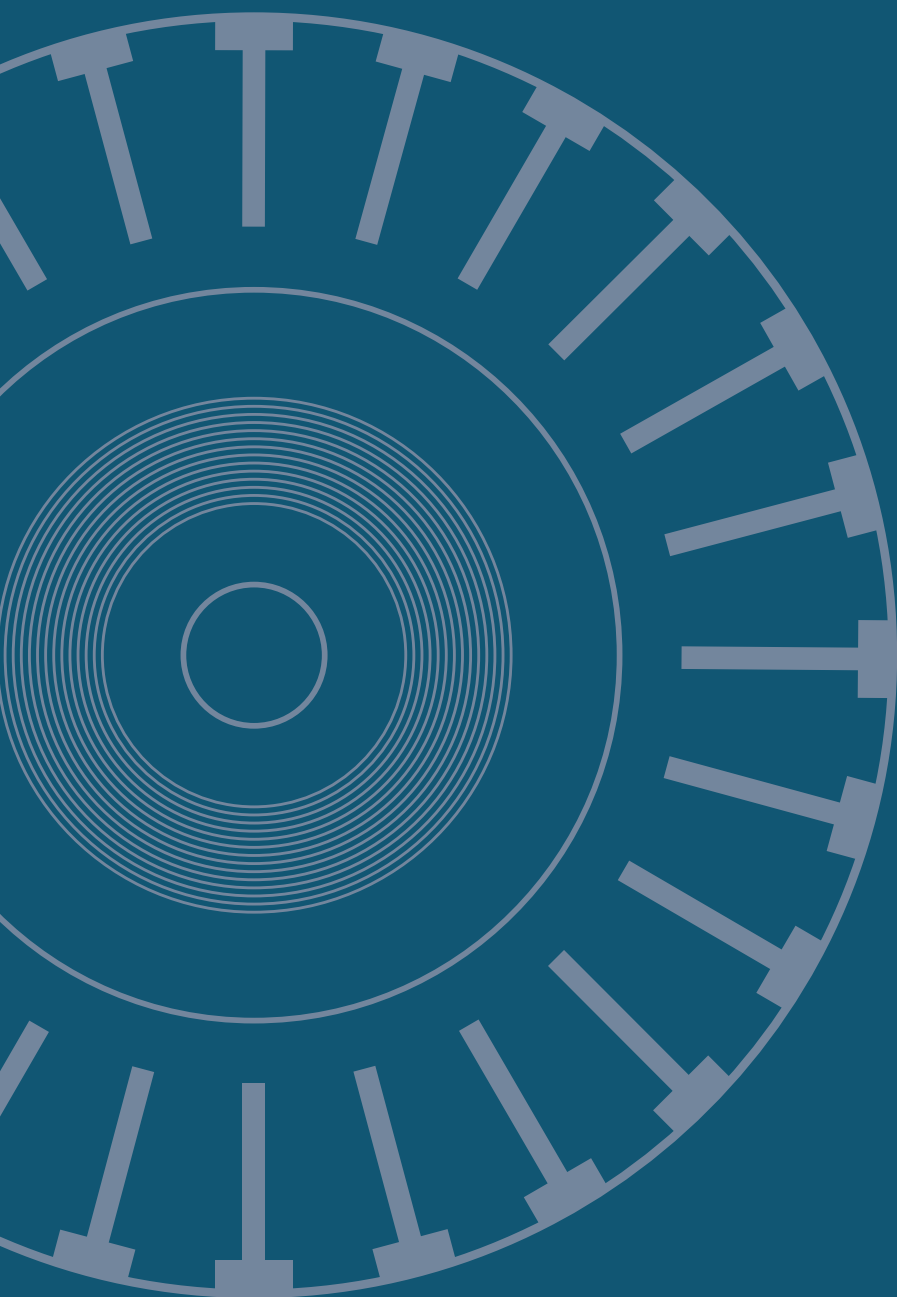


# National Preventive Mechanism – NPM

REPORT FROM THE OPCAT UNIT 2011–2014





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

# Preface

Section 3 of the Act with Instructions for the Parliamentary Ombudsmen states:

“The Ombudsmen are to ensure in particular that the courts and public authorities in the course of their activities obey the injunction of the Instrument of Government about objectivity and impartiality and that the fundamental rights and freedoms of citizens are not encroached upon in public administration.”

When the Parliamentary Ombudsmen began working as Sweden’s National Preventive Mechanism under the Optional Protocol to the UN Convention Against Torture (OPCAT) in 2011, the UN Convention against Torture and Other Cruel or Inhuman Treatment had been applicable in Sweden since 1987. OPCAT creates an visit system stipulating that all places where persons deprived of liberty are detained be inspected regularly. The goal is to identify risks of inhuman or degrading treatment and to work to eliminate these risks.

The supplementary function of National Preventive Mechanism has broadened the Parliamentary Ombudsmen’s mandate in a groundbreaking way. The focus of this function is on prevention through constructive dialogue and is forward-looking. Traditionally, the role of the ombudsman has been to review what has taken place from a formal, legal perspective. There is much to be said for keeping these two functions together. Experience shows that the traditional role of the Parliamentary Ombudsmen has evolved with this supplementary mandate. My personal conviction is that this is how the Parliamentary Ombudsmen does the most good – by identifying risks and finding room for improvement.

Since these activities began, the ombudsmen have conducted over 100 inspections, and this is something about which I am very happy and proud. This means that we are performing well in terms of complying with OPCAT’s requirements for regular inspection activities. I hope that this report will demonstrate how it is a strength that the Parliamentary Ombudsmen also has an explicit preventive remit.



Elisabet Fura



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# Introduction

Since 2011, the Parliamentary Ombudsmen (JO) has discharged the duties incumbent on a national preventive mechanism pursuant to the Optional Protocol of 18 December 2002 to the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). To undertake this function, the ombudsmen are supported by a special unit, the OPCAT unit. The unit's principal task is to conduct inspections on behalf of Parliamentary Ombudsmen in places where people are deprived of their liberty (places of detention).

The Parliamentary Ombudsmen is a part of the Swedish system of parliamentary control. The office was established in 1809 in conjunction with a new instrument of government, and its remit is to specifically ensure that the courts and administrative authorities comply with the Instrument of Government's stipulations concerning objectivity and impartiality and that the fundamental rights and freedoms of citizens are not encroached upon in the public sector. The Parliamentary Ombudsmen's supervision is conducted primarily by processing complaints from members of the public and through inspections. The bulk of their work involves processing complaints, but the ombudsmen also conduct 20–30 inspections per year as part of their traditional activities. Inspecting places of detention, such as prisons, has always been an important part of this remit.

Sweden ratified OPCAT in 2005, and the Riksdag appointed the Parliamentary Ombudsmen and the Office of the Chancellor of Justice (JK) as national preventive mechanisms. As of 1 January 2014, the Parliamentary Ombudsmen is the only national preventive mechanism in Sweden.

In the first three and a half years of its OPCAT remit, the ombudsmen have inspected 109 places of detention. This report summarises the activities in this period and highlights a number of the ombudsmen's statements, in which the ombudsmen have highlighted conditions that it should be possible to improve with the aim of strengthening the rights of persons deprived of their liberty and preventing inhuman or other degrading treatment etc.

The annual report is divided into five sections. The first section provides some brief information about the term torture and conventions in the area etc. The second section describes the Parliamentary Ombudsmen's OPCAT activities. The third section is a summary of the results of OPCAT activities for the years 2011–2014, and the fourth section is a compilation of Parliamentary Ombudsmen decisions following OPCAT inspections. The report concludes with a compilation of other relevant Parliamentary Ombudsmen decisions concerning the rights of persons deprived of their liberty.



Torture and other cruel,  
inhuman or degrading  
treatment or punishment



## General

Acts of torture and cruel, inhuman or degrading treatment constitute direct violations of the respect for human dignity. The desire to address torture and acts of a similar nature, that which is often referred to as cruel, inhuman or degrading treatment or punishment, has meant that the countries of the world have united in condemning such behaviour. For this reason, the prohibition of torture, together with the prohibition of slavery, has long constituted one of the strongest norms within international law. This is a part of international common law.

## Conventions etc.

The United Nations (UN) and regional associations of states, e.g. the Council of Europe, have implemented a range of measures in order to address torture. One of these is the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (the Convention against Torture) of 1984. This contains definitions of what constitutes torture and other cruel, inhuman or degrading treatment or punishment, and also places certain requirements on the states that have acceded to the convention.

That torture is prohibited is also made clear by many other international legal documents. The UN Universal Declaration of Human Rights stipulates that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment (Article 5). The prohibition of torture is also found in the UN International Covenant on Civil and Political Rights<sup>1</sup>, the UN Convention on the Rights of the Child<sup>2</sup> and the UN Convention on the Rights of Persons with Disabilities<sup>3</sup>.

The European Convention for the Protection of Human Rights and Fundamental Freedoms (the European Convention)<sup>4</sup>, and the Charter of Fundamental Rights of the European Union<sup>5</sup> also contain prohibitions of torture. The European Convention's prohibition of torture has been incorporated into Swedish law since 1995.

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1 Article 7 stipulates that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

2 Under Article 37, States Parties shall ensure that (a) no child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offences committed by persons below eighteen years of age. Article 39 states that a child victim of abuse or exploitation is entitled to rehabilitation and social reintegration.

3 Under Article 15.1, no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation. Article 15.2 states that States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.

4 Article 3 stipulates that no one shall be subjected to torture or to inhuman or degrading treatment or punishment.

5 Under Article 4, no one shall be subjected to torture or to inhuman or degrading treatment or punishment.

Sweden's Instrument of Government also prohibits torture. Under Chapter 2, Article 5 of the Instrument of Government, everyone shall be protected against corporal punishment. No one may be subjected to torture or medical intervention with the purpose of extorting or suppressing statements.

Under the European Convention, the perpetrator does not need to be a public official or otherwise represent the public institutions in order for it to be possible to demonstrate a violation of the prohibition of torture (Article 3). This provision protects not just those who are deprived of their liberty because they are suspected or have been convicted of an offence, but also others such as patients receiving compulsory care. States have no opportunity to make derogations from the protections in Article 3, not even in time of war.

## Definitions

Definitions of what constitutes torture are found in various documents. The definition in the Convention against Torture is the most comprehensive and is considered part of international common law.

Article 1 of the convention states:

“ [the term “torture” means] any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions. ”

What is encompassed by the term “cruel, inhuman or degrading treatment or punishment” cannot be inferred from the provisions of the Convention against Torture. That these acts are also prohibited is clear from Article 16 of the convention, which stipulates the following:

“ Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in Article 1, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity [...] ”

The prohibition of torture is absolute and there is no situation in which derogations can be permitted.

### An assessment

The UN Committee against Torture made an assessment of what might be contained within the term cruel, inhuman or degrading treatment in its decision in the case *Agiza v. Sweden* (CAT/C/34/D/233/2003). This decision referred to a decision by the then Chief Parliamentary Ombudsman, Mats Melin. Chief Parliamentary Ombudsman Melin had stated that the treatment that two men had to endure – from the time they were stripped at the airport in Sweden until the time they landed in Egypt – must be characterised as degrading and that enforcement had been carried out in an inhuman and thus unacceptable manner. The Chief Parliamentary Ombudsman also questioned whether enforcement had not been carried out in a manner that constituted a violation of Article 3 of the European Convention (JO 2005/06 p. 101). The praxis that has developed in the European Court of Human Rights (ECHR) is one of the most detailed sources of what is encompassed by the terms torture and inhuman or degrading treatment or punishment. As the European Convention is applicable as Swedish law, this legal praxis is of particular importance to Swedish conditions.

## Praxis

According to the ECHR, torture has some distinct features: it involves severe mental or physical pain or suffering inflicted intentionally for a specific purpose, for example to obtain information, as a punishment or as a form of intimidation. According to the ECHR, torture differs from inhuman or degrading treatment in terms of the intensity or severity of the pain and suffering.<sup>6</sup>

**Inhuman treatment**, according to the court, at least encompasses treatment that intentionally inflicts severe mental or physical suffering and which can be regarded in the specific situation as unjust.

**Degrading treatment** is treatment that evokes a sense of fear, anxiety or inferiority in the victim. Subjective circumstances such as the victim's gender and age are of great significance to determining whether treatment or punishment is degrading. Treatment can be degrading even if no one other than the victim themselves has witnessed or gained knowledge of it.

## Review bodies etc.

The UN Convention against Torture has been applicable in Sweden since 1987. The countries that have signed the convention are scrutinised by a special committee, the Committee against Torture (CAT). States are to report regularly on their compliance with the convention. If allowed by a acceding state, private individuals may also make complaints to the committee.<sup>7</sup> However, the UN convention does not give the committee a mandate to conduct visits in acceding states.

Non-governmental organisations<sup>8</sup> were early in arguing that the most effective way to prevent torture and other violations of persons deprived of their liberty would be to introduce a system that would give them the opportunity to conduct regular visits. Several states agreed with this view, and a protocol supplementing the convention to this effect was adopted in 2002. The Optional Protocol to the UN Convention against Torture is more commonly known as OPCAT.

OPCAT entered into force in 2006. OPCAT established an international committee, the Subcommittee on Prevention of Torture (SPT). It also stated that acceding states are to appoint one or more national preventive mechanisms (NPM<sup>9</sup>). The task of both the SPT and the national preventive mechanisms

### The CAT

The committee monitors how states implement the provisions of the Convention against Torture. This work primarily involves the committee reviewing reports submitted by the states themselves. States are reviewed every five years. Conclusions, comments and decisions from the committee's ten independent experts have the status of guidance with respect to the states that have ratified the convention. Sweden's latest report was reviewed in autumn 2014.

<sup>6</sup> Factors significant to the assessment are the duration of the abuse, its effects on physical and mental well-being, the victim's gender, age and state of health and how the abuse was carried out.

<sup>7</sup> Sweden allows complaints from private individuals.

<sup>8</sup> The International Commission of Jurists (ICJ) and the Swiss Committee against Torture (later the Association for the Prevention of Torture, APT)

<sup>9</sup> National Preventive Mechanism

is to visit places of detention in order to prevent those detained from being subjected to torture and other cruel, inhuman or degrading treatment.

The SPT has 25 independent members who are all experts in areas of relevance to the prevention of torture. These members are appointed by the states that are bound by OPCAT. An annual schedule sets out which countries are to be visited by the SPT. Sweden was the first country to be visited by the SPT.

The idea of independent bodies visiting places where persons may be deprived of their liberty gained an impact in Europe before OPCAT was adopted. The European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment had already entered into force in 1989. This convention established the European Committee for the Prevention of Torture (CPT), the principal task of which is to conduct regular visits to institutions in Europe at which persons deprived of their liberty are being held. All 47 of the Council of Europe's member states have ratified this convention.

Swedish authorities are obliged to cooperate with the SPT and the CPT (see the Act [1988:695] on certain international undertakings against torture etc.).

#### SPT report

The first country to be visited by the SPT was Sweden in 2008. The report with recommendations is available at [www.ohchr.org](http://www.ohchr.org)

### Focus of the work

The work pursuant to OPCAT shall be undertaken with a view to strengthening, if necessary, the protection of persons deprived of their liberty against torture and other cruel, inhuman or degrading treatment or punishment.<sup>10</sup>

Prevention can be conducted in several ways. Prohibiting the acts and prosecuting those guilty of abuses may be assumed to have some effect. Another way is to supervise and monitor the environments and situations in which there is a very high risk of abuse and violations, i.e. in connection with the deprivation of liberty.

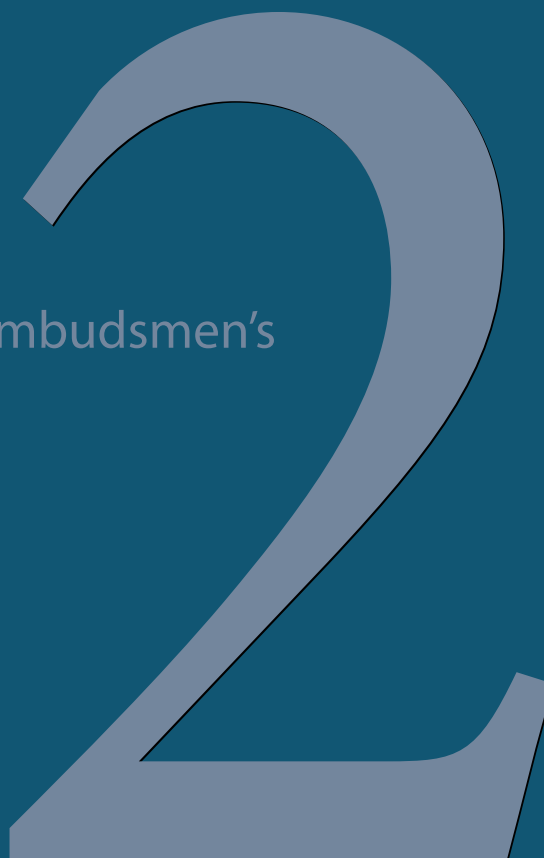
Prevention involves identifying and analysing factors that may directly or indirectly increase or decrease the risk of torture and other forms of ill treatment. It also aims to systematically reduce or eliminate risk factors and to strengthen preventive factors and protection mechanisms. This work is to be proactive. It is also to have a long-range perspective and a focus on bringing about improvements through constructive dialogue, proposals for protective mechanisms and other measures.

<sup>10</sup> Article 4(1) OPCAT





The Parliamentary Ombudsmen's  
OPCAT activities



## The focus of activities

The Parliamentary Ombudsmen supervises the activities of central government agencies, county councils and municipal authorities. This supervision includes individual officials within these agencies and others whose work involves the exercise of authority.

As mentioned earlier, the ombudsmen<sup>1</sup> are assisted by a special unit, the OPCAT unit<sup>2</sup>, in accomplishing the duties incumbent on a national preventive mechanism.

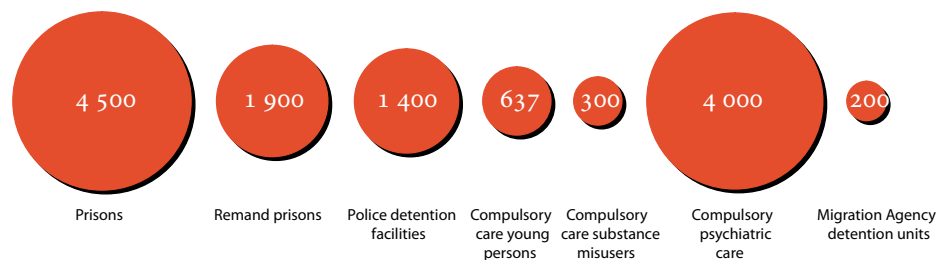
### Instructions

Section 5a The Parliamentary Ombudsmen also undertake the tasks incumbent on a national preventive mechanism pursuant to the Optional Protocol of 18 December 2002 to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

The first few years of the Parliamentary Ombudsmen's OPCAT activities have focused on inspections of the Swedish Prison and Probation Service, the Swedish Police Authority<sup>3</sup>, the National Board of Institutional Care (SiS), the county councils and the Swedish Migration Agency.

In 2014, Sweden had:

- 47 prisons (4 500 places)
- 31 remand prisons (1 900 places)
- 120 police detention facilities (1 400 places)
- 24 homes for the compulsory care of young persons (637 places)
- 11 homes for the compulsory care of substance misusers (300 places)
- At least 80 institutions for compulsory psychiatric care (ca. 4 000 places)
- 5 Migration Agency detention units (200 places)



## Regular inspection activities

OPCAT requires national preventive mechanisms to regularly visit places of detention. Regular inspection activities provide the opportunity to:

- effectively monitor improvements or deteriorations in the conditions of persons deprived of their liberty,
- keep a general watch to ensure that persons deprived of their liberty are informed of their rights,

<sup>1</sup> The ombudsmen are involved in the OPCAT assignment according to their respective supervisory areas.

<sup>2</sup> As of 1 February 2015, the OPCAT unit, formerly the NPM unit.

<sup>3</sup> As of 1 January 2015, the 21 police authorities have been merged into a single authority, see page 23.

- conduct a meaningful dialogue with the persons deprived of their liberty and with representatives of the authorities at both the local and central levels,
- monitor the working conditions of staff who work in the different facilities and obtain knowledge about how their working practices affect the situation of the persons deprived of their liberty.

### Selection of inspection objects

OPCAT activities are planned on a six-month basis. The focus of the plan for the years 2011–2014 was to inspect places other than those the ombudsmen had recently inspected in their traditional activities, that the inspections would be conducted at places all over Sweden and that remand prisons and police detention facilities would be prioritised. The reasons for prioritising remand prisons and police detention facilities was that their inmates are often in a vulnerable situation and have a very limited contact with the outside world.

Inspection objects have also been chosen on the basis of a need to further examine certain questions raised in the ombudsmen's complaints cases. Reports in the media have also led to the ombudsmen visiting certain places.

When planning inspections, it is also important to continuously monitor the work of other supervisory bodies.

### Working method

The elements and the procedure involved in an OPCAT inspection are the same regardless of the type of institution concerned. This contributes to the quality, comparability and credibility of both the performance and reporting of activities. Conversations with persons deprived of their liberty are prioritised and are conducted in the form of interviews. The information that is obtained during an inspection includes staffing and treatment, material conditions, opportunities for contact with the outside world, information about rights, coercive measures and opportunities to spend time outdoors.

Inspections are both announced and unannounced. Just over one third of the ombudsmen's inspections in the period 2011–2014 were unannounced. One lesson learned is that inspections that are announced can often be implemented effectively.

In order to increase the credibility and effectiveness of inspection activities, there should be a greater number of unannounced inspections.<sup>4</sup> Such inspections paint a more realistic picture of the inspection objects and any problems. According to the European Committee for the Prevention of Torture

#### Other supervisory bodies

The Swedish Health and Social Care Inspectorate's (IVO) remit includes the supervision of social services, which means that it can inspect LVU homes and LVM homes. The purpose of this supervision is one of inspection, prevention and promotion. IVO's supervision also focuses on patient safety pursuant to healthcare legislation. IVO supervises the healthcare provided at institutions run by the Swedish Prison and Probation Service and SiS. The Swedish Schools Inspectorate, which supervises schools, scrutinises the educational activities provided by the Swedish Prison and Probation Service and LVU homes.

<sup>4</sup> See JO 2013/14 p. 36.

(CPT), one of the most important elements of prison visits is that they are unannounced.

The observations made during an inspection are documented in a record and reported for each ombudsman. If there is a question that needs to be investigated specifically, an enquiry is initiated. However, the most common procedure now is that the ombudsman comments on the observations directly in the record. In the first two years, statements in records were not common. In 2014, almost every record contained a statement.

Among other things, the statements cover the importance of treating inmates with dignity. Statements sometimes contain reasoning concerning the deliberations in connection with coercive measures. Other issues that might be raised concern the opportunities for contact with the outside world. The records and statements can be accessed on the ombudsmen's website, [www.jo.se](http://www.jo.se).

Unannounced inspections				
Year	Police	Prison	Remand prisons	LVM
2011	1	0	1	0
2012	13	2	5	0
2013	7	2	5	1
2014 <sup>*)</sup>	3	0	1	0
<b>Total</b>				<b>41</b>

\*) In 2014, many inspections were announced one day before they commenced.

### Follow-up inspections and dialogues

That statements and recommendations from a national preventive mechanism actually leads to changes can be said to be the real test of whether the scrutiny conducted is truly effective.<sup>5</sup>

One aspect of follow-up can be to visit an institution again to see how the general situation has changed. The visit may also be the consequence of a specific recommendation directed at the authority or institution. Follow-up visits are generally regarded as constituting a natural part of prevention.

In 2014, the OPCAT unit began a follow-up inspection process. A follow-up visit was then made to the police detention facilities in Umeå to see whether there had been any change in the inmates' opportunities to spend time outdoors. During the inspection, it was noted that the Police Authority had still not ensured the inmates can be given the opportunity spend time outdoors. The ombudsmen then decided to continue monitoring the measures being implemented and are currently communicating with the Police Authority.

<sup>5</sup> Moritz Birk & Gerrit Zach, Enhancing Impact of National Preventive Mechanisms. Strengthening the follow-up on NPM recommendations in the EU: Strategic development, current practices and the way forward, Ludwig Boltzmann Institute of Human Rights, p. 16.

Dialogue is an important cornerstone of prevention. Among other things, the OPCAT unit has participated in the Police Authority's conferences concerning detention facilities and has had conversations at these with representatives of the police service from all across Sweden. The unit has also had several meetings with representatives of SiS.

### **Thematic focus**

The high number of inspections conducted in the initial years has provided a good foundation for how the ombudsmen can proceed with preventive efforts pursuant to OPCAT. One of the questions identified during inspections in the initial years was the situation of women who are deprived of their liberty. This led to the inspection of all the Prison and Probation Service's prisons for women and of a number of clinics for compulsory psychiatric care in 2015 as part of a special theme. Lessons learned from this review will be presented in 2016 in a special report on women in prison.



Opcat inspections 2011–2014



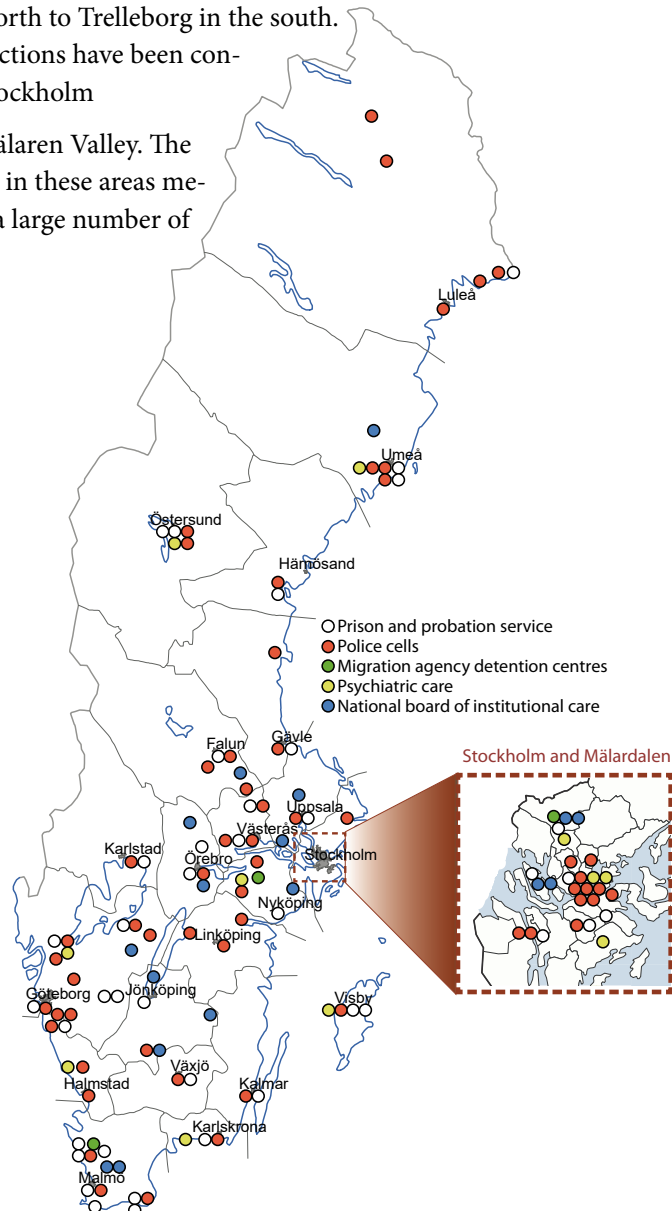
## Completed inspections

In the first three and a half years, a total of 109 inspections have been conducted. These are broken down as follows:

Number of inspections per year			
2011	2012	2013	2014
6	40	32	31

Inspections have taken place throughout Sweden, from Kiruna in the north to Trelleborg in the south. The majority of inspections have been conducted at places in Stockholm

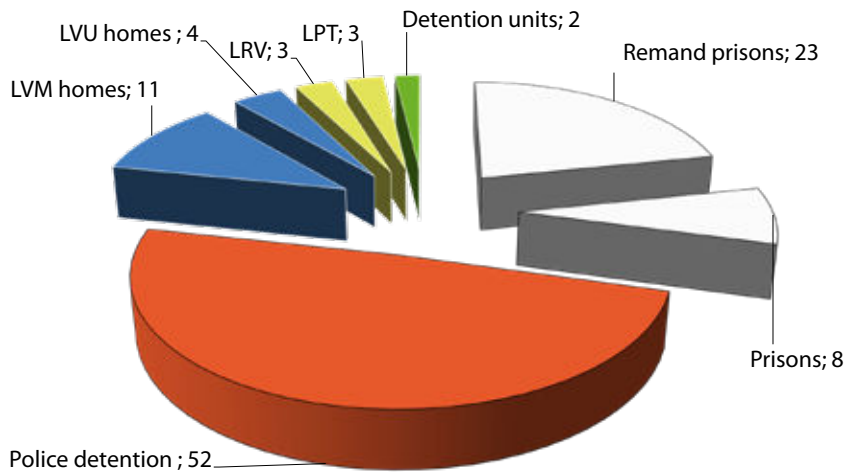
County and in the Mälaren Valley. The large population base in these areas means that there is also a large number of places of detention.





The inspections are broken down as follows:

Remand prisons 23, prisons 8, police detention facilities 52, LVM homes 11 (Care of Substance Misusers Act), LVU homes 4 (Care of Young Persons Act), LRV 3 (Forensic Mental Care Act), LPT 3 (Compulsory Psychiatric Care Act), and Migration Agency detention units 2.



The inspections in the period in question have led to the initiation of 22 enquiries.<sup>1</sup>

The inspections have revealed certain deficiencies in the treatment of inmates, including the way in which coercive measures are used. It is also clear that there are issues that need to be monitored over time. Having completed just over 100 inspections, the ombudsmen have a good evidence base with which to conduct a more systematic analysis of relevant issues. A selection of the observations made about each authority are reproduced below.

## The Swedish Police Authority

### General background

The police service was previously divided into 21 independent police authorities and the National Police Board (RPS). Each police authority was headed by a chief commissioner. The National Police Commissioner led the work at RPS and the principal task was to coordinate police activities in Sweden and allocate central government funding to the police authorities.

On 1 January 2015, the police service became a single authority under the leadership of a National Police Commissioner.

In total, there are about 120 police detention facilities around the country. Having prioritised inspections of police detention facilities, the ombudsmen

<sup>1</sup> See page 59

have visited 52 of these, including inspections of all places of police custody in Stockholm County.

### **Police detention facilities**

The inspections have revealed great differences in terms of the environment of the police detention facilities, the treatment of inmates, opportunities to spend time outdoors, information about rights, etc. Some police detention facilities have employed detention officers, some have agreements with security companies. As opportunities to spend time outdoors and information about rights are discussed in the next chapter, these themes are omitted here.

Aside from the statements in inspection records and in the decisions concerning three enquiries, the prioritisation of police detention facilities has resulted in continuous dialogue with the Police Authority and the unit responsible for detention facilities.

Of the 52 OPCAT inspections of police detention facilities, more than half have resulted in various statements. A selection of the observations is reported here.

#### *The training of cell guards with respect to the inmates' state of health<sup>2</sup>*

OPCAT inspections of police detention facilities always contain an element concerning the training that cell block personnel and police officers have. It is noteworthy that the police service has not previously begun an effort to improve the expertise of cell guards, and future efforts will be monitored during inspections and on other occasions.

In several decisions, the ombudsmen have emphasised the great responsibility that detention facility personnel (police officers and detention officers), inspectors and police commanders, in various respects, have for the inmates' state of health. Among other things, the ombudsmen have pointed out how important it is for cell guards to receive adequate training about confusable diseases. The enquiry initiated by the ombudsmen into the training etc. of cell guards showed that the police service is currently working to improve the expertise of cell guards and others with respect to their ability to assess the inmates' state of health and to take the necessary action.

#### *Risks in connection with camera surveillance<sup>3</sup>*

OPCAT inspections have shown there is a risk that women may be searched in front of a surveillance camera.

In response to the finding that female inmates in some police detention facilities may be searched in front of surveillance cameras, the ombudsmen have emphasised the following:

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<sup>2</sup> Ref. no. 808-2014

<sup>3</sup> Ref. no. 4111-2013, ref. no. 5260-2013, ref. no. 626-2014

If a woman deprived of her liberty is asked to remove all items of clothing from her upper body in front of personnel, this is to be equated with a superficial body search. Pursuant to Chapter 4, Section 7 of the Act on Detention, a body search of a woman may not, except for the taking of urine, breath, saliva, sweat, blood or hair samples, be carried out or witnessed by anyone other than a woman, a doctor or a registered nurse.

The ombudsman presumed that the police authority would review its procedures in order to ensure that searches of female inmates are no longer performed in areas that are subject to camera surveillance, but in another suitable place such as an empty cell.

#### *Cell standard<sup>4</sup>*

Observations have been made in conjunction with several OPCAT inspections about an inadequate standard as regards cell design, particularly in terms of hygiene and natural lighting.

The ombudsmen have requested that the police service review its procedures in order to avoid the placement of persons deprived of their liberty in cells that have not been cleaned or have not been cleaned in a satisfactory manner. Some of the police detention facilities have been asked to review a procedure that results in inmates not having had access to sheets and pillow cases and to take action to increase the amount of natural light in cells. In the record of the inspection of the police cell block in Norrköping, the ombudsmen stated that the police authority should avoid placing apprehended/arrested persons in sobering-up cells as these cells are not equipped with a table and chair. The consequence of such a placement is that apprehended/arrested persons have to sit on the floor to eat their meals.

#### *Inadequate documentation in the supervision of inmates etc.<sup>5</sup>*

The Care of Intoxicated Persons Act (1976:511) contains provisions on how often an inmate is to be attended to. The police service also has a praxis whereby inmates are attended to at least once an hour. The ombudsmen have expressed themselves concerning inadequate documentation and in some cases inadequate supervision of inmates in police detention facilities.

During several inspections, it has been noted when inmates are supervised, their status is rarely documented, for example in terms of whether the inmate is asleep or awake. Documenting information of this kind makes it possible to subsequently review what has happened to the inmate. This documentation is also important for other personnel involved in the supervision of the inmate. According to the ombudsman, it is important that the police service ensures that there are clear procedures for taking notes when supervising inmates.

#### **The Ombudsman for Children**

The Ombudsman for Children in Sweden submitted a report in 2013. The report *Från insidan* is a review of how human rights are respected when children (under 18) are suspected of crimes and deprived of their liberty. The Ombudsman for Children in Sweden visited a total of 13 police detention facilities and remand prisons around the country. Among other things, the agency was critical of how it is not possible to obtain statistics on how many children are placed in police cell blocks and the average duration a child's is deprived of their liberty. The Ombudsman for Children in Sweden states that its review shows systematic and very far-reaching shortcomings in the observance of the fundamental human rights of children deprived of their liberty.

<sup>4</sup> Ref. no. 6385-2013, ref. no. 626-2014, ref. no. 3257-2014

<sup>5</sup> Ref. no. 1997-2013, ref. no. 4111-2013, ref. no. 2574-2013, ref. no. 2187-2014, ref. no. 3284-2014

### *Healthcare in police detention facilities*

Of the 52 police detention facilities inspected, Davidshall in Malmö was the only one to have procured a service that involved a doctor being on site for a number of hours each day to assess the inmates' state of health.

In the period 2011–2014 there were about 20 fatalities in police detention facilities around the country. Over half of these fatalities were people who were detained pursuant to the Care of Intoxicated Persons Act (LOB).

This act states that, if necessary with reference to the condition of the person in custody, they shall be examined by a doctor as soon as this can take place. The person in custody shall be taken to hospital, or a doctor called, as soon as this can take place if the person's condition occasions this. The legislative history of the act stresses the importance of guards having access to instructions that provide guidance in terms of which cases should be subject to regular medical examination and that also highlight conditions in the event of confusable diseases (Govt. bill 1975/76:113, p. 124).

The OPCAT inspections have shown that access of healthcare varies. It is usually the police inspector in charge who decides whether a doctor is to be called and whether medicine is to be administered. The training of police detention facilities personnel includes some healthcare, e.g. cardiopulmonary resuscitation. Most of the inspected police detention facilities have no specific procedures with respect to inmates with diabetes or other confusable diseases. Defibrillators and a small amount of medical equipment were available at all the police detention facilities inspected. If there is a sobering-up unit (TNE), intoxicated persons are taken there if places are available. At all locations where there is a special sobering-up unit, it is the police service's view that there are too few places, which means that intoxicated persons still have to be taken into police cells. At some police detention facilities that have an agreement with the Prison and Probation Service, e.g. City Norrmalm and Uppsala, inmates have access to the Prison and Probation Service's healthcare once their cases have been transferred to the service.

#### **Sobering-up unit – TNE**

There are sobering-up units (TNE) at several locations in Sweden. These are often located in special centres for dependency disorders or hospitals. The number of persons in custody pursuant to the Care of Intoxicated Persons Act in 2009 was approximately 62 000 according to *Missbruksutredningen* (The Substance Misuse Inquiry) (SOU 2011:35 p. 330f.).

As early as the 1970s, the Parliamentary Ombudsmen expressed the opinion that the police should make arrangements for the medical examination of an intoxicated person as soon as there might be the least reason for this (JO 1975/76, p. 124). The Parliamentary Ombudsmen has also made statements saying that there are strong reasons to suggest that diabetics should be examined by a doctor (JO 1982/83 p. 82).

There are also Parliamentary Ombudsmen decisions from more recent years. In one case, which concerned the care of an intoxicated woman, there was a note that she suffered from diabetes. She received no particular attention or any particularly careful check. In the first few hours, her supervision consisted only of establishing that she was lying down. The Parliamentary

Ombudsmen stated that very serious consequences can result from incorrectly assessing the state of health of a person in custody. In this case, the Parliamentary Ombudsman criticised the police because the woman was not attended to in the manner that would have been routine for a diabetic and because the personnel did not have the training required in order to undertake the supervisory duties incumbent on them.<sup>6</sup>

Access to healthcare for inmates in police detention facilities will continue to be an important matter for the Parliamentary Ombudsman to monitor in connection with inspections of police detention facilities.

## The Swedish Prison and Probation Service

### General background

One of the Swedish Prison and Probation Service's tasks is to enforce the punishments decided by the courts. Of the Prison and Probation Service's approximately 4 500 ordinary prison places, about 280 are places specifically for women, and there are 6 women's prisons. The prisons are divided into three security classifications, with classification 1 being the highest. In September 2014, the average occupancy rate in prisons was 84 per cent.

The Prison and Probation Service has remand operations at over thirty remand prisons. Some remand prisons have special sections for women and young persons under the age of 21.<sup>7</sup> Several remand prisons are in the same location as the police and in a number of locations, the Prison and Probation Service and the police have cooperation agreements<sup>8</sup> that involve people who are apprehended, in custody and under arrest are taken care of by the Prison and Probation Service in the remand prison's premises.

For a very long time, the Parliamentary Ombudsmen has been conducting regular inspections of the Prison and Probation Service, particularly its prisons. As part of its remit as National Preventive Mechanism, the Parliamentary Ombudsmen has inspected 23 remand prisons and 8 prisons, two of which are women's prisons.<sup>9</sup> For 18 remand prisons and 3 prisons, it was the first time that they had received a visit from the Parliamentary Ombudsmen. A total of 10 enquiries<sup>10</sup> have been initiated in response to observations made during these inspections.

Since inspections have been taking place for a long time and the Parliamentary Ombudsmen has also made decisions in a very large number of complaints cases, there is an abundance of decisions that provide support to

6 Ref. no. 5244-2011 (JO 2012/13 p. 158)

7 Helsingborg Remand Prison (women's section), Malmö Remand Prison (young person's section).

8 Stockholm, (Kronoberg), Uppsala, Östersund and from 1 February 2015 Göteborg.

9 Färingsö Prison and Ljustadalen Prison.

10 See p. 59

### Victim-offender mediation

Victim-offender mediation (BOS) takes place in specifically designated prisons for those convicted of relational and sexual offences. These prisons have special expert groups to assist in investigations ahead of client decisions, participate in victim-offender mediation and undertake follow-up. Victim-offender mediation visits are an opportunity for victims and offenders to meet in the presence of specially trained correctional care personnel.

In remand prisons, there might be a focus on the victim's perspective when cases are processed, as regards matters including permission for visits and electronic communications.

OPCAT activities. The following section contains a number of observations made in connection with OPCAT inspections and about which the Parliamentary Ombudsmen found no reason to make a statement.

## Remand prisons

### *Victim-offender mediation in remand prisons<sup>11</sup>*

One of the first OPCAT inspections of a remand prison noted that Uppsala Remand Prison worked with victim-offender mediation activities (BOS). The same model was observed at a later inspection of Salberga Remand Prison. The Parliamentary Ombudsman investigated the issue in a special case.<sup>12</sup> The decision emphasised that it is inappropriate to use the terms “victim” and “offender” in the context of inmates who have not been convicted of a crime. It was also established that it is not possible for the Prison and Probation Service to keep a promise to the effect that information from a prospective visitor is never allowed to reach the inmate. The Parliamentary Ombudsman's decision also made a statement about the boundary between the duties of the Prison and Probation Service and social services with regard to contact with the injured party.

### *The temporary remand prison premises in Östersund<sup>13</sup>*

It is extremely doubtful whether the current design of the temporary remand operations in the police detention facilities in Östersund is consistent with the legislature's intentions concerning the treatment of inmates on remand.

The Act on Detention contains two opening paragraphs. Chapter 1, Section 4 of the Act on Detention states that every prisoner shall be treated with respect for his or her human dignity and with understanding for the special difficulties associated with the deprivation of liberty. Furthermore, Chapter 1, Section 5 states that enforcement shall be devised so as to counteract the negative consequences of deprivation of liberty.

Since 2006, the Prison and Probation Service has had nine provisional remand places in the police cell block in Östersund. These remand places are housed in the same corridor as the police's sobering-up and arrest cells. Following an inspection, the Parliamentary Ombudsman noted that the premises are not suitable for longer periods of detention and lacked common spaces and a gym, for example. This leads to a high degree of isolation for inmates. Placement in the remand prison thereby risks reinforcing the negative consequences of deprivation of liberty. For this reason, the Parliamentary Ombudsman stressed that the Prison and Probation Service should seriously consider

<sup>11</sup> Ref. no. 83-2012, ref. no. 1015-2012

<sup>12</sup> Ref. no. 2241-2012

<sup>13</sup> Ref. no. 6386-2013

the appropriateness of continuing to place persons deprived of their liberty in these premises.

#### *Women's opportunities for association<sup>14</sup>*

Women in remand prisons rarely have the opportunity to associate with other inmates as they are few in number or are in one of the smaller remand prisons. According to the Parliamentary Ombudsman, the Prison and Probation Service should actively try to make it possible for women to associate with other inmates.

According to the principal rule in Chapter 2, Section 5, first paragraph of the Act on Detention, inmates on remand shall be given the opportunity to associate during the day with other inmates. Section 2 of the same chapter states that an inmate may not be placed so that he or she is together with inmates of the opposite sex. However, an inmate may be permitted to be together with inmates of the opposite sex if this is appropriate and the prisoners consent to it. As regards female inmates at smaller remand prisons, there are generally two options available. Either the remand prison has its female inmates separated or offers them the opportunity to associate with male inmates. In the Parliamentary Ombudsmen's view, the latter option is preferable.

## Prisons

#### *The situation of inmates in Visby Prison<sup>15</sup>*

Most prisons have more than 30 places. An inspection of Visby Prison, which is Sweden's smallest prison with only five places, revealed that there are limited opportunities for occupation in the relatively small prison premises and that the prison itself questions the suitability of inmates being placed there for periods longer than one year.

The inmate's need of occupation, care and appropriate release planning shall be taken into account to the extent possible when deciding on placement.<sup>16</sup> Following the inspection of Visby Prison, the Parliamentary Ombudsman stressed that it is important that the Prison and Probation Service make a careful assessment of an inmate's needs and of whether the placement might in itself have negative consequences for the inmate when deciding where to place them. This is particularly important for placements at Visby Prison as it is not possible to separate the inmates by category. According to the Parliamentary Ombudsman, it is also important that the prison expands the range of activities offered to inmates, not least the opportunities for meaningful organised occupation.

#### The European prison rules

The recommendation on the European Prison Rules was adopted by the Committee of Ministers of the Council of Europe on 11 January 2006, Rec(2006)2.

The European Prison Rules contain basic principles, including the principle that all persons deprived of their liberty are to be treated in a way that respects their human rights.

Link to the Council of Europe  
[www.coe.int](http://www.coe.int)

<sup>14</sup> Ref. no. 5261-2013, ref. no. 1770-2014

<sup>15</sup> Ref. no. 2768-2013

<sup>16</sup> Chapter 2, Section 1, second paragraph of the Act on Imprisonment

### *When can visitors be frisked?*<sup>17</sup>

Ljustadalen Prison has 20 places for women in the lowest security classification. An inspection of the prison revealed that all visitors are routinely frisked. According to the Parliamentary Ombudsman, the Prison and Probation Service must ensure that an individual examination of the need for a frisk search is performed in connection with visits.

Ljustadalen Prison is not covered by any decision concerning general entry control. During the inspection, when the Parliamentary Ombudsman's employees were frisked, reference was made to the general entry check applied by the prison. The prison's decisions concerning visitor permits did not specify that the visitor might be subject to a frisk search. To avoid an application that in practice means a general entry check, the Prison and Probation Service was requested to ensure that there is an individual examination.

## **The National Board of Institutional Care**

### **General background**

Social service interventions for children and young people with substance misuse problems are based on the voluntary participation of the individuals concerned. Under certain conditions, care without consent can become pertinent. Provisions concerning such compulsory care are found in the Care of Young Persons (Special Provisions) Act (1990:52) [LVU] and the Care of Substance Misusers Act (1988:870) [LVM].

### *LVU*

Care pursuant to the LVU can be provided to those who are under 20 years of age and are subjecting their health or development to a palpable risk of harm through the use of addictive substances, criminal activity or some other socially destructive behaviour.<sup>18</sup>

If a social services investigation concludes that the young person is to be afforded care pursuant to the LVU, social services are to submit an application for care to the administrative court, which examines whether there are grounds for such care.<sup>19</sup>

If it is not possible to wait for the administrative court's decision, social services can under certain circumstances decide that the young person be taken into care immediately.<sup>20</sup>

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<sup>17</sup> Ref. no. 2930-2014

<sup>18</sup> Section 3, LVU

<sup>19</sup> Section 4, LVU

<sup>20</sup> Section 6, LVU



### LVM

A decision to impose compulsory care pursuant to the LVM is to be made if a person, as a result of ongoing misuse of, for example, alcohol or drugs, is in need of care to get away from their misuse, and the care requirement cannot be met with the support of the provisions of the Social Services Act. A decision to impose compulsory care is to be made if the individual, as a result of their misuse, is subjecting their physical or mental health to serious danger.<sup>21</sup>

A decision to impose compulsory care is made by the administrative court. It is social services that investigates the individual's care requirement and applies for compulsory care.<sup>22</sup> Social services can take the individual into care pending the administrative court's examination of the care application, e.g. if it is not possible to wait for the court's decision due to the potential for a serious deterioration in the individual's state of health if he or she does not receive immediate care.<sup>23</sup>

### *Act (1998:603) on the enforcement of institutional care of young persons (LSU)*

If someone has committed an offence before he or she has reached the age of eighteen and the court finds that the sanction of prison should be imposed, the young person shall, according to the main rule, instead be sentenced to a period of institutional care. The period of institutional care of young persons is no less than fourteen days and no more than four years. Institutional care of young persons is to take place at an LVU home (see below). The National Board of Institutional Care is responsible for enforcement.<sup>24</sup>

### **Special residential homes for young people and LVM homes**

For the care of young persons who are in care pursuant to Section 3, LVU and who need to be under particularly close supervision, there shall be special residential homes for young people (referred to below as LVU homes). Compulsory care pursuant to the LVM is provided by means of LVM homes. For substance misusers who need to be under particularly close supervision, there shall be LVM homes adapted for such supervision. The need for LVU and LVM homes is to be satisfied by central government. It is the National Board of Institutional Care (SiS) that operates these homes. The responsibility of SiS includes the planning, management and operation of the homes and the allocation of places at the homes.<sup>25</sup>

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21 Section 4, LVM

22 Sections 5 and 7, LVM

23 Section 13, LVM

24 Chapter 32, Section 5 of the Swedish Penal Code, Sections 1 and 3, LSU

25 Section 12, LVU, Sections 22–23, LVM, Chapter 6, Section 3 of the Social Services Act (2001:453) and Sections 1 and 2 of the Ordinance (2007:1132)

There are 24 LVU homes that are spread throughout Sweden. The LVU homes have emergency, investigatory and treatment places. Most places are at units that can be locked. Some LVU homes accept both boys and girls, but place them in different sections. There are also homes where boys and girls live in the same section.

In the period under review, there were 11 LVM homes. The homes have places for the treatment of withdrawal problems, motivation and transition.

### **IVO's supervision of LVU homes and LVM homes**

The Health and Social Care Inspectorate (IVO) supervises the activities at LVU and LVM homes.<sup>26</sup> Within the scope of this supervision, IVO is to inspect all LVU homes at least once a year. In conjunction with an inspection, IVO is to speak with the children and young persons who consent to this.<sup>27</sup>

In practice, the Parliamentary Ombudsmen's supervision of LVU and LVM homes has long focused on examining complaints from those who are cared for at these homes or from their relatives. The Parliamentary Ombudsmen has also reviewed the homes in enquiries, i.e. investigations not occasioned by a complaint, but which the Parliamentary Ombudsmen has initiated due to reports in the media, for example. During the period covered by this report, the Parliamentary Ombudsmen has inspected four LVU homes and eleven LVM homes as part of its remit as National Preventive Mechanism.

### **Observations during inspections of LVU homes**

#### *How are those inmates who are placed in isolation treated?<sup>28</sup>*

During an interview at the LVU home, Rebecka revealed that an inmate, in conjunction with being placed in isolation, had not been allowed to go to the toilet. During an inspection of the LVU home Stigby, information was obtained that indicated an inmate who is placed in isolation always wore special clothes.

With reference to the information that a young person had not been allowed to go to the toilet, the Parliamentary Ombudsman stated the following:

“Inmates in a residential home for young people have the right to be treated with dignity. In the event of intrusive measures, such as holding someone in isolation, it is important that inmates are not subjected to treatment that might be perceived as degrading or abusive. For example, directing a isolated inmate to urinate in a waste paper basket cannot be considered satisfactory.”

<sup>26</sup> Chapter 13, Section 1 of the Social Services Act (2001:453)

<sup>27</sup> Chapter 3, Section 19 of the Social Services Ordinance (2001:937). Prior to 1 January 2016, IVO would visit LVU homes twice a year.

<sup>28</sup> Ref. no. 2360-2012, ref. no. 2443-2013

SiS submitted a statement in the investigation initiated following an inspection of the LVU home Stigby.<sup>29</sup> It emerged that an inmate placed in isolation has to change into special clothes, a t-shirt and knee-length shorts. The LVU home Stigby had this procedure in order to ensure the safety of the individual during their isolation.

In light of this statement, the Parliamentary Ombudsman made no further comment on the question of clothing. However, the Parliamentary Ombudsman stated that the question of whether it is necessary for an inmate to change clothes before being placed in isolation must always be assessed in the individual case, and the LVU home Stigby was requested to review its procedures.

### Observations during inspections of LVM homes

#### *Inmates' opportunities for contact with the outside world<sup>30</sup>*

No general examination of an inmate's incoming mail is permitted. A decision must be made in each individual case on whether the conditions for this have been fulfilled.

During an inspection of the SiS LVM home Hessleby, it was noted that the home had a mail processing procedure whereby its inmates were forced to open all incoming letters in the presence of personnel. However, no decision concerning examination had been made in the individual cases, and the home was criticised by the Parliamentary Ombudsman for this.

The Parliamentary Ombudsman also made a statement on the possession of mobile phones etc. Pursuant to Section 31, LVM, an inmate at an LVM home may not possess anything that might, among other things, be detrimental to care or order at the home. An inspection of the LVM home Hessleby revealed that its inmates, pursuant to this provision, were not permitted to possess mobile phones. They were, however, allowed to have their own computers with access to the internet. The Parliamentary Ombudsman did not have any views on whether the individual should be allowed to have access to their own mobile phones or computers. However, the Parliamentary Ombudsman did emphasise that it might, as stated by inmates during the inspection, seem "illogical" to ban mobile phones, but allow computers. According to the Parliamentary Ombudsman, this might provide grounds for SiS to consider the issues surrounding the possession of mobile phones and computers in more detail at a central level.<sup>31</sup>

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<sup>29</sup> Ref. no. 5415-2013

<sup>30</sup> Ref. no. 6378-2012, ref. no. 2793-2013

<sup>31</sup> Ref. no. 6378-2012

*Inmates are to be able to eat their meals in a place other than their bed*<sup>32</sup>

An inspection revealed that inmates in the special admission section had to eat their meals in bed. The Parliamentary Ombudsman presumed that this deficiency will be rectified so that inmates can eat their meals in a dignified manner.

The admission section at the LVM home Runnagården has two double rooms. At the time of inspection, there were no tables or chairs in the rooms, which is why the inmates had to eat their meals in bed.

*Opportunity to spend time outdoors?*<sup>33</sup>

Outdoor access that is limited to spending time on a balcony cannot be regarded as satisfying an inmate's needs.

An inspection of the LVM home Renforsen revealed that its women's section does not have an exercise yard. When there is no exercise yard, it is presumed that SiS will take action to ensure that inmates have the opportunity to spend a sufficient period outdoors each day.

*Threats of violence have led to inmates being released from the LVM home*<sup>34</sup>

On several occasions in connection with threatening situations, personnel at the LVM home have chosen to allow inmates to leave the home.

An inspection of the LVM home Rällsögården revealed that personnel at the home lacked the physical prerequisites to forcibly remove inmates to an isolation room and that there had been instances of personnel choosing to allow inmates to leave the home in connection with threatening situations. A special enquiry was initiated on the basis of this information.<sup>35</sup>

## Compulsory psychiatric care

### General background

Institutional compulsory psychiatric care facilities have been inspected by the Parliamentary Ombudsmen on 27 occasions since 1990. In the period 2011–2014, a total of five OPCAT inspections were conducted at compulsory psychiatric care facilities. An inspection has also been made of the National Board of Forensic Medicine's department for forensic psychiatric examination in Stockholm. During these inspections, major variations in how the care environment is designed have been noted. Two special enquiries have been initiated on the basis of these inspections. One enquiry concerned the confiscation of a magazine.<sup>36</sup> The other enquiry concerned the question of whether it is compatible with the regulations concerning care pursuant to the LPT

<sup>32</sup> Ref. no. 1309-2014

<sup>33</sup> Ref. no. 5530-2014

<sup>34</sup> Ref. no. 4939-2014

<sup>35</sup> Ref. no. 7163-2014, see p. 45

<sup>36</sup> Ref. no. 5529-2013, ref. no. 1578-2014

for a patient to be given – voluntarily or forcibly – ECT treatment outside of the county council's care facilities.<sup>37</sup> Below is a summary of the observations made during one inspection.

## Observations during the inspection of a compulsory psychiatric care facility

### *The care environment's significance to patients<sup>38</sup>*

Patients in compulsory psychiatric care are in a vulnerable situation. The care environment is of particular significance as the patients, in practice, live at the care facility, and the care environment becomes part of their living environment. It is vital that attention is paid to the care environment when planning the provision of such services.

During an inspection of the psychiatric department at Visby Hospital, it was found that there were limited opportunities for offering patients who are receiving care pursuant to the LPT something to occupy themselves with. Furthermore, the opportunities for physical exercise were poor and there was, in practice, no opportunity to obtain occupational therapy since this is granted only after a referral is processed. It also emerged that the processing of referrals almost always took so long that the compulsory care of the individual had ceased before the decision on occupational therapy had been made.

The Parliamentary Ombudsman found the system in place at the department in question to be unsatisfactory and emphasised that it was vital that Region Gotland make it possible for the clinic to offer patients a real opportunity to occupy themselves. The Parliamentary Ombudsman also gave a reminder that the European Committee for the Prevention of Torture (CPT), following its visit to Sweden in 2009, had stressed the importance of care containing both therapy and exercise as well as other forms of occupation.<sup>39</sup>

## Migration Agency detention units

### General background

The Swedish Migration Agency has five detention units: Åstorp, Märsta, Kålleröd, Flen and Gävle. A case in which an alien has been detained is processed either by the Swedish Migration Agency or the Police Authority. Until 2009, the Parliamentary Ombudsmen had not inspected the Migration Agency's detention units. In one year (2010), visits were made to all detention units as part of a special project that was reported on in a decision in May 2011. The Parliamentary Ombudsman's decision criticised the Migration Agency for shortcomings that included having placed of detainees who pose only a danger to themselves on remand without legal support and having incorrectly

<sup>37</sup> Ref. no. 1491-2013, ref. no. 3953-2013

<sup>38</sup> Ref. no. 2756-2013

<sup>39</sup> CPT Standards, Extract from the 12th General Report, p. 34

applied the rules concerning placing detainees who constitute a security risk in the correctional care system. The Parliamentary Ombudsman also criticised the Migration Agency for routinely allowing some of these placements in the correctional care system, known as transport placements, to continue for an excessively long period and for having delegated the right to make decisions concerning placement in the correctional care system to too low a level. As part of its OPCAT activities, the Parliamentary Ombudsman has followed up the decision with inspections of two of the detention units.<sup>40</sup>

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<sup>40</sup> Åstorp ref. no. 4858-2012, Märsta ref. no. 2188-2014

OPCAT inspections and  
follow-up ombudsman  
decisions



## Opportunities for persons deprived of their liberty to spend time outdoors

The legislation concerning the right of persons deprived of their liberty to spend time outdoors varies between the different areas. Under the Act on Detention, an inmate in a police cell or remand prison shall be given the opportunity to spend at least one hour each day outdoors unless there are exceptional reasons for not providing this opportunity. A corresponding regulation is found in the Act on Imprisonment.

### Outdoor access

As regards outdoor access, the European Committee for the Prevention of Torture (CPT) has recommended that persons who are deprived of their liberty by the police for 24 hours or longer be offered the opportunity to spend time outdoors (see CPT Standards, Extract from the 12th General Report, p. 48)

The legislation on compulsory psychiatric care (LPT and LRV)<sup>1</sup> contains no provisions that expressly give persons deprived of their liberty the right to spend time outdoors. In addition, the LVU or LVM do not contain any such provisions. With respect to persons receiving care pursuant to the LVU, the Parliamentary Ombudsmen has previously stated that it should perhaps be considered whether there is reason to introduce statutory provisions on the right to outdoor access similar to those in the correctional system.<sup>2</sup> The question of inmates' right to daily outdoor access has been raised in several complaints to the Parliamentary Ombudsmen. During the CPT's visit in 2009, Sweden was recommended to ensure that persons deprived of their liberty are offered daily outdoor access.

The question of the right to outdoor access is being monitored as part of the OPCAT activities. The inspections during the period showed that the police service does not ensure that inmates have the opportunity to go outdoors every day in the same way as the Prison and Probation Service does. Furthermore, the inspections of police detention facilities also indicated deficiencies as regards information about rights. In some cases, it was also found that there was a complete lack of opportunities to offer outdoor access. This question has therefore been subject to special investigation, and a summary of this is presented below.<sup>3</sup>

### Outdoor access for inmates in police detention facilities

In a statement in the Parliamentary Ombudsman's case the National Police Board confirmed the existence of marked shortcomings in terms of opportunities to spend time outdoors and the design of exercise yards. The Parliamentary Ombudsman stated in the decision that it had emerged that not all police detention facilities have exercise yards, and that inmates' opportunities to spend time outdoors at a couple of police detention facilities are dependent on staffing. In the decision, the Parliamentary Ombudsman stressed

<sup>1</sup> The Compulsory Psychiatric Care Act (1991:1128) [LPT] and the Forensic Mental Care Act (1991:1129) [LRV]

<sup>2</sup> Ref. no. 1474-2004

<sup>3</sup> Ref. no. 2054-2013



that the right to outdoor access is normally an unrestricted right that the police must satisfy. It is therefore vital that the police service guarantees this as soon as possible. The Parliamentary Ombudsman also pointed out that it emerged that several police detention facilities lacked procedures for informing inmates of their right to outdoor access. Where procedures for this did exist, they appeared to be inadequate in many cases. For example, it was unclear who was responsible for providing this information. The Parliamentary Ombudsman's decision emphasised the importance of an inmate being informed of their right to outdoor access in order for him or her to have the opportunity to exercise this right. Furthermore, the National Police Board has announced its intention to produce new regulations for police detention facilities, including provisions concerning information to inmates about the opportunity to spend time outdoors each day. In view of the inadequate procedures the investigation has revealed, the Parliamentary Ombudsman noted that it was vital that these regulations come into force as soon as possible.

### **Outdoor access in the prison and probation system**

The meaning of what constitutes “exceptional reasons” for not offering outdoor access has been discussed in two decisions from 2013.<sup>4</sup>

One decision concerned an inmate who had been forced to wear handcuffs in the walking yard because the doors to the remand prison's exercise yards lacked “handcuff hatches”. If the inmate had not accepted wearing handcuffs, there would, according to the remand prison, be exceptional reasons for denying him daily outdoor access. According to the Parliamentary Ombudsman, it would have been possible for the remand prison to anticipate the need for handcuff hatches, thus rendering the exception to the Act on Detention inapplicable. According to the Parliamentary Ombudsman, it should not be possible – if circumstances are within the authority's control – for the Prison and Probation Service to deny an inmate outdoor access with reference to deficiencies in the physical environment and inadequate staffing levels.

The second decision discussed an incident in which the Prison and Probation Service, when separating inmates, had denied an entire section daily outdoor access for a number of days. According to the Parliamentary Ombudsman, the Prison and Probation Service can deny inmates outdoor access in the initial stage of a period of isolation. According to the Parliamentary Ombudsman however, if the isolation period is protracted, it can hardly be claimed that the situation is unforeseen. Immediately after making a decision on isolation, a prison is thereby obliged to commence planning so as to make it possible to offer inmates one hour of daily outdoor access as soon as possible.

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<sup>4</sup> Ref. no. 1864-2013, ref. no. 4379-2013

## Outdoor access for persons deprived of their liberty within the compulsory psychiatric care system

The Parliamentary Ombudsman has also issued a statement concerning opportunities for persons deprived of their liberty receiving care under the compulsory psychiatric care legislation to spend time outdoors. The Parliamentary Ombudsman's decision concerning the Forensic Psychiatry Unit at Falköping Hospital<sup>5</sup> stated, among other things, that the basic premise should be to give patients the opportunity to spend at least one hour per day outdoors.

In the same decision, the Parliamentary Ombudsman took a position on the question of whether balcony access can be equated to outdoor access. The Parliamentary Ombudsman stated that the aim of care is naturally for the patient's condition to improve so much that the need for compulsory care no longer exists. Outdoor access that is limited to taking place on a balcony cannot be considered to satisfy the patient's needs, and such a limitation is probably also incompatible with the CPT's recommendations. This decision has been followed up with statements in several inspection records, for example from the OPCAT inspection of Ward 34 at Löwenströmska Hospital.<sup>6</sup>

During its visit to Sweden in 2009, the CPT stated that exercise yards should have protection against harsh weather conditions. The inspection of the National Board of Forensic Medicine's newly built examination department in Stockholm noted that the exercise yard lacked protection against precipitation. The Parliamentary Ombudsman stated that it was noteworthy that the National Board of Forensic Medicine had chosen not to follow the CPT's earlier recommendation in its new building. The National Board of Forensic Medicine was requested to take action as soon as possible in order to give its inmates the opportunity seek shelter from precipitation etc. under a roof.<sup>7</sup>

## Information about rights

### General

During its visit to Sweden in 2008, the SPT drew attention to the fact that the police did not provide persons deprived of their liberty with information about their rights in a systematic and uniform manner. The police service responded that a draft information sheet<sup>8</sup> existed, but that for various reasons it had not been finalised. The SPT then recommended that the police service

<sup>5</sup> JO 2011/12 p. 471, ref. nos. 6823-2009 and 2196-2010

<sup>6</sup> Ref. no. 4580-2012

<sup>7</sup> Ref. no. 5229-2013

<sup>8</sup> The National Police Board's and the Prosecutor-General's information sheet (Information for persons suspected of a crime and therefore deprived of liberty).

finalise the information sheet as soon as possible for subsequent distribution to all police stations.

In its response to the SPT's report, the Government announced that an information sheet, in 40 different languages, had been finalised and made available in December 2008 for use in police detention facilities.

The issue of information about rights is central in conjunction with a deprivation of liberty. One prerequisite for inmates to be able to assert their rights is that they are aware of them. OPCAT inspectors always ask questions about whether information about rights has been provided and this question is followed up during their conversations with inmates. The Parliamentary Ombudsman has repeatedly found that the authorities do not provide information about rights in a systematic manner. Another question is whether the information that is provided is adapted so that it is understandable to the recipient. The issue of information for inmates in police detention facilities has been investigated by the Parliamentary Ombudsman.

### Police detention facilities

The Parliamentary Ombudsman's decision<sup>9</sup> emphasised that a deprivation of liberty is a serious encroachment on personal freedom and that it is very important that persons deprived of their liberty are given information about their rights. Among other things, this is a prerequisite if they are to be able to assert these rights.

The Preliminary Investigations Ordinance contains provisions concerning information for persons suspected of a crime, stating that this information is to be in a language which the inmate understands and, as regards those arrested and on remand, to be in writing. The inmate is to have access to this information the entire time they are deprived of their liberty.

In the Parliamentary Ombudsman's view, written information should also be provided to persons deprived of their liberty for reasons other than that they are suspected of an offence, and this information should be provided in a language that the inmate understands. All information must also be designed so that it is clear and easy to understand. If there is need, this should be supplemented by oral information. The Parliamentary Ombudsman's decision also emphasised the importance of providing information about rights in as close conjunction with the deprivation of liberty as possible; this should be done no later than when taking the detained person into the police cell block.

#### Example from police detention

Under Chapter 24, Section 9 of the Swedish Code of Judicial Procedure, when persons are apprehended or arrested or when an order for arrest is executed, they shall be informed of the offence for which they are suspected and the grounds for their deprivation of liberty. The rule corresponds to the obligation in Article 5, point 2 of the European Convention, which stipulates that those arrested shall be informed of the reasons for their arrest and of any charges against them. This is to be done promptly and in a language which they understand.

One inmate stated during the inspection that, in conjunction with the execution of an arrest order in his home, he was not informed of the offence of which he was suspected, and when he asked the police, the answer he received was that they did not know. It was the Prison and Probation Service personnel who informed him of the offence of which he was suspected in conjunction with his registration at the police cell block. An underage inmate who had been picked up at home stated that it took four hours before he was informed of the offence of which he was suspected.

<sup>9</sup> Ref. no. 2752-2013

## The Swedish Prison and Probation Service

The Parliamentary Ombudsman has also issued a statement concerning the information provided to inmates in the prison and probation system. For this category of inmates as well, information is a prerequisite if they are to be able to assert their rights. According to the Parliamentary Ombudsman, the information provided to inmates must be provided in a language which the inmate understands, be updated, accurate and nuanced, not least because the inmate's has limited opportunities to acquire supplementary information. There may also be reason to follow up with the inmate to check that they have taken in the information provided.<sup>10</sup> It is not acceptable for the Prison and Probation Service to distribute information that is twenty years old and does not describe current legislation.<sup>11</sup> The Parliamentary Ombudsman has emphasised the importance of ensuring that information about rights and obligations and about the rules and procedures of the remand prison reaches all inmates. The Parliamentary Ombudsman sees it as alarming that inmates in the remand prison claimed that this has not been the case is. A simple measure to ensure that inmates are provided with accurate information is to give them the Prison and Probation Service's brochure, Information for Detained Persons. This brochure states the rules on association, for example.<sup>12</sup>

## Enquiries

As a result of observations made during OPCAT inspections, 22 special enquiries have been initiated in the period 2011–2014.<sup>13</sup> Below are some decisions that are of particular interest.

*Serious criticism of the Swedish Prison and Probation Service, Nyköping Remand Prison, for a person having being detained without legal grounds. Ref. no. 2057-2014, decision of 4 November 2015.*

On 2 April 2014, an OPCAT inspection was conducted of the Prison and Probation Service's Nyköping Remand Prison. In conjunction with this, it was observed that there were some unclear points regarding a person, N.N., who was deprived of their liberty pending the enforcement of a decision on deportation.

The investigation showed that Eskilstuna District Court's certificate of judgement stated that N.N. was to remain in detention until his deportation could be enforced. In the judgement that the District Court later drew up, the order had been changed in such a way that the detention of N.N. could continue until the deportation decision became final or could be enforced before that.

<sup>10</sup> Ref. no. 317-2013

<sup>11</sup> Ref. no. 2767-2013

<sup>12</sup> Ref. no. 475-2013

<sup>13</sup> See appendix p. 59

There is a significant difference between the two orders, and the result of the latter means that there was no basis for a deprivation of liberty after the judgement became final on 24 March 2014. Despite this, N.N. was deprived of their liberty for a further nine days (until 2 April) when the police decided to take him into custody.

The Chief Parliamentary Ombudsman stated that it is extremely rare for a court to change the wording in the manner that had taken place. As the more precise reasons for the change were not known, the Chief Parliamentary Ombudsman found that the significant change would have been noticed if the responsible official at the remand prison had acted in accordance with applicable procedures. The Chief Parliamentary Ombudsman found no reason to believe that it was anything other than a mistake that was behind the incident. However, this mistake did result in a person being deprived of their liberty without legal grounds. This is unacceptable, and the remand prison was seriously criticised for the incident.

*Initiative on the possibility for inmates on remand to look at their surroundings through the windows of residential rooms, etc. ref. no. 7173-2014, decision of 16 November 2015*

The decision found that the possibility for inmates in remand prisons or prisons to see out the window of their living quarters and get an idea of the surroundings may contribute to a stay in a remand prison or prison being perceived as less stressful, and thus counteract the negative consequences of a deprivation of liberty. For that reason it should, according to the Chief Parliamentary Ombudsman, be described as a fundamental right of inmates to be placed in living quarters where the window enables normal daylight for the season to enter the space, and for the inmates to be able to view the surroundings. It should also be considered a fundamental right for inmates to independently control the amount of daylight entering their living quarters. In the same way, this also relates to the inmates' opportunity to view their surroundings from an exercise yard.

These rights may be restricted if the Prison and Probation Service finds that this is necessary in the individual case for reasons of order and security. If an inmate is obliged to stay in an environment where these rights are restricted, the Prison and Probation Service must take action to reduce the negative impact of the restrictions and ensure that their stay in such environments is as short as possible.

In the decision, the Chief Parliamentary Ombudsman also provides an opinion on the actions that individual remand prisons have taken in the attempt to prevent inmates from conducting unwanted communication through the

windows of their living quarters, to protect inmates' integrity and prevent them looking into other agencies' premises.

*Serious criticism of the Swedish Prison and Probation Service, Jönköping Remand Prison, for shortcomings in the treatment of an inmate etc. ref. no. 6413-2014, decision of 21 April 2015*

At the end of October 2013, the Prison and Probation Service requested that the police service transport an elderly woman to a prison to serve a short term of imprisonment. The request was carried out by the police service on 28 August 2014 and the convicted person was brought by the police to Jönköping Remand Prison. Upon arrival at the remand prison, she was put under surveillance due to her advanced age and her "uncertain" state of health. The remand prison took no further action to investigate her condition, for example having her examined by medical personnel. She did not meet with the remand prison nurse until the day after her arrival and she was transported to Ystad Prison later that day. On 30 August, an on-call physician noted that the inmate was confused and dehydrated, and that she needed to be taken to hospital immediately.

The Parliamentary Ombudsman's decision directs serious criticism at Jönköping Remand Prison for not giving the inmate access to the healthcare she needed, and for deciding that she would be transported to Ystad Prison in spite of her poor health. The remand prison is also criticised for not informing the Prison and Probation Service's placement unit of the inmate's condition, which resulted in the prison not being able to prepare for her arrival and to a delay in finding a more suitable placement. Ystad Prison is also criticised for having delayed alerting the on-call physician, even though the inmate was in such a poor condition that she was found on the floor of her living quarters.

The Parliamentary Ombudsman decision also contains statements regarding the Prison and Probation Service's procedures for requesting the assistance of the police service to transport convicted persons to prison.

*Criticism of the National Board of Institutional Care's LVM homes Runnagården and Renforsen for the homes' earlier handling of postcards suspected of being "laced" with drugs ref. no. 7236-2014, decision of 10 December 2015*

During inspections of two LVM homes, the Parliamentary Ombudsman noted that, at that time, the homes had procedures that involved postcards addressed to inmates being confiscated if they were suspected of being "laced" with drugs, and that they were given to the individual when he or she was discharged from the home. These procedures have now been changed.

The Parliamentary Ombudsman is of the opinion that if an item of mail, i.e. the paper, is laced with drugs, then the mail should be handled as if it were drugs. It should therefore be confiscated and destroyed.

A party supplying a postcard laced with drugs to someone can be found guilty of an offence under the narcotics legislation. Supplying such a postcard to this individual also risks counteracting the results of the care they have received. The Parliamentary Ombudsman is therefore critical of how the LVM homes previously handled the postcards.

*Has the LVM home Rällsögården been too passive with regard to preventing inmates from unlawfully leaving the home ref.no. 7163-2014, decision of 26 February 2016*

During an inspection of the LVM home Rällsögården, it emerged that the home, in conjunction with threatening situations, has chosen to allow inmates to leave the home.

When someone is receiving compulsory care at an LVM home, they are expected not to be allowed to leave the home without permission. Staff have the authority to use force to restrain an inmate who is trying to leave the home or exhibiting violent behaviour. The aim of LVM care, however, is to motivate individuals to receive care and support measures on a voluntary basis. The purpose of the compulsory care must be factored into the assessment of what level of force is justifiable to use to prevent someone from unlawfully leaving the LVM home.

Staff may find themselves in difficult situations involving threatening behaviour on the part of inmates where there may also, because of the inmate's behaviour, be a risk to the safety of staff or other inmates. It can therefore not be ruled out that the staff at the home may, in exceptional cases, allow the inmate to leave the home rather than using force that would not appear to be justified given the purpose of the care.

If there is a risk that the staff at a home cannot maintain order, SiS must consider providing the extra resources necessary to allow staff to intervene in violent situations and to prevent inmates leaving the home unlawfully.

*Serious criticism of the Norra Stockholm Psychiatric Clinic at St. Göran's Hospital, Stockholm County Council, for treating a patient taken into care in accordance with the Compulsory Mental Care Act (1991:1128) (LPT) with ECT procedures outside of the county's care facilities ref. no. 3953-2013, decision of 30 April 2015*

Care in accordance with the LPT is to be provided within a care facility operated by a county council (Section 15, LPT). A patient being cared for pursuant to the LPT at the Norra Stockholm Psychiatric Clinic at St. Göran's

Hospital was given electroconvulsive therapy (ECT) at the Capiro clinic at the same hospital, as part of their compulsory care. The Parliamentary Ombudsman expressed serious criticism of these ECT treatments having been conducted, in violation of the provisions in the LPT, at a care facility not operated by the county council.



Other ombudsman  
decisions of importance  
to the rights of persons  
deprived of their liberty



## Inmates' contact with the outside world

One question that has arisen in connection with the Parliamentary Ombudsmen's supervision of the correctional care system is how the rights of persons deprived of their liberty are satisfied. Pursuant to the Aliens Act, there is the opportunity to place detained aliens in a remand prison or in a prison. During an OPCAT inspection,<sup>1</sup> it was noted that this category of inmates has limited opportunities for both phone calls and visits and that they lacked the opportunity to contact the outside world via the internet. According to the Prison and Probation Service's instructions, detainees' contacts are to be checked in advance, and their conversations may be monitored. The Parliamentary Ombudsman investigated the matter and found that the Prison and Probation Service's considerations and instructions meant that the detainees' right to contact the outside world has not been fully satisfied in remand prisons and prisons. According to the Parliamentary Ombudsman, this in turn demonstrated the inappropriateness of placing detainees in such facilities.<sup>2</sup>

### Outdoor access

As regards outdoor access, the European Committee for the Prevention of Torture (CPT) has recommended that persons who are deprived of their liberty by the police for 24 hours or longer be offered the opportunity to spend time outdoors (see CPT Standards, Extract from the 12th General Report, p. 48)

The question of inmates' opportunities to contact with the outside world has arisen in several cases. In one case, a prosecutor was criticised for having refused to send two letters from a person who was on remand with restrictions. The refusal was motivated by the fact that the letters were not written either in Swedish or English.<sup>3</sup> Another case concerned a patient under institutional compulsory psychiatric care who had submitted a complaint to be forwarded to the Parliamentary Ombudsmen. The complaint was not sent on to the Parliamentary Ombudsmen, but was instead placed in the patient's medical records. The Parliamentary Ombudsmen criticised this action.<sup>4</sup> The Parliamentary Ombudsmen also directed criticism at a clinic that conducts compulsory psychiatric care because it had imposed general bans on the use of mobile phones and computers.<sup>5</sup>

In a decision concerning the Prison and Probation Service, the Parliamentary Ombudsman noted that a remand prison had, in practice, limited inmates' opportunities to contact the outside world on the basis of Chapter 6, Section 2 of the Act on Detention. According to the Prison and Probation Service's regulations, inmates are themselves to be able to control how much daylight enters their living quarters.

The detainees in the remand prison lacked this opportunity because the remand prison's management wanted to prevent them from contacting persons

1 Ref. no. 3198-2012

2 Ref. no. 5529-2012

3 Ref. no. 7229-2010

4 Ref. no. 3748-2011

5 Ref. no. 4465-2010

outside the premises. The Parliamentary Ombudsman noted that decisions concerning restrictions must be issued in writing by a prosecutor in relation to each individual inmate. This had not taken place. It is thus not possible to take action against all inmates in the way that had taken place. The absence of a prosecutor's decision had in practice entailed the remand prison making a decision to impose restrictions on the inmates. A remand prison has no such right.<sup>6</sup>

### Information for relatives

When someone has been deprived of liberty, there is a basic premise that relatives are to be informed. Provisions on this are found in Chapter 24, Section 21a of the Swedish Code of Judicial Procedure, Section 17a of the Swedish Police Act and Section 3 of the Ordinance on Detention. The provision in the Swedish Code of Judicial Procedure includes apprehended and arrested persons, and the provision in the Ordinance on Detention concerns, among others, people who have been taken into custody due to intoxication.

On several occasions, the Parliamentary Ombudsman has criticised the police for shortcomings in matters relating to informing relatives.<sup>7</sup> The Parliamentary Ombudsman has stated that it is the police service's responsibility to take the initiative in providing information and offering persons who have been taken into custody the opportunity to contact relatives. If order and security reasons prevent this, persons who have been taken into custody are to be asked if they instead want the police to inform their relatives. Issues concerning information for relatives are also to be documented.

### Access to defence counsel

The Parliamentary Ombudsman has criticised the police for not having allowed persons deprived of their liberty to exercise their statutory right to speak in private with their defence counsel. In one decision, the Parliamentary Ombudsman emphasised that it is the nature of things that a police cell, or similar premises where persons who are under arrest or on remand are held, must have spaces or devices to ensure that the rights of persons deprived of their liberty can be maintained in this respect. In this decision, there was criticism of the procedure whereby the door to the interview room is kept open during the telephone conversation, with a cell guard standing outside, who is able to hear the conversation. This was not considered to be compatible with applicable law. According to the Parliamentary Ombudsman, the security and restriction aspects should have been addressed in a different way.<sup>8</sup> In another

#### CPT recommendation

The CPT has recommended that Sweden take steps to ensure that juveniles deprived of their liberty are not subjected to police questioning without the benefit of a trusted person and/or a lawyer being present

*steps to be taken to ensure that juveniles deprived of their liberty are not subjected to police questioning without the benefit of a trusted person and/or a lawyer being present*

6 Ref. no. 5528-2012

7 JO 2012/13 p. 165, ref. no. 3682-2011 concerned an arrested person and JO 2013/14 p. 222, ref. no. 2293-2012 concerned the care of an intoxicated person.

8 Ref. no. 3551-2011

case, a public counsel had asked to speak privately with a client before a detention hearing, but had been denied this with reference to security aspects; the individual could abscond. The Parliamentary Ombudsman's decision emphasised that detainees should have the opportunity to consult their public counsel undisturbed and that the police service must adapt its premises for this.<sup>9</sup>

The Parliamentary Ombudsman has also criticised the police for not having made personnel available to monitor telephone conversations from persons on remand with restrictions<sup>10</sup> and for having neglected to ensure that suspects (principally young persons) have had access to defence counsel during questioning.<sup>11</sup>

## Coercive measures

### *Placement in isolation*

The Prison and Probation Service has the opportunity to isolate prison inmates for reasons including the investigation of suspected misconduct. The Parliamentary Ombudsman has emphasised that a placement in isolation is a radical measure. To ensure that the period in isolation does not continue for longer than is absolutely necessary, it is, in the Parliamentary Ombudsman's view, essential that the prison have control over which investigative measures have been taken. For this reason, it is important that a prison clearly documents all investigative measures.<sup>12</sup>

Another decision concerns an incident in which a number of inmates were placed in isolation in connection with the investigation of suspected misconduct. The action was taken in order to allow the prison to investigate "what the basis was for a risk of misconduct having been deemed to exist". According to the Parliamentary Ombudsman, no incident had occurred at the time of the placement in isolation that could be investigated as suspected misconduct. There was thus no opportunity to place the inmates in isolation pursuant to the legal text cited.<sup>13</sup>

In one case, the Prison and Probation Service had placed an inmate in isolation for three months. For most of that time, the inmate had been placed in living quarters that were only equipped with a bed. The inmate was also placed under constant supervision. The Parliamentary Ombudsman found that the prison had not taken any significant action to mitigate the effects of isolation and that the inmate had thereby been almost completely isolated for

<sup>9</sup> JO 2013/14 p. 358, ref. no. 594-2012

<sup>10</sup> Ref. no. 3541-2011, ref. no. 65-2012

<sup>11</sup> Ref. no. 4553-2010, ref. no. 4608-2010, ref. no. 3577-2011, ref. no. 3019-2012, ref. no. 1335-2013

<sup>12</sup> Ref. no. 1977-2012

<sup>13</sup> Ref. no. 4379-2013

two months. The Prison and Probation Service was seriously criticised for not having attempted at an earlier stage to rectify the inmate's situation by means of a new placement.<sup>14</sup>

The Parliamentary Ombudsman criticised a forensic psychiatry clinic for deficiencies in its documentation of coercive measures. Criticism was also expressed of the clinic's use of a special procedure – known as restriction – for patients assessed to have a need to be in a limited area with a less stimulus-rich environment and little contact with other patients. The Parliamentary Ombudsman had no objection in itself to care personnel coming to an agreement with a patient for him or her to be in a certain space to have peace and quiet. However, the Parliamentary Ombudsman was critical in many respects that the clinic used a procedure and a concept so similar to the coercive measure of placement in isolation. Among other things, the Parliamentary Ombudsman stated that it cannot be accepted that the room in which patients in isolation stay is used for the purpose in question.<sup>15</sup>

#### *Handcuffs and mechanical restraint*

In one decision, the Parliamentary Ombudsman has criticised a regional forensic psychiatry clinic for having handcuffed a patient who was subject to compulsory psychiatric care in connection with them being mechanically restrained, despite the lack of legal support for this. The clinic was also seriously criticised for the doctor responsible for the mechanical restraint not personally examining the patient prior to each reconsideration (extension) of the measure.<sup>16</sup>

During an inspection of the Prison and Probation Service, Helsingborg Remand Prison, it was revealed that an inmate had been placed under mechanical restraint on numerous occasions. It also emerged that there were some unclear points concerning the procedures in connection with such coercive measures. The issue of mechanical restraint in the case in question was investigated as part of a special enquiry. The decision emphasised that medical examination in connection with mechanical restraint is obligatory and that a doctor is to be called immediately when an inmate is mechanically restrained. The Parliamentary Ombudsman criticised the remand prison for having made the assessment in conjunction with the use of mechanical restraint that there had been no "urgent need" for a medical examination. The remand prison was also criticised for not having taken any further action, e.g. summoning an on-call doctor, after it had emerged that the remand prison's doctor was busy. Finally, the decision underlined the importance of personnel being

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<sup>14</sup> Ref. no. 6211-2013

<sup>15</sup> JO 2014/15 p. 477, ref. no. 1169-2012

<sup>16</sup> JO 2014/15 p. 461, ref. no. 4471-2011

well acquainted with the instructions that exist regarding the use of mechanical restraint and of the decision-makers responsible specifying the provision under which the coercive measure is being implemented.<sup>17</sup>

### Camera surveillance

The issue of the camera surveillance of prison inmates has been subject to a number of different deliberations. One case concerns the issue of camera surveillance of living quarters in the isolation section of a high-security unit.<sup>18</sup> The Parliamentary Ombudsman's decision stated that in those cases where the prison does not decide that an inmate is to be under constant supervision, the camera in the living quarters should be covered. This ensures that inmates know when they are being monitored.

The Parliamentary Ombudsman has also issued a statement concerning camera surveillance in connection with the taking of urine samples in the normal section of a high-security unit. According to the Prison and Probation Service, camera surveillance can serve as a complement to the witness function during sample taking and thereby protect the inmate against improper conduct. The Parliamentary Ombudsman has found no reason to question this. According to the Parliamentary Ombudsman, the inmates are under all circumstances closely supervised during sample taking. Therefore, the Parliamentary Ombudsman finds no reason to question this camera surveillance.<sup>19</sup>

One case involved an inmate in isolation at a prison who had been under camera surveillance for an extended period. It emerged that the personnel responsible for this surveillance via camera were in a different building to the inmate. The prison had had the inmate in isolation under camera surveillance for eight weeks. The prison made the assessment that there was a risk of the inmate harming himself. The Parliamentary Ombudsman stated that surveillance can be done in two ways: either through constant supervision by staff adjacent to the room where the inmate is, or through patrols at certain times. During patrols, camera surveillance can serve as a complement. The prison was seriously criticised for only having exercised supervision through camera surveillance since this prevented personnel from carrying out an immediate intervention in the event of an act of self-harm.<sup>20</sup>

### Treatment

The Parliamentary Ombudsman has criticised deficiencies in the supervision of inmates in police cells.<sup>21</sup> There is also one case in which the Parliamentary

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<sup>17</sup> Ref. no. 1455-2013

<sup>18</sup> Ref. no. 3978-2010

<sup>19</sup> Ref. no. 4632-2010

<sup>20</sup> Ref. no. 115-2013

<sup>21</sup> Ref. no. 2112-2010, ref. no. 5244-2011, ref. no. 5802-2011, ref. no. 4626-2013, ref. no. 1632-2014

Ombudsman criticised how a person assessed to be suicidal had to sit in a police cell without clothes for three days without a medical assessment.<sup>22</sup>

### **Transport of persons deprived of their liberty**

The Prison and Probation Service's transport service does not just transport persons on remand and prison inmates, but also transports others including those taken into custody pursuant to various forms of coercive legislation. This might, for example, involve substance misusers or young persons.

In several decisions, the Parliamentary Ombudsman has criticised the fact that persons in custody have spent too much time in a police cell while awaiting transport.<sup>23</sup>

The opportunity to take a person into custody in connection with judicial assistance has been the subject to consideration in the report, *Transport of Persons Deprived of Their Liberty* (SOU 2011:7). The report notes that current legislation contains a great number of provisions granting the right to restrict liberty, but that these provisions do not always specify whether the restriction of liberty is associated with a right or obligation to take the person into custody, e.g. placement in a police cell or another form of incarceration.

As regards the LVM legislation, this states that the police shall provide assistance to convey a person who is to be given care, or who is immediately taken into custody, to an LVM home. The report states that there may be no uncertainty as regards the opportunity to detain a person taken into custody under LVM in connection with judicial assistance in a police cell while awaiting transport. For this reason, the report proposed the introduction of a provision concerning this into the LVM.<sup>24</sup> The inquiry's proposal has not yet resulted in legislation, but is being processed by the Government Offices.

The Parliamentary Ombudsman has also issued statements in several cases concerning the placement of those taken into custody pursuant to the LVM. In one case, the person taken into custody pursuant to the LVM had spent five days in a police cell while awaiting transport. The Parliamentary Ombudsman stated that although there are some unclear points concerning the legal position, there is nevertheless an opportunity for detention in connection with judicial assistance. However, this opportunity should be used restrictively. The basic premise is to be that the person the measure concerns not be detained under more radical forms than is necessary. Those taken into custody due to a need of care should be promptly conveyed to the treatment home that has been assessed capable of satisfying this need. The period a substance misuser spends in detention should therefore be as short as pos-

<sup>22</sup> Ref. no. 6237-2012

<sup>23</sup> Ref. no. 1519-2012, ref. no. 5182-2013

<sup>24</sup> SOU 2011:7 p. 404 f.

sible. Against this background, the Parliamentary Ombudsman considered it unacceptable to allow the individual to spend five days in the police cell while awaiting transport, and the police should have acted more vigorously to shorten this period.<sup>25</sup>

The issue of detaining people taken into custody in a remand prisons during transport was also relevant in a case involving a 17-year old who had been taken into custody pursuant to the LVU. The Parliamentary Ombudsman's decision gave a reminder that children and young people should only be placed in a remand prison in connection with transport if there are pressing reasons such as a longer distance forcing an overnight stop. In the decision, the Parliamentary Ombudsman criticised the Prison and Probation Service's transport service<sup>26</sup> for having planned the transport in such a way that the person taken into custody was forced to spend the night in a remand prison. The Parliamentary Ombudsman also pointed to the importance of asking persons taken into custody who are temporarily in a remand prison if they want to make an "arrival call" and of documenting these measures.<sup>27</sup>

The issue of placement in a remand prison has also arisen in connection with the transport of prison inmates.<sup>28</sup> When being moved between two prisons, an inmate was placed in a remand prison for eight days. The Parliamentary Ombudsman found there to be legal support for temporarily placing a prison inmate in a remand prison, but noted that eight days exceeds what is acceptable. Another case highlighted the issue of the placement of an inmate in conjunction with transport. The inmate was placed in a prison, but in an isolation section. According to the Parliamentary Ombudsman, the principal rule gives a person who is a prison inmate or who, in connection with transport is temporarily placed in a remand prison, the opportunity to associate other prisoners. If a prison or a remand prison assesses that the inmate cannot associate with other prisoners, a decision must be made in writing for the inmate to be placed in isolation. The decision directed serious criticism at a prison that had routinely placed inmates being transported in isolation without making a decision on the matter in writing.<sup>29</sup>

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25 Ref. no. 5182-2013

26 Now the Prison and Probation Service's transport planning unit.

27 Ref. no. 6939-2012

28 Ref. no. 2346-2013

29 Ref. no. 6878-2012



# Appendices

## Participation in international meetings

There are extensive international activities at which there are discussions of OPCAT issues; issues of both a factual and methodological nature. Over the course of the period in question, the unit has participated in several seminars arranged by various international actors, such as the Council of Europe, universities and other ombudsman institutions.

### 2011

20–21 October 2011, Baku, Azerbaijan: European NPM Project 6th thematic workshop: The protection of persons belonging to particularly vulnerable groups in places of deprivation of liberty.

7 December 2011, Ljubljana, Slovenia: 3rd Annual Meeting of the Contact Persons of the European NPM Network.

### 2012

1–2 February 2012, Helsinki, Finland: Study visit Finland's Parliamentary Ombudsman.

20–21 March 2012, Geneva, Switzerland: European NPM Project 8th Thematic NPM Workshop: The immigration removal process and preventive monitoring.

12–13 June 2012, Belgrade, Serbia: European NPM Project 9th thematic workshop: Irregular migrants, Frontex and the NPMs.

### 2013

21–22 November 2013, Strasbourg, France: “Immigration Detention in Europe” at the invitation of the Council of Europe, PACE and HM Inspectorate of Prisons.

### 2014

12–13 June 2014, Vilnius, Lithuania: “The Baltic-Nordic Ombudsmen Conference”.

28 October 2014, Oslo, Norway: conference “The Effects of International Monitoring Mechanisms to Prevent Torture and Ill-Treatment of Persons Deprived of their Liberty” arranged by Norway's Parliamentary Ombudsman.

27 November 2014, Oslo, Norway: conference on isolation in Scandinavian prisons arranged by the Faculty of Law at the University of Oslo.

## Unannounced inspections

### The Swedish Police Authority

#### *Police detention facilities*

Uddevalla  
Söderort  
Södertälje  
Kiruna  
Gällivare  
Luleå  
Kalix  
Haparanda  
Kungsbacka  
Varberg  
Norrtälje  
Nacka Strand  
Västerås  
Kalmar  
Gotland  
Sollentuna  
Karlskrona  
Växjö  
Sundsvall  
Östersund  
Möln dal  
Täby  
Norrmalm

### The Prison and Probation Service

#### *Prisons*

Haparanda  
Borås  
Visby  
Beateberg

#### *Remand prisons*

Uddevalla  
Salberga  
Gävle  
Västerås  
Helsingborg  
Kronoberg  
Kalmar  
Visby  
Karlskrona  
Växjö  
Östersund  
Kronoberg

### The National Board of Institutional Care

#### *LVM homes*

Rebecka

## Announced inspections

### The Swedish Police Authority

#### *Police detention facilities*

Karlstad

Umeå

Uppsala

Västerås

Kiruna

Gällivare

Luleå

Halmstad

Gävle

Mölnadal

Sala

Örebro

Solna

Malmö

Avesta

Falun

Borlänge

Södermalm

SPT vehicle, Viktorbuss, Stockholm

Visby

Värnamo

Linköping

Norrköping

Mariestad

Skövde

Eskilstuna

Södertälje

Hudiksvall

Flemingsberg

Helsingborg

Nyköping

Ystad

Jönköping

Umeå (follow-up)

Mölnadal (follow-up)

Katrineholm

### The Prison and Probation Service

#### *Prisons*

Storboda

Håga

Färingsö

Ljustadalen

#### *Remand prisons*

Karlstad

Umeå

Uppsala

Borås

Örebro

Malmö

Falun

Huddinge

Nyköping

Mariestad

Trelleborg

Ystad

Jönköping

### **The National Board of Institutional Care**

#### *LVM homes*

Lunden

Hornö

Hessleby

Ekebylund/Östfora

Älvgården

Gudhemsgården

Fortunagården

Runnagården

Rällsögården

Renforsen

#### *LVU homes*

Rebecka

Lövsta

Stigby

Råby

### **Compulsory psychiatric care**

Psychiatric clinic in Varberg, ward 21

Löwenströmska Hospital in Upplands  
Väsby, ward 34

S:t Görans Hospital, ward 5 Visby  
Hospital, ward B

The National Board of Forensic Medi-  
cine, department for forensic psychia-  
tric examination in Stockholm

Psychiatric care unit Haninge, ward  
Lotsen

### **The Swedish Migration Agency**

Detention centre in Åstorp

Detention centre in Märsta

## Enquiries initiated with reference to an OPCAT inspection

### The Prison and Probation Service

3278-2012

2242-2012

2733-2012

3206-2012

5529-2012

5528-2012

1455-2013

2057-2014

6413-2014

7173-2014

### Police

2054-2013

2572-2013

808-2014

### The National Board of Institutional Care

2248-2012

1971-2013

2793-2013

5415-2013

5962-2014

7163-2014

7236-2014

### Compulsory psychiatric care

3953-2013

1578-2014

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Total 22 enquiries

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Opening hours 09.00–12.00 and 13.00–15.00

Telephone hours Monday–Friday 09.00–11.30, 13.00–15.00