivered to the AVI for information. The inspection visit of the psychiatric

unit of Kainuu Central Hospital serves as a good example of such cooperation. The Regional State Senior Medical Officer who participated in the debriefing made follow-up visits to the unit in three and five months from the original inspection visit. On the last visit, the Officer reviewed the recommendations made in the NPM's visit report and the measures taken by the hospital together with representatives of the profit centre. The Regional State Senior Medical Officer notified the Ombudsman of his observations.

Background information is requested from the health care unit's patient ombudsman before each visit. The final visit report is also routinely sent to the patient ombudsman for information.

Owing to the large number of 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 forensic psychiatric hospitals (Niuvan-niemi and the Old Vaasa Hospital) and other units providing forensic psychiatric care. The aim is to make regular visits to these units, which in practice means a visit every couple of years. The aim is also to make regular visits to units that conduct research on and treats underage children who are difficult to treat (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 almost always attended by an external medical expert. In the reporting year, only the visits to the Health Care Services for Prisoners unit (VTH) was not accompanied by an external expert. Involving a medical expert in the visits has made it possible for the NPM to address the use of restrictive measures from a variety of angles and to explore ways of preventing their use. In 2018, the NPM also trained two experts by experience and employed their expertise in four health care visits.

Visits to psychiatric units are nearly always unannounced. However, the unit is notified by letter that a visit will be made within a certain period

of time. This permits the NPM to request materials from the unit in advance. For example, psychiatric units have been requested to deliver lists of basic patient information, such as the date of admittance, legal status, psychiatric diagnoses and significant somatic diagnoses, for each ward. The list permits the NPM to form an overall picture of the ward's patients in a short time. The information also helps with choosing patients for interviews – e.g. the patient last admitted to the ward, or the patient who has spent the longest time in the ward.

The care staff play a major role in the prevention of mistreatment. For this reason, the inspection visits pay a great deal of attention on procedures, the forms used and the orientation and instruction of employees.

A draft of the visit report, containing the Ombudsman's preliminary opinions and recommendations, is sent to the visited facility, which has the opportunity to comment on the draft. In many cases, the health care unit reports on the measures it has taken on the basis of the Ombudsman's preliminary recommendations already at this stage. The Ombudsman welcomes this development as an indication of constructive dialogue.

The NPM made a total of ten visits to health-care units. The visits to VTH were announced in advance. The other visits were made with the limited announcement described above or were completely unannounced. Visits to the larger units lasted 2–3 days. The NPM made visits to the following units (the opinions and responses of the units also include the visit to the psychiatric unit of the Päijät-Häme Joint Authority for Health and Wellbeing, 5338/2017):

The sites visited were:

- VTH outpatient clinic in Kerava, 30 January 2018, (450/2018)
- Psychiatric unit of Kainuu Central Hospital, 19–20 March 2018, 50 beds (727/2018)
- Kainuu Central Hospital emergency clinic, 19 March 2018 (729/2018)
- Psychiatric unit of North Karelia Central Hospital, 22–24 May 2018, 97 beds (1600/2018)
- North Karelia Central Hospital emergency clinic, 23 May 2018 (1601/2018)

- Niuvanniemi Hospital, 25–27 September 2018, 297 beds (3712/2018)
- Niuvanniemi Hospital's research and treatment unit for underage children, the NEVA Unit, 25 September 2018, 13 beds (3713/2018)
- KYS joint emergency clinic, 26 September 2018 (4753/2018)
- VTH outpatient clinic in Pyhäselkä, 10 October 2018 (4986/2018)
- VTH outpatient clinic in Helsinki, 29 November 2018 (5323/2018)

PREVENTION OF THE MISTREATMENT OF PATIENTS

Closed institutions always involve the risk of mistreatment of their patients. Such institutions must employ preventive structures and practices for preventing mistreatment. One such practice is a generally known procedure for reporting mistreatment.

In the opinion of the Ombudsman, the unit should have clear instructions for reporting mistreatment and on how such reports will be processed and what will be done 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. All hospital employees – not just the nursing staff, but all other professions and substitutes as well – should be instructed in the use of the reporting procedure. Patients and their families should also be notified of the instructions. At the same time, it should be made clear that making a report must never lead to any negative consequences for the person making it (5338/2017, 3712/2018).

The authority reported that its development and patient safety unit will consider the reporting procedure issue mentioned in the feedback at the level of the entire authority and seek to find a technological solution for its implementation. In the meantime, the psychiatric ward units have agreed that matters involving mistreatment shall be reported to the patient ombudsman. The patient ombudsman will attend the head nurse meeting at which the pro-

cess will be discussed. After this the units will be instructed on the temporary process applying only to psychiatric units.

SECLUSION PREMISES

Seclusion premises in psychiatric hospitals shall be clean, fresh, ventilated and sufficiently warm rooms in good condition and with windows, equipped with appropriate bed linen, protective clothing and other fixtures (including a clock). Patients must always be able to contact the nursing staff by ringing a bell or in some other way. During visits, the NPM has also paid attention to the furnishings of seclusion rooms; especially the fact that patients should not have to take their meals standing or sitting on the floor. The visit reports frequently cite the National Institute for Health and Welfare's (THL) publication "Decreasing coercion and improving safety in psychiatric care", which also discusses the location and furnishings of seclusion rooms.

According to the Ombudsman, seclusion rooms must be safe and appropriately equipped. The hospital's seclusion premises were more reminiscent of a jail cell than an seclusion room for a psychiatric patient. The Ombudsman considered it to be degrading to force secluded patients to take their meals standing up or sitting on a thin mattress – let alone having to eat on the same floor or mattress on which the patient has urinated or defecated. Such situations expose the patients to degrading and humiliating treatment that is not acceptable under any circumstances. The Ombudsman deemed it possible that staff would not always have the time to take the patient to the toilet or assist the patient in using a bedpan. In such cases, the unit is required to ensure that patients never have to eat or rest on a surface soiled by human excrement. The responsibility for ending such degrading treatment is with the persons in charge of the hospital's operations (5338/2017).

The authority reported that it would take measures to bring the seclusion premises up to an appropriate standard. For example, two-way voice communication equipment has been installed in all se-



In Joensuu, the seclusion facilities in the adolescent psychiatric ward feature a scenery wallpaper, a high mattress and a cube table.

clusion rooms. In 2018, the hospital intended to install armour glass panes on all seclusion room doors, enabling good visibility out of the room and improving interaction with the nurses. The floor surfaces will also be replaced with softer material. In addition, an appropriation for the renovation of the toilet facilities was made in the budget for 2019. High mattresses, cube tables and armchairs will be purchased for all seclusion rooms in 2018.

The Ombudsman recommended that the hospital should pay more attention to the equipment, furnishings and appearance of the seclusion rooms, without compromising safety. The current situation could be improved by measures such as painting the surfaces and adding soft furniture. At a minimum, some furniture is required for eating, so that the patients do not have to set their meal trays down on the bed or floor. The Ombudsman noted that excrement-resistant soft furniture suitable for such purposes is available. The Ombudsman recommended the unit to remove dangerous details and graffiti from the rooms. It is expected that the condition and equipment of the new hospital's seclusion rooms will be up to the required standard. Since the new premises will not be in use for several years yet and the issue is vital for the fundamental rights of the patients, the Om-

budsman felt that the changes required by him could not wait that long (727/2018).

The authority reported that it had started renovating the seclusion premises. The wall surfaces had been painted and sharp grooves removed. New, soft and excrement-resistant furniture had been ordered. A film had been installed on the glass pane in the door of one seclusion room to protect the occupant's privacy. An alarm bell system had been acquired for the rooms. A dedicated wheeled table had been ordered for serving meals in the seclusion rooms so that the patients are not required to eat on their beds. Every patient in seclusion is permitted to use the toilet next to the seclusion premises in the presence of a nurse/nurses. Efforts will be made to protect the privacy of patients when safe and possible. The staff will actively offer the opportunity to use the toilet. Patients who wish to use the toilet can ask the staff or ring the bell.

TREATMENT OF PATIENTS IN SECLUSION

The Ombudsman stated that the dignified treatment of an secluded patient and good health-care standards require that the patient has access to a toilet. Access to the toilet should also be actively offered to patients without waiting for a specific request. For this reason as well, patients in seclusion should always be able to contact the care staff without delay. In his opinions, the Ombudsman has stated that it is inhumane and humiliating if the patient's only means of communicating with nursing staff is to bang on the door or yell. Patients must also be supplied with adequate and humane clothing.

The Ombudsman issued a serious recommendation to the authority to take measures to bring the conditions and treatment of patients in seclusion up to the required standard. The Ombudsman recommended that the guidelines on treatment should more clearly communicate the objective of providing humane treatment for patients in seclusion. At the very least, this means that staff should be instructed to ensure that patient has the opportunity to use the toilet. The implementation of personal surveillance could also be expressed

more clearly in the guidelines. Specific examples of how nurses can assist patients during meals and ensure that they do not take their meals sitting or standing on the floor and eating with their hands. Guidelines alone will not suffice, however, and the management must ensure that everyone participating in the treatment of a patient in seclusion are aware of the guidelines and comply with them (5338/2017).

The authority reported that it had updated its seclusion guidelines as recommended by the Ombudsman. By the end of August 2018, the authority intended to draw up a proposal for increasing the staff's level of training and awareness of these and other guidelines and legislation. The proposed methods for this include reading materials and an electronic exam, which everyone working in the wards would be required to pass.

The Ombudsman was satisfied with the measures and plans reported by the authority for bringing the seclusion premises up to an appropriate standard. The Ombudsman commended the fact that more attention will be paid to the staff's and management's knowledge of legislation, guidelines and national recommendations. Clear instructions and dedicated training programmes are methods that can consolidate the staff's capabilities for encountering challenging patients.

The guidelines gave the impression that patients will not necessarily be visited in the room, but supervision can be performed from "behind the door". The Ombudsman did not find such supervision consistent with the supervision required for patients in seclusion. Neither can such supervision, or event two-way voice communications, replace contact between the patient and staff. Patients should have the opportunity to talk with nurses face-to-face (5338/2017).

The Ombudsman did not deem it sufficient that patients can contact staff by waving to the surveillance camera or banging on the door and shouting. A minimum requirement in this regard would be a call button in the seclusion room. A system enabling two-way communication would be an appropriate way of arranging contact (727/2018).

THE DEPUTY-OMBUDSMAN RECOMMENDED THE PATIENT TO BE COMPENSATED FOR THEIR TREATMENT WHILE IN SECLUSION

The Deputy-Ombudsman felt that the way in which the patient had been treated in seclusion violated patient's dignity. A person with impaired mobility due to cerebral palsy was forced to take their meals in the psychiatric inpatient ward's seclusion room by sitting on a thin mattress on the floor. The plates, cups and utensils were also unsuitable for the patient. The complainant wore diapers during the seclusion which lasted for more than 24 hours. The Deputy-Ombudsman recommended that the Welfare District compensate the complainant for the violations of fundamental and human rights to which the complainant was subjected (3287/2017*).

The Welfare District reported that it would pay the complainant EUR 4,500 in compensation.

DECREASING THE USE OF COERCIVE MEASURES

Every psychiatric unit that employs coercive measures should have a plan with quantitative and qualitative targets for decreasing their use. It is equally important to inform the entire staff of the plan and monitor its realisation constantly.

The hospital did not have a dedicated programme for decreasing the use of coercive measures. The Ombudsman recommended that the hospital continually monitor the implementation of restrictive measures and draw up a plan or guideline for the reduction of the use of coercive measures. He also suggested familiarising the entire staff with the plan or guideline (5338/2017).

The authority reported that, in addition to the restriction notifications made to the AVI, the psychiatric outpatient wards will start compiling statistics on the use of restrictive measures and a monitoring procedure for restrictive measures will be drawn up. Once the availability of this base data has been secured, a programme and targets for decreasing the use of coercion will be drawn up. The induction of personnel in the targets and measures of the plan will constitute a part of the programme. Guidelines

for discussing seclusion with patients will also be drawn up for staff.

During the visit, the NPM did not see convincing evidence of active attempts to decrease the use of coercion. The hospital did not have a dedicated programme for decreasing the use of coercive measures (727/2018).

The authority reported that restrictive measures and their use and documentation had been reviewed with the staff. Restrictive measures will only be employed when other measures will not suffice. The staff was also instructed to document in detail any alternative methods employed to resolve the situation before the use of restriction or seclusion. A training programme for the staff will start soon. There are also dedicated guidelines for decreasing the use of coercion and improving safety in the psychiatric ward, and every staff member has read and signed the guidelines. A specific programme for decreasing coercion and monitoring the use of restrictive measures is being planned. The psychiatric ward uses psychiatric advance directive forms. This voluntary system has been developed to improve the patients' right to self-determination when they are incapable of making decisions for themselves. If an advance directive has been made, it will be respected whenever possible. The new instructions for patients also include written information on the possibility to make an advance directive on psychiatric treatment.

USE OF MECHANICAL RESTRAINTS

The instructions on the use restrictive measures did not state how often physicians should assess the state of restrained patients. The patient documents indicated that, in one case, the physician had only assessed the restrained patient's state once per day. The Ombudsman found this interval to be excessive (727/2018).

All of the inpatient ward's seclusion rooms were equipped with restraint beds as standard fixtures. All new hospital beds ordered for the ward also included the option to install restraints. The Ombudsman felt that this could lower the threshold for using restraints. Some of the patient



Restraint bed in an isolation room at the central hospital in Kajaani.

records inspected gave the impression of a low threshold for the use of restraints in certain cases. As an example, one patient had been permitted to go for a cigarette and go to the sauna in the middle of restraint and seclusion. The Ombudsman stressed that, according to the Mental Health Act, seclusion without mechanical restraints is the primary alternative and restraints can only be employed when other measures are insufficient (727/2018).

During the visit, the NPM noted that patients were transported outside the seclusion rooms with the restraints still attached to their limbs. This could be the case when taking the patient to the toilet or for a cigarette, for example. In the Ombudsman's opinion, moving a patient with the restraints still attached can be considered humiliating for the patient. It can also cause anxiety in other patients. In the Ombudsman's opinion, this practice should be avoided, particularly in the ward's common areas (727/2018).

INVOLUNTARY MEDICATION

If a patient in involuntary care or under observation refuses to take the medication prescribed for them, the medication may be administered against their will only if the failure to provide medication would seriously endanger the health and safety

of the patient or others. In his decision dated 15 March 2018, (1496/2017) the Ombudsman commented on the medication of a patient against their will.

The Ombudsman recommended that, from now on, decisions on involuntary medication should be justified with regard to the requirements of the Mental Health Act. He stressed that psychosis cannot be considered to constitute sufficient grounds for involuntary medication, because all patients under observation and ordered to treatment suffer from psychosis. The patient records should also indicate how the patient was consulted on the medication or why consultation was not possible (5338/2017).

The authority reported that the physician in charge of the psychiatric hospital had started clarifying the guidelines with the objective of assessing the use of restrictive measures in more detail and recording the reasons for employing restrictive measures more systematically. Particular attention will be paid to the use of involuntary medication and recording seclusion situations.

The patient records indicated that involuntary medication was administered in the psychiatric ward. The medication had been justified as "necessary", but the entry in the patient records lacked a detailed assessment of whether the requirements for involuntary medication specified in the Mental Health Act were met (failure to medicate would seriously endanger the safety or health of the patient or others). The Ombudsman recommended that, in the future, involuntary medication should be assessed in the manner required by the Mental Health Act, and that the fulfilment of the conditions be recorded in the patient records (727/2018).

The authority reported that the staff was instructed to accurately document everything related to the administration of involuntary medication.

QUALITY OF CARE AND CARE CULTURE

The Ombudsman recommended that the rehabilitation ward should be made more comfortable to better support rehabilitation. Excrement-resistant furniture suitable for such purposes is available. The Ombudsman felt the shortcomings in the rehabilitation ward's care environment to be significant and urged the ward to take measures to bring the environment up to the required standard. In the opinion of the Ombudsman, it was not possible to wait for the rectification of the situation with the completion of the new hospital building in 2021 (727/2018).

According to the observations made by the NPM, the treatment times of patients in the rehabilitation ward were long, and many patients appeared to be more in need of nursing and care than rehabilitative treatment. The NPM got the impression that a large portion of the ward's patients were not in a correct or appropriate place of care. The offering of rehabilitative activities was sparse. The Ombudsman issued a serious recommendation to the ward to take measures to bring the conditions and treatment of the patients up to the required standard. The Ombudsman considered it necessary to evaluate the suitability of the place of care individually for each patient (727/2018).

According to the observations made by the NPM, not many nurses could be seen in the rehabilitation ward's common areas or among the patients. If the patients wanted to talk to the nurses, they knocked on the door of the office. The nurses seemed to spend a disproportionate amount of time in the office instead of working with the patients. The nurses' working methods also appeared task-oriented. According to the NPM's observations and patients' accounts, the nurses did not actively initiate contact with the patients. The Ombudsman recommended that the ward should continue assessing its care culture and opportunities to lessen the nursing staff's focus on the office. The Ombudsman urged the ward to consider the implementation of visibility between the office and ward so that the patients could see into

the office and the nurses out of it, without compromising confidentiality (727/2018).

According to the authority, it is part of the ward's care culture that the staff should be as available as possible to the patients. This has been discussed with the staff to an even greater extent. Only the necessary work should be done in the office behind closed doors. Whenever possible, work should be arranged so that one or more staff members are always in the ward and available to the patients. For example, care meetings and other meetings should be arranged in a staggered manner, so that a majority of the staff would not be unavailable at any one time.

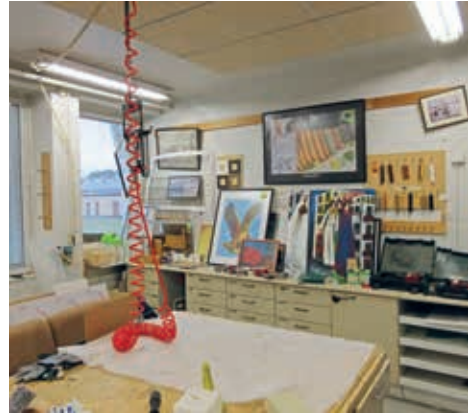
WORK FOR DECREASING THE USE OF COERCION IN A STATE FORENSIC PSYCHIATRIC HOSPITAL

Niuvanniemi Hospital treats patients who have not been convicted due to their mental state (forensic psychiatric patients) and performs psychiatric examinations. The hospital also treats dangerous and/or difficult psychiatric patients. At the end of 2017, the average treatment time of forensic psychiatric patients was 6 years and 8 months (the longest being 35 years and 7 months). The corresponding figures for patients admitted due to difficult conditions was 4 years and 5 months (the longest period being 26 years and 1 month). All of the patients being treated in the hospital had been committed to the hospital against their will. Thus, their right to self-determination can be restricted subject to the conditions provided for in chapter 4a of the Mental Health Act. However, the Act states that a patient's right to self-determination and other fundamental rights may only be restricted to the extent required by the treatment of their condition, the safety of themselves or others, or the safeguarding of other interests provided for in chapter 4a.

In 2011 and 2015, the hospital drew up proposals for plans to decrease the use of coercion, and a steering group for decreasing the use of coercion operates in the hospital. The hospital is committed to decreasing the use of coercive measures on patients. According to the steering group, the hos-



Various activities at the Niuvanniemi Hospital.



pital has succeeded in halving the amount of seclusion and restraint in proportion to treatment days in the 2010s.

Various methods have been developed to decrease the use of restrictive measures. These include the development of special observation (100% observation), facilitating access to occupational therapy, harmonising the practices and record of wards, developing the use of relaxation or sensory deprivation rooms, and replacing traditional violence management training with prevention-oriented training.

The Deputy-Ombudsman commended the hospital's work for decreasing the restrictive measures used on patients. She recommended offering a debriefing opportunity to patients after all restrictions of their right to self-determination, instead of just after seclusion and restraint situations. The Deputy-Ombudsman also commended the hospital's work in reducing the use of seclusion. She nevertheless considered the still occurring long seclusion periods to be problematic. Seclusion is an extremely strong infringement on the patient's personal freedom.

The steering group for decreasing the use of coercion made reducing the use of mobility-restricting garments a focus area for 2018. The use of restrictive clothing is monitored in the hospital. In the last eighteen months, the garment has been used for six patients. At the time of the visit, it was only used for one patient. There are many instances of its use, however, (3,395 in 2017), because the patient is dressed in the garment whenever he moves in the ward's common areas. The hospital has sought to develop alternatives to restrictive clothing (ponchos, muffs). Such clothing permits violent patients to spend time with the other patients. The Deputy-Ombudsman commended the hospital's work for reducing the use of restrictive clothing (3712/2018).

EMERGENCY UNITS

As in previous years, the Ombudsman felt it was important to visit the emergency care units of somatic hospitals, which use so-called secure rooms. Attention is also paid to the privacy of the patient in urgent-care facilities.

Patients can be placed in the secure room because they are, for example, aggressive or confused and cannot be placed with other emergency patients. This situation is problematic because there is currently 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 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 NPM visited the emergency care units of three hospitals in 2018. All visits were made unannounced and during the evening. An external expert participated in the visits. The visits paid attention to the fulfilment of the above-mentioned requirements.

SUPERVISION OF HEALTH CARE FOR PRISONERS

Health Care Services for Prisoners (VTH) operates in connection with the National Institute for Health and Welfare (THL). The VTH is tasked with providing health care services for all prisoners in Finland. As a rule, VTH produces its own primary health care, oral health care and specialised psychiatric health care services. VTH has outpatient clinics in every prison in Finland, with the exception of Suomenlinna Prison, which arranges health care for its prisoners at the Helsinki Prison outpatient clinic. Eleven prisons have dental clinics in connection with the prison clinic. In Vaasa, the dental clinic operates in a municipal health centre. The units of the Psychiatric Prison Hospital in Turku and Vantaa serve as acute clinics for prisoners everywhere in Finland. The Prison Hospital is a national somatic hospital for prisoners, located in Hämeenlinna.

Since the beginning of 2016, the Regional State Administrative Agency of Northern Finland (AVI) has conducted guidance and assessment visits to the outpatient clinics and hospitals of VTH on its own or together with the National Supervisory Authority for Welfare and Health (Valvira). In the reporting year, the AVI conducted five guidance and assessment visits to VTH units. By the end of 2018, the AVI has visited all VTH outpatient clinics and hospitals. A report has been published on the supervision of the national prisoner health care service in 2016–2018: <https://www.avi.fi/web/avi/julkaisut-2019>). In the report, the supervisory authorities assess VTH's operations as part of the national health care system, along with the treatment recommendations and guidelines issued by VTH.

The Ombudsman receives AVI Northern Finland's supervision plans for VTH and guidance and assessment reports following its visits. As part of this collaboration, the Ombudsman sends its own supervision plans and visit reports to Valvira and AVI. The Ombudsman, Valvira and AVI also hold regular meetings on issues in the field of prisoner health care.

The NPM visited three VTH outpatient clinics in 2018. Such visits are combined with prison visits and are usually announced in advance. Before visiting the outpatient clinic, the NPM interview the prisoners on matters such as the functioning of health care and medical care in the prison.

On these visits, the NPM pays attention to how soon medical screenings are performed on new prisoners and how they are investigated for possible signs of violence. The NPM also determine how the health of prisoners placed in solitary confinement is being monitored. The monitoring is not fully in compliance with the Imprisonment Act, since the majority of outpatient clinics are only open during business hours on weekdays. For example, the mental state of a prisoner placed under observation in the weekend is not examined at the schedule required by the Imprisonment Act, i.e. "as soon as possible" after the start of observation, but only on the next weekday. Prisoners frequently criticise the fact that they do not receive replies to the inquiry forms they send to the outpatient clinic, or that getting a physician's or dentist's appointment is difficult. On these visits, the NPM has frequently drawn the outpatient clinics' attention to the fact that, according to the Patient Act, the time of their appointment must be communicated to patients if it is known. The Act does not distinguish between prisoners and other patients in this regard. However, it is necessary to take certain security considerations in to account, particularly for appointments outside the prison, and these can have an impact on the level of detail disclosed to specific prisoners about the times of their appointments.