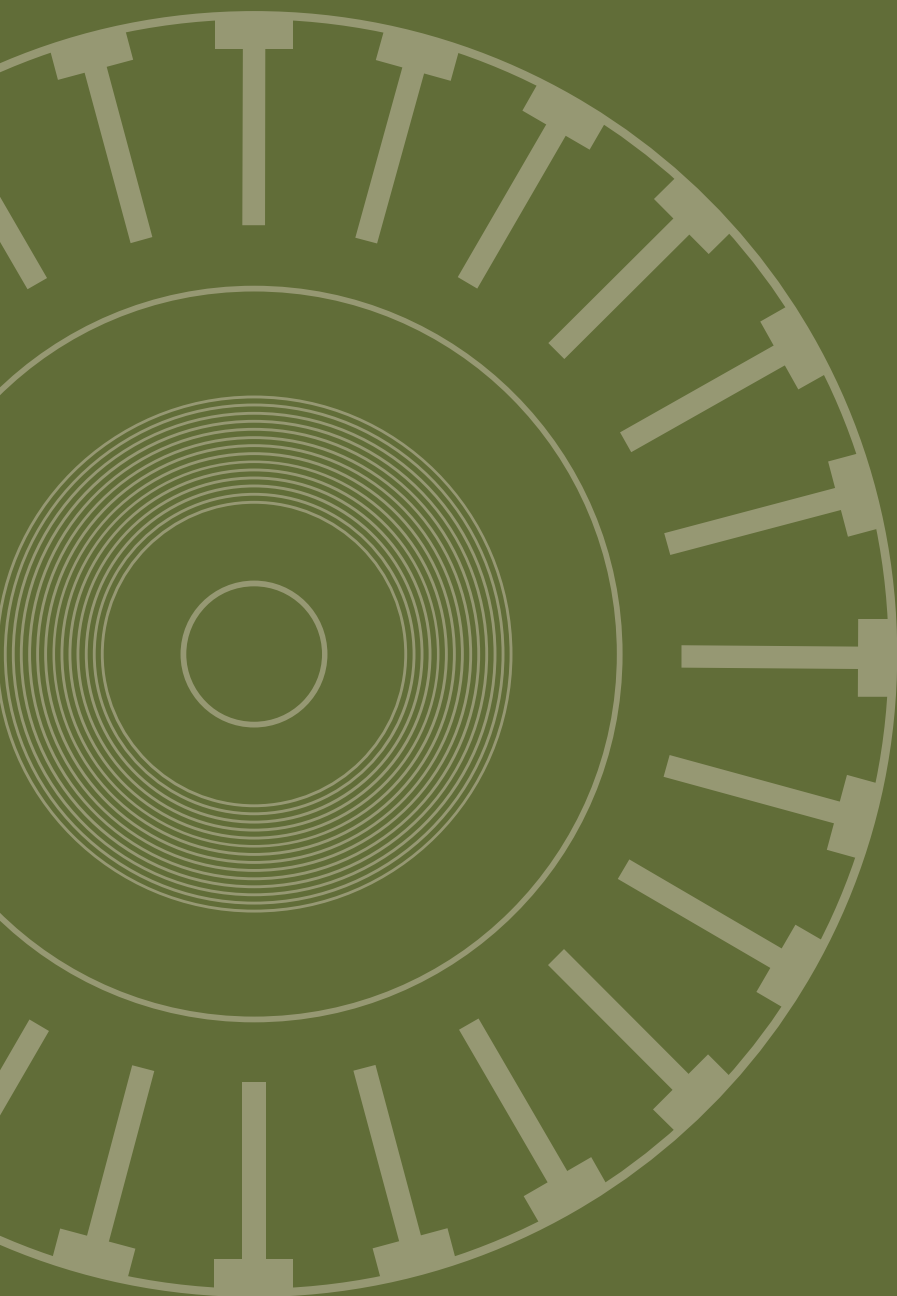


National Preventive Mechanism – NPM

REPORT FROM THE OPCAT UNIT FOR 2015–2017



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

Preface

Since 2011, the Parliamentary Ombudsmen has discharged the duties as National Preventive Mechanism (NPM) in accordance with the UN's Optional Protocol to the Convention against Torture (OPCAT). A principle task of this role is to conduct inspections of locations where individuals are, or may be, deprived of their liberty.

During the first three and a half years (2011–2014), the OPCAT unit focused on developing strategies for the inspection activity. In addition to this, a large number of inspections were made at locations where individuals were deprived of their liberty, which had not previously been inspected by the Parliamentary Ombudsmen. Observations during this build up phase were presented in a report in 2016.

This report forms a summary of observations made during inspections between 2015–2017. The development on various strategies continues as the unit also focus efforts on following up previous inspections. Such inspections have proved to be an important tool to realize how the recommendations of the ombudsmen have been received by the authorities. The development of new strategies has also led the Parliamentary Ombudsmen to ask authorities to report back on certain matters, over the past few years. An example of this is the report I requested from the Prison and Probation Service regarding how the authority works on measures to reduce segregation for individuals in remand prisons.

The unit has also focused on developing new procedures during 2015–2017 by targeting a thematic work process. In 2015, the unit focused on women deprived of their liberty, in 2016 on providing information to individuals deprived of their liberty and in 2017 on supervision of individuals deprived of their liberty. Through this thematic focus, the unit put emphasis on one or several issues. The OPCAT unit's theme for 2018–2019 is transportation of individuals deprived of their liberty. During early 2019, OPCAT will publish a report on observations made in 2018.

I can state that, during the years that the Parliamentary Ombudsmen has discharged the duties as NPM, we have performed more than 150 inspections of locations where individuals are deprived of their liberty. Locations inspected have been varied, from large psychiatric clinics and prison establishments to youth facilities and small police custody facilities. The location's operations differ greatly in regards to environment, rules, and regulations, but the inspections have consistently shown that there are important preventive measures for the authorities to take. That the unit's work leads to result is concluded in the improvement measures in, e.g., the report that the Parliamentary Ombudsmen requests from the authorities. Through the wide range of the inspection activity and the thematic focus, the OPCAT unit has collected meaningful knowledge and directed its attention on the special issues that concern the conditions for individuals deprived of their liberty. The aim of this report is to collectively report on knowledge gathered and lessons learned.



Elisabeth Rynning
Chief Parliamentary Ombudsman

Content

| | |
|--------------------------------------------------------------------------|-----------|
| Preface | 3 |
| Introduction | 7 |
| The OPCAT unit | 9 |
| The Opcat unit | 10 |
| The terms torture and cruel, inhuman or degrading treatment | 10 |
| The Convention on Torture and OPCAT | 10 |
| Preventive work | 11 |
| OPCAT in Sweden | 11 |
| The international examining bodies | 13 |
| A Nordic NPM network | 13 |
| OPCAT celebrated 10 years | 13 |
| The aim of this report | 14 |
| OPCAT inspections 2015–2017 | 15 |
| OPCAT inspections | 16 |
| Working method | 16 |
| Locations where individuals are deprived their liberty | 17 |
| Inspections carried out 2015–2017 | 18 |
| Geographical spread of inspections 2015–2017 | 19 |
| General observations in connection with inspections | 21 |
| Police custody facilities | 22 |
| The police custody facility guard’s training | 22 |
| Shortcomings in the physical environment | 23 |
| Access to health and medical care | 23 |
| Right to clothes | 24 |
| Temporary police custody facilities | 25 |
| Conclusions on police custody facilities | 25 |
| Remand prisons and prison establishments | 26 |
| Isolation of persons held on remand | 27 |
| Reducing isolation | 28 |
| Temporary remand prisons | 28 |
| Migration detainees | 29 |
| Follow-up of previous inspections | 30 |
| Conclusions regarding remand prisons and prison establishments | 32 |
| Youth facilities | 33 |
| Care in isolation and the option of keeping an inmate in isolation | 33 |
| ”Escapees” | 35 |
| Supervision of inmates | 35 |

| | |
|------------------------------------------------------------------------------------------|-----------|
| The physical environment | 36 |
| Conclusions LVU and LVM residential homes | 36 |
| Compulsory psychiatric care | 37 |
| Coercive measures | 37 |
| Patients who have been subject to coercive measures for a long period of time | 39 |
| Opportunity to spend time outdoors on a daily basis | 39 |
| Environment lacking stimuli | 40 |
| Follow-up inspection | 40 |
| Conclusions regarding compulsory psychiatric care | 41 |
| Migration detention centres | 42 |
| Coercive measures | 42 |
| Access to medical care | 43 |
| Conclusions on detention centres | 44 |
| Theme for 2015: Female deprivation of liberty | 45 |
| Female deprivation of liberty | 46 |
| Inspections carried out | 46 |
| The National Assessment Centre | 47 |
| Placing inmates in a suitable institutional placement | 47 |
| Pregnant inmates and inmates staying in an institution with their children | 48 |
| Security assessments in connection to transport healthcare facilities | 49 |
| Conclusions | 50 |
| Theme for 2016: Information about rights of those deprived of their liberty | 51 |
| Information about rights | 52 |
| Police custody facilities | 52 |
| Remand prisons | 53 |
| Migration detention centres | 53 |
| Compulsory psychiatric care | 54 |
| Conclusions | 54 |
| Theme for 2017: Supervision of those deprived of their liberty | 57 |
| Supervision of those deprived of their liberty | 58 |
| Police custody facilities | 58 |
| Remand prisons | 59 |
| Migration detention centres | 60 |
| Youth facilities | 60 |
| Compulsory psychiatric care | 60 |
| Conclusions | 61 |
| Appendices – Tables and summaries | 63 |
| Appendix A: Participation in international meetings | 64 |
| Appendix B: Inspections | 66 |
| Appendix C: Enquiries subsequent to an OPCAT inspection | 69 |
| Appendix D: Issues where the Parliamentary Ombudsmen has requested feedback | 70 |

Introduction

Since 2011, the Parliamentary Ombudsmen has discharged the duties as National Preventive Mechanism (NPM) in accordance with the Optional Protocol to the UN's Torture Convention (OPCAT). In order to complete this task, the Parliamentary Ombudsmen is assisted by a specific unit, the OPCAT unit. The unit's main task is to carry out inspections on behalf of the Parliamentary Ombudsmen, at locations where individuals are, or may be, deprived of their liberty.

The office of the Parliamentary Ombudsmen form a pillar of parliamentary control in Sweden. The office was established in 1809 as part of the new constitution that was adopted that year. The Parliamentary Ombudsmen ensure that courts of law and public authorities abide by the constitution's requirement on objectivity and impartiality and that an individual's basic freedoms and rights are not infringed. The office's supervision is primarily focused on processing complaints from the general public and through inspections. The processing of complaints is the predominant task of the office, but the Parliamentary Ombudsmen also carries out 20–30 inspections, on a yearly basis. Inspections of locations where individuals are deprived of their liberty, such as prison establishments, have always been an important part of the Parliamentary Ombudsmen's assignment.

Over the seven years that the Parliamentary Ombudsmen has discharged the duties of NPM, the OPCAT unit has carried out 167 inspections of locations where individuals are deprived of their liberty. An initial report summarising the 2011–2014 inspection period was presented in 2016. This is the second report in the series and summarises the 58 inspections that took place during 2015–2017.

The report highlight statements made, during inspections over the last year, by the Parliamentary Ombudsmen.

The report is divided into six sections. The first section contains a general description of the OPCAT unit's operations. The second section contains statistics on completed inspections. The third section contains statement made, divided on the basis of the inspection areas, i.e., police custody facilities, remand prisons and prison establishments, Care of Young Persons Act (LVU) and Care of Abusers Act (LVM) residential homes, compulsory psychiatric care and migration detention. The fourth to sixth sections contain descriptions of the three themes of the unit, during this period. The three themes are deprivation of liberty of females (section 4), information and rights of individuals deprived of their liberty (section 5) and supervision of individuals deprived of their liberty (section 6).



The Opcat unit



The OPCAT unit

Pursuant to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment of 1984 (the Convention against Torture), the acceding states have committed themselves to taking effective legislative, administrative, legal or other measures, to prevent torture within each territory under their jurisdiction. Prohibitions against torture are also dealt with in a number of UN conventions.

The Convention for the Protection of Human Rights and Fundamental Freedoms (the European Convention on Human Rights) and the Charter of Fundamental Rights of the European Union (the EU Charter) contain prohibitions against torture. The European Convention has been in force since 1995 in Sweden. In addition, the Swedish constitution contains a prohibition against torture. According to the constitution, each individual is protected against physical punishment, nor may anyone be subjected to torture or medical influence for the purposes of extorting or preventing statements.

The terms torture and cruel, inhuman or degrading treatment

Article 1 of the UN's Convention on Torture contains a relatively comprehensive definition of the term torture. In brief, it can be said that torture means someone being intentionally subjected to serious physical or mental pain or suffering for a specific purpose. This could, for example, take place to extract information or to punish or threaten a person. The Convention lacks definitions of cruel, inhuman and degrading treatment.

The European Court of Human Rights (ECHR) has stated that inhuman treatment shall cover at least the kind of treatment that intentionally causes any serious mental or physical suffering which can be regarded as unjust in a specific situation. Degrading treatment refers to the kind of action that awakes a feeling of fear, anxiety or inferiority in the victim. Subjective circumstances such as the victim's gender and age are of great significance in determining whether treatment or punishment is degrading. Treatment may be degrading even if no one other than the victim has witnessed or become aware of it.

The Convention on Torture and OPCAT

The Convention on Torture has been in force in Sweden since 1987. The countries that have signed the Convention are examined by a special committee, the UN Committee Against Torture (CAT). The states must regularly report on how they enforce the Convention.

If an acceding state has granted a permission, an individual may complain

to the Committee. Sweden allows individual complaints. The Convention on Torture does not give CAT a mandate to carry out visits to acceding states.

In order to make international visits possible, the Optional Protocol to the Convention against Torture, OPCAT, was adopted in 2002 and entered into force in 2006. The Protocol has the stated objective of preventing torture and other cruel, inhuman or degrading treatment. Through OPCAT an international committee, the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (STP) has been established.

Preventive work

The unit's work is to be performed with the objective to – if necessary – strengthen the protection for individuals deprived of their liberty, against torture and other cruel, inhuman or degrading treatment or punishment. Preventive work can be performed in several ways. Forbidding certain behaviour and taking legal proceedings against those who are guilty of transgressions of the law could be assumed to have some preventive effect. Another way is by exercising supervision in environments where the risk of abuse and violations is particularly high.

Another important element of the preventative work is identifying and analysing factors that could, directly or indirectly, increase or reduce the risk of torture and other forms of inhuman treatment etc. This work should also have the aim of systematically reducing or eliminating risk factors and strengthening preventive factors and safety mechanisms. The work should be forward-looking. The work should also be carried out with a long-term perspective and focus on achieving improvements through constructive dialogue, proposals for safety mechanisms and other measures.

OPCAT in Sweden

States acceding to OPCAT are obliged to designate one or more National Preventive Mechanisms. Since 1 July 2011, the Parliamentary Ombudsmen has fulfilled the role of the National Preventive Mechanism (NPM) in accordance with OPCAT (§ 5 a of the Act [1986:765] with instructions for the Parliamentary Ombudsmen). In its role as NPM, the Parliamentary Ombudsmen must perform the following tasks:

- regularly inspect locations where individuals are deprived of their liberty,
- provide recommendations to competent authorities with a view to improve the treatment of and conditions for individuals deprived of their liberty and prevent torture and other cruel, inhuman or degrading treatment or punishment,
- provide proposals and points of views on applicable or proposed legislation affecting the treatment of and conditions for individuals deprived of

The OPCAT entered into force on 22 June 2006 and, over the past decade, this global system of preventing torture and other forms of ill-treatment has enhanced cooperation and exchanges between governmental and non-governmental actors, NPMs and the UN, on improving the treatment of all detained persons. Presently, 81 States from all over the world have ratified or acceded to the OPCAT, another 17 States have signed it and many more are in the process of doing so. More than 60 States have also set up their NPMs.

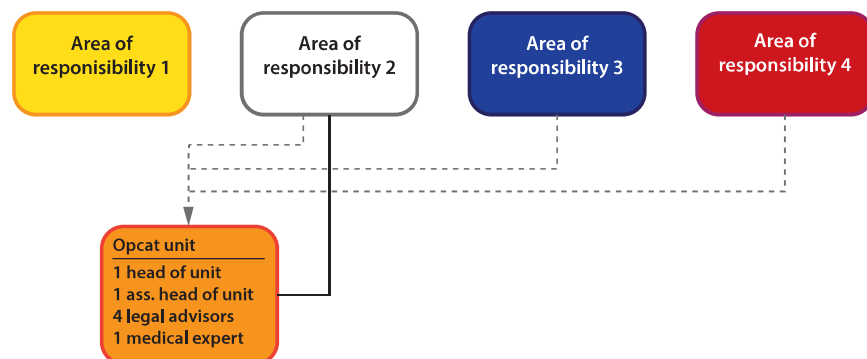
their liberty,

- contribute to dialogues with competent authorities, and
- report on the activity.

Currently it is the ombudsmen's responsibility to fulfil the NPM role. The locations to be inspected, within the framework of this role, have been identified by the Parliamentary Ombudsmen as primarily being prison establishments, remand prisons, police custody facilities, establishments for compulsory psychiatric care and forensic psychiatric care, the Swedish Migration Agency's detention centres and the National Board of Institutional care (SiS)'s Care of Young Persons Act (LVM) residential homes and special juvenile homes, Care of Abuser Act (LVU) residential homes.¹ In the Parliamentary Ombudsmen's rules of procedure the ombudsmen's supervision is divided into four areas of responsibility. Even though all ombudsmen shall fulfil the NPM role, this division means that it is primarily the ombudsmen with responsibility for areas 2–4 that fulfil the role. This division takes the following form:

- Area of responsibility 2: prison establishments, remand prisons and establishments for compulsory psychiatric care and forensic psychiatric care.
- Area of responsibility 3: SiS LVM and LVU residential homes.
- Area of responsibility 4: police custody facilities and the Migration Agency's detention premises.

A special OPCAT unit has been established at the Parliamentary Ombudsmen and, in terms of organisation, abides under the Chief Parliamentary Ombudsmen. The unit's task is to assist the Parliamentary Ombudsmen in their NPM work. The unit consists of a head of unit, a deputy head of unit, four legal advisers and a medical expert.



¹ Certain LVU residential homes have accommodated placements for juveniles who have been sentenced to special youth care (LSU placements).

The international examining bodies

The STP has 25 independent members, all of whom are experts in the areas that are relevant to preventing torture. The members are appointed by the statutes bound by the Protocol. The countries the SPT will be visiting are decided in an annual schedule.

The European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment entered into force in 1989. As a result of the Convention, the Committee for Prevention of Torture, (CPT) was established, the main task of which is to regularly visit institutions for individuals deprived of their liberty in Europe. All of the Council of Europe's 47 member states have ratified the Convention. Swedish authorities are obliged to cooperate with the SPT and CPT (see Certain International Undertakings against Torture Act [1988:695]).

In May 2015, Sweden was visited by the CPT. The report to the government pointed out, at the beginning of 2016, that the Committee considered that the Parliamentary Ombudsmen's OPCAT unit was understaffed. Following a review of the operations, the OPCAT unit was increased with two employees, and now has six full-time employees. The enlargement facilitates the unit to assist the Parliamentary Ombudsmen in their role as NPM.

Since the CPT's report was released, there have been high-level talks between the CPT and the Swedish government. The most important aim of the talks was the implementation of the recommendations provided some time ago, by the CPT, stating that Sweden needed to reduce both the time during which it is possible to impose restrictions on persons in remand prisons, and the scope of such restrictions. This issue was followed up on within the framework of the Parliamentary Ombudsmen's OPCAT unit in 2017 (see also Section 3).

A Nordic NPM network

In 2015, a Nordic NPM network was created with participants from the ombudsman institutions in Denmark, Finland, Norway and Sweden, all of which fulfil the NPM role in accordance with OPCAT. An initial meeting was held in June in Oslo, Norway where it was decided that the network would meet once every six months to exchange experiences regarding factual matters and methods, among other things. At a meeting in Oslo in August 2017, Iceland's ombudsman institution also took part, for the first time, before formally taking on the role of NPM. The themes of the NPM network's meetings have included children deprived of their liberty, detained aliens and compulsory psychiatric care.

OPCAT celebrates 10 years

On 22 June 2016, OPCAT celebrated its 10 year anniversary. The system of independent examining bodies has proved exceptionally strong with regard

In 2015, the CPT visited the following institutions in Sweden:

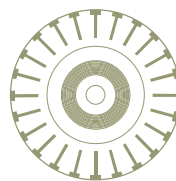
- the prison establishments in Norrtälje and Saltvik (Härnösand),
- the remand prison in Falun, Kronoberg (Stockholm), Malmö, Sollentuna and Växjö,
- the police custody facilities in Stockholm (Arlanda, Norrmalm, Södermalm, Sollentuna and Solna), Borlänge, Falun, Lund, Malmö, Sundsvall and Växjö,
- the regional forensic psychiatry clinic in Växjö, and
- the Migration Agency's detention centre in Märsta.

APT is an acronym for Association for Prevention of Torture. APT is a non-governmental organisation (NGO) that cooperates with governments, civil society and NPMs. Among other things, they support NPMs in exchanging methods and sharing experiences. See www.appt.ch.

to preventive work. In autumn 2016, short accounts of examples of what has been achieved were launched, from 20 countries, on the APT's website. Sweden described how, in connection with an inspection of one remand prison, it was observed how women were subject to protective searches by male wardens as they returned from walks. This led to women refraining from walks. The Parliamentary Ombudsmen stated that protective searches of inmates must be carried out by personnel of the same gender. It was recommended that the remand prison create routines and administrative suitable staffing so that protective searches are carried out in dignified forms for all inmates, regardless of gender. At a new inspection of the same remand prison in 2015, the Parliamentary Ombudsmen was able to conclude that the women no longer expressed complaints about this issue.

The aim of this report

This report contains a summary of the observations that the Parliamentary Ombudsmen has made within the framework of the OPCAT operation in 2015–2017. In addition to the descriptions of the previous years' inspection activity, the report contains analyses, the purpose of which is to identify the issues and areas on which the operation should focus over the coming years. This report should thereby also be regarded as part of the preventive work.



Opcat inspections
2015–2017



OPCAT inspections

One of the most important elements of the Parliamentary Ombudsmen's operations is inspections of locations where individuals are deprived of their liberty. The inspection activity for the 2011–2014 period was planned with a purpose to visit locations other than those recently inspected by the Parliamentary Ombudsmen, to spread inspections geographically evenly and for remand prisons and police custody facilities to be prioritised.

The planning of the inspections during 2015–2017 has partly taken place on the basis of other prerequisites. The ambition has been to have a geographical spread and for a certain percentage of the inspections to be at locations that have not been inspected for a long time. During this period, the thematic focus has, however, had an effect on the choice of subject of inspection. As, for example, to target women deprived of their liberty, which had great significance for the implementation of the inspection activity in 2015. That year all prison establishments that receive women were inspected (see also Section 4). The observations made during 2011–2014 have, in some cases, also affected the choice of inspections, and in addition to this, there have also been a number of follow-up inspections during 2015–2017.

Working method

As a general rule, the OPCAT unit is assigned by an ombudsman to carry out an inspection. Sometimes the ombudsman concerned leads the inspection. An inspection may be either announced or unannounced. Lessons learned from 2011–2014 was that an announced inspection can be performed effectively. In order to increase the credibility of the inspection activity it was decided to increase the percentage of unannounced inspections in the coming period. During the period 2011–2014, approximately a third of the inspections were unannounced. During 2015–2017, this percentage has increased to almost half (44 percent) of all inspections.

Observations made, in connection with an inspection, are documented in a report and submitted to the ombudsman responsible. If an issue that particularly needs to be investigated is noted in the report, the Parliamentary Ombudsmen will take a decision to open an enquiry (see also Appendix C). An ombudsman usually state their opinions in the report on observations made.

The Parliamentary Ombudsmen can also ask the authority to report back on what actions that have been taken on a specific issue. The reports have shown to be an effective tool for following up on the impact of the Parliamentary Ombudsmen's comments and recommendations. The opportunity to request a report was exercised, particularly during the latter part of the period.

Reports will continuously be an important element in the inspection activity since a report can be an important supplement to follow-up inspections.

During 2015–2017, subsequent to 16 inspections¹ the Parliamentary Ombudsmen has requested that an authority reports back to the Parliamentary Ombudsmen. Among others, the Police Authority reported back on measures taken to improve the environment in one of the authority's police custody facilities. The Prison and Probation Service has also been asked to submit details of the measures taken to ensure that the rules regarding body searches are applied in the correct manner, at two of the authority's facilities.

Locations where individuals are deprived of liberty

In Sweden in 2017, individuals deprived of their liberty were placed at the following locations:

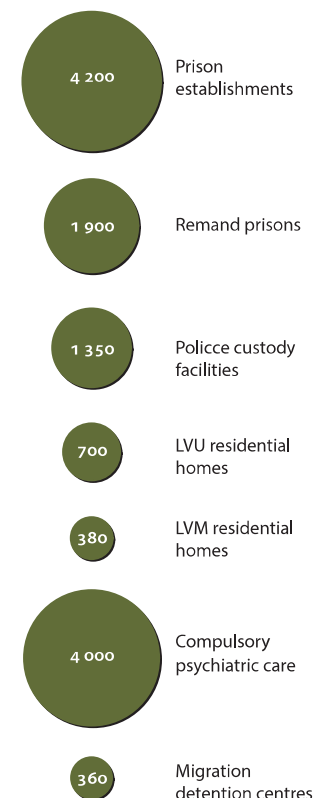
- 45 prison establishments (4,200 places)
- 32 remand prisons (1,900 places)
- 120 police custody facilities (1,350 places)
- 24 LVU residential homes (700 places)
- 11 LVM residential homes (380 places)
- A minimum of 80 institutions for compulsory psychiatric care and forensic psychiatric care (approx. 4,000 places)
- 5 migration detention centres (360 places)

The above is based on an estimate. In a comparison with the latest OPCAT report the number of placements for individuals deprived of their liberty – with the exception of migration detention centres – is at the same level as in 2014. The Migration Agency's placements for detainees has almost doubled since 2014.² In addition to the number of detainees, there has also been an increase in the average time a person spends in a detention unit.³ The Migration Agency is working continuously on increasing the number of detention placements.

Over the past year, the Prison and Probation Service has also increased its capacity and particularly in the country's remand prisons.⁴ The Prison and Probation Service is of the opinion that there is a need to create approximately 500 new placements in remand prisons by 2025. This means an increase of almost 30 percent.

To summaries, there is a current increase of places and individuals deprived of their liberty, and this development is expected to continue in the years to come.

Number of places for individuals deprived of their liberty



¹ See Appendix D.

² See the Parliamentary Ombudsmen's report, National Preventive Mechanism – NPM (2014) p. 16.

³ See the Swedish Migration Agency's annual report for 2017 p. 62.

⁴ See the Swedish Prison and Probation Service and statistics (2017) p. 23.

Inspections carried out 2015–2017

Between 2015 and 2017, 58 inspections were carried out within the framework of the OPCAT operation. These have been divided as follows:

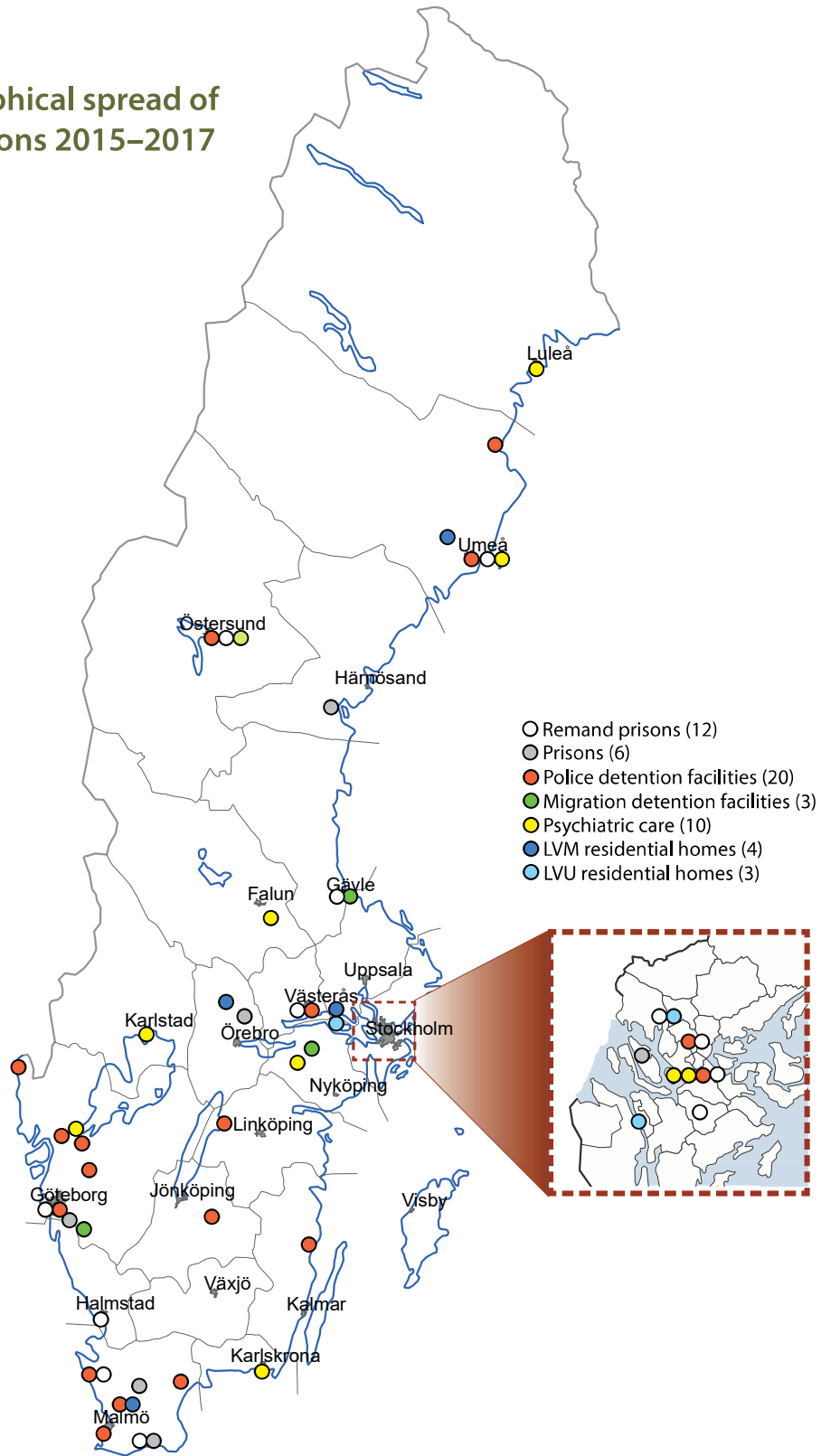
| Year | Prisons | | Remand prisons | | Police custody facilities | | LVU residential homes | | LVM residential homes | | Psychiatric care | | Migration detention centres | | Sum | |
|--------------|----------|---|----------------|---|---------------------------|----|-----------------------|---|-----------------------|---|------------------|---|-----------------------------|---|-----------|----|
| | U | A | U | A | U | A | U | A | U | A | U | A | U | A | U | A |
| 2015 | 2 | 4 | 0 | 3 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 4 | 0 | 0 | 2 | 13 |
| 2016 | 0 | 0 | 0 | 2 | 5 | 10 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 2 | 5 | 16 |
| 2017 | 0 | 0 | 7 | 0 | 2 | 1 | 3 | 0 | 4 | 0 | 3 | 1 | 1 | 0 | 20 | 2 |
| Sum | 2 | 4 | 7 | 5 | 7 | 13 | 3 | 0 | 4 | 0 | 3 | 7 | 1 | 2 | 27 | 31 |
| Total | 6 | | 12 | | 20 | | 3 | | 4 | | 10 | | 3 | | 58 | |

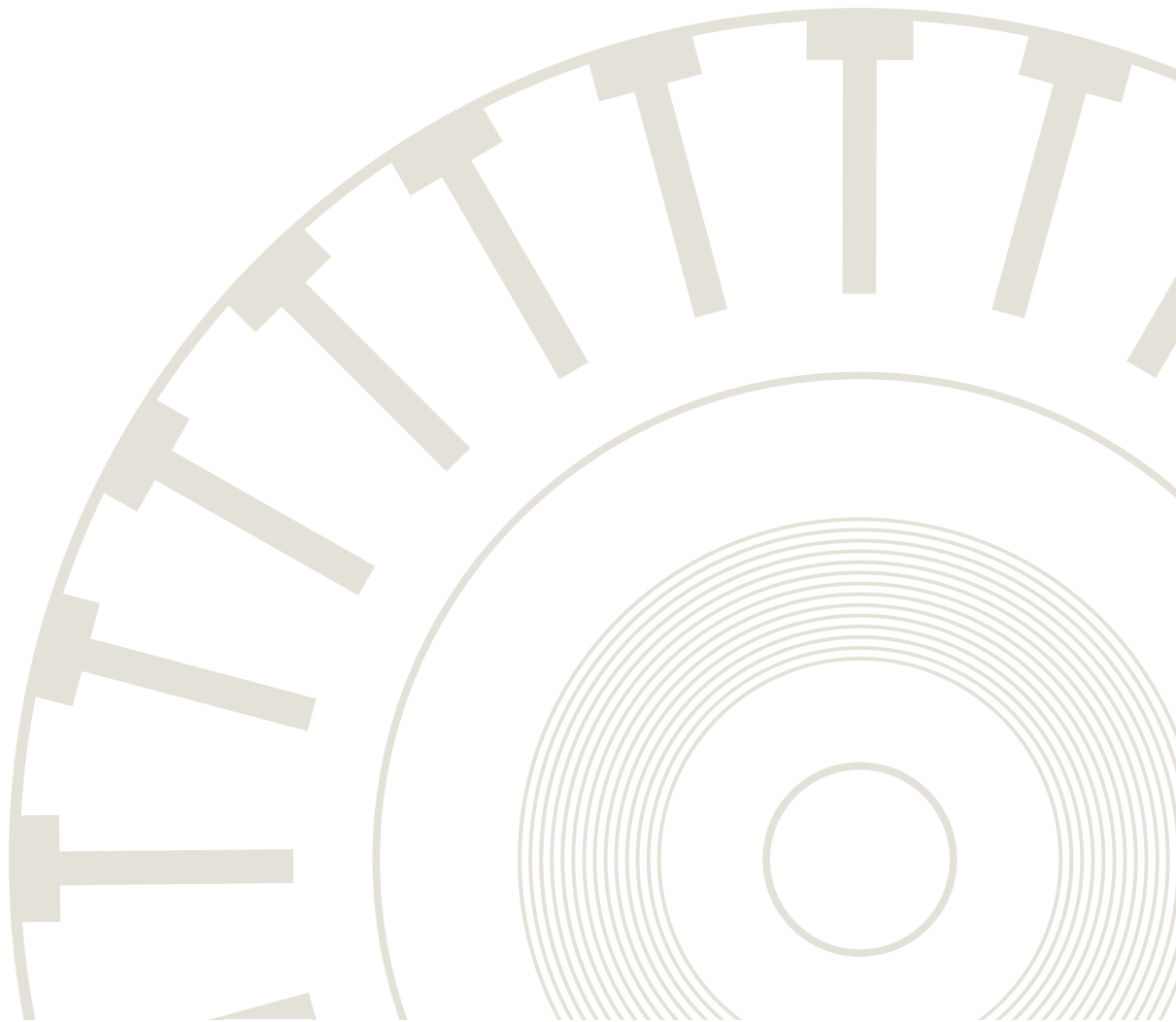
U = Unannounced inspections

A = Announced inspections

A further 11 inspections of locations where individuals are be deprived of their liberty were performed by the Parliamentary Ombudsmen's supervisory sections during the same period (8 prison establishments and 3 remand prisons).

Geographical spread of inspections 2015–2017





General observations
in connection
with inspections



Police custody facilities

At the end of 2017, there were approximately 120 police custody facilities with a total of 1,350 placements. Individuals who have been apprehended or arrested are placed in a police custody facility. From 2011–2014, the Parliamentary Ombudsmen’s OPCAT unit prioritised inspections of police custody facilities and inspected 52 facilities. The high number of inspections was justified by, among other things, the need to acquire the necessary experience in connection with the phase of building the OPCAT unit. During 2015–2017, 20 custody facilities were inspected. Several of these inspections were follow-up inspections.¹ Follow-up inspections have been deemed to be an important element as it facilitates the possibility to assess the impact of the Parliamentary Ombudsmen’s comments. Although there were fewer inspections compared to the previous period, the inspections of police custody facilities still accounted for the greater part of the work under OPCAT.

In addition to individuals arrested, individuals taken into custody pursuant to a preemptory law, such as the Care of Intoxicated Persons Act, are placed in police custody facilities. It is therefore not unusual for individuals who have no experience of deprivation of liberty and/or who find themselves in a particularly vulnerable situation to be spending time in police custody facilities. There is a need for these individuals to be given information on why they have been deprived of their liberty and what rights they have. Among other things, these circumstances justify the still relatively high percentage of inspections of police custody facilities during 2015–2017. During 2016, OPCAT also targets the issue of providing information to individuals deprived of their liberty, as a special theme (see Section 5).

The police custody facility guards’ training

Custody facility guards having undergone relevant training, is an important factor in ensuring that individuals deprived of their liberty are being treated in a lawfully and correct way. The Police Authority frequently enters into agreements with security companies, that are able to provide the necessary staff required at police custody facilities. Police custody facilities in the metropolitan areas may have around a hundred guards appointed to serve as police custody facility guards.

During 2015–2017, it was noted that the Police Authority had no uniform routines for the introduction of new police custody facility guards and it is unclear who is responsible for this. In certain regions, the police provide spe-

In some police custody facilities, no special training is provided and it is up to the guards to introduce their new colleagues. The Parliamentary Ombudsmen has pointed out that this means a clear risk of the serving police custody facility guards not having sufficient knowledge of their duties.

¹ Follow-up inspections were carried out at the police custody facilities in Helsingborg, Malmö, Sollentuna, Södertälje (Stockholm), Uddevalla, Umeå, Västerås and Östersund.

cial training to the guards who staff police custody facilities. In other regions, no such special training is provided and it is up to the guards to introduce their new colleagues. The Parliamentary Ombudsmen has pointed out that police custody facility guards that do not have sufficient knowledge of their duties poses a security risk.² It has also emerged that some police custody facilities have no written procedures and that service regulations for the police custody facility operation have not been updated.³

Shortcomings in the physical environment

A recurring observation during inspections is that there are various shortcomings in the environment in which individuals deprived of their liberty are placed. At certain police custody facilities, it was observed, that windows are equipped with the kind of devices that prevent sufficient daylight from entering the cells.⁴ The Parliamentary Ombudsmen has previously stated that the exercise yards should let in proper light and provide access to fresh air. In addition, an exercise yard should be at least 15 square metres in order to be able to accommodate the need for physical activity.⁵ During 2015–2017, the Parliamentary Ombudsmen found that there were still shortcomings at a number of police custody facilities with regard to the design of the exercise yards. At a follow-up inspection of the police custody facilities in Umeå in 2015, the discovery was, that after four years, there was still no exercise yard and no alternative solution for accommodating the detainees' right to spend time outdoors. In 2017, the Police Authority reported to the Parliamentary Ombudsmen that a temporary exercise yard had been built at the police custody facilities in Umeå, and a permanent solution was planned.⁶

The Parliamentary Ombudsmen has previously stated that exercise yards should let in proper light and provide access to fresh air.

Access to health and medical care

An inmate at a police custody facility who needs health and medical care must be examined by a doctor. If an inmate requests to see a doctor a doctor shall be sent for, if it is not obvious that such an examination is not required. Each detention centre must have access to qualified doctors and personnel with suitable medical training. The Parliamentary Ombudsmen has stated, in a previous decision, that it is important to exercise careful supervision to note whether the state of health of someone taken into custody is such that there is a reason to call a doctor. If a person taken into custody requests that a doctor be contacted, or when he or she otherwise demonstrates symptoms that could suggest illness, police officers and other personnel at the Police Authority, who do not have medical training, must be careful about making a medical

² Ref. no. 2652-2016.

³ Ref. nos. 3240-2016, 3241-2016 and 3902-2016.

⁴ Ref. nos. 871-2016, 3240-2016, 3241-2016, 5308-2016, 6361-2016 and 6465-2017.

⁵ JO 2014/15 p. 115, Ref. no. 2054-2013.

⁶ Ref. no. 3301-2015.

assessment, and instead leave such assessments to a doctor. Incorrect assessments of the state of health of a person taken into custody could have very serious consequences.⁷

During 2015–2017, it was noted that there are great differences between police custody facilities regarding access to health and medical care for those deprived of their liberty. Some of the larger facilities are staffed with a nurse, while smaller facilities are instructed to contact the national health service when necessary. These circumstances also mean that the Parliamentary Ombudsmen will continue to follow up on the matter. At one of the police custody facilities inspected, it was established that there was no service description or instructions for the nurse, which was, in the opinion of the Parliamentary Ombudsmen, unsatisfactory. The Parliamentary Ombudsmen also concluded that it was a problem that staff members, other than health and medical care personnel, were present during health examinations of detainees. During a follow-up inspection just over a year later, it was established that procedures had been introduced for the nurses and that the police had stated that they would attempt to safeguard the integrity of the inmates and the safety of the nurse through, for example, health discussions.⁸

Right to clothes

Sometimes it can be the case that individuals deprived of their liberty are placed in a cell without any clothes because the Police Authority has assessed that the inmate is demonstrating self-harming behaviour.

The measure is intended to prevent self-harming actions. The Parliamentary Ombudsmen has previously stated that it not acceptable to allow a person to stay in police custody facilities without clothes for a long time.⁹ Such measures should therefore only be taken in a more acute situation, if the inmate continues to demonstrate a behaviour which can be a risk to himself/herself, and if so, he or she should be examined by a doctor. The Parliamentary Ombudsmen has also directed criticism towards the authority when an inmate staying in a cell under such conditions has not been given a blanket for cover.¹⁰

For the last few years, the Police Authority's general advice has been that a detainee should always have something to cover himself/herself up with, and a detainee should not spend time in police custody facilities, without clothes, for a longer period of time than necessary, in regards of the detainee's safety. Despite the general advice, it has been noted in a number of cases, during the past inspection period, that detainees have been placed in a cell without clothes and not had access to anything to cover themselves with.¹¹

The Parliamentary Ombudsmen has previously stated that it is not acceptable to allow a person to stay in police custody facilities without clothes for a long time.

⁷ JO 2018/19 p. 352, Ref. no. 2468-2016.

⁸ Ref. nos. 5544-2016 and 6464-2017.

⁹ Ref. no. 6237-2012.

¹⁰ JO 2017/18 p. 244, Ref. no. 2817-2015.

¹¹ Ref. nos. 3241-2016, 3240-2016, 3902-2016, 3903-2016, 6361-2016 and 6363-2016.

Temporary police custody facilities

In connection with the EU summit meeting in Gothenburg in 2017, the Police Authority set up temporary police custody facilities in the garage at the police headquarters. The temporary cells were approximately 11 square metres, with the walls and ceilings made from steel mesh. The authority planned to place a maximum of five persons in each cell. Following an inspection, the Parliamentary Ombudsmen established that the cells did not fulfil the requirements for the size, design and equipment of a detention room pursuant to the regulation on the design of remand centres and police custody facilities. The Parliamentary Ombudsmen also established that there are good reasons for limiting the use of temporary police custody facilities to short-term custody in accordance with the Police Act. Persons suspected of a crime should, in the first instance, be placed in ordinary police custody facilities, or in some cases, in remand prisons. The Parliamentary Ombudsmen also stated that it is very difficult to see how it could be appropriate to place individuals taken into custody, due to intoxication, individuals in poor physical or mental condition, or persons under the age of 18, in cells of this kind. As a result of the Police Authority's intention, to place a maximum of five individuals in each cell, the Parliamentary Ombudsmen emphasised that placing two or more detainees in the same cell must be regarded as an exception and not a general rule.¹²

Conclusions on police custody facilities

Deprivation of liberty, in police custody facilities, lasts at the most, a couple of days, as a general rule. Even if an individual deprived of their liberty is not staying in a facility for a long period of time, it is important that the premises are designed in such a way that the premises do not reinforce the negative consequences of being deprived of one's liberty. Appropriately designed police custody facilities are also an important prerequisite for dealing with detainees in a dignified and respectful manner. The design of the premises is also of great importance for the safety of the detainees.

During the inspection period, it was established, in comparison with the previous period, that there were some improvements regarding the physical environments in the facilities. The lack of daylight in the premises in which the detainees are placed is, however, still a concern. Further measures are required, in order for the premises to fulfil the fundamental requirements for an inflow of daylight. Relatively extensive work also remains to be done before detainees can be offered the opportunity to spend time outdoors, on a daily basis, in suitable exercise yards.

The fact that guards, appointed to be custody facility guards, are completely lacking special training to work as guards in a custody facility means an

Further efforts are required, in order for the premises used for the placement of detainees to fulfil the fundamental requirements to achieve an inflow of daylight. Relatively extensive work also remains to be done before the detainees are offered the opportunity to spend time outdoors, on a daily basis, in suitable exercise yards.

¹² Ref. no. 7081-2017.

increased risk for the detainees. A lack of knowledge regarding the police's regulations and procedures, and regarding what their duties involve, means a risk that the detainees will not have their rights accommodated. There is also a risk of the procedures for supervision not being adhered to, and the detainees not receiving the medical care they are entitled to. Individuals who are very intoxicated or suffering from a mental illness are regularly placed in police custody facilities. It is vital that these persons are supervised in order to avoid unforeseen consequences. In the information to which the Parliamentary Ombudsmen has access, it was concluded that 11 persons died, between 2015 and 2017, when they were deprived of their liberty in a police custody facility, or were taken to a hospital from a police cell. These circumstances means that there are grounds to continue to monitor the Police Authority's work towards ensuring that those working in police custody facility operations have the training required in order for the task to be performed in accordance with the applicable regulations.

These circumstances mean that there are reasons for the Police Authority to continue its work on ensuring that those who work in a police custody facility have satisfactory training for the task.

In conclusion, it should be pointed out that the Police Authority has produced a *special police custody facilities handbook* during the period.¹³ The handbook contains detailed method descriptions of the provisions applying to police custody facility activity, and descriptions for the tasks most regularly performed at a police custody facility. Used correctly, the handbook will be an important tool for ensuring that the rights of individuals deprived of their liberty are accommodated.

Remand prisons and prison establishments

At the end of 2017, there were 32 remand prisons and 45 prison establishments in Sweden with a total of just over 6,000 places. In the first instance, is people deprived of their liberty due to being held on remand or serving a prison sentence, who are placed with the Prison and Probation Service. Sometimes it can be the case that individuals who have been detained pursuant to the Aliens Act are placed with the authority. The latter category of inmates includes both persons detained while awaiting a decision on expulsion in a criminal case, and detained individuals who have been transferred from the Migration Agency because they were deemed unable to stay in a unit for reasons of safety. The number of detainees are placed within the Prison and Probation Service has increased over the past few years. In 2017, the OPCAT unit carried out a number of inspections focusing on, among other things,

¹³ The Swedish Police Authority's handbook on police custody facility activity (PM 2017:63).

the situation for this group of detainees. In 2015, the thematic direction of the OPCAT unit was female inmates in the prison service (see also Section 4). A total of 18 inspections of remand prisons and establishments were carried out during 2015–2017. Several of these were follow-ups to earlier inspections.¹⁴

Isolation of persons held on remand

A basic right for those held on remand and who have no restrictions imposed by the prosecutor is that they be given the opportunity to spend time with other detainees (association). Spending time with other detainees fulfils an important function in preventing the negative consequences that being deprived of one's liberty could have for an individual. The Prison and Probation Service may, however, decide under certain restrictions established in law, that a detainees should be kept separated from other detainees, where this is deemed necessary for reasons of safety.

A prosecutor may be given permission by a court to impose restrictions on those on remand. These restrictions could mean that a person on remand is not allowed to spend time with other detainees. For a relatively long period of time (since the beginning of the 90s), Sweden has received international criticism for its widespread use of restrictions.¹⁵

During an inspection in 2017, it was noted that a large percentage of detainees, who had no restrictions imposed on them, were placed in various remand prisons' restricted places, and thereby *not given the opportunity* to spend time *with other detainees*.¹⁶ The Parliamentary Ombudsmen has emphasised that the Prison and Probation Service has the ability to control the situation by transferring detainees to remand prisons where it is possible to spend time with other detainees, and thereby prevent the majority of situations where detainees cannot use common facilities. It has also been noted that the Prison and Probation Service has not fully taken into account the Parliamentary Ombudsmen's opinion that the lack of resources or inability to differentiate detainees is not an acceptable reason for keeping a detainee separate from other detainees. According to the Parliamentary Ombudsmen, it is not acceptable that a detainee is not given the opportunity to spend time with other detainees, for organisational or other reasons, over which the detainee has no influence.¹⁷

... a large percentage of the detainees who had no restrictions imposed on them received a restricted placement in various remand prisons and were thereby not given the opportunity to spend time in common facilities.

14 Follow up inspections were carried out at the remand prisons in Gävle, Helsingborg, Huddinge, Kronoberg, Umeå, Västerås, Ystad and Östersund and the prison establishments at Färingsö and Ljustadalen.

15 CPT/Inf(2016) 1, p. 48–53.

16 At the Huddinge remand prisons, 31 out of a total of 71 inmates who had no restrictions imposed on them were placed in a restricted section. At the Sollentuna remand prisons, the equivalent figure was 35 out of 123 inmates. At the Kronoberg and Gävle remand prisons, 44 and 17 detainees respectively who did not have restrictions imposed on them were placed under the same circumstances applying to detainees with restrictions.

17 The Parliamentary Ombudsmen's decision of 14 June 2018, ref. no. 5969-2015.

Reducing isolation

It is important to counteract the negative consequences that long-term isolation can cause. This may involve the detainee being allowed to spend time with another detainee by socialising, receiving visits or taking part in activities together with prison service staff. As some detainees choose to *isolate themselves voluntarily*, the Parliamentary Ombudsmen has emphasised that the Prison and Probation Service establish measures to reduce isolation, for these detainees. In order to be able to monitor the measures taken, it is important that the occasions where the detainee receives offers to take part in activities but declines, are put on record. If this occurs, the authority is obliged to follow-up on the reason and motivate the detainee to take part in activities. It is unacceptable just to allow an inmate to choose not to take part in activities, particularly in the case of a young person.¹⁸

The report states that the placement situation in the country's remand prisons is strained, which, according to the Prison and Probation Service, means that it is difficult to provide placements where detainees are given an opportunity to spend time with others.

Following the inspections of the remand prisons in 2017, the Prison and Probation Service was asked to review the procedures for reporting and documenting detainees time in common facilities, and what measures were taken to reduce isolation in relation to detainees not given such an opportunity. In June 2018, the Prison and Probation Service reported back on this work, to the Parliamentary Ombudsmen. The report states that the *placement situation in the country's remand prisons is strained* which means, according to the authority, that it is difficult to provide placements that offer a possibility to be outside, for remand detainee areas.

Following the inspections in 2017, more than 160 new placements with a possibility to spend time in common facilities have been added. Regarding the attempt to reduce isolation, the Prison and Probation Service has commenced work on developing an uniform and suitable plan that supports local measures to reduce isolation and provide correct data, at a national level. The Parliamentary Ombudsmen will return to what the Prison and Probation Service has reported, in a later decision.

Temporary remand prisons

Sometimes it is the case that the Prison and Probation Service sets up temporary remand prisons. During 2015–2017, there were two such prisons at police custody facilities, in Halmstad and Östersund. Regarding the prisons in Östersund, the Parliamentary Ombudsmen stated, in 2013, that the remand premises were unsuitable and that the Prison and Probation Service should *seriously consider* the appropriateness of continuing to place individuals on remand in the premises.¹⁹ At a follow-up inspection in 2016, it was discovered that there had been no real change in the design of the facility, and that areas where detainees can spend time outside were still missing, also, visitors

¹⁸ The Parliamentary Ombudsmen's decision of 14 June 2018, ref. no. 5969-2015.

¹⁹ Ref. no. 6386-2013.

were received in the remand premises. The detainees were not able to look out from the windows of their residential rooms nor could they benefit from daylight in the walking yard. The Parliamentary Ombudsmen maintained its opinion that the premises are unsuitable.²⁰ Similar deficiencies were noted during the inspection of the remand centre in Halmstad and the Parliamentary Ombudsmen urged the Prison and Probation Service to consider the appropriateness of continuing to place individuals on remand in the premises in question.²¹ In spring 2018, the Halmstad remand centre was closed and the Prison and Probation Service decided, in 2016, to build a new remand prison in Östersund.

According to the plans, the new remand prison will be put into operation in spring 2020 and, while awaiting this, the Prison and Probation Service will continue to place remand detainees in the police custody facilities in Östersund. The Parliamentary Ombudsmen has criticised the fact that the remand operation has been conducted in police custody facilities for a long time. The Parliamentary Ombudsmen has also stated that the remand prison should cease and not be resumed in its current form until there are *suitable premises*.²²

The Parliamentary Ombudsmen has directed criticism towards the Prison and Probation Service for using the police custody facilities in Östersund as a remand prison. According to the Parliamentary Ombudsmen, police custody facilities are not a suitable place for remand prisoners.

Migration detainees

In 2017, seven remand prisons were inspected in order to illustrate, among other things, the conditions for detained aliens, placed within the prison service. The general rule is that detainees should be placed pursuant to the Aliens Act at detention centres administrated by the Migration Agency. The authority may, however, decide that an isolated detainee should be placed in a remand prison or prison establishment if he or she cannot stay in one of the Migration Agency's detention centres, for safety reasons (so-called safety placements). During the 2017 inspection period, approximately 80 detainees were placed with the Prison and Probation Service pursuant to the Aliens Act.

A detainee who has been placed at a Prison and Probation Service facility should have the same right to contact the outside world as persons placed at a Migration detention centre. This means that they are entitled to unlimited and uncontrolled use of a mobile phone and access to computers with an internet connection. They must also have the option of uncontrolled visits. As a result of the Prison and Probation Service's operations being adapted to accept individuals suspected of, or who have been convicted of, committing a crime, it has proved difficult to adapt the operation to the needs of the detained persons and accommodate their rights. The Parliamentary Ombudsmen has previously stated that it is inappropriate to place detainees with detainees

²⁰ Ref. no. 872-2016.

²¹ Ref. no. 582-2017.

²² The Parliamentary Ombudsmen's decision of 30 August 2018, ref. no. 1387-2017.

servicing a prison sentence and a placement within the prison service means a much more perceptible restriction to freedom than a stay in a Migration detention centre.²³

The Parliamentary Ombudsmen has also stated that remand prisons and prison establishments are not a suitable environment for detainees.²⁴ The CPT has repeatedly criticised the conditions in Swedish remand centres and has recommended that the authorities cease to place individuals detained pursuant to the Aliens Act with the Prison and Probation Service.²⁵

The 2017 inspections show that migration detainees placed with the Prison and Probation Service are still kept under considerably worse conditions than detainees placed in one of the Migration Agency's detention centres.

The 2017 inspections prove that a detainee, placed pursuant to the Aliens Act, with the Prison and Probation Service, is kept under considerably worse conditions than a person placed in a Migration detention centre. Those detained within the prison service do not have the same opportunity to secure their statutory rights. The Prison and Probation Service facility that best meets the requirements in the legislation to the greatest extent, is the Storboda remand prison. The remand prison has common facilities and good conditions for catering for the rights of detainees, including spending time together in common facilities. At the other end of the spectrum there are, for example, the Huddinge and Sollentuna remand prisons, where detainees often stay under conditions applicable to those on remand with restrictions imposed. This means that a detainee may be locked up in a residential room for 23 hours a day. Findings from the seven remand inspections in 2017 led to the Parliamentary Ombudsmen deciding, within the framework of an enquiry, to again follow up on the matter and investigate what measures are required in order to change the situation for migration detainees placed under the Prison and Probation Service.²⁶ Following the inspection of the Storboda remand prison, the Parliamentary Ombudsmen noted that a previous Parliamentary Ombudsmen had stated that the best thing would be, for the Migration Agency, to take on the responsibility for detainees who are not to be expelled after having served a prison sentence, and that the Prison and Probation Service could be relieved of this task.²⁷ This question will be monitored within the same enquiry.²⁸

Follow-up of previous inspections

The Parliamentary Ombudsmen has stated that it would be reasonable to request that detainees' exercise yards are designed in such a way that it is possible for the detainees to observe their surroundings. It is thereby unacceptable for exercise yards to be designed in such a manner that they become

²³ JO 2011/12 p. 314, Ref. no. 6090-2009.

²⁴ JO 2014/15 p. 216, Ref. no. 5529-2012.

²⁵ CPT/Inf(2016) 1, p. 72.

²⁶ Ref. no. 416-2017.

²⁷ JO 2014/15 p. 216, Ref. no. 5529-2012.

²⁸ Ref. no. 581-2017, enquiry ref. no. 277-2018.

similar to closed rooms with a lattice roof.²⁹ In connection with the inspections in 2017, it was established that several remand prisons still had exercise yards that did not fulfil these basic requirements.³⁰ In a report to the Parliamentary Ombudsmen in 2017, the Prison and Probation Service has stated that the authority has the intention, to the extent that practical and actual conditions allow for it, to rectify the deficiencies noted in the design of the exercise yards.

During the inspection of Huddinge remand prison, a follow-up on the design of the admission area was also carried out. Measures have been taken that have resulted in the admission area now being assessed as *suitable, on the basis of integrity and safety aspects*. During the inspection, a renovation was carried out on the premises used when an inmate is to be discharged or spend time outside the remand prison, e.g., in connection with transport to proceedings or hospital visits. Following a request from the Parliamentary Ombudsmen, the Prison and Probation Service has submitted a report regarding measures taken to ensure that these premises are suitable, based on integrity and safety aspects.³¹

Several of the remand prisons inspected have, in order to ensure access to a doctor, on a 24 hour basis, entered into a “*standby doctor agreement*”. During previous inspections, it was noted that the agreements at Huddinge, Kronoberg and Sollentuna remand prisons were worded in such a way that it was only possible to consult a doctor on standby after 18.00. It was so forth not possible to consult a standby doctor if a general practitioner was absent during the day. The Parliamentary Ombudsmen has previously urged the Prison and Probation Service to review the agreements making it possible to summon a doctor regardless of what time of day the need arises. In connection with the inspections in 2017, it was noted that there had been no change in this respect.³²

During the inspection at Kronoberg remand prison, it was noted that a individual person who had, according to the documentation, been taken into custody pursuant to the Care of Intoxicated Persons Act, had been strapped down. The Parliamentary Ombudsmen has decided to examine in a special enquiry the question of whether it is possible to take such action against a person taken into custody pursuant to the act.³³

29 JO 2016/17 p. 198, Ref. no. 7173-2014.

30 Ref. nos. 416-2017, 417-2017, 418-2017 and 419-2017.

31 Ref. no. 416-2017.

32 Ref. nos. 416-2017, 417-2017 and 419-2017.

33 Ref. no. 417-2017, enquiry ref. no. 279-2018

Conclusion regarding remand centres and prison establishments

It is a problem that detainees placed within the Prison and Probation Service still find themselves in environments where their statutory rights are not catered for. As a result of initiatives taken during 2015–2017, this issue will continuously be a central issue for the Parliamentary Ombudsmen's work under OPCAT.

It is positive that work has been initiated to create more flexible remand prisons that enable detainees to spend time in common facilities.

An important issue for the Prison and Probation Service over the coming years should be reducing isolation to counteract the negative consequences deprivation of liberty can have. It is positive that work on creating a more flexible remand operation has commenced and that more *placements that enable time to be spent in common facilities* have been added. The high capacity in the remand prisons and the increased need for the number of places give grounds for concern since it could lead to a lack of placements in the prison service and thereby difficulties to provide common areas where detainees are able to spend time. It will continue to be a central issue for the Parliamentary Ombudsmen to monitor how the Prison and Probation Service works within this issue. This includes creating a flexible organisation that means that the Prison and Probation Service accommodate rights, without restrictions, for detainees to be able to spend time together in common areas with other detainees. The Prison and Probation Service's report indicates that there is a large amount of work remains to be done on this issue. There are also grounds for the Parliamentary Ombudsmen to continue to monitor how measures to reduce isolation, taken in relation to individual detainees, are registered.

There are grounds for continuing to monitor what measures the Prison and Probation Service will take on to establish measures that improve outdoor environments.

Time spent outdoors, on a daily basis, fulfils an important function in counteracting the negative consequences that being deprived of one's liberty can have. In order to fulfil this function, it is important that the outdoor environments (exercise yards) detainees are referred to are designed so that they can contemplate their surroundings. This aspect has had a hidden role with regards to the design of the exercise yards at, for example, remand prisons, in favour of safety considerations in particular. There are grounds for continuing to monitor what measures the Prison and Probation Service will take on to establish measures that improve *inadequate outdoor environments*.

Finally, there are reasons for the Parliamentary Ombudsmen to carry out a follow-up over the coming years of, among other things, the wording in agreements for standby doctors and the access the country's remand prisons and prison establishments have to medical care personnel.

Youth facilities

The National Board of Institutional care (SiS) is responsible for running facilities where compulsory care is provided in accordance with the Care of Young Persons Act (LVU), the Act on the Enforcement of Institutional Care of Young Persons (LSU) and the Care of Abusers Act (LVM). Care pursuant to LVU and LSU is provided at special residential homes for young people (youth facilities) and, at the end of 2017, there were 24 such facilities with more than 700 places. Care pursuant to LVM is provided at LVM residential homes and, at the end of 2017, there were 11 residential homes with more than 380 places. During 2015 to 2017, four LVM residential homes and three LVU residential homes were inspected.

Care in isolation and the option of keeping an inmate in isolation

Provisions on care in isolation can be found in LVU, LVM and LSU.³⁴ The provisions imply, where required out of consideration for the individual's special need, and safety, that an inmate may be prevented from spending time with other inmates. Care in isolation must be adapted to the inmate's individual need for care. Care in isolation shall be continually examined and reviewed within seven days from the latest review.

If justified, due to the inmate behaving violent or being intoxicated as severely that he or she cannot be kept in order, the individual may be held in isolation. An inmate is kept in isolation only for a very short time.³⁵

Situations sometimes occur where it can be discussed whether an inmate should be prevented from meeting other inmates, and whether the inmate should therefore be kept in isolation. The Parliamentary Ombudsmen has emphasised that care at SiS's youth facilities and LVM residential homes, and the various measures that these homes take during the period of care, must not be designed in such a way that it leads to doubts whether the care is being conducted in a manner that is not in accordance with the legislation.³⁶ The statement was made in a case that concerned isolation at a youth facility, but the statement naturally also applies to isolation at an LVM residential home and also when it comes to the question of care in isolation.

During some of the inspections of youth facilities and LVM residential homes, it was discussed whether the homes had procedures, where inmates were prevented in some situations, from meeting other inmates and whether the inmate could therefore be regarded as being subjected to isolation or could even be regarded as being in isolation.

The Parliamentary Ombudsmen has emphasised that care at SiS's youth facilities and LVM residential homes, and the various measures that these homes take during the period of care, must not be designed in such a way that it leads to doubts whether the care is being conducted in a manner that is not in accordance with the legislation

³⁴ On 1 October 2018, new provisions entered into force on care in isolation, but the changes made have no significance in this context

³⁵ A person cared for by virtue of LVM may be kept in isolation for a maximum of 24 hours in a row. As regards a person cared for in a special youth facility, the time has been limited to 4 hours since 1 October 2018.

³⁶ The Parliamentary Ombudsmen's official report 2008/09 p. 305 particularly pp. 313-314, Ref. no. 1316-2016.

During the inspection of an LVM residential home, it emerged that an inmate could, where there was a shortage of space, live alone or together with other inmates in a unit that the home would otherwise use for care in isolation.³⁷ In connection with an inspection of a youth facility, it was stated that a new inmate would be placed in a special “admission section” on arriving at the home.³⁸ It can be the case that the person placed in “the admission section” would have to live there alone and the individual could then not be guaranteed contact with other inmates. When the Parliamentary Ombudsmen inspected another LVM residential home, it turned out that the home had a procedure that meant that the placements in the home’s “admission section” could be used to offer the inmates “a context where they can be allowed to relax and escape from the environment in which they have experienced a conflict”.³⁹

In all three cases mentioned, doubt arose as to whether any inmate could be regarded, for long or short periods of time, as prevented from meeting other inmates and whether the inmate was therefore cared for in isolation or kept in isolation. It was not very easy to form a clear and reliable opinion on the matter on the basis of what had emerged during the inspections. In one of the records that concerned an inspection of an LVM residential home, the Parliamentary Ombudsmen also stated that care in isolation, or being kept in isolation, must occur only under the conditions in the Care of Abusers Act, section 34. For this reason, the Parliamentary Ombudsmen urged the LVM residential home to investigate to what extent inmates were placed in the admission sections or smaller units in such a way that the inmate was deemed to be cared for in isolation.⁴⁰

The observations that the Parliamentary Ombudsmen made in the other two inspections referred to also led to the Parliamentary Ombudsmen encouraging the residential homes to review their placement procedures for an individual in the “admission” section. The aim of this was to get the homes to change the kind of procedures that could result in an inmate becoming subject to care in isolation or kept in isolation. The Parliamentary Ombudsmen intends to raise the questions now discussed with the SiS’s central management.

During the inspection of an LVU residential home, it was noted, in two cases, that the personnel had delayed, for several days, to make a record of the re-examination results of care in isolation. The Parliamentary Ombudsmen emphasised that it was important that this was documented without delay. It must also be possible to deduce on the basis of the documentation whether

³⁷ Ref. no. 2515-2017.

³⁸ Ref. no. 5672-2017.

³⁹ Ref. no. 2514-2017.

⁴⁰ Ref. no. 2515-2017.

the inmate was informed of the content of the decision and whether the individual has received information regarding how he or she can appeal the decision.⁴¹

At one of the LVM residential homes inspected, the personnel stated that the premises used for care in isolation were not fit for purpose. Since such care can continue for a relatively long period, the Parliamentary Ombudsmen encouraged the home to contact SiS's head office to discuss how the deficiencies could be rectified.⁴²

Following an inspection of an LVU residential home, the Parliamentary Ombudsmen decided to investigate an event where employees at the home had restrained a youth, who was being cared for in isolation at the time, for just under an hour.⁴³ The Parliamentary Ombudsmen has not made a decision on the matter yet.

“Escapees”

During an inspection of a LVM residential home in 2014, the Parliamentary Ombudsmen noted that personnel at the home allowed inmates to leave the home in connection with situations the personnel interpreted as threatening. The Parliamentary Ombudsmen investigated the issue in an enquiry. In its decision, the Parliamentary Ombudsmen stated that the assumption must be that a person who is subject to compulsory care must be prevented from unlawfully leaving the residential home. The personnel have the authority to use force to restrain an inmate who is trying to leave the residential home unlawfully. Regarding the degree of force, which is justifiable in such a situation, the Parliamentary Ombudsmen held that consideration needed to be taken to the fact that the aim of the care is to motivate the individual to accept care and support measures on a voluntary basis. It does not appear reasonable for the personnel at an LVM residential home to use as much force as the personnel at, for example, a prison establishment, is allowed to, to try to prevent an escape.⁴⁴ At an inspection at the same LVM residential home in 2017, it emerged that the personnel had again allowed inmates to leave the home in connection to a threatening situation. The Parliamentary Ombudsmen found no reason to investigate the matter but again emphasised that the personnel must ensure that no one unlawfully leaves the residential home.⁴⁵

The assumption is that the personnel must ensure that no one unlawfully leaves the residential home.

Supervision of inmates

Following the inspections of the LVU residential homes in autumn 2017, the Parliamentary Ombudsmen stated that the issue of supervision, that person-

41 Ref. no. 5903-2017.

42 Ref. no. 1762-2017.

43 Ref. nos. 5903-2017 and 6774-2017.

44 JO 2016/17 p. 571, Ref. no. 7163-2014.

45 Ref. no. 1762-2017.

nel at youth facilities exercise, over children and youths, will be investigated in a complaint case.⁴⁶ During an inspection of two LVM residential homes, it emerged that there were different interpretations among the personnel regarding how frequently inmates in isolation were to be supervised. This is a matter that the management of the homes should clarify, e.g., in a procedural document. Certain shortcomings in how supervision was performed were also noted and recorded, and the residential home was so forth recommended to take action.⁴⁷

The physical environment

During an inspection of an youth facility, it was noted that the premises were neglected. The rooms where inmates spent time were scribbled on, that suggested the staff had stopped keeping the premises in good conditions. The Parliamentary Ombudsmen emphasised that the need for radical improvement of the premises does not exclude cleaning the premises. The management of the residential home was encouraged to ensure that the premises were cleaned regularly and the graffiti removed.⁴⁸

At another residential home, the Parliamentary Ombudsmen noted a positive aspect, namely that *measures had been taken to counteract the negative effects* of the operation being placed at a prison establishment.⁴⁹ One LVM residential home was encouraged to equip its exercise yard with a shelter, with reference to recommendations provided by the CPT, to a psychiatric clinic. The Parliamentary Ombudsmen also questioned the fact that the same LVM residential home lacked equipment for the physically disabled. In the absence of such equipment, the personnel lifted a wheelchair-bound inmate in and out of a wheelchair. This procedure was seen as not just a risk but could also, in the opinion of the Parliamentary Ombudsmen, infringe on human dignity.⁵⁰

Conclusions LVU and LVM residential homes

The inspections of LVU and LVM residential homes carried out since 2011 show that care is conducted in different ways, and on different conditions. In several cases, the homes have no premises for, e.g., care in isolation.

There are also differences in the local procedures. Another reason for the differences in the care is the difficulty the homes have drawing a clear line between care in isolation and keeping an inmate in isolation. There are therefore reasons for continuing to monitor how SiS deals with questions regarding requirements for basic legal security when an inmate is cared for in isolation

⁴⁶ Ref. nos. 5903-2017 and 5902-2017.

⁴⁷ Ref. nos. 2514-2017 and 2515-2017.

⁴⁸ Ref. no. 5672-2017.

⁴⁹ Ref. no. 5903-2017.

⁵⁰ Ref. no. 2515-2017.

or kept in isolation. In this context, the new legislation that came into force on 1 October 2018, regarding specific authorities and right to spend time outdoors, will also be followed up on.

Compulsory psychiatric care

Compulsory psychiatric care in Sweden is conducted almost exclusively by county councils. At the end of 2017, there were an estimated 80 institutions for compulsory psychiatric care and forensic psychiatric care, with a total of around 4,000 placements. Persons who are subject to compulsory psychiatric care pursuant to the Compulsory Psychiatric Care Act as well as persons sentenced to forensic psychiatric care and who are cared for pursuant to the Forensic Mental Care Act are placed at these institutions. During 2015–2017, the OPCAT unit carried out ten inspections of places where compulsory psychiatric care is conducted.

Coercive measures

As outlined in the Compulsory Psychiatric Care Act and the Forensic Mental Care Act a care provider has the option of taking certain coercive measures against persons subject to compulsory care. This involves, among other things, the ability to strap patients down (bed straps), isolate them and perform body searches. It is also possible to administer compulsory medicine when the patient does not voluntarily take prescribed medicine.

When it comes to bed strapping, it has been noted during several inspections that there are unclear points in the clinics' procedures. One clinic's procedural description contained wordings that, in the opinion of the Parliamentary Ombudsmen, could be interpreted as meaning that bed strapping is possible for disciplinary reasons. Such a measure may only be taken if there is an *immediate danger* of a patient seriously injuring themselves or someone else. It was also stated in the procedures that the patient should be given the opportunity for a few minutes to "accept" the coercive measure decided on. Against this background, the Parliamentary Ombudsmen has stressed that the use of bed straps must only be for the purposes of *averting a sudden event* and the measure must not be taken in order to prevent something suspected or occurring.⁵¹

When inspecting two general psychiatry sections, it emerged, that one of the sections had no capacity for strapping down patients. For this reason, the staff

The use of bed straps must only be for the purposes of averting a sudden event and the measure must not be taken in order to prevent something suspected or occurring.

⁵¹ Ref. nos. 643-2015 and 3302-2015.

were forced to carry the patients to another floor and through common areas, if the need to strap someone down arose.

The Parliamentary Ombudsmen holds that this kind of procedure is problematic in several respects. It is, e.g., unclear whether any assessment is done of the risks that such measures pose, in the individual case, and whether there is still a need for strapping down a patient, once the patient has been taken to the area in question. In addition to this, the Parliamentary Ombudsmen states that the patient is exposed to an *offence* when being *carried through common areas*. The Parliamentary Ombudsmen questioned this method and urged the clinic to take action as soon as possible to ensure that the use of force, deemed necessary, can be exercised in such a way as to not jeopardise a patients' integrity and safety.⁵²

At some clinics, so-called limitations apply, which, in brief, can mean that a patient voluntarily comes to an agreement with the staff to, for example, stay in his or her room. This is not a question of isolation, which is a coercive measure. The Parliamentary Ombudsmen states that the word limitation should not be used since it could be confused with the coercive measure of isolation. In order for the procedure of agreements on limitations to be acceptable, this must, in the opinion of the Parliamentary Ombudsmen, be voluntary and kept *strictly separate from coercive measures*. It is of great importance that it is entirely clear to both patients and staff and that the documentation is clear.⁵³

As regards to compulsory medication, it emerged that one clinic had procedures that meant that a patient kept securely could be given "an opportunity to voluntarily accept the injection". If the patient refuses this, the injection is given by force. The nurse informed the patient that the injection had been prescribed by a doctor. One employee also stated that a patient could be *strapped to a bed for preventive purposes* prior to a compulsory injection and that the patient was then often led to the isolation room. As a result of these reports, the Parliamentary Ombudsmen emphasised the need for a review of the compulsory care legislation. This is to clarify what compulsory measures a senior physician should decide on, which coercive measures are required and that the supervisory authority should be informed of the decision.⁵⁴ Following a later inspection, the Parliamentary Ombudsmen has decided that there are grounds for monitoring this issue.⁵⁵

Finally, in several cases, it has been established, that clinics are applying provisions that make it possible to search patients at a general entrance area. Such a check may only take place in inpatient-care establishments with an elevated security classification and pursuant to a separate decision. In other

According to the Parliamentary Ombudsmen, there is a need to review the peremptory law, to clarify which coercive measures may be used to perform compulsory psychiatric care.

⁵² Ref. no. 2945-2017.

⁵³ Ref. nos. 1350-2015 and 2222-2016.

⁵⁴ Ref. no. 2222-2016.

⁵⁵ Ref. no. 3416-2017.

sections, decisions on searches must be made in each individual case.⁵⁶ One clinic was criticised by the Parliamentary Ombudsmen for having forced patients, over a long period of time, to pass through a security gate – which is a form of body search – and thereby having applied *a system not compatible with the legislation*.⁵⁷

Patients who have been subject to coercive measures for a long period of time

In connection with an inspection of a forensic psychiatry clinic, it was noted that two patients had been isolated for many years. They were sentenced in 1986 and 2003, respectively, to forensic psychiatric care. A third patient cared for pursuant to the Compulsory Psychiatric Care Act was staying at the clinic under conditions on a par with isolation and the patient was mostly strapped down.

In the opinion of the Parliamentary Ombudsmen, what emerged concerning these patients raised questions about what other *alternatives* for care and treatment the clinic *had considered*. The Parliamentary Ombudsmen recommended that the clinic engage an independent expert and as such ensure that the patients in question received good care. It was noted that such a recommendation had already been submitted by the CPT. Following the inspection, the Parliamentary Ombudsmen received information that one of the patients at the clinic was no longer isolated.

In its supervision, the Health and Social Care Inspectorate found that it was possible to cease the coercive measures and had also established that the measures taken were not permissible in one of the cases. Against this background, the Parliamentary Ombudsmen stated that there were grounds for continuing to monitor how the psychiatric clinics were dealing with these issues and how the Health and Social Care Inspectorate exercises its supervision.⁵⁸

Opportunity to spend time outdoors on a daily basis

On several occasions, the Parliamentary Ombudsmen has stated that the outset for compulsory psychiatric care and forensic psychiatric care should be that a patient is allowed the opportunity to spend at least one hour outdoors every day. Similar statements have also been made by the CPT.⁵⁹

Despite this, it was noted that the opportunities for spending time outdoors are limited at certain clinics. During one inspection, it also emerged that spending time outdoors had been conditional on patients' "conduct".⁶⁰

It has been noted that the opportunities for spending time outdoors are limited at certain clinics. It has also emerged that spending time outdoors had been conditional on patients' "conduct".

⁵⁶ Ref. nos. 643-2015, 1350-2015 and 6308-2015.

⁵⁷ Ref. no. 2222-2016.

⁵⁸ Ref. no. 5556-2016.

⁵⁹ See JO 2011/12 p.471 and CPT standards, CPT/Inf/E (2002) 1 – Rev. 2013, page 51, para 37.

⁶⁰ Ref. no. 643-2015.

During a later inspection of another clinic, it was established that patients who were voluntarily cared for, only had the opportunity to spend time outdoors together with staff members or relatives. For this reason, the Parliamentary Ombudsmen emphasised that the Health and Medical Care Act does not provide any legal basis for preventing a patient from leaving the clinic. In this respect, the options are limited as to what is provided in the general provisions in the Penal Code's regulations on patient need and so-called safety guarantee, that health and medical care staff may hold, taking into account the patient's maturity and state of health.⁶¹

Environment lacking stimuli

During a number of inspections, it was noted that patients, in some cases, receive care in something described as "environment lacking stimuli". As a general rule, this involves stripped down environments with a minimum of equipment and personal effects. The hospital management, at one regional hospital, stated that such an environment works well and leads to improving motivational work. According to the hospital management, the environment had also contributed to a lower number of incidents.⁶²

In connection with another inspection of a forensic psychiatry clinic, it emerged that one patient had an isolated room as his residential room for a period of two weeks. The patient did not have any personal belongings in the room. The person was acting out and, according to the hospital staff, the placement led to a more peaceful salutation for the patient, and other patients. The Parliamentary Ombudsmen stated that it cannot be generally regarded as appropriate to allow a patient to stay for a long time in the kind of minimalist environment an isolation room consists of.⁶³

Follow-up inspection

A follow-up inspection was also carried out of the National Board of Forensic Medicine's forensic psychiatry examination unit in Stockholm. At the inspection, it was noted that the National Board of Forensic Medicine had equipped the exercise yard with a precipitation shelter.

It was also possible for patients to lock themselves into their residential rooms. According to the Parliamentary Ombudsmen, these measures had improved the inmates' situation. It was stated that the National Board of Forensic Medicine had not yet taken any measures to prevent inmates in another care section from being exposed to inmates in one of the sections.⁶⁴

⁶¹ Ref. no. 3816-2017.

⁶² Ref. no. 6308-2015.

⁶³ Ref. no. 5556-2016.

⁶⁴ Ref. no. 3416-2017.

Conclusions regarding compulsory psychiatric care

Inspections during the period 2015–2017 show that there is a great need for care providers to work on issues concerning coercive measures and for the Parliamentary Ombudsmen to monitor these issues. This involves ensuring that there are clear procedures for using such measures. Care providers must also ensure that the personnel have the training necessary in order to be able to apply the procedures correctly. If these basic requirements are not fulfilled, there is an immediate risk of patients being subject to measures for which there is no legal basis.

During the period, it emerged that it is still difficult to get an idea of how many places there are for compulsory psychiatric care in Sweden. This is troublesome from several aspects. The Health and Social Care Inspectorate has the task of keeping an automated register of hospital establishments and units where care can be provided, in accordance with LPT and LRV, and of units for forensic psychiatric examinations. The Parliamentary Ombudsmen has previously investigated the issue within the framework of an enquiry after the OPCAT unit noted that some elements of details in the Health and Social Care Inspectorate's register were out of date.⁶⁵ In a decision in May 2016, the Parliamentary Ombudsmen expressed criticism of the Health and Social Care Inspectorate not having updated the register. This question has subsequently also been illustrated in the report, *In the Child's Best Interests?* (SOU 2017:1111). The investigation also emphasised that having total control over which clinics conduct compulsory care of children is of great importance for the implementation of the suggestions presented.⁶⁶ It was not part of the remit of the investigation to provide suggestions regarding this. There is therefore no reason for the Parliamentary Ombudsmen to return to this issue.

There are also grounds for the Parliamentary Ombudsmen to continue to monitor how to ensure, within compulsory psychiatric care, that patients are not subjected to more extensive measures than absolutely necessary. This element may require clinics to bring in external experts to a greater extent, to assess what care to provide (so-called second opinions). This is to avoid long periods of care, with static assessments.

Finally, the question of care in environment lacking stimuli and the opportunity to spend time outdoors on a daily basis should continue to be prioritised in the inspection activity in the coming years. Giving patients the opportunity spend time outdoors and get fresh air should be seen as an important element in the provision of care. The OPCAT unit's inspections show that psychiatric clinics relatively frequently lack access to exercise yards that enable even extremely ill patients to spend time in a controlled outdoor environment. The

During the period, it emerged that it is still difficult to get an idea of the number of places that exist for compulsory psychiatric care.

⁶⁵ Ref. no. 733-2015.

⁶⁶ See SOU 2017: 11 p. 279.

lack of such establishments leads to patients not getting the opportunity to be outside.

Migration detention centres

The Migration Agency manages detention centres where aliens who are to be refused entry or deported from Sweden are placed while waiting for the decision to be executed. At the end of 2017, there were five detention centres with approximately 360 placements. During the period 2015–2017, inspections were carried out at three detention centres.

Coercive measures

The Migration Agency is entitled to take certain coercive measures against persons in a detention centre. The authority's staff can carry out body searches of an alien, if there is a reasonable suspicion, that he or she is carrying something that may not be in their possession. A detainee can be isolated if necessary, for order and safety in the premises, or if he or she constitutes a risk to his or her own personal safety, or others. An isolated person may also be placed with the Prison and Probation Service or the Police Authority, in a so-called safety placement, for safety reasons.

During the inspection of the detention centre in Flen in spring 2016, it was noted that the Migration Agency's instructions stated that the detainee's belongings should be searched unless this was deemed as unnecessary. According to the Parliamentary Ombudsmen, this wording was not compatible with the law and the Migration Agency was encouraged to change its instructions.⁶⁷ At an inspection of the detention centre in Gävle in 2016, it was noted that the instruction had changed, which was positive. The Parliamentary Ombudsmen states, however, that the instructions needed to be further adjusted since it was not entirely in accordance with the legal text, in regards to when a search can be performed.⁶⁸ In connection with an inspection of the detention centre in Källered, it was noted that the instructions had been adjusted. It was, however, observed that, despite this, the staff performed body searches of detainees after each visit and that it was not made sufficiently clear in the decisions what circumstances formed the basis for this action.⁶⁹

During two of the inspections, it was established that the detention centres had limited physical capacity for placing detainees in isolation. This circumstance, combined with the fact that it was regularly stated in the decisions that

⁶⁷ Ref. no. 843-2016.

⁶⁸ Ref. no. 4831-2016.

⁶⁹ Ref. no. 1000-2017.

a placement in isolation was not deemed necessary, gave the Parliamentary Ombudsmen the impression that the staff at the detention centre in Källered had decided, from the outset, to put the detainee in a safety placement with the Prison and Probation Service. A placement within the prison service means a more perceptible restriction to freedom for the detainee than if he or she were placed in a detention unit. According to the Parliamentary Ombudsmen, the coercion exercised against a detainee should be as mild as possible and, in principle, resemble a staircase where a restriction of the freedom of movement and isolation should precede a safety placement. In order to facilitate such a scrutiny, the detention units must have access to suitable areas for isolation placements.⁷⁰

The detention centres must have access to suitable areas for isolation placements.

According to the authority's procedures, staff from the Migration Agency must visit detainees in security placements within the prison and remand prison service. There is no statutory obligation for the authority to reconsider such a decision. The Parliamentary Ombudsmen has previously asked for such regulations and has encouraged the Migration Agency to ensure, while awaiting an amendment, that the guidelines for visits to remand centres are adhered to and to ensure that there are procedures for how the conditions for a review are to be investigated.⁷¹ During the inspection of the detention centre in Gävle, it was established that there are still uncertainties regarding these matters. It also emerged that there were no central instructions for the Migration Agency or any local written procedures for carrying out visits to remand prisons.⁷² During the inspection of the detention centre in Källered, it was established that the authority had produced such procedures. The Parliamentary Ombudsmen stated that the procedures needed to be supplemented with a description of the situations in which a visit to a remand prison can be cancelled.⁷³

The Parliamentary Ombudsmen has previously requested an amendment to the law on the obligation to review decisions on safety placements, and urged the Migration Agency to ensure, while awaiting an amendment, that guidelines for visits to remand prisons are adhered to and to ensure that there are procedures for how the conditions for a review are to be investigated.

Since there are still no legal provisions on the obligation to review decisions on safety placements, the Parliamentary Ombudsmen sent a copy of the inspection report to the Ministry of Justice.

Access to medical care

County councils must also offer aliens held in detention, and who have reached 18 years of age, care that cannot be deferred, as well as maternity welfare. County councils must also, unless deemed unnecessary, offer aliens kept in detention a health examination as soon as convenient. On previous occasions, the Parliamentary Ombudsmen has stressed the importance of having medical staff at the detention centre and actively working on the issue of entitlement to health care. The CPT has also recommended that Sweden take

⁷⁰ Ref. no. 1000-2017.

⁷¹ JO 2011/12 p. 314, Ref. no. 6090-2009.

⁷² Ref. no. 4831-2016.

⁷³ Ref. no. 1000-2017.

There are great differences in health and medical care that detainees are offered, at the Migration Agency's detention centres.

measures to ensure a medical assessment is carried out of all detainees when they are registered.⁷⁴

Despite the previous statements, it has been discovered that there are great differences between the Migration Agency's detention centres in regards to the health and medical care offered to individuals deprived of their liberty. During an inspection in 2016, it was established that the detention centre in Flen did not have a nurse on site and that the detainees were not offered any health examination at the time of registration. This created problems for the staff in question, among other things with regards to handling medicines, and the staff were also forced to handle information about the detainees' states of health. The Parliamentary Ombudsmen held that this was unsatisfactory.⁷⁵

During a later inspection of the detention centre in Gävle, six months later, it was established that detainees had received access to a nurse. The detention centre had also taken measures to facilitate the detainees' access to medicines. This reduces the risk of staff having to handle information about the detainees' states of health.⁷⁶

During an inspection of the detention centre in Kålleröd in 2017, it was established that the detainees had access to a nurse. There was, however, no procedure for ensuring that the nurse met all detainees when they were registered. Nor was there any check of whether the detainees had been offered a health examination from the county council before arriving at the detention centre. The Parliamentary Ombudsmen also questioned a method of working that meant that female staff members were always present during the nurse's discussions with detainees.⁷⁷

Conclusions on detention centres

As a result of the inspections of the detention centres, shortcomings have been noted in the Migration Agency's procedures regarding safety placements within the prison service. Some of these deficiencies have been addressed by the authority after being pointed out by the Parliamentary Ombudsmen. The Migration Agency has also addressed shortcomings in the instructions for when a body search can take place. This is positive. There are, however, still grounds for the Parliamentary Ombudsmen to monitor how the Migration Agency applies the rules on coercive measures in order to prevent detainees being subjected to unnecessarily invasive measures. Access to health and medical care within the detention operation will also continue to be a priority issue during inspections of detention centres.

⁷⁴ JO 2011/12 p. 314, ref. no. 6090-2009 and CPT/Inf(2016) 1, p. 25 para. 39.

⁷⁵ Ref. no. 843-2016.

⁷⁶ Ref. no. 4831-2016.

⁷⁷ Ref. no. 1000-2017.



Theme for 2015:
Female deprivation
of liberty



Female deprivation of liberty

Prison security classification

At the present time, the Prison and Probation Service's institutions are divided into three security levels (1–3), with 1 being the highest and 3 the lowest security level. The division into security levels is based on an overall assessment of the conditions an institution has for supervision and controls. Factors that affect the assessment include shell and perimeter protection, the scope of camera surveillance, entry controls and staff density. It is also possible for the Prison and Probation Service to make a special decision to place an inmate in a section with a particularly high level of supervision and control (security section). Such a placement may be relevant if there is a permanent risk of the inmate escaping or being freed and it could be assumed that he or she is particularly inclined to criminal activity.

Women form only a small percentage of those deprived of their liberty within the prison service. In 2015, women made up around 6 percent of the total prison population. Given that the majority of inmates are men, the prison service is, as a general rule, built on the basis of their needs. In this context, female inmates could therefore be said to be a relatively invisible group. At the same time, women form a group of inmates who, to some extent, have different needs. In this context, it is worth mentioning, that it is not uncommon for female inmates to spend time in establishments together with their children. It is also not unusual for female inmates to have more complex problems than male inmates.

The treatment of female inmates places certain demands on the Prison and Probation Service. In the context, female inmates risk not having their rights accommodated. For this reason, the OPCAT unit chose women deprived of their liberty as a special theme in 2015.

Inspections carried out

Female inmates are placed at one of the prisons Hinseberg, Ystad, Ljustadalen, Sagsjön, Färingsö or Ringsjön. At Hinseberg, which holds security level 2, inmates sentenced to a minimum of two years in prison are initially placed. The equivalence is the National Assessment Centre for men in Kumla, where inmates who have been sentenced to a minimum of four years in prison are placed. A special investigation is carried out at the National Assessment Centres that forms the basis for placements in institutions. Female inmates sentenced to prison sentences of less than two years are placed directly in one of the six institutions.

The prisons Färingsö, Sagsjön and Ystad also hold security level 2. There are also security level 3 institutions in Färingsö and Sagsjön. The Ljustadalen and Ringsjön prisons are security level 3. There is no security level 1 prison for female inmates. Nor are there any placements for female inmates that allow so-called safety placements, i.e. places where inmates deemed to be at special risk of being inclined to escape or commit crimes.

In 2015, the OPCAT unit inspected all prisons that accept female inmates. The remand prisons in Helsingborg and Sollentuna, which were the two remand prisons at that time that had special sections for female inmates, were also inspected. The inspections led to the Parliamentary Ombudsmen opening six enquiries.

The National Assessment Centre

In connection with the inspection of the Hinseberg prison, it was noted that the institute did not have access to a psychologist. As a result, investigations at the National Assessment Centre took longer than expected which caused delayed placements. These conditions also led to sentenced women having to wait in remand for a vacant space, at the National Assessment Centre. The long investigation time at the National Assessment Centre, combined with a long time in remand, could lead to the time spent in an institution after the investigation being very short. As a result of these conditions, the Parliamentary Ombudsmen decided to investigate the National Assessment Centre's operations.¹

According to the Prison and Probation Service, inmates placed in the National Assessment Centre has particularly complex needs, which have to be investigated in order to be accommodated during the future stay in an institution. According to the Parliamentary Ombudsmen, it is however unacceptable that the execution of the sentences of this group of women is poorer than that for other inmates, as a result of a lack of investigation resources, at the National Assessment Centre. The need for more advanced investigations must, in the opinion of the Parliamentary Ombudsmen, be put in relation to the limited availability of places in institutions and the current content of the execution of the sentences of female inmates. For this reason, the Parliamentary Ombudsmen has questioned whether, under present circumstances, it is justifiable that women serving a prison sentence of just two years should be investigated at the National Assessment Centre, as a general rule. For this reason, the Parliamentary Ombudsmen looks positive upon the review that the Prison and Probation Service has initiated of, among other, the National Assessment Centre.²

Placing inmates in a suitable institutional placement

The thematic focus has also demonstrated that there are great differences between male and female inmates, in regard to specific placements.

The availability of special placements that can cater for inmates' special needs was considerably greater for men than for women in 2015. It also emerged that specialist placements and treatment programmes were, in the first instance, formulated on the basis of men's needs and had subsequently been adapted for female inmates. In its decision, the Parliamentary Ombudsmen has encouraged the Prison and Probation Service to put greater emphasis on illustrating the special needs of female inmates and developing adapted placements and initiatives on the basis of these.³

According to the Parliamentary Ombudsmen, it is unacceptable that the content of the execution of the sentences of women is poorer than for other inmates, as a result of a lack of investigation resources at the National Assessment Centre.

In the opinion of the Parliamentary Ombudsmen, it is questionable whether women serving a prison sentence of two years should be investigated at the National Assessment Centre, as a general rule.

In its decision, the Parliamentary Ombudsmen has encouraged the Prison and Probation Service to put greater emphasis on illustrating the special needs of female inmates and developing adapted placements and initiatives on the basis of this.

¹ Ref. no. 2527-2015.

² JO 2018/19 p. 165, Ref. no. 1087-2016.

³ JO 2018/19 p. 165, Ref. no. 1087-2016.

In the opinion of the Parliamentary Ombudsmen, there is an obvious need for increased options for differentiating between female inmates. In the opinion of the Parliamentary Ombudsmen, the reality that there is a low number of female inmates is something the Prison and Probation Service needs to take into account when the activity is formulated.

According to the Parliamentary Ombudsmen, the Prison and Probation Service should carry out a review of the security levels at prisons that accept women and investigate whether there is a need for security level 1 placements.

The Parliamentary Ombudsmen has previously established that the conditions for keeping certain inmates separate from each other and thus avoiding unsuitable client groupings are considerably poorer at female institutions than at male institutions. The limited number of placements in institutions for women is a particular challenge for the Prison and Probation Service regarding the ability to transfer inmates. In the opinion of the Parliamentary Ombudsmen there need to be contingencies at the authority for dealing with inmates who are difficult to place. A lack of resources or opportunities for internal differentiation is not an acceptable reason for placing inmates in isolation and thereby denying them their legal rights to spend time with others during day time.⁴ As a result of the inspections in 2015 and the Prison and Probation Service's statement to the Parliamentary Ombudsmen, the Parliamentary Ombudsmen states that there is an obvious need for increased options for differentiating between female inmates. In the opinion of the Parliamentary Ombudsmen, the fact that there is a low number of female inmates is a fact that the Prison and Probation Service needs to take into account when the activity is formulated.⁵

In connection with the inspection of the prison at Färingsö, it was noted that the section for security level 3 inmates (the lowest security level) were located within the perimeter protection of the closed sections (security level 2). This means that security level 3 inmates are also surrounded by a high double fence for most of the day. Ljustadalen prison, which only has security level 3 placements, therefore has no perimeter protection. As stated by the Parliamentary Ombudsmen, there is a risk of the higher degree of monitoring and control having an impact on the lower security level at the institutions. It also appears that the inmates experience a difference in restrictions to freedom depending on the perimeter protection at the prison. For this reason, the fact that, in practice, a placement in security level 3 may correspond to such different conditions, appears unsuitable to the Parliamentary Ombudsmen. As stated by the Parliamentary Ombudsmen, the Prison and Probation Service should carry out a review of the security levels for the prisons that accept women and also investigate whether there is a need for security level 1 placements.⁶

Pregnant inmates and inmates staying in an institution with their children

As a result of inspections made of female institutions, the Parliamentary Ombudsmen decided to investigate, in a special case, the situation for female inmates in prisons with accompanying children, or who are pregnant. As

⁴ JO 2015/16 p. 191, Ref. no. 1277-2014.

⁵ JO 2018/19 p. 165, Ref. no. 1087-2016.

⁶ JO 2018/19 p. 165, Ref. no. 1087-2016

stated by the Parliamentary Ombudsmen, the investigation shows that these inmates and their accompanying children are not attended to in a clear and uniform manner by the Prison and Probation Service when it comes to planning, placements and executing sentences. The fact that the authority lacks coordinated procedures and that prisons deal with the handling of these inmates through temporary solutions alongside their ordinary operation, is a severe failure. In order to address this problem, the Prison and Probation Service should, in the opinion of the Parliamentary Ombudsmen, take the following measures:

- introduce procedures to find suitable placements for women who has an infant child or is pregnant
- introduce procedures, when it is relevant, to request a statement from the Social Welfare Board during the placement investigation. The placement section should also work closely with the prisons so that the matter of accompanying children can be dealt with already in connection with the placement decision
- consider setting up adapted places for women inmates with accompanying children at special institutions where both the inmates' and the children's needs can be better accommodated
- introduce procedures for prisons to administrate a plan, in consultation with the maternity clinic, in good time before an inmate's estimated delivery date. The inmate should be informed that the prison has detailed plans for what will happen once the childbirth commences and ensure that she receives as much information as possible about the plans
- introduce childminding to facilitate for female inmates to take part in activities and programs to prevent recidivism
- take measures so that the authority can deal with situations where male inmates are placed in an institution with their children.⁷

The fact that the authority lacks coordinated procedures, and that the institutions deal with the handling of pregnant inmates and inmates with children, through temporary solutions, alongside their ordinary operation, is a severe failure.

Security assessments in connection to transport to healthcare facilities

In connection to the inspection of Hinseberg prison, details emerged that gave grounds for investigating the Prison and Probation Service's security assessments in connection to transports to healthcare facilities. Details had also emerged that the use of shackles during transport meant that inmates had not been able to make toilet visits on their own and that one pregnant inmate had been provided with handcuffs and a waist shackle in connection with a transport to give birth.

In its decision, the Parliamentary Ombudsmen states that the Hinseberg

⁷ JO 2018/19 p. 184, Ref. no. 1089-2016.

The Parliamentary Ombudsmen states that the Prison and Probation Service need to focus efforts to ensure that a satisfactory level of control and security is achieved in each individual case.

prison's decision on control measures, appeared to be based on standardised assessment regarding the inmate's security level. During the assessment, consideration for the inmates' current state and integrity was neglected. In the opinion of the Parliamentary Ombudsmen, a correct scrutiny would probably not have led to the assessment that it would be proportionate to use handcuffs and waist shackles on a woman with ongoing labour pains being transferred to a maternity ward to give birth. As stated by the Parliamentary Ombudsmen, the same applied to the presence of several prison wardens during childbirth.⁸

The Prison and Probation Service has emphasised that the prison has changed its procedures following the OPCAT unit's inspection. Now an account is taken of whether the inmate is pregnant and at what stage her pregnancy is. The Parliamentary Ombudsmen states that the Prison and Probation Service need to focus efforts to ensure that a satisfactory level of control and security is achieved, in each individual case, without the inmate being subject to measures perceived as degrading and not proportionate on the basis of the individual's condition during, for example, medical care and treatment, when being moved to healthcare facilities or during toilet visits. In order to follow up on security arrangements and results in adjustments to the security assessment, such as the use of shackles, this must be put on record.

Conclusions

The thematic focus has illustrated that the Prison and Probation Service has not succeeded in offering equivalent correctional treatment for men and women. The inspections in 2015 and subsequent enquiries make it clear that women, in several respects, are treated unjust by the existing regulations, and are limited in physical environments and enforcement conditions. The Prison and Probation Service has commenced with some changes in their work and the authority has been made aware of some problems that, among other things, a lack of resources in relation to women inmates gives rise to. As far as can be judged, much work remains to be done – particularly with regard to the question of creating suitable environments for inmates with children – before the authority will have made all the changes necessary in order to be able to offer equivalent correctional treatment for men and women in the future. There are therefore grounds for the Parliamentary Ombudsmen to continue to monitor the issues and, within the not too distant future, perform a follow-up of the results of the changes that the authority now has commenced.

As far as can be judged, much work remains to be done – particularly regarding the issue of creating suitable environments for inmates with children – before the authority will have made all the changes necessary in order to be able to offer equivalent correctional treatment for men and women in the future.

⁸ JO 2017/18 p. 131, Ref. no. 1088-2016.



Theme for 2016:
Information about rights of
those deprived of their liberty



Information about rights

A basic prerequisite, for an individual deprived of their liberty, to be able to exercise their rights, is that he or she is informed of their rights. This could, for example, concern the right to be allowed to speak to his or her defence counsel and the right to an interpreter. This could also involve access to medical care.

It is particularly important that individuals placed in police custody are given the correct information. It is often the case that the individuals find themselves in a vulnerable position which means that they find it difficult to exercise their rights. Moreover, it may be that individuals placed in custody never have experienced this before. This makes it particularly important for persons taken into police custody to be informed of their rights, and to ensure that they have understood the information given to them.

From October 2011 to June 2013, inspections were carried out at 29 police custody facilities. During the inspections, deficiencies in the information given to individuals deprived of their liberty were noted and an initiative launched. In its decision, the Parliamentary Ombudsmen emphasises the importance of such information being provided and there being uniform procedures for this.¹ The preliminary investigation was changed in 2014 and now states that information for individuals taken into custody and on remand must be in writing.

In 2016, information to detainees regarding their rights was the unit's main focus. During the year, inspections were carried out at 15 police custody facilities. It is essential that there are procedures for informing detainees about their rights, at locations where persons are deprived of their liberty. Inspections were carried out at remand prisons, detention centres and places for compulsory psychiatric care. The operations all abide the same regulations on providing individuals deprived of their liberty with information on their rights.

Police custody facilities

As a general rule, the Police Authority must give everyone taken into police custody information about their rights and obligations and it must be documented that such information has been provided. Detainees must also be given the opportunity to inform relatives of where they are. The detainee must be informed of this option. If the detainee cannot personally make this contact, he or she must be asked whether the police should provide this information. These measures must also be registered.

In police custody facilities, it was noted that only in exceptional cases a record was made of providing or not providing written information to those arrested and in custody, pursuant to the Care of Intoxicated Persons Act.

¹ JO 2014/15 p. 104, Ref. no. 2572-2013

The inspections of police custody facilities in 2016 proved that there were deficiencies in these respects. In some police custody facilities, it was noted that only in exceptional cases a record was made of written information being provided to persons taken into custody in accordance with the Care of Intoxicated Persons Act. It was also noted, in several cases, that individuals deprived of their liberty had not been asked whether relatives should be informed of them being taken into custody. Several police custody facilities did not have procedures for making a record of whether the question of informing others had been asked.² In one of the police custody facilities inspected there were procedures to register if information had been provided. It was, however, a failure not to register when this information had been provided.³

The Police Authority has produced a special form on which police custody staff must document that a detainee in the custody facility has received information about his or her rights, been asked whether relatives are to be informed, received information about daily procedures in the custody facility, been informed about any restrictions and, as regards aliens, been informed of the right to contact an embassy or consulate. It must also be stated in the form who provided the information and when.

Following the inspections performed, the Police Authority has produced a special form on which the police custody facility staff must document that a detainee in the police cells has received information about his or her rights.

Remand prisons

In connection with inspections at seven remand prisons in 2017, it was noted that there were also shortcomings in the information given to individuals deprived of their liberty. As stated by the Parliamentary Ombudsmen, this group of individuals are also entitled to be informed of their rights in a language they understand, in writing. During 2018, the Prison and Probation Service has reported back to the Parliamentary Ombudsmen and stated that the Prison and Probation Service has access to an information folder, that informs detainees of their rights, and that this has been translated into eight of the most common languages, within the prison service. The authority has, together with the Migration Agency, produced information material aimed at detainees placed in the prison service. According to the Prison and Probation Service, it has been noted that there are deficiencies in providing the information in question, and informing detainees of the local procedures at a place of operation. For this reason there continues to be a need to clarify the procedures that apply centrally within the authority.⁴

The Prison and Probation Service has, together with the Migration Agency, produced information material aimed at detainees placed in the prison service.

Migration detention centres

Persons placed in the Migration Agency's detention centres must be informed of their rights as a detainee. The detainee must also be informed of his or

² The police custody facilities in Alingsås, Eksjö, Gothenburg, Helsingborg, Kristianstad, Malmö, Motala, Oskarshamn, Skellefteå, Sollentuna, Strömstad, Trollhättan and Uddevalla.

³ Ref. no. 3903-2016.

⁴ Ref. no. 416-2017.

The Migration Agency has produced the written information material previously requested.

her obligations and the rules that apply in the detention premises. During an inspection of the detention centre in Flen, it emerged that the detainees were not informed of their rights etc. The Parliamentary Ombudsmen urged the Migration Agency to address this immediately.⁵ Later in the year, an inspection was carried out at the detention centre in Gävle and it was established that the Migration Agency had produced the written information material previously requested. The information material is available in eight languages. The Parliamentary Ombudsmen emphasised that the information sheet needed to be supplemented with information on the scope of health and medical care that detainees should be offered by the county council.⁶

Compulsory psychiatric care

The legislation regulating compulsory psychiatric care contains provisions on providing individuals deprived of their liberty with information on their rights. There is no requirement that this information must be in writing. The Parliamentary Ombudsmen has stated that a patient may find it initially difficult to take in the information provided. For this reason, it may be appropriate for there to be written information material available as a *supplement to the verbal information* provided. It was noted during one inspection that a forensic psychiatry clinic has such written material. The Parliamentary Ombudsmen recommended that the clinic supplement the material so that it contains all the information to be provided to the patients in accordance with the legislation.⁷

Conclusions

The thematic focus has meant that the importance of providing written information to those deprived of their liberty has been paid particular attention to. The recommendations the Parliamentary Ombudsmen has provided have illustrated the need for clear procedures at the authorities and within compulsory care to ensure that those deprived of their liberty are given the information to which they are legally entitled and that this is registered. The inspections have led to the Migration Agency rectifying the shortcomings that the Parliamentary Ombudsmen has pointed out over the year. The shortcomings noted within the Police Authority have been dealt with in a *manual for police custody facility activity*, which was adopted in December 2017 and applies from 1 January 2018. It is however important that there are procedures for the local police custody facility operation to ensure that the recommendations in the manual are adhered to. The Prison and Probation Service has noted that a lot of work remains for the authority to clarify its obligations so that the

There have been improvements regarding the access for individuals deprived of their liberty to written information concerning their rights. Work is also still ongoing on updating the information material.

⁵ Ref. no. 843-2016.

⁶ Ref. no. 4831-2016.

⁷ Ref. no. 5556-2016.

individual places of operation comply with these.

The thematic themes has led to results as the issues investigated are attended to by the authorities. There have been changes that have led to improvements for individuals deprived of their liberty regarding access to written information. Work is still ongoing at several authorities on, among other things, updating information material. In the future, the OPCAT unit will follow the development in this area.



Theme for 2017:
Supervision of
those deprived
of their liberty



Supervision of those deprived of their liberty

Supervision of individuals deprived of their liberty is handled in different ways by the authorities. In the police's custody facility, people arrested and held are supervised once an hour as a general rule. In the case of people taken into custody due to intoxication, supervision occurs every 15 minutes, as a general rule. The supervision aims to safeguard persons from dying as a result of intoxication or illness. As a general rule, there is no regular supervision of persons admitted to the Prison and Probation Service's remand prisons. The contact the staff have with detainees regularly during the day, for example, in connection with serving food and spending time outdoors, is regarded as part of the basis for assessing how well detainees feel. In all activities where there are individuals deprived of their liberty, procedures are applied for detecting if there is a risk of a detainee being involved in self harm. If there is a suspicion of such a risk, a decision is taken to supervise the detainee at special intervals or constant. The decision that a detainee is to be placed under supervision is therefore of great significance for the individual's safety. A decision on supervision and the supervision performed must also be put on record, in the correct manner.

Police custody facilities

Even from the outset of the Parliamentary Ombudsmen's OPCAT unit, supervision of those deprived of their liberty in police custody facilities has been a priority matter. During 2011–2014, deficiencies were noted in that there were no procedures for regular supervision. It was noted that there are relatively frequent deficiencies in how supervision is put on record. The Parliamentary Ombudsmen has previously emphasised that it is important that detailed notes of the detainee's status be kept, in connection with supervision. It is not sufficient to state in a routine fashion on each occasion of supervision that the detainee is, for example, "lying down".

The inspections during 2015–2017 show that there has been a tangible improvement in this area. During several of the inspections, it was noted that previous opinions voiced by the Parliamentary Ombudsmen have been responded to and that the majority of the police custody facilities nowadays have procedures for regular supervision of the detainees.

The inspections during 2015–2017 show that there has been a tangible improvement in this area. During several of the inspections, it was noted that previous opinions expressed by the Parliamentary Ombudsmen have been taken into account and that the majority of the police custody facilities nowadays have procedures for regular supervision of the inmates. In 2016, an inspection was carried out at a newly-opened police custody facility. In connection with the inspection, it was established that the police custody facility – unlike the majority of the other police custody facilities in the country – had no procedures for regular supervision. During an unannounced follow-up inspection

a year later, it was established that such procedures had been introduced.¹ The notes kept during the supervision were, however, still deemed to be lacking. Such failures were also noted at the inspection of other police custody facilities.²

Over the last few years, technical solutions have been introduced in a number of police custody facilities with a view to facilitate supervision and, in this way, ensure that supervision is actually performed. The system is called Cell-Trac and means that the police custody facility guard reads a magnetic chip in each cell door in connection with the supervision. The detainee's status is recorded along with a supervision code. The system facilitates the supervision, since the police custody facility guard does not need to write down the observation on forms that are not always suitably worded. These technical developments are positive and could contribute to supervision being performed in accordance with applicable procedures. This requires the magnetic chip for electronic reading to be positioned so that the police custody facility guard is able to observe the detainee and record the detainee's status.³

Remand prisons

During the year, there were a number of inspections of remand prisons and it emerged that there were major differences in the wording of procedures for regular supervision. It occurs that detainees who do not attract the attention of the staff and are not subject to regular medication are locked up in their residential room for up to 12 hours in connection with the daily rest period. The Parliamentary Ombudsmen has previously stated that it is appropriate to have a procedure where the night staff keep in personal contact with each detainee. This type of contact reduces segregation and is also an important opportunity for the staff to check the detainees wellbeing.⁴

During the inspection of one remand prison it was noted that the observation room in which detainees are placed in isolation is continuously monitored by a camera. This monitoring is also regularly combined with recording. Camera monitoring violates an individual's integrity. Under certain circumstances, there are grounds for exercising such monitoring in order to guarantee the safety of both detainees and staff in situations where the detainee is anxious, without him or her displaying self-harming behaviour. If it is assessed that such monitoring should take place, this should be noted in the decision on isolation. The Parliamentary Ombudsmen also urged the Prison and Probation Service to install a technical solution to make it possible to switch off the camera when monitoring is not deemed necessary.⁵

The Parliamentary Ombudsmen has previously stated that it is appropriate to have a procedure where the night staff keep in personal contact with each detainee.

1 See Ref. nos. 5544-2016 and 6464-2017.

2 See Ref. nos. 6445-2015, 3902-2016 and 6361-2016.

3 Ref. no. 387-2016.

4 Ref. nos. 416-2017, 417-2017, 418-2017, 419-2017 and 581-2017.

5 Ref. no. 418-2017.

Migration detention centres

During an inspection of a detention centre in Källered, it was noted that the room used for isolation was temporarily set up, and the room only allowed limited opportunities for supervision. The Parliamentary Ombudsmen states that the Migration Agency needed to ensure that the isolation rooms used for detention activity are fit for purpose. The Parliamentary Ombudsmen also urged the detention centre to take prompt action regarding the isolation room to make it possible for the personnel to get a full view of the detainee in order to keep the detainee safe.⁶

Youth facilities

In 2017, four LVM residential homes and three LVU residential homes were inspected. During an inspection of a LVM residential home, it emerged that there were different interpretations among the personnel regarding how frequently inmates in isolation were to be supervised. The Parliamentary Ombudsmen stated that the home needed to clarify how supervision was to be performed.⁷ In connection with the inspection of another LVM residential home, it was established that supervision, decided on as the result of a suicide risk, could continue for several weeks without carrying out any continuous assessment of the need for such supervision.⁸

Compulsory psychiatric care

In 2017, two in-patient psychiatric clinics, one forensic psychiatry examination unit (RPU) and two child and adolescent psychiatry (BUP) clinics were inspected. In connection with the inspection of the RPU, it was noted that the unit's procedures contained many different terms for supervision frequency, e.g., continuous superintendence, a lower degree of supervision, continuous supervision, extra guard and constant supervision. The terms did not provide any detailed explanation and there was a risk of them being confused. Representatives of the examination unit stated that they had commenced work on reviewing the terms, the Parliamentary Ombudsmen looks positive upon this.⁹

During an inspection of BUP Stockholm, it was noted that the supervision of patients spending time in their residential rooms was performed in different ways by the staff, that observations were passed on verbally and that documentation was only in writing "if something particular had happened". In addition, there were no written procedures for what was to be documented and by whom. The Parliamentary Ombudsmen stated that the clinic needed to

⁶ Ref. no. 1000-2017.

⁷ Ref. no. 2514-2017.

⁸ Ref. no. 2515-2017.

⁹ Ref. no. 3416-2017.

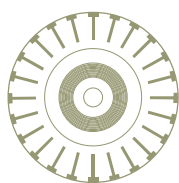
take action to ensure that there are sufficient personnel resources to perform the necessary supervision and that the personnel always have the information they need about the patients, in order to be able to perform the supervision in a safe manner, for the patient.¹⁰

In connection with the inspection of BUP Luleå, it was noted that the clinic needed to review its premises and staffing to ensure that the patients receive adequate and safe care, including the need for sufficient personnel resources around the clock to ensure that the patients receive the supervision deemed necessary. The Parliamentary Ombudsmen also intends to introduce a dialogue with the Health and Social Care Inspectorate as a result of what emerged regarding the physical conditions for children, when being strapped down.¹¹

Conclusions

There has been some improvement, in regards to procedures for supervision of individuals deprived of their liberty, in police custody facilities. The experiences from the inspection period show that there are still some deficiencies and that there is a need for the authority to emphasise, to the staff, the importance of the procedures being adhered to. There are also grounds for the Parliamentary Ombudsmen to continue to monitor this issue.

Other authorities and institutions for compulsory psychiatric care also need to undertake preventive work on reviewing how, when and in which way supervision takes place and to ensure that there are no differences in how supervision is performed depending on which members of staff are on duty.



¹⁰ Ref. no. 3816-2017.

¹¹ Ref. no. 4043-2017.



Appendices

Tables and summaries

Participation in international meetings

Inspections

Enquiries subsequent to an OPCAT inspection

Issues where the Parliamentary Ombudsmen has requested feedback

APPENDIX
A

Participation in international meetings

Issues surrounding the OPCAT unit are frequently discussed in an international context. This includes both factual and methodological issues. The following visits took place during the period:

2015

- 2 March, Strasbourg, France: THE CPT at 25: taking stock and moving forward. Conference arranged by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment of Punishment.
- 29 April, Vienna, Austria: Enhancing Impact of National Preventive Mechanisms. Conference arranged by the Ludvig Boltzmann Institute.
- 5–6 May, Helsinki, Finland: Integrating the Preventive Approach. Workshop arranged by The Association for the Prevention of Torture.
- 28 May, Stockholm, Sweden: The European Committee for the Prevention of Torture's concluding review of its observations after its sixth visit to Sweden.
- 11–12 June, Oslo, Norway: Nordic NPM Meeting.
- 17–19 June, Riga, Latvia: IOI workshop Implementing a preventive mandate.
- 10–13 August, Bristol, UK: Preventing torture and ill-treatment of female detainees through gendersensitive monitoring.
- 19 October, Helsinki, Finland: Visit to Finland's equivalent of the OPCAT Unit, with the focus on women with children in institutions.
- 10–11 December, Copenhagen, Denmark: Nordic NPM meeting.

2016

- 7–8 June, Vienna, Austria: Consultative Workshops for NPM.
- 9–10 June, Stockholm, Sweden: Nordic NPM meeting.
- 21–23 June, Vilnius, Lithuania: IOI workshop Monitoring of Psychiatric Facilities.
- 13–14 October, Vienna, Austria: Technical information meeting of NPM from the OSCE region.
- 16–17 November, Vienna, Austria: The strengthening of the fundamental-

rights based implementation of EU law in criminal matters through cooperation between the judiciary and NPMs.

- 6 December, Brussels, Belgium: Workshop of the setting up and implementing of Frontex individual complaints mechanism with Member States and Schengen Associated Countries.
- 15 December, Stockholm, Sweden: Visit from the Chairman of the UN Subcommittee on Prevention of Torture (SPT).

2017

- 4 January, Oslo, Norway: Visit to the Norwegian Parliamentary Ombudsmen's NFM Unit.
- 17–18 January, Helsinki, Finland: Nordic NPM meeting.
- 21 February, Copenhagen, Denmark: Participation as an observer on a “return-flight”.
- 4–5 April, Strasbourg, France: Network of SPACE national correspondents and Network of national prison monitoring bodies.
- 14–17 August, Bristol, UK: Residential Summer School on Torture Prevention.
- 23–24 August, Oslo, Norway: Nordic NPM meeting.
- 27 September, Berlin, Germany: Strengthening monitoring for the prevention of torture and ill-treatment in places of liberty deprivation.
- 25–26 October, Oslo, Norway: MR seminar Helsepersonells rolle i møte med mennesker som er fratatt friheten i politiarrest og fengsel [Healthcare staff's role when meeting people deprived of their liberty in police custody facilities and prison].



APPENDIX
B

Inspections

Unannounced inspections

| Police custody facilities | |
|---------------------------|-------------------|
| Eksjö | reg.no. 6363-2016 |
| Helsingborg | reg.no. 2240-2016 |
| Lund | reg.no. 6465-2017 |
| Malmö | reg.no. 6464-2017 |
| Motala | reg.no. 2109-2016 |
| Sollentuna | reg.no. 2652-2016 |
| Uddevalla | reg.no. 4771-2016 |
| Sum 7 | |
| Prison establishments | |
| Färingsö* | reg.no. 440-2015 |
| Ljustadalen | reg.no. 3458-2015 |
| Sum 2 | |
| Remand prisons | |
| Gävle | reg.no. 418-2017 |
| Halmstad | reg.no. 582-2017 |
| Huddinge* | reg.no. 416-2017 |
| Kronoberg* | reg.no. 417-2017 |
| Sollentuna | reg.no. 419-2017 |
| Storboda | reg.no. 581-2017 |
| Ystad | reg.no. 583-2017 |
| Sum 7 | |
| LVM residential homes | |
| Hornö* | reg.no. 1722-2017 |
| Lunden | reg.no. 2515-2017 |
| Renforsen | reg.no. 2514-2017 |
| Rällsögården | reg.no. 1762-2017 |
| Sum 4 | |
| LVU residential homes | |
| Eknäs | reg.no. 5672-2017 |
| Rebecka | reg.no. 5864-2017 |
| Tysslinge* | reg.no. 5903-2017 |
| Sum 3 | |

* Inspections where the Parliamentary Ombudsmen had decided to investigate a certain matter within the framework of a special enquiry. See also Appendix C.

APPENDIX
B

| Compulsory psychiatric care | |
|--------------------------------------------------------------------------------------------------|-------------------|
| In-patient general psychiatry at Sunderby Hospital and child and adolescent psychiatry in Luleå | reg.no. 4043-2017 |
| The National Board of Forensic Medicine, the Forensic Psychiatry Examination Unit in Stockholm | reg.no. 3416-2017 |
| Stockholm County's medical services area, Child and Adolescent Psychiatry Clinic's 24-hour care* | reg.no. 3816-2017 |
| Sum 3 | |

| Migration detention centres | |
|-----------------------------|-------------------|
| Kållerød detention centre* | reg.no. 1000-2017 |
| Sum 1 | |

Total 27 unannounced inspections

Announced inspections

| Police custody facilities | |
|---------------------------|-----------------------------|
| Alingsås | reg.no. 3240-2016 |
| Göteborg (2) | reg.no. 387-2016, 7081-2017 |
| Kristianstad | reg.no. 3902-2016 |
| Malmö | reg.no. 5544-2016 |
| Oskarshamn | reg.no. 6361-2016 |
| Skellefteå | reg.no. 5308-2016 |
| Stockholm, Södermalm | reg.no. 3903-2016 |
| Strömstad | reg.no. 4102-2016 |
| Trollhättan | reg.no. 3241-2016 |
| Umeå | reg.no. 3301-2015 |
| Västerås | reg.no. 6445-2015 |
| Östersund | reg.no. 871-2016 |
| Sum 13 | |

| Prison establishments | |
|-----------------------|-------------------|
| Hinseberg* | reg.no. 2527-2015 |
| Ringsjön | reg.no. 2520-2015 |
| Sagsjön | reg.no. 441-2015 |
| Ystad | reg.no. 1752-2015 |
| Sum 4 | |

* Inspections where the Parliamentary Ombudsmen had decided to investigate a certain matter within the framework of a special enquiry. See also Appendix C.

APPENDIX
B

| Remand prisons | |
|----------------------------------------------------------------------------------------------------------------------|-------------------|
| Göteborg | reg.no. 389-2016 |
| Helsingborg* | reg.no. 4632-2015 |
| Umeå | reg.no. 6106-2015 |
| Västerås | reg.no. 6446-2015 |
| Östersund | reg.no. 872-2016 |
| Sum 5 | |
| Compulsory psychiatric care | |
| In-patient general psychiatry at Karlstad Central Hospital, departments 42 and 46 | reg.no. 2945-2017 |
| Blekinge Hospital in Karlskrona, emergency psychiatric department, psychiatric intensive care section and section 28 | reg.no. 3302-2015 |
| NU medical care, Brinkåsen, section 93 | reg.no. 2222-2016 |
| The psychiatric clinic in Umeå, sections 1, 2 and 3 | reg.no. 1350-2015 |
| Karsudden Regional Hospital, section C3 | reg.no. 6308-2015 |
| The forensic psychiatry clinic in Säter* | reg.no. 5556-2016 |
| Östersund Hospital, sections 3A, 3B and 4A | reg.no. 643-2015 |
| Sum 7 | |
| Migration detention centres | |
| Flen detention centre | reg.no. 843-2016 |
| Gävle detention centre | reg.no. 4831-2016 |
| Sum 2 | |
| Total 31 announced inspections | |

* Inspections where the Parliamentary Ombudsmen had decided to investigate a certain matter within the framework of a special enquiry. See also Appendix C.

Enquiries subsequent to an OPCAT inspection

APPENDIX C

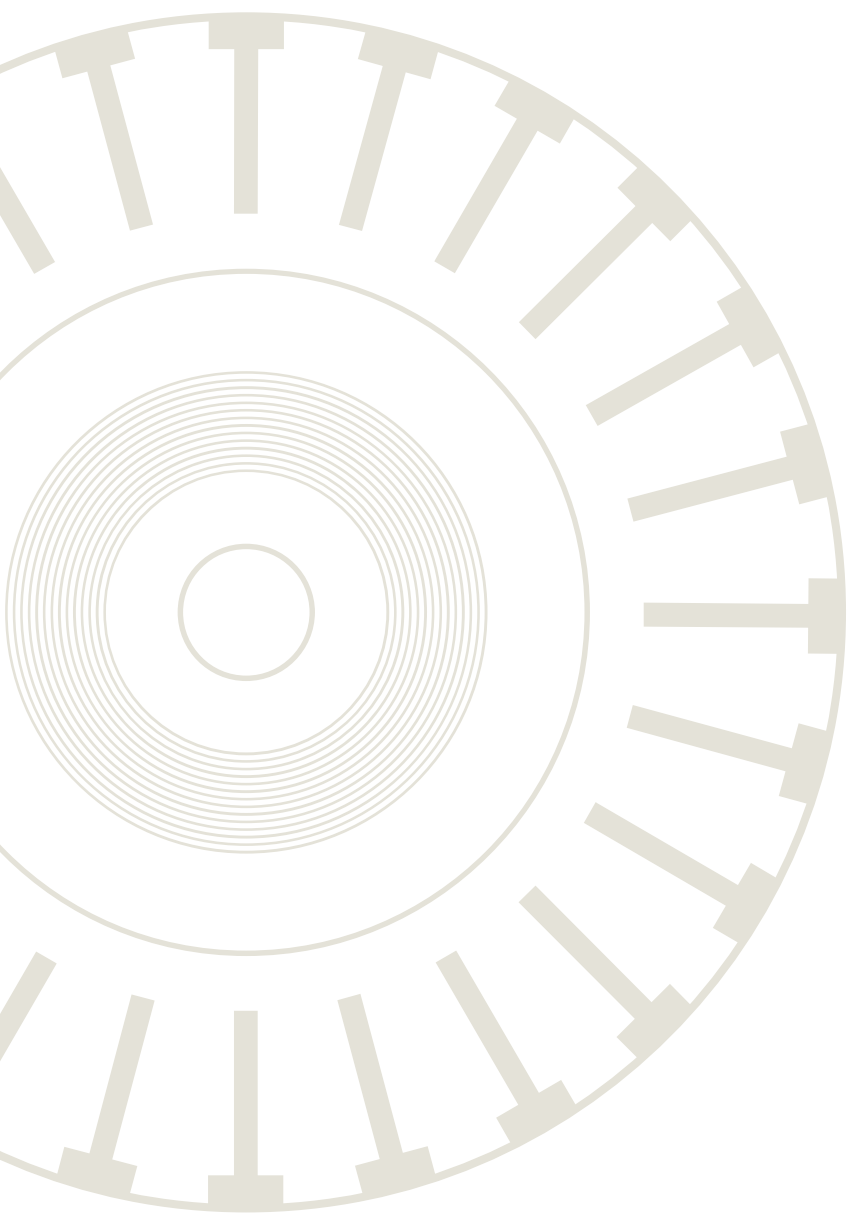
| Prison and Probation Service | |
|------------------------------------------------------------------------------------------------------|---------------------------------------|
| Placement of a large group of inmates in isolation | JO 2016/17 s. 237 (reg.no. 1096-2015) |
| Handling of mail sent to inmates | JO 2016/17 s. 280 (reg.no. 5255-2015) |
| Placement of detainees in remand prisons in isolation | JO 2018/19 s. 146 (reg.no. 5969-2015) |
| The Prison and Probation Service's opportunities for differentiating female inmates in prisons | JO 2018/19 s. 165 (reg.no. 1087-2016) |
| Security assessments in connection with transport of inmates from a prison to a hospital facility | JO 2017/18 s. 131 (reg.no. 1088-2016) |
| The situation for inmates in institutions with accompanying children and for pregnant inmates | JO 2018/19 s. 184 (reg.no. 1089-2016) |
| The conditions for detainees placed within the Swedish Prison and Probation Service | reg.no. 277-2018 |
| Strapping down of a person taken into custody | reg.no. 279-2018 |
| Sum 8 | |
| The National Board of Institutional Care (SiS) | |
| The handling of information regarding inmates' medication | reg.no. 6547-2017 |
| Restraints on juvenile inmates | reg.no. 6774-2017 |
| Sum 2 | |
| The Migration Agency | |
| The Migration Agency and the Police's handling of a deportation matter | reg.no. 2208-2017 (decision in 2018) |
| Sum 1 | |
| Compulsory psychiatric care | |
| The placing of a patient in isolation during a period where there was no decision on compulsory care | JO 2017/18 s. 113 (reg.no. 6694-2016) |
| Administering food and medicine via a tube against a patient's will | reg.no. 2782-2018 |
| Sum 2 | |
| Total 13 cases | |

APPENDIX
D

Issues where the Parliamentary Ombudsmen has requested feedback

| The police authority | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| Reporting of the measures taken to give the detainees in a police custody facility the opportunity to spend daily time outdoors (Umeå police custody facility). | reg.no. 3301-2015 |
| Reporting of the measures taken after criticisms of shortcomings in police custody facilities and an exercise yard (Östersund police custody facility). | reg.no. 871-2016 |
| Reporting of the measures taken to ensure that there is always a foreman scrutiny (Strömstad police custody facility). | reg.no. 4102-2016 |
| Sum 3 | |
| The Prison and Probation Service | |
| Report on the measures taken by the authority to ensure that body searches of visitors to institutions are always preceded by an individual assessment (Ljustadalen prison). | reg.no. 3458-2015 |
| Report on the measures taken to improve the conditions at a temporary remand operation (Östersund remand prison). | reg.no. 872-2016 |
| Report on how the authority is working on isolation-breaking measures in relation to individuals on remand (Huddinge, Kronoberg, Gävle and Sollentuna remand prison). | reg.no. 416-2017 |
| Report on the measures taken to improve the registration premises in a remand centre (Huddinge remand prison). | reg.no. 416-2017 |
| Report on the measures taken to improve the conditions in a temporary remand operation (Halmstad prison). | reg.no. 582-2017 |
| Report on the measures taken as a result of the points of view presented by the Parliamentary Ombudsmen at a small remand section (Ystad remand prison). | reg.no. 583-2017 |
| Sum 6 | |

| The Migration Agency | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| Report on the measures taken as a result of the points of view presented by the Parliamentary Ombudsmen regarding a detention centre's isolation room (Kållerød detention centre). | reg.no. 1000-2017 |
| Sum 1 | |
| Compulsory psychiatric care | |
| Report on measures taken in order to ensure that the supervision of the patients is made in a safe way and that the patients have the opportunity to spend time outdoors on daily basis (In-patient general psychiatry in Karlstad). | reg.no. 2945-2017 |
| Report on measures taken in order to ensure that the supervision of the patients is made in a safe way, that the patients have the opportunity to spend time outdoors on daily basis and that the patients get information about their legal rights in a language they understand (BUP Stockholm). | reg.no. 3816-2017 |
| Report on measures taken in order to ensure that the patients have the opportunity to spend time outdoors on daily basis (In-patient general psychiatry and BUP Luleå) | reg.no. 4043-2017 |
| Sum 3 | |
| Total 13 reports | |





THE SWEDISH PARLIAMENTARY OMBUDSMEN – JO

Box 16327
Västra Trädgårdsgatan 4 A
SE-103 26 Stockholm
SWEDEN

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

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

Opening hours 09.00–11.30 och 13.00–15.00

