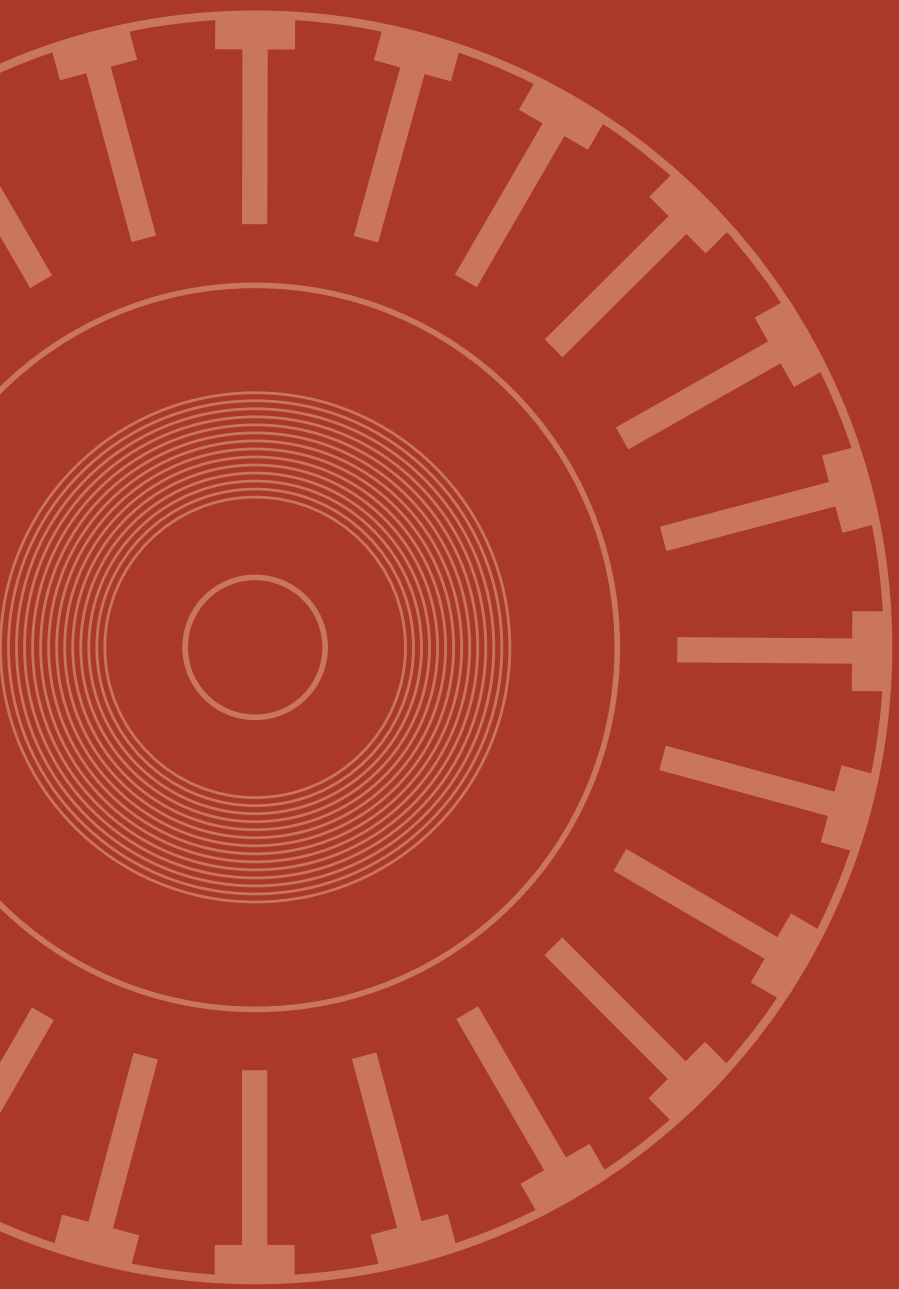
ENGLISH VERSION

National Preventive Mechanism – NPM

REPORT FROM THE OPCAT UNIT 2018



JO RIKSDAGENS OMBUDSMÄN
The Swedish Paliamentary Ombudsmen

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Production: Riksdagens ombudsmän – JO (The Swedsish Parliamentary Ombudsmen)

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

In 2011, the Parliamentary Ombudsmen was assigned the role of National Preventive Mechanism (NPM) in accordance with the UN Optional Protocol of the Convention against Torture (Opcat). Since then, its work has largely focused on establishing regular inspections of institutions where people can be deprived of their liberty. In the work to date, areas that have rarely or never been inspected have been prioritised, for example police detention facilities and the National Board of Institutional Care's special residential homes for young people as well as homes for the compulsory care of substance abusers. In addition, this prioritisation has now led to the Opcat unit having inspected nearly every remand prison within the Prison and Probation Service. As Sweden has been repeatedly criticised for isolating people held on remand, it is important that the Parliamentary Ombudsmen, through its supervision, has now gained an in-depth knowledge of what the actual, real situation for this group is like.

In the preventive work the Parliamentary Ombudsmen performs in accordance with Opcat, the focus is on identifying risks and, if necessary, strengthening the protection of individuals deprived of their liberty from torture and other cruel, inhuman or degrading treatment or punishment. The work is forward-looking and - in addition to inspections and statements in connection with reports - can also be performed by communicating its observations in dialogues with the authorities and agencies concerned. Furthermore, the Parliamentary Ombudsmen can highlight and emphasise the need for legislative changes where necessary.

In the work of the Opcat unit, methodological issues are important and subject to continuous development. For example, the Parliamentary Ombudsmen is evermore requesting reporting back from the authorities under inspection on one or more issues. Such requests to report back usually concern the measures the authority under inspection has taken or intends to take due to shortcomings highlighted during the inspection. Such shortcomings could, for example, concern the physical environment or structural deficiencies. A request to report back assists the Parliamentary Ombudsmen in its follow-up work post-inspection, and can ensure that the authority under inspection takes the necessary measures to prevent inhuman treatment.

It has emerged that authorities also report details of further measures taken after the Parliamentary Ombudsmen's inspections. This could be, for example, with regard to the clarification of internal decision-making processes and control documents. This report presents the outcomes where authorities have been requested to report back to the Parliamentary Ombudsmen in 2018 and where decisions were made no later than during the first half of 2019.

In order to highlight the compiled results of its different inspection activities, the Parliamentary Ombudsmen has prioritised the production of a variety of reports. During 2018, the Opcat unit had the transportation of people deprived of their liberty as a special theme. The work on this theme will be completed in 2019. The inspections performed in 2018 showed that the Prison and Probation Service has had major problems in managing the

increased responsibility which it received on 1 April 2017 regarding transportation. In an interim report, the Parliamentary Ombudsmen has presented its findings from the 2018 inspections and the theme will to be concluded in a special report in 2020.

The reports mentioned above play an important role in highlighting and communicating the situation and reality for people deprived of their liberty. This annual report, meanwhile, presents more general and overarching conclusions from the observations made and experiences gained during the Opcat unit's inspections in 2018. My hope is that this report will contribute to increasing the knowledge of what being deprived of ones liberty means as well as what the Parliamentary Ombudsmen has communicated in order to strengthen the protection against inhuman treatment.

Elisabeth Rynning
Chief Parliamentary Ombudsman

Content

1

The Opcat operation

The Opcat operation

According to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment of 1984 (the Torture Convention), the acceding states have undertaken to take effective legislative, administrative, judicial or other measures to prevent torture in all territories under their jurisdiction. Declared prohibition on the use of torture can also be found in a number of other UN conventions.

The European Convention for the Protection of Human Rights and Fundamental Freedoms (the European Convention) and the European Union Charter of Fundamental Rights (the EU Charter) also prohibit the use of torture. The European Convention was adopted into Swedish law in 1995 and has been applicable ever since. In addition, the Swedish constitution contains a ban on torture. According to the constitution, each and every person is protected against corporal punishment, and no one can be subjected to torture or undue medical influence for the purpose of forcing or obstructing statements.[1]

1.1 Torture and cruelty, inhuman or degrading treatment

Article one of the UN Convention on Torture contains a relatively comprehensive definition of the meaning of torture. In short, torture means someone is intentionally exposed to serious mental or physical pain or suffering for a specific purpose, for example to force information from a person or to punish or threaten a person. The convention lacks definitions for cruelty, inhuman or degrading treatment.

The European Court of Human Rights (the European Court of Justice) has stated that inhuman treatment includes, as a minimum, such treatment that intentionally causes serious mental or physical suffering and which can be considered unfair in the specific situation. Degrading treatment is an act that creates a feeling of fear, anxiety or inferiority within the victim. Subjective circumstances, such as the sex or age of the victim, are of critical importance in determining whether such treatment or punishment is viewed as degrading. Treatment can be seen as degrading even if no one other than the victim him or herself has witnessed or gained knowledge of it.

1.2 The torture convention and Opcat

The Torture Convention has been in force under Swedish law since 1987. The acceding countries to the convention are inspected by a special committee

1 Chap. 2 § 5 the Instrument of Government.

known as the Committee Against Torture (CAT). States subject to the convention regularly report on how they meet the requirements and demands of the convention. If an acceding state has provided permission, individuals can additionally lodge a complaint to the committee. Sweden allows such individual complaints. The torture convention itself does not provide the mandate for CAT to conduct inspections in acceding states.

To enable a range of measures including international inspections, the Optional Protocol to the Convention against Torture (Opcat) was adopted in 2002, and entered into force in 2006. Through Opcat, an international committee was established and known as the Subcommittee on Prevention of Torture (SPT).

1.3 Preventive work

According to Opcat, the work is to be performed with the aim of – where necessary – strengthening the protection of individuals deprived of their liberty from torture and other cruel, inhuman or degrading treatment or punishment. Such preventive work can be carried out in several ways, such as via supervision of the environments where the risk of abuse and violations is particularly high.

An additional important aspect of the preventive work is to identify and analyse factors that can, inter alia, directly or indirectly increase or decrease the risk of torture and other forms of inhuman treatment. The work should be forward-looking and dedicated to the systematic reduction or removal of risk factors, as well as the strengthening of 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 protective measures.

1.4 The Opcat operation in Sweden

States acceding to Opcat are required to designate one or more national inspection bodies as a National Preventive Mechanism (NPM). Since 1 July 2011, the Parliamentary Ombudsmen has been assigned as the national inspection body in accordance with Opcat.[2] When awarding the Parliamentary Ombudsmen this assignment, the Parliamentary Committee on the Constitution observed that the tasks and powers long ago vested in the Parliamentary Ombudsmen corresponded well with the tasks of an NPM. As NPM, the Parliamentary Ombudsmen is tasked with:

- regularly inspecting places where people can be deprived of their liberty;
- making recommendations to the relevant competent authorities with a view to improving the treatment and conditions of individuals deprived of

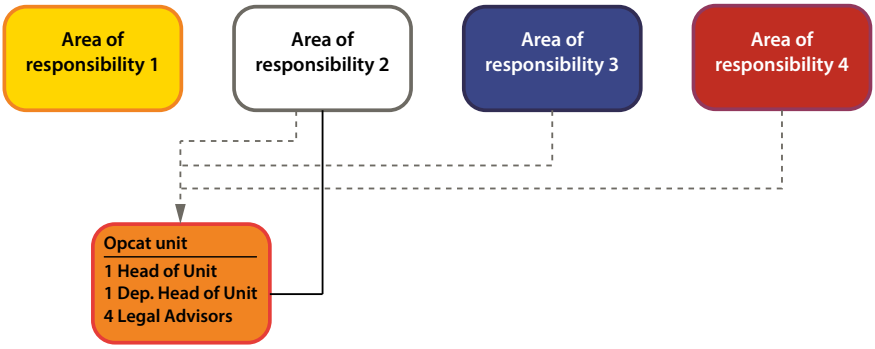
2 § 5 a of the Act (1986: 765) with instructions for the Parliamentary Ombudsmen.

their liberty, and preventing torture and other cruel, inhuman or degrading treatment or punishment;

- submitting proposals and views on existing or proposed legislation relating to the treatment and conditions of individuals deprived of their liberty;
- participating in dialogues with the relevant competent authorities, and
- reporting on Opcat operations.

Each of the parliamentary ombudsmen must fulfil the NPM assignment within their respective areas of responsibility. The Parliamentary Ombudsmen has determined that the places to be inspected within the remit of this assignment are primarily prisons, remand prisons, police detention facilities, institutions for compulsory psychiatric care and forensic psychiatric care, the Migration Agency's custodial facilities and the National Board of Institution Care's (SiS) residential homes for the care of substance abusers (LVM-homes) and special residential homes for young people (LVU).

At the Parliamentary Ombudsmen, a special Opcat unit has been established and tasked with assisting the ombudsmen in their work as the NPM. The work consists primarily of planning and conducting inspections of places where people can be deprived of their liberty. Since 2018, the Opcat unit has consisted of one Head of Unit, one Deputy Head of Unit and four legal advisors.



1.5 International inspection bodies

SPT has 25 independent members who are experts in areas relevant to the prevention of torture. The members are appointed by states bound by the convention. An annual schedule determines which countries SPT visits.

The European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment entered into force in 1989. The Convention established the Committee for Prevention of Torture (CPT), whose main task is to visit institutions for individuals deprived of their liberty in Europe on a

regular basis. All 47 Council of Europe member states have ratified the Convention. Swedish authorities are liable to cooperate with both SPT and CPT.[3]

CAT reviews Sweden periodically, which in practice means every six years. Within the framework of such a review, CAT posed a number of questions to the Swedish government in February 2017. In the letter from CAT, the Government is asked, inter alia, whether Sweden has taken any measures to limit the amount time individuals spend in remand prisons.[4] Sweden responded to CAT in November 2018.[5] The review will continue with a session that will probably take place in 2020.

1.6 Nordic NPM network

The nordic NPM network (formed in 2015) had two meetings during 2018. The first meeting took place in Copenhagen and the other in Lund. The theme for the second meeting was the care of substance abusers and deprivation of liberty. During the meeting, participants visited a LVM-home under the remit of the National Board for Institutional Care.

1.7 Purpose of this report

This report contains a summary of the observations the Parliamentary Ombudsmen made within the remit of the Opcat unit's inspection work in 2018. As well as reports on the past year's inspection activities, the report additionally contains analyses aimed at identifying issues and areas that the unit should focus on in the upcoming years. As such, this report in itself should also be viewed as part of the preventive work. During 2018, the Opcat unit had a thematic focus on the domestic transportation of individuals deprived of their liberty. This theme continues in 2019. The observations made regarding transportation in 2018 can be found in a special report from June 2019.[6]

3 The Act (1988: 695) on certain international commitments against torture etc.

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

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

6 See Report from Opcat 2019 – Transporter Theme.

2

Opcat inspections

Opcat inspections

One of the most important aspects of the Parliamentary Ombudsmen's Opcat work is inspections of the places where people can be deprived of their liberty. As in previous years, the ambition of these inspections has been to have a good geographical spread and that a certain proportion of the inspections should occur at places which have not previously been inspected or have not been inspected for a long time. However, the thematic focus on the transportation of inmates has had a major impact on the selection of inspection objects and locations. This thematic focus has meant, inter alia, that all of the Prison and Probation Service's transport hubs – which have already been inspected within the Opcat work – were inspected during the year.

2.1 Methodology

The 2015–2017 annual reports provide an account of the working methods used in Opcat inspections.[1] The work in 2018 was heavily influenced by the ongoing transportation thematic review within the Opcat unit. Work on the thematic review began as early as 2017, with the Opcat unit developing a number of issues and areas to focus on. A comprehensive description of the planning and execution of this transportation thematic review can be found in the special interim report.[2] Dialogues with representatives from the relevant authorities form an important part of the Opcat unit's inspection work. In 2018, however, no dialogues were conducted.

2.2 Places where individuals deprived of their liberty are held

In Sweden in 2018 the following places, which are listed below, were found to exist where the deprivation of liberty occurs:

- 45 prisons (4,400 places)
- 32 remand prisons (2,200 places)
- 120 police detention facilities (1,350 places)
- 23 LVU special residential homes for young people (700 places)
- 11 LVM homes for care of substance abusers (400 places)
- At least 80 institutions for compulsory psychiatric care and forensic psychiatric care (approx. 4,000 places)
- 5 migration detention units (420 places)

The figures presented above are partly based on estimates. A comparison with the latest Opcat report shows that the number of places where individuals can be deprived of their liberty since 2017 has increased within both the Prison

1 See National Preventive Mechanism – NPM, Report from Opcat 2015–2017 pp. 16 and 17.

2 See Report from Opcat 2019 – Transporter theme pp. 11–14.

and Probation Service and Migration Agency. This increase is likely to continue in 2019.

2.3 Completed inspections

In 2018, the Opcat unit conducted 26 inspections. These included prisons, remand prisons, police detention facilities, special residential homes for young people (LVU) and LVM homes, psychiatric wards and the National Transport Unit (NTE). The selection of objects for inspection was based on the thematic review of the domestic transportation of individuals deprived of their liberty. For this reason, amongst others, all remand prisons where NTE regularly makes transport stopovers were inspected.[3] These transport hubs are located in Gävle, Härnösand (Saltvik), Jönköping and Örebro. In the Stockholm area, transport stopovers take place at any one of the area's three secure remand prisons; Huddinge, Kronoberg and Sollentuna. During the year, the Huddinge and Kronoberg remand prisons were inspected. In connection with the inspections of these remand prisons, NTE's transport groups were also inspected.

The Prison and Probation Service makes additional transport stopovers at specific police detention facilities. These transport stopovers take place at the police detention facilities in Sandviken and Värnamo and, as such, these facilities were inspected during the year. There was an additional special inspection of the group responsible for domestic planning within NTE in Arvidsjaur. During the year, there were no inspections of the Migration Agency's detention units.

Object of inspection	Number of inspections	
	Total	incl. NTE
Prisons	3	
Remand prisons	7	5
Police detention facilities	9	
LVU homes	2	
LVM homes	1	
Psychiatric wards	3	
Migration detention unit	0	
National Transport Unit, NTE	1	1
Sum	**26**	**6**

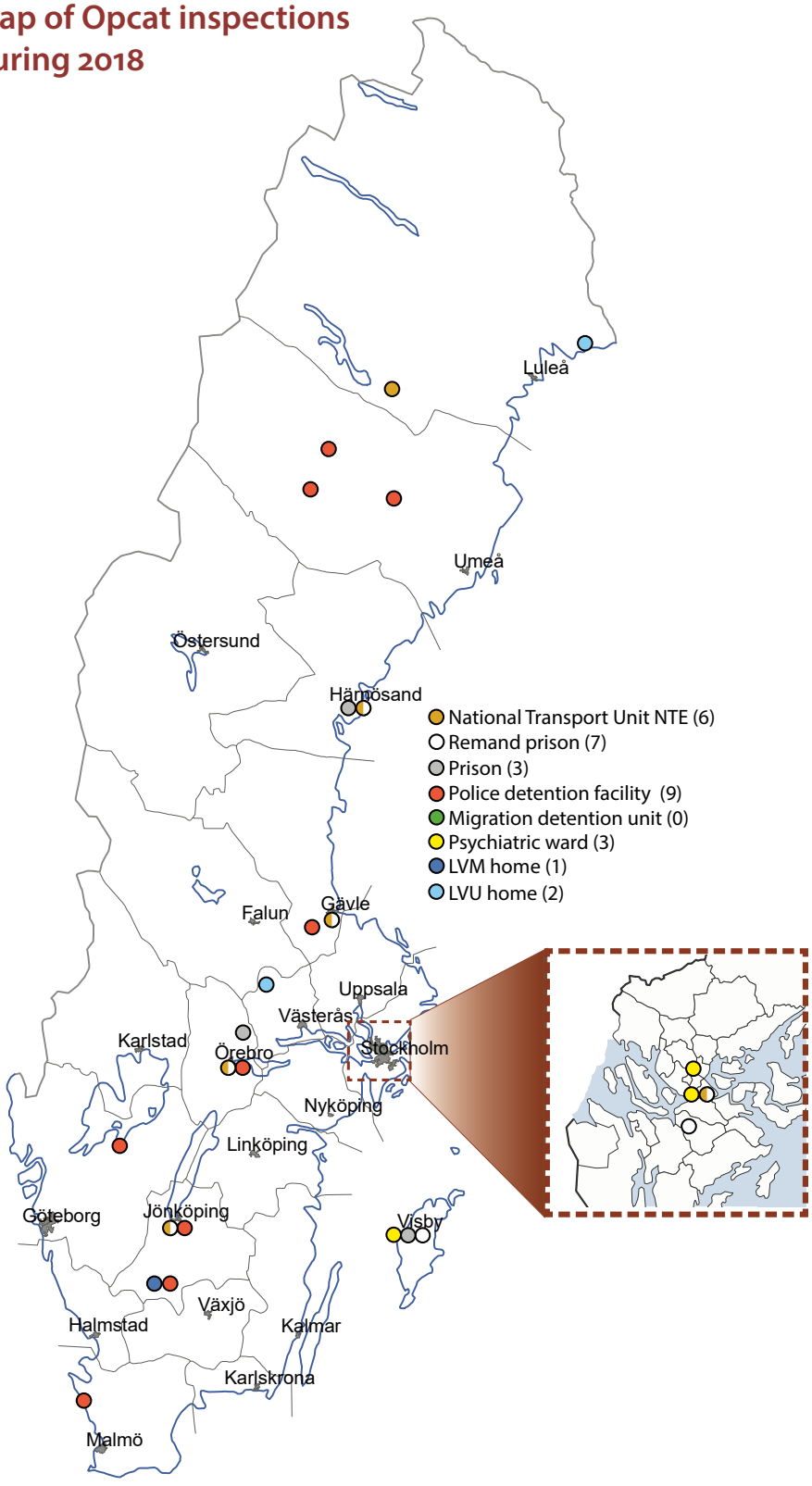
For a complete account of inspections, see Appendix B.

Inspections of a further four places where people can be deprived of their liberty were conducted in 2018 by the Parliamentary Ombudsmen's supervisory departments (two prisons and two institutions for compulsory psychiatric care).[4]

3 i.e. all types of breaks in which the individual deprived of their liberty is taken into any type of place of activity while awaiting continued transport, e.g. detention facility, police cell or LVM home.

4 The institutions Hall and Tidaholm, adult psychiatry in Västerås and the Forensic Psychiatric Regional Clinic in Vadstena.

Map of Opcat inspections during 2018



3

The Police Authority

The Police Authority

The Police Authority is able to deprive individuals of their liberty at police detention facilities. At the year end 2018, there were approximately 120 police detention facilities in Sweden with a total of 1,350 places. Individuals placed in police detention units include, inter alia, individuals apprehended or under arrest. Likewise, intoxicated individuals are regularly placed and taken care of in police detention facilities on grounds provided by the Act on Care of Intoxicated Persons (1976:511) (LOB).

In 2018, nine police detention facilities were inspected of which four were inspected for the first time.[1] Of these inspections, eight units were notified in advance. The main reason for the notification for most of the inspections was that some of the police detention facilities are only open when required. Another reason was that some of the inspections were focused particularly on those police detention facilities used by the Prison and Probation Service for transport stopovers (see section 7).

3.1 Observations from the year's inspections

Police detention facilities are intended to deprive an individual of their liberty for a relatively short amount of time. The duration of an individual's deprivation of liberty can last from a few hours to several days at a maximum depending on the reason for placing the individual in the police detention facility. Therefore, the focus during the inspections of the police detention facilities was primarily on investigating the extent to which some of the fundamental requirements of individuals deprived of their liberty were met. These requirements include inter alia: their right to food, the opportunity to attend to their personal hygiene and right to daily outdoor access. Another key issue for the inspectons is the safety and security of the individuals deprived of their liberty. It is not uncommon for individuals placed in a police detention facility to be in poor physical or mental condition. Therefore, it is important that a person placed in a police detention facility is assessed for his or her safety and well-being. Furthermore, it is important that individuals deprived of their liberty are regularly checked and supervised, which is then documented. The physical environments of the police detention facilities were also inspected.

Shortcomings in the physical environmental conditions

There are clear rules regarding the physical requirements for holding cells in which an individual deprived of his or her liberty is placed. A cell must have

1 The police detention facilities in Helsingborg, Jönköping, Lidköping, Lycksele, Sandviken, Storuman, Vilhelmina, Värnamo and Örebro. The police detention facilities in Lidköping, Lycksele, Storuman and Vilhelmina were inspected for the first time.

a floor area of at least 6 square meters and a cubic content/volume of at least 15 cubic meters. The height from floor to ceiling must be at least 2.40 meters. The cell should also be provided with a window to receive sufficient natural light whilst unauthorised people must be prevented from looking in.[2] A cell in a police detention facility is permitted to deviate from the floor area, cubic content/volume and room height requirements by no more than five percent if special reasons exist. If there exist special reasons regarding temporary needs, a cell which is not used permanently may also deviate from the requirements that the cell must be equipped with windows. This latter exception only applies to cells completed before 1 April 2016.[3]

A police cell must fulfil certain basic requirements

A cell must be appropriately equipped with some basic facilities for the needs of the inmate. The cell must have a chair, table, bed and space for storage of personal belongings. It must also have a signal system for the individual deprived of their liberty to call for attention if required. There should also be a sink and toilet connected to the cell. These facilities may be restricted or limited in cells used for the placement of intoxicated or violent individuals.[4] Based on supplementary regulations, the Police Authority has further decided that a cell should, as a rule, be equipped with a device that regulates the amount of incoming natural light as well as a blanket, pillow, mattress, mirror, clock and radio. There may, however, be reasons to limit or remove such items based on a risk assessment with regard to, for example, self-harming.[5]

The inspections performed during 2018 show that, in the majority of cases, the cells in police detention facilities are designed and equipped in accordance with current regulations. In some cases, it was noted that the premises were worn, but they have generally perceived to have been well-maintained. That said, the Parliamentary Ombudsmen holds the view that a number of individuals deprived of their liberty in some police detention facilities are unable to regulate the inflow of natural light.[6]

In a number of other cases, the Parliamentary Ombudsmen is of the opinion that the measures taken to prevent unauthorised people looking into the cell have caused the inflow of daylight to be excessively limited.[7]

During the inspection of the *police detention facility in Lidköping*, it was discovered that the facility is equipped with a smaller holding cubicle. It has a floor area of approximately four square meters and is equipped with a bench, signal device and surveillance camera that is continually on. Furthermore, it is possible to close this holding cubicle with a windowed door which cannot be

2 § 2 of the Ordinance (2014: 1108) on the design of prison remands and police detention units.

3 § 5 of the above mentioned regulation and second paragraph of the transitional provision to the regulation (2016: 84) amending the Regulation of the Design of the Remand Prison and Police Detention Facilities.

4 § 3 of the Regulation of the Design of Remand Prison and Police Detention Facilities..

5 Chap. 1 § 8 the police authority's regulations and guidelines (PMFS 2015: 7) on police detention facilities and the advisory notes to the regulations.

6 Similar observations were made regarding the police detention facilities at Lycksele and Sandviken.

7 Similar observations were made regarding the police detention facilities at Jönköping and Örebro.

Several inspected police detention facilities' exercise yards do not fulfil the basic requirements

opened from the inside. Parts of one wall consist of clear glass, but the room has no inflow of natural light. According to the Police Authority, the cubicle is used for holding young people awaiting further transportation. Since the holding cubicle does not comply with the requirements set out in the regulations, the Parliamentary Ombudsmen is of the view that individuals deprived of their liberty should be placed in the cubicle only for short periods during registration upon arrival. The Parliamentary Ombudsmen further argues that the deprivation of a young person's liberty in conjunction with transportation under the Care of Young Persons (Special Provisions) Act (1990: 52) (LVU) should only be used as a last resort and for the shortest possible time.[8]

A person deprived of his or her liberty should be provided with outdoor access for at least one hour every day, unless other certain circumstances apply.[9] In order for the purpose of outdoor access to be achieved, an exercise yard should, in the opinion of the Parliamentary Ombudsmen, have an appropriate amount of light and fresh air. In order to meet the need for physical activity during the limited time that an inmate is placed in a cell, an exercise yard should have an area of at least 15 square metres.[10] During the inspections in 2018, it was highlighted on several occasions that the exercise yards did not meet these basic requirements. In several inspection reports the exercise yards were described as closed rooms.[11]

As a main rule, an inmate at a police detention facility must be provided with bedding, clothing and shoes where necessary. As with the facilities within of the cells, access to clothing etc may be restricted if necessary to prevent the inmate from injuring him or herself or others. If such provision of clothing is restricted for safety and security reasons, the inmates should always have something with which to clothe themselves. An inmate in a police detention facility may not be without clothing due to safety and security reasons for longer than is necessary.[12] Upon inspection of the police detention facility in Sandviken, it emerged that individuals apprehended and arrested were requested to change into special clothing provided by the Police Authority. Similar observations were made at the inspection of *police detention facilities in Lidköping*. In the Parliamentary Ombudsmen's view, restricting an inmate's access to his or her own clothing in circumstances other than when deemed necessary to prevent self-injury or injury to others is not allowed. For this reason, the Police Authority should inform individuals deprived of their liberty that changing into the clothing provided by the authority is not compulsory and that they have the right to wear their own clothes.[13]

8 See the Parliamentary Ombudsmen's report in dnr 2094-2018 pages 4 and 11

9 Chap. 2 § 7, cf. chap. 1 § 3 of the Detention Act (2010: 611).

10 See JO 2014/15 p. 115.

11 Similar observations were made regarding the police detention facilities in Jönköping, Sandviken, Värnamo and Örebro.

12 Chap. 3 § 3 The Police Authority's regulations and guidelines on police detention facilities and guidelines of the regulation.

13 See JO's report in dnr 2094-2018 p 12 and dnr 6001-2018 p. 11.

Safety assessment on arrival at a police detention facility

A safety assessment must be carried out as soon as possible after arriving at the police detention facility. The safety assessment must be documented and its purpose is to assess the need for safety or security measures. This may involve measures in connection with transportation, maintaining order and safety in the facility or risks to the inmate or other individual's life or health.[14] The safety assessment is carried out by the police patrol who brought the person to the detention facility and/or the responsible officer. It must be determined by the responsible officer and documented on a special form drawn up by the Police Authority.[15]

During the inspections performed during 2018, several cases were found to have shortcomings in the implementation and documentation of safety assessments. At the inspection of the *police detention facility in Örebro*, it was discovered that the safety officer made the safety assessment and decided upon the frequency of checks and supervision. Upon examination of the safety assessments performed, it was, however, found that in the majority of cases another person had documented the assessments and that they were not signed off by the safety officer on duty. In the Parliamentary Ombudsmen's view, it is important that the documentation made mirrors the delegation and allocation of responsibilities within the detention facility.[16] Similar observations were also made at the inspections of the *police detention facilities in Lidköping* and *Lycksele*.[17]

During the inspection of the *police detention facility in Helsingborg*, it emerged that the police staff who conducted and decided upon the safety assessments found it difficult to make a correct assessment of the inmates, as this is simply a quick check and the police do not usually use an interpreter. Further examination of these safety assessments showed that some police officers did not consider themselves as being capable of assessing an inmate's mental status or their risk of self-harm. In the Parliamentary Ombudsmen's view, supervision should be made several times an hour in cases where it is not possible to perform a safety assessment to ensure, inter alia, that the inmate is in good health. Furthermore, in the Parliamentary Ombudsmen's view, it is important that a follow-up safety assessment takes place in these situations and that the result is comprehensively documented.[18]

Notable shortcomings in the documentation of safety assessments

Upon examination of specific cases during the inspections of the *police detention facilities in Lycksele* and *Vilhelmina,* it was discovered in a number of cases that the safety assessment form was missing in the documentation which

14 Chap. 1 § 6 The Police Authority's regulations and general advice on police detention and the advisory notes to the regulations.

15 See Appendix 9 to the Police Authority's handbook for operating police detention facilities.

16 See the Parliamentary Ombudsmen's report in dnr 701-2018 p. 10.

17 See the Parliamentary Ombudsmen's report in dnr 2094-2018 and dnr 7556-2018.

18 See the Parliamentary Ombudsmen's report in dnr 5424-2018 p. 7.

the facility refers to simply as "detention register". It was therefore not possible to check whether safety assessments had been made on based on the documentation examined. It was also not possible to check whether the necessary forms had been printed out from the Police Authority's computer system and thus made available to the detention staff. In the Parliamentary Ombudsmen's view, all necessary documentation must be printed and saved in such cases where the detention staff on duty do not have access to the information in digital form. It must always be possible to check retrospectively which information concerning an inmate the detention staff had access to.[19]

Information regarding rights

In the view of the Parliamentary Ombudsmen, it is important that the Police Authority has routines to ensure inmates receive information concerning their rights and that all measures are implemented in accordance with the rule of law. This includes ensuring that individuals deprived of their liberty, regardless on what basis, receive information concerning their rights, both orally and in writing, and in a language they understand as soon as possible after being detained. It is also important that these measures are documented[20] in compliance with the regulations and guidelines provided to the Police Authority.[21]

Upon inspection of the *police detention facility in Örebro*, the Parliamentary Ombudsmen found it positive that the facility has written information that can be provided to individuals in care due to intoxication. However, when examining specific cases, it was not possible to see whether such information was actually provided to the individuals deprived of their liberty. The Parliamentary Ombudsmen was therefore of the view that the Police Authority should take measures to ensure that it is retrospectively possible to verify that individuals deprived of their liberty are provided with written information concerning their rights.[22]

In connection with the inspection of the *police detention facility in Helsingborg*, it was discovered that the facility had stopped providing information sheets to intoxicated persons taken into their care. The reason provided for this was that the individuals taken into care tried to then harm themselves with the information sheet. The Parliamentary Ombudsmen stated that they therefore understood why it was considered impossible to provide the information sheet under such circumstances. Nevertheless, it is important that individuals provided with care in such cases are still, nonetheless, provided with the opportunity to obtain written information concerning their rights. In the Parliamentary Ombudsmen's view, the Police Authority should therefore con-

19 See the Parliamentary Ombudsmen's report in dnr 7556-2018 p. 11.

20 See the Parliamentary Ombudsmen 2014/15 p. 104, dnr 2572-2013.

21 Chap. 1 § 4 The Police Authority's regulations and guidelines on police detention facilities and the advisory notes to the regulations.

22 See the Parliamentary Ombudsmen's report in dnr 701-2018 p. 11.

sider putting up the information sheet on, for example, a wall or cell door – as an alternative to distributing the document by hand.[23] During the inspection of the *police detention facility in Värnamo*, it was discovered that intoxicated individuals taken into the facility were not provided with any information.[24]

The Police Authority has produced a special form on which it must be documented that inmates have been, inter alia, informed of their rights. The Parliamentary Ombudsmen welcomed this.[25] At the inspection of the *police detention facility in Helsingborg*, it emerged that the form was not used and that the documentation was instead made on the supervision form. For this reason, the Parliamentary Ombudsmen emphasised, inter alia, that the special form must be used if the inmate's relative has been informed, and if the inmate has been informed of daily routines in the facility and informed of any restrictions in place. This concerns basic information that inmates are entitled to receive. The intention of all such measures being documented on the same form is to reduce the risk of inmates losing information. The form thus plays an important function and the Police Authority should ensure that there are uniform routines that ensure that it is used correctly.[26] Similar observations were made during the inspection of the *Jönköping police detention facility*.[27]

It is positive that there exists a form for documenting that the inmate in the police detention facility has received specific information

Supervision of inmates

Supervision of individuals deprived of their liberty performs a vital function in preventing those individuals from becoming ill or injured during their time at the police detention facility, for example, due to illness or self harm. The safety assessment made when an individual deprived of his or her liberty arrives at a police detention facility is used as the basis for, inter alia, deciding on the frequency with which the individual will be checked. An individual being cared for due to intoxication should be checked on a continuous basis.[28] According to the Police Authority's regulations and guidelines, supervision must be thorough. Anyone who is severely intoxicated should be checked at a maximum of every 15 minutes.[29] Furthermore, the authority recommends that individuals in custody be checked at least every 15 minutes during the first hours of custody in order to minimise the risk of self-harm and for the supervising staff to form an adequate understanding of the individual's well-being.[30]

The Parliamentary Ombudsmen has previously stated that it is important that detailed notes are made at the supervision so that it is clear if the inmate is on his back, stomach, or on the left or right side. This is also important for other

23 See the Parliamentary Ombudsmen's report in dnr 5424-2018 p. 8.

24 See the Parliamentary Ombudsmen's report in dnr 5568-2018 p. 8.

25 See the Parliamentary Ombudsmen's report in dnr 2094-2018 p. 10.

26 See the Parliamentary Ombudsmen's report in dnr 5424-2018 pages 7 and 8.

27 See the Parliamentary Ombudsmen's report in dnr 1366-2018 p. 9.

28 § 6 LOB.

29 Chap. 5 § 1 The National Police Board's regulations and guidelines (RPSFS 2000: 57) on the treatment of intoxicated persons.

30 See Police Authority Handbook for Detention Facilities p. 45.

The supervision is generally performed satisfactorily but there are shortcomings in the documentation

staff involved in the supervision of the inmate.[31] In the inspections of the *police detention facilities in Helsingborg*, *Lycksele* and *Vilhelmina*, it was found that the supervision was carried out satisfactorily, but that the notes taken were in some cases inadequate. For this reason, the Parliamentary Ombudsmen reiterates its previous statements.[32]

During the inspections of the *police detention facilities in Lidköping* and *Sandviken*, it was noted that each supervision carried out on a quarter-hourly basis had been consistently stated as having been carried out exactly every 15 minutes. The Parliamentary Ombudsmen noted that even though a police detention facility is relatively small, it is unlikely that the staff in charge are able to check upon several inmates at exactly the same time for an extended period. In the Parliamentary Ombudsmen's view, documentation of the supervision must reflect the actual time when the supervision occurred. The time indicated is crucial in the ability to retrospectively review what has happened to an inmate where necessary.[33]

Supervisors' remote assessment

Before an individual deprived of their liberty is taken into a police detention facility, a supervisor must assess whether custody of the individual is correct and should therefore continue.[34] The most common method is via a supervisor's assessment performed by the station commander who talks to both the police who brought the individual into custody and with the individual him or herself. Where individuals are taken into custody due to intoxication, the supervisor must examine and thereby determine whether the condition of the individual is such that he or she cannot take care of him or herself or otherwise poses a danger to him or herself or to someone else. A similar examination may be required in accordance with § 13 of the Police Act. The Parliamentary Ombudsmen has previously stated that the supervisor should, in most cases, meet with the individual taken into custody to form an opinion of the individual's state and well-being. This measure is also an important prerequisite for the supervisor to ensure that the condition of the individual is caused by intoxication and not from, for example, a serious medical condition.[35]

On occasion, supervisors' assessments are performed remotely. This occurs most commonly at police detention facilities that are only open when needed and where the police station does not have a station commander on duty. In such cases, the police patrol normally calls the station commander and the assessment is conducted via telephone. This may also be conducted by means

31 See the Parliamentary Ombudsmen's report in dnr 6291-2014 p. 6

32 See the Parliamentary Ombudsmen's report in dnr 5424-2018 p. 7 and d 7556-2018 p. 12.

33 See the Parliamentary Ombudsmen's report in dnr 2094-2018 p. 12 and dnr 6001-2018 p. 11.

34 § 15, first paragraph of the Police Act (1984: 387) and § 5 LOB.

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

of audio and video transmission. The Police Authority has issued guidelines on performing supervisors' remote assessments.[36] The assessment must be documented on a specific form.

Supervisors' remote assessments occur at the *Sandviken police detention facility* and are performed by the station commanders located in Gävle. The Parliamentary Ombudsmen has highlighted that there can be reasons to apply such a procedure when, inter alia, there is a significant geographical distance between the detention facility and the place where the person conducting the assessment is located. Such an arrangement can also be justified in smaller police detention facilities that are only open when needed. The Parliamentary Ombudsmen found that the Sandviken facility has a large number of cells and is located only about 20 km from Gävle police station, which is the police area's central base. At the Sandviken facility, a large number of individuals deprived of their liberty are taken into custody and the Prison and Probation Service carries out many transport stopovers there. These conditions make the Parliamentary Ombudsmen question the decision the Police Authority has taken to use and conduct supervisors' remote assessments. For this reason, in the opinion of the Parliamentary Ombudsmen, the authority should consider placing the person responsible for the assessment at the same location as the person under assessment.[37]

Supervisors' remote assessments should only occur due to a significant geographical distance

Supervisor's remote assessments have taken place at *police detention facilities in Lycksele*, *Storuman* and *Vilhelmina*. At the two latter facilities, there is audio and video equipment. The equipment is, however, not used as the assessment is performed instead by telephone from a station commander located in Umeå. In the Parliamentary Ombudsmen's view, the prerequisites for conducting the required assessment are lessened if the assessment is performed remotely. If the assessment still must be performed in such a way, it should primarily be conducted via audio and video transmission. As such, the supervisor is provided with improved conditions to conduct the assessment compared with being performed only by telephone. In the Parliamentary Ombudsmen's view, the development of technology in recent years should have improved the opportunity to organise the technical aspects required for the assessment to be conducted with sound and image. Therefore, it should only be allowed in exceptional cases for the assessment to be conducted only via telephone. If the examination is still performed only by telephone, in the Parliamentary Ombudsmen's view, the supervisor should also regularly speak directly with the care provider, if permissible.

Supervisors' remote assessments should be performed only via telephone in exceptional cases

In the opinion of the Parliamentary Ombudsmen, it is unacceptable that the technical equipment installed in the *police detention facilities in Storuman* and *Vilhelmina* are not used, and, as such, the station commanders in charge are

36 See the National Police Board's guidelines (RPSFS 2000: 22) on supervisors' remote assessments, etc.

37 See the Parliamentary Ombudsmen's report in dnr 6001-2018 pages 12 and 13.

not provided with the best possible means to conduct supervisors' assessments. For this reason, the Parliamentary Ombudsmen has stated that the Police Authority should immediately take measures to ensure that equipment is put in use for this purpose. The Parliamentary Ombudsmen urges the Police Authority to take the necessary measures immediately so that supervisors' remote assessments currently conducted by telephone can, as soon as possible, be performed with sound and video.[38]

Custody of intoxicated individuals

The purpose of the provisions in LOB is to allow the police to temporarily take a person into custody who, due to intoxication, is unable to take care of him or herself.[39] As a first step, the police should try to find an alternative to placing an individual in a police detention facility. For example, this could mean releasing the individual into the care of a relative or to into the health care system. If the individual is placed in a police detention facility, the custody must be for as short a period of time as possible. This means that there must be a continuous assessment of whether the conditions for continued custody are fulfilled.

During the inspections of *Lycksele*, *Storuman* and *Vilhelmina police detention facilities*, several good examples emerged which show that the police in the local area work in accordance with the law's intentions and actively try to find alternatives to placing individuals in a detention facility. In the Parliamentary Ombudsmen's view, this is very positive. At the same time, in the Parliamentary Ombudsmen's view, it is concerning however that, when examining the supervision forms regarding individuals taken into custody, notes have been made indicating that an individual may be released "at the earliest" at a certain time. Such an approach is incompatible with the legislation, as there must be a continuous assessment of whether the grounds for the custody remain in place or not. In the Parliamentary Ombudsmen's view, the Police Authority must take measures to ensure staff are well-informed of the applicable rules. This is particularly important with regard to supervisors' remote assessments as the police detention facility staff must keep the station commander continually updated regarding the status of the individual in custody.[40]

There are positive examples of where the police have actively sought alternatives to placing an intoxicated individual in a police detention facility

During the inspection of the *police detention facility in Vilhelmina*, it was discovered that a person had had to remain in the police detention facility whilst waiting to be collected despite the terms of his or her custody being rescinded. In another case, the inspection team found that an individual in custody was in such good condition that he was allowed to eat a pizza in the cell. Similar observations were made during the inspection of *Värnamo police detention facility*. Following the final inspection, the Parliamentary Ombuds-

38 See the Parliamentary Ombudsmen report in dnr 7556-2018 pages 10 and 11.

39 § 1 LOB.

40 See the Parliamentary Ombudsmen report in dnr 7556-2018 p. 13.

men stated that it is not possible to extend the deprivation of an individual's liberty without justification, regardless of whether the individual concerned consents or not. In addition, it is obviously inappropriate that individuals who should not be in a police detention facility are there, regardless of whether the facility is locked or not.[41]

3.2 Request to report back to the Parliamentary Ombudsmen

Following inspections of *Jönköping*, *Lycksele*, *Sandviken*, *Värnamo* and *Örebro police detention facilities*, the Parliamentary Ombudsmen requested that the Police Authority should report back with details regarding how it has handled specific issues raised by the Parliamentary Ombudsmen. Such reporting back has been requested primarily for shortcomings in the physical environmental conditions, but other issues have also been raised. The Parliamentary Ombudsmen has requested reporting back on the following issues:

- The environmental conditions in the exercise yards of the police detention facilities (*Jönköping*, *Lycksele*, *Sandviken*, *Värnamo* and *Örebro*).
- Amount of incoming natural light into the cells (*Lycksele* and *Sandviken*).
- The design of the cells (*Lidköping*).
- Staffing of police detention facilities (*Jönköping* and *Lycksele*).

The Parliamentary Ombudsmen has taken decisions on all submitted responses.

Environmental conditions of the exercise yards at police detention facilities

Following the inspection of the Jönköping police detention facility, the Parliamentary Ombudsmen considered the limited inflow of natural light and fresh air into the exercise yard meant that, in its design at that time, it could not be considered to be fit for purpose with regard to adequate outdoor access. Similar observations were made during the inspections of the *police detention facilities in Sandviken*, *Värnamo* and *Örebro*. The Police Authority was requested to report back on what measures had been taken to improve the environmental conditions of the exercise yards.[42] The Police Authority's report back shows that the authority has taken or will take measures to improve the exercise yards. This includes enlarging existing exercise yards to improve the inflow air and light, and removing details that prevent incoming natural light. Following the Police Authority's submission of its report back, the Parliamentary Ombudsmen has closed the cases.[43]

The report back shows that the environmental conditions have improved at a number of exercise yards

41 See the Parliamentary Ombudsmen report in dnr 5568-2018 p. 9

42 See the Parliamentary Ombudsmen's report in dnr 1366-2018 p. 8, dnr 6001-2018 p. 10, dnr 5568-2018 p. 9 and dnr 701-2018 p. 12.

43 See the Parliamentary Ombudsmen's decision on March 14 in dnr 1366-2018 (Jönköping) and dnr 701-2018 (Örebro) and on 17 May 2019 in dnr O 35-2019 (Värnamo) and in dnr O 24-2019 (Sandviken).

During the inspection of the *police detention facility in Lycksele*, it was observed that it was possible to look into the exercise yard from a nearby car park and, as such, identify inmates held there. Following the inspection, the Parliamentary Ombudsmen called on the Police Authority to take measures to restrict the ability to look into the exercise yard and report back to them.[44] In such reporting back, the Police Authority has stated that it plans to take measures to restrict looking into the exercise yard. The planned measures have been welcomed by the Parliamentary Ombudsmen.[45]

Natural light in police detention cells

During the inspection of the *police detention facility in Sandviken*, it was observed that the blinds in the detention cells were angled in such a way as to not allow any incoming natural light. Following the inspection, the Parliamentary Ombudsmen stated that a detention cell should be designed with windows that allow an inmate to receive sufficient natural light. According to the Parliamentary Ombudsmen, it was of the utmost importance that the Police Authority took measures to increase the amount of incoming natural light into detention cells where individuals deprived of their liberty are placed. The authority was requested to report back concerning what measures had been taken.[46] In reporting back, the Police Authority stated that regulators will be installed that allow the amount of incoming natural light through the cell windows to be controlled. The case was then closed by the Parliamentary Ombudsmen.[47]

Upon inspection of the *police detention facility in Lycksele*, the exact opposite situation was found and that the detention cell windows completely lacked any blinds or similar devices. The Parliamentary Ombudsmen urged the Police Authority to remedy this shortcoming. In a report back, the Police Authority stated that the detention cell windows will be fitted with blinds. This decision was welcomed by the Parliamentary Ombudsmen.[48]

Design of police detention cells

During the inspection of the *police detention facility in Lidköping*, it was noted that the inner dimensions of the newly renovated cells differed from those required as set out in the regulations on the design of remand prisons and police detention facilities. In the view of the Parliamentary Ombudsmen, it is woeful that the cells in a newly renovated police detention facility do not meet the dimensions as specified in the regulation. Furthermore, the Parliamentary Ombudsmen found it surprising that the Police Authority did not

44 See the Parliamentary Ombudsmen's report in dnr 7556-2018 pp. 5 and 14.

45 See the Parliamentary Ombudsmen's decision on June 26, 2019 in dnr O 11-2019.

46 See the Parliamentary Ombudsmen's report in dnr 6001-2018 pp. 3 and 10

47 See the Parliamentary Ombudsmen's decision on May 17, 2019 in dnr O 24-2019.

48 See the Parliamentary Ombudsmen's decision on June 26, 2019 in dnr O 11-2019.

ensure that a final measurement of the detention cells was performed during completion of the rebuild. With this background, the Police Authority was given the opportunity to respond regarding how the design of the cells meets the requirements provided in the regulation.[49]

In reporting back, the Police Authority stated that it had been necessary to lower the ceiling height of the cells in order to provide them with new ventilation. As a result, the cells now have a ceiling height that varies between 2.322 and 2.354 meters, and a volume that varies between 14.644 and 14.87 cubic meters. (According to the regulation, the ceiling height must be at least 2.4 meters and a volume of at least 15 cubic meters.) With respect to this information, the Parliamentary Ombudsmen found no reason to take any further measures and the case was closed.[50]

Staffing of police detention facilities

During the inspection of the *Jönköping police detention facility*, the detention staff stated that low staffing levels led to supervision, the provision of food, and toilet visits all being neglected in certain situations. In the Parliamentary Ombudsmen's opinion, this is wholly unacceptable that, for example, supervision could not be performed at the frequency decided. For this reason, the Parliamentary Ombudsmen considered it necessary for the Police Authority to take measures to ensure that the police detention facility is staffed in such a manner that detainees can always be supervised with a sufficiently decided frequency and that basic tasks can be performed in accordance with the applicable regulations, guidelines and work routines for police detention facilities. The Police Authority was requested to report back regarding the relevant measures taken.[51]

In reporting back, the Police Authority stated that the staffing at the police detention facility had been overhauled and, as such, increased to nine full-time detention staff. The reorganisation means that the detention staff never have to work alone. In addition, the staff schedule was reorganised for improved coverage from an operational perspective. The Parliamentary Ombudsmen welcomed these amendments.[52]

At the inspection of the the *police detention facility in Lycksele*, it was discovered that the Police Authority intended to begin staffing the facility with security guards from a security firm. In reporting back, the police stated that it had entered into an agreement with a security firm. The agreement states that the staff must have the necessary skills, education and experience for the work. The firm must also ensure the staff constantly receives all necessary

49 See the Parliamentary Ombudsmen's report in dnr 2094-2018 p. 11.

50 See the Parliamentary Ombudsmen's decision March 14, 2019 in dnr 2094-2018

51 See the Parliamentary Ombudsmen's report in dnr 1366-2018 p. 8.

52 See the Parliamentary Ombudsmen's decision on March 14, 2019 in dnr 1366-2018.

further training. As the employer, the security firm is responsible for its staff's training and development for the work at the police detention facility, according to the Police Authority.

The Parliamentary Ombudsmen noted that it is not uncommon for the Police Authority to enter into an agreement with security firms on the staffing of police detention facilities. Even so, the Police Authority is responsible for the work performed at police detention facilities and that, in every respect, the facilities comply with the applicable laws and guidelines. The authority must therefore ensure early in the procurement process that the security firm is aware of the required levels of skills, education and experience, and that any staff working at a police detention facility have the sufficient competence for the work. As the Police Authority is responsible for the operation of police detention facilities, the Parliamentary Ombudsmen presumes that the authority has routines to continuously monitor and ensure a security firm fulfils its part of the agreement. This is particularly important as it concerns the exercise of state authority over individuals.[53]

The Police Authority must have routines for continuously following up to ensure that on-duty detention staff at police detention facilities have the required skills

3.3 Conclusions

The safety assessment that takes place when an individual deprived of their liberty is taken into custody fulfils a critical function and lays the basis for deciding, inter alia, how often the individual deprived of their liberty will be supervised. During the inspections in 2018, the routines for safety assessment were generally found to be applied correctly. There are, however, some tendencies for the supervision to be determined on a somewhat perfunctory basis.

It is notable that in some cases the frequency of supervision is regularly set at every hour for individuals apprehended and arrested, even when factors emerge in the safety assessment that should suggest a more frequent supervision is required. For example, on one occasion the person who carried out the safety assessment deemed it not possible to assess the mental status of the individual detained. Furthermore, it has come to light that the safety assessments are not properly documented. The Police Authority needs to continue working to improve these aspects.

The Police Authority also has an important role ahead in improving the conditions for supervisors' remote assessments. Such assessments should only be performed in exceptional cases. In order to give the person who is to perform assessments the best possible conditions, they should be performed via audio and video transmission. In 2020, the Parliamentary Ombudsmen's Opcat unit will have a particular focus on this issue to highlight what measures the Police Authority has taken.

53 See the Parliamentary Ombudsmen's decision on June 26, 2019 in dnr O 11-2019.

It is positive that the Police Authority has taken measures to ensure that inmates are informed of their rights. The inspections during 2018 show that the form provided is not always used and it is important that the authority disseminates knowledge concerning why the form should be used. The inspections show that, in most cases, the authority also provides the necessary information to individuals taken into custody due to intoxication. In cases where the staff is of the view that the information cannot be provided directly to the individual in custody, it should be sufficient for the information to be put up on a wall or door in the cells.

The inspections during 2018 show that the supervision of individuals is carried out in accordance with the required frequency, which is very positive. In some cases, however, there are shortcomings in documenting the supervision performed. It is important that the Police Authority continues to inform staff working in the police detention facilities of the importance of supervision being correctly documented.

The past year's inspections show that there are still shortcomings in the physical environmental conditions of police detention facilities. However, the reporting back mechanism in place shows it is possible to rectify such shortcomings. It is important that the experience of improving environmental conditions at police detention facilities does not remain a solely local or regional issue, but instead that knowledge of how the environmental conditions can be changed for the better is disseminated throughout the authority. This can lead to police detention facilities, in general, being designed in such a way to better meet the needs of the individuals deprived of their liberty and ensure prevention of acts of self-harm.

During 2020 the Opcat unit will focus on issues regarding supervisors' remote assessments

4

The Prison and Probation Service

The Prison and Probation Service

At the end of 2018, there were 32 remand prisons in Sweden and 45 prisons with a capacity to hold around 6,600 individuals. Individuals deprived of their liberty are placed in institutions operated by Prison and Probation Service primarily because they are remanded in custody or serving a prison sentence. However, there are also other categories of individuals deprived of their liberty in the custody of the Prison and Probation Service. These are primarily people transported by the Prison and Probation Service's National Transport Unit, NTE. For example, this may include young people in custody under the Care of Young Persons (Special Provisions) Act (1990: 52) (LVU) or individuals in custody for abusing substances under the Care of Abusers (Special Provisions) Act (1988: 870) (LVM). Additionally, foreigners detained under the Aliens Act (2005: 716) can be placed in remand prison.

In 2018, the Opcat unit carried out ten inspections of remand prisons and prisons.[1] Furthermore, an inspection of NTE's group for domestic planning was performed. In connection with the inspections of certain remand prisons, NTE's transport groups were also inspected. These units within NTE had not previously been inspected by the Parliamentary Ombudsmen. Three of the inspections were unannounced.

4.1 Observations from the year's inspections

Inspections of remand prisons and prisons cover a wide range of issues. In addition to inspections' ability to draw attention to shortcomings in the physical environmental conditions, as a rule inspections usually investigate issues concerning the staff's treatment of inmates and how their fundamental rights are satisfied. This can include, inter alia, the rights to association and daily outdoor access.

Conditions at one of the Prison and Probation Service's national reception centres

A male inmate serving a minimum sentence of four years' imprisonment and who is in custody at the time the sentence is passed must, as a main rule, be initially placed in a national reception centre for assessment before any decision on special conditions is made. For female inmates, the same app-

1 Hinseberg, Saltvik and Visby prisons as well as the remand prisons in Gävle, Huddinge, Jönköping, Kronoberg, Saltvik, Visby and Örebro.

lies although only if she is serving a prison term of not less than two years.[2] The national reception centre for men is at *Kumla prison*, while the national reception centre for women is at *Hinseberg prison*. During an inspection of the latter prison, it was found that a person admitted to the national reception centre had been placed into seclusion immediately upon arrival at the facility.

In decisions on placements into seclusion, the Prison and Probation Service noted, inter alia, that the national reception centre lacked the necessary preconditions to enable internal differentiation of inmates (the ability to create smaller units with fewer inmates). In the opinion of the Parliamentary Ombudsmen, this meant that if such an opportunity had existed, the inmate would not have needed to be placed in seclusion. The Parliamentary Ombudsmen has previously stated that the lack of resources or the lack of opportunity for internal differentiation are not acceptable reasons for keeping an inmate secluded from other inmates.[3] In the opinion of the Parliamentary Ombudsmen, it was particularly concerning that, despite the inmate being under assessment at the national reception centre, the staff were not provided with the opportunity to assess how she interacted with other inmates. In the opinion of the Parliamentary Ombudsmen, this was a shortcoming that inevitably meant that the national reception centre was providing a poorer basis for performing its final assessment, compared with if the inmate had been placed in a communal setting. In the opinion of the Parliamentary Ombudsmen, there is a continuing need for the Prison and Probation Service to conduct a review of both national reception centres. Since the review initiated by the Prison and Probation Service is now dormant, the Parliamentary Ombudsmen intends to return to this issue.[4]

In the view of the Parliamentary Ombudsmen, it is concerning that an inmate has been placed in seclusion for the entire time whilst at the national reception centre

Basic requirements at a department in a prison

During the daytime, an inmate in a prison must be allowed to associate with other inmates in a communal setting.[5] The right to association can be restricted by the Prison and Probation Service by deciding to separate an inmate from others. This can be done, for example, for reasons of order or security.[6] Similar provisions exist for individuals held in remand prisons.[7] Association means that the inmate spends time with at least two other inmates.

Following the inspection of *Hinseberg prison*, the Parliamentary Ombudsmen took positive note of the changes implemented in the prison. As such, some of the shortcomings noted in a previous inspection regarding the possibility to differentiate inmates have been remedied. However, the inspection found that

2 Chap. 2 §§ 4 and 5 of the Prison and Probation Service's Regulations and Guidelines (KVFS 2011: 1) on prisons

3 See the Parliamentary Ombudsmen 2015/16 p. 191.

4 See the Parliamentary Ombudsmen's report in dnr 4138-2018 pp. 8 and 9.

5 Chap. 6 §§ 1 and 2 of the Prison Act.

6 Chap. 6 §§ 5–7 of the Prison Act.

7 Chap. 2 § 5 and chap. 6 § 2 of the Remand Prison Act.

the department Aspen, which has two places, is included in the 93 places that the facility can use for the placement of inmates. Even if the places in Aspen are primarily used for seclusion, the organisation, as such, means that even inmates who are not placed in seclusion may be placed in the department.

In the view of the Parliamentary Ombudsmen, a department in a prison should consist of at least three places which allow for association of inmates. The Aspen department consists of two places with an adjoining and windowless corridor as the department's only communal space. In the view of the Parliamentary Ombudsmen, this cannot be regarded as a functional space suitable for satisfying inmates' rights to association. Aspen cannot therefore be considered as a department in itself and should, according to the Parliamentary Ombudsmen, not be used for the placement of inmates other than those who are secluded[8] (see further in section 4.3 regarding the question of reporting back regarding the KV department at *Ystad remand prison*).

A department in a remand or prison facility should consist of at least three cells

Double occupancy of cells in a remand prison

During an inspection of Saltvik remand prison, it emerged that five cells were fitted with bunk beds to enable double occupancy if necessary. Following the inspection, the Parliamentary Ombudsmen noted that the cells the remand prison uses for double occupancy were originally intended to accommodate one person, despite the cells reportedly being slightly larger than a normal cell. The use of double occupancy cells, in the Parliamentary Ombudsmen's view, creates a particular set of risks and the Parliamentary Ombudsmen is very doubtful of such use as an adequate solution. In addition, individuals in remand prisons are usually awaiting a forthcoming trial and not as yet sentenced for any crimes, and therefore can be under a great psychological pressure. Likewise, the remand prison staff may have no prior knowledge of the individuals in custody, and as such lack the sufficient knowledge required to be able to determine which inmates are able to share a cell safely. Thus, double occupancy generally means an increased risk of threats and violence between inmates.

Double occupancy of cells creates a particular set of risks

For these reasons, the Parliamentary Ombudsmen argues the Prison and Probation Service should refrain from using double occupancy cells in remand prisons. If the service still considers that there are grounds for double occupancy in remand prisons or for other special reasons, the service should handle these situations in a standardised manner with respect to the rule of law so as to protect the individual. In the opinion of the Parliamentary Ombudsmen, a minimum requirement should be that double occupancy occurs only in cells that are designed to accommodate more than one inmate. In addition, the Prison and Probation Service was recommended to develop

8 See the Parliamentary Ombudsmen's report in dnr 4138-2018 p. 8.

regulations or written procedures governing this area of its operations.[9] The service has subsequently developed such regulations.

Camera surveillance of inmates

For safety and security reasons, parts of the Prison and Probation Service's premises are regularly under camera surveillance. Such surveillance is found along fences and walls as well as in corridors inside the remand prisons and prisons. During the inspections in 2018, it was noted that remand prisons additionally have camera surveillance of cells where inmates can be placed in seclusion. Such observations were made during inspections of the *remand prisons in Gävle*, *Jönköping* and *Örebro*. At these remand prisons, the surveillance cameras were on continuously and the images were recorded. This means even inmates, whom the Prison and Probation Service had not made a specific decision to monitor via camera, were also under camera surveillance.

It must be made clear to the inmates when they are subject to camera surveillance

After the inspection of the *Örebro remand prison*, the Parliamentary Ombudsmen stated that it is important that there is clarity and predictability concerning the use of camera surveillance. It is unacceptable if the staff mislead inmates regarding the use of camera surveillance or do not disclose such monitoring in accordance with the Camera Surveillance Act (2018:1200). The Parliamentary Ombudsmen recommended the Prison and Probation Service ensure that a technical solution is introduced that allows the camera to be turned off when such a surveillance measure is not deemed necessary. A similar statement was also made after inspection of *Jönköping remand prison*.[10] Following the inspection of *Gävle remand prison*, the Parliamentary Ombudsmen requested the Prison and Probation Service report back on this matter (see further in section 4.3).

Access to healthcare

An inmate who requires healthcare should be examined by a doctor. A doctor should also be called upon an inmate's request and where it is not obvious that an examination is not required. An inmate who requires healthcare must then be treated in accordance with the instructions provided by the doctor. If an inmate cannot be examined or treated satisfactorily in the prison facility, the regular healthcare service should be used. Where necessary, inmates should be transferred to a hospital.[11]

During an inspection of the *Kronoberg remand prison* in 2013, it was discovered that the remand prison could rely upon doctors on call between 18.00 and 7.00 on weekdays. For this reason, according to the management of the remand prison, situations could arise where the remand prison staff had to

9 See the Parliamentary Ombudsmen's report in dnr 5266-2018 pp. 13 and 14.

10 See the Parliamentary Ombudsmen's report in dnr 750-2018 pp. 15 and 16 and the Parliamentary Ombudsmen's report in dnr 1364-2018 pp. 12 and 13.

11 Chap. 5 § 1, first and second paragraphs of the Act on Detention (2010: 611) and chap. 9 § 1 of the Prison Act (2010: 610).

wait some time before a doctor could be called. After an inspection in 2017, the Prison and Probation Service requested the remand prison review its agreement for on-call doctors to ensure an on-call doctor can be relied upon regardless of the time of day.[12] With this background, the Parliamentary Ombudsmen was surprised to discover during a 2018 inspection that the remand prison management could not use their agreement for on-call doctors for emergency medical examinations and staff instead were recommended to contact the regular health service via 1177.[13]

Ability to wear own clothes

An inmate in a remand prison must be provided with bedding, towels and basic items for personal hygiene as well as, if requested, clothes and shoes. However, such items may be restricted where necessary to prevent an inmate from seriously injuring him or herself. Inmates should not normally store more clothes in their cells than are required between two laundry times. If inmates are able to wash their clothes themselves, the permitted clothing amount should be adjusted according to the frequency of each wash.[14]

The written information received by inmates at *Örebro remand prison* lacked any information regarding their ability to wear their own clothes. It was further found that the inmates were neither provided with any oral information regarding this question. For this reason the Parliamentary Ombudsmen emphasised the importance of the information provided to inmates being clear and accurate. Furthermore, the Parliamentary Ombudsmen presumed that the remand prison would, in the future, inform inmates that changing into clothes provided by the remand prison was indeed not compulsory.[15]

4.2 Special case reviews concerning remand prisons and prisons

Following inspections of *remand prisons in Gävle*, *Huddinge*, *Kronoberg* and *Saltvik*, the Parliamentary Ombudsmen decided to investigate specific issues within the framework of a special case review. The Parliamentary Ombudsmen selected the following issues to investigate:

- Conditions for an inmate in a remand prison's healthcare department (*Kronoberg remand prison*)
- Use of transport cells within the Prison and Probation's remand prisons (*Gävle*, *Huddinge* and *Saltvik remand prisons*)
- Conditions for an inmate who died in a prison (*Saltvik prison*)
- Use of the Prison and Probation's security unit (*Saltvik prison*)

12 See the Parliamentary Ombudsmen's report in dnr 6889-2013 pp. 8 and 9 and dnr 417-2017 p. 12.

13 See the Parliamentary Ombudsmen's report in dnr 2643-2018 p. 14.

14 Chap. 1 § 13 Prison and Probation Regulations and Guidelines (KVFS 2011: 2) on detention.

15 See the Parliamentary Ombudsmen's report in dnr 750-2018 p. 16.

Conditions for an inmate in a remand prison's healthcare department

At the inspection of *Kronoberg remand prison*, the Parliamentary Ombudsmen's staff spoke with a bed-ridden elderly inmate in the remand prison's healthcare department. The inmate was seriously ill and required regular treatment. Upon examination of specific documentation, it was found, inter alia, that the inmate had been placed in Kronoberg remand prison on several occasions and that he had been transferred there so as to receive better care than could be offered at Ystad remand prison. He had been transported in a horizontal position and was in very poor physical condition. On several occasions he had been transported to a public healthcare facility. Based on the inspection's findings, the Parliamentary Ombudsmen decided to initiate a special case review to investigate the Prison and Probation Service's treatment of the inmate.[16]

Use of holding cells in the Prison and Probation Service's remand prisons

The *remand prisons in Gävle*, *Huddinge* and *Saltvik* amongst others, have small, windowless rooms named holding cells. These are used for placing inmates on their arrival at or departure from the facility. Following the inspection of the *remand prison in Gävle*, the Parliamentary Ombudsmen found that there are differences in both how the holding cells are designed and how the remand prison uses these cells. For this reason, the Parliamentary Ombudsmen decided to investigate, within the framework of a special case review, how the Prison and Probation Service uses such cells in its operations. [17]

In a decision on 2 September 2019, the Parliamentary Ombudsmen expressed an understanding for the need to use holding cells for the purposes of registration to and discharge from the facility. However, in order to do this, the regulation (2014:1108) on the design of remand prisons and police detention facilities must therefore be amended. In the investigation, it emerged that inmates can be placed in holding cells for several hours. According to the Parliamentary Ombudsmen, custody times exceeding one hour are considered as long in this context. If the Prison and Probation Service is to use holding cells for this purpose, the Parliamentary Ombudsmen holds the view that the regulation should be amended to prevent these cells being designed and used in an arbitrary manner.[18]

16 See the Parliamentary Ombudsmen's report in dnr 2643-2018 pp. 5, 6 and 15 and the Parliamentary Ombudsmen's report dnr 3801-2018.

17 See the Parliamentary Ombudsmen's report in dnr 4675-2018 p. 12 and the Parliamentary Ombudsmen's report dnr 7286-2018.

18 See the Parliamentary Ombudsmen's decision in dnr 7286-2018.

Conditions for an inmate who died in a prison

During the inspection of *Saltvik prison*, it was discovered that an inmate at the facility had died a month prior to the inspection. Prior to his arrival at the prison, the prisoner had reportedly refused to take his medicine or eat. Furthermore, the inmate had stated that he refused all life-sustaining measures and treatment. The Prison and Probation Service's medical expert had requested an opinion from the healthcare staff at the prison to assess whether a lex Maria report would be made (i.e. report to the Health and Social Care Inspectorate). The Parliamentary Ombudsmen decided to investigate the matter in a special case review.[19]

Use of the Prison and Probation Service's secure units

The Prison and Probation Service has three secure units located in *Hall*, *Kumla* and *Saltvik prisons*. The units are intended for the placing of inmates where the Prison and Probation Service determines that (1) there is a long-term risk of the inmate escaping and it may be presumed that he or she has a high probability of continuing serious criminal activity, or (2) there is special reason to assume it necessary to prevent the inmate from carrying out serious criminal activity during their period of imprisonment at the facility.[20]

The secure unit in *Saltvik prison* has been used for several years for placing inmates who need protection. The Parliamentary Ombudsmen has stated that the unique environment that security units create does not make them suitable for placing inmates other than as prescribed by chap. 2 § 4 of the Prison Act.[21] Following an inspection in 2017, the Parliamentary Ombudsmen found that there had been no noticeable improvement in the conditions for inmates placed in the security unit for their own protection. However, work was ongoing to clarify and ease the relief for those inmates who are not covered by chap. 2 § 4 of the Prison Act. However, the Parliamentary Ombudsmen emphasised that the situation for these inmates did not appear to have improved since the Parliamentary Ombudsmen's decision in May 2016. The Parliamentary Ombudsmen was very critical of this.[22]

There is an ongoing investigation into how the Prison and Probation Service uses its secure units

At the Opcat inspection in 2018, inmates placed in the security unit for their own protection in the *Saltvik prison* complained that they did not have the same freedoms as previously. The days were described as less flexible and more mundane. Following the inspection, the Parliamentary Ombudsmen decided to initiate a special case review to investigate the conditions for placing groups of inmates other than those with a decision for a secure placement in the secure units.[23]

19 See the Parliamentary Ombudsmen's report in dnr 6027-2018 pp. 4 and 5 and the Parliamentary Ombudsmen's report in dnr 6300-2018.

20 Chap. 2 § 4 of the Prison Act.

21 See the Parliamentary Ombudsmen's report in 2016/17 p 174, dnr 6384-2014.

22 See the Parliamentary Ombudsmen's report in dnr 7573-2017 p. 18.

23 See the Parliamentary Ombudsmen's report in dnr 6027-2018 pp. 4 and 6.

4.3 Request to report back to the Parliamentary Ombudsmen

After inspections of *Saltvik* and *Ystad prisons*, and *remand prisons in Gävle*, *Jönköping*, *Saltvik* and *Ystad*, the Parliamentary Ombudsmen requested that the Prison and Probation Service respond with details on how the authority has worked with specific issues previously noted. This reporting back mechanism concerned, inter alia, shortcomings in the physical environmental conditions. The Parliamentary Ombudsmen further requested reporting back following the inspections of *Huddinge remand prison* in January 2017 and *Ystad remand prison* in February 2017. The Parliamentary Ombudsmen has requested reporting back on the following issues:

- The environmental conditions in exercise yards (*Saltvik prison* and the *remand prisons in Gävle* and *Jönköping*).
- Inmates ability to look out through the windows (*Saltvik prison*).
- The surveillance camera in a seclusion room (*Gävle remand prison*).
- The design of a prison and remand prison's premises (*prison* and *remand prison in Visby*).
- The environmental conditions in a remand prison's discharge premises (*Huddinge remand prison*).
- The conditions in a remand prison's KV department (*Ystad remand prison*).

In compiling this report, the Parliamentary Ombudsmen has taken decision in the response cases concerning the *prison* and *remand prison in Visby* as well as the r*emand prisons* in *Huddinge*, *Jönköping* and *Ystad*.

Environmental conditions in the Prison and Probation Service's exercise yards

The Parliamentary Ombudsmen has previously stated that inmates' opportunity to see their surroundings from the exercise yards should qualify as a fundamental right upon admission into prisons and remand prisons. Good environmental conditions in exercise yards help counteract the negative consequences of individuals being deprived of their liberty.[24] During inspections of *Gävle* and *Jönköping remand prisons*, it was noted that the exercise yards were designed in such a way that it was not possible to see any of the surroundings from the yard. During the inspection of *Saltvik prison*, it emerged that the Prison and Probation Service had initiated a project to improve the environmental conditions in the seclusion unit's exercise yards. It was, however, noted that from these exercise yards it was also not possible to see any of the surroundings. For this reason, the Prison and Probation Service was

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

requested to report back on which measures had been taken by the authority to improve the exercise yards.[25]

The environmental conditions have improved in some of the Jönköping remand prison's exercise yards

In reporting back to the Parliamentary Ombudsmen, the Prison and Probation Service stated that it has taken measures that now enable inmates to see the surroundings from five of *Jönköping remand prison's* exercise yards. In a decision, the Parliamentary Ombudsmen welcomed the changes.[26]

Ability to look out of the window

Upon inspection of *Saltvik prison*, the Parliamentary Ombudsmen found that the external blinds of the rooms used for seclusion greatly restricted both the inflow of natural light into the room and the ability of the inmates to look out of the window. The Parliamentary Ombudsmen stated that such measures – taken to restrict the ability to see into and from other departments – must not impose greater restrictions than are necessary for the inmates and that such restrictions may particularly affect inmates placed in seclusion. For this reason, the Prison and Probation Service was requested to review the design of the blinds to ensure the rights of inmates to view their surroundings and guarantee an acceptable inflow of natural light.[27]

Camera surveillance in a seclusion cell

Following an inspection of *Gävle remand prison* in January 2017, the Parliamentary Ombudsmen requested the Prison and Probation Service install technology that allows the camera to be turned off in the remand prison's observation room. The aim is to prevent the camera from being used other than when a decision is taken in a case requiring such surveillance.[28] During the 2018 inspection, it emerged that no changes had been made and it was still not possible to turn off the camera. The Parliamentary Ombudsmen requested the Prison and Probation Service report back regarding measures taken.[29]

Design of a prison and remand prison's premises

Visby prison was inspected by the Parliamentary Ombudsmen in 2013 and 2016, and both inspections found that the fact that the prison is located in small premises and consists of only five places makes it difficult to provide inmates with any meaningful occupational activities. Following the inspection in 2016, the Parliamentary Ombudsmen stated that it was unacceptable to operate a prison under such conditions.[30]

25 See the Parliamentary Ombudsmen's report in dnr 1364-2018 pp. 13 and 14, dnr 4675-2018 pp. 13 and 14 and dnr 6027-2018 p. 7.

26 See the Parliamentary Ombudsmen's decision on February 21, 2019 in dnr O 5-2019.

27 See the Parliamentary Ombudsmen's report in dnr 6027-2018 pp. 6 and 7.

28 See the Parliamentary Ombudsmen's report in dnr 750-2018 p. 11.

29 See the Parliamentary Ombudsmen's report in dnr 4675-2018 pp. 13 and 15.

30 See the Parliamentary Ombudsmen's report in dnr 2768-2013 and 6621-2016.

Visby prison and *remand prison* – which are located in the same building – were inspected during 2018 and, following the inspections, the Parliamentary Ombudsmen found that some changes had been made to the facility's exercise yard. These changes, however, did not affect the fundamental problem that the premises are too small to be able to operate a prison and remand prison in a suitable manner. In the view of the Parliamentary Ombudsmen, it was critical that the Prison and Probation Service immediately took the necessary measures which allowed *Visby remand prison* to access more suitable premises. As a first step in this process, the Parliamentary Ombudsmen considered closing *Visby prison* appropriate, and the Prison and Probation Service was requested to submit a report on any measures taken following the Parliamentary Ombudsmen's statement.[31]

In reporting back, the Prison and Probation Service announced that *Visby prison* has been closed and that the premises previously used by the prison have been adapted for the remand prison's use. The Parliamentary Ombudsmen has welcomed these changes.[32]

Visby prison has closed and Visby remand prison now has premises fit for purpose

Environmental conditions at a remand prison's discharge premises

During the inspection of *Huddinge remand prison* in January 2017, it was noted that the premises previously used for registration are now used when inmates temporarily leave the remand prison for external visits (for example to hospital). It was further noted that a rebuild of the premises' "holding cells" was ongoing to make them larger and soundproof. Due to the ongoing rebuilding, the Parliamentary Ombudsmen requested that the Prison and Probation Service reports back on measures taken with regard to the design of the holding cells to ensure the integrity and security of the inmates are maintained.[33]

In a report back on 13 June 2018, the Prison and Probation Service stated that the holding cells had been replaced by four new cells. The walls of the cells meet the ceiling and are soundproofed. Furthermore, the doors have been replaced with cell doors with a window to allow observation.

On 23 August 2018, the Parliamentary Ombudsmen conducted a follow-up inspection of the remand prison. During the inspection, it was noted that the previous four holding cells were replaced by three holding cubicles. After the inspection, the Parliamentary Ombudsmen stated that it was positive that the remand prison had completed the necessary changes to the registration and discharge departments, and that there was now a more suitable system for maintaining, inter alia, inmates' integrity.[34]

31 See the Parliamentary Ombudsmen's report in dnr 4139-2018 p. 9 and dnr 4141-2018 p. 6.

32 See the Parliamentary Ombudsmen's decision on June 10, 2019 in dnr O 40-2019.

33 See the Parliamentary Ombudsmen's report in dnr 416-2017 pp. 14 and 15.

34 See the Parliamentary Ombudsmen's report in dnr 5563-2018 p. 5.

Conditions in a remand prison's KV department

Two Opcat inspections of *Ystad remand prison* have been conducted (September 2014 and February 2017), and on both occasions the Parliamentary Ombudsmen presented their views regarding a specific space with two cells separate from the rest of the remand prison (KV department). The Parliamentary Ombudsmen requested the Prison and Probation Service submit a report on the measures taken following the 2017 inspection to make it possible to monitor which inmates are placed in the KV department and whether they are placed alone or together with any other inmates.

In reporting back, the Prison and Probation Service highlighted that Ystad remand prison strives to place inmates first and fore mostly in regular remand prisons. During periods of pressure to accommodate all inmates or when an individual has special needs, the KV department can be used for such accommodation. According to the Prison and Probation Service, being placed in the KV department does not restrict an inmate's right to associate with others and, as such, cannot be considered as being placed in seclusion. The inmates consume their meals in the KV department and are then discharged into association and occupational activities with inmates from the other departments. After lunch, all inmates are locked in their cells. In the afternoon, inmates again spend time in association or occupational activities. According to the Prison and Probation Service, the KV department can be used, inter alia, as a "halfway station" for inmates who had previously had restrictions placed on them for a long time and who subsequently required a certain amount of time to readjust. In the authority's view, it is not necessary to create special documentation for the KV department and there is no support system for such documentation.

In a decision, the Parliamentary Ombudsmen stated that *Ystad remand prison* is a remand prison with free association and that this term presupposes that inmates are able to associate with others. This means, for example, double occupancy of a cell cannot be equated with exercising the right to association. Furthermore, the Parliamentary Ombudsmen stated that a department must consist of at least three cells in order to be able to meet the basic requirements of the legislation concerning the right to association during the daytime. The KV department does not meet this basic requirement and therefore the term "department," in the view of the Parliamentary Ombudsmen, should not be used to describe this part of *Ystad remand prison*.

The Parliamentary Ombudsmen further stated that it is concerning that the Prison and Probation Service establishes places that, in its own words, are some form of "halfway station" between seclusion and regular association. There may be a need to establish departments that can meet the needs of inmates who require placement in smaller group of inmates. However, in the Parliamentary Ombudsmen's view, such departments must be designed in

such a way that they do not limit the inmates' right to association during the daytime. This is necessary to counteract operating in a grey zone between seclusion and regular association. In the Parliamentary Ombudsmen's view, the places in the KV department should only be used in exceptional cases and furthermore, the remand prison should, in consultation with the head office of the Prison and Probation Service, consider whether these places should in the future be used for the placement of inmates at all.[35]

It is concerning that the Prison and Probation Service have in place cells which mean inmates find themselves in a "halfway station" between seclusion and the general prison association

4.4 Conclusions

A relatively large part of the Opcat unit's work during 2018 was focused on the Prison and Probation Service. One reason for this is the thematic review of the transportation of individuals deprived of their liberty. The Prison and Probation Service now has a statutory mandate to transport other individuals deprived of their liberty and not solely the authority's own clients. A further reason why there have been relatively many inspections within the Prison and Probation Service is that it conducts extensive activities that affect a large number of individuals deprived of their liberty.

An important issue for the Parliamentary Ombudsmen in recent years has been the environmental conditions in which inmates live. This concerns, inter alia, the design of cells and the ability to look out through the cell window as well as the design of exercise yards. The issues which came to the fore primarily during inspections of the Prison and Probation Service's remand prisons and in inspections during 2018, show that there is still a need for the authority to improve these environmental conditions. It is clear from some of the Prison and Probation Service's reports that it is possible to improve the environmental conditions via relatively simple means. These positive experiences should be disseminated within the authority with a view to improving, first and foremostly, the environmental conditions in remand prisons and, as such, reduce the negative outcomes of individuals being deprived of their liberty.

This year's inspections have also raised the issue of the design of departments within remand prisons and prisons. It has been noted that some departments consist of only two cells, which is inconsistent with both the Parliamentary Ombudsmen and the Prison and Probation Service's views on the requirements which should reasonably be in place in one department. This is based on the premise that inmates in both remand prisons as well as prisons should have the right to associate with other inmates. Association in this context means that an inmate associates with at least two other inmates. Departments consisting of only two cells make it difficult for the Prison and Probation Service to fulfil this requirement. Furthermore, some departments lack suitable communal spaces and this is something that has also been noted by the Parliamentary Ombudsmen in 2019. The observations made indicate the need

35 See the Parliamentary Ombudsmen's decision on September 3, 2018 in dnr 583-2017.

for the Prison and Probation Service to take a comprehensive approach in handling questions concerning how a department should be designed to meet the fundamental rights of inmates.

The question of the inmates' right of association is a matter that is currently being investigated by the Parliamentary Ombudsmen in a special case review following several Opcat inspections in 2017. In March 2019, the Parliamentary Ombudsmen held a dialogue meeting with representatives from the Prison and Probation Service.[36]

For a number of years, the Parliamentary Ombudsmen has been engaged in the question of camera surveillance of inmates in remand prisons and prisons. It has been noted that surveillance cameras have been running – and sometimes recording – even where there lacks a decision for any such surveillance. Following the inspection of *Gävle remand prison*, the Parliamentary Ombudsmen requested the Prison and Probation Service submit an account of which remand prisons have cells with camera surveillance. The report shows that most remand prisons have such cells. The positive aspect is that all such cameras are now equipped with different functions which enable them to be switched off when there has not been a decision taken requiring the use of camera surveillance. An additional important issue to follow in inspections is that prison staff know the regulations governing the use of such cameras.

As the Prison and Probation Service has allowed its previously held level of supervision of its national reception centres to lapse, there may be grounds for the Parliamentary Ombudsmen to investigate the situation for inmates in these reception centres in the coming years. In May 2019, an inspection of the national reception centre was conducted at *Kumla prison* and work based on the observations made during the inspection will form the basis for a continued work at the Parliamentary Ombudsmen. Also, the issue of double occupancy of cells for inmates – which was noted during the inspection of *Saltvik remand prison* – is an issue that the Parliamentary Ombudsmen will continue to focus on in 2019.

36 See the Parliamentary Ombudsmen's report in dnr O 7-2018.

5

National Board of Institutional Care

National Board of Institutional Care

The National Board of Institutional Care is responsible for LVM residential homes, where substance abusers can be placed in specific cases with support of The Care of Abusers (Special Provisions) Act 1988:870. The National Board of Institutional Care is also responsible for LVU residential homes. These are for young people who can be placed, and who require particularly close supervision and care, in such homes under § 3 of The Care of Young Persons (Special Provisions) Act (1990: 52). Young people who have been sentenced to secure youth care as a punishment under The Secure Youth Care Act (1998: 603), LSU, can also be placed in these special residential homes. At the end of 2018, there were 23 special residential homes for young people in Sweden with 700 places available and 11 LVM homes with 400 places.

In 2018, three of the National Board of Institutional Care's institutions were inspected of which two were inspected for the first time by the Parliamentary Ombudsmen.[1] Two of the inspections were unannounced.

5.1 Observations from the year's inspections

An important issue to investigate in inspections of the National Board of Institutional Care's institutions is how it applies the regulations to individual care and in secluding individuals from others. Previous years' inspections have experienced that there can sometimes be uncertainty among staff as to how these rules – which restrict the rights of individuals to associate – should be applied. In this year's inspections, the issue of safe and secure care has also been given special attention. Finally, the institutions' ability to satisfy the individuals' right to daily outdoor access has been investigated.[2]

Individual care

An important premise is that an individual in care at one of the National Board of Institutional Care's institutions has the right to associate with other individuals. The National Board of Institutional Care has the mandate to limit this right in certain cases, and the authority may prevent an individual from meeting other individuals due to the individual requiring special care or for reasons of individual safety or the safety of others (individual care). Individual care must be tailored to the individual's specific needs. Whether a person

1 The special residential homes for young people in Johannisberg and Sundbo as well as the LVM home Fortunagården.

2 Since October 1, 2018, new rules apply, according to which individuals who are in a secure unit at the National Board of Institutional Care must be given the opportunity to either spend a day outdoors, partly to engage in physical activity or some other recreational activity (§ 34, third paragraph, LVM and § 15 b, second paragraph LVU).

requires individual care must be continuously reviewed and always reassessed within seven days of the last assessment.[3]

When inspecting the *LVM home Fortunagården*, it emerged that the home lacks premises to conduct individual care for individuals. The home's secure unit is divided into two parts and individuals are usually placed in the smaller section on arrival at the home. In conversations with representatives from the Parliamentary Ombudsmen, an individual stated that she had been the only inmate in this arrivals section. In the opinion of the Parliamentary Ombudsmen, such a placement is comparable to the conditions prevailing for individual care. If an intake is placed alone in the arrivals section because he or she is, for example, under the effects of substances and is not able to stay with others, in the opinion of the Parliamentary Ombudsmen, this is then an issue of individual care as such must be documented in a decision. It is not acceptable for compulsory care to be conducted in a legal grey zone.[4]

In discussions with staff at the *special residential home for young people Sundbo*, it emerged that the home receives many young people who have been relocated from other residential homes for young people. According to the staff, it is not possible to allocate the young people directly to a unit. Therefore, young people are initially provided with individual care with the intention that staff should be able to "get to know" them. After this initial individual care, the young person is usually allowed to spend time together with the other young people for a trial period. During this trial period, the decision to provide individual care remains in force. The young people who are cared for individually have access to staff between 7.30 and 21.00. At other times, the young people are locked in their rooms. According to the management, it is only possible to access the young people's rooms if the night staff receive support from the duty supervisors. During the inspection, the staff also stated that it would be best if young people receiving care in accordance with the LSU provisions could initially be regularly placed in isolation. The staff were, however, aware that such actions are not permitted.[5]

In conversations the Parliamentary Ombudsmen's employees had with 15 young people admitted to the s*pecial residential home for young people Sundbo* (both LVU and LSU), eight young people stated that they had been placed directly into individual care upon arrival. Individual care could run for anything from a few days up to a month. The young people said that they spent the majority of their time isolated.[6]

Placing of individuals in a treatment home's arrivals section can be considered as individual care in certain cases

3 § 34 LVM, § 15 LVU and § 14 LSU.

4 See the Parliamentary Ombudsmen's report in dnr 5569-2018 pp. 16 and 17.

5 See the Parliamentary Ombudsmen's report in dnr 7107-2018 pp. 11 and 15.

6 See the Parliamentary Ombudsmen's report in dnr 7107-2018 pp. 11 and 12.

Seclusion

The National Board of Institutional Care has the opportunity to place an individual under its care in seclusion. An individual may be secluded if specifically requested due to the individual's violent behaviour or if he or she is disorderly due to the effects of substance or alcohol abuse. During seclusion, an individual must be under constant supervision by staff. The individual must not be kept in seclusion for longer than is essentially necessary. An individual in an LVM home must never be in seclusion for more than 24 consecutive hours. For an individual in a special residential home for young people, the maximum amount of time in seclusion is limited to four hours. According to a new provision that came into force on 1 October 2018, doctors or nurses must provide their opinion as a matter of urgency when a young person is secluded, and, if requested by healthcare personnel, the measure should be immediately discontinued.[7]

Some months prior to the inspection of the *LVM home Fortunagården*, an emergency situation arose and an individual was removed from the home's secure unit to the seclusion room. The individual was placed in the room for a short time with staff, but there lacked any form of decision regarding the seclusion. The Parliamentary Ombudsmen noted that the individual was removed from the secure unit due to concerns for her psychological well-being. As such, there is a strong indication that staff would have prevented the individual from leaving the seclusion room if she had attempted to return to the unit. For these reasons, in the Parliamentary Ombudsmen's opinion, the measures taken by staff can arguably be viewed as a seclusion. In the Parliamentary Ombudsmen's view, the situation described highlights the importance of staff having the necessary skills to determine correctly whether it is a question of seclusion or not, and as such whether an obligation to make a formal decision on such a measure is required.[8]

Staff must have the required skills and competence to enable them to make the correct assessment when an individual is in seclusion

During the inspection of the *special residential home for young people Johannisberg*, information emerged concerning an event which, according to the management of the home, was assessed as being a matter of seclusion. The measure had not been documented as any form of decision. Following the inspection, the Parliamentary Ombudsmen emphasised the importance of the management of the home taking all necessary measures to ensure that its staff have the necessary knowledge concerning coercive measures.[9]

Right of association

Some departments of the *special residential home for young people Johannisberg* can be sectioned off. It is then possible to seclude young people who

7 § 34 b LVM, § 15 c LVU and § 17 LSU.

8 See the Parliamentary Ombudsmen's report in dnr 5569-2018 p. 16.

9 See the Parliamentary Ombudsmen's report in dnr 6204-2018 p. 20.

are not considered able to stay or spend time with the others. During the inspection, a department was sectioned off. In one section were two young people. In conversation with one of these young people, it emerged that the sectioning off had occurred because he could not be in the company of another individual placed in the other section. Following the inspection, the Parliamentary Ombudsmen highlighted that a premise for providing care in special residential homes for young people is that an individual should be provided with the opportunity to associate with other individuals during the daytime. This right can be limited by decisions regarding both individual care and seclusion.

The right of association means that an individual in a residential home for young people has the right to associate with at least two other individuals. This right must be satisfied even if a department is sectioned off. If one section contains fewer than three young people, the staff must immediately take measures to ensure that such association is possible in the Parliamentary Ombudsmen's opinion.

During the daytime an individual has the right to associate with others

This could involve staff actively working to relocate young people to another unit or to another residential home for young people. Pending a relocation, staff must actively seek to reduce the negative impacts for young people living under such conditions.[10]

Right to daily outdoor access

Since 1 October 2018, individuals in a secure unit at an LVM home have had the right to daily outdoor access. The same right exists for children and young people in special residential homes for young people.[11] At the inspection of the *LVM home Fortunagården* it was stated that, due to staff shortages, it was not possible to allow individuals out into the exercise yard. For this reason, the Parliamentary Ombudsmen reiterated the new rules regarding the right to daily outdoor access.[12]

Individuals in LVM homes and special residential homes for young people have the right to daily outdoor access

Treatment and occupational activities

A recurring issue during the Parliamentary Ombudsmen's inspections is the extent to which the National Board of Institutional Care is able to provide individuals in LVM homes with meaningful occupational activities and adequate care. At the inspection of the *LVM home Fortunagården*, every individual spoken to by the Parliamentary Ombudsmen's employees complained of the lack of treatment and occupational activities. Following the inspection, the Parliamentary Ombudsmen noted that the home had taken measures to provide individuals in residence more structured content regarding treatment

10 See the Parliamentary Ombudsmen's report in dnr 6204-2018 pp. 19 and 20.

11 § 34, third paragraph LVM, § 15 b, second paragraph LVU and § 12 LSU.

12 See the Parliamentary Ombudsmen's report in dnr 5569-2018 p. 14.

and occupational activities. However, the Parliamentary Ombudsmen emphasised the importance of individuals being offered meaningful occupational activities with substance and effect. This is necessary if the National Board of Institutional Care is to achieve its objective that individuals themselves should have the opportunity to influence and affect their situation.[13]

Shortcomings in the physical environmental conditions

At the inspection of *LVM home Fortunagården*, it was noted that there was an emergency room, located within another room, with a floor area measured at three square meters. The room has a window that opens onto a common room. Anyone who is in the common room can look into the emergency room. In the Parliamentary Ombudsmen's view, the area is therefore not suitable as a living space and the home was recommended to stop using the room for such purposes. In one of the common rooms in the home, a smoking cell had been installed. During the inspection, it was noted that cigarette smoke spread from the cell into the common room and that it had a negative impact on the indoor environmental conditions. The Parliamentary Ombudsmen emphasised that individuals deprived of their liberty should not have to unnecessarily stay in an unhealthy environment. Since the young people are able to smoke outdoors, in the Parliamentary Ombudsmen's view, there is absolutely no need for a smoking cell. For this reason, the Parliamentary Ombudsmen is of the view that the home should consider removing the cell.[14]

Adjustments for individuals with disabilities

The Parliamentary Ombudsmen has previously stated that a special residential home for young people should ensure that the care of individuals with physical disabilities can be performed in a safe and dignified manner.[15] At the inspection of the *LVM home Fortunagården*, it emerged that an individual placed in the home required extra resources for special needs. It emerged that the shower had not been adapted to her needs. Furthermore, she did not have a security alarm. The Parliamentary Ombudsmen urged the management of the home to review, inter alia, the design of the individual's living space and access to security alarms. As similar shortcomings were noted during the inspection of another special residential home for young people[16], the Parliamentary Ombudsmen urged the National Board of Institutional Care to conduct a review into which homes are appropriate to accommodate individuals with physical disabilities.[17]

13 See the Parliamentary Ombudsmen's report in dnr 5569-2018 pp. 14 and 15.

14 See the Parliamentary Ombudsmen's report in dnr 5569-2018 p. 14.

15 See the Parliamentary Ombudsmen's report in dnr 2515-2017 p. 13.

16 See the Parliamentary Ombudsmen's report in dnr 2515-2017 p. 4.

17 See the Parliamentary Ombudsmen's report in dnr 5569-2018 p. 17.

Placing together of young people belonging to different categorisations

Following the inspection of the *special residential home for young people Sundbo*, the Parliamentary Ombudsmen found that the home placed young people taken care of according to LVU together with young people sentenced under LSU. Such placements also occur in other homes, for example in the *special residential home for young people Johannisberg*. When inspecting this home, the management stated that it would be better if the home only received young people in accordance with the provisions of LSU. Several young people who were cared for in the home under the provisions of LVU, felt unsafe being cared for alongside other young people who had been convicted of crimes. In the Parliamentary Ombudsmen's view, there is good reason to continue investigating this issue.[18]

The Parliamentary Ombudsmen will continue to investigate the issue of how the National Board of Institutional Care places young people belonging to different categorisations

5.2 Special case reviews concerning the National Board of Institutional Care

At the request of the National Board of Institutional Care, the Prison and Probation Service will assist with the transportation of young people cared for in special residential homes for young people based on the provisions set out in § 3 LVU. A prerequisite for the National Board of Institutional Care to make such a request of the Prison and Probation Service is that there exist special circumstances entailing a risk that the transport cannot be carried out without the use of the Prison and Probation Service's special coercive measures. The National Board of Institutional Care can additionally request such assistance based on exceptional grounds.[19] Exceptional grounds include: situations where there is an imminent risk that the young person will injure themselves and that it is, therefore, not possible to wait for support to otherwise resolve the situation.[20]

Following the inspection of the *special residential home for young people Johannisberg*, the Parliamentary Ombudsmen stated that the intention of the provisions is such that the National Board of Institutional Care should not request assistance from the Prison and Probation Service in situations other than those specified in the legislation. The Parliamentary Ombudsmen, along with others, believes a well-functioning transport system is based on all authorities concerned having their own means of organising transportation, and as such the Prison and Probation Service's resources are only used as a necessity. The routine used by the residential home for young people of relying on the Prison and Probation Service will be investigated by the Parliamentary Ombudsmen in a special case review.[21]

18 See the Parliamentary Ombudsmen's report in dnr 7107-2018, p. 21

19 § 43 LVU.

20 See Prop. 2016/17: 57 pp. 77 and 83.

21 See the Parliamentary Ombudsmen's report and dnr 6204-2018 p. 18.

5.3 Request to report back to the Parliamentary Ombudsmen

Following inspections of the *home for substance abusers Fortunagården* and the *special residential home for young people Johannisberg* and *Sundbo*, the Parliamentary Ombudsmen has requested the National Board of Institutional Care respond with details on how it has addressed the specific issues raised by the Parliamentary Ombudsmen's employees. Reporting back has been requested on the following issues:

- Measures to provide safe and secure care (the *special residential home for young people Sundbo*).
- Rain shelters in the facility's exercise yards (*LVM home Fortunagården*).
- Routine for following up assisted transportations (the *special residential home for young people Johannisberg*).

At the time of compiling this report, the Parliamentary Ombudsmen has decided on the reponse regarding the *special residential home for young people Sundbo*.

Measures to ensure the provision of safe and secure care

At the inspection of the special *residential home for young people Sundbo*, young people at the home stated that the staff exposed them to unjustified levels of violence. This concerned largely the Aspen department, which the young people described as problematic. Similar information had emerged at an inspection carried out by the Inspectorate for Health and Care a year earlier. In addition, during a period of just under two years, the National Board of Institutional Care had made five Lex Sarah reports of serious abuse at the home. The home's management had taken certain measures to try to remedy the situation.

Following the inspection, the Parliamentary Ombudsmen concluded that the management of the home for young people, as of November 2018, had not taken sufficient measures to change the situation. For this reason, the National Board of Institutional Care was requested to respond with details concerning measures taken, or planned to be taken, to ensure young people receive safe and secure care.[22]

The National Board of Institutional Care has taken measures to rectify shortcomings at the special residential home for young people Sundbo

In reporting back, the National Board of Institutional Care stated that neither the measures taken by the management of the home for young people nor the input and support provided by the responsible office had had the desired effect. The National Board of Institutional Care therefore have taken, or plan to take, inter alia, the following measures:

- To temporarily close the Aspen department.

22 See the Parliamentary Ombudsmen's report and dnr 7107-2018 pp. 19–21

- Temporarily relieve three employees of their duties during the course of an investigation.
- Appoint a deputy manager of the home for young people working directly under and as a resource for the Director of Operations.
- That the deputy manager should initiate an evaluation of the home for young people.
- To establish a routine which means that the Director of Operations of the National Board of Institutional Care has regular contact with the manager of the home for young people and that the Director of Operations in turn has regular contact with the Director General of the authority.
- To evaluate the system for self-regulation and the need to strengthen the head office's HR support.
- To develop an action plan for human rights.

In a decision on 30 April 2019, the Parliamentary Ombudsmen stated, inter alia, that it is clear from the National Board of Institutional Care's statements that the shortcomings in the home for young people have been known to the central management for a long time. It appeared, however, that it was largely for the institution itself and Director of Operations to try to rectify the problems as well as follow up and evaluate any measures implemented. In the Parliamentary Ombudsmen's view, experience shows that this way of managing the problems has not produced a satisfactory outcome. There must exist central governance within the authority that can address these types of problems. In the Parliamentary Ombudsmen's view, the measures taken by the head office following the inspection should have been implemented much earlier. The Parliamentary Ombudsmen noted that the measures taken – inter alia the appointment of a deputy manager as a resource under the Director of Operations – has created the conditions to enable the National Board of Institutional Care's management to continue following and, if necessary, assisting in the work of mapping and evaluating the activities at the facility and then implementing appropriate measures. Furthermore, the Parliamentary Ombudsmen emphasised how important the experience of reappraisal and scrutiny, as conducted by the home for young people, is in preventing similar situations occurring at other institutions under the National Board of Institutional Care.[23]

Central governance within the National Board of Institutional Care must exist to address the serious shortcomings at the authority's homes for treatment

Rain shelters in the institution's exercise yards

Following the inspection of the *LVM home Fortunagården*, the Parliamentary Ombudsmen requested the National Board of Institutional Care provide one of the home's exercise yards with a rain shelter. Due to the new provisions on the right to daily outdoor access, the Parliamentary Ombudsmen viewed it

23 See the Parliamentary Ombudsmen's decision in dnr O 9-2019.

necessary for the National Board of Institutional Care to make an inventory of all its institutions' exercise yards. This is to ascertain any additional exercise yards which require the provision of rain shelters. The result of the inventory and details concerning which measures the National Board of Institutional Care has taken or intends to take should be reported back to the Parliamentary Ombudsmen.[24]

Routine for follow-up of assisted transportations

At the inspection of the *special residential home for young people in Johannisberg*, the management of the home stated that it was considering introducing a routine for follow-up discussions with young people following their transportation by the police or prison staff (assisted transportations). The Parliamentary Ombudsmen stated that the National Board of Institutional Care is responsible for offering young people follow-up discussions as the authority has implemented a decision concerning seclusion, body searches, external body examinations or room inspections. The purpose of the discussion is, inter alia, for the young people to be provided with the opportunity to express their views regarding the coercive measures.[25] However, there is no obligation to offer a follow-up discussion if a young person is the subject of coercive measures during an assisted transportation. This could be, for example, a decision regarding a body search or being hand cuffed.

For this reason, in the view of the Parliamentary Ombudsmen, it is positive that the management of the *Johannisberg special residential home for young people* had considered such a routine. In addition to providing the young people with the opportunity to express their views on any coercive measures used, such follow-up discussions can provide valuable feedback to, inter alia, the Prison and Probation Service regarding how young people have experienced such transportations.[26]

5.4 Conclusions

This year's inspection of the *Sundbo special residential home for young people* revealed very serious details of abuses. In reporting back, the National Board of Institutional Care confirmed the picture that the Parliamentary Ombudsmen had received in that there were significant shortcomings in the home for young people. The National Board of Institutional Care has taken the issue very seriously and took a number of measures to rectify the problems in a timely manner. In addition to the inspection and the reporting of issues that relate to the situation in the homes for young people, what has emerged also raises more fundamental questions. These concern how the National Board of

24 See the Parliamentary Ombudsmen's report in dnr 5569-2018 p. 14.

25 § 20 c LVU and § 18 c LSU.

26 See the Parliamentary Ombudsmen's report in dnr 6204-2018 p. 19.

Institutional Care works with issues of governance and the management of its operations.

The National Board of Institutional Care's evaluation and development work of the *Sundbo special residential home for young people* concerns issues that are relevant to other homes for substance abusers and homes for young people. The work initiated at the home for young people can therefore be expected to have a positive impact on other areas of the National Board of Institutional Care's operations. In the coming years, there are good reasons for the Parliamentary Ombudsmen's Opcat unit to continue to follow how the National Board of Institutional Care works with, inter alia, staff's treatment of individuals and the use of coercive measures. Of additional importance in this context is that the UN Convention on the Rights of the Child enters into Swedish law on 1 January 2020. There may also be grounds for the Opcat unit to highlight the question of whether individuals should continue to be placed together with support of the provisions in LSU or LVU at homes operated by the National Board of Institutional Care.

For a number of years, the Parliamentary Ombudsmen's Opcat operation has noted shortcomings in how the National Board of Institutional Care complies with the provisions on individual care and seclusion. During inspections carried out during 2015–2017, it emerged that some institutions had routines that risked individuals arbitrarily being subject to isolated care or seclusion. The Parliamentary Ombudsmen has reiterated that such measures may only be implemented under the conditions set out in the legislation. It has also been noted that in some cases staff at one institution delayed documenting the decision on isolated care, and at one treatment home it was noted that the room used for such care was not fit for purpose.[27] Similar observations were made in 2018 and this shows that there are good reasons for the Parliamentary Ombudsmen's Opcat unit to continue following and investigating these issues.

An additional issue of importance is the physical environmental conditions at the National Board of Institutional Care's institutions. It has emerged during the 2018 inspections that certain departments are designed, or have been utilised in such a way, such that the right to daily association for individuals cannot be satisfied. This issue will also continue to be in focus for the Opcat unit.

27 See Report from Opcat 2015–2017 pp. 32 and 33.

6

Compulsory psychiatric care

Compulsory psychiatric care

Care according to the Act on Compulsory Psychiatric Care (1991: 1128) (LPT) and the Act on Psychiatric Care Ordered by the Courts (1991: 1129) (LRV) are provided in Sweden almost exclusively by the regions. At the end of 2018, there were an estimated minimum of 80 healthcare facilities where care was provided in accordance with LPT and LRV, with approximately 4,000 places. This care is provided to, inter alia, people subject to compulsory psychiatric care as well as people sentenced to forensic psychiatric care. In addition, these institutions also care for patients who are voluntarily admitted in accordance with the Health and Medical Services Act (2017: 30) (HSL). This may entail the risk of being subject to coercion and/or various types of personal restrictions that lack a legal basis.

In 2018, the Opcat unit conducted three inspections of psychiatric care facilities.[1] All of these, with the exception of Visby hospital, were inspected for the first time by the Parliamentary Ombudsmen. One of the inspections was unannounced.

6.1 Observations from the year's inspections

Inspections of psychiatric care institutions cover a range of issues. These include: the ability to provide sound and secure care, the use of coercive measures and how patients are informed of their rights.

Ability to provide sound and secure care

Healthcare must be provided on the fundamental basis that all people are of equal value and with regard to the dignity of each individual.[2] Healthcare facilities must have the necessary staff, premises and equipment required for providing sound care.[3] Care in accordance with LPT must be provided in line with the requirements for sufficient safety and security in all operations.[4] Furthermore, the care provider must work systematically with patient safety and security. This means that the care provider must plan, manage and check up on the instructions and routines used in its work.[5]

At the inspection of *Department 130 / PIVA at Danderyd Hospital*, it emerged that staff at the department produced a routine document that was unknown

1 Department 130 / PIVA at Danderyd Hospital, the Psychiatric Emergency Department (County Hospital) and Department 1 at Sankt Görans Hospital and the Psychiatric Clinic's departments for full-day care at Visby Hospital.

2 Chap. 3 § 1, second paragraph HSL.

3 Chap. 5 § 2 HSL.

4 § 15 a LPT, cf. § 6, second paragraph LRV.

5 Chap. 3 § 1 of the Patient Safety Act (2010: 659).

to the clinic's management. In the opinion of the Parliamentary Ombudsmen, it is unacceptable that the management of a facility that provides compulsory psychiatric care does not know which routine documents are used in its operations. From the patients' perspective, it is very serious since it may entail a risk that they will not receive sound and secure care.[6] Patients also found it difficult sharing rooms with other patients. After the inspection, the Parliamentary Ombudsmen emphasised that a prerequisite for sound and secure care is, inter alia, that patients feel safe. As such, it may be important for patients to be able to control the locks to their rooms themselves. For this reason, the clinic's management was requested to investigate and take measures to improve safety, and in particular to take into account of the situation of patients in shared accommodation.[7]

A prerequisite for sound and secure care is that patients feel safe

During the year, the Parliamentary Ombudsmen conducted a follow-up inspection of the *psychiatric clinic's departments for full-day care at Visby Hospital*. The clinic was inspected in 2013 and following that inspection, the Parliamentary Ombudsmen found a number of shortcomings in the care conditions at one of the clinic's departments.[8] The 2018 inspection noted the clinic had been provided with new premises and the Parliamentary Ombudsmen welcomed the fact the clinic now has premises which offer an environment for good treatment with pleasantly furnished common spaces, a well-furnished patio, access to a garden and the possibility to section off departments. According to the Parliamentary Ombudsmen, it is also positive that the premises are adapted to patients with physical disabilities and that they provide opportunities for occupational activities as well as physical exercise.[9] At the inspection, representatives for the clinic stated that the Parliamentary Ombudsmen's statements after the 2013 inspection provided the head of operations with the opportunity to emphasise to the regional politicians which requirements should be in place to enable the provision of good care. Furthermore, the representatives emphasised that a poor stimulating environment need not necessarily rely too heavily on the external environment.[10]

The question of a stimulating care environment was also relevant during the inspection of *Danderyd hospital*. During the inspection, it was noted that the intensive care unit's premises were very sparsely furnished and perceived as confined, dark and cramped. The clinic's management shared this view but highlighted that the pared back environment is good during initial care as the patients require help in calming down during this period.[11] The department also lacks a fenced yard for outdoor access. The Parliamentary Ombudsmen reminded the region of earlier statements that a premise for providing com-

6 See the Parliamentary Ombudsmen's report in dnr 3887-2018 p. 17.
7 See the Parliamentary Ombudsmen's report in dnr 3887-2018 p. 20.
8 See the Parliamentary Ombudsmen's report in dnr 2756-2013 p. 6.
9 See the Parliamentary Ombudsmen's report in dnr 3888-2018 p. 11.
10 See the Parliamentary Ombudsmen's report in dnr 3888-2018 p. 9.
11 See the Parliamentary Ombudsmen's report in dnr 3887-2018 pages 4 and 12.

pulsory psychiatric care should be that a patient is given the daily opportunity for at least one hour's outdoor access. The Parliamentary Ombudsmen recommended the Healthcare Provision Stockholm County (SLSO), in consultation with the clinic's management, review how patients can have a better day-to-day care environment and increased opportunities for occupational access and outdoor access.[12]

The design and planning of the care environment was an issue also raised during the inspection of the *Psychiatric Emergency Facility at Sankt Görans Hospital (the County Emergency Facility)*. This is the only emergency psychiatric facility for adults in Stockholm County. During inspection by the Parliamentary Ombudsmen, it was stated that the facility is designed to receive 7,000 patients per year. In 2017, 23,000 patients applied for treatment. Following the inspection, the Parliamentary Ombudsmen stated that the emergency facility today can simply be described as severely undersized. During the inspection, it emerged that, in some cases, patients had to remain at the emergency room facility whilst awaiting transport to a ward. In the Parliamentary Ombudsmen's view, the problems of having an undersized facility are accentuated in these situations. Instead of receiving adequate care, patients were forced to stay in rooms that are not only undersized, but also lack the opportunity to offer them outdoor access and hot meals. In the Parliamentary Ombudsmen's view, it is highly questionable whether this situation satisfies with the basic requirement that all care must be provided with respect to the equal value of all people and for the dignity of the individual.[13]

The County Emergency Facility in Stockholm is severely undersized

An important part of the work in providing sound and secure care is that any deviations are documented. At the inspection of *Danderyd hospital*, it emerged that the clinic's routine document for handling deviations was not used and that the clinic's management suspected that too few events and situations were reported as deviations. Following the inspection, the Parliamentary Ombudsmen emphasised the importance of documentation as necessary in enabling retrospective reviews and controls of events, but also follow ups and improving conditions in the future. Documentation is an important tool in the work to prevent the occurrence of abusive or inhuman treatment. For this reason, the clinic's management was requested to educate and train staff regarding the applicable rules and to clarify the procedures at the department, for example when to make a deviation report.[14]

The staff's supervision of patients plays an important role in, inter alia, preventing self-harm, which, in itself, helps to provide a safe and secure care environment. During the inspection of *Visby hospital*, it emerged that the staff had, on certain occasions, failed in the supervision of patients due to staffing

12 See the Parliamentary Ombudsmen's report in dnr 3887-2018 p. 18.

13 See the Parliamentary Ombudsmen's report and dnr 5990-2018 p. 16

14 See the Parliamentary Ombudsmen's report and dnr 3887-2018 p. 21.

levels being too low. Following the inspection, the Parliamentary Ombudsmen stated that supervision of the patients is necessary for the clinic to be able to provide sound care with sufficient safety and security. The Parliamentary Ombudsmen sets requirements for the clinic to take steps to ensure that there are always sufficient staffing levels to enable the supervision of patients as is deemed necessary.[15]

Coercive Measures

If there is an immediate danger of a patient seriously injuring him or herself, the patient may be briefly restrained using a strap with a belt or similar. Furthermore, a patient may be secluded from other patients if this is deemed necessary due to the patient behaving aggressively or seriously disturbing or disrupting other patients. If necessary, a patient may be subjected to a body search or external body examination, for example to check the patient is not carrying prohibited items.[16] This latter provision may also apply to patients being cared for under HSL.[17] A body search entails a check of a patient's clothing, bags or other items in possession.[18]

At the inspection of *Danderyd hospital*, it emerged that the ward lacked a special room for restraining and seclusion. Such coercive measures were therefore taken in the regular patient rooms. When being placed in restraint, a mobile bed with a belt was rolled into the patient's room. Following the inspection, the Parliamentary Ombudsmen stated that CPT recommended that a patient should not be subjected to restraint in front of other patients.[19] The Parliamentary Ombudsmen shares this view and has set prerequisites for Danderyd hospital to implement procedures and working methods that maintain and satisfy patient integrity with regard to restraining.[20]

Regarding the use of restraining belts, the Parliamentary Ombudsmen has previously questioned a procedure that entails patients being strapped and then released for toilet visits, and then being strapped down again. In the Parliamentary Ombudsmen's view, such an approach may indicate that the coercive measure is being used in excess to that provided under the law.[21] A local routine for the application of § 19 LPT was noted during the inspection of *Visby hospital*. The routine involves strapping patients for a maximum of four hours including toilet visits. Following the inspection, the Parliamentary Ombudsmen reiterated previous statements that the expression "immediate danger" is a matter of averting a sudden event. A restraining belt or strap

15 See the Parliamentary Ombudsmen's report and dnr 3888-2018 p. 12.

16 §§ 19, 20 and 23 LPT.

17 § 23 a LPT.

18 See prop. 1990/91: 58 pp. 148 and 263.

19 See CPT / Inf [2017] 6, p. 3.5.

20 See the Parliamentary Ombudsmen's report in dnr 3887-2018 p. 19.

21 See the Parliamentary Ombudsmen's report in dnr 3816-2017 p. 22.

Restraint cannot be used to prevent something care staff assumes is already underway

must not be used to prevent something that one simply assumes is already underway. Gotland Region was urged to take measures to ensure that restraining occurs only in accordance with the law and for as short a time as possible.[22]

During the inspection of *Visby hospital*, it emerged that it was stated in a routine document that there is no legal basis with which to search patients cared for under the HSL. Following the inspection, the Parliamentary Ombudsmen stated that this is incorrect and that patients who are cared for voluntarily can be searched. The inspection also revealed that staff search all the patients arriving at the clinic. In the Parliamentary Ombudsmen's view, this is comparable to a general arrival check and the clinic lacks the necessary safety classification to perform this. For this reason, the clinic needed to make it clear to the staff that a body search must always be preceded by an assessment in each and every individual case and that any action taken must similarly be preceded by a decision where appropriate, in the Parliamentary Ombudsmen's opinion.[23]

Similar observations were made during the inspection of *Danderyd hospital* and it was noted that staff on the ward used a document which incorrectly stated that HSL patients cannot be searched. The clinic's management lacked any knowledge concerning this document. Following the inspection, the Parliamentary Ombudsmen stated that the clinic's management must take measures to ensure a formal decision on body searches is taken in each case, and that this is preceded by an individual assessment. In addition, the Parliamentary Ombudsmen urged the clinic's management to review the written information provided to patients regarding the use of body searches as the current information was far too general.[24]

There are good reasons to document informal coercion

Medication against a patient's will

During the inspection of *Danderyd hospital*, it emerged that cases where physical coercion was used in connection with administering medication against a patient's will were reported to the The Swedish National Board of Health and Welfare. However, both staff and patients experienced that the use of coercion may occur at an earlier stage, for example when patients are simply "reluctant" to take their medication. Such situations are documented in patients' records. In the Parliamentary Ombudsmen's view, it is positive that the documentation shows whether the patient has been persuaded to take their medication, perhaps to avoid physical coercion. The Parliamentary Ombudsmen further stated that there are good reasons for gathering information on situations and measures that may be perceived as informal coercion in connection with medication against a patient's will. Such data is a prerequisite for

22 See the Parliamentary Ombudsmen's report in dnr 3888-2018 p. 11.

23 See the Parliamentary Ombudsmen's report in dnr 3888-2018 pp. 11 and 12.

24 See the Parliamentary Ombudsmen's report in dnr 3887-2018 p. 19.

being able to evaluate and analyse measures in connection with compulsory medication and to improve the care provided to LPT patients.[25]

Information to patients

A patient should be informed of his or her rights to have a support person, to appeal certain decisions, to use a legal representative or counsel and to obtain a public counsel, and LPT should be made clearly available to patients at the healthcare facility.[26] CPT has a standard statement that written information concerning the healthcare facility's routines and procedures as well as patients' rights should be provided to each patient and their relatives upon admission. The patient should also be assisted in comprehending the information where necessary.[27]

During the inspection of *Visby hospital*, it emerged that the clinic's information sheet lacked information concerning patients' rights to use a representative or counsel. Furthermore, it appeared there was only information in Swedish concerning the clinic's routines. The Swedish Parliamentary Ombudsmen recommended that the clinic complement its existing written information with translations into other languages.[28]

6.2 Special case reviews concerning psychiatric wards and admissions

Following a medical certificate being issued, a doctor may decide that a patient must remain in the care facility until the question of admission has been decided.[29] The question of admission for secure compulsory psychiatric care must be decided promptly upon examination of the patient and no later than 24 hours after their arrival at the hospital.[30] It is stated in the preparatory works of the legislation that healthcare principals have a far-reaching responsibility to organise healthcare as required by law and have the necessary routines which enable admission decisions being made as soon as the patient has arrived at the healthcare facility.[31]

In Stockholm County, compulsory psychiatric care has been organised in such a way that medical certificates are issued by doctors at the *County Emergency Facility*, where decisions to detain patients are also made. Thereafter, the patient is usually transported to a care ward where the question of admission is examined. The guidelines for Stockholm Healthcare Provision (SLSO) state that a detention decision made within an operative psychia-

25 See the Parliamentary Ombudsmen's report in dnr 3887-2018 p. 20.

26 §§ 30 and 48 LPT.

27 See CPT / Inf [98] 12, p. 53.

28 See the Parliamentary Ombudsmen's report in dnr 3888-2018 p. 13.

29 § 6, first paragraph, LPT.

30 § 6 b, first paragraph LPT.

31 See prop. 1999/2000: 44 p. 59.

Stockholm Region's way of organising secure psychiatric care raises fundamental questions regarding the meaning of "care facility"

tric unit in a healthcare facility is valid even in another healthcare facility to which a patient has been transported. At the inspection of *Danderyd hospital*, it emerged that there were different opinions amongst doctors concerning whether a detention decision made at the County Emergency Facility also applies at the hospital, or whether a new decision needs to be made when the patient arrives.[32] Following inspection of the County Emergency Facility, the Parliamentary Ombudsmen stated that these issues raise questions concerning, inter alia, Stockholm Region's way of organising secure psychiatric care, the meaning of the term "care facility" and the scope of a detention decision. These issues will be investigated by the Parliamentary Ombudsmen within the framework of a special case review.[33]

6.3 Request to report back to the Parliamentary Ombudsmen

Following the inspection of the *County Emergency Facility*, the Parliamentary Ombudsmen has requested reporting back on issues concerning the transportation of patients. Furthermore, the Parliamentary Ombudsmen requested reporting back following the inspections of *General Secure Psychiatric Care Facility in Karlstad* in May 2017, *BUP Stockholm*, *General Secure Psychiatric Care Facility in Luleå* and *BUP Luleå* in June 2017. Reporting back has been requested concerning the following issues:

- Ensuring that patients are offered daily outdoor access (*General Secure Psychiatric Care Facility Karlstad*, *General Secure Psychiatric Care Facility in Luleå* and *BUP Luleå* and *BUP Stockholm*).
- Ensuring that patients receive information concerning their rights (*BUP Stockholm*).
- What measures have been taken to reduce the stigma associated with transportation of patients (*County Emergency Facility*).

At the time of compilation of this report, the Parliamentary Ombudsmen has taken decisions on all the reporting back with the exception of the County Emergency Facility.

Daily outdoor access

In connection with the inspections of *General Secure Psychiatric Care Facility in Karlstad*, *BUP Stockholm* and *General Secure Psychiatric Care Facility in Luleå*, it emerged that there were patients who were cared for voluntarily but who were not allowed to leave the clinics without staff accompanying them. During the inspection of *BUP Luleå*, it emerged that there were staff who were of the opinion that, in some cases, patients cared for under HSL could only leave the premises with staff or guardians. In statements following the

32 See the Parliamentary Ombudsmen's report in dnr 3887-2018 p. 18

33 See the Parliamentary Ombudsmen's report in dnr 5990-2018 p. 17 and dnr 1732-2019.

inspections, the Parliamentary Ombudsmen emphasised that HSL does not offer any legal basis to prevent a patient from leaving the clinic. In the opinion of the Parliamentary Ombudsmen, the clinics needed to take measures to ensure, on the one hand, legal certainty regarding the patients' wishes to be allowed to go outdoors, and, on the other, that all patients are offered daily outdoor access.

In reporting back, the *General Secure Psychiatric Facility in Karlstad* stated that walking groups had been created to ensure patients' rights to daily outdoor access were satisfied. In a decision, the Parliamentary Ombudsmen welcomed the initiative and closed the case.[34]

In reporting back, *BUP Stockholm* announced that staff had received training. BUP Stockholm also reported on other changes implemented since the inspection. In a decision, the Parliamentary Ombudsmen welcomed the changes and initiatives, but also emphasised the importance of the clinic offering all patients daily outdoor access.[35]

The Health and Medical Services Act (HSL) does not provide a legal basis to prevent a patient leaving a clinic

Information to patients concerning their rights

At the inspection of *BUP Stockholm*, it emerged that that BUP Stockholm's brochure lacked information that should be provided to patients according to § 48 LPT. Furthermore, the brochure as well as some of the clinic's information sheets were only available in Swedish. Following the inspection, the Parliamentary Ombudsmen recommended the clinic supplement its written information so that it contained all the required information which must be provided to patients. The Parliamentary Ombudsmen urged the clinic to ensure that this written information is available in languages other than Swedish. In reporting back, the clinic stated that a written local routine on information concerning rights whilst in care in accordance with LPT has been introduced, which also contains links to written material in different languages. In a decision, the Parliamentary Ombudsmen welcomed the changes initiated, but noted that the information the clinic uses is from the Swedish Association of Local Authorities and Regions lacks information regarding patients' legal rights to use representatives or legal counsel.[36]

Measures to reduce stigmatisation in connection with the transportation of patients

In connection with the inspection of the County Emergency Facility, it emerged that representatives of the clinic perceived the Prison and Probation Service's methods of conducting assisted transportations as problematic since, inter alia, the prison guards are uniformed and the patients are routinely cuffed. The Parliamentary Ombudsmen stated in a report following the inspection that it is very serious that there is a perception that the Prison and

34 See the Parliamentary Ombudsmen's decision on 17 December 2018 in dnr 2945-2017.

35 See the Parliamentary Ombudsmen's decision on 17 December 2018 in dnr 3816-2017.

36 See the Parliamentary Ombudsmen's decision on December 17, 2018 in dnr 3816-2017.

Probation Service's working methods contributes both to stigmatising, inter alia, mental illness as well as resulting in shortcomings in the treatment of individuals deprived of their liberty. The Parliamentary Ombudsmen further stated that the regions also have a responsibility to set the framework for the transportation of patients to and from their units, and that Stockholm Healthcare Provision (SLSO) should take measures to remedy the problems. The Parliamentary Ombudsmen requested SLSO respond with information on any measures taken or intended to be taken regarding this issue.[37]

The care provider must take measures to reduce the risk for stigmatisation of patients being transported

6.4 Conclusions

The purpose of the Parliamentary Ombudsmen's Opcat unit is to conduct, inter alia, inspections to prevent patients in compulsory psychiatric care from being subject to inadequate treatment and/or coercive measures that lack a legal basis. An important aspect of care providers' work in preventing shortcomings in care is to ensure that staff have the right skills for their roles and tasks. Furthermore, it is essential that staff receive thorough support with, inter alia, routine documents. The inspections during 2018, as well as the cases where the Parliamentary Ombudsmen received reports back, show that there have been shortcomings in these areas. The shortcomings have led to, inter alia, patients not being provided with the opportunity for daily outdoor access and being subjected to coercive measures in excess to those provided by the law. The reports received back by the Parliamentary Ombudsmen show that the relevant stakeholders have taken appropriate measures to some extent. In some cases, the efforts required to safeguard patients' rights have not been particularly comprehensive. As such, this experience indicates the need for continuous work to ensure that staff have the knowledge necessary to ensure the satisfaction of patients' rights.

Once again in 2018 the design of the care environment has been a current and relevant issue. The Opcat unit's annual report 2015–2017 addresses the issue of low-stimulant environments and that some clinic managers consider sparse and pared back environments as a necessary aspect in motivating patients.[38] This view is not undisputed and the experience from *Visby hospital* shows that a stimulating environment is not necessarily based on the physical environment. Instead, other types of measures can be taken to reduce stimuli. The inspection in Visby further shows that it is possible to achieve a good care environment if the design of premises is comprehensively understood.

The two inspections conducted in the Stockholm area show that there exists the potential for improvement regarding the care environment. Regarding the *County Emergency Facility*, it is a fact that the facility is severely undersized and, due to local transport problems, it was forced to treat patients over and

37 See the Parliamentary Ombudsmen's in dnr 5990-2018 p. 15.

38 See National Preventive Mechanism - NPM, Report from the Opcat unit 2015–2017, p. 37.

above the extent intended for the facility. *Danderyd hospital* lacks access to exercise yards and the indoor environmental conditions were dark, cramped and pared back at the time of the inspection.

The design of healthcare environments is an important factor in reducing the use of coercive measures. Experience shows that environments where patients can avoid interaction with fellow patients when needed reduce the risk of conflicts, and thus the need for coercive measures.[39] Even staff training in, for example, conflict management plays an important role in reducing the use of such measures. If there is a need to resort to coercive measures, the staff must have the necessary knowledge to avoid the use of coercion in breach of the legislation or to intervene with unnecessary excess.

Both these issues, as well as the issue of informal coercion, will be important areas of investigation for the Parliamentary Ombudsmen's Opcat unit in the coming years.

An environment lacking stimulation need not necessarily be pared back nor sparse

39 See information obtained in connection with the Opcat unit's dialogue meetings with IVO's supervisory departments during 2019 in JO's dnr. O 5-2018.

7

Thematic review of the transportation of individuals deprived of their liberty

Thematic review of the transportation of individuals deprived of their liberty

As mentioned in the introduction, during 2018 the Parliamentary Ombudsmen's Opcat unit has had a thematic focus on the domestic transportation of individuals deprived of their liberty. This theme continues during 2019. The observations made during 2018, within the framework of the theme, were presented in June 2019 in the *Report from the Opcat Unit 2019 – Transportation Theme*. A final report will be published in 2020. The following is a brief summary of the conclusions from the interim report.

Background

As of 1 April 2017, new provisions apply regarding the transportation of individuals deprived of their liberty. In short, the regulations mean the Prison and Probation Service is responsible for transportations where, due to special circumstances, there entails a risk for the requirement for certain special coercive measures, aka assisted transportation. This means that in such situations, the Prison and Probation Service must transport individuals deprived of their liberty at the request of other authorities, for example individuals deprived of their liberty under the Care of Abusers (Special Provisions) Act (1988: 870), the Care of Young Persons (Special Provisions) Act (1990: 52), the Act on Compulsory Psychiatric Care (1991: 1128) and foreigners detained in accordance with the Aliens Act (2005: 716). Finally, the Prison and Probation Service must carry out transportations on behalf of the Police Authority based on the Police Act (1984: 387).

Shortcomings in the organisation of transportation have resulted in negative outcomes for individuals deprived of their liberty

The Prison and Probation Service's organisation of transportation has not produced the capacity required to carry out assisted transportations to the extent requested by the authorities concerned. This shortcoming has led to negative consequences for the individuals deprived of their liberty.

The transportations of young people to the National Board of Institutional Care's special residential homes for young people, patients to psychiatric care facilities and individuals held on remand from police stations to remand prisons have all experienced delays. In anticipation of such transportation, individuals deprived of their liberty have remained – sometimes up to a week – in environments where they do not actually belong, such as police detention facilities. In addition to the fact that the environments are not adapted for such long deprivations of liberty, the waiting time means, inter alia, that the care that individuals are deemed to require is delayed. The fact that detainees or individuals who are awaiting a transport to a residential home are placed in a police detention facility is not compatible with statements made by by the Parliamentary Ombudsmen.

Details have also emerged which show that the Prison and Probation Service carries out the assisted transportations using methods not in accordance with statements from the Parliamentary Ombudsmen. Regularly, individuals in care under healthcare legislation are taken to detention facilities during transport stopovers. Furthermore, they are transported together with, for example, the Prison and Probation Service's clients. This method of carrying out transportations leaves the individuals feeling stigmatised. Individuals taken into care, who are not suspected of or convicted of a crime, have stated in conversations with the Parliamentary Ombudsmen's staff that they feel like a criminal when transported by the Prison and Probation Service.

Insufficient coordination has resulted in individuals deprived of their liberty being exposed to unnecessary risks

There have been cases where there is no consensus among the authorities concerned as to which transportations can be transferred to the Prison and Probation Service. When the authorities cannot agree on who is responsible for a transportation, there is a risk that the individual deprived of their liberty is in no-man's land and the transportation is delayed. There are also examples of authorities requesting a transfer to the Prison and Probation Service even when the legal conditions are not satisfied. For example, the reason for transferring a transportation might be that the authority lacks its own transportation resources. Such overuse of the Prison and Probation Service's resources risks delaying other transportations.

A lack of coordination has also been noted between the Police Authority and the Prison and Probation Service with regard to the use of police detention facilities for transportation stopovers. Shortcomings in the planning of these breaks have led to situations where the police detention facility staff are so overstretched they have not been provided with a reasonable opportunity to, for example, perform the necessary safety assessments. It has also been

noted in other cases that the authority requesting the assisted transportation does not provide any information concerning the individual deprived of their liberty to the Prison and Probation Service. This can lead to the Prison and Probation Service being overly cautious and deciding upon more extensive coercive measures than would otherwise be necessary. The lack of information regarding, for example, illnesses of the individuals being transported can lead to individuals deprived of their liberty being exposed to unnecessary risks.

Measures that can reduce negative outcomes

According to statements from the Parliamentary Ombudsmen, in order to reduce as far possible the negative consequences for individuals deprived of their liberty, authorities need to take measures to meet the following requirements:

- There must be a capacity within the Prison and Probation Service to carry out assisted transportations within the timeframes set in accordance with the Parliamentary Ombudsmen's statements. The planning and implementation of assisted transportations must be based on the principle that individuals, who are deprived of their liberty under various healthcare legislation, should not be placed in remand prisons or police detention facilities or co-transported with, for example, clients from the Prison and Probation Service.
- Transport stopovers in police detention facilities need to be organised in such a way that the facilities' staff have sufficient time to undertake all necessary checks and measures on admission to the facility.
- Measures are required to reduce the stigmatising elements of assisted transportation. This includes organising the transportations so that people in care under various healthcare legislation are not made to feel like criminals.
- The relevant authorities need to be in agreement concerning what information concerning an individual deprived of their liberty should be provided to the Prison and Probation Service when requesting a transfer.

Appendices

Tables and summaries

A. Participation in international meetings

B. Inspections

C. Special case reviews based on an Opcat unit inspection

D. Issues where the Swedish Parliamentary Ombudsmen has requested reporting back

APPENDIX A

Participation in international meetings

There is a comprehensive international exchange where Opcat issues are discussed. This concerns both material and methodological issues. During 2018, employees from the Parliamentary Ombudsmen's Opcat unit participated in the following meetings::

- January 3–4, 2018, Copenhagen, Denmark: Nordic NPM meeting.
- February 20, 2018, Geneva, Switzerland: International NPM meeting.
- August 29–30, 2018, Lund, Sweden: Nordic NPM meeting.
- October 16–17, 2018, Oranienburg, Germany: Fachhochschule Polizei Brandenburg, Fair treatment of individuals in police custody.
- November 7–9, 2018, Copenhagen, Denmark: 4th IOI Workshop for NPMs, Strengthening the Follow-Up on NPM Recommendations.
- December 3–4, 2018, Milan, Italy: APT / ODIHR's second meeting on Torture Prevention.

APPENDIX B

Inspections

Unannounced inspections

Police detention facilities	
Jönköping	dnr 1366-2018
Sum 1	

Prisons	
Hinseberg (Frövi)	dnr 4138-2018
Sum 1	

Remand prison	
Jönköping including NTE	dnr 1364-2018
Sum 1	

LVM homes	
Fortunagården (Värnamo)	dnr 5569-2018
Sum 1	

LVU homes	
Sundbo (Fagersta)	dnr 7107-2018
Sum 1	

Compulsary psychiatric care	
Danderyd hospital, PIVA/department 130*)	dnr 3887-2018
Sum 1	

Totalt 6 unannounced inspections

Announced inspections

Police detention facilities	
Helsingborg	dnr 5424-2018
Lidköping	dnr 2094-2018
Lycksele	dnr 7556-2018
Sandviken	dnr 6001-2018
Storuman	dnr 7558-2018
Vilhelmina	dnr 7557-2018
Värnamo	dnr 5668-2018
Örebro	dnr 701-2018
Sum 8	

*) Inspections in which JO decided to investigate a specific issue in the context of a special initiative case. See Appendix C.

APPENDIX B

Prisons	
Saltvik (Härnösand)*)	dnr 6027-2018
Visby	dnr 4140-2018
Sum 2	

Remand prisons	
Gävle including NTE*)	dnr 4675-2018
Huddinge*)	dnr 5563-2018
Kronberg including NTE*)	dnr 2643-2018
Visby	dnr 4139-2018
Saltvik including NTE*)	dnr 5266-2018
Örebro including NTE	dnr 750-2018
Sum 6	

The Prison and Probation Service – NTE	
Arvidsjaur*)	dnr 4158-2018
Sum 1	

LVU homes	
Johannisberg (Boden och Kalix)*)	dnr 6204-2018
Sum 1	

Compulsary psychiatric care	
Psychiatric clinic at Visby lasarett	dnr 3888-2018
Psychiatric ward at S:t Görans sjukhus*)	dnr 5990-2018
Sum 2	

Total 20 anounced inspections

*) Inspections in which JO decided to investigate a specific issue in the context of a special initiative case. See Appendix C.

Special case reviews based on an Opcat inspection

APPENDIX C

The Prison and Probation Service	
The use of so-called holding cells for detention	dnr 7286-2018
Work on isolation-breaking measures in detention	dnr O 7-2018
Conditions for a seriously ill inmate	dnr 3801-2018
The circumstances surrounding a death	dnr 6300-2018
Placement of other groups of inmates than those with decisions on security placement at the Prison and Probation Service's security units	dnr 1950-2018
Priority of transportation assignments	dnr 8337-2018
Sum 6	

National Board for Institutional Care	
The special residential home for young people in Johannisberg's routine regarding the Prison and Probation Service's transportation of young people being cared for at the home	dnr 1337-2019
Sum 1	

Secure psychiatric care	
Region Stockholm's way of organising secure psychiatric care, the meaning of the term "care facility" and the scope of a decision on detention	dnr 1732-2019
Sum 1	

Total 8

APPENDIX D

Issues where the Swedish Parliamentary Ombudsmen has requested reporting back in 2017

The Prison and Probation Service		
Issue	**Reference no.**	**Reported back to the ombudsman**
Isolation-breaking measures	dnr 416-2017	2018-06-14
The design of the reception room at a remand prison (**Huddinge remand prison**)	dnr 416-2017	2018-06-13
Conditions in a temporary detention operation (**Halmstad remand prison**)	dnr 582-2017	2018-01-29
The conditions of a remand prison with only two locations (**Ystad remand prison**)	dnr 583-2017	2018-04-27
Sum 4		

The Migration Agency		
Issue	**Reference no.**	**Reported back to the ombudsman**
Conditions for individual placements (**Kållered facility**)	dnr 1000-2017	2018-02-08
Sum 1		

Secure psychiatric care		
Issue	**Reference no.**	**Reported back to the ombudsman**
Supervision of patients and the possibility of daily outdoor access (**Central hospital in Karlstad**)	dnr 2945-2017	2018-11-30
Supervision of patients, the possibility of daily outdoor access and information regarding rights (**BUP Stockholm**)	dnr 3816-2017	2018-06-08
The possibility of daily outdoor access (**Allmänpsykiatriska slutenvården och BUP Sunderby**)	dnr 4043-2017	2019-03-29
Sum 3		

Total 8 reports in 2017

APPENDIX D

Issues where the Swedish Parliamentary Ombudsmen has requested reporting back in 2018

The Police Authority		
Issue	**Reference no.**	**Reported back to the ombudsman**
The design of an exercise yard (**Örebro police detention facility**)	dnr 701-2018	2018-11-01
The design of the exercise yard and staffing at the police detention facility (**Jönköping police detention facility**)	dnr 1366-2018	2018-09-26
The design of the cells (**Lidköping police detention facility**)	dnr 2094-2018	2018-12-11
The design of an exercise yard (**Värnamo police detention facility**)	dnr 5568-2018	2019-03-22
The inflow of natural daylight into cells and the design of an exercise yard (**Sandviken police detention facility**)	dnr 6001-2018	2019-03-22
Training and routine support for police guards and the design of an exercise yard (**Lycksele police detention facility**)	dnr 7556-2018	2019-05-17
Sum 6		

The Prison and Probation Service		
Issue	**Reference no.**	**Reorted back to the mbudsman**
The design of exercise yards and camera surveillance (**Gävle remand prison**)	dnr 4675-2018	2019-03-27
The design of detention rooms (**Visby prison and remand prison**)	dnr 4140-2018 och 4139-2018	2019-05-14
The design of exercise yards and the opportunity to look through cell windows (**Saltvik prison**)	dnr 6027-2018	2019-06-26
Complement the ordering system LIFT so there are opportunities to check grounds for detention (**NTE Arvidsjaur**)	dnr 4158-2018	2019-04-01
Sum 4		

APPENDIX D

National Board of Institutional Care		
Issue	**Reference no.**	**Reported back to the ombudsman**
Measures to ensure that inmates receive safe and secure care (**special residential home for young people, Sundbo**)	dnr 7107-2018	2019-01-31
Measures to introduce routine monitoring of assisted transportations (**special residential home for young people, Johannisberg**)	dnr 6204-2018	2019-09-03
Sum 2		

Secure psychiatric care		
Issue	**Refernce no.**	**Reported back to the ombudsman**
Measures to rectify the Prison and Probation's methods of carrying out assisted transportations (**Psychiatric Emergency Facility and Division 1 at S: t Göran's Hospital**)	dnr 5990-2018	2019-06-14
Sum 1		

Total 13 reports in 2018

JO RIKSDAGENS OMBUDSMÄN

RIKSDAGENS OMBUDSMÄN – JO
Box 16327
Västra Trädgårdsgatan 4 A
SE-103 26 Stockholm

Telefon +46 8 786 51 00 (växel)
Telefax +46 8 21 65 58

E-mail justitieombudsmannen@jo.se
Web site www.jo.se

Opening hours 09.00–11.30 and 13.00–15.00