PARLIAMENTARY OMBUDSMAN OF FINLAND

SUMMARY OF THE ANNUAL REPORT 2020

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To the reader

The Constitution (Section 109.2) requires the Parliamentary Ombudsman to submit an annual report to the Eduskunta, the Parliament of Finland. This must include observations on the state of the administration of justice and on any shortcomings in legislation. Under the Parliamentary Ombudsman Act (Section 12.1), the annual report must include also a review of the situation regarding the performance of public administration and the discharge of public tasks with special attention to the implementation of fundamental and human rights.

The undersigned Mr Petri Jääskeläinen, Doctor of Laws and LL.M. with Court Training, served as Parliamentary Ombudsman throughout the year under review 2020. My term of office is from 1 January 2018 to 31 December 2021. Those who have served as Deputy-Ombudsmen are Licentiate in Laws Ms Maija Sakslin (from 1 April 2018 to 31 March 2022) and Doctor of Laws and LL.M. with Court Training Mr Pasi Pölönen (from 1 October 2017 to 30 September 2021).

Licentiate in Laws and LL.M. with Court Training, Principal Legal Adviser Mr Mikko Sarja was selected to serve as the Substitute for a Deputy-Ombudsman for the period 1 October 2017–30 September 2021. He performed the tasks of a Deputy-Ombudsman for a total of 43 working days during the year under review.

The annual report consists of general comments by the office-holders, a review of activities and a section devoted to the implementation of fundamental and human rights. The findings and statements concerning the corona pandemic are gathered in a separate section. The report also contains statistical data and an outline of the main relevant provisions of the Constitution and the Parliamentary Ombudsman Act. The annual report is published in both of Finland's official languages, Finnish and Swedish.

The original annual report is over 400 pages long. This brief summary in English has been prepared for the benefit of foreign readers. The longest section of the original report, a review of oversight of legality and decisions by the Ombudsman by sector of administration, has been omitted from it. However, the chapter dealing with the oversight of covert intelligence gathering and intelligence operations as well as the chapter of European Union law issues are included in this summary.

The Ombudsman has two special duties based on international conventions. The Ombudsman is the National Preventive Mechanism (NPM) under the Optional Protocol to the UN Convention against Torture and the Ombudsman is part of the national structure in accordance with the UN Convention on the Rights of Persons with Disabilities. Information on the Ombudsman's activities performing these special duties can be found in the section of the annual report concerning fundamental and human rights.

I hope the summary will provide the reader with an overview of the Parliamentary Ombudsman's work in 2020.

Petri Jääskeläinen
Parliamentary Ombudsman of Finland

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The photographs on the front pages of the sections feature shots of the steel statue deplating giant strawberries called "Oma maa mansikka" (2007) by sculptor Jukka Lehtinen, located at the front of the Finnish Parliament Annex. Photos: Office of the Parliamentary Ombudsman photo archive (p. 12, 30, 50, 191, 219, 237, 242).

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1 General comments

Parliamentary Ombudsman
Mr Petri Jääskeläinen

Ombudsman as guardian of the rule of law

The Ombudsman has a key role in upholding and promoting the rule of law.[1] This is due to the fact that the Ombudsman's duties as the supreme overseer of legality are linked to all key elements of the rule of law.

There is no single unambiguous definition of the content of the rule of law.[2] For my part, I understand its key features to be the following.

1) The exercise of public powers being based on and tied to legislation. These elements of the rule of law are expressly stated in section 2 subsection 3 of the Constitution of Finland. It states that the exercise of public powers shall be based on an Act. In all public activity, the law shall be strictly observed.
2) A system of basic rights guaranteeing the rights and liberties of the individual. Chapter 2 of the Constitution lays down the basic rights and liberties so that they safeguard the rights and freedoms of the individual at least at the same level as international human rights conventions.
3) An independent judicial system. The effective realisation of basic rights and liberties hinges on them being possible to implement. The most important aspect of legal protection is the independence of the courts of law, but also the independence of the prosecution system, enforcement authorities and advocates.
4) Independent oversight of legality. The implementation of the different elements of the rule of law requires effective and independent oversight.

The Constitution especially addresses the oversight of legality. This is already evident from the fact that the Constitution contains 11 sections laying down the role, tasks or powers of the

[1] This has been noted in all international recommendations concerning the Ombudsman institution. For example, see the Principles on the Protection and Promotion of the Ombudsman Institution (The Venice Principles) adopted by the Venice Commission in 2019 and the resolution "The role of Ombudsman and mediator institutions in the promoting and protection of human rights, good governance and the rule of law" adopted by the UN General Assembly in 2020.

[2] For example, see the Report on the Rule of Law adopted by the Venice Commission in 2011.

Ombudsman. Finland also has an internationally unique system of two supreme overseers of legality whereby both the legislative and the executive powers have their own designated overseer of legality acting on their behalf. The Parliamentary Ombudsman is elected by the Parliament, and the Government has the Chancellor of Justice appointed by the President of the Republic; these two have identical powers over the supervision of public tasks. In comparison to other countries, only Sweden has a similar system, but the role of the Chancellor of Justice in overseeing legality is clearly narrower there than in Finland.

In this review, I will look at the role of the Ombudsman as guardian of the rule of law and also raise some structural issues relating to the protection of the rule of law. My remarks below on the Ombudsman also largely apply to the Chancellor of Justice.

Oversight of legality

According to section 109 of the Constitution, the Ombudsman shall ensure that the courts of law, the other authorities and civil servants, public employees and other persons, when the latter are performing a public task, obey the law and fulfil their obligations. In other words, supervising the exercise of public powers under the rule of law being tied to legislation is an explicit task of the Ombudsman as laid down in the Constitution, which in fact also includes supervising that it is also based on legislation.

The Ombudsman's remit includes all central and regional government authorities of the state, the authorities of the autonomous Province of Åland, municipal authorities and church authorities. Governmental authorities overseen by the Ombudsman include members and ministries of the Government, the Defence Forces and intelligence authorities. The President of the Republic also falls within the remit of the Ombudsman. Of the bodies of public authority, only Parliament and the members of parliament lie outside the Ombudsman's competence. Such extensive remit, which also includes the courts of law, is internationally unique.

In terms of the rule of law, another key element in Finland is the constitutional arrangement of delegating a public administrative task to a private person or the private sector. According to section 124 of the Constitution, this can only be done by an Act, if it is necessary for the appropriate performance of the task and if it does not endanger basic rights and liberties, legal remedies or other requirements of good governance. However, a task involving significant exercise of public powers can only be delegated to public authorities. It is also essential that the performance of a public administrative task and the exercise of public powers delegated to the private sector fall under the oversight of the Ombudsman directly by section 109 of the Constitution. The purpose of the regulation is to ensure that the rule of law would also extend to these activities when granting public powers to others than official authorities. To my understanding, this arrangement is also unique at the international level.

In practice, a very large proportion of the Ombudsman's oversight of legality is currently targeted at the private sector undertaking public administrative tasks. This is particularly due to the fact that the social welfare and health care services which are the responsibility of municipalities are provided by private operators to a very large extent. In the practice of legal oversight, the Ombudsman has also addressed on several occasions the fact that activities considered a public administrative task have been delegated to the private sector without the provision of an Act required by section 124 of the Constitution. The Ombudsman's actions have led to legislative measures.

In his oversight of legality, the Ombudsman may investigate complaints, take own initiatives and carry out inspections on all sites within the scope of his oversight of legality, and issue statements related to legislative drafting. Under section 111 of the Constitution, the Ombudsman has an unrestricted right to receive information, and the Parliamentary Ombudsman Act lays down a wide range of measures: prosecution, reprimand, opinion as a rebuke or for future guidance, and recommendation to (a) redress an error (b) develop provisions and regulations (c) make recompense or (d) settle the matter in an amicable manner.

Fulfilment of civil service liability under criminal law

Another key element of the rule of law is criminal liability and liability for damages related to the exercise of public powers. The provisions of the Criminal Code of Finland concerning offences in public office apply to all those exercising public powers. The Constitutional Law Committee has consistently insisted that when a public administrative task is assigned to an actor in the private sector, its activities must be governed not only by the general legislation on administration, but also by the provisions on civil service liability under criminal law and the provisions of the Tort Liability Act.

This set of regulations is also related to section 118 of the Constitution, according to which everyone who has suffered a violation of his or her rights or sustained loss through an unlawful act or omission by a civil servant or other person performing a public task shall have the right to request that the person be sentenced to a punishment and be liable for damages. In Finland, the victim of an offence, or the injured party, has an internationally rare independent right to bring charges if the public prosecutor does not prosecute the offence. This right of prosecution of the injured party is thus safeguarded at the constitutional level in terms of civil servants or persons performing a public task.

From this perspective, it is noteworthy that under section 110 of the Constitution, the Ombudsman may prosecute or have charges brought in all matters falling within the purview of his supervision of legality. The Ombudsman therefore has the right to prosecute all activities under the Ombudsman's oversight, meaning all crimes committed by civil servants or persons performing a public task.

With regard to the Members of Government, the Ombudsman has the competence laid down in section 115 of the Constitution to take legal action in matters concerning the legal responsibility of a minister. The decision to bring a charge is made by the Parliament, after having obtained an opinion from the Constitutional Law Committee concerning the unlawfulness of the actions of the minister. These cases are prosecuted by the Prosecutor General in the High Court of Impeachment.

During 2020, there was some discussion in Finland on the possible need to reform the handling of matters concerning ministerial responsibility. It has been suggested that the consideration of charges is poorly suited to Parliament, and it has been proposed for the Ombudsman, the Chancellor of Justice or the Prosecutor General to be appointed to carry out the consideration of charges.[3)]

If this were to be done, I think that the powers of the consideration of charges would be best suited to the Ombudsman. The Parliamentary Ombudsman and the Chancellor of Justice already have exclusive jurisdiction to bring charges against and prosecute the judges of the Supreme Court and the Supreme Administrative Court in the High Court of Impeachment. In the relationship between the supreme overseers of legality, the duties of the prosecutor in matters concerning the legal responsibility of a minister would be better suited to the Ombudsman, as the Ombudsman is an overseer of legality elected by Parliament and acting on Parliament's behalf. Thus, the Ombudsman would indirectly implement the underlying idea of the current order of business regarding ministers' legal responsibility in that the Members of Government are responsible to the Parliament in their official duties not only in the political but also in the legal sense. In addition, the Ombudsman's everyday work is further removed from the Members of Government compared to the Chancellor of Justice of the Government. Under section 113 of the Constitution, the Ombudsman may also initiate a matter concerning the criminal liability of the President of the Republic by informing the Parliament. If the Parliament decides that charges are to be brought, the Prosecutor General will prosecute the President in the High Court of Impeachment.

3) Former Prosecutor General, Professor Matti Kuusimäki in the Helsingin Sanomat guest column 16 December 2020.

Especially in authoritarian states, it is typical that the head of state has immunity from criminal liability. Even in democratic states, the implementation of the criminal liability of the head of state may prove difficult in practice. In the light of these considerations, it should be noted that under section 113 of the Constitution, the criminal liability of the President of the Republic of Finland for an official act is limited to treason, high treason and crimes against humanity. So if the President of the Republic were guilty of something other than those three types of criminal offences, implementing criminal liability would not be possible.[4)]

Oversight and promotion of basic rights

The rule of law includes a system of basic rights and liberties that guarantees the individual certain basic rights and a scope of liberties that the public authorities may not, in principle, intervene in. In 1995, a basic rights reform was carried out in Finland where people's basic rights were comprehensively recorded in the Finnish constitution, titled the Form of Government at the time. In connection with the reform of basic rights, an addition was made to the provision on the Ombudsman, stating that "in the performance of his or her duties, the Ombudsman monitors the implementation of basic rights and liberties and human rights".

Since the basic rights reform, the Ombudsman's constitutional task has therefore been to monitor the implementation of fundamental and human rights in addition to the traditional oversight of legality. This expansion of the Ombudsman's perspective and oversight is currently reflected, for example, in the provision of the Parliamentary Ombudsman Act guiding the investigation of a complaint. It states that arising from a complaint made to him or her, the Ombudsman shall take the measures that he or she deems necessary from the perspective of compliance with the law, protection under the law or implementation of fundamental and human rights. According to the Act, the Ombudsman's Annual Report must pay "special attention to implementation of fundamental and human rights".

The Ombudsman's duties include the promotion of fundamental and human rights. According to the Act, the Ombudsman may "draw the attention of the subject to considerations of promoting fundamental and human rights". In practice, this includes the Ombudsman assessing whether an authority or a person performing a public task could have better promoted the implementation of fundamental and human rights by acting in some other way.

The Ombudsman's task of monitoring and promoting fundamental and human rights is supported by the Human Rights Centre, operating in conjunction with the Office of the Parliamentary Ombudsman, whose statutory duties include providing information, education and training and conducting research on fundamental and human rights. The Ombudsman, the Human Rights Centre and its Human Rights Delegation together form the National Human Rights Institution of Finland in accordance with the UN's so-called Paris Principles.

Supporting the independence of the court system

According to the Constitution, one of the Ombudsman's duties is the supervision of the courts of law. Internationally, it is very rare that the courts fall within the remit of the Ombudsman – in practice, this is the case for only two of the

4) According to the preliminary work of the Constitution, the realisation of a minister's criminal liability may also be caused by the minister's contribution to an unlawful decision or other measure by the President of the Republic (Section 60(2) of the Constitution). According to the preliminary work, the fact that the Government has not refused to implement an unlawful decision of the President in accordance with section 112(2) of the Constitution may also create legal liability for a minister. – In certain situations, the criminal liability for an unlawful official act by the President of the Republic is shouldered by ministers and not personally by the President.

oldest ombudsman institutions in the world: the Finnish and Swedish ombudsmen.

An Ombudsman overseeing the courts of law could be seen as a threat to the independence of the courts. In reality, this is not the case; the Ombudsman is acting in support of the independence of the courts.

The Ombudsman must also respect the independence of the courts of law laid down in the Constitution, a core element of the rule of law. In practice, this is manifested, for example, by the fact that the Ombudsman does not investigate cases pending in a court of law or ones that can still be brought before the court. This is precisely because a statement on such a matter could influence or be interpreted as an attempt to influence the judgement of an independent court. Furthermore, the Ombudsman does not interfere in the assessment of evidence by a court of law, or in the outcome of a decision given by the court within the limits of its extensive discretion. In practice, the Ombudsman's judicial oversight is limited to procedural matters, such as delayed proceedings and the treatment of the parties involved.[5)]

Making decisions as described above is one way for the Ombudsman to demonstrate that in the rule of law, the ultimate legal protection body is the independent court of law and not the Ombudsman. The Ombudsman has also submitted several legislative proposals specifically aimed at strengthening the independence of the courts. Similarly, in his statements related to legislative drafting, the Ombudsman always draws attention to aspects of the independence of the courts, if there is any need to do so.

A democratic society does not allow for any uncontrolled public authority, so the exceptionally significant use of public power by courts and judges must also be subject to oversight. Largely, this oversight is done internally by the court system, but, if necessary, it must also be possible to uphold the civil service liability of judges.

According to section 110 of the Constitution, a decision to bring charges against a judge for unlawful conduct in office can only be made by the Chancellor of Justice or the Ombudsman. Even this arrangement of the right to bring charges aims to support the independence of courts and judges. This independence could be violated by having the implementation of the civil service liability of judges be decided by public prosecutors whose cases the judges preside over. The supreme overseers of legality do not have a similar mutual relationship with judges whereby their right to bring action against a judge could jeopardise the independence of the judges.

The authority overseeing independent courts and judges must be strictly independent itself. The Ombudsman fulfils this requirement. However, this requires that the Ombudsman's independence be upheld in particular.

It is essential for the independence of the court system that the appointments of judges are made in accordance with the general criteria for appointment laid down in section 125 of the Constitution. In Finland, the President of the Republic ultimately decides on all the permanent appointments of judges. This is another factor that makes it important for the oversight of the President of the Republic and the Government in Finland to fall within the competence of the supreme overseers of legality and, in particular, the duties of the Chancellor of Justice.

In Finland, the prosecution system plays a key role in the administration of justice in criminal matters. This is partly due to our very strong principle of precise prosecution. It provides that the court may, at its discretion, only take into account the facts of the proceedings which the prosecutor has expressly invoked. This arrangement, which has been adopted to ensure the legal protection of the suspect, limits the discretionary power of the court, and therefore the independence of the judicial administration of criminal matters also requires an independent prosecution system.

All prosecutors, including the Prosecutor General, are under the competence of the Ombudsman and the Chancellor of Justice. On the other hand, no other party outside the prosecution service can oversee prosecutors. This arrangement

5) I have discussed issues related to the Ombudsman's oversight of the courts of law more extensively in my article in the "90th anniversary of the Parliamentary Ombudsman" commemorative volume (2010).

supports the independence of the prosecution service. In my oversight of legality, I have for example emphasised that the Ministry of Justice cannot direct any oversight of legality to the prosecution system which is in itself part of the administrative branch of the Ministry of Justice.

The Ombudsman and the Chancellor of Justice also have the exclusive right to bring charges for offences in public office made by prosecutors. This arrangement is particularly aimed at safeguarding trust in the handling of suspected cases of offences in public office by prosecutors, to ensure that the prosecution is not decided by a colleague, but it can also be seen to safeguard the independence of prosecutors.

The legality of advocates' actions and their independence also play a role in the overall judicial administration. Of the supreme overseers of legality, the Chancellor of Justice has a special duty to supervise advocates' actions.

Ensuring the preconditions for the supreme oversight of legality

So the Ombudsman plays a very important role in safeguarding the rule of law. For this reason, safeguarding the rule of law is linked to safeguarding the viability of the Ombudsman's work. To do so, it essential that tasks closely related to the legal status of individuals are not excluded from the Ombudsman's competence and that the Ombudsman's independence is not jeopardised.

For example, the activities of credit reporting companies do not fall within the Ombudsman's competence, even though the payment default data collected and disclosed by the companies hinder the everyday life of hundreds of thousands of people in many ways. Another example could be Länsimetro Oy, a limited liability company owned jointly by the cities of Espoo and Helsinki. The company's task is to use public funds to build, own, maintain and develop the western part of the public metro system, but its activities do not fall within the Ombudsman's competence, unlike Helsinki City Transport, which is responsible for the eastern part of the metro system.

With regard to credit reporting companies, the Ombudsman has the option of so-called oversight of oversight, as the credit reporting companies are overseen by the Data Protection Ombudsman, who in turn falls within the scope of the Ombudsman's oversight. On the other hand, the Ombudsman does not have even indirect oversight over Länsimetro Oy. Problems like this could be rectified with ordinary legislation by providing that such tasks fall under the scope of public tasks, in which case they would be directly subject to the Ombudsman's oversight under the Constitution.

In some countries it is expressly stipulated that functions important to people's everyday lives, such as water, waste and electricity management companies, fall within the Ombudsman's competence. It may be worth considering such regulation in Finland as well. The same could apply to telephone operators – at least with regard to tasks related to secret information gathering and coercive measures.

There are recent examples of threats from the European Union. Under the General Data Protection Regulation, the national data protection authority, which is the Data Protection Ombudsman, would also have overseen the Parliamentary Ombudsman. This would have jeopardised the independence of the Parliamentary Ombudsman's oversight of the Data Protection Ombudsman and could also jeopardise the independence of the Parliamentary Ombudsman's oversight of courts of law related to the Data Protection Regulation.

Another example is the Council Regulation on the establishment of the European Public Prosecutor's Office (EPPO), which contains a number of aspects that are problematic with regard to the Ombudsman's constitutional status. For example, under the regulation and proposed national legislation, EPPO prosecutors were at risk of being excluded from the Ombudsman's oversight of legality, even though they exercise significant public powers in Finland.

In both of the above-mentioned cases, the Constitutional Law Committee rejected these threats on the basis of the constitutional status of the supreme overseers of legality in Finland's constitutional identity. However, we must be vigilant about threats like these. This is because the constitutional status of the Ombudsman is not as strong in other Member States of the European Union as it is in Finland. This is why the drafting

process for EU legislation may not take into account what kind of impact the regulations would have on the Ombudsman's constitutional status.

There are international examples, even some within the European Union, where there are efforts to deliberately erode the rule of law. As the Ombudsman plays a key role in safeguarding the rule of law, those in power may try to inappropriately influence the Ombudsman, or even get rid of an Ombudsman who is standing in the way of them gaining more power.[6)]

Although I have criticised Finland's internationally unique system of two supreme overseers of legality because of its overlaps[7)], from the perspective of safeguarding the rule of law, the system has the benefit that it is more difficult to get rid of two overseers of legality than one. The Chancellor of Justice is a permanent state official appointed by the President of the Republic. However, his right to remain in office is weaker than that of an ordinary official, as the President of the Republic may dismiss the Chancellor of Justice when there is an "acceptable and justified reason for it, given the nature of the position". The Ombudsman's task is fixed-term, but according to section 38 of the Constitution, the Ombudsman can be dismissed before the end of his or her term only for extremely weighty reasons by a decision supported by at least two thirds of the votes cast.

While the Ombudsman's activities are secured by provisions at the constitutional level, the provisions of the Parliamentary Ombudsman Act also play a very important role in the Ombudsman's activities. Provisions corresponding to the Ombudsman Act were previously contained in the Rules of Procedure of the Parliamentary Ombudsman adopted by Parliament on a proposal from the Speaker's Council. However, after the constitutional reform, it was considered necessary to include the regulations in legislation for reasons arising from section 80 of the Constitution. In fact, the current Ombudsman Act of 2002 was enacted on the basis of a Government proposal.

From the perspective of safeguarding the viability of the Ombudsman's work, it could also be considered preferable for the legislative provisions concerning the Ombudsman to be adopted on proposal from the Speaker's Council, such as the Act on Public Officials of Parliament pursuant to section 34 of the Constitution.[8)] The background of the system of having two supreme overseers of legality – which is linked to the power relations between the highest organs of the state – could also be considered to be in favour of the Parliament, and not the Government, having the power of initiative to adopt or amend legislation concerning the Ombudsman.

Conclusion

It has been said that take care of the rule of law, and the rule of law will take care of you. In fact, ensuring the rights and freedoms of the individual is the fundamental task of the rule of law.

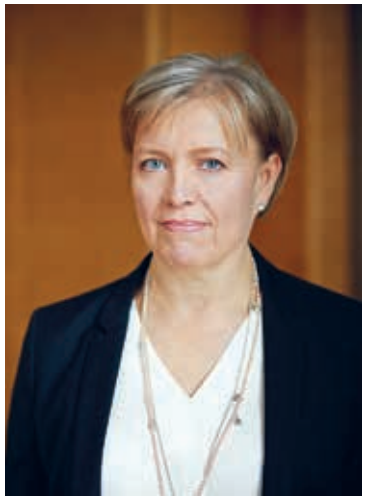
It has also been said that the rule of law is like a garden. It requires constant tending, and if it is not cared for, weeds will take over quickly. This is also true, and there are both good and bad examples of this.

The rule of law has been carefully cared for in Finland, but there is also reason to prepare for other kinds of circumstances. One important gardener of the rule of law is the Parliamentary Ombudsman. Even to the extent that the Constitutional Law Committee has seen the Ombudsman's activities to be a part of Finland's constitutional identity.

6) For example, in its principles of the Ombudsman institution, the Venice Commission has expressed serious concern about the fact that Ombudsman institutions may be subject to different types of attacks and threats.

7) See my review in the Ombudsman's annual reports for 2014 and 2016. During the spring 2021 a Government's proposal for a new act on the division of duties between the Chancellor of Justice and the Ombudsman will be given to the Parliament; it would significantly reduce the overlap of tasks and support both overseers of legality in their appointed duties.

8) Along these lines, the current Ombudsman Act, which was adopted on a Government proposal, was prepared by a working group appointed by the Speaker's Council.



Deputy-Ombudsman
Ms Maija Sakslin

About restrictions and derogations of Fundamental Rights

The coronavirus pandemic has challenged our system of fundamental rights in an unprecedented way. The importance of fundamental rights increases when society faces different crises. Typically, rights are under various threats during crises, but the measures used to combat the threats may also endanger the enforcement of the rights. When the rights are most needed, they are also most in danger.

In the past, Finland has experienced several extremely contagious diseases and epidemics such as the plague, cholera, leprosy, the Spanish flu and tuberculosis. To combat these diseases, drastic restrictions on rights were sometimes imposed, such as isolation and quarantine to halt the spread of the disease. Many of us are familiar with stories of how people were isolated in the island of Seili as from the 17th century. Many also know especially the history of the tuberculosis sanatoriums which were established in the 1920s and 1930s. Even children were in these sanatoriums for up to several years, isolated and far away from their families. The developments in medical science and medicines have made quarantines and isolation rare, mostly unnecessary. The polio epidemic in the 1980s and the swine flu of 2009 and 2010 were extinguished by carrying our extensive vaccination of the population.

The events of 11 September 2001 were followed by an increase in the threat of terrorism and the negative impact that combating it had on people's rights. Terrorist attacks are targeted at several rights, such as the right to life, health, physical integrity and liberty. When the threat of terrorism increased, it was evident that many people were ready to accept even significant derogations to fundamental rights and to concentrate powers for using different anti-terrorist measures by deviating from the constitution-based institutional structures. Although terrorism is detrimental to fundamental rights, fundamental rights must be respected when combating it.

The impacts of the coronavirus epidemic on fundamental rights differ from previous epidemics and the prevention of terrorism in that previously the rights of only those who had been exposed or were ill were restricted through measures such as quarantining. This time, the measures have been targeted at the entire population, including people who are healthy. When terrorism

is combated, some restrictions on rights are also targeted at the entire population (e.g., covert intelligence gathering).

The coronavirus pandemic has been a kind of stress test for our system of fundamental rights. Over a very short time, a large number of restrictions on fundamental rights have been implemented. When the decisions on them were made, it was assessed what fundamental rights it was acceptable to restrict, who had the authority to decide on the restrictions, how the necessity and compliance with the principle of proportionality of the restrictions was assessed, and how the restrictions were implemented. We will be able to judge afterwards how well our legislation was prepared to face the pressure caused by the pandemic, how our institutions, Parliament, Government and the courts succeeded in their actions and how well the judicial culture prevailing in our society was able to deal with the pressure on the system of the rights. The culture prevailing in society in general plays a central role in safeguarding rights. If society strongly supports the values that the system of the fundamental rights represents and on which it is built, violating and restricting these rights is difficult even during emergency conditions as it would mean the actions taken would not have this cultural support.

However, it is difficult to reach a common view on the rights and restricting them. If the focus is on the successful protection of life and promotion of health achieved through restrictions on fundamental rights or exceptions to them, the picture provided is very different from when the focus is on the restrictions imposed on the rights and liberties and their impact on individuals and society. Issues related to restricting fundamental rights are particularly difficult when the same right is both protected and restricted. This happens, for example, when other patients' access to health care is limited to safeguard the carrying capacity of health care and to ensure access to health care.

It is therefore extremely important that, as part of preparing for future pandemics and other serious crises, an assessment be conducted as to whether the restrictions implemented during this pandemic were necessary and in accordance with the principle of proportionality. In addition, it should be assessed whether restricting rights on the basis of specific and general conditions for restricting fundamental rights was the right course of action in all situations, or whether derogations to fundamental rights, which emphasise the exceptional and provisional nature of the measures, should have been chosen. This discretion is not based on legal aspects alone. Especially the assessment of necessity and proportionality also requires scientific knowledge from other fields, particularly from medicine.

When the functioning of the institutions is assessed, it is essential to assess the actions of the Constitutional Law Committee. Soon after the outbreak of the pandemic, it was obvious that our legislation was not sufficiently prepared for measures required during pandemics such as coronavirus. The ability of the Constitutional Law Committee to assess in a very short time the constitutionality of the proposed restrictions has been decisive with regard to their entry into and remaining in force. Changes in the judicial operating environment have for a long time contributed to a situation where the authority of the Constitutional Law Committee is based on the acceptability of the content-related justifications presented in its positions, not only on its authority based on democratic legitimacy. During the coronavirus epidemic, the Committee's position as part of the mechanisms of our representative democracy has strengthened its role as the primary interpreter of the Constitution. At the same time, Parliament's position has also become stronger.

In addition, the greatness of our system lies in the fact that we also have functioning arrangements for the implementation of fundamental rights also after the legislator has completed its work.

The primary task of courts is to provide legal protection. When dealing with individual matters, their task is to assess where the limits of constitutionality are placed. From an individual's point of view, the difference between deciding not to apply an act and annulling it is not big. However, the weakening of this difference would have dramatic consequences in our system based on constitutional law. To prevent abuse of power, it must be

possible for courts to assess and set limits for the duration, scope and extent of measures that restrict fundamental rights, especially during emergency conditions. However, the assessment of constitutionality carried out by the Constitutional Law Committee that has democratic legitimacy takes priority and control by courts is the last resort. Compared to assessment by the Constitutional Law Committee, judgment by courts is more limited and always tied to the individual matter the court is dealing with. The more judgment by courts distances itself from an individual case, the more it may acquire features of retrospective constitutional review. It seems that the coronavirus restrictions assessed by courts during the pandemic have been only restrictions issued by different public authorities. Therefore, the consideration by courts has not included aspects of constitutional review.

Under our Constitution, the task of the Parliamentary Ombudsman as a supreme overseer of legality is to oversee that the law and the implementation of fundamental and human rights are complied with in all use of public powers. When performing its task, the Parliamentary Ombudsman cannot assess the activities of the legislator or change or repeal decisions made by a public authority or courts. The task of the Parliamentary Ombudsman does also not include providing legal protection in the same way as the courts. However, as the supreme overseer of legality the Ombudsman may state that the actions of the party subject to the oversight do not implement fundamental rights even if they appear to be in compliance with the law, and may propose changes to legislation when observing deficiencies in it. The matters assessed by the Parliamentary Ombudsman during the coronavirus epidemic have revealed cases in which competence has been exceeded and restrictions of fundamental rights have violated the Constitution. Based on these observations, the Parliamentary Ombudsman has also made proposals to amend legislation.

During the pandemic, restrictions on fundamental rights or exceptions to them have been implemented or proposed on the basis of at least four different grounds. Firstly, a state of emergency has been declared and powers under the Emergency Powers Act have been introduced. Secondly, powers under the Communicable Diseases Act have been relied on. Thirdly, without powers laid down in law, various restrictions have been introduced with the purpose of implementing recommendations issued by the Government, understood as binding, in order to prevent the spread of coronavirus. Fourthly, based on section 23 of the Constitution, the enactment of an act including powers to use a government decree to lay down provisional exceptions to fundamental rights during a situation of emergency has been proposed. Parliament and its Constitutional Law Committee have been key actors in approving the introduction of the powers under the Emergency Powers Act and deciding on provisional exceptions to fundamental rights proposed on the basis of section 23 of the Constitution. However, measures based on the Communicable Diseases Act as well as measures based on the Government's recommendations must ultimately be assessed by courts. It has been possible to bring the legality of the restrictions on fundamental rights based on different authorities' decisions before a court for assessment. In fact, courts have increasingly investigated these decisions issued by the authorities and some restrictions on fundamental rights have already been found unlawful.

Compared to court proceedings, which rely on the activity of an individual appellant and the legal effects of which are usually limited to the specific case, the impacts of guidance carried out by the Parliamentary Ombudsman may be more comprehensive. The Parliamentary Ombudsman may investigate matters on his own initiative or extend the investigation wider than the original complaint and focus it on several actors simultaneously. The Ombudsman has in fact provided guidance on the requirements of fundamental rights and, in particular, on the fact that, even during a pandemic, no restrictions on fundamental rights are permitted unless there is a legal basis for the restrictions and the restrictions are necessary. A recommendation or wish expressed by the Government does not obligate the authorities even when it is aimed at achieving an acceptable goal. When public powers are used, it must always be ensured that the actions are based on law. From the point

of view of oversight of legality, it is also significant that the Constitutional Law Committee has confirmed the view that the use of powers under the Emergency Powers Act is possible only in ways that are necessary for achieving the purpose of the Act and proportional to the goal of using the powers and that the principles of necessity and proportionality also restrict both their introduction and their use. The large number of complaints received by the Parliamentary Ombudsman during the year under review is likely to be a sign that the complainants have not considered restricting their fundamental rights acceptable. On the other hand, it probably demonstrates confidence that it will be possible for the Ombudsman to intervene in a procedure that is felt to be unlawful.

During the coronavirus pandemic, it has become evident that there are differing views on whether necessary restrictions on fundamental rights should primarily be implemented on the basis of the established implementation and interpretation of the specific and the general requirements for restrictions provided by the constitution, or whether the procedure concerning exceptions to fundamental rights referred to in section 23 of the Constitution should be relied on.

The procedure in accordance with section 23 of the Constitution would be supported by the fact that the scope of the provision has been narrowed down with references to human rights obligations and the definition of emergency conditions, according to which the pandemic must pose a serious threat to the nation. Exceptions to fundamental rights are necessary only when the powers included in legislation under normal conditions are not sufficient. Exceptions to fundamental rights may also go further than the restrictions on fundamental rights. Furthermore, the exceptional nature of exceptions to fundamental rights is emphasised by the fact that they can only be provisional. According to the Constitutional Law Committee, even legislative changes made during emergency conditions must primarily be restrictions that meet the general constitutional conditions for restricting fundamental rights and the specific conditions for restrictions of fundamental right, not deorgations to fundamental rights as referred to in section 23 of the Constitution.

Restricting fundamental rights on the basis of specific and general grounds for restriction requires an assessment of whether the grounds for the restrictions are acceptable. During the coronavirus pandemic, it has been widely agreed that public authorities have the obligation to protect the life and health of the population and therefore also the obligation to safeguard sufficient capacity in medical care. From the point of view of the system of fundamental rights, this is an extremely weighty ground. However, is it more difficult to reach agreement on whether the measures taken are necessary and in accordance with the principle of proportionality. The likely reason is that considering the necessity and proportionality of restrictions is not merely about weighing the legal aspects. Weighing them and the implementation of the principle of proportionality require an adequate and sufficiently multidisciplinary knowledge base. However, it is not possible to be entirely sure whether the spread of the virus, the severe cases of the disease and the deaths could have been prevented through more extensive restrictions on fundamental rights or to what extent the restrictions implemented reduced the number of cases and deaths.

Nevertheless, the rights of the population have been restricted in an unprecedented way during the pandemic, and it has been felt that some of the restrictions have even violated human dignity. In-depth restrictions have been targeted at almost all fundamental rights and the rights of all people. Some of the restrictions have had fatal consequences to people already in a vulnerable position.

The right to self-determination and personal freedom have been restricted in many different ways during the pandemic. The freedom of movement outside one's living unit and place of residence as well as across the national borders has been restricted. Restrictions have been imposed on the protection of private and family life, for example, by restricting contact between family members or the possibility to organise weddings or funerals. The freedom to practise a religion has been significantly restricted because of restrictions such as those imposed on the freedom of assembly. Restrictions on the freedom of assembly have also restricted the freedom of speech by

restricting the right to demonstrate. The electoral and participatory rights have been interfered with by postponing the election. Restrictions have indirectly been imposed on the use of property as a result of restricting the freedom of movement, right to practise a profession and freedom to engage in commercial activity. The right to good health has been restricted as a result of restrictions concerning access to care. Restrictions that have had a negative impact especially on children and young people have been imposed on educational rights. The right to work and the freedom to engage in commercial activity have been restricted, while imposing obligations to work on healthcare personnel. Almost all these restrictions have also affected the realisation of equality.

Based on the experiences gained during the year under review, it is too early to make a final legal, societal or political assessment on how our system of fundamental rights has come through the coronavirus epidemic and the emergency conditions. However, there has already been intense debate on fundamental rights and the permitted restrictions. As a key actor, the Constitutional Law Committee has been able to conduct high-quality oversight of fundamental rights, in spite of the time pressure. Unlike in many other European states, the lock-down and the exceptionally extensive restrictions on the individual's rights have not been possible without the prereview and constitutional control of Parliament in Finland. The ability of courts to maintain the rule of law does not seem to have been at risk, either. However, based on the observations made by the Parliamentary Ombudsman as a supreme overseer of legality, it can already be noted that our current legislation does not include sufficient tools for dealing with future pandemics. Additional cause for concern is the number of observations made by the Ombudsman, which reveal that public powers have been used to halt the spread of the virus in ways that restrict fundamental rights without the powers to do it.

Deputy-Ombudsman
Mr Pasi Pölönen

The Ombudsman as constitutional overseer of legality

The Ombudsman is not positioned in any of the three branches in the separation of powers – the Ombudsman is not a legislator, judge or executive. However, the supreme overseer of legality, as an institution and as a function, is strongly constitutional and situated close to the supreme state powers. The Ombudsman is mentioned multiple times in the Constitution of Finland. The Ombudsman is connected in many ways with the activities of the highest state organ, the Parliament. Ombudsmen are directly appointed by the Parliament, and the Parliament processes the Ombudsman's annual report thoroughly in its committees and plenary session.

The Ombudsman has extensive powers to address any legal issues in the exercise of public authority and public functions. A very particular constitutional duty is the oversight of legality of the judiciary. The Ombudsman's competence to call attention to needs for amendments to legislation and the right to be heard in parliamentary committees when examining legislative proposals is also essential from a constitutional perspective. On the whole, the supreme oversight of legality is deemed to be such an integral part of the Finnish constitutional identity that its supervision is excluded from the supervision of the national data protection authority, i.e. the Data Protection Ombudsman, who operates under the EU's General Data Protection Regulation.

The Ombudsman could be characterised as a constitutional institution, which is "situated" in a place that is somewhat unspecified but high in the division of supreme state powers, and which flexibly monitors all three fundamental branches of state powers. While the Ombudsman is not competent to supervise the exercise of legislative power, he or she may still carry out a form of indirect post-monitoring in this area, if necessary. Next, I will elaborate on this perspective.

Constitutional questions in oversight of legality and submissions

The Ombudsman examines compliance with official duties and the implementation of fundamental and human rights in public tasks. In general, ordinary laws or lower legal rules or the instructions and practices of authorities are examined.

However, interpretative elements that are often built into fundamental and human rights issues can sometimes also lead the overseer of legality towards constitutional issues. This is also the case in normal matters concerning oversight of legality, i.e. complaints, own-initiative investigations and inspections.

Constitutional questions most often arise as part of the legislative consultation procedure, i.e. when providing submissions to a ministry or parliamentary committee. Each year, more than one hundred submissions are provided, which entails a significant amount of work. Constitutional issues are raised the most in hearings of the Constitutional Law Committee.

Through the fundamental rights reform of 1995, the Ombudsman's possibilities of taking a stand on fundamental and human rights compliance of provisions increased. The Ombudsman's task of drawing attention to deficiencies identified in legislation most typically involves the fact that the application of law in some circumstances is considered to lead to problematic outcomes from the perspective of fundamental and human rights. New types of constitutional issues may also be identified and raised. Such actions by the Ombudsman do not constitute actual post-monitoring of the constitutionality of legislation, but they nevertheless do indirectly approach the subject. The Ombudsman's decisions can thus contribute to the constitutional debate and the development of legal order.

Relationship with the ex ante review of the Chancellor of Justice of the Government

A strong characteristic of the constitutional order of Finland is the advance review of the constitutionality of provisions, i.e. before a Government proposal is submitted or a legislative proposal is adopted. This ex ante review is the primary task of the Chancellor of Justice of the Government. The duties of the Chancellor of Justice in supervising the legality of the actions of the Government and the President of the Republic are both ex ante and ex post, as the Chancellor of Justice also handles complaints in addition to this advance review. In fact, the Ombudsman's duties could also be ex ante under the powers conferred by section 112 of the Constitution. In practice, however, the division of labour is clear and established so that the Ombudsman does not actually carry out this task. However, the use of such powers is not completely excluded; in the early stages of the corona pandemic that began in 2020, preliminary preparations were made at the Office of the Parliamentary Ombudsman in case the decision-making capacity of the Chancellor of Justice would be compromised due to cases of COVID-19. Fortunately, this did not happen.

In spite of meticulous advance review, it is not always possible to detect everything in advance even in theory. General terms are used in legal norms and, in principle, regulation always applies to a vague set of future cases. When an individual case becomes more concrete when the law is applied to changing situations in real life, legal terms may become subject to unexpected interpretative pressure. In fact, new questions occasionally arise concerning legislation that has long been in force and has been widely applied. Internationalisation, above all EU law, policies of human rights monitoring bodies and the development of technology generate new fundamental rights problems and challenges. Sometimes a legal problem is simply only detected afterwards. New questions are usually not constitutional, but such cases do exist.

An example of a constitutional problem regarding a highly significant matter from the constitutional perspective was related to the 2010 reform of the district court network. The number of district courts was reduced by a Government decree, leading to complaints to the Ombudsman. District courts had previously been established and abolished at a lower level than the law, and this had not been addressed. The Ombudsman referred to the list inspection of Government decrees carried out by the Chancellor of Justice, but considered that it does not prevent the Ombudsman or the Chancellor of Justice from performing ex post review of the regulatory level of given norms. In terms of content, the Ombudsman assessed the matter more closely from the basis of the Constitution that the general criteria

of central government institutions and significant state administration arrangements must be laid down by law. In drafting the Constitution, several experts heard by the Constitutional Law Committee had proposed that the organisational independence of the courts should be better taken into account in the Constitution. The Ombudsman considered it justified that the development of the district court network would be regulated by law. The Ombudsman's decision was quickly taken into account by an amendment to the District Court Act, in which all district courts were confirmed by law for the first time. Since then, the independence of the court system has been further strengthened, in particular through the establishment of an independent national courts administration.

Regulatory level and accuracy, the performance of public administrative duties and public tasks

In most cases, when the Ombudsman assesses something on the basis of constitutional criteria, it is a question of whether something should be regulated by law or whether a lower level of regulation is sufficient, and whether the regulation is sufficiently precise and delimited. The aim is to use the same criteria in the assessment as those applied by the Constitutional Law Committee. Such issues are often at least somewhat open to interpretation, and the Ombudsman also participates in this discussion through his or her decisions and submissions.

Another typical situation involves the performance of public administrative duties and public tasks. The so-called principle of civil service administration lies in the background here. It is a central constitutional concept in the organisation of public administration. The starting point is that the duties of public authorities are carried out by civil servants appointed to their posts, acting under official liability.

Section 124 of the Constitution restricts and partly prohibits the assignment of public administrative duties to those other than actual authorities. Significant public powers must remain with the authorities. In other situations, the outsourcing of public administrative duties by law or on the basis of law may be appropriate as long as compliance with the requirements of legal protection and good governance is ensured.

The central task of the Constitution in this regard is to safeguard the democratic control and decision-making of public administrative duties and, on the other hand, to ensure the implementation of the rule of law. It is about safeguarding the legality, coherence and objectivity of decision-making in the exercise of public authority. At the same time, this enables the organisation of public administration with resources outside the authorities, where deemed appropriate. In this case, the review of constitutionality is largely about whether the tasks to be outsourced are of a nature that only assists and supports official activities. Lines are drawn at, for example, the extent to which the task is limited to routine technical and administrative activities and whether this can be considered appropriate for the specific task within the meaning of the Constitution.

I examined these thematics in my 2019 decision, in which I recommended measures to clarify the public administrative tasks performed by Business Finland Oy to ensure that the company's tasks are based on a mandate under section 124 of the Constitution (883/2018). As a result of my proposal, the Ministry of Economic Affairs and Employment announced changes such as the reorganisation of the management of funding activities as a task belonging to authorities. The National Audit Office later recommended a reassessment of the division of duties of Business Finland Oy as a whole. During the reporting year, a working group was appointed to reform the legislation concerning Business Finland.

Senate Properties and Defence Properties

As a recent example of the Ombudsman's role in assessing regulation and authorities' activities from a constitutional perspective, I could mention my own initiative (6870/2019) on the management of the state's real estate assets, Senate Properties. Senate Properties' activities are often addressed in the Ombudsman's inspections, especially when examining the conditions of those deprived of their liberty. The site to be inspected, such as a police department or prison, cannot often independently repair an inadequacy detected by the overseer of legality, such as physical conditions in the facility, and can only proceed in the matter with the help of Senate Properties. Against this background, at the end of 2019, I took the initiative to examine the legal basis on which Senate Properties acts as a monopoly landlord for state agencies and institutions and defines the terms of its operations and the limits of its responsibilities in the internal state documents titled rental agreements.

The role of Senate Properties in providing premises services to the state and managing the state's real estate assets was based on a reference in the State Enterprise Act, but more closely related provisions on its operations are only at a decree and order level. My report focused essentially on the question of whether the monopoly status of Senate Properties and the internal state contracts used by Senate Properties should have been laid down by law, bearing in mind that under section 84(4) of the Constitution, the general principles on the functions and finances of state enterprises are laid down by an Act.

At present, regulation is very limited and deficient. The Act on the Right to Transfer State Real Estate Assets and the authorisation to issue decrees contained therein do not apply to in-house rental operations of the state. Despite this, a Government decree on the procurement, rent, management and maintenance of state real estate assets was issued pursuant to this act in 2016. This so-called management decree made Senate Properties a monopoly operator in the state premises administration.

After my assessment began, in early 2020, the Ministry of Finance submitted a Government draft proposal for an act on Senate Properties and Defence Properties and for certain related acts. In connection with this separate project, I made critical observations on the legal basis of Senate Properties' activities as a whole (279/2020). Questions concerning the legal basis for the activities were subsequently examined in detail in the Constitutional Law Committee deliberations on the Government proposal and in hearings of the Defence and Administration Committees. In my submission to the Constitutional Law Committee (3684/2020), I considered these questions to be of a constitutional nature and the fundamental problem to be that there are no opinions on this matter from the Constitutional Law Committee or legislator in general.

Constitutional and other legal shortcomings in this case were addressed in the parliamentary hearing on the matter. When adopting the proposal, after numerous changes and explanatory statements added in accordance with the Defence Committee's report, the Parliament required the Government to submit a comprehensive report on Senate Properties, its subsidiary, Defence Properties, and the Senate Group as a whole by the beginning of the autumn session of 2022.

The parliamentary debate that has already taken place has clarified the legal basis for Senate Properties' operations. It can be said that the monopoly position has not been based on the legal basis required by the Constitution, that Senate Properties' tasks involve at least some aspects of public administrative duties, and that the CEO must be subject to official liability. There was also a lack of clarity as to the nature of the internal state rental agreements, now confirmed to be administrative agreements.

I also took a stance on regulation concerning Senate Properties in a decision on a complaint (777/2019). It was as everyday an issue as snow removal in the courtyard of an enforcement agency. The task was carried out by a private company that had agreed on the matter with Senate Properties, which in turn had agreed with the enforcement agency that Senate Properties was respon-

sible for property maintenance. As the overseer of legality, I examined responsibilities related to the task. I found it legally problematic that there was such asymmetry within a state organisation between the management of the agency acting as a "tenant" and the responsibilities of the personnel of the "landlord" state enterprise in relation to criminal liability in civil service and occupational safety of premises. I called the attention of the Ministry of Finance to the asymmetry in the positions of responsibility in the state rental system.

Legal and constitutional dialogue

This overview has focused on aspects of the Ombudsman's activities that are connected to constitutional questions. It is rather rare for the Ombudsman to handle such matters in practice, but such questions do occasionally appear on the Ombudsman's desk to be answered. Legitimate legal questions generally call for an answer.

Generally, countries adhering to the rule of law define the legal institutions competent to make constitutional interpretations specifically at the constitutional level. In Finland, the focus is on ex ante review of constitutionality. If matters that call into question the constitutionality of regulation get through this "web", the matters must be addressed in one way or another in legal practices. In this connection, let it be noted that there is no constitutional court in Finland, and section 106 of the Constitution limits the possibilities of the courts to carry out an ex post review of constitutionality only to cases, where the application of an Act would be in evident conflict with the Constitution. This situation leaves the supreme overseers of legality the opportunity, when there are sufficient legal grounds for doing so, to also have their say in matters concerning the interpretation of the Constitution.

By making his or her reasoned opinion known to the parties drafting legislation and to the Parliament, the Ombudsman can contribute to securing the rule of law, as is his or her duty, and complement the constitutional dialogue. At best, such positions can lead to correcting regulation in a way that better implements the Constitution.

2 The Finnish Ombudsman institution in 2020

2.1 Review of the institution

The year 2020 was the Finnish Ombudsman institution's 101st year of operation. The Parliamentary Ombudsman began his work in 1920, making Finland the second country in the world to adopt the institution. The Ombudsman institution originated in Sweden, where the office of Parliamentary Ombudsman was established in 1809. After Finland, the next country to adopt the institution was Denmark in 1955, followed by Norway in 1962.

The International Ombudsman Institute (IOI) currently has over 200 members. Some Ombudsmen are regional or local. For example, Germany and Italy do not have a Parliamentary Ombudsman. The post of European Ombudsman was established in 1995.

The Ombudsman is the supreme overseer of legality, elected by the Parliament of Finland (Eduskunta). The Ombudsman exercises oversight to ensure that those who perform public tasks comply with the law, fulfil their responsibilities and implement fundamental and human rights in their activities. The scope of the Ombudsman's oversight includes courts, authorities and public servants as well as other persons and bodies that perform public tasks. By contrast, private instances and individuals who are not entrusted with public tasks are not subject to the Ombudsman's oversight of legality. Nor does the Ombudsman oversee Parliament's legislative work, the activities of Members of Parliament or the official duties of the Chancellor of Justice.

The Ombudsman is independent and acts outside the traditional tripartite division of the powers of state – legislative, executive, and judicial. The objective of the activities is also to ensure that various administrative sectors' own systems of legal remedies and internal oversight mechanisms operate appropriately. The Ombudsman has the right to obtain all information required to oversee legality from the authorities and persons in public office.

The Ombudsman submits an annual report to the Parliament of Finland in which he evaluates, on the basis of his observations, the state of administration of the law and any shortcomings he has discovered in legislation.

The election, powers and tasks of the Parliamentary Ombudsman are regulated by the Constitution of Finland and the Finnish Parliamentary Ombudsman Act. These statutes can be found in Appendix 1.

In addition to the Parliamentary Ombudsman, Parliament elects two Deputy-Ombudsmen; their term of office is four years. The Ombudsman decides on the division of labour between the three. The Deputy-Ombudsmen decide on the matters they are given responsibility for independently and with the same powers as the Ombudsman (unless the matter pertains to what is provided for under Section 14 (3) of the Finnish Parliamentary Ombudsman Act).

In 2020, Parliamentary Ombudsman Petri Jääskeläinen made decisions on cases involving questions of principle, the Government, and other highest organs of state. In addition to this, his responsibilities also included, among others, matters concerning the police, the Emergency Response Centre Administration and rescue services, guardianship, language, the rights of foreigners and persons with disabilities, as well as covert intelligence gathering and intelligence operations. His responsibilities also included the prosecution service; however, not including the Office of the Prosecutor General. He was also responsible for handling matters concerning the coordination of tasks and reporting in the National Preventive Mechanism against Torture.

Deputy-Ombudsman Maija Sakslin dealt with matters such as health care, social welfare, children's rights and rights of the elderly, regional and local government, the Church, distraint and the Customs. In addition, she assumed responsibility for matters relating to taxation, the environment,

agriculture and forestry, traffic and communications as well as Sámi affairs.

Deputy-Ombudsman Pasi Pölönen was responsible for matters relating to the courts, justice administration and legal assistance, criminal sanctions (meaning matters relating to the treatment of prisoners), the enforcement of sentences, and prisoner after-care services as well as military matters, Defence Forces and Border Guard. He also resolved matters concerning social insurance, social assistance, early childhood education and care services, education, science and culture as well as labour affairs and unemployment security. His responsibilities also included matters concerning economic activities, late payments and distraint as well as data protection, data management and telecommunications.

A detailed division of labour is provided in Appendix 2.

If a Deputy-Ombudsman is prevented from performing their tasks, the Ombudsman can invite a Substitute for the Deputy-Ombudsman to stand in. The substitute for the Deputy-Ombudsman in 2020 was Principal Legal Adviser Mikko Sarja, who served as a substitute during the year under review for a total of 43 working days.

2.1.1 THE SPECIAL DUTIES OF THE OMBUDSMAN DERIVED FROM UN CONVENTIONS AND RESOLUTIONS

The Parliamentary Ombudsman is part of the National Human Rights Institution of Finland as set forth in the so-called Paris Principles defined by the UN (A/RES/48/134) together with the Human Rights Centre established in 2012 and its Delegation (see Sections 3.3 and 3.2 for the Human Rights Centre and the National Human Rights Institution of Finland).

Under the amendment to the Parliamentary Ombudsman Act, which came into force on 7 November 2014 (new Chapter 1(a), sections 11(a) – (h)), the Parliamentary Ombudsman was appointed as the National Preventive Mechanism (NPM) under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. The NPM's duties are described in more detail in section 3.5.

On 3 March 2015, the Parliament adopted an amendment to the Parliamentary Ombudsman Act, which entered into force on 10 June 2016, whereby the tasks under Article 33(2) of the Convention on the Rights of Persons with Disabilities of December 2006 would fall legally within the competence of the Ombudsman and the Human Rights Centre and its Delegation. The structure, which must be independent, is tasked with the promotion, protection and monitoring of the Convention's implementation. The duties of the national structure are described in more detail in section 3.4.

2.1.2 DIVISION OF TASKS BETWEEN THE PARLIAMENTARY OMBUDSMAN AND THE CHANCELLOR OF JUSTICE

The two supreme overseers of legality, the Ombudsman and the Chancellor of Justice, have virtually identical powers. The only exception is the oversight of advocates, which falls exclusively within the scope of the Chancellor of Justice. Only the Ombudsman or the Chancellor of Justice can decide to bring legal proceedings against a judge for unlawful action in an official capacity.

In the division of labour between the Ombudsman and the Chancellor of Justice, however, responsibility for matters concerning prisons and other closed institutions where people are detained without their consent, as well as for the deprivation of liberty as regulated by the Coercive Measures Act, has been entrusted to the Ombudsman. The Ombudsman is also primarily responsible for monitoring matters concerning the Defence Forces, the Finnish Border Guard, crisis management personnel, the National Defence Training Association of Finland, and courts martial. The act on the division of tasks between the Parliamentary Ombudsman and the Chancellor of Justice can be found in Appendix 1.

In its statement (PeVL 52/2014) on the Government Report on Human Rights Policy, and in several of its reports when processing the reports

of the supreme overseers of legality, the Parliament's Constitutional Law Committee has considered it important that the division of tasks between the Parliamentary Ombudsman and the Chancellor of Justice is defined and clarified and their cooperation improved. The committee has also submitted its opinion on the matter when processing reports of the overseers of legality, and expedited the making of an examination (e.g. PeVM 2/2019 vp, PeVM 3/2018 vp, PeVM 2/2017 vp). Parliamentary Ombudsman Jääskeläinen dealt with the development of the division of tasks in his Parliamentary Ombudsman's address in the summary of the annual report for 2016 (pp. 12–20).

On 25 September 2018, the Ministry of Justice appointed a working group to determine and evaluate the current status, development needs and possibilities of the division of tasks between the Parliamentary Ombudsman and the Chancellor of Justice, and to prepare policy suggestions on the basis of the evaluation. The instruction was to evaluate the division of tasks and the possibilities for improving cooperation within the boundary conditions as set forth in the Constitution. When the task of the working group was completed, the preparation of the matter was continued at the Ministry of Justice. Now the reform is about to be realised; according to the Government's legislative plan and the information from the Ministry of Justice, a government proposal is to be submitted in May 2021.

The aim of the proposal is to reform the regulations concerning the division of tasks between the Chancellor of Justice and the Parliamentary Ombudsman so that they will correspond to the special duties laid down for the overseers of legality in the Constitution and other legislation and to their actual areas of specialisation and those derived from international agreements. It is proposed that, in accordance with the Act on the Division of Duties between the Chancellor of Justice of the Government and the Parliamentary Ombudsman, the tasks of the supreme overseer of legality in matters concerning the Finnish Defence Forces, the Finnish Border Guard, the crisis management personnel referred to in the Act on Military Crisis Management, the National Defence Training Association of Finland referred to in chapter 3 of the Act on Voluntary National Defence, and courts martial be entrusted with the Parliamentary Ombudsman. According to the proposal, in addition to what is currently provided for in the law on the division of responsibilities, the Parliamentary Ombudsman should also include in its remit matters pertaining to the rights of children, the elderly and persons with disabilities, to social welfare, health care and social insurance, police and customs officials, secret information and intelligence gathering and most aspects of pre-trial investigations.

The proposed extension of the division of duties would mean that the majority of complaints submitted to the supreme overseers of legality would fall within the scope of the division of work under the new act on the division of tasks. If implemented, the reform would mean that approximately 5 per cent of the total number of matters submitted to the Chancellor of Justice and the Parliamentary Ombudsman would be allocated differently from the current practice. This means that slightly more than 500 matters would be reallocated. The immediate increase in the workload resulting from the proposed regulations would focus especially on the Ombudsman, to whom an estimated number of 400–450 matters currently processed by the Chancellor of Justice would be transferred. Considering that one legal adviser can prepare approximately 150 matters per year, the number of matters estimated to be transferred to the Ombudsman would correspond to the work input of approximately three legal advisers. It is therefore estimated that the cases transferring to the Ombudsman as a result of the proposed reform would require three additional person-years in the legal adviser resources of the Office of the Parliamentary Ombudsman. It is proposed that the act enter into force on 1 January 2022.

2.1.3 THE VALUES AND OBJECTIVES OF THE OFFICE OF THE PARLIAMENTARY OMBUDSMAN

Oversight of legality has changed in many ways in Finland over time. The Ombudsman's role as a prosecutor has receded into the background, and the role of developing official activities has been accentuated. The Ombudsman sets standards for administrative procedure and supports the authorities in good governance.

Today, the Ombudsman's tasks also include overseeing and actively promoting the implementation of fundamental and human rights. This has somewhat altered views of the authorities' obligations in the implementation of people's rights. Fundamental and human rights are relevant to virtually all cases referred to the Ombudsman. The evaluation of the implementation of fundamental rights means weighing contradictory principles against each other and paying attention to aspects that promote the implementation of fundamental rights. In his evaluations, the Ombudsman stresses the importance of arriving at a legal interpretation that is amenable to fundamental rights.

The establishment of the Finnish National Human Rights Institution supports and highlights the aims of the Ombudsman in the oversight and promotion of fundamental and human rights. Section 3 of this report contains a more detailed discussion on fundamental and human rights.

The statutory duties of the Ombudsman form the foundation on which the values and objectives for the oversight of legality, as well as the other responsibilities of the Office, are based. The core values of the Office of the Parliamentary Ombudsman were created from the perspectives of clients, authorities, Parliament, the personnel and management.

The following page is a summary of the values and objectives of the Ombudsman's Office.

2.1.4 OPERATIONS AND PRIORITIES

The Ombudsman's primary task is to investigate complaints. The Parliamentary Ombudsman will investigate a complaint, if the concerned matter falls within the scope of his or her oversight of legality, and where there is reason to suspect unlawful conduct or neglect of duty, or if the Ombudsman otherwise deems it necessary. The Parliamentary Ombudsman has discretionary powers in the examination of complaints. Arising from a complaint, the Ombudsman shall take the measures that he or she deems necessary from the perspective of compliance with the law, protection under the law or implementation of fundamental and human rights. In addition to complaints, the Ombudsman can also choose on his own initiative to investigate issues that he or she has observed.

By law, the Ombudsman is required to conduct inspections of public agencies and institutions. He has a special duty to oversee the treatment of persons detained in prisons and other closed institutions, as well as the treatment of conscripts in garrisons. In his capacity as the National Preventive Mechanism against Torture (NPM), the Ombudsman also makes visits to places and facilities where individuals deprived of their liberty are or may be detained (see Section 3.5 for the tasks of the NPM). One of the priorities within the Parliamentary Ombudsman's remit is to monitor the implementation of the rights of persons with disabilities, the elderly and children.

Following a legislative amendment that entered into force at the beginning of 2014, the Ombudsman's remit concerning the special monitoring of covert intelligence gathering was ex-tended to cover all methods of covert intelligence. The amended legislation has also expanded the scope of supervision accordingly. Covert intelligence gathering is used by the police, Customs, the Border Guard and the Defence Forces. In addition, under the intelligence legislation that entered into force in 2019, the Intelligence Ombudsman submits a report of his operation to the Parliamentary Ombudsman once a year. The same applies to military and civilian intelligence: the Ministry of

The values and objectives of the Office of the Parliamentary Ombudsman

Values

The key objectives are fairness, responsibility and closeness to people. They mean that fairness is promoted boldly and independently. Activities must in all respects be responsible, effective and of a high quality. The way in which the Office works is people-oriented and open.

Objectives

The objective with the Ombudsman's activities is to perform all of the tasks assigned to him or her in legislation to the highest possible quality standard. This requires activities to be effective, expertise in relation to fundamental and human rights, timeliness, care and a client-oriented approach as well as constant development based on critical assessment of our own activities and external changes.

Tasks

The Ombudsman's core task is to oversee and promote legality and implementation of fundamental and human rights. In this capacity, the Ombudsman investigates complaints and his own initiatives, conducts inspection visits and issues statements related to legislation. The special tasks of the Ombudsman include monitoring the conditions and treatment of persons deprived of their liberty, the monitoring and promotion of the rights of persons with disabilities and children, and the supervision of covert intelligence gathering.

Emphases

The weight accorded to different tasks is determined a priori on the basis of the numbers of cases on hand at any given time and their nature. How activities are focused on oversight of fundamental and human rights on our own initiative and the emphases in these activities as well as the main areas of concentration in special tasks and international cooperation are decided on the basis of the views of the Ombudsman and Deputy-Ombudsmen. The factors given special consideration in the allocation of resources are effectiveness, protection under the law and good administration as well as vulnerable groups of people.

Operating principles

The aim in all activities is to ensure high quality, impartiality, openness, flexibility, expeditiousness and good services for clients.

Operating principles in especially complaint cases

Among the things that quality means in complaint cases is that the time devoted to investigating an individual case is adjusted to management of the totality of oversight of legality and that the measures taken have an impact. In complaint cases, hearing the views of the interested parties, the correctness of the information and legal norms applied, ensuring that decisions are written in clear and concise language as well as presenting convincing reasons for decisions are important requirements. All complaint cases are dealt with within the maximum target period of one year, but in such a way that complaints which have been deemed to lend themselves to expeditious handling are dealt with within a separate shorter deadline set for them.

The importance of achieving objectives

The foundation on which trust in the Ombudsman's work is built is the degree of success in achieving these objectives and what image our activities convey. Trust is a precondition for the Institution's existence and the impact it has.

Defence and the Ministry of the Interior report on the use and supervision of the intelligence methods, the means of intelligence gathering and their protection to the Ombudsman.

Covert intelligence gathering involves interfering with several constitutionally guaranteed fundamental rights and liberties, such as the right to privacy, confidentiality of communications and protection of domestic peace. The use of covert intelligence gathering is usually subject to the permission of a court; this ensures that it is used lawfully. However, the Ombudsman also plays a vital role in the appropriate monitoring of the use of such intelligence gathering, which must be kept secret from the subject of investigation at the time. The oversight of covert intelligence gathering is detailed in section 5.

Fundamental and human rights are relevant to the oversight of legality not only when individual cases are being investigated, but also in conjunction with inspections and when deciding on the focus of own-initiative investigations. Emphasising and promoting fundamental rights guides the thrust of the Ombudsman's activities. In connection with this, the Ombudsman engages with various bodies, including the main NGOs. The Ombudsman addresses issues in connection with the inspections, as well as on his own initiative, that are sensitive from the perspective of fundamental rights and that have broader significance than individual cases as such. In 2020, the special theme in the monitoring of fundamental and human rights was the provision of sufficient resources for authorities to ensure fundamental rights. The content of the theme is outlined in section 3.8, which discusses fundamental and human rights.

The Office of the Parliamentary Ombudsman is preparing the Parliamentary Ombudsman's operative strategy. The general strategic starting point has been to implement the constitutional task of the Parliamentary Ombudsman such, that its impact is as extensive as possible.

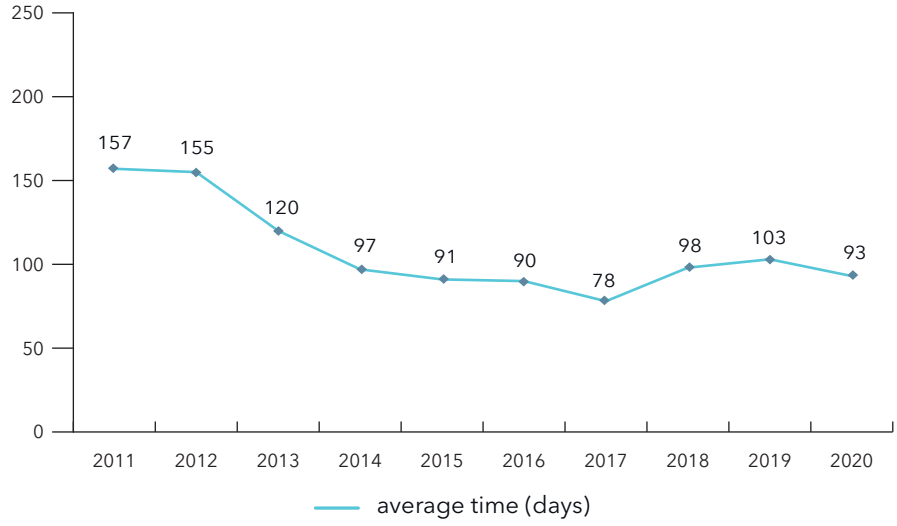
Complaints are processed within one year

With the amendment to the Parliamentary Ombudsman Act, which entered into force in 2011, the oversight of legality was increased by giving the Ombudsman greater discretionary powers and a wider range of operational alternatives, and by a greater focus on the perspective of the citizen. The period within which complaints can be made was reduced from five to two years. The Parliamentary Ombudsman was granted the possibility of referring a complaint to another competent authority. The amendment of the Act also enables the Parliamentary Ombudsman to invite a Substitute Deputy-Ombudsman to discharge the duties of the Deputy-Ombudsman as and when required.

The legal reform made it possible to allocate resources more appropriately to matters in which the Ombudsman could assist the complainant or otherwise take action. The aim is to assist the complainant, where possible, by recommending that an error that has been made be rectified, or that compensation be paid for an infringement of the complainant's rights.

With the more effective processing of complaints, the Ombudsman achieved the target time – of one year for handling complaints – for the first time in 2013. The target has subsequently been met each subsequent year, including the year under review, when there were no complaints older than one year pending a decision.

The average time taken to deal with complaints was 93 days at the end of the year, compared to 103 days at the end of 2019.



Average time taken to deal with complaints in 2011–2020

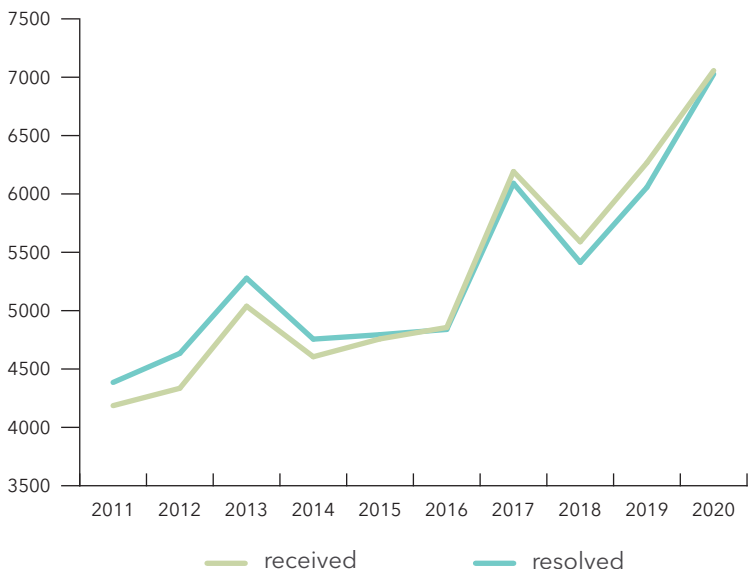
Complaints and other oversight of legality matters

Like the previous year, a record number of complaints were received in 2020, in total 7,059. This is around 800 (13%) more than in 2019 (6,267). Case numbers rose in almost all administrative branches. The largest numbers of complaints concerned social services (1,196), the police (852) and health care (802). The strongest growth was observed in complaints related to teaching. In 2020, 466 complaints related to the Ministry of Education and Culture's administrative branch were received, compared to 256 the previous year. During the year under review, a record number of 7,027 complaints were also resolved. This is around 1,000 (16%) more than in 2019 (6,057).

The number of complaints submitted by letter or fax or delivered in person has decreased in recent years, while the number of complaints sent by email has increased correspondingly. In 2020, the majority of complaints, 84% (76% in 2019), were submitted electronically.

Before the introduction of the electronic case management system, complaints received by the Ombudsman were recorded under their own subject category (category 4) in the register of the Office of the Parliamentary Ombudsman. Other communications were recorded under category 6 ("Other communications"); these included letters from citizens containing enquiries, clearly unfounded communications, matters that fell outside the Ombudsman's remit, and letters with unclear content or letters sent anonymously. These communications were not processed as complaints. They nevertheless counted as matters relevant to the oversight of legality and were forwarded from the Registry Office to the Substitute Deputy-Ombudsman or the Secretary General, who passed them on to the notaries and investigating officers to handle. The senders would receive a response, which was reviewed by the Substitute Deputy-Ombudsman or the Secretary General.

With the introduction of the electronic case management system in 2016, communications that were previously filed under category 6 "Other communications", are now filed under complaints. The processing of these communications, however, remains the same: they are forwarded to the Substitute Deputy-Ombudsman or Secretary Gen-



Complaints received and resolved in 2011–2020

received resolved	2019	2020
Complaints	6,223 6,030	6,962 6,982
Transferred from the Chancellor of Justice	44	97
Transferred to the Chancellor of Justice	27	45
Taken up on own initiative	95 63	66 78
Requests for submissions and attendances at hearings	82 84	116 107
Total	6,444 6,231	7,241 7,212

Oversight-of-legality matters received and resolved in 2019–2020

eral for further distribution and handling. The replies are reviewed by the Substitute Deputy-Ombudsman or the Secretary General.

Once a complaint has been filed with the Office, a confirmation of receipt is sent to the complainant if the complaint leads to an investigation. The complainant also receives an immediate notification of the receipt of the email.

Some complaints are handled through an accelerated procedure. In 2020, slightly over half (56%) of all complaints were dealt with in this way. The purpose of the procedure is to identify immediately on receipt the complaints that require no further investigation. The accelerated procedure is suitable especially in cases where there is manifestly no ground to suspect an error, the time limit has been exceeded, the matter falls outside the Ombudsman's remit, the complaint is non-specific, the matter is pending elsewhere, or the complaint is a repeat complaint with no grounds for a reappraisal. In the accelerated procedure, the complainants do not receive a notification letter. If a complaint proves un-suitable for the accelerated procedure, the matter is referred back for the normal distribution of complaints, and the complainant will receive the letter of ac-

knowledgement from the Registry Office. A draft response is given within one week to the party deciding on the case. The complainant is sent a reply signed by the legal adviser taking care of the matter.

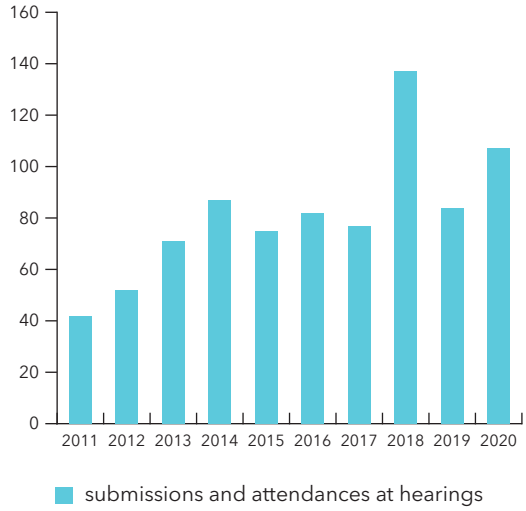
Anonymous messages are not treated as complaints, but the Ombudsman takes the initiative in assessing the need to investigate them.

Communications and messages that were submitted for information only, that are not considered to have been sent for the purpose of initiating action and that are in no way related to any other matter under process, are not recorded. They are, however, always reviewed by the Substitute Deputy-Ombudsman or the Secretary General. Communications sent using the feedback form on the Office website are dealt with in accordance with the principles described above. In 2020, 9,266 (7,471 in 2019) written communications that had arrived for information were received.

In addition, submissions and attendances at hearings in various committees of Parliament are counted belonging to oversight of legality (Appendix 3). The number of statements and hearings increased almost to the level of 2018.

In 2020, 77% (74% in 2019) of all the complaints that arrived were related to the ten largest categories. Statistics on the Ombudsman's activities are provided in Appendix 7.

In 2020, a total of 78 (63 in 2019) matters investigated on the Ombudsman's own initiative were resolved. Of these, 60 (47), or 77% (75%), led to action on the part of the Ombudsman.



Resolved requests for submissions and attendances at hearings between 2011 and 2020

Measures

The most relevant decisions taken in the Ombudsman's work are those that lead to him taking measures. These measures include prosecution for breach of official duty, a reprimand, the expression of an opinion and a recommendation. A matter may also result in some other measure being taken by the Ombudsman, such as ordering a pre-trial investigation or bringing the Ombudsman's earlier expression of opinion to the attention of an authority. A matter may also be rectified while the investigation is still ongoing.

A prosecution for breach of official duty is the most severe sanction available to the Ombudsman. However, if the Ombudsman takes the view that a reprimand will suffice, he may choose not to bring a prosecution, even though the subject of oversight has acted unlawfully or neglected to fulfil their duty. He may also express an opinion as to what would have been a lawful course of action or draw the attention of the oversight subject to the principles of good administrative practice, or to aspects that are conducive to the implementation of fundamental and human rights. The opinion expressed may be formulated as a rebuke or intended for guidance.

In addition, the Ombudsman may recommend the rectification of an error or draw the attention of the Government or other body responsible for legislative drafting to shortcomings that he has observed in legal provisions or regulations. The Ombudsman may also suggest compensation for an infringement that has been committed or make a proposal for an amicable solution on a matter. Sometimes an authority may preemptively rectify an error at a stage when the Ombuds-

MEASURES TAKEN BY PUBLIC AUTHORITIES	Prosecution	Assessment of the need for pre-trial investigation	Reprimand	Opinion	Recommendation	Rectification	Other measure	TOTAL	Total number of decisions	Percentages*
Social welfare	–	–	18	185	10	5	52	270	1,178	22,9
Police	–	1	5	92	12	2	13	125	881	14,2
Health	–	1	13	57	12	5	21	109	771	14,1
Criminal Sanctions field	–	–	3	74	1	2	16	96	406	23,6
Administrative branch of the Ministry of Economic Affairs and Employment	–	–	–	75	4	–	2	81	355	22,8
Soial insurance	–	–	–	60	3	6	5	74	447	16,6
Administrative branch of the Ministry of Education and Culture	–	–	3	37	5	1	12	58	353	16,4
Administrative branch of the Ministry of Defence	–	–	–	31	–	–	1	32	96	33,3
Local government	–	–	4	15	–	4	8	31	243	12,8
Taxation	–	–	1	19	2	2	2	26	173	15,0
Enforcement (distraint)	–	–	–	12	2	1	5	20	240	8,3
Administration of law	–	–	–	12	2	–	2	16	228	7,0
Administrative branch of the Ministry of Transport and Communications	–	–	–	4	1	1	9	15	179	8,4
Aliens affairs and citizenship	–	–	2	10	–	–	2	14	144	9,7
Administrative branch of the Ministry of the Environment	–	–	–	7	–	1	2	10	181	5,5
Guardianship	–	–	–	3	2	–	2	7	102	6,9
Administrative branch of the Ministry of Justice	–	–	–	4	2	1	–	7	75	9,3
Administrative branch of the Ministry of Agriculture and Forestry	–	–	–	5	–	–	1	6	79	7,6
Highest organs of government	–	–	1	3	1	–	1	6	341	1,8
Prosecutors	–	–	–	5	–	–	–	5	98	5,1
Administrative branch of the Ministry of the Interior	–	–	–	2	2	–	–	4	41	9,8
Customs	–	–	–	1	–	–	3	4	12	33,3
Administrative branch of the Ministry for Foreign Affairs	–	–	–	3	–	–	–	3	13	23,1
Administrative branch of the Ministry of Finance	–	–	1	2	–	–	–	3	36	8,3
Other administrative branches	–	–	–	–	–	–	1	1	431	0,2
Total	–	2	51	718	61	31	160	1,023	7,105	14,4

* Percentage share of measures in decisions on complaints and own initiatives in a category of cases

man has already intervened with a request for a report. The proposals are listed in Appendix 4.

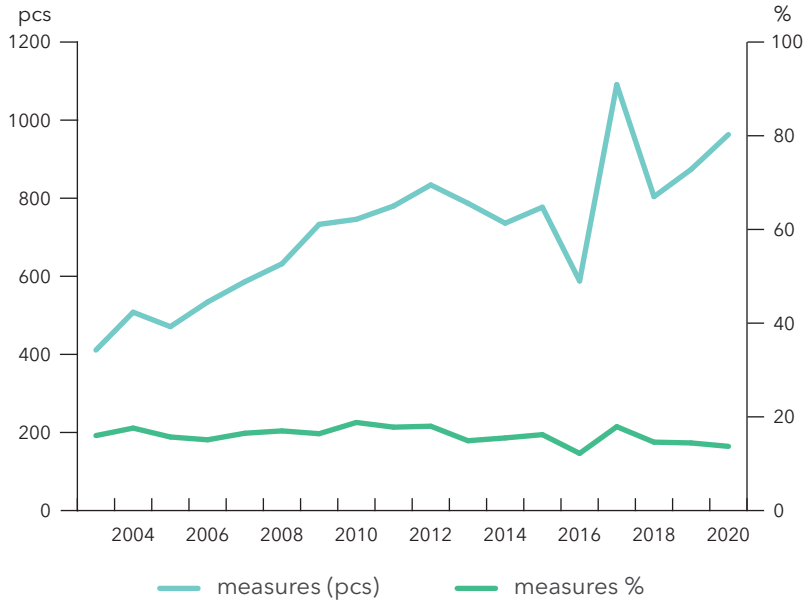
In 2020, decisions on complaints and investigations at the Ombudsman's own initiative that led to measures totalled 1,023, which represented nearly or 14% of all decisions (921, or 15% in 2019). Approximately one fifth of complaints and investigations at the Ombudsman's own initiative were subject to a full investigation; in other words, at least one report and/or statement was obtained.

In about 42% of the cases (2,946), there were no grounds to suspect erroneous or unlawful action, or there was no reason for the Ombudsman to take action. A total of 215 cases (approximately 3%) were found not to involve erroneous action. No investigation was conducted in 41% of the cases (2,903).

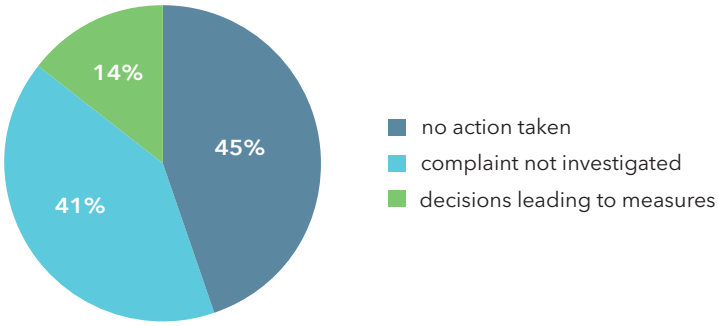
In most cases, the complaint was not investigated because the matter was already pending with a competent authority. An overseer of legality usually refrains from intervening in a case that is being dealt with at the appeal stage or by another authority. Matters pending with other authorities, and therefore not investigated, accounted for 15% (1,034) of all complaints dealt with. Other matters not investigated include those that fall outside the Ombudsman's remit and, as a rule, cases that are more than two years old.

The proportion of all investigated complaints that led to measures, when cases not investigated are excluded, was 23%.

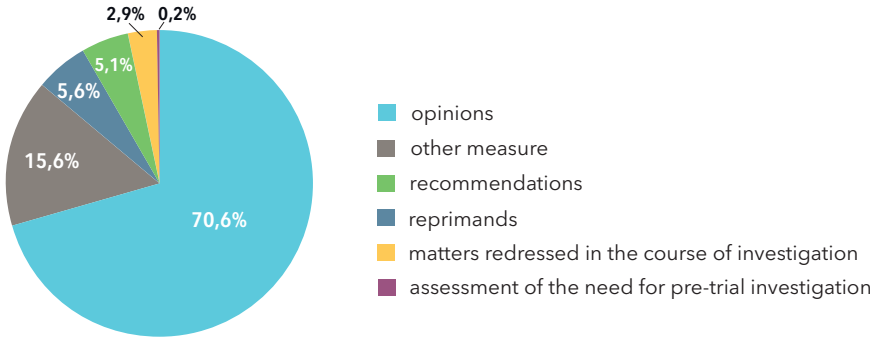
None of the matters handled in the year under review were brought to prosecution for breach of official duty. There were two matters that merited pre-trial investigation by the police. A total of 49 reprimands were given, and 680 opinions were expressed. Rectifications were made in 28 cases while under investigation. Decisions classed as recommendations numbered 54, although opinions regarding the development of governance that count as recommendations were also included in other types of decisions. Other measures



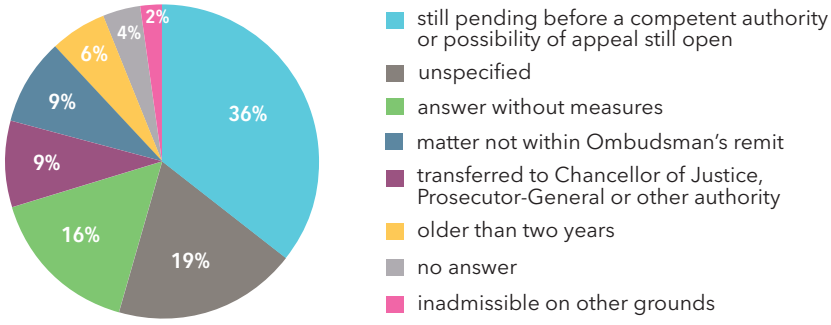
In 2001–2020, the number of measures taken as a result of complaints increased from 320 up to over 1,000. The number of resolved complaints within the same period increased from approximately 2,500 up to over 7,000. The relative proportion of complaints leading to measures (measure %) has remained more or less unchanged.



All cases resolved in 2020



Decisions involving measures in 2020



Complaints not investigated in 2020

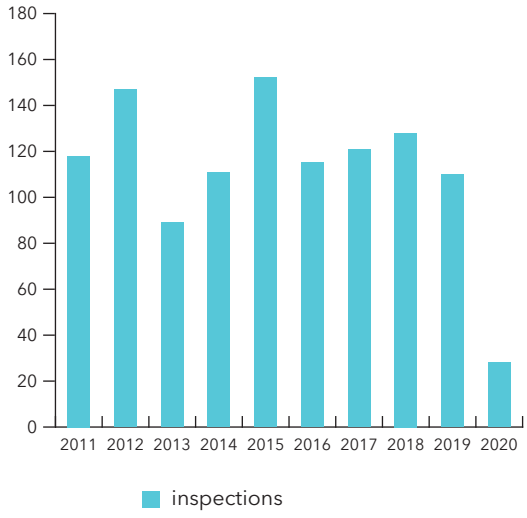
were recorded in 150 cases. In reality, the number of other measures that the decisions lead to is greater than the figure shown above, because only one measure is recorded under each case, even though several measures may have been taken.

Statistics on the Ombudsman's activities are provided in Appendix 6.

Inspections

The number of inspections declined significantly because of the coronavirus epidemic. In 2020, only 28 inspections were carried out (110 in 2019). A full list of all inspections is provided in Appendix 4. The inspections are described in more detail in connection with the respective topic.

Approximately half of the inspections were conducted under the leadership of the Ombudsman or the Deputy-Ombudsmen and the remainder by legal advisers and as documentation reviews because of the coronavirus epidemic. A total of 16 (60 in 2019) visits were made to places and facilities where individuals are or may be kept while deprived of their liberty; 4 (45) of these visits were unannounced. These visits were made in the capacity of the National Prevention Mechanism against Torture (NPM).



The number of inspections between 2011 and 2020

The NPM visits are made, in particular, in prisons, police detention facilities, social welfare and healthcare units, child welfare institutions including youth homes, and residential units of intellectually or physically disabled people. Both the individuals placed in these facilities and the staff are given the opportunity to discuss issues in confidentiality with the Ombudsman or his assistant. An opportunity for a discussion is also given to conscripts during the Ombudsman's visit.

The annual report of the NPM details the observations listed in Section 3.5 and recommendations given and measures taken by authorities as a result. Shortcomings, which are often observed in the course of inspections, are subsequently investigated on the Ombudsman's own initiative. Inspection visits also fulfil a preventive function.

2.1.5 COOPERATION IN FINLAND AND INTERNATIONALLY

100th anniversary of the Parliamentary Ombudsman

The Parliamentary Ombudsman began his operations in Finland on 1 January 1920, 100 years ago. The position of Parliamentary Ombudsman was established by the Constitution of 1919, which means that the institution is almost as old as the independent nation of Finland and the second oldest parliamentary ombudsman institution in the world. Thus the year under review was the centenary of the Parliamentary Ombudsman.

To celebrate the centenary, the Ombudsman organised a seminar to its cooperation partners in February 2020. A jubilee book answering the following questions was published in the event: How did the Ombudsman develop from a formal judicial overseer of legality into one guiding official activities and focusing on fundamental rights? What kind of expectations have Parliament and members of Parliament had regarding the Ombudsman's operation? What kind of visibility has the Parliamentary Ombudsman had in the media

The current and the former Parliamentary Ombudsmen posed for a photograph in the Pikkuparlamentti building.

The programme included rap spiced up with humour, performed in sign language by Signmark. In addition to the music performances, actors Henna Hakkarainen and Eero Enqvist read out excerpts from Parliamentary Ombudsmen's decisions

Jukka Lindstedt (LL.D.), legal journalist Susanna Reinboth and Markus Kari (LL.D.), the authors of the jubilee book.

Larte children and youth choir from Western Uusimaa Conservatoire performed atmospheric music and the double quartet of the Polytech Choir performed both festive and light-hearted tunes.

over these 100 years? In the jubilee book, Markus V. Kari (LL.D.), Jukka Lindstedt (LL.D.) and legal journalist Susanne Reinboth answer these questions and place the operation of the Parliamentary Ombudsman to the societal, political and journalistic context of each period.

The Ombudsman also intended to organise four public events in the Pikkuparlamentti Annex to the Parliament during the spring and another four public events in the autumn. Each event would have addressed one of the areas of the Ombudsman's activities. The Ombudsman also intended to conduct inspections in the different regions and organise information and public events to coincide with these inspections, where possible. However, they had to be cancelled because of the COVID-19 pandemic.

Events in Finland

Ombudsman Jääskeläinen and Deputy-Ombudsmen Sakslin and Pölönen submitted the Parliamentary Ombudsman's annual report 2019 to Speaker of the Parliament Anu Vehviläinen on 17 June 2020. The Ombudsman attended a preliminary debate on the report at a plenary session of Parliament on 22 October 2020. The committee reading of the 2019 report is still under way.

Because of the coronavirus epidemic, only few Finnish authorities, other guests and groups visited the Ombudsman's office. Topical issues and the work of the Ombudsman were discussed with them.

Ombudsman for Children Elina Pekkarinen visited the Office on 6 February, the General Secretary of the Office of the Chancellor of Justice on 21 February and Deputy Data Protection Ombudsman Jari Råman on 4 March. On 24 February, Secretary General Romanov and Principal Legal Adviser Mikko Sarja introduced the operation of the Parliamentary Ombudsman to master's students from the University of Helsinki Faculty of Law and Principal Legal Adviser Håkan Stoor to students from the Swedish School of Social Science remotely on 12 November.

During the year, the Ombudsman, Deputy-Ombudsmen and members of the Office paid visits to familiarise themselves with the activities of other authorities, gave presentations and participated in hearings, consultations and other events.

Deputy-Ombudsman Pasi Pölönen, Deputy-Ombudsman Maija Sakslin and Parliamentary Ombudsman Petri Jääskeläinen handed the Ombudsman's Annual Report for 2019 to Anu Vehviläinen, Speaker of the Parliament, on 17 June 2020.

On 17 January, Parliamentary Ombudsman Jääskeläinen and Deputy-Ombudsman Sakslin attended the Attorney's Day (*Asianajajapäivä*). In the event, Ombudsman Jääskeläinen participated in the panel discussion on the theme "The stumbling blocks of the rule of law". Ombudsman Jääskeläinen selected the regional state administrative agencies as the winner of the Vuoden selväsanainen 2020 competition, organised on good use of administrative language by the Institute for the Languages in Finland, and presented the award in an event organised at Pikkuparlamentti on 5 October.

Deputy-Ombudsman Sakslin introduced the operation of the Parliamentary Ombudsman to students of constitutional law during their visit to Parliament on 13 February and participated in the meeting of overseers of fundamental and human rights on 20 April. In addition, she participated remotely in the round table discussion on the future of institutional care in child welfare, organised by the Ombudsman for Children on 26 October. Deputy-Ombudsman Sakslin participated in the operation of the Human Rights Delegation as a member of the Delegation.

Deputy-Ombudsman Sakslin and Deputy-Ombudsman Pölönen met Archbishop Tapio Luoma on 2 December and discussed topical issues, the position of religion in society and the reform of the Church Act. The Chancellor of Justice also participated in the meeting.

Deputy-Ombudsman Pölönen gave a speech at the seminar for the senior command of the Finnish Defence Forces on 18 September and held a presentation on the topic "Parliamentary Ombudsman as the overseers of courts – the history and regulatory framework for legality oversight" at the training event for Chief Legal Advisers of the Defence Forces on 30 October. In addition, he participated remotely in the discussion event of the Safety Investigation Authority's coronavirus investigation team on 4 December.

International cooperation

In recent years, the Office of the Parliamentary Ombudsman has engaged in an increasing number of various international activities due, among others, to the duties in connection with the UN Conventions mentioned above.

The Ombudsman has traditionally participated as a member of the International Ombudsman Institute (IOI) in the events of the institute and attended the related conferences and seminars, as well as those organised by the IOI's European chapter, IOI Europe. The Institute's World Conference, due to take place in Dublin in the year of the review, was cancelled because of the coronavirus pandemic. Deputy-Ombudsman Sakslin participated in the media training organised by the IOI remotely on 19 November.

The Parliamentary Ombudsman is a member of the European Network of Ombudsmen, the members of which exchange information on EU legislation and good practices at seminars and other gatherings as well as through a regular newsletter, an electronic discussion forum and daily electronic news services. Seminars intended for ombudsmen and other stakeholders of the network are organised every year. The 2020 conference, "ENO web conference on the implications of the COVID-19 crisis", was organised remotely on 12 May. The conference was attended by Deputy-Ombudsman Sakslin.

The Nordic parliamentary ombudsmen have convened on a regular basis every two years, at a meeting held in one of the Nordic countries. The 2020 meeting planned to take place in Iceland was cancelled because of the coronavirus pandemic.

For several years, the Finnish Parliamentary Ombudsman has also engaged in dialogue with the Baltic ombudsmen. The meeting for Nordic and Baltic ombudsmen was cancelled because of the coronavirus pandemic.

Furthermore, the Nordic countries have established a Nordic network for NPMs, with meetings held on 23–24 January in Oslo and remotely on 28 August and 20 November.

Senior Legal Adviser Jari Pirjola has been Finland's representative on the European Commit-

tee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) since December 2011. This representative is elected for a term of four years. The Committee of Ministers of the Council of Europe elected Mr Pirjola for a third four-year term, ending on 19 December 2023.

In 2020, the CPT carried out an inspection visit to Finland. In connection with the inspection visit, a joint meeting of the Office of the Parliamentary Ombudsman and the representatives of the CPT was organised on 7 September. Parliamentary Ombudsman Jääskeläinen, Deputy-Ombudsman Pölönen and legal advisers from the Office participated in the meeting.

Deputy-Ombudsman Sakslin participated remotely in the "After the First Wave" event on 19 October and in the "EU Migration and Asylum Pact" event on 27 October.

On 20 and 21 October, the Council of Europe organised an online seminar entitled "The role of the police in a democratic society European Code of Police Ethics, nearly 20 years". Principal Legal Advisor Juha Haapamäki attended the seminar.

Deputy-Ombudsman Pölönen and Senior Legal Adviser Kristian Holm participated in the conference "Impact of Covid-19 on Ombuds Institutions for the Armed Forces" remotely between 26 and 30 October.

Parliamentary Ombudsman Jääskeläinen, Deputy-Ombudsmen Sakslin and Pölönen, and Principal Legal Adviser Länsisyrjä participated in the European Ombudsman's celebratory conference "25 years of the European Ombudsman - Digital conference on the future of the European Ombudsman and cooperation in the European Network of Ombudsmen" organised remotely on 26 October.

On 3 and 4 November, Principal Legal Adviser Iisa Suhonen participated in remote seminars discussing the role of the NPM in the creation of harmonised standards in closed institutions. The seminars were part of the EU Project "Improving judicial cooperation across the EU through harmonised detention standards - The role of National Preventive Mechanisms (2019–2021)".

Senior Legal Adviser Kristiina Kouros participated in the "Covid-19 and the Ombudsperson – Rising to the Challenge of a Pandemic" event on 24 November.

Principal Legal Adviser Juha Haapamäki participated in the online seminar "Independent Police Complaints Authorities' Network (IPCAN)" on 16 December.

The University of Dublin conducted interviews for a study of OPCAT activities concerning prisons. Deputy-Ombudsman Pölönen, Principal Legal Adviser Suhonen and Senior Legal Adviser Vartia participated in the interview.

The international networks in which Finland's National Human Rights Institution participates are introduced in section 3.2.1.

International visitors

The Office receives visitors and delegations from other countries, who come to familiarise themselves with the Ombudsman's activities. One of the reasons for which the Finnish Parliamentary Ombudsman institution and its activities attract international interest lies in the fact that the Finnish institution is the second oldest of its kind in the world.

UN High Commissioner for Human Rights Michelle Bachelet visited the Office on 6 February. Deputy-Ombudsman Sakslin, Director of the Human Rights Centre Sirpa Rautio, Principal Legal Adviser Riitta Länsisyrjä, and Specialist Susan Villa participated in the meeting.

In addition, Ingemar Strandvik, Quality Manager at the European Commission's Directorate-General for Translation, visited the Office on 10 March. He was met by Principal Legal Adviser Mikko Sarja.

2.1.6 SERVICE FUNCTIONS

Client service

The objective of the Office of the Ombudsman is to make it as easy as possible to turn to the Ombudsman. Information on the Ombudsman's tasks and instructions on how to make a complaint can be found on the website of the Office and in a leaflet entitled "Can the Parliamentary Ombudsman help?", which contains a complaint form. A complaint may be sent by post, email or fax or by completing the online form. The Office provides clients with services by phone, on its own premises and by email. Because of the coronavirus epidemic, client service at the Office was restricted with regard to visits by clients in 2020.

An on-duty lawyer at the Office is tasked with advising clients on how to make a complaint. The Legal Advisers of the Office also provide advice on matters that concern their field of activity.

The Office's Registry receives and logs arriving complaints and responds to related enquiries, as well as documents requests and provides general advice on the activities of the Office of the Parliamentary Ombudsman. The Registry received around 2,600 (2,200) calls during the year. There were approximately 10 (70) visits from clients and 900 (800) requests for documents/information.

Communications

A new collection of information regarding elderly care and the rights of the elderly was published on the website of the Office of the Parliamentary Ombudsman. The information is presented in text and video format. The new brochure published by the Office on elderly care is also available online.

In 2020, the Office published 26 (29) press releases on the Ombudsman's decisions, inspections and statements, if they were of particular legal or general interest. In addition, information was actively provided on the special tasks of the Office. The press releases are given in Finnish and Swedish and are also posted online in English. The Office has increasingly transferred to utilising Twitter when providing information.

The Office commissioned an analysis of its media visibility, which showed that the Ombudsman had been visible in the online media in the context of 2,386 (2,499) news items or articles during 2020. The number of hits in social media totalled 10,226 (10,303) in 2020.

A total of 347 (335) anonymous solutions were posted online. The website includes decisions and solutions that are of legal or general interest.

The Ombudsman's website is in English at www.oikeusasiamies.fi/en, in Finnish at www.oikeusasiamies.fi and in Swedish at www.ombudsman.fi. At the Office, information is provided by the information officers as well as the Registry and legal advisers.

The Office and its personnel

The role of the Office of the Parliamentary Ombudsman, headed by the Ombudsman, is to prepare issues for the Ombudsman's resolution and manage other relevant duties and the tasks of the Human Rights Centre. The Office is located in the Parliament Annex at Arkadiankatu 3.

The Office has four sections and the Ombudsman and Deputy-Ombudsmen each head their own section. The administrative section, which is headed by the Secretary General, is responsible for general administration. The Human Rights Centre at the Ombudsman's Office is headed by the Director of the Human Rights Centre.

At the end of 2020, there were 70 permanent positions in the Office, including the Ombudsman and two Deputy-Ombudsmen. At the end of the year under review, the share of women on the staff was 70%, including the personnel at the Human Rights Centre.

At the end of 2020, there were no vacant posts at the Office. In addition to the Parliamentary Ombudsman and the Deputy-Ombudsmen, the permanent staff at the Office comprised the Secretary General, 16 principal legal advisers, 16 senior legal advisers, one on-duty lawyer and the Director, five specialists and an assistant of the Human

The Finnish Parliament Annex.

Rights Centre. The Office also had an information officer, an information management specialist, two investigating officers, five notaries, an administrative secretary, a filing clerk, an assistant filing clerk, two departmental secretaries, two records management secretaries, an assistant for international affairs and six office secretaries.

At the end of the year, the share of personnel at least 45 years of age was 82.9% (85.3%). The personnel's education level index was 6.5 (6.6). The share of personnel possessing a university-level degree was above 81.4% (83.8%). Of this, the share of personnel with a Master's level university degree was 72.9% (75%) and the share of those who have completed research training was 12.9% (10.3%).

During a part of the year or the whole year, there were 19 persons working in the Office in fixed-term positions, including the fixed-term positions in the Human Rights Centre. A list of the personnel is provided in Appendix 5.

In accordance with its rules of procedure, the Office has a Management Group that includes the Parliamentary Ombudsman, the Deputy-Ombudsmen, the Secretary General, the Director of the Human Rights Centre and three staff representatives. The Management Group discusses in its meetings matters relating to, among others, the personnel policy and the development of the Office. The Management Group convened 9 times. A cooperation meeting for the entire staff of the Office was held on three occasions.

The Office had permanent working groups in the areas of education, wellbeing at work, and equitable treatment and equality. The Office also has a job evaluation working group, as required under the collective agreement for parliamentary officials. Temporary work groups included the working group and steering group for case management and online service development projects.

The electronic case management system introduced in 2016 allows for the electronic handling and archiving of matters related to the oversight of legality and administration. This has significantly shortened handling times and the manual handling of papers at the Office. With the new system, none of the documents are archived in paper format.

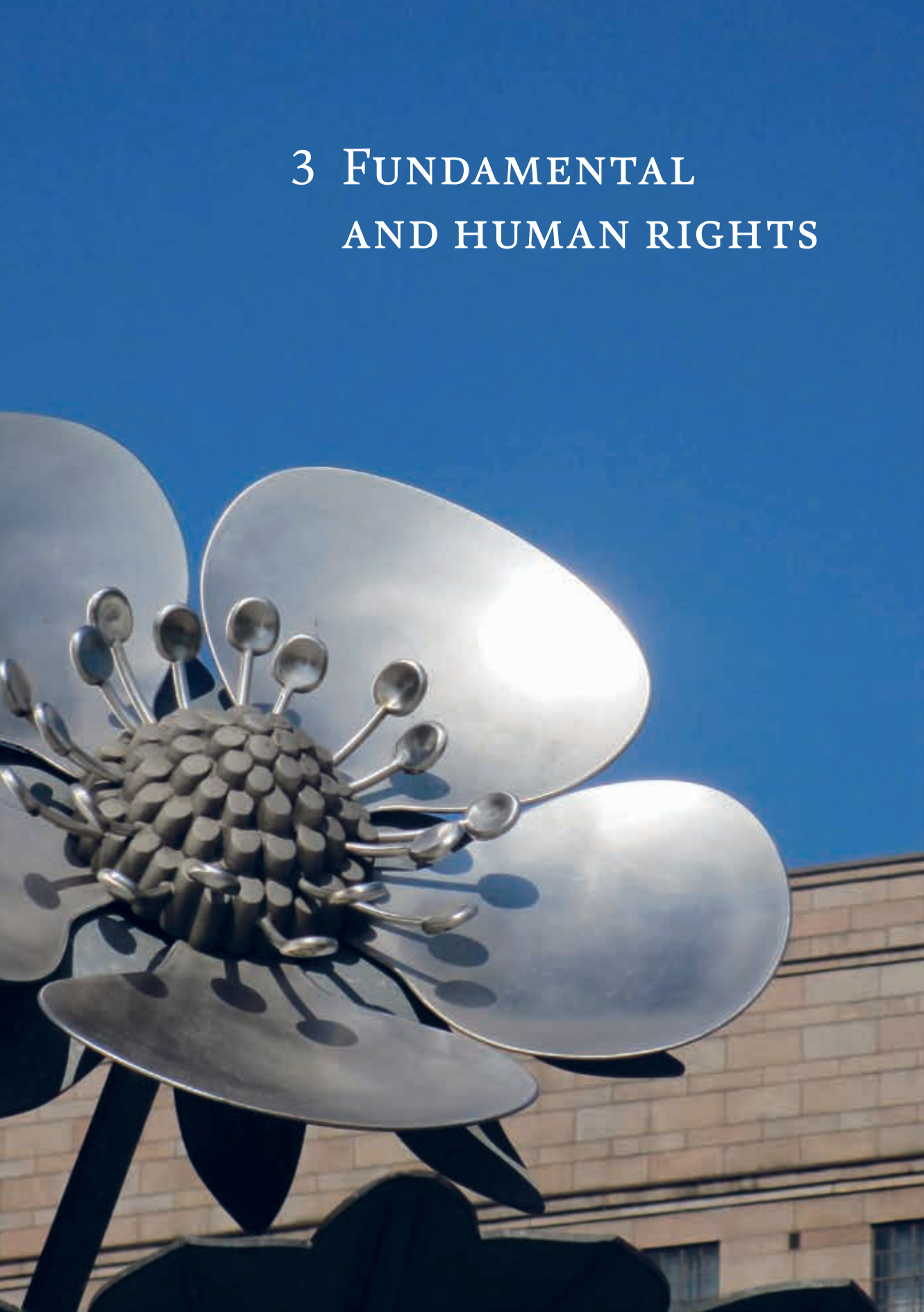
Office finances

The activities of the Office are financed through a budget appropriation each year. Rents, security services and some of the information management costs are paid by Parliament, and these expenditure items are therefore not included in the Ombudsman's annual budget.

The Office was given an appropriation totalling EUR 6,371,000 for 2020. Of this, EUR 6,190,947 was used. EUR 180,053 remained unused.

The Human Rights Centre drew up its own action and financial plan and its own draft budget.

3 Fundamental and human rights



3.1 The Ombudsman's fundamental and human rights mandate

The term "fundamental rights" refers to all of the rights that are guaranteed in the Constitution of Finland and all bodies that exercise public power are obliged to respect. The rights safeguarded by the European Union Charter of Fundamental Rights are binding on the Union and its Member States and their authorities when they are acting within the area of application of the Union's founding treaties. "Human rights", in turn, means the kind of rights of a fundamental character that belong to all people and are safeguarded by international conventions that are binding on Finland under international law and have been transposed into domestic legislation. In Finland, national fundamental rights, European Union fundamental rights and international human rights complement each other to form a system of legal protection.

The Ombudsman in Finland has an exceptionally strong mandate in relation to fundamental and human rights. Section 109 of the Constitution requires the Ombudsman to exercise oversight to "ensure that courts of law, the other authorities and civil servants, public employees and other persons, when the latter are performing a public task, obey the law and fulfil their obligations. In the performance of his or her duties, the Ombudsman monitors the implementation of basic rights and liberties and human rights."

For example, this is provided for in the provision on the investigation of a complaint in the Parliamentary Ombudsman Act. Under Section 3 of the act, arising from a complaint made to him or her, the Ombudsman shall take the measures that he or she deems necessary from the perspective of compliance with the law, protection under the law or implementation of fundamental and human rights. Similarly, section 10 of the Parliamentary Ombudsman Act states that the Ombudsman can, among other things, draw the attention of a subject of oversight to the requirements of good administration or to considerations of implementation of fundamental and human rights.

For a more extensive discussion of the Ombudsman's duty to promote the implementation of fundamental and human rights, see Parliamentary Ombudsman Jääskeläinen's article on this subject in the Annual Report for 2012 (pp. 12–17).

Oversight of compliance with the Charter of Fundamental Rights is the responsibility of the Ombudsman when an authority, official or other party performing a public task is applying Union law.

Both the Constitution and the Parliamentary Ombudsman Act state that the Ombudsman must give the Eduskunta an annual report on his activities as well as on the state of exercise of law, public administration and the performance of public tasks, in addition to which he must mention any flaws or shortcomings he has observed in legislation, "with special attention to implementation of fundamental and human rights".

In conjunction with a revision of the fundamental rights provisions in the Constitution, the Eduskunta's Constitutional Law Committee considered it to be in accordance with the spirit of the reform that a separate chapter dealing with implementation of fundamental and human rights and the Ombudsman's observations relating to them be included in the annual report. Annual reports have included a chapter of this kind since the revised fundamental rights provisions entered into force in 1995.

The fundamental and human rights section of the report has gradually grown longer and longer, which is a good illustration of the way the emphasis in the Ombudman's work has shifted from

overseeing the authorities' compliance with their duties and obligations towards promoting people's rights. In 1995 the Ombudsman had issued only a few decisions in which the fundamental and human rights dimension had been specifically deliberated and the fundamental and human rights section of the report was only a few pages long (see the Ombudsman's Annual Report for 1995 pp. 26–34). The section is nowadays the longest of those dealing with various groups of categories in the report, and implementation of fundamental and human rights is deliberated specifically in hundreds of decisions and in principle in every case.

3.2 The National Human Rights Institution of Finland

3.2.1 COMPOSITION, DUTIES AND POSITION OF THE HUMAN RIGHTS INSTITUTION

The National Human Rights Institution of Finland consists of the Parliamentary Ombudsman and the Human Rights Centre along with its Human Rights Delegation.

National human rights institutions are independent and autonomous bodies established by law that promote and safeguard human rights. Their position, duties and composition are defined by the Paris Principles, a set of criteria approved by the UN in 1993.

National human rights institutions must apply to the UN international coordinating committee for human rights institutions (the Global Alliance of National Human Rights Institutions or GANHRI) for accreditation. The accreditation status shows how well the relevant institution meets the requirements of the Paris Principles. The 'A status' indicates that the institution meets the requirements in full, and the 'B status' indicates some shortcomings. The accreditation status is re-evaluated every five years.

The 'A status' is considered highly significant in the UN and, in more general terms, in international cooperation. Besides its intrinsic and symbolic value, the A status also has legal relevance: a national institution with A status has, for example, the right to take the floor in sessions of the UN Human Rights Council and to vote at GANHRI meetings. The Finnish Human Rights Institution has also joined the European Network of National Human Rights Institutions (ENNHRI). The Finnish institution was a member of the ENNHRI and GANHRI Bureaus until year 2019.

3.2.2 RENEWAL OF A STATUS

The Human Rights Centre and its Delegation were established under the aegis of the Ombudsman's Office with the aim of creating a structure which, together with the Ombudsman, would meet the requirements of the Paris Principles to the best possible extent. This process, which started in the early 2000s, achieved its objective when the Finnish Human Rights Institution was awarded an A status for 2014–2019 in December 2014.

In December 2019, the National Human Rights Institution of Finland was awarded an A status for the second time, covering the period from 2020 to 2025. The granting of an A status may be accompanied by recommendations on how to improve the institution. The recommendations given to Finland stressed, among other things, the need to safeguard the resources necessary to ensure that the tasks of the Finnish National Human Rights Institution are effectively discharged and that it is able to make its own decisions concerning the focal points of its activities. In addition, GANHRI emphasised the importance of submitting the Human Rights Centre's annual report to the Parliament in addition to the Parliamentary Ombudsman's report.

3.2.3 THE HUMAN RIGHTS INSTITUTION'S OPERATIVE STRATEGY

The different sections of the Finnish National Human Rights Institution have their own functions and ways of working. The Institution's first joint long-term operative strategy was drawn up in 2014. It defined common objectives and specified the means by which the Ombudsman and the Human Rights Centre would individually endeavour to accomplish them. The strategy successfully depicts how the various tasks of the functionally independent yet inter-related sections of the Institution are mutually supportive with the aim of achieving shared objectives.

The strategy outlined the following main objectives for the Institution:

1. General awareness, understanding and knowledge of fundamental and human rights is increased, and respect for these rights is strengthened.
2. Shortcomings in the implementation of fundamental and human rights are recognised and addressed.
3. The implementation of fundamental and human rights is effectively guaranteed through national legislation and other norms, as well as through their application in practice.
4. International human rights conventions and instruments should be ratified or adopted promptly and implemented effectively.
5. The rule of law is implemented.

3.3 Human Rights Centre and Human Rights Delegation

3.3.1 THE HUMAN RIGHTS CENTRE'S MANDATE

The Human Rights Centre's (HRC) statutory tasks are:

- to promote information, education, training and research associated with fundamental and human rights
- to draft reports on implementation of fundamental and human rights
- to present initiatives and issue statements in order to promote and implement fundamental and human rights
- to participate in European and international cooperation associated with promoting and safeguarding fundamental and human rights
- to perform other comparable tasks associated with the promotion and implementation of fundamental and human rights

The HRC does not handle complaints or other individual cases.

The HRC's budget in 2020 was EUR 855,000. The HRC had seven permanent posts: the director, five expert officials, and an administrative assistant. In 2019, the HRC gained two fixed-term expert positions to promote the rights of older people, and the positions were made permanent at the beginning of 2020. In addition to permanent posts, one fixed-term assistant expert worked at the HRC. Three research assistants were hired for report projects under assignments of different lengths.

3.3.2 THE HUMAN RIGHTS CENTRE'S OPERATION

The Human Rights Centre's Plan of Action for 2020 was approved in December 2019. The HRC considers that it achieved the set targets well, even though the outbreak of the coronavirus pandemic at the beginning of the year significantly changed the operating environment and the HRC moved to work almost completely remotely in March. The Human Rights Delegation approves the annual report and the action plan.

During the year, the HRC closely monitored the COVID-19 pandemic's impact on fundamental and human rights, and a special theme page on the topic was added on the HRC's website. Monitoring was also improved in other ways during the year, and a new monitoring tool developed by the HRC will be introduced and work processes for monitoring will be established in 2021.

The HRC continued its operation strongly in monitoring and promoting the rights of both persons with disabilities and older persons. The purpose is to improve the social inclusion of persons with disabilities, to raise awareness of the rights of persons with disabilities and to strengthen the legal perspective in activities, decision-making and broader attitudes related to older people.

The HRC's activities on research and studies took a leap forward, and they gained new partnerships with research institutes and researchers in the field. The HRC participated in a number of working groups and networks, such as the government network on fundamental and human rights and the working group developing indicators for it, the Advisory Body on International Human Rights Affairs under the Ministry for Foreign Af-

fairs, and working groups on discrimination, the rights of persons with disabilities and the rights of older people.

The promotion of fundamental and human rights

At the initiative and partial funding of the HRC, the teacher training of the faculty of educational sciences at the University of Helsinki continued the Human Rights, Democracy, Values and Dialogue in Education project to strengthen competence in fundamental and human rights. The project overlapped with the National Democracy Programme 2025 launched by the Ministry of Justice in 2020. One of the programme's focus areas is democracy and human rights education in teacher training. The HRC and the project have been presented and involved in the Democracy and human rights education and participation of young people (DINO II) coordination group under the Ministry of Justice and the Democracy and human rights education steering group coordinated by the Ministry of Education and Culture in 2020–2023. The project cooperation with teacher training will end in mid-2021, but the cooperation will continue in different ways with the parties involved in the project.

The various events for the public and specialists are important for the HRC as a means of providing information and training related to topical fundamental and human rights themes. In 2020, the coronavirus pandemic clearly reduced the number of events compared to previous years. Due to the limitations imposed by the pandemic, events and meetings were held online only.

The Human Rights Centre's events:

- Youth, Climate Change, and the European Court of Human Rights online conference in cooperation with the University of Tampere and the ALL-YOUTH – All youth want to rule their world research project, 27 November 2020
- A webinar on reforming the Act on Disability Services and Assistance in cooperation with the parliamentary group on disability matters (vammaisasian yhteistyöryhmä, VAMYT), 2 December 2020

Press releases, statements, news and reviews of fundamental and human rights were published on the HRC website and on the Twitter and Facebook accounts. The news articles covered the HRC's activities as well as international and domestic fundamental and human rights themes and events. A reform of the website was launched in 2020 to improve accessibility. Information on various human rights themes, such as the rights of persons with disabilities and the rights of older people, was also disseminated using targeted communications.

Monitoring fundamental and human rights

Monitoring fundamental and human rights means collecting information on the implementation of fundamental and human rights, analysing the data and maintaining up-to-date knowledge of the situation. Based on the collected data, it is possible to assess how best to promote the fulfilment of rights. Experience-based information on the realisation of rights is collected with surveys, for example.

The problem with human rights monitoring in Finland is still the lack of comprehensive information, which is due to the limited resources allocated to monitoring and the fragmentation of the human rights field. During the year, the HRC continued to systematically develop its own monitoring work. The aim is for the HRC to have a comprehensive picture and knowledge base on the fundamental and human rights situation in Finland. For this purpose, a new platform and tool were developed that create the technical preconditions for systematic and continuous monitoring of fundamental and human rights. The monitoring covers a wide range of fundamental and human rights and broader themes. The aim

is to monitor the rights of persons with disabilities and older people at the level of the fulfilment of rights. New topics will be added to monitoring as the fundamental and human rights situation changes and as resources allow.

The HRC is involved in the periodic reporting procedure for the human rights treaties, issuing statements and attending consultation events. It provides information about the recommendations of the treaty bodies and monitors the implementation of recommendations of the treaty bodies. The HRC also encourages NGOs to participate in reporting by submitting their own statements.

The HRC's director is an independent expert member in the government network of contact persons for fundamental and human rights.

The Government submitted its periodic report to the UN on the implementation of the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), the Convention Against Torture (CAT), and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 2020. The Government also updated its Common Core Report for the UN. The HRC participated proactively in the reporting cycles by submitting material and suggestions for questions and recommendations to UN committees. The Government will report to the Council of Europe on the implementation of the European Social Charter.

Monitoring the implementation of the UN Convention on the Rights of Persons with Disabilities

The HRC's work with persons with disabilities focuses on promoting the social inclusion of persons with disabilities, raising public awareness of their rights and monitoring the fulfilment of the rights extensively.

As a result of the coronavirus pandemic, the HRC adapted work related to the rights of persons with disabilities to the changed operating environment. The activities acknowledged problems that the pandemic raised in relation to the rights of persons with disabilities. The theme website discussed restrictions on mobility and gatherings, ensuring social welfare and healthcare services, the protection and safety of other persons in need of help, equal access to information and equal access to care from the perspective of fundamental and human rights. The theme site also contains comprehensive guidelines compiled by authorities during the pandemic and opinions of various organisations on problems related to the rights of persons with disabilities.

In cooperation with the parliamentary group on disability matters (vammaisasian yhteistyöryhmä, VAMYT), the HRC organised a webinar on the reform of the legislation on services for persons with disabilities. The Human Rights Centre published a summary of the discussion.

You can read more on the special mandate related to the rights of persons with disabilities in section 3.4 The rights of persons with disabilities.

Promoting and monitoring the rights of older persons

The HRC began its work on promoting the rights of older people as a new priority in spring 2019 after the Parliament granted additional funds for it. The two new expert positions of the HRC were made permanent at the beginning of 2020, after which the work could be developed over a longer term and systematically.

The objectives of the HRC's work to promote the rights of older people include:

- strengthening a rights-based perspective in services for older people
- influencing values and attitudes
- influencing knowledge/awareness of the rights of older people and
- influencing the quality of legislative drafting related to the rights of older people and the content of the laws/recommendations.

In 2020, the Human Rights Delegation's division on the rights of older people became a new cooperation body. The division is a preparatory body of the delegation and it can make proposals and initiatives and provide expert assistance to the HRC in tasks related to the promotion of the rights of older people.

During the year, the HRC cooperated closely on the rights of older people with the team handling matters related to older people within the Office of the Parliamentary Ombudsman. The cooperation brought significant synergy gain through the tasks of both actors – the oversight of legality and the general monitoring and promotion of rights. The HRC continued its goal-oriented and extensive cooperation in older people's matters with organisations representing older people, Regional State Administrative Agencies, Valvira, researchers and other authorities, organisations and experts. The HRC also participated in the activities of the national VAASI network of experts in elder law.

Cooperation with municipalities and service providers was emphasised more than in the previous year.

The HRC began working with Valvira and the Regional State Administrative Agency for Southern Finland on a pilot project aimed at promoting the right to self-determination of elderly clients and the implementation of fundamental and human rights in 24-hour housing services. The HRC also launched a study on the activities, good practices and potential challenges of municipal councils for older people.

The OITIS project (*Oikeutta ikäihmisille! – tarinoita ikääntyvästä Suomesta*) was launched in December 2020 aiming to explore the legal problems that older people (over the age of 65) face and whether or not they have found solutions to their problems. The project partners include the Institute of Criminology and Legal Policy at the University of Helsinki, the Institute of Law and Welfare at the University of Eastern Finland, the University of Tampere and the Human Rights Centre.

During 2020, the HRC continued to monitor the objectives related to the promotion of the rights of older people included in the Government Programme and to ensure that fundamental and human rights of older people are taken into account in the implementation of the objectives. During the year, the HRC issued several statements on the rights of older people. They concerned customer fees for social welfare and healthcare services, the quality recommendations for older people, palliative and terminal care and the establishment of the Ombudsman for Older Persons.

During 2020, the HRC's experts organised several training events for social welfare and healthcare professionals on the fundamental and human rights of older people and the right to self-determination.

The HRC participated in an expert role in the SIHTI research project launched in May 2020. The project was conducted under the analysis, assessment and research activities coordinated by the Prime Minister's Office, and it aimed at assessing how Finnish companies are fulfilling their human rights responsibilities, meaning how they have implemented the UN Guiding Principles on Business and Human Rights. Approximately 80 Finnish companies were reviewed, including companies in the care sector. Based on the research results, the HRC assesses how it can promote the human rights responsibility of companies in the care sector in the future. In addition to the Human Rights Centre, the project consortium included Hanken School of Economics' and the University of Helsinki's joint research and development institute Centre for Corporate Responsibility (project leader), FIANT Consulting Oy and 3bility Consulting.

International and European cooperation

The HRC participated actively in cooperation between national human rights institutions in their thematic working groups, and an expert of the HRC chaired the ENNHRI Legal Working Group. The HRC supported the strengthening of the rule of law in the activities of ENNHRI and contributed by writing Finland's part in the institutions' first joint rule of law report.

Close cooperation with the European Union Agency for Fundamental Rights was carried out in research and communication. This year's key themes in European cooperation were the coronavirus pandemic's impacts on fundamental and human rights. Michael O'Flaherty, Director of the EU Agency for Fundamental Rights, was heard on the topic at an open meeting of the Human Rights Delegation in September. The term of office of Sirpa Rautio, Director of the Human Rights Centre, as Chair of the Management Board of the European Union Agency for Fundamental Rights ended in the summer. Leena Leikas, an expert at the HRC, was appointed as an alternate member of the Management Board through an open application process, and professor Tuomas Ojanen, a member of the Human Rights Delegation, was appointed as a full member. The link between the HRC and the Agency for Fundamental Rights will thus remain strong.

3.3.3 THE HUMAN RIGHTS DELEGATION'S OPERATION

The Human Rights Centre's Human Rights Delegation functions as a national cooperative body of fundamental and human rights actors. It deals with fundamental and human rights issues of far-reaching and significant importance and approves the HRC's plan of action and annual report every year.

The third Human Rights Delegation began its four-year term on 1 April 2020. Members of the Delegation apply through an open application process, and the composition of the delegation is appointed by the Parliamentary Ombudsman. In this round of applications, there were more applicants than ever before, over 130. The Delegation has 38 members, including special ombudsmen, representatives of the supreme overseers of legality and the Sámi Parliament of Finland. The Human Rights Delegation and its working committee are chaired by the director of the HRC. Esa Iivonen, member of the Delegation, is the deputy chairman in 2020–2022.

The work of the Human Rights Delegation began with a survey of the members' wishes regarding the discussion topics and operating methods. The topics that came up included general influence on human rights policies and political decision-making, the pandemic's impact on the implementation of fundamental and human rights, climate change, corporate responsibility, indigenous rights, violence against women, the right to self-determination of older people and persons with disabilities, and the general monitoring of the fundamental and human rights situation.

In 2020, the activities of the Human Rights Delegation focused on four themes and the implementation of related rights during the coronavirus pandemic: rule of law development, the rights of children and young people, the rights of persons with disabilities and older people, and violence against women. The Delegation made recommendations to the Government on these issues at the end of the year, on the basis of which the HRC compiled and published the report "The impacts of the coronavirus pandemic on the implementation of fundamental and human rights – recommendations by the Human Rights Delegation".

The permanent divisions under the Delegation include a working committee, the division for the rights of persons with disabilities, i.e., the Disability Rights Committee (VIOK), and the division on the rights of older people. The working committee participates in preparing the Delegation's meetings.

The HRC publishes its own annual report, which is submitted to the Human Rights Delegation for approval. The report of the Parliamentary Ombudsman contains a summary of the HRC's report. See www.ihmisoikeuskeskus.fi.

3.4 Rights of Persons with Disabilities

3.4.1 SPECIAL MANDATE TO IMPLEMENT THE RIGHTS OF PERSONS WITH DISABILITIES

The ratification of the UN Convention on the Rights of Persons with Disabilities (CRPD) and its Optional Protocol on 10 June 2016 brought the Parliamentary Ombudsman a new special task, which is laid down in the Parliamentary Ombudsman Act. The duties set out in Article 33(2) of the CRPD are attended to the Parliamentary Ombudsman, the Human Rights Centre and its Human Rights Delegation, which together form Finland's National Human Rights Institution.

The purpose of the CRPD is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. The leading principles of the CRPD are accessibility and non-discrimination. Other key principles of the CRPD include respect for the right to individual autonomy, and participation and inclusion of persons with disabilities in society.

The Convention contains a broad definition of disability, which can be adequately relied upon to ensure the rights and equality of the disabled in different ways. The Convention defines persons with disabilities as those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others. For example, persons with memory disorders and psychiatric patients are therefore covered by the Convention.

Decisions on cases in this category were made by Parliamentary Ombudsman *Petri Jääskeläinen*, the presenting officer was Principal Legal Adviser *Minna Verronen*, and the Senior Legal Adviser was *Juha-Pekka Konttinen*.

3.4.2 TASKS AND ACTIVITIES OF THE NATIONAL MECHANISM

Promoting, monitoring ja protecting the implementation of the CRPD require an input from all the parties involved in the National Human Rights Institution, as their different tasks complement each other.

Promotion refers to future-oriented active work that includes guidance, advice, training and information sharing. The purpose of monitoring is to determine how effectively the rights of persons with disabilities are realised formally and in practice. Monitoring means the gathering and further use of information related to the practical fulfilment of the CRPD obligations with a view to remedying any defects found in this area. Protection means both the direct and indirect obligations of the state with regard to protection of persons against any violations of the rights laid down in the CRPD.

Parliamentary Ombudsman

The Parliamentary Ombudsman protects, promotes and monitors the implementation of the CRPD within the limits of his or her specific mandate. The Ombudsman's tasks include overseeing legality in the exercise of public authority and supervising (protecting) the implementation of fundamental and human rights. Over time, the Ombudsman's activities have evolved towards promoting fundamental and human rights. In decisions on complaints and during visits and inspections, instead of focusing solely on the legality of practices, an effort is made to guide authorities and other subjects of oversight towards adopting practices that implement fundamental and human rights as effectively as possible. Over-

sight and monitoring are interlinked in the Ombudsman's work, as observations of inadequacies in realising the rights of persons with disabilities made in the course of the oversight of legality are also part of general follow-up of how CRPD obligations are implemented in practice.

For the main part, the Ombudsman exercises oversight of legality by investigating complaints, but he or she also examines shortcomings on his or her own initiative and when conducting inspections. In addition to the oversight of legality, the Ombudsman also serves as the National Preventive Mechanism (NPM) under the Optional Protocol to the UN Convention against Torture (OPCAT). The NPM visits places where persons are or may be deprived of their liberty, including residential units for persons with intellectual disabilities or memory disorders. When performing this task, the Ombudsman may rely on the assistance of experts appointed by him, who have expertise significant for the NPM mandate. The Ombudsman's experts include, among others, health care specialists, including two physicians who specialise in intellectual disabilities. The Ombudsman also receives assistance from experts who are disabled themselves. After training, the Ombudsman may invite them to participate in the inspections of OPCAT sites in an expert capacity. As no physical inspections were carried out during the year under review due to the coronavirus pandemic, no experts took part in the audits of the monitoring body as external experts. Other forms of cooperation with persons with disabilities and disability organisations have been and will continue to be increased.

Human Rights Centre

The core tasks of the Human Rights Centre include promoting fundamental and human rights and monitoring their realisation. Unlike the Parliamentary Ombudsman, the Human Rights Centre does not investigate complaints or exercise oversight of legality. Rather than being limited to the activities of the authorities, the Human Rights Centre's competence also extends to promoting and monitoring CRPD implementation in the activities of private stakeholders.

One priority of the HRC in work with persons with disabilities is to promote the social inclusion of persons with disabilities and raise public awareness of their rights.

As a result of the coronavirus pandemic, the HRC adapted work related to the rights of persons with disabilities to the changed operating environment. The aim was to implement the action plan drawn up for the term with minimal changes, while including themes related to the rights of persons with disabilities highlighted by the pandemic. Due to changes in the operating environment, regular evaluation discussions on the focus of activities were conducted during the term under review.

At the early stages of the coronavirus pandemic, the HRC included a separate theme page on its website, dealing extensively with issues related to the implementation of fundamental and human rights that had emerged in monitoring during and after the exceptional circumstances. From the perspective of fundamental and human rights, the theme page addressed issues such as mobility and meeting restrictions imposed on persons with disabilities, safeguarding of social welfare and health care services, the protection and safety of other persons in need of help, equal access to information and equal right to treatment. The theme page also contains comprehensive guidelines related to the rights of persons with disabilities and compiled by authorities during the pandemic, and opinions of various NGOs on problems related to the rights of persons with disabilities.

Members of the Disability Rights Committee (VIOK) were appointed at the meeting of the Human Rights Delegation on 20 May 2020. The Delegation convened four times during the term of office. During autumn, the Committee prepared its own work programme and planned the appointment of external experts to complement the composition of the Committee. The themes of the Committee's work programme for the period from 2020 to 2024 include poverty and employment of persons with disabilities, education, involvement and social inclusion, discrimination and equality, and the impact of the coronavirus

pandemic on the rights of persons with disabilities. The Committee also focuses on monitoring the Government Programme throughout the period.

During autumn, all members of the Committee participated in a workshop organised by the Human Rights Delegation to discuss how the coronavirus pandemic and the various restrictions and measures taken to combat it affect the implementation of fundamental and human rights. Based on the workshop discussions, the HRC compiled a condensed snapshot of the implementation of fundamental and human rights. The publication also includes the Delegation's recommendations on how, among other things, the rights of persons with disabilities should be safeguarded during the coronavirus pandemic and in its aftermath ("*The impacts of the coronavirus pandemic on the implementation of fundamental and human rights – recommendations by the Human Rights Delegation*").

In cooperation with the parliamentary group on disability matters (vammaisasian yhteistyöryhmä, VAMYT), the HRC organised a webinar on the reform of the legislation on services for persons with disabilities. At the event, an official from the Ministry of Social Affairs and Health gave an up-to-date review of the timetable for the reform of the legislation on services for persons with disabilities and the related consultation procedure. Representatives of four different disability organisations spoke at the event and raised issues that, from their own perspective, are important in the reform of the Act on Services and Assistance for the Disabled. The Human Rights Centre published a summary of the discussion.

During the term under review, the HRC cooperated with the Finnish Institute for Health and Welfare to finalise the report on the Fundamental Rights Barometer project and prepare it for publication. The report will be published in spring 2021. In addition, the HRC was involved in supporting the survey on everyday life at school conducted by the Finnish Disability Forum and directed at the parents of children with disabilities.

For several years, the HRC has monitored the preparation of an additional protocol to the Convention on Human Rights and Biomedicine (the 'Oviedo Convention') of the Council of Europe regarding involuntary treatment measures. During the term under review, the HRC issued a statement on the drafted additional protocol. In its statement, the HRC stated that the drafted additional protocol still includes significant problems in relation to the UN Convention on the Rights of Persons with Disabilities. In addition, the HRC noted that the drafted additional protocol does not contain an article that would specify what kind of measures are taken in order to strengthen the right to self-determination of persons subject to involuntary treatment and other related restraints, and how these measures are implemented.

Disability Team

The Disability Team of the Office consisted of three experts from the Office of the Parliamentary Ombudsman, a notary and one expert from the Human Rights Centre. During 2020, the Disability Team worked in close cooperation with the Disability Sub-Committee. Matters highlighted in the Sub-Committee and Disability Team's meetings were discussed fluently on both sides, since two members of the Disability Team also served as experts in the Sub-Committee.

The Disability Team's meetings focused on discussing the impact of the coronavirus epidemic on the selection of inspection sites and carrying out of inspections, updating the Disability Team strategy, planning training within the Office related to the theme of disability, and planning to include content focused on the rights of persons with disabilities on the websites of the HRC and the Ombudsman. As part of identifying the tasks of the national mechanism, the Team conducted discussions with the employees of the Office and assessed the scope of the concept of persons with disabilities in the administrative branches of the oversight of legality. The Disability Team also considered different ways of cooperating with and involving persons with disabilities.

During the term under review, the Disability Team finalised the self-assessment tool prepared during the Fundamental and Human Rights in Housing Services project. The self-assessment

tool is intended for supporting the efforts of special care service providers to strengthen clients' right to self-determination. The tool consists of questions that guide the special care providers to make an independent assessment on how well the activities and operating methods of residential units support and strengthen the clients' right to self-determination. The questions were finalised in extensive cooperation with authorities and NGOs. Among other things, a consultation meeting was organised in the autumn for authorities and NGOs in which they presented their own views and development proposals regarding the self-assessment tool. The final version was reviewed by three providers of special care. In the following term, the aim of the project is to support the activities of providers and producers of special care services in the implementation of the tool.

Cooperation with other authorities encompassed Valvira, regional state administrative agencies and the National Non-Discrimination and Equality Tribunal. Cooperation with regional state administrative agencies was related to inspections and the selection of inspection sites.

Members of the Disability Team participated in disability rights events organised by the parliamentary group on disability matters (*vammaisasian yhteistyöryhmä*, VAMYT). Two members of the Disability Team participated as separately invited experts in meetings of the legal team for the handbook on disability services (*Vammaispalvelun käsikirja*, maintained by the Finnish Institute for Health and Welfare), on topics including the latest case law relating to disability services and the monitoring of the reform of the Act on Services and Assistance for the Disabled.

A member of the Disability Team also participated in the work of the Act on the Provision of Digital Services Monitoring Group. During the term under review, the Monitoring Group focused on monitoring the implementation of accessibility regulation and supporting the Regional State Administrative Agency for Southern Finland in its implementation of the monitoring of the requirements of the Act on the Provision of Digital Services (306/2019).

A member of the Disability Team had also been appointed an expert member of the Advisory Board on the Rights of Persons with Disabilities (VANE). The task of the Advisory Board is to promote the national implementation of the UN Convention on the Rights of Persons with Disabilities and to take into account the rights of persons with disabilities in all areas of government. During the term under review, the Advisory Board focused on preparing a national action plan for the UN Convention on the Rights of Persons with Disabilities. The HRC also gave its own expert views as an independent actor at a hearing in which the drafted action plan was assessed. At the hearing, the Centre highlighted, amongst other things, the need to reinforce the measures in the action plan in order to combat discrimination against persons with disabilities. The Centre also proposed that entries on preparedness for exceptional circumstances should be highlighted, persons with disabilities from a Roma background should be taken into account in the action plan and measures supporting the inclusion of persons with disabilities in employment should be strengthened.

On the initiative of the Disability Team, training related to the theme of disability was organised in the Office. The training focused on two topics: challenging behaviour and the right to self-determination of persons with intellectual disabilities, as well as ageing and intellectual disability (25 November 2020). The instructor was a Psychologist specialised in Neuropsychology, Oili Sauna-aho, PhD, PsycLic.

A member of the Disability Team gave a guest lecture on the rights of persons with disabilities and the activities of the Ombudsman at the University of Helsinki on the course on disability research on 28 January 2020, in the Assistentti.info development webinar on 29 September 2020, and at the meeting of the regionalised network of services for persons with disabilities (*maakunnallistuvat vammaispalvelut*) on 4 December 2020.

During the term under review, the HRC intensified its cooperation with the secretaries of the disability advisory councils. A representative of the Centre participated in a cooperation meeting for the secretaries of the disability advisory coun-

cils twice during the term under review. At the first meeting, the representative of the Centre introduced a subject and held a discussion with the secretaries on how to implement the inclusion obligation of the UN Convention on the Rights of Persons with Disabilities at local level. The second meeting introduced and discussed the theme of how to implement the obligations of the Convention on the Rights of Persons with Disabilities in a cross-cutting manner in local government.

A member of the Disability Team was consulted as an expert in two studies related to the employment of persons with disabilities. One was a study carried out by a research group at the University of Amsterdam and it examined the reasons behind the weaker labour market participation of people with a disability in the member states of the European Union. The research publication is available online ("Explaining the disability employment gap in European countries: the influence of labour market policies and public opinion towards people with a disability"). The second study explored the structural obstacles to the employment of persons with a disability in Finland. This report was published by the Ministry of Economic Affairs and Employment ("Structural obstacles to the employment of persons with a disability").

International cooperation

As a result of the coronavirus pandemic, international cooperation decreased significantly in comparison to previous years. During the term under review, all meetings of the ENNHRI CRPD working group were remote meetings, and the focus of the working group's activities shifted to assessing and monitoring the impact of measures related to the coronavirus pandemic. The working group regularly shared information on the measures taken in different countries to protect the rights of persons with disabilities and to safeguard their health. During the term under review, the working group's work programme was also updated.

The annual Conference of States Parties to the UN Convention on the Rights of Persons with Disabilities was cancelled in the spring and finally organised as a remote conference in December. The main theme of the conference was the implementation of the CRPD and the 2030 Agenda for Sustainable Development for all persons with disabilities. The sub-themes of the conference were older persons with disabilities, inclusive environments and the right of persons with disabilities to work. Members of the Disability Team attended discussions during the three-day conference. The members of the Disability Team also followed the discussion on the rights of persons with disabilities (particularly issues related to coronavirus) and international decision policies (such as the CRPD Committee).

During the term under review, a representative of the Disability Team participated in a debate on Article 13 of the Convention on the Rights of Persons with Disabilities organised by the UN Special Rapporteur on the Rights of Persons with Disabilities. This Article obliges the contracting parties to ensure effective access to justice for persons with disabilities on an equal basis with others. At the event, the participants commented and discussed in detail the guidelines drawn up by the Special Rapporteur on the content of the Article. The guidelines were published later during the term ("International Principles and Guidelines on Access to Justice for Persons with Disabilities").

3.4.3 OPERATING ENVIRONMENT AND CURRENT LEGISLATIVE PROJECTS

It has been estimated that there are some 50,000 persons with intellectual disabilities in Finland. In the service structure of care for people with disabilities, a trend that favours assisted living rather than institutional care has continued throughout the 2000s. In the 2012 government resolution on the individual living arrangements of persons with intellectual disabilities and service provision, the target was that after 2020 no person with disability would live in an institutional setting. However, the intention has been to implement the change without forced transfers, taking into account people's age and life situation. The objective of the national plan is that children with

intellectual disabilities should no longer be placed in institutions.

According to a statistical report compiled by the Finnish Institute for Health and Welfare, there were 452 long-term residents at institutions at the end of 2019 (631 in 2018 and 920 in 2016). Long-term residents are deemed those placed in long-term care by a decision or those who have been in care for over 90 days. Despite the objectives, the proportion of children living in an institution increased slightly. At the end of 2019, 131 of the long-term residents were under the age of 18 (118 in 2018), but the number of those aged 0–7 remained the same as in the previous year (13 children). Short-term treatment periods in an institution typically last less than 7 days. The total number of persons with disabilities in institutional care was 556 at the end of the year (795 in 2016 and 962 in 2015). The proportion of institutional care varies from region to region, with the highest proportion of institutional care taking place in South Savo (14%) and the lowest in Päijät-Häme (0.5%). In the whole country, institutional care involves 6% of all people with disabilities in 24-hour residential care, and is mainly implemented in the units of public service providers (91%).

The number of clients in 24-hour residential care (assisted living) has increased by an average of 7 per cent a year in the 2000s, while the number of clients in institutional care has decreased by an average of 8 per cent a year. At the end of 2019, the number of clients in assisted living for people with intellectual disabilities was 9,155, and the number of clients increased by 6 per cent from the previous year. Public service providers accounted for 50 per cent of all service providers in assisted living.

As agreed in Prime Minister Sanna Marin's Government Programme, a Signed Memories (*Viitotut muistot*) research project was launched in the summer of the year under review to collect information on violations against the rights of deaf people and the sign language community from the beginning of the 20th century to the present day. Data collected in the research project is to be used in the planning of the reconciliation process and, later, in the actual reconciliation process. A multidisciplinary research group commissioned by the Government includes the University of Helsinki, the Finnish Institute for Health and Welfare, Tampere University, the Humak University of Applied Sciences and the University of Eastern Finland.

In December of the year under review, the Ministry of Social Affairs and Health published a report by the Inclusion Working Group on efforts to secure the inclusion of persons with disabilities in the services for people with disabilities. In the future, the intention is to make use of the working group's report and the related statements when drafting the Government's proposal for a comprehensive reform of the legislation on services for persons with disabilities. The goal of the Inclusion Working Group was to secure and further increase the participation of persons with disabilities in the decision-making and organisation of services concerning themselves, and to clarify the legal remedies related to choosing the way in which the services are provided. The aim was also to improve the quality of services, to strengthen the right to services based on individual needs, and to increase the equality of persons with disabilities.

The reform of the disability legislation mentioned in the Government Programme and the development of legislation relating to the right of self-determination were often brought up in discussions with authorities and organisations.

3.4.4 OVERSIGHT OF LEGALITY

The Ombudsman oversees the realisation of the rights of persons with disabilities concerning all authorities and private bodies performing public tasks, regardless of the administrative sector of the authority. In statistics, complaints are primarily filed under the authorities and administrative branch (social welfare, social insurance, health care, education, and cultural authorities, etc.) that are discussed in the decisions. Some decisions taken in the course of the oversight of legality relating to the rights of persons with disabilities involved several different administrative branches. This section deals with areas that are vital for the implementation of the rights of persons with dis-

abilities regardless of which administrative branch the matter involved.

The Ombudsman's annual reports and action plans have emphasised the importance of the rights of persons with disabilities since the year 2014, which was the first time that the annual report included a section dedicated specifically to the oversight of legality related to the rights of persons with disabilities.

The oversight of legality related to the rights of persons with disabilities focuses, in particular, on fundamental rights, such as access to adequate social welfare and health-care services, equality, legal protection, and accessibility, as well as individual autonomy and inclusion in society.

Disability services provided by local authorities are an important area from the perspective of the oversight of legality. Many complaints relate to shortcomings in service plans and special care programmes, the advice and guidance given in relation to services, as well as delays and procedural errors in decision-making and other aspects of case management.

Inspections are vital for the oversight of legality, as persons with disabilities are not always able to file complaints themselves. On inspection visits, supervisory measures are targeted at public and private actors providing disability services and their self-monitoring systems, and the local authorities responsible for the provision and supervision of services. The Ombudsman also oversees other special supervisory authorities, such as Valvira and the regional state administrative agencies.

Complaints and own initiative investigations

The number of complaints and own-initiative investigations falling into this category on which decisions were issued was 306. The number was higher than in the previous year (281) and in 2018 (257). The Ombudsman investigated 14 cases in total on his own initiative. Nine of these mainly involved shortcomings related to the coronavirus pandemic in matters concerning elderly people with memory disorders, and four involved deficiencies in accessibility and securing the confidentiality of polls at certain advance polling stations. A larger number of investigations warranted further action than in previous years, that is, 97 cases in total (32%). Similarly to previous years, the percentage of cases warranting further action was higher than average at the Office of the Parliamentary Ombudsman (14,5). A reprimand was issued in five cases, and a proposal was made in six cases. Two reprimands were issued in education and health care, and one in social welfare. The Ombudsman gave his opinion on 63 (65) cases, and 16 (4) cases led to other measures. Due to the high number of cases that led to measures, it is not possible to give an account or mention of all decisions concerning disability rights. An increasing effort is being made to publish the decisions on the Ombudsman's website www.oikeusasiamies.fi.

As in previous years, the social welfare category had the highest number (215) of decisions concerning persons with disabilities (179 in 2019 and 150 in 2018). The reason is that local authorities are responsible for the provision of social services, such as special care for persons with intellectual disabilities, services and support measures provided on the basis of disability and services for persons with memory disorders. Of the services provided under the Act on Services and Assistance for the Disabled (137 decisions), 35 decisions (26 in 2019 and 38 in 2018) concerned personal assistance, 44 cases (30 in 2019 and 19 in 2018) involved transport services and 29 cases (25 in 2019 and 28 in 2018) concerned the rights of persons with intellectual disabilities. Interpreting services for persons with disabilities were also included in the social welfare category, in which Kela, the Social Insurance Institution of Finland, serves as the service provider. Seven of these cases were addressed in the year under review (28 in 2019 and 11 in 2018). During the year under review, a number of complaints were resolved (at least 43) concerning the treatment of elderly people with memory disorders in care units during the pandemic and the ban on visiting relatives and loved ones (see separate section 4 on issues related to coronavirus).

During the year under review, decisions related to social insurance were made 32 (46 in 2019 and 28 in 2018), 51 issues related to health care (57 in

2019 and 55 in 2018) and 15 issues related to education (5 in 2019 and 7 in 2018).

Complaints relating to service provision under the Act on Services and Assistance for the Disabled concerned e.g. decision-making related to services and customer charges, guidance and advice related to services, complainant's treatment in a customer service situation or residential unit, assessment of service needs, delayed processing of an application or a complaint, and local authorities' service provision and application directives. The practices of the Social Insurance Institution (Kela) were assessed as an organiser of interpretation services and a body granting benefits, such as disability and rehabilitation allowances. In the health care sector, cases were related to the care and treatment of persons in mental health rehabilitation, the funding of a medical rehabilitation aid, the provision of medical rehabilitation and adequate health care provision.

Vaalijala expertise and support centre, the spacious common area at Luotain residential home for young people.

Inspection visits

Practically all inspections of psychiatric hospitals and residential and institutional units for persons with disabilities combine the two special mandates that the Ombudsman has under international conventions (CRPD and OPCAT). Inspections are carried out to ensure that client treatment and services are implemented in a manner that respects the fundamental rights and human dignity in compliance with the legislation.

The Ombudsman's inspections focus particularly on the implementation of the rights that persons with disabilities have under the United Nations Convention on the Rights of Persons with Disabilities in respect of, for example, individual autonomy, the use of restraints, opportunities for participation, and the accessibility of facilities. In his capacity as Finland's National Preventive Mechanism under the Optional Protocol to the UN Convention against Torture, the Ombudsman also strives to prevent the ill treatment of persons who have been deprived of their liberty and violations of the right to individual autonomy. The inspectors talk to the management, staff, and clients of the residential units, and inspect documents, the communal areas of the units; and the surrounding area, as well as clients' private rooms with their permission.

Due to the coronavirus pandemic, the audits were carried out as remote inspections, mainly by consulting the clients and their relatives by telephone and requesting documents and clarification from the audited entity. The remote inspections focused on investigating the effects of the pandemic on the content and quality of services and the use of restraints. Remote inspections were carried out in Rinnekoti (3649/2020) run by the Helsinki Deaconess Institute Foundation, the joint municipal authority of Vaalijala (3650/2020), institutional and residential services for persons with disabilities provided by the social welfare sector of Satakunta Hospital District and the Antinkartano rehabilitation centre (3651/2020), residential services for persons with intellectual disabilities in the municipality of Loppi, and the Pajukoti residential unit for persons with intellectual disabilities (3652/2020), institutional and residential services for persons with intellectual disabilities in the city of Pietarsaari (3653/2020), and Validia house run by Validia Oy's residential services in Lahti, (3654/2020).

Inspection findings related to coronavirus are described in section 4. For details of the observations made by the Ombudsman in his role as the National Preventive Mechanism, see section 3.5 of this Annual Report.

3.4.5 DECISIONS

Social welfare

Shortcomings and procedural errors in the implementation of the rights of children with disabilities

According to Article 7 of the UN Convention on the Rights of Persons with Disabilities, States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children. In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration.

In the case 5086/2019, the Parliamentary Ombudsman considered the procedures of disability services provided by the South Savo Social and Health Care Authority completely unacceptable in matters involving a child with severe disabilities in need of special support. In addition to the assessment of the need for services, decision-making on applications for personal assistance for school mornings and activities outside the home were unlawfully delayed.

According to the decision, section 36.3 of the Social Welfare Act is unconditional in that the assessment of service needs of a child in need of special support must be completed no later than 3 months after the time a case becomes pending. The Ombudsman generally emphasised the importance of the service plan in the individual planning, organisation and implementation of services for persons with disabilities. The service plan is an action plan drawn up by the authorities and the client cooperatively, and based on the assessment of the client's service needs.

When assessing the seriousness of the delay, the Ombudsman considered the fact that the authorities had already been aware of the child's need for help during school mornings approximately five months before school had begun. Despite this, the decision was delayed. In the Ombudsman's opinion, the decision on aid for the child's school mornings should have been made well in advance before school started. In terms of the second application, the Ombudsman considered that the delay was due to a procedural error by the authority. According to the Ombudsman, the authority should have informed the complainant at an earlier stage that an informal statement is sufficient in the case of personal assistance.

The Ombudsman stated that, at the early stage of the process, it is of paramount importance that the authorities ensure that sufficient additional information is obtained. If the applicant refuses to provide the requested additional clarification, a decision must be made in the matter immediately, unless it is appropriate to obtain an alternative clarification in the matter. The authority shall advise and instruct the applicant on all options and stages of the process. The Ombudsman stated that if the authority itself requests further clarifications, it shall supervise and monitor that the required additional statements are delivered. When requesting additional information from the applicant (client), the authority shall provide clear guidance on what impact the requested information will have on the decision, and how the clarification will affect the schedule of the decision-making.

Another decision 2893/2019 also concerned unlawful delays in decision-making in the processing of applications involving a child in need of special support. The delay remained unacceptable despite the fact that the child's summer time care and support family had been arranged by family social services instead of services for persons with disabilities to whom the application was submitted. The Ombudsman emphasised that, from the perspective of clients' legal protection, it is particularly important that they receive a decision that is

eligible for appeal on the basis of their application without undue delay or otherwise within the statutory deadline.

In case 412/2019, the Ombudsman stated that in its decision on support for informal care, the local government official should explicitly justify the start date of support for informal care if it deviates from the date requested. The Ombudsman considered that the decision on support for informal care of a child in need of special support and the payment of such support had been unlawfully delayed. The Ombudsman emphasised that the leave referred to in the Act on Support for Informal Care must be expressly agreed in the agreement. The agreement must also specify how and where the leave will be organised.

In the case 320/2020, the Ombudsman considered that the authority had failed to reply to the complainant's reminder within a reasonable time. The Ombudsman considered the procedure to be highly reprehensible because the reminder had concerned a child with severe disabilities.

Placing a child with intellectual disability in a residential school for a period of special care

The Deputy-Ombudsman examined the case 2727/2019 on her own initiative, and called the attention of the Social Services of the City of Turku to the matter that the disability of a child should be taken into account in the provision of services included in substitute care. The child had been diagnosed with intellectual disabilities during the special care period in a residential school. Thereafter the child had been placed in a unit that provides substitute care which also has competence in the care of children with intellectual disabilities. The child's intellectual disability had only been noticed during the period of special care, although, according to the Deputy-Ombudsman, the child's state of health should also have been investigated before the start of the special care period, when assessing how to arrange substitute care for the child in a manner that would serve the child's best interest during the period in special care.

The Deputy-Ombudsman emphasised that when changes occur or are observed in the child's circumstances that may affect the content of the substitute care provided, the child's client plan must be reviewed in the manner required by the change, while also assessing the ways and means of arranging substitute care for the child in the future. The Deputy-Ombudsman had not been able to find out from the report submitted whether such an assessment regarding the child's intellectual disability had been carried out, even when special care was continued.

The Deputy-Ombudsman also stated that special care services could have been arranged for the child already earlier because the documents indicated that the child had been diagnosed with atypical autism and ADHD prior to being placed in a period of special care. In any case, such diagnoses would have required a more in-depth assessment of the child's state of health. On the basis of the child's diagnosis, the Deputy-Ombudsman considered that the possible intellectual disability of the child should also have been investigated in this context. If the city's social services had done so in the capacity of an authority responsible for arranging substitute care for the child, the special care period would perhaps not have been arranged in the residential school. In any case, it would have been arranged some other way, taking into account the child's disability and the special needs arising from it.

According to the Deputy-Ombudsman, the report strongly suggested that the planning of services for the child and the related social work had not been successful in all respects. This may have led to a failure to identify all special needs arising from the child's disability and to resolve the child's problems and essential questions related to the need for services and their provision in an appropriate, correct and timely manner.

A joint municipal authority neglected the preparation of a service plan and the revision of the special care programme

For future reference, the Ombudsman issued a reprimand to a joint municipal authority operating under the South Savo Social and Health Care Authority, as no special care plan or other decision had been made for the complainant's adult daughter, which would have appropriately determined how to arrange her housing services in the changed situation after her assessment and treatment period in an institution 4063/2019.

In its decision, the Parliamentary Ombudsman drew the attention of the joint municipal authority's social services to the fact that a decision regarding an individual's need for services or termination of the right to a certain service cannot be legally made by means of a statement presented at a network meeting or by a notification given by a person in charge of a residential home. The legal procedure requires that, before making a decision, the client is appropriately consulted in a manner laid down in the Administrative Procedure Act, an individual assessment of the client's service needs is drafted, and an appealable decision is issued on the termination of the service. From the perspective of realising the legal protection of the complainant's daughter, it would have been particularly important to obtain a written decision in order to enable her or the complainant to exercise their lawful right of appeal in the situation in which the public official had issued a decision by announcing it verbally at the closing meeting of the examination period, despite the objection expressed by the daughter and her mother. The Ombudsman also drew the attention of the joint municipal authority to the fact that an incomplete service plan does not prevent making a decision on the service.

From the perspective of legal protection, the Ombudsman considered the negligence of decision-making to be highly reprehensible, as the case involved a person with intellectual disabilities with long-term need for support. Moreover, the provision of the service in question is part of the special duty of the joint municipal authority. In this case, an effort must be made to arrange the client's support so that the continuity of services is ensured, unless it is in the client's interest to change the services. The Ombudsman also drew the attention of the joint municipal authority to the fact that, by law, the special care plan must be reviewed as necessary.

In the same decision, the Ombudsman considered that the complainant's daughter's service needs should have been assessed and a new service plan should have been drawn up for her without delay. This should have been done as soon as it had become apparent that the supervised housing services provided by the residential home were no longer suitable for her. The Ombudsman considered it inappropriate to justify the delay in the drafting of the service plan by the fact that the complainant had raised the possibility of acquiring a private apartment for her daughter at a network meeting. In the Ombudsman's opinion, the acquisition of a private apartment would have been a new reason for revising the service plan. However, it was not an appropriate justification for not drafting a service plan and assessing the service needs at the time when the complainant's daughter could no longer return from an institution to her privately rented accommodation supervised by residential services.

The Ombudsman emphasised that the service plan should ensure the individuality and continuity of services provided for a client, and the different services should be harmonised into a seamless whole. The purpose of the plan is also to guide the client to seek services and support measures determined as necessary.

According to the Ombudsman, the conduct of the disability services was neither appropriate nor customer-oriented. The documents did not reveal that the client had been informed of her rights and obligations or different options for arranging the services, or that the service needs had been assessed in a situation in which the supported housing service was no longer considered possible and the circumstances relevant to her access to the service had changed significantly. The Ombudsman stated that the assessment of service needs of a person with a disability is particularly important when their service needs have increased and can no longer be met with the services granted earlier. An individual service plan is particularly

important when a person with a disability and an authority disagree on how the services should be organised and implemented.

In another decision 3689/2019, the Ombudsman also considered that the joint municipal authority of wellbeing had neglected its duty to draft a special care programme for the complainant's daughter. The Ombudsman emphasised that services arranged as special care must be based on a special care plan. Moreover, in order to ensure the continuity of services organised in special care, it is important to start reviewing the special care plan well in advance before the planned deadline. A regular review of the special care plan is important for the full implementation of the rights of persons with intellectual disabilities. In addition, the Ombudsman stressed that the obligation to consult and cooperate is not eliminated by the fact that no significant changes to the services of persons with intellectual disabilities are in the pipeline regarding the preparation of the special care plan.

In the decision 2811/2019, the Ombudsman again emphasised that if conflicts of problems arise during the organising of services, the clients should be informed of their rights and obligations, the different alternatives and their effects, as well as other matters of importance to their own case.

Obligation to draw up a service plan

The substitute for the Deputy-Ombudsman stated that even appropriately completed entries about the client do not remove the authority's statutory obligation to draw up a service plan for a person with a severe disability. In this case, the substitute for the Deputy-Ombudsman took the view that social services had neglected the duty to prepare a timely multidisciplinary and multiprofessional service plan. The substitute for the Deputy-Ombudsman emphasised that a multidisciplinary and multiprofessional service plan allows considering the individual needs of a person with severe disabilities, and contributes to the implementation of cooperation between authorities in different administrative branches. The aim is that social welfare, health care and, if necessary, other administrative sectors will form an entity that serves the best interests of clients. In light of the above, a person with a severe disability has a special need and the statutory right to receive a service plan without undue delay 2549/2019.

In the opinion of the Ombudsman, in cases when the client does not contribute to the preparation of the service plan, the authority should draw up the service plan on the basis of the information and documents available. The Ombudsman stressed that a decision on the extension of a fixed-term decision on services for persons with disabilities should be made in good time before the earlier decision expires (138/2020).

Delays in decision-making and neglecting the authority's duty to make decisions

The most common shortcomings found in the oversight of legality by the Ombudsman involve delays in processing applications for benefits or services granted to persons with disabilities and neglecting the authority's duty to make decisions. These procedural errors jeopardise the implementation of legal protection of persons with disabilities, as the customer's appeal is delayed. The decisions emphasise that support for persons in need of long-term support must be organised in such a way that the continuity of services is ensured.

In case law, it has been consistently considered possible to lodge a complaint to an appeal instance regarding the implementation (method of implementation) of a service concerning subjective right. In the Ombudsman's practice of legal oversight, it has been considered that if the employer model for personal assistance in accordance with the Act on Disability Services and Assistance is not suited to a client with a severe disability, alternative methods of organising the service must be examined and offered to the client (service voucher model, outsourced service, local authority's own activities and a combination of these methods) and, if necessary, alternative providers of personal assistance services should be mapped out.

The organising of services for persons with disabilities and the selection of methods to organise them must always respect the client's right to self-determination and strengthen the client's independent initiative. Decisions on services and support provision under the Disability Services Act must be issued without undue delay and in any case within three months from the date of the application for a service or support measure by a person with disability or his or her representative.

In case 1271/2019, the Ombudsman considered that the enforcement of an official decision concerning a professional support person had been delayed unlawfully. The Ombudsman considered the procedure to be reprehensible because there was no acceptable reason for the delay. The complainant had not been offered a compensatory service in the situation when the professional support person could not be arranged.

In connection with complaint 431/2020, it became apparent that the city's common practice was not to write an administrative decision on the so-called minor apartment alterations granted to clients through disability services. The Deputy-Ombudsman concluded that the city's social and health services centre had acted contrary to the law in that it had not given the complainant a written decision on an application for apartment alterations in accordance with the Act on Services and Assistance for the Disabled.

Another case 6233/2019 showed that the city had not carried out housing alterations in accordance with the Act on Disability Services and Assistance. The stated reason was the fact that the complainant had expressed her willingness to move in the service plan. The Ombudsman concluded that the provider of disability services had acted unlawfully. The Ombudsman drew the attention of the authorities responsible for the provision of disability services to the fact that decisions on an individual's rights cannot be made in the service plan. The Ombudsman's considers that, in such a situation, the disability services official must deliver a negative decision to the complainant, enlisting reasons for not carrying out the alterations to the apartment. The Ombudsman drew the attention of disability services to the fact that the authorities are required to pay special attention to the expediency of the processing of the matter with regard to subjective rights under the Act on Services and Assistance for the Disabled, such as alterations to apartments.

In the Parliamentary Ombudsman's practice of overseeing legality, it has been emphasised that the Act on Services and Assistance for the Disabled does not leave the authority responsible for special care any discretion power with regard to whom a special care plan is prepared. Instead, it requires that a special care plan is prepared for all persons in need of special care. In addition to the special care plan, separate official decisions subject to appeal can be made regarding possible client fees, the number of services arranged as special care services, and their individual implementation methods.

Transport services provided under the Act on Services and Assistance for the Disabled

In Decision 1551/2019, the Ombudsman considered it a shortcoming that the statement on the right of a client to apply for a standard taxi right had been removed from the client instructions for transport services under the Act on Services and Assistance for the Disabled, as these special rights had been particularly significant for the realisation of transport services for several clients. The Ombudsman drew the attention of Siun sote (Joint municipal authority for North Karelia social and health services) to the authority's duty to provide advice and clarification. He emphasised that the authority must inform the clients and provide them with clear and consistent instructions on the application procedure for special rights related to transport services. The Deputy-Ombudsman emphasised the fact that, due to their nature as a subjective right, transport services for persons with severe disabilities cannot be organised by local application directives in such a way that the use of transport services, and thus the mobility of a person with severe disabilities outside their home would, in practice, be made impossible.

In another decision 2821/2019, the Ombudsman considered that the reasons given for the decision made by the authority did not show sufficiently clearly which factors affected the decision of rejection and how. The Ombudsman considered that the processing of the transport service application was unlawful and reprehensible because the assessment of the service needs and the client plan had been incomplete and the complainant had not been informed of the negative decision. The Ombudsman found the procedure to be reprehensible despite the fact that the complainant's decision on transport services was extended for three months after the error had been noticed. For the purposes of the complainant's legal protection, it would have been particularly important to receive a written decision in a situation in which the complainant was about to obtain a negative decision after a positive decision had remained in force for long. In the decision, the Ombudsman also drew attention to the fact that, on the basis of the report, the additional time was not used for correcting the shortcomings in the assessment of service needs or the preparation of the service plan.

The Ombudsman stressed that the granting of services is based on an assessment of severity of a disability in relation to the required service. The matter must be resolved by assessing the impact of the disability or illness on the need for transport services for persons with severe disabilities. The Ombudsman stated that, on a general level, the ability to work or access to an informal carer are not legal grounds for not granting a transport service to a person with disability. Instructions issued by local authorities or joint municipal authorities cannot deviate from the provisions laid down in law.

In decision 1482/2019, the substitute for the Deputy-Ombudsman considered that social welfare services had violated the requirements of the Administrative Procedure Act, because they had not waited for the additional report (doctor's certificate) as notified by the complainant in advance, nor had it asked the complainant about the report before making the decision. Moreover, the complainant had not been given a deadline for submitting the additional report. In this respect, the substitute for the Deputy-Ombudsman considered the procedure of the social welfare services unacceptable, even though an attempt had been made to process the claim for rectification concerning the provision of transport services as an urgent matter as required by law. In the view of the substitute for the Deputy-Ombudsman, the complainant could rightly have expected, in the circumstances of the case, that the authority would have waited for the additional clarification to be completed and submitted in accordance with the prior notification, before making a decision on the matter.

In the same case, the complainant had not appealed against the decision made by the social welfare board to the administrative court. However, in a reminder to the director of social and welfare service, the complainant had requested that their principal's case be reviewed by the social welfare board. In the view of the substitute for the Deputy-Ombudsman, the social services authority should have asked the complainant whether they would like the matter to be dealt with as a new application on the basis of the additional clarification. In addition, in this unclear situation, the authority should have clearly advised the complainant that the only legal remedy is to appeal in accordance with the instructions for appeal.

Reporting home visits and responding to client feedback

In the case 6795/2019, the Ombudsman drew the attention of the city's social welfare services to the fact that the appropriate processing of a matter involves respecting the privacy of the client so that the authorities agree on home visits in advance with the client. In this case, it is also necessary to jointly agree on which authorities take part in the visit, and what the purpose of the visit is. In addition, the Ombudsman drew the attention of the social welfare services to the fact that the processing of letters from clients, such as client feedback and reminders, should take place flexibly, easily and within a reasonable time.

In this case, the complainant had not received a reply to her feedback, and the social welfare ser-

vices had only provided the Ombudsman with a clarification after a complaint had been made in the case. Had the complainant had been contacted within a reasonable time by a letter, a copy of this letter could have been attached to the report sent to the Ombudsman. The Ombudsman also drew the attention of the social welfare services to the need to draw up a self-monitoring plan to ensure the quality, safety and appropriateness of social welfare services.

Shortcomings in the accuracy of information in a guide prepared by an authority

In his decision 4993/2019 on the complaint made by Heta ry (the Association of Employers of Personal Assistants), the Ombudsman considered Vantaa City's conduct to be reprehensible in the drafting of a guide for persons with disabilities acting as employers and their assistants, as the content of the guide deviated from the legislation on employment relationships in various parts. The Ombudsman emphasised that when a local authority is responsible for paying the salary of a personal assistant, it must contribute to the payment taking place appropriately and lawfully as required by the regulations.

Since the city had already taken corrective measures in the matter, the Ombudsman was only required to draw the attention of the City of Vantaa to the fact that an authority is responsible for ensuring that its guide to the clients of disability services corresponds to the legally valid decisions of the case law and that it is otherwise lawful, and the information it contains is correct and up-to-date. The guide published by the authorities is of great practical importance for persons with disabilities who act as employers for their personal assistants. The Ombudsman considered it important that persons with disabilities acting as employers are provided with information on the determination and payment of salaries and other compensation for personal assistance. However, the guide is not legally binding and the instructions it contains do not allow for derogations from obligations established by law.

Enabling the travel of persons with intellectual disabilities living in a housing unit

In his decision 1008/2019, the Ombudsman considered that, from the perspective of the right to self-determination of a client with intellectual disabilities, the unconditional prohibition that a person with intellectual disabilities should, under no circumstances, be allowed to compensate for the costs of instructors was problematic. Similarly, in the housing unit, residents' travels are categorically restricted only because not all residents can travel due to their personal financial situation. The financial situation of people with disabilities living in the same housing unit may vary, and they should be able to use their funds as they wish. The Ombudsman considered it important that when the authorities make policies in the matter, the service users should be involved as extensively as possible in the preparation of the policies.

Conduct of the Regional State Administrative Agency in a matter concerning the maintenance fee for a person with intellectual disabilities

In his decision 6749/2019, the Ombudsman considered the Regional State Administrative Agency's decision in the supervisory matter to be too absolute and categorical in terms of the costs that may be included in the maintenance fee for housing services for persons with intellectual disabilities.

The Regional State Administrative Agency had issued a reprimand to social welfare services on an unlawful procedure in the collection of housing charges for persons with intellectual disabilities. According to the supervisory decision, a client in assisted living may not be obliged to pay a certain amount per month for a service that they do not use. Moreover, the maintenance fee cannot include anything purchased for the unit's shared facilities or shared use.

The Ombudsman paid attention to the fact that the legislation on the maintenance fee for persons with intellectual disabilities and the practices based on it are difficult to understand and

interpret. Customer fees charged from people with intellectual disabilities and other housing service users with disabilities may be different depending on the law under which the service is organised. Assisted living can be organised as special care in accordance with the Act on Special Care for Persons with Intellectual Disabilities, assisted living in accordance with the Act on Services and Assistance for the Disabled, and assisted living and intensified assisted living accordance with the Social Welfare Act. In addition, various forms of supported housing are available.

The Ombudsman is of the opinion that equal treatment is currently not sufficiently achieved in terms of determining fees for persons with disabilities using housing services. For this reason, the Parliamentary Ombudsman sent his decision to the Ministry of Social Affairs and Health for information and proposed that the above statement be taken into account in the overall reform of the Act on Client Charges and the reform of the legislation for the Disabled.

Interpreting services for persons with disabilities

The duty to provide interpreting services for people with hearing impairments, hearing and vision impairments or speech impairments was transferred from local authorities to the Social Insurance Institution on 1 September 2010. As of 1 January 2014, Kela's Centre for Interpreting Services for Clients with Disabilities has provided interpretation services as part of its own activities. Interpreting services for persons with disabilities are aimed at promoting the non-discrimination of persons who require interpreting services compared to people without disabilities in order to facilitate their participation, communication and interaction with other people.

A person with disability is not entitled to interpreting services if he or she already has access to sufficient and appropriate interpreting on the basis of other laws. Such laws include the Basic Education Act and the Act on the Status and Rights of Patients.

In decision 276/2019, the Ombudsman considered that Kela's Centre for Interpreting Services for Clients with Disabilities had neglected its duty to ensure that it performs its tasks appropriately and effectively. In the Ombudsman's view, the Centre should have continued to look for interpreters and revised the situation of interpreter resources closer to the scheduled interpretation session in a situation where an appropriate interpreter had not previously been found for the interpretation order. The Ombudsman emphasised that the provision of interpretation services and the client's right to an interpreter should be implemented in such a way that the possibility of a person with a disability to act as an equal member of society is facilitated in all possible ways. The obligation of the UN Convention on the Rights of Persons with Disabilities to make reasonable adjustments must also be taken into account, as far as possible, in the organisation of services for a client in an individual case.

In case 3595/2019, the Ombudsman is of the opinion that Kela should have reacted more promptly to ensure the functioning of the list of interpreters in a situation where the complainant did not have any interpreters on the list, and in which the complainant did not usually want to use interpreters from outside the list of interpreters. However, when assessing Kela's conduct, the Ombudsman took into account the fact that, based on the statement, the difficulties in arranging interpreters were mainly caused by the fact that either the complainant had not accepted an interpreter on their list of interpreters, or that the interpreter had not wanted to be on the complainant's list of interpreters.

Social insurance

In two decisions 3866/2019 and 1022/2019, the Ombudsman criticised Kela for an undue delay in the processing of a medical rehabilitation application for a child with severe disabilities. The Ombudsman considered it important that in the future, Kela takes the increase in the amount of work resulting from the tendering process into account in advance and prepares for it, so that it will not affect the processing times of applications or the client's legal protection, as has happened in the cases under review. According to the Ombudsman, work resulting from tendering is not in itself a valid justification for the processing of an application to considerably exceed the set target date.

In the case 1904/2019, the social security appeal board neglected hearing a person with a disability as an interested party in the processing of a vocational rehabilitation matter. The Ombudsman considered it worrying that the procedure he considered wrong had been an established practice.

Early childhood education and teaching

In case 2720/2019, a child with severe disabilities was in a vulnerable position and had not received a place for early childhood education and care in the time and manner as required by the Act on Early Childhood Education and Care. In his overall assessment, the Deputy-Ombudsman decided to issue a reprimand to the local authority because it had neglected its duty to make a decision in the matter and because it had not taken action to examine the individual needs of the child as provisioned in the Act on Early Childhood Education and Care. The conduct of the local authority could have seriously jeopardised the individual rights of the child in question. Due to the passivity of the local authority, the complainant's possibility to have their case heard before a court of law has been significantly delayed.

Cases 4230/2019, 1586/2019 and 2221/2020 involved shortcomings in decision-making concerning special support and assistance services.

Reasonable adjustments to the matriculation examination

In case 2356/2019, the Deputy-Ombudsman's substitute proposed that the Matriculation Examination Board should improve their guidelines further so that the range of measures of reasonable accommodation is not unnecessarily limited in advance. The grading of test performances could pay special attention to the inadequacy of the arrangements for reasonable accommodation. The consideration of factors that weaken test performance in the assessment of the test should also be extended to other situations than only when a candidate is failing a test.

The Matriculation Examination Board announced that at its general meeting on 11 December 2020, it amended the regulations and instructions concerning extenuating circumstances in the test performance. Changes and clarifications have been made to the regulations based on the decision.

Health care

According to Article 25 of the UN Convention on the Rights of Persons with Disabilities, persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. The contracting parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. The contracting parties have agreed to provide persons with disabilities with the same range, quality and standard of health care as other persons.

In decision 101/2020, the Deputy-Ombudsman considers that the use of milk cartons as drink containers for isolated patients in psychiatric hospitals should be abandoned, because procedures that can be perceived as disparaging towards patients must be avoided particularly in involuntary care. Milk cartons have been used because they are regarded as safe water containers. According to the report, the use of rinsed milk cartons had been

taken under scrutiny in the ward, and more pleasant but still safe alternatives were being sought (1601/2020).

In the same decision, the Deputy-Ombudsman considered that a decision to restrict the telephone use of a patient placed in isolation should be made appealable, at least when the restriction takes place on the initiative of the staff. The Deputy-Ombudsman is of the opinion that patients placed in isolation are not in a position for their consent to be regarded as genuinely voluntary. As acknowledged in a statement submitted by the hospital, the procedure had been incorrect.

In case 285/2020, there were shortcomings in the provision of care for a resident with intellectual disability living in Rinnekoti between Helsinki University Hospital HUS and the City of Espoo. The client was forced to make an excessive number of visits to the city healthcare centre and Jorvi Hospital due to the lack of clarity regarding medication. The Ombudsman agreed with Valvira that, in terms of the condition in question, it would have been appropriate to arrange the client's care by one operating unit, the Espoo Hospital at Home. The Ombudsman noted that the joint municipal authority of the hospital district is obliged to plan and develop specialised medical care in cooperation with the municipality responsible for primary health care so that the primary health care and specialised medical care form a functional entity. The Ombudsman drew HUS's attention to the provisions of the Health Care Act on cooperation between specialised medical care and primary health care.

In the same decision, the Ombudsman agreed with Valvira that it would be a good idea for a social worker to meet the client at least once a year and to check whether the services received by the client correspond to their care and service plan. In this case, the Ombudsman estimated that the social worker of the disability services in the City of Helsinki had not met the client in person frequently enough.

In decision 2816/2019, the substitute for the Deputy-Ombudsman gave a reprimand to the psychiatry branch of HUS for future notice concerning an unlawful procedure, because a decision on restricting the contact between the complainant and the patient had not been drafted or communicated in accordance with the Mental Health Act.

In another case, 373/2019, the Deputy-Ombudsman also gave a reprimand to the hospital district on the grounds that the decision to take over the complainant's child's possessions had not been communicated in any way in accordance with the law. The hospital's conduct had jeopardised the possibility of the child's guardians to submit the matter for judicial review. Therefore the failure to notify was a serious mistake, particularly given that a decision to take over the possessions is not a temporary one, such as restrictions on contacts.

In decision 2295/2019 relating to the complaint of Inclusion Finland KVTL, the Deputy-Ombudsman considered it necessary that the Ministry of Social Affairs and Health reviews its instructions before publishing the next update of its guide (National criteria for the handing over of assistive devices for medical rehabilitation). According to the Deputy-Ombudsman, greater individual consideration should be used in the guide in the section that categorically prohibits the handing over of two-person tandem bikes and quadricycles for the purposes of medical rehabilitation.

Decisions regarding the accessibility of polling stations

At the beginning of the year, the Ombudsman issued decisions on four investigations on his own initiative 3332/2019, 3333/2019, 3334/2019 and 3335/2019, which concerned shortcomings detected at the polling stations of the Elections to the European Parliament observed during inspections carried out on the election day. The Ombudsman was pleased to note the fact that the cities of Somero and Riihimäki and the municipalities of Tammela and Loppi reported that they would

Stairs leading to the polling stations for the European Elections in Tammela (left) and Loppi (right).

take corrective measures and engage in other development activities as a result of the inspection observations. Due to the corrective measures announced by the municipalities and cities, the Ombudsman's own initiatives did not lead to any other measures in terms of oversight of legality carried out by the Ombudsman. The only exception was that the Ombudsman drew the attention of the Central Election Board and the municipal or city executive to problems arising from issues identified in the inspection minutes concerning accessibility and election secrecy.

In his decision on complaint 2615/2019, the Ombudsman drew the attention of the City of Tampere and its Central Election Board to the accessibility of advance polling stations, as the heavy old doors of the Central Office Building caused an accessibility problem. The Ombudsman was pleased to note that the City of Tampere had taken measures to improve the accessibility of the Central Office Building.

A polling station equipped with privacy screens at the municipal government office in Jokioinen during the European Elections.

3.5 National Preventive Mechanism against Torture

3.5.1 THE OMBUDSMAN'S TASK AS A NATIONAL PREVENTIVE MECHANISM

On 7 November 2014, the Parliamentary Ombudsman was designated as the Finnish National Preventive Mechanism (NPM) under the Optional Protocol of the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). The Human Rights Centre (HRC) at the Office of the Parliamentary Ombudsman, and its Human Rights delegation, fulfil the requirements laid down for the National Preventive Mechanism in the Optional Protocol, which refers to the 'Paris Principles'.

The NPM is responsible for conducting inspection visits to places where persons are or may be deprived of their liberty. The scope of application of the OPCAT has been intentionally made as broad as possible. It includes places like detention units for foreigners, psychiatric hospitals, residential schools, child welfare institutions and, under certain conditions, care homes and residential units for the elderly and persons with intellectual disabilities. The scope covers thousands of facilities in total. In practice, the NPM makes visits to, for example, care homes for elderly people with memory disorders, with the objective of preventing the poor treatment of the elderly and violations of their right to self-determination.

The OPCAT emphasises the NPM's mandate to prevent torture and other prohibited treatment by means of regular inspection visits. The NPM has the power to make recommendations to the authorities with the aim of improving the treatment and the conditions of the persons deprived of their liberty and preventing actions that are prohibited under the Convention against Torture. It must also have the power to submit proposals and observations concerning existing or draft legislation.

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

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

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

Participation in the visits and the other tasks of the Ombudsman, especially the handling of complaints, are mutually supportive activities. The information obtained and experience gained during visits can be utilised in the handling of complaints, and vice versa. For this reason, too, it is important that those members of the Office's personnel whose area of responsibility covers facilities within the scope of the OPCAT also participate in the tasks of the NPM. In practice, this means the majority of the Office's legal advisers, nearly 30 people.

The OPCAT requires the States Parties to make available the necessary resources for the functioning of the NPM. The Government proposal concerning the adoption of the OPCAT (HE 182/2012 vp) notes that in the interest of effective performance of obligations under the OPCAT, the personnel resources at the Office of the Parliamentary Ombudsman should be increased.

The Office of the Parliamentary Ombudsman's operating and financial plan for 2019–2022 states that allowances should be made for increasing the human resources in the NPM's area of responsibility during the planning period. In the budget proposals for 2018 or 2019, however, the Parliamentary Ombudsman did not propose an appropriation for the new posts. This was largely due to the savings targets set by the Office Commission. In 2019, several cases of negligence were identified in service units for the elderly. The Parliament granted additional funding for the Office of the Parliamentary Ombudsman for 2019 to step up the supervision of the rights of the elderly. In 2019, new instances of neglect were identified, and closures of service units were carried out. The Office of the Parliamentary Ombudsman was granted additional funding for 2020 to establish new posts. Three of the new posts concentrate on the supervision of the rights of the elderly, which also contributes to the resourcing the NPM, as most of the inspection visits to elderly care units are carried out under the NPM mandate.

3.5.2 OPERATING MODEL

The tasks of the National Preventive Mechanism have been organised without setting up a separate NPM unit in the Office of the Parliamentary Ombudsman. To improve coordination within the NPM, the Ombudsman has assigned one legal adviser exclusively to the role of coordinator. At the beginning of 2018, the role of principal legal adviser and full-time coordinator for the NPM was assumed by Principal Legal Adviser *Iisa Suhonen*. She is supported by Principal Legal Adviser *Jari Pirjola* and Senior Legal Adviser *Pia Wirta*, who coordinate the NPM's activities alongside their other duties, as of 1 January 2018 and until further notice.

The Ombudsman has also appointed an OPCAT team within the Office. Its members are the principal legal advisers working in areas of responsibility that involve visits to places referred to in the OPCAT. The team has ten members and is led by the head coordinator of the NPM.

The NPM has provided induction training for external experts regarding the related visits. The NPM currently has 12 external health-care specialists available from the fields of psychiatry, youth psychiatry, geriatric psychiatry, forensic psychiatry, geriatrics, and intellectual disability medicine. A further three external experts represent the Sub-Committee on the Rights of Persons with Disabilities operating under the Human Rights Delegation at the Human Rights Centre. Their joint expertise will benefit visits carried out at units where the rights of persons with disabilities may be restricted. In addition, the NPM has trained five experts by experience to support this work. Three of them have experience of closed social welfare institutions for children and adolescents, while the expertise of the other two is used in health-care inspection visits.

3.5.3 INFORMATION ACTIVITIES

A brochure on the NPM activities has been published, and it is currently available in Finnish, Swedish, English, Estonian, and Russian.

The reports on the inspection visits conducted by the NPM have been published on the Parliamentary Ombudsman's external website since the beginning of 2018. The NPM has enhanced its communications on inspection visits and related matters in social media.

3.5.4 TRAINING

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

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

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

3.5.5 NORDIC AND INTERNATIONAL COOPERATION

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

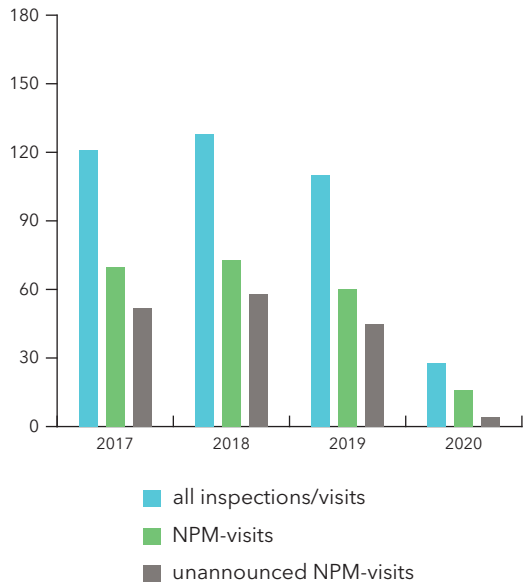
The NPM's report on the year 2019 was submitted for information to the UN Subcommittee on Prevention of Torture (SPT).

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

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

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

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



Visits in 2017–2020.

3.5.6 VISITS

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

Now that fewer visits are being made, there is an opportunity to look back and reflect on the effectiveness of the NPM's duties during the period 2015–2020, i.e. when the Parliamentary Ombudsman has acted as the NPM. In the following sections, themes that the NPM has to draw attention to year after year are presented from each administrative branch, as well as more uncommon themes that play an important role in the treatment of persons deprived of their liberty. Measures taken at the institutions visited or at the national level after the NPM's visits and the Ombudsman's recommendations are also brought up.

3.5.7 POLICE DETENTION FACILITIES

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

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

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

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

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

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

Prevention of deaths in police custody

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

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

Detention of remand prisoners in a police prison

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

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

Keeping criminal investigation and detention duties separate

It has been noted on nearly each visit to police detention facilities that criminal investigators participated in many ways in duties that fall under the remit of the detaining authorities. The Ombudsman has requested that the investigation of a criminal case and the detention of a person deprived of their liberty be kept strictly separate.

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

Legal protection of persons deprived of their liberty

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

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

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

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

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

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

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

Cells and their equipment and furnishing

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

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

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

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

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

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

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

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

Outdoor exercise

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

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

It can be concluded from the police departments' reports to the Ombudsman that even though reasonably extensive renovation is carried out on police prisons, the possibilities to change the basic solutions in existing buildings are fairly limited. It is not possible for police departments to have much say about the size or structures of outdoor exercise facilities. However, they have reacted to the Ombudsman's recommendations to improve the level of cleanliness in police prisons and the level of cleanliness has been improved.

Catering

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

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

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

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

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

Health care in police detention facilities

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

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

The CPT has also in the preliminary comments on its visit in autumn 2020 considered the absence of health-care staff problematic with respect to remand prisoners, who were still not systematically and routinely medically screened upon arrival. This has not been observed even in the few establishments where health-care professionals deliver care on a regular basis. Neither did the National Police Board in the circular mentioned above provide guidance to organise medical screening. However, the situation will improve in at least one police department. After the NPM visit, the police department notified that it had begun discussions on the possibility of the city's sobering-up station operating adjacent to the central police station to provide everyone detained for more than 24 hours with the opportunity to meet a health-care professional (1201/2019).

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

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

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

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

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

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

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

The role of Senate Properties as the lessor of detention facilities

Senate Properties serves as the lessor of government agency facilities. This also applies to police detention facilities, prisons, state residential schools and state forensic psychiatry clinics. It is regularly brought to the attention of the Ombudsman and the NPM during site visits that addressing any deficiencies at the leased premises is not possible without a contribution from Senate Properties. An example of this is the case investigated by the Ombudsman on his own initiative (5680/2018). According to the statement the operating in temporary facilities was challenging and caused by factors that the Central Finland Police Department could not influence through its own actions. The National Police Board had repeatedly demanded that Senate Properties carry out repair measures in the so-called module prisons. It was not possible for the National Police Board to carry out repair measures itself.

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

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

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

Oversight of oversight

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

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

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

- In February 2019, the National Police Board issued a plan according to which an audit of the current condition and suitability of detention facilities for detaining persons deprived of their liberty was begun. The aim was to issue an approval decision on the fitness for use of all detention facilities by the end of 2020.
- In November 2019, the National Police Board issued guidelines on the approval of detention facilities for persons in police custody, which entered into force on 1 January 2020. The guidelines refer to the Ombudsman's and the CPT's statements on the treatment of persons in detention, which had to be taken into account when approving facilities.
- Police departments have inspected police detention facilities based on the National Police Board guidelines. These inspections have revealed deficiencies regarding the right to privacy and lighting in cells, and access to verbal communication channels for persons deprived of their liberty. Evacuation safety has also been given attention. In addition, a representative of the National Police Board has conducted an inspection of the premises, which has identified, among other things, the need to update the rules of police prisons. The detention facilities have been approved by the National Police Board. Some conditions have been set for the approval of the premises. The decisions of approval have been forwarded to the Ombudsman.

3.5.8 DEFENCE FORCES AND BORDER GUARD AND CUSTOMS

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

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

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

3.5.9 THE CRIMINAL SANCTIONS FIELD

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

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

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

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

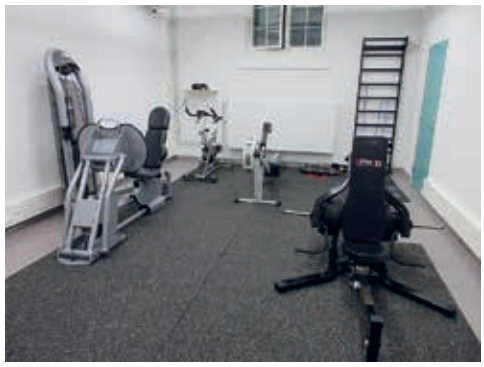
The Legal Affairs Committee of the Parliament submitted a statement on the Parliamentary Ombudsman's 2019 Annual Report to the Constitutional Law Committee (LaVL 1/2021 vp). In the statement, it brought up the Ombudsman's observations of problems related to the placement of organised criminal groups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

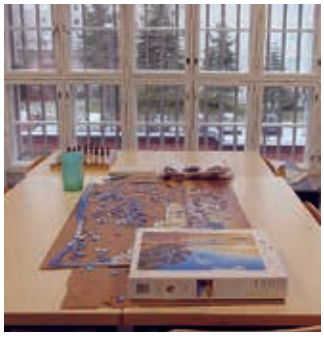
The following are some of the themes that have been highlighted on the NPM's visits in the criminal sanctions field between 2015 and 2020. This time, the perspective is what kind of impacts the observations and recommendations made on the visits have had on the operation of the prisons, the rights and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

Time outside the cell and constructive activities

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

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







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

Placement of remand prisoners

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

- In the case of four remand prisoners, the communications restrictions imposed by the court were so strict that the only option left to the prison was to place them on an isolation ward separately from the other prisoners. According to the prison, the pre-trial investigation would otherwise have been risked and the other prisoners would have had less time outside their cells. Although on the isolation ward, the remand prisoners had the opportunity to take outdoor exercise and use the gym, as well as a limited opportunity to cook (1185/2016).
- After the NPM visit, the prison set up two wards for remand prisoners. In spite of this, some remand prisoners had to be placed separately from others to enforce the communications restrictions. Efforts have been made to shorten the time remand prisoners are placed in segregation and segregation will be discontinued as soon as the prisoner's communications restrictions are decreased (3628/2016).

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

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

Female remand prisoners

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

- The Ministry of Justice reported that the Decree on Prisons Serving as Remand Prisons was amended on 1 July 2017 by discontinuing the use of Kuopio prison as a remand prison for women because of the observations made by the Deputy-Ombudsman after the NPM visit (4988/2015).
- The Regional Centre of the Criminal Sanctions Region of Western Finland reported that the number of places for females in Vaasa prison was changed from three to two. In addition, no female prisoners will in future be placed there, nor will decisions be made to transfer female remand prisoners to Vaasa prison. The Regional Centre had also made an initiative on discontinuing the use of Vaasa prison as a remand prison for women (2705/2017).
- The Central Administration Unit of the Criminal Sanctions Agency stated that placing persons in facilities such as those in Vaasa prison was unsustainable and female remand prisoners were not in an equal position compared to male remand prisoners. However, the matter had to be assessed from the national point of view, and not only from the perspective of only one prison. As a measure, the Central Administration Unit proposed specifying the definition of prison places so that remand prisoner places and female remand prisoner places could be added to the definition in the future (2705/2017).
- The Ministry of Justice did not consider it justified to amend the Decree on Prisons Serving as Remand Prisons. The Ministry stated that places for female remand prisoners will have to be centralised to some extent to bring the conditions to an appropriate level. The Ministry specified definition of prison places proposed by the Central Administration Unit could be considered a more justified way to influence the situation. The Ministry considered the Ombudsman's views, which demanded immediate measures to rectify the presented procedure violating law and humane treatment, very serious (2705/2017).

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

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

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

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

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

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

A cramped double cell for female prisoners.

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

Underage prisoners

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

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

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

- According to the guideline issued by the Criminal Sanctions Agency, a lack of facilities does not give the right to ignore a person's minority. According to the Deputy-Ombudsman's understanding, in practice, prisons very rarely have suitable facilities or the number of prisoners does not make it possible to reserve separate facilities for minors. How have prisons been thought to be able to comply with the guideline and independently solve the problem that suitable facilities are not available?
- Has the point of view of sufficient/enhanced supervision of underage prisoners been taken into account in the resourcing of prison staff and in shift planning?
- Has a house arrest or an enhanced travel ban been imposed to minors instead of remand imprisonment?

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

Foreign prisoners

The proportion of foreign prisoners has in the past few years increased and is 15–20% of all prisoners. Year after year, the same problem areas concerning foreign prisoners are repeatedly identified by the Ombudsman during his visits. It would appear that while some arrangements may have been made by prisons through the provision of written material and interpretation services to better communicate with foreign prisoners, these options are not fully utilised. It has been established during visits that foreign prisoners appear to have no or only sporadic access to essential information. The following section presents reports that prisons have submitted to the Deputy-Ombudsman on measures taken to improve the conditions and treatment of foreign prisoners.

Prison libraries have varying selections of books in foreign languages.

Information on rights and obligations. The possibility of foreign prisoners to obtain information on their rights and responsibilities and prison practices has been improved by having the prisoners' induction guides and the prison rules translated at least into English (3628/2016, 4397/2016, 3005/2017, 2339/2018, 4652/2018, 4653/2018). Some prisons have paid special attention to the induction of new foreign prisoners:

- The prison launched a project to create a model for arriving at the prison. One part of the model is an induction in which attention is separately paid to foreign prisoners. This includes a familiarisation form in different languages and the use of interpretation services. A guidebook for new prisoners will be updated as part of the project and a version in Arabic will also be produced. Information on Skype meetings will be added to the induction guide (5563/2018).
- The prison uses a familiarisation form, which is completed with arriving prisoners. The form is also available in Swedish, English and Russian. A personal officer that the prisoner can primarily turn to in their daily matters has been appointed to each prisoner. The prison has appointed a senior instructor whose job description specifically consists of working with foreign prisoners and developing the activities and communication targeted at foreign prisoners (2449/2019).

The Criminal Sanctions Agency has made an induction guide video for new prisoners to be used in prisons. The video is available in Finnish, Albanian, Arabic, Polish, Latvian and Turkish. In addition, the lawyers of the criminal sanction regions have during 2019 ensured that English translations of the Imprisonment Act and the Remand Imprisonment Act are available in the statute folders of the institutions in their territories.

Using an interpreter. On the visits, the prison has sometimes been requested to report how much money it has used for interpretation services over a certain period of time. The Deputy-Ombudsman has observed a need to increase the use of interpretation services in almost all the prisons he has visited. Prisons have indeed reported an increase in their use of interpretation services. After the NPM visit, one prison has increased the possibility for special personnel to use telephone interpretation and the Deputy-Ombudsman proposed on the follow-up visit that the same should also be possible for guarding staff (3005/2017). Technology has also been helpful. Prisons have begun to use a service in which a telephone connection can be used to reach interpretation services swiftly in several languages. The service enables contacting the interpretation service with a low threshold (6206/2017).

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

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

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

The Deputy-Ombudsman decided to investigate on his own initiative the opportunities of foreign prisoners to follow TV programmes (757/2019). In his decision of 16 January 2020, the Deputy-Ombudsman asked the Central Administration Unit of the Criminal Sanctions Agency to investigate how easy it is for foreign prisoners to access international TV programmes in different prisons. He also asked the Central Administration Unit to find suitable ways for prisons to subscribe to foreign TV channels as soon as possible. The Deputy-Ombudsman asked the Central Administration Unit to report the measures taken by prisons. He also noted that he will pay attention to the access of foreign prisoners to foreign-language TV programmes on his future visits.

Conditions in isolation

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

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

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

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

Under the Imprisonment Act, the cell must have an alarm device through which it is possible to contact prison staff immediately. Different versions of the alarm button location have been detected on the NPM visits. In some observation cells, the alarm button has been placed outside the cell and all prisoners cannot necessarily reach it (4653/2018). To use the alarm button of the isolation cell, the person placed in the cell may have had to go down on their knees and further on their abdomen to reach it (3005/2017, 2338/2018, 2449/2019). The Deputy-Ombudsman considered this humiliating from the point of view of the person deprived of their liberty and was of the view that it may put the life of the person in danger if the person has a fit of illness. The Deputy-Ombudsman has required that the location of the button be changed.

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

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

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

Right to privacy

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

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

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

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

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

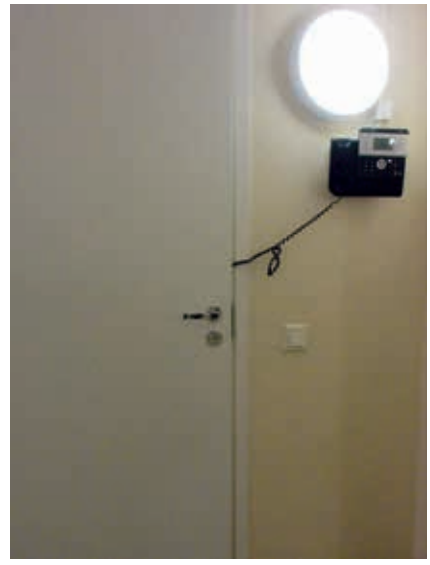
Taking a urine sample. The Deputy-Ombudsman has investigated on his own initiative how taking a urine sample is supervised in prisons. On the NPM visits, it had been discovered that there were considerable differences in the procedures between different prisons. Moreover, the instructions provided on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

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





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

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

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

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

Transport of prisoners

Transport by a prisoner transport vehicle. Restraining the prisoner during transport is possible only after consideration on a case-by-case basis. Despite this, prisoners have systematically been restrained for the duration of transport from Vantaa prison to court. The Ombudsman has stated that the procedure is unlawful. A decision was finally reached in the matter when the prison acquired two prisoner transport vehicles, in which the prisoners are divided into compartments of their own separately from the other prisoners and the staff. According to the information received on the NPM visit, after the new transport fleet was obtained, there has no longer been a need to restrain the prisoners during transports to court (6206/2017).

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

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

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

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

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

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

On the follow-up visit (4575/2019), it was established that bottled water was now available to prisoners. The prisoners were also informed of the possibility to use the toilet and a non-smoking space. Prisoners interviewed during the visit confirmed they were aware of these facilities. However, the prisoners were not aware of the call buttons that can be used to contact a prison officer and to flush the toilet. The level of cleanliness of the cells had not improved. Communication with the private cleaning service provider was also found to be a problem. As a positive improvement, the mattresses in the cells had been replaced by new ones. In addition, the windows of prisoner carriage had been fitted with heat and light-reflecting films. According to the staff, these helped lower the temperature in the prisoner carriage. Significant changes had been made in food provision. Prisoners were given a hot meal for dinner if they had missed a meal because of the transport.

After the Deputy-Ombudsman's statements on the follow-up visit, the Criminal Sanctions Agency reported that VR would attach a pictogram (a drawing) to inform all users that tap water in the toilets is not suitable for drinking. The guard call button and the toilet flush button would be marked with pictograms indicating their purpose. The Criminal Sanctions Agency considered it particularly important that the standard of cleaning be improved and any deficiencies in the quality of the service be addressed without delay. VR has reported that it will step up the quality control of the cleaning and give prison officers in prisoner carriage contact details for the cleaning service provider to give any immediate feedback on the standard of cleanliness.

Atmosphere in the prison / treatment of prisoners

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

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

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

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

- The prison reported that it would launch various projects concerning the treatment of prisoners and the relations between prisoners and staff in accordance with its action and development plan. The prison would also introduce a prisoner feedback system (4397/2016).
- A follow-up visit was made to the prison, during which the overall picture of the institution seemed to be positively different from the previous visit. The relationships between the prisoners and the staff appeared to be appropriate and natural. It seemed that the measures taken by the prison had significantly contributed to how the prisoners felt they were treated. For example, the prison had given up the practices that clearly deviated from those of other prisons, were not based on law and were also partly in conflict with the legal provisions. In addition, prisoners' opportunities to stay in contact with their loved ones outside prison had improved. The nature of the prison had generally changed and was clearly more open than before. The most important change was a very significant increase in the time the cells were kept open (3005/2017).

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

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

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

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

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

In discussions with representatives of the staff and special personnel, concerns were brought up about prisoners capable of working and without links to organised crime who preferred to live in closed wards instead of wards from which inmates went to work. On the other hand, prisoners with links to organised criminal groups had been placed on these so-called workmen's wards. Discussions with prisoners revealed the problems related to placement on wards. A number of prisoners had requested to serve their sentence in the closed ward for fear of threats and pressure. Families had also been intimidated. Prisoners did not apply for unsupervised family visits and prison leaves for fear of pressure from other prisoners.

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

Oversight of oversight

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

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

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

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

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

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

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

3.5.10 PRISONER HEALTH CARE

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

Human resources

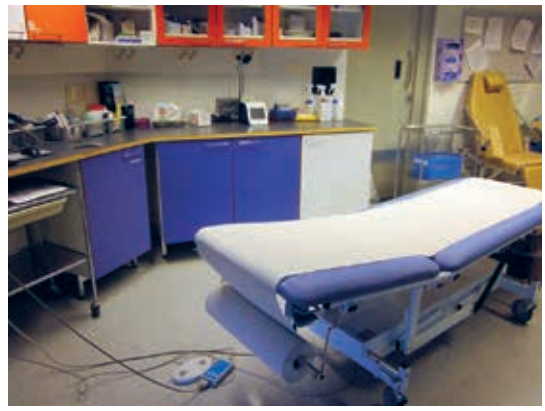
The Ombudsman has considered it particularly problematic that at most VTH's outpatient clinics, no health-care personnel is present in the evenings or at weekends. This affects the timetable for conducting the routine medical screening on the arrival of new prisoners and examining the health of a prisoner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

Medical screening on arrival

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

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

In May 2018, VTH issued a guideline on interviewing prisoners on their arrival. It instructs the person interviewing to record all possible external signs of an assault. The patient is therefore asked to undress at the appointment. Especially any injuries to the head should be paid attention to. However, no separate item on this has been included in the actual form for the interview on arrival.



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

Notification of appointment

Prisoners frequently criticise the fact that they do not receive replies to the messages they send to the outpatient clinic, or that access to a doctor is difficult. The Ombudsman has frequently drawn the outpatient clinics' attention to the fact that, according to the Act on the Status and Rights of Patients, the time of their appointment must be communicated to patients, if it is known. The Patient Act does not distinguish between prisoners and other patients in this regard. However, it is necessary to take certain security considerations into account, particularly for appointments outside the prison, and these can have an impact on the level of detail disclosed to specific prisoners about the times of their appointments.

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

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

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

Monitoring the health of prisoners placed in segregation

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

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

Taking into account self-destructive behaviour during prisoner transport

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

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

3.5.11 Detention units for foreigners

Under section 121 of the Aliens Act, an asylum seeker may be held in detention for reasons such as establishing their identity or enforcing a decision on removing them from the country. There are two detention units for foreigners in Finland (in Helsinki and Joutseno), both of which are currently units under the Finnish Immigration Service (Migri).

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

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

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

Informing detained persons of their rights

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

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

Medical screening on arrival

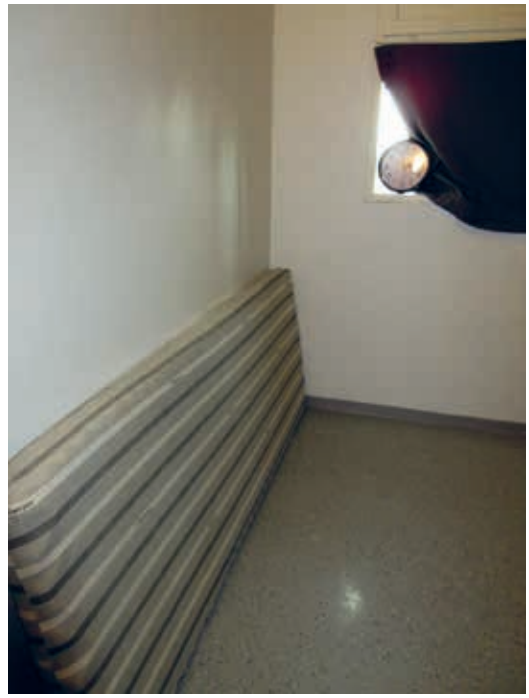
On visits to both detention units, it has been observed that there was no systematic medical screening of newly arrived detainees on their arrival. Instead, the arriving detainee may have filled in a health interview form, on the basis of which their need for health care has been assessed. However, the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

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

Health assessment after a failed attempt at removal from the country

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

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



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

Conditions in isolation

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

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

Privacy in the shower facility in isolation

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

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

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

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

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

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

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

Monitoring the health of a detainee placed in segregation

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

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

Identification of self-destructive behaviour and prevention of suicides

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

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

Reporting on mistreatment

The Helsinki detention unit had no system or guidelines in place indicating how and to whom the detainees or staff could report any mistreatment observed. The Ombudsman noted that the detention unit should operate an effective complaint system that both the detainees and the staff would be aware of, and that would enable the filing of complaints to both an external remedial body (such as the Parliamentary Ombudsman) or internally (such as to the director of the unit). Under international recommendations, the complaints procedure must be accessible, transparent, and sufficiently advertised. In addition to this, all complaints and actions arising from them must be documented (6841/2019).

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

3.5.12 CHILD WELFARE FACILITIES

The visits made to child welfare facilities over the past few years have been proven to have a far-reaching impact. The observations made during the visits have also led to an urgent amendment to the Child Welfare Act. For example, systematic measures will be required in the future to help reduce the use of restrictions to a minimum. Each child welfare institution will be required to present a plan for the good treatment of children as part of their self-monitoring plan. It is also required to involve and engage the children placed in the institution in the creation of the plan. If restrictive measures are used, they must be discussed with the child in a mandatory debriefing. A child's care and education plan drawn up by

the institution must include measures agreed by the social worker and the child on how the use of restrictive measures could be avoided. The amendments entered into force on 1 January 2020.

Following visits by the NPM, many child welfare institutions have reviewed their practices and rules as recommended in the visit reports. Observations made during these visits have gained wide publicity. At the same time, the awareness of children placed in institutions of their rights has improved. This shows in the substantial increase in the number of complaints filed by the children. Although institutions usually correct their practices after the visit to fit the recommendations of the Deputy-Ombudsman, the implementation of these changes would require follow-up monitoring, which the NPM does not always have the opportunity to do. For this reason, the Deputy-Ombudsman has occasionally asked the competent Regional State Administrative Agency (AVI) to monitor the institution's operations by conducting a follow-up visit to the institution, for example (such as in 5916/2018).

The parliamentary Audit Committee has issued a statement to the Constitutional Law Committee on the Parliamentary Ombudsman's 2019 report. The committee has expressed its opinion that the division of the supervision of child welfare services between different actors and the complex regulation of the matter impede effective guidance and supervision activities and increase the risk that supervision is neglected. The committee has also considered the resources for supervision of child welfare services to be insufficient. As a result, supervision is mainly reactive and based on reports of shortcomings and complaints. According to experts, proactive supervision would be more effective and efficient. The committee has stressed that adequate resources must be secured for child welfare and its supervision, and that children within the scope of child welfare services should be better informed of their rights and their personal social worker. Children's participation in child welfare supervision should also be increased. According to the committee, the self-monitoring of operating units should be developed further, but it should not replace the supervision carried out by the authorities. The committee also expressed its concern over the COVID-19 pandemic's impact on the supervision of child welfare services.

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

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

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

Child treatment and educational culture at the institution

Some visited institutions were identified to have an educational culture that is based on the strong restriction of children. According to the Deputy-Ombudsman, neither the rules and practices of the institutions nor their application supported and promoted such high-quality care, education,

and rehabilitation that would serve to prepare the placed children for the kind of daily life that can be considered normal in today's society.

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

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

with both the personnel and children. A plan for good treatment has been drawn up together with the children (5930/2019).
- The institution's rules have been drawn up together with the student body. In the future, attention will be paid to their regular processing and updating, also with new children (883/2020).

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

Child's right to meet their social worker

Based on the inspection findings, the child's right to meet their social worker confidentially does not come true often enough. Some children did not know who their personal social worker was or they did not have the contact details. The children have said that social workers visit the unit, but do not necessarily talk to the children in private. The children also lacked a clear picture of their personal social worker's tasks and that they could turn to them in a conflict situation. The children's stories have given the impression that not nearly everyone have had a confidential relationship with their personal social worker. The child may also have lost their trust in the worker's opportunity or willingness to investigate any shortcomings that the child has mentioned.
- The institution found it very regrettable that a child might be under the impression that the institution's aim was to make interaction between children and social workers more difficult. After the NPM visit, the personnel have been instructed to ensure that child's right to have a confidential discussion with their social worker is realised. They will also ensure that the child's introductory folder contains the contact details of the responsible social worker (1353/2018).
- After the NPM visit, the unit has made sure that each young person has the contact details of their personal social worker and that they can always contact them by letter, personal phone or the unit's telephone (4099/2018).

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

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

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

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

- The readiness of social workers for monitoring and hearing children has been increased. In addition, the joint authority's supervision plan has been updated and the joint authority has increased the supervision of units located in its area and the supervision of foster families (Oulunkaari joint authority).
- The placed children have had meetings at the substitute care provider without the presence of institution's personnel. The NPM visit report, the institution's comments on the children's experiences and the Deputy-Ombudsman's recommendations on measures to fix the shortcomings have been reviewed with the child. There have also been discussions on the shortcomings that arose during the visit and the child's current experiences of daily life at the child welfare unit. During the meetings, the children talked about situations that they had recently experienced as shortcomings. After the meeting, the experiences were forwarded to the head of the institution (Tornio Social Office).
- The responsible social workers have met the children and explained the contents and significance of the NPM visit report for the children (City of Vantaa).
- Special attention has been paid to the private meetings of children in substitute care and the up-to-datedness of customer plans as well as the use of restrictive measures. However, according to the joint authority, there are many children whose care is challenging. This poses challenges to finding substitute care facilities and is reflected in the child welfare institutions as an increase in the number of restrictive decisions. Today, child welfare services need more services for children provided by special units of child welfare institutions (Kainuu Social and Health Care Joint Authority, which no longer had children placed in institution when the report was given).

Child's right to self-determination

The Deputy-Ombudsman has emphasised that children placed in institutional or foster care have the right to decide on their own appearance and clothing. Piercings, clothing, and matters such as dyeing your own hair are an essential element of a person's self-expression. The rules of an institution concerning the appearance of the child interfere with the child's right to freely determine their own body and appearance. The rules may not restrict a child's right to self-determination any more than is necessary. Situations must be evaluated on a case-by-case basis with each individual. The place of substitute care may offer the child support and guidance through discussion and may help the child choose their outfits taking into consideration the event they may be attending, the weather conditions, and their health.

- The institution announced that the children's choice of clothing, piercings, personal appearance, and self-determination will no longer be intervened in. Previously, these aspects were

intervened in if they supported or maintained symptomatic behaviours. In the future, the use of hair dyes and piercings will not be restricted (5377/2018).
- According to the institution, children have the right to decide on their appearance and clothing. In the past, the institution had intervened mainly if the child wore clothes that were too revealing. These matters are still discussed with the children. In the future, they will focus on how these discussions are held and to the fact that these matters are discussed with the personal instructor (5930/2019).

Girls were not allowed to decide for themselves which hygiene products they would use on their menstrual period whilst at the institution. The Deputy-Ombudsman considered that this rule was an example of the extent to which the institution exercised control over the children's personal lives. The institution's practices on menstrual protection severely restricted the rights of a girl to make decisions concerning her own body and privacy. The practice was demeaning for girls.
- The institution will no longer interfere with the residents' personal privacy and does not dictate which type of period protection the girls are allowed to use. To the contrary, the personnel encourage, advice, and give guidance on personal hygiene (5377/2018).
- After the visit, the institution decided to give each child a hygiene allowance so that they can buy the hygiene products they want. The institution also has various hygiene supplies available in the office (5930/2019).

Restrictive measures and educational boundaries are different

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

It is challenging to distinguish between the aforementioned matters in child welfare. The NPM visits have revealed that institutions often justify measures by educational reasons, whilst in the Deputy-Ombudsman's opinion, they are actually restrictive measures that require a justification under the Child Welfare Act and for which a decision must be made. In the NPM visit reports the Deputy-Ombudsman has reviewed this distinction and expressed her views on what falls under education and what not. For example, instructing a child to go their room without locking the door and having the child stay in their room on the basis of an oral request alone can be considered generally acceptable as an educational matter. On the other hand, it may be the case of isolation as mentioned in the act if the child is prevented from leaving their room and the child has to stay there against their will for a long time without the child behaving as defined by the isolation provision.
- The institution stated that in addition to internal induction, the employees have received training on restrictive measures organised by a third party (1353/2018).
- Employees have received training on restrictive measures in accordance with the Child Welfare Act. The training focused on the issues raised in the NPM visit report. The training also included an exam that ensured that the employees learned and understood the information they received on the training (4099/2018).

Restriction decisions and recording them

It has been repeatedly necessary to remind institutions of the provisions of the Child Welfare Act when making decisions on restrictive measures. The Deputy-Ombudsman has drawn the serious attention of the institutions to, for example, the fact that a restrictive measure must always be based on a separate decision, for which the pro-

visions of the law are reflected on a case-by-case basis. The institution must ensure that these conditions are met in the case of each restrictive measure employed. The requirement is especially relevant now that the aim of avoiding the use of restrictive measures is enshrined in law.

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

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

Restricting the freedom of movement

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

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

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

movement, children are not isolated, but have the opportunity to go to school, outdoors and practise hobbies with an instructor depending on their condition (5930/2019)
- Following the NPM visit, the practices for restricting the freedom of movement were changed at the institution. The child may move around the institution's premises and leave the area if they have no decision on restricting the freedom of movement issued under the Child Welfare Act (883/2020).

Restricting communication and preventing social relations

Institutions restrict children's communication with other people in different ways, such as by limiting visits to the institution, cancelling the child's holidays or restricting the use of a phone. The last one is probably the most common restriction on communication. The NPM visits revealed phone practices in which the time to make and receive calls was very limited. A child might have also been allowed to have only one phone call in a day, with limited call length. These practices actually restrict, or at least reduce, the children's right to communicate.
- After the NPM visit, the institution made a change to the children's phone usage practices. As a rule, the children have access to their phones. During the night, the phones are kept in the unit's office to ensure that the young persons have sufficient sleep. Even then, the children can use the unit's phone. According to the instructions, phones can also be removed for educational reasons in order to have peace when eating and when doing something together, for example (1353/2018).
- At the follow-up visit following the joint inspection visit of the NPM and the Regional State Administrative Agency (5916/2018), AVI stated that the unit had restricted the use of a phone during school and night also for children placed in open-care. AVI instructed the institution to follow the Deputy-Ombudsman's instructions for taking possession of a phone. A phone cannot be confiscated at night and during school only for the sake of certainty. Nor can the rules of the institution prohibit a child from taking a phone with them to outdoor activities, for example. AVI stated that a child's use of a phone during the school day can only be restricted on the basis of the Basic Education Act, even if the teaching takes place in the premises of the substitute care unit. In this case, the power to decide lies with the school alone.
- The institution announced that it would pay attention to phone practices in the future. At the same time, it proposed that a common set of guidelines be drawn up for the state residential schools concerning the use of a phone (883/2020).

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

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

free to interact with each other. Maintaining social relationships is supported by allowing children the use of their phone. Social relationships are no longer restricted or supervised in daily life without appropriate restriction decisions. Normal conversation is allowed during mealtimes and children can freely choose where they sit at the table (5377/2018).

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

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

Bodily search

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

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

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

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

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

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

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

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

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

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

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

Isolation

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

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

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

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

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

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

Toilet facilities for a child placed in isolation.

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

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

Debriefing of restrictive measures

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

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

Oversight of oversight

The NPM's visits have paid more and more attention to the effectiveness of the work carried out by the supervisory authorities that are primarily responsible for monitoring child welfare institutions. There are cases where the monitoring efforts fall far short of satisfactory. The visit reports may also have requested the local Regional State Administrative Agency, as the authorising authority, to ascertain that the institution complies with the licence under which it operates. For example, does the institution genuinely employ personnel as specified in its licence, or does the children's extensive demand for various services call for a re-evaluation of the licensing decision or the licensing criteria (5377/2018).

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

The NPM visited a youth home (5930/2019) that had several complaints. In her decisions, the Deputy-Ombudsman considered that municipalities had neglected the supervision of substitute care for children. She also stated that the social worker responsible must assess the practices and rules of the institution and intervene if they restrict the rights of the child in an unlawful manner. Three decisions issued a reprimand to the municipality on its failure to comply with the supervisory obligation. In her three other decisions the Deputy-Ombudsman drew the municipalities' serious attention to the proper performance of their statutory tasks (4566/2018, 5679/2018, 5682/2018, 5683/2018, 5685/2018 and 3662/2019).
- NPM visit carried out at a youth home revealed that young people were still restricted based on the rules drawn up by the institution itself without the individual consideration of the young person's situation as required by the Child Welfare Act.
- The Deputy-Ombudsman required that every social worker responsible for a child and who

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

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

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

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

3.5.13 SOCIAL WELFARE UNITS FOR OLDER PEOPLE

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

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

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

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

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

Mistreatment and obligation to report

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

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

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

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

Based on one visit, it may be difficult to make observations on mistreatment. However, when serious shortcomings are found in the basic care and treatment of residents, it can be assumed that actual mistreatment might occur in the unit. For one care unit, the Deputy-Ombudsman stated that the quality of care and treatment did not safeguard a dignified life as required by the Constitution. Some residents were afraid of the personnel and some employees were afraid of the unit management. The management was informed of at least some of the activities, but the measures taken to improve the situation were insufficient. The Deputy-Ombudsman drew serious attention to the way in which the shortcomings were dealt with in the work community. The Deputy-Ombudsman required that the unit immediately take measures to prevent the mistreatment from continuing and to ensure the flow of information so that similar events would no longer be possible (6032/2019).

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

Adequacy of personnel

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

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

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

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

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

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

- The joint authority reported that there was a shortage of trained nursing staff in its area. The joint authority had an agreement with two vocational education institutions in the region on a training package for nursing assistants, the first of which was to start in both institutions already in spring 2020. Attention will also be paid to the nature of social services. The personnel structure will be changed to recruit Bachelors of Social Services, geriatric nurses or other professionals with a similar qualification (3015/2019).
- The joint authority announced that they have introduced a modern technology system, motion sensors and surveillance cameras to support the night time resources. Residents' rooms have electric locks that can always be opened from the inside. In the event of a fire, all locks will open. If a fire breaks out, the entire unit's personnel will be alarmed as well as the fire brigade, guard and supervisor. The residents' rooms are fire safe, so leaving the room is not always the best option. Instead, the residents should wait for help in the room with the door closed. There are also motion sensors that can be placed on different sides of the floor or a resident's room. If the resident moves around the floor or in the room, the nurses' phones will receive an alert. Floor-specific security cameras are also used (4743/2019).

Right to privacy

The protection of privacy is a fundamental right, and care for elderly people is no exception. The aim is that every older person in long-term care should have their own room, including sanitary facilities. When residents unknown to one another are placed in the same room in long-term care, this should be based on the persons' own free will. In twin rooms, attention should also be paid to respecting privacy, especially in the delivery of personal care.

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

Some of the rooms at a care facility had doors with a narrow glass window allowing a view into the room. The members of staff reported that the windows were difficult to cover. They also found it convenient that they could monitor the well-being of the residents without waking them up by opening the door. The Deputy-Ombudsman re-

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

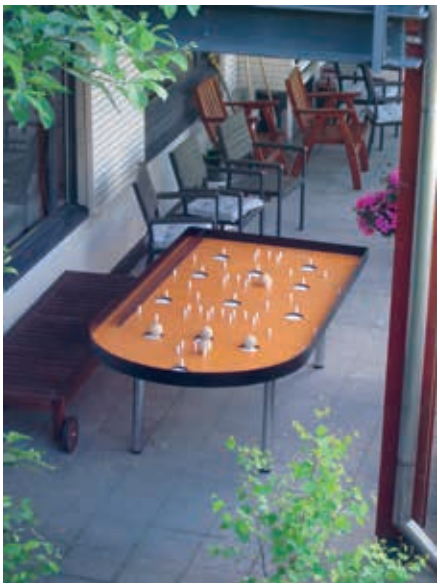
Outdoor activities and recording them

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

- The group home informed, that it will pay particular attention to the fact that the activities carried out with the help of other professional groups and actors (summer youth, students, assistants and family members) will also be recorded. At least one employee will also go out with the residents every day to ensure adequate outdoor activities (3290/2018).
- In the future, outdoor activities will be recorded in a separate form and in the electronic customer information system. Residents confined to a bed will also be taken out when the weather allows it (3016/2019).
- After the NPM visit, the unit's instructions for recording were specified. Outdoor activities will be recorded as part of the resident's care plan, and their implementation will be monitored with daily recording. The resident's refusal will also be recorded. Supervisors monitor the implementation of outdoor activities regularly. Work shifts are planned so that the units will have enough personnel for organising outdoor activities especially in the afternoon during shift change (3763/2019).
- The Deputy-Ombudsman was informed that the unit has a residents' outdoor list. Willingness to go outside is part of the resident's right to self-determination, which should be respected. It is also important to take into account the weather conditions prevailing locally (Lapland), especially in winter. A plan for organising continuous outdoor activities is recorded in the resident's care and service plan. Shift planning allows time for the personnel to take residents outside (5023/2019).
- The Deputy-Ombudsman was informed that the unit has ensured that every resident can get out if they wish. Outdoor activities and refusals of outdoor activities are included in the list. The outdoor activities are carried out by their own personnel (6032/2019).

Oral health

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



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

idents' state of health. The Deputy-Ombudsman has found it important to ensure on arrival that a new resident has a recent dental care plan in place and that the personnel are aware of what steps to take to follow that plan. Maintaining oral health also requires that the nursing staff have a general understanding of how oral health is maintained and how various oral diseases can be prevented. The Deputy-Ombudsman has therefore recommended that the personnel be provided with oral health training.

Some units have shortcomings in the regular cleaning of residents' teeth. The Deputy-Ombudsman has noted that regular tooth brushing prevents many oral conditions and is beneficial for overall health and well-being. For patients with memory disorders, oral pain can cause anxiety and restlessness, and can make it difficult to eat. The unit should make sure that regular tooth brushing is not neglected. If brushing has to be skipped during a shift, it must be recorded so that the matter can be rectified later.

After the NPM visits, the nursing units have started implementing the Deputy-Ombudsman's recommendations, although the dental care for older persons with severe memory disorders has also been considered challenging:

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

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

whose previous oral examination was a long time ago are referred to the municipal dentist's or the resident's own dentist's appointment. The dentist draws up a care plan for the resident, which the nursing staff will add to the resident's care plan. The nursing staff assume the further care of the resident in accordance with the care plan (4210/2017).
- It was agreed with the joint authority's senior dentist that an oral hygienist will make a free first visit to the residents of the nursing unit from now on. The oral hygienist will also train the nurses in oral care (6198/2017).
- The municipality announced that new residents will be referred to oral care as they arrive. The dental assistant will visit the resident to make an oral care plan. Internal training is organised at the unit through dental care services (3016/2019).
- The unit will add care for oral health in the care plan for when the resident arrives. The oral hygienist will also visit the unit once a year for a check-up. The unit will also organise oral health training for personnel in accordance with the Deputy-Ombudsman's recommendation (5880/2019).

Nourishment

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

A low number of personnel in a nursing unit may have an impact on the residents' meals and eating. The NPM team discussed with the personnel whether the evening snack could be served later to prevent the overnight fast from becoming too long. The unit stated that there were so many residents to feed that delaying the evening snack would mean that it could last until midnight. The unit did not consider it possible to extend the evening work shift (3016/2019).
- The joint authority announced that the nourishment of the nursing unit's residents is monitored with different indicators. If the state of nourishment raises concerns, a mini nutritional assessment will be conducted. The duration of the residents' overnight fasting is monitored and a separate snack is served when needed (3015/2019).

Every other resident in the housing unit was found to have a weight index of 24 or below, which may indicate problems related to nourishment. The Deputy-Ombudsman required that the unit ensure adequate food supply for residents and address any signs of malnutrition immediately.
- According to the municipality's report, the nutritional condition of the nursing unit's residents is monitored and a nutrition therapist is consulted when necessary. Dietary supplements and food enrichment are used if a resident is in a state of malnutrition or needs it for health reasons. The unit has supplies for night-time snacks for residents (3016/2019).

Palliative treatment and end-of-life care

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

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

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

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

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

The Deputy-Ombudsman has stated that end-of-life care requires acknowledgement in personnel allocation. This is the only way to ensure humane treatment of a person in end-of-life care. The processes for obtaining/asking additional personnel in end-of-life care situations should also be reviewed with the personnel. The unit should ensure that appropriate end-of-life care is also arranged at night.

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

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

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

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

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

- The report of the city that purchased the nursing service stated that the unit's personnel must have the professional skills, competence and motivation required for carrying out the tasks. This also applies to competence in end-of-life care. The service provider must ensure additional and further training for personnel. The service provider organises training for the personnel, and the city organises further training if necessary. In the visited nursing home, end-of-life care training is organised for nursing staff (3367/2018).
- The city announced that end-of-life care training is currently organised in cooperation with the university of applied sciences. The self-monitoring plan is updated, fixing the shortcomings in end-of-life care (3016/2019).
- The unit announced that instructions on end-of-life care will be added to its self-monitoring plan. In January 2021, the unit appointed a person in charge of end-of-life care whose task is to ensure the unit's competence in this matter. The unit will organise end-of-life care training for the personnel. The Deputy-Ombudsman has received the unit's end-of-life care plan (5880/2019).

Restriction of the right of self-determination

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

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

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

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

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

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

The way many elderly care units feel about locking the door of a resident's room speaks for the need for training (such as 2217/2018 and 2009/2019). The Deputy-Ombudsman has stressed that security is not in itself sufficient reason to restrict a person's fundamental rights. Each restriction of a fundamental right must meet all criteria for restrictions, such as the requirements of necessity and proportionality.

When weighing various options, the goal is to ensure that a person receives appropriate care and

is not subject to abandonment. If a situation arises in which a person is in immediate danger, it is possible to intervene in the situation based on self-defence or emergency. However, these are only relevant in an acute situation. They cannot be referred to as a justification for locking doors. However, this is not always understood. They may have told the Deputy-Ombudsman that locking rooms is an extreme means of ensuring the safety of residents without mentioning whether other less restrictive means were considered or tried (2217/2018). The Deputy-Ombudsman has also drawn attention to the fact that even if the resident's door is locked only from the outside, the resident does not always have a genuine possibility of getting out of their room if they do not know how to use the door button or cannot find it (4743/2019).

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

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

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

Reduction of restrictions

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

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

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

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

Self-monitoring

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

- The unit announced that each new employee will go through the self-monitoring plan and thus learn to use it in their practical work. The themes of the nursing director's regular discussion events on good care also rise from the self-monitoring plan. In this way, the unit reviews instructions and rules that are central to self-monitoring and maintains discussion on important topics (3763/2019).
- The municipality announced that the self-monitoring plan was revised in late spring of 2020 to correspond to the National Supervisory Authority for Welfare and Health' (Valvira) regulation and instructions. After the exceptional circumstances return to normal, the self-monitoring plan will be updated together with the personnel and a responsible employee/employees will be selected from the personnel (5023/2019).

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

Oversight of oversight

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

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

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

Sometimes the Deputy-Ombudsman is required to take further measures to ensure that the elderly care unit is properly functioning and supervised. An example of this is NPM visit carried out in September 2019, in which the Deputy-Ombudsman drew attention to the fact that the elderly care unit for older people had been under enhanced supervision since 2017 and that there were still reports of shortcomings. The Deputy-Ombudsman found it extremely concerning that the authorities had not required improvements immediately. The effectiveness of supervision may have been affected by the extensive workload of the supervisory bodies, insufficient resourcing, and inadequate time reserved for reflecting on practices.

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

3.5.14 RESIDENTIAL UNITS FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

On visits to units providing institutional care and residential services for persons with disabilities, special attention is paid to the use of restrictive measures and the relevant documentation, decision-making, and appeals procedures. These must be carried out in accordance with the provisions of the Act on Special Care for the Persons with Intellectual Disabilities, which entered into force on 10 June 2016.

With the ratification of the UN Convention on the Rights of Persons with Disabilities (10 June 2016), the Parliamentary Ombudsman became part of the mechanism referred to in Article 33(2) of the Convention designated to promote, protect, and monitor the implementation of the rights of persons with disabilities. This special task of the Ombudsman is discussed further in section 3.4 (Rights of persons with disabilities). In addition, the monitoring of the rights of persons with disabilities during the COVID-19 pandemic is discussed in section 4 (Issues related to coronavirus).

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

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

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

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

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

Human resources

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

With regard to the private sector operator, the Ombudsman has emphasised that the number of staff must be at least equal to that required in the licence and the Act on Private Social Services. Challenges in recruitment do not justify deviation from the minimum staffing as based on the unit's operating licence. The Ombudsman was also concerned about the long shifts of some nursing staff members, which may have a detrimental impact on their capacity and the delivery of care to the residents.
- After the NPM visit, the service provider reported that the situation concerning the shortage of personnel had been fixed (1683/2019). Regardless of the notification, the Ombudsman requested that the licensing and supervisory authorities monitor the adequacy of staffing by the service provider and the personnel allocation, within their respective spheres of jurisdiction.

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

The Ombudsman reminded the units that a student working temporarily as a social welfare or healthcare professional is subject to regulations concerning professionals, so they may also be subject to sanctions for incorrect procedures.
- The rehabilitation unit announced that only apprenticeship students in training who have been hired by the organisation will be included in the unit's strength in the future. Apprenticeship students do not participate in the use of restrictive measures (7007/2017).

Identifying restrictive measures

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

The NPM team was informed that no "actual" restrictive measures were used in the unit, but raised bedrails were sometimes used for reasons of safety. In many cases, the resident's consent could be obtained for the purpose. The visit also revealed that the lobby doors of certain group homes were locked. This effectively limited the basic right to personal freedom of residents who did not get out of the unit upon request or with their own key (3351/2018).

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

The Ombudsman has stated that monitoring movement with technical devices requires a decision in writing that can be appealed (2008/2019). The NPM visit also revealed that the freedom of movement of all children in the unit was restricted outside the unit for safety reasons. According to the personnel, all the children placed in the home needed adult support and/or supervision when moving outside. However, none of the children had been subject to appealable decisions on monitored movement in accordance with the Act on Special Care for Persons with Intellectual Disabilities. According to the personnel, the supervised movement of children had been discussed with the local authorities responsible for the cost of the children's accommodation, but the authorities had not required any decisions to be made. The local authorities had not paid attention to the issue during their own monitoring visits. The freedom of movement of children who could not be subjected to restrictions under the Act of Special Care for Persons with Intellectual Disabilities was nonetheless restricted (1684/2019). The Ombudsman started investigating the matter separately (2757/2019, pending).

Decision-making in restrictive measures

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

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

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

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

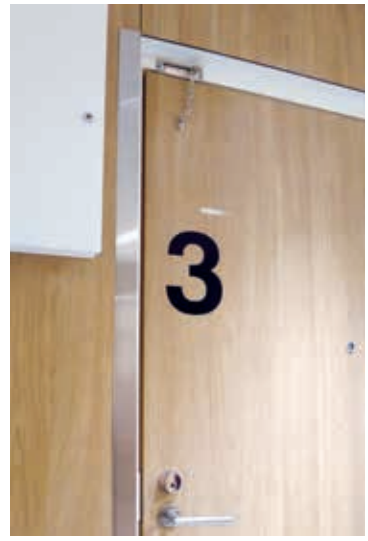
During the NPM visits, attention has also been paid to shortcomings in the restrictive decisions, such as scarce justifications, lack of instructions for appeals or a mention of which authority made the decision.

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

Various restrictive measures and instruments observed during visits

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

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



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

Sometimes units have to restrict the rights of all residents due to the behaviour of one challenging resident. The Ombudsman has recommended that the undesirable behaviour of one resident be addressed in other ways than by keeping the bathroom door locked for all residents (4362/2015). The Ombudsman has also noted that when a person is placed under supervised movement, it is important to ensure that the freedom of movement of other persons is not restricted at the same time (2008/2019).

Safety belt and wrist cuffs. It was discovered during a visit that a safety belt and wrist cuffs were used to control a resident's compulsive movements and to prevent them from disturbing the PEG feeding tube button. It had been taken into consideration in the decision passed by the authority that the restrictive equipment would not restrict the voluntary movement of limbs and body parts to more than a minor degree, and they would be used for as a short a period of time as possible (3375/2018). The Ombudsman decided to take the issue of safety belts and wrist cuffs and the related documentation practices under investigation on his own initiative (902/2020, pending).

Wrapping a resident in a rug. A resident at a care unit was prevented from harming themselves and others by being wrapped in a soft rug, leaving their head free. The Ombudsman found the procedure problematic. It prevented the individual from moving and was similar to restraining. According to the Act on Special Care for the Persons with Intellectual Disabilities, restrictive equipment or clothing may be used in highly dangerous situations only. A person can be restrained only if no other method proves sufficient.

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

Caged bed. The institution for persons with intellectual disabilities used metal caged beds that had a roof. Similar beds had not previously been detected during visits by the Ombudsman or the NPM. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has stated that the use of caged beds can be regarded as violating human dignity and must be stopped immediately.

Mat used as a restrictive measure.

The Ombudsman urged them to stop using caged beds and to find alternative solutions instead. The legality of restrictive measures used in the care of persons with intellectual disabilities can be referred to a court for evaluation. The court will make the final decision on whether the restrictive measure or piece of equipment can be considered legal in each specific case. The Ombudsman also emphasised that restrictive equipment must comply with the requirements of the act on health care devices and equipment. These include hospital beds with siderails.

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

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

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

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

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

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

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

The NPM visit revealed that the use of the security room had decreased significantly in the unit since 2016. The reduction was found to be linked to changes in the Act on Special Care for the Persons with Intellectual Disabilities. The aim of the rehabilitation unit was to address challenging situations without having to resort to the security room. If isolation is required, it has usually been dismantled within 1–2 hours. Efforts have been made to promote this by making consultation visits to different units and increasing resources proactively for crisis situations (7007/2017).

3.5.15 PSYCHIATRIC UNITS

Reporting on mistreatment

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

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

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

have locked feedback boxes and an electronic feedback system for the entire city, which can be used to provide anonymous feedback on a patient's poor treatment, for example (1046/2016).
- The joint authority's development and patient safety unit will begin planning the reporting procedure at the group's level and will strive to find a technical solution to it. Before this, the psychiatric units have agreed for now that matters related to poor treatment should be reported to the patient ombudsman (5338/2017).
- The hospital had a statement prepared already in 2010, which shows that poor treatment is not accepted and also provides a brief instruction for what to do if you notice poor treatment. Following the NPM visit, more in-depth guidelines were drawn up and published on the hospital's website (3712/2018).

Information distributed to patients and their families

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

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

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

Right to privacy

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

The Deputy-Ombudsman has also recommended that a secluded patient's visit to a toilet is supervised only when this is necessary and the patient is aware of the supervision. The situation must not become a humiliating experience for the patient.
- According to the joint authority, the surveillance footage can be blurred over the toilet seat. They should also ensure that the patient

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

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

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

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

Transporting patients outside the hospital

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

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

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

Restrictive measures

Restriction instructions. Under the Mental Health Act, a hospital that provides psychiatric care should have written and adequately detailed instructions on how restrictions of the patient's right to self-determination are implemented. In many cases, the unit reviews the instructions on restrictions already during the NPM visit, and the unit announces that it will correct the shortcomings identified already at that time. For example, the instructions have not always clearly stated that the condition of a restrained or minor patient must be continuously monitored so that the nursing staff has continuous visual and hearing contact with the patient. This obligation cannot be fulfilled by camera surveillance alone. Camera surveillance in general cannot replace personal interaction between the patient and the nursing staff. The instructions on restrictions should also note how often a physician should assess a restrained patient.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The conditions in isolation facilities vary greatly between units.

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

– The joint authority announced that the psychiatric departments will take action to bring the facilities for seclusion to an appropriate level. After the NPM visit, a two-way speech connection had been added to all seclusion rooms. The aim was to have armour-glass on the doors of all seclusion rooms that allow a large visual connection from the seclusion to the interspace, improving interaction with the nurses. The floor coatings will also be softened. The next year's budget will have an appropriation for the renewal of toilet facilities. A high mattress, cubic table and armchair will be acquired for each seclusion room (5338/2017).
– The joint authority announced that the renovation of the seclusion rooms had begun. The wall surfaces were painted, and the sharp

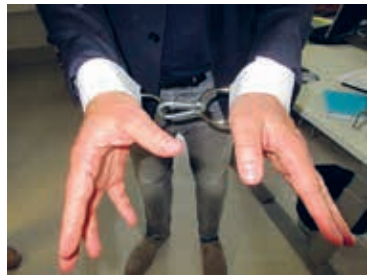
chutes were removed. New, soft furniture that withstand secretion had been ordered. Coating was installed in the window of one seclusion room's door to protect privacy. A bell system had also been acquired for the rooms. A separate table on wheels was ordered for meals so that the patient does not have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

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

The Ombudsman considered it possible that this would lead to a lower threshold to restraint a patient. The examination of patient documents also gave the impression that the unit's threshold for mechanical restraining was low (727/2018). Restraining can also be a humiliating experience for the patient. The NPM visit revealed that patients could be transported outside the seclusion room in mechanical restraints. The Ombudsman considered that this procedure had to be avoided, especially if the patient was moving in the common premises of the ward (727/2018).

A typical limb restraint bed on an adult psychiatric ward.

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



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

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

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

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

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

Legal remedies of a secluded patient

A patient cannot appeal an isolation decision made by a physician. Instead, they can complain to the Regional State Administrative Agency, Valvira or the Ombudsman about the situation. However, examining individual conditions in seclusion in a written complaint procedure has proved difficult, which is problematic for the patient's legal protection. For this reason, the Deputy-Ombudsman has emphasised in the NPM visit reports the statement the Constitutional Law Committee made in the parliamentary hearing regarding the provisions on seclusion and restraining. In this statement, the committee considers it possible that the prolongation of the seclusion or restraining of a patient may become a legal matter concerning their rights, which the patient may refer directly to a court under the Constitution (PeVL 34/2001 vp).

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

Debriefing after restrictive measures

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

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

Reporting events that seriously endanger patient safety

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

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

Reducing the use of coercive measures

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

- The joint authority announced that a monitoring procedure for restrictions will be devised for the psychiatric wards. Once basic information on restrictions has been obtained, a programme for reducing the use of coercive measures and related objectives will be drawn up. Teaching the objectives to the personnel is part of this programme (5338/2017).
- The joint authority announced that personnel had been instructed to document any alternative means used to resolve a situation before the restriction or seclusion. A separate programme is planned for reducing the use of coercive measures and monitoring the use of restrictive measures (727/2018).
- The joint authority announced that the plan to reduce the use of coercive measures was drawn up in accordance with the Ombudsman's recommendations (1600/2018).

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

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

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

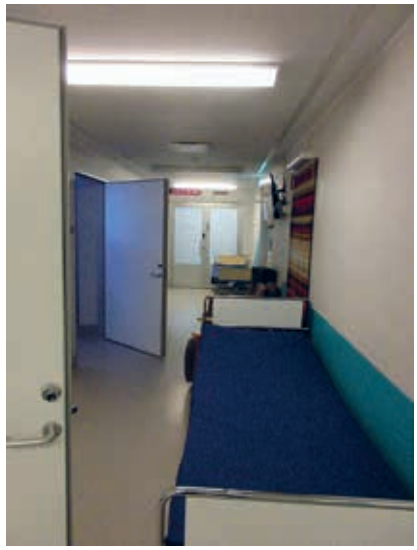
with a clear risk of suicide. Based on the restriction lists, 100% supervision has been successful in reducing the use of seclusion (2150/2017).

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

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

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

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



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

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

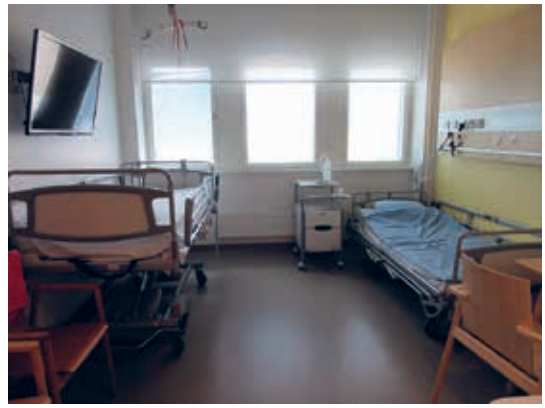
3.5.16 VISITS TO GERIATRIC PSYCHIATRY

Right to privacy

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

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

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



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

The Deputy-Ombudsman has also recommended that patients are always offered the opportunity to discuss their situation with a physician in private if they share a room with other patients.

- After the NPM visit, a separate calm space was introduced for rooms that have several patients, in which the patient and their relatives can discuss matters related to treatment and rehabilitation in peace (2458/2019).
- According to the joint authority, physicians have two fully accessible offices on the ward that can be used. The patients are offered the opportunity to see the physician in private (3264/2019).

The NPM visits have also focused on camera surveillance in the psychiatric units for older people. Camera surveillance in patient rooms always interferes with the patient's privacy. However, there is no specific legislation on camera surveillance in patient rooms yet. The Deputy-Ombudsman has emphasised that camera surveillance should not be used for the observation of patients unless absolutely necessary. Understaffing is not an adequate basis for camera surveillance. The patient and their relatives should be informed about camera surveillance and the possibility of supervision (1706/2019 and 2458/2019).

- The city announced that camera surveillance is relied on only in extreme cases to ensure the

safe treatment of a patient, and the patient and their relatives would always be informed about its use. Camera surveillance is discontinued as soon as it stops being in the patient's best interest (2458/2019).

Identifying restrictions

In the absence of applicable law, it is vital that care facilities provide sufficiently detailed guidance on the application of restrictive measures. The guidance should include a complete list of all restrictive measures in order to achieve a common understanding among the staff on the concept of restricting a patient's fundamental rights. The guidelines should also indicate the grounds for the use of restrictive measures, decision-making, monitoring and dismantling of restrictions.

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

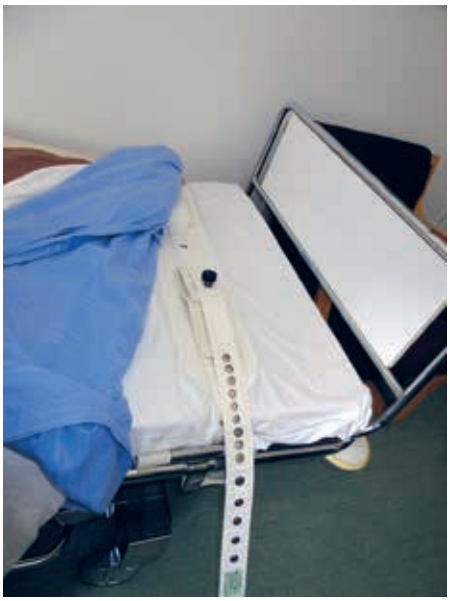
Use of restrictive measures in geriatric psychiatry

In principle, the Deputy-Ombudsman has considered it problematic that the psychiatric hospital uses restrictive measures in geriatric psychiatry that are not based on the Mental Health Act. On the other hand, the Mental Health Act does not take into account the safety equipment used in the care for older people, the use of which may be justified. One of the most common restrictions used in geriatric psychiatry is **the magnetic belt**. The Ombudsman has stated that safety equipment such as a magnetic belt are usually used to restrict or prevent the patient from moving. The units often interpret the use of a magnetic belt as restricting freedom of movement, not restraining. These patients are often not in involuntary treatment and therefore cannot be subject to the provisions of the Mental Health Act on the restriction of the patient's fundamental rights.

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

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

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



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

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

The 100% supervision, or special observation, has also become increasingly more common in geriatric psychiatry. The Deputy-Ombudsman has welcomed this if it prevents the use of other, more intrusive restrictions. On the other hand, the NPM visit has revealed that the patient under special observation may have been tied to their bed if a nurse has had to leave. The Deputy-Ombudsman has found it problematic that the practice was for a patient to be restrained "to be safe" for the period the nurse had to leave the patient. Moreover, understaffing is never an acceptable justification for restraining a patient.

Some units also use **hygiene overalls** (overalls that the patient cannot remove themselves), which is not always recorded as a restriction. However, the Ombudsman has considered that it is restrictive clothing that interferes with the patient's right to self-determination and the use of which must be regulated by law. The Ombudsman has recommended that ending the use of the hygiene overalls should be seriously considered if their use is already minor. Instead, alternative methods should be explored. If the unit uses the 100% supervision method, it could be an alternative to using the hygiene overalls.

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

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

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

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

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

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

Monitoring and reducing the use of restrictions

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

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

Use of security guards

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

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

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

3.6 Shortcomings in implementation of fundamental and human rights

The Ombudsman's observations and comments in conjunction with oversight of legality often give rise to proposals and expressions of opinion to authorities as to how they could promote or improve the implementation of fundamental and human rights in their actions. In most cases, these proposals and expressions of opinion have had an influence on official actions, but measures on the part of the Ombudsman have not always achieved the desired improvement. The way in which certain shortcomings repeatedly manifest themselves shows that the public authorities' reaction to problems highlighted in the implementation of fundamental and human rights has not always been adequate.

Since 2009, following a recommendation by the Constitutional Law Committee (PeVM 10/2009 vp), the Ombudsman's Annual Report has included a section outlining observations of certain typical or persistent shortcomings in the implementation of fundamental and human rights. As per the request of the Constitutional Law Committee, (PeVM 13/2010 vp) this section has become a permanent feature of the Ombudsman's Annual Report.

Since 2013, this section has been presented as a list of ten critical problems identified in the implementation of fundamental and human rights in Finland. The list was first presented in 2013 by the Ombudsman at an expert seminar on the evaluation of Finland's first national action plan on fundamental and human rights, and was thereby integrally linked to the implementation of the action plan. As the same ten problems consistently appear on the list each year, a revised list has been published in subsequent years describing potential changes and progress made in each area.

When evaluating the list, it is important to note that it includes typical or ongoing problems that have been identified specifically through the observations compiled by the Ombudsman under his remit. The Ombudsman mainly obtains information on failures and shortcomings through complaints, inspection visits and his/her own initiatives. However, not all fundamental and human rights problems are revealed by the Ombudsman's actions.

The Ombudsman's oversight of legality is primarily based on complaints, which typically concern individual cases. Broader phenomena (such as racism and hate speech) do not clearly come up in the Ombudsman's activities. What is more, some matters that reflect shortcomings are directed towards other supervisory authorities, such as special ombudsmen (including the Non-Discrimination Ombudsman). Because some problems rarely surface in the Ombudsman's activities, they have not been included on the list (such as the rights of the Sámi people).

Some problems relating to fundamental and human rights which are clearly identified in other contexts may be absent from the list, if they have not been encountered in the Ombudsman's work. And some problems may be absent from the list because they are at least in some respects related to the private sector or the actions of private individuals to the extent that they do not come under the Ombudsman's oversight.

For the above reasons, the list cannot provide an exhaustive picture of the various problems relating to fundamental and human rights in Finland.

There can be several reasons for possible defects or delays in redressing a legal situation. In general, it is fair to say that the Ombudsman's statements and proposals are complied with very well. There can be several reasons for possible defects or delays in redressing a legal situation. When this does not happen, the explanation is generally lack of resources or defects in legislation.

Delays in legislative measures also often appear to be due to insufficient resources for law drafting.

Some of the listed problems will probably never be entirely eliminated. This does not mean, however, that such problems should not be addressed through continuous effort. Most of the listed problems could be eliminated through sufficient resourcing and legislative development. In fact, significant improvements have been made with regard to some issues. On the other hand, some shortcomings have become more common.

3.6.1 TEN CENTRAL FUNDAMENTAL AND HUMAN RIGHTS PROBLEMS IN FINLAND

SHORTCOMINGS IN THE LIVING CONDITIONS AND TREATMENT OF THE ELDERLY

Tens of thousands of elderly customers in Finland live in institutional care and assisted living units. Shortcomings are continuously being identified in relation to nutrition, hygiene, change of adult nappies, rehabilitation and access to outdoor recreation. Shortcomings have also been identified in relation to the frequency of doctor's visits, medical treatment and dental care. Shortcomings are often due to insufficient personnel numbers or flawed management.

Measures limiting the right to self-determination in the treatment and care of the elderly should be based on law. However, the required legislative foundation is still entirely lacking. During the coronavirus epidemic, the provisions of the Communicable Diseases Act have been found to be insufficient, especially in connection with visiting bans. There have been observations of restrictive measures being used even in cases where the situation could have been addressed through other means with less severe impact on fundamental rights.

There are also shortcomings in terms of the adequacy and quality, safety, access to outdoors and support services for elderly people living at home.

Shortcomings are also evident in decision-making. Despite the increased need for services, the authority does not always make decisions on supplementing services provided at home or arranging care in an assisted living facility or elderly people's home. In terms of legal protection, the lack of an official decision on service provision is a problem, because it means that the scope of a local authority's service provision duty cannot be ascertained by the Administrative Court.

Supervision of service quality by local authorities is insufficient, and problems in private care homes can go on for long periods before any interventions. The guidelines issued by Regional State Administrative Agencies are not always followed, and issues sometimes take an unreasonably long time to rectify. Local authorities are not always able to provide substitute services, even in severe problem situations.

Self-monitoring and retrospective oversight of the adequacy and quality of services provided to customers at home is insufficient, and new supervisions methods are required.

Digitalisation of services may endanger the availability of services for elderly persons.

SHORTCOMINGS IN CHILD WELFARE SERVICES

The general lack of resources allocated by local government to child welfare services and, in particular, the poor availability of qualified social workers and the high turnover of employees impact negatively on the standard of child welfare services.

The supervision of foster care under child welfare services inadequate. Local child protection authorities do not visit foster care facilities frequently enough, and they are not sufficiently familiar with children's living conditions and treatment. The regional state administrative agencies do not have enough resources for inspections.

Supervision of family care by local authorities is inadequate. Regional state administrative agencies do not have sufficient powers to supervise foster care in private homes.

Repeated changes in foster care placements may compromise the stable conditions and relationships that are particularly important to children placed in care. Child welfare services do not have the correct types of foster care placements available for the children who have the worst standards of well-being and are the most difficult to treat. Child protection services are not able to provide the right kinds of placements for children who are especially distressed or challenging.

Moreover, children's right to access to information is not sufficiently observed. Children who have been placed in care are often unaware of their rights, the rights and obligations of the institution or the duties and responsibilities of their named social worker.

The right of children placed in institutional care to meet their social worker in person is not observed as provided under the Child Welfare Act. The children are often left without their social worker's support, which is guaranteed to them by law.

Restrictive measures are used in violation of the Child Welfare Act. They are used in circumstances or ways that the Act does not allow. Decisions on restrictive measures are not made as prescribed by the Child Welfare Act. Units providing foster care and local authorities' social workers who place children in care have deemed it possible to restrict a child's fundamental rights on educational grounds. There are competence gaps in identifying whether a restriction comes under normal, acceptable educational restrictions or whether it is a restriction of a child's fundamental rights within the meaning of the law, which is permitted only if the legal prerequisites are met and in accordance with lawful procedure.

The case plans include deficiencies, even though they have an important role in the arrangement of social welfare services, decision-making and enforcement of decisions. Case plans to support parenting are not always drawn up for parents whose children are placed in fosters care.

Substance abuse and mental health services for children and young people are inadequate. There are problems in joining up the service systems of child protection, child and adolescent psychiatry and substance abuse treatment. The service structure lacks suitable placements and services for children with severe behavioural disorders and need services which are not available at children's homes or psychiatric hospitals.

Shortcomings in the implementation of the rights of persons with disabilities

Equal opportunities with regard to participation are not being realized for persons with disabilities. There are shortcomings in the accessibility of premises and services, and the implementation of reasonable accommodation.

The policies for limiting the right to self-determination vary in institutional care While the amendment to the Act on Special Care for Persons with Intellectual Disabilities (381/2016) has helped to improve the situation, the practical application of the law is still marred by significant lack of awareness, and shortcomings and failures.

Statutory service plans and special care programmes are not always prepared, they are inadequate, or there are delays in their preparation. Decisions regarding services and the implementation of such decisions are often delayed without just cause.

Application practices regarding disability services are inconsistent between municipalities, and the adopted policies may prevent customers from accessing statutory services.

The competitive tendering of services for persons with disabilities may have jeopardized the rights to services for special individual needs.

Inspections ordered by the Parliamentary Ombudsman at polling stations used for advance voting and voting on the election day revealed that almost all polling stations had some deficiencies in terms of the accessibility of the voting premises themselves or the routes for accessing the premises. The inspections also revealed that the lack of accessible polling booths or facilities could jeopardize the election secrecy.

Restriction practices violating the right of self-determination in institutionalized care

Measures limiting the right to self-determination may lack legal grounds and be solely based on "institutional power", for example. Restrictive measures may be excessive or inconsistent. The supervision of policies limiting self-determination is insufficient, and the controllability of such measures is affected by shortcomings, particularly in cases where there are no procedural guarantees of protection under law.

The requisite legal basis is still completely lacking in such fields as care for the elderly and somatic health care.

Long processing times of alien affairs and the insecurity of undocumented immigrants

The Finnish Immigration Service is unable to meet the deadlines for processing asylum applications, residence permit applications based on family ties and residence permit applications based on employment as laid down in the Aliens Act. Certain new deadlines have further lengthened the processing times of old applications that were not subject to the new deadlines. The Parliamentary Ombudsman has issued numerous reprimands to the Finnish Immigration Service in relation to the unlawful delays in processing cases, but processing times have remained poor.

Shortcomings have been identified in meeting the basic needs such as health and social care services, of undocumented immigrants. A government bill was submitted to the Parliament in 2014 (HE 343/2014 vp) that would have improved the right to health services of certain groups among undocumented immigrants (including pregnant women and minors), but the bill lapsed. Municipalities have adopted different policies on what types of social and health services are still offered to persons who no longer have the right to reception services.

Flaws in the conditions and treatment of prisoners and remand prisoners

For many prisoners, lack of activity is a serious problem. The Council of Europe Committee for the Prevention of Torture (CPT) recommends that prisoners be allowed to spend at least eight hours per day outside their cells. In closed units, prisoners get to spend less than eight hours outside their cells in many cases. Some prison facilities have begun to pay more attention to increasing outside time and, in some cases, providing more activities, and the situation has improved in such facilities.

Often, when prisoners are placed in units, the legal principle of placing remand prisoners in separate locations from prisoners serving sentences is not observed. The principle of the law is that minors should not be housed in adult units. According to the available information, no units have yet been arranged for minors. During the report year, the Deputy-Ombudsman investigated on its own initiative the treatment of detained and incarcerated minors, and specifically the separation of minors and adults.

The CPT has criticized Finland for more than 20 years for its excessive detention of remand prisoners in police prisons. The Remand Imprisonment Act was amended by an act (103/2018) that entered into force on 1 January 2019 with the effect that remand prisoners must not be kept in a police detention facility for longer than seven days without an exceptionally weighty reason. According to the information obtained during the Parliamentary Ombudsman's inspections, the detention periods for remand prisoners in police prisons are now shorter. The act on treatment for detainees in police custody is currently under review.

SHORTCOMINGS IN THE AVAILABILITY OF HEALTH CARE SERVICES AND THE RELEVANT LEGISLATION

There are shortcomings in the provision of statutory health care services. For example, there are problems with the distribution of care supplies and the handing over of assistive devices for medical rehabilitation. For financial reasons, sufficient quantities of supplies and assistive devices are not always distributed.

There are shortcomings in health care provision for special groups such as prisoners.

Some emergency and care units have secure rooms, in which aggressive and intoxicated patients can be placed. There is no legislation governing the use of secure rooms. The grounds for and the duration of loss of liberty, the person making the decision, the decision-making process and the legal protection of patients should be provided for in legislation in compliance with the criteria for restricting fundamental rights.

The Mental Health Act includes no provisions on the use of coercive measures by care personnel to restrict a patient's freedom of movement outside a hospital area or to bring a patient to the hospital from outside the hospital area. Nor does the Mental Health Act include any provisions on patient transport to destinations aside from healthcare service units, such as courts of law, or on the treatment and conditions of the patient during transport or the competencies of the accompanying personnel. The lack of a legislative framework repeatedly results in situations that are problematic and potentially dangerous.

Private security guards may be used in psychiatric hospitals in duties for which the security guards are not authorised.

SHORTCOMINGS IN LEARNING ENVIRONMENTS AND DECISION-MAKING PROCESSES IN PRIMARY EDUCATION

The right of schoolchildren to a safe learning environment is not always observed. The means available for schools to identify and intervene with bullying are not always sufficient, and problems with indoor air are prevalent.

There are shortcomings that cause legal protection problems in the legal knowledge, administrative processes and decision-making of education providers and schools. For example, administrative decisions that are open to appeal are not always made, are not based on law or do not meet the requirements of the Administrative Procedure Act.

LONG PROCESSING TIMES IN LEGAL PROCESSES AND SHORTCOMINGS IN THE STRUCTURAL INDEPENDENCE OF COURTS

Delayed legal processes are a long-standing problem in Finland. This has been identified in both the national oversight of legality and in ECHR case law. Despite legislative reforms to improve the situation, court cases can still take an unreasonably long time. Cancellations of court sessions due to the coronavirus epidemic have brought further delays.

In criminal cases, the total duration of the process depends on the length of the pre-trial investigation, which may be exceptionally long in many complex cases, such as financial crimes. The number of exceptionally extensive cases has increased in recent years. It has become clear that the current criminal process and appeal system are not designed to handle such cases. The delays in processing criminal cases are also affected by the limited resourcing of the entire criminal process chain – the police, prosecutors and courts.

In practice, high trial costs and court fees can prevent due legal protection.

With respect to the structural independence of the courts, the fact that the court system is led by a ministry has been problematic. The legislation

on the National Courts Administration of Finland, which took effect on 1 January 2020, has improved the structural independence of the courts.

However, the large number of temporary judges and the fact that, in practice, local councils select jury members for District Courts on the basis on political quotas, remain problematic issues from the perspective of the independence of courts.

Shortcomings in the prevention and compensations of violations of fundamental and human rights

Awareness of fundamental and human rights can be lacking, and authorities do not always pay sufficient attention to their implementation and promotion. Education and training on fundamental and human rights are insufficient, even though there have been some positive developments.

The legislative foundation for the recompense for basic and human rights violations is inadequate. Substantive amendment of the Tort Liability Act (the liability of public officials in basic or human rights violations) has not been initiated.

3.6.2 EXAMPLES OF POSITIVE DEVELOPMENT

This section of Parliamentary Ombudsman's reports for 2009–2014 has usually contained examples of cases in different branches of administration where, as a result of a statement or proposal issued by the Ombudsman or otherwise, there has been favourable development with respect to fundamental or human rights. The examples have also described the impact of the Ombudsman's activities. The cases are no longer included in this section.

For the Ombudsman's recommendations concerning recompense for mistakes or violations and measures for the amicable settling of matters, see section 3.7. These proposals and measures have mostly led to positive outcomes.

3.7 The Ombudsman's proposals concerning recompense and matters that have led to an amicable solution

The Parliamentary Ombudsman Act empowers the Ombudsman to recommend to authorities that they correct an error or rectify a shortcoming. Making recompense for an error or a breach of a complainant's rights on the basis of a recommendation by the Ombudsman is one way of reaching an amicable settlement in a matter.

Over the years, the Ombudsman has made numerous recommendations regarding recompense. These proposals have in most cases led to a positive outcome. In its reports (PeVM 12/2010, 2/2016 and 2/2019 vp), the Constitutional Law Committee has also taken the view that a proposal by the Ombudsman to reach an agreed settlement and effect recompense is in clear cases a justifiable way of enabling citizens to enjoy their rights, bring about an amicable settlement and avoid unnecessary legal disputes. In the latter two reports, the Committee has considered it a positive development that the focus of the Parliamentary Ombudsman's tasks have shifted even more clearly from the oversight of authorities to promoting of people's rights. The grounds on which the Ombudsman recommends recompense are explained more extensively in the 2011 and 2012 annual reports (p. 84 and p. 65).

Making recompense was recommended by the Ombudsman in 17 cases in the reporting year. In addition, during the handling of complaints, communications from the Office to authorities often led to the rectification of errors or insufficient actions and therefore contributed to reaching an amicable settlement. For example, as a result of a complaint, the police took up a case for reconsideration during the reporting year in 15 cases, and in at least five of them a pre-trial investigation was started. In some cases, the consideration is still in progress. In numerous other cases, guidance was provided to complainants and authorities by explaining the applicable legislation, the practices followed in the administration of justice and oversight of legality, and the means of appeal available.

Under the act on state indemnity operations, the majority of claims for damages addressed to the State are processed by the State Treasury. The act is applied to the processing of a claim for damages from the central government if the claim is based on an error or neglect by a central government authority. The act on state indemnity operations (*Laki valtion vahingonkorvaustoiminnasta* 978/2014) entered into force on 1 January 2015. According to information obtained from the State Treasury, 298 decisions were issued and 413,549 euros in compensation were paid in the reporting year. Since then, both the decisions made and the compensations paid have increased. In 2017, the number of decisions seems to have stabilised at slightly over 800. On the other hand, the amount of compensation paid has increased from EUR 500,000 in 2017 to EUR 750,000 in the year under review.

As agreed with the State Treasury, it will annually send all decisions on recompense under the act on state indemnity operations to the Ombudsman for the Ombudsman's information. In 2020, a total of 887 claims for damages were submitted to the State Treasury. Four cases were initiated as a proposal for recompense made by the Parliamentary Ombudsman. In matters falling within the scope of the act on state indemnity operations, 68 actions were brought against the state. Under the act, the State Treasury issued 837 decisions and paid compensation totalling EUR 753,220 in 2020. A significant part of the decisions, 506, and the compensation paid, EUR 291,948, concerned the Ministry of Justice. The next largest amounts of compensation paid concerned the administra-

tive branches of the Ministry of Defence and the Ministry of Transport and Communications to the amounts of EUR 152,860 and EUR 100,886 respectively.

The number of decisions and the amount of compensation paid in the administrative branch of the Ministry of Justice was particularly affected by a significant number of compensation decisions concerning the office of guardianship services of the state's legal aid and public guardianship districts, with amounts varying from a few euros to thousands of euros in delinquency charges of bills and taxes. In the latter, the compensations were related to issues such as failure to apply for care and housing allowances or retirement pension, or a telephone subscription left uncancelled, for example. A significant case of misconduct was revealed at one office of guardianship services. A secretary at the guardianship office had used a client's account to pay their personal bills. The secretary had also asked the guardian to add a new account for the clients and provided their personal account number for the purpose. After that, the secretary made significant transfers from the clients' accounts to their personal account. With a decision on the applications of the guardianship office, the State Treasury paid the financial damages caused to these clients.

A significant number of claims for damages were also related to the criminal sanctions within the administrative branch of the Ministry of Justice. They largely concerned items and clothing that were lost or broken in prison. In its decision on 21 July 2020, the State Treasury stated that the investigative isolation period, i.e. slightly more than one day, had not been subtracted from a three-day disciplinary solitary confinement imposed on a person in a disciplinary matter even though this should have been done according to the disciplinary decision. The State Treasury deemed that the amount of compensation had to be assessed by using the same principles as provided in the act on state indemnity operations that are used when assessing the compensation for an innocent person being imprisoned or sentenced. The normal compensation for the suffering of a person deprived of their liberty is EUR 120. According to the State Treasury, in this case the matter to consider was that the person being punished was serving a prison sentence before and throughout the disciplinary punishment and also after it. The person's circumstances during the disciplinary punishment were more limited than they would have been without it. On these grounds, the State Treasury deemed that the correct amount of compensation for not subtracting the investigative isolation period was EUR 60 in this case.

For the administrative branch of the Ministry of the Interior, compensations mainly involved personal injuries or damage to objects caused by police measures. In its decision on 23 June 2020, the State Treasury, on the basis of a Supreme Court ruling, paid compensation to a total sum of EUR 4,000 for pain and suffering and temporary harm caused by delayed access to treatment in a police detention facility for a person's dislocated hip joint on the basis of negligent breach of official duty and cause of injury to a person. Another decision of the State Treasury on 27 November 2020 stated that the police had apprehended a person on the basis of an arrest warrant that was erroneously in force. The person's deprivation of liberty based on this warrant was unfounded. The person had been deprived of their liberty from 14 March 2020 at 21:20 to 16 March 2020 at 10:20. Consequently, the State Treasury deemed that the correct amount of compensation in this case was EUR 240.

Some claims for damages were also made to the State Treasury due to the COVID-19 pandemic. In a claim for damages, a person stated that they worked as a physician at a hospital in Sweden and also at a health centre in Finland. After the quarantine restriction entered into force, they could not travel to their second job in Sweden starting from 15 April 2020. According to the person, the total amount of their loss of income was SEK 54,000 per month. Another person claimed damages on the grounds that they and their family could not access a rented cottage due to the Uusimaa lockdown imposed by the Government. They had to cancel the rental agreement and pay a part

of the rent. The person applied for a compensation of EUR 266.88 for damages caused by a public authority.

In its decisions on 29 September 2020, the State Treasury rejected both claims for damages against the Government. According to Chapter 3 Section 5 of the Tort Liability Act, no action for damages can be brought for injury or damage caused by a decision of the Government, a Ministry, the Cabinet Office, a court of law or a judge, unless the decision has been amended or overturned or unless the person committing the error has been found guilty of misconduct or rendered personally liable in damages. According to the State Treasury, the claims for damages concerned damage caused by a Government decision referred to in the Tort Liability Act that is subject to the claims limitation in the Act. The claims were therefore matters where an action for liability for damages cannot be brought.

According to the State Treasury, there was therefore no justification for the State's liability for damages (in these cases). In the latter decision, the State Treasury did not investigate the claim for the part that concerned the Parliament. According to the State Treasury, it does not have the competence to process a claim for compensation that is based on the Parliament being considered to have acted incorrectly by not revoking the Government Decree on the Emergency Powers Act concerning the restriction of mobility between Uusimaa and the rest of Finland.

3.7.1 RECOMMENDATIONS FOR RECOMPENSE

The following gives an overview of the recommendations for recompense made by the Ombudsman during the year under review. A response from the authority regarding the action that the matter has resulted in has not yet been received for all of the recommendations.

Implementation of the rights of the child and equality

Special protection and support for a child abused in substitute care

The child's right to physical integrity was violated during substitute care. The foster care unit and the municipality had acted appropriately to investigate the offence and to make the perpetrator liable after the incident.

The child had to live against their will in the room where the abuse had taken place. Later, the child was isolated in the same room. In addition, the child did not find the support they received sufficient to deal with the event. As a country committed to the UN Convention on the Rights of the Child, Finland must guarantee special protection and support for a child in foster care. The Finnish Constitution guarantees the right of the child to necessary care. The Deputy-Ombudsman considered that these rights were not fully safeguarded by the foster care unit and the municipality after an offence against the child, and she therefore argued that they would compensate for the violation of the rights of the child. The Deputy-Ombudsman requested the municipality of foster care to report on their actions (4031/2019).

Seeking of citizenship for a child in foster care

In an own-initiative investigation, the Deputy-Ombudsman investigated how the seeking of Finnish citizenship for a child placed in a child welfare unit had been promoted by social services.

During an inspection of a child welfare unit, the inspectors personally spoke with a child born in 2004. In the discussions, the child explained that they had a custodian. According to the child, they had asked on multiple occasions that Finnish citizenship be sought for them, but the matter had not progressed. The city's social services admitted that the submission of the child's application to the Finnish Immigration Service had not been fulfilled even by the time the social services

provided their account on the matter to the Deputy-Ombudsman.

It is not possible to establish, based on the Nationality Act or the preparatory documents to the act, what action should be taken if a child placed in foster care requests the filing of an application for citizenship but the guardian does not have the will or the capacity to submit the citizenship application to the authorities. However, there is a provision in the Nationality Act allowing for granting Finnish citizenship on an application made by a child's custodian, if there are weighty reasons for it. The preparatory documents to the act do not itemise what weighty reasons refer to. According to the Deputy-Ombudsman, the Nationality Act is somewhat unclear and subject to interpretation in this respect regarding the naturalisation of a minor.

The Deputy-Ombudsman stated, however, that as the matter has been about filing a Finnish citizenship application for a child placed in foster care and submitting the application to an authority, the capacity of the social welfare authority to investigate and promote the matter in the interest of the child can be taken into account in the assessment of the matter. Pursuant to the Child Welfare Act, the municipal body responsible for social services, which may act as another legal representative of a child, is responsible during substitute care for the implementation of the interest of the child during substitute care. Thus, a matter that must be considered significant for the implementation of the interest and rights of the child cannot be left as the responsibility of a guardian or a custodian under the Child Welfare Act when the social services know that the guardian cannot, due to their situation in life or for other reasons, supervise the child's interests or is passive regarding the matter.

According to the Deputy-Ombudsman, as the social welfare authority noticed that the child's citizenship matter had made no progress for several months – and possibly for a much longer time – the social welfare authority should have at least started to investigate and assess other measures, such as seeking a substitute custodian for the matter related to the child's application for citizenship. As the matter, however, is somewhat unclear with respect to the legislation on the application for citizenship, the Deputy-Ombudsman settled for drawing the attention of the city's social welfare services to the above.

The Deputy-Ombudsman proposed, however, that the city's social welfare services aim to find a solution for filing the child's application for citizenship without delay, should the child still wish it. The Deputy-Ombudsman also recommended that the city's social welfare service consider how it could make recompense to the child for the harm incurred from the delay of the matter. The Deputy-Ombudsman asked the social welfare services to report on the actions it has taken as a consequence of the decision (2911/2020).

According to the city's social welfare service, there was no discussion with the child about seeking citizenship during other meetings organised to prepare customer plans or encounters with the child except in November 2019 and the spring of 2020. The social worker in charge of the child's matters had apologised to the mother and the child for the delay of the process and for the payment of financial support from the child's emancipation funds.

The social worker in charge of the child's matters had now remunerated this amount of EUR 130 to the child in such a way that it is not taken into account as a factor lowering the emancipation funds but that the payment is annulled. It was agreed with the child that a public custodian be sought for filing the citizenship application from the Digital and Population Data Services Agency. The application had been sent on 29 January 2021.

Television reception problems

There were hundreds of terrestrial antenna households in the Sea Lapland region with insufficient signal strength for TV reception. The reasons for the reception problems reported in the area were primarily other than low signal transmission strength. In cases where TV reception had not been rendered technically satisfactory in the terrestrial distribution network, the households had been offered satellite reception as an alternative.

Such a satellite package incurred charges that were payable by the consumer. In addition, the consumer was responsible for ordering the installation of the system on their property.

The Deputy-Ombudsman noted that although the additional investments incurred from the satellite package for the households are not considerably high compared to the reception antenna for terrestrial TV network and its installation, an additional expense of some amount was incurred from the use of this reception technology. In addition, it was possible that the renewal of the antenna system would not have become current for a long time without the necessity of obtaining a satellite package for blind spots.

The Deputy-Ombudsman sent its decision to the Ministry of Transport and Communications and the Finnish Transport and Communications Agency, presenting for consideration the matter of whether it would be possible to compensate consumers for the additional expenses incurred from the alternative reception technology in such a way that the equal treatment enshrined as a fundamental freedom would be better realised between consumers using the terrestrial distribution network and those relying on the alternate method of satellite reception (5412/2019).

Right to personal liberty and integrity

Right of elderly spouses to live together during the COVID-19 pandemic

The complainant's parents were placed in adjacent in-patient facilities of housing services for elderly people provided by the joint municipal authority for social and health care, against their will and in violation of the Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons.

The complainant had not received any information about the possibility of taking their parents out, which was strictly forbidden in early March. The complainant's father was no longer allowed to eat together with the three other residents of the same cell, but the meals were arranged at the father's flat instead. He was not allowed to leave his flat, and the corridor doors were locked. The complainant had not received information about how taking relatives out and meeting them could be arranged.

According to the Deputy-Ombudsman, the legislation had not been changed in such a way as would entitle the prevention of contact between close relatives and a resident or restrict the resident's roaming outdoors in situations where a doctor in charge of communicable diseases has not made a decision regarding the resident on quarantine or isolation pursuant to the Act on Communicable Diseases. The Constitution of Finland and international treaties on human rights guarantee everyone the right to respect for their family life without arbitrary or undue intervention of the authorities or other external parties. The prohibition on visits and meetings outdoors was significant for the residents and their relatives with respect to several fundamental and human rights, in particular with respect to family life. Both the management of the joint municipal authority for social and health care and its other staff should have understood, based on current legislation, that they did not have the right to restrict the meetings between the spouses and that they would have had the right to live together. Nor had national guidelines been aimed at forbidding people from roaming outside of operating units when accompanied by relatives.

The Deputy-Ombudsman noted that the Ombudsman may, in a matter concerning the oversight of legality, submit proposals to a competent authority for rectifying an error or shortcoming that has taken place or for making recompense for a breach of rights. To this end, the Deputy-Ombudsman requested the joint municipal authority for social and health care to report on its actions (4070/2020).

Cultural rights

Incorrectness of pupil records and application for upper secondary school

The Deputy-Ombudsman considered that the school had acted incorrectly regarding entries about a pupil in the records. The incorrectness of the pupil's entries had not, however, been the only reason the pupil was not considered in discretionary application to upper secondary school. The appropriate entry of the details of home-schooled pupils in the automated information system was not possible because of a system error. This was attributable to shortcomings in the pupil information system that was the responsibility of the Finnish National Agency for Education. According to its position, the Finnish National Agency for Education had already taken action to remedy the shortcomings identified.

The Deputy-Ombudsman considered that the city should, as the municipality monitoring the progress of the pupil's compulsory education, have actively and on its own initiative monitored how the pupil's joint application procedure was progressing. Once the error became apparent, the municipality should, as provided by the Convention on the Rights of the Child and laid down in the Administrative Procedure Act, have guided and advised the pupil and their guardian on access to secondary studies in order to safeguard the interest of the child. As the consequences of the matter had been grave for a pupil in a vulnerable position and because it was a matter of a child entitled to special protection, the Deputy-Ombudsman proposed that, despite the end of the pupil's compulsory education, the city take action as it deems most appropriate in order to advise and guide the pupil on access to secondary education (5571/2020).

According to the statement of the city, the city's head of education services had, as a result of the Deputy-Ombudsman's decision, contacted the school's principal and guidance counsellor. The guidance counsellor offered the pupil help with counselling on studies. In addition, the head of the education services contacted the upper secondary school's principal who, with their decision of 7 December 2020, admitted the pupil as a first-year student at the upper secondary school.

Decision-making about school travel benefit

The total processing time of a matter on a school travel benefit for 2018–2019, from the decision made by a public servant in April 2018 to the rulings of the Administrative Court on 30 October 2020, had already been approximately two and a half years. The Deputy-Ombudsman considered a total processing time of this length unreasonable for the guardians.

As the Administrative Court overruled the decisions in June 2019 and returned them to the head of education services for revision, the matters should have been processed and solved without delay. The Administrative Court had stated in its ruling that the decisions by the public servant did not indicate the amount of benefit the appellants were entitled to or what the amount of the benefit was based on. The head of education services did not process the cases returned by the Administrative Court until September 2019, stating in their decisions that because valid decisions by the head of education services existed in the case, new decisions would not be issued. In addition, the decisions were accompanied by a prohibition on appeal, which was not based on law. Because new decisions had not been made, the Administrative Court returned the matters for new processing on 30 October 2020.

According to the Deputy-Ombudsman, the above shortcomings in the city's administrative procedure and decision-making had resulted in a significant delay in processing a relatively simple administrative matter. Therefore, the Deputy-Ombudsman proposed that the city make such recompense to the guardians as, according to the city's discretion, should be considered reasonable, considering the incorrectness of the city's conduct. The Deputy-Ombudsman requested that the city report on the solution that has been reached in the matter (6381/2019).

The city's board of education decided that it will apologise for the delay of the pupils' school transport issue in the school years 2018–2019. It was the

intent of the board of education to compensate for the delay in processing the administrative matter, and it authorised the head of education, director of education services and the group lawyer to process and decide on the compensation.

Right to work

Delay of the implementation of the employment obligation

According to the Act on Public Employment and Business Service, a municipality must provide a work opportunity so that the person to be employed can start work upon expiry of the maximum time for which a daily unemployment allowance is paid. The provisions of the act were temporarily amended due to the temporary deterioration of the operating conditions due to the COVID-19 pandemic. The Government has not, however, proposed changes to the regulations pertaining to the employment obligation.

According to the Deputy-Ombudsman, the city should have acted in the matter in such a way that the complainant could have started their work upon expiry of the maximum time for which a daily unemployment allowance is paid. Although the reasons indicated in the city's account were understandable for the city, they were not acceptable from the perspective of the oversight of legality as reasons for postponing the implementation of the employment obligation. As a result of the city's conduct, the complainant's unemployment benefit was reduced, as they received labour market support instead of daily unemployment allowance. The complainant's subjective right to work as municipal obligation immediately following the expiry of the period for which daily unemployment allowance is paid was delayed because of the city's unlawful conduct. This delay resulted in financial loss to the complainant.

The Deputy-Ombudsman urged the city to discuss the matter as a proposal for recompense, assess its conduct regarding the delay in implementing work as municipal obligation and rectify any shortcoming caused by its conduct. The Deputy-Ombudsman requested that the city report on its actions regarding the matter (2401/2020).

According to the statement of the city, the complainant was employed by the city under the obligation as of 15 June 2020. The municipality's employment obligation commenced on 1 April 2020, so the city granted a one-off recompense of EUR 2,645.18 to the complainant for loss of income between 1 April and 14 June 2020. The basis for the one-off recompense was the loss of income during the waiting period less the labour market support paid by Kela.

Delay of the processing of an unemployment matter

The Deputy-Ombudsman considered that the TE Office had acted in breach of the fundamentals of good governance when neglecting sufficient diligence, as it did not pay sufficient attention, when the complainant reported as an unemployed job-seeker, to the specialist designated as the clerk in charge of the complainant's matter no longer being employed by the TE Office. This negligence resulted in a lack of responses to the complainant's contact requests in accordance with the service promise and without undue delay. This, in turn, resulted in a delay to the commencement of the processing of the complainant's unemployment benefit matter. As a result of the TE Office's negligence, the complainant was left without income.

The basic subsistence of an unemployed job-seeker during unemployment is compensated for with an unemployment benefit (unemployment allowance and labour market subsidy). Diligence in the processing of cases is essential in securing basic subsistence. Because of the TE Office's negligence, the complainant was without basic subsistence for four months. According to the Deputy-Ombudsman, the requirement of effective implementation of fundamental and human rights in this case necessitated that the complainant be entitled to appropriate recompense for the harm incurred from negligence of diligence.

The Deputy-Ombudsman sent its decision to the State Treasury and asked it to contact the complainant in an appropriate way and settle the

matter on the basis of the act on state indemnity operations. The Deputy-Ombudsman asked the State Treasury to report on the actions it has taken as a consequence of the proposal for recompense (5708/2020).

The State Treasury paid EUR 350 in recompense to the complainant for the violation of fundamental rights. The State Treasury deemed that, considering the processing time of at most 30 days, a delay of approximately three months had occurred in the processing of the unemployment matter, so it deemed the amount paid a reasonable recompense.

RIGHT TO SUFFICIENT SOCIAL AND HEALTH CARE SERVICES

Negligence of the payment of compensation for family care

The city's social welfare service had approved the child's private placement, and co-custody was confirmed for the complainant. The complainant had had financial difficulties, to which the social welfare service had responded only occasionally, with the support measures in open care pursuant to the Child Welfare Act, by granting social assistance in 2009 and 2010 partly for housing expenses and by paying compensation for expenses to the complainant as of 2008. However, no fee pursuant to the act on family care was paid to the complainant. This fee had only been paid as of 2018.

The complainant had not been guided and advised as provided in the Act on the Status and Rights of Social Welfare Clients. The complainant did not have the possibility to exercise their rights because they were not provided with documents pertaining to the child, which belonged to them. The Deputy-Ombudsman considered the social welfare service's negligence to be grave and to compromise the legal protection of the child and the complainant. The authority must seek amicable settlement and remedy the flaws in its conduct. The authority must not subject the client to resort to legal remedies if the outcome of the decision can clearly be anticipated. The complainant's only legal remedy in this matter was an administrative dispute in an Administrative Court.

The Deputy-Ombudsman proposed that the social welfare service consider how it could compensate for the breaches of the complainant's rights and pay recompense to the complainant for the fees and compensations unpaid (342/2019).

According to the statement of the city's social welfare service, it had started investigating the amount to be compensated for unpaid fees and compensations. The city will contact the complainant regarding the payment of compensation and will apologise for its negligence in the processing of the complainant's matters. According to information later obtained from the city, the complainant was paid EUR 45,000 in compensation and, according to the complainant's own statement, a further EUR 90,000 was paid later.

Housing of a child and private placement

The complainant and the father-custodian of the child had agreed in 2018 on the housing of the child in the complainant's family. According to the investigation, the custodian had since then objected to the child's housing arrangement and the transfer of the child's registered address to the complainant's address. According to the investigation, the child had themselves objected to living with their father. The benefits payable for the child, child benefit and child maintenance allowance, had been paid to the child's custodian. It could be deducted from the statement obtained that the objection of the child's father – the custodian – had at least partly prevented the transfer of the payment of said benefits to the complainant to cover the costs incurred from the care and attention of the child.

The complainant had factually been responsible for the daily care and attention of the child living in their family and for the costs incurred from said care. The housing arrangements of the child and the results leading to them had been known by the city's social welfare service at all times. Similarly, the social welfare service had known how the child's father had participated in the maintenance of the child. Although in this matter the complainant could no longer be approved as the child's private carer, at least not af-

ter March 2019, the need for support of the child and consequently of the complainant should have been secured. This was particularly the case on the basis that while living in the complainant's family, the child was a child protection customer.

The complainant had repeatedly asked for financial support for the costs incurred from the care of the child. At this point, the complainant should have been informed of their rights and obligations and the various options and their effects, as well as other factors of relevance to their case. In addition, the complainant should have been advised to seek financial benefits regardless of how the authority had possibly assessed the fulfilment of the preconditions for said support. In this way, in a potential case of disagreement, the complainant would ultimately have had the possibility to have a decision by an authority on the arrangement of support evaluated by a court.

The Deputy-Ombudsman considered the negligence of the city's social welfare service to be grave and to compromise the legal protection of the complainant and the child in the complainant's care. The Deputy-Ombudsman proposed that the social welfare service consider how it could make recompense for the above breaches of the rights of the complainant and the child (3446/2019).

According to a statement by the city's social welfare service, EUR 5,000 had been compensated jointly to the child and the complainant by a decision of a public servant, to be spent as they would mutually agree. The amount of the compensation was affected by the child's child benefit still having been paid to the child's father after 2018 although the child had, as of that time, lived with the complainant. The complainant and the child were left without EUR 3,700 of benefits intended for the maintenance of the child. They had received EUR 880 of financial support between November 2018 and February 2019 from child protection services. Thus, the support left unpaid amounted to approximately EUR 2,820. Approximately EUR 2,200 of the total compensation paid was recompense for the breach of the rights of the complainant and of the child.

Processing of a travel compensation matter

The communication between the complainant and their daughter had been subsidised for the entire duration of the substitute care. As of September 2017, the complainant had been paid mileage allowance of EUR 0.41/km for staying in touch with their daughter and other travel. The decision on the matter may have been made for the year 2017. In light of the information obtained, it had been continued without interruption following the end of 2017. In addition, it had been provided for the complainant on 16 December 2019. The city's family unit apparently intended to amend the decision regarding the following month (1–31 January 2020). According to the decision, the new compensation was EUR 0.20 per kilometre. However, the decision in question had not been made until 13 February 2020, that is, retroactively. In addition, the decision had not been appropriately provided to the complainant until March 2020.

Having received the decision, the complainant had written an e-mail message to the acting social worker who made the decision. The complainant had demanded that the decision be rectified. According to the Deputy-Ombudsman, it was possible to consider the message a claim for adjustment, although the instructions for appeal contained in the decision in question require appeal submitted personally or by mail. In any case, the period for appeal (30 days from provision of decision) was still valid. If the text could not have been considered an appropriate claim for adjustment, the complainant should, in any case, have been advised to make a claim for adjustment or supplement it under section 8 of the Administrative Procedure Act. There was sufficient time available for this.

In its conclusion, the Deputy-Ombudsman stated that a retroactive decision on the amount of a benefit had been made in the matter without due legal basis, the provision of notification of the decision was delayed and the complainant's message concerning the matter had not been processed as a claim for adjustment, nor had guidance been provided on making a claim for adjustment. According to the Deputy-Ombudsman, the conduct compromised realisation of a fundamental

and human right concerning the complainant's legal protection. The conduct in the matter had been unlawful. The Deputy-Ombudsman proposed that, owing to the incorrect application of law, the unpaid part of the travel compensation be paid to the complainant (2613/2020).

Processing of an application for social assistance

The complainant submitted a basic social assistance application on 20 September 2019 for the period 1–30 September 2019. The complainant was given a decision on 27 September 2019, and assistance was granted for the period 1–30 September 2019. The decision stated that the electronic payment commitment to the pharmacy would be valid until the end of September 2019. The decision reached the complainant on 2 October 2019, and they could no longer buy their medicine. The complainant had contacted Kela and advised it in a customer service encounter that they could not retrieve their vital medicines.

Kela's investigation confirmed its incorrect conduct. Kela apologised to the complainant that a one-time payment commitment had not been granted to them and that they had not been informed of the granting and validity of the electronic payment commitment so that the complainant could have gotten the medicine they needed. In addition, Kela apologised for not assessing the need for urgent social assistance because of medicines.

The Deputy-Ombudsman considered it appropriate and part of good governance that when an authority detects the incorrectness of its conduct, it also apologises for it. According to the Deputy-Ombudsman, a further obligation of the authority is to rectify its incorrect conduct and, if necessary, explain to its customer the reasons resulting in the incorrect conduct. The Deputy-Ombudsman considered the errors in the execution of the decision related to the decision-making to be grave and to compromise the complainant's rights. What made the error particularly grave was that it was a matter of the complainant's necessary medicine and securing of the continuity of medicinal treatment. After identifying the matter, Kela had, owing to the contacts by the complainant, had the chance to remedy its error in accordance with its instructions. Kela had also had the opportunity to process the complainant's contact as an urgent application pursuant to the Act on Social Assistance. These measures had been neglected in the case of the complainant.

The Deputy-Ombudsman proposed that Kela, having the obligation for organising social assistance, would compensate the complainant for the breaches of their fundamental rights. The Deputy-Ombudsman asked Kela to report on the actions it has taken as a consequence of the proposal for recompense (6269/2019).

Kela stated it had paid a recompense of EUR 25 to the complainant because of the proposal for recompense.

Realisation of specialised healthcare

Insufficient examination of the patient at a healthcare station and the resultant insufficient referral to specialised healthcare had resulted in the referral being returned from the ophthalmology clinic. This had resulted in the complainant's delayed access to specialised healthcare.

According to the Deputy-Ombudsman, the complainant's right to good healthcare and nursing in accordance with their medical needs were not realised in the best possible way as obliged by the Patient Act and Health Care Act. Owing to the delayed treatment, the error had also apparently incurred costs for the patient from getting a referral from a private physician and possibly also from referral to after-care in the private sector.

The district authority for wellness had apologised for the matter. As the error had apparently incurred expenses for the patient, the Deputy-Ombudsman proposed that the district authority for wellness consider how it could, in addition to the apology, compensate the complainant for the extra trouble and expenses incurred. The Deputy-Ombudsman requested the district authority for wellness to report on its actions (4500/2019).

According to a statement of the district authority for wellness, the treatment of the patient took

place at a healthcare station whose services were outsourced to a private health service company at the time of the incident. Therefore, it was agreed with the health service company that it will compensate for the extra cost incurred by the patient. The company had requested a statement from the patient regarding the costs incurred and had paid a compensation of EUR 160 in accordance with it.

Legal protection and good governance

Conducting the inheritance taxation of a tax subject residing in Sweden

A Swedish citizen residing in Sweden since 1968 was their brother's heir, and the inventory of their late brother's estate was carried out in 2016. Their current address had been valid since 1983, and their current name since 1997. According to the complaint, the complainant's valid name and contact details were clearly indicated in the estate inventory prepared for the late brother, submitted to the tax administration for the carrying out of inheritance taxation.

The Finnish Tax Administration carried out the complainant's inheritance taxation using the outdated address information in the tax administration's information system, and the complainant's old last name was entered as the tax subject on that basis. The taxation decision and other notices sent by the tax administration did not return from Sweden to the Finnish Tax Administration. The Finnish Tax Administration sent the inheritance tax to the Swedish enforcement authority for execution by request for executive assistance.

The legal instructions of the inheritance and gift tax act are built on the principle that the inheritance taxation is carried out according to the estate inventory and the information contained therein. The appropriate processing of a case includes that the authority make sure that it has the information and accounts necessary for settling the case.

The Finnish Tax Administration stated that it had amended its practice in such a way that the address information contained in the estate inventory will be used in the future if the tax subject resides abroad and is not a Finnish citizen. The Deputy-Ombudsman stated that the inheritance taxation was carried out incorrectly in the complainant's case, as the basis used was the complainant's name information outdated decades ago regardless of the information in the estate inventory. Thus, the new practice reported by the Finnish Tax Administration did not rectify the situation for the complainant. The Deputy-Ombudsman was not able to become assured of the differing practices regarding address information on the basis of citizenship and place of residence being acceptable in light of the Finnish Constitution and the European Union's rule against discrimination on the basis of citizenship.

According to the Deputy-Ombudsman, the Finnish Tax Administration did not carry out inheritance taxation for the complainant in an appropriate manner, as it had not investigated the differences between the information in the estate inventory and the customer register. As a result of the negligence, the complainant's taxation was carried out using outdated information, and the complainant did not receive the inheritance tax decision or the tax payment slips. The inheritance tax was sent to enforcement. Only after this did the complainant become aware of the tax levied on them. The complainant incurred extra tax increase and delay consequences and enforcement expenses. In addition, the complainant felt offended. According to the Deputy-Ombudsman, the efficient realisation of the guarantee of good governance included in the legal protection secured as a fundamental right and the right to effective legal remedies secured in the European Convention on Human Rights both require that the Finnish Tax Administration compensate for expenses incurred by the complainant from the failure to appropriately investigate the matter and the negligence of its obligation to provide advice and for the harm, worry and uncertainty caused (1318/2019).

According to the Finnish Tax Administration, it paid the complainant compensation for financial damage, such as overdue interest and enforcement expenses, according to the complainant's demand for the amount of 9,558.70 Swedish crowns. Insofar as the complainant demanded compensation for immaterial damage, such as worry and trouble, the

Finnish Tax Administration transferred the demand to the State Treasury for settling on the basis of the act on state indemnity operations.

In its decision on 21 December 2020, the State Treasury rejected the claim for damages of SEK 1,000 due to pain and suffering. The State Treasury referred to the provisions of the Tort Liability Act and stated that the applicant had not explained how the inheritance taxation decision of the Tax Administration would have caused personal injury to them. Under the Tort Liability Act, a person's right to compensation for pain and suffering due to a personal injury must be rejected due to a lack of causal connection.

Conduct of a custodian in seeking child increase

According to the complainant, their custodian had neglected to seek child increases for pension from Kela. The Ombudsman proposed to the office of guardianship services that it would still, together with the complainant, seek to find out whether the custodian's conduct had caused harm to the complainant and, if so, that it would consider the prerequisites for an application for compensation to be filed with the State Treasury. If, however, the office of guardianship services would not deem itself capable of acting in the matter for a legally justified and acceptable reason, it should notify the complainant without delay so that they could themselves consider sending an application for compensation (1701/2019).

Processing time of a special permit application for medicine

Additional statements were requested by Finnish Medicines Agency Fimea on 14 October 2019 regarding the complainant's special permit application, arrived on 2 September 2019. After the additional statements arrived on 25 October 2019, the special permit was immediately granted on 26 October 2019.

According to the medicines decree, applications pertaining to permits and registrations referred to in the Medicines Act must be processed in parallel with other activities in such a way that the processing time for a special permit is 30 days. Fimea has a so-called express permit procedure in effect with a higher processing fee. The complainant had paid the express permit fee. According to information on Fimea's website, express permit applications are handled as quickly as possible.

Although the complainant's original application was insufficient, the processing had been delayed in violation of the medicines decree, as the additional statements were not requested until after the expiry of the statutory 30-day processing period. Considering further that the complainant had applied with the express procedure, they had justified reason to believe that their application would be processed more expediently than normal. Pursuant to the Administrative Procedure Act, an authority must protect expectations that are justified on the basis of the legal system. Although the express permit procedure is based not on law but on Fimea's own practice, the principle of protection of legitimate expectations derived from the Administrative Procedure Act must, in the Deputy-Ombudsman's opinion, be taken into account in all administrative actions. Therefore, the Deputy-Ombudsman deemed that the processing of the matter had been unlawfully delayed at Fimea. Fimea apologised for the delay in processing the matter. The Deputy-Ombudsman recommended that Fimea additionally compensate the complainant for the extra fee charged for the urgent processing of the application (5591/2019).

Fimea stated that it had paid the recommended compensation of EUR 20 to the complainant. In addition, it apologised for the errors in the processing again.

Processing of a claim for adjustment of a healthcare centre fee

The complainant had visited a healthcare centre on 26 June 2019 and had not shown a document entitling them to exemption from the fee during the visit, and had therefore received an invoice for the physician's certificate and an invoice for the healthcare centre visit. Having received the invoice, the complainant had not contacted the unit that had rendered the service but had sent a

claim for adjustment to the registry office of the wellness services on 17 July 2019, requesting adjustment to both invoices by stating they were on "TT support". However, the claim for adjustment was not accompanied by a document on the social assistance support, which would entitle them to a free physician's appointment at a healthcare centre.

No further account has been received in the matter on why the claim for adjustment was not appropriately processed after registering it. In addition, there was no further account on the content of the telephone advice received by the complainant. The result was that the invoices had been transferred to a collection company. According to the account, out of the fees referred to here, the complainant would have been entitled to eliminate only the healthcare centre fee. The payment had later been returned to the complainant during the processing of the complaint. It had been assessed that the payment was undue because the complainant had stated they had sent a certificate of having received unemployment benefit on the date of visiting the doctor.

The wellness service's conduct had been in violation of the Administrative Procedure Act with regard to investigating the matter, processing the claim for adjustment and obligation to provide advice. The Deputy-Ombudsman emphasised that the city must ensure that its payment processing process with procedures for adjustment guarantee the realisation of the requirements of good governance, and that the customers' right to have their matter investigated by a competent appeals body can be guaranteed. As the city's error has resulted in the matter having been transferred for collection to a collection agency, the city, according to the Deputy-Ombudsman, had to ensure that the complainant would not have to pay undue collection expenses and to compensate the complainant for the expenses incurred from the collection and the investigation of the matter (5156/2019).

According to the city's report, the customer had been refunded for the healthcare centre fee they had paid. The invoice had been recalled from collection, and the collection expenses had been paid to the customer.

Erroneous instructions for appeal

The sole ruling by Justice of a Court of Appeal A, which was the subject of the complaint, had accidentally contained incorrect instructions for appeal to the Supreme Court, and apparently the complainant had also received the corresponding incorrect instructions for appeal from there. Although the Justice of a Court of Appeal's error per se was clear and although it had pertained to legal ruling activities, i.e., the core duties of the Justice of a Court of Appeal, the matter was only about an occasional mistake resulting from carelessness. The error gave no rise to measures applicable to the Justice of a Court of Appeal. The appeals procedure in question had already served as a reminder of the significance of diligence and alertness in also routine judicial tasks that, in practice, largely involve text processing, which were previously handled by referendaries and secretaries.

The Court of Appeal's error had incurred unnecessary expenses for the complainant, as they had incorrectly filed the matter with the Supreme Court in accordance with the incorrect instructions for appeal. However, a contributing factor to the emergence of the damage is that the attorney serving as the complainant's assistant did not notice the Court of Appeal's error either. According to the Deputy-Ombudsman, however, a clear breach of rights of the complainant had taken place in the matter. The conduct of the authorities did not meet the requirements of legal protection secured as a fundamental right, and therefore there were grounds for making recompense.

The Deputy-Ombudsman sent its decision to the State Treasury and asked it to contact the complainant in an appropriate way and settle the matter on the basis of the act on state indemnity operations. The Deputy-Ombudsman asked the State Treasury to report on the actions it has taken as a consequence of the proposal for recompense (1331/2020).

The State Treasury stated that it had paid EUR 5,510 in compensation to the complainant for the breach of fundamental rights. The State Treasury stated that although the amount of the expenses incurred by the complainant was rather large, it could be deemed to be incurred from the erroneous conduct of the Court of Appeals.

Delay of application for leave to appeal

The application for leave to appeal had been submitted late to the Supreme Administrative Court, which on that basis had left the application for leave to appeal uninvestigated. According to the statement of the legal aid office, it was a matter of the legal aid office's error. The counsel should have seen to it that the application for leave to appeal was delivered within the appeal period to the Supreme Administrative Court. It was not possible to investigate the reasons for the error admitted in the statement of the legal aid office.

The matter of the complainant, who was a customer of the legal aid office, had not been handled in such a way that their right to seek appeal pursuant to section 21 of the Finnish Constitution would have been realised. According to the Deputy-Ombudsman, a clear and grave breach of rights had taken place in the matter, and therefore there were grounds for making recompense.

The Deputy-Ombudsman sent its decision to the State Treasury and asked it to contact the complainant in an appropriate way and settle the matter on the basis of the act on state indemnity operations. The Deputy-Ombudsman asked the State Treasury to report on the actions it has taken as a consequence of the proposal for recompense (6053/2019).

By its decision of 23 February 2021, the State Treasury had paid a compensation of EUR 1,000 to the complainant for a breach of their fundamental rights. When assessing the amount of the compensation to be paid, the State Treasury had taken into account its prior compensation practice regarding proposal for recompense. The breach in question was, per se, to be considered a serious procedural mistake, which, given the nature of the matter, was of particularly great significance to the breached party, as the matter pertained to a complaint filed on the basis of an application for asylum.

The State Treasury had, however, taken into account in the consideration of the amount of the recompense that the asylum matter had been processed in an administrative court and that the appeal in the matter had not been entirely prevented, which was to be considered in the amount of compensation payable for the breach of the fundamental rights. Based on the accounts used in the matter, the error did not result in concrete danger to the asylum-seeker. Thus, the State Treasury considered EUR 1,000 a reasonable amount of compensation.

3.7.2 CASES RESULTING IN AN AMICABLE SETTLEMENT

In numerous cases, communications from the Office during the processing of the complaint to authorities often led to the rectification of errors or insufficient actions and therefore contributed to reaching an amicable settlement. The Parliamentary Ombudsman may also make proposals to authorities for the amicable settlement of a matter. The following describes certain examples of such cases.

Treatment of the parent of a child placed in foster care

The complainant voiced suspicions about the impartiality of the processing of their matter at a regional state administrative agency. According to the complainant, the regional state administrative agency had not evaluated all of their claims in sufficient detail either. With the complainant's consent, the processing of the matter was commenced at the Office of the Parliamentary Ombudsman, with the aim of reaching an amicable settlement that could help the parties collaborate better in the future.

The city's child protection service provided an account to the Office of the Parliamentary Ombudsman, indicating that the social worker in charge of the matters of the complainant's child had been replaced by the city's decision and that the new worker apparently also had a new supervisor–partner. According to the account, several discussions had subsequently been had with the complainant, which had been constructive and good. The complainant had indicated their satisfaction with the change made.

However, the complainant later stated they would revoke their consent to amicable settlement and wanted the complaint to be investigated according to the original claim. The Deputy-Ombudsman stated that the complainant's criticism emphasised their experience of being misunderstood and treated with bias. According to the Deputy-Ombudsman, the Deputy-Ombudsman did not, based on the complainant's texts and the attachments, have reason to suspect unlawfulness or negligence of duties of the kind that the Deputy-Ombudsman, as the supreme overseer of legality, should address.

According to the Deputy-Ombudsman, the child protection service had been ready to take unusual action as a result of the complaint. As a result of the child protection service's own discretion and measures, a favourable turn was reached in the matter, at least for some time. The Deputy-Ombudsman expressed the wish that the city's child protection service would pay attention to its ability to take discretionary measures in the future, with the aim of improving the complainant's experience of their treatment (1061/2019).

Information concerning guardianship and notification of decision

According to the complaint, Kela had also sent a decision on a child's disability allowance to the child's father, who, however, was not the child's legal guardian.

In its account, Kela stated it had acted in accordance with the law and its instructions on the realisation of disability allowance when it sent the decision on the disability allowance. The instructions state that a decision should be sent to guardians living at different addresses whenever a decision is made on disability allowance for a person under the age of 16.

The Deputy-Ombudsman stated that the information in the population information system did not indicate guardianship for the child's father and neither did the information obtained from the magistrate. In addition, an agreement on guardianship had never been made, according to the child supervisor of the city's social service. An additional statement was requested from Kela on how the information in the population information system is shown and where the guardianship information comes from to Kela.

As a result of the case, Kela had asked for a statement from the Population Register Centre (VRK) as to why there had been an error in the information relayed. According to the explanation received, the error had taken place in the conversion information service that relays information from VRK's population information system. Kela had processed the matter as a personal data breach pursuant to the EU's General Data Protection Regulation and had filed a notice to the supervisory authority pursuant to the Regulation. In addition, according to Kela, the complainant had been informed as required by the Regulation.

According to the Deputy-Ombudsman, Kela had in itself acted correctly based on the population information system information it had at its disposal. As Kela had taken the necessary rectifying measures in the relaying of the guardianship data, no further action was taken on the matter (2498/2019).

Considering housing expenses in social assistance

The complainant had moved to their current home on 1 October 2017. The complainant's child and spouse were living with them. Pursuant to Kela's specifications, the reasonable housing expenses for three persons were the rent for the flat and other management expenses, i.e., approximately EUR 830. In addition to the rent, Kela had paid heating expenses to the complainant according to consumption since the time of moving into the flat. The complainant's housing expenses had been approximately EUR 936 per month, exceeding the amount of reasonable housing expenses by Kela's specifications. The complainant was not informed of the reasonable housing expenses until April 2019 for the first time, at which point they were told that the housing expenses that would be considered in the future would be adjusted. They were later informed that in reasonable housing expenses, the rent must include heating, sweeping

and wastewater fees, and these would no longer be considered separately as expenses in the social assistance.

According to Kela's account, the complainant's applications for social assistance were not settled according to Kela's instructions. The complainant had repeatedly been paid more social assistance for heating expenses than Kela's guidelines for benefits would have required. The consideration for the benefit of the customer was not justified. The practice had unexpectedly been changed with notice of one month, and the customer was not given time to find a less expensive flat. The practice of settling the applications was not consistent or in line with the principle of protection of legitimate expectations.

According to Kela, the complainant's housing expenses had been taken into consideration in their entirety for more than a year, and the customer had gained legitimate expectations of this continuing in full in the future. On this basis, the complainant's decisions had been adjusted in such a way that the housing expenses had been taken into consideration in their entirety in the social assistance calculation, and the housing expenses will also be taken into consideration in their entirety in the customer's calculation. The housing expenses that will be considered reasonable will be reviewed if changes take place in the customer's circumstances or housing expenses. Kela apologised for the harm caused to the complainant by the inconsistent conduct and for not implementing the change of the settling practice in a manner acceptable in terms of the principle of protection of legitimate expectations.

As the matter had, according to Kela's statement, been remedied after the request for statement sent by the Deputy-Ombudsman, and as Kela had apologised for its conduct, the writing gave rise to nothing other than that the Deputy-Ombudsman drew Kela's attention to the consistency of decision-making (4204/2019).

Kindergarten's practice of requiring certificate of COVID-19 testing

According to the complainant, the city's early childhood education service and the kindergarten required a certificate of COVID-19 testing in order for the child to attend early childhood education.

The referendary in the matter had telephone contact with the city's early childhood education and education service's decision-making support unit. According to information received from the head of the unit, there is no need to present an official certificate of the test result of a child in early childhood education at the city's early childhood education units. The decision-making support unit will contact the kindergarten named by the complainant without delay in order to investigate the matter and rectify the incorrect conduct reported by the complainant. Therefore, there was no reason to investigate the matter further (5628/2020).

Designation of a child's preschool place

The complainant criticised the city's decision on the child's preschool place. The complainant had filed a claim for adjustment of the decision in accordance with the instructions for appeal enclosed with the decision, addressing it to the city's board of education and culture.

The Deputy-Ombudsman stated that the Basic Education Act provides for preschooling. A claim for adjustment of a decision referred to in the Basic Education Act may be requested from a regional state administrative agency if the decision involves admission as a pupil. The city's board of education and culture had stated that it had had incorrect instructions for appeal regarding preschool decision, and that it had taken action to rectify the matter. The board of education and culture stated that it would transfer the complainant's claim for adjustment to the regional state administrative agency for handling.

The Deputy-Ombudsman noted that the complainant's claim for adjustment had been transferred to the competent authority, and no loss of

legal rights was thus caused to the complainant. Therefore, the complaint gave rise to no further action (3624/2020).

Suitability of afternoon activity facilities for children

According to the complaint, there were shortcomings in the healthiness and safety of the city's facilities for the school's morning and afternoon activities. For example, the upstairs of the old fire brigade house used for the activities had dangerous stairs and dirty toys. The complainant had contacted the city to no avail.

The complainant did not indicate when or whom the complainant had contacted. The referendary of the matter had telephone contact with the city's head of culture. According to information received from them, the facilities will be reviewed in the near future. According to the head of culture, the complainant may contact them to present their views and to get more information on the matter. Therefore, the complaint gave rise to nothing further from the Deputy-Ombudsman (7584/2020).

Language of traffic signs

According to the complaint, there was a sign at a street intersection that had only the English-language title "No parking zone". The title was followed by more specific sections in Finnish, English, Polish and Russian. On the same street, there was also a speed display that showed the text "your speed" in Finnish only.

In the initial review of the matter, the Parliamentary Ombudsman considered the sign and the speed display incorrect in terms of the national languages and their equal treatment. As the city stated that it had removed the "No parking zone" sign and that the speed displays were to be rendered bilingual, the Parliamentary Ombudsman deemed that the matter necessitated no further action by the Parliamentary Ombudsman (5938/2020).

Barriered entrance to district court

According to the complaint, the threshold at the entrance to the district court was higher than 20 millimetres.

According to the initial statement by the district court's chief judge requested as a result of the complaint, the chief judge had immediately contacted a contractor and the threshold had been removed. The access was now barrier-free, according to the chief judge's understanding. Therefore, the complaint gave rise to no further action (7026/2020).

Finnish Tax Administration's telephone service

According to the complainant, they had to investigate the property taxation of their mother via the Finnish Tax Administration's telephone service. The call lasted for 35 minutes, and the complainant considered it unfair that they had to queue and pay for the telephone call for that duration. According to the complaint, the customer should be provided with the possibility of requesting call-back.

As a result of the complaint, the referendary of the matter had contacted the Finnish Tax Administration's communications unit. According to information obtained from there, the Finnish Tax Administration offers the possibility for call-back on its various service numbers between 9 a.m. and 1 p.m. If the customer calls a service number and the number is busy, the customer will be offered the possibility for call-back. The referendary of the complaint did not find information about these services on the Finnish Tax Administration's website, for which reason the senior adviser of the communications unit said they would expediently start investigating the matter so that this information regarding the telephone services would also be indicated on the website. No further action by the Deputy-Ombudsman was thus required in this case (7815/2020).

3.8 Special theme in 2020: Sufficient resources for authorities to ensure fundamental rights

3.8.1 OVERVIEW

The special annual theme of the Office of the Parliamentary Ombudsman was "Sufficient resources for authorities to ensure fundamental rights". The annual theme is raised during inspection activities, the processing of complaints and when considering the office's own initiatives. Previous themes have included "Right to privacy" in 2018 and 2019, and "Right to effective legal remedies" in 2016 and 2017.

The theme for 2020 is linked to several constitutional rights. According to the Constitution, the constitution safeguards the inviolability of human dignity and the freedom and rights of the individual and promotes justice in society (Section 1). The Constitution safeguards everyone's right to have their case dealt with appropriately and without undue delay by a legally competent court of law or other authority, as well as to have a decision pertaining to their rights or obligations reviewed by a court of law or other independent organ for the administration of justice. (Section 21). Further, according to the Constitution, public authorities must safeguard the observance of fundamental rights and human rights (section 22), and the use of public powers must be based on an Act (section 2). According to the Constitution, a civil servant is responsible for the lawfulness of their official actions (section 118), and public authorities must take responsibility for the protection of the labour force (section 18). Each ministry is responsible for the preparation of matters to be considered by the Government and for the appropriate functioning of administration (Section 68).

Under the UN Charter, states have a duty to promote universal respect and observance of human rights and freedoms. A similar provision is contained in the Statute of the Council of Europe and in the EU Charter of Fundamental Rights. Obligations to safeguard and promote fundamental and human rights impose not only an obligation on the state to refrain from violating rights, but also positive obligations to implement them.

3.8.2 PERSPECTIVES ON THE SPECIAL THEME IN OVERSIGHT OF LEGALITY

Sufficient resources for official activities have a direct impact on the appropriateness of the authorities' activities and thus on how reliable, credible and high-quality the authorities' activities are perceived to be.

In principle, the Ombudsman's task is not to monitor the sufficiency of the authorities' resources. However, if a lack of resources leads to a failure to observe fundamental rights, for example by making it more difficult or even impossible to fulfil the statutory obligations imposed on the authority due to a lack of resources, the oversight of legality cannot override issues related to resourcing. However, it is not appropriate or reasonable to focus the assessment and evaluation of legal oversight solely on an individual public servant in situations where shortcomings in the activities of the authorities have been caused by resource-related matters that the civil servant has not been able to influence. In some cases, even an individual authority or administrative branch has limited opportunities to influence the correction of problems caused by resource issues. For example, the reorganisation of operations does not necessarily solve problems caused by the lack of human resources if the resources had already been limited from the beginning.

The theme proved to be very multifaceted in terms of the impact of insufficient resources.

Problems related to resourcing could lead to the authority not being able to deal with a matter within the time limit laid down in an Act, or the system development was significantly hampered due to a lack of financial resources. In addition, the theme proved to be quite broad in terms of its personal impacts. On one hand, resource problems directly caused issues with observing the fundamental rights of persons involved in authority services e.g. in the form of long processing times, but correspondingly also affected the position of civil servants through e.g. unreasonable workloads.

In general, the theme is especially present in inspection activities, but due to corona, the number of inspections was low in the year under review. For this reason, the following is a more detailed description of the individual observations made on the theme in the handling of complaints.

Processing times

Legislation often sets a time limit for the processing of matters by authorities. Even if there is no legal deadline for processing a matter, the authority is required to process the matter without undue delay. Failing to follow this principle cannot be justified by reasons related to the authority's resources. It has been noted in the Ombudsman's decision practice for several years that problems related to processing times often arise from resource issues, which has led to exceeding the statutory processing times.

As regards the tasks of the Police Administration, resource issues were often raised in relation to complaints concerning the duration of the pre-trial investigation. Reports on complaints revealed that the investigations by various police departments had become concerningly backlogged due to the work load. The available investigative resources were insufficient in relation to the number of cases.

The Criminal Investigation Act requires that a pre-trial investigation be carried out without undue delay. With regard to a delay in the pre-trial investigation, the Ombudsman found that the basic reason for the delay of the pre-trial investigation had been that the criminal investigation of the police department had become very The police department had taken measures to resolve the issues with the work load. There was no reason to criticise the actions of individual police officers because they had had to operate under rather difficult working conditions (5988/2019). In another complaint decision, the Ombudsman found that in a situation where the head of the investigation had had about 1,700 pending cases during the year, it was impossible for the head of the investigation to monitor the status of the cases, including those about to expire, in real time without the help of a system. The consequences of the system's operational deficiencies could not be considered to be the failure of the head of the investigation (2122/2020).

Under the Criminal Investigation Act, when a pre-trial investigation authority receives a report about an offence or an incident that the person who made the report suspects to be a crime, the pre-trial investigation authority must record the report without delay. In the practice of legal oversight, it has been established that recording the report must not be delayed for many days. On his/her own initiative, the Parliamentary Ombudsman has investigated the delays of a police department in recording criminal reports. In August 2020, the police department had more than 22,000 open cases, and 1,930 unrecorded criminal reports as e-mails and 20 as paper copies. The delay in recording a report of an offence was about six weeks.

In the Ombudsman's request for clarification, the Ombudsman stated that it is important to promptly record the report and immediately examine it to determine the urgency of the matter. In most cases, investigating a crime is more successful the faster the pre-trial investigation can begin. The report might also concern an ongoing act or acts in which case it is also important to intervene immediately in the interests of the injured party. In extreme cases, someone's life or health might be in danger.

The Ombudsman asked the police department for an account of whether and how the police de-

partment has ensured that pending reports do not include matters requiring immediate action and whether the measures taken at the police department have improved the situation. The Ombudsman also asked for an explanation on whether the matter has been known to the National Police Board and what measures may have been taken there (6445/2020).

The limitation of the right to prosecute is also a statutory deadline and the prosecutor's duties include supervising that the matter does not pass the statute of limitation to bring charges during the consideration of charges. The Ombudsman considered that when assessing the statute of limitation to bring charges during the consideration of charges, the prosecutor's work load and the complexity of the matter subject to the consideration must be taken into account (3198/2019).

On his/her own initiative, the Deputy-Ombudsman has examined compliance with the processing times related to the functioning of the courts. The Deputy-Ombudsman has requested a report from the Ministry of Justice on whether inadequate resources or structural factors have contributed to delays in sentencing in the courts of appeal that exceed the 30-day deadline referred to in Chapter 24, section 17, subsection 2 of the Code of Judicial Procedure, and what measures can be taken to rectify the situation (2472/2020). In addition, the Deputy-Ombudsman has taken the initiative to examine the extent to which the objective set by the legislator for administrative courts to treat certain categories of matters as urgent has been realised in practice in 2019 and 2020 (matters related to custody of a child and other child welfare matters as well as matters concerning involuntary psychiatric treatment) (8164/2020).

The Deputy-Ombudsman considered that the expected 12-month processing time that the Tax Administration reported on its website in relation to claims for adjustment for income tax could not be considered satisfactory. Such a long general processing time is problematic since it does not meet the requirement for a timely and undelayed processing of an administrative matter. In particular, the service principle of good governance, which is part of the foundations of good governance, requires that matters concerning claims for adjustment be resolved flexibly and efficiently. Effective processing of claims for adjustment is also important when assessing the implementation of a fair trial. In cases in which an appeal is filed after a claim for adjustment, the appeal phase extends the total processing time of the matter. It is therefore essential for the proper observance of legal protection that the claims for adjustment are processed promptly.

In addition, the Deputy-Ombudsman drew the Tax Administration's attention to the fact that a backlog in the processing of claims for adjustment highlights the obligation to provide customers with appropriate guidance and advice. As required by the Act, the authority is required to submit an estimate of when the decision will be issued when a customer files a claim, and they must respond to inquiries concerning the progress of the matter (6549/2019).

With regard to the processing time of the application for international protection under consideration at the Finnish Immigration Service, the Ombudsman stated that the application had been pending at the Finnish Immigration Service for about 13 months after it had been referred back from the Administrative Court, which had to be considered too long for a processing period. The processing time had been affected by the backlog in the processing of cases returned from the Administrative Court to the Finnish Immigration Service, the corona pandemic and the complainant's own activities. However, the Finnish Immigration Service had taken various measures to speed up the processing of applications (5183/2020).

According to the Act on the Consumer Disputes Board, the Consumer Disputes Board must issue a recommendation with justifications in writing no later than 90 days after all the material necessary for resolving the matter has become available to the Board. In highly complex disputes, the Board may, at its discretion, extend the period of 90 days. The Ombudsman's decision practice has for long

stated that the Consumer Disputes Board is unable to comply with the statutory deadline.

In its complaint decisions (e.g. 7554/2020, 2830/2019), the Deputy-Ombudsman has referred to the previously issued Parliamentary Ombudsman's decision (4079/2017), which stated that long processing times have ultimately been due to insufficient resources in relation to the work load and procedure of the Consumer Disputes Board. Despite recent development projects and additional resource allocations, the Consumer Disputes Board was still not able in all cases to meet the statutory 90-day requirement within which a recommendation should be issued.

A specific deadline for issuing a labour policy statement is laid down in the legislation. According to the Decree of the Ministry of Economic Affairs and Employment on the issuing of a labour policy statement and information to be included in the statement, the labour policy statement referred to in the Unemployment Security Act must be issued without undue delay, however, within 30 days of the applicant submitting the report that is required for issuing the statement or when the deadline for submitting the report has expired. The Deputy-Ombudsman considered that the workload on the customer service caused by the number of new customers which was mentioned in the TE Office's report cannot be considered an acceptable reason for exceeding the deadlines. The TE Office had to prepare for matters that could affect the organisation of interviews with jobseekers and thus the processing of unemployment benefit matters (1640/2020).

The amount of human resources

Sufficient human resources in official activities are of paramount importance. If the human resources are limited from the start, unexpected sick leaves and education-related absences will have a significant impact on the smooth functioning of the authority activities. Problems related to the availability of skilled personnel are also very relevant in many administrative branches.

In the field of criminal sanctions, shortcomings in human resources contributed to the failure to implement prisoners' free time activities. The shortcomings in resources were caused by unforeseeable sick leaves of guards and guidance workers working in shifts. The Deputy-Ombudsman did not consider it acceptable that prisoners were relatively often prevented from participating in activities for reasons that were ultimately due to resource problems in the prison (313/2020). The savings obligations imposed on prisons have also been found to have a detrimental effect on the practical operation of the prison (1917/2020).

In addition to having sufficient human resources, it is essential that the personnel are competent and adequately trained. For example, the Criminal Sanctions Agency has been subjected to significant resource cuts, and staff have been significantly reduced. Furthermore, the lack of qualified trained guards is a serious and acute problem. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) also drew attention to this issue during its periodic visit in September 2020.

The Deputy-Ombudsman noted that the proper treatment of prisoners, as well as the order and safety of prisons, require that the prisons have adequately trained and skilled staff in guidance and supervision tasks. It is clear that if permanent guard posts cannot be filled with trained staff, there will also be no trained staff in fixed-term employment relationships. Those working in guidance and supervision tasks should have the capacity to perform individual local work and to handle, understand and adopt processes in the field of criminal sanctions and legal, administrative and social issues within the scope of the criminal sanctions system (4153/2019).

The issue of human resources has also been raised in a separate initiative on the separation of minors in prisons. The Deputy-Ombudsman has requested clarification on, among other things, whether the perspective of adequate/enhanced supervision of minors has been taken into account in the human resourcing and shift planning in prisons (4760/2020).

In the decision on the organisation of early childhood education and care in Swedish, the Ombudsman stated that it is the responsibility of the public authorities to ensure, among other things, sufficient resources to ensure that fundamental rights, such as equality, and other obligations laid down in the law (reference to a law in general, not a specific act) are also implemented in practice, and that a municipality must independently ensure the realisation of linguistic rights and equality and, within its decision-making power, ensure sufficient resources for the implementation of early childhood education and care as stated in the legislation.

The Ombudsman noted that from the perspective of oversight of legality, it was essential to examine not only what kind of measures the municipality had taken under its authority but also how it had otherwise sought to improve the situation to the extent that the matter was not under the municipality's own control. This as such did not remove the unlawfulness of the situation, but it affected the criticism (7233/2019).

Findings from inspections

In inspections carried out in the area of responsibility for the environment and natural resources of ELY Centres, the Deputy-Ombudsman drew attention to the fact that the authority must have sufficient resources to carry out statutory tasks. In an inspection, it was found that the increase in person-years in the entire area of responsibility does not follow the development of the number of pending cases at the unit level so that, as the number of pending cases increases, human resources would also increase. The number of person-years in relation to the number of pending matters was different between the units. It is also necessary to take into account the dimensions of civil service liability in the organisation of activities (1442, 1443 and 1445/2020).

The basic idea behind automating the systems and functions used by authorities is to improve the efficiency of the authorities' operations as well as to ensure proper and documented processing of matters. However, success in these objectives depends largely on the schedule and extent to which the systems are available to authorities.

The audits carried out at the National Police Board, the Central Administration Unit at the Criminal Sanctions Agency and the Department of Criminal Policy and Criminal Justice of the Ministry of Justice found that the funding granted for the development of the systems was rather limited. System development was often granted funding for one year at a time, which increased the uncertainties associated with development work. Further development after the introduction of the systems could also be an area that lacked resources. For example, with regard to the development of the case management system in the field of criminal sanctions, the Deputy-Ombudsman expressed concern about the resource needs related to development work and the implementation of the system (1039, 1040 and 1750/2020).

3.9 Statements on fundamental rights

This section discusses certain statements on fundamental rights made in the course of the Ombudsman's oversight of legality. The section focuses exclusively on individual decisions that involve a new aspect of fundamental rights or are of importance in principle. They are also included in section 3.7, which describes the Ombudsman's decisions leading to a recommendation for compensation. Fundamental rights statements concerning a specific administrative sector or category can be found in section 5, and statements related to the coronavirus epidemic can be found in section 4.

3.9.1 STATEMENTS

Organisation of early childhood education and care in Swedish (the Constitution, sections 6, 16, 17 and 19)

A situation in which a Swedish-speaking child did not receive early childhood education and care in their mother tongue was not only contrary to the explicit provision of the Act on Early Childhood Education and Care, but also violated the child's equality and social, cultural and linguistic rights guaranteed by the Constitution of Finland.

The public authorities have a responsibility to ensure, among other things, sufficient resources to ensure that fundamental rights, such as equality, and other obligations provided by law are also implemented in practice. The Constitution of Finland emphasises the equal treatment of children (7233/2019).

Reasonable accommodation in the Finnish matriculation examination (the Constitution, sections 6 and 16)

According to the Act on the Matriculation Examination, a candidate may take the matriculation examination tests in an alternative way, due to an illness or disability for example. On application, the Matriculation Examination Board decides on the use of the special arrangements. In sudden and unforeseen situations, the use of special arrangements may also be decided by the school principal.

In grading test performances, the Matriculation Examination Board may also take into account that the candidate's test performance was impaired by an illness or disability if the special arrangements were not sufficient to ensure that the candidate could take the test on equitable terms with other candidates.

The UN Convention on the Rights of Persons with Disabilities (CRPD) obliges to ensure reasonable accommodation for individual requirements of people with disabilities. The measures are decided case-by-case and they must correspond to the needs of the person with disabilities and the specific situation.

In connection with the reform of the provisions concerning the matriculation examination, the Matriculation Examination Board has developed its guidelines and task formulation so that individuals from as many special groups as possible can take the test.

The Substitute for a Deputy-Ombudsman proposed that the board should improve their guidelines further so that the range of measures of reasonable accommodation is not unnecessarily limited in advance. The grading of test performances could pay special attention to the inadequacy of the arrangements for reasonable accommodation. The consideration of factors that weaken test per-

formance in the assessment of the test should also be extended to other situations than only when a candidate is failing a test (2356/2019).

Emergency call and the right to life (the Constitution, section 7)

The fundamental right to be guaranteed in emergency call risk assessments may be the right to life guaranteed by section 7 of the Constitution of Finland. The right to life can have a generally obliging influence on public authoritative measures promoting the prerequisites for life.

One such measure could be to have as little ambiguity and vagueness in the instructions concerning the handling, transmission and management of tasks issued by the authority participating in emergency response centre activities (3386/2019).

From the point of view of the fundamental right to life, it is also justified that when the urgency assessment concerns a situation subject to interpretation that might involve a risk to life, the urgency class providing faster assistance is used (3109/2019).

Freedom of movement and protection of family life when the border of Uusimaa was closed (the Constitution, sections 7, 9 and 10)

According to the decree on the application of the Emergency Powers Act, the police were not allowed to prevent the movement of persons appealing to the necessary reasons specified in the decree. According to the Ombudsman's understanding, the police could only prevent border crossing if it was obvious that there was no necessary reason as referred to in the decree.

The complainant had appealed to the need to assist their 86-year-old father, who was in the high-risk group and lived alone, to procure food and medical supplies when needed. As a close relative's need for care is an acceptable reason to cross the regional border according to the decree, the complainant's journey to their father should not have been prevented (3213/2020).

Restriction of border traffic (the Constitution, section 9)

In order to realise the Government's will, the border guard authorities demanded persons who were trying to cross the border to provide a necessary reason as outlined in the Government decision documents. However, the content of the constitutional right to enter and leave the country had not been introduced in this context. Many planning to cross the border might have justifiably been under the impression that leaving the country was not permitted.

On the other hand, there was also confusion in the implementation of the right to enter the country. Based on its hierarchy of norms, the constitutional right to enter or leave the country practically confirms that the proposed travel restrictions are only recommendations. However, fundamental rights are also guaranteed against unlawful interference. The legal norms concerning the procedure and powers of an authority to interfere with an individual's legal status must be at the level of law (3257/2020).

Notification of reading correspondence between two prisoners (the Constitution, section 10)

Reading correspondence intervenes with the secrecy of confidential communications guaranteed by section 10 of the Constitution of Finland. An authority may refrain from notifying of its action that intervenes with the right to privacy only if it is expressly provided for in legislation. When reading correspondence between two prisoners, both parties must be informed even if the grounds for reading it are related to only one of them (5348/2019).

Police access to a place protected by the sanctity of the home (the Constitution, section 10)

A person was apprehended in an apartment under the sanctity of the home. Based on the person's disturbing behaviour in Alko Oy's store, the police had assessed them likely to cause significant disturbance or danger to public order and safety.

According to the Ombudsman, as the sanctity of the home is guaranteed as a fundamental right, it is legally a different matter whether the removal or apprehension is carried out at the sanctity of the home or a public place. From the point of view of the criteria for restricting basic rights, the Ombudsman deemed it unsatisfactory that the power of the police in the sanctity of the home was not reflected in the wording of the current legal provision, but only in the preparatory documents of the previous version.

The Ombudsman also stated that the police must have legal grounds for disturbing domestic peace. There was no legal provision that would allow the police to enter the sanctity of the home to carry out removal or apprehension in order to protect public order or security referred to in chapter 2, section 10 of the Police Act (6314/2019).

Exclusivity of purpose regarding personal data (the Constitution, section 10)

The police used a person's photo from the passport register in connection with automatic surveillance to determine the identity of a person who was suspected of a traffic violation.

From the perspective of fundamental rights and the internal consistency of the relevant provisions, the Ombudsman considered the most justified interpretation that data in the passport register should not be used to investigate a traffic violation.

The Ombudsman also noted that the interest in investigating a traffic violation is not so strong that it would be justified to deviate from the exclusivity of purpose regarding personal data in determining the identity of a person photographed in automatic traffic surveillance (6632/2019).

Control of the restrictions on gatherings (the Constitution, section 13)

The Ombudsman stressed that the authorities can only use statutory powers to limit the coronavirus epidemic. The Government's policies or recommendations have not afforded the police any additional powers.

Section 58 of the Communicable Diseases Act regarding restrictions on gatherings refers to general meetings and public events as defined in the Assembly Act. This provision affecting fundamental rights cannot be interpreted, contrary to its clear wording, in such a way as to cover all events where people gather.

The Police Act allows intervention in situations that pose a concrete threat to public order and security. However, the provisions on police powers laid down in the Police Act cannot justifiably be interpreted in such a way that they would allow the police to take measures to prevent the spread of a communicable disease that affect people's fundamental rights to which specific special legislation (Communicable Diseases Act) does not provide the right (2678/2020).

A minor's registration as a private entrepreneur (the Constitution, section 18)

The right of a legally incompetent child to engage in business activities is regulated by provisions that are open to interpretation from the perspective of fundamental rights. On the basis of the provisions, it is possible to conclude that carrying on a trade requires no consent from a guardian if the trade in question is not subject to notification.

In addition to regulatory business law, the matter must be assessed in the light of the Act on Child Custody and Right of Access. Under the Guardianship Services Act, a legally incompetent person may take legal action that is normal and of minor significance in relation to the circumstances.

The question of whether registration as a private entrepreneur as such is a normal and minor legal act is open to interpretation, given that registration does not have a direct legal effect. How-

ever, in order to protect the rights of the child and ensure their financial security, it is justifiable to assess the actual effects of registration that follow the start of business activities and are dependent on the scale and nature of the activities (5025/2019).

Fair trial before the Social Security Appeal Board (section 21 of the Constitution)

According to the Ombudsman, the hearing of the complainant as a party concerned had not been carried out in accordance with the requirements of a fair trial pursuant to the Administrative Judicial Procedure Act and section 21 of the Constitution of Finland. The complainant was not informed of or given an opportunity to express their opinion about attaching their letter of complaint and medical report related to a different case in the complaint statement of the Finnish Social Insurance Institution (Kela), which could have influenced the decision on the matter.

The Social Security Appeal Board (Samu) had agreed with Kela that Kela would hear the complainant as a result of Kela's complaint statement. In the Ombudsman's opinion, the agreed approach could seriously jeopardise a fair trial. This may happen if Kela attaches documents to their statement to Samu without hearing the complainant's opinion on the documents or even informing of their inclusion in the trial documents. Based on reports, this was the established practice when the documents were submitted to Kela by the complainant themselves in connection to another matter. According to Samu, the purpose for which the document was previously submitted to Kela is irrelevant (1904/2019).

Removing a limited liability company from the trade register (the Constitution, section 21)

The Deputy-Ombudsman noticed a lack of clarity in the regulation of legal remedies related to the removal of a register entry.

The legal remedy system for trade register entries is open to interpretation. As stated by the Supreme Administrative Court in its decision (KHO 2012:91), it is a question of an appealable administrative decision also when a company is removed from the register. Then it should be considered what kind of an administrative decision and appeal instructions should be issued for removal from the register to enable the use of regulatory means of appeal (1737/2019).

3.10 Complaints to the European Court of Human Rights against Finland

A total of 120 new applications were brought against Finland that were allocated to a judicial formation at the European Court of Human Rights (ECHR or the Court) in 2020 (131 in the previous year). A response from the Finnish Government was requested in five cases (4 in 2019). At the end of the year, 35 (19) cases concerning Finland were pending.

Complaints to the ECHR must be lodged using the form prepared by the ECHR Secretariat, and the requested information must be provided, along with copies of all documents relevant to the case. If an application is not properly filed, the case will not be investigated. The decision on the admissibility of an application is made by the ECHR in a single-judge formation, in a Committee formation (3 judges) or in a Chamber formation (7 judges). The Court's decision may also confirm a settlement, and the case is then struck out of the ECHR's list. Final judgments are given either by a Committee, a Chamber or the Grand Chamber (17 judges). In its judgment, the ECHR resolves an alleged case of a human rights violation or confirms a friendly settlement.

A very large proportion of the applications lodged with the ECHR are declared inadmissible. In 2020, a total of 103 (131) complaints concerning Finland were declared inadmissible or struck out of the case list. In 2020, the ECHR issued one judgment on Finland (two in 2019, no judgments in 2018, two in 2017). It found an infringement of Article 2 (right to life) of the Convention on Human Rights.

In the case ruled against Finland (*Kotilainen and others v. Finland*, 62439/12, 17 September 2020), the matter concerned procedures and negligence in the local police concerning the firearms permit of a young man guilty of the school shooting in Kauhajoki in 2008. As ECHR sees it, the withdrawal of a firearm permit and the confiscation of the firearm would have been a reasonable precaution in circumstances where doubts had arisen as to the suitability of the offender for possession of a dangerous firearm. The ECHR therefore considered that the national authorities had failed to comply with the special duty of diligence which they were subject to due to the particularly high risk to life associated with the improper use of firearms. For these reasons, the ECHR considered the state of Finland to have violated substantive positive obligations based on Article 2 of the Convention on Human Rights. With regard to the claims for compensation in the case, the ECHR divided the complainants into 10 different households and ordered the State to compensate the complainant belonging to the first household (Kotilainen) for EUR 31,571 in compensation for pecuniary damage and for each of the other households, EUR 30,000 in compensation for non-pecuniary damage. In addition, the Court ruled that the legal costs of the complainants would be reimbursed.

In October 2020, the State Prosecutor brought charges for serious fraud and serious counterfeiting in a case in which the ECHR ruled against Finland on 14 November 2019 (*N.A. v. Finland*, 25244/18). In its ruling, the ECHR had considered Finland to have violated the Convention on Human Rights by returning an asylum seeker to Iraq in December 2017 who was allegedly killed shortly after returning to Iraq. At the same time, Finland was ordered to pay compensation to the woman who filed the human rights complaint. However, according to the accusations, the information provided to the ECHR on the death of the asylum seeker was untrue and the relevant written evidence was falsified. The District Court sentenced the accused to imprisonment on 11 February 2021.

The total number of judgments issued by the ECHR to Finland by the end of 2020 was 191. The total number of ECHR judgments confirming a violation of rights by Finland since the country's accession is strikingly large, at 142 (approximately 75% of all judgments). Of these, 99 were judgments confirming a violation of rights relating to the duration of court proceedings or shortcomings in the implementation of a fair trial. Whereas Sweden, Norway, Denmark and Iceland have been State Parties to the ECHR for considerably longer than Finland, the Court has only ruled against them in a total of 142 cases, 7 of which were issued in 2020.

The Committee of Ministers of the Council of Europe monitors the execution of ECHR judgments. The monitoring carried out by the Committee focuses on three different aspects: the payment of compensation, individual measures, and general measures taken as a result of a judgment. The monitoring primarily takes place by diplomatic means.

Where necessary, the Committee of Ministers can refer a question of execution to the ECHR for confirmation. Within six months of the ECHR judgment becoming final, the states shall submit either an action report or an action plan comprising a report on any measures that have been taken and/or that are being planned. The reports are published on the Committee of Ministers' website.

4 Issues related to coronavirus

4.1 Overview

4.1.1 DESCRIPTION OF THE SITUATION

In December 2019, cases of pneumonia were diagnosed in China that were caused by the new coronavirus SARS-CoV-2. The virus disease COVID-19 started spreading around the world rapidly. On 11 March 2020, the World Health Organisation (WHO) declared the COVID-19 epidemic a pandemic.

In Finland, the coronavirus epidemic began in March 2020. On 16 March 2020, the Government and the President of the Republic declared a state of emergency in Finland over coronavirus outbreak. The Government issued the first decrees on the commissioning of the powers laid down in the Emergency Powers Act on 17 March 2020. The Government also issued several other commissioning decrees and decrees on continuing the use of powers under the Emergency Powers Act, which were under evaluation by the Parliament. On the basis of the decrees on the commissioning of powers under the Emergency Powers Act, four application decrees were issued as well as new application decrees on the basis of each decree on continuing the use of powers under the Emergency Powers Act.

The commissioned powers concerned social welfare and healthcare activities, employment, education and training as well as restrictions on mobility in Uusimaa. The commissioning of the powers of the Emergency Powers Act was based on the assessment that the powers were necessary to protect the population from the consequences of a highly widespread communicable disease and to ensure fundamental and human rights in emergency conditions. The main aim has been to prevent the spread of the virus, protect special groups and ensure the adequacy of social welfare and healthcare personnel and the capacity of intensive care in a crisis.

The state of emergency was declared over on 15 June 2020 and the decision entered into force on the following day. At that point, the Government considered that the pandemic could be managed under the statutory powers of the authorities, i.e. the legislative powers of normal conditions. The powers of the Communicable Diseases Act were increased as well as the normal legislation concerning education and food and beverage service businesses.

The coronavirus disease has caused significant social and economic disturbances and changes worldwide. Even though Finland has survived the pandemic well from an international point of view, the disease has also greatly affected Finland on many levels. The epidemic has also had major social and health impacts, which are not yet fully known.

The COVID-19 epidemic put society and the authorities in an unprecedented situation. The situation progressed rapidly and the fight against serious threats required prompt measures from the authorities to protect the lives and health of the population. There was very little time left for the authorities to plan and implement the measures required by the epidemic. Decisions were made in a situation where research data on the

disease and its spread were limited and inadequate. The authorities were also required to provide directive policies and measures on a quick schedule.

Due to its nature and the transmission mechanism of the virus, the epidemic required strong interference with people's lives and fundamental rights. It was necessary to restrict the freedom of movement and trade in an unprecedented manner. In their activities, the authorities had to assess the prerequisites for restricting fundamental rights and weigh up the different fundamental rights. In this situation too, the authorities could only use their legal powers, even if many other means could have been effective in combating the epidemic.

The epidemic showed that the legislation in force was not fully satisfactory and did not allow the necessary measures to combat the epidemic in the best possible way. Efforts have been made to develop legislation during the epidemic. During the epidemic, the authorities also issued a number of different guidelines and recommendations. In the oversight of legality, it was found that the legal nature of the instructions, recommendations and regulations issued by the authorities was sometimes unclear.

4.1.2 IMPACT ON THE ACTIVITIES OF THE OFFICE OF THE PARLIAMENTARY OMBUDSMAN

The situation caused by COVID-19 was also unpredictable and unprecedented in the Office of the Parliamentary Ombudsman and in the oversight of legality. It resulted in major changes in the handled issues and working methods. From the beginning of the epidemic, the Ombudsman received complaints about the activities of the authorities. The epidemic also gave grounds for clarifying matters on the Ombudsman's own initiative. During the year under review, nearly one thousand (953) cases of oversight of legality became pending that were somehow related to the COVID-19 epidemic. The issues were very diverse and included questions related to almost all administrative branches. In addition to matters related to the epidemic, there were, of course, also other, usual cases of oversight of legality. Despite the increased number of complaints, the office was able to achieve the time target for processing complaints at the end of the year, when there were no complaints pending that had been submitted more than one year ago.

Legal oversight matters related to the COVID-19 epidemic (complaints + own initiatives):

received	resolved	decisions leading to measures	percentage of cases leading to measures
953	611	109	17,84

The coronavirus epidemic and related restrictive measures created new types of legal questions in the oversight of legality. Many of the restrictions to combat the epidemic, such as mobility restrictions and visiting bans on various institutions, significantly influenced people's fundamental rights. Restrictions often had the biggest impact on the most vulnerable groups of people, such as the elderly or persons with disabilities, by making their position even more difficult. The importance of oversight of legality is emphasised under these circumstances. The oversight of legality was therefore focused on the control issues related to the epidemic in those areas where the likelihood of endangering fundamental and human rights was high. The aim was to identify these situations and intervene promptly.

As the coronavirus epidemic concerned all of society very extensively, it required more exchange of information, cooperation and agreeing on the division of labour between different authorities in several administrative branches. The Office of the Parliamentary Ombudsman also cooperated internationally in considering the challenges posed by the epidemic and the new methods introduced in inspection activities.

Due to coronavirus, the customer service of the Office of the Parliamentary Ombudsman was restricted so that no personal meetings with customers were arranged. Documents were received

and customers served by telephone as usual. Due to the epidemic, the public events planned for the year under review related to the 100-year anniversary of the Ombudsman had to be cancelled. In March, the personnel of the Office of the Parliamentary Ombudsman transferred mostly to remote work, which caused its own challenges to operating processes and other work. Extensive remote work was technically and productively successful.

4.1.3 COMPLAINTS

A total of 931 complaints related to the COVID-19 epidemic were received in the year under review. Of them, 601 were resolved. The administrative branches in which the largest number of complaints were submitted were education, social welfare and healthcare. However, complaints were directed at almost all administrative branches. For a sector-specific description of the content and special features of complaints in different administrative branches, see section 4.2.

Complaints related to the COVID-19 epidemic by administrative branch:

Administrative branch	Received	Resolved
Administrative branch of the Ministry of Education and Culture	214	89
Social welfare	150	88
Health	125	74
Highest organs of government	93	89
Administrative branch of the Ministry of Economic Affairs and Employment	87	57
Criminal sanctions field	66	53
Administrative branch of the Minisry of Defence	45	37
Police	39	18
Social insurance	24	21
Administrative branch of the Ministry of Transport and Communications	23	21
Local government	14	12
Aliens affairs and citizenchip	13	12
Enforcement (distraint)	9	6
Other administrative branches	4	4
Administrative branch of the Ministry of the Environment	4	4
Administration of law	4	3
Administrative branch of the Ministry for Foreign Affairs	4	1
Taxation	3	3
Administrative branch of the Ministry of the Interior	2	2
Guardianship	1	0
Administrative branch of the Ministry of Justice	1	0
Administrative branch of the Ministry of Finance	1	0

4.1.4 THE PARLIAMENTARY OMBUDSMAN'S OWN INITIATIVES

The COVID-19 epidemic gave rise to several questions on the Ombudsman's own initiative. A total of 22 cases were taken up on an own initiative basis. They related to restrictions on the care of the elderly, the Kela social insurance institution's service during the epidemic, internal border control, detention of foreigners and school meals. Ten cases were resolved on an own initiative basis. For a more detailed description of cases dealt with on an own initiative basis, see section 4.2.

4.1.5 INSPECTIONS

Inspections are an important part of the oversight of legality. The epidemic had a significant impact on the inspections by the Office of the Parliamentary Ombudsman. For the safety of the inspection sites and the inspectors, there were not many opportunities to visit the inspection sites during the year under review. The situation led to consider the possibilities of carrying out inspections in a manner other than by visiting the site physically. Some inspections were carried out remotely. The inhabitants, relatives and personnel of the inspection sites were heard by telephone and the management by video connection. Information was also obtained in writing from the inspection sites or various stakeholders. Some inspections of police sites were carried out through a secure video connection from the premises of the National Police Board. The development of alternative and safe inspection methods will continue, and in the future, inspection activity will be increased to the extent and within the timetable that is safely possible. International experiences are also utilised in the development of inspection activities.

A total of 23 inspections were carried out during the year under review, while in the previous year, the number was over one hundred. The highest number of inspections (10) were carried out in the field of social welfare. The realised sector-specific inspection activities are described in more detail in section 4.2. The inspection activities are also described in section 3.5 (National Preventive Mechanism against Torture).

4.1.6 STATEMENTS

In the year under review, ten statements or so were issued on the COVID-19 epidemic. In March, the Ombudsman issued three statements on the first government decrees concerning the commissioning or application of the powers laid down in the Emergency Powers Act. Statements were also issued on matters such as the government decree on the right of a municipality to deviate from the time limits for non-urgent healthcare and the assessment of the need for social welfare services, and on the proposal for the introduction of a contact tracking application (koronavilkku) to support the management of the COVID-19 epidemic.

4.2 Issues related to coronavirus by authorities

4.2.1 COURTS OF LAW

The effects of the pandemic were reflected in the courts of law as cancellations of sessions, increased use of remote connections, and process management measures and recommendations related to safe distances and masks. However, these measures or the continuation of sessions despite general restrictions did not lead to more than three complaints to the Ombudsman. The complaints did not give rise to action. However, the cancellations and transfers of sessions evidently had a negative impact on the length of court proceedings, which may later lead to an increase in the number of complaints about delays.

4.2.2 POLICE

There were some thirty complaints about police activities in relation to the coronavirus epidemic. Most of the complaints concerned the supervision of restrictions on gatherings and the closure of Uusimaa's borders. Ombudsman Jääskeläinen also investigated questions related to these issues on his own initiative. Some complaints were also made concerning the difficulties of using services and the longer processing times as a result of the epidemic. Only part of the cases was resolved during the year under review.

The oversight of legality concerning the police was most influenced by the fact that inspections could not be carried out on site, so the planned inspections on police prisons were postponed to the future, for example. The Lapland and Ostrobothnia police departments were inspected through documents and video connections. The inspections examined how the police departments had prepared for the coronavirus epidemic and how it had affected their activities.

According to the information received by the Ombudsman, police personnel avoided infections fairly well by separating functions and making other preparations. On the other hand, the inspection of the Ostrobothnia Police Department revealed that mass exposure had put 60–70 police officers in quarantine and that the Seinäjoki police prison had to be temporarily closed.

National Police Board interpreted assembly restrictions too broadly

Ombudsman Jääskeläinen took an initiative 2678/2020 commenting on the interpretations of supervision of restrictions on gathering presented in the guiding letter issued by the National Police Board in spring 2020. The Ombudsman did not consider them to be legally sustainable in all respects. According to the letter, the police could have intervened in events other than public meetings or public events as referred to in the Assembly Act.

The Ombudsman stressed that, although many means could be effective in limiting the epidemic, the authorities can only exercise powers based on law. The Government's policies or recommendations have not afforded the police any additional powers.

Section 58 of the Communicable Diseases Act cannot be interpreted, contrary to its clear wording, in such a way as to cover all events where people gather. The assembly restrictions imposed by the Regional State Administrative Agencies can only apply to public meetings and public events as referred to in the Assembly Act. With regard to these, the powers exercised by the police are laid down in the Assembly Act.

In addition, the Police Act otherwise allows for the police to intervene in situations that pose a concrete threat to public order and security – in this case, the number of people present is not as a

rule significant. However, the provisions on police powers laid down in the Police Act cannot justifiably be interpreted in such a way that they would allow the police to take measures to prevent the spread of a communicable disease that affect people's fundamental rights to which specific special legislation (Communicable Diseases Act) does not provide the right.

The Ombudsman noted that particularly in the spring, the situation was new to all authorities and the prevention of serious threats required swift measures. The National Police Board had since changed its guiding letter investigated in this case so that it mostly corresponded to the Ombudsman's views. For these reasons, the Ombudsman felt that bringing his views to the attention of the National Police Board was a sufficient measure.

There were also nearly twenty complaints about the supervision of restrictions on gatherings at the Black Lives Matter demonstration held in June 2020. They are being processed.

Unjustified fines were imposed in the supervision of the Uusimaa border's closure

On his own initiative 2464/2020, the Ombudsman also investigated the police fining practices in the supervision of crossing the regional border of Uusimaa.

A government decree issued under the Emergency Powers Act banned crossing the regional border of Uusimaa without a necessary justification, and a violation of the ban was punishable. The investigation showed that the police had issued several unjustified fines for attempts to cross the regional border.

The supervision operation outlined that if a person who had been refused entry tried to cross the regional border again without an acceptable reason, they could be fined for a violation of the Emergency Powers Act. Under the Criminal Code, an attempted criminal offence is punishable only if the attempt is punishable by a provision on intentional crime. However, an attempt to violate a mobility restriction issued under the Emergency Powers Act is not punishable. A constant or recurring attempt to cross the regional border against the government decree was thus not punishable.

The fines imposed by the police were not final decisions, which are made by the prosecutor. The Ombudsman considered it justified that the prosecutors should carefully review all cases where a fine had been imposed for a violation of the Emergency Powers Act and ensure that a lawful decision has been made (or will be made).

In August 2020, the Prosecutor General announced that the majority of penal orders for violations of the Emergency Powers Act had been lawful. In the case of unjustified fines, the penal order had not been issued. Some of the cases related to fines had specifications of the act in question. Individual recipients of a penal order had appealed to the District Court, and the Prosecutor General declared that they would submit at least one request for the reversal to the Supreme Court.

Travel from Uusimaa was unjustifiably prevented

There were seven complaints on police operation in the supervision of the border of Uusimaa. One of them (3213/2020) gave rise to criticism of the police procedure when the complainant was not allowed to cross the regional border. The complainant had said their reason for travel was to assist their 86-year-old father, who was in the high-risk group and lived alone, to procure food and medical supplies when needed.

A close relative's need for care was explicitly mentioned as a justified reason to cross the border in the decree concerning the closing of the Uusimaa border. In the opinion of the Ombudsman, the regulation was not intended to prevent a close relative from travelling, at least not on the grounds that the assistance of an authority might be available. The Ombudsman considered that in this case, the need for care met the criterion of necessity for border crossing, taking into account the complainant's father's age and the contemporary recommendations by authorities that people in high-risk groups should avoid close contact.

According to the decree, the journey of a person appealing to a necessary reason referred to in the decree could not be prevented. According to the Ombudsman's understanding, the police could only prevent border crossing if it were obvious that there was no necessary reason as referred to in the decree. The complainant's perception of the necessity of their journey due to the need for care for their immediate relative was not clearly unjustified. The Ombudsman thus considered that there were no grounds for preventing the complainant from travelling to their father. However, the sergeant had evidently acted in accordance with the instructions they had received, and the decision was not arbitrary. The Ombudsman considered it sufficient to bring his opinion to the attention of the sergeant.

The police were also criticised in case 2792/2020, where six people taken into custody were placed in the same small cell for seven hours in March 2020.

4.2.3 NATIONAL DEFENCE AND BORDER SURVEILLANCE

The Finnish Defence Forces have not been the primary player in combating the coronavirus, and their role has been mainly in supporting other authorities, such as providing executive assistance to the police in isolating Uusimaa and providing assistance suitable for the cleaning of protective equipment.

The Finnish Border Guard has played the role of an executive authority in the implementation of border control related to the fixed-term restoration of internal border control. Dozens of complaints were made to the highest supervisors of legality concerning the Border Guard's procedure, mainly at the western border of Finland. Several of the citizens who had filed complaints said that they had been denied the possibility to cross the border, even though there were no legal justifications for it.

Restricting border traffic

Deputy-Ombudsman Pölönen concluded that recommendations and binding orders given to persons wishing to cross the border had been confused on some levels in the early phases of the restoration of monitoring of internal borders. A binding order or command given by an official to a citizen must always be based on a regulation contained in legislation that provides a legal mandate to do so. If necessary, the citizen must also be informed if a binding order, or simply a recommendation handed down by an official is involved.

In accordance with government decisions, border control was restored to the internal borders as referred to in the Schengen Borders Code, and border traffic was restricted due to measures required to address the threat to Finland's internal security due to the COVID-19 disease outbreak. The Government's intention was to prevent the spread of the communicable disease, to protect people in high-risk groups and to prevent overloading healthcare and thus safeguard the lives and health of all citizens. The Government defined the permitted border crossing points and the allowed modes of transport as well as the permitted border crossing purposes. Accordingly, the surveillance of Finland's western land border and the border checks that are part of it were changed by adding elements related to finding out about the purpose of travel and health status as required by the government decision. The Finnish Border Guard played the role of an executive authority in the temporary restoration of internal border control.

Based on complaints and the public debate related to the topic, activities aimed at consciously limiting border crossing traffic had caused a great deal of uncertainty as to whether or not crossing the border was permitted. Taking into account the freedom of movement under section 9 of the Constitution of Finland and union law, the policy caused unavoidable challenges to the Border Guard that was responsible for border control's operational activities. In order to realise the Government's will, the border guard authorities demanded persons who were trying to cross the border to provide a necessary reason as outlined in

the government decision documents. However, the content of the constitutional right to enter and leave the country had generally not been introduced in this context. Many planning to cross the border might have justifiably been under the impression that leaving the country was not permitted. On the other hand, there was also confusion in the implementation of the right to enter the country.

Due to the general relevance of the matter and the several complaints made to the highest supervisors of legality, the Deputy-Ombudsman decided to investigate the matter on his own initiative.

According to a report by the Border Guard, a public official cannot at the same time be held responsible for guiding the behaviour of people in accordance with the Government's will on the one hand and ensure that citizens are educated about their constitutional freedom of movement on the other. The Finnish Border Guard had weighed up the fundamental rights that concern the protection of life and freedom of movement and attempted to guide citizens' behaviour in such a way that the most important fundamental right, everyone's right to life, was primarily ensured.

The Deputy-Ombudsman noted that, based on its hierarchy of norms, the constitutional right to enter or leave the country practically confirms that the proposed travel restrictions are only recommendations. However, fundamental rights are also guaranteed against unlawful interference. The legal norms concerning the procedure and powers of an authority to interfere with an individual's legal status must be regulated at the level of law. From the perspective of public authorities' requirement for rule of law, recommendations should not give the impression that they have a stronger legal significance than a recommendation. The importance of appropriate and legally precise expressions used in the provision of information is also particularly emphasised.

The situation in border control was at least challenging due to political steering related to the preparation of decisions related to border crossing traffic and the urgent need for preparation. The authorities had to act in an exceptional and unexpected situation and under heavy pressure. However, an authority is responsible for providing advice, and a border guard must always take fundamental and human rights into account in their activities and act in such a way that these rights are interfered with as little as possible. As an individual citizen can easily perceive the advice and requests given by a border guard as binding orders, the situation was very susceptible to misunderstandings.

Under the Constitution of Finland, a Finnish citizen always has the right to enter Finland and to leave Finland. If there were no legal impediments to leaving the country, people intending to cross the border should have been informed that they have the right to cross the border without negative legal consequences and that it is a question of their freedom of choice. In the same situation it would have been possible to advise them that leaving the country was nevertheless not advisable in line with the Government's guidelines. The overall security of Finnish citizens and the protection of their lives and health was emphasised in the situation at hand, which means that giving recommendations concerning travel as such was justified. This was a case of implementing the recommended behavioural standards at the lower levels of administration, so it would have been unreasonable to blame individual border guards in this context. The Deputy-Ombudsman brought his opinion to the attention of the Border Guard (3257/2020).

4.2.4 CRIMINAL SANCTIONS FIELD

The coronavirus epidemic has had significant effects in the field of criminal sanctions. In March 2020, the Central Administration of the Criminal Sanctions Agency instructed prisons to stop granting prisoners permissions of leave and arranging meetings in prisons. The activities of prisoners were also limited. Personal meetings were replaced by video connections. The purpose of the restrictive measures was to prevent the spread of coronavirus infections to and inside prisons.

At the same time, the Ministry of Justice issued a decree according to which the enforcement of imprisonment as a substitute for non-collectible

fines and sentences to imprisonment of a maximum of six months will not start between 19 March and 19 June 2020. The aim was to reduce the number of short-term prisoners entering prisons, thus reducing the risk of the spread of coronavirus among prisoners and personnel. In April, the Parliament decided to adopt an act based on a proposal from the Ministry of Justice according to which the enforcement of imprisonment as a substitute for non-collectible fines and sentences to imprisonment of a maximum of six months will not start before 31 July 2020. The objective of this measure was also to ensure the safe implementation of sanctions and the functional capacity of prisons during the epidemic.

Restrictions made in prisons due to the coronavirus epidemic were eased starting from 1 June 2020. The first restrictions were lifted from the internal activities of prisons by opening gyms, exercise halls, saunas and libraries for prisoners. Supervised meetings between prisoners' close relatives and underage children began on 24 June 2020. With regard to meetings, prisons returned to normal practices as of 1 July 2020, when also permissions of leave were granted again.

The preventive measures were successful in prisons. According to a press release published by the Criminal Sanctions Agency on 1 July 2020, no coronavirus had been found in prisons. In November 2020, the Criminal Sanctions Agency reported that a prisoner in the criminal sanctions region of Southern Finland had been diagnosed with a coronavirus infection on 6 November 2020.

As the number of infections started increasing in society again, preventive measures were reintroduced in prisons as instructed by the Central Administration on 27 November 2020. Prisons in regions where the coronavirus outbreak was in the acceleration or community transmission phase limited meetings, permissions of leave and activities. Once again, the Ministry of Justice restricted admitting those sentenced to a substitute for non-collectible fines or for a maximum of six months' imprisonment. The Ministry of Justice decree on the restriction entered into force on 4 December 2020 and is valid until 3 March 2021.

Community sanctions offices increased their remote services. Due to COVID-19, some community service locations were closed. It was easier to continue other community sanctions by changing to remote connections.

Following the coronavirus epidemic, the Ombudsman interrupted on-site inspection visits to prisons. As visits were no longer possible, Deputy-Ombudsman Pölönen decided, in April 2020, to investigate how the coronavirus epidemic affected prison activities (2606/2020), especially the treatment and conditions of those deprived of their liberty. This was examined by requesting observations from Kriminaalihuollon tukisäätiö (The Finnish Foundation for Supporting Ex-offenders) and the Finnish Bar Association on the measures taken in prisons due to the coronavirus pandemic. The request did not concern the Prisoners' Health Care Unit, whose activities were examined under a separate initiative (2736/2020).

On 29 April 2020, the Central Administration of the Criminal Sanctions Agency was asked to provide a report on prison activities during the coronavirus epidemic for the Deputy-Ombudsman's own initiative. Further clarification was also requested on 17 June 2020. Among other things, the Deputy-Ombudsman asked the Central Administration what measures they had taken to steer subordinate administration in the coronavirus epidemic, how they had ensured that the prisoners and their relatives were informed about the coronavirus epidemic and related measures in prisons, and whether the prisoners had been given increased access to video calls and telephones. The Deputy-Ombudsman also requested clarification on complaints related to restrictive measures in the coronavirus epidemic and other contacts concerning the Criminal Sanctions Agency. The Deputy-Ombudsman also asked the Criminal Sanctions Agency to investigate their cooperation and exchange of information between the Prisoners' Health Care Unit and the Ministry of Justice related to the coronavirus epidemic.

One theme of the Deputy-Ombudsman's own initiative is also whether the Criminal Sanctions Agency has found that the current legislation does not, in some respects, permit the restrictions necessary during the pandemic, or that the legality of

the necessary restrictions is subject to interpretation. According to a clarification by the Central Administration, legislation contains problems related to meetings, permissions of leave and various functions. In the further clarification, the Deputy-Ombudsman asked for a more detailed legal assessment of the problems of legislation and the types of restrictions that would be needed.

Due to apparent shortcomings in legislation, the Ministry of Justice appointed a working group on 1 October 2020 to prepare a draft government proposal to Parliament on legislation for combating communicable diseases posing a public health risk in the implementation of sanctions. On 13 January 2021, the Deputy-Ombudsman issued a statement on the working group's draft proposal and assessed that the matter requires further preparation.

In 2020, there were nearly 70 complaints concerning the Criminal Sanctions Agency and the coronavirus epidemic. Most of the complaints were about discontinuing meetings and the other restrictions in prisons. One complaint concerned the enforcement of a monitoring sentence and two preparations for probationary liberty under supervision. Most of the complaints have been resolved.

In relation to the preparation of probationary liberty in supervision, in order to avoid social contacts, the Criminal Sanctions Agency issued instructions in March 2020 to stop the preparations for prisoners who share an apartment together with another person. However, the Central Administration of the Criminal Sanctions Agency changed the instructions without delay so that the preparation of probationary freedom and the clarification of preconditions can also be carried out in apartments where the prisoner lives together with other people. As the matter had been corrected, the Deputy-Ombudsman had no reason to take action. With regard to specific leisure activities, the Deputy-Ombudsman stated that the prison had an appropriate and justified reason to temporarily prohibit the use of saunas as the prohibition was justified by the fact that the risk of infection may increase with sweating and when several people are close to each other in the sauna and shower facilities. In general, the decisions did not otherwise comment on the legality of the Criminal Sanctions Agency's activities regarding the procedure of individual prisons, as the matter is to be assessed generally in the above-mentioned Ombudsman's own initiative, which has not yet been resolved.

The own initiative concerning the Prisoners' Health Care Unit is also unresolved. Towards the end of the year, most of the complaints received after the instructions issued by the Central Administration Unit to prisons on 27 November 2020 have been transferred to the Central Administration for processing.

4.2.5 ECONOMIC ACTIVITIES, DISRUPTION IN PAYMENTS AND ENFORCEMENT

In the enforcement process, temporary legislative amendments improved flexibility. The preconditions for restricting the amount of distraint and granting free months were eased, for example, and the provisions on payment schedules and the date of eviction were amended. In bankruptcies, the creditor's right to petition for bankruptcy was restricted.

The Ombudsman received some complaints concerning the limitation of the amount of distraint or granting free months, in which it was considered that these concessions of enforcement should have been granted pursuant to the temporary amendment. These complaints did not lead to any action by the Deputy-Ombudsman.

During the year under review, there were also some 30 pending complaints concerning various business subsidies for the financial difficulties caused by the epidemic as well as funding for business development in these disruptive circumstances. Most of the complaints concerned Business Finland's procedure for selecting support targets and the granting procedure, as well as the guidelines of the Ministry of Economic Affairs and Employment on the preconditions for grant-

ing support. A few complaints were also addressed to municipalities, the ELY Centre and the State Treasury as the body granting the support.

4.2.6 ALIEN AFFAIRS

The coronavirus pandemic also affected the activities of authorities managing alien affairs. For example, asylum interviews at the Finnish Immigration Service had to be interrupted between 16 March and 14 April 2020. The interview activities could not be returned to normal until summer 2020. The coronavirus pandemic also influenced the handling of various application matters in Finnish missions abroad.

In one case the Embassy of Finland in Warsaw was criticised for not accepting passport applications due to the coronavirus pandemic. The Ombudsman stated that the Ministry for Foreign Affairs is responsible for the general planning, steering and monitoring of consular services pursuant to the Consular Services Act. The Ministry for Foreign Affairs had instructed missions to grant only emergency passports and temporary passports after the declaration of a state of emergency on 18 March 2020. The Ministry for Foreign Affairs changed the above-mentioned instructions later and gave the missions discretion on how to serve their customers during the coronavirus pandemic. These instructions concerned all consular services in missions, including the acceptance of passport applications. The embassy in Warsaw had misinterpreted the instructions and thought that accepting regular passport applications was prohibited. In principle, the Ombudsman supported that the Ministry for Foreign Affairs steers the operation of missions so that consular services can be provided safely to both personnel and customers during the state of emergency.

The Ombudsman drew the attention of the Ministry for Foreign Affairs generally to the provisions of the Constitution of Finland according to which the use of public powers must be based on an act and all public activities must strictly comply with legislation. For this reason, Finland's missions must also organise their activities during the coronavirus epidemic so that they can carry out the tasks determined in the Act on the Foreign Service, including the reception of passport applications. The Ombudsman sent a copy of his reply to inform the Ministry for Foreign Affairs (4290/2020).

On his own initiative, the Ombudsman investigated the activities of both the police and the Border Guard in connection with detaining foreigners and holding them in detention during the coronavirus pandemic. The Ombudsman asked the authorities in question to provide reports on how the coronavirus pandemic has affected the removal from the country and detention of foreigners.

The reports show that the coronavirus pandemic has had a major impact both on the detention of foreigners and their removal from the country. The enforcement of escorted removal from the country of foreigners was suspended until 1 June 2020. The removal of persons of certain groups (such as guilty of an offence) was normally continued after individual consideration. The pandemic had also been taken into account in detaining foreigners. As of March 2020, according to a report submitted to the Ombudsman, the Helsinki Police Department had regularly ensured that the preconditions for keeping each foreigner in detention were met in this changed situation. This meant that the threshold for detaining was raised in practice and that mostly only foreigners who are a danger to public order and security were detained. At the end of the year, the cases were still being processed (2615 and 2807/2020).

4.2.7 SOCIAL WELFARE

A total of 150 complaints concerning the state of emergency and COVID-19 impacts were initiated in the field of social welfare. The complaints in social welfare concerned particularly the limitation of social relationships of persons living or placed in different social welfare units, and above all, the restriction of communication rights. This section deals with the oversight of legality in relation to child protection and social assistance. Social

welfare matters are also included later in the sections on the rights of the child, the rights of older persons and the rights of persons with disabilities (4.2.9, 4.2.10 and 4.2.11).

Child protection

In total, 19 complaints concerning the state of emergency and COVID-19 were received in the field of child protection. In the early stages of the pandemic, complaints in child protection concerned the implementation of children's communication and restrictive measures in child welfare institutions. One of the complaints made by a child concerned the use of a mask in an institution. Later complaints have concerned the organisation of other child protection services, such as after-care services.

As soon as the pandemic broke out, a solution by the Substitute for a Deputy-Ombudsman (2130/2020) was published on the Ombudsman's website concerning the implementation of placed children's communication. At the same time, the Ministry of Social Affairs and Health issued instructions to social welfare units on how the Communicable Diseases Act and the Emergency Powers Act impact freedom of movement (VN/7643/2020).

In connection with the investigation of complaints related to substitute care, municipalities and places for substitute care were asked to issue reports on the effects of coronavirus and the measures taken in child protection. The requests for clarification also asked how the parents of children placed in institutions and the children themselves were advised and instructed in the pandemic and what kind of information on coronavirus and its impacts on practices were provided to them.

Social assistance

The new pending complaints (29) concerned decision-making of social assistance in the state of emergency, acknowledging the costs of face masks and payments of temporary epidemic compensation. Most of the writings concerned basic social assistance provided by the Kela social insurance institution.

At the beginning of the second wave of the pandemic, the mask recommendations also changed. The Deputy-Ombudsman's decision (5627/2020) concerned acknowledging the costs of acquiring face masks when deciding on social assistance. Previous decisions had stated that the costs can be taken into account for a special reason as expenditure entitling to social assistance on the basis of individual consideration. A statement from the Ministry of Social Affairs and Health was requested. The statement contained the same content as the Ombudsman's previous decisions. The costs of face masks are part of the basic amount of social assistance. In certain situations, it may be a matter of necessary work-related costs or healthcare expenses determined by a physician that will be separately taken into account when considering social assistance. For other special reasons of the family or applicant, the costs of face masks may be reimbursed as supplementary or preventive municipal social assistance. Following the statement request for the Ministry of Social Affairs and Health, the Ministry gave guidance for the relevant municipalities and Kela on the matter (Ministry of Social Affairs and Health 9/2020).

4.2.8 HEALTH CARE

There were 125 new pending healthcare complaints related to the coronavirus epidemic, of which 74 were resolved. The complaints concerned topics such as the guidelines of the Finnish Institute for Health and Welfare on isolating a person with a coronavirus in their home, announcements related to the coronavirus infections, acquiring coronavirus vaccines, instructions given to a person assigned to quarantine, the "applied" quarantine

and order to work, the shutdown of non-urgent surgery and the resulting healthcare debt, the failure to arrange non-urgent oral healthcare, limiting the presence of a support person in birth and the interruption of family training, as well as visiting bans on the acute hospital wards and the health centre wards for inpatients.

The Deputy-Ombudsman issued two decisions leading to measures concerning the ban on visiting the inpatient ward of a health centre.

The right of a guardian to meet their principal in inpatient care

The complainant was not allowed to meet their principal in the inpatient ward of the health centre because of a decision by the municipal healthcare authorities.

The Deputy-Ombudsman considered it justified to draw up guidelines in the epidemic which aim at ensuring that patients or personnel are not endangered in the inpatient ward from interaction of relatives and patients. However, the municipality acted unlawfully when it imposed a ban on visiting the inpatient ward on the basis of section 17 of the Communicable Diseases Act.

The Deputy-Ombudsman considered it positive that during the restriction, the inpatient ward aimed to maintain patient and family interaction by increasing telephone and video communication. The Deputy-Ombudsman was also pleased to note that the complainant's request to visit the patient had been carefully considered. However, the situation was not assessed individually enough but rather mainly in comparison to the exceptions mentioned in the guidelines of the Ministry of Social Affairs and Health.

According to the complainant, they were unable to contact the patient through the means of communication available because the patient was unable to express themself. According to the Deputy-Ombudsman, this fact should have been given importance when considering contact options of the complainant and patient. It was also not clear from the documents whether it would have been possible to organise the meeting using appropriate protective equipment. An incorrect understanding that the restriction was based on an act led to a situation where the options for how to arrange meetings without causing other patients or employees of the unit a risk of infection were not considered together with the relative (3823/2020).

Ban on visiting the health centre's nursing ward

The Deputy-Ombudsman considered that the nursing ward of the health centre acted incorrectly when the arrangement of an immobile patient's family member's visits without causing a risk of infection were not considered individually enough. The patient's inability to move and the patient room's location on the third floor of the building were not statutory reasons for restricting the right to meet (3739/2020).

4.2.9 RIGHTS OF THE CHILD

Complaints concerning the rights of the child related to the coronavirus epidemic mainly concerned child protection (section 4.2.7) and school activities (section 4.2.15). In addition, there have been some complaints related to healthcare, social welfare and, for example, the field of criminal sanctions. There were 76 new pending cases of which 58 were resolved.

Even though the coronavirus epidemic does not seem to have had an immediate impact on the number of complaints concerning the rights of the child or the content of the complaints in 2020, the indirect effects of the epidemic are expected to be visible later in the oversight of legality.

Several studies on the coronavirus epidemic's impact on the lives of children and young people have been conducted during the year. In January 2021, the Government published *Children, youth and the COVID-19*, Assessment of the materialisation of the rights of the child and proposals for post-crisis measures presented by a working group on the National Child Strategy (Publications of the Finnish Government 2021:2). The extensive report assesses the need for services, the availa-

bility of services and the special questions of different minority groups, for example. The report estimates that the coronavirus pandemic has had a serious impact on the well-being of children and young people.

According to the report, well-being has become polarised. Functional and prosperous families have been able to enjoy a closer everyday life and a stronger relationship between family members. In some families with children, however, the exceptional time has strained the family members' relationships. The number of police home alerts has increased. Children have also missed their hobbies, friends and relatives, for example. It is also known that the coronavirus crisis has worsened the income difficulties of families with children.

Coronavirus-related restrictions and exceptional arrangements have made the provision and availability of services harder. For example, meetings and home visits in social welfare, child health clinics and child protection had been reduced and the deficit could not be fully covered later. In addition to everything else, the need for child protection may have gone unnoticed. On the other hand, the supervision of substitute care for children already committed to care could not be carried out as planned. The coronavirus crisis has been said to worsen the position of vulnerable children and families in particular.

4.2.10 RIGHTS OF OLDER PERSONS

During the coronavirus pandemic, the public target set by the highest organs of government has been to ensure the adequacy of healthcare resources and protect particularly the risk groups from infection. The emphasised aim of protecting life in the care of older persons has raised questions about the implementation of other fundamental and human rights.

The majority of those who have died of the coronavirus disease have been over 70 years old. At an early stage of the spread of the disease, it was estimated that age is a significant risk factor for the severe COVID-19 disease. Older people living at home and in assisted living facilities as well as their families were given a large number of national and local guidelines and recommendations to prevent the spread of the virus.

Avoiding close contact is considered the most effective way to prevent the spread of the disease. It is particularly difficult to avoid close contact in institutions and assisted living facilities where encountering one infected employee or family member can lead to mass death. The application of the Communicable Diseases Act has produced difficulties in both social welfare and healthcare units. The objective set for assisted living facilities of protecting older people from infection has been difficult to implement without precise and defined legislation that would justify preventive measures that restrict individual rights and, on the other hand, would clearly guide the use of other means instead of restricting them.

The ambiguity of how obliging the decisions-in-principle and national and local instructions are has led to numerous complaints. In 2020, the Office of the Parliamentary Ombudsman received almost one hundred complaints about shortcomings in the implementation of the rights of older persons during the COVID-19 epidemic. About half of the complaints concerned the treatment of older people with memory disorders in care and nursing units during the epidemic and the prohibition of visits from family and and other persons close to the older persons. Some 20 new complaints concerned the equal treatment of people over the age of 70.

Deputy-Ombudsman Sakslin started on her own initiative nine investigations related to the rights of older persons and the COVID-19 pandemic. The investigations concerned instructions and supervision, services provided at home and the implementation of informal care and assisted living facilities. As complaints concerning the prohibition of visits have still come after the state of emergency ended, the Deputy-Ombudsman launched an investigation in autumn 2020 on the procedures of several different municipalities and service providers regarding how the residents of assisted living facilities meet their family mem-

bers or other persons close to them as well as their mobility outside the unit (5463/2020).

During the year under review, four inspections were carried out. Three of them included a follow-up inspection during the coronavirus epidemic. The OPCAT inspections are described in section 3.5.

During the epidemic, the following observations concerning informal care were made in an inspection on the organisation of services for older people (1389/2020).

The Deputy-Ombudsman welcomed the fact that during the coronavirus outbreak in spring 2020, the case managers of Siun sote (joint municipal authority for North Karelia social and health services) contacted all families of informal care support and the families were also informed of the impacts the coronavirus outbreak has on services in writing.

The Deputy-Ombudsman drew attention to the fact that the informal care providers have not been provided with sufficient services to support them during the coronavirus period. According to the information received during the inspection, there have not been enough services to compensate for the partial closure of 24-hour care facilities. The Deputy-Ombudsman emphasised that municipalities and joint municipal authorities must organise the necessary social and healthcare services. The services already granted to a customer must be arranged. The Deputy-Ombudsman noted that together the closure of services may have caused unreasonable circumstances for the families under support for informal care because some of the families have accumulated service needs already before the coronavirus outbreak due to the long period of updating their care and service plans (1389/2020).

Activities of the highest authorities during the epidemic

The ban on visits and instructions on treatment and care in all care and nursing units for older people in Finland during the epidemic have been based on the guidelines issued by the Ministry of Social Affairs and Health and the Finnish Institute for Health and Welfare.

On the basis of the complaints, Deputy-Ombudsman Sakslin started investigating the way in which the highest authorities have ensured that municipalities and various care service units for older people comply with the legislation in force, and that the measures to prevent the disease from spreading do not unnecessarily and unlawfully restrict older people's movement or face-to-face contact with family members and other persons close to them. The Finnish Institute for Health and Welfare, the National Supervisory Authority for Welfare and Health (Valvira) and the Ministry of Social Affairs and Health were asked for a clarification.

In decision 3232/2020, the Deputy-Ombudsman stated that the Communicable Diseases Act does not specifically give the right to restrict a person's fundamental rights in situations other than quarantine and isolation, and that binding visiting bans cannot be imposed on housing units under section 17 of the Communicable Diseases Act.

In its instructions (20 March 2020, adjusted 16 April 2020), the Ministry of Social Affairs and Health had informed the municipalities that under section 17 of the Communicable Diseases Act, visiting bans may be imposed and only some exceptions may be permitted. The Deputy-Ombudsman noted that the instructions issued by the Ministry of Social Affairs and Health concerning the care institutions for older people and housing service units have been incorrect. The error in the instructions has resulted in visits being unlawfully prohibited or restricted.

Particularly in the care for older people, the enforcement of a visiting ban led to a situation where, in addition to preventing family members from going inside the unit, the meetings were either completely prevented, strongly reduced or

the unit was unable to arrange them so that communication with family members was possible. The realisation of the rights of older people in particular may also require that a person in need of help of another person can obtain it. According to the information received by the Deputy-Ombudsman, the possibility of outdoor recreation has decreased considerably due to the restrictions used, as no assistance was available for outdoor recreation.

The Deputy-Ombudsman noted that people with memory disorders find it difficult to exercise their right to self-determination. Under the current law, when a person has difficulties in expressing their will, family members and other persons close to them should be allowed to help determine their will. This has also become either more difficult or completely impossible during the visiting ban.

The visiting ban is relevant for the individual's right to self-determination and the right to private life guaranteed by paragraph 1 of section 10 of the Constitution of Finland and for the right to respect for their private and family life, home and correspondence, as guaranteed by the European Convention on Human Rights. According to article 8 of the European Convention on Human Rights, there shall be no interference by a public authority with the such as is in accordance with the law and is necessary in a democratic society, among other things, in the interests of national security and public safety or for the protection of the rights and freedoms of others.

The assessment of restrictions is also relevant in section 21 of the Constitution and article 6 of the European Convention on Human Rights. They ensure everyone's right to have any restriction of their rights properly processed and within a reasonable period of time, in a fair manner before an independent court or a competent authority.

The Deputy-Ombudsman noted that article 8 of the European Convention on Human Rights advocates a permissive attitude towards visits by persons close to the customer. However, the Deputy-Ombudsman considers it clear that, even under normal conditions, there may be a need to control visits in order to ensure good and safe care. When it is necessary to restrict the right to visit a unit in general, the restrictions must be based on an act, at least regarding family members and persons close to the customer. By restricting the visits of persons close to them, the rights of both the guest and the customer in care are interfered with significantly. Therefore, both the conditions for restriction and legal protection must be provided for by law.

A view of procedural shortcomings was brought to the attention of the Ministry of Social Affairs and Health, Valvira and the Finnish Institute for Health and Welfare. The Deputy-Ombudsman proposed that the Ministry of Social Affairs and Health immediately initiate careful preparation of legislative amendments.

Equal treatment of older persons during the coronavirus epidemic

As a result of the complaints, the Deputy-Ombudsman took an initiative to investigate whether the measures targeted at older persons were discriminatory during the coronavirus epidemic (3787/2020). It was assessed whether setting the age limit of 70 in the guidelines concerning the coronavirus epidemic violated equal treatment or the prohibition of discrimination, and whether the measures targeted at older persons mentioned in the complaints to prevent the spread of the coronavirus epidemic included other forms of direct or indirect discrimination.

The Deputy-Ombudsman stated the following regarding restricting visits.

Under section 11 of the Non-Discrimination Act, different treatment is not discriminatory if it is based on law, its objectives are otherwise acceptable, and the means for achieving the objectives are proportionate.

According to experiences gained during the coronavirus epidemic, reducing contacts has had a significant impact on reducing morbidity and, consequently, mortality. Almost half of the people who have died of a coronavirus infection have been residents of 24-hour social welfare units. It is likely that by reducing the number of visits, mass deaths have been avoided especially in care units for older people. The restriction of visits can

therefore undoubtedly be considered to have an acceptable objective.

In addition to having an acceptable objective, the treatment must be based on law and the means to achieve the objective are proportionate to avoid discrimination.

The Deputy-Ombudsman stated that the implementation of the visiting ban was not based on an act. In the absence of detailed and precise legislation, the units have had major difficulties in assessing whether alternative arrangements would adequately safeguard residents against a coronavirus infection.

With regard to the instructions for people over 70 years of age, the Deputy-Ombudsman stated that the obligation to avoid contacts with other people as far as possible (Ministry of Social Affairs and Health press release 55/2020) has been a guideline aimed at protecting older people. This recommendation for citizens has not been discrimination against people over the age of 70.

When assessing whether there is direct discrimination, it had to be assessed whether the request had been binding. The guidelines use the word 'obligation'. However, it did not refer to any specific legal provision, and the text of the guidelines was not otherwise based on any legal obligation. The Deputy-Ombudsman agreed with the Non-Discrimination Ombudsman's statement that the guidelines were not written in a binding form as a whole. The guidelines contain several expressions that leave room for discretion, such as 'as far as possible', 'urges to avoid' and 'if it is necessary to visit a shop yourself – –'. Neither do the guidelines refer to legal provisions in a way would imply that they are an obligation laid down by an act.

However, the Deputy-Ombudsman considered that, due to the use of the word 'obligation', individual persons over 70 years of age could reasonably have considered the instructions legally binding. The Deputy-Ombudsman noted that to achieve equality as a fundamental and human right, it would have been preferable that the instructions on how to prevent virus infections were addressed to the general population and they should have explained who belongs to the high-risk groups and on what grounds as well as give special instructions to persons belonging to different high-risk groups on how to protect themselves from an infection.

With regard to the assessment of the proportionality of the instructions, the Deputy-Ombudsman stated that several people expressed that they considered it offensive that they were not deemed to be able to decide on their own actions. Many people over the age of 70 experienced labelling based on their age. In order to avoid discriminatory treatment based on age, it is necessary to continuously assess the recommended measures, whether the age limit should be changed and whether an age limit should be set at all. The Deputy-Ombudsman understood that setting an age limit may have been justifiable in terms of the clarity and comprehensibility of the instructions. However, if the age limit of 70 is not justifiably acceptable, it should not be used in the instructions.

A view of legislative and instructive shortcomings was brought to the attention of the Ministry of Social Affairs and Health and the Finnish Institute for Health and Welfare. The Deputy-Ombudsman proposed to the Ministry of Social Affairs and Health that the presented aspects be taken into account in the drafting of legislation and guidelines, and that the supervision of units be enhanced nationally. To realise this purpose, the decision was also sent to Valvira for information.

Instructions for people over 70 years of age during the coronavirus pandemic

In case 2889/2020, the Deputy-Ombudsman found it understandable that communication may have been unclear in some respects, especially in the early stages of the outbreak. The initial assessment of the seriousness of the pandemic threat was difficult and it was therefore very important to make every effort to protect the health and life of citizens. At that time, there was only little information available on the behaviour of the virus and the situation was assessed to require urgent measures.

When the situation became more stable, it had to be ensured that the instructions and informa-

tion were up to date, timely and clear. It is important that the message is understood correctly. The Deputy-Ombudsman requested that the Ministry of Social Affairs and Health and the Finnish Institute for Health and Welfare together clarify communications directed at municipalities and other actors.

Right of elderly spouses to live together

The public officials were not aware that under the Act on Care Services for Order Persons, married and cohabiting elderly spouses must be provided with an opportunity to live together. The Deputy-Ombudsman drew attention to the fact that it is not possible to act against the will of the customers in this matter. During the coronavirus pandemic, visits between care units were also prohibited. The Deputy-Ombudsman stated that the complainant's parents had the right to live together and that their meetings should not have been restricted at all. The personnel did not recognise that they were acting arbitrarily and unduly in breach of the protection of spouses' family life. They had no legal right to prevent spouses from living together, talking to each other without obstacles or holding each other's hands. (4070/2020) See more about the case in section 3.7.

Close relative denied from attending a funeral due to the emergency circumstances

In case 3513/2020, a service centre had denied the complainant's mother access to her husband's funeral. The employees were under the impression that they had both the right and obligation to prohibit the complainant's mother from taking part in her husband's funeral under section 86 of the Emergency Powers Act and the guidelines of the Ministry of Social Affairs and Health. During the state of emergency, the Government issued a decree on the enforcement of the powers laid down in section 86 of the Emergency Powers Act. However, the Deputy-Ombudsman stated that the decree did not grant any powers to restrict the movement of persons with memory disorders or other disabilities.

The Deputy-Ombudsman emphasised that even detailed guidelines issued by a ministry or other authority are not legally binding in nature so that they allow restricting fundamental rights. Those responsible for the activities must be familiar with the legislation in their field and also comply with the Constitution and international human rights conventions. Actors must know how to comply with the principles of the rule of law, proportionality and equality in practice. The management must always ensure that personnel's instructions are in accordance with legislation and that by following the instructions they do not violate any provisions of law.

The blameworthiness of the procedure was lessened by the fact that it was difficult for the actors to understand from the official instructions that the procedure was not based on legislation. Based on the guidelines of the Ministry of Social Affairs and Health (instructions on the prevention of coronavirus infections in units providing 24-hour care and treatment 15 May 2020), it could also be understood that the purpose was to restrict residents' mobility outside the units. The mistake led to a situation where the ban was used despite, in the Deputy-Ombudsman's view, there being a possibility to find a solution together by discussing that would have respected the deceased's family's right to family life.

The Deputy-Ombudsman sent a copy of her decision to the Ministry of Social Affairs and Health, the Finnish Institute for Health and Welfare and Valvira for consideration in the drafting of legislation and guidelines.

Implementation of oral healthcare for persons with memory disorders

An unannounced inspection revealed that in the employees' experience, dental care for older people has often been neglected for a long time before the older person moves to a 24-hour institutional service. The Deputy-Ombudsman took an initiative to investigate the implementation

of oral healthcare for older people with memory disorders and older people's dentist visits.

Oral diseases can have serious consequences for a person's health and well-being, as they increase the risk of developing other illnesses, such as cardiac and respiratory diseases. Weakening functional capacity and initiative due to ageing have a significant impact on a person's ability to take care of their oral hygiene on a regular basis. The possibility for an older person with a memory disorder to express themselves about problems related to oral health might also be very limited.

The Deputy-Ombudsman stated that it is not appropriate that the responsibility for deciding on the oral healthcare measures of a customer with a memory disorder rests solely on the assessment of the nursing staff. Social welfare customers with memory disorders should have an oral care plan prepared by a dentist and carried out by the nursing staff. This should be done especially for customers who are unable to independently look after their oral health. The nursing staff must monitor the implementation of the plan on a daily basis.

The Deputy-Ombudsman noted that the coronavirus epidemic has caused a major deficit in the implementation of oral healthcare services. For this reason, the Deputy-Ombudsman considered it very important that an effort be made to eliminate the so-called healthcare debt in oral healthcare as soon as possible after the coronavirus outbreak settles (6646/2019).

Notifications of disappearances of older people

Deputy-Ombudsman Sakslin decided to investigate the police reports on the disappearance of older persons to the social services and the measures taken by the social services on the basis of the reports during the state of emergency. Based on the received clarifications, the social services received police reports of missing older people during the state of emergency in the same way as before the coronavirus pandemic. The assessment of the need for services was carried out by telephone when it was possible in view of the overall situation. More emphasis was placed on the help of close relatives and services provided at home, and the organisation of crisis accommodation was carefully considered due to the coronavirus outbreak. The Deputy-Ombudsman considered this procedure appropriate and its justifications understandable, but stressed that even in exceptional circumstances, the other social welfare services in addition to the necessary services provided at home must also be arranged (4682/2019).

4.2.11 THE RIGHTS OF PERSONS WITH DISABILITIES

In total, there were some 80 complaints concerning the coronavirus pandemic and persons with disabilities. The majority of them were in the administrative branches of social welfare and healthcare. The complaints concerned a nursing home's procedure for organising visits, restricting holidays to visit home for persons with intellectual disabilities, the possibility of a disabled person to meet with their family members, the use of a personal assistant in a housing service unit during the state of emergency, the procedure of a city's disability services in organising activity centre services for persons with intellectual disabilities, and organising a school assistant for a child with a disability in distance education. The number of complaints and the number of problems that emerged was the highest in cases involving older people with memory disorders. Complaints concerning them are presented above under 'rights of older persons'.

During the first wave of the epidemic in spring 2020, there was public discussion that there had been decisions on the exclusion of respiratory machine treatment (Do Not Resuscitate decision, or DNR) or that they were being prepared for persons with intellectual disabilities and persons with severe disabilities living in housing service units. This led to one complaint. The Ombudsman's decision considered that the case did not give cause for action, at least for the time being, as according to the hospital, the COVID-19 epidemic was not relevant to the treatment of patients, which are

influenced only by the patient's functional capacity. The hospital had announced that it would organise a new treatment negotiation in the matter (2480/2020). No concrete cases or instructions had been brought to the attention of the Office of the Parliamentary Ombudsman in which the care of a person with an intellectual disability or a person with a severe disability was restricted due to the disability (2420/2020).

In his decision regarding restricting the home holidays of persons with intellectual disabilities, the Ombudsman considered that the case had not revealed such an erroneous procedure of the housing unit during the state of emergency that would have required measures in the Ombudsman's oversight of legality at that stage of the investigation. However, the Ombudsman stated that the housing unit should individually assess how and to what extent the residents' right to keep contact and go home for a holiday can be implemented (2219/2020).

The Ombudsman did not initiate an investigation of the decision on the visiting ban by the head of disability services at the same time as the city's Social and Health Services Committee, which was investigating the request for an administrative review regarding the decision (3483/2020). The Supreme Administrative Court has since investigated an appeal concerning the same matter and issued a Yearbook decision (KHO:2021:1). The Supreme Administrative Court considered that the decision by the head of disability services could not have imposed a visiting ban on housing units providing disability services. The decision of the head of disability services was thus unlawful.

The procedure of a housing unit was criticised in a case where a personal assistant was not allowed access to the housing unit during the state of emergency (4247/2020). In addition, there is a complaint about the city's disability services' procedure in organising activity centre services for persons with intellectual disabilities (4203/2020).

During the year under review, the Government Situation Centre monitored the development of the coronavirus-related circumstances and the tacit signals of the field of disabilities. Organisations in the field of intellectual disabilities (Finnish Association on Intellectual and Developmental Disabilities, Inclusion Finland KVTL, FDUV, Vammaisperheyhdistys Jaatinen ry) collected information for the Government Situation Centre on their observations of acute and troubling issues and good practices in their members since the beginning of the pandemic.

The disability team of the Office of the Parliamentary Ombudsman received the situational reviews, which the organisations had sent the Government, for information. The situational reviews also provided estimates of how the authorities' communications and guidelines reached different population groups. For example, according to a review, the number of visitors to the website of the Finnish Centre for Easy Language (*Selkokeskus)* under the Finnish Association on Intellectual and Developmental Disabilities had clearly increased at the end of the year in comparison to the same time of the previous year. People with intellectual disabilities can also contact the simplified Verneri.net guidance, where the number of users increased by 104% in 2020 compared to 2019.

Inspection visits

The information obtained from the situational reviews was used as background material in the preparation of remote inspections' requests for clarification for six inspection sites, one of which was a housing unit for persons with severe disabilities and five were institutional and housing service units for persons with intellectual disabilities. In these mainly document-based inspections, the Ombudsman wanted to investigate particularly how the coronavirus epidemic has affected the activities of the operating units and the treatment and conditions of residents during the epidemic.

In addition to requests for clarification and documents, the disability team continued to improve telephone interview procedures in connection with these remote inspections. A total of 35

residents with disabilities or their families participated in telephone interviews. The inspections are still ongoing (3649, 3650, 3651, 3652, 3653 and 3654/2020).

The following problems and good practices were highlighted in the reports requested from the inspected sites.

According to one report, a unit had imposed a visiting ban after the Ministry issued the guidelines. Customers and relatives were informed of the visiting ban on 14 March 2020, and they had been asked to avoid visiting housing units and to be in contact with their close relative by telephone instead of visiting them. Residents' time off to visit home had also been cancelled, which was why the number of personnel was increased on weekends (3652/2020). The visiting ban was in force in several units of the inspected site from March to May/June. In one unit, the first visitors were able to meet the customers outdoors as of 10 May 2020, taking safety measures into account. However, the relatives of a resident in terminal care were allowed to visit the unit in the inhabitant's own room (3652/2020).

In two inspection sites, the residents had been able to meet their family members outside the unit (3653/2020 and 3649/2020), and in one inspection site, the customers had also been allowed to go outside independently (3649/2020).

At one inspection site, the housing units had a strong recommendation that customers avoid visiting parents and other close relatives. According to the report, home visits had been possible again from 25 June 2020 (3653/2020).

The interviews of the relatives and customers highlighted their experience that the information on the visiting bans provided by housing units had been inadequate (3649/2020).

In some units, a podiatrist and physiotherapist were allowed to visit the unit taking safety into account in their protective equipment (3652/2020). In one unit, therapists were not allowed to make home visits at the unit, but the customers were allowed to go to physiotherapy outside the unit (if the physiotherapist allowed it). Physiotherapists were able to visit the unit again as of 1 June 2020 (3653/2020).

According to the report, the use of personal assistant services and the implementation of essential rehabilitation services, such as physiotherapy and occupational therapies, were also possible in 24-hour housing units using protective equipment. In addition, remote rehabilitation had also been used (3649/2020).

According to the report, quarantine and isolation were always carried out in accordance with the instructions given by the municipality or hospital district's doctor specialised in infectious diseases. Customers had been instructed to stay in their own apartments. There was no need to implement restrictive measures for preventing exposure to coronavirus or communicable diseases for customers assigned to quarantine or isolation, but different directive methods were used to manage these situations (3649/2020).

The reports showed that customers had been provided with opportunities to participate in daytime activities in different ways in the housing unit (3649/2020). In another inspected site, substitute services were also implemented after personnel organising daytime activities moved to work in the housing unit. Daytime activities personnel (around 160 employees) moved to work in housing units and there was no need to hire more workforce (3649/2020).

In another unit, additional employees had been hired to activate customers from Monday to Friday from 9 a.m. to 3 p.m. following the end of daytime activities (outsourced service). The daytime activities of customers living at home continued in the activity centre in small groups a few times a week. According to the report, daytime activities returned on 3 August 2020 (3653/2020).

According to the report, exemplary employment, daytime activities and other activities outside the housing unit, such as weekly clubs, adult education centre activities and swimming pool trips, were interrupted on week 12. Daytime activities were organised for residents in smaller groups without participants from outside the housing unit. Outdoor activities were also invested in more than before (3652/2020).

According to the report, services outside the housing unit had been avoided. This was particularly to protect the customers belonging to high-risk groups from coronavirus. The restrictions applied to persons who had moved outside the housing unit. Actual restrictions on the use of services were not prohibited, but they had been discussed. According to the report, restrictive measures under the Act on Special Care for Persons with Intellectual Disabilities had been applied on the same principles as in the normal situation before the coronavirus pandemic's exceptional circumstances. No restrictive decisions under the Communicable Diseases Act were made. There were no cases of coronavirus in the unit (3652/2020).

According to the report, the customers could not participate in an association's activities outside the housing unit because such activities were not organised. The customers were not able to visit a café, library, swimming pool or cinema. Joint food purchases were made online. They also had to cancel a joint trip abroad due to coronavirus (3653/2020).

In its report, one inspected site stated that it had reduced the supply of daytime activities, temporary care and research and rehabilitation periods, agreeing on the matter with the municipalities. For compelling reasons, activity centre services were continued for some customers. Due to a reduction in the supply of daytime activities and a partial suspension, daytime activities were offered to customers exceptionally at the housing units and as a remote service. Schoolchildren attended distance school in spring 2020 (3649/2020).

According to the report, opportunities for customer participation had been increased during the coronavirus outbreak and they had created new digital ways for participating and influencing. All customers assigned to quarantine or isolation had been provided with daily, frequent human contacts as employees visited their apartment. There were numerous daily encounters, which were mainly realised in actions related to the customer's basic needs (such as hygiene care, home care and meals). In connection to these visits, there was also activities that promote social relationships and the customer's activity and functional capacity such as video calls to relatives, discussion and games. The report showed that customers had been provided with, for example, iPads and Yetitablets, which were hoped to increase the opportunities for customer participation and strengthen their right to self-determination and the skills needed for it (3649/2020).

4.2.12 GUARDIANSHIP

The exceptional circumstances and the coronavirus pandemic were hardly visible in guardianship matters, as only one such case was initiated. This concerned extending the period for submitting a guardian's annual accounts due to the coronavirus outbreak. The case is still pending.

4.2.13 SOCIAL INSURANCE

Based on the number of new complaints (24), the social insurance sector seems to have overcome the challenges caused by the coronavirus epidemic. The complaints concerned the Kela social insurance institution and the benefits administered by it, such as temporary financial assistance due to an epidemic outbreak and sickness allowance on account of an infectious disease. On the basis of the complaints, there was no congestion in the processing of any benefit. Kela also received additional funding for the increasing costs of application processing and customer service during the year.

In the spring, the Deputy Chancellor of Justice took initiative to investigate Kela's preparation for a significant increase in the number of cases due to the pandemic (OKV/7/50/2020).

Kela seems to have managed to also provide telephone services well during the epidemic. Just before the pandemic, Deputy-Ombudsman Pölönen received a number of letters criticising the congestion of Kela's telephone service at the turn of the year 2019–2020. The situation of the telephone service was still congested and problematic in January–February. The coronavirus epidemic significantly changed Kela's focus of customer service. Kela transferred personnel from physical customer service to the telephone service to ensure its proper functioning during the pandemic. According to the press releases published by Kela, their measures to ensure the proper functioning of the telephone service seem to have been successful, nor has the Ombudsman received complaints about the telephone service.

In decision 2488/2020, Deputy-Ombudsman Pölönen decided to investigate Kela's procedure in closing service points. In the spring, Kela had restricted customer service at service points to prevent the spread of coronavirus. Some of the service points had been completely closed, and some of the activities had been reduced to pre-booked appointments. This meant a reduction of the service level for Kela customers and the elimination of one form of service from their use. However, the Deputy-Ombudsman considered that, due to the exceptional circumstances caused by the pandemic, Kela had reasonable grounds to restrict customer service provided face-to-face at service points. At the same time, Kela ensured the proper functioning of other service channels, especially telephone services and online services, through internal personnel transfers. Kela had also started to receive applications on the telephone orally in order to reduce the need for physical office services.

The Deputy-Ombudsman emphasised that Kela should assess the possibilities of opening service points that are completely closed, possibly in reduced opening hours at first. He urged Kela to cooperate with other actors (municipalities) to seek solutions for opening service points, or to think of another solution that could provide customers in these areas with opportunities to access Kela's office services also under emergency conditions on an equal basis with other customers. Kela had already announced the beginning of the gradual dismantling of restrictions on service points in the Helsinki Metropolitan Area in June. The Deputy-Ombudsman considered that Kela should also assess the operation of service points located elsewhere in Finland and their restrictions and dismantling them in accordance with the same operating principles. Kela must serve its customers equally in all service channels throughout Finland, taking into account epidemiological and other criteria related to the state of emergency. The Deputy-Ombudsman also drew Kela's attention to the fact that it must announce the up-to-date opening hours of its service points during the state of emergency and any changes in them also on its website's service point search.

4.2.14 LABOUR AND UNEMPLOYMENT SECURITY

According to the Employment Bulletin of the Ministry of Economic Affairs and Employment, the number of unemployed jobseekers increased rapidly and in great deal in the Employment and Economic Development Offices (TE Offices) as a result of the COVID-19 epidemic. At the end of February, TE Offices had some 248,000 unemployed jobseekers, of whom around 19,000 were fully laid off. The number of unemployed jobseekers began to grow in March reaching its peak at the end of April, when there were some 433,000 unemployed jobseekers, of which some 164,000 were fully laid off. At the end of December, there were some 357,000 unemployed jobseekers, of which around 78,000 were fully laid off. The number of unemployed jobseekers grew most in the region of the Uusimaa TE Office, where there were around 71,000 unemployed jobseekers at the end of February and 148,000 unemployed jobseek-

ers at the end of May. At the end of December, there were approximately 117,000 unemployed jobseekers in the TE Office's area.

Some provisions of the Act on public employment and business service and the Unemployment Security Act regulating the tasks of TE Offices were temporarily amended due to the COVID-19 epidemic. The amendments entered into force at the beginning of May. Some of the changes were valid until the end of the year and some will continue in 2021. According to the government proposal on the changes, the central task of the Employment and Economic Development Offices regarding laid-off and otherwise unemployed and registered jobseekers is to ensure that the jobseeker's application period becomes active and that the labour policy-related preconditions for paying unemployment benefits are resolved. For this reason, the amendments aimed to ensure the jobseeker's right to unemployment benefit and support the appropriate allocation of the resources of Employment and Economic Development Offices during the pandemic. There were no amendments to the provisions on issuing a labour policy statement and processing an unemployment benefit application.

In total, 44 complaints concerning the COVID-19 epidemic and TE Offices, unemployment funds and unemployment security managed by Kela were initiated and resolved. There were no complaints concerning the processing time of unemployment benefit to the TE Office after July or to the unemployment funds after September. Based on the number of complaints, the mentioned actors seem to have overcome the challenges associated with the increase in the number of customers following the pandemic.

Almost 80 per cent (34) of the decisions on complaints led to measures by the Deputy-Ombudsman. Deputy-Ombudsman Pölönen issued 16 decisions on TE Offices and 12 on unemployment funds in cases where the legal deadline for issuing a labour policy statement and processing an unemployment benefit application was exceeded. All decisions concerning the TE Office concerned the Uusimaa TE Office (2935/2020). In the decisions on the processing time, the Deputy-Ombudsman stated that exceeding the deadlines was a violation of legal provisions. When assessing the blameworthiness of the procedure, the Deputy-Ombudsman took into account the fact that the TE Office and the unemployment funds had immediately used the measures available to them at the beginning of the epidemic to ensure service capacity as the number of customers increased to record high numbers.

4.2.15 EDUCATION AND CULTURE

General description of the impacts of COVID-19 on the administrative branch

In March, schools and educational institutions adopted exceptional teaching arrangements, when the Regional State Administrative Agencies ordered that the educational institutions be mainly closed with regard to contact teaching, and the obligation to organise contact teaching and guidance at different education levels was restricted by the government's application decrees (126/2020, amending decree 131/2020, 191/2020) under the Communicable Diseases Act. The restrictions on the obligation to provide early childhood education and care, education and training and the possibility of distance education laid down in the latter application decree were valid until 13 May 2020.

The education and training providers were facing a new, unprecedented situation when they had to quickly adopt a new way of organising teaching. This resulted in practical issues of interpretation, especially in the early stages, and strong pressure on the directing authorities to instruct and support education and training providers sufficiently and consistently in the implementation of the changes to teaching.

The pupils of basic education returned to contact teaching on 14 May, after which the use of pre-primary and basic education facilities was managed by measures in accordance with the Communicable Diseases Act. The purpose of the temporary amendments to basic education legislation (1 August 2020–31 December 2020 and 1 January 2021–31 July 2021) is to ensure the pupils'

right to education, even when education cannot be organised following the provisions concerning regular conditions due to a decision made under the Communicable Diseases Act, as well as to allow education providers to act from a local perspective.

The majority of general upper secondary schools continued mainly in distance education until the end of the spring term 2020. Due to the coronavirus outbreak, the matriculation examinations in humanities and natural sciences were organised a week earlier in the spring of 2020. The partially free-of-charge renewal of individual matriculation examinations was possible for students who had to change their plans and take several examinations in one week. Restrictions caused by the coronavirus pandemic also affected the traditional spring graduation celebrations of educational institutions. During the autumn term, the organisers of general upper secondary education decided on the appropriate and safe organisation of teaching within the framework of legislation on normal conditions.

In basic education, the capacity of education providers, teachers and pupils to move to distance education varied and support for learning and school attendance as well as pupil welfare were implemented in different ways. Concern over the learning of pupils who also need a lot of guidance in contact teaching came up in many contexts. On the other hand, there was significant improvement in the digital capabilities of teaching during the distance education period.

The Ministry of Education and Culture gathered the experiences of pupils in basic education about the organisation of distance education in the spring of 2020 and the beginning of schoolwork in the autumn by means of a national online interview in October 2020. According to it, pupils were mostly satisfied in teaching with remote connections in the spring, and the majority of the pupils felt that schoolwork was safe in autumn 2020.

Decisions related to oversight of legality

The exceptional circumstances gave rise to numerous complaints and enquiries in the oversight of the legality of education.

The complaint topics included bringing parts of the matriculation examination forward, organising pre-primary education and support for learning, requiring mask use, and the day-care centre procedure to require coronavirus testing. Deputy-Ombudsman Pölönen decided to investigate the support for learning and school attendance of pupils in distance education and the realisation of school meals during the state of emergency.

Most of the complaints concerning the highest education were about changing student admission criteria (102 cases). The complaints also concerned topics such as the possibility of arranging compulsory teaching training, providing information on the organisation of teaching, requiring the principal's permission for leisure travel and requiring the use of face masks from students and the museum's customers.

The following themes were highlighted in the complaints about changing the admission criteria: 1) changing the admission criteria fundamentally in the middle of the application process by increasing the proportion of certificate-based admissions in at least some fields, 2) the appropriateness of announcing the changes, 3) the necessity/appropriateness of cancelling exams in person and 4) any problems related to the organisation of electronic preliminary selection exams, such as the availability of equipment, technical conditions and the possibility for cheating. The Deputy-Ombudsman will assess the matter particularly from the perspective of equality between applicants and equal treatment of good administration, protection of trust, the requirement of proportionality and the obligation to provide advice as well as the appropriateness of providing information. The Deputy-Ombudsman also assesses aspects related to electronic preliminary selection. The matter is still pending (2628/2020, etc.)

Performing work-related tasks on your personal phone

This case concerns an employer's order obliging teachers to use their personal phones during the distance learning period to carry out their work tasks. The Deputy-Ombudsman stated that an employee does not in principle need to use their own tools. Instead, an employer must provide the employee with appropriate and adequate tools for performing the work (5000/2020).

Organising school meals during the state of emergency

The municipal social services coordinated the distribution of school food in the early stages of distance education for families who reported a need for it. The Deputy-Ombudsman did not consider this to give cause for action. The Deputy-Ombudsman considered that even though the government's recommendations and the communications of the authorities did not fully reflect the position of school meals early on in the state of emergency as outlined by the Parliament's Constitutional Law Committee and the Education and Culture Committee, they aim to ensure pupils' right to free basic education and the school meals included in it in a satisfactory manner under the circumstances (2393/2020).

4.2.16 LANGUAGE ISSUES

Only a few complaints concerning the state of emergency, coronavirus pandemic and linguistic rights were received and resolved. In two cases, the Ombudsman assessed the appropriateness of provision of information. One complaint that is still pending concerned the language of the quarantine decision. A bilingual library had announced the coronavirus situation's impact on customer service only in Finnish (4594/2020). The second case concerned the Swedish announcements on the Border Guard's website regarding arrival to and exit of the country (3192/2020). The complainant had already received a reply from the library explaining why the announcement had been incomplete and apologies on the matter. The website of the Border Guard had been updated after the complaint was filed. The complaints did not require any action by the Ombudsman.

4.2.17 TRANSPORT AND COMMUNICATIONS

In the transport and communications sector, complaints related to the state of emergency and the pandemic concerned mostly compensation for unused tickets or travel time in public transport, the removal of the cash payment option in means of transport, safety distances and other safety arrangements related to the epidemic. The complaints also concerned the proceedings of the Finnish Broadcasting Company (YLE) in broadcasts related to COVID-19 and Posti Group Oyj's proceedings in the delivery of mail. The Ombudsman's power over YLE, Posti Group Oyj, and VR Group is very limited, and thus the complaints were largely about matters outside the Ombudsman's authority.

The Deputy-Ombudsman decided to investigate how the exceptional procedure for renewing a driver's licence during the pandemic had been announced. The exception procedure allowed persons who needed a medical certificate for the renewal to receive an additional six months to obtain the statement. On the day of its enforcement, the procedure had been announced on the agency's website. The agency had also issued detailed instructions to Ajovarma and the police, for example. Several newspapers also reported on the change. There was no separate letter or other targeted contact method to the persons covered by the exceptional procedure.

According to the Deputy-Ombudsman, as the situation was sudden, it is possible that it would have been impossible to inform all persons subject to the exceptional procedure in sufficient time to allow the person to take into account the ad-

ditional period of time for the submission of the medical certificate. Despite this, the Deputy-Ombudsman considered that the targeted announcement of the procedure to the persons covered by it would have followed the principles of good administration better than what had now been done. The Deputy-Ombudsman brought her opinion on procedure under good administration to the attention of the Finnish Transport and Communications Agency (3405/2020).

4.2.18 HIGHEST ORGANS OF GOVERNMENT

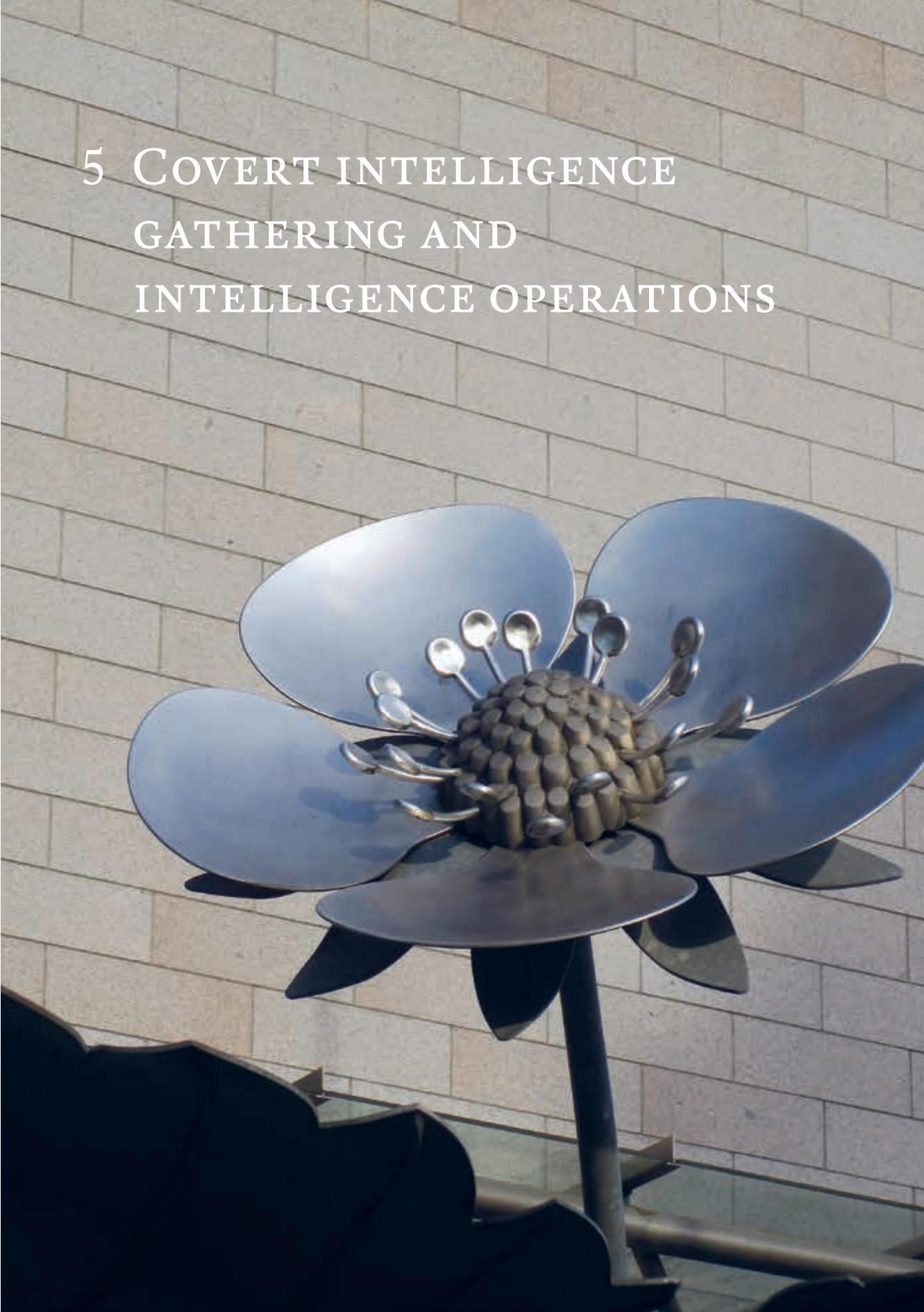
During the year under review, the total number of complaints by the group increased considerably, which is explained by the large number of complaints related to state of emergency and the coronavirus pandemic (93). On the other hand, their number is explained by the Government's central role in the management of the coronavirus pandemic and by the fact that they concerned a large number of measures that had a strong impact on fundamental rights and everyday life, be it individuals or entrepreneurs.

Most of the complaints concerned individual coronavirus-related restrictions, such as guidelines for persons over 70 years of age and their equal treatment (see section 4.2.10), mobility and travel restrictions and border surveillance, restrictions on restaurants' activities, quarantine of people from high-risk countries, and contact and distance education in schools. The Government's announcements related to the coronavirus pandemic and issues concerning respiratory protection were also subjects of complaints. Many complaints concerned the Government's coronavirus-related action more generally, such as the introduction of the Emergency Powers Act and the adopted coronavirus strategy and its compliance with the Communicable Diseases Act.

Most of the cases resolved in the year under review did not lead to action by the Ombudsman. This is explained, for example, by the fact that the introduction of powers under the Emergency Powers Act was assessed in Parliament in accordance with the Emergency Powers Act, and the Ombudsman has no authority to intervene in Parliament's proceedings. The complaints also mainly contained general dissatisfaction with the Government's measures, by considering restrictions either too strict or too free, for example. On the other hand, many cases had either been brought before the Office of the Chancellor of Justice earlier, or due to their nature, it was appropriate to refer the complaint to the Chancellor of Justice, who is primarily responsible for the supervision of the government. Some of the cases were such that the Chancellor of Justice had already assessed them, which is why the Ombudsman's actions were no longer appropriate.

The Ombudsman issued three statements to the Constitutional Law Committee concerning government decrees on the commissioning or application of the powers laid down in the Emergency Powers Act (2033/2020).

5 Covert intelligence gathering and intelligence operations



5 Covert intelligence gathering and intelligence operations

The oversight of covert information gathering and intelligence operations fell within the remit of Parliamentary Ombudsman *Petri Jääskeläinen*. The principal legal adviser responsible for the area was *Mikko Eteläpää*. Themes included in this area are also presented by Legal Adviser *Minna Ketola* and Principal Legal Adviser *Juha Haapamäki*.

Covert intelligence gathering refers first of all to the covert coercive measures used in criminal investigations and to the corresponding covert methods of gathering intelligence that may be used to prevent or detect offences or avert danger. Such methods include, for example, telecommunications interception and traffic data monitoring, technical listening and surveillance as well as undercover operations and pseudo purchases. The use of these methods is kept secret from their targets and to some extent they may, based on a court decision, remain permanently undisclosed to the targets.

The police have the most extensive powers to use covert intelligence gathering, but the Finnish Customs also have access to a wide range of covert methods of gathering intelligence with respect to customs-related offences. The powers of the Finnish Border Guard and the Defence Forces are clearly more limited.

This chapter also discusses a report on the witness protection programme submitted to the Parliamentary Ombudsman. The witness protection programme act (*laki todistajansuojeluohjelmasta 88/2015*) entered into force on 1 March 2015. According to the act, the Ministry of the Interior must annually report to the Parliamentary Ombudsman on decisions and measures taken under the act.

In 2019, a new regulatory framework for intelligence gathering was adopted. The Act on the Oversight of Intelligence Gathering (121/2019) entered into force on 1 February 2019. The amendment to the Police Act, Chapter 5a (civilian intelligence, 581/2019), Act on Telecommunications Intelligence in Civilian Intelligence (582/2019) and Act on Military Intelligence (590/2019) entered into force on 1 June 2019. The legislation includes the obligation of the authorities to submit an annual report to the Ombudsman on their operations.

The amendments to the Parliament's Rules of Procedure and Section 9 of the Act on Parliamentary Civil Servants concerning parliamentary oversight of intelligence operations entered into force on 1 February 2019.

5.1 SPECIAL NATURE OF COVERT INTELLIGENCE GATHERING

Covert intelligence gathering involves secretly intervening in the core area of several fundamental rights, especially those concerning privacy, domestic peace, confidential communications and the protection of personal data. Its use may also affect the implementation of the right to a fair trial. For intelligence gathering to be effective, the target must remain unaware of the measures, at least in the early stages of an investigation. Thus, the parties at whom these measures are targeted have more limited opportunities to react to the use of these coercive measures than is the case with "ordinary" coercive measures, which in practice become evident immediately or very soon.

Due to the special nature of covert intelligence gathering, questions of legal protection are of accentuated importance from the perspective of those against whom the measures are employed and more generally the legitimacy of the entire legal system. The secrecy that is inevitably associated with covert intelligence gathering exposes

the activity to doubts about its legality, whether or not there are grounds for that. Indeed, an effort has been made to ensure legal protection through special arrangements both before and after intelligence gathering. Their key components include the court warrant procedure, the authorities' internal oversight and the Ombudsman's oversight of legality.

5.2 OVERSIGHT OF COVERT INTELLIGENCE GATHERING

Courts

To ensure legal protection, it has been considered important that telecommunications interception and mainly also traffic data monitoring can only be carried out under a warrant issued by a court. These days, undercover operations during a criminal investigation also require authorisation from a court (Helsinki District Court). Depending on the target location, technical surveillance can in some cases also be carried out on the basis of the authority's own decision without court control. The same applies to the majority of other forms of covert intelligence gathering. The decision-making criteria laid down by law are partly rather loose and leave the party making the decision great discretionary power. For example, the "reason to suspect an offence" threshold that is a basic precondition for issuing a warrant for telecommunications interception is fairly low.

Requests concerning coercive measures must be dealt with in the presence of the person who has requested the measure or by using a video conference – written procedures are only allowed under limited circumstances when renewing an authorisation. When considering the prerequisites for using a coercive measure, a court is dependent on the information it receives from the criminal investigation authority, and the object of the utilisation of the method is not present at the hearing. The only exception is on-site interception in domestic premises: in these cases, the interests of the target of the coercive measure are overseen (naturally without his or her knowing) by a public attorney, usually an advocate or public legal aid.

The Supreme Court stressed the responsibility of a civil servant requesting a covert coercive measure in its decision KKO:2020:95. The matter concerned a breach of office where the police officer on charge had deceived the District Court into granting unlawful traffic data monitoring and telecommunications interception permits on the basis of false and misleading information. According to the Supreme Court, the reprehensibility of the acts was heightened by the fact that the matter concerned covert coercive measures, in which the court may not be able to ascertain the accuracy of the information the applicant has reported to it and in which trust in the appropriateness of the activities of the civil servant is emphasised. In addition, the acts had been detrimental to the trust of the police responsible for investigating crimes.

According to law, a complaint may be lodged with a Court of Appeal against a District Court's decision concerning covert intelligence gathering, with no time limit. Thus, a suspect may even years later refer the legality of a decision to a Court of Appeal for assessment, and some people have done so. In such cases, courts of higher instances establish case law on covert intelligence gathering. The importance of the courts' role in ensuring a suspect's legal protection and in examining the grounds for the requested coercive measure has been highlighted, for example, in the Supreme Court's decisions KKO:2007:7 and KKO:2009:54.

The courts also play a key role with respect to the parties' right of access to information concerning covert intelligence gathering. As a rule, the target of covert intelligence gathering must be notified of the use of the method no later than one year after the use has ceased. Based on the grounds laid down by law, a court may grant permission to postpone the notification or an exemption from the notification obligation. However, it is important to ensure that the total exemption, in particular, is only granted when it is absolutely necessary. In a state governed by the rule of law, measures that interfere with fundamental rights and are kept completely secret can only be allowed

to a very limited extent. The Supreme Court has considered the issue of parties' right to obtain information on undercover operations in its decision KKO:2011:27 concerning the Ulvila homicide case, which was widely covered in the media.

On 28 September 2016, the Supreme Administrative Court issued two decisions on public access to documents on covert intelligence gathering by the police (4077, 62/1/15 and 4078, 2216/1/15). The decisions concerned a request for information about regulations concerning the use of covert human intelligence sources by the police and the SALPA system. In its decisions, the Supreme Administrative Court was of the view that the information contained in the regulations regarding the use of covert human intelligence sources, the related safety and security measures and the organisation of the protection of intelligence gathering must be kept secret because, if these were disclosed in public, there is a risk that the identities of human intelligence sources and the police officers involved in the operations would be revealed.

Authorities' internal oversight

The oversight of the use of covert intelligence gathering primarily involves normal supervision by superior officials. Moreover, provisions separately emphasise the oversight of covert intelligence gathering.

Under law, the use of covert intelligence gathering methods by the police is overseen by the National Police Board (apart from the Finnish Security Intelligence Service, Supo) and the heads of the police units using such methods. Responsibility for overseeing the covert intelligence gathering methods used by Supo was transferred to the Ministry of the Interior at the beginning of 2016. At the Finnish Border Guard, the special oversight duties fall within the responsibility of the Border Guard Headquarters and the administrative units operating under it. At Finnish Customs, covert intelligence gathering is overseen by supervisory personnel of Customs and the units employing the methods in their respective administrative branches. At the Finnish Defence Forces, records drawn up on the use of covert intelligence gathering must be sent to the Ministry of Defence.

In addition to various acts, a government decree has been adopted on criminal investigations, coercive measures and covert intelligence gathering (122/2014). The decree lays down provisions on, for example, drawing up records on the use of different methods and reports on covert intelligence gathering. The authorities have also issued internal orders on covert intelligence gathering.

The Ministry of the Interior, the Headquarters of the Finnish Border Guard (which is a department of the Ministry of the Interior), the Ministry of Finance (which governs Finnish Customs) and the Ministry of Defence report annually by 15th March to the Parliamentary Ombudsman on the use and oversight of covert intelligence gathering in their respective administrative branches.

The authorities reporting to the Parliamentary Ombudsman receive a substantial part of their information on the use of covert intelligence gathering from the SALPA case management system. The only exception is the Finnish Defence Forces, which do not – at least yet – use the SALPA system. SALPA is a reliable source of statistical data. However, it does not cover all methods of covert intelligence gathering, such as undercover operations, pseudo purchases and the use of covert human intelligence sources. The superior agencies also receive information on the activities through their own inspections and contacts with the heads of investigation.

The police have centralised all intelligence gathering from telecommunications operators to be conducted through the SALPA system maintained by the National Bureau of Investigation (NBI). The NBI's telecommunications unit oversees the quality of activities and provides guidance to the heads of investigation when necessary. Centralising the activities under the NBI has improved the quality of the functions.

In the police administration, several officials have been granted supervisory rights in SALPA for the oversight of legality. These officials work mainly in the legal units of police departments. Their task is to oversee activities in accordance with the unit's legality inspection plan and by conducting spot checks.

In addition to internal oversight at police departments, the National Police Board also oversees the units operating under it through the SALPA system and by conducting separate inspections.

In accordance with the previously mentioned decree, the National Police Board has established a working group to monitor the use of covert coercive measures and covert intelligence gathering methods. The members of the group may include representatives from the National Police Board, the National Bureau of Investigation, the Finnish Security Intelligence Service and police departments. Moreover, representatives of the Ministry of the Interior, the Border Guard, the Defence Forces and Customs are also invited to participate as members of the group. The group is tasked with monitoring the authorities' activities, collaboration and training, discussing issues that have been identified in the activities and collaboration or that are important for the oversight of legality and reporting them to the National Police Board, proposing ways to improve activities, and coordinating the preparation of reports submitted to the Parliamentary Ombudsman.

Parliamentary Ombudsman's oversight of legality

Overseeing covert intelligence gathering has been one of the special tasks of the Parliamentary Ombudsman since 1995. At the time, it was provided that the Ministry of the Interior would give the Ombudsman an annual report on telecommunications interception, traffic data monitoring and technical listening by the police as well as on technical surveillance in penal institutions. The National Board of Customs submitted a report on the use of the methods by Finnish Customs. The Ministry of Defence and the Finnish Border Guard prepared similar reports on the methods they had used. In 2001, the scope of the Ombudsman's special oversight was extended to also include undercover operations and in 2005 to cover pseudo purchases. Both measures were only available to the police.

It was not until the beginning of 2014 that the Ombudsman's special oversight duties were extended to cover all covert gathering of intelligence. In addition to the extended powers, the use of these methods has also significantly increased over the years.

The annual reports obtained from various authorities improve the Ombudsman's opportunities to follow the use of covert intelligence gathering on a general level. Where concrete individual cases are concerned, the Ombudsman's special oversight can, for limited resources alone, be at best of a random check nature. At present and in the future, the Ombudsman's oversight mainly complements the authorities' own internal oversight of legality and can largely be characterised as "oversight of oversight".

Complaints concerning covert intelligence gathering have been few, with no more than approximately ten complaints received a year. This is most likely due, at least in part, to the secret nature of the activities. However, it should be noted that covert intelligence gathering operations remain completely unknown to the target only in very rare and exceptional cases. On inspection visits and in other own-initiative activities, the Ombudsman has striven to identify problematic issues concerning legislation and the practical application of the methods. Cases have been examined, for example, on the basis of the reports received or inspections conducted. However, opportunities for this kind of own-initiative examination are limited.

5.3 LEGISLATION

At the beginning of 2014, the Coercive Measures Act and the Police Act underwent a complete reform, including a significant expansion in the scope of regulation concerning covert intelligence gathering. The provisions on the previously used methods were also complemented and specified in the reform.

With respect to the Defence Forces, the act on military discipline and crime prevention in the Defence Forces (*laki sotilaskurinpidosta ja rikostorjunnasta puolustusvoimissa 255/2014*) entered into force on 1 May 2014. Under the act, when the De-

fence Forces conduct a criminal investigation they may use certain, separately determined methods of covert intelligence gathering as referred to in the Coercive Measures Act, such as extended surveillance and technical observation and listening. In the prevention and detection of crimes, the Defence Forces similarly only have access to certain methods of covert intelligence gathering, although the range is wider than in criminal investigations. However, the Defence Forces cannot use, for example, telecommunications interception, traffic data monitoring, undercover operations or pseudo purchases. If these measures are needed, they are carried out by the police.

The act on the prevention of crime by Finnish Customs (*laki rikostorjunnasta Tullissa 623/2015*) entered into force on 1 June 2015. In the act, the powers of Customs were harmonised with those laid down in the new Criminal Investigation Act, Coercive Measures Act and Police Act. One significant change was that Customs were given powers to conduct undercover operations and pseudo purchases, even though the measures are in practice implemented by the police at Customs' request. Moreover, the use of covert human intelligence sources in the prevention of customs-related offences was harmonised with the provisions of the Police Act and the Coercive Measures Act.

The act on crime prevention by the Finnish Border Guard entered into force on 1 April 2018. The crime prevention provisions currently included in the Border Guard Act were transferred to the new act. In addition to the previous powers, the right to use a basic form of human intelligence source was added to the powers of the Finnish Border Guard.

5.4 REPORTS ON COVERT INFORMATION GATHERING SUBMITTED TO THE PARLIAMENTARY OMBUDSMAN

The following presents certain information on the use and oversight of covert intelligence gathering obtained from the reports submitted by the Ministry of the Interior, the Headquarters of the Finnish Border Guard, the Ministry of Finance and the Ministry of Defence. The precise figures are partly confidential. For example, the covert intelligence gathering activities of the Finnish Security Intelligence Service are not included in the figures presented below.

Use of covert intelligence gathering in 2020

Coercive telecommunications measures under the Coercive Measures Act

The police were granted 3,279 telecommunications interception and traffic data monitoring warrants for the purpose of investigating an offence (2,738 in 2019). However, in the statistical evaluation of covert coercive measures the most important indicator is perhaps the number of persons at whom coercive measures were targeted. In 2020, simultaneous telecommunications interception and traffic data monitoring activities carried out by the police under the Coercive Measures Act were targeted at 507 (410) suspects, of whom 54 were unidentified. The use of mere traffic data monitoring was targeted at 1,604 (1,537) suspects.

Simultaneous telecommunications interception and traffic data monitoring activities carried out by Customs were targeted in 2020 at 101 (146) persons, and the number of warrants issued was 625 (518). According to Customs, the increase in the number of warrants – while the number of persons targeted decreased – is explained by the increase in the number of extensions to warrants applied for and the increase in the number of targeted telecommunications terminal end devices. The targeted persons have more telecommunications and terminal end devices than before. It is more usual now for the terminal end devices to have two SIM card slots, in which case a permit for one physical device may be recorded as two permits.

The traffic data monitoring activities carried out by the Customs were targeted at 149 (230) persons, with 627 (701) warrants issued.

The most common grounds for simultaneous telecommunications interception and traffic data monitoring by the police were aggravated nar-

cotics offences (59%) and violent offences (25%). Within the administrative branch of Customs, the most common grounds were aggravated narcotics offences (80%) and aggravated tax frauds (14%).

The Finnish Border Guard used telecommunications interception and traffic data monitoring much less frequently than the police and Customs. One simple reason for this is that under the law the Border Guard can only use coercive telecommunications measures in the investigation of a few specific types of offences (mainly aggravated arrangement of illegal immigration and the related offence of human trafficking). The numbers of the Border Guard remained approximately at last year's level – around one hundred.

In the Finnish Defence Forces, the use of covert intelligence gathering is even less frequent.

Telecommunications interception and traffic data monitoring under the Police Act

Telecommunications interception and traffic data monitoring under the Police Act was targeted at twelve (five) persons. Mere traffic data monitoring was targeted at 149 (129) persons. The method was used most frequently to avert a danger to life or health and to investigate the cause of death.

Traffic data monitoring under the Act on the Prevention of Crime by Finnish Customs

The number of traffic data monitoring warrants issued to prevent or detect customs offences was 19 (32),-most often on the grounds of aggravated tax fraud or an aggravated narcotics offence.

Technical surveillance

In 2020, the police used technical surveillance under the Coercive Measures Act 36 times with respect to premises covered by domiciliary peace, technical surveillance 141 times, on-site interception 141 times and technical tracking 291 times. On-site interception in domestic premises was used 16 times. Data for the identification of a network address or a terminal end device were obtained 47 times. The most common reason for using these surveillance methods was an aggravated narcotics offence.

Under the Police Act, technical observation was used 9 times, on-site interception 5 times and technical tracking 38 times.

Customs used technical tracking under the Coercive Measures Act in 43 (57) instances. On-site interception was used 12 (38) times and technical surveillance 28 (20) times.

Technical tracking under the Act on the Prevention of Crime by Finnish Customs was used eight (nine) times. On-site interception was not used at all (twice) neither was technical surveillance (11).

In the Finnish Border Guard, the number of decisions concerning technical surveillance and extended surveillance was nearly twice as compared to last year (21 in order to solve an offence and 11 in order to prevent an offence).

Extended surveillance

Extended surveillance means other than short-term surveillance of a person who is suspected of an offence or who, with reasonable cause, might be assumed to commit an offence. The National Police Board has interpreted this to mean several individual and repeated instances of surveillance (approximately five times) or one continuous instance of surveillance lasting approximately 24 hours.

According to the report that the Parliamentary Ombudsman received from the Ministry of the Interior, the police made 277 (198) decisions on the use of extended surveillance in 2020. Customs took 44 (85) similar decisions.

Special covert coercive measures

In 2020, a few new decisions were taken to use undercover operations and to continue the validity of previously issued decisions on undercover operations. Undercover operations performed in data networks are more frequent than such operations

in real life. Pseudo purchases were also mainly used to detect and investigate aggravated narcotics offences, although property offences also featured as grounds for the use of this investigation method.

The prerequisites for controlled delivery are very strict which in practice has restricted the use of this method. The police have only performed a few controlled deliveries during the time the act has been in force; however, during the year under review, no controlled deliveries were carried out. Customs reported having used controlled deliveries five (18) times in 2020.

Rejected requests

There was no significant change in the number of rejected requests for the use of coercive telecommunications measures. In 2020, courts rejected ten requests for coercive telecommunications measures submitted by the police. Usually, the cause of a rejection has been insufficient general or special preconditions for the request or a misinterpretation of the law. None of the requests made by Customs were rejected. No requests of the Border Guard were rejected.

Notification of the use of coercive measures

As a rule, the use of a covert intelligence gathering method must be notified to the target no later than one year after the gathering of intelligence has ceased. A court may under certain conditions authorise the notification to be postponed or decide that no notification needs to be given.

During the year under review, there were 19 police cases in which the notification of the use of a covert intelligence gathering measure was delayed. The number of authorisations for postponing a notification or for not giving one at all was very low. In Customs, the filing periods of notices were postponed on court order in six cases. In the Border Guard, notices were duly filed for all cases.

Internal oversight of legality

In the National Police Board's supervision plan on the oversight of legality in 2020, the supervision of the use of covert intelligence gathering methods was defined as one of the national priorities of legality inspections. In the inspections of remote connections of police units, attention was paid to the organisation, processes and responsibilities of oversight in the unit.

The National Police Board inspected the traffic data monitoring carried out to avert a danger to life or health in accordance with the Police Act. On this basis, a total of 122 decisions on traffic data monitoring were made during the year. In these cases, the decision is almost always taken in an urgent situation, in which case the general director or head of investigation acting as the decision-maker must be able, even on the basis of incomplete situational data, to identify the preconditions for the use of covert intelligence gathering methods, to dare use them and to know the limits of competence. In some cases, the urgency of the decisions emerged as limited justifications, mainly as to what extent the danger was immediate.

In the case of the National Bureau of Investigation, in addition to other covert intelligence gathering, the National Police Board separately inspected the decisions of 2020 concerning undercover operations performed in data networks, pseudo purchases and controlled deliveries. There was nothing to comment on the decisions concerning undercover operations performed in data networks and the pseudo purchases made on items offered exclusively for public consumption, or the related proposals, action plans and drawing of records.

According to the National Police Board, the quality of the operative processes of organising, using and overseeing covert intelligence gathering is still good. The number of shortcomings and flaws has stabilised at a low level, and the majority of cases requiring interference by the National Police Board and the cases of note were of a technical nature.

The National Police Board states that the general level of the decisions and requirements regarding the use of covert intelligence gathering

methods is good. There were only isolated cases of qualitative noncompliance, and no recurring errors or a pattern of qualitative noncompliance were detected with any intelligence gathering method. Most of the instances of qualitative noncompliance related to decisions or requests detected in the remote inspections concerned incomplete or missing reports about the connection between the person subject to traffic data monitoring and the network address. There were some shortcomings in consent-based traffic data monitoring in the entries related to giving consent.

The National Police Board finds that the use of covert coercive and intelligence gathering measures has been extensively monitored by the police internally, and the use of these measures has also regularly been one of the focus areas of oversight of legality outside the administration. Oversight and training have contributed to ensuring that the use of different intelligence gathering measures is at a good level in accordance with the inspection findings presented in the report. Potential legislative changes to the powers to intervene in the privacy of the target of information gathering so that he or she is only informed of this afterwards will also highlight the importance of oversight in the future.

The oversight of the Finnish Security Intelligence Services falls under the remit of the Ministry of the Interior, not the National Police Board. On 17 February 2021, the Ministry of the Interior carried out a legality oversight inspection of the Finnish Security Intelligence Service. The inspection did not reveal any infringement of official duties or the law. The recommendations issued in the previous inspection report by the Ministry of the Interior have been observed at the Finnish Security Intelligence Service. The recommendations concerned the development of legality oversight practices and an isolated matter involving methods of information gathering.

More resources have been allocated to the internal legality oversight of the Finnish Security Intelligence Service and its independence has been strengthened by separating the oversight activities into a separate function. The Finnish Security Intelligence Service has carried out continuous inspections of legality, which is relevant given the nature of the activities. The Ministry of the Interior supports the development of supervision into a direction that is more focused on the content of the activities. The report received by the Ministry of the Interior did not reveal systemic or serious quality issues or other errors. The Finnish Security Intelligence Service has a recognised fundamental and human rights perspective. The key principle of internal guidelines is to use the methods and means that best take into account the implementation of fundamental and human rights.

The Ministry of the Interior found the measures taken by the Finnish Security Intelligence Service to be appropriate and of a high standard, as they support in real time and proactively the lawfulness of the organisation's activities, promote the honouring of fundamental rights, support the Finnish Security Intelligence Service leadership and the guidance and oversight exercised by the Ministry of the Interior within its administrative branch. The Ministry of the Interior finds that with the entry into force of new intelligence surveillance legislation, the emphasis of the legal oversight exercised by the Ministry on the Finnish Security Intelligence Services with regard to secret information gathering has also been affected by the legality oversight performed by the Intelligence Ombudsman under the Act on the Oversight of Intelligence Gathering and the mandate of the Parliamentary Intelligence Oversight Committee. In the new situation, the duties of the Ministry of the Interior concentrate on the strategic guidance of the Finnish Security Intelligence Service and civilian intelligence gathering as well as administrative oversight, which is a natural direction in the development of the legality oversight performed by the ministry.

There are eight regional SALPA officials who have been granted supervisory powers to the daily overseeing of the use of covert intelligence gathering methods in Customs and they compile a report of their observations each year to the Customs official responsible for the national oversight of legality of use of covert intelligence gathering methods.

The Customs Enforcement Department inspected a total of 352 covert information gathering records for 2020 (approx. 86% of all covert infor-

mation gathering records) involving coercive telecommunication measures and surveillance-type information gathering methods as well as documents on certain other aspects of covert information gathering. The legality oversight of Customs brought forward no serious shortcomings. The records that were not reviewed as part of the institutional inspection were reviewed by the unit managers as part of the management review, and they were reported on to the authority in charge of the oversight of secret information gathering, in compliance with the applicable regulations.

In the Finnish Border Guard, overseeing is being performed by the Border Guard Headquarters and the authorised administrative units. In accordance with the standing regulation on crime prevention carried out by the Finnish Border Guard, the Border Guard's SALPA overseeing is performed by an official who does not participate in operative crime prevention. In the Border Guard Headquarters, oversight is ensured by the legal department's crime-prevention unit which is also responsible for the general steering of crime prevention.

According to the observations made by the Border Guard during its oversight activities, the inspected requests were mainly well-founded and comprehensive. Only a few individual decisions made by the head of the investigation had somewhat meagre grounds. In some of the traffic data monitoring requests, it remained unclear what the basis was for assuming that the network address or terminal end device was in the possession of the suspect or otherwise used by the suspect. In these cases, too, the permit had been granted in accordance with the request; apparently the justification has been established during the processing of the permit matter.

The Ministry of Defence has not identified any unlawful conduct in the use of covert coercive measures and covert intelligence gathering methods of the Finnish Defence Forces. All decisions and minutes drawn up in 2020 at the Defence Command belong to the sphere of inspection. In addition, the Ministry of Defence has found the internal legality oversight in the Defence Forces effective, comprehensive and appropriately organised.

5.5 PARLIAMENTARY OMBUDSMAN'S OVERSIGHT OF LEGALITY

During the year under review, the decisions made by the Lapland and Ostrobothnia police departments on covert coercive measures and intelligence gathering measures were inspected. Because of the COVID-19 epidemic, the inspections were carried out as documentation review. Documentation reviews were also complemented with discussion events organised as video conferences. For the reviews, the police departments were requested to provide coercive telecommunications measures from the periods preceding the reviews, as well as the related decisions of the District Courts, decisions on technical surveillance and decisions on so-called controlled pseudo purchase.

The material received from the Lapland police department included a decision on fast-tracked locating in accordance with Chapter 5, section 8 of the Police Act. The Parliamentary Ombudsman stated that the precondition for fast-tracked locating under that provision is that the use of the measure is "essential that it be conducted [...] to avert an immediate danger to life or health". The Parliamentary Ombudsman found that this was not the case.

The review of the Ostrobothnia police department included two notable decisions on technical surveillance where the relationship between the suspect and the vehicles placed under surveillance remained unclear on the basis of the decisions. The Parliamentary Ombudsman stressed the importance of justifications when deciding on covert coercive measures. It is for example important for the ex-post evaluation of the use of these measures that the justifications for connecting the target of the use of the measures with the suspected offence become completely apparent from the decisions.

The Ombudsman's own initiative resolved during the year under review concerned so-called consent-based traffic data monitoring referred to in Chapter 10, section 7 of the Coercive Measures Act. According to the Act, in a situation where a person has been killed due to an offence, traffic data monitoring does not require the consent of the legal successor of the person who has been

killed. As the case under investigation concerned attempted manslaughter and the injured party had not been killed, the Act would not have allowed traffic data monitoring to be directed at the injured party's network address without the express consent of the injured party. On the basis of the information received, the injured party had later – before the urgent decision on the matter had been brought to court in accordance with the law – given their consent to traffic data monitoring. The court granted the permission for the same period as in the fast-tracked decision made by the head of the investigation, knowing that there was no consent from the injured party when making the fast-tracked decision. In view of this, the Parliamentary Ombudsman considered it sufficient to bring his statement to the attention of the detective inspector who made the fast-tracked decision. In addition, the Parliamentary Ombudsman sent his decision to the Ministry of Justice for assessment of the need for legislative review (3227/2019).

During the year under review, there was an ongoing inspection of covert intelligence gathering and partly of intelligence operations by the Finnish Security Intelligence Service and the Defence Forces.

During the year under review, the Ombudsman did not receive complaints related to covert intelligence gathering or covert coercive measures that would have been cause for inspection.

5.6 EVALUATION

General problems in oversight

Resources must be invested in internal oversight

The Ombudsman's oversight of the legality of covert intelligence gathering focuses on overseeing the internal oversight of authorities. The inspections of the legal units of police departments are used for emphasising the units' internal oversight of the covert intelligence gathering methods used by the police departments.

The authorities using covert intelligence gathering have in recent years invested resources and efforts in internal oversight. According to the National Police Board, the operation of the legal units of police departments has become established and the scope of activities has become clear, although the constantly expanding task description does take time away from inspection activities.

In its report, the National Police Board brought up the fact that inspections revealed a need for using an information system to provide the pre-trial investigation authority with the decision data from the judicial administration system to be used to implement and monitor the destruction of information obtained through covert intelligence gathering measures.

At the Finnish Customs, Border Guard and Defence Forces, internal oversight has functioned very well according to the authorities' own assessment. In these authorities, oversight is easier because the volume of operations is much smaller than in the police.

The Ombudsman conducts retrospective oversight of a fairly general nature. The Ombudsman is remote from the actual activities and cannot begin directing the authorities' actions or otherwise be a key setter of limits, who would redress the weaknesses in legislation. Annual or other reports submitted to the Ombudsman are important but do not solve the problems related to oversight and legal protection.

The oversight of covert coercive measures is partly founded on trust in the fact that the person conducting the oversight activities receives all the information he or she wants. Due to the nature of the activities, precise documentation is a fundamental prerequisite for successful oversight.

Real-time active recording of events and measures also helps operators to evaluate and develop their own activities, to ensure the legality of their operations and to build trust in their activities. Keeping records is also an absolute precondition for the Ombudsman's retrospective oversight of legality.

In the oversight of legality, the Ombudsman has continuously emphasised the importance of providing justifications for requests and decisions.

The grounds and justifications should be recorded, for example, to enable the control of decisions. If a court does not require the applicant to provide sufficient justifications or if the court neglects to provide sufficient justifications, there is a risk that warrants will be issued for cases other than those intended by the legislator.

5.7 INTELLIGENCE

Intelligence gathering methods

Intelligence operations may be used to gather information on military operations or other operations that form a clear threat to national security.

Chapter 5a (civilian intelligence) of the Police Act provides for information gathering conducted by the Finnish Security Intelligence Services and the utilisation of information to protect national security, support government decision-making and the statutory national security duties of other authorities and state agencies.

According to the Act on Military Intelligence, the purpose of military intelligence is to gather and analyse information about military operations targeted against Finland or significant to Finland's security environment or the activities of a foreign state or other such activities that place a significant risk on the military defence of Finland or threaten the essential functions of society. The purpose of information gathering is to support government decision-making and the execution of the specific statutory duties of the Defence Forces.

Network traffic intelligence refers to technical gathering of information that crosses the national boundaries of Finland on the information network, based on automated analytical tools, and the processing of the information gathered.

Differences between intelligence gathering and secret information gathering methods

There are certain decisive distinctions to be made between intelligence gathering and secret information gathering.

The same secret information gathering methods may be used in intelligence gathering under less restrictive criteria, because intelligence gathering is not offence-based and its targeting can be less accurate.

The targets of intelligence gathering may be quite vague compared to the targets of secret information gathering. According to Chapter 5 of the Police Act, secret information gathering may be utilised only on a named person when there are reasonable grounds to believe that he or she would commit an offence. However, in intelligence gathering, it can remain unclear under which authorisation, which circumstances and within which limits an intelligence gathering method may be targeted at other than an individual who is personally engaging in or associated with military operations or operations forming a substantial threat to national security.

For example, traffic data monitoring, when conducted as part of secret information gathering, can only be targeted at a person when there are reasonable grounds to believe that he or she would commit an offence referred to. In the military intelligence context, the use of these methods need not be limited to a person; it is sufficient that traffic data monitoring can be shown to have a significant role in gathering information necessary for an intelligence operation. In civilian intelligence gathering, the legal provisions on traffic data monitoring, personalised targeting is not mentioned.

With many intelligence gathering methods, the permission can be issued for up to six times as long (1 months/6 months) than is possible in secret information gathering. These methods include telecommunications interception, traffic data monitoring, technical surveillance, technical surveillance of devices and pseudo purchases.

The scope of secret information gathering methods in intelligence operations has been ex-

panded both in terms of content and methods. In secret information gathering, the target of telecommunications interception must be a named network address or terminal device, while in intelligence gathering, the target may be a person (in which case the connection between a network address or terminal device and the target of information gathering remains outside the control of the courts). In intelligence gathering, many of the methods can be targeted at groups of individuals while in secret information gathering, the same methods must be targeted at a named individual. In secret information gathering, the technology enabling the obtaining of the identifying data of a network address or terminal device must not be suited for telecommunications interception, whereas in intelligence gathering no such limitations exist. In intelligence gathering, telecommunications interception may be carried out using the intelligence agency's own equipment whereas in secret information gathering, an external operator is used as a rule. The methods of secret information gathering can be used on a court order or other official authorisation within Finnish territory only, whereas in intelligence operations, the same methods can also be used abroad, subject to the decision of the Finnish Security Intelligence Service or the Chief of Intelligence for the Defence Command and without the legal remedies available in Finland.

In addition to the methods available for secret information gathering, intelligence gathering methods also include methods that cannot be adopted in secret information gathering. These include intelligence gathering on specific locations, reproduction, intercepting a shipment for the purpose of reproduction, gathering of information from a private organisation and network traffic intelligence.

Oversight of intelligence

The domain of the oversight of intelligence includes the following elements: the parliamentary oversight, the oversight of legality, court proceedings on intelligence powers, internal supervision of authorities and supreme oversight of legality.

The parliamentary oversight of intelligence is conducted by the Parliamentary Intelligence Oversight Committee. The duties of the Committee are provided for in Section 31 b of the Parliament's Rules of Procedure.

According to Section 2(3) of the Act on the Oversight of Intelligence Gathering, the legality oversight of intelligence gathering is the responsibility of the Intelligence Ombudsman. The Intelligence Ombudsman also supervises the non-intelligence operations of the Finnish Security Intelligence Service. This supervision is provided for in Chapter 3 of the Act on the Oversight of Intelligence Gathering where applicable. Hence, the Intelligence Ombudsman has all the powers referred to in the act for the purpose of overseeing all other operations of the Finnish Security Intelligence Service excepted for intelligence operations, with the exception of powers specifically concerning intelligence gathering methods. Thereby, the jurisdiction of the Intelligence Ombudsman, for example, also covers the activities of the Finnish Security Intelligence Service including the non-intelligence activities.

An independent court of law is a central instrument in the control of intelligence gathering methods. That the use of certain intelligence powers requires the authorisation by a court is of vital importance when ensuring that their application remains within the law and for the purpose of honouring fundamental and human rights.

The responsibility for internal legality oversight of authorities in civilian intelligence gathering is divided between the Finnish Security Intelligence Service and the Ministry of the Interior, where the legality oversight of the police is carried out by the Police Department. Military intelligence is overseen by the Chief of Defence Command. The Chief Legal Advisor of the Defence Forces is responsible for the internal legality oversight of military intelligence gathering. Military intelligence gathering is also supervised by the Ministry of Defence (the Legal Unit and the Permanent Secretary).

The Parliamentary Ombudsman and the Chancellor of Justice have, by virtue of their powers, an equal authority to oversee civilian and military intelligence authorities as well as courts of law and the Intelligence Ombudsman.

In practice, however, the supreme legality oversight must be exercised in line with the established practice according to which the oversight of secret information gathering and secret coercive measures is a special duty of the Parliamentary Ombudsman. This division of duties is based on the obligation by which the ministries responsible for the operations of the authorities exercising these methods must submit an annual report on the use of these methods as well as their protection and oversight to the Parliamentary Ombudsman. According to the regulations in force, the reports must be submitted every year by 15 March.

The same practice has been adopted with intelligence legislation. Therefore, the legality oversight has concentrated on the Parliamentary Ombudsman. Moreover, attention should be paid to Section 1 (1)(1) of the Act on the Division of Responsibilities between the Chancellor of Justice of the Government and the Parliamentary Ombudsman, under which the Chancellor of Justice is released from the obligation of legal oversight in such matters as those within the jurisdiction of the Parliamentary Ombudsman related to the Ministry of Defence and the Finnish Defence Forces. This, in turn, has practical implications on the supreme legality oversight on military intelligence.

With the intelligence legislation, the expansion of the scope of supervision under the remit of the Ombudsman, including the reports on intelligence submitted to the Ombudsman shall, in part, increase the share of oversight directed by the Ombudsman at the 'secret methods' during the oversight of legality exercised by the Ombudsman.

The operations of the Parliamentary Intelligence Oversight Committee do not fall under the jurisdiction of the Parliamentary Ombudsman.

Parliamentary Ombudsman's oversight of legality

The purpose of supreme oversight of legality in intelligence is the same as in that of secret information gathering. In the oversight of secret information gathering and secret coercive measures, the Ombudsman's attention has, in practice, focused on the "oversight of supervision", that is, that the internal legal oversight exercised by authorities adopting these methods would be as effective as possible. However, the Ombudsman's "direct" oversight is of particular importance with methods that the authorities can use without a court order.

Within the scope of the Ombudsman's jurisdiction, the legality oversight of intelligence gathering is important with respect to methods that fall outside the jurisdiction of the Intelligence Ombudsman. One such aspect is the secret information gathering conducted by the Defence Forces, which is provided for in Chapter 9 of the Act on Military Discipline and Combating Crime in the Defence Forces. This oversight is important because of, for example, the boundary between secret information gathering and intelligence. During the year under review, there was an ongoing inspection of covert intelligence gathering and partly of intelligence operations by the Defence Forces.

The Intelligence Ombudsman falls partly under the oversight of the Ombudsman. However, the oversight of the Intelligence Ombudsman takes mainly the form of collaboration rather than inspection in the traditional sense, although the latter is not ruled out. Complaints filed on the Intelligence Ombudsman are processed following the normal procedure.

The oversight of courts of law is by virtue of their independence always mainly based on dialogue. However, the oversight of courts carried out by the Ombudsman is important in that the jurisdiction of the Intelligence Ombudsman does not extend to the courts of law.

During the year under review, the Ombudsman did not receive complaints related to intelligence operations that would have been cause for inspection.

The intelligence oversight system is illustrated in the table on the following page.

During the year under review, the Parliamentary Ombudsman was heard in the Intelligence Oversight Committee for the Intelligence Ombudsman's report for 2019. In his statement, the Parlia-

OVERSEEING SYSTEM

SUBJECTS OF OVERSIGHT	OVERSEERS			
	Parliamentary Ombudsman	Chancellor of Justice of the Government	Intelligence Oversight Committee	Intelligence Ombudsman
Finnish Security and Intelligence Service Chapter 5a of the Police Act and the Act on Telecommunication Intelligence in Civilian Intelligencea	O + A + R	O + A	O + A + R	O + A + R
Finnish Security and Intelligence Service Chapter 5 of the Police Act	O + A + R	O + A	O + A	O + A
Finnish Security and Intelligence Service other activities	O + A	O + A	O + A	O + A
The Finnish Defence Forces Act on Military Intelligence	O + A + R	O* + A	O + A + R	O + A + R
The Finnish Defence Forces Chapter 9 of the Act on Military Discipline and Combating Crime in the Defence Forces	O + A + R	O* + A	–	–
The Finnish Defence Forces other activities	O + A	O* + A	–	–
Intelligence Ombudsman	O + A + R	O + A	A +R**	
Court	O + A	O + A	A	A + P
Public administrative task	O + A	O + A	A	A
Public task	O + A	O + A	A	–

O = oversight
A = access to information
R = report
P = procedural powers

* see Section 1 of the Act on the Division of Duties between the Chancellor of Justice of the Government and the Parliamentary Ombudsman
** Report to the Parliament; Section 19 of the Act on the Oversight of Intelligence Gathering

mentary Ombudsman emphasised, among other things, the Intelligence Ombudsman's role in the oversight of legality and the fact that, despite close and intensive oversight, the relationship between the Intelligence Ombudsman and the intelligence authority must not change from a relationship between an overseer and an entity subject to oversight into a cooperative relationship. The Parliamentary Ombudsman stated that he has no reason to suspect that this would have happened in practice and that he does not suspect that the current Intelligence Ombudsman would have not been aware of these dangers. However, the Parliamentary Ombudsman found these issues very important, especially as the role of the Intelligence Ombudsman is taking shape.

As regards the supervision of the Finnish Security Intelligence Service, the Parliamentary Ombudsman stated that the Intelligence Ombudsman is responsible for the supervision of the Finnish Security Intelligence Service as a whole, and the Intelligence Ombudsman is also responsible for investigating any complaint concerning the activities of the Finnish Security Intelligence Service. However, in some cases concerning the Finnish Security Intelligence Service that have no connection to intelligence activities, it may be appropriate for the matter to be investigated by a competent supervisory authority other than the Intelligence Ombudsman. Although this is not provided for by law, it is possible to transfer such a matter (e.g. a complaint) to another supervisory authority (e.g. The Parliamentary Ombudsman) when the transfer is agreed.

The Parliamentary Ombudsman considered that the Intelligence Ombudsman's interpretation of the so-called firewall provision of intelligence legislation is problematic, especially as it concerns the disclosure of intelligence data to the pre-trial investigation authority in order to investigate offences falling "within the scope of the task of the intelligence authority" without being limited by firewall regulation. The Parliamentary Ombudsman found it very important to examine the interpretation and its grounds in more detail.

The Ombudsman subsequently decided to investigate on his own initiative the matter of interpreting the firewall provision (289/2021).

In his statement, the Parliamentary Ombudsman considered the discretionary nature of the regulation on the targeting of intelligence and stated that the kind of connection the person targeted for intelligence should have with activities that seriously threaten national security is one of the most important questions when assessing the acceptability of the intelligence operations from the perspective of protecting fundamental rights. In his statement, the Parliamentary Ombudsman emphasised the adequacy of the resources of the Intelligence Ombudsman's function and its significance for the acceptability and legitimacy of intelligence operations (6084/2020).

Reports submitted to the Parliamentary Ombudsman

The Ministry of the Interior has as one of its duties to evaluate the legality and relevance of civilian intelligence operations based on the report submitted by the Finnish Security Intelligence Service. According to the Ministry of the Interior, the report provided by the Finnish Security Intelligence Service is appropriate and provides sufficient information on the operations.

According to a report submitted by the Finnish Security Intelligence Service to the Ministry of the Interior, civilian intelligence operations have been subject to comprehensive internal oversight of legality and supervisory oversight. According to the report, in the supervision of the legality of the Finnish Security Intelligence Service, particular attention is paid to measures that are relevant to fundamental rights. No breaches of legislation were found in the internal oversight of legality by the Finnish Security Intelligence Service.

According to the Ministry of the Interior, the internal monitoring at the Finnish Security Intelligence Service has been as timely as possible with respect to methods of civilian intelligence gathering and any findings have been addressed as necessary. The Ministry of the Interior states that according to the report provided, the powers have been applied under the conditions laid down in legislation.

The Ministry of Defence notes in its report that it has reviewed all decisions and minutes made in 2020 by the military intelligence authority. In addition, the Ministry of Defence has reviewed all inspection reports prepared by the Defence Command Legal Division. The views expressed by the Ministry of Defence on the aforementioned documents have been duly taken into account. During the review of the documents, legal issues and other development needs and topical issues have been discussed with representatives of the military intelligence authority. The Ministry of Defence welcomes the fact that the military intelligence authority has commenced its activities in line with the new legislation with great discretion and rigour.

The Ministry of Defence has not identified any specific development areas or unlawful conduct in its legality oversight of military intelligence in 2020.

Unlike intelligence authorities, the Intelligence Ombudsman is not under any deadline for submitting an annual report to the Parliamentary Ombudsman. For this reason, the report of the Intelligence Ombudsman was not available for this report by the Parliamentary Ombudsman. As intelligence authorities submit their reports to the Intelligence Ombudsman at the same time as to the Parliamentary Ombudsman, it is difficult to reconcile the schedule for completing the Intelligence Ombudsman's annual report with the timetable for the Parliamentary Ombudsman's annual report. However, it would be useful for the Intelligence Ombudsman's report to be available when preparing the Parliamentary Ombudsman's annual report.

5.8 WITNESS PROTECTION

The witness protection programme act (*laki todistajansuojeluohjelmasta 88/2015*) entered into force on 1 March 2015. The act constitutes a major reform in terms of fundamental rights and the rights of the individual. It safeguards the right to life, personal liberty and integrity and the right to the sanctity of the home, as enshrined in the Constitution.

A person may be admitted to a witness protection programme in order to receive protection if there is a serious threat against the life or health of the person or someone in their family, because the person is being heard in a criminal matter or for some other reason and the threat cannot be efficiently eliminated through other measures. Together with the protected person, the police will draw up a personal protection plan in writing that includes the key measures to be implemented as part of the programme. They may include, for example, relocating the protected person to another region, arranging a new home for the person, installing security devices in their home and providing advice on personal safety and security. The programme focuses on the protection of the individual, not the criminal investigation.

If necessary for the implementation of the witness protection programme, the police may make and create false, misleading or disguised register entries and documents to support the protected person's new identity. The police may also monitor the person's home and its surroundings. Protected persons may also receive financial support to ensure their income security and independent living.

The National Bureau of Investigation (NBI) is responsible for the implementation of the witness protection programme together with other authorities. The director of the NBI makes decisions about beginning and terminating witness protection programmes and certain related measures. The Ministry of the Interior submits annual reports to the Parliamentary Ombudsman on decisions and measures taken under the act.

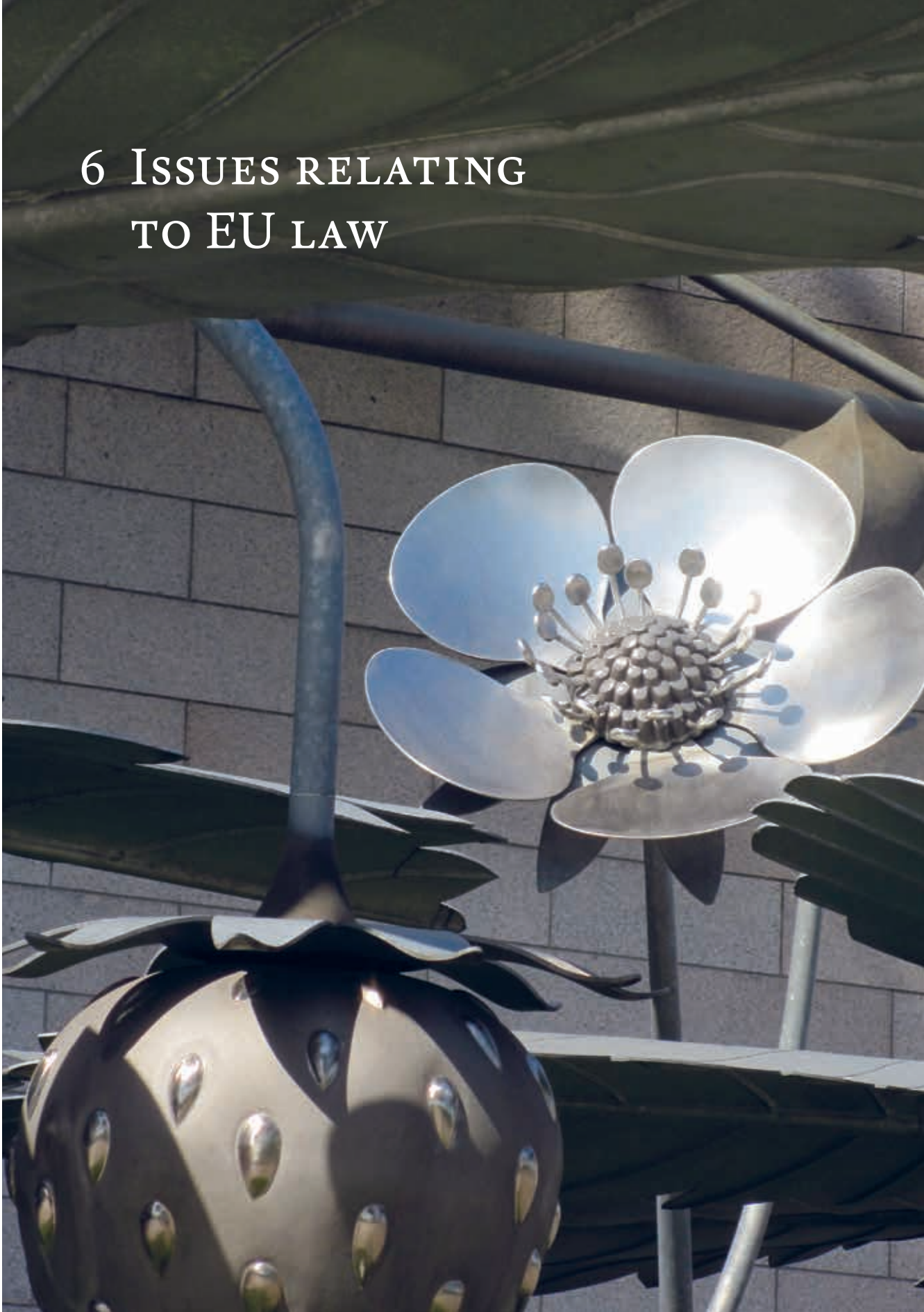
According to a report by the Ministry of the Interior, the National Police Board carried out in November 2020 an audit of the legality of the National Bureau of Investigation, which also involved discussion on the witness protection programme and the records of the report on the Ministry of the Interior's witness protection programme 2019. The National Police Board considers that the annual report of the National Bureau of Investigation for 2020 describes the activities related to witness protection in a fairly comprehensive and versatile manner, and it is possible to form an understanding of the implementation of the activities, their volume and the related challenges. The National Police Board, as the supervisory agency of the National Bureau of Investigation, did not find any shortcomings during the inspection visit in question, and it did not give rise to any measures by the National Police Board.

The Ministry of the Interior refers to the annual report of the National Bureau of Investigation, which, like the previous year, highlights challenges related to, among other things, the resourcing of the function and the inaccuracies of legislation observed in practical operations. According to the National Bureau of Investigation, the regulation on appeals should be specified in such a way that the possibility of appealing would only be possible if the authority decided to terminate the programme against the will of the person under protection.

The Ministry of the Interior agrees with the National Police Board's view that it is important to continue collecting observations on the functioning of the witness protection programme act.

The Ombudsman received no complaints regarding witness protection.

6 Issues relating to EU law



6
Issues relating to EU law

6.1
SUBMISSIONS AND DECISIONS

Regulation of the European Parliament on the European Border and Coast Guard and national regulation

Deputy-Ombudsman Pölönen issued a statement on the draft national legislation on the European Border and Coast Guard. He drew attention to the fundamental rights strategy, the action plan and the appeals mechanism for potential violations of fundamental rights that will be drawn up to ensure procedural guarantees for the protection of fundamental rights, and to the fundamental rights monitors recruited to the Agency.

The Deputy-Ombudsman emphasised that the EU Regulation is valid as it is and it must not be explained or specified with national regulations. However, in his view, it would be justified to specify at the level of the proposal whether this monitoring of compliance with fundamental rights refers to the monitoring of the national fundamental rights of each Member State or only to the monitoring of the fundamental rights referred to in the Charter of Fundamental Rights of the European Union that are recognised by EU law. In his opinion, the monitoring arrangement was a procedure mainly comparable with internal oversight of legality.

The Deputy-Ombudsman further emphasised that the proposal for the act should also deal with the issue of how it is ensured that foreign officials in Finland and, on the other hand, Finnish officials as members of a group remaining abroad know exactly what their powers are. For example, would it be possible to lay down provisions on the Finnish authorities' "obligation to verify" this? In practice, Finland would partly meet this obligation if the officials sent to international tasks were primarily officials with the language proficiency and other skills required for the tasks.

In the end, the Deputy-Ombudsman drew attention to the provisions on the extent of the Parliamentary Ombudsman's competence. He emphasised that although foreign officials operating in Finland may from the point of view of legislation concerning public officials be subject to the statutes of their own country or those of the European Union, this cannot narrow down the Parliamentary Ombudsman's constitutional powers to oversee that officials and other parties comply with legislation and fulfil their responsibilities when performing a public task. The legislator should explicitly take a stand on this (4267/2020).

Council Regulation on the establishment of the European Public Prosecutor's Office ('the EPPO') and Finland's participation in its operation

In autumn 2020, the Government issued a proposal (HE 39/2020 vp) on issuing an act on Finland's participation in the operation of the European Public Prosecutor's Office.

Parliamentary Ombudsman Jääskeläinen issued statements on national regulations concerning the European Public Prosecutor's Office to the

Constitutional Law Committee and to the Legal Affairs Committee. In his statements, the Parliamentary Ombudsman drew attention to the questions resulting from the Council Regulation (EU) 2017/1939 and the government proposal with regard to the constitutional position of the Ombudsman, the oversight of legality of the EPPO prosecutor, liability under the criminal law and the position of the European Prosecutor and the European Delegated Prosecutor as a prosecutor.

The Treaty of Lisbon gave the European Council the opportunity to extend the Union's competence to the use of significant public power in the Member States. The Parliamentary Ombudsman posed a question on how far into the structure of the national constitutional use of public power it is possible and necessary for a regulation based on the Treaty to "intrude". The Ombudsman stated that excluding the supreme overseers of legality from the obligation to report information to the EPPO and not giving the EPPO the right to take over such matters from the Ombudsman would not endanger the objective of the EPPO Regulation. However, as it may no longer be possible to intervene in this constitutional contradiction at the national level, the Parliamentary Ombudsman was of the view that the provision proposed to the EPPO act with regard to resolving in a district court such disagreements about the use of powers in which one of the parties is a supreme overseer of legality was acceptable. Since then, the Constitutional Law Committee has in its statement considered that because of the importance of the resolution, the proposed prohibition on appeal should be removed. The Parliamentary Ombudsman considered the appeals arrangement that was subsequently proposed during the review of the matter to be acceptable.

The Parliamentary Ombudsman considered the provision on the independence of the European Prosecutors and the European Delegated Prosecutors in Article 6 of the EPPO Regulation as open to different interpretations in relation to the supreme overseers of legality. The Ombudsman is of the opinion that the activities of the EPPO prosecutor, who uses significant public powers, should have an unequivocally clear position in terms of the oversight of legality. The Ministry of Justice later proposed that a provision according to which provisions on the oversight of the legality of the EPPO prosecutors' activities by the supreme overseers of legality in Finland are laid out in the Constitution be included in the act. In his statement, the Ombudsman considered that this proposal clarified the regulations.

Article 13 on the powers of the EPPO prosecutor was problematic in cases where the decision on bringing charges involved special arrangements, such as in matters concerning ministerial responsibility. The Ombudsman was of the view that the proposal in which the request for lifting privileges and immunities, referred to in Article 29 of the Regulation, must be submitted to the Chancellor of Justice or the Parliamentary Ombudsman when the request concerns a member of the Government was justified. The Chancellor of Justice or the Parliamentary Ombudsman resolves the request by complying with the provisions on cases of oversight of legality, as applicable. In the Ombudsman's view, because of the national constitutional structures, the EPPO would not be able to take more measures.

Overall, the Ombudsman considered that in many respects, the EPPO Regulation and the legislative proposal seem to lead to a conflict with the institutional solutions in the Constitution of Finland and the constitutional identity (7418/2020 and 7918/2020).

According to the Constitutional Law Committee (PeVL 39/2020 vp), the proposal was significant from the point of view of the Constitution's provisions on the position of the supreme overseers of legality and their prosecution activities, especially from the point of view of sections 108–110 and 115. According to sections 108 and 109 of the Constitution, the Chancellor of Justice and the Parliamentary Ombudsman shall ensure that the courts of law, the other authorities and civil servants, public employees and other persons, when the latter are performing a public task, obey the law and fulfil their obligations. In the performance of their duties, the Chancellor of Justice and the Parliamentary Ombudsman monitor the implementation of basic rights and liberties and

human rights. According to the report received by the Constitutional Law Committee, it is not quite clear whether the EPPO Regulation enables them to oversee the legality of the European Delegated Prosecutors and European Prosecutors referred to in the EPPO Regulation. This issue is particularly significant because the prosecutor's activities involve significant use of public power (also see PeVL 36/2006 vp, p. 11/I).

The Committee also drew attention to the fact that the provisions in the EPPO Regulation require the EPPO to comply with the national legislation of the Member State in their investigations and prosecution activities. According to the Committee, the independence secured to the prosecutors by the EPPO Regulation does not mean that the EPPO prosecutors must have immunity from the oversight of legality practised by the supreme overseers of legality. The Committee is of the view that such a premise must also be reflected in legislation. The reprimand affected the order of enacting the proposal.

Towards the end of the year, Parliament adopted the proposed acts with some amendments. Among other things, a specific provision on the oversight of legality of the activities of the European Prosecutor and the European Delegated Prosecutor by the Parliamentary Ombudsman and the Chancellor of Justice in Finland and on the requirement that, in a case of a breach of office committed by the former two, the prosecutor be either the Parliamentary Ombudsman or the Chancellor of Justice or a prosecutor appointed by them was included in an act. The acts will enter into force on the date laid down in a Government Decree.

Competence of Finnish authorities according to the Brussels IIa Regulation

Deputy-Ombudsman Sakslin issued a decision on a complaint in which it was claimed that the Finnish child welfare authorities had neglected their responsibility to determine the need for child protection for a child with Finnish citizenship in the al-Hol camp in Syria. Under EU law, it was first and foremost a question of whether the Finnish child welfare authorities were competent under the so-called Brussels IIa Regulation (EC) No 2201/2003 and the 1996 Hague Child Protection Convention supplementing it.

In these international instruments, the authorities' international competence is primarily determined by the habitual residence or secondarily by the presence of the child. As neither of the above-mentioned grounds determining the competence was fulfilled, under Article 14 of the Brussels IIa Regulation, in situations where the authority in none of the Union's Member States is competent, the international competence is determined under the legislation of the Member State. The Deputy-Ombudsman considered that in this case, the competence was therefore determined under Finland's legislation (3173/2019).

Other decisions

Deputy-Ombudsman Sakslin has paid attention to aspects of the EU law in connection with the administrative procedure for the taxation of imports. In her two decisions concerning the duration of the rectification procedure for the excise duty on imported alcoholic beverages and the taxation of cars, the Deputy-Ombudsman stated that the requirement of sufficiently swift execution of administrative matters can also be derived from the objective of efficient realisation of EU law. Prolonged administrative processing times may, per se, be also assessed as an administrative obstacle. They may also be considered an action prohibited in Article 28 of the Treaty, the effect of which corresponds to quantitative restrictions on imports (5936/2019 and 6517/2019).

In her decision on an own-initiative investigation, Deputy-Ombudsman Sakslin commented on the national flexibility provided by the so-called new EASA Regulation (EU) 2018/1139 concerning the safety of civil aviation with regard to unmanned aircraft, which now fall within the scope of the Regulation. Article 56 of the EASA Regulation gives national flexibility in regulations on the protection of privacy and personal data, among other

things. The national aviation rules required in the provisions were being prepared when the decision was issued.

The Deputy Ombudsman therefore considered it appropriate to bring to the attention of the Ministry of Transport and Communications and the Finnish Transport and Communications Agency her opinion that according to the provisions in the EASA Regulation, when issuing regulations concerning unmanned aircraft, attention must be paid to how and what kind of requirements should be set for the activities to ensure the protection of privacy and personal data in the flying of unmanned aircraft. However, the Deputy-Ombudsman was of the view that, in this context, she was not able to estimate in more detail what these requirements could be like (7321/2017).

Deputy-Ombudsman Sakslin evaluated the realisation of the provision on workers' right to information and consultation within the undertaking laid down in Article 27 of the Charter of Fundamental Rights of the European Union in a complaint regarding the termination of a hospital ward. Under the Article, workers or their representatives must, at the appropriate levels, be guaranteed information and consultation in good time in the cases and under the conditions provided for by Union law and national laws and practices. The complainants were of the opinion that the personnel had not been heard in compliance with the Act on Co-operation within Undertakings. A Directive of the European Parliament and of the Council (2002/14/EC) has been issued on informing and consulting employees in undertakings and establishments. In Finland, the Directive has been considered to also apply to municipalities and central government as employers.

As a conclusion, the Deputy-Ombudsman stated that the co-operation procedure was started too late for the personnel to have real opportunities to influence the final outcome in the way meant in the Act. As a result, the personnel's right to be informed and consulted confirmed in the Charter of Fundamental Rights of the Union had not been fully implemented (5908/2019).

7 Appendixes

Constitutional Provisions pertaining to Parliamentary Ombudsman of Finland

11 June 1999 (731/1999), entry into force 1 March 2000

Section 27
Eligilibity and qualifications for the office of Representative

Everyone with the right to vote and who is not under guardianship can be a candidate in parliamentary elections.

A person holdin military office cannot, however, be elected as a Representative.

The Chancellor of Justice of the Government, the Parliamentary Ombudsman, a Justice of the Supreme Court or the Supreme Administrative Court, and the Prosecutor-General cannot serve as representatives. If a Representative is elected President of the Republic or appointed or elected to one of the aforesaid offices, he or she shall cease to be a Representative from the date of appointment or election. The office of a Representative shall cease also if the Representative forfeits his or her eligibility.

Section 38
Parliamentary Ombudsman

The Parliament appoints for a term of four years a Parliamentary Ombudsman and two Deputy Ombudsmen, who shall have outstanding knowledge of law. A Deputy Ombudsman may have a substitute as provided in more detail by an Act. The provisions on the Ombudsman apply, in so far as appropriate, to a Deputy Ombudsman and to a Deputy Ombudsman's a substitute. (802/2007, entry into force 1.10.2007)

The Parliament, after having obtained the opinion of the Constitutional Law Committee, may, for extremely weighty reasons, dismiss the Ombudsman before the end of his or her term by a decision supported by at least two thirds of the votes cast.

Section 48
Right of attendance of Ministers, the Ombudsman and the Chancellor of Justice

Minister has the right to attend and to participate in debates in plenary sessions of the Parliament even if the Minister is not a Representative. A Minister may not be a member of a Committee of the Parliament. When performing the duties of the President of the Republic under section 59, a Minister may not participate in parliamentary work.

The Parliamentary Ombudsman and the Chancellor of Justice of the Government may attend and participate in debates in plenary sessions of the Parliament when their reports or other matters taken up on their initiative are being considered.

Section 109
Duties of the Parliamentary Ombudsman

The Ombudsman shall ensure that the courts of law, the other authorities and civil servants, public employees and other persons, when the latter are performing a public task, obey the law and fulfil their obligations. In the performance of his or her duties, the Ombudsman monitors the implementation of basic rights and liberties and human rights.

The Ombudsman submits an annual report to the Parliament on his or her work, including observations on the state of the administration of justice and on any shortcomings in legislation.

Section 110
The right of the Chancellor of Justice and the Ombudsman to bring charges and the division of responsibilities between them

A decision to bring charges against a judge for unlawful conduct in office is made by the Chancellor of Justice or the Ombudsman. The Chancellor of Justice and the Ombudsman may prosecute or order that charges be brought also in other matters falling within the purview of their supervision of legality.

Provisions on the division of responsibilities between the Chancellor of Justice and the Ombudsman may be laid down by an Act, without, however, restricting the competence of either of them in the supervision of legality.

Section 111
The right of the Chancellor of Justice and Ombudsman to receive information

The Chancellor of Justice and the Ombudsman have the right to receive from public authorities or others performing public duties the information needed for their supervision of legality.

The Chancellor of Justice shall be present at meetings of the Government and when matters are presented to the President of the Republic in a presidential meeting of the Government. The Ombudsman has the right to attend these meetings and presentations.

Section 112
Supervision of the lawfulness of the official acts of the Government and the President of the Republic

If the Chancellor of Justice becomes aware that the lawfulness of a decision or measure taken by the Government, a Minister or the President of the Republic gives rise to a comment, the Chancellor shall present the comment, with reasons, on the aforesaid decision or measure. If the comment is ignored, the Chancellor of Justice shall have the comment entered in the minutes of the Government and, where necessary, undertake other measures. The Ombudsman has the corresponding right to make a comment and to undertake measures.

If a decision made by the President is unlawful, the Government shall, after having obtained a statement from the Chancellor of Justice, notify the President that the decision cannot be implemented, and propose to the President that the decision be amended or revoked.

Section 113
Criminal liability of the President of the Republic

If the Chancellor of Justice, the Ombudsman or the Government deem that the President of the Republic is guilty of treason or high treason, or a crime against humanity, the matter shall be communicated to the Parliament. In this event, if the Parliament, by three fourths of the votes cast, decides that charges are to be brought, the Prosecutor-General shall prosecute the President in the High Court of Impeachment and the President shall abstain from office for the duration of the proceedings. In other cases, no charges shall be brought for the official acts of the President.

Section 114
Prosecution of Ministers

A charge against a Member of the Government for unlawful conduct in office is heard by the High Court of Impeachment, as provided in more detail by an Act.

The decision to bring a charge is made by the Parliament, after having obtained an opinion from the Constitutional Law Committee concerning the unlawfulness of the actions of the Minister. Before the Parliament decides to bring charges or not it shall allow the Minister an opportunity to give an explanation. When considering a matter of this kind the Committee shall have a quorum when all of its members are present.

A Member of the Government is prosecuted by the Prosecutor-General.

Section 115
Initiation of a matter concerning the legal responsibility of a Minister

An inquiry into the lawfulness of the official acts of a Minister may be initiated in the Constitutional Law Committee on the basis of:

1) A notification submitted to the Constitutional Law Committee by the Chancellor of Justice or the Ombudsman;
2) A petition signed by at least ten Representatives; or
3) A request for an inquiry addressed to the Constitutional Law Committee by another Committee of the Parliament.

The Constitutional Law Committee may open an inquiry into the lawfulness of the official acts of a Minister also on its own initiative.

Section 117
Legal responsibility of the Chancellor of Justice and the Ombudsman

The provisions in sections 114 and 115 concerning a member of the Government apply to an inquiry into the lawfulness of the official acts of the Chancellor of Justice and the Ombudsman, the bringing of charges against them for unlawful conduct in office and the procedure for the hearing of such charges.

Parliamentary Ombudsman Act

14 March 2002 (197/2002)

CHAPTER 1
OVERSIGHT OF LEGALITY

SECTION 1
Subjects of the Parliamentary Ombudsman's oversight

(1) For the purposes of this Act, subjects of oversight shall, in accordance with Section 109 (1) of the Constitution of Finland, be defined as courts of law, other authorities, officials, employees of public bodies and also other parties performing public tasks.

(2) In addition, as provided for in Sections 112 and 113 of the Constitution, the Ombudsman shall oversee the legality of the decisions and actions of the Government, the Ministers and the President of the Republic. The provisions set forth below in relation to subjects of oversight apply in so far as appropriate also to the Government, the Ministers and the President of the Republic.

SECTION 2
Complaint

(1) A complaint in a matter within the Ombudsman's remit may be filed by anyone who thinks a subject has acted unlawfully or neglected a duty in the performance of their task.

(2) The complaint shall be filed in writing. It shall contain the name and contact particulars of the complainant, as well as the necessary information on the matter to which the complaint relates.

SECTION 3
Investigation of a complaint (20.5.2011/535)

(1) The Ombudsman shall investigate a complaint if the matter to which it relates falls within his or her remit and if there is reason to suspect that the subject has acted unlawfully or neglected a duty or if the Ombudsman for another reason takes the view that doing so is warranted.

(2) Arising from a complaint made to him or her, the Ombudsman shall take the measures that he or she deems necessary from the perspective of compliance with the law, protection under the law or implementation of fundamental and human rights. Information shall be procured in the matter as deemed necessary by the Ombudsman.

(3) The Ombudsman shall not investigate a complaint relating to a matter more than two years old, unless there is a special reason for doing so.

(4) The Ombudsman must without delay notify the complainant if no measures are to be taken in a matter by virtue of paragraph 3 or because it is not within the Ombudsman's remit, it is pending before a competent authority, it is appealable through regular appeal procedures, or for another reason. The Ombudsman can at the same time inform the complainant of the legal remedies available in the matter and give other necessary guidance.

(5) The Ombudsman can transfer handling of a complaint to a competent authority if the nature of the matter so warrants. The complainant must be notified of the transfer. The authority must inform the Ombudsman of its decision or other measures in the matter within the deadline set by the Ombudsman. Separate provisions shall apply to a transfer of a complaint between the Parliamentary Ombudsman and the Chancellor of Justice of the Government.

Section 4
Own initiative

The Ombudsman may also, on his or her own initiative, take up a matter within his or her remit.

Section 5
Inspections (28.6.2013/495)

(1) The Ombudsman shall carry out the on-site inspections of public offices and institutions necessary to monitor matters within his or her remit. Specifically, the Ombudsman shall carry out inspections in prisons and other closed institutions to oversee the treatment of inmates, as well as in the various units of the Defence Forces and Finland's military crisis management organisation to monitor the treatment of conscripts, other persons doing their military service and crisis management personnel.

(2) In the context of an inspection, the Ombudsman and officials in the Office of the Ombudsman assigned to this task by the Ombudsman have the right of access to all premises and information systems of the inspection subjeft, as well as the right to have confidential discussions with the personnel of the office or institution, persons serving there and its inmates.

Section 6
Executive assistance

The Ombudsman has the right to executive assistance free of charge from the authorities as he or she deems necessary, as well as the right to obtain the required copies or printouts of the documents and files of the authorities and other subjects.

Section 7
Right of the Ombudsman to information

The right of the Ombudsman to receive information necessary for his or her oversight of legality is regulated by Section 111 (1) of the Constitution.

Section 8
Ordering a police inquiry or a pre-trial investigation (22.7.2011/811)

The Ombudsman may order that a police inquiry, as referred to in the Police Act (872/2011), or a pre-trial investigation, as referred to in the Pre-trial Investigations Act (805/2011), be carried out in order to clarify a matter under investigation by the Ombudsman.

Section 9
Hearing a subject

If there is reason to believe that the matter may give rise to criticism as to the conduct of the subject, the Ombudsman shall reserve the subject an opportunity to be heard in the matter before it is decided.

Section 10
Reprimand and opinion

(1) If, in a matter within his or her remit, the Ombudsman concludes that a subject has acted unlawfully or neglected a duty, but considers that a criminal charge or disciplinary proceedings are nonetheless unwarranted in this case, the Ombudsman may issue a reprimand to the subject for future guidance.

(2) If necessary, the Ombudsman may express to the subject his or her opinion concerning what constitutes proper observance of the law, or draw the attention of the subject to the requirements of good administration or to considerations of promoting fundamental and human rights.

(3) If a decision made by the Parliamentary Ombudsman referred to in Subsection 1 contains an imputation of criminal guilt, the party having been issued with a reprimand has the right to have the decision concerning criminal guilt heard by a court of law. The demand for a court hearing shall be submitted to the Parliamentary Ombudsman in writing within 30 days of the date on which the party was notified of the reprimand. If notification of the reprimand is served in a letter

sent by post, the party shall be deemed to have been notified of the reprimand on the seventh day following the dispatch of the letter unless otherwise proven. The party having been issued with a reprimand shall be informed without delay of the time and place of the court hearing, and of the fact that a decision may be given in the matter in their absence. Otherwise the provisions on court proceedings in criminal matters shall be complied with in the hearing of the matter where applicable. (22.8.2014/674)

Section 11
Recommendation

(1) In a matter within the Ombudsman's remit, he or she may issue a recommendation to the competent authority that an error be redressed or a shortcoming rectified.

(2) In the performance of his or her duties, the Ombudsman may draw the attention of the Government or another body responsible for legislative drafting to defects in legislation or official regulations, as well as make recommendations concerning the development of these and the elimination of the defects.

CHAPTER 1 a
National Preventive Mechanism (NPM) (28.6.2013/495)

Section 11 a
National Preventive Mechanism (28.6.2013/495)

The Ombudsman shall act as the National Preventive Mechanism referred to in Article 3 of the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (International Treaty Series 93/2014).

Section 11 b
Inspection duty (28.6.2013/495)

(1) When carrying out his or her duties in capacity of the National Preventive Mechanism, the Ombudsman inspects places where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence (place of detention).

(2) In order to carry out such inspections, the Ombudsman and an official in the Office of the Ombudsman assigned to this task by the Ombudsman have the right of access to all premises and information systems of the place of detention, as well as the right to have confidential discussions with persons having been deprived of their liberty, with the personnel of the place of detention and with any other persons who may supply relevant information.

Section 11 c
Access to information (28.6.2013/495)

Notwithstanding the secrecy provisions, when carrying out their duties in capacity of the National Preventive Mechanism the Ombudsman and an official in the Office of the Ombudsman assigned to this task by the Ombudsman have the right to receive from authorities and parties maintaining the places of detention information about the number of persons deprived of their liberty, the number and locations of the facilities, the treatment of persons deprived of their liberty and the conditions in which they are kept, as well as any other information necessary in order to carry out the duties of the National Preventive Mechanism.

Section 11 d
Disclosure of information (28.6.2013/495)

In addition to the provisions contained in the Act on the Openness of Government Activities (621/1999) the Ombudsman may, notwithstanding the secrecy provisions, disclose information

about persons having been deprived of their liberty, their treatment and the conditions in which they are kept to a Subcommittee referred to in Article 2 of the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

Section 11 e
Issuing of recommendations (28.6.2013/495)

When carrying out his or her duties in capacity of the National Preventive Mechanism, the Ombudsman may issue the subjects of supervision recommendations intended to improve the treatment of persons having been deprived of their liberty and the conditions in which they are kept and to prevent torture and other cruel, inhuman or degrading treatment or punishment.

Section 11 f
Other applicable provisions (28.6.2013/495)

In addition, the provisions contained in Sections 6 and 8–11 herein on the Ombudsman's action in the oversight of legality shall apply to the Ombudsman's activities in his or her capacity as the National Preventive Mechanism.

Section 11 g
Independent Experts (28.6.2013/495)

(1) When carrying out his or her duties in capacity of the National Preventive Mechanism, the Ombudsman may rely on expert assistance. The Ombudsman may appoint as an expert a person who has given his or her consent to accepting this task and who has particular expertise relevant to the inspection duties of the National Preventive Mechanism. The expert may take part in conducting inspections referred to in Section 11 b, in which case the provisions in the aforementioned section and Section 11 c shall apply to their competence.

(2) When the expert is carrying out his or her duties referred to in this Chapter, the provisions on criminal liability for acts in office shall apply. Provisions on liability for damages are contained in the Tort Liability Act (412/1974).

Section 11 h
Prohibition of imposing sanctions (28.6.2013/495)

No punishment or other sanctions may be imposed on persons having provided information to the National Preventive Mechanism for having communicated this information.

CHAPTER 2
Report to the Parliament and declaration of interests

Section 12
Report

(1) The Ombudsman shall submit to the Parliament an annual report on his or her activities and the state of administration of justice, public administration and the performance of public tasks, as well as on defects observed in legislation, with special attention to implementation of fundamental and human rights.

(2) The Ombudsman may also submit a special report to the Parliament on a matter he or she deems to be of importance.

(3) In connection with the submission of reports, the Ombudsman may make recommendations to the Parliament concerning the elimination of defects in legislation. If a defect relates to a matter under deliberation in the Parliament, the Ombudsman may also otherwise communicate his or her observations to the relevant body within the Parliament.

Section 13
Declaration of interests (24.8.2007/804)

(1) A person elected to the position of Ombudsman, Deputy-Ombudsman or as a substitute for a Deputy-Ombudsman shall without delay submit to the Parliament a declaration of business activities and assets and duties and other interests which may be of relevance in the evaluation of his or her activity as Ombudsman, Deputy-Ombudsman or substitute for a Deputy-Ombudsman.

(2) During their term in office, the Ombudsman the Deputy-Ombudsmen and the substitute for a Deputy-Ombudsman shall without delay declare any changes to the information referred to in paragraph (1) above.

CHAPTER 3
General provisions on the Ombudsman, the Deputy-Ombudsmen and the Director of the Human Rights Centre (20.5.2011/535)

Section 14
Competence of the Ombudsman and the Deputy-Ombudsmen

(1) The Ombudsman has sole competence to make decisions in all matters falling within his or her remit under the law. Having heard the opinions of the Deputy-Ombudsmen, the Ombudsman shall also decide on the allocation of duties among the Ombudsman and the Deputy-Ombudsmen.

(2) The Deputy-Ombudsmen have the same competence as the Ombudsman to consider and decide on those oversight-of-legality matters that the Ombudsman has allocated to them or that they have taken up on their own initiative.

(3) If a Deputy-Ombudsman deems that in a matter under his or her consideration there is reason to issue a reprimand for a decision or action of the Government, a Minister or the President of the Republic, or to bring a charge against the President or a Justice of the Supreme Court or the Supreme Administrative Court, he or she shall refer the matter to the Ombudsman for a decision.

Section 15
Decision-making by the Ombudsman

The Ombudsman or a Deputy-Ombudsman shall make their decisions on the basis of drafts prepared by referendary officials, unless they specifically decide otherwise in a given case.

Section 16
Substitution (24.8.2007/804)

(1) If the Ombudsman dies in office or resigns, and the Parliament has not elected a successor, his or her duties shall be performed by the senior Deputy-Ombudsman.

(2) The senior Deputy-Ombudsman shall perform the duties of the Ombudsman also when the latter is recused or otherwise prevented from attending to his or her duties, as provided for in greater detail in the Rules of Procedure of the Office of the Parliamentary Ombudsman.

(3) Having received the opinion of the Constitutional Law Committee on the matter, the Parliamentary Ombudsman shall choose a substitute for a Deputy-Ombudsman for a term in office of not more than four years.

(4) When a Deputy-Ombudsman is recused or otherwise prevented from attending to his or her duties, these shall be performed by the Ombudsman or the other Deputy-Ombudsman as provided for in greater detail in the Rules of Procedure of the Office, unless the Ombudsman, as provided for in Section 19 a, paragraph 1, invites a substitute for a Deputy-Ombudsman to perform the Deputy-Ombudsman's tasks. When a substitute is performing the tasks of a Deputy-Ombudsman, the provisions of paragraphs (1) and (2) above concerning a Deputy-Ombudsman shall not apply to him or her.

Section 17
Other duties and leave of absence

(1) During their term of service, the Ombudsman and the Deputy-Ombudsmen shall not hold other public offices. In addition, they shall not have public or private duties that may compromise the credibility of their impartiality as overseers of legality or otherwise hamper the appropriate performance of their duties as Ombudsman or Deputy-Ombudsman.

(2) If the person elected as Ombudsman, Deputy-Ombudsman or Director of the Human Rights Centre holds a state office, he or she shall be granted leave of absence from it for the duration of their term of service as as Ombudsman, Deputy-Ombudsman or Director of the Human Rights Centre (20.5.2011/535).

Section 18
Remuneration

(1) The Ombudsman and the Deputy-Ombudsmen shall be remunerated for their service. The Ombudsman's remuneration shall be determined on the same basis as the salary of the Chancellor of Justice of the Government and that of the Deputy-Ombudsmen on the same basis as the salary of the Deputy Chancellor of Justice.

(2) If a person elected as Ombudsman or Deputy-Ombudsman is in a public or private employment relationship, he or she shall forgo the remuneration from that employment relationship for the duration of their term. For the duration of their term, they shall also forgo any other perquisites of an employment relationship or other office to which they have been elected or appointed and which could compromise the credibility of their impartiality as overseers of legality.

Section 19
Annual vacation

The Ombudsman and the Deputy-Ombudsmen are each entitled to annual vacation time of a month and a half.

Section 19 a
Substitute for a Deputy-Ombudsman (24.8.2007/804)

(1) A substitute for a Deputy-Ombudsman can perform the duties of a Deputy-Ombudsman if the latter is prevented from attending to them or if a Deputy-Ombudsman's post has not been filled. The Ombudsman shall decide on inviting a substitute to perform the tasks of a Deputy-Ombudsman. (20.5.2011/535)

(2) The provisions of this and other Acts concerning a Deputy-Ombudsman shall apply *mutatis mutandis* also to a substitute for a Deputy-Ombudsman while he or she is performing the tasks of a Deputy-Ombudsman, unless separately otherwise regulated.

CHAPTER 3 a
Human Rights Centre (20.5.2011/535)

Section 19 b
Purpose of the Human Rights Centre (20.5.2011/535)

For the promotion of fundamental and human rights there shall be a Human Rights Centre under the auspices of the Office of the Parliamentary Ombudsman.

Section 19 c
The Director of the Human Rights Centre (20.5.2011/535)

(1) The Human Rights Centre shall have a Director, who must have good familiarity with fundamental and human rights. Having received the Constitutional Law Committee's opinion on the matter, the Parliamentary Ombudsman shall appoint the Director for a four-year term.

(2) The Director shall be tasked with heading and representing the Human Rights Centre as well as resolving those matters within the remit of the Human Rights Centre that are not assigned under the provisions of this Act to the Human Rights Delegation.

Section 19 d
Tasks of the Human Rights Centre (20.5.2011/535)

(1) The tasks of the Human Rights Centre are:
1) to promote information, education, training and research concerning fundamental and human rights as well as co-operation relating to them;
2) to draft reports on implementation of fundamental and human rights;
3) to present initiatives and issue statements in order to promote and implement fundamental and human rights;
4) to participate in European and international cooperation associated with promoting and safeguarding fundamental and human rights;
5) to take care of other comparable tasks associated with promoting and implementing fundamental and human rights.

(2) The Human Rights Centre does not handle complaints.

(3) In order to perform its tasks, the Human Rights Centre shall have the right to receive the necessary information and reports free of charge from the authorities.

Section 19 e
Human Rights Delegation (20.5.2011/535)

(1) The Human Rights Centre shall have a Human Rights Delegation, which the Parliamentary Ombudsman, having heard the view of the Director of the Human Rights Centre, shall appoint for a four-year term. The Director of the Human Rights Centre shall chair the Human Rights Delegation. In addition, the Delegation shall have not fewer than 20 and no more than 40 members. The Delegation shall comprise representatives of civil society, research in the field of fundamental and human rights as well as other actors participating in the promotion and safeguarding of fundamental and human rights. The Delegation shall choose a deputy chair from among its own number. If a member of the Delegation resigns or dies mid-term, the Ombudsman shall appoint a replacement for him or her for the remainder of the term.

(2) The Office Commission of the Eduskunta shall confirm the remuneration of the members of the Delegation.

(3) The tasks of the Delegation are:
1) to deal with matters of fundamental and human rights that are far-reaching and important in principle;
2) to approve annually the Human Rights Centre's operational plan and the Centre's annual report;
3) to act as a national cooperative body for actors in the sector of fundamental and human rights.

(4) A quarum of the Delegation shall be present when the chair or the deputy chair as well as at least half of the members are in attendance. The opinion that the majority has supported shall constitute the decision of the Delegation. In the event of a tie, the chair shall have the casting vote.

(5) To organise its activities, the Delegation may have a work committee and sections. The Delegation may adopt rules of procedure.

CHAPTER 3 b
Other tasks (10.4.2015/374)

Section 19 f (10.4.2015/374)
Promotion, protection and monitoring of the implementation of the Convention on the Rights of Persons with Disabilities

The tasks under Article 33(2) of the Convention on the Rights of Persons with Disabilities concluded in New York in 13 December 2006 shall be performed by the Parliamentary Ombudsman, the Human Rights Centre and its Human Rights Delegation.

CHAPTER 4
Office of the Parliamentary Ombudsman and the detailed provisions

Section 20 (20.5.2011/535)
Office of the Parliamentary Ombudsman and detailed provisions

For the preliminary processing of cases for decision by the Ombudsman and the performance of the other duties of the Ombudsman as well as for the discharge of tasks assigned to the Human Rights Centre, there shall be an office headed by the Parliamentary Ombudsman.

Section 21
Staff Regulations of the Parliamentary Ombudsman and the Rules of Procedure of the Office (20.5.2011/535)

(1) The positions in the Office of the Parliamentary Ombudsman and the special qualifications for those positions shall be set forth in the Staff Regulations of the Parliamentary Ombudsman.

(2) The Rules of Procedure of the Office of the Parliamentary Ombudsman shall contain more detailed provisions on the allocation of tasks among the Ombudsman and the Deputy-Ombudsmen. Also determined in the Rules of Procedure shall be substitution arrangements for the Ombudsman, the Deputy-Ombudsmen and the Director of the Human Rights Centre as well as the duties of the office staff and the cooperation procedures to be observed in the Office.

(3) The Ombudsman shall confirm the Rules of Procedure of the Office having heard the views of the Deputy-Ombudsmen and the Director of the Human Rights Centre.

CHAPTER 5
Entry into force and transitional provision

Section 22
Entry into force

This Act enters into force on 1 April 2002.

Section 23
Transitional provision

The persons performing the duties of Ombudsman and Deputy-Ombudsman shall declare their interests, as referred to in Section 13, within one month of the entry into force of this Act.

Entry into force and application of the amending acts:

24.8.2007/804
This Act entered into force on 1 October 2007.

20.5.2011/535
This Act entered into force on 1 January 2012 (Section 3 and Section 19 a, subsection 1 on 1 June 2011).

22.7.2011/811
This Act entered into force on 1 January 2014.

28.6.2013/495
This Act entered into force on 7 November 2014 (Section 5 on 1 July 2013).

22.8.2014/674
This Act entered into force on 1 January 2015.

10.4.2015/374
This Act entered into force on 10 June 2016.

Act on the Division of Duties between the Chancellor of Justice and the Parliamentary Ombudsman

21 December 1990 (1224/1990)

Section 1

The Chancellor of Justice is released from the obligation to monitor compliance with the law in issues within the remit of the Parliamentary Ombudsman concerning:

1) the Ministry of Defence, excluding the oversight of legality of the official activities of the Government and its members, the Defence Forces, the Border Guard, the crisis management personnel referred to in the Act on Military Crisis Management (211/2006), the National Defence Training Association of Finland (MPK) referred to in chapter 3 of the Act on Voluntary National Defence (556/2007) as well as military court proceedings; (11.5.2007/564)

2) the apprehension, arrest, remand and travel ban as well as taking into custody or other deprivation of liberty referred to in the Coercive Measures Act (806/2011);

3) prisons and other institutions, to which persons have been admitted against their will.

(22.7.2011/813)

The Chancellor of Justice is also released from handling an issue within the remit of the Ombudsman initiated by a person, whose liberty has been restricted by remand or arrest or by other means.

Section 2

In cases referred to in section 1, the Chancellor of Justice must refer the matter to the Ombudsman, unless there are special reasons for deeming it appropriate to resolve the matter him-/herself.

Section 3

The Chancellor of Justice and the Ombudsman may also mutually transfer other issues within the remit of both parties, when the transfer can be considered to speed up the processing of the issue or if it is justified for other special reasons. In cases related to complaints, the complainant must be notified about the transfer.

Section 4

This act shall enter into force on 1 January 1991.

This act repeals the Act on the Principles of the Division of Duties between the Chancellor of Justice and the Parliamentary Ombudsman, issued on 10 November 1933 (276/33), as well as the Act on Releasing the Chancellor of Justice from Certain Duties issued on the same day (275/33).

When this act enters into force, it shall apply to the cases pending in the Office of the Chancellor of Justice as well as the Office of the Parliamentary Ombudsman.

Rules of Procedure of the Parliamentary Ombudsman

5 March 2002 (209/2002)

Under section 52(2) of the Constitution of Finland, the Finnish Parliament has approved the following rules of procedure for the Parliamentary Ombudsman:

Section 1
Staff of the Office of the Parliamentary Ombudsman

The potential posts in the Office of the Parliamentary Ombudsman include the post of secretary general, principal legal adviser, senior legal adviser, legal adviser, on-duty lawyer, investigating officer, information officer, notary, departmental secretary, filing clerk, records clerk, assistant filing clerk and office secretary. Other officials may also be appointed to the Office.

Within the limits of the budget, officials may be employed by the Office of the Parliamentary Ombudsman in fixed-term positions.

Section 2
Qualification requirements of the staff

The qualification requirements are:

1) the secretary general, principal legal adviser, senior legal adviser and legal adviser have a Master of Laws degree or a different master's degree as well as the experience in public administration or working as a judge required for the task; and

2) those working in other positions have a master's degree suitable for the purpose or other education and experience required by their duties.

Section 3
Appointing officials

The Ombudsman appoints the officials of his/her office.

Section 4
Leave of absence

The Ombudsman grants a leave of absence to the officials of the Office of the Parliamentary Ombudsman.

Section 5
Entry into force

These rules of procedure shall enter into force on 1 April 2002.

These rules of procedure repeal the rules of procedure of the Parliamentary Ombudsman issued on 22 February 2000 (251/2000).

Division of labour between the Ombudsman and the Deputy-Ombudsmen

Ombudsman Mr Petri Jääskeläinen
decides on matters concerning:

- the highest organs of state
- questions involving important principles
- the police, the Emergency Response Centre and rescue services
- public prosecutor, excluding matters concerning the Office of the Prosecutor General
- legal guardianship
- language legislation
- asylum and immigration
- the rights of persons with disabilities
- covert intelligence gathering and intelligence operations
- the coordination of the tasks of the National Preventive Mechanism against Torture and reports relating to its work
- matters concerning statements issued by the administrative branch of the Ministry of Justice

Deputy-Ombudsman Ms Maija Sakslin
decides on matters concerning:

- social welfare
- children's rights
- rights of the elderly
- health care
- municipal affairs
- the autonomy of the Åland Islands
- taxation
- traffic and communications
- environmental administration
- agriculture and forestry
- Sámi affairs
- Customs
- church affairs

Deputy-Ombudsman Mr Pasi Pölönen
decides on matters concerning:

- courts, judicial administration and legal aid
- the Office of the Prosecutor General
- Criminal sanctions field
- distraint, bankruptcy and dept arrangements
- social insurance
- income support
- early childhood education and care, education, science and culture
- labour administration
- unemployment security
- military matters, Defence Forces and Border Guard
- data protecton, data management and telecommunications

Proposals for the development of legislation and regulations and for the redressing of errors

Addressed to the cities of Espoo, Helsinki, Kuopio, Oulu, Pietarsaari, Tampere, Turku and Vantaa, the municipality of Kittilä and the social and health district Eksote in South Karelia

– Deputy-Ombudsman Sakslin stated that there are serious shortcomings in municipal operating practices concerning the care of the elderly: Decision-making processes include elements that jeopardise the client's legal protection and are not lawful. The Deputy-Ombudsman also stated that most municipalities do not have a comprehensive action plan for crisis situations. Even if the plan had been prepared, insufficient attention has been paid to assessing its feasibility. (4944/2019).

The Financial Supervisory Authority (Fiva)

– Deputy-Ombudsman Pölönen found it problematic that according to their statement, Fiva does not have the opportunity to request regular reports from insurance companies on the handling of motor vehicle insurance matters. The Deputy-Ombudsman urged Fiva to examine its own supervisory activities and authorisations and, if necessary, to consider the need to amend its regulations on authority (6997/2019).

The joint municipal authority of the Hospital District of Helsinki and Uusimaa (HUS)

– Substitute for the Deputy-Ombudsman Sarja considered it necessary to supplement the instructions of the Chief Physician so that the instructions include information on how the reservation and organisation of terminal care facilities should be implemented in case the facilities are overwhelmed (3110/2019).

City of Helsinki

– According to Deputy-Ombudsman Sakslin, the compliance with the current guidelines and policies related to the processing of requests for information may in practice result in persons in a more marginalised position being unable to exercise their rights, and to the right to essential income and care provided for in the Constitution being compromised (239/2019).

Eastern Finland Police Department

– According to the Ombudsman, it would be justified to reconsider the preconditions for initiating a pre-trial investigation (6116/2019).

Jyväskylä Health Care Centre

– The Deputy-Ombudsman Sakslin informed the Health Care Centre of the need to specify instructions on the vaccination protection of employees (6165 / 2019).

Kela

– According to Deputy-Ombudsman Pölönen, the explicit documentation of the health data on rehabilitation matters to be submitted to the applicant's therapist would help to assess whether the disclosure of documents is necessary as referred to in the Act (1003/2019)

- Deputy-Ombudsman Pölönen considered that Kela should actively seek to correct the consequences of the inadequate information given in the annual income supervision of student financial aid and that it should not require the applicant to request a review of their case in the income supervision of the following year (3918/2020).

The working committee of the Board of Directors of the Exam Consortium for higher education institutions

- Deputy-Ombudsman Pölönen considered that if an electronic exam is the only way to complete the exam or if special arrangements are required on the basis of a disability or illness, the institute should assess the development of its practices for organising access to bathrooms during examinations (3791/2019).

The Ministry of Justice

- Parliamentary Ombudsman Jääskeläinen proposed to the ministry an assessment of the need to revise the legislation on the supervision of telecommunications (3227/2019).
- According to Deputy-Ombudsman Pölönen, in order to clarify the role of the police, the provisions on bringing to court and search warrants should be specified either in the legislation concerning the police or in the process laws (23/2017).
- Ombudsman Jääskeläinen proposed that the Ministry consider whether the regulation of Chapter 7, section 15 of the Coercive Measures Act should be clarified (784/2019).
- According to Parliamentary Ombudsman Jääskeläinen, changing the decision concerning pre-trial investigations is a question of on what grounds and who can change the head of investigation's decision not to carry out a pre-trial investigation. The Ombudsman suggested that the legal status could be clarified if the supervisor's competence vis-à-vis the investigator in charge of the investigation had been more clearly laid down (1205/2019).
- Deputy-Ombudsman Pölönen stated that the Imprisonment Act does not contain a provision on the basis of which a residential ward could be closed for a longer period due to an epidemic nor that the activities that the prisoners should be provided with under the law could be cancelled for the same reason. The Deputy-Ombudsman also drew attention to the lack of provisions on the cancellation of free time and other activities in prisons (1887/2019).
- Parliamentary Ombudsman Jääskeläinen asked the Ministry to assess the General Comment No 1 (2014) of the Committee on the Rights of Persons with Disabilities on Article 12 of the Convention on the Rights of Persons with Disabilities and its possible significance from the perspective of the existing guardianship legislation (2012/2019).
- Parliamentary Ombudsman Jääskeläinen proposed that the Ministry consider clarifying the language regulation on consumer disputes before the Consumer Disputes Board (5987/2019).
- Parliamentary Ombudsman Jääskeläinen proposed that the Ministry consider assessing questions related to advance requests for documents in the working group preparing the updating of the Act on the Openness of Government Activities (6094/2019).
- Ombudsman Jääskeläinen considered that the Act on the Openness of Government Activities should be reformed. He proposed that the ministry consider whether the reform of the confidentiality criteria for pre-trial investigation documents should be separately prepared (579/2020).
- Deputy-Ombudsman Sakslin considered that the assessment of the need for regulation related to filming in a matter concerning health care activities also included points of association with the exercise of freedom of expression and offences regulated in Chapter 24 of the Criminal Code (1190/2020, See also the proposal to the Ministry of Social Affairs and Health).

- Parliamentary Ombudsman Jääskeläinen considered it justified that a pretrial investigation should be performed urgently in cases in which the injured party is under the age of 18. Provisions concerning prosecution and criminal trials should also be reviewed in the same manner (5625/2020).

The Ministry of Education and Culture

- The Deputy-Ombudsman Pölönen also proposed that the ministry assess whether the Basic Education Act should be specified in such a way that it would clearly state the right of all pupils to free access to the services and aids required for participation in teaching and the related decision-making obligation of the education provider (4230/2019).

The Ostrobothnia Police Department

- The Parliamentary Ombudsman Jääskeläinen considered that, when assessing the need to submit a pre-trial investigation, careful consideration should be given to the prerequisites for a pre-trial investigation, and the pre-trial investigation decision should be sufficiently justified. According to the Ombudsman, it would be justified to reconsider the preconditions for a pre-trial investigation (6881/2019).

The Ministry of the Interior

- According to Parliamentary Ombudsman Jääskeläinen, the Ministry should consider whether the prerequisites for preventive action by the police could be developed and proposed for consideration to develop legislation (2186/2019).
- Ombudsman Jääskeläinen proposed that the ministry consider whether it would be appropriate to specify the provisions of Chapter 2, section 10 of the Police Act (6314/2019).
- Parliamentary Ombudsman Jääskeläinen proposed that the Ministry consider amending the regulations concerning the texts on police uniforms (6685/2019).

The Ministry of Social Affairs and Health

- Deputy-Ombudsman Sakslin stated that there were no uniform basic guidelines for treatment or separate national treatment recommendations for treating patients with chronic pain disorders for when the pain suddenly becomes worse (5975/2019).
- Deputy-Ombudsman Sakslin proposed to the Ministry that it initiate an investigation to reform the regulation on the disclosure of patient data of a deceased person so that the provision would better take into account the implementation of fundamental and human rights in individual situations, while protecting the privacy of the deceased (3958/2019).
- According to Deputy-Ombudsman Sakslin, the outsourcing of a task related to the handling of a patient injury meant subdelegation of a public administrative task, which is not provided for by law. The Deputy-Ombudsman considered that the Patient Insurance Centre and the Ministry should take action without delay (4557/2019).
- Ombudsman Jääskeläinen drew attention to the fact that the legislation on the maintenance fee for persons with intellectual disabilities and the practices based on it are difficult to understand and ambiguous. The Parliamentary Ombudsman delivered the proposal for the consideration of the Ministry in the overall reform of the Act on Customer Charges and Disability Legislation (6749/2019).
- Deputy-Ombudsman Sakslin considered the current legal status related to filming problematic for the realisation of the fundamental rights of health care patients and staff. Deputy-Ombudsman Sakslin asked the Ministry to consider possible legislative measures to safeguard the freedom of expression and privacy in health care units and activities (1190/2020, See also the proposal to the Ministry of Justice).

- Deputy-Ombudsman Sakslin stated that the Communicable Diseases Act does not specifically give the right to restrict a person's fundamental rights in situations other than quarantine and isolation, and that binding visiting bans cannot be imposed on housing units under section 17 of the Communicable Diseases Act. The Deputy-Ombudsman noted that the instructions issued by the Ministry of Social Affairs and Health concerning the care institutions for older people and housing service units have been incorrect. The Deputy-Ombudsman proposed that a careful preparation of legislative amendments be initiated without delay at the Ministry (3232/2020).
- Deputy-Ombudsman Sakslin proposed to the Ministry that it take measures to determine whether it is justified to supplement the legislation so that health care units should report an incident that seriously endangered patient safety to the health care supervisory authorities (8066/2020).

The National Police Board

- Ombudsman Jääskeläinen presented to the consideration of the National Police Board and the Emergency Response Centre Administration whether they should supplement their instructions on the handling of emergency notifications related to the threat of suicide (3109/2019).
- Parliamentary Ombudsman Jääskeläinen proposed that the National Police Board consider providing instructions on the use of pepper spray and on first aid after its use (3986/2019).
- The Parliamentary Ombudsman Jääskeläinen proposed to the National Police Board to consider whether the regulation on uniforms should be specified. The National Police Board should also assess whether regulation subordinate to the law is compliant with the Police Act and the Constitution (923/2020).
- Ombudsman Jääskeläinen asked the National Police Board to consider whether the instructions issued by the police should be supplemented by instructions on the reporting obligation laid down in section 25 of the Act on the Care Services for Older Persons (4712/2020).

The City of Tampere

- The Deputy-Ombudsman Sakslin stated that the city should ensure that the contents of the treatment in the reimbursement treatment it has purchased are also appropriate and that the personnel resources are sufficient in relation to the number of customers and the need for reimbursement treatment (877/2019).

Ministry of Economic Affairs and Employment

- According to Deputy-Ombudsman Pölönen, it is necessary to clarify the legal remedies for removing a trade register entry of a limited liability company (1737/2019).
- Deputy-Ombudsman Pölönen drew attention to the possible need to regulate the right of minors and other incompetent persons to pursue a business and its prerequisites and to submit a trade register notification (5025/2019).

National Enforcement Authority

- According to Deputy-Ombudsman Pölönen, the bailiff is obliged to ensure equal treatment of potential buyers in the organisation of a free sale of a seized property by means of an online auction (1674/2019).

Tax Administration

– Due to unlawful negligence in the processing of an estate's application for advance tax, Deputy-Ombudsman Sakslin asked the Tax Administration to further consider whether the complainant should be compensated for these penalties that were caused by the Tax Administration's own negligence (5372/2019).

The Matriculation Examination Board

– Substitute for the Deputy-Ombudsman Sarja considered that the accessibility of persons with disabilities should be ensured in the arrangements for the matriculation examination. He proposed to the Matriculation Examination Board that instructions be further developed so that the possible means of reasonable accommodation should not be unnecessarily restricted in advance (2356/2019).

Inspections

#) = unannounced inspection

Finnish Prosecution Service

- 17 September Prosecution District of Western Finland, Vaasa office – documentation review (4569/2020)
- 19 November Prosecution District of Western Finland, Rovaniemi office – documentation review (3188/2020)

Police administration

- 2 March Pasila Police Station, police prison (1706/2020)
- 9 March National Police Board, Vitja project (1750/2020)
- 3 November Lapland Police Department (2957/2020)
- 3 November Lapland Police Department, covert coercive measures and intelligence gathering - documentation review (4722/2020)
- 1 December Ostrobothnia Police Department (4602/2020)

Defence Forces and Border Guard

- 14 October The Defence Command Finland, intelligence gathering and activities (6719/2020)

Criminal Sanctions

- 24 February Criminal Sanctions Agency, Central Administration Unit (1039/2020)
- 27 February Ministry of Justice, Department for Criminal Policy and Criminal Law (1040/2020)

Social welfare/Children

- 12–14 February 2020 Sairila Residential School#), in Mikkeli (883/2020)

Social welfare/Persons with disabilities

- 1 June Helsingin Diakonnissalaitoksen säätiö, Rinnekoti – documentation review, consultation by phone (3649/2020)
- 1 June Vaalijala joint municipal authority – documentation review, consultation by phone (3650/2020)
- 1 June Social welfare sector under the joint municipal authority of Satakunta Hospital District, institutional and residential services for persons with disabilities and the Antinkartano rehabilitation centre – documentation review, consultation by phone (3651/2020)
- 1 June Residential services for persons with intellectual disabilities in the municipality of Loppi and the Pajukoti residential unit for persons with intellectual disabilities – documentation review, consultation by phone (3652/2020)
- 1 June Validia Oy's residential services, Validia house in Lahti – documentation review, consultation by phone (3654/2020)
- 22 June Institutional and residential services for persons with intellectual disabilities in the city of Pietarsaari – documentation review, consultation by phone (3653/2020)

Social welfare/Elderly units

- 11 March 2020 Joint municipal authority for North Karelia social and health services, Koivupiha, in Joensuu (1760/2020)
- 11 March 2020 Hoitokoti Annala Oy[#)], in Kesälahti (1823/2020)
- 11 March 2020 Annalakodit Oy[#)], in Kesälahti (1824/2020)
- 5 October 2020 Joint municipal authority for North Karelia social and health services, Koivupiha, in Joensuu – remote follow-up inspection (1760/2020)
- 9 October 2020 Joint municipal authority for North Karelia social and health services, Elderly care services – remote inspection, consultation by phone (1389/2020)
- 19 November 2020 Hoitokoti Annala Oy[#)], in Kesälahti – remote follow-up inspection (1823/2020)
- 19 November 2020 Annalakodit Oy[#)], in Kesälahti – remote follow-up inspection (1823/2020)

Social insurance

- 10 September Kela, Cooperation meeting (5975/2020)

Other inspections

- 5 March Pirkanmaa ELY Centre, area of responsibility for the environment and natural resources (1442/2020)
- 9 March Uusimaa ELY Centre, area of responsibility for the environment and natural resources (1443/2020)
- 5 November Lapland ELY Centre, area of responsibility for the environment and natural resources (1445/2020)

Staff of the Office of the Parliamentary Ombudsman

Parliamentary Ombudsman
Mr Petri Jääskeläinen, LL.D., LL.M. with court training

Deputy-Ombudsmen
Ms Maija Sakslin, LL.Lic.
Mr Pasi Pölönen, LLD., LL.M. with court training

Secretary General
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Mr Jarmo Hirvonen, LL.M. with court training
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Ms Kirsti Kurki-Suonio, LL.D.
Ms Ulla-Maija Lindström, LL.M.
Ms Riitta Länsisyrjä, LL.M. with court training (on leave since 10 November)
Mr Juha Niemelä, LL.M. with court training
Mr Jari Pirjola, LL.D., M.A.
Mr Pasi Pölönen, LL.D., LL.M. with court training (on leave)
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Mr Tapio Räty, LL.M.
Mr Mikko Sarja, LL.Lic., LL.M. with court training
Mr Håkan Stoor, LL.Lic., LL.M. with court training
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Ms Minna Verronen, LL.M. with court training

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Ms Riitta Burrell, LL.D. (since 1 July)
Ms Elina Castrén, LL.M. with court training (on fixed term till 29 February)
Mr Kristian Holman, LL.M., M.Sc. (Admin.)
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Ms Anne Ilkka, LL.M. with court training (since 1 December)
Ms Riikka Jackson, LL.M. (on leave 30 January–8 December)
Ms Marja-Liisa Judström, LL.M. with court training (on fixed term till 31 March)
Ms Minna Ketola, LL.M. with court training (on leave 15 January–31 July)
Ms Johanna Koli, M.Soc.Sc. (since 22 June)
Mr Juha-Pekka Konttinen, LL.M.
Ms Heidi Laurila, LL.M. with court training
Ms Kaisu Lehtikangas, M.Soc.Sc. (on fixed term till 30 April and 1 June–30 June).
Ms Päivi Pihlajisto, LL.M. with court training
Ms Piatta Skottman-Kivelä, LL.M. with court training (on leave 1 March–31 May)
Ms Mirja Tamminen, LL.M. with court training
Mr Jouni Toivola, LL.M. (till 24 May)
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Ms Helena Kataja

Assistant Filing Clerk
Ms Anu Forsell

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Mr Matti Rautala (on fixed term since 1 September)
Ms Mervi Stern

Case Management Secretary
Ms Anna-Liisa Tapio, B.B.A
Mr Taneli Palmén, M.A., B.A. (since 1 October)

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Ms Susan Villa, M.Soc.Sc.

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Ms Kupiainen Emmi LL.M, LL.B (on fixed term since 11 May)

Assistant
Ms Katariina Huhta (since 24 April)

Statistical data on the Ombudsman's work in 2020

MATTERS UNDER CONSIDERATION

Oversight-of-legality cases under consideration			**8,985**
Cases initiated in 2020		7,241	
– complaints to the Ombudsman	6,962		
– complaints transferred from the Chancellor of Justice	97		
– taken up on the Ombudsman's own initiative	66		
– submissions and attendances at hearings	116		
Cases held over from previous years		1,913	
Cases resolved			**7,212**
Complaints		6,982	
Taken up on the Ombudsman's own initiative		78	
Submissions and attendances at hearings		107	
Cases held over to the following year			**977**
Other matters under consideration			**1,108**
Inspections		28	
Administrative matters in the Office		1,048	
International matters		32	

RESOLVED CASES BY PUBLIC AUTHORITIES

Complaint cases	7,027
Social welfare	1,161
Police	871
Health	759
Social insurance	444
Criminal sanctions field	397
Administrative branch of the Ministry of Economic Affairs and Employment	355
Administrative branch of the Ministry of Education and Culture	351
Highest organs of government	340
Local government	239
Enforcement (distraint)	236
Administration of law	228
Administrative branch of the Ministry of Environment	181
Taxation	172
Administrative branch of the Ministry of Transport and Communications	171
Aliens affairs and citizenship	144
Guardianship	102
Prosecutors	96
Administrative branch of the Ministry of Defence	95
Administrative branch of the Ministry of Agriculture and Forestry	79
Administrative branch of the Ministry of Justice	74
Administrative branch of the Ministry of the Interior	40
Administrative branch of the Ministry of Finance	36
Customs	12
Administrative branch of the Ministry for Foreign Affairs	12
Subjects of oversight in the private sector	2
Other administrative branches	430

RESOLVED CASES BY PUBLIC AUTHORITIES

Taken up on the Ombudsman's own initiative		**78**
Social welfare	17	
Health	12	
Police	10	
Criminal sanctions field	9	
Administrative branch of the Ministry of Transport and Communications	8	
Local government	4	
Social insurance		
Administrative branch of the Ministry of Education and Culture	3	
Prosecutors	2	
Administrative branch of the Ministry of Justice	2	
Administrative branch of the Ministry of Defence	1	
Administrative branch of the Ministry of the Interior	1	
Taxation	1	
Administrative branch of the Ministry for Foreign Affairs	1	
Highest organs of government	1	
Other administrative branches	1	
Total number of decisions		**7,105**

MEASURES TAKEN BY THE OMBUDSMAN

Complaints		**7,027**
Decisions leading to measures on the part of the Ombudsman		**963**
– prosecution		–
– assessment of the need for pre-trial investigation		2
– reprimands		49
– opinions		680
– as a rebuke	423	
– for future guidance	257	
– recommendations		54
– to redress an error or rectify a shortcoming	9	
– to develop legislation or regulations	26	
– to provide compensation for a violation	17	
– to rech an agreed settlement	2	
– matters redressed in the course of investigation		28
– other measure		150
– to rech an agreed settlement	–	
No action taken, because		**3,161**
– no incorrect action found		215
– no grounds		2,946
– to suspect illegal or incorrect procedure	1,678	
– for the Ombudsman's measures	1,268	
Complaint not investigated, because		**2,903**
– matter not within Ombudsman's remit		270
– still pending before a competent authority or possibility of appeal still open		1,034
– unspecified		550
– transferred to Chancellor of Justice		45
– transferred to Prosecutor-General		6
– transferred to Regional State Administrative Agency		76
– transferred to ELY Centre		1
– transferred to other authority		133
– older than two years		161
– inadmissible on other grounds		48
– no answer		124
– answer without measures		455

MEASURES TAKEN BY THE OMBUDSMAN

Taken up on the Ombudsman's own initiative		**78**
Decisions leading to measures on the part of the Ombudsman		60
– prosecution		–
– assessment of the need for pre-trial investigation		–
– reprimands		2
– opinions		38
– as a rebuke	14	
– for future guidance	24	
– recommendations		7
– to redress an error or rectify a shortcoming	1	
– to develop legislation or regulations	5	
– to provide compensation for a violation	1	
– to rech an agreed settlement	–	
– matters redressed in the course of investigation		3
– other measure		10
No action taken, because		12
– no incorrect action found		–
– no grounds		12
– to suspect illegal or incorrect procedure	1	
– for the Ombudsman's measures	11	
Own initiative not investigated, because		6
– still pending		–
– transferred to other authority		–
– inadmissible on other grounds		1
– no answer		5

INCOMING CASES BY AUTHORITY

Social welfare	1,196
Police	852
Health	802
Administrative branch of the Ministry of Education and Culture	466
Social insurance	383
Criminal sanctions field	377
Administrative branch of the Ministry of Economic Affairs and Employment	369
Highest organs of government	328
Administration of law	254
Local government	239
Enforcement (distraint)	224
Administrative branch of the Ministry of Environment	160
Taxation	157
Administrative branch of the Ministry of Transport and Communications	149
Aliens affairs and citizenship	126
Guardianship	102
Administrative branch of the Ministry of Defence	100
Administrative branch of the Ministry of Justice	96
Prosecutors	95
Administrative branch of the Ministry of Agriculture and Forestry	62
Administrative branch of the Ministry of Finance	49
Administrative branch of the Ministry of the Interior	34
Customs	19
Administrative branch of the Ministry for Foreign Affairs	11
Subjects of oversight in the private sector	1
Other administrative branches	408

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