



PARLIAMENTARY OMBUDSMAN OF FINLAND

SUMMARY
OF THE ANNUAL REPORT
2020

National Preventive Mechanism
against Torture

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3.5

National Preventive Mechanism against Torture

3.5.1

THE OMBUDSMAN'S TASK AS A NATIONAL PREVENTIVE MECHANISM

On 7 November 2014, the Parliamentary Ombudsman was designated as the Finnish National Preventive Mechanism (NPM) under the Optional Protocol of the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). The Human Rights Centre (HRC) 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 inspection 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 inspection visits. The NPM has the power to make recommendations to the authorities with the aim of improving the treatment and the conditions of the persons deprived of their liberty and preventing actions that are prohibited under the Convention against Torture. It must also have the power to submit proposals and observations concerning existing or draft legislation.

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

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

In the case of the Parliamentary Ombudsman's Office, however, it has been deemed more appropriate to integrate its operations as a supervisory body with those of the Office as a whole. Several administrative branches have facilities that fall within the scope of the OPCAT. However, there are differences between the places, the applicable legislation and the groups of people who have been deprived of their liberty. Therefore, the expertise needed on visits to different facilities also varies. As any separate unit within the Office of the Ombudsman would in any case be very small, it would not be practical to assemble all the necessary expertise in such a unit. The number of inspection visits would also remain significantly 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.

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 has assigned one legal adviser exclusively to the role of coordinator. 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 Senior Legal Adviser *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 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 inspection visits and related matters in social media.

3.5.4 TRAINING

In 2020, members of the Office of the Parliamentary Ombudsman participated in the following courses as part of their duties under the NPM:

- The rights of persons with disabilities – The training focused on two topics: challenging behaviour and the right to self-determination of persons with intellectual disabilities, as well as ageing and intellectual disability. The instructor was a Psychologist specialised in Neuropsychology, Oili Sauna-aho, PhD, PsycLic.
- CPT's activities during the coronavirus pandemic (the Office's own training)
- Restrictive measures in health care, care of older people and in the life of persons with disabilities (the Office's own training)
- The EU Project "Improving judicial cooperation across the EU through harmonised detention standards – The role of National Preventive Mechanisms, organised by Associazione Antigone, Bulgarian Helsinki Committee, Hungarian Helsinki Committee and the Ludwig Boltzmann Institute of Fundamental and Human Rights.

In addition to the above, a separate induction into the NPM's mandate and duties is always organised to new employees.

3.5.5 NORDIC AND INTERNATIONAL COOPERATION

The Nordic NPMs have met regularly, twice a year. Themes topical at the time have been discussed in each meeting. In January 2020, the Norwegian NPM organised a meeting in Oslo. The theme of the meeting was the rights of children and restrictive measures affecting children. Because of the COVID-19 pandemic, the subsequent meetings were organised using a remote connection. In August 2020, the theme was the NPMs' experiences of monitoring visits during the pandemic. The participants considered it necessary to convene once more towards the end of the year to enable follow-up of what kind of new forms of monitoring had been developed by the NPMs. The subsequent remote meeting was organised in November 2020.

The NPM's report on the year 2019 was submitted for information to the UN Subcommittee on Prevention of Torture (SPT).

On 31 March 2020, the Ministry for Foreign Affairs sent the advice of the SPT for the duration of the coronavirus pandemic to the Parliamentary Ombudsman. The advice was issued to the parties to the OPCAT and to the NPMs, and they applied to all institutions and facilities where persons are deprived of their liberty as well as to quarantine facilities.

The SPT sent a letter dated on 9 April 2020 to the NPMs requesting them to report the measures they had taken concerning the exercise of their mandate during the COVID-19 pandemic and how the advice approved by the SPT had been taken into account. The Finnish NPM replied to the SPT with a letter dated on 30 April 2020 (2407/2020). In the letter, it explained, among other things, that a letter template had been prepared for the NPM requesting information from places of deprivation of liberty on the impact that the COVID-19 pandemic has had on the operation of the facility and the rights and treatment of those deprived of their liberty. The cover sheet of this letter contained information on the SPT guidance for NPMs and the CPT principles published on 20 March 2020 for the treatment of persons deprived

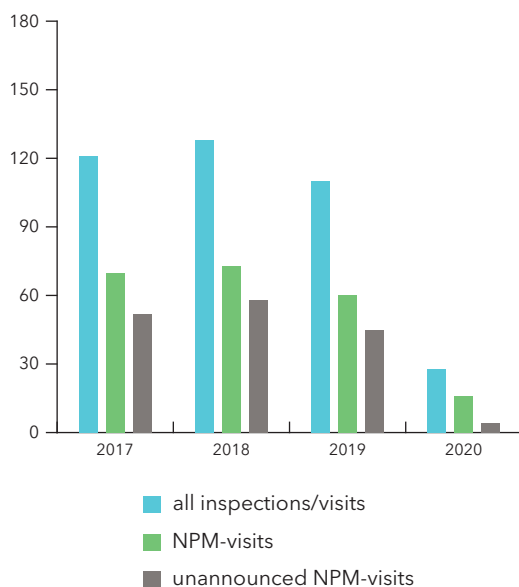
of their liberties during the COVID-19 pandemic (CPT/Inf/2020/13). The other measures mentioned in the letter have been described in different sections below.

On request, the NPM submitted two summaries related to the special themes of the European NPM Newsletter to be published in the newsletter. One of them dealt with the supervision of elderly prisoners and the newsletter related to it was published in November 2020 (European NPM Newsletter new series issue no. 8). The other theme dealt with the supervision of nursing units for older people and the newsletter was published in February 2021 (1/2021).

3.5.6 VISITS

On 16 March 2020, a state of emergency was declared in Finland over coronavirus outbreak. The Parliamentary Ombudsman was of the view that it was not possible to ensure the safety of the detainees or the staff in places of deprivation of liberty or for the NPM to such degree that visits to these units during the COVID-19 pandemic would be free of risk. Therefore, all site visits by the NPM were suspended. Before the suspension, only a few visits had been made at the beginning of the year. As Finland did not have separate quarantine facilities, there was no need to visit any. Instead, the need for supervision in elderly care increased during the pandemic. However, the measures taken differed from usual. The methods and the remote visits made to units for elderly people and persons with disabilities are explained in Section 4 (Issues related to coronavirus). In other administrative branches, NPMs visiting mandate primarily took place by collecting information and requesting information from the units concerned. These are explained in the sections discussing the administrative branches.

Now that fewer visits are being made, there is an opportunity to look back and reflect on the effectiveness of the NPM's duties during the period 2015–2020, i.e. when the Parliamentary Ombudsman has acted as the NPM. In the following sections, themes that the NPM has to draw



Visits in 2017–2020.

attention to year after year are presented from each administrative branch, as well as more uncommon themes that play an important role in the treatment of persons deprived of their liberty. Measures taken at the institutions visited or at the national level after the NPM's visits and the Ombudsman's recommendations are also brought up.

3.5.7 POLICE DETENTION FACILITIES

Two remote visits were made in 2020, to the Lapland Police Department (2957/2020) and to the Ostrobothnia Police Department (4602/2020). The documents were ordered from the police departments in advance and the actual visit was carried out using a secure remote connection from the facilities of the National Police Board. Issues concerning persons deprived of their liberty were discussed during both visits – especially how cases of deprivation of liberty were recorded and how

the COVID-19 pandemic had been taken into account in the operation of the police department, including police prisons. The visit to the Ostrobothnia Police Department revealed that mass exposure had put 60–70 police officers in quarantine and the Seinäjoki police prison had had to be closed temporarily as a result.

In addition, an on-site visit was made to the Helsinki Police Department to see the Pasila police prison renovation plans (1706/2020). The renovation is due to be completed during 2021, after which the police department will give up the Töölö custodial facilities and the detention of all persons deprived of their liberty will be centralised to Pasila.

Police prisons do not have health care of their own. This was one of the reasons why the information leaflet given to prisoners by the Health Care Services for Prisoners (VTH) was sent for information to the National Police Board and it was proposed that similar information should also be given to persons deprived of their liberty who are in police custody. The CPT's (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment) principles for the treatment of persons deprived of their liberty during the coronavirus pandemic were also submitted to the National Police Board. Later, the National Police Board submitted to the Ombudsman a circular (guidance) addressed to the police departments and discussing matters such as the prevention of a dangerous communicable disease in police prisons. An information leaflet on the COVID-19 pandemic, intended for persons deprived of their liberty, had been attached to the guidelines. The information in it was based on the instructions drawn up by VTH. The CPT's principles had also been attached to the guidelines.

The long awaited comprehensive reform of the Act on the Treatment of Persons in Police Custody (the Police Custody Act) is due to be brought to the Parliament for discussion in 2021.

The Administration Committee of the Parliament issued a statement on the Parliamentary Ombudsman's 2019 annual report to the Constitutional Law Committee (HaVL 1/2021 vp). The Committee considered it positive that the supervision of the police by the overseers of legality has contributed to the development of police activities and measures have regularly been taken in police administration to rectify the shortcomings observed by the Ombudsman when resolving complaints. This is also likely to apply to the Ombudsman's and the NPM's visiting mandate to police detention facilities. The following section describes how the observations made by the NPM during visits to police detention facilities and the subsequent recommendations issued by the Ombudsman have influenced the operation of police prisons between 2015 and 2020.

PREVENTION OF DEATHS IN POLICE CUSTODY

The Ombudsman has on his own initiative carried out investigations into deaths in police custody. In the decision of 2019, he called upon the National Police Board and other bodies to improve the prevention and monitoring of deaths in police custody (4103/2016). In their reports, the authorities informed the Ombudsman of the measures they have taken to remedy the matter:

- The National Police Board announced that it is updating its guidelines on deaths in police custody to secure the availability of accurate data. It also reported it is investigating new technological solutions for improving safety in custody. Above all, the police intends to focus on improving its procedures in relation to custody in 2020.
- The Prosecutor General has reviewed her guidance on the prosecutor's role in investigating deaths in police custody.
- The Ministry of Justice reported that projects to reform the Criminal Investigation Act and the Coercive Measures Act will begin in 2020. The Ombudsman's positions will also be taken into consideration as part of the reforms of the Police Custody Act and the Act on Determining the Cause of Death currently under way.

DETENTION OF REMAND PRISONERS IN A POLICE PRISON

The Ombudsman has repeatedly criticised the practice of detaining remand prisoners in police facilities, which are not suited for long-term detention. During its visits to Finland, the CPT has also drawn serious attention to it. Highlighting this issue has finally produced results.

- Since 1 January 2019, the detention of remand prisoners in police detention facilities for longer than seven days has been prohibited without an exceptionally weighty reason considered by a court.
- Based on the observations made during the NPM monitoring visits, the amendment has shortened the time persons deprived of their liberty can be detained in police prisons.
- According to the Ministry of Justice, legislation governing the placement of remand prisoners in prisons is awaiting a further review. The aim is that in 2025, remand prisoners will no longer be held in police detention facilities, but in prisons. The permitted detention time in police facilities would be shortened to four days.

KEEPING CRIMINAL INVESTIGATION AND DETENTION DUTIES SEPARATE

It has been 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. 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.

- After the NPM visits, police departments have taken measures to address the Ombudsman's observations in their operation and guidelines. For example, the new prison rules for detention facilities will address keeping investigation and detention separate (1950/2019, 1954/2019, 3622/2019, 3623/2019).
- According to the information received by the Ombudsman, keeping criminal investigation and detention separate will be one of the objectives of reforming the Police Custody Act.

LEGAL PROTECTION OF PERSONS DEPRIVED OF THEIR LIBERTY

Regrettably often, visits have revealed that persons deprived of their liberty are not informed of their rights. Furthermore, the Ombudsman has often had to draw the attention of the police departments to the fact that police prison staff must be familiar with the decision-making and appeals procedures required by law. An official is obliged to know the situations in which a written decision must be made. Police prisons also did not have any written information about the authorities overseeing the operation of police prisons to give to the detained persons.

In 2017, the National Police Board sent a circular on matters to be taken into account in police detention facilities to all police departments. The circular contained 17 rectification requests that were mainly based on observations made by the Ombudsman and the legality oversight unit of the National Police Board. On the visits made by the NPM in 2018, systematic shortcomings were observed in how the matters required in the National Police Board's circular had been implemented by different police prisons. The police departments were requested to report to the Ombudsman how they had implemented the matters stated in the circular after the visit. As a rule, they



Clean bedclothes and a laminated information sheet on the rights of prisoners have been distributed to the cell of a person deprived of liberty.

reported measures taken by the police prisons to improve the legal protection of persons deprived of their liberty.

During visits made in 2019, it was still observed that all of the matters required in the National Police Board's circular had not been fully implemented. One of the requirements was that persons deprived of their liberty should be informed of the conditions at the detention facilities as soon as possible on arrival. This is done by handing detainee a form explaining their rights and obligations and the police prison's house rules. Fulfilling this obligation must be recorded in the data system. However, shortcomings in communicating this information were found in six of the nine visited police prisons. The police departments were requested to report the measures they had taken with regard to the Ombudsman's statements on self-monitoring and shortcomings related to providing information.

For example, the Ombudsman was informed that the police department will provide guidance to the custodial staff so that they will inform everyone of the essential basic details of the conditions and activities at the facility on arrival. In future, written instructions will be made available on arrival at the detention facility (3621/2019).

The police departments also reported how they were going to implement the self-monitoring. For example, managers and separate legal units review detention forms on a regular basis and notify the staff of any deficiencies in the information (1950/2019, 1954/2019).

CELLS AND THEIR EQUIPMENT AND FURNISHING

The Ombudsman has emphasised that the conditions in police detention facilities must be organised in a way that meets the requirements of the Police Custody Act and the rights guaranteed to persons deprived of their liberty. The Act or any other legislation does not expressly lay down provisions on providing better conditions to persons suspected of having committed a criminal offence than to those detained because of intoxication. In reality, the detention facilities for those detained because of intoxication are, as a rule, much more austere than the cells for those suspected of a crime. Cells for intoxicated persons usually have no furniture and only a mattress on the floor, while those detained because of a suspected crime usually have a mattress and the bedclothes on a bed (made of concrete) and a tabletop. The cells for intoxicated persons have camera surveillance while persons suspected of a crime are, as a rule, accommodated in cells without camera surveillance.



A typical cell for an intoxicated person and a modern cell for a person suspected of a crime.



The prohibition to use the cell because of a non-functioning alarm button has been placed on the notice board of the detention facilities.



In some police prisons, persons deprived of their liberty can wash their clothes.

Over the years, the Ombudsman has identified a wide variety of deficiencies in the cells of police detention facilities. Some of them, such as the lack of natural light, the police department has little influence on, while others have been such that the Ombudsman has urged the police department to avoid using the cell until the deficiency has been rectified. These deficiencies have included a non-functioning call button or audio connection or no call button at all. Better conditions have also been required for detaining remand prisoners in a police prison.

After the NPM visit, the police prison acquired a washing machine and a tumble drier to enable persons deprived of their liberty to wash and dry their clothes. On arrival, the person deprived of their liberty is given instructions drawn up by the National Police Board explaining matters such as the right of the persons detained to wash their clothes in the detention facility. A translation of the instructions is available in 17 languages (849/2018).

On its future visits, the NPM is likely to pay more attention to ensuring that the conditions of persons deprived of their liberty meet the requirements set for living quarters better. This is indicated by the Ombudsman's recent decision of 2 September 2020 (5680/2018), which was based on a visit to police detention facilities (4392/2018). Among other things, the Ombudsman stated in his decision that when a meal must according to provisions be served to the person deprived of their liberty, the conditions in the cell must be such that the person does not have to sit on the floor or stand when having the meal. According to the Ombudsman's view, this did not apply only to the detention facility examined.

The Ombudsman considered it justified that the National Police Board investigate what kind of solutions other authorities have implemented in isolation facilities and, if necessary, acquire furniture centrally, or at least guide police departments in the procurement. The Ombudsman understood that police departments have not in all respects been able to influence the situation themselves, especially once the building of the facilities has been completed. This underlines the importance of careful planning of the facilities and also sets requirements for approving them for use.

OUTDOOR EXERCISE

As a rule, the outdoor exercise yards at police prisons are small. Some of them are very enclosed and protected. Sometimes there is no view to the outside. The Ombudsman has considered it questionable whether being in such areas can be called outdoor exercise at all. The CPT has also during its visit to Finland in 2020 drawn attention to this and stated as its observation that none of the police detention facilities visited by it offered suitable conditions for longer period of detention. The main reason for this was the absence of genuine outdoor exercise facilities.

Attention should also be paid to ensuring that the solutions made during renovation are acceptable. Even if the solution were a temporary one, the minimum legal requirements must be fulfilled. Renovations are also not considered unexpected exceptional circumstances that would justify limiting the right of persons deprived of their liberty to outdoor exercise.

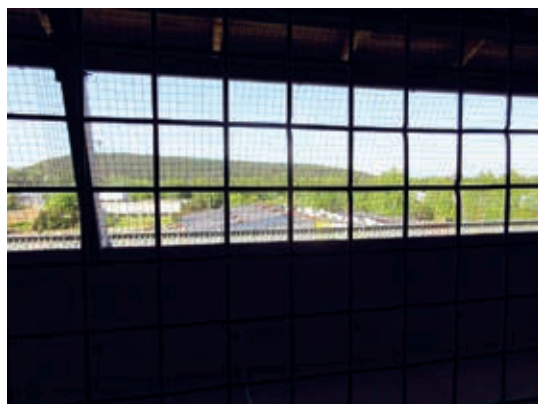
It can be concluded from the police departments' reports to the Ombudsman that even though reasonably extensive renovation is carried out on police prisons, the possibilities to change the basic solutions in existing buildings are fairly limited. It is not possible for police departments to have much say about the size or structures of

outdoor exercise facilities. However, they have reacted to the Ombudsman's recommendations to improve the level of cleanliness in police prisons and the level of cleanliness has been improved.

CATERING

On visits to police prisons, attention has also been paid to catering and the intervals between meals, which have sometimes been long. The Ombudsman has stated that special attention should be paid to the diet and the meal rhythm in detention facilities, particularly if the health of the person deprived of their liberty requires it, such as persons with diabetes). The Ombudsman asked the Ministry of the Interior to assess whether the prevailing practice and the current provisions secure healthy, diverse and sufficient nutrition to persons deprived of their liberty in all situations (59/2018).

The visits have also raised the question how the catering in police prisons should be assessed from the point of view of food legislation. The Deputy-Ombudsman decided to investigate the matter on his own initiative (39/2018). He considered it appropriate that the National Police Board together with the Finnish Food Safety Authority Evira (the Finnish Food Authority from 1 January



Examples of police prison outdoor exercise areas that are not suitable for outdoor exercise.

2019) examine what requirements food legislation sets on the catering services of police prisons as a whole and when the different local arrangements are taken into account. The Deputy-Ombudsman also stated that the aspects emerging in the report should probably be taken into account in the reform of the Police Custody Act and the regulations and instructions based on it. The National Police Board was of the view that food safety was not fully implemented in all police prisons. It reported that it would continue to investigate the matter in cooperation with Evira.

The Deputy-Ombudsman has also proposed in his decision on a complaint that the National Police Board compensate for the harm caused to the complainants when it had seriously neglected its duty to take care of catering in police prisons, which is based on the Police Act. Four people had been detained on the basis of the Police Act and the deprivation of their liberty had lasted 19 hours. No food was offered to them during this time. The National Police Board reported that it had agreed with the complainants on compensating for the harm and paid them a monetary compensation.

HEALTH CARE IN POLICE DETENTION FACILITIES

Health care arrangements have room for improvement in all police prisons. Most police prisons are not visited by health-care staff on a regular basis. Instead, police departments have made various arrangements with public health care operator or private health care provider to safeguard the health care of persons deprived of their liberty.

When persons deprived of their liberty arrive at the facility, they are not medically screened and their health is not checked during the deprivation of liberty unless they request it. At least since 2016, the Ombudsman has recommended that all detainees are medically screened within 24 hours of their arrival at a police prison.

The CPT has also in the preliminary comments on its visit in autumn 2020 considered the absence of health-care staff problematic with

respect to remand prisoners, who were still not systematically and routinely medically screened upon arrival. This has not been observed even in the few establishments where health-care professionals deliver care on a regular basis. Neither did the National Police Board in the circular mentioned above provide guidance to organise medical screening. However, the situation will improve in at least one police department. After the NPM visit, the police department notified that it had begun discussions on the possibility of the city's sobering-up station operating adjacent to the central police station to provide everyone detained for more than 24 hours with the opportunity to meet a health-care professional (1201/2019).

On visits made to police prisons, it has also been observed that persons deprived of their liberty have not been informed of their right to receive health care at their own expense with permission from a doctor arranged by the police. This is because the police custodial staff has not been aware of this provision in the Police Custody Act. The NPM has highlighted this during its monitoring visits and the National Police Board has also provided guidance on it in the above-mentioned circular to police departments. Police departments have informed the Ombudsman after the NPM visits that they will supplement their guidelines in this respect (1382/2017, 2487/2018) or that the matter will be brought up in training organised to the staff (2982/2019).

The custodial staff has been given very little training on distributing medicines, even though they have to do it constantly. The Ombudsman has found this very problematic from the point of view of legal protection of both the persons deprived of their liberty and the employees. The National Police Board has finally begun to rectify the situation. The objective has been to have all police custodial officers complete the training by June 2019.

After the NPM visits, police departments have realised that they are responsible for ensuring that their employees have sufficient competence for the duties assigned to them. As revealed by

reports submitted to the Ombudsman, police prisons have begun to cooperate with different parties in the implementation of medication:

- The police department submitted its medical treatment plan, the first known plan to have been drawn up for medication provided in police prisons, to the Ombudsman (1488/2018).
- The police department reported that because the medicine distribution training organised by the National Police Board was delayed, the police department had begun to prepare medicine distribution by health-care professionals in the police prisons in its own area (2485/2018).
- According to the police department, paramedics are visiting the police prison every day to distribute the medicines. As a result, the persons detained have the opportunity to meet health-care professionals (2490/2018).
- The police department cooperated with the emergency services of the joint municipal authority in the implementation of medication of persons deprived of their liberty by having the medicines distributed to pill dispensers by a paramedic. In addition, a registered nurse whose duties included the distribution of mental health medication in the police prison was about to start working in the joint municipal authority (3332/2018).
- The police department reported that the city's sobering-up station operating next to the detaining facility for intoxicated persons at the central police station took care of the health care of detainees. Consent for allowing the sobering-up station to access the patient records was requested from persons deprived of their liberty. All medicines that were distributed came through the sobering-up station. The medicines were distributed to the detainees by a police custodial officer, who had completed the medicine distribution training organised by the National Police Board (2982/2019).

Wide variation in recording the distributed medicines has also been discovered at police prisons. Guidance on this was provided in the above-mentioned circular sent to the police departments by

the National Police board in 2017. Health-care professionals working at the police prison have not had access to an electronic patient information system organised by the police department, but may have recorded the entries manually on paper. An exception to this may be the arrangement in which it has been agreed that health care at the police prison is the responsibility of the staff of the sobering-up station. In this case, the staff of the sobering-up station has recorded the entries related to the medication of persons deprived of their liberty in the station's patient information system (2982/2019). Progress has finally been made in this matter, as the first police department reported to the Ombudsman that it had acquired an electronic health-care information system for the health-care personnel of the police prison. The system is likely to be introduced in 2021 (1488/2018).

During its visits, the NPM has also brought up the fact that people working at a police prison do not have the right to access the health information of a person deprived of their liberty without the person's express written consent. The National Police Board has instructed the police departments in this regard that the detainee should be asked for written consent to processing their health information. Attached to the instructions was a model of the form to be signed by detainees to consent to processing of their health information. On its visits, the NPM has examined how well this has been implemented in police prisons. A form was found in some establishments, but it was not used. Only after the NPM visit have the police departments taken measures to rectify the situation and reminded the police detention staff of the need to use the consent form (2487/2018, 2489/2018, 3332/2018).

THE ROLE OF SENATE PROPERTIES AS THE LESSOR OF DETENTION FACILITIES

Senate Properties serves as the lessor of government agency facilities. This also applies to police detention facilities, prisons, state residential schools and state forensic psychiatry clinics. 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. An example of this is the case investigated by the Ombudsman on his own initiative (5680/2018). According to the statement the operating in temporary facilities was challenging and caused by factors that the Central Finland Police Department could not influence through its own actions. The National Police Board had repeatedly demanded that Senate Properties carry out repair measures in the so-called module prisons. It was not possible for the National Police Board to carry out repair measures itself.

The Deputy-Ombudsman decided to investigate on his own initiative the legal status and possible responsibilities of Senate Properties with regard to the management and maintenance of the detention facilities of persons deprived of their liberties and other facilities used by the central government (6870/2019). In his decision, the Deputy-Ombudsman stated, among other things, that from the point of view of oversight of legality, the central government's internal agreements are likely to obscure the liability of the parties that effectively control decision-making on whether the requirements prescribed for the facilities in legislation will be fulfilled.

For example, the treatment of arrested persons and the appropriateness of the detention facilities of persons deprived of their liberty is ultimately always the responsibility of the state. The internal arrangements made by the state do not affect its liability. The legal issues related to the operation of Senate Properties are now subject to a reporting procedure imposed by the Parliament. The Deputy-Ombudsman therefore refrained from taking further measures.



Containers have been used to form the cells in the temporary module prison at the police station.

OVERSIGHT OF OVERSIGHT

To maximise the impact of visits, it is important that inspection visits to police detention facilities are made regularly, including as part of the independent legality oversight of the police. Internal oversight of legality at police departments is conducted by separate legal units. The Ombudsman has emphasised that these units should also inspect the operations of police prisons in their respective territories.

The Ombudsman makes annual inspection visits to the Ministry of the Interior Police Department and the National Police Board. The Ombudsman then has the opportunity to go through such observations made during visits to police prisons that concern all or most police prisons and require wider measures. For example, in 2015, the Deputy-Ombudsman questioned the adequacy of internal steering in the police if proven good practices are only spread by means of the Ombudsman's and NPM visits, if then. After this, the National Police Board assumed a stronger role in steering the police departments and issued the above-mentioned circular on matters that must be taken into account at police detention facilities.

Under the Police Custody Act, police detention facilities must be approved by the National Police Board. In 2019, the Ombudsman discovered that no specific approval decisions had been issued in the area of any police department. The Ombudsman placed an inquiry with the Ministry of the Interior regarding the approval process for detention facilities (4609/2018).

- In February 2019, the National Police Board issued a plan according to which an audit of the current condition and suitability of detention facilities for detaining persons deprived of their liberty was begun. 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 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 Ombudsman's and the CPT's statements on the treatment of persons in detention, which had to be taken into account when approving facilities.
- Police departments have inspected police detention facilities based on the National Police Board guidelines. These inspections have revealed 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. In addition, a representative of the National Police Board has conducted an inspection of the premises, which has identified, among other things, the need to update the rules of police prisons. The detention facilities have been approved by the National Police Board. Some conditions have been set for the approval of the premises. The decisions of approval have been forwarded to the Ombudsman.

3.5.8 DEFENCE FORCES AND BORDER GUARD AND CUSTOMS

During visits to **the detention facilities at the Defence Forces**, attention is paid to the conditions and treatment of those deprived of their liberty, informing them of their rights, and their security. No visits to these detention facilities were made in 2020. The Defence Forces have always taken a constructive view of the Parliamentary Ombudsman's statements and taken the recommended measures. The following is an example of this:

The Defence Command Legal Division prepared a document on the rights and obligations of persons deprived of their liberty and the provisions and orders concerning detention facilities and deprivation of liberty. All authorities responsible for Defence Forces detention facilities have been informed about the document, and it has been sent to them for immediate distribution to persons who have been deprived of their liberty.

On visits to **the detention facilities of the Border Guard and Customs**, special attention has been paid to verifying that the facilities used for detaining persons deprived of their liberty have been appropriately approved and house rules have been confirmed for them. No visits were made to these detention facilities in 2020.

3.5.9 THE CRIMINAL SANCTIONS FIELD

No site visits were made to prisons in 2020 because of the COVID-19 pandemic. Instead, the monitoring was carried out in other ways. These activities and the impact of the COVID-19 pandemic on the entire criminal sanctions field are described in section 4 (Issues related to coronavirus).

Before site visits were suspended, the Deputy-Ombudsman conducted visits to the Central Administration Unit of the Criminal Sanctions Agency (1039/2020) and the Department for

Criminal Policy and Criminal Law at the Ministry of Justice (1040/2020).

Contacts with prisoners revealed that they had not received enough information about COVID-19. The Office of the Parliamentary Ombudsman contacted the Health Care Services for Prisoners (VTH), which purpose is to provide all prisoners in Finland with health care services. VTH was requested to provide information on how prisons and prisoners had been instructed because of COVID-19. It was discovered that VTH had cooperated with the Central Administration Unit of the Criminal Sanctions Agency and the prisons. However, no information on COVID-19 had been distributed to prisoners. After the Ombudsman's enquiry, VTH prepared an information sheet for prisoners in several languages.

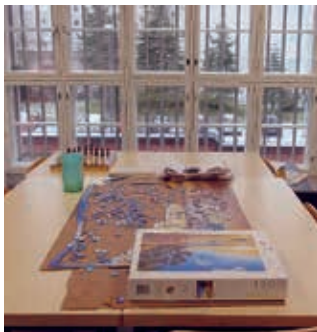
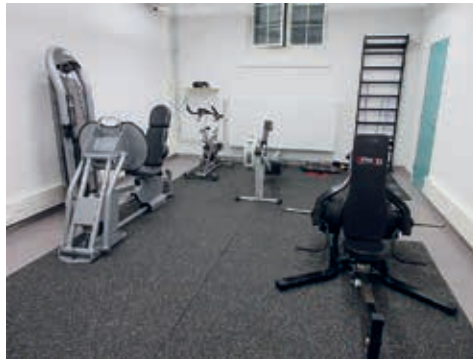
The Legal Affairs Committee of the Parliament submitted a statement on the Parliamentary Ombudsman's 2019 Annual Report to the Constitutional Law Committee (LaVL 1/2021 vp). In the statement, it brought up the Ombudsman's observations of problems related to the placement of organised criminal groups in some prisons. In this context, the Committee referred to the statement it issued on the 2021 budget proposal, in which it expressed its concern over the tight financial situation of the Criminal Sanctions Agency and its impact on matters such as the security of prisons. In the Committee's view, the Agency's scarce staff resources also have a negative effect on the time prisoners can spend outside their cells and the activities available to them. On the other hand, the Committee considered it positive that cells without toilets were no longer used.

The following are some of the themes that have been highlighted on the NPM's visits in the criminal sanctions field between 2015 and 2020. This time, the perspective is what kind of impacts the observations and recommendations made on the visits have had on the operation of the prisons, the rights and conditions of the prisoners, and legislation.

TIME OUTSIDE THE CELL AND CONSTRUCTIVE ACTIVITIES

The Parliamentary Ombudsman's decisions and international recommendations are based on the premise that prisoners should be permitted to spend a reasonable amount of time outside their cells, at least eight hours each day. During that time, they should be able to engage in rewarding and stimulating activities, such as work, rehabilitation, training, and exercise. The prisons have been informed of the fact that it is neither acceptable nor legal to keep prisoners inactive in their cells. This problem often stems from lack of resources in prisons, rather than ignorance of the provisions or unwillingness to organise activities for the prisoners. Sometimes better planning and work organisation can also make a difference. This is reflected in the measures reported after the NPM visits:

- A number of measures were taken by the prison to increase activities and the time outside the cell. New daily schedules were introduced and their implementation was monitored (2603/2015). During a further visit a year later, the prison director said that the prisoners had more time outside the cell than in any other closed prison (1653/2016).
- Follow-up monitoring of the measures recommended by the Deputy-Ombudsman (4397/2016) was also conducted by the Central Administration Unit of the Criminal Sanctions Agency. The report on the follow-up visit submitted by the Central Administration Unit revealed that the prison had taken a number of measures. On normal accommodation wards, the time outside cells had increased to the minimum of eight hours and on some wards even more. Especially a significant increase in the time the cells were kept open and its impact on the prisoners were observed very clearly during the visit and in the hearings of prisoners. As a result of these changes, the nature of the entire institution appeared to have changed from highly closed to more open (3005/2017).



- The prison had increased the activities and the time outside the cell. According to the report submitted by the prison, the prison had launched shift planning for the guarding staff with the aim of obtaining additional resources for evening activities. The idea was that, during evening activities, a ward that did not participate in the activities at a particular time would be open and the prisoners would be able to carry out their chores better in the evening (e.g., cooking, phone calls and cleaning). As a result, the time outside the cell would also increase. The reorganisation of rehabilitative work had also progressed (4653/2018).
- A dedicated special instructor had been allocated for two wards to organise activities to the prisoners, in particular. The measure was aimed at increasing the time outside the cell. Within the limits of prison officer resources, efforts were made to enable prisoners to have their cells open on the ward, allowing them to carry out chores such as cleaning and cooking. The prison also reported that it intended to continue increasing the activities by finding cooperation partners among different third-sector operators with whom the activities could be further increased and extended (5563/2018).

otherwise have been risked and the other prisoners would have had less time outside their cells. Although on the isolation ward, the remand prisoners had the opportunity to take outdoor exercise and use the gym, as well as a limited opportunity to cook (1185/2016).

- After the NPM visit, the prison set up two wards for remand prisoners. In spite of this, some remand prisoners had to be placed separately from others to enforce the communications restrictions. Efforts have been made to shorten the time remand prisoners are placed in segregation and segregation will be discontinued as soon as the prisoner's communications restrictions are decreased (3628/2016).



PLACEMENT OF REMAND PRISONERS

Placing remand prisoners separately from other prisoners is a clear premise in national legislation and international recommendations. It is based on the presumption of innocence. The Ombudsman has considered that the matter cannot be solved merely by changing the placement of individual prisoners on different wards. The solution requires a more extensive change in the prison's operating practice in accommodating prisoners and organising activities.

- In the case of four remand prisoners, the communications restrictions imposed by the court were so strict that the only option left to the prison was to place them on an isolation ward separately from the other prisoners. According to the prison, the pre-trial investigation would

- The prison changed five of its wards, reserving them only for remand prisoners. In future, remand prisoners and prisoners serving sentences will, as a rule, be placed on wards of their own. An exception to this is made when the remand prisoner requests the opportunity to participate in an activity in which the participants are mainly prisoners serving sentences and the remand prisoner consents to being accommodated on the same ward with them (4397/2016).
- According to the prison, there was great variation in the number of remand prisoners. Because of limited space, it was not possible to reserve a specific ward only for remand prisoners (4653/2018).

According to the information received in connection with the visit made to the Ministry of Justice in March 2020 (1040/2020), a project to move remand prisoners from police detention facilities had been launched in January 2020. This means that by 2025, except for very exceptional situations, remand prisoners will be placed in a prison immediately after the decision on their detention.

FEMALE REMAND PRISONERS

The Deputy-Ombudsman has observed problems in the conditions of female remand prisoners in all of those prisons visited by the NPM in which female remand prisoners are placed (4988/2015, 3628/2016, 2705/2017, 6206/2017, 4653/2018, 2449/2019). Among other things, the Deputy-Ombudsman was of the view that Vaasa prison (2705/2017) and Vantaa prison (6206/2017) were not suitable for accommodating female remand prisoners. The Deputy-Ombudsman also did not consider it acceptable that female prisoners serving sentences and remand prisoners had been placed on the same ward in all of the prisons visited.

- The Ministry of Justice reported that the Decree on Prisons Serving as Remand Prisons was amended on 1 July 2017 by discontinuing the use of Kuopio prison as a remand prison for women because of the observations made by the Deputy-Ombudsman after the NPM visit (4988/2015).
- The Regional Centre of the Criminal Sanctions Region of Western Finland reported that the number of places for females in Vaasa prison was changed from three to two. In addition, no female prisoners will in future be placed there, nor will decisions be made to transfer female remand prisoners to Vaasa prison. The Regional Centre had also made an initiative on discontinuing the use of Vaasa prison as a remand prison for women (2705/2017).
- The Central Administration Unit of the Criminal Sanctions Agency stated that placing persons in facilities such as those in Vaasa prison was unsustainable and female remand prisoners were not in an equal position compared to

male remand prisoners. However, the matter had to be assessed from the national point of view, and not only from the perspective of only one prison. As a measure, the Central Administration Unit proposed specifying the definition of prison places so that remand prisoner places and female remand prisoner places could be added to the definition in the future (2705/2017).

- The Ministry of Justice did not consider it justified to amend the Decree on Prisons Serving as Remand Prisons. The Ministry stated that places for female remand prisoners will have to be centralised to some extent to bring the conditions to an appropriate level. The Ministry specified definition of prison places proposed by the Central Administration Unit could be considered a more justified way to influence the situation. The Ministry considered the Ombudsman's views, which demanded immediate measures to rectify the presented procedure violating law and humane treatment, very serious (2705/2017).

In spring 2018, the Deputy-Ombudsman decided to investigate on his own initiative the conditions and treatment of female remand prisoners. The Deputy-Ombudsman found the situation problematic on the basis of the NPM's observations during the visits and even after he had received reports from the Criminal Sanctions Agency and the Ministry of Justice on the observations made during visits to Vaasa and Vantaa prisons. The matter also had to be investigated because there seemed to be conflicting ideas and needs regarding the placement of female remand prisoners.

In reports submitted to the Deputy-Ombudsman, the prisons have considered the situation with prison places for women nationally very difficult. The use of the prison building of Hämeenlinna prison had to be suddenly discontinued at the beginning of 2019 because of an indoor air problem. This further weakened the possibilities in placing female remand prisoners. In addition, the reform of the Remand Imprisonment Act, which entered into force on 1 January 2019, shortened the detention period of remand prisoners in police prisons from 4 weeks to 7 days. The pris-

ons reported that they could not guarantee that female prisoners serving sentences and remand prisoners could be placed on different wards in all situations (4653/2018, 2449/2019).

As a performance target for 2020, the Ministry of Justice announced that, before the opening of Hämeenlinna prison (which took place in November 2020), the Central Administration Unit was required to provide a report regarding the placement of female remand prisoners. The ministry wanted to know in which prisons it would be justified and necessary to place female remand prisoners so that the conditions in remand prisons for women comply with the law and their position is equal to that of men.

A report on female prisoners was launched at the Criminal Sanctions Agency and it was completed in autumn 2020. The report was commissioned to investigate how the activities and safety of female prisoners were ensured. The conditions of female remand prisoners were also mentioned in the assignment. Among other things, the report recommends that prison places for women should in future be increasingly centralised. It also proposes that, in addition to Hämeenlinna prison, there should be another closed female prison and the required number of remand prisoner wards for women. Variation in the usage rate of remand prisoner wards should be accepted. Furthermore, the report makes prison-specific proposals for improving the conditions and treatment of female prisoners. These would also benefit female remand prisoners. The report also expressed hopes that the plan to build an additional building with 19 places for female remand prisoners at Vantaa prison would be realised (Rikosseuraamuslaitoksen monisteita 4/2020).

The Deputy-Ombudsman issued a decision on his own initiative concerning female remand prisoners on 17 June 2020 (1626/2018). The Deputy-Ombudsman drew the attention of the Ministry of Justice and the Criminal Sanctions Agency to the fact that the serious problems and manifestly unlawful irregularities in the placement and treatment of female remand prisoners mainly existed and emerged before the use of Hämeenlinna prison building was discontinued. The Deputy-Ombudsman stated that the lack of resources



A cramped double cell for female prisoners.

at the Criminal Sanctions Agency had long been a problem and an obstacle to lawful treatment of remand prisoners and prisoners serving sentences. The Ministry of Justice and the Criminal Sanctions Agency have been aware of these problems for a long time. In the Deputy-Ombudsman's view, this was not so much a case of deficient legislation. The problem was that laws and recommendations could not be complied with, largely because of the lack of resources. The Deputy-Ombudsman also highlighted the fact that one part of the problem in the treatment of female remand prisoners are prisons that are not remand prisons intended for women in accordance with the Ministry of Justice's decree, but in which women may still be placed.

UNDERAGE PRISONERS

The Imprisonment Act and the Remand Imprisonment Act as well as international agreements and recommendations require that minors have their own accommodation facilities to which adult prisoners do not have access. The Ombudsman has in his decision issued in 2010 (979/2008) and in several visit reports widely justified the reason why minors must always be accommodated in separate facilities. According to the Ombudsman, it must also be ensured that minors have an op-

portunity to participate in activities and interact with other people. Furthermore, accommodation in segregation must not in any other way mean conditions similar to isolation. If there are no other minors in the prison or their number is very low, it is usually in the minor's best interests and therefore acceptable that the activities organised to the minor take place selectively together with adults. However, supervision must then be sufficient. The Criminal Sanctions Agency has issued a guideline on underage prisoners (1/004/2017). Among other things, the guideline contains instructions on placing a minor in the prison and in the activities.

With regard to the placement of minors on wards, the situation in prisons has not changed much in 10 years, in other words, since the Ombudsman issued the above-mentioned decision. Minors continue to be accommodated on the same wards with adults. In 2020, the Deputy-Ombudsman decided to investigate the segregation of underage prisoners on his own initiative (4760/2020). The case is still pending. In the Deputy-Ombudsman's view, the problem is specifically the unsuitable space solutions in prisons and probably also a lack of staff. Dedicated, suitable facilities should exist and be reserved for minors, but currently there were none. Working with minors and ensuring sufficient supervision when they are in contact with adult prisoners is also likely to require more staff than working with adults. In addition, the staff should have special expertise in working with young people. According to the Deputy-Ombudsman, Vantaa prison and Turku prison had tried to address the problem by establishing a ward for young people. However, even these wards did not meet the requirements of the regulations and recommendations because the people placed in them were mainly adult remand prisoners and prisoners serving sentences, albeit young. In his request for report and statement to the Ministry of Justice, the Deputy-Ombudsman requested answers to the following questions, among other things:

- According to the guideline issued by the Criminal Sanctions Agency, a lack of facilities does not give the right to ignore a person's minority. According to the Deputy-Ombudsman's

understanding, in practice, prisons very rarely have suitable facilities or the number of prisoners does not make it possible to reserve separate facilities for minors. How have prisons been thought to be able to comply with the guideline and independently solve the problem that suitable facilities are not available?

- Has the point of view of sufficient/enhanced supervision of underage prisoners been taken into account in the resourcing of prison staff and in shift planning?
- Has a house arrest or an enhanced travel ban been imposed to minors instead of remand imprisonment?

In addition, the Deputy-Ombudsman requested that the Ministry investigate the possibility of cooperation with the Ministry of Social Affairs and Health with regard to placing a minor to an external institution. Would child welfare legislation make it possible to place a minor sentenced to imprisonment to a child welfare institution? In the end, the Deputy-Ombudsman requested that the Ministry of Justice inform him of whether it intended to take measures and what these possible measures would be.

FOREIGN PRISONERS

The proportion of foreign prisoners has in the past few years increased and is 15–20% of all prisoners. Year after year, the same problem areas concerning foreign prisoners are repeatedly identified by the Ombudsman during his visits. It would appear that while some arrangements may have been made by prisons 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 following section presents reports that prisons have submitted to the Deputy-Ombudsman on measures taken to improve the conditions and treatment of foreign prisoners.

Keeping in contact. It is important especially for foreign prisoners to have an opportunity to stay in contact with their loved ones either by phone or through a video connection (Skype). It has sometimes been discovered on a visit that the prisoner has not been aware of the possibility to make Skype calls in prison. After the NPM visit, the prison has reported that it has informed all foreign prisoners of this possibility (4397/2016, 2705/2017, 3005/2017, 1592/2019). Sometimes the prison has not had the equipment to arrange enough Skype meetings or allow a reasonable time for each meeting:

- After the NPM visit the prison informed that it would receive two additional computers intended for prisoners. As a result, more flexibility was coming to prisoners' Skype meetings in the near future. The time allowed for video meetings had been increased from 20 to 30 minutes. The prison will have an instructor developing the use of electronic services for six months. The instructor's job description also includes developing the electronic meeting practices (4653/2018).

Availability of foreign TV channels. It was also discovered on the visits that access to media in a prisoner's preferred language varies between prisons. Foreign TV channels were not available in all prisons. In spite of the Deputy-Ombudsman's recommendations, prisons did not consider it possible to rectify the situation because it was expensive, among other things. However, when investigating the matter, the Deputy-Ombudsman also obtained different information about access to foreign TV channels and its costs in different prisons. On the visit to the detention unit in Joutseno, the Deputy-Ombudsman discovered that it was possible to access approximately 100 TV channels in approximately 20 languages in the unit and these channels appeared on standard television sets.

The Deputy-Ombudsman decided to investigate on his own initiative the opportunities of foreign prisoners to follow TV programmes (757/2019). In his decision of 16 January 2020, the Deputy-Ombudsman asked the Central Administration Unit of the Criminal Sanctions Agency to

investigate how easy it is for foreign prisoners to access international 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. The Deputy-Ombudsman asked the Central Administration Unit to report the measures taken by prisons. He also noted that he will pay attention to the access of foreign prisoners to foreign-language TV programmes on his future visits.

CONDITIONS IN ISOLATION

In his decision issued in 2018 (1276/2017), the Deputy-Ombudsman commented on the furnishings in the cells of isolation wards. He considered it problematic that all or some of the cells in the isolation wards of the visited prisons were unfurnished. Prisoners are placed into the cells in the isolation ward on different grounds. For this reason, the type of cell and conditions that each prisoner should be placed in must be considered on a case-by-case basis. The Deputy-Ombudsman also stated that prisons should acquire pieces of furniture to give to the prisoner in the cell. For example, it was not acceptable from the point of view of humane treatment that prisoners had to eat on the floor. The Deputy-Ombudsman considered it important that the Criminal Sanctions



A typical isolation cell in a prison, with only a thin mattress on the floor.

Agency provide prisons with instructions on how and in what kind of conditions placement on an isolation ward should be carried out.

- In 2019, the Criminal Sanctions Agency issued a guideline with the intention of harmonising and clarifying the practices of different prisons when placing prisoners into segregation. According to the guideline, it was to be considered on a case-by-case basis in what kind of cell and conditions the prisoner must be placed in an individual situation. The guideline also states that the prisoner must not have to eat on the floor and that, as a rule, an isolation cell should have something that can be used as a table or a chair, such as a cube made of soft material. A possibility to have furniture must be offered to prisoners unless it causes a real safety risk. In addition, the Central Administration Unit surveyed the furniture of the cells on the isolation wards of all prisons in December 2019 and investigated the need to acquire furniture for isolation cells centrally.

Under the Imprisonment Act, the cell must have an alarm device through which it is possible to contact prison staff immediately. Different versions of the alarm button location have been detected on the NPM visits. In some observation cells, the alarm button has been placed outside the cell and all prisoners cannot necessarily reach it (4653/2018). To use the alarm button of the iso-

lation cell, the person placed in the cell may have had to go down on their knees and further on their abdomen to reach it (3005/2017, 2338/2018, 2449/2019). The Deputy-Ombudsman considered this humiliating from the point of view of the person deprived of their liberty and was of the view that it may put the life of the person in danger if the person has a fit of illness. The Deputy-Ombudsman has required that the location of the button be changed.

- The prison reported that it had placed another alarm button on the wall outside the bars of isolation cells according to the building planning instructions of the Criminal Sanctions Agency. This button was easier for the prisoner to reach than the one on the floor (3005/2017). On the follow-up visit to the cells of the prison's isolation ward, it was observed that the rectifying measure recommended by the Deputy-Ombudsman had been carried out appropriately, i.e. the alarm button had been moved. It was also ensured on the visit that the button was working (2340/2018).
- The Criminal Sanctions Region of Eastern and Northern Finland reported that the old alarm buttons in the prison were no longer used and the new buttons were now at the height of the door handle. Photographs of the new locations of the buttons were attached to the report (2338/2018).



There has been a need to address the location and accessibility of the alarm button in isolation cells.

- The Criminal Sanctions Region of Western Finland reported that the location of the alarm buttons of isolation cells was being changed at the time. The buttons were being moved from the floor level to the usual level of switches, which is approximately 100 cm above the floor and makes them easy to use. The work would be completed during May 2020 (2449/2019).

RIGHT TO PRIVACY

Use of prisoner's own clothes. The Ombudsman's policy has been that, if they wish, prisoners must be able to change into civilian clothes for meetings. Especially when meeting a child, prisoners must have the opportunity to wear their own clothes. This also applies to the skirts worn by Roma prisoners (3628/2016). Prisons have changed their practices after the NPM visits.

Privacy of phone calls. The Ombudsman has consistently emphasised that the confidentiality of phone calls also applies to prisoners. The phone assigned to prisoners must be placed or protected in a way that prevents outsiders from hearing a telephone conversation conducted in normal voice. Prisons have taken measures to improve the privacy of phone calls, for example, by building separate phone booths to accommodation wards (4653/2018, 5563/2018). However, this has not always been possible, in which case efforts have been made to improve the situation in some other way:

- According to the prison, improving the privacy of phone calls proved to be more challenging than expected because of the costs. In the end, the prison decided to install an acoustic board as a ceiling to all 40 phones on its wards and change their structure so that it is possible to make a call at the telephone station only by going further inside the station. The prison believed that this will improve privacy to a reasonable level (2449/2019).

Camera surveillance. A special issue related to cells with camera surveillance is the prisoner's use of the toilet. The possibility of seeing the prisoner

use the toilet cannot be considered acceptable even in all those situations where camera surveillance of the prisoner is allowed. It is acceptable only if the prisoner has been placed to isolation under observation for the purposes of detecting prohibited substances. Even then, arrangements must be made that allow at least some privacy when the prisoner uses the toilet. Prisons have reacted to the Deputy-Ombudsman's statement by obscuring the toilet seat in the surveillance camera picture (e.g., 6206/2017) or by leaving the toilet seat outside camera surveillance (e.g., 2338/2018).

- The Criminal Sanctions Agency announced that the procedural guideline issued in 2019 also provides instructions on the privacy of a person placed under observation during toilet use. The prison must ensure that the conditions in isolation cells correspond to what is stated in the procedural guideline.

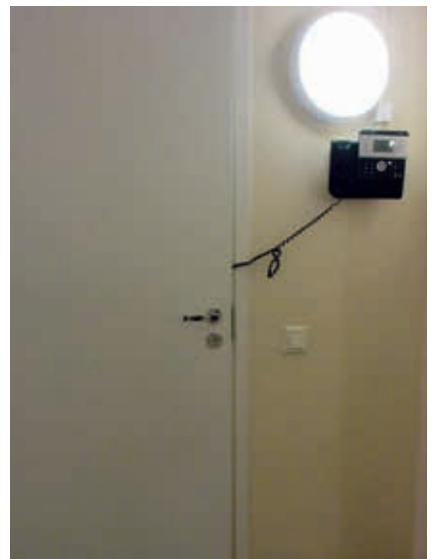
Taking a urine sample. The Deputy-Ombudsman has investigated on his own initiative how taking a urine sample is supervised in prisons. On the NPM visits, it had been discovered that there were considerable differences in the procedures between different prisons. Moreover, the instructions provided on the matter by the Criminal Sanctions Agency were not sufficiently detailed. There are no express provisions on the procedure for taking a urine sample in the Imprisonment Act. The Ombudsman has as such accepted that the right to request the sample also includes the right to supervise giving the sample. The question is how the supervision can be performed.

In his decision (6034/2016) in 2019, the Deputy-Ombudsman emphasised that taking a urine sample must be carried out as discreetly as possible. Making the prisoner undress and be naked while giving the sample is against the instructions issued by the Criminal Sanctions Agency. The Deputy-Ombudsman also drew attention to the sample collection facilities. According to observations made on visits, several prisons still collected urine samples from prisoners in facilities where the structural solutions did not sufficiently take into account discreet supervision of giving the sample.

FUNDAMENTAL AND HUMAN RIGHTS
3.5 NATIONAL PREVENTIVE MECHANISM AGAINST TORTURE



The privacy of prisoners' phone calls is not always realised. Prisons have sought different solutions to improve their privacy.



According to the Deputy-Ombudsman, the Criminal Sanctions Agency had to decide how the supervision can be done as discreetly as possible and by violating the prisoners' protection of privacy as little as possible, while still ensuring the certainty of supervision. The Deputy-Ombudsman also considered exploring alternative ways of supervision justified. The Deputy-Ombudsman's decision was also sent to the Ministry of Justice for information and consideration of whether the provisions should be specified.

- The Criminal Sanctions Region of Southern Finland reported that, after the NPM visit, its management team had discussed the statements made by the Deputy-Ombudsman concerning the procedure of giving a urine sample under supervision. In this context, it has been emphasised that the prisoner must not have to be completely naked in the situation (5563/2018).
- The Criminal Sanctions Agency reported that the guideline for the prevention of substance abuse was being updated. For example, it will define what is the legal and correct procedure when supervising prisoners giving a urine sample. The updating has been delayed and had not yet been completed at the beginning of 2021.

In 2020, the Ombudsman received two complaints about the conditions in which urine samples had been given. According to the report of the Criminal Sanctions Agency, it intends to investigate the practices related to giving a urine sample in the criminal sanctions field widely from different perspectives.

TRANSPORT OF PRISONERS

Transport by a prisoner transport vehicle. Restraining the prisoner during transport is possible only after consideration on a case-by-case basis. Despite this, prisoners have systematically been restrained for the duration of transport from Vantaa prison to court. The Ombudsman has stated that the procedure is unlawful. A decision was finally reached in the matter when the prison

acquired two prisoner transport vehicles, in which the prisoners are divided into compartments of their own separately from the other prisoners and the staff. According to the information received on the NPM visit, after the new transport fleet was obtained, there has no longer been a need to restrain the prisoners during transports to court (6206/2017).

Transport by train. The prisoner transport route begins from Helsinki and ends in Oulu. The longest time a prisoner may have to stay on board the train is almost 10 hours. Two NPM visits have been made to prisoner train transport, in May 2018 and August 2019. The latter was a follow-up visit made to investigate how the Deputy-Ombudsman's recommendations had been implemented. Both times, the Criminal Sanctions Agency was also requested to provide a report of the measures taken.

On the first visit, serious deficiencies were observed in the prisoners' conditions during transport (2648/2018). The Criminal Sanctions Agency reported the implemented or planned measures to the Deputy-Ombudsman as follows:

- As an immediate measure, bottled water had been arranged for the prisoners and an information sheet was being prepared about it. In addition, the information sheet explains that the tap water on board should not be drunk because its quality was being examined. The information sheet for the passengers of the prisoner carriage will be drawn up in eight different languages.
- An information sheet was being prepared for the cells of the prisoner carriage about the possibility to ask the prison officers to give access to the separate toilet facility alone. In future, this will also be explained verbally to everyone transported.
- In future, the functioning of the call buttons for flushing the toilet and contacting the prison officer would be checked regularly.
- The railway company (VR) had contacted the private service provider cleaning the prisoner carriage about raising the level of cleanliness. The inscriptions on the walls had been re-

moved as an immediate measure. VR reported that it would replace the mattresses in the prisoner carriages and have the ventilation channels swept regularly. In addition, possible ways of alleviating excessive heat would be explored.

- A comprehensive reform of the food provision was due, in which the issues raised by the Deputy-Ombudsman would be taken into account. The content of the lunch bags would be changed and the new lunch bag would be introduced at the beginning of 2020.



During prisoner transport, the prisoner can now receive a warm meal in addition to the previous lunch bag.

On the follow-up visit (4575/2019), it was established that bottled water was now available to prisoners. 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 prison officer 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 carriage 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.

After the Deputy-Ombudsman's statements on the follow-up visit, the Criminal Sanctions Agency reported that VR would 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 would be marked with pictograms indicating their purpose. The Criminal Sanctions Agency considered 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 cleaning and give prison officers in prisoner carriage contact details for the cleaning service provider to give any immediate feedback on the standard of cleanliness.

ATMOSPHERE IN THE PRISON / TREATMENT OF PRISONERS

In discussions about the position of **Roma prisoners** with the prisoners, it emerged that, when requesting to be transferred to a different ward, the Roma prisoner had themselves asked the other prisoners for acceptance for the transfer. In the final discussion with the prison management, the need and possibilities to not allow other prisoners'

attitudes to prevent prisoners belonging to minorities from being placed on wards were discussed (4337/2015).

Some foreign prisoners felt that Finnish prisoners had a hostile attitude towards them. These prisoners had therefore limited their interaction with the rest of the prisoner community. The NPM team got an impression that if a prisoner with a foreign background tries to retire from the company of others because of the nature of their crime or cultural factors, they can do so without much intervention by the prison staff. The Deputy-Ombudsman stated that the prison should pay attention to the insecurity felt by foreign prisoners and aim to find operating practices for addressing the discriminatory atmosphere (2705/2017).

The attitude adopted towards prisoners seemed very strict. **The confrontation and tension between prisoners and staff** in the prison seemed to be stronger than usual. The situation was also made worse by the fact that the prison's actions regarding many issues were arbitrary and not justified. The Deputy-Ombudsman considered it highly important to change the prison's operating culture and attitude towards its inmates. The atmosphere would be likely to improve if the prison discontinued its unjustified and unlawful practices that were very different from those applied in other prisons.

- The prison reported that it would launch various projects concerning the treatment of prisoners and the relations between prisoners and staff in accordance with its action and development plan. The prison would also introduce a prisoner feedback system (4397/2016).
- A follow-up visit was made to the prison, during which the overall picture of the institution seemed to be positively different from the previous visit. The relationships between the prisoners and the staff appeared to be appropriate and natural. It seemed that the measures taken by the prison had significantly contributed to how the prisoners felt they were treated. For example, the prison had given up the practices that clearly deviated from those of other prisons, were not based on law and were also

partly in conflict with the legal provisions. In addition, prisoners' opportunities to stay in contact with their loved ones outside prison had improved. The nature of the prison had generally changed and was clearly more open than before. The most important change was a very significant increase in the time the cells were kept open (3005/2017).

During the visit, the NPM team got the impression that it was difficult to prevent **substance abuse** among the prisoners. The Deputy-Ombudsman found the observations made during the visit concerning from the point of view of the security of both the prisoners and the staff. He considered it necessary that the Central Administration Unit of the Criminal Sanctions Agency and the Criminal Sanctions Region of Western Finland assess the situation in more detail and take the required measures to improve prison safety.

- The Regional Centre of the Criminal Sanctions Region of Western Finland reported that it had invested in the safety of the prison and measures supporting intoxicant-free life of prisoners. After the NPM visit, follow-up meetings on how the prison had progressed in implementing the action plan on enhancing safety had been held with the prison management almost every month. The assessment centre paid special attention to prisoner placement. As a result, the prisoner structure in the prison could be changed so that the prison would not be the primary place for prisoners with substance abuse problems. The Regional Centre was able to add one post of a prison officer to the ward. In addition, permission was given to fill a temporary post of a senior instructor, which was aimed at enhancing substance abuse prevention, in particular (3733/2017).

Approximately 18% of all inmates in the prison were **members of organised criminal groups**. In spite of that, the prison had an extremely open operating culture. Organised crime prisoners had not been placed on wards for prisoners whose behaviour puts the order and safety of the prison at risk. Instead, a high proportion of the prison-

ers (approximately 20%) had requested to live in segregation. There had been several violent altercations between inmates at the prison. The Deputy-Ombudsman considered the situation serious. He recommended that the prison and the Regional Centre of the Criminal Sanctions Agency investigate what remedial measures could and should be taken.

- The 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. The senior criminal sanctions officials deciding on prisoner placement are now informed about a prisoner's involvement in organised crime. It was established that it would be difficult to change the physical structures of the prison, but that the prison had introduced a new operating practice, so-called structural wards, which was aimed at reducing the encounters of prisoners from different wards. A ward for incoming prisoners would be established on which it would be possible to better assess the placement of the prisoners on accommodation wards (5291/2019).
- The Criminal Sanctions Region of Eastern and Northern Finland stated in its report that there were problems in the structural safety of the prison. The possibilities for the assessment centre to increase the institutional safety of the prison were mainly related to enhancing assessment and the flow of information. At the beginning of the year, a uniform model for safety assessment had been introduced as part of the prisoner's sentence plan. The model provides the prison with more detailed information on the prisoner's safety needs, which can be used in the placement of prisoners on wards within the prison.

In discussions with representatives of the staff and special personnel, concerns were brought up about prisoners capable of working and without links to organised crime who preferred to live in closed wards instead of wards from which inmates went to work. On the other hand, prisoners with

links to organised criminal groups had been placed on these so-called workmen's wards. Discussions with prisoners revealed the problems related to placement on wards. A number of prisoners had requested to serve their sentence in the closed ward for fear of threats and pressure. Families had also been intimidated. Prisoners did not apply for unsupervised family visits and prison leaves for fear of pressure from other prisoners.

The prison management was also aware of the phenomenon reported by staff and prisoners. According to the management, it was difficult to obtain the information required for intervening. In the Deputy-Ombudsman's view, legislation made it possible to intervene through the placement of prisoners on accommodation wards. The NPM team got the impression that the staff was very careful about using knowledge about problems between prisoners in the decision-making. However, methods must be found to intervene in coercion among prisoners. The Deputy-Ombudsman stated that, according to legislation, a party involved in such a situation does not have the right to all the information about themselves. In addition, the structure of the prison allowed for a high level of security through compartmentation into fairly small wards. This should make it possible to remedy the discovered distorted situation in which some prisoners can as widely as possible compromise the safety of other prisoners because of their placement on the same ward (2449/2019).

OVERSIGHT OF OVERSIGHT

The Parliamentary Ombudsman has increasingly begun to require that other supervisory authorities also perform their oversight duty. The following is a good example of this in the criminal sanctions field.

The Deputy-Ombudsman considered that the prison was not able to ensure the lawfulness of its operation. On the other hand, the task of the Regional Centre is to guide the operation of the units and ensure that the implementation of legislation and the treatment of persons deprived of their liberty are lawful, appropriate and consistent. The Deputy-Ombudsman emphasised that the task

of the Regional Centre was primarily to supervise the prison's compliance with the regulations and intervene in its operation if it did not do so. The Deputy-Ombudsman considered it necessary that the actions of the Regional Centre in the oversight of legality of the prison's operation be also investigated. The Deputy-Ombudsman requested a report from the Central Administration Unit of the Criminal Sanctions Agency and the Regional Centre.

The Deputy-Ombudsman stated that the oversight of legality of the prison, carried out by the Regional Centre by processing complaints and claims for a revised decision, appeared to have been mainly formal. The Centre had not addressed the prison's incorrect decisions and procedures. On the other hand, only few complaints and claims for a revised decision had been filed, and it was also not possible to exercise appropriate oversight of legality based on that. The Deputy-Ombudsman also stated that, in practice, oversight of legality of the operation is not possible without inspection visits to the prison. The Regional Centre had not made any.

The Deputy-Ombudsman considered the oversight by the Regional Centre neither appropriate nor sufficient. The Regional Centre was considered to have neglected its duty to oversee and ensure the lawful treatment of prisoners at the prison. The Deputy-Ombudsman agreed with the Central Administration Unit on the need to investigate the possibility to increase the resources allocated for the oversight of legality and the guidance and instructions provided to prisons. He also considered it good that plans had been made to enable the prison management to familiarise themselves with the operation of other prisons. He also welcomed that the Central Administration Unit had explored and considered measures to increase the oversight of legality at the national level. (4397/2016)

On his inspection visit to the Central Administration Unit of the Criminal Sanctions Agency in March 2020, the Deputy-Ombudsman was told that the Unit's objective was to inspect each closed institution every two years. The Central Administration Unit was in the process of drawing

up a model for the implementation of visits and self-monitoring.

In March 2020, the Deputy-Ombudsman also made an inspection visit to the Ministry of Justice. The Ministry explained that one of the priority areas was to develop self-monitoring. The Ministry was about to begin its own inspections targeted at central administration and the decisions made on matters concerning prisoners. The aim was also to go through the guidelines and regulations issued by the Criminal Sanctions Agency and update them as necessary during 2020.

3.5.10 PRISONER HEALTH CARE

Because of the COVID-19 pandemic, no on-site visits were made to prisoner health care in 2020. Instead of visits, Health Care Services for Prisoners (VTH) was requested to report the procedures resulting from the pandemic in prisoner health care both at outpatient clinics and in the operation of hospitals (2736/2020). At the time of writing this annual report, the Deputy-Ombudsman's decision on the matter was still pending.

HUMAN RESOURCES

The Ombudsman has considered it particularly problematic that at most VTH's outpatient clinics, no health-care personnel is present in the evenings or at weekends. This affects the timetable for conducting the routine medical screening on the arrival of new prisoners and examining the health of a prisoner placed in isolation. The CPT has also drawn attention to this – most recently on its visit in autumn 2020. In addition, prison health care has increasingly had to resort to the services of outsourced physicians and even remote physicians. In practice, this has meant that the nurses at the outpatient clinics have to assume the main responsibility of the care of prisoners. Attention has also been paid to the fact that adequate psychiatrist's services are not available in prison.

MEDICAL SCREENING ON ARRIVAL

The CPR has constantly recommended that prisons must have a comprehensive medical screening within 24 hours of newly arrived prisoners. The Imprisonment Act does not have any provisions in this respect. VTH has instructed that a nurse must conduct an interview with new prisoners within 3 days of their arrival. The Ombudsman has also recommended that prison health care should meet the prisoner within 24 hours of their arrival. Some outpatient clinics has achieved this target. In 2020, compromises have had to be made with the schedule and content of routine medical screening on arrival because of the additional work caused by the COVID-19 pandemic. According to VTH, a limited version of the interview on arrival is conducted within 3 days mainly to assess the risks of the detainee. A more extensive medical screening is conducted within a week of the person's arrival. The routine medical screenings of short-term prisoners, such as fine default prisoners, are likely to remain limited. On the other hand, the execution of short-term sentences has repeatedly been postponed.

The Ombudsman has also observed that the routine medical screenings of newly arrived prisoners are almost exclusively based on an extensive interview. Also, the form used in the screening does not contain questions about injuries or a body chart in which injuries could be recorded. The Ombudsman has recommended that these items should be included in the form. The persons conducting the medical screening should take into account the possibility that the prisoner may have been subjected to physical violence before arrival in the prison while in the custody of another authority as a person deprived of his or her liberty. This is important in terms of the legal protection of persons deprived of their liberty and, on the other hand, of those authorities or other actors at whom suspicions are levelled.

In May 2018, VTH issued a guideline on interviewing prisoners on their arrival. It instructs the person interviewing to record all possible external signs of an assault. The patient is therefore asked to undress at the appointment. Especially any



The facilities for prisoner health care appointments are located within the prison.

injuries to the head should be paid attention to. However, no separate item on this has been included in the actual form for the interview on arrival.

NOTIFICATION OF APPOINTMENT

Prisoners frequently criticise the fact that they do not receive replies to the messages they send to the outpatient clinic, or that access to a doctor is difficult. The Ombudsman has frequently drawn the outpatient clinics' attention to the fact that, according to the Act on the Status and Rights of Patients, the time of their appointment must be communicated to patients, if it is known. The Patient 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.

- In April 2020, VTH issued guidelines on answering to the questions in the form and notifying appointment times. The guidelines state that, as a general rule, the patient will be notified of the appointment time or resched-

uling in accordance with the Patient Act. The guidelines also briefly address contacting the outpatient clinic electronically instead of paper forms, which will be possible in the smart prisons of the future.

In the past few years, the decline in the prison officer resources has affected the appointments at outpatient clinics and oral health care in such a way that fewer transports of prisoners are organised and the appointments are not implemented as planned when the patients are unable to attend. In 2020, the COVID-19 pandemic has further complicated the situation because only one prisoner at a time can be brought to the outpatient clinic.

MONITORING THE HEALTH OF PRISONERS PLACED IN SEGREGATION

The Imprisonment Act does not contain specific provisions on how often the health care professional should visit prisoners placed in isolation. The CPT standards require that the health care professional visits a prisoner placed in isolation immediately and, subsequently, at least once a day. VTH's guidelines require that prison health care must monitor the health of a prisoner in isolation on a daily basis.

The Ombudsman has investigated on his own initiative a case concerning the monitoring of the health of a prisoner placed in segregation at their own request. During the NPM visit to the prison, it was discovered that the health-care personnel had come to meet the prisoner approximately once a year and a doctor had met the patient once during the three years. In his decision issued on 18 November 2019, the Ombudsman considered it necessary that VTH draw up guidelines for health-care personnel on how to implement the monitoring of the health of prisoners placed in segregation (247/2016).

TAKING INTO ACCOUNT SELF-DESTRUCTIVE BEHAVIOUR DURING PRISONER TRANSPORT

During the NPM visit, it emerged that a prisoner had committed a suicide in the prison while waiting for further transport to the Turku Unit of the Psychiatric Prison Hospital. The Deputy-Ombudsman also investigated the matter separately from the point of view of prisoner health care. In his decision (2289/2018), the Deputy-Ombudsman stated that the prisoner should have been transported directly to Turku instead of using prisoner transport, the duration of which (5 days) had been known. The doctor at VTH has chosen the form of transport without knowing that separate transport should have been chosen according to the guidelines issued by the Criminal Sanctions Agency. There were also many shortcomings in the communication of information between the different parties involved.

- VTH reported that it had drawn up a separate guideline for choosing prisoner transport. In addition, guidelines have been drawn up on a report between the units involved in situations where patients are transferred.

3.5.11 DETENTION UNITS FOR FOREIGNERS

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. There are two detention units for foreigners in Finland (in Helsinki and Joutseno), both of which are currently units under the Finnish Immigration Service (Migri).

No visits to the detention units were made in 2020 because of the COVID-19 pandemic. Instead, the Ombudsman decided to investigate on his own initiative the restrictive measures in both units since 1 August 2020. At the same time, he requested a report on how health care is organised at weekends and on any suicides or cases related to self-destructive behaviour (7392/2020, 7605/2020). No decisions have yet been made at the time of

writing this annual report. Other requests for information concerning the detention of foreigners during the COVID-19 pandemic (2615/2020, 2807/2020) and measures taken by the police to remove a person from the country (2615/2020) have been explained in section 4 (Issues related to coronavirus).

The following is an overview of the themes to which attention was paid during the NPM visits. Regular visits have been made to monitor the measures taken by the units to remove the deficiencies observed.

INFORMING DETAINED PERSONS OF THEIR RIGHTS

The Ombudsman has drawn the attention of both detention units to the requirement that detained persons must immediately be informed of their rights and obligations (6966/2017, 5145/2018).

- The Joutseno detention unit reported that each detained person receives information on their rights and obligations in a so-called initial briefing and signs an invitation to the briefing, which is stored. This way, it is possible to ensure afterwards that the information has been provided. The practice has been improved after the NPM visit by introducing a specific confirmation form that the detainee signs to confirm they have received the information. In the form, the most important items of the briefing have been mentioned separately, i.e., the house rules, the legal position and the prohibition to take photographs or film.
- The following inspection visit to the Helsinki detention unit revealed that detainees are informed of their rights and obligations as soon as they arrive. The detainees confirm receipt of the information with their signature (6841/2019).

MEDICAL SCREENING ON ARRIVAL

On visits to both detention units, it has been observed that there was no systematic medical screening of newly arrived detainees on their arrival. Instead, the arriving detainee may have filled in a health interview form, on the basis of which their need for health care has been assessed. However, the conclusions addressed to Finland by different international bodies have recommended that a medical screening should be carried out on persons deprived of their liberty within 24 hours of their arrival. The Ombudsman has also recommended to both detention units that they should carry out a medical screening on detainees during the first 24 hours (4561/2015, 6123/2016). At the same time, any experiences of torture and injuries of detainees can be examined. The Ombudsman has had to repeat the same recommendation on his follow-up visits to both units (1868/2017, 6966/2017).

- The Joutseno detention unit reported that sections for possible experiences of physical and psychological violence and injuries sustained during transport would be included in the arrival interview form during 2019 (5145/2018).
- During the inspection visit made to the Helsinki detention unit in December 2019, the NPM was told that the aim was the medical screening of each arriving detainee within 24 hours from their arrival, and that this goal was achieved with 83% of the detainees. The aim is to carry out a medical screening on all arriving detainees. An exception to this rule is made with persons deprived of their liberty who are detained for less than 24 hours, who arrive during the weekend, or who decline the medical screening. During the assessment, they are also asked about any injuries they may have and how the transport to the detention unit had gone. Detainees transferred from another detention unit also undergo the same procedure. Any findings are recorded and the detainee is referred to a doctor if necessary (6841/2019).

HEALTH ASSESSMENT AFTER A FAILED ATTEMPT AT REMOVAL FROM THE COUNTRY

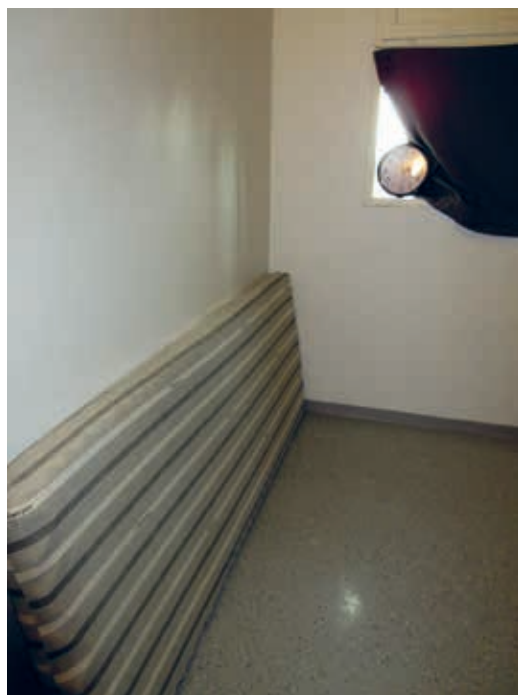
The Ombudsman already recommended to both detention units in 2014 and 2015 that a health assessment must always be carried out on a foreigner who is returned to the unit after a failed attempt at removal from the country, unless one has already been carried out somewhere else. The assessment should take place as soon as possible after the person's return (5099/2014, 4561/2015).

- On the visit made to Helsinki detention unit in 2016, the unit reported that after each failed attempt at removal from the country, the foreign national returned to the unit is offered a possibility of meeting a qualified nurse (6123/2016).
- In 2019, the same unit said that health care pays attention to any signs of violence in persons deprived of their liberty in connection with failed attempts at removal from the country. Any findings are recorded and the patient is referred to a doctor if necessary (6841/2019).

CONDITIONS IN ISOLATION

On the NPM visits, the isolation facilities of the detention units were found clean, but very ascetic and cell-like. The Ombudsman recommended to the Joutseno detention unit that the unit should take measures to secure appropriate, humane treatment of the detainee in facilities intended for isolation. The facility should always have a level surface on which the detainee can have a meal. The thin mattress used as a bed should be replaced with a higher, bed-like mattress. The Ombudsman also recommended placing safe clocks in the isolation facilities.

- The detention unit reported that it had ordered safety beds 30 cm in height and cube tables for the isolation rooms. In addition, clocks were also acquired that will be fixed to safely to the wall so that the detainee cannot remove the button cell battery to swallow it (5145/2018).



The bleak isolation facility at the detention unit. Improvements were due regarding the furniture.

PRIVACY IN THE SHOWER FACILITY IN ISOLATION

On the visit to the Joutseno detention unit, attention was paid to the surveillance camera in the isolation room, which had been installed to a position that enabled the upper body of the person having a shower to be seen in the picture. The Ombudsman was not convinced that camera surveillance was necessary in the shower facility (1868/2017).

- According to Migri, camera surveillance was needed especially to ensure the safety of suicidal detainees and to prevent possible vandalism. However, because of the Ombudsman's opinion, camera surveillance in the shower facility was changed to no longer show the upper body of the person in the shower. In addition, a sign was put on the wall of the



The surveillance camera in the shower of the isolation facility and a notice about what is visible in the camera view.

shower facility to explain what areas had been obscured in the camera surveillance. The camera in the shower facility had no recording capability.

On the next inspection visit, the Ombudsman stated that no other administrative sector with facilities in which persons deprived of their liberty can be detained has a statutory right to use technical surveillance to the same extent as detention units for foreigners. This applied to psychiatric hospitals as well as prisons and police detention facilities. All of them also isolate suicidal persons and persons with a higher risk of causing material damage.

The Ombudsman was still not convinced that it was necessary to supervise the shower in the isolation facility through a camera. If constant supervision of a person is considered necessary in an

individual case because the person is suicidal, the Ombudsman considered it better to supervise the individual in the shower in person. He considered the situation extremely problematic especially from the point of view of the privacy of foreigners placed in the detention unit. The toilet and shower in the isolation facility may be used by both female and male detainees. Both female and male employees participate in the supervision. The detainee supervised does not know who supervises them and cannot know whether there are several persons supervising in the control room. The Ombudsman was also not convinced that the changes made to the camera surveillance in the shower facility were sufficient to protect the privacy of its user. It can be concluded from the surveillance view that the person entering the shower can be followed until the person stands under the shower (5145/2018).

- The Joutseno detention unit reported to the Ombudsman that it still considered surveillance necessary. However, the obscured blocks in the camera views of the showers will be further expanded to better secure privacy when showering. The person placed into isolation has a towel that they can, if they wish, use to protect their privacy until they have reached the area obscured by the above-mentioned blocks, which is the shower. In future, all detainees placed in segregation will be advised to inform the staff through the phone in the room of their intention to have a shower. This gives time to staff the control room only with employees of the same sex.

MONITORING THE HEALTH OF A DETAINEE PLACED IN SEGREGATION

The Ombudsman has considered it important that a health-care professional visit a person placed in isolation every day (4561/2015). However, it was established on the visit that this did not happen (6123/2016).

- On the NPM visit, it was observed that a health-care professional visited all detainees in segregation at least once a day and more often, if necessary (6841/2019).

IDENTIFICATION OF SELF-DESTRUCTIVE BEHAVIOUR AND PREVENTION OF SUICIDES

Several cases related to self-destructive behaviour and one suicide had occurred at the Joutseno detention unit during the year. During the NPM visit, information on the Criminal Sanctions Agency's training material on preventing suicides and assessing the need for urgent treatment was given to the management of the detention unit. The NPM team got the impression that the detention unit was not aware of Migri's guidelines concerning this matter. The Ombudsman recommended that Migri go through its guidance concerning suicides and assess whether identifying the risk of suicide and the actions of the employees, the division of responsibilities and the flow of information to prevent suicides is sufficiently discussed in it. More training on preventing suicides should be provided to the staff and their awareness of the guidelines should be increased (5145/2018).

- The detention unit improved the instructors' awareness of Migri's material on suicides. The availability of the material has also been improved. In addition, a project aimed at developing the mental health work competence of the staff of reception centres and detention units is beginning in the Migri. A mental health work manual including more detailed guidance on preventing suicides will be drawn up as part of the project.

REPORTING ON MISTREATMENT

The Helsinki detention unit had no system or guidelines in place indicating how and to whom the detainees or staff could report any mistreatment observed. The Ombudsman noted that the detention unit should operate an effective complaint system that both the detainees 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 (6841/2019).

- Migri reported that in the future the possibility to give feedback on the unit's operation or complain to its management and to the authorities charged with the oversight of legality was explained to the detainee in the induction given to them in their mother tongue on their arrival. A form in which the detainee can record the feedback or complaint has also been introduced. Information on the operation of the authority charged with the oversight of legality is displayed clearly on the notice board and the complaint forms are available next to it. The completed feedback and complaint forms are submitted either to the staff or to the locked letter box in the customer facilities, which only the management of the unit has access to. The feedback and complaint procedure for the staff includes a discretionary opportunity to report deficiencies to the supervisors or complain to the director of the unit, to Migri or to the authorities charged with the oversight of legality. A written description has been drawn up of the complaint procedure of the Helsinki detention unit and included in the internal guidelines and the orientation programme for the staff in the unit.

3.5.12 CHILD WELFARE FACILITIES

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 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.

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. Although institutions usually correct their practices after the visit to fit the recommendations of the Deputy-Ombudsman, the implementation of these changes would require follow-up monitoring, which the NPM does not always have the opportunity to do. For this reason, the Deputy-Ombudsman has occasionally asked the competent Regional State Administrative Agency (AVI) to monitor the institution's operations by conducting a follow-up visit to the institution, for example (such as in 5916/2018).

The parliamentary Audit Committee has issued a statement to the Constitutional Law Committee on the Parliamentary Ombudsman's 2019 report. The committee has expressed its opinion that the division of the supervision of child welfare services between different actors and the complex regulation of the matter impede effective guidance and supervision activities and increase the risk that supervision is neglected. The committee has also considered the resources for supervision of child welfare services to be insufficient. As a result, supervision is mainly reactive and based on reports of shortcomings and complaints. According to experts, proactive supervision would be more effective and efficient. The committee has stressed that adequate resources must be secured for child welfare and its supervision, and that children within the scope of child welfare services should be better informed of their rights and their personal social worker. Children's participation in child welfare supervision should also be increased. According to the committee, the self-monitoring of operating units should be developed further, but it should not replace the supervision carried out by

the authorities. The committee also expressed its concern over the COVID-19 pandemic's impact on the supervision of child welfare services.

In 2020, one NPM visit was carried out at the Sairila Residential School (883/2020). The findings, the recommendations of the Deputy-Ombudsman and the institution's reports of the measures they made have been included in the summary below.

Instead of on-site inspections, the supervision of child welfare institutions was carried out by sending a request for information to seven municipalities. The municipalities were asked to provide information on how communications with a child placed in a child welfare institution was ensured, what guidance and orders had been given to the institutions and how restrictive measures had been monitored under the a state of emergency. More information was also requested on how information and advice on communication and COVID-19 had been arranged for children placed in the institution and their guardians and parents. The municipalities were also asked to inform how the child welfare institutions had been instructed on protection against the COVID-19 pandemic (2689/2020). The reports have not yet been analysed at the time of writing.

The following is a review of the statements and recommendations from the NPM visits carried out in the recent years and how they have influenced the practices of child welfare units and the treatment of children placed in them. The notifications by state-run residential schools have highlighted that they need common instructions and guidelines for residential schools, at least on telephone usage and bodily search methods.

CHILD TREATMENT AND EDUCATIONAL CULTURE AT THE INSTITUTION

Some visited institutions were identified to have an educational culture that is based on the strong restriction of children. 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 was also particularly concerned over the impression that the documents and children's stories conveyed, in which children's efforts to influence their daily lives had not been considered desirable behaviour. The Deputy-Ombudsman has required that the institutions ensure children's opportunities to participate in and influence matters concerning themselves in the future. They must find out the child's opinion and genuinely take it into account when making administrative decisions and in the everyday life in substitute care. The child must not be penalised for expressing their opinion. The institutions have taken the recommendations of the Deputy-Ombudsman seriously and undertaken action to implement them:

- The institution announced that the activities described in the NPM visit report were neither in line with the values of the institution nor acceptable. The rules of each unit of the institution have been reviewed during community meetings together with the children. In the two units where shortcomings were the most severe, the service manager and a special worker have participated in the unit's community meetings. They have also discussed the practices of the units and the personnel's activities separately with the children. The operating practices have been specified on the basis of these discussions. The instructors' abilities for encountering children and understanding their situation will be improved. The units have been provided with written instructions corresponding to the contents of the NPM visit report. There will be a survey for the children and personnel of the institution to investigate experiences of participation and assess the impacts of the measures taken (1353/2018).
- The institution has started using personal introductory folders for the children. The child goes through its contents with their personal instructor at the beginning of the placement. In addition to the contact details of the child's responsible social worker and their municipality's Social Ombudsman, the folder will contain the contact details of the person the child currently considers a trusted adult. The folder also contains the unit's rules and weekly programme, which are discussed with the child. In addition, the introductory folder contains instructions on how to report any shortcomings they may experience and how to appeal against the decisions concerning restrictions. The contact details of the local AVI and information on the Parliamentary Ombudsman's website for children and young people will also be attached. The personal instructor ensures that every child arriving at the institution is also informed of who is the head of the residential school, where their office is located and how to reach them (1353/2018).
- A plan has been prepared for the institution to support the implementation of the right of self-determination and fulfilment of good treatment for children placed in the unit. The working group that drew up the plan included employees and children of the unit. Each child participates in the planning of their rehabilitation. Close interaction with the personal instructor aims to establish a confidential relationship between the child and the adult. The institution has ensured that each child is aware of the contact details of the unit director, the responsible instructor and special workers who they can contact also when they experience shortcomings in the unit (4099/2018).
- The institution has rules devised in accordance with the Deputy-Ombudsman's instructions, which are available to children. The children also participated in devising the rules. The institution also announced that it had abandoned the call waiting practice, which the Deputy-Ombudsman considered to be demeaning for the children, similar to room arrest (5377/2018).
- Children's opportunities to participate and influence have been increased both in everyday life and in administrative decisions. There are no consequences for expressing your opinion. The department's rules have been reviewed

with both the personnel and children. A plan for good treatment has been drawn up together with the children (5930/2019).

- The institution's rules have been drawn up together with the student body. In the future, attention will be paid to their regular processing and updating, also with new children (883/2020).

In the discussions conducted during the NPM visits, the children talked about inappropriate behaviour of the institution's personnel, to which the Deputy-Ombudsman has drawn the institution's attention. Some institutions have denied such claims, but many institutions have addressed the personnel's inappropriate behaviour with self-monitoring:

- The personnel have discussed children's experiences about adult behaviour. All employees of the institution have been reminded of their professional language in relation to children. Employees have been reminded of the employee's obligation to report shortcomings (1353/2018).
- Private discussions have been held with all employees on how to work with children and what is appropriate behaviour. The unit has changed employees based on feedback from children after the NPM visit. When recruiting new employees, particular attention has been paid to increasing the level of education and the employee's strengths in cooperating with children (4099/2018).
- The follow-up visit after the visit by the NPM and the local AVI (5916/2018) revealed that poor treatment still came up in the interviews with children. However, according to AVI's overall estimation, the treatment had improved since the visit one year earlier. AVI provided guidance in this respect and stated that the person in charge of the institution must perform self-monitoring to ensure that the operating unit's services meet the requirements set for them.

CHILD'S RIGHT TO MEET THEIR SOCIAL WORKER

Based on the inspection findings, the child's right to meet their social worker confidentially does not come true often enough. Some children did not know who their personal social worker was or they did not have the contact details. The children have said that social workers visit the unit, but do not necessarily talk to the children in private. The children also lacked a clear picture of their personal social worker's tasks and that they could turn to them in a conflict situation. The children's stories have given the impression that not nearly everyone have had a confidential relationship with their personal social worker. The child may also have lost their trust in the worker's opportunity or willingness to investigate any shortcomings that the child has mentioned.

- The institution found it very regrettable that a child might be under the impression that the institution's aim was to make interaction between children and social workers more difficult. After the NPM visit, the personnel have been instructed to ensure that child's right to have a confidential discussion with their social worker is realised. They will also ensure that the child's introductory folder contains the contact details of the responsible social worker (1353/2018).
- After the NPM visit, the unit has made sure that each young person has the contact details of their personal social worker and that they can always contact them by letter, personal phone or the unit's telephone (4099/2018).

The institution and social worker should record in the child's documents when the social worker has met the child and how the meeting has been carried out. The Deputy-Ombudsman emphasizes that it is the only way to realize procedures that implement and promote the rights of the child. They should also record whether the meeting was arranged in private without the presence of personnel. This procedure was not in place in many visited units. After the NPM visit, the institutions have instructed the personnel to record this information.

The Deputy-Ombudsman has proposed a new possible procedure for the institutions to ensure that the child's opinion is brought to the attention of their social worker on a monthly basis. This would allow the child to write a confidential message to their social worker, which would be attached to the monthly report in an envelope sealed by the child. The opportunity to write a private and confidential message could also increase the child's willingness to tell their social worker even the more sensitive matters concerning their life in the institution.

- The institution announced that it had initiated a new practice in line with the recommendation of the Deputy-Ombudsman. In the future, the child can write a confidential letter to their social worker (1353/2018).

Many social workers in child welfare push themselves to the limit at work, which is why they may not be able to carry out the supervision required by the Child Welfare Act. In the NPM visit report, the Deputy-Ombudsman required municipalities to provide information on how many children they had placed in the unit and how many other children the same social worker was responsible for in addition to those placed in the unit (4099/2018). In the reports, municipalities also reported on their measures or views as follows:

- The readiness of social workers for monitoring and hearing children has been increased. In addition, the joint authority's supervision plan has been updated and the joint authority has increased the supervision of units located in its area and the supervision of foster families (Oulunkaari joint authority).
- The placed children have had meetings at the substitute care provider without the presence of institution's personnel. The NPM visit report, the institution's comments on the children's experiences and the Deputy-Ombudsman's recommendations on measures to fix the shortcomings have been reviewed with the child. There have also been discussions on the shortcomings that arose during the visit and the child's current experiences of daily life at the child welfare unit. During the meetings, the children talked about situations that they

had recently experienced as shortcomings.

After the meeting, the experiences were forwarded to the head of the institution (Tornio Social Office).

- The responsible social workers have met the children and explained the contents and significance of the NPM visit report for the children (City of Vantaa).
- Special attention has been paid to the private meetings of children in substitute care and the up-to-datedness of customer plans as well as the use of restrictive measures. However, according to the joint authority, there are many children whose care is challenging. This poses challenges to finding substitute care facilities and is reflected in the child welfare institutions as an increase in the number of restrictive decisions. Today, child welfare services need more services for children provided by special units of child welfare institutions (Kainuu Social and Health Care Joint Authority, which no longer had children placed in institution when the report was given).

CHILD'S RIGHT TO SELF-DETERMINATION

The Deputy-Ombudsman has emphasised that children placed in institutional or foster care have the right to decide on their own appearance and clothing. Piercings, clothing, and matters such as dyeing your own hair are an essential element of a person's self-expression. The rules of an institution concerning the appearance of the child interfere with the child's right to freely determine their own body and appearance. The rules 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. 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.

- The institution announced 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 (5377/2018).

- According to the institution, children have the right to decide on their appearance and clothing. In the past, the institution had intervened mainly if the child wore clothes that were too revealing. These matters are still discussed with the children. In the future, they will focus on how these discussions are held and to the fact that these matters are discussed with the personal instructor (5930/2019).

Girls were not allowed to decide for themselves which hygiene products they would use on their menstrual period whilst at the institution. 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 privacy. The practice was demeaning for girls.

- The institution will no longer interfere with the residents' personal privacy and does not dictate which type of period protection the girls are allowed to use. To the contrary, the personnel encourage, advice, and give guidance on personal hygiene (5377/2018).
- After the visit, the institution decided to give each child a hygiene allowance so that they can buy the hygiene products they want. The institution also has various hygiene supplies available in the office (5930/2019).

RESTRICTIVE MEASURES AND EDUCATIONAL BOUNDARIES ARE DIFFERENT

The child's care and upbringing also include setting educational boundaries for the child. The educational boundaries must be kept separate from the restrictive measures referred to in the Child Welfare Act. Educational boundaries do not interfere with the child's fundamental and human rights. Instead, they concern the organisation of the child's daily care and supporting the child's

growth and development. The purpose, duration and intensity of educational measures cannot be the same as the restrictive measures referred to in the Child Welfare Act.

It is challenging to distinguish between the aforementioned matters in child welfare. The NPM visits have revealed that institutions often justify measures by educational reasons, whilst in the Deputy-Ombudsman's opinion, they are actually restrictive measures that require a justification under the Child Welfare Act and for which a decision must be made. In the NPM visit reports the Deputy-Ombudsman has reviewed this distinction and expressed her views on what falls under education and what not. For example, instructing a child to go their room without locking the door and having the child stay in their room on the basis of an oral request alone can be considered generally acceptable as an educational matter. On the other hand, it may be the case of isolation as mentioned in the act if the child is prevented from leaving their room and the child has to stay there against their will for a long time without the child behaving as defined by the isolation provision.

- The institution stated that in addition to internal induction, the employees have received training on restrictive measures organised by a third party (1353/2018).
- Employees have received training on restrictive measures in accordance with the Child Welfare Act. The training focused on the issues raised in the NPM visit report. The training also included an exam that ensured that the employees learned and understood the information they received on the training (4099/2018).

RESTRICTION DECISIONS AND RECORDING THEM

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 pro-

visions 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 institutions have announced that they will pay attention on the individual criteria for decisions on restrictive measures and recording them in the future. Training on restrictive measures will be organised for the personnel. The decision on restrictive measures will also be reviewed with the child in the future, so that the young person understands the purpose of the restriction. The child is also informed of the possibility of appeal and offered assistance in making it when necessary (1353/2018, 1605/2018, 4099/2018, 5377/2018, 5930/2019 and 883/2020). Sometimes, more guidance is needed to make the practices legal:

- On the basis of its follow-up visit following the joint inspection visit by the NPM and the Regional State Administrative Agency (5916/2018), AVI considered that the institution still had significant shortcomings in devising and recording the decisions on restrictions. For example, documents for supervising isolation were incomplete or missing. The institution was instructed by AVI on which matters concerning the isolation should be included in the decision and separate documents.

RESTRICTING THE FREEDOM OF MOVEMENT

There is also a lot of uncertainty about restrictions related to mobility – both among children and personnel of the institution. It is not nearly always clear when it is a question of restricting the freedom of movement that requires a decision in accordance with the Child Welfare Act. The NPM visit reports (such as 356/2018 and 5930/2019) and Deputy-Ombudsman's complaint decisions (such as 5682/2018) have tried to make a distinction to this.

Despite the statements published by the Deputy-Ombudsman, the NPM visits will continue to pay attention to the freedom of movement being restricted only when the conditions laid down in the law are met and that there is a case-specific decision about the restriction. Even other supervisory authorities may have considered the restriction of children's movement illegal, but nevertheless, the NPM visit revealed that the institution has not corrected its procedure (883/2020). Following a visit by the NPM, the institution may also have adopted a new practice that is similar to isolation and unlawful, in which the child was allowed to be only in their own room during the restriction of mobility (5916/2018). In general, the institutions have changed their guidelines and practices after the NPM visit in accordance with the recommendations of the Deputy-Ombudsman. Here are some examples:

- The institution announced that the decision on restrictions of the freedom of movement will always contain a separate mention on how the young person's school attendance is arranged and justification if it is not possible during the restriction (4099/2018).
- The institution's practices have been changed so that if a decision on the restriction of the freedom of movement has not been made in accordance with the Child Welfare Act, the 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 the 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 (5377/2018).
- The institution announced that the children can go outdoors, visit the city and attend hobbies outside the institution as agreed. If necessary, a decision restricting the child's freedom of movement will be made, and more attention will be paid to recording these kinds of decisions in the future. During the restrictive period, the need for restriction will be assessed in a working group and in discussions with the child. During the restrictions of freedom of

movement, children are not isolated, but have the opportunity to go to school, outdoors and practise hobbies with an instructor depending on their condition (5930/2019)

- Following the NPM visit, the practices for restricting the freedom of movement were changed at the institution. The child may move around the institution's premises and leave the area if they have no decision on restricting the freedom of movement issued under the Child Welfare Act (883/2020).

RESTRICTING COMMUNICATION AND PREVENTING SOCIAL RELATIONS

Institutions restrict children's communication with other people in different ways, such as by limiting visits to the institution, cancelling the child's holidays or restricting the use of a phone. The last one is probably the most common restriction on communication. The NPM visits revealed phone practices in which the time to make and receive calls was very limited. A child might have also been allowed to have only one phone call in a day, with limited call length. These practices actually restrict, or at least reduce, the children's right to communicate.

- After the NPM visit, the institution made a change to the children's phone usage practices. As a rule, the children have access to their phones. During the night, the phones are kept in the unit's office to ensure that the young persons have sufficient sleep. Even then, the children can use the unit's phone. According to the instructions, phones can also be removed for educational reasons in order to have peace when eating and when doing something together, for example (1353/2018).
- At the follow-up visit following the joint inspection visit of the NPM and the Regional State Administrative Agency (5916/2018), AVI stated that the unit had restricted the use of a phone during school and night also for children placed in open-care. AVI instructed the institution to follow the Deputy-Ombudsman's instructions for taking possession of a

phone. A phone cannot be confiscated at night and during school only for the sake of certainty. Nor can the rules of the institution prohibit a child from taking a phone with them to outdoor activities, for example. AVI stated that a child's use of a phone during the school day can only be restricted on the basis of the Basic Education Act, even if the teaching takes place in the premises of the substitute care unit. In this case, the power to decide lies with the school alone.

- The institution announced that it would pay attention to phone practices in the future. At the same time, it proposed that a common set of guidelines be drawn up for the state residential schools concerning the use of a phone (883/2020).

Institutions have not always understood that they should also make a decision on restrictions when the child's contact with their family and friends is restricted in reality. Such situations include cancelling an agreed time off to visit home or changing its dates, imposing special conditions on the holiday, not giving time off at all or arranging a meeting with the child and their family member at the institution under supervision. The units have been reminded of making a decision on restricting communication in a situation where, if the conditions for restricting communication are met, the child's home practice period has to be transferred. The units have also been reminded that the child's contact with their parent cannot be restricted for control purposes and they cannot set conditions for it (1353/2018).

The NPM visits have also shown that discussions between the children placed at an institution have been restricted or supervised. The Deputy-Ombudsman has considered that children have the right to establish and maintain social relationships also within the institution. Methods by which a child is prevented from speaking with another person for long periods of time are illegal and above all, inhumane.

- The institution's practices were changed after the NPM visit. In the future, children will be

free to interact with each other. Maintaining social relationships is supported by allowing children the use of their phone. 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 (5377/2018).

Some institutions have also been uncertain about the fact that the social worker has the decision-making power to restrict communication – not in the substitute care facility.

- The institution stated that the unit does not restrict a young person from communicating with their parents/loved ones or transfer/cancel the agreed holidays without contacting the social worker and making a decision that can be appealed under the Child Welfare Act (4099/2018).

BODILY SEARCH

When there are reasonable grounds to suspect that a child has prohibited substances or objects on their clothing or otherwise, a bodily search may be performed on them to examine the matter. Such reasons are always individual and must be evaluated individually for each child. A large number of shortcomings have been identified in the inspections of institutions' documents in relation to records on bodily searches. The decisions do not indicate what has been the reason of suspicion that is required by legislation. Neither do the records always show clearly how the search was carried out and implemented. In such a case, it is not possible to confirm afterwards that the bodily search was carried out properly.

The Deputy-Ombudsman has required that the child's age, sex, level of development, individual attributes, religion, and cultural background must be taken into account when conducting bodily searches. In practice, the search in itself is always humiliating for the child. For this reason, the way in which the search is carried out must always

be assessed individually, choosing a method that minimises harm to the child.

- The institution noted that the children's experiences of bodily searches mentioned in the NPM visit report were such that their implementation method must be developed. The institution intended to order movable screens to the units for the purpose of carrying out bodily searches. The instructions also now state that the manner in which the person is inspected must be recorded (1353/2018).
- According to the institution, there was a lack of clear instructions on how to carry out bodily searches. The institution participated in developing practices related to bodily searches together with other residential schools. The purpose is to identify the current methods used in bodily searches and to prepare a proposal for common guidelines (1353/2018).
- The institution announced that more attention had been paid to recording the reasons and that the matter had been discussed at personnel meetings. Attention has also been paid to recording how the search is carried out in practice (5930/2019).

The institution does not have the right to carry out routine checks whenever the child returns to the institution or when family members have visited the institution, for example. Neither does the Child Welfare Act allow mass bodily searches. When performing a bodily search, the reason behind the "justified reason to suspect" that led to the search must always be marked clearly on the documents concerning the child. It should be an individual reason that must be assessed separately for each child and each time a bodily search is performed.

- The institution announced that in the future, bodily searches will only be carried out on individual grounds. In addition, the decision describes how the restrictive measure was implemented in practice (1605/2018).

Sometimes after NPM visit, the institution may change its practices in such a way that restrictive measures are no longer taken even when there is a legal reason for doing so. This may lead to situations that the restrictive measures were designed to prevent and which the Child Welfare Act allows:

- Attention has been paid to the grounds for bodily searches recording them at the institution. The number of bodily searches performed has been significantly reduced. According to the institution, this has led to an increase in the influx of drugs, fire-making tools, and blunt instruments into the young people's rooms. Personnel observations are not considered to form a sufficient basis for performing bodily searches (5377/2018).

The Child Welfare Act does not give authorisation to undress a child. If a child's clothing has to be examined during a bodily search, it must be carried out as discreetly as possible. For this reason, the child must be allowed to undress under a large towel or bathrobe, for example. Protective screens can also be used alternatively. A procedure in which the instructor holds a towel behind which the child takes off their clothes cannot be considered acceptable.

- The institution announced that in the future, the children will be given a bathrobe to cover themselves when changing their clothes. A bodily search is always performed in a room without cameras or with the surveillance camera covered. It is always performed by two members of personnel who are of the same gender as the young person (5377/2018).

The NPM visit has also revealed that non-authorised persons outside the institution have participated in the bodily searches.

- According to the institution's new instructions, employees outside the institution may no longer participate in the implementation of restrictive measures (1353/2018).

ISOLATION

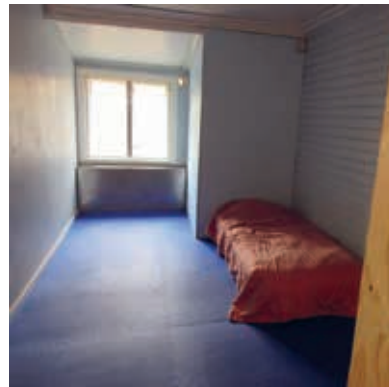
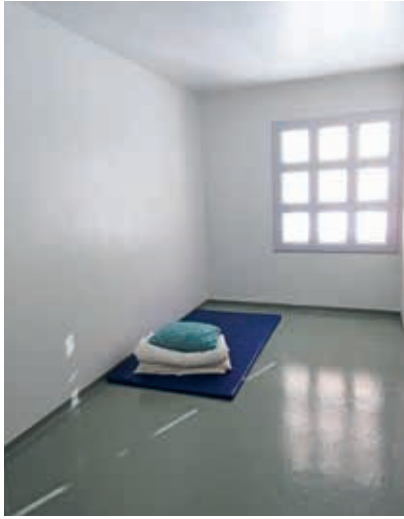
Isolating a child must be the last resort to address a situation in which the child behaves dangerously. Instead of isolation, we must always consider other milder measures. The NPM visits have revealed practices similar to isolation, which the institutions themselves did not consider isolation.

- After the NPM visit, the institution announced that the personnel had been reminded that isolation in the child's own room requires justification for isolation as laid down in the Child Welfare Act. After the visit, the institution also discussed the fact that the interruption of social encounters by obliging the young person to perform written tasks in their room is actually isolation, which must be justified under the Child Welfare Act (1353/2018).

In some institutions, the practice has been that a child arriving to the institution has been unlawfully isolated from other children at the beginning of their placement for several days or weeks. Isolation has sometimes been used in a penal manner, for example, when a child escapes and returns to the institution calmly and is still isolated. Neither does intoxication alone justify isolating the child.

- The institution announced that there are no longer talking bans between children or a practice to eat alone, separately from others (1353/2018).
- Children will no longer be placed automatically in a safety room when they arrive. Based on the child's condition and behaviour at the time of arrival, it will be assessed whether they can be placed directly in their room and whether they can participate in the joint activities of the institution immediately (5377/2018).

The Deputy-Ombudsman has required that one institution abandons their practice of having children undress when they are taken to an isolation room. In the future, taking someone into isolation and any bodily search associated with it will be carried out in a manner that respects the child's



Isolation facilities at child welfare institutions. Their general appearance is often very bleak.



Toilet facilities for a child placed in isolation.

human dignity so that the child has the opportunity to cover their body during the search.

- According to the institution, one of the important changes in the operating culture is related to reducing the excessive anticipation and prevention of safety risks and dangerous situations. In the future, the institution will pay particular attention to the therapeutic nature of the isolation measure and to maintaining absolute discretion in the situation. The new instructions prohibit changing clothes when entering the calming room (1353/2018).

There have been many shortcomings in recording the matters related to isolation, such as the situation that led to the isolation and the child's behaviour, the way in which isolation was implemented, how the grounds for continuing isolation were assessed during the isolation and how was the decision to stop isolating the child made. Since the NPM visit, the institutions have announced that they will better record the issues raised by the Deputy-Ombudsman (1353/2018, 5377/2018 and 5930/2019).

DEBRIEFING OF RESTRICTIVE MEASURES

The child-specific assessment of the restriction became a statutory obligation on 1 January 2020. This means that if a child has been subject to restrictions referred to in the Child Welfare Act, the child welfare institution must assess their use together with the child in accordance with the Child Welfare Act. The aim of the debriefing is to assess with the child how the use of restrictions could be avoided in the future. At the same time, the institution must assess its own activities and consider ways to avoid a similar situation in the future. The Deputy-Ombudsman has also recommended drawing up a plan for restrictive measures. The plan would contribute to reducing the need for restrictions and to increasing the personnel's and children's knowledge of lawful, appropriate and acceptable practices.

After the NPM visits, child welfare institutions have announced that they will pay attention to the debriefing of restrictions (5930/2019 and 883/2020).

OVERSIGHT OF OVERSIGHT

The NPM's visits have paid more and more attention to the effectiveness of the work carried out by the supervisory authorities that are primarily responsible for monitoring child welfare institutions. There are cases where the monitoring efforts fall far short of satisfactory. The visit reports may also have requested the local Regional State Administrative Agency, as the authorising authority, 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).

Following visits conducted by the NPM, amended legislation entered into force on 1 January 2020, requiring that children residing at a unit visited by AVI must be given an opportunity to be heard in person. Here are some examples of how the Deputy-Ombudsman has addressed shortcomings observed in self-monitoring.

The NPM visited a youth home (5930/2019) that had several complaints. In her decisions, the Deputy-Ombudsman considered that municipalities had neglected the supervision of substitute care for children. She also stated that the social worker responsible must assess the practices and rules of the institution and intervene if they restrict the rights of the child in an unlawful manner. Three decisions issued a reprimand to the municipality on its failure to comply with the supervisory obligation. In her three other decisions the Deputy-Ombudsman drew the municipalities' serious attention to the proper performance of their statutory tasks (4566/2018, 5679/2018, 5682/2018, 5683/2018, 5685/2018 and 3662/2019).

- NPM visit carried out at a youth home revealed that young people were still restricted based on the rules drawn up by the institution itself without the individual consideration of the young person's situation as required by the Child Welfare Act.
- The Deputy-Ombudsman required that every social worker responsible for a child and who

placed children in a youth home meet with the child and explain the contents and meaning of the NPM visit report for the child. For this purpose, the social worker had to provide the child with an opportunity for a private discussion.

In the NPM visit report of the residential school (883/2020), the Deputy-Ombudsman commented on the organisation of supervision and stated that the Regional State Administrative Agency (AVI) plays a key role in ensuring the child's legal protection as the supervisory authority. AVI must also monitor the activities of child welfare institutions through visits on its own initiative and, in particular, monitor the use of restrictive measures in child welfare institutions.

The Deputy-Ombudsman stressed that hearing the child and access to the documents and restrictive measures concerning the child are an essential part of the supervision. The children should also be given an opportunity to have a confidential discussion during the visits. With the discussions, AVI can monitor the treatment and conditions of children individually and also in general, and assess the realisation of the operative conditions of the Child Welfare Service. In order to ensure effective supervision, monitoring visits should also be carried out unannounced and during the time the children are present.

In addition to the above, the Deputy-Ombudsman has considered it necessary that the authorities supervising substitute care immediately report any issues or shortcomings they have observed in the operation of the substitute care facility to the municipality in question as well as AVI and other municipalities that have placed children in the same substitute care facility. The Deputy-Ombudsman has considered it important that also AVI informs particularly the municipalities of any shortcomings it finds.

3.5.13 SOCIAL WELFARE UNITS FOR OLDER PEOPLE

In 2020, the NPM conducted three on-site visits on social welfare units for elderly as well as separate remote visits to the same units. The visited facilities were:

- Hoitokoti Annala Oy, 24-hour residential service, Kesälahti, Siun sote Joint Authority (1823/2020)
- Annalakodit, 24-hour residential service, Kesälahti, Siun sote Joint Authority (1824/2020)
- Koivupiha, 24-hour residential service, Joensuu, Siun sote Joint Authority (1760/2020)

The purpose of the remote follow-up visits was to assess how the COVID-19 pandemic had affected the operation of the units. A contact request had been sent to the units' residents and their families to gain information on their experiences. Contacts were received by telephone and email.

You can read more on other monitoring of the care of older people during the COVID-19 pandemic in section 4 (Issues related to coronavirus).

The following is a summary of how the Ombudsman with the mandate of the NPM has supervised the social welfare units for older people by visits in 2015–2020. Visits to geriatric psychiatry institutions are discussed in section 3.5.16.

MISTREATMENT AND OBLIGATION TO REPORT

Those working in a social welfare unit are obliged to report poor treatment to the person in charge of operation without delay. The municipality and private service provider must inform their personnel of this obligation to report and matters related to it. The Deputy-Ombudsman has stated that the unit should include clear instructions on reporting poor treatment in the self-monitoring plan as well as how the notifications are processed and how mistreatment is addressed. This also requires the identification and definition of poor treatment and, on the other hand, a clear statement by the management that poor treatment is not permitted.

and that there are consequences for mistreating someone. The guidance should be reviewed with all those working in the unit - not only the nursing staff but also other professional groups and temporary employees. At the same time, it should be clarified that reporting will not have negative consequences for the notifier.

The NPM visits have shown that employees have not always been aware of the obligation to report under the Social Welfare Act. Employees might have mentioned irregularities, but they have not been able to identify which cases were mistreatment or some other irregularity that should be reported under the law. A supervisor's negative attitude to reports may also have influenced the fact that they were not made.

- The joint authority stated that it had prepared guidelines on the social welfare personnel's obligation to report. The guidelines were available to all units on the joint authority's website. The guidelines included a reporting form that can be filled in. The unit's updated self-monitoring plan included instructions for the obligation to report in relation to the poor treatment of a customer (3015/2019).

Based on one visit, it may be difficult to make observations on mistreatment. However, when serious shortcomings are found in the basic care and treatment of residents, it can be assumed that actual mistreatment might occur in the unit. For one care unit, the Deputy-Ombudsman stated that the quality of care and treatment did not safeguard a dignified life as required by the Constitution. Some residents were afraid of the personnel and some employees were afraid of the unit management. The management was informed of at least some of the activities, but the measures taken to improve the situation were insufficient. The Deputy-Ombudsman drew serious attention to the way in which the shortcomings were dealt with in the work community. The Deputy-Ombudsman required that the unit immediately take measures to prevent the mistreatment from continuing and

to ensure the flow of information so that similar events would no longer be possible (6032/2019).

- The unit prepared a plan for good treatment after the NPM visit.

ADEQUACY OF PERSONNEL

During the NPM visits, the units' attention has been drawn to the fact that the personnel allocation should be based on direct customer work. If the unit's objective is set to the minimum of the current recommendations, it requires a careful assessment of the tasks. The Deputy-Ombudsman has emphasised that no more residents may be placed in the unit than what the personnel's capacity is in offering high-quality care that ensures a dignified life. If the number of personnel is regularly too low in view of the number of residents, the number of residents must be reduced (3016/2019, 5023/2019 and 6032/2019).

- The municipality, which is located in Lapland, announced that it is challenging to prepare to have adequate personnel during acute sick and work leave. There were no backup personnel. No trained personnel were available in the municipality for short-term work (5023/2019).
- A private service provider announced that a group home's workforce had been strengthened so that two employees were on duty in each shift. The service provider had also started recruiting additional personnel to strengthen the workforce resources during night time (6032/2019).

The NPM visits have revealed that the safety of residents has been compromised in too many units, especially at night. The night nurse often has the task of distributing medicine, which requires full concentration. At the same time, the night nurse may be responsible for residents of several departments (3082/2018). There have also been units where the night nurse's duties have been to assist the night nurse of another nursing home in addition to looking after their own unit (659/2018) or to respond to the alarms of the sheltered housing residents (657/2018). The night

nurse may also have different support service tasks, which may result in situations that endanger customer safety (1842/2019 and 4743/2019).

- The municipality announced that two fixed-term practical nurses will be hired for the nursing home, and the two nurses will be given night shifts. The night nurse of the nursing home no longer had to take care of the alarms of the residents of sheltered housing (657/2018).
- The municipality reported that the doors of individual residents' rooms had to be locked at night due to residents with severe memory disorders wandering off. The addition of one nurse will be made on 1 January 2021. In addition, an increase of four nurses has been proposed in the 2021 budget for housing services (3016/2019).
- The joint authority stated that during the night, nurses will take care of laundry and dishwashing if they have time to do so in addition to nursing duties. Laundry is supposed to be done mainly in the afternoon, when there are more personnel resources (4743/2019).

The low number of personnel may also affect the use of restrictive measures. The Deputy-Ombudsman did not consider the number of personnel assigned to treatment and care sufficient if restrictive measures had to be used due to the low number of personnel. The Deputy-Ombudsman has also emphasised that locking the doors of persons with memory disorders is not problematic only for fire safety reasons (3015/2019, 4743/2019 and 5595/2019).

- The joint authority reported that there was a shortage of trained nursing staff in its area. The joint authority had an agreement with two vocational education institutions in the region on a training package for nursing assistants, the first of which was to start in both institutions already in spring 2020. Attention will also be paid to the nature of social services. The personnel structure will be changed to recruit Bachelors of Social Services, geriatric nurses or other professionals with a similar qualification (3015/2019).

- The joint authority announced that they have introduced a modern technology system, motion sensors and surveillance cameras to support the night time resources. Residents' rooms have electric locks that can always be opened from the inside. In the event of a fire, all locks will open. If a fire breaks out, the entire unit's personnel will be alarmed as well as the fire brigade, guard and supervisor. The residents' rooms are fire safe, so leaving the room is not always the best option. Instead, the residents should wait for help in the room with the door closed. There are also motion sensors that can be placed on different sides of the floor or a resident's room. If the resident moves around the floor or in the room, the nurses' phones will receive an alert. Floor-specific security cameras are also used (4743/2019).

RIGHT TO PRIVACY

The protection of privacy is a fundamental right, and care for elderly people is no exception. The aim is that every older 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 free will. In twin rooms, attention should also be paid to respecting privacy, especially in the delivery of personal care.

The NPM visits draw attention to the fact that residents have an opportunity to privacy and that the resident's information is processed in such a way that their privacy is not violated. The Deputy-Ombudsman's statements usually cause a desired reaction and the unit's practices are changed as recommended by the Deputy-Ombudsman.

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 well-being of the residents without waking them up by opening the door. The Deputy-Ombudsman re-

quired that the doors be changed to protect the privacy of the residents. After the NPM visit, the unit reported that the doors had been repaired and that the direct view had been blocked (3763/2019).



OUTDOOR ACTIVITIES AND RECORDING THEM

The Deputy-Ombudsman has emphasised the importance of the daily outdoor activities of residents as part of good quality care. The visits have revealed that in several units, daily outdoor activities are either not realised or it is not possible to confirm their realisation retrospectively due to incomplete documentation. The Deputy-Ombudsman has recommended that outdoor activities be included in the resident's care and service plan. They should also record the residents' wishes for outdoor activities. The arrangement of outdoor activities should not be left solely to relatives and volunteers. The outdoor activities must be recorded so that they can be verified. After the Deputy-Ombudsman's observations, the units have increased outdoor activities and started monitoring the realisation of outdoor activities:

- The group home informed, that it will pay particular attention to the fact that the activities carried out with the help of other professional groups and actors (summer youth, students,

assistants and family members) will also be recorded. At least one employee will also go out with the residents every day to ensure adequate outdoor activities (3290/2018).

- In the future, outdoor activities will be recorded in a separate form and in the electronic customer information system. Residents confined to a bed will also be taken out when the weather allows it (3016/2019).
- After the NPM visit, the unit's instructions for recording were specified. Outdoor activities will be recorded as part of the resident's care plan, and their implementation will be monitored with daily recording. The resident's refusal will also be recorded. Supervisors monitor the implementation of outdoor activities regularly. Work shifts are planned so that the units will have enough personnel for organising outdoor activities especially in the afternoon during shift change (3763/2019).
- The Deputy-Ombudsman was informed that the unit has a residents' outdoor list. Willingness to go outside is part of the resident's right to self-determination, which should be respected. It is also important to take into account the weather conditions prevailing locally (Lapland), especially in winter. A plan for organising continuous outdoor activities is recorded in the resident's care and service plan. Shift planning allows time for the personnel to take residents outside (5023/2019).
- The Deputy-Ombudsman was informed that the unit has ensured that every resident can get out if they wish. Outdoor activities and refusals of outdoor activities are included in the list. The outdoor activities are carried out by their own personnel (6032/2019).

ORAL HEALTH

As the functional capacity of an older person deteriorates, responsibility for their daily oral hygiene remains with the family members or nursing staff. The NPM visits to nursing homes have revealed that oral health care is not given sufficient attention and it does not involve the same systematic nature as other matters related to the res-



Various activities and comfortable balconies can be found in residential units for older people.

idents' state of health. The Deputy-Ombudsman has found it important to ensure on arrival that a new resident has a recent dental care plan in place and that the personnel 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 has therefore recommended that the personnel be provided with oral health training.

Some units have shortcomings in the regular cleaning of residents' teeth. The Deputy-Ombudsman has 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. The unit should make sure that regular tooth brushing is not neglected. If brushing has to be skipped during a shift, it must be recorded so that the matter can be rectified later.

After the NPM visits, the nursing units have started implementing the Deputy-Ombudsman's recommendations, although the dental care for

older persons with severe memory disorders has also been considered challenging:

- The service provider hoped that the municipality's dentist or oral hygienist could come to the nursing unit to check the oral health of residents confined to beds and give the personnel instructions on care (4210/2017 and 3763/2019).
- The municipality informed the Deputy-Ombudsman that oral health services are part of the treatment and included in the daily care fee for older people living in 24-hour intensified assisted housing. However, no annual oral health examinations are carried out on residents, as the examinations do not in themselves improve oral hygiene. Instead, the oral care of each resident and the use of health services should be based on an individual care plan. The municipality announced that it had offered a training event for personnel of the nursing unit.

The training aims to increase the competence of nursing staff in assessing the residents' oral condition and implementing daily care as part of high-quality basic and nutritional care. Residents who need dentist care or

whose previous oral examination was a long time ago are referred to the municipal dentist's or the resident's own dentist's appointment. The dentist draws up a care plan for the resident, which the nursing staff will add to the resident's care plan. The nursing staff assume the further care of the resident in accordance with the care plan (4210/2017).

- It was agreed with the joint authority's senior dentist that an oral hygienist will make a free first visit to the residents of the nursing unit from now on. The oral hygienist will also train the nurses in oral care (6198/2017).
- The municipality announced that new residents will be referred to oral care as they arrive. The dental assistant will visit the resident to make an oral care plan. Internal training is organised at the unit through dental care services (3016/2019).
- The unit will add care for oral health in the care plan for when the resident arrives. The oral hygienist will also visit the unit once a year for a check-up. The unit will also organise oral health training for personnel in accordance with the Deputy-Ombudsman's recommendation (5880/2019).

would mean that it could last until midnight. The unit did not consider it possible to extend the evening work shift (3016/2019).

- The joint authority announced that the nourishment of the nursing unit's residents is monitored with different indicators. If the state of nourishment raises concerns, a mini nutritional assessment will be conducted. The duration of the residents' overnight fasting is monitored and a separate snack is served when needed (3015/2019).

Every other resident in the housing unit was found to have a weight index of 24 or below, which may indicate problems related to nourishment. The Deputy-Ombudsman required that the unit ensure adequate food supply for residents and address any signs of malnutrition immediately.

- According to the municipality's report, the nutritional condition of the nursing unit's residents is monitored and a nutrition therapist is consulted when necessary. Dietary supplements and food enrichment are used if a resident is in a state of malnutrition or needs it for health reasons. The unit has supplies for night-time snacks for residents (3016/2019).

NOURISHMENT

The upper limit of overnight fasting is 11 hours according to the National Nutrition Council's nutritional recommendations for older people. The NPM visits pay attention to the length of the residents' overnight fasting and whether the residents' weight is monitored. In view of the fact that the majority of the residents of nursing units for older people have memory disorders, late-night snacks should not be available only at the resident's request, but also offered.

A low number of personnel in a nursing unit may have an impact on the residents' meals and eating. The NPM team discussed with the personnel whether the evening snack could be served later to prevent the overnight fast from becoming too long. The unit stated that there were so many residents to feed that delaying the evening snack

PALLIATIVE TREATMENT AND END-OF-LIFE CARE

Competent end-of-life care is an essential part of good care to which every older person is entitled. The Deputy-Ombudsman has considered it unacceptable that decisions on end-of-life care are not always made or they are made at a very late stage. A decision on end-of-life care is an important medical treatment policy made by a physician that guides the care of a resident. Without it, the nursing staff cannot work properly for the best of the resident. A decision on end-of-life care made for a dying person also makes it easier for family and friends to adapt to the situation. The Deputy-Ombudsman has stated that the provision of palliative care and end-of-life care is based on a proactive treatment plan and decision made well in advance (1764/2019, 1765/2019 and 2009/2019).

The Deputy-Ombudsman has also considered it important that the physician who made the decision on end-of-life care explain the grounds for the decision and its significance to the resident and/or family members. The NPM visit has revealed that family members may be unaware of the grounds for the decision. According to the nurses, the relatives were worried that their loved one was without proper care and treatment as death approached. The Deputy-Ombudsman noted that this conflicting experience may have influenced the family members' grieving after the death of their loved one (3015/2019). The Deputy-Ombudsman has also recommended that the resident's own wishes for end-of-life care are recorded in the care plan.

- The unit announced that it will record the residents' wishes for end-of-life care in their care plans from now on, in accordance with the Deputy-Ombudsman's recommendation (5880/2019).

The Deputy-Ombudsman has considered that end-of-life care is problematic in twin rooms in terms of the privacy and dignified care of older people. This can sometimes be changed by a renovation (5417/2016), but often the aim is to ensure privacy in other ways.

- The Deputy-Ombudsman was informed that the aim was to guarantee peace in the resident's room if possible when they are in end-of-life care. Movable screens bring privacy for a resident in end-of-life care. If the twin-room resident's situation of end-of-life care is such that it would definitely require them to be cared for in a single room, the residents and their relatives can be asked about moving the resident to another resident's room for a while. This requires that the arrangement is suitable for both the moved resident and the one whose room the resident would temporarily be transferred to (4210/2017 and 4211/2017).

The Deputy-Ombudsman has stated that end-of-life care requires acknowledgement in personnel allocation. This is the only way to ensure humane treatment of a person in end-of-life care. The processes for obtaining/asking additional personnel in

end-of-life care situations should also be reviewed with the personnel. The unit should ensure that appropriate end-of-life care is also arranged at night.

- End-of-life care is always very individual, and the need for additional hands is assessed according to the situation. The housing services had no prohibition on hiring an additional person in situations where the resident has experienced insecurity, fear or restlessness, or when no family members have been present (6712/2017 and 4743/2019).
- According to the instructions on end-of-life care, the nursing staff on duty are allowed to call for additional workers if they consider it necessary. A full-time nurse's post was proposed for the nursing unit for 2020, but it was not established (5023/2019).
- The service provider announced that it was possible to increase personnel in an end-of-life care situation if necessary. This is also included in the service agreement with the municipality (6032/2019).

The Deputy-Ombudsman has also started paying more attention to the quality of end-of-life care during NPM visits. This has been made possible by an expert in palliative and end-of-life care attending the visit. The external expert has drawn attention to the fact that the symptoms of residents in end-of-life care or the effectiveness of the treatment provided are not measured in any systematic way. The Deputy-Ombudsman has recommended that the recommendation of Ministry of Social Affairs and Health on the provision and improvement of palliative care services in Finland (2019) should be taken into account when updating the self-monitoring plan.

- The unit often contacts its responsible physician about end-of-life care and relief of pain. The unit has also received consultation and on-site help from the home care unit. According to the unit's experience, these measures have improved the quality of pain relief and end-of-life care (1764/2019).
- The NPM visit revealed that there was uncertainty in the initiation of pain treatment for a resident in end-of-life care and that it was not

implemented in accordance with recommendations. According to the Deputy-Ombudsman, the aim of pain treatment should be to keep the patient free of pain and not to give medicine until the patient expresses pain. In the unit, the start of medication was based on the nurse's assessment. The service provider informed the Deputy-Ombudsman that the principles for implementing end-of-life care in the nursing unit are now in line with national recommendations. End-of-life treatment is implemented under the guidance of a geriatrician and nurses (6032/2019).

According to the Deputy-Ombudsman, the principles describing end-of-life care must be recorded in the unit's self-monitoring plan. It must also be ensured that the personnel are trained and familiarised with the implementation of appropriate end-of-life care. The NPM have revealed that the nurses have not had enough training on end-of-life care. In some nursing homes, nurses have hoped to receive further training in this matter. The instructions for end-of-life care may also have been completely missing or lacking. When outsourcing services, the party responsible for organising the training must be decided upon – the customer of the service or the service provider. After the NPM visits, the nursing units have prepared end-of-life care plans, updated their instructions and started organising training for the personnel.

- The report of the city that purchased the nursing service stated that the unit's personnel must have the professional skills, competence and motivation required for carrying out the tasks. This also applies to competence in end-of-life care. The service provider must ensure additional and further training for personnel. The service provider organises training for the personnel, and the city organises further training if necessary. In the visited nursing home, end-of-life care training is organised for nursing staff (3367/2018).
- The city announced that end-of-life care training is currently organised in cooperation with the university of applied sciences. The self-monitoring plan is updated, fixing the shortcomings in end-of-life care (3016/2019).

- The unit announced that instructions on end-of-life care will be added to its self-monitoring plan. In January 2021, the unit appointed a person in charge of end-of-life care whose task is to ensure the unit's competence in this matter. The unit will organise end-of-life care training for the personnel. The Deputy-Ombudsman has received the unit's end-of-life care plan (5880/2019).

RESTRICTION OF THE RIGHT OF SELF-DETERMINATION

Restrictions on the fundamental rights of care recipients in elderly care are not provided for in the law. However, the Ombudsman has consistently considered that an elderly resident may only be restricted under a physician's decision. The physician should also monitor that the restriction procedure is not used further or for longer than is necessary. Furthermore, the method used must not be excessive in relation to the objective. The use of the restrictive measure must be stopped immediately when it is no longer necessary. There must be appropriate records of the restriction measures in use. The measures should be discussed with the family or other close relatives before taken into use. They should also be informed why the restrictive measure is necessary. The unit must ensure that there are appropriate decisions by a physician on the restrictive measures. Decision-making concerning the use of restrictions and assessing their duration may be jeopardised if the physician rarely visits the unit and does not meet the residents.

The elderly care units do not usually have separate instructions on the use of restrictive measures. In many cases, the guidelines on the use of restrictive measures are included in the self-monitoring plan. Very often, the Deputy-Ombudsman has had to draw the units' attention to the fact that the self-monitoring plan does not mention which cases are considered restriction of the right of self-determination. Moreover, not all plans included all the restrictive measures used in the unit or described the principles of their use. It has been discovered during NPM visits that the person-



The right to self-determination and moving around of persons with memory disorders can be restricted by locking the fridge or closing the stairway.

nel were not always able to recognise a restrictive measure. Understanding the concept of restriction is important, so that the personnel can make the right decisions.

The Deputy-Ombudsman has required that the Ombudsman's policies on the use of restrictive measures, defined in the NPM visit report, and the restrictive practices to be observed be clearly recorded in the self-monitoring plan. In addition, more attention should be paid to practical implementation. The central objective of the unit must be to prevent the use of restrictive measures and to prepare a plan for alternative operating methods. Restrictive measures must not be used because of an insufficient number of personnel. After the NPM visits, the elderly care units have devised separate guidelines on the principles of restricting the residents' right of self-determination and on the use of restrictive measures (4211/2017 and 3015/2019). Also the already existing guidelines have been updated in accordance with the Deputy-Ombudsman's recommendations (3763/2019). Some units' self-monitoring plans have been updated in accordance with the Ombudsman's policies (3016/2019, 5880/2019 and 1823/2020).

The inspection visit findings have also indicated that the nursing staff is not adequately trained in restrictions. The Deputy-Ombudsman has recommended that personnel should receive training on the conditions for using restrictions and on reducing their use. Some of the visited units have reviewed their updated guidelines or self-monitoring plans with the personnel after the NPM visit (3016/2019 and 3763/2019). However, based on the visits, it is not certain if simply reviewing the guidelines is enough. It may be necessary to provide more extensive training for the unit's management and personnel on supporting the right of self-determination.

The way many elderly care units feel about locking the door of a resident's room speaks for the need for training (such as 2217/2018 and 2009/2019). The Deputy-Ombudsman has stressed that security is not in itself sufficient reason to restrict a person's fundamental rights. 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 emergency. However, these are only relevant in an acute situation. They cannot be referred to as a justification for locking doors. However, this is not always understood. They may have told the Deputy-Ombudsman that locking rooms is an extreme means of ensuring the safety of residents without mentioning whether other less restrictive means were considered or tried (2217/2018). The Deputy-Ombudsman has also drawn attention to the fact that even if the resident's door is locked only from the outside, the resident does not always have a genuine possibility of getting out of their room if they do not know how to use the door button or cannot find it (4743/2019).

In addition, the physician's role at the start and end of restrictive measures may not have been fully understood. The unit's guidelines on restrictions may appropriately state that the physician decides on the start of restriction and the physician must monitor that the restriction is not used for further or longer than is necessary. Nevertheless, the practice may be that the physician rarely visits the unit, which can jeopardise the decision-making concerning the use of restrictions and assessing their duration.

The Deputy-Ombudsman has recommended that the physician meet the resident subject to the restriction on a regular basis. Where meetings with residents are rare, there is a risk that the use of restrictions will continue, even if they are no longer necessary. When there is no physician's decision on restriction, the units sometimes appeal to the fact that the restriction was authorised by the resident and/or their relative. However, the Deputy-Ombudsman has not considered it acceptable that restrictive measures are used with the permission of a person with a memory disorder who does not necessarily understand the matter. The use of therapeutic restrictive measures must always be based on a physician's assessment and decision.

The elderly care units have almost always reported that they have changed their procedures and instructed the personnel to act correctly after the visit. The biggest challenge has perhaps been to make the role of a physician more active, especially in monitoring the necessity for the use of restrictions. At the moment, nurses assume a lot of responsibility in this, and reducing the use of restrictions depends on their activity. However, changing the procedure would require a physician to make regular and sufficiently frequent visits to residents under restriction. On the basis of the replies received by the Deputy-Ombudsman, municipalities and private service providers are not willing to change medical services contracts and increase the number of a physician's visits. Based on the visits, nurses are also used to using medical services remotely. Even ward rounds made by the physician are made remotely – also before the COVID-19 pandemic.

REDUCTION OF RESTRICTIONS

The Deputy-Ombudsman has considered it necessary to monitor the restrictions applied in each unit that uses restrictive measures. Without qualitative and quantitative data on the measures adopted, systematic monitoring of the practice is difficult or impossible. Monitoring also serves to reduce the systematic use of restrictive measures. The main goal must be to avoid the use of restrictive measures and to make a plan for alternative methods. The creation of preventive methods and practices requires training the entire work community and involving them in the development of practices.

The Deputy-Ombudsman has also recommended devising a plan for good treatment as part of the self-monitoring plan. It would help find ways to prevent the emergence of situations in which the use of restrictions has been considered as well as other ways of reducing the use of such restrictions. Particular consideration should be given to the use of means that improve the residents' well-being and reduce restless and aggressive behaviour, for example. The NPM visit might

have also revealed that non-pharmaceutical methods of addressing the challenging behaviour of a person with a memory disorder may have been inadequate (6032/2019).

After the NPM visits, the units have regularly started monitoring the restrictive measures used and their amount. Municipalities and private service providers have announced different ways in which the units have attempted to reduce the use of restrictive measures and find alternative ways to prevent the need for restrictions. For example, the unit has started to regularly implement alternative sedative measures, such as outdoor activities and spending time together. The residents' medication is also actively examined together with a physician (4743/2019).

SELF-MONITORING

Self-monitoring means that the service provider independently ensures the quality of the service and customer safety. Each social welfare unit must have a self-monitoring plan which must be visible to both employees and residents and their relatives. The Deputy-Ombudsman has also recommended that the self-monitoring plan be found on the public website of the operating unit or the municipality. The Deputy-Ombudsman has emphasised that sufficient and appropriate self-monitoring can only be achieved if the personnel are aware of the content and objectives of the plan.

- The unit announced that each new employee will go through the self-monitoring plan and thus learn to use it in their practical work. The themes of the nursing director's regular discussion events on good care also rise from the self-monitoring plan. In this way, the unit reviews instructions and rules that are central to self-monitoring and maintains discussion on important topics (3763/2019).
- The municipality announced that the self-monitoring plan was revised in late spring of 2020 to correspond to the National Supervisory Authority for Welfare and Health' (Valvira) regulation and instructions. After the

exceptional circumstances return to normal, the self-monitoring plan will be updated together with the personnel and a responsible employee/employees will be selected from the personnel (5023/2019).

The NPM visits have revealed that the units usually have a self-monitoring plan prepared, but it has often not been updated (such as 1764/2019 and 3015/2019). Regrettably often, the plan has not been made public nor published on the website (such as 6712/2017 and 3016/2019). After the visits, the units promised to update the plan and submitted it to the Deputy-Ombudsman. The units have also announced that the plan is available to residents, their relatives and the personnel.

OVERSIGHT OF OVERSIGHT

In her contribution to the Ombudsman's annual report in 2017, Deputy-Ombudsman Sakslin discussed the oversight of oversight. She states that direct supervision during visits and hearing individuals also provides information on the state of the supervision of other parties responsible for monitoring the activities. Supervision based on inspection visits has therefore also focused on monitoring the primary supervisors and in improving their efficiency. These visits can be used to address infringements of rights, but they also provide invaluable information for the oversight of primary supervisors.

The Deputy-Ombudsman has supervised the authorities responsible for monitoring elderly care units by requesting a report from the municipality on how it supervises the operation of the unit (1764/2019). Due to the seriousness of the observations, the Deputy-Ombudsman may also have requested the municipality to take immediate measures to ensure that the unit residents' treatment and care is properly implemented as well as in order to prevent mistreatment. The municipality has subsequently imposed a placement ban within the municipality on the elderly care unit. The municipality has also been prepared to

temporarily place its own employees in the unit in order to ensure the sufficiency and competency of personnel. The Deputy-Ombudsman has also required that the municipality closely monitors the implementation of sufficient personnel allocation in the unit in relation to the needs of the residents (6032/2019).

Sometimes the Deputy-Ombudsman is required to take further measures to ensure that the elderly care unit is properly functioning and supervised. An example of this is NPM visit carried out in September 2019, in which the Deputy-Ombudsman drew attention to the fact that the elderly care unit for older people had been under enhanced supervision since 2017 and that there were still reports 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 inadequate time reserved for reflecting on practices.

However, the Deputy-Ombudsman welcomed the fact that Valvira and the Regional State Administrative Agencies (AVI) had identified the shortcomings and were working on further developing their operations. However, the Deputy-Ombudsman stressed that the public service unit itself and the local authority providing the service have the primary responsibility for ensuring that services are delivered to a high standard and in compliance with the law. The Deputy-Ombudsman required that the unit implements the measures mentioned in the NPM visit report and the measures required by Valvira and AVI immediately. In addition, the Deputy-Ombudsman required the local authorities to ensure that the shortcomings do not recur. The municipality also had to ensure that the unit had sufficient workforce, also at night (4921/2019).

3.5.14 RESIDENTIAL UNITS FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

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. These must be carried out in accordance with the provisions of the Act on Special Care for the Persons with Intellectual Disabilities, which entered into force on 10 June 2016.

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 task of the Ombudsman is discussed further in section 3.4 (Rights of persons with disabilities). In addition, the monitoring of the rights of persons with disabilities during the COVID-19 pandemic is discussed in section 4 (Issues related to coronavirus).

In 2020, there were five remote NPM visits of units for persons with intellectual disabilities and one remote visit of a housing unit for persons with severe disabilities. The visits were carried out as reviews of documentation. The units' clients, their legal representatives and family members were also given the opportunity to have a confidential discussion by telephone with representatives of the NPM/Office of the Parliamentary Ombudsman. The purpose was to obtain information on the treatment, care and conditions of clients in institutional and housing services, especially during the emergency conditions caused by the COVID-19 pandemic. The total number of calls was 37.

The discussions provided information on how the clients and their relatives had experienced COVID-19 -related restrictions and how they had been implemented. The discussions showed that there were shortcomings in the provision of infor-

mation. The suspension of daytime activities and restriction of outdoor activities were highlighted as special problem areas. The final visit report is not yet available at the time of writing, but preliminary observations related to COVID-19 are described in section 4.

The visited units were:

- Rinnekoti, Helsinki Deaconess Foundation (3649/2020)
- Nenonpelto's Kaisla unit, Vaalijala joint authority (3650/2020)
- Antinkartano rehabilitation centre, Satakunta Hospital District (3651/2020)
- Pajukoti residential unit for people with intellectual disabilities, the municipality of Loppi (3652/2020)
- Institution and housing services for people with intellectual disabilities at the city of Pietarsaari or its region (3653/2020)
- Lahti Validia house, Validia Oy's residential services in Lahti (3654/2020)

The following summarises the NPM visit findings made between 2015 and 2020 and the Ombudsman's recommendations as well as how they have influenced the treatment and conditions of persons with disabilities in institutions and housing units.

HUMAN RESOURCES

Under the Act on Special Care for Persons with Intellectual Disabilities, the special care unit must have a sufficient number of social welfare and healthcare professionals and other personnel in relation to its activities and the special needs of the people under its special care. The Ombudsman has had to draw both the private and public service providers' serious attention to the fact that the operating units must have the personnel required for their operations (1376/2018 and 1871/2018).

With regard to the private sector operator, the Ombudsman has emphasised 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.

- After the NPM visit, the service provider reported that the situation concerning the shortage of personnel had been fixed (1683/2019). Regardless of the notification, the Ombudsman requested that the licensing and supervisory authorities monitor the adequacy of staffing by the service provider and the personnel allocation, within their respective spheres of jurisdiction.

The NPM visit revealed that the unit had also included students in the personnel numbers. The Ombudsman drew attention to the fact that a student is not yet a social welfare or healthcare professional. The employer is responsible for ensuring that only persons with adequate professional skills are involved in the use of restrictive measures. In the case of students, it must be assessed carefully whether the student's professional skills are sufficient to participate in the implementation of a restrictive measure. Neither can the use of restriction measures be the students' responsibility. Instead, the guidance and supervision of professionals is needed.

The Ombudsman reminded the units that a student working temporarily as a social welfare or healthcare professional is subject to regulations concerning professionals, so they may also be subject to sanctions for incorrect procedures.

- The rehabilitation unit announced that only apprenticeship students in training who have been hired by the organisation will be included in the unit's strength in the future. Apprenticeship students do not participate in the use of restrictive measures (7007/2017).

IDENTIFYING RESTRICTIVE MEASURES

Residential units for people with disabilities do not always recognise what restrictions are. The NPM visit of a joint authority's care unit in one hospital district showed that involuntary medical treatment was not always understood, or at least recorded, as involuntary treatment. The personnel of the other unit were reminded that holding on to a customer for a short while, even less than 15 minutes, in order to calm them down is also a restrictive measure.

The NPM team 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. The visit also revealed that the lobby doors of certain group homes were locked. This effectively limited the basic right to personal freedom of residents who did not get out of the unit upon request or with their own key (3351/2018).



Access to the kitchen of the unit's residential cell was restricted to all residents.

The Ombudsman has stated that monitoring movement with technical devices requires a decision in writing that can be appealed (2008/2019). The NPM visit also revealed that the freedom of movement of all children in the unit was restricted outside the unit for safety reasons. According to the personnel, all the children placed in the home needed adult support and/or supervision when moving outside. However, none of the children had been subject to appealable decisions on monitored movement in accordance with the Act on Special Care for Persons with Intellectual Disabilities. According to the personnel, the supervised movement of children had been discussed with the local authorities responsible for the cost of the children'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 monitoring visits. 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 (1684/2019). The Ombudsman started investigating the matter separately (2757/2019, pending).

DECISION-MAKING IN RESTRICTIVE MEASURES

The Act of Special Care for Persons with Intellectual Disabilities was reformed in June 2016. One key reason for the reform was that the act lacked provisions on the procedure to be followed in making decisions on restrictive measures and on legal remedies. Even after over six months since the amendments entered into force, the NPM visits revealed that there had been no decisions on the restrictive measures. Due to the procedure, the residents lacked the opportunity to have their case heard before the court.

After two inspection visits, the Parliamentary Ombudsman started investigating on his own initiative whether the units had not made written appealable decisions as required by the Act of Special Care for Persons with Intellectual Disabilities, even though the children's right of self-deter-

mination had been restricted. The first decision concerned the entire joint authority, not just one operating unit. In his decision, the Ombudsman stated that the practical implementation of the Act of Special Care for Persons with Intellectual Disabilities had not been given enough attention, and the resources needed for its implementation were not sufficient. There were also shortcomings in the flow of information. The Ombudsman issued a reprimand to the unit and the joint authority on the unlawful procedure (872/2017).

In the second decision, the Ombudsman considered that the service provider had neglected its decision-making obligation concerning restrictive measures as laid down in the Act of Special Care for Persons with Intellectual Disabilities. The fact that the reformed Act had been in force for more than a year at the time of the NPM visit and that the restrictions on self-determination were imposed on vulnerable children with intellectual disabilities increased the blameworthiness of the case. The Ombudsman issued a reprimand to the service provider concerning negligence in decision-making on restrictive measures (6942/2017).

During the NPM visits, attention has also been paid to shortcomings in the restrictive decisions, such as scarce justifications, lack of instructions

for appeals or a mention of which authority made the decision.

- After the NPM visit, the joint authority announced that the unit had been orally instructed to make decisions on restrictive measures. More detailed instructions on the matter will also be added to the guidelines concerning the right of self-determination (3375/2018).

VARIOUS RESTRICTIVE MEASURES AND INSTRUMENTS OBSERVED DURING VISITS

Keeping doors locked. According to the Ombudsman, residents who have been locked up, even in their own rooms, should have the possibility of contacting the personnel immediately.

- On the previous inspection visit, it had been observed that the doors to some residents' rooms were kept locked at night, and the residents had no bell for calling the personnel if necessary. During the follow-up visit, the unit announced that this practice had been dropped, and the doors of all residents are kept unlocked, also at night. This was made possible by increasing the number of night staff (1050/2016).



In residential units, the movement of residents is restricted both with a chain lock on the front door and with locks accessible only to staff in the doors of residents' rooms.

Sometimes units have to restrict the rights of all residents due to the behaviour of one challenging resident. The Ombudsman has recommended that the undesirable behaviour of one resident be addressed in other ways than by keeping the bathroom door locked for all residents (4362/2015). The Ombudsman has 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).

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. It had been taken into consideration in the decision passed by the authority 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). The Ombudsman decided to take the issue of safety belts and wrist cuffs and the related documentation practices under investigation on his own initiative (902/2020, pending).

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 Ombudsman found the procedure 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 joint authority announced that this restriction instrument had been decommissioned after the NPM visit (3375/2018).

Caged bed. The institution for persons with intellectual disabilities used metal caged beds that had a roof. Similar beds had not previously been detected during visits by the Ombudsman or the NPM. The European Committee for the



Mat used as a restrictive measure.

Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has stated that the use of caged beds can be regarded as violating human dignity and must be stopped immediately.

The Ombudsman urged them to stop using caged beds and to find alternative solutions instead. The legality of restrictive measures used in the care of persons with intellectual 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 emphasised that restrictive equipment must comply with the requirements of the act on health care devices and equipment. These include hospital beds with siderails.

- The joint authority announced that beds that meet the requirements of the act on health care devices and equipment will be sought to replace the beds with high rails (6311/2017).

Security room. In order to calm down someone in special care for persons with intellectual disabilities, a security room may be used in a situation where the person behaving in a challenging manner would otherwise be likely to endanger their own health or safety, the health or safety of other persons or significantly damage property. The security room may not be used for longer than two hours. The security room can also be used when it is estimated that shutting a person in their room



Above, cage beds, the use of which has since been given up. Below, a yellow special bed with CE approval. In the same unit, beanbags had been placed next to the bed to avoid the need to use bed rails.





A security room in the rehabilitation unit that provides psychiatric and psychosocial rehabilitation for young people.

would cause a negative emotional experience of their room, which should be a safe and pleasant place.

On the other hand, if isolation in their own room has a calming effect on the person, the use of their room must be considered a preferred alternative. A resident placed in a security room must always have a way to contact the personnel, for example in situations where the bathroom door is locked, and the resident needs to use the toilet. The NPM visits have revealed that this has not always happened. Instead, the resident may have had to use the floor drain in the security room instead of a toilet.

- The joint authority reported that in the future, residents will have free access to the bathroom beside the security room, as the connecting door will be removed.

The NPM visit revealed that the use of the security room had decreased significantly in the unit since 2016. The reduction was found to be linked to changes in the Act on Special Care for the Persons with Intellectual Disabilities. The aim of the rehabilitation unit was to address challenging situations without having to resort to the security room. If isolation is required, it has usually been

dismantled within 1–2 hours. Efforts have been made to promote this by making consultation visits to different units and increasing resources proactively for crisis situations (7007/2017).

3.5.15 PSYCHIATRIC UNITS

REPORTING ON MISTREATMENT

Closed institutions always involve the risk of mistreatment. For this reason, there must be structures and operating methods that prevent mistreatment. One of these is the practice of reporting mistreatment, which is known to everyone. A healthcare employee does not have the same statutory obligation as a social welfare employee to report any mistreatment they have observed. Most of the healthcare units visited have not provided instructions on how to report mistreatment – or at least the personnel were not aware of it.

In all NPM visits to psychiatric units, the Deputy-Ombudsman has recommended that the units draw up clear guidelines on reporting on poor treatment as well as on how the reports are processed and how the poor treatment is addressed. This requires the identification and definition of poor treatment and, on the other hand, a clear statement by the management that poor treatment is not permitted and that there are consequences for mistreating someone. All those working in the unit – not only nursing staff, but also other professional groups and temporary employees – should be given induction on the reporting procedure. Patients and their families should also be informed of the guidelines. At the same time, it should be clarified that reporting will not have negative consequences for the notifier.

- The hospital's management has informed the personnel of what the poor treatment of patients means, and that poor treatment will be addressed. The personnel have been informed that any observations on poor treatment of a patient must be reported immediately to the management. The departments also

have locked feedback boxes and an electronic feedback system for the entire city, which can be used to provide anonymous feedback on a patient's poor treatment, for example (1046/2016).

- The joint authority's development and patient safety unit will begin planning the reporting procedure at the group's level and will strive to find a technical solution to it. Before this, the psychiatric units have agreed for now that matters related to poor treatment should be reported to the patient ombudsman (5338/2017).
- The hospital had a statement prepared already in 2010, which shows that poor treatment is not accepted and also provides a brief instruction for what to do if you notice poor treatment. Following the NPM visit, more in-depth guidelines were drawn up and published on the hospital's website (3712/2018).

INFORMATION DISTRIBUTED TO PATIENTS AND THEIR FAMILIES

It is essential for the purpose of securing patients' rights that patients and their families are aware of patients' rights and the legal remedies available to them (objection, complaint, and notice of patient injury). The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has also called for a brochure on the legal status of a psychiatric patient in Finland. It should be noted that information on the status and rights of the patient is available on the website of the National Supervisory Authority for Welfare and Health (Valvira), which the Ombudsman has also often referred to.

The Ombudsman has recommended that patients and their families be given clear information about the ward and the patient's rights both orally and in writing when entering the ward. It is particularly important to provide information in a situation where the patient is admitted for observation or being restricted. The personnel should also familiarise themselves with this information material so that they can explain the patient's rights to patients and their family members in

an understandable manner. The wards must also have information on the patient ombudsman and healthcare supervisory authorities.

Patient interviews during NPM visits to psychiatric wards have revealed that patients may have been unaware of their legal status, i.e., whether the patient is being treated voluntarily or involuntarily. The Ombudsman has recommended the state forensic psychiatric hospital to prepare individual guides for those whose state of mind will be examined as well as different patient groups (dangerous, difficult to treat and forensic psychiatric patients) according to their legal status. The guides are important for the realisation of patients' legal protection (2147/2017). The Ombudsman's recommendations have made psychiatric units improve the provision of information to patients and their families.

RIGHT TO PRIVACY

Patients, including patients in involuntary care, have the right to privacy during care. The Ombudsman has had to intervene in the placement of surveillance cameras or in the location of monitors in a ward during visits to psychiatric units. A surveillance camera in public facilities may have been placed so that it has scanned the patient room through the door's window and endangered the patient's privacy. Sometimes, the surveillance's monitor that is used to monitor a patient in the seclusion room may have been located at a place that other patients can access. These issues had already been corrected during the NPM visit (2147/2017) or they had been addressed after the visit (1600/2018).

The Deputy-Ombudsman has also recommended that a secluded patient's visit to a toilet is supervised only when this is necessary and the patient is aware of the supervision. The situation must not become a humiliating experience for the patient.

- According to the joint authority, the surveillance footage can be blurred over the toilet seat. They should also ensure that the patient

is informed if they are monitored with camera surveillance during toilet visits. The practice described above is also added to the seclusion room's instructions (1600/2018).

The psychiatric units have still not reached a situation where the patient does not have to share their room with another person. The Deputy-Ombudsman has recommended adding single rooms.

- The hospital stated that its buildings are very old and do not fully meet modern requirements. Most rooms are for two or even three people. Toilet and shower rooms are usually located by corridors. The renovation that begins in 2019 will remove the last rooms for three people. Arranging single rooms for all patients would require an additional building of approximately 100 rooms. The strategic goal concerning the facilities is to increase the number of single patient rooms from the current situation (3712/2018).

TRANSPORTING PATIENTS OUTSIDE THE HOSPITAL

The Ombudsman has already stated in his 2013 decision (1222/2011) that the transport of psychiatric patients, their treatment and circumstances during transport, and the powers of escorts should be expressly provided for in legislation. As the inadequacy of legislation continuously caused problems in practice, the Ombudsman considered it urgent to reform the law and submitted a proposal to the Ministry of Social Affairs and Health that the legislation be specified. However, the matter did not progress. As the inadequacy of legislation continuously caused problems in practice, the Ombudsman considered it urgent to reform the law and submitted a new proposal to the Ministry of Social Affairs and Health in 2017 that the legislation be specified (2459/2016).



A three-bed room on the psychiatric ward of a central hospital.

A visit to the state forensic psychiatric hospital in 2018 revealed that the hospital found it challenging that the Mental Health Act does not contain provisions on transporting a patient with the help of the police outside the healthcare units. The situation caused major problems because a nurse had no powers outside the hospital to prevent a patient from escaping by force. A private security guard had no such competence anywhere. However, services outside the hospital were necessary for obtaining, for example, a patient's ID and banking credentials.

In the NPM visit report, the Deputy-Ombudsman considered the completion of the provisions on the transport of patients to be extremely important. Therefore, he decided to urge that the amendments be rushed. Again, the Deputy-Ombudsman drew the attention of the Ministry of Social Affairs and Health to the shortcomings of the Mental Health Act in this respect (3712/2018). The draft for a new act on clients and patients by the Ministry of Social Affairs and Health proposes increasing the powers of nursing staff and guards. However, the preparation of the matter is still ongoing in 2021.

RESTRICTIVE MEASURES

Restriction instructions. 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. In many cases, the unit reviews the instructions on restrictions already during the NPM visit, and the unit announces that it will correct the shortcomings identified already at that time. For example, the instructions have not always clearly stated that the condition of a restrained or minor patient must be continuously monitored so that the nursing staff has continuous visual and hearing contact with the patient. This obligation cannot be fulfilled by camera surveillance alone. Camera surveillance in general cannot replace personal interaction between the patient and the nursing staff. The instructions on restrictions should also note how often a physician should assess a restrained patient.

- After the NPM visit, the joint authority announced that the hospital had started to specify the instructions on restrictions. The aim was to assess the use of restrictive measures in more detail and to record the reasons that led to the restrictions more systematically. Special attention will be paid to the use of involuntary medical treatment and recording of seclusion (5338/2017).

Involuntary medication. If a patient in involuntary treatment or observation refuses to take the prescribed medication, they may only be medicated against their will if the failure to medicate seriously endangers the health or safety of the patient or others. In his decision issued on 15 March 2018 (1496/2017), the Ombudsman has commented on medication against a patient's will. The Ombudsman recommended that decisions concerning involuntary medication be justified in the future, taking into account the requirements defined in the Mental Health Act. A patient's psychotic status cannot be considered a sufficient basis for involuntary medication, as all patients

under observation and ordered to treatment suffer from psychosis.

The NPM visits have revealed that forced medication has been justified by the fact that it was "necessary". However, the documents have lacked a more detailed assessment of whether the requirements of the Mental Health Act were met for giving the medicine by force. The Deputy-Ombudsman has emphasised that patient documents should also indicate how the patient has been heard about the medication or the reason why the hearing could not be carried out, and whether the patient has been given a report on the medication as required by the Patient Act. After the NPM visit, the units have updated their instructions on restrictions regarding forced medication (5338/2017) and instructed the personnel to document all aspects related to involuntary medication (727/2018).

Seclusion of a patient. A patient in involuntary care may be secluded if the requirements for seclusion of the Mental Health Act are met and no other milder alternative is available. The Ombudsman has stated that seclusion should be considered a serious interference in the right for self-determination and should therefore be the last resort. Seclusion always affects a person negatively. The Ombudsman has urged the psychiatric units to take serious action to achieve the required level for the conditions and treatment of secluded patients.

Guidelines for seclusion. The Ombudsman has recommended that the guidelines on the treatment of secluded patients should convey the objective of humane treatment of isolation patients more clearly. Personnel should be actively instructed to ensure that all secluded patients have access to the toilet. The guidelines could also show more clearly how the patient's personal supervision is carried out. The guidelines could include a separate mention of how the nurse could assist the patient in eating and ensure that they do not eat on the floor or standing up. After the NPM visits, the units have announced that they

have revised their guidelines in accordance with the Ombudsman's recommendations (2150/2017, 5338/2017 and 727/2018).

However, the guidelines alone are not enough; the management should ensure that those involved in treating a secluded patient are aware of the guidelines and comply with them. The Ombudsman has also considered it important that more attention is paid to the knowledge of legislation, guidelines and national recommendations of both management and personnel. Clear instructions and a separate training programme are means to strengthen the competence of nursing staff to encounter challenging patients in particular.

- The joint authority announced that the hospital had considered how to increase the personnel's knowledge of guidelines and legislation. One solution can be a reading package on the topic and an online exam, which would be required of those working in psychiatric departments (5338/2017).

In one of his decisions, the Deputy-Ombudsman has also proposed compensation for the treatment of a secluded patient. The Deputy-Ombudsman considered that the complainant's treatment during the seclusion was a violation of human dignity. A person with reduced mobility due to cerebral palsy had to eat by sitting on a thin mattress in the seclusion room of the psychiatric ward. In addition, the dishes and cutlery were unsuitable for them. The complainant wore adult nappies during the seclusion period of more than 24 hours. The Deputy-Ombudsman proposed that the joint authority of well-being pay compensation for the violations of the patient's fundamental and human rights (3287/2017).

- The joint authority announced that it would pay the patient a financial compensation.

Conditions in seclusion. The Ombudsman has stated that the seclusion room of the psychiatric hospital must be safe and equipped appropriately. The room should be in good condition, clean, fresh, ventilated and sufficiently warm, and there should be a window. The patient must also always have the opportunity to contact the nursing staff.

The NPM visits have also paid attention to the furnishing of the seclusion room. The Ombudsman has recommended that more attention be paid to the equipment, furniture and appearance of the seclusion rooms in use, without forgetting safety considerations. It is possible to achieve this by painting surfaces and adding soft furniture that can withstand secretions. There should at least be furniture for meals so that the food tray can be placed elsewhere than on the bed or on the floor.

The Ombudsman has also suggested to remove hazardous details and wall writing from the seclusion rooms. The NPM visit reports often refer to the guide for reducing the use of coercive measures by the National Institute for Health and Welfare (THL), which addressed the location and equipment of seclusion rooms.

Unfortunately, hospitals' facilities intended for seclusion often resemble a police jail rather than a room for isolating a psychiatric patient. The Ombudsman has considered it humiliating if the secluded patient has to eat on the floor whilst sitting or standing on a thin mattress – not to mention having to eat on the same floor or mattress to which they have urinated or defecated. Many seclusion facilities have also lacked a bell or similar device to allow the patient to immediately contact the personnel. The Ombudsman has not considered it acceptable that the patient's only way to get the personnel's attention is to bang on the door. The absence of a clock has also been common, and the patient has thus not been able to follow the passage of time.

- After the NPM visit, the hospital announced that the seclusion rooms would be equipped with furniture and a device that allows the patient and personnel to communicate. A high mattress similar to a bed has been ordered for two wards. In planning the new hospital, particular attention will be paid to architectural solutions that might reduce the need for seclusion (2148/2017).
- The hospital district reported that thick mattresses and table cubes had been purchased for the seclusion rooms of two wards. The room which the Ombudsman considered jail-like had been decommissioned. A new call system



The conditions in isolation facilities vary greatly between units.



had been ordered for the seclusion rooms (2150/2017).

- The joint authority announced that the psychiatric departments will take action to bring the facilities for seclusion to an appropriate level. After the NPM visit, a two-way speech connection had been added to all seclusion rooms. The aim was to have armour-glass on the doors of all seclusion rooms that allow a large visual connection from the seclusion to

the interspace, improving interaction with the nurses. The floor coatings will also be softened. The next year's budget will have an appropriation for the renewal of toilet facilities. A high mattress, cubic table and armchair will be acquired for each seclusion room (5338/2017).

- The joint authority announced that the renovation of the seclusion rooms had begun. The wall surfaces were painted, and the sharp

chutes were removed. New, soft furniture that withstand secretion had been ordered. Coating was installed in the window of one seclusion room's door to protect privacy. A bell system had also been acquired for the rooms. A separate table on wheels was ordered for meals so that the patient does not have to eat on the bed (727/2018).

Restraining a secluded patient. The Ombudsman has emphasised that restraining a secluded patient can only be a last resort. Efforts should be made to eliminate mechanical restraining and seclusion in general, or at least to reduce their use. This idea is poorly promoted by the observation during a NPM visit that a restraint bed was standard in all the seclusion rooms of the unit. All new patient beds to be ordered were also suitable for mechanical restraining.

The Ombudsman considered it possible that this would lead to a lower threshold to restrain a patient. The examination of patient documents also gave the impression that the unit's threshold for mechanical restraining was low (727/2018). Restraining can also be a humiliating experience for



A typical limb restraint bed on an adult psychiatric ward.

the patient. The NPM visit revealed that patients could be transported outside the seclusion room in mechanical restraints. The Ombudsman considered that this procedure had to be avoided, especially if the patient was moving in the common premises of the ward (727/2018).

The hospital district's instructions on restrictions provided that fastening adhesives or similar equipment are not considered restrictive measures under the Mental Health Act. Fastening adhesives refer to sticker tape with metal rings attached around the wrists. The rings could be attached to each other or to the belt with a metal hook. The NPM team was told that the adhesives were used when transporting an unpredictable patient, for example. However, the justifications listed in the Mental Health Act mention that restraining refers to placing a patient on limb restraints in which the patient is tied with a belt or belts. The provision does not allow any other form of restraining.



A member of the NPM team tested the use of a device restricting the use of upper limbs.

The Deputy-Ombudsman noted that the fastening adhesives attached to wrists were similar to some sort of handcuffs, and their use in the treatment of a psychiatric patient was considered humiliating. In the care of persons with intellectual disabilities, Valvira has also considered that the arm or leg bindings do not comply with the requirements of the act on healthcare devices and equipment, and therefore, they cannot be used as

restrictive equipment. In Valvira's view, arm or leg bindings can also be considered to violate human dignity.

- The hospital announced that the use of arm bindings that can be linked to each other was extremely rare. They had mainly been used in patient transfer to ensure the safety of the patient and the personnel. They will no longer be used at all (2301/2019).

Supervision in seclusion. The Ombudsman has stated that camera surveillance can never compensate for personal contact, but it may be a good tool in supervising a secluded patient. The NPM visits have revealed that units have many differences in the implementation of supervision. Very often there is a lack of guidelines on the implementation of supervision and how to visit a regularly secluded patient in particular. Sometimes supervision was performed by being behind the seclusion room's door, not by the patient. The Ombudsman has not considered such supervision to be personal, which is required for supervising a secluded patient. Nor does it – or even a two-way speech connection – replace the patient's communication with the personnel. The patient should have the opportunity to talk face-to-face with the nurse.

LEGAL REMEDIES OF A SECLUDED PATIENT

A patient cannot appeal an isolation decision made by a physician. Instead, they can complain to the Regional State Administrative Agency, Valvira or the Ombudsman about the situation. However, examining individual conditions in seclusion in a written complaint procedure has proved difficult, which is problematic for the patient's legal protection. For this reason, the Deputy-Ombudsman has emphasised in the NPM visit reports the statement the Constitutional Law Committee made in the parliamentary hearing regarding the provisions on seclusion and restraining. In this statement, the committee considers it possible that the prolongation of the seclusion or restraining of a patient may become a legal matter concerning their rights, which the patient may

refer directly to a court under the Constitution (PeVL 34/2001 vp).

In other words, a long-lasting seclusion or restraining can possibly already be brought before the court on the basis of current legislation. The most recent draft of the new act on clients and patients proposes that a decision on the seclusion and restraining of a psychiatric patient be made appealable. The Deputy-Ombudsman has considered improving the legal remedies of a secluded patient extremely important. For this reason, she has urged that the legislation is amended quickly. She has also drawn the attention of the Ministry of Social Affairs and Health on the shortcomings they have identified in the Mental Health Act concerning the legal remedies of a secluded patient (3712/2018).

DEBRIEFING AFTER RESTRICTIVE MEASURES

THL's guide for reducing the use of coercive measures considers it necessary to debrief each coercive measure, occurrence of violence and near misses. It helps avoid recurrence and alleviates the adverse and traumatic effects of coercive measures on the nurses, patients and witnesses. The Ombudsman has recommended that patients should always be automatically offered an opportunity to go through the restrictive measure after the restriction on their right to self-determination ends. Such debriefing is usually carried out in psychiatric units only after seclusion or restraining.

- After the NPM visit, the hospital district provided updated guidelines on the debriefing. The guidelines acknowledged the Ombudsman's recommendations. (2150/2017).
- The joint authority announced that instructions on how to debrief a seclusion situation with the patient will be prepared for the personnel (5338/2017).

REPORTING EVENTS THAT SERIOUSLY ENDANGER PATIENT SAFETY

In connection with the review of documentation performed during a NPM visit, it was found that a patient had died in a seclusion room where they had slept with open doors. The hospital investigated the case with the hospital district's clarification process for serious incidents. The investigation led to a revision of the patient monitoring guidelines. A forensic investigation of the cause of death was also carried out. However, it was revealed that the Regional State Administrative Agency (AVI) and Valvira were not aware of the incident.

The Deputy-Ombudsman noted that according to the Act on Health Care Professionals, Valvira guides and supervises healthcare professionals nationally and the local AVI in its area of operation. From the perspective of this task, it seems important that supervisory authorities of healthcare are informed of events that have seriously endangered patient safety, so that information on risks and their prevention can be made more widely available to healthcare units. The Deputy-Ombudsman made a proposal to the Ministry of Social Affairs and Health to create a reporting procedure (2301/2019).

REDUCING THE USE OF COERCIVE MEASURES

The Ombudsman has proposed that each psychiatric unit that uses coercive measures should have **a plan for reducing their use of coercive measures** which defines quantitative and qualitative objectives. It is equally important that the entire personnel are informed of the plan and that its implementation is continuously monitored. The Ombudsman has therefore recommended that the units continuously monitor the use of restrictive measures and draw up a programme or operating instructions for reducing the use of coercive measures.

- The joint authority announced that a monitoring procedure for restrictions will be devised for the psychiatric wards. Once basic

information on restrictions has been obtained, a programme for reducing the use of coercive measures and related objectives will be drawn up. Teaching the objectives to the personnel is part of this programme (5338/2017).

- The joint authority announced that personnel had been instructed to document any alternative means used to resolve a situation before the restriction or seclusion. A separate programme is planned for reducing the use of coercive measures and monitoring the use of restrictive measures (727/2018).
- The joint authority announced that the plan to reduce the use of coercive measures was drawn up in accordance with the Ombudsman's recommendations (1600/2018).

The Ombudsman has also referred to the Valvira decision according to which **placing acute psychiatric patients in single rooms** reduces violence and the need for coercive measures, speeding up rehabilitation.

- The hospital district announced that the new psychiatric building, which will be completed in 2021, will have single patient rooms designed for all patients. The aim is to arrange single rooms in the current wards for those patients who most need them in terms of treatment (2150/2017).

The Ombudsman has considered it positive that the psychiatric wards have tried to find new procedures aimed at intervening in the patient's right to self-determination in the slightest possible way and when necessary. From the perspective of the overseer of legality, the fact that the Mental Health Act does not recognise these new procedures that reduce the use of coercive measures makes their use problematic. The THL guide for reducing the use of coercive measures discusses avoiding seclusion and restraining. It lists 13 alternative approaches to avoid them. One of these is **100% supervision (special observation)**. On the basis of the NPM visit findings, it can be concluded that a 100% supervision is often used in situations where the other option would be to seclude the patient – for example, in the case of a patient

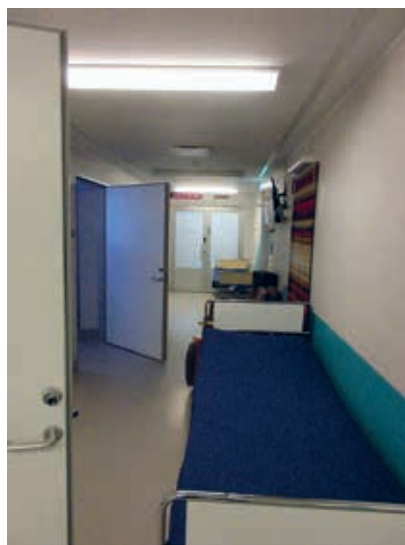
with a clear risk of suicide. Based on the restriction lists, 100% supervision has been successful in reducing the use of seclusion (2150/2017).

A procedure that is less common than special observation is **placing the patient in a so called security cell** instead of seclusion. In the version viewed by the NPM, the security cell consisted of several rooms, one of which was a common space. The patient could not exit the security cell independently to the ward. In the Ombudsman's view, when a patient is locked alone in a security cell and is mainly monitored through camera surveillance, it is considered a seclusion from other patients. According to the joint authority, the patient is not alone during the day, but is under the special observation of a nurse. There is no nurse at night, but the patient has the opportunity to go to the ward, as the door leading to the ward is not locked at night. An alarm device has been installed in the door to alert if the patient enters the ward, informing the personnel.

The Ombudsman has required instructions for the use of the security cell, describing not only the content of the use of the security cell but also the related decision-making and implementation processes and responsibilities.

- The joint authority announced that the instructions for the use of the security cell have been specified on the basis of the Ombudsman's observations after the NPM visit (1600/2018).

The Deputy-Ombudsman considered the hospital's measures to reduce restrictions to be very positive as they had attempted to find a more humane alternative to seclusion using **a safety corridor**. However, there were also features of seclusion in placing a patient in the corridor. The Deputy-Ombudsman considered that placing a patient in the safety corridor means isolating the patient at least when the patient is alone in the corridor and not allowed to leave it (2301/2019).



A picture of a facility called a safety corridor, which is more spacious than in an isolation room. The facility also has an armchair and a television.

In addition to the above, other methods have been introduced to reduce the use of restrictions. In addition to using special observation, the state forensic psychiatric hospital has made it easier for patients to access occupational therapy, developed the use of relaxation and sensory rooms and replaced traditional training in the control of force with training based on prevention. The hospital's steering group on reducing coercion has also highlighted **reducing the use of clothing that restricts movement** as one of its priorities. The NPM visit revealed that the hospital monitored the use of restrictive clothes. Restrictive clothing was used with only one patient, whereas two years earlier it had been used for six patients. The hospital had also introduced clothes to replace restrictive clothing (ponchos and muffs). With their help, a patient who otherwise behaved violently was able to spend time with other patients (3712/2018).

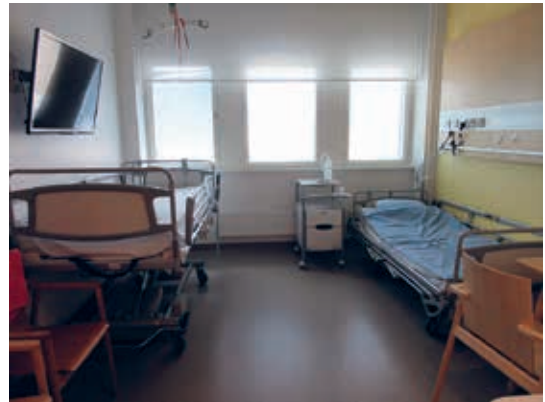
3.5.16 VISITS TO GERIATRIC PSYCHIATRY

RIGHT TO PRIVACY

During the NPM visits, it has been necessary to draw the attention of the units to the fact that the protection of patients' privacy must be ensured in all situations and especially during treatment procedures. This is especially emphasised when there are several patients in the same room. Even a visual barrier between beds will not secure the patient's privacy if there is only a little space. The notifications made to the Deputy-Ombudsman after the NPM visits show that the units consider the privacy of patients important and that efforts are made to realise it (such as 2458/2019, 3264/2019). However, sometimes the circumstances are challenging. During the NPM visit it was found that the patients' beds did not always have a visual obstruction between them. The unit announced that screens and curtains had been tested but found to be a safety risk.

The Deputy-Ombudsman stated that the ward clearly had too many patients in relation to the premises. The Ombudsman had already paid attention to it in 2016. The shortcomings identified were serious. The facility arrangements did not respect the privacy of patients and they impeded the work of the nursing staff and hindered patient rehabilitation.

- The hospital announced that the planning of the new psychiatric building had started after the Ombudsman's visit in 2016. The council's investment decision for it was made in the summer of 2019. Single en-suite rooms are planned for the building. The building's planned completion is in 2023–2024. If the number of beds is reduced before the new hospital is completed, the right of an increasing number of older people to access psychiatric hospital care will be prevented. The other wards of the hospital were unsuitable for the treatment of older patients, and empty wards were unusable. For this reason, no solution has been found to find more spacious facilities for the wards for older people or to reduce the number of beds (5592/2019).



A double room without a visual barrier in a city hospital memory unit.

The Deputy-Ombudsman has also 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.

- After the NPM visit, a separate calm space was introduced for rooms that have several patients, in which the patient and their relatives can discuss matters related to treatment and rehabilitation in peace (2458/2019).
- 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 (3264/2019).

The NPM visits have also focused on camera surveillance in the psychiatric units for older people. Camera surveillance in patient rooms always interferes with the patient's privacy. However, there is no specific legislation on camera surveillance in patient rooms yet. The Deputy-Ombudsman has emphasised 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 supervision (1706/2019 and 2458/2019).

- The city announced that camera surveillance is 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 (2458/2019).

IDENTIFYING RESTRICTIONS

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 guidelines should also indicate the grounds for the use of restrictive measures, decision-making, monitoring and dismantling of restrictions.

The NPM visits have revealed that the units may use restrictive measures that are not identified as restrictions and are not mentioned in the unit's guidelines. This endangers hearing the patient on the restrictive measure and the measure's recording. Neither has the use of the restriction been subject to a physician's decision in such a case. Instead, its use was decided by the nurses. Such restrictions include a magnetic belt and raised bedrails. After the NPM visit, the units have announced that they will devise or update their guidelines so that they take into account the Deputy-Ombudsman's recommendations (1706/2019, 2458/2019 and 3264/2019).

USE OF RESTRICTIVE MEASURES IN GERIATRIC PSYCHIATRY

In principle, the Deputy-Ombudsman has considered it problematic that the psychiatric hospital uses restrictive measures in geriatric psychiatry that are not based on the Mental Health Act. On the other hand, the Mental Health Act does not take into account the safety equipment used in the care for older people, the use of which may be justified. One of the most common restrictions used in geriatric psychiatry is **the magnetic belt**. The Ombudsman has stated that safety equipment

such as a magnetic belt are usually used to restrict or prevent the patient from moving. The units often interpret the use of a magnetic belt as restricting freedom of movement, not restraining. These patients are often not in involuntary treatment and therefore cannot be subject to the provisions of the Mental Health Act on the restriction of the patient's fundamental rights.

The Ombudsman has considered that, as long as there is no legislation on the matter, the principles set out in Valvira's (the National Supervisory Authority for Welfare and Health) instructions must be complied with in the use of a magnetic belt when it comes to restricting the movement of a patient in voluntary care. According to the Ombudsman, each time they are used, it should be considered whether the restriction is necessary or whether other suitable means of increasing safety can be used.

- The aim of psychogeriatric wards was to stop using safety equipment that restrict the patient's movement by the end of 2016. The wards had continuous training, discussion and changes in practices to reduce the use of methods that restrict patient movement (1046/2016).
- The joint authority stated that the magnetic belt was only used due to the risk of an older patient falling and with their consent. If the patient opposes the use of the magnetic belt, it is not used. Valvira's guideline for the use of magnetic belts will be reviewed again in the psychogeriatric ward (1600/2018).

The NPM visit revealed that a psychogeriatric patient was restrained with a magnetic belt nearly every day (1049/2016). The Ombudsman decided to investigate the matter and asked the Regional State Administrative Agency (AVI) to examine the appropriateness of the patient's long-term restraining. According to the report received in the case, the patient's period under restraints was occasionally prolonged due to heavy workload in the ward. The patient's behavioural symptoms had been controlled by medication, after which the magnetic belt was used rarely. AVI stated that relieving workload does not justify restricting the patient's personal freedom. AVI considered it



Magnetic belts used to restrict the movement of elderly patients were seen during visits.

important that the training of hospital personnel pays particular attention to respecting patients' fundamental rights. In its decision, the Deputy-Ombudsman agreed with the AVI's conclusions (3711/2016).

The 100% supervision, or special observation, has also become increasingly more common in geriatric psychiatry. The Deputy-Ombudsman has welcomed this if it prevents the use of other, more intrusive restrictions. On the other hand, the NPM visit has revealed that the patient under special observation may have been tied to their bed if a nurse has had to leave. The Deputy-Ombudsman has 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.

Some units also use **hygiene overalls** (overalls that the patient cannot remove themselves), which is not always recorded as a restriction. However, the Ombudsman has considered that

it is restrictive clothing that interferes with the patient's right to self-determination and the use of which must be regulated by law. The Ombudsman has recommended that ending the use of the hygiene overalls should be seriously considered if their use is already minor. Instead, alternative methods should be explored. If the unit uses the 100% supervision method, it could be an alternative to using the hygiene overalls.

- According to the hospital district, there was a need for using the hygiene overalls in the geriatric psychiatry ward, and that guidelines for their use were being prepared. After the hospital district's notification, the Ombudsman stated that he still recommend that the use of the restrictive clothing be abandoned as a priority. He referred to the client and patient law under preparation, the draft of which banned the use of hygiene overalls (the drafting of the law is still ongoing in 2021). Despite this, the hospital district provided guidelines for the use of breast and crotch belts and the hygiene overalls afterwards (2150/2017).



On the left, hygiene overalls used on a geriatric psychiatry ward. On the right, corresponding overalls used on an inpatient ward at a health centre.

A **safety cover** has also been used daily at the psychogeriatric ward to prevent the patient from getting out of bed (2301/2019).

The Deputy-Ombudsman has particularly welcomed the fact that the personnel are familiar with the content of the guidelines on restricting movement. It is also good if preventive action, continuous assessment of the situation and seeking the milder method are key objectives related to restrictions in everyday work. However, particular attention should be paid to assessing which fundamental right is being protected and whether the means are proportionate to the objective to be achieved. The Deputy-Ombudsman has also stressed that a permit granted by a family member or other close relative does not justify the use of a restrictive measure.

After the NPM visit, the hospital announced that the updated guidelines included the changes required by the Deputy-Ombudsman's statements on restricting the patient's fundamental rights. They have also ensured that the practices will be changed to comply with the guidelines (2301/2019).



A safety cover that restricts the movements of an elderly patient.

MONITORING AND REDUCING THE USE OF RESTRICTIONS

The NPM visits focused on geriatric psychiatry have revealed that the units have no separate statistics on the restrictions used and there is no gathered data on how often they were used. As with other psychiatric units, the Deputy-Ombudsman has recommended monitoring the use of restrictive measures in geriatric psychiatry. This also serves to reduce the systematic use of restrictive measures.

- The hospital reported that it would start systematic monitoring of the most restrictive measures (1706/2019).
- The social welfare and healthcare sector announced that the hospital will devise instructions for the monitoring of restrictive measures and operating instructions for reducing their use at the same time as the guidelines on restriction (2456/2019).
- The city announced that the statistics on the use of restrictive measures will be specified as part of the implementation of the hospital's guidelines on restriction. The new patient information system will facilitate better monitoring and record-keeping on the use of restrictive measures. An instruction on reducing the use of coercive measures will also be implemented (2458/2019).

USE OF SECURITY GUARDS

A security guard cannot perform tasks belonging to a healthcare professional. On the other hand, the guard's duty is to secure the personnel's integrity in a care situation. The Deputy-Ombudsman has stated that the units should provide better instructions for both the guards and the nursing staff on guard's duties in situations where the patient has to be restricted. Guards working in healthcare units should also receive induction on encountering patients.

The Deputy-Ombudsman has considered it important that all operators have a clear understanding of who issues the guard's duties and instructions for action. In the NPM visits to healthcare, attention has been paid to the guards' role in implementing restrictions (such as 727/2018). Based on the findings, a guard had been used in geriatric psychiatry in situations where an aggressive patient needed to be injected with a sedative. The Deputy-Ombudsman has stated that in these situations, the nursing staff should provide the guard with guidance on how to act.

- The hospital announced that the guidelines for security have been changed to comply with the Ombudsman's recommendations (1046/2016).
- The social welfare and healthcare sector reported that the unit will train the personnel to a situation where a guard is present when caring for a patient and that the guard's task is to ensure the safety of the personnel and possibly other patients (2456/2019).