PARLIAMENTARY OMBUDSMAN OF FINLAND

SUMMARY
OF THE ANNUAL REPORT
2019

National Preventive Mechanism against Torture

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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) at the Office of the Parliamentary Ombudsman, and its Human Rights delegation, fulfil the requirements laid down for the National Preventive Mechanism in the Optional Protocol, which refers to 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 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, and the number of visits conducted would remain considerably smaller. Participation in the visits and the other

tasks of the Ombudsman, especially the handling of complaints, are mutually supportive activities. The information obtained and experience gained during visits can be utilised in the handling of complaints, and vice versa. For this reason, too, it is important that those members of the Office'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. In giving his opinion, the Ombudsman stated that the Office had received no additional human resources to fulfil its remit as the NPM, although such increases had 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 during the planning period. In the budget proposals for 2018 or 2019, however, the Parliamentary Ombudsman did not propose an appropriation for the new posts. This was largely due to the savings targets set by the Office Commission.

In 2019, several cases of negligence were identified in service units for the elderly. The Parliament granted additional funding for the Office of the Parliamentary Ombudsman for 2019 to step up the supervision of the rights of the elderly. In 2019, new instances of neglect were identified, and closures of service units were carried out. The Office of the Parliamentary Ombudsman was granted additional funding for 2020 to establish new posts. Three of the new posts concentrate on the supervision of the rights of the elderly, which also contributes to the resourcing the NPM, as most of the inspection visits to elderly care units are carried out under the NPM mandate.

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 Principal 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 and 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 is led by the head coordinator of the NPM.

The NPM has provided induction training for external experts regarding the related visits. The NPM currently has 12 external health-care specialists available from the fields of psychiatry, youth psychiatry, geriatric psychiatry, forensic psychiatry, geriatrics, and intellectual disability medicine. A further three external experts represent the

Sub-Committee on the Rights of Persons with Disabilities operating under the Human Rights Delegation at the Human Rights Centre. Their joint expertise will benefit inspection visits carried out at units where the rights of persons with disabilities may be restricted. In addition, the NPM has trained five experts by experience to support this work. 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 inspection visits.

3.5.3 INFORMATION ACTIVITIES

A brochure on the NPM activities has been published, and it is currently available in Finnish, Swedish, English, Estonian, and Russian.

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

3.5.4 EDUCATION AND TRAINING ON FUNDAMENTAL AND HUMAN RIGHTS

The Parliamentary Ombudsman and the Human Rights Centre launched a joint initiative in 2018 to promote fundamental and human rights within residential service units for persons with disabilities. In preparation for the project, experts employed by the Human Rights Centre participated in inspection visits of service units for disabled people. The aim is to develop an assessment framework as part of the self-monitoring plan to guide the residential unit staff to assess how well the human rights of the residents with disabilities are respected. The initiative is introduced in section 3.4.

3.5.5 TRAINING

In 2019, members of the Office of the Parliamentary Ombudsman participated in the following events and courses as part of their duties under the NPM:

- Memory Disorders Expertise seminar, 17 May 2019. The programme included a presentation on the elements in a living environment for persons with memory disorders by Laura Arpiainen, architect and professor at Aalto University. Organised by the Finnish Society for Memory Disorders Expertise.
- Seminar on elderly care, 10 June 2019. The programme included presentations on the conditions in elderly care (Professor Teppo Kröger, University of Jyväskylä) and increasing life expectancy, leading to changes in demand and access to care (Professor Marja Jylhä, University of Tampere). Organised by the Parliamentary Ombudsman.
- Internal training for the Office of the Parliamentary Ombudsman on obtaining the opinion of a child with a disability, 12 June 2019. The training included expert guidance on methods and tools suitable for establishing the views of adults with memory disorders and learning disabilities.
- Internal training on conducting interviews during visits made in the capacity of the NPM, 13 September 2019.
- Violence and domestic violence against women, 25 September 2019. The theme was the recommendations for Finland based on the first evaluation procedure under the Istanbul Convention. The event was joined by Iris Luarasi, Member of the Group of Experts on Action against Violence against Women and Domestic Violence (GREVIO). The event was organised by the Human Rights Centre.
- Use of coercion in social and health-care services – where to draw the line? seminar, 2 October 2019. Themes included: 1) restrictive measures in social and health-care services, 2) restrictive measures in institutions, and 3) improving quality through increasing monitoring. The discussion on restrictive measures

involved representatives from different fields of practice: child welfare and foster care, services for persons with learning disabilities, elderly care, and mental health care. The event was organised by FCG Finnish Consulting Group Oy.
- Rights of the elderly seminar, 10 October 2019. The themes included services for the elderly and inclusion and self-determination in elderly care. The event was organised by the Human Rights Centre.
- Kalle Könkkölä Symposium, 22 October 2019. The theme was the rights of persons with disabilities – a snapshot. The event was organised by the Parliamentary Ombudsman and the Human Rights Centre.
- Internal training on the legislative implementation of the Convention on the Rights of Persons with Disabilities, 30 October 2019. The speaker was Professor Tuomas Ojanen, University of Helsinki.
- Internal training on identification and prevention of radicalisation in Finnish prisons, 3 December 2019. The presentation was delivered Annika Finnberg, who has served as a temporary deputy investigating officer at the Office of the Parliamentary Ombudsman.
- Internal training on oral health care for the elderly, 17 December 2019. The training was delivered by specialist dentist Pauli Varpavaara.

3.5.6 NORDIC AND INTERNATIONAL COOPERATION

The Nordic NPMs meet regularly, twice a year. The Finnish NPM organised a cooperation meeting in Helsinki in January 2019. The main theme of the meeting was inspection visits at elderly care units. The opening address was given by Jari Pirjola, Principal Legal Adviser and Member of the Committee for the Prevention of Torture, on the topic "Are elderly people in social care homes deprived of their liberty?". Furthermore, the Finnish NPM gave a presentation of the visits it had made to residential units for persons with disabilities, while the Swedish NPM shared its observations on the special theme of transport of persons deprived of their liberty.

Iceland ratified the Optional Protocol to the Convention against Torture (OPCAT) on 20 February 2019, and the Icelandic NPM hosted its first cooperation meeting in August 2019 in Reykjavik. The topic was "Ethical issues regarding therapeutic treatment, a person´s rights to privacy and security measures in secure settings – where do we draw the line?. Principal Legal Adviser Håkan Stoor gave a talk on "Ethical issues in NPM visits in Finland". Principal Legal Adviser Jari Pirjola discussed the same topic from the perspective of the CPT. The meeting included a site visit to a psychiatric hospital (Kleppur).

The implementation of the UN Convention against Torture is overseen by the Committee against Torture (CAT). Parties to the convention have the obligation to report at regular intervals on the implementation of the Convention. According to the reporting procedure, to which Finland has agreed, CAT presents a document known as the List of Issues Prior to Reporting (LOIPR), with responses submitted to the list serving as the report. For the purpose of compiling the 8th periodic report, in June 2019, the Parliamentary Ombudsman and the NPM submitted a list to the UN Committee Against Torture (CAT) of the issues they wished to bring to the attention of the committee and to be raised in the list of questions submitted by the committee to the Finnish Government. A total of eight topics were covered. These covered themes such as preventing the mistreatment of the elderly, securing and improving the right to self-determination of persons with disabilities, honouring the rights of children placed in child welfare institutions, and the detention of intoxicated persons in police custody. A general theme relevant to everyone who has been deprived of the liberty is the need for training in fundamental and human rights for those who, in their professional capacity, must intervene with a person's right to self-determination and integrity (3513/2019).

3.5.7 VISITS

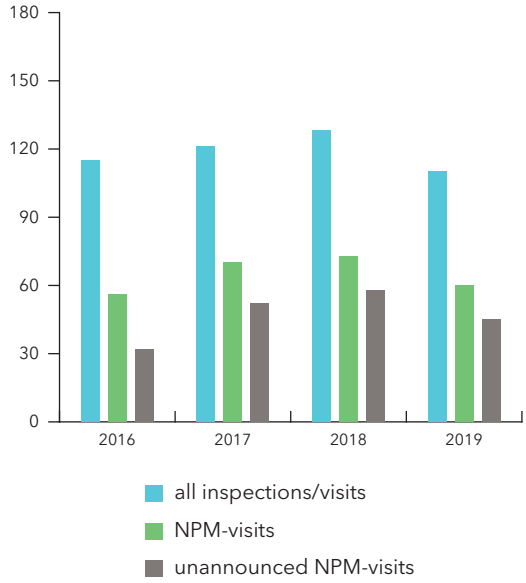
Fulfilling the role of an NPM requires regular visits to sites. In some administrative branches, such as the police and criminal sanctions, such visits are also possible in practice. However, in the case of social services and health care, the number of units is so large that sites must be selected for visits on the basis of certain priorities. In 2019, some follow-up visits were also made in order to determine how the recommendations of the NPM had been implemented in practice. Compliance with the recommendations is monitored by requesting the facility visited and sometimes also the officials responsible for its supervision to report any changes and improvements in the practices.

During 2019, the NPM carried out 60 visits (compared to 73 in 2019). The total number of site visits carried out by the Office of the Parliamentary Ombudsman was 110 (120). The majority (45) of the NPM visits were carried out unannounced.

Of these, 25 visits included participation by one or several external experts (compared to 19 in the previous year). On five visits to housing service units for persons with disabilities, a medical expert was also accompanied by two representatives from the Sub-Committee on the Rights of Persons with Disabilities. Two visits to health-care units included participation by an expert by experience. Involving external experts in visits has become an established practice in certain administrative branches. During 2019, a total of ten external experts (of 15 experts available) were invited to join inspection visits.

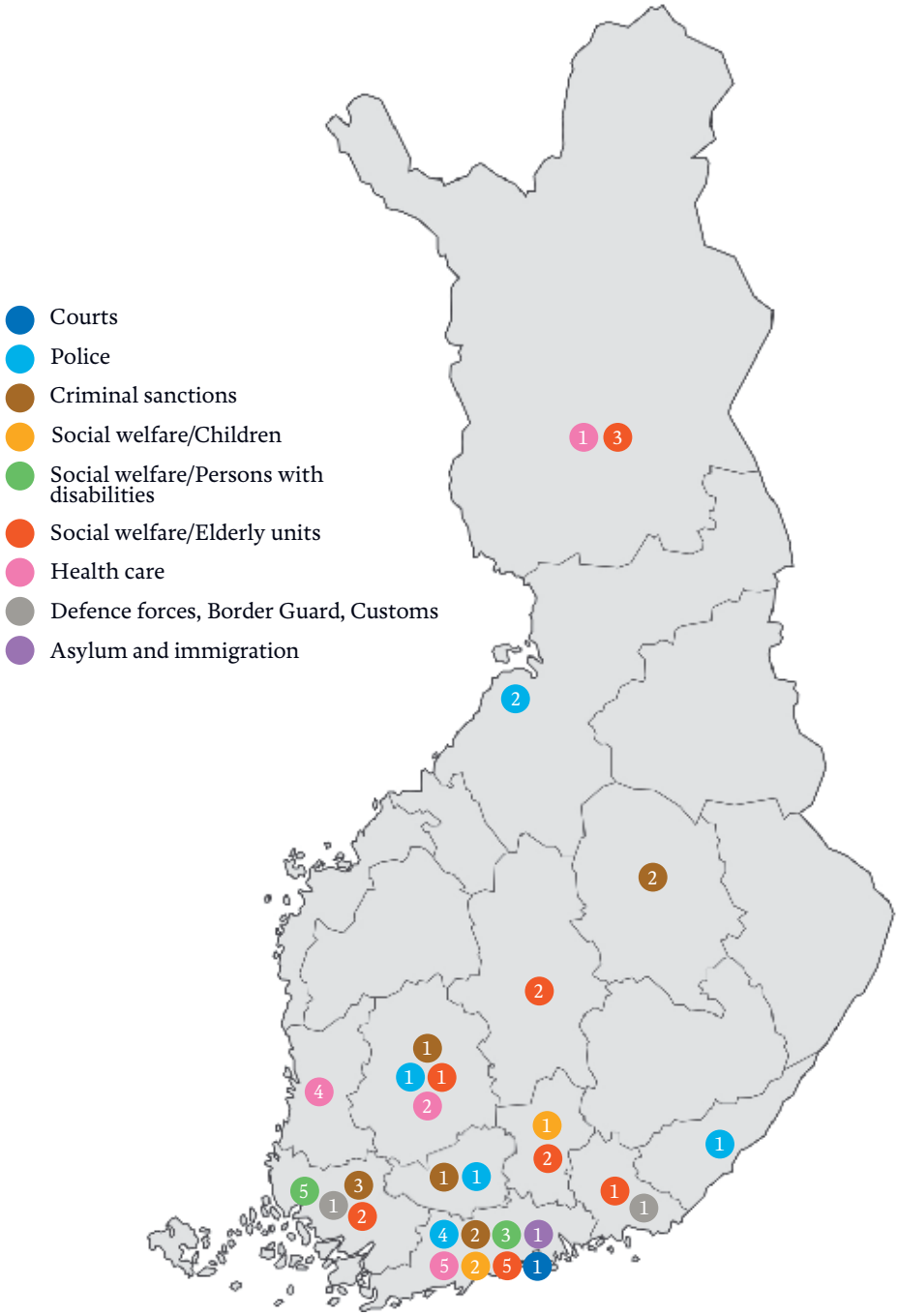
Of the other visits conducted by the Parliamentary Ombudsman, five were related to the duties of the NPM, including visits made to the National Police Board of Finland, the Border Guard Headquarters, and the Defence Command of the Finnish Defence Forces.

Since the establishment of the NPM, the inspectors have increasingly focused on interviewing persons who have been deprived of their liberty. The aim is to give a voice to those in the most vulnerable positions, such as minors and foreign nationals. This has meant an increase in the use of interpreter services, among other things. The confidential discussions held with children in foster care during visits made to child welfare institutions have been crucial in producing effective outcomes in the exercise of NPM's visiting mandate.



Visits in 2016–2019.

One of the key themes for the Office of the Parliamentary Ombudsman for 2019 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 Parliamentary Ombudsman, namely, the rights of children, the elderly, and the disabled, are considered on each visit. The visits also involve the "oversight of oversight", meaning the realisation of the NPM's duty to oversee the activities of other supervisory authorities. A good example of this is the measures put forward on the visit reports, which the supervisory authorities of child welfare institutions and elderly care units are expected to observe.



NPM visits by region in 2019. Most of the population and the sites visited are located in Southern and Western Finland. A full list of all visits and inspections is provided in Appendix 5.

3.5.8 THE IMPACT OF NPM'S PREVENTIVE MANDATE

Regardless of the number or frequency of visits, their impact will be inconsequential if recommendations made based on the visits do not lead to improved treatment and conditions of persons deprived of their liberty at the respective institutions. If tangible results cannot be documented, the visits will lose their corrective impact. Overall, the opinions and recommendations of the Ombudsman lead to positive actions. Often, the dialogue during the actual visit alone helps establish mutual understanding on how operations could be improved and issues addressed. Following the visit, a draft visit report is sent to the visited facility, which has the opportunity to comment on the provisional opinions and recommendations made by the Ombudsman. In many cases, the visited unit reports on the measures it has taken on the basis of the preliminary recommendations already at this stage.

An official request for information is sometimes enough incentive to take the necessary actions. A good example of this is the plan launched by the police administration that led to an investigation into the suitability of detention facilities and the introduction of an approval system. Sometimes putting recommendations into practice takes time, as was the case in organising training on the distribution of medicines for guards working at police detention facilities.

On occasion, the operations of the NPM have led as far as the amendment of legislation; for example, the Child Welfare Act was amended as a matter of urgency based on the findings of the NPM. Other administrative branches have also benefitted from the identification and addressing of legislative gaps, leading to improved legislation.

3.5.9 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 are apprehended because they are intoxicated: more than 50,000 every year. The second largest group is formed by persons suspected of an offence, numbering approximately 22,000. A small number of people detained under the Aliens Act are also held in police prisons.

Visit reports are always sent to both the National Police Board and the visited police department. Internal oversight of legality at police departments is conducted by separate legal units. Each year, the National Police Board provides the Parliamentary Ombudsman with a report on the oversight of legality.

According to information provided by the National Police Board, its plan is to focus more attention in 2020 on developing detention and guarding practices. The prioritisation stems from observations made by the police themselves and the Parliamentary Ombudsman. The development work is also informed by observations made by the Ombudsman in connection with deaths in custody. The rights of persons deprived of their liberty is also a focus area in the internal oversight within the police in 2020.

The police currently have 45 police prisons in use. The NPM visits are usually carried out at police detention facilities unannounced. This is why it is important that the Ombudsman has reliable and up-to-date information on whether, for example, a detention facility in use. The information obtained from the National Police Board was partly outdated. For this reason, the Ombudsman requested an updated list of police detention facilities from the National Police Board in March 2019 and the immediate notification of the Ombudsman of any changes to the list. Another finding to surface in 2019 was that the Ombudsman has not received fully updated information on the actual use of detention facilities (6000/2019 Imatra).

In 2019, 9 inspection visits were made to police prisons (compared to 13 visits made in the previous year). The visit to the Espoo police prisons also included an inspection visit at the adjacent City of Espoo sobering-up station. All of the visits were made unannounced. The sites visited were:

date of inspection	target	number of inmates	case number	other / previous visit
27 February 2019	Espoo police prison#	30 cells	1201/2019	Ombudsman included, previous visit 2017 (1382/2017)
27 February 2019	City of Espoo sobering-up station#	15 places	1202/2019	Ombudsman included, previous visit 2017 (1606/2017)
10 April 2019	Raahe police prison#	15 cells	1950/2019	previous visit 2016 (1940/2016)
10 April 2019	Haukipudas police prison#	18 cells	1954/2019	previous visit 2005
27 May 2019	Tampere Central Police Station, police prison#	64 cells	2982/2019	previous visit 2018 (4394/2018)
1 July 2019	Hämeenlinna police prison#	59 cells	3621/2019	previous visit 2011
1 July 2019	Hyvinkää police prison#	18 cells	3622/2019)	previous visit 2016 (212/3/16)
1 July 2019	Järvenpää police prison#	14 cells	3623/2019	previous visit 2016 (211/3/16)
6 November 2019	Lappeenranta police prison#	24 cells	5999/2019	previous visit 2009
6 November 2019	Imatra police prison#	1 cell	6000/2019	previous visit 2015 (4620/3/15)

#= unannounced inspection

During 2019, one visit was also made to the Police University College, where the themes raised included guard training and deaths in custody. During the visit to the National Police Board, the issues raised included police prisons and their renovation work, and the NPM visits to police prisons. During the visit to the Oulu Police Department, the previous day's visits to Raahe and Haukipudas police prisons and the observations during the visits were discussed (1951/2019).

The following issues were repeatedly identified during the visits to the police detention facilities:

- guards are working alone
- guards are assigned additional duties such as recording personal descriptions, which could interfere with their guarding duties
- police officers are used as guards without sufficient training
- guards are aware of the rectification procedure but are unable to identify which actions require a written decision
- persons deprived of their liberty are not notified of their rights
- the outdoor spaces are not suitable for outdoor exercise
- the detention facilities are not suitable for long-term stays
- cells used for intoxicated persons lack privacy when using the toilet
- persons deprived of their liberty have no facilities to wash daily
- the level of cleanliness of the facilities is unsatisfactory

The impact of inspection visits

The opinions and recommendations of the NPM are sent to the respective police departments for comment before finalising the visit report. The police departments have taken a constructive view of the opinions and recommendations. For example, more than half of the police departments visited during 2019 reported at the commentary stage the actions they were taking to improve their practices and the conditions of persons deprived of their liberty. However, as is evident from the list above, some issues remain, although they have been repeatedly raised, sometimes repeatedly with certain police prisons.

To maximise the impact of visits, it is important that visits to police detention facilities are made regularly, including as part of the independent legality oversight of the police. In November 2017, the National Police Board issued a circular (guidelines) on matters that should be considered in police detention facilities. The circular required, for example, that persons deprived of their liberty should be informed of the conditions of the detention facilities as soon as possible on arrival. This could be arranged by handing persons deprived of their liberty a form specifying their rights and obligations and a list of house rules (as required by the National Police Board guidelines). Records should be made indicating that the information has been duly provided. Regardless of this, more room for development in communications was identified in the visits to police detention facilities in 2019 (1201/2019 Espoo, 3621/2019 Hämeenlinna, 3622/2019 Hyvinkää, 1950/2019 Raahe, 1954/2019 Haukipudas, 5999/2019 Lappeenranta). The National Police Board finds it reasonable to expect that every police detention facility make available a written list of oversight authorities, which can be given to persons deprived of their liberty for information. Although such as list was appended to the National Police circular, it had not been made available at sites visits in 2019 (1950/2019 Raahe, 3621/2019 Hämeenlinna, 3622/2019 Hyvinkää).

Police departments have reported the following with regard to deficiencies in information dissemination and self-monitoring:

- Line managers at detention facilities have been reminded of the importance of handing out written information materials to all persons deprived of their liberty and also communicating the same information verbally. Managers and the Legal Unit review detention forms on a regular basis and notify the staff of any deficiencies in the information (1950/2019 Raahe, 1954/2019 Haukipudas).
- The police department will issue guidance to all detention facility guards to give all detained persons, on arrival, the necessary information about the facilities and procedures while in detention, such as the use of the cell alarm, mealtimes, outdoor exercise, shower facilities, and phone calls. The detained persons, including those detained under the Police Act (intoxicated persons), will also be informed about supervisory authorities and their contact details. Written instructions will also be made available in Swedish at the reception desk on arrival at the detention facility (3621/2019 Hämeenlinna).
- The police department reported that the notifications and records of persons deprived of their liberty, as well as information provided to them on the conditions at the facility, have been given attention both in self-monitoring and legal oversight. Checklists have been distributed amongst staff to support this measure. Following the visit of the NPM, the records have been monitored in real time. New guidelines are also under preparation, including instruction on verbally informing new arrivals of the conditions at the facility and the regulations governing police detention facilities (5999/2019 Lappeenranta).

It would seem that changes in practices require ongoing training for detention facility staff. This, in turn, requires that managers at the facilities are motivated to actively influence and develop the practices at their facilities. The training received

by guards, and senior guards as their line managers, has a key role when further aligning the treatment of persons deprived of liberty and the condition of detention facilities with fundamental and human rights.

There are, however, examples of how practices can be overhauled at a rapid pace. In 2017, the NPM intervened in the use of a restraining bed discovered at Espoo police prison. It was noted during a visit at the same facilities in 2019 that the restraining bed had been removed and the space was used as an ordinary cell. According to the staff, any problem situations have been dealt with by other methods, such as placing the detained person under observation (1201/2019 Espoo).

Approval of police detention facilities

Under the Act on the Treatment of Persons in Police Custody, police detention facilities must be approved by the National Police Board. However, specific approval decisions have not been issued.

The Ombudsman placed an inquiry with the Ministry of the Interior regarding the approval process for detention facilities. The National Police Board issued a plan in February 2019, according to which an audit of the current condition and suitability of detention facilities for detaining persons deprived of their liberty began the same year. The aim was to issue an approval decision on the fitness for use of all detention facilities by the end of 2020.

In November 2019, the National Police Board also issued guidelines on the approval of detention facilities for persons in police custody, which entered into force on 1 January 2020. The guidelines refer to the statements issued by the Ombudsman and the CPT on the treatment of detained persons, which must be observed when approving detention facilities. The condition for approval is that the space meets the criteria laid down in the legislation on detention facilities for persons deprived of their liberty and that the facilities allow for due compliance with the legislation governing the detention of persons deprived of their liberty. The space must be safe and must honour the detained person's right to privacy. The space must be equipped so that a person deprived of their liberty has access to all the rights that they have not been deprived of on the basis of the law, such as the right to meetings or the right to follow public media. The space must provide conditions that comply with the principle of normality. The facilities must be organised so that different persons of different genders, age groups, and grounds for detention can be kept apart.

Police departments have since initiated inspections of police station detention facilities based on the National Police Board guidelines. During these inspections, observations have been made of any issues and deficiencies regarding the right to privacy and lighting in cells, and access to verbal communication channels for persons deprived of their liberty. Evacuation safety has also been given attention. Following these measures, a representative of the National Police Board has carried out an audit at the facility. In conjunction with this, a need has also arisen to update the house rules at police stations. The National Police Board has started its process of approval for detention facilities. The precondition for approval is that the required measures have been carried out within the agreed time scale. At the time of writing this annual report, the matter was still pending with the Ombudsman. The Ombudsman has already received some completed approval decisions.

The role of Senate Properties as the lessor of detention facilities

Senate Properties serves as the lessor of all government agency facilities, including police detention facilities. It is regularly brought to the attention of the Ombudsman and the NPM during site visits that addressing any deficiencies at the leased premises is not possible without a contribution from Senate Properties. The Deputy-Ombudsman has launched an investigation at his own initiative into the role of Senate Properties as the sole lessor of government agency facilities. Issues requiring further inquiry include the division of liability for maintaining the condition and healthiness of detention facilities for persons deprived of their liberty.

The pictures show outdoor recreation facilities in different police prisons.

Serious deficiencies at Haukipudas detention facilities

The detention facilities used at the Oulu Police Department's Haukipudas Police Station were previously used as police cells (already decommissioned in 2009) and were modules built from shipping containers in the police station courtyard. The facilities were originally designed for temporary use for only a few months but have since remained in permanent use. It was not yet known at the time of the visit when the facilities would be finally decommissioned. However, the Ombudsman finds it obvious that even temporary facilities must meet all the requirements laid down in the law on the treatment of persons deprived of their liberty.

The Ombudsman found it problematic from the perspective of legal requirements for the facilities that sections of the modular space needed regularly to be closed off for reasons of fire safety, indoor temperature, and drainage. The following other issues that were integrally linked with the humane treatment and safe detention of persons deprived of their liberty:

- The right of persons deprived of their liberty to immediately contact staff was compromised because cell calls were received at the control room, which was not always manned.
- Furthermore, the lack of an audio connection to the old police station cells presented a clear safety risk for the detained persons. An audio connection to the modular cells could be made only if the detained person had first pressed the call button.
- Persons deprived of their liberty were received and examined in a narrow corridor that was not fit for the purpose and could also present an occupational health and safety risk.
- The rules regarding the storage of personal property were unclear, as there was no designated space for the purpose.

- The outdoor exercise premises did not meet the needs for exercise as intended in the law. The outdoor exercise premises must offer plenty of fresh air and a view to the outside.
- The outdoor exercise area had been out of use at times, so that persons deprived of their liberty had no access to outdoor exercise.
- Due to a lack of meeting rooms, visits by a legal counsel or family members took place in the changing room next to the shower rooms, under camera surveillance. A changing room is not a suitable meeting room. Visits by a legal counsel, in particular, should take place without camera surveillance.
- Camera surveillance should not be used in washing facilities or changing rooms, where persons deprived of their liberty may be naked.
- Up to six persons could be detained in one cell, where they were forced to use the toilet in full view of the others and under camera surveillance. This practice is against the right to privacy of persons deprived of their liberty.

The Ombudsman found it highly problematic that the detention of persons deprived of their liberty at Haukipudas police prison had been organised using a temporary arrangement that is, in many respects, unsatisfactory or even illegal. This situation has remained unchanged for years. The Ombudsman considered it paramount that these practical issues at the detention facilities be remedied as a matter of urgency, if the facilities are to continue to be used for detaining persons deprived of their liberty.

Besides the police department in question, the Ombudsman also requested that the Ministry of the Interior and the National Police Board submit a report on measures carried out. The National Police Board reported that the facilities have been or will be upgraded to a satisfactory standard during spring 2020. According to the report of the Ministry of the Interior, the Haukipudas police prison will remain in use until the new police station building is completed. At the time of writing this annual report, the National Police Board was pending its decision on the approval of the Haukipudas detention facilities.

The separation of police detention and investigation operations

It was noted on nearly each visit to police detention facilities that criminal investigators participated in many ways in duties that fall under the remit of the detaining authorities. Investigating officers could decide on various aspects of civilian life and purchases, and sometimes even on meetings and phone calls allowed for persons deprived of their liberty (3622/2019 Hyvinkää, 3623/2019 Järvenpää). The head of the investigation could also decide on access to private property, such as having a TV in the cell. In some units, the house rules specifically assigned certain detention duties to the investigating officer.

On a general level, it is acceptable according to legality oversight that police officers with appropriate training may participate in the supervision of persons deprived of their liberty, and it is obvious that the head of investigation can decide on the restriction of communication as provided in the law. However, the Deputy-Ombudsman finds it problematic that the police officer investigating the matter concerning a person deprived of their liberty participated in the detention duties and decisions concerning the latter at the police prison. The Ombudsman has requested that the investigation of a criminal case and the detention of a person deprived of their liberty be kept strictly separate.

Following the opinions expressed by the Ombudsman, police departments have taken the following measures, among others:

- The house rules have been updated with guidelines prohibiting criminal investigators or the head of investigation from participating in decisions regarding the basic care, meetings, phone calls, civilian matters, or purchases of persons deprived of their liberty. The head of the crime prevention sector has guided all heads of investigation to make sure that criminal investigation and detention duties are kept separate in all eventualities (1950/2019 Raahe, 1954/2019 Haukipudas).
- The police station has reported that it will adjust and clarify the conduct by guards at the detention facilities and by the investigating police officer when making decisions on the detention of a person and the conditions of the detained person (3621/2019 Hämeenlinna).
- The police department commented that, based on its own observations, investigators do not make decisions on the affairs of persons deprived of their liberty as described in the visit report. However, the updated rules for the detention facilities will issue guidance on keeping the police prison operations and criminal investigations as separate entities. The police department will also take note of the Ombudsman's observations in their future operations and guidance (3622/2019 Hyvinkää).
- The new rules for the police detention facilities will include guidance on the appropriate conduct for the police prison and criminal investigation (3623/2019 Järvenpää).
- The aim is to keep these two domains as strictly separate as possible. The staff serving in guarding duties at a police prison work under different management from those investigating crime. Only police prison staff have access to the cells of persons detained at the police prison (1201/2019 Espoo).

According to information based on a visit made by the National Police Board, the separation of criminal investigation and detention is one of the reasons for amending the Act on the Treatment of Persons in Police Custody.

Catering in police detention facilities

Catering in police prisons was discussed in the 2018 annual report in section 3.4.8. During 2019, the Ombudsman has brought to completion matters under investigation at his own initiative. The Ombudsman has noted, for example, that catering for persons deprived of their liberty should be more tightly regulated in the reformed Act on the Treatment of Persons in Police Custody. The intervals between meals should not be too long, and food safety must be secured.

Prevention of deaths in custody

The Ombudsman has carried out investigations on his own initiative into deaths in custody (4103/2016). The Ombudsman recommended in his decision of July 2019 that the National Police Board step up its actions to prevent and monitor deaths in custody. The report revealed that the National Police Board had no detailed statistics on the number of deaths in custody. According to the data obtained, the annual number of deaths in custody in the 2000s varied between 6 and 27. In addition to statistical data, it is essential to analyse the information gathered for investigations and possible criminal procedures following the deaths. This would provide valuable knowledge that could help prevent deaths in custody and could be used in the training of police officers and police prison guards.

Since the beginning of 2014, it has been the law to report all deaths in custody to prosecution services. According to the Ombudsman, the role of the prosecutor in the process is unclear. The Ombudsman also drew attention to the lack of separate sobering-up stations even in some of the largest cities, although it is widely agreed that it is not an appropriate use of resources for the po-

lice to care for intoxicated persons. According to the Ombudsman, the act on treating intoxicated persons, which dates back to the 1970s, needs to be reviewed. The Ombudsman has also identified needs for amendment in the acts on the treatment of persons in police custody, criminal investigation, and the investigation of the cause of death. The Ombudsman presented his findings and views regarding these acts to the ministries responsible for the respective legislation.

The Ombudsman also urged the National Police Board to pay closer attention to deaths in custody that take place during transport and to the prevention of suicide by persons deprived of their liberty. As the Ombudsman discussed the training of police officers and police prison guards in his decision, this was also submitted for the attention of the Police University College. The Ombudsman asked the National Police Board, the Ministry of the Interior, the Ministry of Justice, the Ministry of Social Affairs and Health, and the Office of the Prosecutor General to report on the measures they have taken to remedy the matter.

The reports submitted by public authorities concur with the Ombudsman's views. The National Police Board reported, for example, that it is updating its guidance on deaths in custody to secure the availability of accurate data. It also announced it is exploring technologies that could be used to improve safety in custody. Above all, the organisation intends to focus on improving its operations in relation to custody in 2020. The Prosecutor General has also reviewed her guidance on the prosecutor's role in investigating deaths in police custody. According to the Ministry of Justice, projects to reform the Criminal Investigation Act and the Coercive Measures Act will begin in 2020. The process will also involve assessing the prosecutor's role in investigating deaths in police custody, including in cases where a person dies or is severely injured as a consequence of the use of force by the police. Reforms of the Act on the Treatment of Persons in Police Custody and the Act on Determining the Cause of Death are currently underway, and the Ombudsman's positions will also be taken into consideration as part of these reforms.

Positive observations

Health care at detention facilities

Based on visits to police detention facilities, increased attention has been paid to access to health care. As a rule, all facilities visited had appropriate arrangements in place for the storage of medicines, as well as the documentation of their distribution. All guards at police detention facilities have completed medicine distribution training.

The Ombudsman has recommended that any person deprived of their liberty for more tha 24 hours in police detention facilities should receive a health check on arrival. This recommendation has not been observed even in places where health-care professionals deliver care on a regular basis. Furthermore, the National Police Board has not provided guidance in its circular to organise health checks. However, the Western Uusimaa Police Department has notified the Ombudsman that negotiations with the manager of the Espoo sobering-up station have been initiated to enable those kept at the Espoo police prison for longer tha 24 hours to be seen by a health-care professional (1201/2019* Espoo).

Training

One of the topics raised during the visit to the Police University College was the training of police prison guards and senior guards. The guard training with a reformed curriculum provided by the police administration started in autumn 2018 and the reformed senior guard training in spring 2019. The guard training provides the competence to serve independently as a guard at police detention facilities and to apply the relevant legislation while honouring fundamental and human rights. The senior guard training provides qualifications to work independently as a line manager of guards.

Detention of remand prisoners

Since 1 January 2019, the detention of remand prisoners in a police detention facilities for longer than seven days has been prohibited without an exceptionally weighty reason considered by a court. Based on observations made during visits, the amendment has shortened the time that persons deprived of their liberty spend at the police prison (1201/2019 Espoo, 1950/2019 Raahe, 3621/2019 Hämeenlinna, 3622/2019 Hyvinkää, 3623/2019 Järvenpää, 5999/2019 Lappeenranta).

The Ombudsman has repeatedly criticised the practice of detaining remand prisoners in police facilities, which are not suited for long-term detention. According to the Ministry of Justice, legislation governing the placement of remand prisoners in prisons is awaiting review. The aim is to place all remand prisoners in prisons following the detention hearing, rather than in police detention facilities, from 2025 onwards. The period of detention would be shortened to four days.

Reform of the Act on the Treatment of Persons in Police Custody

According to the legislative plan of the Government, the reformed Act on the Treatment of Persons in Police Custody will be enacted in January 2021.

3.5.10 DEFENCE FORCES AND BORDER GUARD AND CUSTOMS

The treatment of person deprived of their liberty in Defence Forces facilities is governed by the Act on the Treatment of Persons in Police Custody. During these visits, attention is paid to the conditions and treatment of those deprived of their liberty, their access to information, and their security. A preannounced visit to the detention facilities at Utti Jaeger Regiment was carried out on 17 April 2019 (2420/2019). The detention facilities had last been used in 2013. Regardless of this, the NPM received all the necessary information from the person introducing the facilities regarding the staff, rules, supervision arrangements, arrival health assessment, and delivery of health care. In addition, a handout explaining the rights and obligations of persons deprived of their liberty was made available, together with a folder containing information about the rules of the facility. The facilities were in clean and tidy condition. The room had a call button and a fire alarm. The area for outdoor exercise was not protected from outsiders, but it was located within a closely guarded and fenced-off military property. The visit gave rise to no measures.

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. These detention facilities are used for short-term detention before transferring detained persons to a police prison, detention unit for foreigners or reception centre. The treatment of persons deprived of their liberty at Customs or Border Guard facilities is governed by the Act on the Treatment of Persons in Police Custody. The duration of detention in these facilities varies from one to several hours. The maximum detention time is 12 hours in all cases. The locations, standard and furnishing of the facilities vary. The Border Guard Headquarters has approved the Border Guard's detention facilities and issued the house rules for detention facilities No visits to the Border Guard's detention facilities were made in 2019. Customs has approved the detention facilities that is uses and has issued its own rules for its detention facilities.

The crime prevention unit of Customs Enforcement Department has a detention room at Turku Customs, where an unannounced visit was made on 17 December 2019 (7048/2019). The new space had not yet been used. A need for a detention facility for persons deprived of their liberty had arisen following the closure of Turku police prison. The purpose was not to hold anyone at the detention facility for longer than a few hours and never, for example, overnight. The Deputy-Ombudsman made some suggestions on what the rules of the facility should contain and how the monitoring should be organised.

3.5.11 DISTRICT COURT DETENTION FACILITIES

An unannounced visit to the detention facilities for persons deprived of their liberty at Helsinki District Court was carried out on 11 September 2019 (5072/2019). This was a follow-up visit based on the 2017 visit (5560/2017). During this visit, special attention was paid to issues on which recommendations had been made during the previous visit.

During the previous visit, the Deputy-Ombudsman had commented on the size of the single reserve cells on different floors and, in particular, on their size, lighting, and lack of alarm equipment. These cells were no longer in use in 2019. The Deputy-Ombudsman had also recommended that at least one cell should be reserved for non-smokers. During the 2019 visit, it was noted that the non-smoking cells were tidy and fresh, and the walls were clean and white.

However, the cleanliness of the other cells, as well as the meeting rooms for persons in custody and their legal counsels, still had room for improvement. For example, there were inscriptions on the walls, which in the Deputy-Ombudsman's view undermine the purpose of the restriction on communication. The Deputy-Ombudsman suggested that the walls and the doors should be checked on a regular basis, and inscriptions such as those discovered should be removed immediately. The Deputy-Ombudsman repeatedly drew the District Court's attention to the requirement that all persons in custody and their legal counsels should have access to a space where confidentiality can be ensured. Furthermore, the Deputy-Ombudsman found it problematic that there was only one room for the meetings.

The District Court noted that the graffiti and inscriptions on the walls would be given more attention in the future. The walls will be repainted at shorter intervals, more than once a year. If there is a clear indication that the walls are used for communication between persons in detention, or for naming or shaming other individuals or similar conduct, the inscriptions will be removed before the cell is used for the next person.

Furthermore, the District Court reported that it has negotiated with the owner of the property to carry out alterations in the meeting space and to build a new meeting space, as intended in the report. The design and alteration work in these premises will commence in the near future. The alterations will be carried out in compliance with the provisions of Chapter 14, section 4 of the Remand Imprisonment Act.

3.5.12 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. THE NPM visits mainly focus on closed prisons. The average number of prisoners has remained stable at around 3,000 prisoners for several years now.

During 2019, the Deputy-Ombudsman issued one statement to the Legal Affairs Committee of Parliament on a government proposal related to prisoners. In addition, eleven proposals were made, mostly related to legislation or internal guidance within an administrative branch. The biggest point of public debate was the smoking ban for prisoners. The Deputy-Ombudsman found the regulations governing the smoking ban unclear and proposed their speedy amendment. The Deputy-Ombudsman also proposed that the prison should compensate the cost of nicotine replacement products for the duration of the time that the prisoner is suffering from withdrawal symptoms (5349/2019).

The Deputy-Ombudsman proposed that compensation be paid to a prisoner in a matter that involved the inappropriate treatment and violation of human dignity of the prisoner while placed under observation (5960/2018). This issue is discussed further in section 3.7.

During 2019, a decision was issued on the monitoring of the health of a prisoner living in segregation at their own request (247/2016). The decision is discussed in section 3.5.17 on health care.

A delegation from the national the national support organisation for prisoners and prisoners' families (VAO) visited the Office of the Parliamentary Ombudsman during 2019.

In the field of criminal sanctions, visit reports are sent for information to the visited prison, the Central Administration of the Criminal Sanctions Agency, the management of the criminal sanctions region in question, and the Department for Criminal Policy and Criminal Law at the Ministry of Justice. In addition, the prison and 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.

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. The NPM visits also draw attention to the processing of prison leave applications, emphasising the importance of taking the related decisions individually, based on the law and reasonable grounds.

Indoor smoking area.

In previous years, the NPM visits have been made to prisons with the focus exclusively on accessibility. In 2019, accessibility was covered during regular visits as one of the points of interest. Observations of accessibility in prisons are discussed in section 3.4 on the rights of persons with disabilities.

Prisons and prisoner transport facilities were visited 6 times during 2019 (compared to 13 in 2018). The visits were preannounced except for the visit to the prisoner transport facilities, which was a follow-up visit based on the visit in 2018. The visited facilities were:

date of inspection	target	number of inmates	case number	other / previous visit
8 April 2019	Vilppula Prison	capacity 73	1592/2019	previous visit 2006
7-8 May 2019	Jokela Prison	capacity 65	1936/2019	Deputy-Ombudsman included, previous visit 2016
28-29 May 2019	Turku Prison	capacity 255	2449/2019	Deputy-Ombudsman and external expert included, previous visit 2016
25 June 2019	Vanaja Prison, Ojoinen Unit	capacity 50	3420/2019	previous visit 2012
20 August 2019	Prisoner transport by train#		4575/2019	previous visit 2018
5.-7.11.2019	Sukeva Prison	capacity 181	5291/2019	Deputy-Ombudsman included, previous visit 2015

#= unannounced inspection

In addition, three visits were made to prisoner health-care units (also three in 2018). These visits are discussed in section 3.5.17 on health care. Opinions and recommendations based on prison visits were issued on the following topics:

- updating the sentence plan
- communication to prisoners on prison conditions/prisoner induction

Inside view of Turku Prison transport vehicle.

- access to regulations and other information
- conditions in isolation cells
- placement of remand prisoners
- position of Roma prisoners
- meeting arrangements, particularly for child and Skype visitors
- outdoor exercise facilities
- library services
- duration of detention in so-called "travelling cells" for temporary accommodation

The special theme on all the Ombudsman's prison visits was "Right to privacy". Observations and opinions on privacy are further introduced in section 3.8. In prisons, privacy issues are related to the use of the toilet, the arrangements for testing as part of illegal substance control, and the privacy of telephone conversations.

Prisoners need more constructive activities and time outside their cells

International recommendations and the Parliamentary Ombudsman's decisions have for a long time been based on the premise that prisoners and remand prisoners should be permitted to spend a reasonable amount of time outside their cells:

Prisoners have access to a variety of activities.

at least eight hours each day. During that time, they should be able to engage in rewarding and stimulating activities, such as work, training, and exercise. This is considered essential for prisoners' mental and physical wellbeing. It has been noted during prison visits that most closed prisons still have problems in this respect (2449/2019 Turku, 5291/2019 Sukeva).

Time spent outside the cell is important not only to avoid extended solitary incarceration. It is particularly important in order to allow prisoners to fill their time with activities that will be beneficial to the prisoner and their eventual adjustment back to society. Access to constructive activities outside the cell is also necessary for remand prisoners.

For this reason, the Deputy-Ombudsman found it necessary that prisoners' use of time is researched in more detail. However, collection of such data has proved a challenging and labour-intensive task, particularly with prisoners who are not placed in work activity wards. Prisoners' use of time could not be established based on daily programmes or prisoner information statistics. Judging by the daily programmes, activities mostly involved sports and exercise, making the choice of activities extremely limited. As a result, the Deputy-Ombudsman has requested the Regional Centre in conjunction with prison to provide data on the activities in which prisoners participate and the time engaged in these activities (2449/2019 Turku).

Pictures of Sukeva Prison.

Coercive behaviours among prisoners

A prisoner has the right to serve their sentence free of any pressure or threat placed on them by other prisoners. The way prisoners are placed in different wards is essential for maintaining order in prisons and for the safety of prisoners and prison staff. Legislation gives tools for intervening in coercion among prisoners. Authorities have wide discretion concerning the prison or ward in which a prisoner is placed and to which activities they are given access. However, a successful prisoner placement requires that the authorities who decide on the placement have all the necessary information available. Such information includes possible membership of criminal organisations.

Two closed prisons were visited during 2019, both housing a high number of prisoners with connections to organised crime. However, the two prisons were very different in that the structure of one prison allowed for a high level of security through compartmentation into fairly small wards (2449/2019 Turku). According to the prison management at the other prison, compartmentation was not possible in the building, which, together with the increased time outside the cells, created ample opportunities for coercion and violence among inmates (5291/2019 Sukeva). There had been several violent altercations between prisoners at the prison, some extremely serious.

In both prisons, prisoners who exercised coercion and made threats against other prisoners were placed in the more open wards. This led to a situation in which other prisoners, who otherwise would have been suitable for an open setting, refused to move to these wards. It also appeared that organised crime prisoners had the power to decide which courses other prisoners were able to attend. In Sukeva Prison, the guarding staff found it problematic that organised crime prisoners ran the narcotics trade inside the prison and were in control of the lives of the other inmates.

It was noted during the visit to Sukeva Prison that the entire operating culture in the prison was quite open. Prisoners from different wards were in contact with each other in workspaces, during outdoor exercise and mealtimes, and at the gym. Organised crime prisoners made up approximately 18% of all the prisoners at Sukeva, and none of them were placed in wards for prisoners whose behaviour puts the order and safety of the prison at risk. A high proportion of the prisoners (20%) had requested to live in segregation. The same phenomenon was discovered in Turku Prison,

where a number of prisoners have requested to serve their sentence in the closed ward for fear of threats and pressure. Prisoners' families had been intimidated, and opportunities for unsupervised meetings and leave were declined to avoid pressure from other prisoners.

The challenge in intervening in coercive behaviours at Turku Prison seemed to be the reluctance of the staff to use information about the problems between prisoners in their decision-making. The staff felt that prisoners spoke to them about their issues in confidence, and acting based on this could place them at serious risk. The Deputy-Ombudsman understands that this is a very real risk. However, methods must be found to intervene in coercion among prisoners. According to legislation, a party involved in such a situation does not have the right to all the information about themselves. For the prison authorities to place prisoners in appropriate wards, they must have all possible information about prisoners who form a threat to other prisoners. This should make it possible to remedy a situation in which some prisoners can compromise the safety of other prisoners because of their placement in the same ward.

The situation in Sukeva Prison was, in the Deputy-Ombudsman's view, extremely grave. The prison was unable to organise its operations so that prisoners could serve their sentences without experiencing coercion or threats from other prisoners. The Deputy-Ombudsman recommended that the prison and the Regional Centre of the Criminal Sanctions Agency investigate what remedial measures could and should be taken. The Deputy-Ombudsman also found it necessary for the Regional Centre, the prison, and the assessment centre to cooperate to optimise prisoner placement. The Deputy-Ombudsman considered it justified to request that the prison thoroughly examines the grounds for the placement of each prisoner. The prison should make sure that those deciding on prisoner placement have all the necessary information available.

Sukeva Prison has since reported having initiated the requested measures to improve safety at the prison and to intervene more effectively in coercive behaviours among prisoners. The measures were also aimed at improving staff health and safety. According to the prison's subsequent report, the criminal sanctions managers deciding on prisoner placement are now informed about a prisoner's involvement in organised crime.

Position and treatment of foreign prisoners

The proportion of foreign nationals in the prison population has varied between 15–20% over the years, which is near the European average. It is typical in Finland that an exceptionally large proportion of foreign prisoners are remand prisoners. In international matters, the most common problems experienced by foreign prisoners include the language barrier and gaps in knowledge about their rights, inadequate training of prison staff, and difficulties in maintaining contact with families and people close to them (for further discussion, see Jussi Pajuoja: *Rikosseuraamuslaitoksen toiminta- ja asiakasprosessien tulevaisuus,* (in Finnish only) Publications of the Ministry of Justice 2019:15).

The aforementioned problem areas are also repeatedly identified by the NPM during inspection visits. It would appear that while some arrangements have been made at a prison through the provision of written material and interpretation services to better communicate with foreign prisoners, these options are not fully utilised. It has been established during visits that foreign prisoners appear to have no or only sporadic access to essential information. The Deputy-Ombudsman has, therefore, recommended that prisons review their practices regarding foreign prisoners. It must be clearly established whose role it is to manage foreign prisoners' induction and how the induction is to be carried out. Moreover, it should be clear to everyone how to communicate with foreign prisoners in the course of daily routines (2449/2019 Turku).

There are many prisoners with whom the prison staff are unable to communicate because of the language barrier. However, according to the law, all prisoners must be informed about the conditions at the prison and their rights and obligations, without delay on arrival. This information must be made available in the most commonly spoken languages, as necessary. Interpretation services must be utilised as much as possible. Prisons nowadays have access to a tablet-based mobile interpretation service, through which an interpreter can be contacted remotely. The purpose of the visits has been to establish how widely the interpretation services are used by requesting the prison to report their annual interpretation costs and by interviewing the staff and foreign prisoners regarding the use of interpretation services.

Prisoners' induction guides and prison rules are increasingly available in foreign languages other than English, which is a positive development. However, during visits, the NPM still come across foreign prisoners who report having no or insufficient access to the necessary information about prison procedures or the rights and obligations of the inmates. Prisoners may have had insufficient information about their opportunities to contact their families through video calls, or how to gain access to their personal belongings. There has also been uncertainty as to what is prohibited and what is allowed in prison, what the sanctions are for breaking these rules, and how health-care services can be contacted. The NPM heard on occasion that the guarding staff never once made use of interpretation services. Documents have shown that interpretation services have not been used even in situations where a breach of the rules has been investigated (2449/2019 Turku).

The Ministry of Justice published unofficial English translations of the Imprisonment Act and the Remand Imprisonment Act in spring 2019, which have subsequently been distributed to the Central Administration Unit of the Criminal Sanctions Agency. Information about the publication of the translations was also shared with prisons through the Central Administration Unit's intranet, from where they can be printed out. Some prisons have unfortunately overlooked the opportunity to print out the translations for prisoner use, as was discovered during some visits (1936/2019 Jokela, 5291/2019 Sukeva).

Video meetings (Skype calls) may be the only way for a foreign prisoner to see their family and people close to them. However, this option is not always actively offered, or the instructions for organising a Skype meeting are available in Finnish only. This may give the staff the wrong impression on how much demand there is for Skype meetings. Once this need was recognised, the prison in question had the Skype meeting guidelines translated into English. The Deputy-Ombudsman finds it important that the possibility of video meetings is sufficiently communicated among both Finnish speakers and non-Finnish speakers (1592/2019 Vilppula).

Access to media in a prisoner's preferred language varies between prisons. The selection of TV channels in prison is not necessarily extensive enough to serve all major languages spoken by foreign prisoners. Even in prisons where over 30% of the population are foreign nationals, only Finnish channels can be accessed. The Deputy-Ombudsman requested the Central Administration Unit of the Criminal Sanctions Agency to investigate how easily foreign prisoners can access interna-

tional TV programmes in different prisons. He also asked the Central Administration Unit to find suitable ways for prisons to subscribe to foreign TV channels as soon as possible. As a result of this request, it was discovered that some prisons already had a wide selection of international TV channels available for foreign-language speaking prisoners. It was also discovered that several foreign channels were available free of charge through satellite TV packages, which can be installed at a very reasonable cost. The Central Administration Unit urged prisons to investigate the actual situation of their foreign inmates and take measures to offer them reasonable opportunities to follow television programmes in languages spoken by them. The Deputy-Ombudsman asked the Central Administration Unit to provide a report on the measures taken in prisons to address this matter. The Deputy-Ombudsman also noted that he will pay attention on future visits to the access of foreign prisoners to foreign-language TV programmes (757/2019).

The number of titles in foreign languages in prison libraries varies. As a positive observation, the action plan of the prison included a plan to allow foreign prisoners to borrow literature as interlibrary loans from the Multilingual Library (5291/2019 Sukeva).

The prison library had the Ombudsman's annual reports available for the use of prisoners.

Prisoner transport by train

The NPM visit of prisoner train transport was made in May 2018, when serious deficiencies were identified in the conditions for prisoners during transport. The Deputy-Ombudsman gave recommendations on 1) access to drinking water, 2) the use of a toilet without the presence of others, 3) testing the alarm equipment, 4) the temperature of the prisoner carriage, 5) meals, 6) the level of hygiene, and 6) the comfort of non-smoking prisoners In addition, the Deputy-Ombudsman made some observations regarding health care. The Central Administration Unit of the Criminal Sanctions Agency reported in October 2018 to the Deputy-Ombudsman on the measures it had taken.

The NPM carried out a follow-up visit of prisoner train transport in August 2019 The Deputy-Ombudsman was mostly satisfied with the measures taken by the Criminal Sanc-tions Agency and The Railway Company (VR) since the previous visit The NPM noted that prisoners were now given

View of a prisoner train carriage.

bottled water to drink. The prisoners were also informed of the possibility to use the toilet and a non-smoking space. Prisoners interviewed during the visit confirmed they were aware of these facilities. However, the prisoners were not aware of the call buttons that can be used to contact a guard and to flush the toilet. The level of cleanliness of the cells had not improved. Communication with the private cleaning service provider was also found to be a problem. As a positive improvement, the mattresses in the cells had been replaced by new ones. In addition, the windows of prisoner carriages had been fitted with heat and light-reflecting films. According to the staff, these helped lower the temperature in the prisoner carriage. Significant changes had been made in food provision. Prisoners were given a hot meal for dinner if they had missed a meal because of the transport.

The Central Administration Unit of the Criminal Sanctions Agency reported that VR will attach a pictogram (a drawing) to inform all users that tap water in the toilets is not suitable for drinking. The guard call button and the toilet flush button will be marked with pictograms indicating their purpose. The Central Administration Unit considers it particularly important that the standard of cleaning be improved and any deficiencies in the quality of the service be addressed without delay. VR has reported that it will step up the quality control of the prisoner carriage cleaning and give prisoner carriage guards contact details for the cleaning service provider to give any immediate feedback on the standard of cleanliness.

Positive observations and good practices

Prisoners' access to the Internet and video meetings (Skype) has been organised in Sukeva Prison by appointing a supervisor exclusively for electronic communications at the prison. Because of the remote location of the prison, which makes the journey to meet prisoners exceptionally long, it is important that the prisoners are given easy access to contacts through video technology. The Deputy-Ombudsman noted that the prison had organised Skype meetings and Internet access

An official from the inspection team trying out a terminal available for prisoners to file a complaint electronically with the Ombudsman.

exceptionally well and with great flexibility. He found the arrangements at Sukeva Prison a good example for other prisons who wish to improve prisoners' access to electronic communications in the same way.

Sukeva Prison has reported that the prison has appointed a new supervisor as of 1 February 2020 to deputise for the regular Internet and Skype meeting supervisor.

3.5.13 ALIEN AFFAIRS

Finland had 38 reception centres for adults and families at the end of 2019. 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 accommodation. Under section 121 of the Aliens Act, an asylum seeker may be held in detention for reasons such as establishing their identity or enforcing a decision on removing them from the country. Finland has two detention units for foreigners in operation, one in Metsälä, Helsinki (40 places), and one in Konnunsuo, adjacent to the Joutseno reception centre (68 places). Both units operate under the Finnish Immigration Service.

Some residents in reception centres and detention units may be victims of human trafficking, and recognising such residents is a challenge. The assistance system for victims of human trafficking operates in connection with the Joutseno reception centre. According to the media release of the Finnish Immigration Service, a record-high number of new customers, 229, were accepted into the assistance system in 2019. Of these, 70 were estimated to have become victims of exploitation indicative of human trafficking in Finland. It was estimated that most of the victims of exploited in Finland were subject to forced labour. There were a total 676 people within the scope of the assistance system's services at the end of 2019 (compared to 455 in 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.

Until now, visits to reception centres have been made under the jurisdiction of the Parliamentary Ombudsman.

The aim is to make regular visits to both detention units. The detention unit at the Joutseno reception centre was last visited in November 2018 (5145/2018) and the Helsinki detention unit in December 2019 (6841/2019).

At the Joutseno detention unit, the NPM was informed about a male asylum seeker who had been brought to the unit from Helsinki Police Department's Pasila police prison. Prior to this, the asylum seeker had been hospitalised for periods at a psychiatric hospital, where he had been placed under an order of treatment and isolation. On arrival at the detention unit, the asylum seeker, who had been deprived of his liberty, had to be placed directly in isolation. On the same day, he was transferred to Lappeenranta police prison, from where he was taken to the emergency care unit on several occasions and the psychiatric ward of the South Karelia Social and Health Care District for assessment. Owing to his aggressive behaviour, he was not admitted to the hospital for observation, and instead he remained in police detention facilities. At the hospital, he was prescribed antipsychotic medication, which became the responsibility of the police prison staff to administer. Eventually, he was admitted to Niuvanniemi Hospital. The Ombudsman decided to launch an investigation into the case on his own initiative (5675/2018). Based on the initial findings, it would appear that the conduct of the police or the detention unit gave no rise to suspect of any wrongdoing that would merit an intervention by the Ombudsman. However, it remains questionable whether the detainee received appropriate treatment. On request by the Ombudsman, the National Supervisory Authority for Welfare and Health (Valvira) initiated an inquiry into the care aspects of the case. At the time of writing this annual report, the matter is in process at Valvira.

The following opinions and recommendations following the visit conducted by the NPM concern the Helsinki detention unit only. The visit was made unannounced. The detention unit had 29 detainees at the time of the visit. The detainees reported to the NPM that they had been treated well at the unit.

Information on rights and obligations

Following the previous visit in December 2017, the Ombudsman drew attention to, for example, the duty to inform persons placed under detention of their rights and obligations immediately upon their arrival. The NPM was now told that the residents are given information about their rights and obligations as soon as they arrive. The detainees confirm receipt of the information with their signature.

Health-care resources and health assessment on arrival

Following the previous visit, the Ombudsman reiterated the recommendation that all detainees should receive a health assessment within 24 hours of arrival. Fulfilling this recommendation naturally requires adequate health-care personnel resources. At the time of the visit, there was one nurse on site responsible for the delivery of health care at the unit. It was discovered during the December 2019 visit that there were two nurses on duty at the unit, with one of them on a temporary contract. According to the director of the unit, they would be allowed to keep the one temporary contract nurse in addition to the permanent nurse in 2020. This was considered highly necessary. The nurse is on duty from Monday to Saturday.

The NPM was told that the aim was the health assessment of each arriving resident within 24 hours from their arrival, and that this goal was achieved with 83% of the residents. The aim is to carry out a health assessment on all arriving residents. An exception to this rule is made with detainees who are detained for less tha 24 hours, who arrive during the weekend, or who decline the health check. The arrival health assessment covers the individual's mental and physical well-being, medications, oral health, vision, and hearing. The person is also asked questions about possible infectious diseases and injuries, and their experience of the transport to the detention unit. Detainees transferred from another detention unit also undergo the health assessment. A more extensive arrival interview form will be introduced with the new electronic patient information system.

On arrival and in the case of unsuccessful repatriation or deportation, health-care providers will pay special attention to possible signs of violence on a detainee. Any findings are recorded in the medical history of the individual, and the patient is referred to a physician if necessary.

Consent to release medical records

The Ombudsman considered it good practice to use a separate consent form in the detention unit, with which the detained person can give their consent to the sharing of their medical records between other health-care organisations. The Ombudsman was also pleased to note that the form is available in several languages. However, the Ombudsman also noted that only the medical records for which the consent has been given may be shared. The person giving their consent must be made aware of which specific records are released and for what purpose. Ultimately, the party releasing the medical records must ensure that the person giving the consent was given the appropriate information before the release.

Premises

The outdoor exercise space at the detention unit had no rain shelter. According to the director of the unit, residents could borrow raincoats to spend time outdoors.

The premises cannot be compartmented, which could help reduce the need for segregation.

Moreover, the health-care staff had no separate space for medicine distribution. Medicines were given at the surgery, so when the room was occupied for a medical examination, the nurse had no access to the medicine cabinet.

Medication times, or, the times a nurse dispenses medications.

Reporting on mistreatment

The detention unit had no system or guidelines in place indicating how and to whom the detainees or staff could report any mistreatment observed. The feedback box was used only little, as far as is known, and it was not clear to the NPM whether the detainees were aware of the feedback box or its purpose.

The Ombudsman noted that the detention unit should operate an effective complaint system that both the detainee and the staff would be aware of, and that would enable the filing of complaints to both an external remedial body (such as the Parliamentary Ombudsman) or internally (such as to the director of the unit). Under international recommendations, the complaints procedure must be accessible, transparent, and sufficiently advertised. In addition to this, all complaints and actions arising from them must be documented.

Positive observations

All supervisors at the detention unit had received medicine distribution training in 2018.

Health-care professionals monitor the detainees' health is segregation at least once a day, and more frequently if necessary.

The NPM was told about a detainee whose background information was not available and who had to be placed in isolation because of their aggressive behaviour. It transpired only later that the detained person had an autism spectrum disorder. Some of their behaviour derived from the fact that their special needs were not understood from the beginning. After the incident, a representative of the Autism Foundation Finland was invited to the unit to talk about how to act with persons in need of special support, and how to prevent the escalation of similar situations.

3.5.14 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 currently some 1,000 units in Finland offering substitute care. There are seven residential schools; five are managed by the state, and two are privately run. The state residential schools operate under the guidance and supervision of the National Institute for Health and Welfare and the Finnish National Agency for Education as non-profit child welfare institutions.

Visits by the NPM have been made exclusively to institutions or similar units. As many children as possible, that is, everyone who is willing to share their issues with the NPM, are interviewed during child welfare visits. When speaking with children, they are informed of the possibility to contact the NPM if they are subjected to disciplinary measures or similar conduct as a result of the visit. The personnel are also reminded that any retaliatory measures against the children are prohibited. This is also mentioned in every NPM visit report.

It has not been entirely unproblematic to communicate the rationale and importance of the prohibition on retaliatory measures. The dialogue with the child welfare institution revealed that the unit's employees had not always comprehended the contents of the UN Convention against Torture in this regard, and had experienced the prohibition against retaliatory measures, noted in the NPM visit report, as insulting. Ultimately, it is the duty of the institution management to ensure that their staff are aware of the legal provisions governing their work. It is also vital for them to be knowledgeable about the duties and powers of different supervisory authorities. The Deputy-Ombudsman has required the institution to arrange training on these matters for its employees (4099/2018 Child Welfare Unit Jussinkodit).

As will become apparent from the opinions and recommendations presented later in this report, the management and staff at child welfare institutions have an obvious need for further training on fundamental rights and the content of the Child Welfare Act and the principles presented in the rationale of the Act. The comments submitted by the child welfare institutions on the reports suggest that the child welfare service providers do not always understand what concepts such as the good treatment of a child, an acceptable method of upbringing, restriction on the freedom of movement, isolation, or requesting a person to remove their clothes entail from a legal perspective. It has repeatedly proved necessary during visits to draw the institution staff's attention to the importance of always documenting a specific and reasoned decision when restrictive measures are applied.

Inspection visits to child welfare institutions are carried out unannounced and last for 1–3 days. The NPM pays attention to the treatment of the children and to any restrictive measures to which they may be subjected, and to the related decision-making process. The visits have revealed 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, without delay, the municipality of placement, the State Regional Administrative Agency (AVI), and any other municipalities that are known to have placed children in the same place of foster care of any issues identified. 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.

The NPM visit reports are sent to the visited unit and the local AVI. According to the Child Welfare Act, the local AVI is responsible for the supervision and monitoring of restrictive measures, in particular. In addition, the report is submitted to the local authorities of the municipality that has placed children in the institution in question. The Deputy-Ombudsman has required that social workers discuss the content of the report with the placed child and explain what it means. The Deputy-Ombudsman may also have required that the social worker ensures that the child is aware of their rights and of what actions they may take if they face inappropriate treatment in the future. In such situations, the Deputy-Ombudsman has requested information on how the child was met with for the purpose of providing this information (5377/2018 Special Child Welfare Unit Loikalan kartano). Reports are often sent for information to the National Supervisory Authority for Welfare and Health (Valvira), which is responsible for the national guidance and supervision of social services.

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. However, it has become apparent in recent years that the institutions have taken a more critical

view of the inspection operations of the Parliamentary Ombudsman and NPM. Some institutions have publicly criticised the inspections and the observations made during them. It has even been claimed that the Parliamentary Ombudsman's and NPM's actions could create obstacles to finding suitable institutions for children placed in care outside the home. The Deputy-Ombudsman has been forced to strictly remind an institution of its obligation to comply with the opinions of the authority charged with the oversight of legality. The Deputy-Ombudsman was also forced to emphasise that child welfare institutions have the obligation to cooperate with the Parliamentary Ombudsman, the NPM, or other overseers of legality in order to provide them with all of the information required to perform the inspection and effectively fulfil the children's right to be heard during the visit (1353/2018 Residential School Pohjolakoti).

The visits made to child welfare facilities over the past few years have been proven to have a far-reaching impact. The observations made during the visits have also led to an urgent amendment to the Child Welfare Act. For example, systematic measures will be required in the future to help reduce the use of restrictions to a minimum. Each child welfare institution will be required to present a plan for the good treatment of children as part of their self-monitoring plan. It is also required to involve and engage the children placed in the institution in the creation of the plan. If restrictive measures are used, they must be discussed with the child in a mandatory debriefing. A child's care and education plan drawn up by the institution must include measures agreed on by the social worker and the child on how the use of restrictive measures could be avoided. The amendments entered into force on 1 January 2020.

Observations made by the NPM have led to several other legislative projects focusing on the legal position of children placed in care and their right to necessary services during the placement. There will also be a review of what amendments to legislation governing restrictive measures would be required.

Following visits by the NPM, many child welfare institutions have reviewed their practices and rules as recommended in the visit reports. Observations made during these visits have gained wide publicity. At the same time, the awareness of children placed in institutions of their rights has improved. This shows in the substantial increase in the number of complaints filed by the children.

More attention has also been paid to the effectiveness of the work carried out by respective supervisory authorities responsible for the monitoring of child welfare institutions. There are cases where the monitoring efforts fall far short of satisfactory. The Deputy-Ombudsman has reprimanded Valvira for negligence in the supervision of substitute care provision and, in particular, the use of restrictive measures in this setting (4168/2018). Following visits conducted by the NPM, amended legislation entered into force on 1 January 2020, requiring that children residing at a unit visited by a Regional State Administrative Agency must be given an opportunity to be heard in person.

The visit reports may also have requested the local AVI, as the authorising public official, to ascertain that the institution complies with the licence under which it operates. For example, does the institution genuinely employ personnel as specified in its licence, or does the children's extensive demand for various services call for a re-evaluation of the licensing decision or the licensing criteria (5377/2018 Loikala). In some cases, it is may be left for the local AVI to verify that the recommendations made on the visit report have been implemented by the institution, in which situation a separate report on the measures from the institution is not necessary. This is the case when, for example, a Regional State Administrative Agency has conducted their own guidance and assessment visit at the institution concurrently with the Ombudsman's visit and reported that it will continue to monitor the standard of foster care provided by the institution and the nature of restrictive measures applied (5916/2018 Family Home Ojantakanen).

During 2018, the NPM carried out 10 visits to child welfare institutions. The reports on the visits are extensive and detailed. In 2019, it was necessary to give priority to finalising past visits instead of carrying out new ones, so the number of visits made during the year was only one. The institution was Jaloverso youth home in Hollola, and the visit took place on 28–29 October 2019 (5930/2019). The visit was carried out unannounced and concurrently with the inspection of AVI Southern Finland. The visit focused, among other things, on measures taken at the institution following the decisions made by the Ombudsman in summer 2019. These decisions were made as a response to complaints filed by five children placed at the institution. These covered the isolation of a child and the inappropriate conduct by institution staff (4566/2018) and withholding of an incentive payment (3662/2019). At the time of writing this annual report, the final report on the visit to Jaloverso was not yet available.

Picture of Loikala Manor.

Some of the key opinions and recommendations issued on the basis of the visits are presented below. They concern visits made in 2018, with the respective opinions issued in 2019. The institutions visited were Children's Home Sutelakoti (1605/2018), Children's Home Rivakka (1606/2018), Special Child Welfare Unit Loikalan kartano (5377/2018), and Family Home Ojantakanen (5916/2018).

The Deputy-Ombudsman has ordered pretrial investigations to be carried out on instances of suspected unlawful conduct at two child welfare institutions. The pretrial investigations are currently in process.

House rules and educational culture at the unit

A child welfare institution must continually evaluate how to best sustain the growth and development of a child, and how the institute can support the child's independence and life skills after the placement in substitute care ends. The rules and practices at an institution must support the achievement of these goals. The rules of the institution cannot override the provisions of the Child Welfare Act, and they may not restrict a child's right to self-determination any more than is necessary. Situations must be evaluated on a case-by-case basis with each individual. Collective punishment aimed indiscriminately at all the children is not an acceptable method of upbringing.

Based on observations, the institution had adopted a culture of upbringing heavily based on restrictions. The rules placed unlawful restrictions on the children's freedom of movement, social life, and self-determination. The policy was deliberate, and the staff members endorsed this approach. The fact that restricting the rights of a child must be based on the law was simply ignored in daily life at the institution. According to the Deputy-Ombudsman, neither the rules and practices of the institutions nor their application supported and promoted such high-quality care, education, and rehabilitation that would serve to prepare the placed children for the kind of daily life that

can be considered normal in today's society. The Deputy-Ombudsman required that the rules of the institution and their implementation must be brought into line with the provisions of the Child Welfare Act (5377/2018 Loikala).

The Deputy-Ombudsman has made the recommendation to a number of institutions that they work together with the resident children to draw up rules that are understandable and fair, so that the children will find it possible to commit to them. Changes to the rules should also be agreed on in cooperation (1606/2018 Rivakka, 5377/2018 Loikala, 5916/2018 Ojantakanen).

The institution reported that the unit had adopted rules that were in line with the recommendations, that were drawn up in cooperation with the resident children, and that were available for the children to read at all times (5377/2018 Loikala).

It was noted during the visit that children were expected to knock on their door if they wished to leave their room. Permission to leave the room was not necessarily given immediately. The practice was a rule adopted by the institution which restricted the child's right to freely leave their room. The rule was enforced at all times. The practice was against the law, according to which a child has the right to free movement within the indoor areas of an institution that serves as the child's home. In reality, the practice constituted confinement in one's room. The Deputy-Ombudsman found that the practice had no basis in the Child Welfare Act, and there were no acceptable educational grounds to justify it. The practice was demeaning for the children (5377/2018, Loikala).

The institution has since reported that it has abandoned the practice.

Decision-making on restrictive measures

It has been repeatedly necessary to remind institutions of the provisions of the Child Welfare Act when making decisions on restrictive measures. The Deputy-Ombudsman has drawn the serious attention of the institutions to, for example, the fact that a restrictive measure must always be based on a separate decision, for which the provisions of the law are reflected on a case-by-case basis. The institution must ensure that these conditions are met in the case of each restrictive measure employed. The requirement is especially relevant now that the aim of avoiding the use of restrictive measures is enshrined in law.

The institution has since reported that its staff has received training in the assessment of restrictive measures in individual circumstances. Moreover, the customer data system Nappula has added consistency in the use of restrictive measures (1605/2018 Sutelakoti).

The institution reported that it will pay further attention to the individual grounds for decisions on restriction in the future. The staff will receive training in the use of restrictive measures (5377/2018, Loikala).

Restrictive measures are not to be applied routinely on all children in certain situations. It is prohibited to search through each child's belongings on arrival as a routine practice. Conducting "mass raids" in children's rooms is unacceptable, and children's freedom of movement may not be restricted as a matter of regular practice (5916/2018 Ojantakanen).

Restrictive measures and disciplinary methods must be documented as required by the law (5377/2018 Loikala, 5916/2018 Ojantakanen).

The institution reported that attention had been paid to the documentation of restrictive measures and customer records in the Nappula data system. Authorised access to customer records has also been limited (5377/2018, Loikala).

A child should also receive the original decision, or a copy of it, on the use of restrictive measures concerning them. The delivery of the decision should be indicated in the child's records. If the child does not wish to keep the decision themselves, the child should be informed that the original or the copy of the decision will be archived in a place where they can access it on request. The decision should be kept within easy access at least during the appeals period, should the child wish to see the decision (1606/2018 Rivakka).

The child should always be appropriately notified of restrictive measures. The child should always be given sufficient and understandable information about the content of the decision. The child should also be informed about their rights and the obligations of the institution. The way the information has been delivered must be described in the child's records (5377/2018 Loikala).

Restrictions on contact

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. This must be assessed on a case-by-case basis. The authority to make such decisions lies with the social worker responsible for the child's affairs, not the place of foster care. The restriction of communication always requires a decision open to appeal. In no case should restrictions on communication be based on the rules of the institution alone. The Deputy-Ombudsman required that the institution inform the child's social worker in advance about their plan to restrict the child's communications (e.g. when a child's leave is being cancelled). The institution cannot exercise powers that by law belong to the social worker (5377/2018 Loikala).

The institution reported that the restriction of communication is mainly aimed at restricting the use of the phone. The restriction does not apply to maintaining contacts with the child's parents, as the child has access to a phone for that purpose. When a decision to restrict a child's communication needs to be made during the weekend or evening, it has not always been possible to consult the social worker.

In situations when it is necessary to cancel the child's leave, the matter is always first discussed with the social worker. There have been situations when the child's leave has been cancelled because of the parents' situation. If the leave has been cancelled because of an event or a camp organised by the institution, the child's leave has been rescheduled rather than cancelled. It is possible that the child's records are not appropriately updated on these details, and the institution will take steps to remedy this in the future. According to the institution, it has not used, and has never intended to use, powers that belong to the social worker. Any restrictions on communication have not been imposed based solely on the rules of the institution.

The starting point for a child's access to their own phone is that each child can use their phone as is appropriate for their age and level of development, as any child outside an institutional setting would. If using their phone causes no harm to the child, there are no educational grounds to intervene in the child's use of their phone by confiscating it "just to be safe", let alone as a punishment. The Deputy-Ombudsman has proposed that the institution draw up a plan on procedures that would help reduce or completely avoid the use of certain restrictive measures (5916/2018 Ojantakanen).

Encouraging social relationships

Every child has the right to build and maintain social relationships within and outside the institution. A child must have opportunities to interact with other people. Methods by which a child is prevented from speaking with another person for long periods of time are inhumane and reprehensible. It transpired during a visit that the institution restricted and even completely prevented the children's social interaction by limiting or prohibiting conversations between children in certain situations. For example, the institution had adopted quiet mealtimes as a permanent practice. All social contacts between children during mealtimes were prohibited. Under the rules, the mealtime continued until everyone had emptied their plates. The children had been compelled to agree to this practice for fear of repercussions. The Deputy-Ombudsman found that the institution was exercising institutional powers that were not based on law. The Deputy-Ombudsman requested that the institution immediately discontinue the

Dining room at a child welfare institution.

unlawful and demeaning practice of restricting the children's social relationships (5377/2018 Loikala).

The institution reported that it has reviewed its practices and the children are allowed to freely communicate with each other. Maintaining social relationships is supported by allowing children the use of their phone at all times of the day. Exceptions include restriction measures by which a child's phone has been confiscated. Social relationships are no longer restricted or supervised in daily life without appropriate restriction decisions. Normal conversation is allowed during mealtimes and children can freely choose where they sit at the table. Children are encouraged to taste different foods. However, they are not expected to eat anything against their will.

The children's movements within and outside the property will no longer be restricted without an appropriate restriction decision. Children's conversations are no longer intervened in except in cases of verbal abuse witnessed by an adult. The children are allowed to spend time in each other's rooms for an agreed period of time. The children will be given the opportunity to visit the shopping centre in the nearby town for independent shopping once a week.

Violations of a child's right to self-determination and privacy

The children placed in substitute care also reported to the NPM that they were forbidden from using make-up in the institution, dyeing their hair, having piercings, and wearing tops or other clothing that the institution deemed inappropriate. The children could not understand the purpose or reason for these rules. The institution confirmed that the rules described by the children were in force at the institution. The Deputy-Ombudsman found that piercings, clothing, and matters such as dyeing one's hair are an essential element of a person's self-expression. The rules of the institution regarding the physical appearance of the children violate children's fundamental right to self-determination and privacy, in other words, their rights over their own bodies and appearance. The rules may not restrict a child's right to self-determination any more than is necessary. Each case must be considered within its own context (5377/2018, Loikala).

The institution reported that the children's choice of clothing, piercings, personal appearance, and self-determination will no longer be intervened in. Previously, these aspects were intervened in if they supported or maintained symptomatic behaviours. In the future, the use of hair dyes and piercings will not be restricted.

The children reported to the NPM that they were not allowed to dye their hair. Some children reported restrictions on their choice of clothing. The baseline in the protection of personal integrity is that everyone has the right to live their own lives without arbitrary or unjustified intervention by authorities or anyone else in their private life. The Deputy-Ombudsman noted that the place of substitute care may offer the child support and guidance through discussion, and may help the child choose their outfits taking into consideration the event they may be attending, the weather conditions, and their health. Such situations are an opportunity to guide a child to understand traditions and customs related to clothing in different cultures. The Deputy-Ombudsman empha-

sised that a child has the right to decide on their appearance and clothing (5916/2018 Ojantakanen).

A review of documentation during the visit revealed that under the institution's rules, girls were allowed to use tampons only when participating in sports or swimming and in the sauna. According to the documents, girls were not allowed to decide for themselves on the type of period protection to use while residing at the institution. They were not allowed to purchase the type of menstrual pads they preferred from the shop, as the institution prohibited shopping. The Deputy-Ombudsman considered that this rule was an example of the extent to which the institution exercised control over the children's personal lives. The institution's practices on menstrual protection severely restricted the rights of a girl to make decisions concerning her own body and to decide on matters intimately related to her own person and privacy. The practice was demeaning and did not respect the girls' right to dignified treatment. The practice violated the central element of personal privacy protected by section 10 of the Constitution: everyone's right to make decisions concerning their private life (5377/2018, Loikala).

The institution reported that it no longer interferes with the residents' personal privacy and does not dictate which type of period protection the girls are allowed to use. To the contrary, the staff give encouragement, advice, and guidance on personal hygiene.

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 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. Restrictions are always subject to a written decision open to appeal.

Restricting a child's freedom of movement may not be used as a punishment for the child's behaviour. If the child's personal contacts are restricted while restrictions of the child's freedom of movement are in place, a separate decision must be made on the restriction on personal contacts.

The institution reported that, in the future, an individually reasoned restriction decision will be made on the possible restriction of a child's freedom of movement, if the conditions for such as decision exist (1605/2018 Sutelakoti).

The de facto restrictions on the children's freedom of movement imposed by the institution affected every child at the institution and were in force at all times. Restrictions on the children's freedom of movement were based solely on the institution's own rules and without an individual assessment of the child's situation based on the law. It was not a matter of restricting the free movement as provided in the Child Welfare Act, but a much farther-reaching practice concerning all the children. The Deputy-Ombudsman requested that the free movement of children be restricted only if the conditions determined by law are met. Restrictions on the freedom of movement must be based on decisions in due process, open to appeal. Restricting a child's freedom of movement may not be used as a punishment for the child's behaviour. The Deputy-Ombudsman required that during a restriction on the freedom of movement, the child's right to social relationships must be ensured. The child's right to education and hobbies must also be safeguarded during a period of restriction (5377/2018 Loikala).

The institution reported the practices have been changed so that if a decision on the restriction of freedom of movement has not been made in accordance with the Child Welfare Act, child will be allowed to move freely within and outside the institution. Curfew times are agreed on together with the child. Decisions on restrictions of freedom of movement and the grounds for the restrictions are made according to due process, and they will not prevent the child from attending school or hobbies or participating in activities organised by the institution.

The Deputy-Ombudsman drew the institution's attention to their decision-making obligation under the Child Welfare Act. If it is necessary to restrict the child's freedom of movement by prohibiting their access to areas outside the institution's grounds or otherwise, the institution must make a decision on the matter. The decision on a restriction on the freedom of movement does not allow for the actual isolation of the child or the prohibition of social contacts (5916/2018 Ojantakanen).

Confiscation of substances and objects

The Deputy-Ombudsman has drawn the attention of institutions to the legal provision under the Child Welfare Act that a child's property can only be confiscated under certain, specified circumstances. If a child's property is confiscated by the institution, a decision required by law must be duly made and entered into the records. Confiscation may never be used as a punishment (1605/2018 Sutelakoti, 5377/2018 Loikala, 5916/2018 Ojantakanen).

Adolescents' possessions in safekeeping at the institution.

The child's mobile phone cannot be confiscated by the institution as a precautionary or punitive measure (1605/2018 Sutelakoti).

A child has the right to keep their belongings in their own room. A child's property cannot be taken for storage without the child's own request (5377/2018 Loikala).

Bodily search and physical examination

The bodily search of a child must be based on due statutory decisions with the required documentation in place. The child's records must provide the reason for a bodily search or physical examination. According to the law, only when there is a justified reason to suspect that the child has in their clothing or otherwise on them prohibited substances or objects, a bodily search or physical examination may be carried out on them for the purpose of investigate the matter. Such reasons are always individual and must be evaluated individually for each child. The child's documents must also describe the practical implementation of any bodily search or physical examination.

The institution has since reported that it has made a focused review of the practices regarding this issue. In the future, bodily searches and physical examinations will be performed only on a case-by-case basis. In addition, the decision describes how the restrictive measure was implemented in practice (1605/2018 Sutelakoti).

According to the institution, attention has been paid to the grounds for the decisions and the accuracy of the related records. The number of bodily searches performed has been significantly reduced, which has led to an increase in the influx of drugs, fire-making tools, and blunt instruments into the residents' rooms. Staff observations are not considered to form a sufficient basis for performing bodily searches (5377/2018 Loikala).

Bodily searches may not be performed routinely every time a child goes on leave or returns to the institution (5916/2018 Ojantakanen).

Several of the children reported to the NPM that on occasions they had been required to undress during a bodily search. This meant having to

remove all their clothes and turn around in front of the supervisors. According to the children, the undressing practice had taken place at least after each unauthorised absence (5916/2018 Ojantakanen).

Upon arrival at the institution, the child is subjected to a bodily search. The children reported to the NPM that they had been asked to remove all their clothes for the bodily search and that their bodies had been contemplated by supervisors. Most of the children said they had been subjected to the practice more than once, some up to 5–6 times. According to the children, all their clothes are removed until they are completely naked, and they must place their clothes in a basket. Once naked, the children are required to wear the institution's clothes, including the underwear. During the visit debriefing with the institution, the institution admitted to the practice of requiring children to undress until they are naked (5377/2018 Loikala).

The Deputy-Ombudsman seriously emphasised the importance of taking the child's age, sex, level of development, individual attributes, religion, and cultural background into account when conducting bodily searches and physical examinations on a minor. Such searches and examinations must be carried out in a manner that causes the least harm to the child. The Deputy-Ombudsman required that the practice be discontinued immediately, as the Child Welfare Act does not allow for the undressing of a child in connection with a bodily search. A child's personal consent to the method is not sufficient justification for a bodily search (5377/2018 Loikala, 5916/2018 Ojantakanen).

The institution reported that, in the future, the children will be given a bathrobe to protect themselves when changing their clothes. The bodily search is always carried out in a camera-free room (the surveillance camera is covered) by two staff members of the same sex as the child (5377/2018 Loikala).

Isolation

The Deputy-Ombudsman requested the institution to immediately discontinue the ongoing practice of de facto isolation. Isolation may only be used as a measure when specific conditions laid down by law are met. In the future, a decision to isolate a child must clearly indicate: 1) the situation and behaviour that led to the isolation, 2) the implementation method of the isolation, 3) the assessment of the grounds for continuing the isolation, and 4) the grounds for ending the isolation. The Deputy-Ombudsman emphatically drew the institution's attention to the fact that the time limits for isolation laid down in the law are absolute and may never be exceeded (5377/2018, Loikala).

The institution has reported that it will pay further attention and be more careful in documenting the use of restrictive measures, observing time limits, and assessing the necessity of each measure taken. According to the institution, the use of the safety room on a resident's arrival is justified to establish the resident's initial situation, wellbeing, and physical condition, and to protect their privacy. The present practice is to carry out an assessment of a new arrival based on their current wellbeing and behaviour, to decide whether they can be placed directly in their own room and whether they are immediately able to participate in shared activities at the unit. For example, if the resident is intoxicated, they cannot participate in any activities.

However, the institution disagreed with the finding in the report according to which the institution imposed isolation on the children lasting for days or weeks. In the view of the institution, enhanced adult supervision and monitoring of the residents' wellbeing on arrival or in times of crisis does not constitute isolation. The child may have been taken to their room for a reasoned didactic purpose for the duration of the staff handover report, which takes place on weekdays.They were not obliged or forced to stay in the room for several hours, as described in the visit report. At the moment, the residents are free to move in and out of their rooms and around and outside the institution grounds.

Security room used for isolation.

A child may be isolated only if the specifically assessed conditions laid down in the Child Welfare Act are met. Isolation may not continue any longer than is necessary and must be discontinued as soon as the conditions for isolation have ceased to exist. The Deputy-Ombudsman required the institution to discontinue all practices resembling isolation (5916/2018, Ojantakanen).

Transport services in child welfare service provision

During 2019, the Substitute Deputy-Ombudsman issued a decision in an investigation on his own initiative concerning the use of private companies providing transport services in child welfare service provision (4771/2017). It was noted during NPM visits to child welfare institutions that institutions with children with extensive needs for services relied heavily on private transport services. The users of private transport services include state residential schools, private child welfare institutions, and local authorities. The Substitute Deputy-Ombudsman requested Valvira to investigate the use of private transport services and the oversight of the services by the relevant authorities.

In their decision, the Substitute Deputy-Ombudsman found it a serious failure from the perspective of a child's legal rights and right to self-determination that the authorities responsible for the child, state residential schools, and other places of substitute care have, in practice, not supervised the operations of the businesses providing search and transport services. Moreover, there is no documentation on the transport and searching of a child as required by law. It remained unclear to what extent local authorities and child welfare institutions had disclosed confidential information about the children or other persons (such as their relatives) to private companies. It also remained unclear how that information had been recorded and possibly stored in companies' databases. The Substitute Deputy-Ombudsman considered it a grave malpractice that, according to the information obtained during the visits, children would have been subjected to coercive or restrictive measures during transport. However, under no circumstances do the employees of a private company have the right to use coercive or restrictive measures on a child without the express authorisation provided by law.

There has been uncertainty within the child welfare services sector whether or not the use of private companies has been lawful. This uncertainty is partly due to the lack of explicit provision in the law on the transport and search of a child. The uncertainty has been compounded by the fact that at least one Regional State Administrative Agency has entered two service providers within its jurisdiction in its register of private social service providers. In the registration information, both companies had stated that they provided transport services as well as other open-care child welfare services. It was not clear from the decisions of the local AVI that transport and search activities would have been excluded from the scope of the registration, or in other words, that their registration for these services would have been specifically rejected.

The use of private companies for transport in child welfare services was brought to the attention of the Ministry of Social Affairs and Health as a result of the Ombudsman's findings, as well as through other channels. As a result, a provision

(Section 69a) was added to the Child Welfare Act on the acceptable methods of returning a child to an institution from unauthorised leave and how the transport should be safely organised. The provision entered into force on 1 January 2020. It explicitly stipulates that a child welfare institution or a social worker may not use a private company to search for and transport a child back to the place of substitute care. The transport may only be carried out by a professionally qualified member of the institution's care and educational staff, the child's own social worker, or another public authority. The amendment also provides for the safe transport of a child, the related decision-making process, and documentation obligations.

The Substitute Deputy-Ombudsman considered it necessary for the Regional State Administrative Agencies to issue guidance to the local authorities and service providers in their area on the changes in the Child Welfare Act, including provisions on the safe transport of a child in accordance with the new legislation.

3.5.15 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 institutional care and residential unit, where they receive care round the clock, including end-of-life care if necessary. 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. There are some 2,000 social welfare units providing full-time care for older people in Finland. Visits made by the Parliamentary Ombudsman and the NPM 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 the detection of any differences in the standard of care.

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

NPM visits to care units for older people pay special attention to the use of restrictive measures. The use of such measures is made problematic by the fact that there is still no legislation on imposing restrictive measures on older people with memory disorders. According to the Constitution, restrictive measures must be based on law. The Parliamentary Ombudsman has issued several opinions in which he has demanded legislation to be passed on the matter. It is the opinion of the Parliamentary Ombudsman that, even though there is no legislation on restrictive measures yet, their use should be transparent and respectful of human dignity. As a minimum, the provisions on restrictive measures under other relevant legislation, such as the Mental Health Act and the Act on Special Care for Persons with Intellectual Disabilities, should be observed. On its visits, the NPM paid attention to matters such as the grounds, duration, and recording of restrictive measures and deciding on them.

All NPM visit reports are published on the website of the Ombudsman. The purpose of the publication is to inform the general public that the operations are being monitored. The reports also provide residents, family members, and staff with important information on the observations made during the visit. The visit report may also stipulate that the 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.

Restraint clothing.

The Parliament granted additional funding for the Office of the Parliamentary Ombudsman for 2019 to step up the supervision of the rights of the elderly. In 2019, new instances of neglect were identified, and closures of service units were carried out. Since the promotion of the rights of the elderly required additional resources, the Office of the Parliamentary Ombudsman was granted supplementary funding for 2020 to establish new posts.

Most visits to social welfare units for the elderly in 2019 were made under the NPM mandate. A total of 16 visits were made in 2019 (compared to 11 in 2018). Four of these were made to private service providers' facilities. All of the visits were made unannounced. In addition, nine visits were carried out at general health-care units, with the focus on the health care of the elderly. The findings and recommendations based on these visits are presented in section 3.5.17 on health care.

During visits to care units for the elderly, special attention was paid to the use of restrictive measures and the safety of the residents during the night. In addition, attention was paid to the protection of privacy, oral health care, and the availability of outdoor activities. Several of the visited units provide end-of-life care, which is why the visits also touched upon the principles of end-of-life care and how the humane and dignified treatment of elderly patients and their right to self-determination can be provided in practice.

There are also cats living at the Lizelius Home.

The following is a summary of the NPM visits to social welfare units for the elderly and the observations and recommendations made in connection with visits:

date of inspection	target	number of inmates	case number	other
19 March 2019	Mariahemmet, City of Raasepori	29 places	1764/2019	institutional care, Deputy-Ombudsman included
19 March 2019	Villa Rosa, Folkhälsan, Karjaa	21 places	1765/2019	24-hour residential service, Deputy-Ombudsman included
28 March 2019	Pihlajakoti, Päijät-Häme Joint Authority for Health and Well-being, Padasjoki	20-30 places	1842/2019	24-hour residential service
10 April 2019	Lizeliuskoti, Akseli Joint Authority for Social Services, Mynämäki	15+33 places	2009/2019	24-hour residential service 15 places and institutional care 33 places
10 April 2019	Moisiokoti, Akseli Joint Authority for Social Services, Nousiainen	50 places in total	2010/2019	24-hour residential service and institutional care
11 June 2019	City-koti, Joint Authority for Health Care and Social Services in Kymenlaakso, Kotka	60 places	3015/2019	24-hour residential service, external expert included
13 June 2019	Mäntylä residential service unit, Päijät-Häme Joint Authority for Health and Wellbeing, Heinola	73 places	3016/2019	24-hour residential service, external expert included
4 July 2019	Pakilakoti, Helsingin Seniorisäätiö, Helsinki	210 places	3763/2019	short-term and long-term institutional care
27 August 2019	Vaahterakoti, Keski-Uusimaa Joint Authority for Health Care and Social Services, Järvenpää	27+60 places	4743/2019	short-term care 27 places and 24-hour residential service 60 places
2 September 2019	Esperi Hoivakoti Niva, Rovaniemi	31 places	4921/2019	short-term and long-term 24-hour residential service
3 September 2019	Palvelukoti Onnela, Municipality of Pelkosenniemi	24 places	5023/2019	24-hour residential service, Deputy-Ombudsman included
3 September 2019	Saukoti, Municipality of Savukoski	25 places	4922/2019	24-hour residential service, Deputy-Ombudsman included
17 October 2019	Himminkoto, Municipality of Lempäälä	76 places	5595/2019	24-hour residential service
29 October 2019	Villa Mäntykoto, Hoiva Mehiläinen, Hyvinkää	38 places	5880/2019	24-hour residential service, 2 external experts included
5 November 2019	Palvelukeskus Lehtiniemi, Keuruu	41 places	6033/2019	24-hour residential service
5 November 2019	Kotikylä Sammonkoti, Humana, Jyväskylä	67 places	6032/2019	24-hour residential service, external expert included

#= unannounced inspection

The Saukoti Sheltered Home features a large fenced outdoor area.

Service Center Lehtiniemi lobby area.

Oversight of oversight

In 2017, the National Supervisory Authority for Welfare and Health (Valvira) took under its supervision a group of private companies that delivered residential care services for the elderly. Valvira passed a decision in April 2019 that each company was required to take measures specified by Valvira to remedy any malpractices and failures and to submit a report of these measures to Valvira by the end of July 2019. The decision extended to all residential service units in elderly care managed by the provider.

At the order of the Deputy-Ombudsman, one of the units of the above-mentioned group was visited in September 2019 (4921/2019 Niva). Both the local AVI and the municipal authorities had made several inspections at the unit. Most of them were pre-announced. The local AVI had carried out its first inspection at the facility in December 2017, based on several notification of shortcomings made by the staff. The municipal authorities had placed the unit under special supervision and steering for 2018. The most recent inspections prior to the NPM visit were an unannounced inspection by the local authorities in March 2019 and one by the local AVI in May 2019. Following the earlier NPM visit and based on a new notification, an additional unannounced visit was conducted by the local AVI in 2019 and attended by representatives from Valvira as experts.

The Deputy-Ombudsman drew attention to the fact that the institution had been under special supervision since 2017. In spite of that supervisory authorities received continually notifications of shortcomings on the institution. It was obvious that the supervision and special measures were not sufficient to remedy the issues in the standard of care and treatment and to prevent the emergence of new shortcomings. The short duration of the inspections carried out by the authorities, and their implementation mostly as pre-announced visits, may have led to a delay in the identification of shortcomings. The Deputy-Ombudsman found it extremely concerning that the authorities had not required improvements immediately.

The effectiveness of supervision may have been affected by the extensive workload of the supervisory bodies, insufficient resourcing, and in-

adequate time reserved for reflecting on practices. However, the Deputy-Ombudsman welcomed the fact that Valvira and the AVIs had identified the shortcomings and were working on further developing their operations. However, the Deputy-Ombudsman stressed that the public service unit itself, as well as the local authority providing the service, has the primary responsibility for ensuring services are delivered to a high standard and in compliance with the law.

The Deputy-Ombudsman required that the unit immediately take the measures mentioned in the NPM report, as well as any measures requested by Valvira and the local AVI in other documents. In addition, the Deputy-Ombudsman required the local authorities to ensure that the shortcomings does not recur. The local authorities were also to take measures to ensure that the service provided to a resident met their service needs and that the unit delivering the service had sufficient staff, as required by the service decisions. If a resident was not in reality able to live at the unit with no staff on site at night, or if they would not be able to independently seek help when needed, a decision on 24-hour residential service for them should be made. Service decisions were to meet the needs of the residents and the delivery of services were to meet the conditions for a licence.

Right to privacy

Sharing a room or bathroom with another resident

The protection of privacy is a fundamental right, and care for the elderly is no exception. The aim is that every elderly person in long-term care should have their own room, including sanitary facilities. When residents unknown to one another are placed in the same room in long-term care, this should be based on the persons' own fee will. The Deputy-Ombudsman stated that in an institutional setting, attention should be paid to maintaining the privacy of residents living in double-occupancy rooms in, for example, the delivery of personal care (1764/2019 Mariahemmet).

In a 24-hour residential service unit, some residents did not have a private room and thereby no private toilets and bathrooms. Furthermore, it was not always possible to determine whether clients were willing to be placed in a double-occupancy room with a stranger, due to the clients' diminished cognitive capacity. However, these clients had given their consent to be accommodated in a double-occupancy room. The Deputy-Ombudsman emphasised the importance of privacy protection, which is a fundamental right, and of listening to the will of the clients (1842/2019 Pihlajakoti).

The long-term care ward had a total of 37 residents and 8 double-occupancy rooms. Some residents could not have a private room despite having requested one. The toilet between some rooms was shared by the residents of the two rooms and could not be locked from the inside. Adjacent rooms could accommodate people of different sexes, who then had to share the toilet. In the short-term care ward, some residents also used the toilet independently, so it was possible that residents would need to use the toilet at the same time (3763/2019 Pakilakoti).

Protection and use of confidential information

In the short-term care ward, patient records were updated in a room that also served as a staff break room and kitchen. The space could be separated from the residents' quarters by a sliding door. However, the sliding doors were kept open to allow for the monitoring of the residents. Therefore, the residents in the dining area could overhear discussions between staff members (3763/2019 Pakilakoti).

It was discovered during a visit that a unit no longer had the practice of inquiring about residents' biographical information. The policy had changed after one relative prohibited questions about a resident's biographical information, finding it to be unlawful. A note had been posted in the staff office informing that biographical information could no longer be inquired about for reasons of security. The Deputy-Ombudsman noted that clarifying the biographical information of a

person with memory disorders was important in order to respect their preferences and, for example, religious beliefs. It is, therefore, the view of the Deputy-Ombudsman that residents' biographical information can and should be inquired about in elderly care units. However, data protection and data security must be observed in the care unit in accordance with legislation. This does not conflict with the need to inquire about biographical information from clients or their relatives for the purpose of delivering high-standard care. Since the Deputy-Ombudsman found that data protection law had, in this respect, been generally misinterpreted, it was important that relevant care units were informed about the correct interpretation of the law. The unit in question has since changed its practice following the Deputy-Ombudsman's decision (4922/2019 Saukoti).

Protection of privacy

Some of the rooms at a care facility had doors with a narrow glass window allowing a view into the room. The members of staff reported that the windows were difficult to cover. They also found it convenient that they could monitor the wellbeing of the residents without waking them up by opening the door. The Deputy-Ombudsman drew attention to the lack of privacy and required that doors like this be altered to protect the residents' privacy. The Deputy-Ombudsman requested the unit to provide clarification on the remedial measures (3763/2019 Pakilakoti).

The Deputy-Ombudsman stated that a high standard of care includes respectful treatment. The Deputy-Ombudsman considered it inappropriate to keep a resident's catheter bag in full view. It was hung on the back of a resident's wheelchair, including when spending time in the common areas. The Deputy-Ombudsman found that respecting the dignity and privacy of a resident cannot solely depend on whether their relatives have provided sufficient supplies for them (4922/2019 Saukoti).

Self-monitoring plan

A unit delivering institutional care for the elderly was to ensure that its self-monitoring plan was reviewed and updated. The plan was also to be made available to the staff and relatives without a separate request. It was also recommended that the self-monitoring plan be made publicly available on the website of the unit of the local authority (1764/2019 Mariahemmet).

The original self-monitoring plan had been drawn up in 2015. The entire staff had been involved in authoring the plan. The plan had been updated in 2017 and 2019, but no revision dates were indicated on the plan, and the updated plan had not been signed off. At the time of the visit, the self-monitoring plan was not publicly available, and the staff were not aware of where it was kept. The Deputy-Ombudsman emphasised that sufficient and appropriate self-monitoring can only be achieved if staff are aware of the content and objectives of the plan. The Deputy-Ombudsman recommended updating the plan together with the staff. The plan was also to be made publicly available (4922/2019 Saukoti).

The self-monitoring plan should be added, with procedural guidance on the implementation of the notification obligation, and it should be ensured that all staff members are familiar with the guidance. It is essential for the purpose of honouring a person's legal rights while ensuring effective self-monitoring that the person in charge of self-monitoring at the unit is knowledgeable about applicable laws, regulations, and recommendations, and takes them into consideration when planning and exercising self-monitoring (5595/2019 Himminkoto).

The use of restrictive measures

Restrictions on the fundamental rights of care recipients in elderly care are not provided for in the law. However, the established view of legality oversight authorities is that restrictive measures applied to elderly residents must be subject to a physician's permission. The use of restrictions should be monitored by the staff and the physi-

cian. Restrictions may not be used to any greater extent or for longer than is necessary, and the methods used must not be excessive for the purpose.

The Deputy-Ombudsman drew attention to the fact that a unit did not have written guidelines on restrictive measures. Moreover, restrictive measures were not addressed in any detail in the self-monitoring plan. The Deputy-Ombudsman required that care policies and practices be clearly recorded in the self-monitoring plan. The main goal must be to avoid the use of restrictive measures and to make a plan for alternative methods. The unit had several restrictive measures in place. The grounds for the measures and the name of the person who had authorised them had not been recorded in the care and service plans. The Deputy-Ombudsman required that the unit make sure, for each resident individually, that the restrictive measures applied are based on a physician's decision and that this decision is duly recorded. In addition, it was important to ensure that the necessity of restrictive measures be continuously assessed (4922/2019* Saukoti).

The Deputy-Ombudsman drew attention to the documentation of decisions on restrictive measures. The self-monitoring plan included a mention that restriction decisions could be made for a maximum period of one month. Among the restriction decisions submitted to the Deputy-Ombudsman, there was a decision issued by a physician according to which the restrictions were to be reassessed in one year's time at the latest, when the decision would expire. The Deputy-Ombudsman found that a restriction on a resident's freedom of movement is permissible only on the basis of a physician's decision. The physician should ensure that restrictive measures are not used to any greater extent or for a longer period of time than necessary. A restrictive measure may be introduced only if there is no other alternative, less restrictive method available. Residents' records must include information on the use of restrictive measures, and the use of restrictive measures must be stopped immediately as soon as they become unnecessary. Restrictive measures should be discussed with the resident themselves, or their relatives or next of kin, before their use. Restrictions cannot be based solely on the consent of a relative or next of kin (1765/2019 Villa Rosa).

According to the unit's self-monitoring plan, restrictive measures were used only in extreme cases. The restrictions applied included a wheelchair seat belt and raised bed rails at night. According to the plan, involuntary treatment and its criteria are regulated separately in, for example, the Mental Health Act and the Act on Social Work with Substance Abusers. At the time of the NPM visit, one resident was wearing back-zip overalls. No other restrictive measures were observed during the visit. It was noted that the supporting and/or restriction of a resident's right to self-determination was described in the self-monitoring plan mainly from the perspective of the health-care assistants and medical care. Some of the restrictive measures in use had not been specified in the principles for restrictive measures, and the principles for their application had also not been described. The Deputy-Ombudsman drew attention to the fact that the elderly care unit in question did not, as such, deliver involuntary treatment. None of the units referred to were authorised to deliver involuntary treatment measures without a specific legal basis. In order to avoid misunderstandings, the Deputy-Ombudsman recommended that concepts related to self-determination and involuntary care be further clarified in the self-monitoring plan (2009/2019 Lizeliuskoti).

A unit was applying restrictive measures subject to a physician's assessment and decision, according to the guidelines. According to the Deputy-Ombudsman, the physician should visit the unit frequently and meet all the residents at regular intervals. Where meetings with residents are rare, there is a risk that the use of restrictions will continue, even if they are no longer necessary (3763/2019 Pakilakoti).

Definitions of restrictive measures

In a 24-hour residential service unit for persons with memory disorders, a chair would be placed in front of the door of a single-occupant room at night to alert the staff if the resident attempted to leave their room. According to the staff, the resident in question was in the habit of wandering around the unit at night and going into the rooms of other residents. The Deputy-Ombudsman considered the approach adopted by the unit inappropriate because the restriction on movement constituted a restriction on the resident's right to self-determination and freedom. The chair also posed a potential safety risk. The Deputy-Ombudsman recommended that the unit consider other ways to resolve the situation (2009/2019 Lizeliuskoti).

It was discovered during a visit that the staff were not always able to recognise a restrictive measure. The Deputy-Ombudsman emphasised the importance of understanding the concept of restriction, so that the staff would be able to make the right decisions. For example, a resident has the right to prevent another resident from entering their room. Closing a door and placing an obstacle in front of the door does not violate another person's freedom of movement. However, if the door of the resident's own room is closed because of another resident's behaviour while they themselves wish to keep the door open, or they are unable to make their preference known, this constitutes a restriction. According to established legal practice, a person cannot give consent on behalf of another person to use restrictive measures. A relative or next of kin cannot give definitive permission on behalf of a resident to close a door. The Deputy-Ombudsman noted that security is not in itself sufficient reason to restrict a person's fundamental rights, as each restriction of a fundamental right must meet all criteria for restrictions, such as the requirements of necessity and proportionality. When weighing various options, the goal is to ensure that a person receives appropriate care and is not subject to abandonment. If a situation arises in which a person is in immediate danger, it is possible to intervene in the situation based on self-defence or compelling circumstances. However, self-defence and compelling circumstances are relevant only in acute situations. They cannot be referred to as a justification for locking doors.

It should be possible to deliver appropriate care and treatment without compromising the rights and safety of other residents. With insufficient staffing, locking the door of a resident's room may be dangerous, even if the resident has asked for their door to be locked. It must be possible in the case of fire for residents to leave the building or to be evacuated. The Rescue Act has special provisions on evacuation safety in residential units. Locking a person in their room, especially if the unit does not have staff on site at all times who can rapidly evacuate the residents, poses a serious fire safety risk. However, if the door mechanism and the resident's functional capacity allow them to open the door by themselves both from the inside and outside, the resident will not be restricted, and their safety will not be at risk. However, in assessing the situation, it must be taken into consideration that it may not be possible for a person to unlock their door if they are alone and in distress (5595/2019 Himminkoto).

Palliative treatment and end-of-life care

The dignity, humane treatment, and self-determination of a resident at a care unit must be safeguarded at all times, including during palliative treatment and end-of-life care. For this reason, principles governing palliative treatment and end-of-life care must be documented in the unit's self-monitoring plan. In addition, it should be ensured that the staff are trained and instructed in the delivery of appropriate palliative treatment and end-of-life care (1842/2019 Pihlajakoti).

The delivery of palliative treatment and end-of-life care should be based on a predictive care plan and end-of-life care decision that has been drawn up well in advance (2009/2019 Lizeliuskoti).

In the short-term care ward of a care unit, the physician in charge made the decision on end-of-life care in acute situations, and the care was delivered as part of home nursing. In these situations, it was possible to have extra staff on duty and the patient would be placed in a private room. Family members were able to stay the night on the ward. In the long-term care ward, the aim was to give residents a private room for the duration of end-of-life care, but this was not always possible. A family member was able to stay the night with the patient, who would be given a private room. Palliative medication was available on the ward, and administration of intravenous medication was taken care of by the home nursing team. The Deputy-Ombudsman welcomed the fact that a number of staff members at the unit had received training in end-of-life care, and they were available for other staff members for consultation. The Deputy-Ombudsman suggested increasing training in end-of-life care so that each member of the nursing staff could participate in it. When reviewing the end-of-life care guidelines, the national guidelines for palliative treatment and end-of-life care should be referenced (3763/2019 Pakilakoti).

The Pakilakoti nursing home features a pleasant outdoor area.

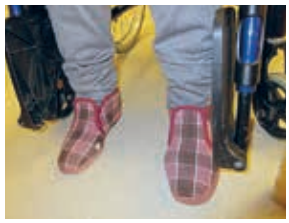
Outdoor exercise and stimulating activities

Providing sufficient time outdoors is part of caring for the residents' basic needs and respecting their human dignity. It is important that residents with memory disorders but a high level of physical function should have the opportunity for regular outings. Special attention should be paid to those residents who are unable to move independently and cannot clearly express their views. The time planning for the entire staff should allow adequate time for outdoor exercise and stimulating activities in accordance with the needs of the residents (4921/2019 Niva, 5023/2019 Onnela).

The Deputy-Ombudsman found the 24-hour residential service for persons with memory disorders somewhat understaffed. The Deputy-Ombudsman drew attention to the fact that long-term treatment and care should also include access to personalised stimulating activities, outdoor exercise, and the maintenance of social relationships (2009/2019 Lizeliuskoti).

The unit aimed to offer various outdoor activities as much as was possible. In short-term care, daily coffee breaks were held outdoors. It was emphasised at the long-term care ward that sitting on a balcony could not replace outdoor activities. However, there were no systematic records of the residents' access to outdoor activities. The ward has volunteers visit once a week to take the residents outdoors. In addition, the time use of holiday cover staff is directed towards outdoor activities. When other acute duties took longer than anticipated, the time for outdoor activities was reduced. For residents who actively expressed their wish to spend time outside, more opportunities for outdoor activities were arranged. The Deputy-Ombudsman emphasised the importance of giving residents daily access to outdoor activities. With no systematic records in place, there is the danger that individual residents end up inadvertently spending long periods of time indoors. The Deputy-Ombudsman recommended that outdoor time be included in the residents' care and service plan and that the execution of each plan is monitored (3763/2019 Pakilakoti).



The Deputy-Ombudsman welcomed the contribution of volunteers who took the residents at the 24-hour residential service unit outdoors. However, the access of the residents to the outdoors cannot rely on volunteers alone. Sufficient and regular outdoor activities should be arranged based on the residents' needs. Outdoor activities should be included in the resident's care and service plan with a daily monitoring practice in place, involving either customer-specific records or a unit-specific list, to ensure the completion of the plan (5595/2019 Himminkoto).

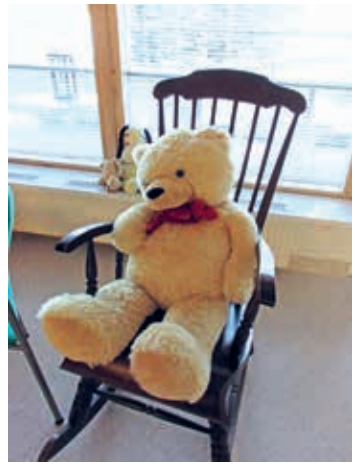
Physician's services

The Deputy-Ombudsman welcomed the fact that the nursing staff on the ward had the opportunity to consult a doctor through various channels, including times when the doctor was not at the unit. However, it was considered a disadvantage that the actual appointments with patients were very few and that they were carried out by a specialist in general medicine. The residents were severely memory-impaired elderly care recipients considered to need institutional care. The Deputy-Ombudsman found that the ward should also employ a consultant in geriatrics (3763/2019 Pakilakoti).

Oral health care

The care plans at a care unit included no information on the oral and dental care of the residents or even whether the resident had their own teeth or dentures. The daily notes could include sporadic mentions of brushing a resident's teeth. The Deputy-Ombudsman noted that oral and dental health is of great importance in the well-being and general health of an elderly person. Therefore, more attention should be paid to daily oral and dental hygiene (1764/2019 Mariahemmet).

The unit was visited by a dental hygienist if the resident themselves had booked an appointment. There was nobody with specialised knowledge of oral health on the staff. Efforts were made to take notes about dental care. The goal was to deliver dental care twice a day, but this was not always possible due to the workload of the nursing staff. If necessary, relatives would book a dental appointment for a resident. The nursing staff also had the opportunity to be in contact with dental care if a resident had an acute need for dental care. The Deputy-Ombudsman noted that regular tooth brushing prevents many oral conditions and is beneficial for overall health and well-being. For patients with memory disorders, oral pain can cause anxiety and restlessness, and can make it difficult to eat. Regular tooth brushing is an integral part of good treatment and care of every elderly person. The unit should make sure that regular tooth brushing was not neglected. If the brushing had to be skipped during the shift, this needed to be recorded in the notes so that the matter could be rectified later. The services of a dental hygienist should be available to all residents. The



Pictures of units for the elderly.

unit should also provide a dental care plan by a dentist without delay and ensure that the staff adhere to the plan (4921/2019 Niva).

No separate guidance for the oral health care of the residents with memory disorders at the unit were available, and the services of a dental hygienist were not available. The Deputy-Ombudsman pointed out that oral hygiene should be part of daily care. If dental care is not monitored and recorded, the residents may go without dental care for extended periods of time, and problems arising from poor oral hygiene may go unnoticed (3763/2019 Pakilakoti).

The checklist for the nursing staff in a group home showed that special attention was paid to the oral health and dental care of the residents. The dental hygienist from the local health centre visited the unit once a year to check the oral health of each resident. If necessary, the hygienist referred a patient to the dentist. If a resident needed acute dental health, they were taken to the dentist. The Deputy-Ombudsman commended the correct approach of an annual dental check to maintain good oral health among the residents. The Deputy-Ombudsman finds it important to ensure on arrival that a new resident has a recent dental care plan in place and that the staff are aware of what steps to take to follow that plan. Maintaining oral health also requires that the nursing staff have a general understanding of how oral health is maintained and how various oral diseases can be prevented. The Deputy-Ombudsman recommended that the care facility organise staff training in oral health (3015/2019 City-koti).

3.5.16 RESIDENTIAL UNITS FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

A goal set in the 2012 Government Resolution on independent living and services for persons with intellectual disabilities was that no disabled person will be living in an institution after 2020. The Finnish Association on Intellectual and Developmental Disabilities reports that the customer volumes in 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 fewer than 1,000 intensified assisted living units for people with learning disabilities in Finland, and approximately 400 of these are run by private service providers. There are 22 institutional care units, of which only one is run by private service providers. The majority of these units employ restrictive measures.

On visits to units providing institutional care and residential 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 the 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 a person in special care repeatedly requires restrictive measures, it should be assessed whether the unit they are currently residing in is suitable and appropriate for their needs. The practices of the unit should always be assessed as a whole. Restrictive measures should only be resorted to when this is necessary in order to protect another basic right that takes precedence over the basic right subject to restriction. It follows from this principle that restrictive measures should never be used for disciplinary or educational purposes. The purpose of the NPM visits is to assess the use of restrictive measures, as well as the living conditions and the accessibility and feasibility of the facilities, while appraising the attainment of the disabled residents' right to self-determination and the availability of adequate care and treatment.

With the ratification of the UN Convention on the Rights of Persons with Disabilities (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 and the promotion of inclusion, are discussed in more detail in section 3.4.

The Parliamentary Ombudsman and the Human Rights Centre have jointly prepared a project with the aim of promoting the fundamental and human rights of assisted living services for persons with learning disabilities. The project is also introduced in section 3.4.

The number of residential units for persons with learning and physical disabilities visited in 2019 was 8 (compared to 11 in 2018). Three of the visits were made unannounced. One unit was run by private service providers. One of these was offering intensified round-the-clock assisted living services for adults with severe disabilities It was also suitable for adults with neurological conditions (such as ALS). At the time of the visit, the unit also had one resident who was in hospice care. Another unit run by the private service provider offered temporary individual and rehabilitative round-the-clock care to children and adolescents with learning disabilities, severe disabilities, and autism spectrum disorders. The other sites visited were mainly units for persons with intellectual disabilities. In one of the units visited, there were disabled residents under involuntary special care.

The sites visited were:

date of inspection	target	number of inmates	case number	other
21 March 2019	Omakoti Oiva, Mehiläinen Oy, Vantaa	10 places	1683/2019	
21 March 2019	Tilapäishoitokoti Alma, Mehiläinen Oy, Vantaa	7 places	1684/2019	
4 April 2019	Eteva Joint Authority's residential service units, Nurmijärvi	33 places	2008/2019	
5 November 2019	KTO Medical care, research and rehabilitation unit, Paimio	11 places	5491/2019	3 external experts included
5 November 2019	KTO Neuropsychiatric research and rehabilitation unit NEPSY1, Paimio	13 places	6769/2019	3 external experts included
5 November 2019	KTO Neuropsychiatric research and rehabilitation unit NEPSY2, Paimio	16 places	6770/2019	3 external experts included
5 November 2019	KTO Neuropsychiatric research and rehabilitation unit for children and adolescents, Paimio	10 places	6771/2019	3 external experts included
5 November 2019	KTO Neuropsychiatric crisis and research unit, Paimio	20 places	6772/2019	3 external experts included

#= unannounced inspection

The NPM visits conducted in the KTO units included participation by several external experts. One of them was a medical expert specialized in intellectual disability medicine. Two other external experts were representatives of the Sub-Committee on the Rights of Persons with Disabilities, which operates under the Human Rights Delegation of the Human Rights Centre. An expert 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 2018, but with opinions issued in 2019.

Human resources

The Ombudsman has emphatically drawn the attention of both private and public service providers to the issue of understaffing. With regard to the private sector operator, the Ombudsman noted that the number of staff must be at least equal to that required in the licence and the Act on Private Social Services. Challenges in recruitment do not justify deviation from the minimum staffing as based on the unit's operating licence. The Ombudsman was also concerned about the long shifts of some nursing staff members, which may have a detrimental impact on their

capacity and the delivery of care to the residents (1683/2019 Omakoti Oiva).

The service provider reported that the problem of understaffing had been resolved during the spring.

Regardless of the notification, the Ombudsman requested that the licensing and supervisory authorities monitor the adequacy of staffing by the service provider and the staff allocation, within their respective spheres of jurisdiction.

With regard to the public service providers, the Ombudsman emphasised that care should be taken at a unit providing intensified assisted living services for persons with learning disabilities that the residents are guaranteed round-the-clock care, treatment, and monitoring, as required by their individual needs (2008/2019 Eteva).

Temporary nursing home Alma encourages residents to exercise their right of self-determination.

Promotion of self-determination

The Ombudsman has emphasised that in the social care units, situations should be resolved through methods other than restrictive measures. These methods include individual service planning, preventive procedures and development work, and reasonable adjustments made in individual cases. The primary goal should always be to support an individual's right to self-determination.

Where restrictions are placed on the personal freedom or self-determination of a person with a disability, it must always be ensured that no other, less restrictive methods are available. Restrictions should never be applied to a greater extent or for a longer period of time than is necessary. The Ombudsman finds it important that the use of restrictive measures is supervised. The legality of restrictive measures should ultimately be evaluated in court. If the use of restrictive measures is not based on law, the right to self-determination is not honoured in practice.

Identifying restrictive measures

Residential unit staff are not always aware of what constitutes a restriction. It was discovered during a visit that the freedom of movement outside the unit was restricted for all residents for reasons of safety. The door leading from the unit to the stairwell was always kept locked. The unit could be exited only with a key, which the children were not given. According to the staff, all the children and adolescents placed in the home needed adult support and/or supervision when moving outside. According to the self-monitoring plan, the restrictions on a child's freedom of movement were agreed on in cooperation with the social services and families. The restrictions were based on a medical evaluation, and they were always motivated by a child's own safety. None of the children had been issued decisions under the Act on Special Care for the Persons with Intellectual Disabilities on supervised movement, even in cases in which the child's freedom of movement had been restricted.

According to the staff, the supervised movement of children had been discussed with the local authorities responsible for the cost of the chil-

dren's accommodation, but the authorities had not required any decisions to be made. The local authorities had not paid attention to the issue during their own inspections. The freedom of movement of children who could not be subjected to restrictions under the Act of Special Care for Persons with Intellectual Disabilities was nonetheless restricted. The Ombudsman decided to take the issue of the procedure and decision-making process concerning the restrictive measures applied by the service provider and the residential unit under investigation on his own initiative (1684/2019 Tilapäishoitokoti Alma).

The door of the group home was kept locked on the inside and outside, but a staff member was not always present. The movements of the residents were also monitored with technical equipment. The Ombudsman noted that the practice seemed to meet the criteria for restrictive measures under the Act on Special Care for the Persons with Intellectual Disabilities. Supervised movement should always be based on a written decision open to appeal. The Ombudsman also noted that when a person is placed under supervised movement, it is important to ensure that the freedom of movement of other persons is not restricted at the same time (2008/2019 Eteva).

The NPM was informed that no "actual" restrictive measures were used in the unit, but raised bedrails were sometimes used for reasons of safety. In many cases, the resident's consent could be obtained for the purpose. It was noticed during a visit that the doors downstairs leading from the group homes to the lobby were locked. This meant that the fundamental right to personal liberty of residents, who could not get out of the unit upon request or with their own key, was effectively restricted (3351/2018 Valkamahovi).

Decisions on restrictions

It was noted during the NPM visit that the grounds cited for the restriction decisions were very uninformative. The decisions did not include instructions on how to appeal, and the person authorising the decision also remained unclear. The Ombudsman drew the service centre's attention to these shortcomings. Each decision must clearly indicate the name of the public official issuing the decision. The decisions must include a description of how the criteria for a restrictive measure are met for the subject of the decision. The Ombudsman also pointed out that the decision on the repeated use of restrictive instruments or clothing in dangerous situations must clearly indicate the maximum period of time for which restrictive instruments or clothing can be applied at one time, and the reasons why other available methods are not appropriate and sufficient in the given situation. The Ombudsman emphasised that when making a decision, expert assessments must be requested and taken into consideration (3375/2018 Kolpene joint authority, service homes Metsärinne, Mäntyrinne, and Mustikkarinne).

The director of the joint authority recounted during the debriefing of the NPM visit that the issue of the appeal instructions would be remedied immediately.

The joint authority has since reported that the service managers at the service centre had been verbally instructed on the correct procedure for making decisions on restrictive measures. The guidance on the right of self-determination is currently being updated, and more detailed instructions on making decisions on restrictive measures will be added.

Restrictive measures

Safety belt and wrist cuffs

It was discovered during a visit that a safety belt and wrist cuffs were used to control a resident's compulsive movements and to prevent them from disturbing the PEG feeding tube button (Section 42 k of the Act on Special Care for the Persons with Intellectual Disabilities). It had been taken into consideration in the decision passed by the office holder that the restrictive equipment would not restrict the voluntary movement of limbs and body parts to more than a minor degree, and they would be used for as a short a period of time as possible (3375/2018 Kolpene). The Ombudsman decided to take the issue of safety belts and wrist cuffs and the related documentation practices under investigation on his own initiative.

Wrapping a resident in a rug

A resident at a care unit was prevented from harming themselves and others by being wrapped in a soft rug, leaving their head free. The wrapping method was said to help calm the resident down and to minimise the consequences of the episode. Usually the resident would calm down in less than an hour, after which the rug would be removed. If the rug is not used, it takes several hours for the individual to calm down. The NPM had constructive dialogue with the care unit staff about the wrapping method and the possibility of other methods (such as a weighted blanket) replacing the use of a rug The staff reported that the resident themselves felt that the rug was a good method for calming down. On occasion, the resident wanted to be wrapped in a rug at their own request.

The Ombudsman found the method of wrapping a resident in a rug to be problematic. It prevented the individual from moving and was similar to restraining. According to the Act on Special Care for the Persons with Intellectual Disabilities, restrictive equipment or clothing may be used in highly dangerous situations only. A person can be restrained only if no other method proves sufficient. The Ministry of Social Affairs and Health only recognises medical restraining equipment as a legal form of restraint. The legality of restrictive measures used in the care of persons with learning disabilities 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 noted that restrictive equipment must comply with the requirements of the Act on health care devices and equipment (3375/2018 Kolpene).

Mat used as a restrictive measure.

The joint authority commented on the draft report that the use of the restraining method in question had been discontinued following the NPM visit.

Debriefing of restrictive measures

The Act on Special Care for the Persons with Intellectual Disabilities requires that restrictive measures must be followed by a debriefing, which must be documented. However, observations made during the NPM visits suggest that debriefings and their documentation are not always carried out as required by law. The Ombudsman drew the service centre's attention to the fact that the person subject to the restrictive measure must be invited to a debriefing to discuss the reasons for and impact of the measure. The law regulates

in great detail what information must be recorded (3375/2018 Kolpene).

The joint authority reported that the staff have received guidance on the evaluation of the use of restrictive measures and their documentation in the client records.

Privacy of residents

The Ombudsman has referred to the Convention on the Rights of Persons with Disabilities (CRPD) and noted that the goal should be for each person with a disability living in a residential unit to have access to a private room, including a bathroom.

The unit had four apartments, with two apartments sharing a toilet and shower facilities. The bathrooms were located between two apartments with direct access from the apartments to the space. According to the staff, sharing the facilities had not presented problems because the residents used them at different times. This was because the residents required assistance in personal hygiene. 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 apartments. The need for a private toilet and shower room is emphasised in long-term accommodation (1683/2019 Omakoti Oiva). This principle should also be observed in temporary care and accommodation services (1684/2019 Tilapäishoitokoti Alma).

In the view of the Ombudsman, the use of a technical listening device at a resident's apartment could prove problematic from the perspective of privacy and private life (2008/2019 Eteva).

Positive observations and good practices

The resident had a bed which was lowered for the night. A soft bedside rug was used to soften any possible fall from the bed (3375/2018 Kolpene).

Two residents had been provided with activity passes. These included personal information

Power outlets in the rooms of the Tempo housing unit residents can be either on view or behind a locked door, according to an individual assessment.

on guidance and communication for the resident, meaningful activities, and the anticipation and handling of challenging situations (3375/2018 Kolpene).

The NPM found it commendable that spatial design had been used to support the resident's self-determination and wellbeing. This was made possible by the spacious architecture of the service home. The unit offered its resident a sensory room, an echo room (empty room), and a workshop for a resident who was unable to go outside the unit for daytime activities. The needs of two residents with challenging behaviours had been met by placing them in sub-units with several rooms. The solution effectively supported their rehabilitation. A resident with impaired hearing has a doorbell outside their room that activates a flashing light inside the room. The staff push the doorbell before entering the room, so the resident's room cannot be accessed by surprise and without the knowledge of the resident (3375/2018 Kolpene).

3.5.17 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 and geriatric care units), or where persons deprived of liberty are treated (VTH).

The Ombudsman and the NPM collaborate in the health-care sector with the National Supervisory Authority for Welfare and Health (Valvira) and Regional State Administrative Agencies (AVI). Before NPM visits, as a rule, the competent Regional State Administrative Agency is contacted in order to gain information on its observations and possible measures concerning 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. During 2019, this practice was followed during the visit to Harjavalta Hospital. The final NPM visit report is also delivered to the AVI for information.

Background information is requested from the health-care unit's patient ombudsman before each visit. According to the Act on the Status and Rights of Patients, a patient ombudsman shall be appointed for each health care unit. A patient ombudsman's task is amongst other things to inform patient of their rights. The final NPM visit report is also sent to the patient ombudsman for information.

Owing to the large number of health-care facilities 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 the most coercive measures are taken, and where the patients are most challenging. These include the state forensic psychiatry clinics (Niuvanniemi 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 studies 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 always attended by an external medical expert. Involving a medical expert in the visits has made it possible to address the use of restrictive measures from a variety of angles and to explore ways of preventing their use.

Visits to psychiatric units are nearly always unannounced. However, the unit may be notified in advance by letter that a visit will be made within a certain period of time. This lets the NPM 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 discussions with the NPM: for example, the patient last admitted to the ward, or the patient who has spent the longest time on the ward.

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

A draft of the NPM 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 preliminary recommendations already at this stage. The Ombudsman welcomes this development as an indication of constructive dialogue.

A total of 15 visits were made to health-care units in 2019 (compared to 10 in 2018). The focus of the visits to health-care units was on somatic care for elderly patients. The following visits were made:

date of inspection	target	number of inmates	case number	other / previous inspection visit
26 March and 3 April 2019	Espoo Hospital	247 beds	1706/2019	external expert included
26 March 2019	HUS Jorvi, joint emergency clinic		1707/2019	external expert included
8-9 May 2019	Katriina Hospital, Vantaa	163 beds	2458/2019	2 external experts included
9 May 2019	HUS, geriatric psychiatric research and care	7 beds	2759/2019	2 external experts included
15 May 2019	Vantaa Hospital, acute geriatric unit	48 beds	2456/2019	external expert included
28 May 2019	Psychiatric Prison Hospital, Turku Unit	40 beds	2570/2019	Deputy-Ombudsman and external expert included, previous visit 2009
29 May 2019	VTH, Turku outpatient clinic		2571/2019	external expert included, previous visit 2016
11-12 June 2019	Satakunta Hospital District psychiatric wards/ Harjavalta Hospital	102 beds	2301/2019	3 external experts included, previous visit 2008
11 June 2019	Satakunta Hospital District Satasairaala joint emergency unit		3009/2019	2 external experts included
11 June 2019	Keski-Satakunta joint authority for health care, Harjavalta Health Centre Hospital	30 beds	3264/2019	external expert included
13 June 2019	Pori City Hospital	148 beds	3007/2019	2 external experts included
3 September 2019	Pelkosenniemi-Savukoski joint authority for public health, inpatient ward	12 beds	5022/2019	Deputy-Ombudsman included
16 October 2019	TAYS Pitkäniemi Hospital, geriatric psychiatry	17 beds	5592/2019	external expert included
16 October 2019	Hatanpään puistosairaala, geriatric psychiatric wards	28 beds	5593/2019	external expert included
6 November 2019	VTH, Sukeva outpatient clinic		5468/2019	previous visit 2015

#= unannounced inspection

The visits to VTH units were announced in advance. The rest of the visits were made either completely unannounced (emergency clinics) or the sites were informed that an inspection visit would be carried out within a certain time period.

Visits to elderly care units

Adequate staffing

A "hybrid ward" had only one night nurse, which the Deputy-Ombudsman found a matter of concern. The ward had a number of separate corridors. Covering two wards seemed a challenging task, especially if a patient required two nurses for handling or was restless (2458/2019 Katriina Hospital).

The Deputy-Ombudsman drew attention to the long shifts of the nursing staff. These could pose a risk to patient safety. The Deputy-Ombudsman urged the managers to actively monitor the workload of the nurses. The Deputy-Ombudsman also recommended that effective measures be identified to recruit more nurses (3264/2019 Harjavalta Health Centre, inpatient ward).

The joint authority reported that the Deputy-Ombudsman's opinion had been forwarded for the attention of the management group of the joint authority and line managers at the health centre hospital. The authority had succeeded in recruiting an adequate number of experienced nurses to cover for planned leave by the nursing staff.

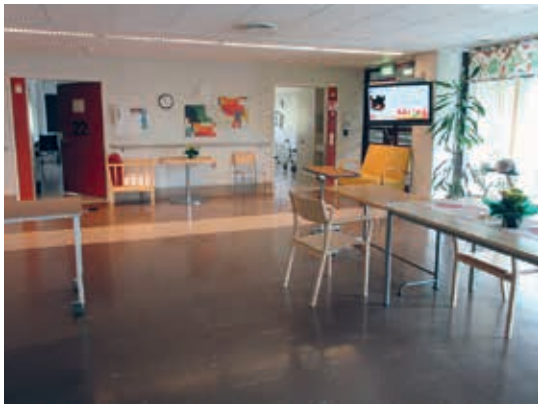
Acknowledging the needs of patients with memory disorders in spatial design

The spaces in hospitals should be well designed and easy to negotiate by their intended users. When caring for the elderly and patients with memory disorders, it is particularly important to support the orientation and functional capacity of the patients through spatial and interior design. The orientation skills of patients with memory disorders can be improved by paying more attention to the distinctive features of patients' rooms and other facilities, such as wall colours and pictures. Finding one's own care unit or room can be made easier by the use of signs and personal items.

Innovation developed in the Pori City Hospital's memory disorder ward, the bus stop.

It was discovered during the visit that a very monotonous colour scheme had been used in the design of the wards. All wards looked remarkably similar. Colour or other visual features had not been used to help distinguish between wards or rooms. The lack of colour and the "clinical" appearance were particularly noticeable on the hospice ward, where comfort and personable details would be of particular importance owing to the nature of the treatment. The Deputy-Ombudsman recommended that the hospital should estimate whether they could improve the interior decoration of the wards or post signs to make it easier for patients with memory disorders in particular to obtain an overall picture of the hospital and its wards and to move around in them (1706/2019 Espoo Hospital).

The patient rooms had no radio or television. The television sets were placed in the common premises. It remained unclear to the NPM whether the seclusion rooms had television sets. The arrangements were intended to motivate the patients to move around. However, the practice was prob-



The ward only had a television in the shared spaces.

lematic, especially if a patient was bedridden or in seclusion. The Deputy-Ombudsman urged the hospital to consider whether the individual needs of the patients could be more flexibly considered in the furnishing of the rooms, without compromising the rehabilitative goals of the care. At least the seclusion rooms should have a television (2458/2019 Katriina Hospital).

The hospital reported that its goal was to support the activeness and independence of its patients to improve their functional capacities and rehabilitation. Following the NPM visit, the common premises have been improved to better meet patients' needs. The aim is to increase the number of activities for the patients during the day. As a result, the patients are encouraged to participate in daytime activities and move as much as possible within the limits of their health and functional capacity. For this reason, television and other stimulating activities are kept mainly in the common premises. In addition, the hospital wants to consider the individual needs of patients more flexibly, including in situations where a patient may be unable to spend time and participate in activities in the common premises. Seclusion rooms can be furnished with a television, as the hospital has movable televisions.

Important decisions concerning treatment

The Deputy-Ombudsman recommended that the hospital provide guidelines to help determine when a decision concerning a patient with diminished capacity is important enough to warrant the involvement of the family or people close to them (2458/2019 Katriina Hospital).

The local authorities reported that, in order to clarify its guidance, the hospital has launched a guidelines project for predictive care planning. With the guidelines, the role of families will be better taken into consideration in situations in which the patient is no longer able to decide on their own treatment. If the patient is unable to make decisions concerning their treatment, the patient's family members will be consulted. The purpose of consulting the family is to establish what the patient's wishes most likely would be and what would be in their best personal interest. In connection with the guidelines, specific procedures will also be developed to support the staff in implementing the guidelines and ensure that the staff are aware of the guidelines. The guidelines will be updated annually in the future. The guidelines are drawn up as a multiprofessional collaboration and they were scheduled for release in February 2020.

Discharging an elderly patient

Discharging a patient is a crucial and also a risky stage from the perspective of patient safety. The discharge process should be seamless so that good communication between service providers is ascertained and services are delivered on time without disruptions. The City of Espoo and Espoo Hospital have acknowledged a number of problems related to patient discharge and have taken measures to improve their processes. The Deputy-Ombudsman considered this issue to be of major importance and considered it necessary that development measures be continued and the situation closely monitored in the future (1706/2019* Espoo Hospital).

With elderly patients, it is often necessary to involve a representative from social services in the planning and implementation of the discharge process. The Deputy-Ombudsman reiterated that a patient who is unable to manage independently at home should not be discharged before making sure that there is someone to meet the patient at home and that all services required by the patient are arranged (3264/2019 Harjavalta Health Centre, inpatient ward).

According to the joint authority, cooperation between municipal residential units and care homes, as well as home nursing, has been successful. Patients are never discharged without a realistic chance of coping. The discharge process has been allocated plenty of resources: there is a full-time nurse on the ward concentrating exclusively on patient discharge.

Patients waiting for a place in a care facility

A hospital ward had patients waiting for a transfer to a care facility who no longer required hospital care. At the time of the NPM visit, there were five and eight patients on two wards, respectively, waiting for a place in a care facility. The waiting time for a care home place could be months. According to the information provided by the local authority, it was able to organise care places within the maximum time of three months, as determined by law. Waiting for a care place did not, according to the hospital, mean that the patient's rehabilitation was suspended. However, the NPM finds that the above factors were impairing the progress of the care chain. Patients kept on hospital wards "for no real reason" took up beds that could have been used for patients who required hospital treatment. Those waiting for a place in a care facility did not have access to appropriate activities, outdoor exercise, and a home-like environment, in accordance with the care plan. While at hospital, the patients were also unnecessarily exposed to infections and were at risk of becoming institutionalised (2458/2019 Katriina Hospital).

According to information received from the local authority, the goal of the hospital was to facilitate a speedy return to the patient's own home or a home-like residential environment. The planning of discharge begins as soon as the patient arrives at the hospital. The hospital has initiated the development of proactive and supported discharge together with the providers of independent living services.

The Deputy-Ombudsman decided to take the problems in allocating care facility places under a separate investigation.

The Deputy-Ombudsman drew attention to the fact that, for some patients, the inpatient ward had become a much longer-term solution than their health situation required. Owing to the lack of exercise in a hospital setting, the functional capacity of the elderly may rapidly deteriorate. In these situations, active efforts should be made to seek other solutions for the care and treatment of the patient (5022/2019 Pelkosenniemi).

Methods to avoid the use of restrictions

The NPM was informed that various measures were taken in the course of the delivery of care to prevent the occurrence of patients' behavioural symptoms and the associated risk of mistreatment. The non-pharmaceutical methods included music, physical exercise, and stimulating and creative activities. The aim was for the patients to leave their beds; this means that all patients were assisted as needed. The unit also paid attention to the manner in which patients were approached. The guidance was that care is delivered taking an individual patient's natural daily rhythm into account.

The importance of recognising different behaviours was emphasised at the unit, and different situations were regularly discussed. For example, the acoustics of the spaces and the high level of noise, and restless behaviour in the evening were among topics raised. The unit considered outdoor exercise to be of vital importance, and all those who wished to go outdoors could do so. Outdoor time was worked into the daily programme and shifts so that those arriving for their evening shift first took patients outside before changing into their work clothes. The care principles emphasised the importance of engaging with the patients, as

this was believed to create a sense of security and calm on the ward. The nurses' breaks were phased so that there was always at least one nurse in the view of the patients. The nurses did not spend their time in the office but rather in the company of the patients. The fruits of this approach were clearly visible during the NPM visit. The choice and the personality of the nurse assigned to a patient was also carefully considered.

All employees had attended the MAPA (Management of Actual or Potential Aggression) training as well as the Dementia MAPA training, which aims to prevent aggressive behaviour. The nursing staff participate in supervision sessions once a month. The ward had adopted a rehabilitative approach, and the staffing level supported the implementation of the approach. The multiprofessional teamwork was evident in the delivery of care. The ward had its own physiotherapist. There were also three wellbeing assistants, whose role was to offer stimulating activities and to engage with the patients (5593/2017 Hatanpää).

In special observation (100% observation), the nurse remains close to the patient at all times. There are three levels of special observation: 1) intensive observation, 2) within eyesight, 3) within arm's length. On one ward, one nurse was involved in special observation, and on another ward sometimes even two. The most common reason for special observation was the risk of a fall. If special observation was required, this was based on a physician's decision that was documented in the patient records. According to information obtained from the hospital, the physician determined the required number of nursing staff based on a medical assessment (risk of self-harm, aggressiveness, restlessness, patient safety, risk of falling).

The Deputy-Ombudsman welcomed the method of using special observation for the prevention of falls in the care of the elderly with memory disorders. The special observation approach reduced the need for restrictive equipment and supported the patient's rights to freedom of movement and self-determination. Special observation is also a suitable method in other situations where there is no imminent risk of violence. The staff all gave consistent descriptions to the NPM of the practices adopted in special observation. However, the written guidance referred to special observation only as part of seclusion. The Deputy-Ombudsman recommended updating the guidance to correspond to the actual practice on the ward (5592/2019 Pitkäniemi).

Restrictive measures

The Deputy-Ombudsman welcomed the wide adoption of the special observation method on the wards, as this eliminates the need for some of the more restrictive measures. The NPM was told that sometimes a patient must be restrained to their bed for the time a nurse needs to step out of the section. Following the visit, the hospital reported that the nursing staff leaves the section or room of a patient under special observation only in exceptional circumstances. The Deputy-Ombudsman found it problematic that the practice was for a patient to be restrained "to be safe" for the period the nurse had to leave the patient. Moreover, understaffing is never an acceptable justification for restraining a patient (1706/2019 Espoo Hospital).

The restrictive measures adopted at the hospital were: 1) restraint belt (waist strap with possible wrist and/or ankle straps), 2) pelvic strap (while the patient is seated), 3) back-zip overalls, 4) raised bedrails, and 5) sedative medication. Furthermore, the doors of one ward were locked, and at least some patients were prevented from leaving the ward. Based on the records, the use of restrictions seemed justified in most cases. Decisions on restrictive measures were made by a physician. However, it appeared that raised bedrails and back-zip overalls were not considered methods of restriction. The duration of restrictive measures was also not defined. Permission to use restrictions could be granted beforehand, particularly before weekend shifts (2458/2019 Katriina Hospital).

The anti-strip jumpsuit has a zipper on the back that cannot be opened by the user. In the picture, a member of the inspection team is trying on the jumpsuit.

The NPM was told that if a patient refused to take medication, attempts would be made to reason with the patient. Patients are not forced to take their medication. The unit used, albeit very rarely, the back-zip overall as restrictive clothing. Its use was not always based on a physician's decision (3264/2019 Harjavalta Health Centre, inpatient ward).

Guidance on restrictive measures and their documentation

In the absence of applicable law, it is vital that care facilities provide sufficiently detailed guidance on the application of restrictive measures. The guidance should include a complete list of all restrictive measures in order to achieve a common understanding among the staff on the concept of restricting a patient's fundamental rights. The guidance should also specify how long a restrictive measure may be applied and how often a physician should re-evaluate the need for the continuation of a restrictive measure.

The documentation should comply with the provisions of the Ministry of Social Welfare and Health decree on patient records. Under the decree, the patient records should indicate the cause, nature, and duration of a measure, as well as the assessment of the impact of the measures on the patient's treatment, and the names of the physician authorising the measure and those delivering the measure. It should also be clearly indicated if the measure is based on patient consent.

The Deputy-Ombudsman noted that the hospital's guidance on protective and restrictive measures failed to give a full list of the restrictive measures in use. These included involuntary administration of medication and technical surveillance, such as camera surveillance. There was also no mention in the instructions of how the patient's relatives are consulted or informed about the use of the restrictions unless the patient is able to decide on their own treatment (1706/2019 Espoo Hospital).

The hospital reported that, in the absence of applicable law, it will utilise the recommendations made by the Deputy-Ombudsman in the development of its guidance on the use of protective and restrictive measures. The guidance was due for an update to align with the Deputy-Ombudsman's recommendation during autumn 2019.

The Deputy-Ombudsman commended the hospital for providing guidance on the use of restrictive measures. The hospital guidance differentiated between protective and restrictive measures, but the grounds on which these definitions were based were not clear from the guidance. Nor did the guidance refer to any applicable regulatory framework or provide a full list of all restrictive measures used. The guidance should also specify

how long a restrictive measure may be applied and how often a physician should re-evaluate the need for the continuation of a restrictive measure. The guidance mentioned the necessity of consulting a "legal representative" of a patient incapable of self-determination, but no definition of a "legal representative" was given. According to the Act on the Status and Rights of Patients, a legal representative refers to a guardian or a person authorised by the patient. If the patient has no such representative, the Deputy-Ombudsman recommended that a close relative or a person closely connected with the patient who is incapable of self-determination be consulted, as provided for in section 6 of the Act on the Status and Rights of Patients. The nursing staff appeared to be well aware of the hospital guidance on restrictive measures. However, the physicians and the ward physiotherapists were not all familiar with the guidance. The Deputy-Ombudsman requested the hospital to ensure that the entire staff was duly informed about the existence of the guidance (2458/2019 Katriina Hospital).

The local authorities reported that the Service Area for the elderly and persons with disabilities would receive updated guidance in accordance with the instructions of the Deputy-Ombudsman. Studying the guidance would be part of the hospital staff's onboarding training. Furthermore, the ward staff and multiprofessional teams would also be expected to study the guidance.

There should be written guidelines on restrictive measures, specifying the restrictive measures to be used at the unit, as well as the grounds and decision-making process for their application and how these measures are monitored and when they must be discontinued. The unit had no such guidelines in place (3264/2019 Harjavalta Health Centre, inpatient ward).

The chief physician in charge of home nursing and institutional care has drawn up written guidelines on restrictive measures, dated 10 February 2020, which are in line with the Deputy-Ombudsman's recommendations.

Monitoring of restrictions

Each unit where restrictive measures are adopted should also monitor their implementation. Without qualitative and quantitative data on the measures adopted, systematic monitoring of the practice is impossible. Monitoring also serves to reduce the systematic use of restrictive measures.

A hospital's quality assurance and patient safety plan and the information on the notice boards on wards showed that a wide range of care-related data was collected at the hospital. No separate statistics on the types of restrictions were maintained, however, and no quantitative data was available. The Deputy-Ombudsman recommended that the hospital start keeping systematic records on the use of restrictive measures (1706/2019 Espoo Hospital).

The hospital reported that it would start systematic monitoring of the most restrictive measures.

No separate statistics on the types of restrictions were compiled at a hospital and no summary of quantitative data was available. The Deputy-Ombudsman recommended that the hospital continually monitor the implementation of restrictive measures and draw up a plan or guidelines to reduce the use of coercive measures (2458/2019 Katriina Hospital).

The local authorities reported that the hospital has adopted guidelines on the use of restrictive measures on patients. As part of developing the guidelines, the systematic and ongoing documenting of the use of restrictive measures will be emphasised. The new patient information system, Apotti, will facilitate better monitoring and record-keeping on the use of restrictive measures. In addition, guidance to reduce the use of coercive measures will be developed in collaboration with Elderly Services and Services for the Disabled.

Restraining as a restrictive measure

Restraining imposes a heavy restriction on a patient's right to self-determination and integrity. Restraining involves serious, even life-threatening risks. A restrained patient must remain under special medical observation for the duration of the application of the measure. The need for observation must be assessed individually for each patient and situation. Therefore, the Deputy-Ombudsman has recommended that patients at a somatic care unit who have been immobilised should be monitored according to the principles provided in the Mental Health Act, at least in situations where the immobilisation has been deemed necessary because of the patient's acutely agitated and confused state. This would mean, among other things, that the status of the restrained patient is constantly monitored so that the nursing staff can see or hear the patient at all times (1706/2019 Espoo Hospital, 2458/2019 Katriina Hospital).

Restricting the freedom of movement

If a patient is prohibited or prevented from moving outside a designated space or area, the practice constitutes a restriction on the freedom of movement. The national legislation of Finland does not offer legal remedies in the event of a loss of the freedom of movement in a somatic care setting, as referred to in the Human Rights Convention. Furthermore, admission to a ward does not require an administrative decision open to appeal. The Human Rights Convention forms a legal provision directly applicable in Finland. According to legal practice, complaints from clients in institutional care have been investigated in the light of the Human Rights Convention, although there is no national legislation governing the matter (e.g. KHO 2013:142).

The ward provided care for patients with various degrees of confusion. The patients were mostly elderly people, but there were also younger patients who had sustained injuries as a result substance abuse. The doors leading outside from the ward were kept locked, and certain patients were not allowed to leave the ward without permission. The Deputy-Ombudsman recommended that the patient or their representative be referred to legal aid if they requested clarification of the legal basis for the patient's deprivation of liberty (2458/2019 Katriina Hospital).

The local authorities reported that the ward had been profiled as a unit for treating and rehabilitating patients with impaired orientation to time, place, and/or person. The patients' moods could be highly volatile, and they could present aggressive behaviours and delusions. Owing to the patients' acute symptoms and to ensure patient safety, the doors of the ward were kept locked. The practice at the ward was that the doors were opened for patients on request if they were capable of independent outdoor activities.

The NPM was told that the doors to the ward were locked so that patients with memory disorders would not wander outside. Patients are allowed out on request unless the staff deem this to pose a risk to their safety. The doors of patients' rooms were not kept locked. If a patient wished to leave the hospital, the patient's capacity to make reasonable decisions and to understand the consequences of their decisions would be assessed. If the patient is considered to be incapable of taking responsibility for such a decision, the patient is not allowed to leave the hospital (3264/2019 Harjavalta Health Centre, inpatient ward).

Outdoor activities

The right of patients in voluntary psychiatric care to spend time outdoors should be at least as equally honoured as it is in involuntary treatment. The aim should be that those whose situation allows, are arranged a possibility to spend time outdoors on a daily basis. This goal should be adhered to systematically, including by increasing the number of staff, if necessary.

For patients who could not go outside alone or with the assistance of relatives, it was not possible to arrange outdoor activities except during the summer, when summer workers oversee the outdoor activities. The Deputy-Ombudsman welcomed the hospital's aim of increasing the patients' access to the outdoors during the summer. However, the situation was problematic, particularly on a ward where the freedom of movement of some patients was restricted. While the average length of stay on the ward was 30 days, some patients stayed on the ward up to one year. In the view of the Deputy-Ombudsman, the principle of daily outings should also apply to patients whose freedom of movement had been restricted (2458/2019 Katriina Hospital).

The local authorities reported patients with memory disorders were taken outdoors by their relatives, and during the summer, they could also go outside with staff assistance. The ward also employed an activity supervisor, whose task was to support and engage patients to participate in stimulating activities. They would accompany the patients outdoors to some extent.

The Deputy-Ombudsman further stressed that the patients' access to the outdoors should be guaranteed outside the summer period, as well. Furthermore, a patient's access to the outdoors should not rely solely on the assistance of relatives.

Patient information

It is essential for the purpose of securing patients' rights that patients and their next of kin are aware of patients' rights and the legal remedies available to them, including objection, complaint, and notice of patient injury. Patients on all wards, and their families, should be provided on arrival with clear and simple information on the rights and obligations of the patients, both verbally and in writing. Public information provided by the government and local authorities in a bilingual municipality must be issued in Finnish and Swedish.

A hospital's wards did not provide a brochure on the important information about the ward, such as contact details or visiting hours. Each ward had a notice board, where general information about the ward was posted, but information about patients' rights or the Patient or Social Welfare Ombudsman was not made available. The material on the notice board was provided almost entirely in Finnish. The wards also had electronic information screens. The Deputy-Ombudsman found that, particularly with elderly patients, the electronic communication channels could not fully replace information provided in paper format. The Deputy-Ombudsman recommended that information about the Patient Ombudsman and the Social Welfare Ombudsman be posted on the notice boards. He noted that any information shared on the notice board, verbally, or in writing should also be provided in other languages than Finnish (1706/2019 Espoo Hospital, 2458/2019 Katriina Hospital, 3264/2019 Harjavalta Health Centre, inpatient ward).

The local authorities reported that the hospital will update its brochure on its services and different wards, which is handed out to patients and their relatives on admission. The brochure will introduce the operations of the ward, as well as the services and practices adopted at the hospital. In conjunction with this, patients and relatives will be informed of the contact details of special workers, such as social welfare supervisors and the hospital chaplain. In addition, the hospital had ordered posters in Finnish, Swedish, and English to be posted on the notice boards on the wards explaining the role of the Patient Ombudsman and Social Welfare Ombudsman and providing their contact details. The posters are posted on the notice boards of each ward (2458/2019).

The joint authority reported that the matter had already been acknowledged on the ward during the NPM visit and that the information was posted on the notice boards of each treatment group immediately after the visit (3264/2019).

Protection of privacy

Camera surveillance

The hospital had the technical capability for camera surveillance in patient rooms. CCTV could be used for either observing the patient or alerting of potential falls. No recording CCTV cameras were used. The camera image could be viewed in real time on the ward, at an office next to the service desk. The NPM was told that camera surveillance was seldom used at the hospital for observation, and mainly on the acute ward. The hospital also operated a fall detection system. This was based on patient room cameras and produced data on the movements of a person, which made it possible to detect a fall. This triggered an alert through the nurse intercom. The camera did not transmit any actual image. The Deputy-Ombudsman noted that placing a camera in a patient's room always constituted an intervention into the patient's privacy. There are currently no legal provisions regulating the use of camera surveillance in patients' rooms. The Deputy-Ombudsman found that camera surveillance should not be used for the observation of patients unless absolutely necessary. Understaffing is not an adequate basis for camera surveillance. The patient and their relatives should be informed about camera surveillance and the possibility of observation (1706/2019 Espoo Hospital).

Two patient rooms on a ward had camera surveillance. The camera image could be viewed in the nurse break room and the office. The Deputy-Ombudsman considered it important that patients whose rooms are monitored by the camera are made aware of the monitoring and that the camera is turned off if there is no special need for monitoring (2458/2019 Katriina Hospital).

The local authorities reported that there was camera surveillance equipment in two patient rooms on a ward. The camera surveillance was in use only under special circumstances, such as when the condition of a patient in a room required close observation but the presence of a nurse in the room would disturb the patient (a restless, anxious patient, etc.). Camera surveillance was relied on only in extreme cases to ensure the safe treatment of a patient, and the patient and their relatives would always be informed about its use. Camera surveillance is discontinued as soon as it stops being in the patient's best interest.

Protecting confidential data

A hospital operated workstations along corridors and mobile workstations that were moved around the ward. It was possible for unauthorised persons to view text on the computer screen at a workstation in the corridors, or at the mobile computer station. The Deputy-Ombudsman recommended that the visibility of the screens of workstations and mobile computers to outsiders should be prevented by, for example, installing separate privacy filters on the screens (1706/2019 Espoo Hospital).

Mobile workstation.

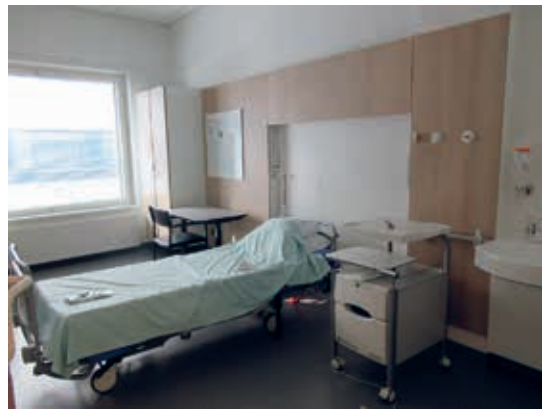
Protection of patient privacy

Some patient rooms in a hospital had three beds, which made the room overcrowded. While curtains and screens could be placed between the beds, securing the privacy of patients was difficult owing to the small size of the room. The doors of the patient room were heavy. They were kept open to the corridor so that patients relying on support equipment could access the common spaces on the ward. From the perspective of privacy, however, this practice presented some problems. The NPM noted during its visit to one ward that the door was kept open even when the patient was being washed. In the debriefing of the visit, the hospital representative admitted this error and said that the staff had been reminded of the importance of honouring the privacy of the patients. The Deputy-Ombudsman requested the hospital to ensure that patients' privacy is protected, especially during treatment, and that the locks on the lockers in all patient rooms are intact. The Deputy-Ombudsman also urged the hospital to consider a way of reducing the number of patients from three in one room (2458/2019 Katriina Hospital).

The local authorities reported that the matter has been raised as a key issue with the staff of the department in autumn 2019, with guidance on the delivery of care while respecting a person's right to privacy. In addition, owing to the multiple-occupancy patient rooms, a separate quiet space has been designated for patients and their family members, where they can discuss treatment and rehabilitation and carry out the personal rehabilitation programme. A plan has been drawn up together with property maintenance on checking the locks on patient lockers, the management of keys, and carrying out necessary repairs. Any issues will be corrected by the property maintenance personnel during January and February.

The Deputy-Ombudsman found the large patient rooms hosting five patients problematic. The Deputy-Ombudsman found that a large room such as this was not conducive to optimal patient recovery. The Deputy-Ombudsman recommended that patients be placed in rooms with fewer beds, if possible, to allow them more peace and privacy (3264/2019 Harjavalta Health Centre, inpatient ward).

The joint authority reported that the aim of the ward was to keep the number of patients in each room fewer than the maximum of 5 patients in the largest patient rooms whenever possible. The aim was to reduce the number of beds from the current 30 to 20 by the end of 2020. The reduction in the number of beds will mean that fewer patients need to be placed in one room.



Left-side image shows a three-person shared room. Right-side image shows a spacious one-person room with a private bathroom.

The Deputy-Ombudsman recommended that patients are always offered the opportunity to discuss their situation with a physician in private, if they share a room with other patients. Attention must be paid to honouring a patient's right to privacy not only during the doctor's rounds but also in connection with treatment procedures (3264/2019 Harjavalta Health Centre ward).

According to the joint authority, physicians have two fully accessible offices on the ward that can be used. The patients are offered the opportunity to see the physician in private.

Prevention of inappropriate treatment

Identifying inappropriate treatment or mistreatment is difficult, as is defining what constitutes inappropriate treatment. The management of each caregiving unit is responsible for providing a definition of mistreatment. Mistreatment may involve overmedication, verbal threats, physical abuse, shouting, poor positioning in a bed or geriatric chair, or leaving a resident in a soiled or wet bed or clothing. It should be emphasised to staff that mistreatment is never acceptable, and it will always carry consequences.

The hospital had no specific whistle-blowing policy in place should any mistreatment of patients be detected or suspected. The staff were expected to report any observations of mistreatment to their superiors. The Deputy-Ombudsman noted that the hospital would benefit from clear staff guidance on the concept of mistreatment and on the process by which reports are handled. Patients and their families should also be provided with instructions on the matter. At the same time, it should be made clear that reporting on mistreatment or deficiencies must never lead to any negative consequences for the person filing the report (1706/2019 Espoo Hospital).

The hospital reported that it would bring the Deputy-Ombudsman's opinion on the reporting practice for mistreatment to the attention of the City of Espoo Social and Health Services for information and action.

According to the Deputy-Ombudsman, the hospital should provide the staff with clear guidance on how to report mistreatment. It should also clearly indicate that reporting mistreatment or deficiencies will never lead to any negative consequences for the person filing the report. The Deputy-Ombudsman also emphasised that informing patients about patients' rights and the legal remedies available could not be based solely on online information (2458/2019 Katriina Hospital).

The local authorities reported that the hospital's management system was overhauled during the autumn of 2019, including a review of the hospital's operating methods, culture, and policies. The hospital also launched a two-year development scheme in November 2019 with the aim of improving customer service and quality of care by focusing on patient safety, pharmaceutical therapies, the smooth care process, the quality of care chain, and the leadership of multiprofessional teams. The new leadership and management goals include supporting staff members' professional development and making leadership and management work more transparent and accessible through proactive interaction, Gemba walks, and timely communications. In conjunction with this, guidelines on identifying, reporting, and processing cases of mistreatment will be published.

Inspection visits of emergency units

As in previous years, the Ombudsman felt it was important to visit the emergency care units of somatic hospitals, which use 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 a problem 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 in

Emergency clinic entrance.

his legal practice that the legal provisions and ethical norms governing the actions of doctors and other health care professionals must also be taken into account in these situations, and, as a result, the application of two parallel sets of standards. Furthermore, the procedure may not violate the patient's human dignity.

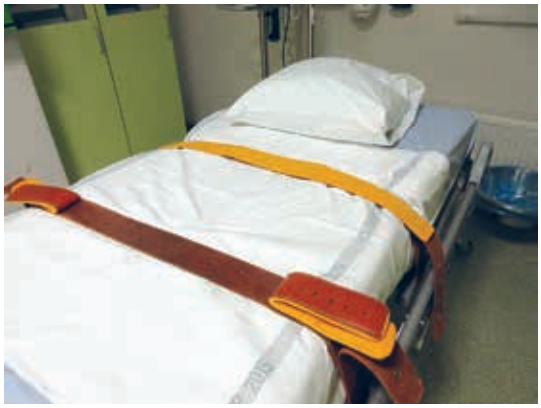
Having appropriate equipment in the seclusion room is of major importance when assessing whether a patient's seclusion has, as a whole, been implemented in a manner that qualifies as dignified treatment and high-quality health and medical care. The criteria laid down in the Mental Health Act for the seclusion of a psychiatric patient are also applicable as minimum requirements for secure rooms in somatic hospitals. A patient placed in a secure room must be continuously monitored. This means that the patient must be monitored by visiting the seclusion room in person and observing the patient through a video link with image and audio. Appropriate records must be kept of the monitoring at all times.

The NPM visited the urgent care units of two hospitals in 2019. Both visits were made unannounced and during the evening. An external expert participated in both visits. In both emergency units, the monitoring of aggressive or disruptive patients had been carried out in a different manner to that described above.

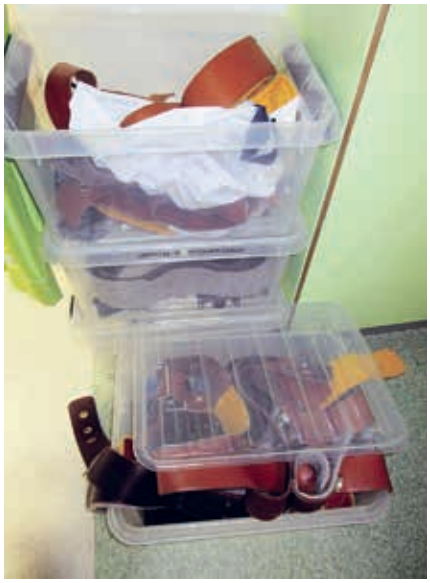
The NPM visits were conducted at HUS Jorvi to both the adult and paediatric joint emergency units, which have separate entrances and facilities. As provisional observations, the NPM noted that neither unit had a separate space for isolating a patient showing aggressive behaviour or presenting a danger to themselves or others. The established practice is that, as a last resort, a patient may be restrained on a bed. In the adult emergency unit, the bed equipped with restraints was located in the acute observation ward, with a total of nine beds. The beds were in one room, where curtains could be drawn between the beds for privacy. Aggressive patients under the age of 16 would be treated in the paediatric observation ward and for them, too, the treatment of last resort would be restraint. In all cases, the use of restraint was decided on by a physician. It remained unclear to the NPM why the practice of restraining a patient had been adopted instead of introducing a safety room, as in most other emergency care units. At the time of writing this annual report, the Deputy-Ombudsman's final opinions and recommendations based on the observations made during the visit were still pending (1707/2019).

An aggressive or disruptive patient who has sought treatment or has been brought into the emergency unit at Satasairaala hospital will be referred to acute care, the sobering-up unit Selma, or an examination room, based on a case-by-case assessment. The unit also had a designated room where a patient could be placed in seclusion from other patients. However, the use of this room has been discontinued, and the space was used as storage at the time of the visit. It remained unclear why this space was no longer in patient use. A bed equipped with restraints was provided near the separate ambulance entrance. Based on a prealert from the first response personnel, the physician could make a preliminary decision on the use of restraints prior to the patient's arrival. Mental health patients with no aggressive symptoms were usually placed in an examination room from which unnecessary medical equipment is removed. One such room was in use.

The NPM was told that the room was used weekly. If there is no medical reason for the pres-



Emergency clinic limb restraint bed.



Spare leather limb restraint belts in a box.

ence of a nurse, the observation of the patient is trusted to a security guard. The guard may remain in the same space as the patient or may monitor the patient through a window in the door. The room also has camera surveillance, with the image visible on the screen in the nurses' office and security guard room. If necessary, restraints could be applied in the room. The sobering-up unit Selma is located adjacent to the emergency department as a separate facility operating under the emergency department. Usually the patients placed in Selma arrived at the joint emergency unit escorted by first responders or the police. The beds in Selma are also equipped with restraints in case they are needed. The Deputy-Ombudsman's final opinions based on the visit are still pending (3009/2019).

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 outpatient clinics in connection with the prison outpatient clinic. In Vaasa, the dental outpatient clinic operates in a municipal health centre. The units of the Psychiatric Prison Hospital in Turku and Vantaa serve as acute psychiatric outpatient clinics for prisoners everywhere in Finland. The Prison Hospital is a national somatic hospital for prisoners, located in Hämeenlinna.

Since the beginning of 2016, AVI Northern Finland has conducted guidance and assessment visits to the outpatient outpatient clinics and hospitals of VTH on its own or together with Valvira. By the end of 2018, the AVI had visited all VTH outpatient clinics and health-care units. 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 larger health-care system,

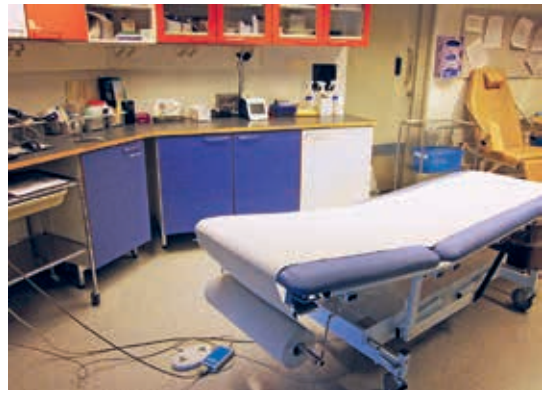
along with the treatment recommendations and guidelines issued by VTH. In 2019, the local AVI conducted three guidance and assessment visits to prisoner health-care units. The units were chosen based on a risk and needs assessment.

The Ombudsman receives AVI Northern Finland's annual 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 reports, for information, to Valvira and the AVI Northern Finland. The Ombudsman, Valvira, and AVI Northern Finland also hold regular meetings on issues in the field of prisoner health care.

During 2019, the Office of the Parliamentary Ombudsman visited two units of the VTH. These inspection visits were combined with prison visits and were announced in advance. Before visiting the outpatient clinic, the practice is for the NPM to interview the prisoners on matters such as the functioning of health care and medical care in the institution. In addition, a visit was conducted to the Psychiatric Prison Hospital in Turku. The visits to the Turku Outpatient clinic and the Psychiatric Prison Hospital were attended by an external expert in psychiatry.

On outpatient clinic visits, the Ombudsman pays attention to how soon arrival examinations 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 isolation 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 at the weekend is not always examined on the schedule required by the Imprisonment Act, which is "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 forms they send to the outpatient clinic, or that getting a physician's or dentist's appointment is difficult. On these inspections, the Ombudsman has frequently drawn the outpatient clinics' attention to the fact that,



Examination room.

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 into 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.

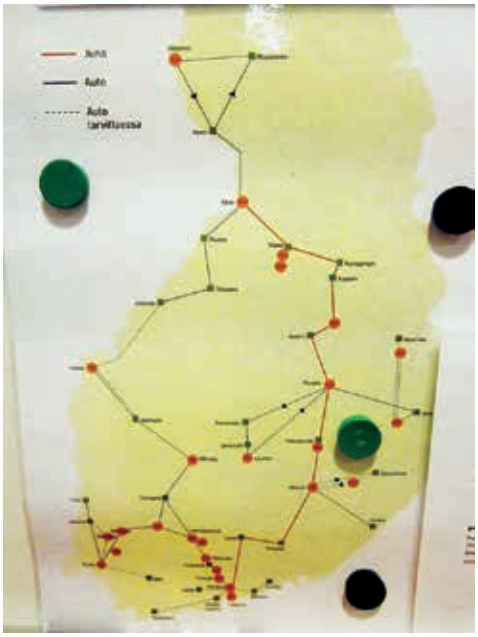
The visit to the *Psychiatric Prison Hospital Turku* (2570/2019) was the first visit made by the Ombudsman and the NPM to the unit since VTH was moved from the remit of the Criminal Sanctions Agency on 1 January 2016. Separating the delivery of health care and guarding duties supports the autonomy of health-care providers. However, the change has not been without its problems at a unit such as the Psychiatric Prison Hospital, where patients are treated both with their own consent and against their will. What makes the situation challenging is that a prisoner receiving treatment as a patient at the unit is governed by the provisions of the Imprisonment Act and the Remand Imprisonment Act, as well as health-care legislation. Prisoner health care is still regulated by the Imprisonment Act and the Remand Imprisonment Act, although the responsibility for implementing health care for prisoners has been transferred to the Ministry of Social Affairs and

Health. It is stated in the Government proposal to Parliament for new legislation that although the VTH is administratively a separate entity and falls under a different administrative branch, as a service provided within prisons, it constitutes a part of the prison service.

It was not possible to focus adequately on all aspects within the confines of one visit to allow for the Deputy-Ombudsman to issue an opinion. For this reason, a follow-up visit to the unit was scheduled for March 2020. Owing to the coronavirus epidemic (COVID-19), the visit was postponed until further notice. The key opinions and recommendations based on the first visit are presented in the following:

The prison guards of Turku Prison serving at the Psychiatric Prison Hospital conduct an initial examination on each patient arriving at the unit. In this situation, the prisoner must remove all their clothes. While they are changing their clothes, the guard also inspects the soles of the patient's feet, their underarms, and their hair. According to the Central Administration Unit of the Criminal Sanctions Agency, the initial examination is not the arrival check, as referred to in the Imprisonment Act, but rather a security check. The Deputy-Ombudsman agreed with this statement and notes that in a security check, a prisoner may be obliged to change their clothes in the presence of the staff. However, the prisoner may not be made to undress until naked, and the body may not be searched in detail, as was now done. This constitutes a bodily search, which requires a separate assessment and decision. The Deputy-Ombudsman also stressed that the changing of clothes should always be carried out with tact and respect for the prisoner's privacy.

Prisoners arrive at the Psychiatric Prison Hospital sometimes following an exceptionally long journey. It may have been necessary during the journey to use force or coercive methods, such as handcuffing. The Deputy-Ombudsman recommended that with each arriving prisoner, possible signs of the use of force are examined, and the prisoners are actively asked about any use of force. The Deputy-Ombudsman also considered it important that the health-care providers also enter into the records on arrival how the prisoner was transported and what possible means of restraint were used, if known. It remained unclear to the NPM why the arrival check does not involve a somatic medical examination of the patient. It also remained unclear how patients suffering from delirium would be treated and where.



Prisoner transport routes marked on a map of Finland.

The seclusion rooms at the hospital were almost identical to isolation cells in prisons. They were very austere and the only "furnishing" was a thin plastic-covered mattress on the floor. One isolation room had a thick mattress. The Deputy-Ombudsman recommended that the hospital should pay more attention to the equipment and furnishings of the seclusion rooms, without compromising safety.

The seclusion room at the hospital was used for purposes other than secluding a patient under involuntary treatment. A patient arriving under an observation (M1) referral is taken directly to the

seclusion room, which serves as a holding cell (so-called "travelling cells") until the duty physician has examined the patient. The seclusion room is also used as a holding cell when the patient is discharged from the hospital and has to wait for transportation to prison. In this situation, the prisoner is placed in the holding cell to await transportation. The Deputy-Ombudsman noted that, in its present condition, the seclusion room is not suitable for use as a holding cell. Even when used for the seclusion of a patient, its condition merits attention so that the patient need not, for example, eat while seated on the floor without a table.

The Turku unit reported that when the "isolation cell" is used as a temporary holding cell, the patient is always given a thick mattress, an isolation chair/table, normal patient clothes, and the same personal items as in the normal unit.

The Deputy-Ombudsman found it problematic that the hospital seclusion room was used as a prison holding cell. This could jeopardise the international legal principle in criminal sanctions, according to which the prisoner's health-care staff should not be involved in any kind of guarding or policing tasks. It did not become clear during the NPM visit on whose authorisation and based on which section of the law a prisoner was placed in the seclusion room. It also remained unclear whose duty it was to look after a prisoner's basic needs during the placement, when the placement took place under the Imprisonment Act or the Remand Imprisonment Act.

The Ombudsman's established policy has been to take a negative view of a patient being taken directly into seclusion on arrival at a psychiatric unit under an M1 referral. Health-care providers have often defended this practice by the fact that the care staff are not familiar with the patient at this stage. However, the legal criteria for seclusion must always be met before a patient may be placed in seclusion under the Mental Health Act, and the assessment of these criteria must always be conducted on a case-by-case basis. The fact that the patient is unknown to the care staff is not, by itself, sufficient reason for seclusion. The Deputy-Ombudsman considered whether it would be possible to place the patient directly in a hospital cell from which objects that could be used for self-harm had been removed as necessary. The unit's opinion was not available for this report.

According to the Deputy-Ombudsman, an alternative during patient discharge could be to place the prisoner temporarily in the holding cell of Turku Prison. In its response, the prison did not oppose the use of the holding cell in the prison when a discharged prisoner has to wait for transportation to their designated prison. The Deputy-Ombudsman decided to issue an opinion on the use of the seclusion room after a follow-up visit.

The Deputy-Ombudsman found it a deficiency that there was no guard at the unit during the night. The guard working at the unit locked the patient rooms for the night in the early evening. The NPM was informed that if the door needs to be unlocked after this time, the nursing staff is not authorised to lock the door, and a guard from Turku Prison must be called specifically for the purpose. The prison reported that the level of supervision at the hospital could not be extended due to a cost-saving scheme. The Deputy-Ombudsman noted that the issue of prisoners' opportunity to spend time outside their room and the

absence of a guard after 6/7 p.m. were matters dependent on resourcing. The Ombudsman cannot ignore the question of resources if the statutory duties imposed on the authority have become more difficult or impossible due to a lack of resources. It would appear that the potential of the Psychiatric Prison Hospital or Turku Prison to take any remedial measures independently is extremely limited. The Deputy-Ombudsman noted this, and before being able to take any measures, they would need to form a more detailed picture of how the under-resourcing affects various official duties and operations, as well as prisoners' conditions and treatment.

Health-care legislation does not allow for routinely locking the doors of patient rooms, even for patients in involuntary care. It is the view of the Central Administration Unit that the Turku unit should have a daily programme, as provided for in the Imprisonment Act, indicating the time period when, for example, the rooms of prisoners are kept locked. The Deputy-Ombudsman recommended confirming the daily programme, and noted that this was the duty of the director of the prison.

It was noted during the visit that the intervals between meals for the prisoners was exceptionally long. The interval between meals on weekdays was 17 hours and at weekends up to 18 hours. The weekly programme included no mention of an evening snack. It seemed that the hospital catering provisions had been arranged in line with the catering services at Turku Prison, even to the extent that only one hot meal was offered to patients at weekends. The Deputy-Ombudsman questioned the rationale of organising the catering around the mealtimes observed in the prison. The Ombudsman has not noticed during visits to any other psychiatric hospitals that the provision of main meals would be reduced at weekends. It is stated in the Criminal Sanctions Agency order that food is provided more infrequently on non-working days, which is a principle ill-suited for the prisoner psychiatric hospital.

According to the report by the Turku Unit, the Criminal Sanctions Agency and Leijona Catering Oy have a partnership agreement on the organisation of catering services, which the Psychiatric Hospital has joined. The Criminal Sanctions Agency has negotiated the content of the catering services agreement. The VTH did not participate in the negotiations. Therefore, the unit was not able to explain the grounds for the reduced meals and prolonged meal intervals at weekends.

The Deputy-Ombudsman recommended that the hospital ensure that patients under imprisonment receive appropriate, clear, and sufficient information about their situation, rights, and obligations, as well as the treatment and examinations provided to them. Information for patients should be available in at least Finnish and Swedish.

Under the Mental Health Act, a hospital that provides psychiatric care should have written and adequately detailed instructions on how restrictions of the patient's right to self-determination are implemented. The Turku Unit had guidance in place at the time of the NPM visit that only covered the seclusion and restraint of a prisoner but did not discuss any other restrictive measures. The lack of appropriate guidance was already commented on once, during the 2016 visit made by Valvira and AVI Northern Finland. The Deputy-Ombudsman considered it inappropriate that, even after recommendations provided by a supervisory authority, the hospital had failed to produce guidance on the use of measures restricting a person's right to self-determination. The Deputy-Ombudsman urged the hospital to immediately

produce guidance that covered all restrictions referred to in Chapter 4a of the Mental Health Act. The Deputy-Ombudsman also requested the unit to ensure that the staff are familiar with the guidance and implement it in practice.

The Psychiatric Prison Hospital's instruction dated 12 February 2020 on restricting a patient's right to self-determination during involuntary psychiatric treatment was submitted by the Turku unit.

The Deputy-Ombudsman welcomed the hospital's guidance on the reduction of the use of coercive measures. The Deputy-Ombudsman recommended that the hospital monitor the use of all restrictive measures, not only seclusion and restraint. The Deputy-Ombudsman also recommended the assessment of whether a separate coercion reduction programme or a more detailed code of conduct for staff, in addition to the existing guidance, was needed.

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. According to the Deputy-Ombudsman, the hospital should provide the staff with clear guidance on how to report mistreatment.

Monitoring the health of a prisoner placed in segregation

The Ombudsman gave a decision on 18 November 2019 in an investigation on his own initiative concerning the monitoring of the health and health care of a prisoner placed in segregation at their own request. It had been brought to the attention of the Ombudsman during a visit to a prison that a prisoner had remained in segregation for more than two years. The placement was based on the prisoner's own request to be accommodated separately from other prisoners. The prisoner declined to discuss his situation with the NPM.

An investigation revealed that the prisoner health-care services had almost completely neglected to monitor the impact of long-term segregation on the prisoner. A nurse had met with the prisoner on the day when he had been placed under observation in a cell with camera surveillance. The prisoner had made it known that he did not require health-care services. The health-care service providers did not see the prisoner at the point when he was moved from isolation (under observation for safety purposes) to segregation. The health-care providers left the prisoner "in peace", and the prisoner met with the nursing staff approximately once a year. The most recent of these meetings took place on the initiative of the health-care services. The physician met the prisoner only once over a three-year period and not until the prisoner had been in the prison in question for 1 year 7 months, of which 1 year 3 months was in segregation.

The Ombudsman understood the views presented in the report that the privacy of a person deprived of their liberty must also be respected. This must not, however, lead to a situation in which the regular monitoring of a prisoner's health and assessment of the impact of segregation on the prisoner is neglected. While there was a need to use discretion in the allocation of the limited resources, the Ombudsman saw no acceptable justification for seeing a prisoner in segregation for a health check only once a year. The Ombudsman considered it necessary for the health-care services for prisoners to prepare guidelines for medical and nursing staff on how to arrange monitoring of the health of prisoners in segregation.