National Preventive Mechanism – NPM

Report on the activities 2025

JO
RIKSDAGENS OMBUDSMÄN
1809

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The Swedish Parliamentary Ombudsmen

Print: Riksdagens tryckeri, Sweden, 2026

Production: Riksdagens ombudsmän – JO

Photos: All photos were taken by employees at The Parliamentary Ombudsmen

Cover: Exercise yard of the Flen detention centre.

Foreword

The Parliamentary Ombudsmen fulfils the function of a National Preventive Mechanism (NPM) as described in the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). Among other things, an NPM is tasked with preventing the inhuman or degrading treatment or punishment of people who are deprived of their liberty. The work of an NPM must be proactive and based on a long-term strategy.

This report compiles the Parliamentary Ombudsmen's most significant observations and conclusions from the year's inspections. It also includes examples of the recommendations made by the Parliamentary Ombudsmen to improve the situation for inmates. A total of 18 inspections were conducted during the year.

Over the course of the year, the office of the Parliamentary Ombudsmen has continued to streamline the agency's OPCAT activities to facilitate more inspections and to focus to a greater extent on the preventive aspects of the OPCAT assignment. The Parliamentary Ombudsmen have also continued to develop dialogue with civil society organisations in order to better utilise their valuable opinions and experiences.

Erik Nymansson
Chief Parliamentary Ombudsman

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The OPCAT assignment

Under the 1984 UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture), State Parties have undertaken to take effective legislative, administrative, judicial and other measures to prevent acts of torture within any territory under its jurisdiction. The Convention against Torture has been in force in Sweden since 1987.

The Convention against Torture provides a relatively comprehensive definition of torture (Article 1). In short, torture is the intentional infliction of severe mental or physical pain or suffering for a specific purpose, for example to extract information or to punish or threaten a person. On the other hand, the Convention lacks definitions of cruel, inhuman or degrading treatment, but the State Parties must also prevent such acts from being carried out by representatives of public authorities within their territory (Article 16).

The countries that have signed the UN Convention Against Torture are reviewed by a special committee, the Committee against Torture (CAT). In its country reports, the Committee makes statements and recommendations on compliance with the Convention. If a signatory state has authorised it, the UN Committee can also examine individual complaints if there has been a violation of the Convention. The Convention against Torture does not in itself mandate the Committee to conduct visits in member states. In order to allow, inter alia, international visits, the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) was adopted by the UN in 2002. The Protocol entered into force in Sweden in June 2006. OPCAT established another committee, the Subcommittee on Prevention of Torture (SPT).

The work performed in accordance with OPCAT is to be conducted with the aim of strengthening the protection of individuals deprived of their liberty against torture and other cruel, inhuman or degrading treatment or punishment. Preventive work can be carried out in a number of ways, including through visiting the environments where the risk of abuse and violations is particularly high. Another important aspect of the preventive work is the identification and analysis of factors that can directly or indirectly increase or reduce the risk of torture and other forms of inhuman treatment. The activities must be proactive and aimed at systematically reducing or eliminating risk factors and strengthening preventive factors and protective mechanisms. Furthermore, the work shall have a long-term perspective and focus on achieving improvements through constructive dialogue, proposals for safeguards and other measures.

State Parties to OPCAT are also obliged to designate one or more bodies charged with the role of National Preventive Mechanism (NPM). Since 1 July 2011, the Parliamentary Ombudsmen have carried out the tasks of a National Preventive Mechanism pursuant to OPCAT. As a National Preventive Mechanism, among other things the Parliamentary Ombudsmen are to regularly inspect places where people may be deprived of their liberty. Another task is to make recommendations to the competent authorities with a view to improving the treatment of and conditions for individuals deprived of their liberty and preventing torture and other cruel, inhuman or degrading treatment or punishment. The Parliamentary Ombudsmen shall also participate in dialogues with competent authorities and civil society.

The Parliamentary Ombudsmen's OPCAT activities

A dedicated OPCAT Unit is tasked with assisting the Parliamentary Ombudsmen in their work as a National Preventive Mechanism (NPM). The number of staff at the unit varied between four and six during 2025. One member of staff is a social scientist and the others are lawyers. An expert in medicine and another in psychology are also attached to the unit.

The most important element of the Parliamentary Ombudsmen's OPCAT activities is regular inspections of institutions in which people are deprived of liberty. During the year, the Parliamentary Ombudsmen visited forensic psychiatric clinics, care homes for substance abusers, special residential homes for young people, clinics providing compulsory psychiatric care for adults, and migrant detention centres.

The following 18 inspections were conducted within the scope of our assignment as an NPM in 2025.

Inspection object	Number
Forensic psychiatric clinics	4
Care homes for substance abusers	3
Special residential homes for young people	4
Compulsory psychiatric care clinics	4
Migrant detention centres	3
Total	**18**

In addition to these visits, since 2020, the Parliamentary Ombudsmen have held dialogue meetings with civil society organisations concerning the situation and rights of people deprived of liberty. Two such dialogue meetings were held in 2025. The theme of one meeting was the situation of people with disabilities who are deprived of liberty. At the other meeting, the situation of children and young people deprived of liberty was discussed.

The OPCAT Unit is part of the Nordic NPM network established in 2015. A meeting of the network was held in Reykjavik on 28 and 29 August 2025. The agenda included how recommendations should be formulated and the various ethical issues arising in OPCAT activities.

During the year, staff from the OPCAT Unit also took part in four workshops in Strasbourg organised by the European NPM Forum. These meetings included discussions of the role each country's NPM plays in mitigating the effects of overcrowding in European prisons, how migrant detention centres and police detention facilities should be inspected, how hierarchies within the prison system should be dealt with, and various methodological issues concerning what makes an NPM effective. One member of staff also attended a seminar at Stockholm University concerning an international research project on children who are deprived of their liberty.

More about our inspections

Forensic psychiatric clinics

Background

Forensic psychiatric care is a form of compulsory psychiatric care regulated in the Forensic Psychiatric Care Act (1991:1129). Such care is almost exclusively provided by regional health authorities at various hospitals around the country. During 2024, 1,780[1] people received forensic psychiatric care in secure facilities pursuant to the Act.

The four forensic psychiatric clinics inspected during the year are located in Trelleborg, Gothenburg, Vadstena and Säter. The overall purpose of the inspections was to review the care environments for those committed to institutional forensic psychiatric care. More specifically, the aim was to investigate what risks deficiencies in the care environment may entail for inmates. For this purpose, the term care environment refers in part to the nursing, therapy and occupational and other activities provided for inmates as part of their care. The inspections had the following focus areas.

- The design of accommodation, common areas and areas set aside for occupational and other activities
- The inmates' actual access to nursing and therapy, as well as occupational and other activities
- The impact of the occupancy rate on the physical environment and the content of care

1 Data retrieved from the National Board of Health and Welfare's statistical database.

Ward corridor in Säter

The Parliamentary Ombudsman's most significant conclusions

The inspections showed that several of the clinics visited can offer inmates a good everyday care environment in certain respects. It was however apparent that conditions were deficient in several areas.

There were significant differences in *the physical environment* between the older clinic in Säter and the other more recently constructed clinics. Parts of the Säter clinic were cramped, gloomy and sparsely decorated. It was also noted that cigarette smoke was leaking in from the balconies designated as smoking areas to such an extent that it adversely affects air quality and odour on the wards. The other clinics were in good condition.

Activities facility at Rågården, Gothenburg

The Parliamentary Ombudsman emphasised that all areas must be continuously maintained to ensure a good physical environment over time. The Parliamentary Ombudsman noted that good physical conditions are particularly important as inmates are committed to forensic psychiatric care for an indeterminate and often extended period of time.

With regard to *the content of care*, it emerged that inmates were not particularly involved in their ongoing care. The care plan intended to function as an aid to care seldom included specific, individualised goals and measures. At three of the four clinics, care plans were not continuously followed up.

Moreover, inmates actual access to therapy was limited, which in itself implies a risk that many individuals did not have access to the care they needed. The Parliamentary Ombudsman also noted that clinic management and some staff

appeared to have limited knowledge of the therapeutic interventions that were actually available to inmates.

With regard to inmates actual access to occupational and other activities, the review revealed that, in general, much of their time is spent on unstructured activities on the ward, such as watching television or staying in their room. In some cases, access to more structured activities was so limited that it raises the question of whether inmates have access to a good care environment at all, something the Parliamentary Ombudsman found very problematic. Obvious deficiencies also emerged in the clinics' efforts to motivate inmates to take part in activities.

The strain of *overcrowding* was less noticeable at the clinics than expected. That said, alarming information did emerge about the long queues for admission to forensic psychiatric clinics. The Parliamentary Ombudsman noted that regions face a considerable task in attempting to make more places available.

In summary, the Parliamentary Ombudsman noted that the inspection series demonstrated that regions need to take further measures to ensure that all inmates have access to a good everyday care environment.

The Parliamentary Ombudsman's recommendations

The Parliamentary Ombudsmen made a number of recommendations to regions on how to improve the situation for inmates. For example, regions should ensure that

- all areas to which inmates have access are repaired and maintained on an ongoing basis;
- when balconies are designated as smoking areas, there is adequate ventilation and insulation to prevent cigarette smoke from leaking in to wards;
- goals and planned measures in care plans are formulated in such a manner that both inmates and relevant staff members are aware of what is expected of them;

- care plans are routinely and continuously followed up;
- staff resources are adequate to allow the prioritisation and development of care plans;
- staff resources are adequate to be able to offer inmates the necessary multidisciplinary care and therapy;
- staff and management can remain updated on which therapeutic interventions are actually available at the clinics;
- inmates are offered the opportunity and encouraged to take part in at least one structured activity per day, including weekends and public holidays;
- staff resources are adequate to be able to offer inmates at least one structured activity per day, including weekends and public holidays; and
- continuous and structured efforts are made to motivate inmates to participate in activities.

Day room in Trelleborg

Care homes for substance abusers

Background

The Swedish National Board of Institutional Care (SiS) is tasked with managing compulsory care for the harmful use of alcohol, controlled drugs or prescription drugs, or a combination of these, pursuant to the Care of Substance Abusers (Special Provisions) Act (1988:870). SiS runs nine homes with just under 400 places for substance abusers[1].

Three of these homes were inspected during the year: Runnagården, Älvgården and Hornö. The inspections had the following focus areas.

- The physical environment in the homes
- The content of the care provided
- Staffing levels, staff competence and the treatment of inmates

The Parliamentary Ombudsman's most significant conclusions

The inspections revealed several shortcomings in *the physical environment*. While premises were generally in good condition, several wards were in need of renovation. Shared toilets were described as dingy and dirty. At two homes, it was noted that not all accommodation had adequate daylight. The Parliamentary Ombudsman expressed concern about several of the shortcomings and recommended that SiS take a number of specific measures to improve the living environment.

The inspections also revealed that several accommodation rooms could only be locked from the outside using a key held by staff, but that not all inmates were aware of this. Several incidents involving violence between inmates in accommodation rooms were reported, including when an inmate entered another inmate's room without permission. The Parliamentary Ombudsman noted that inmates may feel insecure if they are unable to lock their rooms.

1 Data retrieved from the agency's website

Exercise yard in Hornö

With regard to *the content of care*, the inspections revealed that the treatment programmes offered by the homes vary in form, extent and methodology. It was not always possible to implement the therapeutic interventions included in these programmes due to staff shortages or lack of interest among inmates. However, many inmates were unaware of the available interventions and stated that they would be interested in participating. Some inmates had requested specific therapeutic interventions but had not been offered them. The Parliamentary Ombudsman noted that the interventions offered must

be appropriate and adapted to the inmate's needs during the period they are receiving care. The fact that some inmates did not participate in any interventions whatsoever was deemed a matter for concern, especially if they had requested interventions.

Many inmates described being relatively inactive on both weekdays and weekends. The range of organised activities was limited and much of the time spent on the ward was unstructured. Few inmates had the opportunity to take part in activities outside the home. The Parliamentary Ombudsman noted that, with a limited range of activities, there was a risk that inmates would be bored and less likely to perceive care as meaningful. The objective should be to provide inmates with access to organised activities, exercise and at least one hour of outdoor recreation on a daily basis, including on weekends.

Television room in Hornö

Staffing at one home was described as characterised by high staff turnover and constant recruitment needs. Meanwhile, SiS has difficulty in attracting applicants with *the right skills*. While in theory all permanent employees should undergo the agency's compulsory basic training, the inspections revealed that there are members of staff who have been employed for as long as two years who have yet to undergo basic training.

The treatment of inmates by staff was described as generally good, at least with regard to those working the day shift. Several inmates described those working nights as sometimes disengaged, inaccessible and afraid to intervene when conflicts arose. The Parliamentary Ombudsman found it particularly worrying that, contrary to the home's procedures, staff on the night shift might be unavailable when inmates needed help of various kinds. The Parliamentary Ombudsman noted that a lack of staff presence on wards could quickly undermine security and even lead to violent incidents, consequences that are clearly unacceptable.

The Parliamentary Ombudsman's recommendations

The Parliamentary Ombudsmen made a number of recommendations to the agency on how to improve the situation for inmates. For example, the agency should ensure that

- common sanitary facilities are kept clean;
- all inmates are able to lock their rooms when they are out on the ward;
- all inmates are aware of and have information concerning the home's treatment programmes;
- treatment programmes are adapted to the needs of inmates;
- staff are always available to conduct planned activities;
- inmates are offered opportunities for daily exercise;
- inmates have the opportunity to spend at least one hour a day outdoors;
- inmates are offered a wide range of meaningful activities and at least one

scheduled activity with staff each day;

- new recruits undergo basic training organised by the agency as soon as possible after being employed; and
- staff working nights at the home are available to inmates throughout the night.

Day room in Hornö

Special residential homes for young people

Background

The Swedish National Board of Institutional Care (SiS) is tasked with managing compulsory care homes pursuant to the Care of Young Persons (Special Provisions) Act (1990:52). SiS is also responsible for enforcing compulsory care orders pursuant to the Act (1998:603) on the Enforcement of Institutional Youth Care. SiS runs 22 special residential homes for young people with a total of approximately 700 places[1].

Four of these homes were inspected during the year: Bärby, Folåsa, Ljungbacken and Råby. The overall purpose of the inspections was to review the care environments for the children and young people placed in care pursuant to the Care of Young Persons (Special Provisions) Act, and those who enforce such institutional care. The aim was to investigate what risks deficiencies in the care environment may entail for them. For this purpose, the term care environment refers in part to access to care and treatment, schooling and activities. The inspections had the following focus areas.

- The design of accommodation, common areas and areas set aside for occupational and other activities
- The inmates' actual access to care and treatment, as well as occupational and other activities
- The impact of the occupancy rate on the physical environment and the content of care

The Parliamentary Ombudsman's most significant conclusions

With regard to *the physical environment*, the inspections revealed that SiS provides care in premises that are rundown, substandard and not fit for purpose. It was noted that many premises were in considerable need of repair and main-

1 Data retrieved from the agency's website.

Exercise yard in Folåsa

tenance. Some had poor ventilation, were mouldy, inadequately cleaned and had unhygienic sanitary facilities. The Parliamentary Ombudsman underlined the risk that such conditions may have consequences for the physical health of inmates.

Accommodation rooms in the homes were generally suitably equipped with bed, bedside table, desk, chair and adequate space to store clothing. However, the premises in general were sparsely furnished and often gave an unpleasant impression. There were however exceptions; for example, one home had walls decorated in shifting colours and patterns and composite furniture in various colours.

All special residential homes inspected had separate facilities for activities, including gyms, sports halls and multi-purpose sports courts. In practice, however, not all inmates had the same access to activities, such as opportunities to use multi-purpose sports courts. There were several reasons for this, including the inmate's security classification and staff shortages. At two homes, certain inmates were strictly confined to their own wing for all activities, with the concomitant risk that they would have insufficient day-to-day stimulation.

With regard to *the content of care*, the inspections revealed relatively large variations between homes in terms of opportunities for inmates to receive individualised treatment, such as participating in programmed activities. Two homes had failed to organise their activities in a manner that ensured that all inmates could be offered a programme. The Parliamentary Ombudsman noted that inmates with extensive problems had no access whatsoever to programmed interventions, meaning they did not have access to the care they needed.

The inspections also revealed that one consequence of overcrowding in special residential homes is that inmates sentenced to secure youth care are sometimes placed in accommodation with inmates place in care pursuant to the Care of Young Persons (Special Provisions) Act. It is inappropriate for inmates with different security classifications to be cared for in the same home and wing. The fact that this occurs is down to the lack of places the agency has at its disposal. The Parliamentary Ombudsman expressed concern that these target groups are placed together. It may mean that individual inmates are confined more than is necessary; for example, if for reasons of security schooling can only take place on the wing rather than in the separate school block at the home.

Many inmates describe the school as a positive element of their day-to-day lives. The inspections revealed that inmates had access to schooling of varying quality and to various extents. Inmates taught on the wing for security reasons, rather than in the home's school block, did not have the same access to

Accommodation room in Folåsa

teachers, learning support and study materials. The Parliamentary Ombudsman noted with concern the risk that some inmates – especially those serving a secure youth care sentence – might be receiving inferior schooling.

During the inspections, it was apparent that inmates had good access to healthcare. However, concern was expressed that inmates of one home felt compelled to describe their medical issues to staff in order to get an appointment with a nurse or doctor, and that staff accompanied them to appointments. SiS

must always give due consideration to the duty of confidentiality regarding healthcare matters that applies with regard to inmates. The Parliamentary Ombudsman pointed out that, as a point of departure, inmates must be permitted to see a nurse or doctor in private.

The Parliamentary Ombudsman's recommendations

The Parliamentary Ombudsmen made a number of recommendations to the agency on how to improve the situation for its inmates. For example, the agency should ensure that:

- all areas to which inmates have access are repaired and maintained on an ongoing basis, regularly cleaned and kept neat and tidy;
- wings are appropriately and pleasantly furnished and decorated;
- inmates have continuous access to suitable, fit-for-purpose areas and facilities for, for example, activities;
- all inmates are offered the opportunity to participate daily in sport and other activities, and that staff resources are adequate to implement these activities;
- an inmate is placed in a home that meets their individual need for care;
- inmates placed in care pursuant to the Care of Young Persons (Special Provisions) Act are not placed together with those serving a secure youth care sentence;
- all inmates have access to good and adequate teaching; and
- there are procedures in place for access to healthcare that both restrict staff from obtaining more medical information than is necessary to maintain security and order in the home and are consistent with the principles of healthcare confidentiality and respect for individual integrity and dignity.

Compulsory psychiatric care clinics for adults

Background

Adults may be placed in compulsory psychiatric care pursuant to the Compulsory Psychiatric Care Act (1991:1128). Such care is almost exclusively provided by regional health authorities at various hospitals around the country. During 2024, just over 12,000[1] people were in institutional care pursuant to the Compulsory Psychiatric Care Act.

Four of these clinics were inspected during the year. The clinics are located at hospitals in Växjö, Gothenburg, Linköping and Sundsvall. The inspections had the following focus areas.

1 Data retrieved from the National Board of Health and Welfare's statistical database.

Activity room in Växjö

- The care environment and secur ity for older adults
- Coercive measures
- Staffing levels, staff competence and the treatment of inmates

The Parliamentary Ombudsman's most significant conclusions

At one clinic located at Sahlgrenska University Hospital i Gothenburg, the care environment was clearly strained due to overcrowding. Many inmates were temporarily accommodated in, for example, ward corridors without appropriate screens or other protection from view. This posed an imminent risk to the personal integrity of these individuals. There appeared to be a significant risk that inmates would perceive the living environment as unsafe and disturbing. In another part of the same hospital, older inmates were cared for in substandard facilities.

Among other things, the Parliamentary Ombudsman recommended that the regional health authority in question cease operations in those premises where there are very extensive and severe deficiencies. According to the Parliamentary Ombudsman, until such time as this can be done, there are a number of measures that can improve the situation for inmates. It was also recommended that, as a matter of urgency, the region refrain from placing inmates in corridors and take a number of specific additional measures.

With regard to the *care environment* and *security of older adults*, the inspections revealed problems such as poor accessibility adaption, for example, inmates were forced to leave aids outside sanitary facilities because there was no room for them inside. Furthermore, inmates at all clinics had limited access to outdoor areas, among other things due to high thresholds to courtyards and lack of automatic door openers. The Parliamentary Ombudsman noted that, for various reasons, there was a risk that inmates would be dependent on the assistance of staff to get outside, and that the regions in question needed to ensure that all inmates were offered the opportunity to be outdoors for a least one hour a day.

Restraint bed in Växjö

Many inmates appeared to be unaware of the content of their care plan or what information they had been given regarding their rights and the clinic's procedures. The Parliamentary Ombudsman found this worrying and emphasised the importance of ensuring that inmates actually understood the information they were given.

With regard to *coercive measures*, rooms in which such measures are implemented should be safe for inmates who are acting out. However, the inspections revealed that this is not always the case. There were rooms with fixtures and

fittings that could be broken by inmates and used to harm themselves. The Parliamentary Ombudsman also noted that inmates' rooms should be a personal sphere in which they can feel secure, and therefore questioned whether it was appropriate to, for example, restrain inmates in their own rooms.

Two of the clinics had taken various measures to minimise the use of coercive measures. The Parliamentary Ombudsman took a very positive view of this and emphasised the importance of continuing this work over time. At another clinic, it was found that several inmates had been the subject of repeated decisions on forced medication and physical restraint. The Parliamentary Ombudsman considered this a matter for concern, underlining that it is vital to make an assessment of whether coercive measures are actually necessary prior to each individual decision.

The treatment of inmates by staff was described as generally good. With regard to staffing, the Parliamentary Ombudsman noted that *staffing* is not always adequate, which could give rise to risks in both the work environment and care environment. At one clinic, management reported high staff turnover, skills shortages among staff and difficulty in recruiting competent and suitable personnel.

The Parliamentary Ombudsman's recommendations

The Parliamentary Ombudsmen made a number of recommendations to regions on how to improve the situation for inmates. For example, regions should ensure that

- all inmates have access to accessible toilets and showers;
- there are places on wards where inmates can be alone if they wish;
- all inmates in compulsory care are offered the opportunity to spend at least one hour a day outdoors;
- inmates are informed of their care plan and involved in their care to the greatest possible extent;

- inmates receive information about their rights and procedures in a manner they can assimilate and, when necessary, the information is adapted and repeated;
- no rooms with fixtures and fittings that could be broken by inmates and used to harm themselves are used for coercive measures;
- an assessment of whether coercive measures are actually necessary is made prior to each individual decision;
- staff with the necessary skills are available to inmates; and
- staff awareness-raising measures are implemented so that inmates have access to a good and safe care and living environment.

Provisional accommodation at Sahlgrenska

Migrant detention centres

Background

The Swedish Migration Agency is tasked with running fit-for-purpose detention centres in which foreign nationals can be held while awaiting the enforcement of decisions on refusal of entry to or deportation from Sweden. The Swedish Migration Agency has six detention centres with a total of approximately 600 places[1].

Three of these detention centres were inspected during the year: Åstorp, Flen and Gävle. The inspections had the following focus areas.

- The physical environment at the detention centres
- Inmates' access to healthcare
- Staff competence and the treatment of inmates
- Specific risks for people with disabilities or special care needs

The Parliamentary Ombudsman's most significant observations

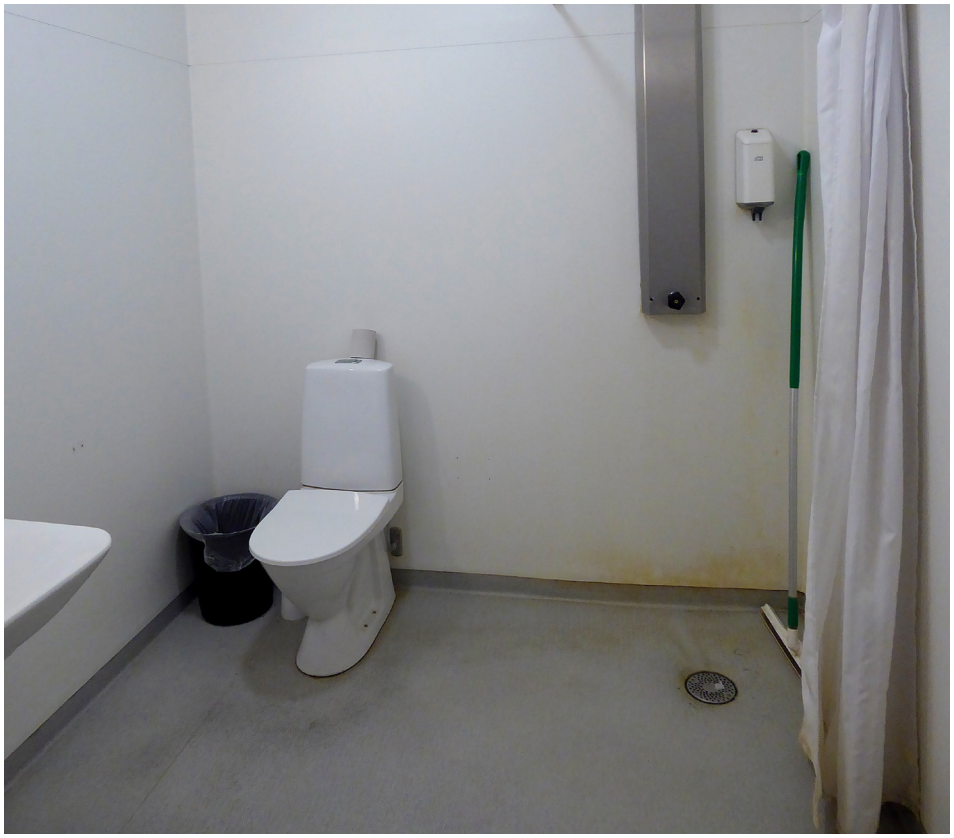
A number of shortcomings in the *physical environment* came to light during the inspections. Common areas were described as dirty and poorly ventilated. The Parliamentary Ombudsman noted that none of the cells were large enough to provide inmates with access to four square metres per person. The Parliamentary Ombudsman pointed out that overcrowding could pose risks to the health of inmates; not least, poor air quality in combination with noise can lead to sleeping problems and increase the risk of infections spreading. One detention centre had only three or four communal toilets and a small number of communal showers on each wing to be shared by at least 24 inmates. These facilities were poorly maintained, with extensive discolouration and limescale.

Many inmates described days of relative inactivity. Only one of the detention centres was able to offer an organised activity, in the form of group exercise

1 Data retrieved from the agency's website.

Exercise yard in Gävle

in a corridor. The Parliamentary Ombudsman noted that inmates must be provided with opportunities for activities, recreation, physical exercise and time outdoors. Pastimes of various kinds are not sufficient. The Parliamentary Ombudsman emphasised the importance of detention centres offering activities with meaningful content. With regard to time outdoors, the Parliamentary Ombudsman held that the detention centres were not in full compliance with the recommendations of the European Committee for the Prevention of Torture (CPT) that inmates should have free access to an outdoor environment throughout the day, and at the very least for two hours a day.



Sanitary facility in Åstorp

With regard to *access to healthcare*, inmates were not offered a medical examination on admission to the detention centre, with the concomitant risk that any health problems would not be picked up. This may pose a health hazard not only to the inmate in question but also to others at the detention centre. The Parliamentary Ombudsman noted that, while responsibility for medical examinations rests with the regional health authority, the detention centre needs to facilitate examinations. This did not happen in any systematic way.

Many inmates reported mental health issues but had no access to psychological support. As a rule, inmates were not permitted to keep medication in their cells. Instead it was kept under lock and key in the staff room. The Parliamentary Ombudsman took a dim view of the lack of procedures for managing medication at the detention centres.

The inspections revealed that inmates often received no written information about their rights or procedures at the detention centre. The Parliamentary Ombudsman found this unacceptable. *Staff treatment of inmates* was otherwise generally good. That said, inmates of one detention centre felt that they were treated like criminals and addressed in an aggressive, condescending and nonchalant manner when, for example, they asked about procedures or asked staff for assistance. The Parliamentary Ombudsman stated that the poor treatment of inmates by certain members of staff is unacceptable.

Cell in Flen

On the matter of *specific risks* for people with disabilities, the Parliamentary Ombudsman found it problematic that the inspected detention centres had no accessible rooms or bathrooms for inmates with disabilities. It also emerged that neither premises nor staff were equipped to receive inmates with special care needs. The Parliamentary Ombudsman also found it problematic that there were no procedures in place for how people with special care needs were to be cared for while in detention. In the long term, these shortcomings posed a risk for inhuman or degrading treatment.

The Parliamentary Ombudsman's recommendations

The Parliamentary Ombudsmen made a number of recommendations to the agency on how to improve the situation for inmates. For example, the agency should ensure that

- multiple occupancy cells provide a minimum of four square metres per inmate;
- all sanitary facilities are kept clean and well maintained;
- inmates are offered meaningful occupational activities;
- inmates have free access to an outdoor environment throughout the day, and at the very least for two hours a day;
- inmates are offered a medical examination on admission to the detention centre in accordance with applicable legislation;
- an assessment is made of the possibility of increasing access to adequate psychological support for inmates who need it;
- guidelines on appropriate and safe medication management are prepared at agency level as a matter of urgency;
- immediately upon admission, all inmates have access to written information in a language they understand about their rights and obligations, as well as the detention centre's rules;

- all staff have the requisite competence for inmates to be treated well;
- inmates with disabilities have access to suitable accommodation, including adapted beds and the necessary aids to move around the room; and
- guidelines are prepared on how inmates with special care needs are to be cared for at the detention centre.

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