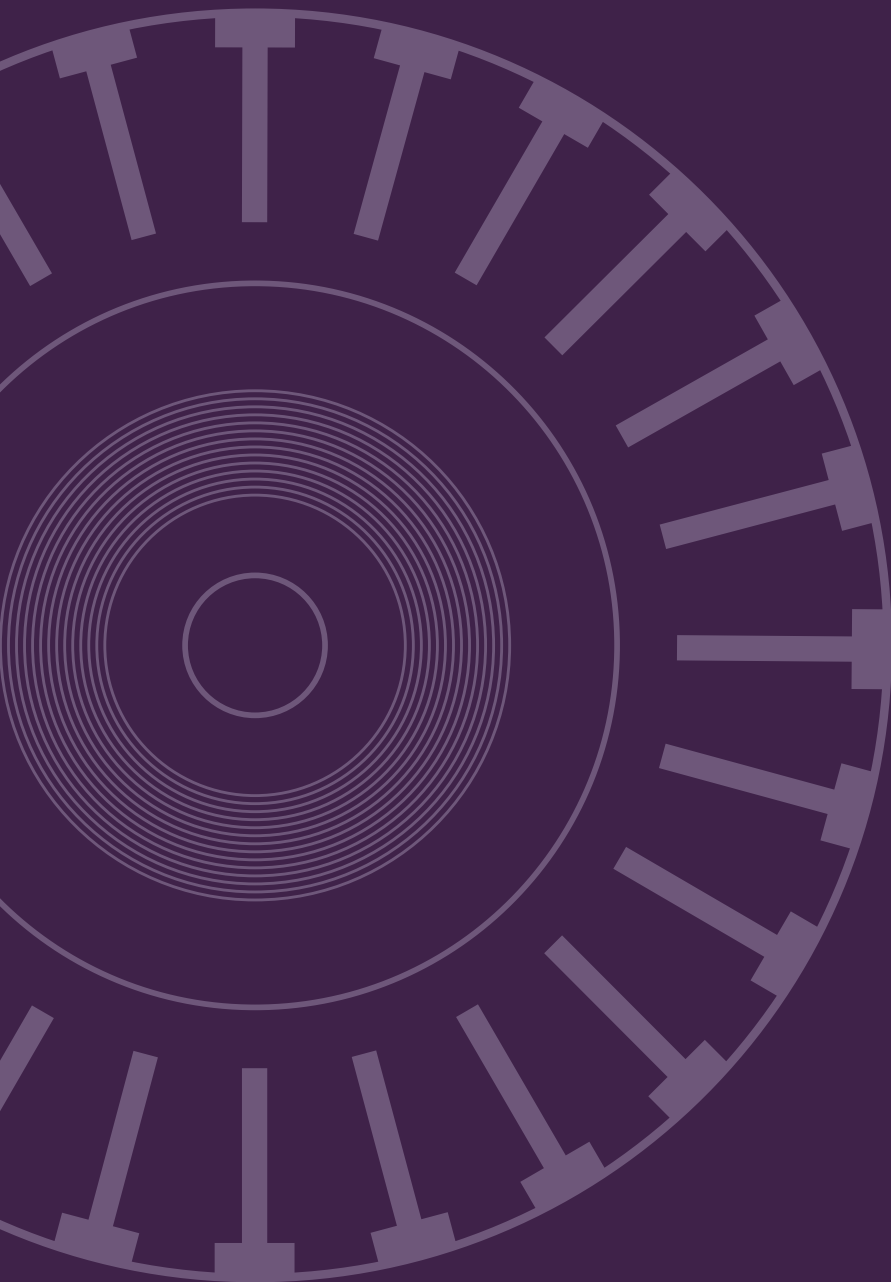
ENGLISH VERSION

National Preventive Mechanism – NPM

REPORT FROM THE OPCAT UNIT 2019



JO RIKSDAGENS OMBUDSMÄN
The Swedish Parliamentary Ombudsmen

National Preventive Mechanism – NPM

REPORT FROM THE OPCAT UNIT 2019

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Cover: Part of a sketch of the Panoptikon, a prison in which all the cells can de monitored from one point. A design introduced by the English philosopher Jeremy Bentham in the late 18th century.

Foreword

Since 2011, the Parliamentary Ombudsmen have fulfilled their role as National Preventive Mechanism (NPM) under the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). The regular inspections of places where people are deprived of their liberty are an important part of that work and is an issue that the Parliamentary Ombudsmen have also previously focused on in their regular mandate. In 2019, we carried out 34 inspections in total of places where people are held deprived of their liberty. The majority of these were of the Prison and Probation Service's remand prisons and prisons. One of the reasons why a relatively large part of the OPCAT activities concerned the Prison and Probation Service was the strained occupancy situation in remand prisons and prisons in 2019. There is always a risk that overcrowding will lead to negative consequences for inmates, and it was, therefore, necessary to examine the situation through a number of inspections. The strained occupancy situation has continued into 2020 and the Parliamentary Ombudsmen will have reason to return to this issue.

In addition to the inspections, we held a number of dialogue meetings with representatives of the Prison and Probation Service, the National Board of Institutional Care, and the Health and Social Care Inspectorate during the year. These dialogue meetings are a method being tested in order to, in a more concentrated manner, discuss the important observations made in the framework of the inspections. These meetings may concern questions regarding the application by the agencies of the various legislative provisions on coercive measures, as well as other issues concerning legal certainty that are important for persons deprived of their liberty. The intention is that these dialogue meetings help clarify the importance of the agencies addressing issues raised regularly during various inspections. One of the dialogue meetings, held in March 2019, concerned the possibilities for inmates held on remand to associate with other inmates during the daytime and the Prison and Probation Service's work with isolation-breaking measures. At the end of February 2020, the Parliamentary Ombudsmen published a report on the isolation of inmates in the Prison and Probation Service's remand prisons. A summary of this report can be found in Section 8 of this report.

Issuing reports based on the OPCAT activities is also a priority. The idea is that the observations and statements made by the individual Parliamentary Ombudsmen regarding the conditions for individuals deprived of their liberty should be more accessible and clear when presented together in an annual or thematic report. As such, the reports themselves become an important part of the preventive work.

Finally, I would like to draw attention to the fact that, as I write this foreword, there is an ongoing pandemic. Covid-19 has affected all parts of society, and the agencies responsible for individuals deprived of their liberty also have taken measures to prevent the spread of infection. In some cases, these measures have restricted the rights and freedoms of individuals deprived of their liberty. The spread of Covid-19 has additionally led the Parliamentary Ombudsmen to review our working methods to ensure the implementation of our role as an NPM. In March 2020, we assessed that, in view of the infection risks, it was not possible to carry out those ordinary inspections we had planned for spring and summer. Instead, we quickly developed new inspection methods in order to fulfil the NPM assignment. The prevention of inhuman treatment of individuals deprived of their liberty can be of particular urgency when society is in crisis and this preventive work must not stop during a pandemic. The question of how individuals deprived of their liberty are affected by, inter alia, agencies' measures to prevent the spread of infection will be addressed in future reports.

Elisabeth Rynning
Chief Parliamentary Ombudsman

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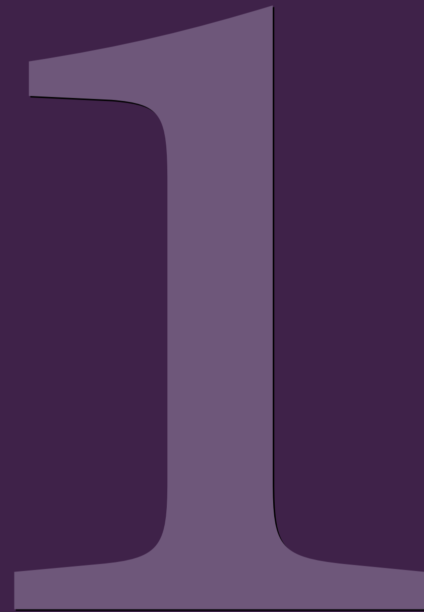
The OPCAT activities



The OPCAT activities

Under the 1984 UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("Convention against Torture"), states parties have undertaken to take effective legislative, administrative, judicial and other measures to prevent acts of torture within any territory under its jurisdiction. Explicit torture bans are also contained in a number of other UN conventions.

The European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) and the Charter of Fundamental Rights of the European Union (EU Charter) also contain bans on torture. The ECHR has been in force under Swedish law since 1995. In addition, the Instrument of Government, a part of the Swedish Constitution, contains a ban on torture.[1] According to the Instrument of Government, each and every individual is protected against corporal punishment, and no one may be subjected to torture or undue medical influence for the purpose of forcibly extracting or obstructing a statement.

1.1 Torture and cruel, inhuman or degrading treatment

The first article of the UN Convention against Torture contains a relatively comprehensive definition of the meaning of torture. In short, torture means that someone intentionally suffers serious psychological or physical pain or suffering for a specific purpose, for example to extract information forcibly or to punish or threaten an individual. The Convention lacks definitions of cruel, inhuman or degrading treatment.

The European Court of Human Rights (ECHR) has ruled that inhuman treatment should include, as a minimum, treatment that intentionally causes someone serious psychological or physical suffering and which, in a specific situation, can be regarded as unjust. Degrading treatment refers to an act that produces a feeling of fear, anxiety or inferiority in the victim. Subjective circumstances such as a victim's gender and age are of great importance in determining whether certain treatment or punishment is degrading. Treatment can be degrading even if no one but the victim themselves has witnessed or learned about it.

1.2 The Convention against Torture and OPCAT

The Convention against Torture has been in force in Sweden since 1987. State parties to the Convention are examined by a special committee known as the

1 Chapter 2, Section 5 of the Instrument of Government.

Committee against Torture (CAT). State parties must regularly report on how they comply with convention.

If allowed by a state party, individuals may additionally complain to the Committee. Sweden allows individual complaints. The Convention against Torture itself does not provide CAT the mandate to conduct visits of member states.

In order to allow, inter alia, international visits, the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) was adopted in 2002. The Protocol entered into force in 2006. OPCAT established an international committee known as the Subcommittee on Prevention of Torture (SPT).

1.3 Preventive activities

The work performed in accordance with OPCAT is to be conducted with the aim of strengthening, if necessary, the protection of individuals deprived of their liberty against torture and other cruel, inhuman or degrading treatment or punishment. Preventive work can be carried out in a number of ways, including via monitoring of the environments where the risk of abuse and violations is particularly high.

Another important aspect of the preventive work is the identification and analysis of factors that can directly or indirectly increase or reduce the risk of torture and other forms of inhuman treatment, etc. This work is forward-looking with the aim of systematically reducing or eliminating risk factors whilst strengthening preventive factors and safeguards. Furthermore, the work should have a long-term perspective and focus on achieving improvements through constructive dialogue, proposals for safeguards and other such measures.

1.4 OPCAT activities in Sweden

States party to OPCAT are obliged to designate one or more bodies charged with the role of National Preventive Mechanism (NPM). Since 1 July 2011, the Parliamentary Ombudsmen have been fulfilling the role of NPM in accordance with OPCAT.[2]

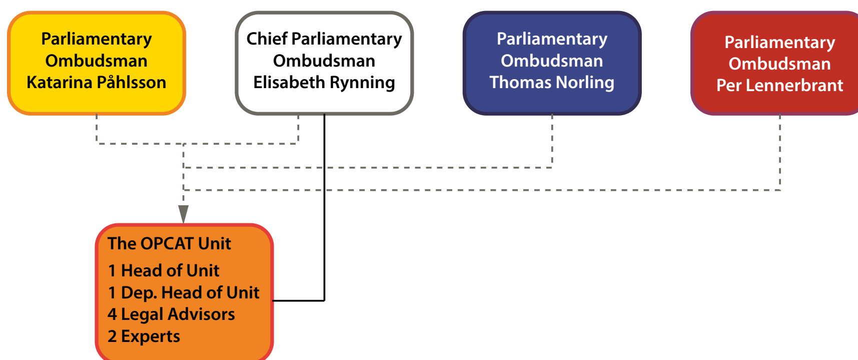
In designating the Parliamentary Ombudsmen this role, the Committee on the Constitution stated that the tasks and powers that the Parliamentary Ombudsmen have had for many years matches well with the role of NPM. Ever since the establishment of the institution, the Parliamentary Ombudsmen have inspected places where people may be held deprived of their liberty. The overall aim of the Parliamentary Ombudsmen's traditional assignment is to promote legal certainty, and this includes, inter alia, ensuring that the fundamental rights and freedoms of individuals are not violated by the public sector.

2 Section 5 a of the Act with Instructions for the Parliamentary Ombudsmen (1986:765).

As NPM, the Parliamentary Ombudsmen are tasked with:

- regularly inspecting places where individuals may be held deprived of their liberty;
- making recommendations to the relevant authorities with the aim of improving the competent agencies with a view to improving the treatment of and conditions for individuals deprived of their liberty and preventing torture and other cruel, inhuman or degrading treatment or punishment;
- submitting proposals and observations on existing or proposed legislation relating to the treatment of and conditions for individuals deprived of their liberty;
- engaging in dialogues with competent agencies, as well as;
- reporting on the OPCAT activities.

Likewise, all the individual Parliamentary Ombudsmen must fulfil the NPM assignment within their respective areas of supervision. The Parliamentary Ombudsmen have assessed that the places to be inspected in its role as NPM are primarily prisons, remand prisons, police custody facilities, psychiatric and forensic psychiatric care facilities, the Swedish Migration Agency's detention centres and the National Board of Institutional Care's special residential homes for substance abusers and special residential homes for young people.



The Parliamentary Ombudsmen have set up a special OPCAT unit tasked with assisting the individual Parliamentary Ombudsmen in their roles as NPM. The main work consists of planning and carrying out inspections of places where people may be held deprived of their liberty. Since the end of 2019, the OPCAT Unit consists of a head of unit, a deputy head of unit, four legal advisors and two experts (a medical expert and an expert in psychology).

1.5 International oversight bodies

The SPT has 25 independent members who are experts in areas of relevance to the prevention of torture. The members are appointed by the states party

to the Protocol. An annual schedule determines which countries the SPT is to visit.

The European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment entered into force in 1989. Through the Convention, the Committee for the Prevention of Torture (CPT) was established. Its main task is to visit regularly institutions in Europe where individuals may be held deprived of their liberty. All 47 member states of the Council of Europe have ratified the Convention. Swedish public agencies are obliged to cooperate with the SPT and CPT.[3]

The CAT reviews Sweden periodically every six years. In February 2017, the CAT posed a number of questions to the Swedish Government. In a letter, the CAT asked the Government, inter alia, whether Sweden has taken any measures to limit remand periods and about access to health and medical care for individuals deprived of their liberty.[4] Sweden's response was submitted to the CAT in November 2018.[5] The review will continue with a dialogue meeting in 2020.

1.6 The Nordic NPM network

The Nordic NPM network (formed in 2015) held two meetings in 2019. The meetings took place in Helsinki and Reykjavik. The theme of the meeting in Finland was homes for the elderly.[6] The meeting in Iceland addressed various aspects of the conditions for patients subject to compulsory psychiatric care.[7]

1.7 Purpose of this report

This report contains a summary of the observations made by the Parliamentary Ombudsmen in its OPCAT activities during 2019. In addition to details of last year's inspection work, the report includes analyses aimed at identifying issues and areas that the work should focus on in the coming years. Therefore, this report should also be seen as a part of the preventive work. In 2019, the OPCAT activities focused on the domestic transportation of individuals deprived of their liberty. A special interim report on these transportations was presented in June 2019.[8] A final report will be prepared in 2020.

3 Act relating to Sweden's Accession to the European Convention for the Prevention of Torture, etc (1988:695).

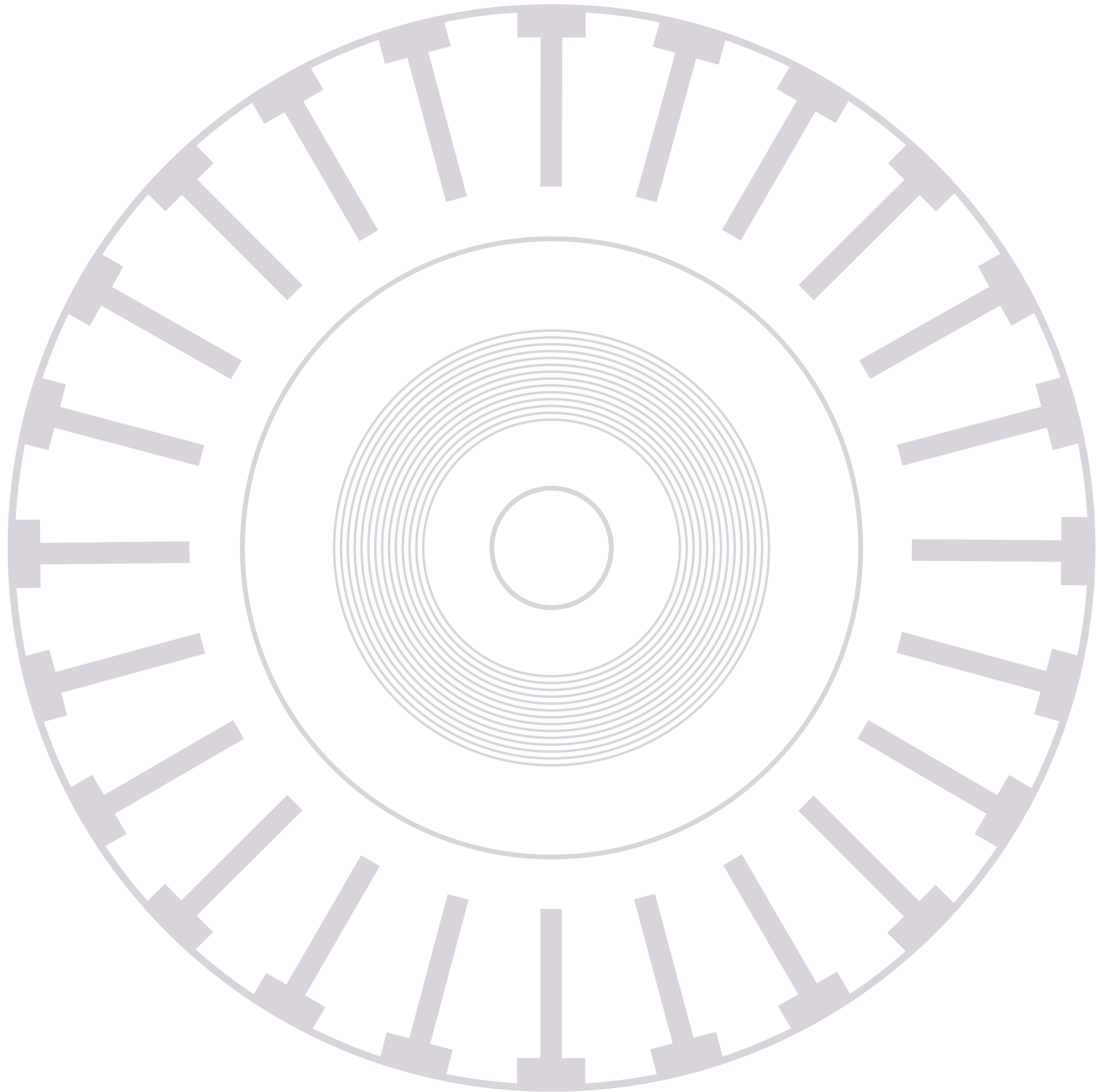
4 See CAT/C/Eng/QPR/8.

5 See Sweden's eighth periodic report to the UN Committee against Torture.

6 "Are elderly people in social care homes deprived of their liberty?"

7 "Ethical issues regarding therapeutic treatment, an individual's rights to privacy and security measures in secure settings – where do we draw the line?"

8 See Report from the OPCAT Unit 2019 – Theme *Transportation*.



OPCAT inspections in 2019

OPCAT inspections in 2019

One of the most important features of the Parliamentary Ombudsmen's OPCAT activities is the inspections of places where people may be held deprived of their liberty. In planning the inspections carried out in 2019, the ambition was for the inspection work to have a large geographical spread. As in previous years, a number of inspections have been made of establishments that have either not previously been inspected by the Parliamentary Ombudsmen or have not been inspected for a long time. Much of the Parliamentary Ombudsmen's traditional supervisory work and its assignment in accordance with OPCAT overlap and complement one another. For this reason, as a rule, the OPCAT Unit's employees participate in inspections by supervisory divisions of places where people may be held deprived of their liberty. For the same reason, employees from the different supervisory divisions regularly participate in the inspections that the OPCAT Unit is tasked to carry out.

2.1 Method

In the annual report 2015-2017, there are details of the method used in an OPCAT inspection.[1] In addition to inspections, the Parliamentary Ombudsmen also held two dialogue meetings with representatives of the Prison and Probation Service and the National Board of Institutional Care in 2019. In addition, Parliamentary Ombudsmen employees visited the Health and Social Care Inspectorate's six regional departments. A dialogue meeting was then held with the Health and Social Care Inspectorate's Director General.

In December 2019, the Parliamentary Ombudsmen also held a meeting to establish a forum for dialogue on the rights of individuals deprived of their liberty. The Parliamentary Ombudsmen invited a number of representatives of actors in civil society who, in various ways, have contact with individuals deprived of their liberty. The purpose of the meeting was to discuss the modality of a forum which enables the Parliamentary Ombudsmen to have a regular dialogue with civil society actors concerning the rights and situations of individuals held deprived of their liberty. The response from the participants was positive and, following the meeting, the Chief Parliamentary Ombudsman decided to set up the forum. The first meeting of this new forum took place in

1 See *National Preventive Mechanism – NPM, Report from the OPCAT Unit 2015-2017* p. 16 and 17.

March 2020. The intention is for the Parliamentary Ombudsmen to hold such forum meetings twice a year.

2.2 Places where individuals are deprived of their liberty

At the end of 2019, individuals were deprived of their liberty at, inter alia, the following places:

- 45 prisons with approximately 4,500 places (the Prison and Probation Service)
- 32 remand prisons with approximately 2,200 places (the Prison and Probation Service)
- 124 police custody facilities with approximately 1,300 places (the Police Authority)
- 23 special residential homes for young people with approximately 700 places (the National Board of Institutional Care)
- 11 special residential homes for substance abusers with approximately 400 places (the National Board for Institutional Care)
- At least 80 institutions for compulsory psychiatric care and forensic psychiatric care with approximately 4,000 places (Regions)
- 6 migration detention centres with 528 places (the Swedish Migration Agency)

The figures presented above are based partly on estimates and include only permanent places. Compared with the latest OPCAT report, the number of places has increased in the Swedish Migration Agency's detention centres. The strained occupancy situation within the Prison and Probation Service has led to work within the agency to create different types of temporary places. Such places are not included in the enumeration above.

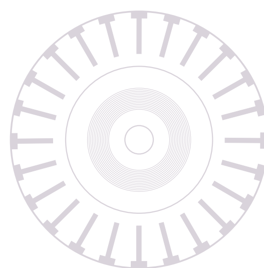
2.3 Inspections and dialogue meetings

In 2019, the OPCAT Unit conducted 29 inspections and held nine dialogue meetings. In selecting the objects for inspection, the theme domestic transportation of individuals deprived of their liberty was an important factor. Furthermore, at the beginning of the year the Parliamentary Ombudsmen started an own-initiative inquiry into the occupancy situation within the prison and remand prison regime. This own-initiative inquiry required a reprioritisation of the OPCAT inspections to be carried out. During this own-initiative inquiry, the Parliamentary Ombudsmen carried out ten targeted inspections of, inter alia, remand prisons.

Inspection items	Number of inspections	Dialogues
Prisons	4	
Remand prisons	9	
The Prison and probation Service		1
The Prison and Probation Service (National Transportation Unit)	1	
Police custody facilities	7	
Special residential homes for young people	2	
Special residential homes for substance abusers	2	
The National Board of Institutional Care		1
Psychiatric units	3	
The Swedish Migration Agency's detention centres	1	
The Health and Social Care Inspectorate		7
Total	**29**	**9**

For a full account of the inspections carried out and dialogue meetings held, see Annex B.

In 2019, the Parliamentary Ombudsmen's supervisory divisions carried out five additional inspections of places where people may be held deprived of their liberty (four prisons, one detention centre and two facilities for compulsory psychiatric care). Employees from the OPCAT Unit took part in three of these inspections.[2]



2 Hall, Salberga, Saltvik and Ystad prisons, Salberga remand prison, child and youth psychiatric unit (BUP) in Malmö and Forensic Psychiatric Care Stockholm, Section Nord.

The Police Authority

The Police Authority

The Police Authority may hold individuals deprived of their liberty in police custody facilities. At the end of 2019, there were 124 custody facilities in Sweden with 1,291 places in total. Individuals apprehended or arrested are among those who are placed in police custody facilities. Individuals detained due to intoxication under the Care of Intoxicated Persons Act (1976:511) are also regularly placed in police custody facilities.

In 2019, seven police custody facilities were inspected of which three were inspected for the first time.[1] Four of the inspections were announced. The majority of these announced inspections concerned police custody facilities which are only open when needed. All inspections were carried out by or on behalf of the then Parliamentary Ombudsman Cecilia Renfors. She made statements following the inspections of the police custody facilities in Borlänge, Karlskrona, Luleå and Växjö. The current Parliamentary Ombudsman Per Lennerbrant made statements following the inspections of the police custody facilities in Arvika, Karlskoga and Kristinehamn. Parliamentary Ombudsman Per Lennerbrant has made decisions in all the cases involving a response from the Police Authority.

3.1 Observations made during this year's inspections

Police custody facilities are intended for short-term deprivations of liberty. Depending on the reason for which an individual has been placed in police custody, a period of deprivation of liberty can last from a few hours up to a maximum of a couple of days. In the inspections of police custody facilities, the focus is primarily on how the basic needs of individuals deprived of their liberty are met. These include their right to food, their ability to meet their individual hygiene needs and daily outdoor access. Another key issue is the safety and security of individuals deprived of their liberty. It is not uncommon for individuals held in police custody to be in poor physical or mental condition. Therefore, it is important to make a safety and security assessment of the individual held in custody. Furthermore, it is important that individuals deprived of their liberty are regularly monitored and that this monitoring is documented.

1 Police custody facilities in Arvika, Borlänge, Karlskoga, Karlskrona, Kristinehamn, Luleå and Växjö. The police custody facilities in Arvika, Karlskoga and Kristinehamn were inspected for the first time.

Individuals held on remand in police custody facilities

Following a decision to hold an individual on remand, the individual must then be taken to a remand prison without delay. If it is of exceptional importance that the individual on remand is held at another location during the criminal investigation into the offences they are suspected of, a court may, upon a prosecutor's request, order the individual held on remand not to be placed in a remand prison for the time being. After an individual held on remand has been brought to a remand prison has been taken to a remand prison, a court or prosecutor may decide that the he or she should be taken to a place other than the remand prison for questioning or other measures.[2] In the Parliamentary Ombudsman's view, the transportation from a police custody facility to a remand prison should, as a rule, take place on the same day as when the remand order is made.

In exceptional cases, it may be acceptable for the transportation to be delayed until the following day.[3] During the inspection of *the police custody facility in Borlänge*, it emerged that the Police Authority had to use the police custody facility in Mora as a temporary remand prison because the remand prison in Falun was fully occupied. An individual on remand was held in the police custody facility in Mora for thirteen days while waiting for a place in a remand prison. At the time of the inspection, a further six individuals on remand were held in the police custody facilities in Borlänge and Mora. In none of the cases had the court or prosecutors decided that they should be placed in police custody. The fact that the individuals had been placed in police custody had no connection with the need for investigative measures, but was because the Prison and Probation Service lacked the capacity to accept them in the agency's remand prisons.

Following the inspection, the Parliamentary Ombudsman stated that it is not in compliance with the legislation that individuals deprived of their liberty have to be held in police custody facilities and that it is unacceptable to be kept there in situations where it should not occur, without a decision from a court or prosecutor. The Parliamentary Ombudsman further emphasised that individuals on remand being held in police custody facilities has direct negative consequences for individuals on remand as the physical conditions for satisfying their rights and needs are lacking. During the inspection, the head of the police custody facility stated that he intended to review what measures the Police Authority could take to reduce the negative consequences for individuals on remand who were held in the police custody facility, which was welcomed by the Parliamentary Ombudsman.[4]

Placing individuals deprived of their liberty in police custody facilities due to lack of space in the Prison and Probation Service's remand prisons is not in compliance with the legislation

2 See Chapter 24, Section 22, first and second paragraphs of the Code of Judicial Procedure.

3 See the Parliamentary Ombudsmen 2016/17 p. 159, ref. no. 3315-2014.

4 See the Parliamentary Ombudsmen's report p. 7, 8, 14 and 15, ref. no. O 13-2019.

Holding individuals in custody in connection with assisted transportation

A transportation of an individual detained for care must begin as soon as possible

The Police Authority is able to transfer the responsibility for transportations of individuals deprived of their liberty to the Prison and Probation Service. The Prison and Probation Service is to then carry out these transportations.[5] In order to facilitate the carrying out of these transportations, provisions have been introduced which provide the Police Authority with the right to take into custody, inter alia, young individuals taken into care in accordance with the Care of Young Persons Act (1990:52). This option may only be used if it is necessary to carry out an assisted transportation, i.e. a transportation that has been requested by another public agency and the young individual is over 15 years of age.[6] Similar provisions are found in the Care of Substance Abusers Act (1988: 870).[7] The preparatory works to the provisions state that the option to hold an individual in custody is to be used as a last resort and for the shortest time possible.[8] The Parliamentary Ombudsman has stated that there is an urgency requirement in the transportation to treatment homes of individuals taken into custody for care in accordance with the Care of Substance Abusers Act. The premise should be that the transportation must begin no later than the day after the individual has been encountered. Sometimes, however, there may be reason to deviate from this principle, for example if a doctor assesses that the transportation may not be carried out.[9]

During the inspection of *the police custody facility in Borlänge*, it emerged that at least 20 young persons taken into custody under the Care of Young Persons Act had been held in the police custody facility pending transportation in 2018 and 2019. Several young persons had to wait in the police custody facility for more than two days. One of the young persons turned 15 the same day she was taken into custody, and she was detained for almost three days. Following the inspection, the Parliamentary Ombudsman stated that a police custody facility as a rule is an unsuitable place for placing young persons who, in many cases, lack previous experience of such environments. If a young person is to be placed in police custody facility at all, a transportation must be initiated as soon as possible and no later than the day after they have been taken into custody. In the view of the Parliamentary Ombudsman, it was unacceptable that an individual who had just turned 15 was had been held in the police custody facility for almost three days whilst awaiting transportation.[10]

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5 See Section 29 a of the Police Act (1984:387) and Section 6, first paragraph of the Ordinance with Instructions for the Prison and Probation Service (2007:1172).

6 See Section 43 c of the Care of Young Persons Act.

7 See Section 45 c of the Care of Substance Abusers Act.

8 See Government Bill 2016/17:57 p. 78.

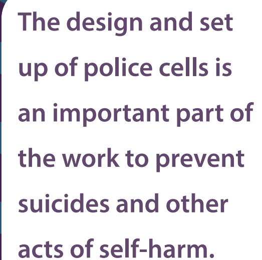
9 See the Parliamentary Ombudsmen 2016/17 p. 378, ref. no. 6293-2014.

10 See the Parliamentary Ombudsmen's report p. 7 and 16, ref. no. O 13-2019.

During the inspection of *the police custody facility in Karlskrona*, it emerged that it is very unusual for young persons taken into custody under the Care of Young Persons Act to be placed in police custody pending transportation. As a rule, a young person is taken into custody only once the Prison and Probation Service has confirmed that the transportation will take place and only then in as close a proximity as possible to when the transportation should occur. The individual is usually only then detained for a couple of hours and is not locked in a police cell. Following the inspection, the Parliamentary Ombudsman stated that it is positive that the police in Karlskrona apply the provision on detention in a way that means that the amount time spent in the police custody facilities need not be any longer than is absolutely necessary.[11]

Attempted suicides and acts of self-harm

During the inspection of *the police custody facility in Luleå*, it emerged that there had been a large number of attempted suicides during 2007–2018. In over 20 of the cases, inmates had attached nooses to the interior fittings and fixtures of the police detention cells. In the majority of cases, the noose had been attached to the toilet door hinge or crevice. In four cases, the noose had been attached to the wall-mounted chairs found in detention cells. It also emerged that staff had pointed out that the cells are inadequate with respect to suicide and self-harm prevention on several occasions during the years in question. In August 2018, two further suicide attempts occurred in a similar manner, one of which was fatal. Following these incidents, the Police Authority decided that all inmates in the Norrbotten area's police custody facilities would be monitored at intervals of no more than 15 minutes. The Police Authority also decided to renovate all its cells to reduce the ability to attach nooses to the interior fittings and fixtures. However, there was no change to the wall-mounted chairs.[12]



Following the inspection, the Parliamentary Ombudsman stated that an important aspect of the work in preventing suicides and other acts of self-harm is to ensure the police cells are designed and set up to prevent suicide attempts to the greatest possible extent. Shortcomings in the physical environment that increase the risk of such acts must be remedied as soon as they are discovered. In the view of the Parliamentary Ombudsman, it is very serious that it took more than ten years before the necessary changes were made to the police custody facility in Luleå and that this delay had very serious consequences. In the view of the Parliamentary Ombudsman, it was also remarkable that the wall-mounted chairs in the police cells had not been changed. The Parliamentary Ombudsman also stated that it is important that the Police Authority learns from the experiences at the police custody facility

11 See the Parliamentary Ombudsmen's report p. 3 and 5, ref. no. O 33-2019.

12 See the Parliamentary Ombudsmen's report p. 3 and 4, ref. no. O 2-2019.

in Luleå, and uses them in its continued work in preventing suicide and other acts of self-harm.[13] See also under the heading "Cases where responses from the Police Authority have been requested".

During the inspections of *the police custody facilities in Kristinehamn* and *Växjö*, information emerged of attempted suicides carried out in a similar way as in *the police custody facility in Luleå*.[14]

Shortcomings in the physical environment

Any individual held in a police custody facility must be treated with respect for their human value and with an understanding of the special difficulties associated with a deprivation of liberty. Furthermore, the execution of a decision to deprive someone of their liberty must be conducted in such a manner that negative consequences are counteracted.[15]

During the inspections of *the police custody facilities in Arvika* and *Kristinehamn*, it emerged that several of the cells were covered in graffiti. In *the police custody facility in Arvika*, there was, inter alia, a large swastika engraved into the table in one of the cells and another cell smelled of urine. Furthermore, there was derogatory and hateful graffiti scrawled in the cells in both Arvika and Kristinehamn.[16]

Inmates are not to be placed in cells that are dirty or covered in graffiti

During the inspection of *the police custody facility in Karlskrona*, it emerged that the cells were worn and dirty, and that even the cells that had been cleaned stank of urine. Furthermore, it was very cold in the cells during the winter and inmates can need up to three blankets to keep warm.[17]

Following the inspections, the Parliamentary Ombudsman reiterated that individuals held in police custody facilities should be treated with respect for their human dignity and with an understanding of the special difficulties associated with being deprived of one's liberty. This means, inter alia, that individuals deprived of their liberty – regardless of the reason for the decision – must be held in cells of an acceptable hygienic standard. For the same reason, an inmate should not have to stay in a cell that is covered in graffiti. Furthermore, cells must have an acceptable temperature even in winter.[18]

During the inspection of *the police custody facility in Växjö*, it emerged that the cells were generally worn and that the number of cells did not correspond to the actual need. Following the inspection, the Parliamentary Ombudsman stated that, occasionally, intoxicated individuals were held in detention cells. The Parliamentary Ombudsman further emphasised that the police custody

13 See the Parliamentary Ombudsmen's report p. 10 and 11, ref. no. O 2-2019.

14 See the Parliamentary Ombudsmen's report p. 3, ref. no. O 49-2019 and report p. 7, ref. no. O 21-2019.

15 See Chapter 1, Sections 4 and 5 of the Remand Prisons Act.

16 See the Parliamentary Ombudsmen's report p. 4, ref. no. O 47-2019 and report p. 3, ref. no. O 49-2019.

17 See the Parliamentary Ombudsmen's report p. 3, ref. no. O 33-2019.

18 See the Parliamentary Ombudsmen's report p. 9, ref. no. O 47-2019 and report p. 5, ref. no. O 33-2019.

facility in Ljungby – located in a much smaller town than Växjö – has more cells than the police custody facility in Växjö. In addition, the police custody facility in Växjö is the only one open 24 hours a day in Kronoberg County. There is no sobering up facility in Växjö, which means that people who are detained due to intoxication remain in police custody. The police custody facility does not have its own exercise yard and has only limited access to the exercise yard in the remand prison in Växjö. In light of these circumstances and the fact that the police custody facility lacked rooms for lawyer-client meetings, it appeared, in the Parliament Ombudsman's view, that it is necessary for the Police Authority to review the adequacy of its custody facilities.[19]

Inmates' clothing and bedding

If needed, an inmate must be provided with bedding, clothing and footwear. These items may be restricted if it is necessary to prevent inmates from injuring themselves or others. An inmate should have something to cover themselves with and is not allowed to be in custody without clothing for longer than is necessary for their safety.[20] The Parliamentary Ombudsman has previously stated that it is unsatisfactory, from a hygiene and dignity perspective, that individuals held in police custody facilities do not receive bedding.[21] The Parliamentary Ombudsman has also stated that individuals in custody's access to clothing may only be restricted to prevent them from harming themselves or others. In other situations, individuals held in custody have the right to wear their own clothes if they wish, and changing into clothing provided by the Police Authority cannot, for that reason, be mandatory.[22]

During the inspections of *the police custody facilities in Arvika, Karlskoga* and *Kristinehamn*, it emerged that individuals detained due to intoxication did not generally receive a blanket upon arrival. In *the police custody facility in Växjö*, individuals apprehended, arrested or otherwise detained received blankets, pillows and pillowcases but not sheets. Individuals detained due to intoxication did not have access to blankets. Similar information emerged during the inspection of *the police custody facility in Karlskrona*. The Parliamentary Ombudsman stated in the reports following the inspections that an individual held in police custody should, as a general rule, be provided with bedding and reiterated previous statements made on this issue. Regarding *the police custody facility in Växjö*, the Parliamentary Ombudsman also stated that an individual detained due to intoxication should normally be offered a blanket or similar for cover and for warmth.[23]

19 See the Parliamentary Ombudsmen's report p. 2–4, 9 and 10, ref. no. O 21-2019.

20 See Chapter 3 Section 3 of the Police Authority's regulations and general advice on police custody facilities, PMFS 2015: 7, FAP 102-1.

21 See the Parliamentary Ombudsmen's report p. 9, ref. no. 6363-2016.

22 See the Parliamentary Ombudsmen's report p. 8, ref. no. 6361-2016.

23 See the Parliamentary Ombudsmen's report p. 3 and 5, ref. no. O 33-2019, report p. 5, 11 and 12, ref. no. O 47-2019, report p. 7, ref. no. O 48-2019 and report p. 4, ref. no. O 49-2019 and report p. 3, 8 and 9, ref. no. O 21-2019.

During the inspections of *the police custody facilities in Arvika* and *Växjö*, it emerged that individuals deprived of their liberty must change into clothing provided by the Police Authority upon registration. In the report following the inspections, the Parliamentary Ombudsman reiterated previous statements made on this issue as well.[24]

Persons detained due to intoxication

A police officer is authorised to detain and take into protective care an individual who is so intoxicated by alcohol or other intoxicants that they cannot take care of themselves, or otherwise poses a danger to themselves or others. The detainee is to be released as soon as is possible without the risk of harm to themselves and there are no longer grounds for detention. However, the detainee must always be released no later than eight hours after detention, unless it is clearly in their own interest that they may remain for a short period beyond that.[25]

Decisions to detain persons due to intoxication must be reviewed continuously and last for as short a time as possible

During the inspection of *the police custody facility in Borlänge*, it emerged that some police custody facility staff were of the opinion that an individual who had been detained due to intoxication should be held deprived of their liberty for at least six hours, and that the custody officer does not normally need to be contacted before then. Similar information emerged during the inspections of *the police custody facilities in Arvika, Karlskoga*, and *Kristinehamn*. Following the inspections, the Parliamentary Ombudsman stated that detention for reasons of care should last for as short a time as possible and that there should be a continuous review of whether the conditions for continued detention are met.[26]

During the inspection of *the police custody facility in Borlänge*, it emerged that sobering up places had recently been established at Falu Hospital. Furthermore, Dalarna Region is able to admit intoxicated individuals to the accident and emergency units at the hospitals in Ludvika and Mora. The police responsible in the Dalarna Police District have produced a checklist to be used for detentions made in accordance with the Care of Intoxicated Persons Act. The checklist is used to assess whether an intoxicated individual should be taken to a healthcare facility for treatment or into police custody. Following the inspection, the Parliamentary Ombudsman stated that it is positive that the Police Authority works systematically with this issue.[27]

Supervisors' remote reviews

A police officer who has detained an individual into custody in accordance with the Police Act or the Care of Intoxicated Persons Act must report this ac-

24 See the Parliamentary Ombudsmen's report p. 5 and 12, ref. no. O 47-2019 and report p. 4 and 9, ref. no. O 21-2019.

25 See Section 1, first paragraph and Section 7, third paragraph of the Care of Intoxicated Persons Act.

26 See the Parliamentary Ombudsmen's report p. 6 and 11, ref. no. O 13-2019 and report p. 6 and 11, ref. no. O 47-2019, report p. 5 and 6, ref. no. O 48-2019 and report p. 5, ref. no. O 49-2019.

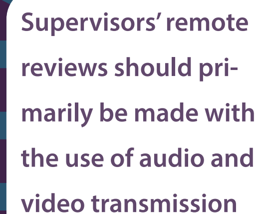
27 See the Parliamentary Ombudsmen's report p. 5 and 17, ref. no. O 13-2019.

tion to their supervisor as soon as possible. If custody has not already ended, the supervisor must immediately review whether it should continue.[28] Immediately after an individual deprived of their liberty has been detained, this must be reported to the responsible officer (usually the custody officer).

A supervisor's review of an individual held in custody is usually performed by a custody officer going to the police custody facility and talking to the police officers who detained the individual. For individuals detained due to intoxication, the custody officer must, in his examination, inter alia, decide whether the detainee's condition is such that they cannot take care of themselves or that they pose a danger to themselves or others. A similar examination may be needed of individuals held in custody in accordance with Section 13 of the Police Act. The Parliamentary Ombudsman has previously stated that a supervisor should normally meet the detainee and by, inter alia, talking to the individual form an opinion regarding their condition. This measure also constitutes an important prerequisite for the supervisor to be able to ensure that a detainee's condition is caused by intoxication and not by, for example, a serious illness.[29]

During the inspections of *the police custody facilities in Arvika* and *Kristinehamn*, it emerged that supervisors' reviews of individuals taken into custody are carried out remotely via telephone. The custody officer in Karlstad carries out the review by talking to the police officers who detained the individual. The custody officer in Örebro conducts a similar supervisors' review for individuals deprived of their liberty in custody in *the police custody facility Karlskoga*. This police custody facility has a camera-monitored entry area, which enables the custody officer to see the detainee via image transfer.[30]

During the inspection of *the police custody facility in Luleå*, it emerged that the custody officer there is responsible for the reviews of individuals taken into custody in Arjeplog, Arvidsjaur, Boden, Gällivare, Haparanda, Jokkmokk, Kalix, Kiruna, Pajala and Piteå. These supervisory reviews are performed remotely by telephone. Furthermore, it emerged that the custody officers in Luleå sometimes experience difficulties carrying out a proper review solely by telephone because, inter alia, important information is not always communicated to them.[31]



Following the inspections, the Parliamentary Ombudsman referred to an earlier statement that supervisors' remote reviews should primarily be made with the use of audio and video transmission. If a supervisory review is performed only by telephone, the supervisor should also regularly speak to the detai-

28 See Section 15, first paragraph of the Police Act and Section 5 of the Care of Intoxicated Persons Act.

29 See the Parliamentary Ombudsmen 1998/99 p. 116.

30 See the Parliamentary Ombudsmen's report p. 4, ref. no. O 47-2019, report p. 3 and 4, ref. no. O 48-2019 and report p. 3, ref. no. O 49-2019.

31 See the Parliamentary Ombudsmen's report p. 6, ref. no. O 2-2019.

nee, if permitted. The Parliamentary Ombudsman further stated that police custody facilities did not manage their documentation in a uniform manner. In the Parliamentary Ombudsman's view, it is important that police custody facility staff and custody officer who are responsible for individuals held in police custody have access to the same documentation. Furthermore, it is important that the documentation is saved for the purpose of review. The Police Authority must ensure that the documentation is prepared and handled in a uniform manner within the Police Authority.[32]

Information on rights

In the view of the Parliamentary Ombudsman, it is important that the Police Authority has routines which mean that individuals held in custody receive information concerning their rights and the meaning of the measures used against them in a legally secure manner. This means, inter alia, that individuals deprived of their liberty, regardless of the grounds for the deprivation, receive information concerning their rights, orally and in writing, in a language they understand in as close a proximity as possible upon being detained. It is also important that these actions are documented.[33]

The Parliamentary Ombudsman has previously stated that the special form that the Police Authority has produced to document that detainees are informed, inter alia, of their rights plays an important role as it concerns the basic information that the detainee has the right to receive. The purpose of such comprehensive documentation is to reduce the risk of a detainee not receiving the information.[34]

During the inspection of *the police custody facility in Växjö*, it emerged that the facility does not use the form. Furthermore, it was not possible to determine from the documentation whether the individuals deprived of their liberty had received any such information. Similar observations were made during the inspections of *the police custody facilities in Arvika, Karlskoga* and *Kristinehamn*. The Parliamentary Ombudsman stated that the Police Authority should ensure that the form is used.[35]

During the inspection of *the police custody facilities in Karlskoga* and *Kristinehamn*, it emerged that the facilities do not provide the Police Authority's written information to individuals detained due to intoxication. Following the inspections, the Parliamentary Ombudsman stated that the Police Authority should take the necessary measures to provide individuals deprived of their liberty the opportunity to receive the written information, and referred to an

32 See the Parliamentary Ombudsmen's report p. 12 and 13, ref. no. O 2-2019 and report p. 10 and 13, ref. no. O 47-2019.

33 See the Parliamentary Ombudsmen 2014/15 p. 104.

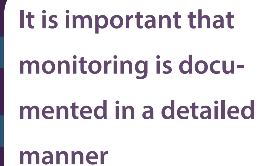
34 See the Parliamentary Ombudsmen's report p. 7 and 8, ref. no. 5424-2018.

35 See the Parliamentary Ombudsmen's report p. 6 and 12, ref. no. O 47-2019, report p. 6, ref. no. O 48-2019, report p. 5, ref. no. O 48-2019 and report p. 5 and 7, ref. no. O 21 -2019.

earlier statement that the information could alternatively be posted on the wall or door of the cell.[36]

Monitoring

The Parliamentary Ombudsman has previously stated on several occasions that the documentation of supervision must reflect the actual time when the supervision took place. This indication of time can be of decisive importance in enabling subsequent examination of what has happened to an individual held in custody. It is a basic requirement with regard to legal certainty and control that the documentation of supervision is made in accordance with the applicable rules. The Parliamentary Ombudsman has also stated that it is important that detailed notes are kept in connection with supervision.[37]



During the inspection of *the police custody facility in Luleå*, it emerged that the facility guards signed the supervision sheets before the supervision took place. It further emerged that it was consistently written that the supervision took place at 00, 15, 30 and 45. In the view of the Parliamentary Ombudsman, the Police Authority needed to take the necessary measures to ensure that the documentation of supervision reflects the real circumstances.[38]

During the inspection of *the police custody facilities in Arvika* and *Kristinehamn*, it emerged that the notes of observations made during supervision were often deficient. The detainees' status was often stated in no other way than "awake" or "asleep". Similar observations were made at *the police custody facility in Växjö*. Following the inspections, the Parliamentary Ombudsman called on the Police Authority to take the necessary measures to ensure that inspections carried out are documented correctly.[39]

Police custody guards' training

During the inspection of *the police custody facility in Luleå*, information emerged that showed that the guards who are employed by the hour were in need of extra training. Furthermore, it emerged that civilian guards were being recruited to replace the guards employed by the hour during office hours. Guards from a security company were supposed to staff the facility for the rest of the time. The Parliamentary Ombudsman stated that it is important that the new guards, as well as the security company's guards, receive the necessary training for them to be able to work in the police custody facility.[40]

During the inspections of *the police custody facilities in Arvika, Karlskoga* and *Kristinehamn*, it emerged that the Police Authority employs guards on an

36 36 See the Parliamentary Ombudsmen's report p. 12 and 13, ref. no. O 47-2019.

37 See the Parliamentary Ombudsmen's report p. 11, ref. no. 6465-2017 and report p. 6, ref. no. 6291-2014.

38 See the Parliamentary Ombudsmen's report p. 5 and 11, ref. no. O 2-2019.

39 See the Parliamentary Ombudsmen's report p. 6 and 11, ref. no. O 47-2019, report p. 4 and 5, ref. no. O 49-2019 and report p. 4, 5 and 8, ref. no. O 21-2019.

40 See the Parliamentary Ombudsmen's report p. 2, 3 and 12, ref. no. O 2-2019.

hourly basis. In Arvika and Kristinehamn, no further training is arranged, and at the police custody facility in Karlskoga, the guards are not offered any further training at all. The police custody facilities are used relatively infrequently and only when necessary, which means that the guards do not work on a regular basis. Several of the guards expressed a desire for further training. The Parliamentary Ombudsman stated that the Police Authority should ensure that the guards can maintain their skills and competence, for example through regular training sessions, and that they should have adequate support in the form of local, written routines.[41]

3.2 Cases where responses from the Police Authority have been requested

Following the inspections of *the police custody facilities in Karlskrona, Luleå* and *Växjö*, the Parliamentary Ombudsman has requested that the Police Authority respond with information on how it has handled certain issues that have been raised. Such responses have been requested in respect of shortcomings in the physical environment etc. The Parliamentary Ombudsman has requested responses on the following issues:

- The design and set up of cells (*the police custody facility in Luleå*).
- The environment in cells (*the police custody facility in Karlskrona*).
- Natural light entry into cells (*the police custody facility in Luleå*).
- The design of police custody premises (*the police custody facility in Växjö*).
- The environment in an exercise yard (*the police custody facility in Luleå*).
- Detainees' access to bedding (*the police custody facility in Karlskrona*).

In compiling this report, the Parliamentary Ombudsmen have taken decisions on all the responses received.

Physical design of cells

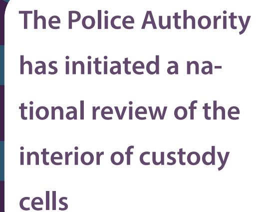
During the inspection of the police custody facility in Luleå, it emerged that the fixed furnishings in the cells had been used for acts of self-harm on a large number of occasions. Following the inspection, the Parliamentary Ombudsman emphasised the importance of the Police Authority drawing lessons from the experiences at this facility, and using these lessons in its continued work to prevent suicide and other acts of self-harm. The Parliamentary Ombudsman requested that the Police Authority respond detailing the measures taken.[42]

In its response, the Police Authority stated it had initiated a national review of the furnishings within its detention cells and will change its premises with

41 See the Parliamentary Ombudsmen's report p. 3 and 12, ref. no. O 47-2019, report p. 2, ref. no. O 48-2019 and report p. 2 and 3, ref. no. O 49-2019.

42 See the Parliamentary Ombudsmen's report p. 10 and 11, ref. no. O 2-2019.

regard to the wall-mounted chairs. The Parliamentary Ombudsman stated it was positive that the Police Authority will conduct this national review and that the authority had crucial work ahead. The case requesting a response was closed.[43]



In a letter to the Parliamentary Ombudsman in December 2019, the Police Authority announced that, on 17 December 2019, it had decided to rebuild all wall-mounted chairs. The space under the chairs will be covered and all cells with this type of chair are expected to be rebuilt by 31 December 2020.[44]

Cell environment

During the inspection of *the police custody facility in Karlskrona*, it emerged that the cells were neither properly cleaned nor had an acceptable temperature. Furthermore, it emerged that individuals arrested were placed in cells used for sobering up that only have a bunk with a plastic mattress, which meant that the individuals deprived of their liberty had to sit on the bunk when they ate. The Parliamentary Ombudsman stated that the Police Authority should avoid placing individuals detained by the order of a prosecutor in this type of cell and that it must ensure that the cells in which individuals deprived of their liberty are held are properly cleaned and have an acceptable temperature. The Parliamentary Ombudsman requested that the Police Authority respond detailing the measures taken.[45]

In its response, the Police Authority stated that all the cells in the custody facility had been thoroughly cleaned. Furthermore, there will be random checks of the cleaning as well as quality checks together with the local cleaning supplier. Furthermore, there had been a review of the settings of the thermostats. Finally, the Police Authority had instructed the person responsible for the custody facility that individuals detained by the order of a prosecutor should only be placed in cells used for sobering up in exceptional cases and, only when regular cells were not available. The Parliamentary Ombudsman found that the reported measures appeared to be adequate and the case requesting a response was closed.[46]

Entry of natural light into cells

During the inspection of *the police custody facility in Luleå*, it emerged that it was not possible to regulate the incoming natural light in the cells. The Parliamentary Ombudsman requested the Police Authority respond detailing the measures it intended to take to remedy this shortcoming.[47] The Police Authority responded that it intended to install blinds in the cell windows.

43 See the Parliamentary Ombudsmen's decision of 22 November 2019, ref. no. O 23-2019.

44 See document 6, ref. no. O 23-2019.

45 See the Parliamentary Ombudsmen's report p. 5 and 6, ref. no. O 33-2019.

46 See document 2 and the Parliamentary Ombudsmen's decision on 11 October 2019, ref. no. O 38-2019.

47 See the Parliamentary Ombudsmen's report p. 12, ref. no. O 2-2019.

This measure was welcomed by the Parliamentary Ombudsman and the case was closed.[48]

The design and layout of a police custody facility

During the inspection of *the police custody facility in Växjö*, it emerged that the facility lacked a meeting room and, as a result, detainees suspected of crimes had to talk to their defence counsel in the cell with the door ajar. During the inspection, it further emerged that the police custody facility is not soundproof. In the view of the Parliamentary Ombudsman, this meant that there was a risk that the suspects' right to confidential conversations with their defence counsels could not be met.[49] The Parliamentary Ombudsman, therefore, requested that the Police Authority respond detailing the measures it had taken to remedy the situation.[50]

The response shows that the Police Authority has prepared a room that can be used for visits and conversations by suspects and their defence counsels. The Parliamentary Ombudsman stated that the Police Authority had rectified the highlighted shortcomings in a satisfactory manner. The case requesting a response was closed.[51]

Exercise yard environment

During the inspection of *the police custody facility in Luleå*, it emerged that the exercise yard only allowed for limited natural light and fresh air. The Parliamentary Ombudsman stated that it could not be considered to fulfil the purpose of outdoor access and requested the Police Authority respond detailing the measures taken.[52]

The response shows that the Police Authority will rebuild the exercise yard's snow and privacy screening to increase the inflow of daylight. The Parliamentary Ombudsman welcomed the measure and the case was closed.[53]

Access to bedding

During the inspection of *the police custody facility in Karlskrona*, it emerged that individuals deprived of their liberty did not receive any bedding. The Parliamentary Ombudsman requested the Police Authority respond detailing the measures taken to ensure that individuals deprived of their liberty are given such items.[54] The Police Authority responded that the police custody facility staff had been instructed that individuals deprived of their liberty should be provided with bedding.[55]

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48 See the Parliamentary Ombudsmen's decision of 22 November 2019, ref. no. O 23-2019.

49 See Chapter 21, Section 9 of the Code of Judicial Procedure.

50 See the Parliamentary Ombudsmen's report p. 9 and 10, ref. no. O 21-2019.

51 See the Parliamentary Ombudsmen's decision of 29 November 2019, ref. no. O 42-2019.

52 See the Parliamentary Ombudsmen's report p. 12, ref. no. O 2-2019.

53 See the Parliamentary Ombudsmen's decision of 22 November 2019, ref. no. O 23-2019.

54 See the Parliamentary Ombudsmen's report p. 3 and 6, ref. no. O 33-2019.

55 See document 2, ref. no. O 38-2019.

3.3 Conclusions

As previously mentioned, police custody facilities are not designed for anything other than short-term deprivations of liberty that last for a maximum of a couple of days. During this year's inspections, it has emerged that individuals deprived of their liberty have spent significantly longer periods than this in police custody facilities. The situation has been caused by the strained occupancy situation in the Prison and Probation Service's remand prisons. The Prison and Probation Service has, therefore, occasionally been forced to close certain remand prisons for new admissions of individuals deprived of their liberty. The situation that has arisen is beyond the control of the Police Authority. However, the Police Authority does have a great responsibility for taking measures to reduce the negative consequences for remand prisoners who remain in a police custody facility.[56] Such measures can, for example, mean bringing in extra staff to be able to offer remand prisoners both isolation-breaking measures and more time outside their cells, for example in an exercise yard. Furthermore, there may be a need to review how cells are equipped and increase remand prisoners' opportunities for different types of stimulation.

During the year, it has emerged that, inter alia, young individuals taken into care for treatment in accordance with the Care of Young Persons Act have remained for several days in the Police Authority's custody facilities pending transportation to a special residential home for young people. The reason why these situations have arisen is that the Prison and Probation Service has not had sufficient capacity to carry out requests for assisted transportations. The agency has down-prioritised transportations requested by the Police Authority. As previously mentioned, the Parliamentary Ombudsman has stated that a police custody facility is usually an unsuitable place for placing young persons taken into care for treatment. If a young individual is to be placed in custody at all, a transportation must be initiated as soon as possible, and no later than the day after they have been taken into custody. There are positive examples within the Police Authority where staff members work actively to avoid, as far as is possible, young individuals being placed in a police custody facility. In these cases, the Police Authority orders a transportation from the Prison and Probation Service and the young individual is collected only once the transportation can be performed. As such, young individuals taken into care need not be placed in a police custody facility. Such an approach is probably not possible in all situations, but there should be room for the Police Authority to review its routines in these cases in order to reduce the time that young individuals have to be held in a police custody facility.

In 2019, the Police Authority took a comprehensive approach in looking at the issue of the interior design and set up of its cells. There will be a review of all cells to reduce the risk of detainees harming themselves on the interior.

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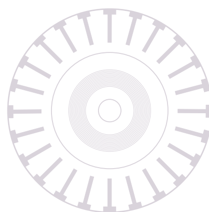
56 See Chapter 1, Section 5 of the Remand Prisons Act, which, for example, states that the execution of a decision to deprive someone of their liberty must be conducted in such a manner that negative consequences are counteracted.

Ensuring that the physical environment is as safe as possible is one of several components required to reduce the number of suicides and acts of self-harm in police custody facilities. Other important aspects of the preventive work are that safety and security assessments are made of individuals detained and that decided monitoring is carried out and documented. Furthermore, it is important that detainees in need of medical care are allowed to see a doctor.

The issue of individuals deprived of their liberty's access to medical care has been an important issue for a long time in the Parliamentary Ombudsmen's supervisory work.

Every police custody facility must have both access to a licensed doctor and staff with adequate health and medical care training.[57] The Parliamentary Ombudsmen's inspections show that access to health and medical care varies between the country's police custody facilities. Some police custody facilities have healthcare personnel employed, while other police custody facilities have resolved issues of access to health and medical care through agreements with the regional authorities meaning that healthcare personnel come to the police custody facility when necessary. However, several police custody facilities do not have such agreements in place. In the reports that international bodies have submitted following visits to or other inspections of Sweden, there are statements regarding inmates' access to health and medical care. The European Committee for the Prevention of Torture (CPT) has called on Sweden to ensure that individuals deprived of their liberty by being taken into police custody are examined by qualified healthcare professionals. Furthermore, the CPT has recommended that Sweden takes measures to ensure that individuals detained due to intoxication have immediate access to a nurse, if necessary.[58] The UN Committee against Torture (CAT) has stated that Sweden must take measures that guarantee that an individual is given the opportunity for a medical examination by an independent doctor already at the start of a deprivation of liberty.[59] The Police Authority has begun a review of this very important issue. Detainees' access to health and medical care whilst held in police custody will continue to be a key issue for the Parliamentary Ombudsmen's OPCAT activities.



57 See Section 15 of the Remand Prisons Ordinance.

58 See CPT/Inf (2016) 1 para 14 and 19.

59 See CAT/C/SWE/CO/6-7 para 7.

4

The Prison and Probation Service

The Prison and Probation Service

At the end of 2019, there were 32 remand prisons in Sweden and 45 prisons with approximately 6,900 places in total. The Prison and Probation Service's institutions primarily hold people who are deprived of their liberty because they are on remand or serving a prison sentence. Other categories of individuals deprived of their liberty are also placed in the Prison and Probation Service's remand prisons. These are primarily people who are transported by the Prison and Probation Service's National Transportation Unit. These may be, for example, young individuals taken into care in accordance with the special provisions in the Care of Young Persons Act (1990:52) or the Care of Substance Abusers Act (1988:870). Likewise, foreigners who are held detained in accordance with the Aliens Act (2005:716) can, under certain conditions, be held in remand prisons.

In 2019, the OPCAT Unit carried out 13 inspections of remand prisons and prisons.[1] During an inspection of a remand prison, a transportation group of the National Transportation Unit's was also inspected. This group within the National Transportation Unit had not been previously inspected by the Parliamentary Ombudsmen. Twelve of the inspections were unannounced. Furthermore, two dialogue meetings were held with the Prison and Probation Service regarding both the isolation of inmates held on remand and the prioritisation of transportations.

All inspections were carried out, and dialogue meetings held, by or on behalf of Chief Parliamentary Ombudsman Elisabeth Rynning. She additionally made statements following all the inspections and decided on the cases where a response from the Prison and Probation Service had been requested.[2] A further four prisons and one remand prison were inspected by the supervisory division.

4.1 Observations made during this year's inspections

The inspections of the remand prisons and prisons cover a number of different issues. In addition to the inspections providing an opportunity to draw attention to shortcomings in the physical environment, they usually also concern questions regarding staff's treatment of inmates and how inmates'

1 The prisons in Haparanda, Kumla (national reception centre), Västervik Norra and Umeå as well as the remand prisons in Falun, Göteborg, Helsingborg (Berga), Kalmar, Karlskrona, Malmö, Nyköping, Trelleborg and Växjö.

2 See the Parliamentary Ombudsmen's case ref. no. O 7-2018 and ref. no. 8337-2018.

fundamental rights are met. The latter may concern the right of association with other inmates, outdoor access, etc.

Observations made during the year concerning the isolation of remand prisoners are reported separately in Section 8 of this report.

Placing inmates in segregation

As a main rule, an inmate in a prison must, during the time when they are obliged to perform or participate in occupational activities, associate with other inmates. Furthermore, according to the main rule, an inmate must be given the opportunity to associate with other inmates in their free time. Association with others may be limited by the Prison and Probation Service deciding that an inmate should be segregated. Inmates may be segregated at night during the so-called daily rest period. Furthermore, the Prison and Probation Service may take decisions to segregate for reasons of maintaining order or security, when investigating misbehaviour or to carry out a strip search. An inmate in a prison can also be placed in segregation at their own request.[3] The Prison and Probation Service may also place a remand prisoner in segregation if it is deemed necessary for reasons of maintaining order or security.[4]

During a number of prison inspections in 2019, it was noted that the Prison and Probation Service's decisions on segregating were inadequately formulated.[5] It was not always possible to read why the inmates had been segregated. Following the inspections, the Chief Parliamentary Ombudsman emphasised that a decision that can be assumed to affect an individual's situation in a not insignificant manner must, unless it is unnecessary, contain a clear justification with information detailing the circumstances that have been decisive for the agency to take such a position. If an inmate is segregated, the measure must be documented and the documentation must state the reasons for the measure. The Chief Parliamentary Ombudsman called on the Prison and Probation Service to review its procedures for decisions on segregation and the application of the current provisions.[6]

Placing inmates segregated at their own request should only be used in exceptional cases once other alternatives are exhausted

During the inspection of *the prison Västervik Norra*, it emerged that it has a special unit for holding inmates segregated at their own request. The unit is divided into two parts; the "locked" and the "semi-open side". Several of the inmates had been segregated for very long periods of time. One of the inmates had been segregated for over 600 days. In conversations with the Parliamentary Ombudsmen's employees, a couple of the inmates stated that they would rather be placed in association with others in secure places for their own protection, but that the lack of such places had led them to not seeing

3 See Chapter 6, Sections 1–9 of the Prisons Act (2010:610).

4 See Chapter 2, Section 5 of the Remand Prisons Act (2010:611).

5 Such observations were made during the inspections of the prisons in Haparanda and Umeå.

6 See the Parliamentary Ombudsmen's report p. 11 and 12, ref. no. O 1-2019 and report p. 11 and 13, ref. no. O 54-2019.

The Prison and Probation Service needs to review what premises it has available to place inmates in need of protection

any alternative than being placed in segregation. Following the inspection, the Chief Parliamentary Ombudsman reiterated that the intention behind the provisions regarding segregation state that if a situation – for example where an inmate feels threatened – can be resolved in another way than holding an inmate segregated, such a measure should be the primary choice.[7] The Chief Parliamentary Ombudsman further stated that segregation should only be used in exceptional circumstances when all other alternatives have been exhausted. If an inmate is nonetheless segregated, the Prison and Probation Service must work actively to ensure that it lasts for as short a period as possible. Placing an inmate in need of protection in segregation should only occur pending a more permanent solution, for example relocation to a secure places for their own protection.[8]

It further emerged from the inspection that the inmates who are placed on the semi-open side associate with each other for most of the day. The only reason they are locked in during the day is that the inmates on the unit's locked side should be able to use the unit's balcony. In the view of the Chief Parliamentary Ombudsman, this means that the real reason for being placed in segregation on the semi-open side is the design and layout of the prison's premises. During the conversations that the Parliamentary Ombudsmen's employees had with inmates, they expressed that they wanted to be on the semi-open side because it is calmer there. According to the Chief Parliamentary Ombudsman, this indicates that there is a need to set up smaller units, where the inmates' needs to associate in a smaller group and with less stimuli can be met. The Chief Parliamentary Ombudsman finally noted that the management of the prison has expressed that the mandate of its so-called RO Department[9] is unclear. In the view of the Chief Parliamentary Ombudsman, what emerged regarding inmates who were segregated at their own request suggested that the Prison and Probation Service needs to review the premises it has available to place inmates who are in need of protection or inmates who need to associate in smaller groups. At the same time, the Prison and Probation Service needs to take measures to ensure that segregating inmates at their own request is only used in exceptional circumstances and for as limited a time as possible.[10]

Finally, during the inspection of *the prison Västervik Norra*, it was noted that some of its segregation cells are equipped with high-positioned, so-called basement windows. As a result, an inmate is not able to look out the window and, in addition, the windows lacked the equipment that would make it possible to regulate natural light into the cell. One inmate had been held in such a cell for several weeks. The Chief Parliamentary Ombudsman stated that the

7 See Government Bill 2009/10: 135 pp. 138.

8 See the Parliamentary Ombudsmen's report p. 16, ref. no. O 46-2019.

9 A department that enables, for example, inmates associating with each other in small groups.

10 See the Parliamentary Ombudsmen's report p. 16, ref. no. O 46-2019.

cells are not adequate for long periods of segregation. The Prison and Probation Service, therefore, needs to take measures to prevent such situations from occurring in the future.[11]

Body searches

An inmate may be subject to a body search for unauthorised objects. As a rule, such a body search may not be performed or witnessed by someone of the opposite sex. If necessary, however, a body search or a strip search of a man may be witnessed by a woman.[12]

During the inspection of *the remand prison in Göteborg*, attention was drawn to the fact that pat-down searches of male inmates were carried out by female staff, and that body searches of male inmates were carried out in front of a camera and in the presence of female staff. Following the inspection, the Chief Parliamentary Ombudsman stated that the premise must be that a search must be carried out by staff of the same sex as the inmate. The remand prison is Sweden's largest and over 50 percent of the guards are men. For this reason, the remand prison should be able to have staffing that ensures that there are both male and female staff members on duty in the units, so that pat-down body searches can be performed in a dignified manner for all inmates, regardless of sex.[13]

During the inspection of *the prison in Umeå*, details emerged that inmates were allowed to undress in a camera-monitored room when they were admitted to the prison. There was a curtain that could be used so that the undressing could be performed away from the surveillance camera. In conversations with the Parliamentary Ombudsmen's employees, several inmates stated that the curtain had not been used and that female staff were also present when they changed clothes. Following the inspection, the Chief Parliamentary Ombudsman called on the prison to ensure that staff use the curtain to make body searches less intrusive.[14]

Conditions for young people under 18 held on remand

An individual can be remanded in custody by a court at a prosecutor's request, inter alia, if they are suspected on probable cause of a crime for which imprisonment is prescribed for a year or more. In order for an individual to be remanded in custody, it is also required that there is a risk of flight, disrupting or complicating the investigation or reoffending. Young people under the age of 18 may only be remanded in custody if it is obvious that adequate supervision cannot be arranged and there are special reasons for remand.[15]

All staff who have contact with young people must receive training in order to be able to treat them in the best possible way

11 See the Parliamentary Ombudsmen's report p. 15, ref. no. O 46-2019.

12 See Chapter 4, Section 7, second paragraph of the Remand Prisons Act and Chapter 8, Section 7 of the Prisons Act.

13 See the Parliamentary Ombudsmen's report p. 17, ref. no. O 7-2019.

14 See the Parliamentary Ombudsmen's report p. 11, ref. no. O 54-2019.

15 See Chapter 24, Section 1 of the Code of Judicial Procedure and Section 23 of the Young Offenders (Special Provisions) Act (1964:167).

During the inspection of *the remand prison in Göteborg*, the Parliamentary Ombudsmen's employees talked to young persons under 18 years of age. Inter alia, they stated that they had not received information concerning how to contact the nurse and that it had taken several days before they were given the opportunity to take a shower. Following the inspection, the Chief Parliamentary Ombudsman emphasised the importance of all prison staff who have contact with young people held on remand having or receiving the necessary training to treat them in the best possible way. The premise must be that the treatment of individual young person is adapted to their degree of maturity. Part of the work can be to communicate pedagogically, on several occasions both in writing and orally, the rights the young personhas whilst in remand prison. Staff should also make sure that the young person has understood the information to ensure that young people can understand their rights.[16]

Conditions in an association remand prison

The Prison and Probation Service has a number of so-called association remand prisons where inmates without restrictions are allowed to associate with other inmates during the day.

The *remand prison branch Berga of Helsingborg remand prison* was established in premises that were previously used as a prison. This means that inmates are given the opportunity to associate with other inmates for a large part of the day. During the inspection, it emerged that the inmates were not given the opportunity to associate outdoors in the former prison area and that they were not allowed to use the sports hall. Instead, the individuals held on remand were directed to use small exercise yards and small exercise rooms.

The Prison and Probation Service's remand prisons that receive individuals on remand without restrictions must have premises intended for inmates' association with others

Following the inspection, the Chief Parliamentary Ombudsman stated that the remand prison branch is a positive example of how the Prison and Probation Service can organise its operations to give remand prisoners the opportunity to associate with each other. By establishing the association remand prison in premises that were previously used as a prison, remand prisoners without restrictions are given significantly better conditions for associating with others compared with if they were held in an association place. An inmate in the remand prison branch has the opportunity to associate with others for seven hours a day on weekdays. The experiences from the remand prison branch and other association remand prisons (for example, the remand prisons Salberga, Storboda and Ystad) show, in the Chief Parliamentary Ombudsman's view, the need for remand prisons that receive individuals on remand without restrictions to have premises intended for association amongst the remand prisoners. At the same time, the Chief Parliamentary Ombudsman stated that if the inmates in the Berga remand prison branch were given the opportunity to use, for example, the sports hall, it could

16 See the Parliamentary Ombudsmen's report p. 17, ref. no. O 7-2019.

further contribute to counteracting the negative consequences of deprivation of liberty. For this reason, the Chief Parliamentary Ombudsman recommended the Prison and Probation Service examine what opportunities exist and what measures need to be taken to ensure individuals deprived of their liberty can also use these premises and areas.[17]

One of *the Berga remand prison branch's* departments (Department 1: 5) lacks common areas, and for this reason the inmates were directed to associate with each other in the department's corridor. Up to seven inmates could associate in this limited space at one time and it was only equipped with a dining area designed for two people. Following the inspection, the Chief Parliamentary Ombudsman stated that it could be strongly questioned whether the corridor could be described as a department. Furthermore, it could be questioned whether the way in which the space was used was compatible with the basic provision that each inmate must be treated with respect for their human dignity and with an understanding of the special difficulties associated with deprivation of liberty. For this reason, the Prison and Probation Service should consider whether the premises should be used as a department and, therefore, constitute permanent places in the remand prison branch's operations. Finally, the Chief Parliamentary Ombudsman stated that if the Prison and Probation Service still intended to use the cells as permanent remand prison places, it must immediately review the inmates' opportunities to associate with each other. In the view of the Chief Parliamentary Ombudsman, it is inadequate to direct the inmates to associate with one another in the corridor, and it is remarkable that the Prison and Probation Service expects inmates to eat their meals in this very limited space.

For this reason, the agency must take the necessary measures to enable the individuals deprived of their liberty in Department 1:5 to be able to associate with each other on the same terms as inmates in the other units of the remand prison branch.[18]

Work to prevent acts of self-harm

Individuals held on remand are in a vulnerable situation and the execution of a decision to deprive someone of their liberty must be conducted in such a manner that negative consequences are counteracted.[19] The Prison and Probation Service works with preventive measures to, inter alia, detect the risk of suicide and other acts of self-harm. An important part of this work is that the remand prison cells are designed and set up in a way to prevent, as far as is possible, inter alia, suicide and that the Prison and Probation Service carefully considers the risks regarding the items placed in the cells.

17 See the Parliamentary Ombudsmen's report p. 11, ref. no. O 39-2019.

18 See the Parliamentary Ombudsmen's report p. 11, ref. no. O 39-2019.

19 See Chapter 1, Section 5 of the Remand Prisons Act.

During the inspection of *the remand prison in Trelleborg*, it emerged that an inmate had taken his life by, inter alia, using a cord to a game console. After the suicide, the remand prison provided cordless games. The inspection revealed that the televisions used in some rooms had normal-length cables. The Chief Parliamentary Ombudsman emphasised that it is important that the Prison and Probation Service ensures that the experiences from the remand prison in Trelleborg are also used within the entire agency in its work in preventing suicide. It is, of course, important that inmates have access to television. The Chief Parliamentary Ombudsman reiterated that the remand prison, however, should always consider what measures can be taken to reduce the risk of suicide when loose items are placed in a cell.[20]

Possibility to visit the toilet at night

During the inspection of *the prison Västervik Norra*, shortcomings in the physical environment such as worn premises, that all cells lacked toilets and that some of the cells lacked sinks were noted. During the inspection, the planning for an extensive renovation of the prison was in progress. In connection with this, the cells will be equipped, inter alia, with toilets. However, it will take several years before the work is completed. Until the renovation is completed, the inmates will be dependent on staff unlocking the cell door for toilet visits at night. In conversations that the Parliamentary Ombudsmen's employees had with inmates, it emerged that they fulfilled their needs in assigned "urinal bottle" and in waste bins. Following the inspection, the Parliamentary Ombudsmen stated that the distribution of such urinal bottles sends a signal to the inmates that they must first and foremost fulfil their needs in the cell, and that it can be questioned whether this is compatible with the Prisons Act's provision that each inmate must be treated with respect for human dignity. Pending the work of improving the physical environment in the prison, in the view of the Parliamentary Ombudsmen, the Prison and Probation Service should take the necessary measures to ensure that inmates have access to a toilet after being locked up for the night. One measure could be to increase staffing at night.[21]

4.2 Own-initiative inquiries concerning remand prisons and prisons

Following the inspections of *the prison Västervik Norra* and the remand prison inspections in April and May, the Parliamentary Ombudsman decided to investigate certain issues within the framework of an own-initiative inquiry. The questions that the Parliamentary Ombudsman chose to investigate are:

- An inmate's access to health and medical care (*the prison Västervik Norra*).
- The occupancy situation within the Prison and Probation Service.

20 See the Parliamentary Ombudsmen's report p. 7, ref. no. O 28-2019.

21 See the Parliamentary Ombudsmen's report p. 15, ref. no. O 46-2019.

During 2018 and 2019, the Parliamentary Ombudsman also made a decision in an own-initiative inquiry following an OPCAT inspection. The case concerns the isolation of inmates held on remand (Huddinge et al.).

An inmate's access to medical care

During the inspection of *the prison Västervik Norra*, the Parliamentary Ombudsmen's employees spoke to an inmate who had undergone a medical procedure at the prison. According to the inmate, the procedure was performed without anaesthesia. After the operation, the inmate had suffered bleeding that lasted for an entire night. According to the inmate, he contacted the night staff, but they stated that the officer on duty did not want to transport him to hospital. It was only during unlocking the next morning that the inmate received help. By then there was blood over "the whole cell", and he was taken to hospital. Due to the details that emerged during the inspection, the Parliamentary Ombudsman decided to open an own-initiative inquiry to investigate the Prison and Probation Service's treatment of the inmate.[22] At the time of compiling this report, the Parliamentary Ombudsman had not yet made a decision in the case.

Occupancy situation in the Prison and Probation Service

During the winter of 2018/19, it was reported on several occasions in the media that the Prison and Probation Service had a shortage of, inter alia, places in remand prisons. Overcrowding in remand prisons meant that individuals held on remand had remained in the Police Authority's police custody facilities. Similar information emerged during OPCAT inspections in the spring of 2019. For these reasons, the Parliamentary Ombudsman decided to investigate the occupancy situation in the Prison and Probation Service within the framework of an own-initiative inquiry.[23] In spring 2019, ten inspections were carried out of which eight were unannounced. In addition to the eight remand prisons, a prison and a police custody facility were also inspected.[24]

During the inspections, it emerged, inter alia, that due to overcrowding, the double occupancy of cells occurs and that rooms unintended for holding inmates are used for occupancy. This means that inmates are held in, inter alia, visitor rooms and rooms intended for isolation-breaking measures, and that these rooms, therefore, cannot be used for the purposes for which they are actually intended.

Furthermore, it emerged that overcrowding caused difficulties for staff in satisfying inmates' right to daily outdoor access and the need for isolation-breaking measures. Two of the inspected remand prisons had, on several

22 See the Parliamentary Ombudsmen's report p. 17, ref. no. O 46-2019.

23 See the Parliamentary Ombudsmen's case, ref. no. O 19-2019.

24 Remand prisons in Falun, Helsingborg (Berga), Kalmar, Karlskrona, Malmö, Nyköping, Trelleborg and Växjö, the prison in Kumla (National Assessment Unit) and the police custody facility in Karlskrona.

occasions during the year, stopped receiving remand prisoners.[25] One consequence of this was that individuals held on remand had remained in the Police Authority's police custody facilities.[26] At the time of compiling this report, the Parliamentary Ombudsman had not yet made a decision in the case.

Isolation of inmates in remand prisons

Over the past 30 years, Sweden has repeatedly received international criticism for the conditions for inmates held on remand. The criticism has concerned long remand periods and the widespread use of restrictions. Restrictions can lead to inmates being isolated, which in turn can lead to both mental and physical problems. In spring 2017, the Parliamentary Ombudsmen conducted a series of OPCAT inspections, and then stated that the Prison and Probation Service should ensure that the time that inmates associate with others is reported and documented in a consistent manner. Furthermore, the Chief Parliamentary Ombudsman stated that for inmates who, for various reasons, do not associate with others, isolation-breaking measures should be reported and documented. Finally, the Chief Parliamentary Ombudsman requested that the Prison and Probation Service should respond on how it follows up on the time inmates associate with others and the use of isolation-breaking measures.[27]

The response was received in June 2018 and what emerged from this led the Chief Parliamentary Ombudsman to follow up on the issues of holding remand prisoners in association places and the use of isolation-breaking measures in an own-initiative inquiry. Within the framework of the own-initiative inquiry, the Chief Parliamentary Ombudsman held a dialogue meeting in March 2019 with representatives of the Prison and Probation Service.[28]

In a decision on 5 February 2020, the Chief Parliamentary Ombudsman directed very serious criticism at the Prison and Probation Service because it has not progressed any further in the work of preventing remand prisoners being isolated. Subsequently, the Parliamentary Ombudsmen also published a thematic report entitled *Isolation of inmates held on remand*. A summary of the report can be found in Section 8.

4.3 Cases where responses from the Prison and Probation Service have been requested

Following the inspection of *the prison in Haparanda*, the Parliamentary Ombudsman has requested the Prison and Probation Service respond with information on how it has worked with certain issues that have received attention. Furthermore, in 2018, the Parliamentary Ombudsman requested a response following the inspections of *the prison in Saltvik, the remand prison*

25 Remand prisons in Falun and Malmö, ref. nos. O 30-2019 and O 27-2019.

26 Remand prison in Falun, ref. no. O 30-2019.

27 See the Parliamentary Ombudsman's report from the remand prison in Huddinge, ref. no. 416-2017.

28 See the Parliamentary Ombudsmen's ref. no. O 7-2018.

in Gävle and *the national planning group at the National Transportation Unit*. The Parliamentary Ombudsman has requested responses regarding the following issues:

- The possibility of checking the legal basis for individuals' deprivation of liberty during transportations (*the National Transportation Unit's national planning group*).
- The design and layout of segregation cells etc. (*the prison in Haparanda*).
- The ability to look out through cell windows (*the prison in Saltvik*).
- The environment in the Prison and Probation Service's exercise yards (*the prison in Saltvik and the remand prison in Gävle*).
- The surveillance camera in a segregation cell (*the remand prison in Gävle*).

The possibility of checking the legal basis for individuals' deprivation of liberty during transportations

Following the inspection of the National Transportation Unit's national planning group, the Chief Parliamentary Ombudsman stated that there was no requirement for the agency ordering a transportation to state the basis for a deprivation of liberty. In a system that is based on several agencies cooperating in holding an individual in deprivation of their liberty, it must, according to the Chief Parliamentary Ombudsman, be clear what the legal basis is for taking a certain measure. If it is not possible to check the basis for the deprivation of liberty, there is a not insignificant risk that individuals will be subjected to coercive measures with no legal basis. For this reason, the Prison and Probation Service was asked to make supplementary changes to the ordering system and respond detailing the measures it has taken.[29]

In a response to the Parliamentary Ombudsman, the Prison and Probation Service announced that external orders must now state the legal basis upon which a deprivation of liberty has been decided. Therefore, the Prison and Probation Service can check that the order has been made by a competent agency and that the individual to be transported is deprived of their liberty in accordance with a provision that gives the Prison and Probation Service the legal basis to perform the transportation. In the light of what has emerged in the response, the Chief Parliamentary Ombudsman decided to close the case.[30]

The design and set up of segregation cells etc

An inspection of *the prison in Haparanda* revealed that the prisons's medical room and sobering up cell were used to hold inmates in segregation. The latter cell is normally equipped with only a mattress on the floor. The cell lacks electrical outlets that make it possible to supply it with, for example, a reading lamp, radio and television. One inmate had been held in the cell for almost

29 See the Parliamentary Ombudsmen's report p. 13, ref. no. 4158-2018.

30 See the Parliamentary Ombudsmen's decision of 23 December 2019, ref. no. O 34-2019.

three weeks. Following the inspection, the Chief Parliamentary Ombudsman stated that there were no safety reasons that justified the cell's equipment being so limited. In the view of the Chief Parliamentary Ombudsman, it was unacceptable for an inmate to be held for such a long time in a cell the prison describes as "poor". The Chief Parliamentary Ombudsman called on the Prison and Probation Service to stop using the sobering up cell for segregation other than for very short periods.

As early as 2017, the Chief Parliamentary Ombudsman had noted in a case that the prison had limited practical conditions for holding segregated inmates in adequate spaces. The Prison and Probation Service provided information that its North Region had applied for permission to set up special segregation places in the prison. The Chief Parliamentary Ombudsman stated that the situation had not changed since 2017, and that, at the inspection in 2019, the prison still lacked adequate cells for segregation purposes and an adequate exercise yard for segregated inmates. For this reason, the Chief Parliamentary Ombudsman recommended the Prison and Probation Service take the measures necessary to remedy the situation. Finally, the inspection revealed that the prison's doctor was at the prison one afternoon a week and that the prison did not have an on-call doctor's agreement. When inmates need to see a doctor at other times, they are transported to healthcare facilities in Haparanda, Kalix or Luleå. The Chief Parliamentary Ombudsman called on the Prison and Probation Service to take immediate action to ensure the prison is able to meet the Prisons Act's requirements for medical examinations for inmates held in segregation. The Prison and Probation Service was asked to respond detailing the measures taken.[31]

In a response to the Parliamentary Ombudsman, the Prison and Probation Service stated that it had initiated a special construction project with the aim of creating more segregation places and a special exercise yard in the prison in Haparanda. The design was made together with the property owners and was expected to be completed shortly. Furthermore, the agency stated that the prison's doctor is available for telephone consultation every day and, if necessary, can also examine inmates held in segregation at other times. If the prison doctor is prevented from performing an examination, the prison meets the need for a medical examination by transporting the inmate to the nearest healthcare facility as soon as possible. As such, the prison ensures in each individual case that it meets the requirements set out in the Prisons Act with regard to medical examinations for individuals held in segregation. In the light of the details provided in the response, the Chief Parliamentary Ombudsman did not find any reason to take any further action.[32]

31 See the Parliamentary Ombudsmen's report p. 10 and 11, ref. no. O 1-2019.

32 See the Parliamentary Ombudsmen's decision of 23 December 2019, ref. no. O 59-2019.

The ability to look out through cell windows

During an inspection of *the prison in Saltvik* (2018), the Parliamentary Ombudsmen's employees found that the external blinds in the rooms used for segregation severely limited access to natural light and the inmates' ability to look out. Following the inspection, the Chief Parliamentary Ombudsman stated that the type of measures – taken to limit looking to and from other departments – must not entail greater restrictions than are necessary for the inmates and that such measures may be particularly sensitive to inmates who are held in segregation. For this reason, the Prison and Probation Service was requested to review the design of the blinds to find a solution that ensures inmates' right to see their surroundings and guarantees an adequate entry of light.[33]

In a response to the Parliamentary Ombudsman, the Prison and Probation Service stated that it, together with the property owner, is trying to develop a type of privacy protection directly on the façade to prevent inmates from communicating with inmates in other units. With the new construction, inmates should have better opportunities to look out the windows and see the surroundings while at the same time having their privacy protected. According to the Prison and Probation Service, these possible improvements and solutions may be used in several of its properties and it investigated the issue with this in mind. Investments connected to these measures are in the investment plan for 2020–2022. In a decision, the Chief Parliamentary Ombudsman welcomed the fact that the Prison and Probation Service plans to take measures to improve the cell environments and that it tries to take a comprehensive approach to the issue by achieving similar solutions throughout the country.[34]

The environment in the Prison and Probation Service's exercise yards

The Parliamentary Ombudsmen have previously stated that it should be seen as a fundamental right upon admission to remand prison and prison that inmates have the opportunity to view their surroundings from the exercise yards. Adequate environments in the exercise yards can contribute to counteracting the negative consequences of deprivation of liberty.[35] During the inspections of *the Saltvik prison* and *the remand prison in Gävle* (2018), it was noted that the exercise yards were designed in such a way that it was not possible to view the surroundings. For this reason, the Prison and Probation Service was asked to respond detailing the measures it has taken to improve the design of these exercise yards.[36]

In responding to the Parliamentary Ombudsman regarding *the Saltvik prison*, the Prison Service stated that it had requested funds to improve the ability for

33 See the Parliamentary Ombudsmen's report p. 6 and 7, ref. no. 6027-2018.

34 See the Parliamentary Ombudsmen's decision on 23 December 2019, ref. no. O 20-2019.

35 See the Parliamentary Ombudsmen 2016/17 p. 198.

36 See the Parliamentary Ombudsmen's report p. 13 and 15, ref. no. 4675-2018 and p. 6 and 7, ref. no. 6027-2018.

Not making extensive renovations may be justified if a move to new premises is imminent

inmates to better view their surroundings. Pending notification, the agency would review the possibility of temporary solutions, such as a design to raise the floor beside the window. The Prison and Probation Service stressed that the issues are nationwide and that investments connected to these issues would be made in 2020–2022 in order to achieve and finance similar solutions from a national perspective. In a decision, the Chief Parliamentary Ombudsman welcomed the fact that the Prison and Probation Service plans to take measures to improve the environment in its exercise yards and that it is trying to take a comprehensive approach to the issue, therefore achieving similar solutions across the country.[37]

In the response to the Parliamentary Ombudsman regarding *the remand prison in Gävle*, the Prison and Probation Service stated that it is possible to widen the openings in the exercise yard's wall to the outside area without compromising security. Such a solution is costly. In the Prison and Probation Service's view, such a change is not justified because there are plans to move the remand prison to new premises. In a decision, the Chief Parliamentary Ombudsman stated she understood the Prison and Probation Service needing to make this type of consideration.[38] It may be justified not to initiate an extensive rebuilding if, for example, a move to new premises is imminent. The Chief Parliamentary Ombudsman stated, however, that the Prison and Probation Service had not provided any details in the response regarding when the remand prison will move. The agency's summary of future renovation projects of its premises states that the "aim" is that the remand prison in Gävle will be co-located with the prison in Gävle. The project has not started and is estimated, according to the Prison and Probation Service, to take five years to complete from the start of the project process. In the view of the Chief Parliamentary Ombudsman, the information presented by the Prison and Probation Service is vague and the only concrete detail is that the current remand prison facilities will be used for at least another five years. The uncertainty that applies to the project means that this time may well be significantly longer. This means that for a relatively long time, in the view of the Chief Parliamentary Ombudsman, inmates will continue to be directed to exercise yards that do not meet the basic requirements that should reasonably be set. In the Chief Parliamentary Ombudsman's view, it is not acceptable for the Prison and Probation Service to refrain from taking measures to improve its exercise yards in such circumstances. For this reason, the Chief Parliamentary Ombudsman recommends that the Prison and Probation Service also includes the remand prison in Gävle in the national review of, inter alia, exercise yards that it announced in its response following the inspection of the prison in Saltvik.

37 See the Parliamentary Ombudsmen's decision of 23 December 2019, ref. no. O 20-2019.

38 See the Parliamentary Ombudsmen's decision of 23 December 2019, ref. no. O 32-2019.

The surveillance camera in a segregation cell

During the inspection of *the remand prison in Gävle*, the Parliamentary Ombudsmen's employees noticed that a camera in the prison's segregation cell was constantly switched on. Following the inspection, the Chief Parliamentary Ombudsman stated that the Prison and Probation Service, in December 2017, was called upon to install technology that makes it possible to turn off the camera in the cell when such monitoring is deemed unnecessary. For this reason, the Chief Parliamentary Ombudsman noted with some surprise that there had been no change in this regard. The Chief Parliamentary Ombudsman requested the Prison and Probation Service respond detailing the measures it will take to rectify this shortcoming. The agency was also asked to make an inventory of which prisons and remand prisons have camera-monitored cells and whether these cameras can be switched off.

In a response to the Parliamentary Ombudsman, the agency announced that *the remand prison in Gävle* had introduced a routine which means that the camera is provided with a "hat" when no decision had been made to use camera surveillance. The staff who make decisions concerning camera surveillance had been informed of the importance of documenting whether an inmate should be held under camera surveillance or not. Written instructions were also being prepared. In a decision, the Chief Parliamentary Ombudsman stated that the measures that the Prison and Probation Service had taken appeared to be adequate.[39] The Chief Parliamentary Ombudsman also welcomed the fact that the Prison and Probation Service's inventory shows that it is possible to turn off the surveillance cameras in situations where no decision has been made to use such a measure.[40]

4.4 Conclusions

Of a total 28 OPCAT inspections in 2019, 13 inspections concerned the Prison and Probation Service's prisons and remand prisons. In addition, there were five more inspections by the supervisory division. One of the reasons for the large proportion of OPCAT inspections in 2018 and 2019 devoted to the agency was its wide-ranging operations, another the thematic focus on the transportations of individuals deprived of their liberty. Another reason for the relatively high number of inspections is the Parliamentary Ombudsmen's own-initiative inquiry regarding the occupancy situation in the prison and probation regime.

During this year's inspections, it has emerged that the Prison and Probation Service has had to take far-reaching measures to deal with the strained occupancy situation. In addition to closing certain remand prisons for new admissions of individuals deprived of their liberty, the agency has increased

39 See the Parliamentary Ombudsmen's report p. 13 and 15, ref. no. 4675-2018.

40 See the Parliamentary Ombudsmen's decision of 23 December 2019, ref. no. O 32-2019.

the number of places at short notice. Primarily, this has been achieved by double occupancy of cells, but also by holding inmates in spaces not intended for occupancy. In recent cases this has meant inmates being held in visiting rooms or rooms intended for isolation-breaking measures.

The situation that has arisen has had a negative impact on the conditions for individuals deprived of their liberty. Individuals on remand have remained in the Police Authority's police custody facilities pending transportation to a remand prison. Police custody facilities are not built nor equipped to meet the needs for, inter alia, isolation-breaking measures that arise during long remand periods. When, for example, visitor rooms and rooms for isolation-breaking measures are used for holding inmates, they cannot be used for the purposes for which they are actually intended. Double occupancy of cells occurs in both prisons and remand prisons. Especially in remand prisons – where the inmates usually spend most of their time in their cells – double occupancy can increase the risk of conflicts between inmates. The fact that inmates share a cell also risks leading to situations that can be described as degrading, when inmates, for example, have to fulfil their toilet needs in rooms that do not have a door.

When writing this report, the occupancy situation remains strained within the Prison and Probation Service. Inmates continue to share cells and the number of double-occupancy cells has increased during the latter part of 2019. Therefore, there will also continue to be a risk that conflicts will arise between inmates etc. The Parliamentary Ombudsmen will return to these issues in 2020 in an own-initiative inquiry concerning the occupancy situation in the prison and probation regime.

The Chief Parliamentary Ombudsman has recently directed very serious criticism at the Prison and Probation Service as a large proportion of inmates in its remand prisons are isolated (see also Section 8). On several occasions during 2019 as well as in 2020, details have emerged that the strained occupancy situation has led to staff, who are tasked with working with isolation-breaking measures, being used for other work tasks. The lack of staff increases the risk of inmates being isolated. The Government has relatively recently decided on a bill which entails, inter alia, that the Prison and Probation Service is liable to offer remand prisoners under the age of 18 at least four hours of isolation-breaking measures per day.[41] In compiling this report, the Swedish Parliament has not yet made a decision on the matter. The change will mean an important step in the work in preventing children held on remand being isolated, and this is in line with the UN Committee on Torture's (CAT) recommendations to Sweden.[42] An important issue for the Parliamentary Ombudsmen's OPCAT operation in the coming years will be to investigate

41 See Government Bill 2019/20:129.

42 See CAT/C/SWE/CO/6-7 para 9.

how the Prison and Probation Service manages to fulfil this new obligation and reduce the isolation of other inmates in remand prisons whilst simultaneously satisfying their rights to associate with others.

A recurring issue during inspections of prisons and remand prisons is inmates' access to health and medical care. The Prison and Probation Service has chosen to provide certain health and medical care by using primary care and outpatient psychiatry. Prisoners who cannot have their health and medical care provided by the Prison and Probation Service receive care from the public healthcare system. Individuals detained in police custody facilities that the Prison and Probation Service manages on behalf of the Police Authority do not have access to the same health and medical care as other inmates within the Prison and Probation Service. Both the CAT and the European Committee for the Prevention of Torture (CPT) have drawn attention to inmates' access to health and medical care as well as dental care within the Prison and Probation Service. The CPT has recommended that the availability and quality of doctors, dentists and psychologists needs to be improved in certain prisons and remand prisons.[43] The CAT has drawn attention to the question of how inmates receive information concerning the right to request an independent medical examination (a new medical examination).[44] Inmates' access to health and medical care is an issue that the Parliamentary Ombudsmen will continue to follow.

With regard to coercive measures, following its most recent visit to Sweden the CPT has recommended that restraint beds with belts should not be used in environments other than in healthcare.[45] The Government has replied that this coercive measure can be used in exceptional cases in order for inmates not to harm themselves.[46] The Parliamentary Ombudsmen will return to this issue in 2020.[47]

Finally, it is clear that the responses that the Parliamentary Ombudsmen have requested from the Prison and Probation Service show that it is possible to take measures to improve the environment in cells and exercise yards. Changes made have given inmates' increased opportunities to view their surroundings through cell windows and from exercise yards whilst ensuring privacy. It is also positive that the Prison and Probation Service has announced that it will take a comprehensive approach to these issues in order to improve the environment for inmates in remand prisons and prisons.

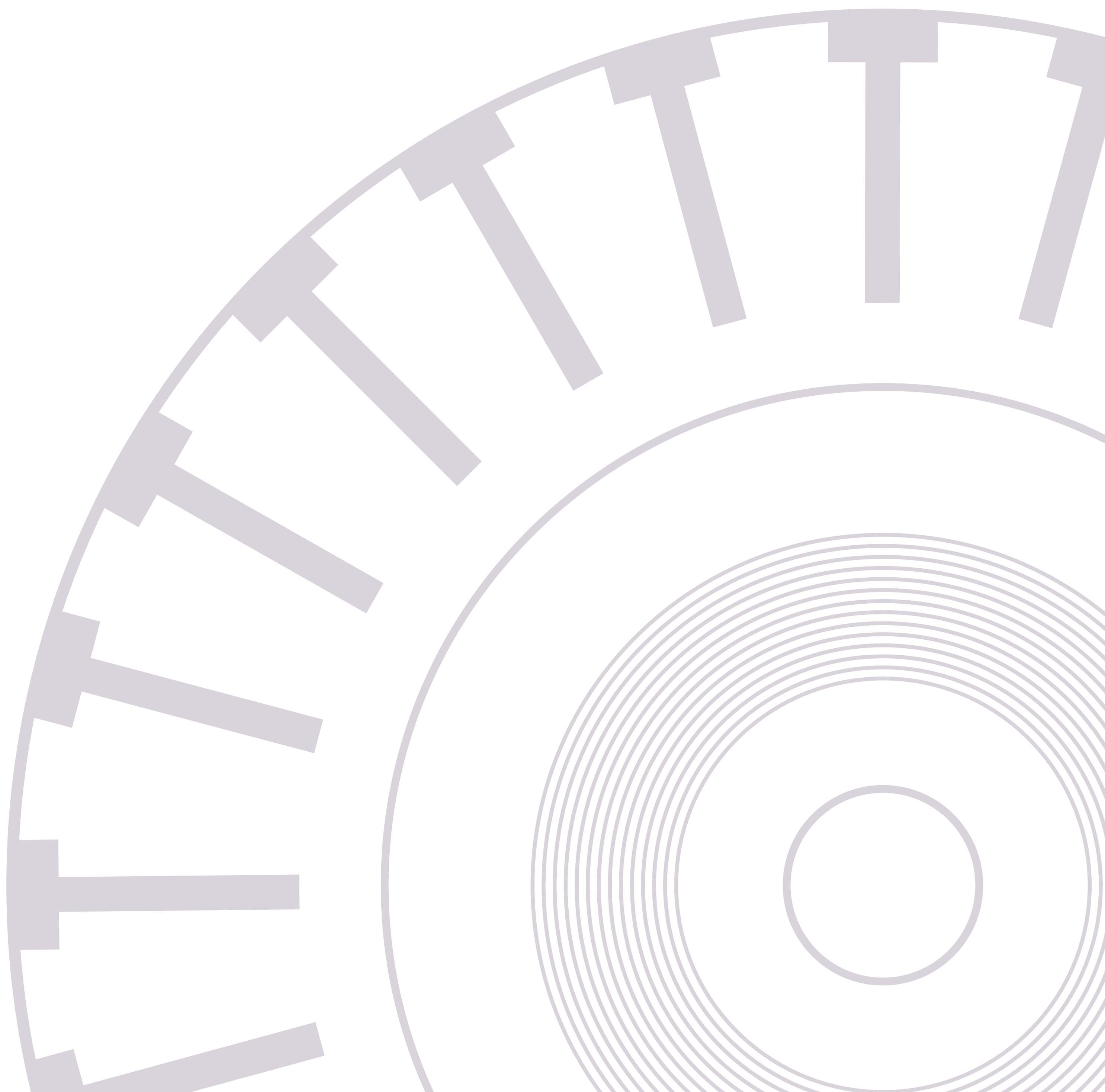
43 See CPT/Inf (2016) 1 para. 77.

44 See CAT/C/ SWE/QPR/8, 3 b.

45 See CPT/Inf (2016) 1 para. 90.

46 See CPT/Inf (2016) 20, pp. 47.

47 See ref. no. 279-2018.



The National Board of Institutional Care

The National Board of Institutional Care

The National Board of Institutional Care is responsible for the special residential homes where substance abusers who are cared for in accordance with the Care of Substance Abusers Act (1988:870) are placed. The National Board of Institutional Care is also the principal of the special residential homes where young people who are cared for pursuant to section 3 of the Care of Young Persons Act (1990:52) and who require particulary close attention may be placed. In the special residential homes, young people who have been sentenced to so-called special youth care, and who serve their sentences pursuant to the Secure Youth Care Act (1998:603) are also placed. At the end of 2019, there were 23 special residential homes for young people in Sweden[1] with approximately 730 places and 11 special residential homes for substance abusers with approximately 390 places.

In 2019, four of the National Board of Institutional Care's institutions, two special residential homes for substance abusers and two special residential homes for young people, were inspected.[2] The two homes for young people were inspected for the first time by the Parliamentary Ombudsmen. All the inspections were unannounced. The Parliamentary Ombudsman also held a dialogue meeting with the National Board of Institutional Care's Director General and senior management team in October 2019. The dialogue meeting was held in connection with statements made by the Parliamentary Ombudsman following a number of OPCAT inspections and own-initiative inquiries.

Parliamentary Ombudsman Thomas Norling has decided on all the inspections and the dialogue meeting as well as made statements following the inspections.[3]

5.1 Observations made during this year's inspections

As in previous years, an important issue during the inspections of the National Board of Institutional Care's institutions has been to examine how it applies the legislative provisions on separate care and the segregation of individuals. The experience from previous years' inspections is that there can sometimes be uncertainty among staff concerning how these rules – which allow the limiting of individuals' rights to associate with others – are to be

1 The special residential home for young people in Lövsta was closed in 2019.

2 The special residential homes for young people Vemyra and Långanäs and the special residential homes for substance abusers Gudhemsgården and Hessleby. At the time of compiling this report, the report from the special residential home for substance abusers in Hessleby was not completed.

3 See the Parliamentary Ombudsmen's ref. no. O 55-2019.

applied. The design and layout of the institutions' premises has also proved to be important when applying these special powers. During this year's inspections, the issue of incidents of threats and violence as well as staff's treatment of inmates has also received special attention.

Separate care

An important premise is that individuals cared for at one of the National Board of Institutional Care's institutions have the right to associate with others. The National Board of Institutional Care is able to limit this right in certain cases. It may prevent an individual from associating with others if this is required due to an individual's special care needs, their safety or the safety of other individuals (separate care). Separate care must be adapted to the individual's specific care needs. A decision on separate care must be reviewed continuously and always reviewed within seven days since the last review.[4]

During the inspection of *the special residential home for young people Långanäs*, it emerged that a decision on separate care is a prerequisite for an individual to be cared for in one of the home's treatment departments, Trollebo. According to the home, the department specialises in receiving young people with very special needs. The department, therefore, has a higher staff density than other departments within the National Board of Institutional Care. Individuals in Trollebo are described by the home as individuals who act out with neuropsychiatric disabilities, mental problems and difficulties with social interaction. During conversations with the staff, it emerged that several of the young people had received habilitative measures in accordance with the Support and Service for Persons with Certain Functional Impairments Act (1993:387). When examining decisions on separate care, the Parliamentary Ombudsmen's employees noted that the reasoning in the majority of the review decisions were identical. According to a mapping exercise conducted by the National Board of Institutional Care in 2017, the average length of care for an individual in the department was 16 months. The mapping exercise also revealed that the longest time an individual had been admitted to the department, and therefore placed in separate care, was seven years. Following the inspection, the Parliamentary Ombudsman stated that the details that had emerged regarding the lengthy care periods led to several questions. For this reason, the Parliamentary Ombudsman announced that an inspection of *the special residential home for young people Brättegården* would be made in the near future, as a department there admits young people with similar problems. Thereafter, there may be reasons for the Parliamentary Ombudsman to return to the conditions at the special residential home for young people Långanäs.[5]

4 See Section 15 d of the Care of Young Persons Act, Section 14 a of the Secure Youth Care Act and Section 34 a of the Care of Substance Abusers Act.

5 See the Parliamentary Ombudsmen's report p. 5-7 and 15, ref. no. O 57-2019.

It is important that staff takes measures to counteract isolation of individuals subject to separate care

During the inspection of *the special residential home for substance abusers Gudhemsgården*, it emerged that several individuals had received separate care at their own request. Furthermore, an individual in conversation with the Parliamentary Ombudsmen's employees stated that during the care he was alone during the daytime. He had reportedly not refused having the staff be with him. Another inmate compared the time in separate care to being held on remand. Following the examination, the Parliamentary Ombudsman highlighted that, when providing separate care, there is often reason to consider an individual's wish to be alone. However, there is a risk that individuals will isolate themselves. For this reason, it is important that measures are taken to prevent inmates from becoming isolated while receiving separate care, and that the separate care should not be required to last longer than is strictly necessary.[6]

Segregation

The National Board of Institutional Care has the possibility to segregate individuals. An individual may be segregated if there is a particular need because the individual behaves violently or is so influenced by intoxicants that they cannot be kept in under control. During the segregation, individuals must be continuously monitored by staff. Individuals must not be segregated for longer than is absolutely necessary. An individual in a special residential home for substance abusers must never be segregated for more than 24 consecutive hours. For an individual in a special residential home for young people, the longest segregation period is limited to four hours. A doctor or nurse should promptly be consulted when a young person is segregated, and if the healthcare staff so requests, the action should be stopped immediately.[7]

Using an individual's living space for the purposes of separate care is completely inappropriate

At all the institutions inspected in 2019, shortcomings were noted in the design and layout of the rooms that are used for segregating individuals. *The special residential home for young people Vemyra* did not have a room specifically for the purposes of segregation during the inspection. Instead, young persons were segregated in their living spaces or in the room designated for separate care. Several of the staff at the home stated that there is a risk that individuals could harm themselves with their belongings if the segregation occurs in living spaces. Following the inspection, the Parliamentary Ombudsman found that it is common for individuals at the home to be segregated. For this reason, the Parliamentary Ombudsman was positive that the home would establish special rooms for this purpose. The Parliamentary Ombudsman also emphasised that living spaces – with their furnishings in particular – are completely unsuitable for segregation purposes.[8]

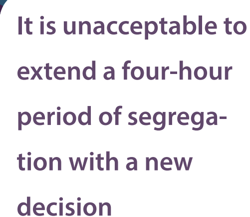
6 See the Parliamentary Ombudsmen's report p. 15 and 16, ref. no. O 58-2019.

7 See Section 34 b of the Care of Substance Abusers Act (1988:870), Section 15 c of the Care of Young Persons Act (1990:52) and Section 17 of the Secure Youth Care Act (1998:603).

8 See the Parliamentary Ombudsmen's report p. 7 and 22, ref. no. O 44-2019.

During the inspection of *the special residential home for young people Långanäs*, the Parliamentary Ombudsmen's employees noted that the segregation room in one of the departments was located on a different floor to the department. For this reason, staff had to take individuals down a flight of stairs when segregating them. On some occasions, the staff had even carried individuals. Following the inspection, the Parliamentary Ombudsman found that such a method of transfer obviously entails considerable physical risks for everyone involved, not least the young persons being segregated. For this reason, the Parliamentary Ombudsman called on the National Board of Institutional Care to take measures to ensure that segregation can take place in a way that is safe and dignified for both the individuals and staff members.[9] Also, during the inspection of *the special residential home for substance abusers Gudhemsgården*, the Parliamentary Ombudsmen's employees noted that some of the segregation rooms were inadequately set up.[10]

During the inspection of *the special residential home for young people Långanäs*, it was noted that the decisions stated that a nurse or doctor "consented" to the segregations, and that, via two consecutive decisions, a young person had been segregated for seven and a half hours. Following the inspection, the Parliamentary Ombudsman stated that the role of the health and medical care staff is not to take a position on the measure taken. Furthermore, the Parliamentary Ombudsman stated that the legislation provides no room for a segregation to continue for longer than four hours. A segregation that in practice is extended by staff directly making a new segregation decision when the deadline has expired is, therefore, unacceptable. When the four hours have passed, the National Board of Institutional Care must, therefore, break the segregation and let the young person return to their department. Only if it turns out that the individual continues to be disruptive, should a new segregation decision be considered.[11]



Use of "pinning down"

During several inspections, the Parliamentary Ombudsmen's employees noted the fact that the National Board of Institutional Care's staff use physical restraint through "pinning down" individuals when enforcing segregation decisions. Following an OPCAT inspection in 2017 of *the special residential home for young people Tysslinge*, the Parliamentary Ombudsman decided to investigate a situation where the staff had pinned down a young person. According to Chapter 2, Section 6 of the Instrument of Government, each and every individual is protected against forced physical intervention. This protection may be limited by law. In the view of the Parliamentary Ombudsman,

9 See the Parliamentary Ombudsmen's report p. 15 and 16, ref. no. O 57-2019.

10 See the Parliamentary Ombudsmen's report p. 5, ref. no. O 58-2019.

11 See the Parliamentary Ombudsmen's report p. 16, ref. no. O 57-2019.

pinning down is one such measure that requires a legal basis for its use by staff at, for example, a special residential home for young people. Physical restraint through pinning someone down is not listed among the special powers in the Care of Young Persons Act (1990:52), and the concept is not defined in law. In the view of the Parliamentary Ombudsman, a perception must not be allowed to develop among staff at the National Board of Institutional Care's institutions that staff, in addition to the special powers provided in the Care of Young Persons Act (1990:52), have other unwritten powers, which in reality mean that they may perform acts in violation of Chapter 2, Section 6 of the Instrument of Government. It is inevitable that staff, for example in enforcing a segregation decision, may need to apprehend an inmate to take them to a segregation room. Such a measure is supported by Chapter 24, Section 2 of the Penal Code. In the view of the Parliamentary Ombudsman, a segregation decision may never be enforced by pinning down an individual instead of taking them to a segregation room. The National Board of Institutional Care is required to ensure that its institutions are designed in such a way that staff – in cases where the conditions to segregate an individual are met – are able to hold individuals segregated. Poor design and set up, for example by a lack of segregation rooms or problems with long distances to these rooms, may lead to staff not feeling compelled to take measures that do not fall within the special powers in, inter alia, the Care of Young Persons Act.[12]

A segregation decision may never be enforced by "pinning down" individuals instead of taking them to a segregation room

During the inspection of the *special residential home for young people Vemyra*, it emerged that that, on occasion, staff restrained an individual to prevent her from harming herself when she was held segregated in her living space. The segregation decision described how she was taken to her living space where she was then "pinned down in a lying position for up to 20 minutes each time, about 8 times during a 4 hour period".[13]

Likewise, during the inspection of *the special residential home for young people Långanäs*, it emerged that staff had pinned down individuals without taking them to a segregation room. It was also not clear whether there was any intention to do so. Furthermore, it was not always documented how long the young persons had been pinned down, but there were several examples of young persons being restrained for more than 10 minutes without being taken to a special segregation room. Following the inspection, the Parliamentary Ombudsman stated that the National Board of Institutional Care must take measures by, inter alia, designating suitable rooms for segregation purposes to ensure that segregation decisions can be enforced in accordance with the law.[14]

The National Board of Institutional Care must ensure segregation decisions are enforced in accordance with the law

12 See the Parliamentary Ombudsmen's decision on 29 November 2019, ref. no. 6774-2017.

13 See the Parliamentary Ombudsmen's report p. 7 and 8, ref. no. O 44-2019.

14 See the Parliamentary Ombudsmen's report p. 15 and 16, ref. no. O 57-2019.

Safety and security of young people

In connection with the inspection of *the special residential home for young people Vemyra*, it emerged that many of the young people at the home felt unsafe. One of the reasons for this was that there had been fires at the home on several occasions. During the Parliamentary Ombudsman's inspection, one of the departments was closed due to fire damage. It also emerged that one of the individuals had been beaten, bullied and exploited by fellow young persons. The Parliamentary Ombudsmen's employees perceived that the staff thought that this particular individual was annoying and that they tried to have as little as possible to do with her. The young persons said they manipulated the so-called door alarms that will alert the staff if the young people leave their rooms. This then allowed them to enter each other's rooms without the staff noticing.

In conversations, staff members described themselves as "overrun" and said that the substitutes brought in were inexperienced and did not know the girls very well. This picture of staff problems was confirmed by the individuals who, inter alia, stated that the staff were "stressed out". They also stated that the staff did not have control over the departments and did not always react even though they saw things happen, for example when individuals harm themselves. According to the young persons, one of the staff members had been so rough that several of them had been injured.[15] The National Board of Institutional Care's management had known that there were shortcomings at the home in terms of, inter alia, management and governance. Following the inspection, the Parliamentary Ombudsman stated that the National Board of Institutional Care needed immediately to review what measures are required to ensure that young individuals receive safe and secure care. The Parliamentary Ombudsman questioned whether the measures taken so far had been sufficient. The particularly vulnerable situation of children and young people deprived of their liberty means that the relevant agencies must always take reports of violence and other misconduct very seriously. A premise in the work to improve the situation at the special residential home for young people Vemyra should be the experiences gained in dealing with the shortcomings noted at the special residential home for young people Sundbo.[16]

Additionally, during the inspection of *the special residential home for young people Långanäs*, several young persons stated there were problems with bullying and that staff members do not intervene when threatening situations arise between the young persons or when one of them is bullied.[17]

15 See the Parliamentary Ombudsmen's report p. 2, 3 and 8–10, ref. no. O 44-2019.

16 See the Parliamentary Ombudsmen's report p. 19–21, ref. no. O 44-2019.

17 See the Parliamentary Ombudsmen's report p. 4, ref. no. O 57-2019.

Treatment and activities

A recurring issue during the inspections of the National Board of Institutional Care's special residential homes for young people and substance abusers is the content of the care, and individuals in care experiencing a lack of activities. During the inspection of *the special residential home for young people Vemyra*, all the young people that the Parliamentary Ombudsmen's employees spoke to asked for more activities. During a review of the activity schedules for the young people, it was noted that the degree of activity varied greatly: from one hour per week to several hours every day.[18] Following the inspection, the Parliamentary Ombudsman called on the National Board of Institutional Care to take measures to ensure that all individuals are offered structured daily activities to a sufficient degree on weekdays and, in addition, meaningful activities at the weekends. The Parliamentary Ombudsman also recalled a recommendation by the Council of Europe's Committee for the Prevention of Torture that young persons deprived of their liberty have special needs for physical activity and intellectual stimulation and should be offered a full programme of education, sport, vocational training, recreation and purposeful activities.[19]

At *the special residential home for substance abusers Gudhemsgården*, several of the individuals that the Parliamentary Ombudsmen's employees spoke to in the home's locked departments stated that they mostly watched television and did not receive any treatment, and that the stay there was reminiscent to "warehousing".[20]

During the inspection of *the special residential home for young people Vemyra*, it was noted that one of the young persons admitted to the home during the year was only 13 years old and, therefore, did not belong in the target group of girls above elementary school age.[21] The Parliamentary Ombudsman stated, inter alia, that he will continue to follow the issue in future inspections and that it is important that the consequences for the young people placed at the home are also brought to the attention of the social welfare committees.[22]

Other shortcomings in the physical environment

There are major differences between the National Board of Institutional Care's institutions regarding their respective physical environments. Several of the institutions were not originally intended to accommodate individuals deprived of their liberty and the premises are often old and in need of renovation. During the inspection of *the special residential home for young people Vemyra*, the Parliamentary Ombudsmen's employees noticed that the home's

18 See the Parliamentary Ombudsmen's report p. 11, ref. no. O 44-2019.

19 See the Parliamentary Ombudsmen's report p. 21 and 22, ref. no. O 44-2019.

20 See the Parliamentary Ombudsmen's report s 8, ref. no. O 58-2019.

21 See the Parliamentary Ombudsmen's report p.3, ref. no. O 44-2019.

22 See the Parliamentary Ombudsmen's report p. 22, ref. no. O 44-2019.

residential departments were worn and sparse with graffiti on the walls, and that some common areas lacked furniture because they had been broken by individuals. The young persons' living areas often contained many items and were messy.[23] The Parliamentary Ombudsman reiterated that the Council of Europe's Committee for the Prevention of Torture has stated that places where young people are held deprived of their liberty must be adequately furnished and decorated in a way that provides adequate visual stimuli. For this reason, the Parliamentary Ombudsman recommended that the National Board of Institutional Care takes measures that contribute to the premises being adequately and pleasantly furnished while at the same time the risk of vandalism is handled.[24]

Places where young people are deprived of their liberty must be adequately furnished

Overnight stay at the National Board of Institutional Care institutions in connection with transportations

During the inspection of *the special residential home for substance abusers Gudhemsgården*, it emerged that the home received individuals from other residential homes for substance abusers for overnight stays during transportations. Following the inspection, the Parliamentary Ombudsman emphasised that it is preferable if individuals can spend the night at the National Board of Institutional Care's institutions rather than in, for example, a remand prison. A remand prison is set up for a completely different purpose than an institution operated by the National Board of Institutional Care, and remand prison staff usually do not have the same experience as the National Board of Institutional Care's staff do in taking care of individuals.[25] The Parliamentary Ombudsman has previously stated that, from a medical and humanitarian perspective, a remand prison is an inadequate place to detain individuals deprived of their liberty with care needs. Remand prisons should, therefore, only be used for detaining individuals with these needs for a very limited period of time.[26]

From a medical and humanitarian perspective, a remand prison is an inadequate place to detain individuals in need of care

During the inspection of the special residential home for substance abusers, staff stated that it only helps to arrange overnight stays at other institutions operated by the National Board of Institutional Care for individuals who are deemed to be at risk of self-harm. In other cases, the entire responsibility for planning the transportation is handed over to the Prison and Probation Service (National Transport Unit). Following the inspection, the Parliamentary Ombudsman stated that, in the inquiry's report that preceded the introduction of the current transportation provisions, the government inquiry emphasised that agencies requesting assisted transportations in accordance with, for example, the Care of Substance Abusers Act (1988:870), bear a responsibility

23 See the Parliamentary Ombudsmen's report p. 5 and 6, ref. no. O 44-2019.

24 See the Parliamentary Ombudsmen's report p. 21, ref. no. O 44-2019.

25 See the Parliamentary Ombudsmen's report p. 17, ref. no. O 58-2019.

26 See the Parliamentary Ombudsmen 2013/14 p. 249.

for the availability and use of adequate premises during transportations.[27] In the subsequent bill, the Government stated that the agency requesting assisted transportation retains responsibility for the transportee's care and is presumed to participate in the assisted transportation when necessary.[28] Although the National Transport Unit is responsible for planning and carrying out transportations, the National Board of Institutional Care should, therefore, have a responsibility to participate so that the assisted transportation with judicial assistance does not become unnecessarily intrusive. In the opinion of the Parliamentary Ombudsman, this means that the National Board of Institutional Care should ensure that there are accommodation options within its institutions. As such, the National Board of Institutional Care can contribute to, for example, remand prisons only needing to be used for overnight stays in very exceptional cases.

5.2 Own-initiative inquiries concerning the National Board of Institutional Care

Following the inspection of *the special residential home for young people Johannisberg* in October 2018, the Parliamentary Ombudsman decided to investigate the home's routine for using the Prison and Probation Service for transportations. During the inspection of the home, details emerged indicating the home had an informal routine which meant, for example, it requested assistance for transportations to court hearings even though the prerequisites for such requests were not fulfilled.[29]

Therefore, the Parliamentary Ombudsman investigated the home's routine concerning the use of the Prison and Probation Service for the transportations of young people cared for at the home. In the National Board of Institutional Care's response, the home's manager stated, inter alia, that most of the young individuals' court hearings are carried out via video link and that the home's staff transport the young individuals to the location for video-linked hearings. When the older individuals are to appear in person at a court hearing, the National Board of Institutional Care usually requests assistance from the Prison and Probation Service if justified based on the risk assessment made. Based on this, the Parliamentary Ombudsman had no basis for directing any criticism at the institution.

However, the Parliamentary Ombudsman reiterated in its decision that the system of transportation with judicial assistance requires agencies to cooperate loyally with each other and not to use the Prison and Probation Service's resources in situations when the necessary prerequisites are lacking. The National Board of Institutional Care does not have a agency-wide transportation

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27 See Government Inquiry 2011: 7 p. 395 and 396.

28 See Government Bill 2016/17: 57 p. 40.

29 See the Parliamentary Ombudsmen's report p. 12 and 18, ref. no. 6204-2018.

organisation, and must therefore ensure, inter alia, that individual homes are provided with the adequate resources to carry out transportations.[30]

5.3 Case where responses from the National Board of Institutional Care have been requested

The Parliamentary Ombudsman did not request any responses in 2019. The Parliamentary Ombudsman did, however, request responses in 2018 following two inspections. The responses were received in 2019. The Parliamentary Ombudsman requested responses on the following issues:

- Rain shelters in institution's exercise yards (*the special residential home for substance abusers Fortunagården*).
- Routine for follow-up of transportations with judicial assistance (*the special residential home for young people Johannisberg*).

Rain shelters in institutions' exercise yards

Following the inspection of the special residential home for substance abusers Fortunagården in September 2018, the Parliamentary Ombudsman urged the National Board of Institutional Care to provide one of its home's exercise yards with a rain shelter. In view of the new rules on the right to daily outdoor access, the Parliamentary Ombudsman deemed it necessary for the National Board of Institutional Care to make an inventory of all its institutions' exercise yards. This was to find out which other exercise yards need to be provided with rain shelters. The National Board of Institutional Care responded that a standard rain shelter solution has now been developed for the institutions' exercise yards and will continuously provide rain shelter for the institutions' exercise yards. The work was expected to be completed in the first quarter of 2020. The Parliamentary Ombudsman stated that the measures were adequate and closed the case.[31]

Routine for follow-up of assisted transportations

During the inspection of *the special residential home for young people Johannisberg* in October 2018, the home's management stated that it was considering introducing a routine for follow-up conversations with the young individuals after they had been transported by police or prison officers (assisted transportations). The Parliamentary Ombudsman stated that the National Board of Institutional Care has an obligation to offer the young people follow-up conversations after it enforces a decision on, for example, segregation. The purpose of these conversations is, inter alia, for the young people to be given the opportunity to express their opinions on the coercive measure

30 See the Parliamentary Ombudsmen's decision on 4 February 2020, ref. no. 1337-2019.

31 See the Parliamentary Ombudsmen's decision of 22 August 2019, ref. no. O 51-2019.

taken.[32] Conversely, there is no obligation to offer a follow-up conversation if a young person is the subject of a coercive measure during a transportation with judicial assistance. It may, for example, be a decision on a body search or use of restraints. The Parliamentary Ombudsman saw the initiative as positive and requested that the management of the home respond detailing the measures taken on the matter following the inspection and what results these had given.[33]

In its response, the National Board of Institutional Care stated that, for a few months, the management of the special residential home for young people Johannisberg had followed up on how the young people who come to the home had been transported. This was conducted within the framework of its weekly self-monitoring. It was not clear whether the details that emerged were then sent to the agencies responsible for the transportation with judicial assistance, i.e. the Prison and Probation Service or the Police Authority. In the Parliamentary Ombudsman's view, an account of the young people's experiences could improve the performance of assisted transportations and, therefore, prevent individuals deprived of their liberty from being subjected to unnecessary violations. The Parliamentary Ombudsman recommended that the National Board of Institutional Care considers introducing a routine for following up how assisted transportations have been conducted at its other institutions.[34]

5.4 Dialogue meeting with the National Board of Institutional Care

In October 2019, the Parliamentary Ombudsman held a dialogue meeting with representatives of the National Board of Institutional Care. The meeting was attended by, inter alia, the Director General of the agency.[35]

Occupancy situation at the National Board of Institutional Care's special residential homes for young people and special residential homes for the care of substance abusers

For a long time, the Parliamentary Ombudsmen have observed that, at times, the National Board of Institutional Care has had difficulty in arranging places in its institutions.[36]

At the dialogue meeting in October 2019, the management of the National Board of Institutional Care stated that the occupancy situation was good in both juvenile and substance abuse care. During the past year, there have been

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32 See Section 20 c the Care of Young Persons Act (1990:52) and Section 18 c the Secure Youth Care Act (1998:603).

33 See the Parliamentary Ombudsmen's report p. 19, ref. no. 6204-2018.

34 See the Parliamentary Ombudsmen's decision of 13 December 2019, ref. no. O 12-2019.

35 See the Parliamentary Ombudsmen's report, ref. no. O 55-2019.

36 See for example the Parliamentary Ombudsmen 2015/16 p. 434 and the Parliamentary Ombudsmen 2017/18 p. 458.

no queues for treatment places within the National Board of Institutional Care. There has been a net increase in the number of places and the occupancy rate was 80 per cent in the special residential homes for substance abusers and 90 per cent in the special residential homes for young people. The management of the National Board of Institutional Care further stated that there has been an inventory of its premises. It showed that the majority of the National Board of Institutional Care institutions have premises that were not originally intended for custodial, institutional care and are, additionally, very worn. Most of the new construction that will take place will be for the special residential homes for young people.

The situation at the residential home for young people Sundbo

During an inspection of *the special residential home for young people Sundbo* in November 2018, young persons there stated that, on occasion, staff members used unjustified violence, especially in the Aspen Department. Following the inspection, the Parliamentary Ombudsman stated that the National Board of Institutional Care needed to take action aimed at, inter alia:

- effective measures in order to prevent that young people are subjected to unjustified violence;
- how staff treat of young people; and
- the composition and competence of staff.

In responding to the Parliamentary Ombudsman, the National Board of Institutional Care stated that, following the inspection, it had taken several measures to remedy the situation. It had, inter alia, temporarily closed the Aspen department. In his decision in the case, the Parliamentary Ombudsman noted that the shortcomings at the special residential home for young people Sundbo had been known to the National Board of Institutional Care's management for a long time. The Parliamentary Ombudsman emphasised, inter alia, that there must be a central control at the agency to handle this type of problem.[37]

At the dialogue meeting in October 2019, the National Board of Institutional Care's management reported on how it worked with following up on the shortcomings that existed, not only in the Aspen department, but in all the departments at the home. Part of that work has been introducing measures for better documentation and enhanced self-monitoring. The staff at the Aspen unit has also been complemented with new staff members with additional skills and competences. According to the management of the National Board of Institutional Care, the department was still closed in October 2019. The National Board of Institutional Care planned to open the department later in the autumn, but with fewer places and a new name. To avoid similar

37 See National Preventive Mechanism – NPM Report from the OPCAT Unit 2018 p. 51 and 52.

situations in the future, the National Board of Institutional Care will provide ethical guidance to counteract destructive cultures and improve the staff's attitudes. The National Board of Institutional Care's three operational branches have also begun work on collegial learning. At a planning conference for 2020, all heads of institutions participated and discussed issues based on the follow-up of the measures taken in relation to the special residential home for young people Sundbo.

Staff attitudes, competence and composition

At the dialogue meeting, the National Board of Institutional Care's management stated that it has appointed an ethics coordinator for all its institutions. According to the National Board of Institutional Care's management, it has identified the problem that there is no manager on site at most of its institutions after office hours. The National Board of Institutional Care works with its employer brand and with validating its staff's competence in ensuring qualification requirements are met. It has also begun special work to strengthen its competence in matters relating to human rights. Finally, the management of the National Board of Institutional Care stated that it does not have guidelines for the rotation of staff between departments.

Placing individuals in a so-called intake area

During inspections of the National Board of Institutional Care's institutions, the Parliamentary Ombudsmen have noted that there are often so-called intake areas where inmates can be placed for an initial period of their stay at the home.

The National Board of Institutional Care's management stated at the dialogue meeting that there are no guidelines concerning when an individual can be placed in an intake area. In substance abuse care, many new inmates can be affected by intoxicants upon arrival and are then initially placed in an intake area. At the beginning of care in a youth home, however, young people shall not be routinely separated from others and placed in an intake area. The criteria for separate care must be met before a decision is taken on such a measure. According to the National Board of Institutional Care's management, a decision must be taken concerning separate care if staff members determine that an individual cannot be placed with others due to the affects of intoxication. If two individuals are placed in an intake area and one of them is moved, this does not in itself mean that there is a legal basis for taking a decision on separate care. It is not the availability of premises that determines whether an inmate can be subject to separate care, but crucially if and when the requirements as set out in law are met. If an individual who is not in separate care is left alone in an intake area, the institution needs to consider whether the individual can, for example, participate in activities or go to school with others.

Premises used for the purposes of segregation and separate care

In several cases, OPCAT inspections of special residential homes for substance abusers have highlighted the lack of premises for carrying out separate care.

At the dialogue meeting in October 2019, the National Board of Institutional Care's management stated that it was only *the special residential homes for substance abusers Fortunagården* and *Rällsögården* which lacked special areas for separate care. According to the National Board of Institutional Care's management, there is strong support for the view that some young persons who have difficulties being in a large group could be cared for together with other young people in a smaller group. This would probably result in fewer decisions on segregation and separate care. The National Board of Institutional Care is running a pilot project at *the special residential home for young people Brättegården* with a unit containing fewer places intended for young people who belong to group 1 in the Support and Service for Persons with Certain Functional Impairments Act (1993:387) (i.e. individuals with intellectual disabilities, autism or autism-like conditions).

Monitoring and access to staff

The Parliamentary Ombudsman has criticised the National Board of Institutional Care in a case concerning an individual who died whilst in care at *the special residential home for substance abusers Rällsögården*. The staff on duty at the time lacked the competence to carry out their monitoring tasks as they were not aware of the routine developed by the National Board of Institutional Care for how monitoring is to be carried out for cases of individuals suspected of being under the influence of drugs.[38] Another case concerned a young individual who took her own life whilst receiving separate care at a special residential home for young people. The Parliamentary Ombudsman pointed out that there is reason for the National Board of Institutional Care to consider whether it should prepare central guidelines that more clearly state how separate care should be carried out and supervision exercised.[39]

At the dialogue meeting in October 2019, the National Board of Institutional Care's management stated that it has guidelines for issues related to suicide prevention and monitoring. According to the National Board of Institutional Care's decision on compulsory training for its employees, care staff must receive basic training in suicide prevention within their first three months of employment. Periodic or constant monitoring must be carried out by staff with specialist knowledge. In the event of individuals under the influence of drugs, there are guidelines for psychological or somatic supervision within the substance abuse care homes.

38 See the Parliamentary Ombudsmen 2019/20 p. 555.

39 See the Parliamentary Ombudsmen 2019/20 p. 502.

The National Board of Institutional Care's management emphasised that its guidelines partly address issues of access to staff. If a department, for example, does not have sufficient staffing levels to administer separate care, there is then no basis for the department to make a decision concerning such care. The National Board of Institutional Care's guidelines for separate care state, inter alia, that an individual should be able to be left alone for a short time, but never for long periods and not in conditions similar to isolation.

5.5 Conclusions

The Parliamentary Ombudsman inspected *the special residential home for young people Sundbo* in November 2018. During the inspection, very serious details emerged concerning misconduct. This picture was confirmed by the National Board of Institutional Care following the inspection, and it took a number of measures to address the problems that were highlighted. The measures were aimed not only at the situation at the home, but also at the agency's work with care and treatment in general. At the dialogue meeting between the Parliamentary Ombudsman and the National Board of Institutional Care, the management reported, inter alia, on how the follow-up on what had happened at Sundbo had formed the basis for discussions between all heads of institutions.[40] This is positive. What emerged during this year's inspection of *the special residential home for young people Vemyra*, however, shows that it still has several fundamentally important issues to deal with in order to ensure the legal security for the individuals. Similar to the findings at the special residential home for young people Sundbo, the National Board of Institutional Care had noted serious shortcomings at the home long before the Parliamentary Ombudsman's inspection. However, these shortcomings had not been addressed at a central level within the agency, which meant that the management of the home did not receive the support it needed to provide the individuals with safe and secure care. The problems at the home had then escalated. The Parliamentary Ombudsmen's OPCAT operation, therefore, will continue to follow questions concerning the safety and security of young individuals and the treatment by staff in the coming years. The Parliamentary Ombudsmen will also carry out a follow-up inspection of the special residential home for young people Vemyra in 2020.

A recurring issue during the Parliamentary Ombudsmen's inspections of the National Board of Institutional Care's institutions concerns highlighting routines that have led to individuals being held in conditions that can be compared to being placed in separate care or segregation. This issue was also raised at the dialogue meeting with the management of the National Board of Institutional Care. At the meeting, the representatives of the National Board of Institutional Care stated, inter alia, that young people admitted to a

40 See the Parliamentary Ombudsmen's report ref. no. O 55-2019.

special residential home for young people should not be placed routinely in a so-called intake area on arrival and that no one may be placed in separate care without the criteria for this being met. However, there are still no rules regarding what level of staff presence is adequate at an intake area or other department.[41] The issue of conditions when individuals are placed in small intake areas at the National Board of Institutional Care's institutions or in connection with separate care will, therefore, continue to be of interest to follow in the coming years.

During the inspection of *the special residential home for young people Långanäs* in October 2019, the Parliamentary Ombudsman noted that the care in a treatment department presupposed that the young individuals were placed in separate care. The periods of care at the department have been very long in some cases, a year or more, and in conversations with staff it emerged that the activities and conditions there can be compared to a special residential home for individuals in accordance with the Support and Service for Persons with Certain Functional Impairments Act (1993:387). During the inspection, questions were raised concerning how the National Board of Institutional Care applies the provisions on separate care, and the Parliamentary Ombudsman will follow up on these questions during an inspection of *the special residential home for young people Brättegården*. In this context, it is of additional interest to shed light on the activities at certain special residential homes for individuals in accordance with the Support and Service for Persons with Certain Functional Impairments Act (1993:387).

Shortcomings in the premises used for separate care and segregation at the National Board of Institutional Care's institutions can lead to difficult demarcations for staff. It results in, for example, staff physically restraining individuals through pinning them down instead of taking them to a segregation room. This has emerged from the OPCAT inspections of *the special residential homes for young people Vemyra* and *Långanäs*. During the year, the Parliamentary Ombudsman directed very serious criticism at the National Board of Institutional Care due to an incident of when a young person was pinned down at *the special residential home for young people Tysslinge*.[42] There is reason to continue to follow this issue during OPCAT inspections in the coming years.

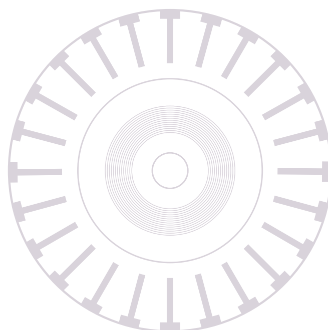
The National Board of Institutional Care's review of its premises shows that many institutions are very worn and that the premises are not adequately designed or set up for their purpose. It is positive that it now uses standard-designed residential departments for new constructions. Hopefully, this can contribute to more predictability in the National Board of Institutional Care's operations dealing with individuals deprived of their liberty. Due to the fact

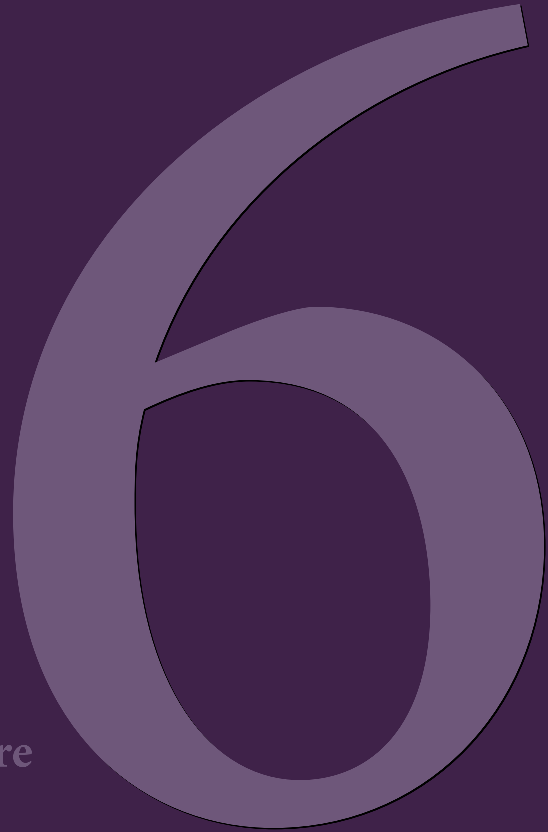
41 See the Parliamentary Ombudsmen's report p. 8, ref. no. O 55-2019.

42 See the Parliamentary Ombudsmen's decision of 29 November 2019, ref. no. 6774-2017.

that the majority of the National Board of Institutional Care's premises are worn, cramped and originally not designed for custodial care, the physical environment will continue to be in focus in OPCAT's work.

Finally, it can be stated that during the inspections in 2018 of *the special residential homes for young people Johannisberg* and *Sundbo*, the fact that young people cared in accordance with the Care of Young Persons Act (1990:52) and young people serving a sentence pursuant to the Secure Youth Care Act (1998:603) are often cared for together was highlighted. Following the inspections, the Parliamentary Ombudsman stated that this issue will be followed up on in future inspections. At the dialogue meeting between the Parliamentary Ombudsman and the National Board of Institutional Care in October 2019, it emerged that it intends to investigate whether there are conditions to differentiate between these categories of young people in the future. There is reason for the Parliamentary Ombudsman to follow this issue during next year's inspections.





Compulsory psychiatric care

Compulsory psychiatric care

Care in accordance with the Compulsory Psychiatric Care Act (1991:1128) and the Forensic Mental Care Act (1991:1129) are conducted in Sweden almost exclusively on a regional basis. At the end of 2019, there were estimated to be at least 80 care facilities operating pursuant to the Compulsory Psychiatric Care Act and the Forensic Mental Care Act with approximately 4,000 places in total. At these institutions, individuals are cared for who, inter alia, are subject to compulsory psychiatric care or have been sentenced to forensic psychiatric care. There can also be patients cared for at these facilities voluntarily in accordance with the Health and Medical Services Act (2017:30).

In 2019, the OPCAT Unit conducted three inspections of care facilities that provide care in accordance with the Compulsory Psychiatric Care Act and the Forensic Mental Care Act. All of these were inspected for the first time by the Parliamentary Ombudsmen and were announced.

All the inspections were carried out by or took place on behalf of Chief Parliamentary Ombudsman Elisabeth Rynning. She also made statements following the inspections and decided on the cases where a response was requested.[1] Two more inspections of similar care facilities were carried out by the supervisory division.

6.1 Observations made during this year's inspections

During the inspections of the psychiatric care facilities, the Parliamentary Ombudsmen's employees highlighted issues concerning, inter alia, the institutions' possibilities to provide adequate and safe care, the staff's use of coercive measures and the patients' access to electronic communication services.

The possibility to provide good and safe care

Health and medical care work must be carried out so that the requirements for good care are met. This means that the care must specifically cater to, inter alia, the patients' needs for security, continuity and safety, and that it must be based on respect for patients' self-determination and integrity.[2] Where health and medical care work is carried out, there must be the staff, premises and equipment needed for providing good care.[3] Care in accordance with

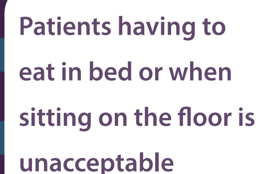
1 Stockholm Forensic Psychiatry Care, Section South (Helix), Sahlgrenska University Hospital's Emergency Psychiatric Unit at Östra Hospital and Växjö Regional Forensic Psychiatric Clinic.

2 See Chapter 5, Section 1, 2 and 3 of the Health and Medical Services Act (2017:30).

3 See Chapter 5, Section 2 of the Health and Medical Services Act (2017:30).

the Compulsory Psychiatric Care Act (1991:1128) must be conducted so that it meets the necessary safety requirements.[4] Furthermore, the care provider must conduct systematic patient safety work. This means that the care provider must plan, lead and check the instructions and routines used in its work.[5]

Stockholm Forensic Psychiatry Care, Section South (Helix) has a special observation unit where patients are initially placed when they are admitted to the facility. The unit has four patient rooms with floor-mounted beds equipped with restraining devices, which patients must sleep on. Patients who find the bed uncomfortable may instead sleep on a mattress on the floor. As there are no tables or chairs, patients must eat their meals in bed or sitting on the floor. The patient rooms have glass walls so that staff can monitor the patients. In conversations with the Parliamentary Ombudsmen's employees, patients stated that it was a breach of their privacy that the blinds were never pulled down when they were on the toilet or showering. Following the inspection, the Chief Parliamentary Ombudsman stated that it is unacceptable for a patient's bed to be constantly equipped with a belt and that it is unacceptable for patients to have to eat their meals in bed or sitting on the floor. The premise for the clinic should be to offer care that does not result in unnecessarily abuse of the individual. The Chief Parliamentary Ombudsman recommended the care provider to review how the care environment can be improved in order to ensure that the patients who stay there receive good care and are treated with respect for their human value.[6]



During the inspection of *Sahlgrenska University Hospital's Emergency Psychiatric Unit at Östra Hospital* (*Sahlgrenska emergency unit*), it emerged that the emergency unit has a significantly larger patient base than was originally intended for, especially during on-call time. Furthermore, it emerged that patients need to stay there overnight despite the fact that the facility officially does not have places for care. The majority of the emergency unit's patient admissions can be described as troublesome and resource-intensive, and who would have been admitted to an emergency substance abuse clinic if there were one in Göteborg. On occasion, 30 patients, some of them with relatives, have stayed on the premises at the same time. The staff, who have a joint responsibility for the so-called normal monitoring of patients, has then not been able to monitor sufficiently the patients and any monitoring made is not documented. Following the inspection, the Chief Parliamentary Ombudsman stated that on occasions when there is a high influx of patients, it is therefore particularly important that there are clear protective measures in order to reduce the risk of someone suffering harm. The Chief Parliamentary Ombudsman recommended that Västra Götaland Region takes measures to ensure

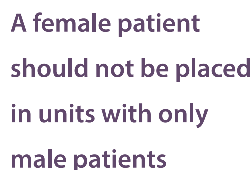
4 See Section 15 a of the Compulsory Psychiatric Care Act (1991:1128).

5 See Chapter 3, Section 1 of the Patient Safety Act (2010:659).

6 See the Parliamentary Ombudsmen's report p. 16, ref. no. O 3-2019.

that there are sufficient staffing levels in the emergency psychiatric unit so that the staff are, inter alia, able to perform the monitoring in a manner which maintains patient safety. Furthermore, the Chief Parliamentary Ombudsman stated that there is reason to continue to follow how the emergency psychiatric units are organised in the regions and what risks may entail for patients in the framework of future OPCAT inspections.[7]

The Chief Parliamentary Ombudsman also commented on the care environment following the inspection of *Växjö Regional Forensic Psychiatric Clinic*. During the inspection, it was noted that the premises in one of the buildings were worn and not completely fit for purpose as, inter alia, the common areas were small and the environment lacked stimuli. During the inspection, attention was also highlighted to the fact that lone women were placed in units with only male patients. In conversations with the Parliamentary Ombudsmen's employees, female patients stated that they lacked having other women to talk to and that they felt insecure in a unit with only male patients. During the inspection, it was also noted that two patients were placed in rooms that lacked basic equipment, which meant that they had to eat their meals in bed. One of these rooms was an ordinary patient room reminiscent of the environment in a police custody facility. With reference to the statements made after, inter alia, the OPCAT inspection of Unit 130/PIVA at Danderyd Hospital the Chief Parliamentary Ombudsman found reason to recommend additionally that Kronoberg Region, together with the management of *Växjö Regional Forensic Psychiatric Clinic*, review the possibilities that exist for making the care environments less lacking in stimuli. Furthermore, the Chief Parliamentary Ombudsman recommended that the clinic's management take measures in order to prevent female patients from being placed in a unit with only men, and to satisfy the female patients' needs for association with others and security. The Chief Parliamentary Ombudsman reiterated that it is undignified to have to sit in bed and eat and the Chief Parliamentary Ombudsman urged the clinic to review immediately the furnishings in the relevant rooms and, as far as one room is concerned, to consider whether it is appropriate to use as an ordinary patient room.[8]



Use of mechanical restraints and segregation

If there is an immediate risk of a patient seriously injuring themselves or others, they may be briefly restrained with a belt or similar device. Furthermore, a patient may be segregated from other patients if necessary due to the patient seriously impeding the care of the other patients through aggressive or disruptive behaviour. A decision on segregation is valid for a maximum of eight hours. The segregation period may be extended with a new decision by

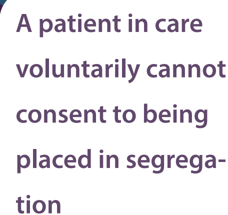
7 See the Parliamentary Ombudsmen's report p. 12 and 13, ref. no. O 6-2019.

8 See the Parliamentary Ombudsmen's report p. 17, ref. no. O 18-2019.

a maximum of eight hours. If there are special reasons, a decision on segregation may contain to a fixed period exceeding eight hours.[9]

According to the National Board of Health and Welfare's regulations, the decision-making doctor must examine the patient before a decision is made on restraint for longer than four hours or on segregation for longer than eight hours.[10] The provision is intended to ensure a legally secure assessment is made before a decision on extension of coercive measures. This should be seen as a minimum requirement and the premise must always be that the decision-making doctor conducts a personal examination of the patient also before, or as soon as possible after, an initial decision for a period of less than four and eight hours, respectively.[11]

Following this year's inspections, the Chief Parliamentary Ombudsman has found reason to comment on the legal basis for the use of segregation. During the inspection of *Helix*, it emerged that on occasion the Prison and Probation Service's patients are cared for voluntarily at the clinic and that they are initially placed in the observation unit, where they are segregated from other patients. Additionally, it emerged that newly admitted patients are initially segregated regularly for more than eight hours and that a reassessment is made by doctors during the rounds every morning. Following the inspection, the Chief Parliamentary Ombudsman stated that being placed in the observation unit, for a longer time period than is required for the registration process itself, means that the patient is segregated. The Chief Parliamentary Ombudsman emphasised that a patient who is cared for voluntarily cannot consent to segregation and she assumed that the clinic's management would review the routines and ensure that such situations do not arise.[12]



Following the inspection of *Helix*, the Chief Parliamentary Ombudsman underscored that it is not sufficient that the care of other patients is disturbed or made more difficult or that such a risk is deemed to exist for a patient to be segregated. The legislative provision on segregation contains a seriousness prerequisite. In order to ensure that the prerequisites are met, the decision should clearly state the actual circumstances that mean the conditions for segregation are met.[13]

Following the inspections of *Helix* and *Växjö Regional Forensic Psychiatric Clinic*, the Chief Parliamentary Ombudsman also commented on the possibility of segregating a patient for a specific period exceeding eight hours with reference to the existence of special reasons. According to the provision's le-

9 See Section 19 and 20 of the Compulsory Psychiatric Care Act (1991:1128).

10 10 See Chapter 3, Section 2 of the National Board of Health and Welfare's regulations and general guidelines (SOSFS 2008:18) on compulsory psychiatric care and forensic psychiatric care.

11 See Compulsory Psychiatric Care and Forensic Psychiatric Care. Handbook with information and guidance for the application of the National Board of Health and Welfare's regulations and general advice on compulsory psychiatric care and forensic psychiatric care (SOSFS 2008:18), July 2009, p. 50.

12 See the Parliamentary Ombudsmen's report p. 16, ref. no. O 3-2019.

13 See the Parliamentary Ombudsmen's report p. 16, ref. no. O 3-2019.

The need to segregate a patient for more than eight hours should only arise in distinctive, exceptional cases.

gislative history, the intention is that this is an exceptional provision aimed at certain extreme cases where a patient's situation is so difficult that segregation must take place for a period longer than a few days. Such a need should only arise in distinctive, exceptional cases. The Chief Parliamentary Ombudsman also referred to an earlier decision concerning Sundsvall Regional Forensic Psychiatric Clinic, where the Parliamentary Ombudsman stated that a decision meaning segregation should apply for "a maximum of 72 hours" does not reference such a specific time as pertained to in the law.[14]

During the inspection of *Helix*, it was noted that the clinic had a routine which means that newly admitted patients were regularly initially segregated for longer than eight hours. In the view of the Chief Parliamentary Ombudsman, this raised the question of whether the conditions are normally such that the high requirements set for a segregation are met and that special reasons exist. The Chief Parliamentary Ombudsman was strongly critical of the way in which *Helix* has chosen to expand extensively the possibilities of segregating patients during initial care by placing them in the observation unit. Furthermore, the Chief Parliamentary Ombudsman assumed that the clinic would immediately review its practices and adapt them to the current legislation. With regard to the details that have emerged, the Chief Parliamentary Ombudsman announced that a follow-up inspection of the clinic would be carried out during the first half of 2020.[15]

A patient segregated or restrained must be examined by a doctor as soon as possible

During the inspection of *Växjö Regional Forensic Psychiatric Clinic*, the issue of medical assessments in connection with restraint or segregation was raised. The written routines state that doctors must individually examine the patient on site before making a decision on restraint for more than four hours and segregation for more than eight hours. In conversations with several of the employees, it emerged that the doctors did not always come to the units during the first decision on restraint or segregation. The Chief Parliamentary Ombudsman recommended Kronoberg Region to take measures to ensure patients are examined by a doctor as soon as possible in connection with a decision to take a coercive measure.[16]

Patients segregated for lengthy periods

For several years, the Parliamentary Ombudsmen have followed how the regions conduct the care of patients who are segregated for a lengthy periods. What has emerged concerning these patients' living conditions raises, inter alia, questions regarding which alternatives have been considered by the clinics for the care and treatment of these patients. Following the OPCAT inspection of Säter Forensic Psychiatric Clinic, the Parliamentary Ombuds-

14 See the Parliamentary Ombudsmen's report p. 18 and 19, ref. no. O 3-2019 and report p. 17 and 18, ref. no. O 18-2019.

15 See the Parliamentary Ombudsmen's report p. 22, ref. no. O 3-2019.

16 See the Parliamentary Ombudsmen's report p. 23, ref. no. 3816-2017 and the Parliamentary Ombudsmen's report p. 18, ref. no. O 18-2019.

man stated that independent experts should be hired to ensure that long-term segregated patients receive good care.[17] This is also a recommendation that the European Committee for the Prevention of Torture (CPT) reiterated during its visit to Sweden in 2015.[18]

It is important that patients segregated for lengthy periods receive adequate care which includes, inter alia, outdoor access

During the inspections of both *Helix* and *Växjö Regional Forensic Psychiatric Clinic*, it emerged that there were patients who had been segregated for lengthy periods. Following the inspection of *Helix*, the Chief Parliamentary Ombudsman highlighted that an important question is whether the legislation provides the scope for some of the measures taken during the ongoing segregation, for example that the patient regularly associates with other patients for parts of the day and is then returned to segregation without any new decision having been taken. Furthermore, what has emerged concerning these patients' living conditions also raised questions regarding which alternatives for care and treatment the clinics have considered. The Chief Parliamentary Ombudsman stated that it is important that long-term segregated patients receive good care that includes the opportunity for outdoor access and exercise, and that they can be provided with adequate activities. The Chief Parliamentary Ombudsman recommended the clinic puts together good examples of efforts made in order to prevent patients from having to be segregated for very lengthy periods.[19]

Decisions on keeping patients in hospital and admission

After a care certificate has been issued, a doctor may decide that the patient should be kept in the care facility until the question of admission has been decided.[20] The question of whether to admit an individual to inpatient compulsory psychiatric care is to be made promptly following examination of the patient and no later than 24 hours after their arrival at the care facility.[21] Health and medical care principals have a far-reaching responsibility to organise health and medical care with adequate routines that mean decisions on admissions can be made as soon as possible after patients arrive at a health-care facility.[22]

During the inspection of *Sahlgrenska Emergency Unit*, it emerged that decisions on admission to psychiatric compulsory care are made at the reception in exceptional cases. These are cases where the deadline for a decision to keep a patient in the care facility will shortly expire, or where the patient is to be transported to another hospital. In normal cases, decisions to keep a patient in the care facility are made at the emergency unit, after which the

17 See the Parliamentary Ombudsmen's report p. 16, ref. no. 5556-2016.
18 See CPT/Inf (2016) 1 p. 58.
19 See the Parliamentary Ombudsmen's report p. 18, ref. no. O 3-2019.
20 See Section 6 first paragraph of the Compulsory Psychiatric Care Act (1991:1128).
21 See Section 6 b, first paragraph of the Compulsory Psychiatric Care Act (1991:1128).
22 See Government Bill 1999/2000: 44 p. 59.

unit that then receives the patient for further care decides on admission. The Chief Parliamentary Ombudsman stated that questions arise concerning how legal certainty is affected by the way in which psychiatric care at Sahlgrenska University Hospital is organised, where, inter alia, patients in need of compulsory psychiatric care need to be transported between different hospitals. The questions will be dealt with in an own-initiative inquiry concerning an examination of how Stockholm Region Healthcare Service has organised inpatient psychiatric care.[23]

6.2 Own-initiative inquiries

Following the inspection of *Växjö Regional Forensic Psychiatric Clinic*, the Chief Parliamentary Ombudsman chose to investigate the clinic's transfer of information to the Prison and Probation Service in an own-initiative inquiry. The clinic regularly receives patients who, inter alia, are serving prison sentences in a prison. These so-called prison clients can stay at the clinic for a very long time.

During the inspection, it emerged that the clinic provides information that is covered by confidentiality restrictions pursuant to Chapter 25 of the Public Access to Information and Secrecy Act (2009: 400) to the Prison and Probation Service. This occurs regarding prison clients being returned to a prison or remand prison. Such information is also provided every month regarding prison clients who continue to be cared for at the clinic. The clinic does not document what information is submitted to the Prison and Probation Service.[24]

6.3 Cases where responses from healthcare providers were requested

In 2018, the *Psychiatric Emergency Unit and Unit 1 at Sankt Göran Hospital* were inspected. During the inspections, it emerged that the staff had a perception that the Prison and Probation Service's working methods for assisted transportations contributed to stigmatising, inter alia, mental illness. Furthermore, there was a perception that the Prison and Probation Service's staff failed to act respectfully towards patients.

Following the inspection, the Chief Parliamentary Ombudsman requested that Stockholm Region Healthcare Service respond detailing the measures taken or those which it intended to take in connection with this information.[25]

Stockholm Region Healthcare Service's response was received by the Chief Parliamentary Ombudsman on 14 June 2019. The response shows that Stockholm Region Healthcare Service has initiated extensive collaborative

23 See the Parliamentary Ombudsmen's report p. 14, ref. no. O 6-2019 and the Parliamentary Ombudsmen's ref. no. 1732-2019.

24 See the Parliamentary Ombudsmen's report p. 20, ref. no. O 18-2019 and the Parliamentary Ombudsmen's ref. no. 842-2020.

25 See the Parliamentary Ombudsmen's report p. 15, ref. no. 5990-2018.

work, nationally and regionally, with, inter alia, the Police Authority and the Prison and Probation Service. Meetings have taken place between representatives of the agencies at the regional level and representatives from forensic psychiatry in Stockholm Region have participated in an in-house training for the Prison and Probation Service's transportation staff. The training has primarily focused strongly on showing respect to people with severe mental illnesses. Furthermore, development work is underway regarding transportation in several other areas of psychiatry in Stockholm Region, for example in prehospital care. In a decision, the Chief Parliamentary Ombudsman stated that the reported measures appear to be adequate. The Chief Parliamentary Ombudsman emphasised the importance of the initiatives taken not becoming a one-off event, but that there is continuity in contact with the relevant actors regarding, inter alia, questions concerning training initiatives. These actors have a shared responsibility to ensure that the assisted transportations are carried out as safely and securely as possible for the patients.[26]

6.4 Conclusions

The regions must conduct healthcare so that it meets the requirements for good care. This means, inter alia, that it must satisfy patients' needs for safe and secure care.[27] Where healthcare is provided, there must be the staff, premises and equipment needed for good care to be provided.[28]

During this year's inspections, the Chief Parliamentary Ombudsman has once again highlighted the conditions under which healthcare facilities have to conduct good and safe care. Of particular importance for this is that the staffing corresponds to the needs in terms of staffing levels, competence and that the staff always have the required information concerning the patients to be able to perform the monitoring in a patient-safe manner. Shortcomings in these areas have been noted, and the Chief Parliamentary Ombudsman will, therefore, continue to follow these issues. Furthermore, it is central that premises are adapted to the number of patients that are expected to be admitted. The fact that psychiatric emergency units are undersized and understaffed entails obvious risks for patients, who initially may be regarded as particularly vulnerable. There are, therefore, reasons for the Parliamentary Ombudsmen to continue to follow how other regions organise their psychiatric emergency units.

During the year, the Chief Parliamentary Ombudsman highlighted the importance of the care environment for patient safety. This includes female patients being placed in environments where they did not feel safe spending time in the common areas. Furthermore, the Parliamentary Ombudsmen

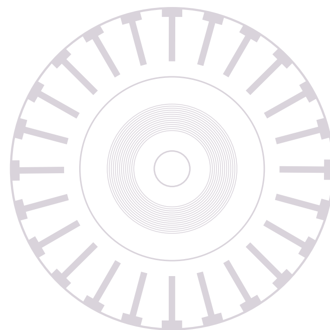
26 See the Parliamentary Ombudsmen's decision on 7 January 2020, ref. no. O 16-2019.

27 See Section 2 a of the Health and Medical Services Act (2017:30).

28 See Section 2 e of the Health and Medical Services Act (2017:30).

have noted that patients' rooms lacked furniture, which meant that patients had to eat their meals in bed or on the floor. The care environment is particularly important for patients who are deprived of their liberty and, therefore, the Parliamentary Ombudsmen will continue to examine it.

This year's inspections have also shown that, in the coming years, there is reason to continue to examine the care facilities' application of the legislative provisions relating to coercive measures and, in particular, the use of segregation. For this reason, there will be a follow-up inspection of the forensic psychiatric clinic *Helix*. In addition, there is reason to follow up on the question of medical assessments in the use of coercive measures and how, in compulsory psychiatric care, it is ensured that patients are not exposed to more far-reaching measures than are absolutely necessary. The Parliamentary Ombudsmen will continue to monitor the conditions for patients who are segregated for lengthy periods. The review will include both the care facilities' measures to prevent a patient being segregated for a lengthy period, as well as the question of renewed medical assessments and what measures are taken to ensure that segregation can end.



7

The Swedish Migration Agency

The Swedish Migration Agency is tasked with, inter alia, operating detention centres where foreigners can be placed pending enforcement of a decision on expulsion or deportation from Sweden.[1] Foreigners may also be detained if necessary to investigate a foreigner's identity. A detention decision may be made by the Swedish Migration Agency, Police Authority, Security Police and migration courts.[2] At the end of 2019, the Swedish Migration Agency had six detention centres with 528 places. In September 2019, the OPCAT Unit carried out an unannounced inspection of *the detention centre in Ljungbyhed*. The detention centre was put into use in May 2019. The inspection was carried out on behalf of Chief Parliamentary Ombudsman Elisabeth Rynning. Parliamentary Ombudsman Per Lennerbrant made a statement following the inspection.

7.1 Observations made during this year's inspection

All of the reported observations took place in connection with the inspection of *the detention centre in Ljungbyhed*.[3]

The detention centre's physical environment

The detention centre is housed in a former fire station and has 44 places. During the inspection, it was noted that the detention centre's two residential units lack their own common areas. The only space in the units that can be described as a common area is a dining room. However, this only has seating for approximately half of the detainees who may reside in the unit. The detention centre has a larger common area that is separate from the residential units, which the individuals detained have access to for one hour per day. The detainees are able to smoke on six occasions daily and spend one hour in the detention centre's exercise yard.

In conversations with the Parliamentary Ombudsmen's employees, several staff members stated that there were too many detainees staying in the detention centre's relatively limited space. The detainees do not have the opportunity to retreat to a calmer environment. The lack of common areas also makes it difficult for the staff to have meaningful contact with the detainees. The limited times for smoking meant that detainees smoked indoors and

1 See Chapter 3, Section 4 of the Ordinance with Instructions for the Swedish Migration Agency (2019: 502).

2 See Chapter 10, Sections 12–17 of the Aliens Act (2005: 716).

3 See the Parliamentary Ombudsmen's report, ref. no. O 52-2019.

this created conflicts with the staff. The staff also stated that it was difficult for all the detainees to have time to eat because the food is served for only 30 minutes and there are not enough places for all the detainees to sit and eat at the same time. The detainees emphasised that the conditions at the detention centre were more similar to a prison in terms of the rules, routines and times for smoking.

Following the inspection, the Parliamentary Ombudsman stated that the conditions for the detainees at *the detention centre in Ljungbyhed* differ to the conditions at the Swedish Migration Agency's other detention centres. Life for a detainee in Ljungbyhed appears to be more limited and regulated. The limited access to common areas and the exercise yard means that the detainees spend large parts of the day in the residential unit's corridor and dining room or in their bedrooms. In the view of the Parliamentary Ombudsman, it is clear that the design and set up of the detention centre has, to a large extent, been characterised by the limitations that exist in the premises in which it is situated. This, in turn, creates far-reaching restrictions for the detainees, which – in the view of the Parliamentary Ombudsman – is regrettable. From details that have emerged concerning the physical environment, it also became clear that the detention centre is not sufficiently large to hold 44 detainees. For this reason, the Swedish Migration Agency should, in the view of the Parliamentary Ombudsman, immediately consider reducing the number of places in the detention centre. Furthermore, the agency should take measures to ensure that the detainees are given the opportunity for daily outdoor access to a greater extent than they have been given thus far.

Segregation and security placements

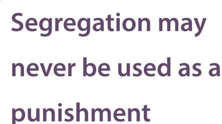
A foreigner who is detained and has reached the age of 18 may be segregated from other detainees if it is necessary to maintain order and safety or security at the centre or if they pose a serious danger to themselves or others. A decision on segregation is made by the Swedish Migration Agency. The decision must be reviewed as often as there is reason to do so, but at least every three days. A foreigner who is segregated because they pose a danger to themselves must be examined by a doctor as soon as possible.[4] The Swedish Migration Agency may decide that a foreigner who is segregated and who, for security reasons, cannot be held in a detention centre must instead be placed in a prison, remand prison or police custody facility (security placement). The Swedish Migration Agency may also decide on such a placement if the foreigner is to be deported by a court of law due to a crime, it is necessary for transportation reasons or other special reasons. A foreigner who has been placed in a prison, remand prison or police custody facility and who has not been deported by a court order due to a crime must be segregated from other

4 See Chapter 11, Section 7 of the Aliens Act (2005:716).

inmates. Children detained may not be placed in a prison, remand prison or police custody facility.[5]

During the inspection of *the detention centre in Ljungbyhed*, it emerged that the limited opportunities for smoking in several instances led to indoor smoking and, by extension, a segregation decision. In addition, it was found that several segregation decisions seemed to have been based on several separate events which individually were not sufficiently serious to justify segregation but had all nonetheless led to a segregation decision. It also emerged that a segregation decision had been made the day after the event that was stated as the basis for the measure. During the concluding review, the representatives of the detention centre stated that the centre is relatively newly opened and that there have been shortcomings regarding the staff's knowledge concerning the prerequisites upon which a coercive measure may be decided.

Following the inspection, the Parliamentary Ombudsman emphasised that the use of segregation is a significant restriction to a detainee's freedom of movement. Any coercive measure exercised against a detainee must always have a legal basis and be able to be communicated to an individual in an understandable way. For a segregation decision, it is required that there are concrete circumstances that lead to the assessment that a segregation of a detainee is necessary for maintaining order or security and safety at the detention centre or that a detainee constitutes a serious danger to themselves or others. In the Parliamentary Ombudsman's view, there should never be any doubt, whether to staff or detainees, the grounds on which a coercive measure is taken.



The Parliamentary Ombudsman further stated that the aim of a segregation decision is to maintain order and security or safety at the detention centre. There is some scope to consider the previous behaviour of a detainee, but a balance must be struck between the seriousness of that behaviour and how long ago it occurred. However, segregation must never be used as a punishment. For this reason, the Parliamentary Ombudsman called on the Swedish Migration Agency to ensure that its staff have sufficient knowledge of the regulations so that coercive measures of the type in question are used on the basis specified in law. *The detention centre in Ljungbyhed* should also consider what preventive measures can be taken to avoid conflicts at the detention centre.

The detention centre in Ljungbyhed has two rooms for segregation purposes. The rooms are constantly monitored by cameras and there is also a window for supervision of the individuals segregated. In the corridor outside the rooms there is, inter alia, a toilet and a space where a segregated detainee can watch television. In order not to have to take out violent detainees into the

5 See Chapter 10, Section 20 of the Aliens Act (2005:716).

corridor for toilet visits, the detention centre has a portable so-called sanitary toilet that can be placed in the segregation room. The sanitary toilet consists of a box in which the inmate can fulfil his needs. During the inspection, it had yet to be used. According to the details which emerged, there is no possibility for segregated detainees to, for example, wash their hands when needed.

Following the inspection, the Parliamentary Ombudsman emphasised that a foreigner held in detention must be treated humanely and their dignity must be respected.[6] In the view of the Parliamentary Ombudsman, it is doubtful whether the intended use of the sanitary toilet meets the requirements of the Aliens Act (2005:716). However, the Parliamentary Ombudsman refrained from commenting further on the issue, but may return to it, inter alia, during future inspections of the Swedish Migration Agency's detention centres. In the view of the Parliamentary Ombudsman, however, the Swedish Migration Agency should consider whether the camera surveillance can be switched off when the toilet is in use.

Body searches

A foreigner who is held in detention may not, without permission, possess alcoholic beverages or other intoxicants or anything else that may harm someone or be detrimental to maintaining order within the centre. If there is a reasonable suspicion that a foreigner held in detention possesses these items, or any such that according to the Narcotics Drugs Penal Law (1968:64) may not be possessed, it is possible to carry out a body search of the foreigner to check whether he or she carries such items.[7]

Following the inspection of *the detention centre in Ljungbyhed*, the Parliamentary Ombudsman emphasised that the requirement of reasonable suspicion means that detainees may not be subject to a routine body search upon admission to a detention centre. The Swedish Migration Agency's ability to carry out for body searches is, therefore, more limited than, for example, the Prison and Probation Service's abilities to carry out body searches of individuals taken into remand. Individuals taken into remand must, at the latest upon arrival, be searched or examined for unauthorised items, unless this is clearly unnecessary.[8]

The Parliamentary Ombudsman further stated that the Swedish Migration Agency, in a letter to the Government Offices, has emphasised that the current possibilities for carrying out body searches are not sufficient. According to the agency, the possibilities for carrying out body searches need to be expanded in connection with, inter alia, admission to detention centres. The number of incidents where unauthorised items were found increased between

6 See Chapter 11, Section 1 of the Aliens Act (2005:716).

7 See Chapter 11, Sections 8 and 9 of the Aliens Act (2005:716).

8 See Chapter 4, Section 2 of the Detention Act (2010:611).

2014 and 2015. For this reason, in the Swedish Migration Agency's view, there is a need to reduce unauthorised items in the detention centre with the intention of increasing security for detainees, for example.[9]

The Parliamentary Ombudsman expressed an understanding of the Swedish Migration Agency's view that increased possibilities to search for illicit items would increase security at the detention centre. However, the Parliamentary Ombudsman reiterated that the Aliens Act (2005:716) currently allows body searches of a detainee only under the prerequisites specified in Chapter 11, Section 9.

Camera surveillance

The Swedish Migration Agency must ensure that camera surveillance is only used when absolutely necessary

Due to the fact that the segregation rooms in *the detention centre in Ljungbyhed* are constantly under camera surveillance, the Parliamentary Ombudsman emphasised, following the inspection, that the Parliamentary Ombudsman has previously stated that camera surveillance of a detainee in a cell or equivalent within the Prison and Probation Service is a particularly integrity-infringing measure. In order to reduce the risk of detainees being exposed to unnecessary integrity infringements, such a surveillance system should be able to be switched off when its use is not deemed necessary.[10] The Parliamentary Ombudsman stated the basis and reasoning for this view can also be applied to, for example, a segregation room in a detention centre. For this reason, the Parliamentary Ombudsman called on the Swedish Migration Agency to take immediate measures to ensure that camera surveillance is not used in other cases than when it is deemed necessary. In cases where the Swedish Migration Agency determines that there is exists such a need, the Parliamentary Ombudsman reiterated that information concerning the use of surveillance must be provided through clear signage or some other effective way.[11]

Detainees' access to health and medical care

During the inspection of *the detention centre in Ljungbyhed*, it emerged that the nurse does not meet all the individuals admitted to the detention centre. Following the inspection, the Parliamentary Ombudsman referred to the fact that the Council of Europe's Committee for the Prevention of Torture, the CPT, has recommended that Sweden takes measures that ensure that there is always a medical examination of detainees upon admission. The CPT has emphasised that it is important partly to detect the risk of self-harm and infectious diseases, and partly to document any physical injuries.[12] It may also have been a relatively long time since a detainee last received a medical examination, and they may have lived under difficult conditions and without

9 See the Swedish Migration Agency ref. no. 1.1.2-2017-125520.

10 See the Parliamentary Ombudsmen's report, ref. no. 750-2018.

11 See Section 15, first paragraph of the Camera Surveillance Act (2018:1200).

12 See CPT/Inf [2016] 1, para. 39.

access to health and medical care since an examination was last made. For this reason, in the view of the Parliamentary Ombudsman, there is great value in a medical professional conducting an examination of everyone admitted to a detention centre. The Swedish Migration Agency should, therefore, consider reviewing its admission routines in this respect in order to ensure that detainees receive the care they need and to reduce the risk of spreading infectious diseases.

There is a great value in a medical professional examining all individuals admitted to a detention centre

During the inspection of *the detention centre in Ljungbyhed*, it further emerged that the Swedish Migration Agency holds the view that a detainee must be examined by a doctor at the detention centre before they can be transported to an psychiatric emergency unit. According to details received, it can take up to 12 hours before a doctor arrives. In the view of the Parliamentary Ombudsman, the conditions described raised questions concerning access to health and medical care in a situation where a detainee segregated because there is a risk that they will injure themselves. Therefore, the Parliamentary Ombudsman will continue to follow this issue in future inspections of the Swedish Migration Board's detention centres.

Documentation

During the inspection of *the detention centre in Ljungbyhed*, it was noted that the detention centre kept a manually entered, so-called detention and segregation log in an accounting ledger. During the examination of the logs, the Parliamentary Ombudsmen's employees were able to note that, in some cases, no time had been specified for the decisions taken or when a period of segregation had ended. In some cases, there was no date for when a detainee was in a security placement. There were, in general, no times specified for security placements. It was, therefore, not possible to see how much time had elapsed between the decisions on segregation and the security placements in cases where the decisions were made on the same day, nor when the detainee was notified of the decision.

Following the inspection, the Parliamentary Ombudsman emphasised that if the documentation in a log is to fulfil the function of, inter alia, monitoring deadlines, it needs to be filled in correctly so that it is always possible to obtain a reliable picture of the handling of cases.

The Swedish Migration Agency must ensure that the detention centre can document necessary details in a uniform manner

Incorrect information entails a risk that deadlines will not be noticed in time and that detainees will, therefore, not have their rights met.

An accounting book was also used at the detention centre in Kållered to maintain the log. Following an inspection, the Parliamentary Ombudsman stated that it was surprising that the Swedish Migration Agency had not ensured that there was a technical solution or other documentation system, so that

notes can be made in a more adequate manner.[13] Following the inspection of *the detention centre in Ljungbyhed*, the Parliamentary Ombudsman stated that to ensure the rights of the detainees are met, the Swedish Migration Agency needs to review how the detention centre can document the necessary information in a uniform and more adequate manner.

Transportations

If the Swedish Migration Agency so requests, the Prison and Probation Service must provide the assistance needed to transport a foreigner held in detention. Such a request may only be made if, due to special circumstances, there is a risk that the transportation cannot be carried out without the Prison and Probation Service's special powers to carry out body searches and use restraints, or there exist other, special reasons.[14]

During the inspection of *the detention centre in Ljungbyhed*, it emerged that there was no documentation of the assistance that the agency requests from the Prison and Probation Service. Following the inspection, the Parliamentary Ombudsman emphasised that – in view of the fact that it can have negative consequences for detainees if the assisted transportation is delayed, for example by holding them in segregation – the Swedish Migration Agency should consider taking measures that mean that it systematically follows up on such delays. In this way, the Swedish Migration Agency can also obtain its own documentation on the outcomes of its requests for assisted transportations.

7.2 Cases where responses from the Swedish Migration Agency have been requested

The Swedish Migration Agency has adopted a standard for visiting detainees who have been placed in a prison, remand prison or police detention centre. The standard states, inter alia, that the Swedish Migration Agency is to make "contact" with the detainee and that such contact can be made via video conference call. In exceptional cases, telephone calls can also be used. Physical visits can be made if deemed necessary. The contacts must take place every two weeks and the Swedish Migration Agency is also able to decide on a longer interval between contacts when it is obvious that readmission to a detention centre cannot be considered. If the detainee does not want any contact with the Swedish Migration Agency, the agency should instead contact the Prison and Probation Service to ensure that the detainee has not changed their mind regarding contact or a visit, and obtain details concerning the detainee's security placement.

The premise should be that the Swedish Migration Agency visits detainees in security placements

13 See the Parliamentary Ombudsmen's report, ref. no. 939-2018.

14 See Chapter 10, Section 19 a of the Aliens Act (2005:716).

Following an inspection of the Swedish Migration Agency's national prison and remand prison coordination unit in October 2018, the Parliamentary Ombudsman stated that the premise should be that the Swedish Migration Agency continuously visits detainees subject to a security placement. In the view of the Parliamentary Ombudsman, the Swedish Migration Agency should ensure that the visiting standard is designed in such a way that there is no doubt concerning its implementation.[15]

During the inspection of *the detention centre in Ljungbyhed*, the Parliamentary Ombudsmen's employees noticed that there had been no change to the visiting standard. Following the inspection, the Parliamentary Ombudsman reiterated that the Swedish Migration Agency must take measures to ensure that there is no doubt that contacts with a detainee in a secure placement are to take place via a visit. The Swedish Migration Agency was asked to respond detailing what measures it had taken.

7.3 Conclusions

The Swedish Migration Agency's detention centre operations have expanded significantly in recent years. According to the letter of instruction for 2020 to the Swedish Migration Agency, the number of detention places must amount to at least 520. In planning the locations for detention centres, the Swedish Migration Agency must pay special attention to the need for detention centre sites in northern Sweden.[16] At the end of 2019, the detention centre in Gävle was the Swedish Migration Agency's northernmost detention centre. The Swedish Migration Agency has initiated a close collaboration with the Police Authority and the Prison and Probation Service to try to find a joint solution with access to detention places in the nothernmost counties in Sweden.[17]

When establishing an additional detention centre, it is important that the Swedish Migration Agency uses the experiences from the establishment of *the detention centre in Ljungbyhed*. These include issues such as which premises are suitable for use as a detention centre and how many places can reasonably be established in a certain space. Furthermore, it is important that the detention centre is designed and set up in such a way that the Aliens Act's (2005:716) fundamental provisions on the treatment of individuals in detention can be met. This concerns detainees being treated humanely and their dignity being respected. Furthermore, the operative work related to detention must be designed in a way that involves the least possible infringement on foreigners' integrity and rights.[18] How well the Swedish Migration Agency meets these requirements in the design and set up of its detention centre operations

15 See the Parliamentary Ombudsmen's report, ref. no. 6665-2018.

16 See letter of instruction for the financial year 2020 regarding the Swedish Migration Agency.

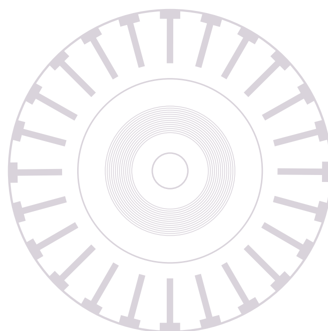
17 See the Swedish Migration Agency's Annual Report 2019 p. 77.

18 See Chapter 11, Section 1 of the Aliens Act (2005:716).

will continue to be an important issue for the Parliamentary Ombudsmen's OPCAT operation.

Another recurring issue that covers the supervisory areas of several Parliamentary Ombudsmen concerns so-called security placements of detainees. This means that a detainee who is segregated for security reasons is considered not able to be held in a detention centre, and is instead placed at the Prison and Probation Service, preferably in a remand prison. The question of when a decision on a security placement is made, how a review of a security placement decision is made and the conditions for detainees placed in the Prison and Probation Service have been the subject of statements and recommendations from the Parliamentary Ombudsmen for more than a decade. Due to the fact that the Parliamentary Ombudsman has stated that detainees should, in principle, not be placed with the Prison and Probation Service and that there is still uncertainty concerning what the Swedish Migration Agency's responsibility for these individuals is exactly, it will be a continued priority when examining detention centres.

Finally, the organisation of health and medical care at detention centres can be mentioned. The Swedish Migration Agency is not a care provider, and the formal responsibility for detainees' health and medical care rests with the regions. What the access to health and medical care actually looks like, therefore, varies from detention centre to detention centre. The question of detainees' access to an initial medical examination has also been the subject of repeated international criticism, and the Parliamentary Ombudsman has, for example, on several occasions highlighted shortcomings in the information provided to detainees concerning their access to health and medical care. There may be reason to pay attention to this issue in future inspections.



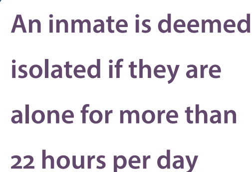
Isolation of individuals held on remand

Isolation of individuals held on remand

Since 2017, the Parliamentary Ombudsmen's OPCAT work has followed the situation for inmates in the Prison and Probation Service's remand prisons. In addition to conducting a number of inspections of remand prisons, in 2019 Chief Parliamentary Ombudsman Elisabeth Rynning invited representatives of the Prison and Probation Service to a dialogue meeting. At the meeting, she raised issues concerning inmates' rights to association with others and the Prison and Probation Service's work with isolation-breaking measures.

In a decision on 5 February 2020, the Chief Parliamentary Ombudsman commented on these issues.[1] On 26 February 2020, the Parliamentary Ombudsmen's OPCAT Unit published a thematic report *Isolation of inmates in remand prisons*. This section contains a summary of the report.

Inmates in remand prisons have the right to associate with others



An inmate has the right to associate with other inmates during the day. In the Chief Parliamentary Ombudsman's opinion, this means that an inmate has the right to associate with several other inmates. This fundamental right can be limited by both restrictions set by a prosecutor and segregation decisions. A denied right to associate with others may result in an inmate being isolated. Isolation can lead to both mental and physical problems.

Isolation is defined as an inmate being alone for more than 22 hours per day without meaningful human contact. An inmate is considered as being long-term isolated if they have been isolated for a period exceeding 15 days.

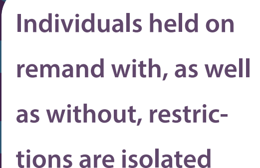
The majority of inmates in Swedish remand prisons are isolated

The Prison and Probation Service has great difficulty in achieving its own objective that remand prisoners held with restrictions should be able to receive isolation-breaking measures for at least two hours per day. It also does not succeed in giving all remand prisoners held without restrictions isolation-breaking measures to this extent, despite the fact that this group of inmates actually has the right to associate with others during the day. The Prison and Probation Service's objective in this regard is modest in comparison with the European Committee for the Prevention of Torture's (the CPT) standard, according to which all inmates in remand prisons and prisons must be given the opportunity to spend at least eight hours outside their cell every day.

1 See the Parliamentary Ombudsmen's decision of 5 February 2020, ref. no. O 7-2018.

The Prison and Probation Service's 2018 annual report states that it did not succeed in reaching the objective of at least two hours of human contact in relation to 83 percent of the remand prisoners held with restrictions. It did not reach this objective in relation to 76 percent of the young individuals held on remand with restrictions. The corresponding figure for adult remand prisoners held without restrictions or segregation decisions – and who have a legal right to associate with others during the day – was 33 percent. These inmates were, therefore, to be regarded as isolated and at risk of suffering from mental and physical ill health.

In her decision in February 2020, the Chief Parliamentary Ombudsman states that the international reviews that have taken place of Swedish remand prisons have primarily focused on the widespread use of restrictions. The review that the Chief Parliamentary Ombudsman has made shows that the problem of isolation in remand prisons is not limited to inmates that the Prison and Probation Service has the right to hold segregated. Isolation also risks affecting inmates who have a legal right to associate with others.



The Chief Parliamentary Ombudsman further states that this situation has not arisen suddenly, instead Sweden has received international criticism for several decades for, inter alia, holding remand prisoners in isolation. Additionally, these shortcomings have been highlighted by the Parliamentary Ombudsmen on several occasions. For this reason, it is – in the view of the Chief Parliamentary Ombudsman – very serious that the Prison and Probation Service has not progressed further in its work with the use of isolation-breaking measures. This entails a risk of serious consequences for those who are in the Prison and Probation Service's remand prisons.

The Prison and Probation Service lacks adequate premises

One of the reasons why the Prison and Probation Service has great difficulty in achieving its objectives for the use of isolation-breaking measures is that its remand prisons do not have adequate premises where inmates can associate with others. Another reason is that the staff tasked with working with, inter alia, isolation-breaking measures are used for other purposes.

In its decision in February 2020, the Chief Parliamentary Ombudsman states that the Prison and Probation Service needs to take a joined up approach to both the issues of premises and staffing. It must ensure that existing as well as newly produced remand prisons have adequate premises for association purposes and the use of isolation-breaking measures, and that the staffing is sufficient for the remand prisons to be able to offer inmates association time with others as well as isolation-breaking measures.

In the view of the Chief Parliamentary Ombudsman, the Prison and Probation Service's difficulties are caused by, inter alia, several of its remand prisons being designed to segregate inmates instead of allowing them to associate

with others. Another reason is that there are not enough staff allocated to man the common areas. In the view of the Chief Parliamentary Ombudsman, the Prison and Probation Service deserves very serious criticism for the continued shortcomings in these respects, shortcomings that lead to restrictions on a fundamental right for the inmates.

Isolation-breaking measures

Today, the Prison and Probation Service measures its work with the use of isolation-breaking measures seven times a year. The Prison and Probation Service carries out isolation-breaking measures on all inmates held on remand, i.e. even inmates who have a legal right to associate with others. The Chief Parliamentary Ombudsman emphasises in her decision that if the Prison and Probation Service satisfies inmates' rights to associate with others, then there is no risk that they will be isolated. In this context, to talk of using isolation-breaking measures is, therefore, wrong. Such measures only need to be used for inmates who are segregated. In the view of the Chief Parliamentary Ombudsman, it must be considered a serious failure that the Prison and Probation Service offers inmates isolation-breaking measures instead of association with others.

Only measures regarded as meaningful human contact are isolation-breaking

The Prison and Probation Service's reporting on the use of isolation-breaking measures includes activities that mean that inmates both meet other people and spend time alone outside their cells. The latter category of activities includes, inter alia, inmates being alone in an exercise yard or gym. In order for a measure to be effective and isolation-breaking in the true sense of the word, it must – in the view of the Chief Parliamentary Ombudsman – mean that an inmate has meaningful human contact. This can be, for example, receiving a visit or spending time with another inmate. In the view of the Chief Parliamentary Ombudsman, measures that do not involve such human contact should be reported as different types of environmental changes.

The Prison and Probation Service's measurements of the use of isolation-breaking measures

The method the Prison and Probation Service uses to measure the use of isolation-breaking measures has a number of shortcomings. As a result, there is uncertainty concerning the figures presented by the agency. According to the Prison and Probation Service, the few measurement occasions mean that differences between the years can be caused by chance. Comparisons between the years should, therefore, be made with great caution. Furthermore, according to the Prison and Probation Service, there is a risk that details are missing because a remand prison does not respond to the survey or does not register activities.

In December 2017, the Chief Parliamentary Ombudsman called on the Prison

and Probation Service to introduce a system that makes it possible to follow the isolation-breaking work over time. In a 2018 report, the Prison and Probation Service determined that the data provided by the current measurements is sufficient in providing an approximate picture of the extent of the use of isolation-breaking measures at a national level.

The Chief Parliamentary Ombudsman again raised the issue of a planning and follow-up tool at the dialogue meeting in March 2019 with representatives of the Prison and Probation Service. According to the representatives of the Prison and Probation Service, it wants to develop and introduce a central support system for the use of isolation-breaking measures. A reasonable estimate was stated that it would take approximately five years from the start of the project until there is a functioning system in place.

In the decision in February 2020, the Chief Parliamentary Ombudsman states that the shortcomings in the Prison and Probation Service's measurements of the use of isolation-breaking measures make it difficult for it to follow the work that takes place at the local level to break the isolation of inmates held on remand. Additionally, the measurements cannot be used for comparisons on a general level. This means that the measurements become almost useless.

In the view of the Chief Parliamentary Ombudsman, a continuous recording of the extent to which inmates benefit from isolation-breaking measures is necessary in order for the Prison and Probation Service to be able to follow the work over time and for the agency's staff to be able to notice and draw attention to inmates who are at risk of being isolated. For this reason, it is very important that the Prison and Probation Service has a system support in place and that it is used correctly. In the view of the Chief Parliamentary Ombudsman, the estimated introduction time of a support system of five years appears to be unacceptable.

The Prison and Probation Service must have a national support system to enables it to follow the work with the use of isolation-breaking measures

The need for legislative amendments to, inter alia, the Remand Prisons Act

In the view of the Chief Parliamentary Ombudsman, there needs to be a review of, inter alia, the Remand Prisons Act (2010:611) in order to clarify the right for inmates to associate with others and to prevent isolation. A first necessary measure, in the view of the Chief Parliamentary Ombudsman, is the introduction of a legal definition of association in both the Remand Prisons Act (2010:611) and Prisons Act (2010:610). A reasonable premise is that association is given the meaning that an inmate is spends time with several other inmates.

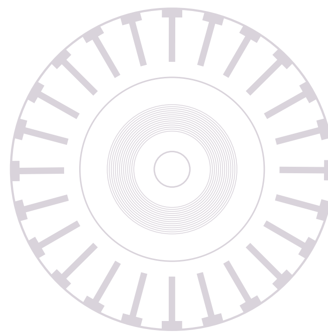
In order for the right of association with others to be meaningful, the legislation also requires information on the extent to which an inmate has the right to associate with other inmates on a daily basis. Since this is a fundamental right, in the view of the Chief Parliamentary Ombudsman, it is not sufficient

that the detailed meaning is only stated in the Prison and Probation Service's regulations, as is currently the case for prisoners in a prison. Nor is it acceptable that such provisions are completely lacking for remand prisons. Until now, in some cases, remand prisoners have been denied this right in entirely, or some remand prisoners have significantly less access to associating with others compared to inmates in other remand prisons or in a prison.

The Remand Prisons Act must be supplemented with provisions on inmates' rights to isolation-breaking measures

In the report following the government inquiry, *the Remand Prison and Restriction Inquiry,* there is a proposal that the Remand Prisons Act (2010:611) should include a provision stating that adults held with restrictions should always be entitled to a minimum of two hours' association with another individual every day. The Chief Parliamentary Ombudsman shares this view of the need for such regulation, but points out that remand prisoners placed in segregation should have the right to isolation-breaking measures.

On the basis of the UN Standard Minimum Rules for the Treatment of Prisoners, two hours of isolation-breaking measures are exactly the limit where an inmate is considered to be isolated. In order to reduce such a risk for inmates, the Chief Parliamentary Ombudsman holds the view that the minimum requirements in the Swedish prison and remand regimes should be set higher. According to the CPT, the objective should be to give all inmates the opportunity to spend at least eight hours a day outside their cell and, in this context, to participate in purposeful activities of a varying nature. This view should be taken into account – in the Chief Parliamentary Ombudsman's view – in a future legislative framework.



Annexes

Tables and summaries

A. Participation in international meetings

B. Inspections and dialogue meetings

C. Own-initiative inquiries due to an OPCAT inspection

D. Issues where the Parliamentary Ombudsmen have requested a response in 2018 and where the answers have been received in 2019

E. Issues where the Parliamentary Ombudsmen have requested a response in 2019

ANNEX A

Participation in international meetings

OPCAT issues are discussed in a number of different international contexts. These are both factual and methodological issues. In 2019, employees from the Parliamentary Ombudsmen's OPCAT Unit participated in the following meetings:

- January 9, 2019, Copenhagen, Denmark: Seminar on Enhancing Monitoring Methodologies for National Prevention Mechanisms.
- 23 and 24 January 2019, Helsinki, Finland: Nordic NPM meeting.
- 29 and 30 August 2019, Reykjavik, Iceland: Nordic NPM meeting

ANNEX B

Inspections and dialogue meetings

Unannounced inspections

Police custody facility	
Karlskrona	ref. no. O 33-2019
Luleå	ref. no. O 2-2019
Växjö	ref. no. O 21-2019
Sum 3	

Prison	
Haparanda	ref. no. O 1-2019
Umeå	ref. no. O 54-2019
Västervik Norra*)	ref. no. O 46-2019
Sum 3	

Remand prison	
Falun	ref. no. O 30-2019
Helsingborg (Berga Remand Prison Branch)	ref. no. O 39-2019
Kalmar	ref. no. O 26-2019
Karlskrona	ref. no. O 25-2019
Malmö	ref. no. O 27-2019
Nyköping	ref. no. O 29-2019
Trelleborg	ref. no. O 28-2019
Växjö	ref. no. O 22-2019
Sum 8	

Migration detention centre	
Ljungbyhed	ref. no. O 52-2019
Sum 1	

Special residential homes for substance abusers	
Gudhemsgården (Falköping)	ref. no. O 58-2019
Hessleby (Mariannelund)	ref. no. O 62-2019
Sum 2	

Special residential homes for young people	
Vemyra (Sollefteå)	ref. no. O 44-2019
Långanäs (Eksjö)	ref. no. O 57-2019
Sum 2	

A total of 19 unannounced inspections

*) Inspections where the Parliamentary Ombudsmen have decided to investigate a certain issue within the framework of an own-initiative inquiry. See also Annex C.

ANNEX B

Announced inspections

Police custody facility	
Arvika	ref. no. O 47-2019
Borlänge	ref. no. O 13-2019
Karlskoga	ref. no. O 48-2019
Kristinehamn	ref. no. O 49-2019
Sum 4	

Prison	
Kumla (National Assessment Unit)	ref. no. O 36-2019
Sum 1	

Remand prison	
Göteborg including National Transport Unit	ref. no. O 7-2019
Sum 1	

Transportation	
National Transport Unit	ref. no. 8337-2018
Sum 1	

Compulsory psychiatric care	
Stockholm Forensic Psychiatry Care, Section South, Helix	ref. no. O 3-2019
Växjö Regional Forensic Psychiatric Clinic*)	ref. no. O 18-2019
Sahlgrenska University Hospital, Östra Psychiatric Emergency Unit	ref. no. O 6-2019
Sum 3	

A total of 10 announced inspections

The supervisory division carried out further announced inspections of the Prison and Probation Service at Hall, Salberga, Saltvik and Ystad prisons and Salberga remand prison, Child and Adolescent Psychiatry (BUP) in Malmö and the Stockholm Forensic Psychiatric Care, Section North.

*) Inspections where the Parliamentary Ombudsmen have decided to investigate a certain issue within the framework of an own-initiative inquiry. See also Annex C.

ANNEX B

Dialogue meetings

Dialogue	
Health and Social Care Inspectorate, management group*) (Stockholm)	ref. no. O 5-2018
Health and Social Care Inspectorate, department mid-Sweden (Örebro)	ref. no. O 5-2018
Health and Social Care Inspectorate, department north (Umeå)	ref. no. O 5-2018
Health and Social Care Inspectorate, department south (Malmö)	ref. no. O 5-2018
Health and Social Care Inspectorate, department southwest (Göteborg)	ref. no. O 5-2018
Health and Social Care Inspectorate, department southeast (Jönköping)	ref. no. O 5-2018
Health and Social Care Inspectorate, department east (Stockholm)	ref. no. O 5-2018
The Prison and Probation Service, regarding the isolation of individuals held on remand	ref. no. O 7-2018
The National Board of Institutional Care	ref. no. O 55-2019
Sum 9	

ANNEX C Own-initiative inquiries based on an OPCAT inspection

The Prison and Probation Service	
Treatment of an inmate in connection with medical treatment	ref. no. 506-2020
Sum 1	

Compulsory psychiatric care	
A forensic psychiatric clinic's routine for submitting information to the Prison and Probation Service	ref. no. 842-2020
Sum 1	

The National Board of Institutional Care	
A special residential home for substance abusers' application of the legislative provision on separate care	ref. no. 2797-2020
Sum 1	

A total of 3 cases

Issues where the Parliamentary Ombudsmen have requested responses in 2018 and where the responses were received in 2019

ANNEX D

The Prison and Probation Service		
Question	**Reference number**	**Response was received**
The possibility to see out through cell windows (the Saltvik prison)	ref. no. O 20-2019	2019-06-26
The environment in exercise yards (the Saltvik prison)	ref. no. O 20-2019	2019-06-26
Surveillance camera in a segregation cell (the Gävle remand prison)	ref. no. O 32-2019	2019-03-27
The environment in exercise yards (the Gävle remand prison)	ref. no. O 32-2019	2019-03-27
The possibility of checking the basis for deprivation of liberty (the National Transportation Unit)	ref. no. O 34-2019	2019-04-01
Sum 5		

A total of 5 requested responses in 2018 where responses were received in 2019

ANNEX E

Issues where the Parliamentary Ombudsmen have requested responses in 2019

The Police Authority

Question	Reference number	Response was received
The design of cells (the police custody facility in Luleå)	ref. no. O 23-2019	2019-06-27
Light entry into cells (the police custody facility in Luleå)	ref. no. O 23-2019	2019-06-27
The environment in an exercise yard (the police custody facility in Luleå)	ref. no. O 23-2019	2019-06-27
The design of a custody facility (the police custody facility in Växjö)	ref. no. O 42-2019	2019-11-13
Individuals deprived of their liberty's access to bed linen (the police custody facility in Karlskrona)	ref. no. O 38-2019	2019-08-29
The environment in cells (the police custody facility in Karlskrona)	ref. no. O 38-2019	2019-08-29
Sum 6		

The Prison and Probation Service

Question	Reference number	Response was received
The design of cells for segregation (the Haparanda prison)	ref. no. O 59-2019	2019-10-18
Sum 1		

The Swedish Migration Agency

Question	Reference number	Response was received
Review of the Swedish Migration Agency's standard for visits to individuals deprived of their liberty (the detention centre in Ljungbyhed)	ref. no. O 15-2020	2020-06-24
Sum 1		

Compulsory psychiatric care

Question	Reference number	Response was received
Implementation of assisted transportations (Stockholm Region, psychiatric emergency department S:t Göran Hospital)	ref. no. O 16-2019	2019-06-14
Sum 1		

A total of 9 requested responses in 2019

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