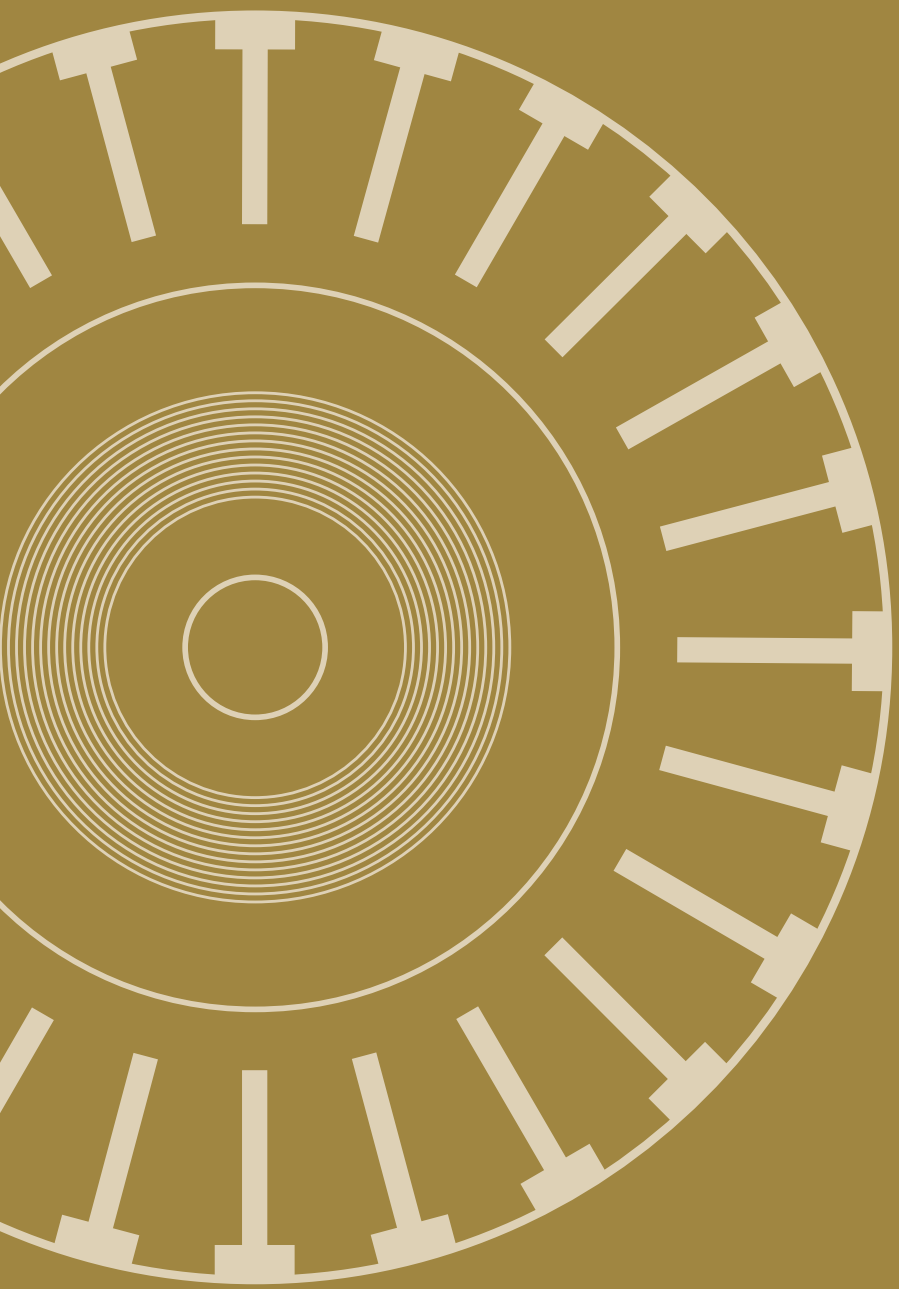
National Preventive Mechanism – NPM

REPORT ON THE ACTIVITIES 2020-21



JO RIKSDAGENS OMBUDSMÄN
The Swedish Paliamentary Ombudsmen

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

Foreword

Our role as a National Preventive Mechanism (NPM) under OPCAT includes regular inspections of places where people are deprived of their liberty. With the outbreak of the pandemic in 2020, it impacted our society and daily lives in a way unprecedented in modern times. We were able to establish early on that one of the groups at particular risk of being affected by the pandemic was people deprived of their liberty, and that it was very important that we continued our inspection activities to the extent possible. However, the pandemic meant that we needed to make special considerations to be able to carry out our work as a National Preventive Mechanism in a responsible manner. During 2020 and the spring of 2021, we carried out inspections using other tools than only physical visits. For example, digital interviews were conducted with inmates and staff, questionnaires were sent out to inmates and, for physical visits, conversations were conducted outdoors. Other digital inspections also took place and a great number of issues relating to individuals deprived of their liberty were reviewed within the scope of our supervisory activities. The inspections and other investigations that we carried out provided us good opportunities to contribute knowledge and analyses, which in the future can help ensure that measures taken in the event of similar major pressures on society are appropriate, legally secure, and proportionate. Some of the experiences and conclusions are set out in the report published by the Parliamentary Ombudsmen in December 2020, concerning the situation for people deprived of their liberty during the COVID-19 pandemic. A summary of this report can be found in Section 10.

Although we maintained our inspection activities to some extent during the pandemic, we were pleased to be able to resume our physical inspections in the autumn of 2021.

In addition to inspections, we have held several dialogue meetings with civil society. As part of the role as a National Preventive Mechanism, the Parliamentary Ombudsmen also submitted opinions in 2020 and 2021 on Sweden's eighth report to the UN Committee Against Torture in connection with the periodic report, which normally takes place every six years.

In conclusion, we can establish that supervision of the situation of individuals deprived of their liberty is greatly affected by external factors and, for this reason, it is also of great importance that we can continue to contribute to the preventive work to prevent inhumane treatment, etc., through regular visits.

Erik Nymansson
Chief Parliamentary Ombudsman

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Content

1 The OPCAT activities

The OPCAT activities

Under the 1984 UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the 'Convention against Torture'), the States Parties have undertaken to take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction. Explicit prohibitions on torture are also included in a number of other UN conventions.

The European Convention on Human Rights (ECHR) and the Charter of Fundamental Rights of the European Union (EU Charter) also prohibit torture. The ECHR has applied as Swedish law since 1995. In addition, the Swedish Instrument of Government includes a prohibition on torture. According to the Instrument of Government, every individual is protected against corporal punishment, and no one may be subjected to torture or undue medical influence for the purpose of forcibly extracting or obstructing statements.[1]

1.1 Torture and cruel, inhuman or degrading treatment

The first article of the UN Convention against Torture contains a relatively comprehensive definition of the term torture. In short, torture means that someone is intentionally subjected to severe psychological or physical pain or suffering for a specific purpose, such as to extract information forcibly or to punish or threaten a person. The Convention lacks definitions of cruel, inhuman or degrading treatment.

The European Court of Human Rights (ECHR) has stated that inhuman treatment should include, at a minimum, such treatment that intentionally causes someone serious mental or physical suffering and which, in a specific situation, can be considered unjust. Degrading treatment refers to actions that evokes a feeling of fear, anxiety, or inferiority in the victim. A treatment can be degrading even if no one but the victim has witnessed or learned about it.

1.2 The Convention Against Torture and OPCAT

The Convention Against Torture has been in force in Sweden since 1987. State parties to the Convention are examined by a special committee, the Committee against Torture (CAT). States Parties must regularly report on their compliance with the Convention. If allowed by a State Party, individuals may also complain to the Committee. Sweden allows individual complaints. The Convention against Torture does not in itself give the CAT a mandate to conduct visits of member states.

1 Chapter 2, Section 5 of the Instrument of Government.

To enable, inter alia, international visits, the Optional Protocol to the Convention against Torture (OPCAT) was adopted in 2002. The Protocol entered into force in 2006. OPCAT established an international committee, the Subcommittee on Prevention of Torture (SPT).

The CAT periodically reviews Sweden, normally every six years. As part of the review, the Parliamentary Ombudsmen, in their role as National Preventive Mechanism, have been given the opportunity to submit an opinion on Sweden's eighth report on compliance with the UN Convention against Torture. A statement was issued by then Chief Parliamentary Ombudsman Elisabeth Rynning in October 2020. The review was postponed due to the pandemic and a supplementary statement by Chief Parliamentary Ombudsman Erik Nymansson was submitted in October 2021.[2] The review of Sweden took place in November 2021 and the CAT submitted its report in December 2021.[3]

1.3 Preventive activities

The work performed in accordance with OPCAT shall be conducted with the aim of strengthening, if necessary, the protection of individuals deprived of their liberty against torture and other cruel, inhuman, or degrading treatment or punishment. Preventive work can be carried out in several ways, including through supervision in environments where the risk of abuse and violations is particularly high.

Another important part of the preventive work is to identify and analyse factors that can directly or indirectly increase or reduce the risk of torture and other forms of inhumane treatment, etc. The work must be proactive and dedicated to systematically reducing or eliminating risk factors and strengthening preventive factors and safeguard mechanisms. Furthermore, the work must have a long-term perspective and focus on achieving improvements through constructive dialogue, proposals for safeguard mechanisms and other measures.

1.4 OPCAT activities in Sweden

States party to OPCAT are required to designate one or more bodies charged with the role of National Preventive Mechanism (NPM). Since 1 July 2011, the Ombudsmen have been fulfilling the role of National Preventive Mechanism (NPM) in accordance with OPCAT.[4] In assigning the Ombudsmen this role, the Committee on the Constitution stated that the tasks and powers that the Parliamentary Ombudsmen have had for many years matches the tasks of an NPM.

2 See the Parliamentary Ombudsmen's statements in ref. no. O 67-2019 and O 26-2021.

3 Concluding observations on the eighth periodic report of Sweden, website of the United Nations Human Rights Treaty Bodies, CAT/C/SWE/CO/8.

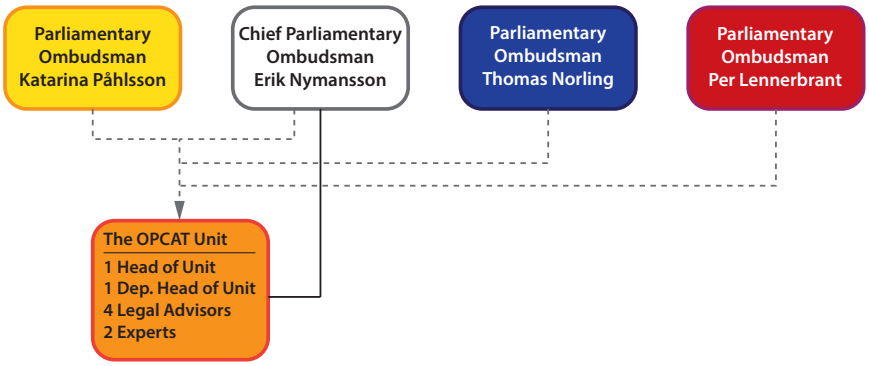
4 Section 5 a of the Act with Instructions for the Parliamentary Ombudsmen (SFS 1986:765).

An NPM has the following tasks:

- regularly inspecting places where individuals may be deprived of their liberty;
- making recommendations to the competent authorities with the aim of improving the treatment of and conditions for individuals deprived of their liberty and preventing torture and other cruel, inhuman, or degrading treatment or punishment;
- submitting proposals and comments on existing or proposed legislation relating to the treatment and conditions of individuals deprived of their liberty;
- engaging in dialogues with competent authorities and civil society; and
- reporting on the OPCAT activities.

The Parliamentary Ombudsmen have assessed that the places to be inspected within the scope of this assignment are primarily prisons, remand prisons, police detention facilities, facilities for compulsory psychiatric care and forensic psychiatric care, the Swedish Migration Agency's detention centres, and the National Board of Institutional Care's special residential homes for young people and residential homes for the compulsory care of substance abusers.

A special OPCAT unit is tasked with assisting the individual Parliamentary Ombudsmen in their role as NPM. The work primarily consists of planning and carrying out inspections of places where individuals may be deprived of their liberty. Two experts (a medical expert and an expert in psychology) are part of the OPCAT activities.



1.5 Dialogue forum

In January 2020, a dedicated forum for dialogue with civil society on the situation and rights of individuals deprived of their liberty was established.[5] The starting point is that the Parliamentary Ombudsmen invite a number of stakeholders from civil society to a meeting two times a year.

5 See the Parliamentary Ombudsmen's decision in ref. no. ADM 39-2020.

In 2020 and 2021, dialogue meetings were held in the spring and autumn, a total of four meetings. At these meetings, the Ombudsmen have presented current issues within their respective areas of responsibility. The special review carried out by the Parliamentary Ombudsmen in connection with COVID-19 has also been presented.[6] In addition, discussions have been held, including on the basis of civil society's alternative report to the UN Committee Against Torture. The Children's Rights Agency has also presented its report on violence against children in special residential homes for young people.

1.6 International oversight bodies

SPT has 25 independent members who are experts in areas relevant to the prevention of torture. The members are appointed by the States party to the Protocol. An annual schedule determines which countries the SPT will visit.

The European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment entered into force in 1989. The Convention established the European Committee for the Prevention of Torture (CPT), whose main task is to regularly visit institutions in Europe for individuals deprived of their liberty. All 47 member states of the Council of Europe have ratified the Convention. Swedish authorities are obliged to cooperate with the SPT and CPT.[7]

1.7 The Nordic NPM Network

The Nordic NPM network (which was formed in 2015) held two meetings in 2020, one in Oslo where the theme was the rights of children deprived of their liberty and one digital meeting. In 2021, three digital meetings were held. The digital meetings were led from Oslo, Copenhagen, Stockholm, and Helsinki, and the central theme of the meetings was how the NPM mandate could be fulfilled during the pandemic. Methodological issues were also discussed at the meetings.

1.8 Purpose of this report

This report contains a summary of the observations made by the Parliamentary Ombudsmen as part of the OPCAT activities in 2020 and 2021. 2020 started with on-site inspections, but in mid-March the planned inspections were cancelled as a result of the pandemic. The Ombudsmen considered it important to be able to maintain inspection activities as much as possible. They therefore decided to investigate each of the authorities responsible for individuals deprived of their liberty in the spring of 2020. These reviews and

6 The report *Situation for people deprived of their liberty during the COVID-19 pandemic. The Parliamentary Ombudsmen's review of the measures taken by four authorities.*

7 Act (SFS 1988:695) on Certain International Undertakings Against Torture etc.

the methods of conducting them have been presented in a special thematic report.[8] In autumn 2021, it was possible to carry out a limited number of on-site inspections. As part of the preventive work, a decision concerning the isolation of inmates in remand prisons has been presented in a special thematic report.[9] In 2019, OPCAT activities had a thematic focus on domestic transportation of individuals deprived of their liberty. A special interim report on transport was presented in June 2019.[10] The final report was published in September 2021.[11]

8 See a summary of the report *Situation for people deprived of their liberty during the COVID-19 pandemic. The Parliamentary Ombudsmen's review of the measures taken by four authorities*.

9 See the report *Theme: Isolation of inmates in remand prisons*.

10 See the report *Theme: Transport*.

11 See a summary of the report *Transport of individuals deprived of their liberty, Section 9*.

2

OPCAT inspections

OPCAT inspections

One of the most important features of the Parliamentary Ombudsmen's OPCAT activities is the inspections of places where people may be held deprived of their liberty. As in previous years, the inspections that could be carried out on site during the period January–March 2020 and during autumn 2021 primarily covered activities that had not previously been inspected by the Parliamentary Ombudsmen or not been inspected for a long time. When planning the inspections, the ambition was for the work to have a good geographical spread. The Parliamentary Ombudsmen's traditional supervisory activities and the Parliamentary Ombudsmen's assignment under OPCAT have many similarities. For this reason, as a rule, employees from the OPCAT Unit participate in inspections conducted by the supervisory departments of places where people may be held deprived of their liberty. For the same reason, employees from the supervisory departments participate in inspections assigned to the OPCAT Unit.

Since December 2020, the Parliamentary Ombudsmen have access to a medical expert and an expert in psychology. They participate in inspections and other investigations related to individuals deprived of their liberty.

2.1 Method

The annual report 2015-2017 includes an account of the method used in an OPCAT inspection.[1] In 2020, special housing established for one user was also inspected in accordance with the Act Concerning Support and Service for Persons with Certain Functional Impairments (SFS 1993:387) (LSS) (see section 8). The inspection was carried out after information had emerged alleging that the user had been deprived of their liberty.

2.2. Places where individuals may be deprived of their liberty

In 2020 and 2021, individuals were deprived of their liberty at, inter alia, the following places:

- 124 police custody facilities with approximately 1,300 beds (Swedish Police Authority)
- 32 remand prisons with approximately 2,300 beds (Swedish Prison and Probation Service)
- 45 prisons with approximately 4,500 beds (Swedish Prison and Probation Service)
- 21 special residential homes for young people with approximately 700 beds (National Board of Institutional Care, SiS)

1 See the report *National Preventive Mechanism – NPM, 2015–2017.*

- 11 residential homes for the compulsory care of substance abusers with approximately 400 beds (National Board of Institutional Care)
- At least 80 institutions for compulsory psychiatric care and forensic psychiatric care with approximately 4,100 beds (21 regions)
- 6 migration detention centres with approximately 300 beds (Swedish Migration Agency)

The figures presented above are partly based on estimates. The account only includes permanent beds. The high occupancy rate and strained capacity within the Swedish Prison and Probation Service has led to ongoing work within the authority to create different types of temporary beds. Such beds are not included in the account. A comparison with the 2019 annual report shows that the number of beds in the Swedish Migration Agency's detention centres has decreased, which, according to the agency, is explained by an adaptation to reduce the risk of COVID-19 infection.

2.3 Inspections carried out

In 2020, 18 inspections were carried out as part of the OPCAT mission. Of these, 12 agencies were inspected within the scope of the investigation of the situation for people deprived of their liberty during the COVID-19 pandemic.[2]

In 2021, 16 inspections were carried out. The inspections of special residential homes for young people were carried out within the scope of a thematic review of young people's safety and security in the National Board of Institutional Care's special residential homes for young people. The inspections of compulsory psychiatric care facilities were carried out as part of an investigation of long periods of stay in forensic psychiatric inpatient care.

Inspection item	2020	2021
Police custody facilities	3	3
Remand prisons	3	3
Prisons	4	
Special residential homes for young people	1	4
Special residential homes for substance abusers	1	
Psychiatric units[3]	3	5
Swedish Migration Agency's Migration detention centres	2	
LSS housing with special services	1	
The National Board of Institutional Care, Placement Unit		1
Total	**18**	**16**

For a full account of the inspections carried out, see Annex B.

2 See *Report 2020 – Situation for people deprived of their liberty during the COVID-19 pandemic. The Parliamentary Ombudsmen's review of the measures taken by four authorities.*

3 Two of the inspections concerned the National Board of Forensic Medicine's investigation units.

In 2021, the Parliamentary Ombudsmen's supervisory units carried out two additional inspections of places where people may be held deprived of their liberty (one remand prison and one prison). Employees from the OPCAT Unit also participated in the two inspections.[4]

4 Uppsala remand prison and Skänninge prison.

3

The Police Authority

The Police Authority

The Police Authority has the power to hold people in police custody facilities. At the end of 2021, there were 124 police custody facilities with a total of about 1,300 beds. Individuals apprehended or arrested are among those placed in police custody facilities. Individuals detained due to intoxication under the Care of Intoxicated Persons Act (SFS 1976:511) are also regularly placed in police detention facilities.

In 2020 and 2021, a total of six police custody facilities were inspected, one of which was inspected for the first time.[1] The inspections were carried out on site; three were unannounced and three were announced.

All inspections were carried out by or on behalf of Parliamentary Ombudsman Per Lennerbrant.

3.1 Observations made during the inspections

Police custody facilities are intended for deprivation of liberty for anything from a few hours to a few days at most. Inspections of police custody facilities focus primarily on how the basic needs of the individuals deprived of their liberty are met. These include their right to food, their ability to meet their individual hygiene needs and daily outdoor access, as well as receiving the necessary information and being treated in a dignified manner. Another key issue is how to ensure the safety and security of individuals deprived of their liberty. It is not uncommon for individuals held in police custody facilities to be in poor physical and mental condition. It is therefore important to make a safety and security assessment of each individual held in a police custody facility. Based on that assessment, it is then important that individuals deprived of their liberty are regularly monitored and that this monitoring is documented. Another aspect in this context is that the individuals deprived of their liberty's need for health and medical care is met. In most police custody facilities, the Swedish Police Authority is responsible for staffing and supervising the inmates. However, the Police Authority occasionally transfers the operation of a police detention facility to the Prison and Probation Service or the staffing of a police custody facility to a security company.

Communication between station commanders and detention guards

A police officer who has detained an individual into custody in accordance with the Police Act or the Care of Intoxicated Persons Act must report this ac-

1 The police custody facilities in Borås, Eskilstuna, and Varberg were inspected in 2020 and the police custody facilities in Västberga, Malmö, and Karlstad were inspected in 2021. The Borås police custody facility was inspected for the first time.

tion to their supervisor as soon as possible. If custody has not already ended, the supervisor must immediately review whether it should continue.[2] In a police custody facility, it is usually a custody officer who conducts the review and security assessment and decides on the frequency with which the inmate is to be looked after.

During the inspection of the *police custody facility in Varberg*, it emerged that the custody officer had a routine of going out and informing themselves about the situation in the detention facility, both when starting and finishing their shifts. The police custody facility staff were of the opinion that they had a good contact with the custody officers.

Following the inspection, the Parliamentary Ombudsman stated that, as a rule, a custody officer is responsible for the inmates in the police custody facility. However, the custody guards have a great responsibility to ensure, through proper supervision, that the inmates are not harmed during their stay in the police custody facility. In the performance of their duties, custody guards may be faced with more or less difficult situations, where they need the support of the custody officer. Furthermore, the custody officer needs to have a good knowledge of the situation in the police custody facility to be able to make correct decisions regarding the inmates. For example, it may be a decision to change the frequency of supervision, call a doctor, or release a detainee. According to the Parliamentary Ombudsmen, a well-functioning police custody facility requires good cooperation between the station commanders and the detention guards. In particular, the Parliamentary Ombudsman emphasised the custody officers' routine of going out and informing themselves about the situation in the police custody facility, both when starting and finishing their shifts. This provides good conditions for the communication between the custody officer and the custody guards, which, according to the Parliamentary Ombudsmen, is necessary for creating a safe and secure environment for the inmates.[3]

A good cooperation between custody officers and custody guards is required for a well-functioning police custody facility

During an inspection of *the police custody facility in Eskilstuna*, it emerged that there was both an actual and perceived distance between custody staff and the custody officers. The custody guards felt that the supervisor rarely was in the police custody facility and that great responsibility had been placed on the custody guards to contact the custody officer if necessary. Following the inspection, the Parliamentary Ombudsman stated, inter alia, that the Police Authority should consider whether there were grounds to review the procedures for the custody officers contact with the custody facility staff so that the custody officers more actively take part of what happens in the custody facility. In this context, the Parliamentary Ombudsman emphasised the custody officers' routine in the Varberg police custody facility to visit the

2 See Section 15 of the Police Act and Section 5 of the Care of Intoxicated Persons Act.

3 See the Parliamentary Ombudsmen's report, ref. no. O 8-2020.

custody facility and inform themselves about the situation there, both when starting and finishing their shifts. Of course, there may be grounds for the custody officer to go out to the premises of the police custody facility more often than that.[4]

The Police Authority's management of police custody facility when staffed by a security company or the Prison and Probation Service

During the inspection of the *Västberga police custody facility*, it emerged that the Stockholm Police Region had entered into an agreement with a security company regarding the staffing of the custody facility. The police custody facility staff were supervised by a police officer with special responsibility for the detention operations. During the inspection, it was clear that these police officers were uncertain about the duties of their supervisory role and who was responsible for different parts of the detention operations.

Following the inspection, the Parliamentary Ombudsman stated that the findings gave the impression that the responsible supervisors excessively hand over responsibility for the day-to-day operations of the police custody facility to the employees of the security company. Furthermore, there was uncertainty about what the role of custody officer in charge of the police custody facility entails and a varying degree of knowledge of important routine matters. Therefore, according to the Parliamentary Ombudsman, it was not possible to draw any other conclusion than that the supervisor in charge of the police custody facility in Västberga generally do not have such control over the detention operations that a responsible officer should have. This can have a negative impact on the safety and security of inmates.

The Police Authority is responsible for ensuring that the detention operations are carried out in accordance with applicable rules and regulations, also when staffed by a security company

The Parliamentary Ombudsman emphasised that, even in the event of a contractual agreement with a security company, the Police Authority is responsible for the detention operations being carried out in accordance with applicable rules and regulations. Furthermore, the Parliamentary Ombudsman considered that the Police Authority needs to follow up on how supervision was exercised in the police custody facility and ensure that the officer in charge at any given time has the prerequisites and knowledge required for the task.[5]

During the inspection of the *police custody facility in Karlstad*, it was revealed that, according to an agreement between the Police Authority and the Prison and Probation Service, the Prison and Probation Service was responsible for the operation of the custody facility and for the supervision of arrested and detained persons as well as of detainees under the Care of Intoxicated Persons Act or the Police Act in the police custody facility. Following the inspec-

4 See the Parliamentary Ombudsmen's report, ref. no. O 3-2020.

5 See the Parliamentary Ombudsmen's report, ref. no. O 21-2021.

tion, the Parliamentary Ombudsmen stated that the Police Authority is the authority ultimately responsible for the activities in police custody facilities. The Police Authority's overall responsibility therefore remains even if an agreement is reached with another authority on the day-to-day operation of the police custody facility, provided that there are no statutory provisions to the contrary.

The Parliamentary Ombudsman expressed understanding that there may be practical advantages for the Police Authority to cooperate with the Prison and Probation Service in certain localities. However, agreements on cooperation between the authorities may entail risks for the inmates. The Parliamentary Ombudsman emphasised that there must never be any ambiguity about, for example, who is to carry out the supervision in the day-to-day operations and at what interval. Nor must there be any ambiguity as to what applies to access to health and medical care.[6]

Shortcomings in the physical environment

A cell in a police custody facility should have windows so that it gets enough daylight. In addition, a cell shall be equipped with a daylight control device.[7]

During the inspection of *the police custody facility in Borås*, it was discovered that several of the cells in the police custody facility had windows with fully frosted glass. In addition to the fact that it was impossible to see out of the windows, the frosted glass meant that there was a semi-darkness in the cells even during the daytime. All windows also lacked blinds or similar devices, which meant that the inmates could not regulate the inflow of natural light when they were going to sleep. In addition, there were spaces between the fixtures and the wall of the holding cells which made it possible for an inmate to fasten, for example, a noose and thus try to harm themselves. During the inspection, it emerged that there were far-reaching plans to build a new police station in Borås with a police custody facility.

Following the inspection, the Parliamentary Ombudsman stated that it will probably be a number of years before there is a new police custody facility, and that, in the meantime, the Police Authority should take measures to improve the environment in the current police custody facility. In addition to changing the cell windows, the authority should, according to the Parliamentary Ombudsman, also consider acting on, inter alia, dangerous interior fittings in the cells.[8] Similar statements were made by the Parliamentary Ombudsmen following the inspection of *the police custody facility in Eskilstuna*.[9] During that inspection, it was also revealed that the Eskilstuna police custody

6 See the Parliamentary Ombudsmen's report, ref. no. O 33-2021.

7 See Section 2 of the Ordinance on Remand Prisons and Police custody facilities (SFS 2014:1108) and Chapter 1, Section 8 of the Swedish Police Authority's Regulations and general advice on Police custody facilities, PMFS 2015:7, FAP 102-1.

8 See the Parliamentary Ombudsmen's report, ref. no. O 1-2020.

9 See the Parliamentary Ombudsmen's report, ref. no. O 3-2020.

facility is housed on two floors and that inmates when transferred to the upper floor of the custody facility must be taken via, among other things, a narrow spiral staircase. The Parliamentary Ombudsman pointed out that this is a security risk and that the Police Authority should investigate in what ways it could be reduced or completely eliminated.[10]

Holding cubicles

During the inspection of *the police custody facility in Västberga*, two so-called holding cubicles were observed, located adjacent to the police custody facility's area for registration. The holding cubicles were windowless spaces with a floor area of about one square metre. About half of the floor area was occupied by a bench. In conversations with staff, it emerged that there had been cases of people being locked up in the holding cubicles for short periods. However, no clear answers were given as to which situations would prompt the use of the holding cubicles.

Following the inspection, the Parliamentary Ombudsman expressed an understanding that there may be a need for placing an individual deprived of their liberty in a holding cubicle for a short period of time in certain situations. The Parliamentary Ombudsman pointed out that a placement in a holding cubicle should be supported by law and noted that there is no such regulation. A copy of the report was therefore submitted to the Government Offices for information.[11]

It needs to be regulated when inmates can be placed in holding cubicles

Security assessment and supervision

A safety assessment must be carried out as soon as possible after intake. The purpose of the security assessment is to assess the need for security measures concerning the detainee, for example in connection with transport, to maintain order and security in the police custody facility or in case of danger to the inmate's or other person's life or health.[12] The security assessment must be documented on the nationally produced form *Säkerhetsbedömning avseende intagna i polisarrest* [Security Assessment for Inmates in Police Custody Facility].[13] In connection with placement in a cell, the responsible supervisor shall decide on the frequency of the supervision. The frequency of supervision shall continuously be reviewed. The decision on the frequency of supervision must be documented, among other things, on the security assessment form. If necessary, the decision shall also include instructions on how to check the inmate's condition in greater detail.[14]

10 See the Parliamentary Ombudsmen's report, ref. no. O 3-2020.

11 See the Parliamentary Ombudsmen's report, ref. no. O 21-2021.

12 See Chapter 1, Section 6 of the Swedish Police Authority's Regulations and general advice on Police Detention Facilities, PMFS 2015:7, FAP 102-1.

13 See appendix 9 to the Swedish Police Authority's manual for police custody facilities.

14 See appendix 11 to the Swedish Police Authority's manual for police custody facilities.

During the inspection of the *Borås police custody facility*, a review of a number of security assessments showed that the Police Authority had only assessed there was an increased risk in one case. Furthermore, it emerged that the police custody facility applied a standardised system for the frequency of supervision of individuals deprived of their liberty. Following the inspection, the Parliamentary Ombudsman emphasised the importance of conducting a thorough security assessment in each individual case. According to the Parliamentary Ombudsman, if the person conducting the security assessment is concerned about the detainee's mental health, this must also be reflected in the decision on supervision. It is not enough to give the person carrying out the supervision a verbal instruction.[15]

During the inspection of the *Karlstad police custody facility*, it emerged that, according to an agreement between the Police Authority and the Prison and Probation Service, the Prison and Probation Service was responsible for the operation of the police custody facility and for the supervision of arrested and detained persons as well as of detainees under the Care of Intoxicated Persons Act or the Police Act in the police custody facility. As a result of this arrangement, the Parliamentary Ombudsman indicated a number of areas where the agreement could pose risks for the inmates. According to recommendations from the Police Authority in the Authority's manual for police custody facilities, a detained person must be checked at least once an hour. During a parallel inspection of the Karlstad remand prison, it emerged that the prison staff did not check on the detainees in the custody facility with the regularity stated in the manual for police custody. Detainees in the Karlstad police custody facility thus risk not receiving the supervision that they would have received if they had been placed in a custody facility operated by the Police Authority. In the opinion of the Parliamentary Ombudsmen, it was not acceptable that the Police Authority seemed to accept a different standard of supervision in the Karlstad police custody facility. What emerged from the two inspections also showed that there were different opinions among the supervisors on the one hand and the prison staff on the other as to what applied to the examination of an inmate's need for supervision, which is of course also not acceptable. As the situation was described, there was, in the Parliamentary Ombudsmen's opinion, a clear risk that there could be ambiguity about how the supervision shall be carried out.[16]

Ability to maintain confidentiality between authorities

During the inspection of the *Karlstad police custody facility*, it emerged that the Police Authority's supervisor's assessment and security assessment took place in the presence of the Prison and Probation Service's staff. In conver-

15 See the Parliamentary Ombudsmen's report, ref. no. O 1-2020.

16 See the Parliamentary Ombudsmen's report, ref. no. O 33-2021.

sations with the Prison and Probation Service's staff, they stated that it gives them an opportunity to ask supplementary questions about, for example, illnesses and medications when an individual deprived of their liberty is admitted. During the inspection of the remand prison, it was also revealed that the Police Authority receives a copy of the Prison and Probation Service's supervision sheet in connection with release from the police custody facility.

Following the inspection, the Parliamentary Ombudsman stated that, as a general rule, confidentiality applies between authorities.[17] It appears likely that information obtained in the course of a security assessment, such as health status, is covered by confidentiality. Admittedly, there are provisions in the Public Access to Information and Secrecy Act (OSL) that override the secrecy between authorities. The Parliamentary Ombudsman did not know exactly what considerations lay behind the scheme described or if there had been any consideration of whether it was compatible with, for example, the Public Access to Information and Secrecy Act. The observations raised the question of whether it is possible to maintain confidentiality when two authorities cooperate in a police custody facility the way they did in Karlstad. According to the Parliamentary Ombudsman, it rather appeared as if the authorities had designed a working method that primarily saw to their practical needs.

Treatment

During the inspection of the *Eskilstuna police custody facility*, it emerged that male custody guards had supervised detained women who, for security reasons, had been stripped of their clothing and thus stayed in their cells naked. The Parliamentary Ombudsmen have previously stated that supervision by male staff should be avoided or limited in such a situation. During the same inspection, it was also found that those taken into custody due to intoxication were not usually given access to a blanket. One of the reasons given for this was that a blanket complicates the supervision of the inmate.

Following the inspection, the Parliamentary Ombudsman pointed out that an inmate – regardless of gender – staying in a cell naked is in a very vulnerable situation. For this reason, according to the Parliamentary Ombudsmen, female custody guards should not supervise male inmates in such a situation. Furthermore, the Parliamentary Ombudsmen pointed out that a prisoner e.g. should be provided with bedding. The equipment may be restricted if necessary to prevent the inmate from harming themselves or others.[18] This means that, as a rule, people taken into custody due to intoxication should also be offered a blanket when they are admitted to the custody facility. In the opinion of the Parliamentary Ombudsmen, the fact that the blanket risks complica-

17 See Chapter 8, Section 1 of the Public Access to Information and Secrecy Act (OSL).

18 See Chapter 3, Section 3 of the Police Authority's Regulations and general advice on Police custody facilities, PMFS 2015:7, FAP 102-1.

ting supervision is not an acceptable reason for regularly denying a blanket to those taken into care.[19]

During the inspection of *the police custody facility in Västberga*, it was reported that the custody guards regularly restricted inmates' access to e.g. sheets and shoes. Following the inspection, the Parliamentary Ombudsmen stated that the Police Authority's own regulations state that inmates must be provided with bedding and, if necessary, clothing and footwear. Restrictions on such equipment may only be made if it is necessary to prevent the inmate from seriously injuring themselves or others. This is an assessment that must be made in each individual case and, according to the Parliamentary Ombudsmen, it is not possible to systematically limit inmates' access to sheets or shoes. As a rule, such an assessment must be made by the responsible supervisor in the police custody facility.[20]

During the inspection of *the police custody facility in Borås*, it emerged that inmates had to hand over their glasses for security reasons on a regular basis. In addition to the fact that the inmate could temporarily get the glasses back if they needed to read, the glasses were not returned until the inmate left the police custody facility. The Parliamentary Ombudsman emphasised that the seizure of an inmate's glasses must be preceded by an examination of whether possession could jeopardise order and security. It is therefore not acceptable for inmates to regularly be deprived of their glasses when they are admitted to the police custody facility.[21]

There must be an examination of whether the possession of glasses in a cell could jeopardise order and security

Children in police custody facilities

A person under the age of eighteen who has been arrested or detained may, according to Section 6 a of the Young Offenders Act (LUL), be held in police custody only if it is absolutely necessary. The provision entered into force on 1 July 2021. The Government Bill for the provision stated, inter alia, the following. A police custody facility is not adapted to the special needs of a child and a placement, even temporarily, in a police custody facility should be avoided as it is not a suitable environment for children. Only in exceptional cases may the detention of children in a police custody facility be considered.[22]

During the inspection of the *Malmö police custody facility,* it emerged that there is a furnished room adjacent to the custody facility where children who are arrested or detained can be placed and kept under surveillance. It also emerged that children were sometimes placed in a cell in the police custody facility if the child stayed overnight, there was overcrowding in the remand prison, or the Police Authority could not allocate staff to monitor the child in the special room.

19 See the Parliamentary Ombudsmen's report, ref. no. O 3-2020.

20 See the Parliamentary Ombudsmen's report, ref. no. O 21-2021.

21 See the Parliamentary Ombudsmen's report, ref. no. O 1-2020.

22 See Government Bill 2019/20:129 p. 46 and 60.

Following the inspection, the Parliamentary Ombudsmen stated that the provision in Section 6 a of the Young Offenders Act and the clear intentions of the legislation require the Police Authority to plan and have the capacity to ensure that several, sometimes many, children are arrested or detained at the same time. In a large city like Malmö, this is often the case. According to the Parliamentary Ombudsmen, the Police Authority's premises in the Malmö police custody facility and the organisation that existed at the time of the inspection appeared to lack capacity to handle children who are arrested or detained. These circumstances may lead to children being held in the police custody facility even in cases other than those intended by the legislator. The Parliamentary Ombudsmen finds this unacceptable.

During an inspection of the *Karlstad police custody facility*, it emerged that the custody officer's perception was that children had previously been placed in a cell in the custody facility, but that new routines had been introduced and that this no longer occurred. The Parliamentary Ombudsmen were positive to the fact that the provision that children may not be held in a police custody facility unless it is absolutely necessary seemed to have led to a changed working method in the Karlstad police custody facility.

Healthcare in police custody facilities

An individual deprived of their liberty in a police custody facility who is in need of health and medical care must be examined by a doctor. A doctor must also be summoned if the individual deprived of their liberty so requests and it is not obvious that such an examination is unnecessary. An individual deprived of their liberty in a police custody facility who is in need of health and medical care must be treated as instructed by a doctor. If the individual deprived of their liberty cannot be examined or treated properly in the custody facility, the national health system must be used. If necessary, the individual deprived of their liberty must be taken to hospital.[23] Each custody facility shall have access to a qualified medical practitioner and staff with adequate medical training.[24]

During the inspection of *the Västberga police custody facility*, it was noted that the inmates' medicines were stored openly in the custody guards' rooms and that no further details were documented, e.g. what medicines the inmate had taken. The representatives of the Police Authority stated at the final briefing that this was not in accordance with the Authority's procedures in the area. Following the inspection, the Parliamentary Ombudsman stated that if this had not already been done, he presumes that the Police Authority will take measures to rectify the shortcomings in the medication management.[25]

23 See Chapter 1, Sections 2 and 3 and Chapter 5, Section 1 of the Act on Detention (SFS 2010:611).

24 See Section 15 of the Ordinance on Detention (SFS 2010:2011).

25 See the Parliamentary Ombudsmen's report, ref. no. O 21-2021.

During the inspection of *the Malmö police custody facility*, it emerged that the Police Authority had contracted a care company that provided nurses in the police custody facility. The contract stipulated that the company is the healthcare provider and, as such, responsible for compliance with all relevant healthcare legislation. It emerged that the engaged care company trained a number of custody guards in the handling of medicines, etc. They were then delegated to distribute medicine to inmates in the police custody facility. Furthermore, there was a routine that the care provider had produced and in it was stated that custody guards should be present in a cell when the nurse has a conversation with an inmate.

Following the inspection, the Parliamentary Ombudsmen stated that the issue of the division of responsibilities between the care provider and the Police Authority, e.g. with regard to the delegation and medicine management, should be reviewed by the regular supervisory authority in the field of healthcare. A copy of the report was therefore sent to the Health and Social Care Inspectorate. [26]

During the inspection of *the Karlstad police custody facility*, it was clear from an agreement between the Police Authority and the Prison and Probation Service that the remand prison's health and medical care staff were not available to persons taken into custody due to intoxication, but to other inmates in the police custody facility. In the Parliamentary Ombudsmen's opinion, there is a risk that this type of special arrangement will lead to misunderstandings as to who is responsible for ensuring the inmate's access to healthcare. The Parliamentary Ombudsmen pointed out that an inmate in a police custody facility a few years ago got into trouble because the responsibility for healthcare was not clearly regulated between the Prison and Probation Service and the Police Authority.[27]

Furthermore, it followed from the agreement that the Police Authority was responsible for transporting persons taken into custody due to intoxication to hospital if necessary. A custody officer stated during the inspection that a security assessment is made of whether those detained under the Care of Intoxicated Persons Act can be placed in a cell in the police custody facility or if they should be taken to hospital. The assessment is made by custody officer. If the Prison and Probation Service makes the assessment that the person should instead be taken to hospital, the Police Authority drives the inmate there. Another custody officer was of the opposite opinion and stated that if the supervisor does not share the Prison and Probation Service's assessment, the person will be placed in a cell. The management of the Karlstad remand prison stated that the Prison and Probation Service can refuse to put an inmate in a cell if the prison staff makes the assessment that they are in such poor

26 See the Parliamentary Ombudsmen's report, ref. no. O 27-2021.

27 See JO 2014/15 p. 204, ref. no. 3076-2012.

physical or mental condition that the person is in need of hospital care. Thus, there were different opinions about who has the right to make decisions in a crucial issue for the inmate. According to the Parliamentary Ombudsmen, this is not acceptable and can lead to negative consequences for the inmates.[28]

3.2 Enquiries

Judicial assistance for a 13-year-old who has been taken into custody based on the Care of Young Persons Act

In connection with the OPCAT activities' thematic focus on the transportation of individuals deprived of their liberty, the Parliamentary Ombudsmen obtained anomaly reports on assisted transportation from the Police Authority. One of the reports revealed that a social welfare board had requested assistance (judicial assistance) from the Police Authority in transporting a 13-year-old girl who had been taken into custody under the Care of Young Persons Act (LVU) to one of the National Board of Institutional Care's youth homes. It was not until about 17 hours after the girl had been taken into custody that the transport could begin by car, and after just over 10 hours of transport, she arrived at the youth home. In light of the findings of the report, the Parliamentary Ombudsmen decided to investigate the handling of the case by the Police Authority, the National Board of Institutional Care, and the social welfare board in a special case.

The investigation showed that relatively soon after the girl had been taken into custody by a police patrol, a discussion arose between the Police Authority and the Emergency Social Services as to whether a representative of the social welfare board (i.e. staff from Social Services) should be present during the transport. The Police Authority made the assessment that it was appropriate, while the Emergency Social Services were of the opinion that it was not necessary. According to the Parliamentary Ombudsmen, the findings of the investigation showed the need for authorities and others who may need to participate in judicial assistance to have well-developed procedures. The person requesting judicial assistance must be prepared for questions relating to the request arising 24 hours a day. Furthermore, preparation should be made for staff to be able to be present during transport if necessary. The Parliamentary Ombudsmen stated that the question of whether staff should be present during the transport should be decided based on what is best for the young person.

According to the Parliamentary Ombudsmen, it is reasonable to require that there should be an overall plan for how the transportation shall be carried out. Furthermore, it should be possible for the person requesting judicial assistance to book a trip if necessary. Preparation must also be made by the

28 See the Parliamentary Ombudsmen's report, ref. no. O 33-2021.

requesting judicial authority for withdrawing the request and carrying out the transport by themselves, should it turn out that there is no need for special police powers. Such flexibility is necessary in order to avoid a young person being unnecessarily transported by the police or taken into a police custody facility.

The investigation showed that the girl was initially placed for a couple of hours in a civil police car parked in the custody facility intake. She then spent the night in a hotel and the next day she was transported by the Police Authority 760 km to the youth home. During the entire time she was in custody, she was accompanied by police officers or police personnel.

According to the Parliamentary Ombudsmen's assessment, the girl was not detained at any time during the time she was in police custody. The Police Authority's treatment of the girl had thus been in accordance with the Care of Young Persons Act. However, the Parliamentary Ombudsmen pointed out that even if the young person is not locked up in a cell and is with staff, a custody facility intake is usually an unsuitable environment for a young person. Persons suspected of a crime or persons who are apprehended due to intoxication are regularly admitted to a police custody facility. It is not uncommon for chaotic situations to arise that can make the environment feel unsafe for a young person. For this reason, according to the Parliamentary Ombudsmen, the starting point should be that persons under the age of 15 should not be taken into, an interrogation room or any other room in a police cutody facility while awaiting transport. Instead, the young person should be placed in some other suitable space together with staff.[29]

3.3 Concluding remarks by Parliamentary Ombudsman Per Lennerbrant

As of 1 July 2021, a person under the age of eighteen who has been arrested or detained may be held in police custody only if absolutely necessary. The legislator has assessed that a police custody facility is not adapted to the special needs of a child and a placement, even temporarily, in the police custody facility should be avoided as it is not a suitable environment for children. In 2021, during the inspections of the police custody facilities in Malmö and Karlstad, I drew attention to how they worked with the placing of children in custody. I was able to note that this regulation had not had a similar effect in the two police custody facilities. The Police Authority must ensure that children who are arrested or detained are not detained in a police custody facility other than when it is absolutely necessary. This, of course, applies to all police custody facilities in the country. I will continue to monitor this issue.

As a rule, deprivation of liberty in custody facilities does not last longer than a few days. It can be concluded that the environment in older police custody

29 See the Parliamentary Ombudsmen's decision of 20 April 2021 in ref. no. O 6-2020 and the Parliamentary Ombudsmen's final report Transportation of individuals deprived of their liberty 2021.

facilities does not meet the requirements that can be placed on the physical environment. The lack of daylight on the premises where individuals deprived of their liberty are placed remains a concern. During the inspections in Borås and Eskilstuna, it emerged that the Police Authority has far-reaching plans to build new police custody facilities. Newly built custody facilities usually provide an improved physical environment for inmates placed there. However, it often takes several years before a police custody facility can be put into use. I have therefore emphasised that, in the meantime, the Police Authority should take measures to improve the environment in the current police custody facilities.

For the safety and security of the inmates in the police custody facility, the security assessment is of fundamental importance. People who are very intoxicated are regularly placed in police custody facilities, and people who may be suffering from a mental illness are also admitted. The security assessment provides a basis for assessing whether the inmate is in need of medical care and how often he or she needs to be checked on in the police custody facility. Against this background, I have on several occasions pointed out the importance of a thorough security assessment in each individual case and of the assessment being fully documented.

The Police Authority has solved the staffing problem in police custody facilities in various ways, and it became clear during the inspection period that there is a risk that this will lead to ambiguity in various liability issues. In my statements, I have also stressed the need to maintain good communication between the police officer in charge and the custody guards to create a safe and secure environment for the individuals deprived of their liberty. Between 2020 and 2021, six people died while deprived of their liberty in a police custody facility. The Police Authority must continue to strengthen its security work in police custody facilities to prevent situations from arising that pose serious risks to the inmates. The Parliamentary Ombudsmen will continue to monitor the authority's work to ensure that those who work in police custody facilities have the training required for the assignment to be carried out in accordance with the regulations that apply to detention operations.

4

The Swedish Prison and Probation Service

The Swedish Prison and Probation Service

At the end of 2021, there were 32 remand prisons and 45 prisons in Sweden with a total of approximately 6,700 permanent beds. In addition, the Swedish Prison and Probation Service has beds for temporary needs, emergency beds in case of double occupancy and temporary beds in other types of rooms than resident rooms that do not meet the standard of cells. In 2020 and 2021, the use of emergency beds and temporary beds increased.[1]

The Prison and Probation Service's institutions primarily hold people who are deprived of their liberty because they are on remand or serving a prison sentence. Other categories of individuals deprived of their liberty are also placed in the Prison and Probation Service's remand prisons. For example, people who have been taken into care under the Care of Young Persons Act (SFS 1990:52) or the Care of Substance Abusers Act (SFS 1988:870) and who are transported by the Prison and Probation Service's National Transport Unit (NTU). Another group that can be placed in remand prisons and prisons are foreigners who are detained under the Aliens Act (SFS 2005:716).

In 2020, seven inspections of remand prisons and prisons were carried out.[2] Of these, one inspection was unannounced and was carried out on site.[3] The other six inspections were carried out through audio and video transmission and questionnaires that were answered by inmates. The inspections were part of the investigation of the situation for people deprived of their liberty during the COVID-19 pandemic. A summary of the investigation can be found in Section 10.

In 2021, three inspections of remand prisons were carried out.[4] The inspections were carried out on site and two of them were unannounced.[5]

All inspections were carried out by or on behalf of Parliamentary Ombudsman Katarina Påhlsson and she made decisions in three enquiries. Chief Parliamentary Ombudsman at the time, Elisabeth Rynning, made decisions in three enquiries. For more information on the enquiries, see Section 4.2.

4.1 Observations made during the inspections

The inspections of remand prisons and prisons cover a number of different issues. In addition to the inspections providing an opportunity to draw atten-

1 See the Prison and Probation Service's Annual Report 2021.

2 The prisons Beateberg, Färingsö, Hall, and Svartsjö and the remand prisons Färingsö, Kronoberg, and Sollentuna.

3 Sollentuna remand prison.

4 The remand prisons in Huddinge (Nacka department), Malmö, and Karlstad.

5 The remand prisons in Huddinge (Nacka department), Malmö, and Karlstad.

tion to shortcomings in the physical environment, they usually also concern questions regarding staff's treatment of inmates and how the inmates' fundamental rights are met. The latter may concern the right of association with other inmates, daily outdoor access, etc.

Association with others

An inmate in remand prison must be given the opportunity to spend time with other inmates during the day (association). The right of association can be limited by the Prison and Probation Service deciding that the inmate should be segregated if it is necessary for security reasons. A detainee may also be denied association with others if placed in a detention facility other than a remand prison and the conditions of the premises do not allow for association or if it is necessary to carry out a body search. Finally, an inmate may be denied association with others if they are subject to restrictions imposed by a prosecutor.[6]

During the inspection of *the Sollentuna remand prison* in January 2020, it was noted that there were not enough places in the units for placement of inmates with a right to associate with others. At the start of the inspection, there were 101 detainees on remand with the right to associate with others, but only 83 beds in wards for placement in association. Following the inspection, the Parliamentary Ombudsman stated that it is serious that the Sollentuna remand prison could not satisfy the inmates' right to association and pointed out that the conditions of the premises and practical conditions are not acceptable reasons for not meeting their statutory right.[7]

Isolation-breaking measures

The Prison and Probation Service aims to offer at least two hours a day of activities to break isolation for inmates who are not allowed to associate with others. On 1 July 2021, new legislation entered into force stating that children must receive four hours of isolation-breaking measures per day.[8]

During the inspection of the Sollentuna remand prison, detention plans for children and young people (born between 1999 and 2003) in the remand prison were reviewed. In a detention plan, the staff must document the isolation-breaking measures implemented in relation to the inmate. During the review, several of the detention plans gave the impression that the staff were actively working to try to break the isolation of children and young people. There were also notes that showed that the staff tried to motivate inmates to use isolation-breaking measures despite previously declining to do so.

Following the inspection, the Parliamentary Ombudsmen stated that it was of course very good that the remand prison was actively working with

6 See Chapter 2, Section 5 and Chapter 6, Sections 1 and 2 of the Act on Detention (SFS 2010:611) and Chapter 24, Section 5 a of the Code of Judicial Procedure.

7 See the Parliamentary Ombudsmen's report, ref. no. O 5-2020.

8 See Chapter 2, Section 5 a of the Act on Detention.

isolation-breaking measures, but at the same time noted that the efforts were distributed unevenly. Some inmates had received relatively regular interventions, while other inmates had received none. Nor was it possible to ascertain the considerations behind these differences. According to the Parliamentary Ombudsman, the review of the detention plans showed that *the Sollentuna remand prison* had difficulty in breaking isolation solely with the help of staff-led activities in relation to one inmate at a time. The Parliamentary Ombudsman pointed out that the opportunity to sit together or to spend time in a shared space in so-called restriction groups are important elements of systematic work to break isolation over time. According to the Parliamentary Ombudsman, it was clear that the Sollentuna remand prison must strengthen and prioritise its work on reducing isolation of inmates by meaningful isolation breaking measures. Furthermore, the Parliamentary Ombudsman emphasised that it is extremely serious that there are children and young adolescent who are isolated in remand prisons.

It is extremely serious that there are children and young people who are isolated in remand prisons

In connection with the inspection in October 2021 of *the Malmö remand prison (Red department)*, it emerged that children under the age of 18 were offered at least four hours of isolation-breaking measures in accordance with the new legal requirement in the Act on Detention. As this work had to be prioritised and the lack of premises didn't allow for it, the remand prison could not offer other groups of inmates isolation-breaking measures to the desirable extent. Following the inspection, the Parliamentary Ombudsman stated that it was very worrying that the resources and premises for such measures basically only was enough to uphold these measures for the children. The Parliamentary Ombudsman emphasised that the remand prison must further strengthen and prioritise its work to in a meaningful way end the isolation of all groups of inmates.[9]

Placement of inmates in segregation

The Prison and Probation Service can limit the inmate's right to association with others through a segregation decision. Such decision may be taken if deemed necessary for security reasons, e.g., it may be necessary to keep an inmate segregated from other inmates if there is a risk of extraction or escape or if the inmate is violent or under the influence of narcotics.[10]

In connection with the inspection of the *Sollentuna remand prison*, it emerged that a number of inmates who were suspected of relationship and sexual offences were placed in isolation for security reasons. According to the remand prison's management, their safety would be jeopardised if they were to be placed in a regular association ward. These inmates were therefore in a queue to be transferred to a special association ward in the Huddinge remand prison.

9 See the Parliamentary Ombudsmen's report, ref. no. O 20-2021.

10 See Government Bill 2009/10:135 p. 186.

Following the inspection, the Parliamentary Ombudsman stated that the Prison and Probation Service has a responsibility to protect the inmates and that she therefore understands that measures must be taken to protect inmates who are detained on suspicion of e.g. sexual offences. On the other hand, the Parliamentary Ombudsman expressed doubts as to whether the remand prison's application of the provision in the Act on Detention is compatible with the intention of the legislation. According to the Parliamentary Ombudsmen, it should be the person who poses a threat to a fellow inmate, is violent, or otherwise poses a security risk who that by a decision can be placed in segregation. In light of this situation the Parliamentary Ombudsman expressed that the Prison and Probation Service should consider to establish more special wards where inmates who, due to the alleged criminal offence, live under threat in a remand prison can have their right to association with others met.

Inmates who are 'segregated at their own request'

Furthermore, several inmates in the *Sollentuna remand prison* were 'segregated at their own request'. The Parliamentary Ombudsman expressed doubts about this description as it gave the impression that the Prison and Probation Service has a legal basis for keeping them segregated. According to the Parliamentary Ombudsman, there is no legal basis for segregating an inmate in a remand prison on this ground. and she pointed out that the wording risks leading to the remand prison's staff not working actively to change the situation for such an inmate or in the ward. Furthermore, the Parliamentary Ombudsman emphasised that the remand prison has a great responsibility to ensure that such inmates do not isolate themselves and that the staff make daily efforts to try to come to grips with the conditions for them. This may involve breaking the inmate's isolation in various ways by offering interpersonal contact of another kind, trying to motivate the inmate to spend time in association at the ward or trying to find alternative placements in the Sollentuna remand prison or other remand prisons.

There is no legal basis for segregating an inmate in a remand prison at their own request

The physical environment in the Sollentuna remand prison

Over the years, both the Parliamentary Ombudsmen and the European Committee for the Prevention of Torture (CPT) have commented on the exercise yards of the *Sollentuna remand prison*. Following a visit in 2015, the CPT recommended that Swedish agencies should take measures to improve the environment in the exercise yards and make it possible for the inmates to be able to contemplate their surroundings.[11] All exercise yards at the remand prison are like enclosed storage spaces with high concrete walls and lattice roofs. It is not possible to view the surroundings from the exercise yards and it is difficult to experience any fresh air.

CPT has commented on the Sollentuna remand prison's exercise yards

11 Se CPT/Inf (2016) 1, para. 3.

Following the inspection, the Ombudsman pointed out that the Parliamentary Ombudsmen's medical expert stated during the inspection that the exercise yards in their current form risk having an adverse effect on the health of the inmates. According to the Parliamentary Ombudsman, the remand prison's exercise yards still do not meet the requirements that can reasonably be placed on such spaces and emphasised that the plans for improvements should also include measures so that the inmates can look out and view the surroundings.

Restraint in bed

During the inspection of the *Malmö remand prison*, it was noted that an inmate had been placed in a restraint bed for more than 15 hours on one occasion.[12] Following the inspection, the Parliamentary Ombudsman noted that the use of bed strapping is one of the most intrusive measures that the Prison and Probation Service can take against an inmate in remand prison. Considering the long period of time that the prisoner was restrained in bed, the Parliamentary Ombudsman emphasised the importance of the Prison and Probation Service, then using such coercive measure, continuously assess whether the need still remains or if a less intrusive coercive measure can be used instead. Furthermore, the Parliamentary Ombudsman referred to previous statements that there is a need to review the legislation as it is not clear in the Act on Detention and the Act on Imprisonment who can make a decision on the use of restraints in bed or how long a decision on bed strapping a patient can apply before it must be reviewed.[13] The Parliamentary Ombudsman agreed with this assessment and pointed out that, pending such a review, the Prison and Probation Service needs to work to minimise the use of this far-reaching coercive measure.

Remand prisons established in former custody facilities

In the past, the Prison and Probation Service has established so-called temporary remand prisons. Between 2015 and 2017, there were two such activities located in police custody facilities.[14] Due to a strained occupancy situation, the Prison and Probation Service has once again established cells in some of the Police Authority's custody facilities. Since April 2020, the *Huddinge remand prison* has rented the Police Authority's custody facility in Nacka Strand and has 18 beds there for remand prisoners with restrictions, the *Nacka department*. There is about 20 km between that department and the Huddinge remand prison in Flemingsberg. Since February 2020, the Malmö remand prison has also rent premises from the Police Authority, a corridor with 22 beds for remand prisoners with restrictions, *Red department*. The

12 See the Parliamentary Ombudsmen's minutes in ref. no. O 25-2021.

13 See JO 2021/22 p. 241 and this report, p. 51

14 See Annual Report 2015-2017, p. 28

corridor is directly connected to the Police Authority's custody facility.[15] The other premises of the remand prison are located in the same building.

Physical environment in former police custody facilities

In connection with the inspections of the two departments, it was noted that some efforts to raise standards with regard to the physical environment had been made. Among other things, the Prison and Probation Service said that the cells had been furnished in a way that would correspond to the standard of a remand prison. However, several of the cells are equipped with a steel toilet without a lid and where the detainee could not flush on their own. Instead, they have to be assisted by the prison staff. In some cells in the *Red department* in Malmö, the toilet is also not separated from the rest of the cell. In addition, more than half of the cells do not have a sink, which meant that inmates were unable to wash their hands after defecating and urinating.

Following the inspections, the Parliamentary Ombudsman concluded that the previous custody facilities are not suitable for remand prison operations. The physical conditions may be acceptable if the cells are only used for deprivation of liberty that usually only last for a few days. On the other hand, it is undignified to allow inmates to stay in cells of the standard of the two departments for long periods of time.

The premises of both departments are – unlike what is usually the case with remand prisons – on street level, which limits the ability for the inmates to look out the window and to get incoming natural light in the cells. During the inspections, both inmates and staff questioned whether being in the exercise yards could really be described as being outdoors. The Parliamentary Ombudsman stated that it should be regarded as a fundamental right for inmates to be placed in a cell where it is possible to get normal seasonal daylight, and that inmates can regulate the flow of daylight into a cell themselves. It should also be considered a fundamental right for the inmate to be able to observe their surroundings from an exercise yard.[16] According to the Parliamentary Ombudsmen, the premises rented by the Prison and Probation Service from the Police Authority in Nacka and Malmö do not meet these basic requirements.

Lack of premises for activities in the former custody facilities

The two departments lack many of the premises that a remand prison normally has access to and which, according to the Parliamentary Ombudsmen, are needed for appropriate and lawfuldetention operations. This concerns, among other things, a lack of meeting rooms. Both departments also lack premises for sports facilities. In order to exercise, inmates in *the Nacka depart-*

15 The observations after the inspections are reported in separate minutes in ref. no. O 20-2021 and O 25-2021. The Parliamentary Ombudsmen's statements are collected in the minutes following the inspection of the Karlstad remand prison in ref. no. O 34-2021.

16 See, e.g., JO 2016/17 p. 198.

Former custody facilities have fewer or no rooms where inmates can exercise and receive visits

ment were offered to borrow an exercise bike that could be brought into the cell or out to the exercise yard. Inmates in the *Red department* were offered to borrow weights to work out in the cell. The Parliamentary Ombudsman noted that the inmates in the two departments have a significantly more limited existence than they would have had if they were placed in other departments in the two remand prisons.

Inmates without restrictions were also placed in *the Nacka department* and *the Red department.* It emerged that there was no limit as to how long an inmate could be placed there. The staffing levels in the departments was higher than in the other departments in both remand prisons. The higher staffing in *the Red department* was partly due to the fact that more logistics were required to be able to manage inmates and routines there. The staff in the Nacka department stated that they met inmates more often compared to other departments in the remand prison. The staff were able to adapt their duties to the needs of the inmates. In the Red department, inmates were allowed to come out into the corridor and get their food and the staff tried to create extra opportunities for conversation.

Following the inspections, the Parliamentary Ombudsman stated that the treatment that the inmates received in both departments appeared to be very good. However, the shortcomings noted relating to activities in the former custody facilities negatively affect the inmates, e.g. the possibility of obtaining isolation-breaking measures when there are a lack of rooms. To limit the negative consequences, the Parliamentary Ombudsman stated that she assumed that the Prison and Probation Service would review the way in which the agency could facilitate the situation for the inmates who are placed in previous custody facilities. According to the Parliamentary Ombudsman, it is self-evident that inmates should not need to be placed in such premises for longer than absolutely necessary.

Access to healthcare

During the inspection of *the Nacka department*, it emerged that inmates were transported to the remand prison's premises in the Huddinge remand prison to receive visits and to meet with a nurse or doctor at the remand prison. The inmates felt that their access to healthcare was poor. It was difficult to get in touch with the nurses and the inmates also felt that they were not listened to, for example, it was difficult to get support for expressed needs such as rehabilitation aids. Dissatisfaction was also expressed with the fact that it took several days for so-called nurse notes to be answered.

Following the inspections, the Parliamentary Ombudsman stated that each detention facility must have access to a qualified medical practitioner and staff with adequate medical training.[17] The department in Nacka did have access to the Huddinge remand prison's healthcare professionals but, accor-

17 See Section 15 of the Ordinance on Detention (SFS 2010:2011).

ding to the Parliamentary Ombudsman, the circumstances at the time of the inspection left a great deal to be desired. The fact that the detainees did not have direct access to healthcare professionals led to delays and miscommunication. According to the Parliamentary Ombudsman, it would of course have been easier if the healthcare professionals were on site in Nacka one or two days a week. The system chosen by the Prison and Probation Service means that the inmates in Nacka have less access to health and medical care than other inmates in the remand prison. The Parliamentary Ombudsman stated that if this has not already been done, the agency should as soon as possible take measures to give the inmates in Nacka access to healthcare professionals on the same terms as the other inmates in the remand prison.

The Parliamentary Ombudsmen's conclusion on the activities in former custody facilities

Following the inspections, the Parliamentary Ombudsman concluded that it is unacceptable that the strained occupancy situation in remand prisons and prisons leads to the Prison and Probation Service conducting correctional services in inadequate premises. This is also something that the Prison and Probation Service has previously been criticised for.[18]

Agreement between the Prison and Probation Service and the Police Authority on conducting detention operations

During the inspection of the *Karlstad remand prison*, it emerged that the Police Authority and the Prison and Probation Service had a regional agreement since 2014 regarding the custody of arrested, detained and apprehended persons. During the inspection, the remand prison management explained that the operation of the police custody facility in accordance with the agreement means that the Prison and Probation Service, on behalf of the Police Authority, handles the care of the individuals deprived of their liberty on the Police Authority's premises and that the Prison and Probation Service invoices the Police Authority for this service. In parallel with the inspection of the Karlstad remand prison, an inspection of the *Police Authority, Karlstad police custody facility* was carried out on behalf of Parliamentary Ombudsman Per Lennerbrant.

Placement of detainees in a holding cell

According to the agreement between the Prison and Probation Service and the Police Authority, the Karlstad remand prison can place inmates who are subject to detention in six of the police custody facility's holding cells. A similar order was described during an inspection of the Uppsala remand prison in September 2021.[19]

18 See the Parliamentary Ombudsmen's minutes in ref. no. 582-2017 and JO 2019/20 p. 203.

19 See the Parliamentary Ombudsmen's minutes in ref. no. 6684-2021.

Following the inspection, the Parliamentary Ombudsman noted that the working method means that detainees on remand in Karlstad and Uppsala can remain or be placed in a police custody facility, which predominately seems to take place due to overcrowding, despite the fact that it is required by law that a court or prosecutor has approved it.[20] The Parliamentary Ombudsman assessed that the fact that the Prison and Probation Service, and not the Police Authority, is responsible for the operation of the custody had a significant bearing on the provision not being upheld. According to the Parliamentary Ombudsman, there is a risk that this will lead to inmates being treated differently depending on their location and thus whether the Prison and Probation Service or the Police Authority is responsible for the operation of the custody facility. Furthermore, the Parliamentary Ombudsman stated that in order to realise the intention of the legislator – and to ensure that individuals deprived of their liberty are not placed in environments deemed inappropriate – it is important that the distinction between police custody facilities and remand prisons is maintained in practice. As a rule, it is not a problem if different agencies are responsible for the operation of police custody facilities and remand prisons. On the other hand, there is a clear danger that this boundary will be blurred in cases where the Prison and Probation Service is also responsible for custody operations.

It is important that the distinction between police custody facilities and remand prisons is maintained in practice

Furthermore, the Parliamentary Ombudsman pointed out that it is not only the standard of the cell that is decisive for the assessment that it is inappropriate to place a detainee in a police custody facility. If the cell is located in premises where other categories of individuals deprived of their liberty are placed, such as those apprehended due to intoxication, the detainee risks being in an environment where there are also unruly and intoxicated persons.[21] This is an environment not suitable for longer periods of deprivation of liberty and this is a perception that, according to the Parliamentary Ombudsmen, is reflected in the design of Chapter 24, Section 22 of the Code of Judicial Procedure.

Supervision of inmates placed in police custody facility

In connection with the inspections of the *Karlstad remand prison and police custody facility,* it emerged that the remand prison staff made their own assessment of an inmate's need for supervision after the Prison and Probation Service assumed responsibility for them from the Police Authority. In addition, conflicting information emerged among the staff as to who was responsible for deciding on changes to the frequency of the supervision. When talking to police personnel, a station commander explained that the Police Authority is responsible for the custody facility and that the custody

20 See Chapter 24, Section 22 of the Code of Judicial Procedure.

21 See Government Bill 2019/20:129 p. 46 f.

officer decides the frequency for the supervision of inmates. Representatives of the Police Authority also stated that this authority is responsible for ensuring compliance with the supervision ordered. Station commanders can ask for more frequent supervision if they receive information that an inmate is unwell. Police leadership could not explain what responsibility the Prison and Probation Service's officer on duty had for supervision of inmates in the police custody facility.

Following the inspection, the Parliamentary Ombudsman stated that the supervision of detainees in a police custody facility constitutes exercise of public authority and it is of particular importance that the supervision is carried out correctly. Inmates in a police custody facility are usually in a vulnerable situation and it can have far-reaching negative consequences if they are not checked on with some regularity. As the conditions were described during the two inspections, there is, in the opinion of the Parliamentary Ombudsman, an obvious risk that it will be unclear how often supervision of a detainee in the police custody facility shall be conducted and who in practice decides on such matters. Considering the descriptions provided, the Parliamentary Ombudsmen concluded that, for example, there could be different decisions from the Prison and Probation Service and the Police Authority on the frequency of supervision for the same inmate. According to the Parliamentary Ombudsman, there must be no doubts whatsoever regarding decisions on and the exercise of supervision and any changes in the frequency of supervision.

Regulation of health and medical care through agreement

From the agreement on the detention operations in Karlstad, it is clear that the remand prison's healthcare professionals is not available to persons taken into custody due to intoxication, but to other inmates in the police custody facility. Furthermore, it follows from the agreement that the Police Authority is responsible for transporting persons taken into custody due to intoxication to hospital if necessary. Following the inspection, the Parliamentary Ombudsman stated that there is a risk that this type of special arrangement will lead to misunderstandings as to who is responsible for an inmate and their access to healthcare. The Parliamentary Ombudsman reminded that an inmate in a police custody facility got hurt a few years ago because the responsibility for healthcare was not clearly regulated between the Swedish Prison and Probation Service and the Police Authority.[22]

The Parliamentary Ombudsman's conclusion on the authority's activities in Karlstad

Following the inspection, the Parliamentary Ombudsman stated the following. There is no definition of a police custody facility and a remand prison,

22 See JO 2014/15 p. 204.

There is no definition of what constitutes a police custody facility and a remand prison

but it is clear that the legislator has assumed that there are differences.[23] The Prison and Probation Service is responsible for enforcing sanctions imposed, conducting detention activities, and conducting personal case studies in criminal matters.

Neither the instruction nor the appropriation directions state that the authority shall conduct detention operations.[24] Instead, the Prison and Probation Service and the Police Authority have entered into agreements stating that the Prison and Probation Service shall be responsible for the operation of police custody facilities in a number of cities. The Parliamentary Ombudsman stated that she considers there to be an obvious risk of ambiguity arising regarding the responsibilities when an agency takes on more tasks and expands its area of responsibility in such a way. She expressed that these concerns also became clear during the inspection of the Karlstad remand prison. When the Prison and Probation Service and the Police Authority enter into regional agreements that the Prison and Probation Service will be responsible for the operation of police custody facilities, a number of complex challenges arise. In addition, the fact that it takes place regionally results in different solutions that lead to inmates not being treated in a uniform way. It also poses unacceptable risks to the inmates. That is not acceptable. According to the Parliamentary Ombudsman, it can be debated if it is appropriate and within the legal scope for the Prison and Probation Service to assume responsibility for the operation of police custody facilities in the manner described. Although there may be advantages to the agency collaborating with others, the problems with the current management are extensive and serious. A more comprehensive approach to the issues should be taken to achieve a uniform solution that is legally secure for the inmates within the prison and probation system. The Parliamentary Ombudsman therefore submitted a copy of the report to the Government.

Regional agreements between the Police Authority and the Prison and Probation Service lead to unacceptable risks for the inmates

4.2 Enquiries concerning remand prisons and prisons

In 2020 and 2021, the Parliamentary Ombudsmen made decisions in six enquiries that had been initiated following an OPCAT inspection. A case concerning the circumstances of an inmate who was elderly and had cancer was reported in the final report on *Transportation Theme* and has not been included in this report.

Conditions for migration detainees placed with the Prison and Probation Service

Under certain circumstances, the Swedish Migration Agency may decide that a foreigner who is detained shall be placed in a prison, remand prison, or

23 See the Parliamentary Ombudsmen's report, ref. no. O 34-2021, p. 10 and 11.

24 See Section 1 of the Ordinance (2007:1172) with instructions for the Swedish Prison and Probation Service.

police custody facility. This applies, among other things, if the detainee is kept segregated and for security reasons cannot be held in a Migration Agency's detention centre, so-called security placement.[25] For many years, the Parliamentary Ombudsmen have examined the conditions for the group of migration detainees placed with the Prison and Probation Service. This has led to several critical statements from the Parliamentary Ombudsmen and to the Government being made aware of the need for changed rules several times.[26] Sweden has also been recommended by the international community to cease placing persons detained under the Aliens Act with the Prison and Probation Service.[27]

After a series of inspections in 2017, then Chief Parliamentary Ombudsman Elisabeth Rynning found that detainees were still in significantly worse conditions than those placed in the Migration Agency's detention centre.[28] During the inspections of five remand prisons, it emerged that there were detainees who had been placed in remand prison from about a week up to a year and a half. In some cases, a migration detainee who was placed in remand prison could be locked in their resident room 23 hours a day. Furthermore, it emerged that the detainees were not allowed to possess mobile phones and did not have access to the internet. In some remand prisons, phone permissions were processed within the Swedish Prison and Probation Service's special system for controlled calling for inmates (the INTIK system). It was also noted that the detainees' possibilities to receive visits were more limited in remand prison compared to if they had stayed in the Migration Agency's detention centre. It also emerged that detainees placed with the Prison and Probation Service did not have the same opportunities to exercise their legally protected rights. The Chief Parliamentary Ombudsman decided to initiate an investigation of migration detainees placed with the Prison and Probation Service, and the starting point for the investigation was primarily to shed light on the situation of so-called security placed detainees.[29]

A migration detainee placed in a remand prison or prison must be kept separate from inmates who are held on remand or serving a sentence.[30] The Swedish Prison and Probation Service stated in its statement that the detainees – to the extent possible – are placed in the same department to enable association with others. It is not permitted to allow a migration detainee, who has not been expelled on account of a criminal offence, to stay with other inmates in a prison, remand prison, or police custody facility (Chapter 10, Section 20, second paragraph of the Aliens Act). However, the Prison and Probation

25 See Chapter 10, Section 20, first paragraph (2) of the Aliens Act.

26 See JO 2011/12 p. 314, JO 2014/15 p. 216, and JO 2019/20 p. 623.

27 See CPT/Inf[2016] 1, p. 72.

28 See the Parliamentary Ombudsmen's reports, ref. no. O 416-2017 and 581-2017.

29 See JO 2021/22 p. 221.

30 See Chapter 10, Section 20, second paragraph of the Aliens Act.

Service was of the opinion that in some establishments there are significant difficulties in meeting the detainees' right to association with others. The Chief Parliamentary Ombudsman stated that, in her view, it is obvious that detainees who are security placed in establishments within the Prison and Probation Service that have not been specially adapted for them are at great risk of becoming isolated.[31] Furthermore, the Chief Parliamentary Ombudsman emphasised that it is not acceptable that structural shortcomings in the Prison and Probation Service's operations lead to detainees being denied their right to associate with others. She pointed out the importance of the Prison and Probation Service working actively to be able to provide establishments where detainees placed in security are given the opportunity for association with others.

The Prison and Probation Service needs to work actively to be able to provide establishments where security placed detainees can associate with others

When placed in one of the Migration Agency's detention centres, a migration detainee can normally have contact with people outside the detention centre by calling, using the internet, and receiving visitors. According to the preparatory work, this means that the foreign national must have the same right to contact with persons outside the facility as a detainee in a detention centre.[32] According to the Prison and Probation Service, the design of the agencies' premises, including access to visiting rooms, means that the opportunities for visits are limited in some cases. The Prison and Probation Service does not normally allow detainees to possess a mobile phone or otherwise have access to other means of communication with an internet connection. The Chief Parliamentary Ombudsman stated that it may be regarded as a significant restriction of freedom for those waiting to be expelled or returned to another country not to be able to use the internet and mobile phones to, for example, access news and keep themselves informed about the conditions in the country in question or to be in contact with relatives there.

In addition, detainees expelled on account of a criminal offence and security placed inmates were placed together in the Storboda remand prison. The Prison and Probation Service's consultative opinion stated that at the beginning of 2019, there were 82 detainees within the Prison and Probation Service and that 48 of them were placed in security. Storboda remand prison is an association remand prison but has only 24 beds. In order to give security placed detainees better opportunities for association with others, the Prison and Probation Service could, according to the Chief Parliamentary Ombudsman, consider whether these beds should be reserved for detainees placed in security. In the case of migration detainees who have been expelled on account of a criminal offence, they can also have their right to association

31 See JO 2020/21 p. 164. According to the UN Standard Minimum Rules for the Treatment of Prisoners (the so-called Nelson Mandela Rules), an inmate is considered to be isolated if they are alone for more than 22 hours a day, without meaningful human contact. An inmate is considered to be in long-term isolation if they have been in solitary confinement for a period exceeding 15 days (Rule 44 of the UN Minimum Rules for the Treatment of Prisoners).

32 See Government Bill 2011/12:60 p. 94.

with others fulfilled by placement together with inmates held on remand or serving sentences.

The Chief Parliamentary Ombudsman noted that the majority of detainees placed with the Prison and Probation Service are still staying in significantly worse conditions than those placed in the Swedish Migration Agency's detention centres. The situation of those placed due to security reasons was particularly worrying. The Prison and Probation Service has no control over the decision to place a detainee in security, nor over how long the placement lasts. However, the Prison and Probation Service is responsible for ensuring that a person who is placed in one of the agencies' establishments is treated in accordance with the regulatory framework. In the Chief Parliamentary Ombudsman view it was very serious that the Prison and Probation Service has not made more progress in this work. She was of the opinion that the Government must review how the regulatory framework for detainees work in practice and that it needs to be clarified how the detainees' legally protected rights can be met when placed with the Prison and Probation Service. According to the Chief Parliamentary Ombudsman, there is also reason to strongly question whether detainees who are not being expelled on account of a criminal offence should be placed with the Prison and Probation Service in the first place. If this is nevertheless considered appropriate, the legislation covering migration detainees rights needs to be clarified, including with regard to the right to associate with others and to contact the outside world.

If detainees who are not being expelled on account of a criminal offence are placed with the Prison and Probation Service, the legislation regarding their rights needs to be reviewed

An inmate's access to medical care

During the inspection of *the prison Västervik Norra*, the Parliamentary Ombudsmen's employees spoke to an inmate who had undergone a medical procedure at the prison.[33] After the procedure, the inmate had suffered a bleeding that lasted for an entire night. It wasn't until the next morning that he received adequate help. Parliamentary Ombudsman Katarina Påhlsson decided to investigate the treatment of the inmate in a special enquiry.[34]

The investigation of the case revealed that, after the surgical procedure had been performed, the prison's healthcare services had not informed the staff who worked closely with the inmate of his health status. On the other hand, the inmate had told prison staff that he was bleeding heavily and he was then given a new compress to stop the bleeding. The officer on duty had also been informed hereof. The Parliamentary Ombudsman considered that these circumstances, which had also been the view of the Prison and Probation Service, should have given the officer on duty reason to place the inmate under supervision to follow up on his condition and well-being. This way, the officer on duty would have had a better basis for deciding whether it would have

33 See the Parliamentary Ombudsmen's report, ref. no. O 46-2019.

34 See the Parliamentary Ombudsmen's case in ref. no. 506-2020.

been necessary to contact medical personnel for an assessment of the inmate's need for medical care. The Parliamentary Ombudsman found that the officer on duty had taken an unacceptable risk through his actions and was criticised for this. The Prison and Probation Service was also criticised for the lack of information transfer after the medical treatment of the inmate.

The occupancy situation in the Prison and Probation Service

During the autumn of 2018 and spring of 2019, it was reported in the media that there was a shortage of beds in the Prison and Probation Service's remand prisons and prisons. The bed shortage meant that two inmates were placed in the same cell, so-called double occupancy, that inmates were placed in visitor rooms, and that individuals held on remand remained in police custody facilities. The Parliamentary Ombudsmen decided to investigate how the Prison and Probation Service handled the shortage of beds in remand prisons and at the National Reception Centre in Kumla Prison in the spring of 2019.[35] As part of the investigation, remand prisons in particular were inspected.[36] The inspection objects were selected taking into considering, inter alia, whether the remand prison had been closed for new admissions, with the result that detainees could not be transferred there from police custody facilities, whether inmates had been placed in other holding areas than a so-called normal cell, and whether inmates shared a cell. The National Reception Centre in Kumla was inspected due to the overcrowding at the time.

During the inspections, information was provided that the occupancy rate varied and in some remand prisons it had been up to 116 per cent on some days. At the time of the inspection, the National Reception Centre had an occupancy rate of 160 per cent. It was clear that some remand prisons were under more pressure than others, but it was obvious that in the spring of 2019, the Prison and Probation Service generally had difficulty meeting inmates' right to association with others or receive isolation-breaking measures, as well as to be outdoors on a daily basis. In addition, the capacity for providing suitable occupational activities was affected. In practice, the right to receive visitors had also been restricted by the fact that inmates had been placed in visiting rooms. Parliamentary Ombudsman Katarina Påhlsson pointed out that she has repeatedly emphasised that visits are a crucial element of a humane prison service. It is not acceptable that overcrowding or a lack of resources lead to restrictions in this regard. Furthermore, the Parliamentary Ombudsman stated that it is of crucial importance that the agency, in connection with new construction and renovation of remand prisons and prisons, plans for and ensures that existing and newly produced premises have sufficient space for

35 See JO 2021/22 p. 261.

36 See the Parliamentary Ombudsmen's reports, ref. no. O 22-2019, O 25-2019, O 26-2019, O 27-2019, O 28-2019, O 29-2019, O 30-2019, and O 39-2019.

communal activities and, in detention operations, isolation-breaking measures.

Regarding the size of cells in double occupancy, the Parliamentary Ombudsman referred to the fact that the European Committee for the Prevention of Torture (CPT), in a standard concerning living spaces for inmates, has stated that a cell in which two inmates are placed should have a floor area of at least ten square metres, excluding sanitary facilities. [37] If the cell is equipped with a toilet, it must be separated from the rest of the living space from floor to ceiling. In cases where there is no toilet or sink in the cell, it must be ensured that the inmate has prompt access to such facilities.

According to the CPT, a cell in which two inmates are placed should have a floor area of at least ten square meters

During the inspections, it was found that cell size varies, but that the cells used for the placement of two inmates were at least eight square meters. The Parliamentary Ombudsman stated that in the event of double occupancy in both remand prison and prison, only cells that have a floor area of at least ten square metres, excluding toilets, should be considered. It was noted that the remand prisons currently in use, in essence, have cells intended for an inmate. In cases where inmates in remand prison and prison share cells with a floor area of less than ten square metres (excluding toilet space), this should, in the opinion of the Parliamentary Ombudsman, only occur in exceptional cases, and only for an extremely limited period after assessment in the individual case.

The Parliamentary Ombudsmen shares the CPT's view on cell size in case of double occupancy

Furthermore, the Parliamentary Ombudsman pointed out that the Swedish regulation is based on the assumption that an inmate in remand prison normally has an interest in being placed in their own cell. According to the Parliamentary Ombudsman, this starting point should continue to apply and she refers to the fact that an inmate in remand prison normally needs their own space, if for no other reason than a nightly rest period. Furthermore, the Parliamentary Ombudsman stated that the Prison and Probation Service has a responsibility to follow up and document how sharing a cell works for inmates. According to the Parliamentary Ombudsman, it is not acceptable for inmates to share a cell for several weeks. The time that an inmate shares a cell should be limited.

The Parliamentary Ombudsman considers that the starting point that an inmate in remand prison is normally placed in a separate cell should continue to apply

A cell to be used for double occupancy must be equipped for two inmates. According to the Parliamentary Ombudsman, it is not acceptable for inmates to sleep on mattresses placed on the floor or in cots, nor for them to have meals sitting in their bed. In addition, if the inmates are not given equal opportunities when they share a cell, this is likely to increase the risk of conflicts. According to the Parliamentary Ombudsman, the information about the problems experienced by inmates in having to share a toilet without a door underscores the difficulties that can arise in case of double occupancy and that

37 See JO 2021/22 p. 282.

It must be described as undignified for both inmates to have to be within the limited space of a cell, when one of them uses a toilet without a proper door

it must be described as undignified for both inmates to have to be within the limited space of a cell when one of them uses a toilet without a proper door. According to the Parliamentary Ombudsman, it is reasonable for inmates to be given the opportunity to use another toilet than the one in the cell if they so wish. In order for such calls to be answered within an acceptable time, it is necessary that a sufficient number of personnel are on duty around the clock.

During the inspection of the National Reception Centre in Kumla Prison, it was found that, as a rule, no suitability assessment was made before deciding on the placement of two inmates in the same cell. Instead, the prison applied a principle that meant that the inmates who arrived last at the National Reception Centre had to share a cell. Such a placement normally lasted about three weeks. According to the prison management, exceptions to this rule were made when a remand prison had provided information to the effect that an inmate was not considered suitable. Several inmates told the Parliamentary Ombudsmen's staff about the anxiety they felt about having to share a cell with an unknown fellow inmate. Among other things, the concern was that the fellow inmate was mentally unstable and could hurt them, or that the fellow inmate was convicted of very serious violent crime. There were inmates who said they were 'terrified' of being locked up at night with a stranger.

The Parliamentary Ombudsmen questions whether it is appropriate for inmates at the National Reception Centre to share a cell

The Prison and Probation Service stated in its statement that after the inspection, a routine had been introduced in which a thorough risk assessment is carried out prior to double occupancy there, which was welcomed by the Parliamentary Ombudsmen. Considering the observations made during the inspection of *Kumla Prison, National Reception Centre,* when the occupancy rate exceeded 160 per cent, the Parliamentary Ombudsmen questioned whether the prison had the resources and conditions needed for its operations in the spring of 2019. Furthermore, the Parliamentary Ombudsman questioned whether it is at all appropriate for the Prison and Probation Service to double occupy cells at the National Reception Centre.

Finally, the Parliamentary Ombudsman referred to the fact that it is part of the Prison and Probation Service's task to continuously adapt the number of beds to the need. It is therefore important that the Prison and Probation Service develops methods for both remand prison and prison operations to better forecast future space requirements, as well as create a flexibility that makes it possible to handle temporary occupancy peaks without neglecting the actual content of the prison and probation service. The Parliamentary Ombudsman stated that she has great respect for the fact that it is a complex task to make such forecasts, but it is part of the Prison and Probation Service's mission to continuously adapt the number of beds to the need. In the work of increasing the number of beds, the Prison and Probation Service needs to analyse the reasons that led to the strained situation and learn from the experiences to avoid such ad hoc solutions that were implemented in the spring of 2019 and affected the inmates.

Conditions for restraint in bed in the Prison and Probation Service

During an inspection of *the Kronoberg remand prison*, information emerged that an inmate had been placed in a restraint bed (so-called strapping) on two occasions.[38] The Chief Parliamentary Ombudsman at the time, Elisabeth Rynning, decided to investigate the circumstances surrounding the use of restraint bed in a own inquiry with a focus on issues of principle in connection with the use of restraint beds within the prison and probation system. [39]

There is no definition of what the term restraint covers in the Act on Imprisonment and the Act on Detention. Older preparatory work shows that the term includes, inter alia, the possibility of strapping down an inmate.[40] A list of the different means of restraints that the Prison and Probation Service has 'approved' for use can be found in the agency's so-called security handbook.

Using restraint in bed is one of the most intrusive measures that the Prison and Probation Service can take against an inmate under the Act on Imprisonment and the Act on Detention. The Chief Parliamentary Ombudsman noted that the use of restraint bed within the prison and probation system is not subject to the same procedural safeguards as within compulsory psychiatric care. In the decision, she pointed out that it is a serious shortcoming that it is not clear from the Act on Imprisonment or the Act on Detention who can make a decision on restraint in bed or how long a decision on such a measure can be valid before it must be reviewed.

Furthermore, the Chief Parliamentary Ombudsman pointed out that there were ambiguities in the regulatory framework regarding how quickly a medical examination should be carried out and ambiguities in how the coercive measure should be followed up. In compulsory psychiatric care, it is required by law that healthcare professionals are present during the time the patient is placed in restraints. Neither the Act on Imprisonment nor the Act on Detention have a corresponding provision. According to the Chief Parliamentary Ombudsman, there are good reasons for involving healthcare professionals in the supervision from the start of the coercive measure, as this would reduce the risk that the strapping down would lead to the inmate's rights being violated or that they otherwise suffer mental or physical harm from the measure. The Chief Parliamentary Ombudsman noted that the current regulatory framework for the use of restraint in bed in the prison and probation system do not meet the recommendations that the CPT submitted to the Government following its visit to Sweden in 2015. Furthermore, she stated that there are strong reasons to review the provisions of the Act on Imprisonment and the Act on Detention on means of restraint, including the question

The legislator needs to review the issue of whether the Prison and Probation Service should have the right to strap down inmates in remand prisons and prisons

38 See the Parliamentary Ombudsmen's report, ref. no. 417-2017.

39 See JO 2021/22 p. 241.

40 See, for example, Government Bill 1975/76:90 p. 69 and 1980/81:1 p. 28 f.

whether the Prison and Probation Service should have the right to strap down inmates in the first place. Against this background, a petition was made to the Government for a review of the legislation.[41] Pending such a review, the Chief Parliamentary Ombudsman pointed out that the Prison and Probation Service needs to ensure that the use of this far-reaching coercive measure is minimised.

The European Prison Rules stipulate, inter alia, that a doctor or nurse reporting to a doctor must pay particular attention to the health status of inmates held in isolation. A doctor or a nurse reporting to a doctor must visit such inmates daily and immediately provide them with medical attention at their request or that of the prison staff

Conditions of an inmate who refused to eat and died in a prison

During an inspection of the *Saltvik prison* in August 2018, it was reported that an inmate had died in the prison in July of the same year after more than two months of hunger strike. The Chief Parliamentary Ombudsman at the time, Elisabeth Rynning, decided to investigate the circumstances surrounding the death in an own inquiry. The purpose of the investigation was to try to investigate what the conditions were like for the inmate during his refusal to eat and whether the Prison and Probation Service had failed in its treatment of him.

The case was about an inmate who in June 2018 had been relocated to the Saltvik prison from Kumla prison, but it was not clear from the decision documentation that he refused to eat. Of significance in this context was that it took just over a month between the Kumla prison's request for transfer and the time he was transported to the Saltvik prison. During that period, the inmate had continued his hunger strike and his condition had most likely deteriorated during this time. The relocation also meant that the inmate, who also had an underlying serious illness, was moved from the Prison and Probation Service's only prison with a care unit. According to the Chief Parliamentary Ombudsman, it was serious that the Prison and Probation Service, when deciding on the relocation, did not seem to have taken into account the fact that the inmate refused to eat or what impact a transfer would have on the possibility of providing him with adequate care. As the decision to transfer the inmate had been taken after he had been transported to Saltvik prison, he was also deprived of the opportunity to request a review of the decision before it was enforced.

Furthermore, the Chief Parliamentary Ombudsman noted that the Prison and Probation Service provides certain healthcare and is to be regarded as a care provider within the meaning of the Health and Medical Services Act. In the Prison and Probation Service's statement the agency stated that nurses at the Saltvik prison met the inmate 'at least' nine times between the time he arrived in mid-June 2018 and his death just over a month later. In addition, the inmate met with the prison's doctor on seven occasions. Three of these visits were conducted by a psychiatrist. The responsibility for the day-to-day con-

41 See JO 2021/22 p. 241.

tact with him lay with other prison staff, i.e. staff who generally lack health education.

The decision mentions that issues concerning the Prison and Probation Service's responsibility for inmates who hunger strikes were noted as early as the 1980s in some legislative preparatory works.[42] It was pointed out, inter alia, that even if the initial examination shows that the hunger striker does not suffer from a mental illness or equivalent mental state, he should obviously be under continued medical supervision. It is stated that it cannot be incumbent upon the staff of the Prison and Probation Service to assess whether and when transfer to medical care should take place and medical measures should be taken as a result of the strike. These are questions that must be assessed exclusively by doctors.[43]

The Chief Parliamentary Ombudsman was of the opinion that there were good reasons for such an arrangement and she supported these statements. She emphasised, among other things, that it is not acceptable that only staff without health and medical training are responsible for the daily contact with an inmate in need of care. She noted that this is particularly true in relation to inmates with as extensive needs as in the present case. The Chief Parliamentary Ombudsman stated that the care instructions given to other prison staff by healthcare professionals must be based on up-to-date information. This presupposes that qualified medical staff meet the inmate on a regular basis, i.e. daily, and make an assessment of whether the decided interventions are sufficient or whether they should be changed. According to the Chief Parliamentary Ombudsman, such an arrangement is more in line with the above-mentioned preparatory statements concerning inmates who refuses to eat and also in line with the European Prison Rules and the recommendations in the Declaration of Malta that a patient's autonomy in connection with hunger strike must always be respected, and that a doctor should ensure on a daily basis that an inmate wants to continue refusing to eat.

The investigation also showed that situations may arise where the Prison and Probation Service should consider taking an inmate to hospital if they are unable to examine or be treated appropriately in the prison, even if the inmate has previously expressed that they do not consent to receiving care. When the inmate's refusal to eat progressed, the Prison and Probation Service had to decide whether the inmate could be given the necessary care in prison or whether there were grounds for transferring him to hospital. One important question in this context is whether it is possible to transfer an inmate from the prison to a medical facility against their will for an examination.

The starting point for all healthcare is that it should be received on a voluntary basis. An inmate must not be required to submit to treatment of a medi-

World Medical Association The World Medical Association, an international non-governmental organisation that includes the Swedish Medical Association, has adopted a declaration on hunger strikers (the so-called Declaration of Malta). The declaration states, inter alia, that a patient's autonomy in connection with food refusal/food strike must always be respected.

The healthcare services in the Saltvik prison were not sufficiently involved in the care of the inmate

42 See Government Bill 1983/84:148 p. 19 ff.

43 See Government Bill p. 24.

cal nature.[44] Such treatment includes both somatic and psychiatric treatment. Medical treatment of an inmate can, as elsewhere in society, normally only be given on a voluntary basis. A person's refusal to eat for a long time can in itself give rise to medical conditions that fall under the compulsory psychiatric care legislation. The question of the extent to which care interventions contrary to the patient's express will can otherwise be considered justifiable is complicated. With regard to urgent physical care of patients who are subject to compulsory psychiatric care, it is stated in the preparatory works that society has assumed a special responsibility for persons forcibly detained in a care facility, and that there should therefore be no doubt that life-saving measures may be taken against the patient's will.[45] The Chief Parliamentary Ombudsman emphasised that, even in these cases, the assessment must be based on assumptions of a lack of decision making capability and stated that she found it difficult to see that the mere fact that a person is deprived of their liberty would affect the right to autonomy with regard to medical care and treatment. She referred to the fact that necessity is intended to apply only in exceptional cases where the danger to health is really serious and imminent.

In this case, the key question is what information the healthcare services provided to the head of the prison when the inmate's health deteriorated. It was apparent from a note that, when the inmate requested to see a psychiatrist, a nurse referred to the fact that an assessment would be carried out later in the week and that there was no question of taking the inmate to hospital as he did not appear to meet the requirements for an institutional psychiatric care certificate. The Chief Parliamentary Ombudsman emphasised that only doctors, following their own examination of the inmate, can make an assessment of whether there are grounds for a care certificate under the Forensic Psychiatric Care Act. However, such a certificate relates to the conditions for psychiatric care without consent and is not decisive for whether a patient is to be considered to lack the ability to decide on urgent physical care. However, assessments of the latter issue, which may have an impact on the applicability of the necessity rules, should also be made primarily by a doctor. For this reason, according to the Chief Parliamentary Ombudsman, the responsible decision-maker within the Prison and Probation Service should have been notified to make a decision on whether the inmate should be taken to hospital for assessment or whether a doctor should be called.

Only doctors, following their own examination of the inmate, can make an assessment of whether there are grounds for a care certificate under the Forensic Psychiatric Care Act

Health and medical care also include patient transport.[46] The starting point is that a patient who is competent to make decisions can decline an ambulance transport, for example. However, when it comes to transportation by the Prison and Probation Service in fulfilment of the obligation under the

44 See Chapter 9, Section 1 of the Prison Act.

45 See Government Bill 2009/10 p. 129.

46 See Chapter 2, Section 1 of the Health and Medical Services Act.

Act on Imprisonment to take an inmate to hospital in certain situations, the situation does not, according to the Chief Parliamentary Ombudsman, appear to be quite as clear. Partly due to that the agency only acts as a care provider in certain cases. If an inmate cannot be examined or treated in an appropriate manner in the prison, the agency has a legal obligation to use the public healthcare services. In some cases, staff from the public healthcare services may come to the prison for an assessment of the need for care, but if necessary, the inmate shall be transferred to hospital. According to the Chief Parliamentary Ombudsman, if the transport is carried out without the participation of health and medical care personnel, it should not be regarded as a patient transport within the meaning of the Health and Medical Services Act. It would therefore be only upon arrival at the healthcare facility that the inmate's willingness to receive care and treatment on a voluntary basis can be assessed. Even when it comes to inmates' ability to refuse ambulance transport, the requirement of voluntariness can sometimes take a back seat when there are no conditions for a reliable assessment of the inmate's decision-making capacity in an emergency.

If a transport is carried out without the participation of health and medical care personnel, it should not be regarded as a patient transport within the meaning of the Health and Medical Services Act

The Chief Parliamentary Ombudsman also pointed out that there may be situations where the Prison and Probation Service should consider taking an inmate from a prison to a hospital if they cannot be examined and treated appropriately in the prison, even if the inmate has previously expressed that they do not consent to receiving care at a healthcare facility. The conditions for carrying out a thorough examination in the case of serious conditions may normally be considered to be better in a healthcare facility than in a prison, where it may also be difficult to obtain a reliable assessment of the inmate's decision-making capacity in an emergency. Therefore, the medical staff in the Saltvik prison should have independently assessed whether the inmate's care needs under the healthcare acts could be met by the Prison and Probation Service and communicated their assessment to the competent head of prison services.

The investigation of the case showed that a doctor had, after visiting the inmate, noted that inmate had been informed that he would be taken to hospital if he became vacant, unresponsive, had reduced consciousness, or similar. Furthermore, it was noted that the staff should then contact an ambulance for 'medical care according to what is deemed indicated and possible at the time'. A few weeks later, when prison staff noticed that the inmate had deteriorated and had pressure sores, a nurse was contacted. During an examination at 11.10, the nurse noted that the inmate's health had deteriorated sharply but that he refused to be examined. The Prison and Probation Service then decided that the inmate should be taken to the hospital emergency the same day between 14.00 and 21.00. The decision was based on the fact that he was deemed to be in need of medical care and that this need could not be met

in the prison. The inmate died alone in his cell three hours after it was noticed that his health had seriously deteriorated.

The Chief Parliamentary Ombudsman noted that despite the fact that there were medical records by doctors about how medical staff should act in an emergency, it was clear that there had been shortcomings in communication between the healthcare services, the prison staff, and the management of the prison. It was not possible to tell from the prison register whether the prison had a clear plan for how to act when the inmate seriously deteriorated. Nor did the medical records indicate how urgent the need for hospital care was considered to be. The Chief Parliamentary Ombudsman stated that despite this, it should have been obvious that the inmate, after more than 60 days of hunger strike, did not have long to live at this stage. She therefore questioned why the Prison and Probation Service did not immediately call an ambulance.

As the Prison and Probation Service decided to carry out its own transport, the Chief Parliamentary Ombudsman referred to the fact that she had previously criticised the agency for the fact that risk assessments prior to transportation had not been sufficiently based on individual and current factors, but rather based on standardised security assessments. [47] In this case, it was a matter of an emergency transport of a seriously ill person. According to the Chief Parliamentary Ombudsman, it goes without saying that it takes longer to arrange such transportation than to call for an ambulance via 112. The Chief Parliamentary Ombudsman considered that the agency needs to take this task seriously as it is crucial to ensure that a prompt and individual examination takes place when there is an urgent need for transport to hospital. In this case, there should have been readiness and clearer planning for how the inmate would be taken care of in the event of a serious deterioration. When the Prison and Probation Service failed to arrange a quick transport, it led to that the inmate dying alone in a cell. The Chief Parliamentary Ombudsman was very critical of how the agency handled the situation that had arisen.

An inmate who been hunger striking for 60 days was allowed to die alone in a cell

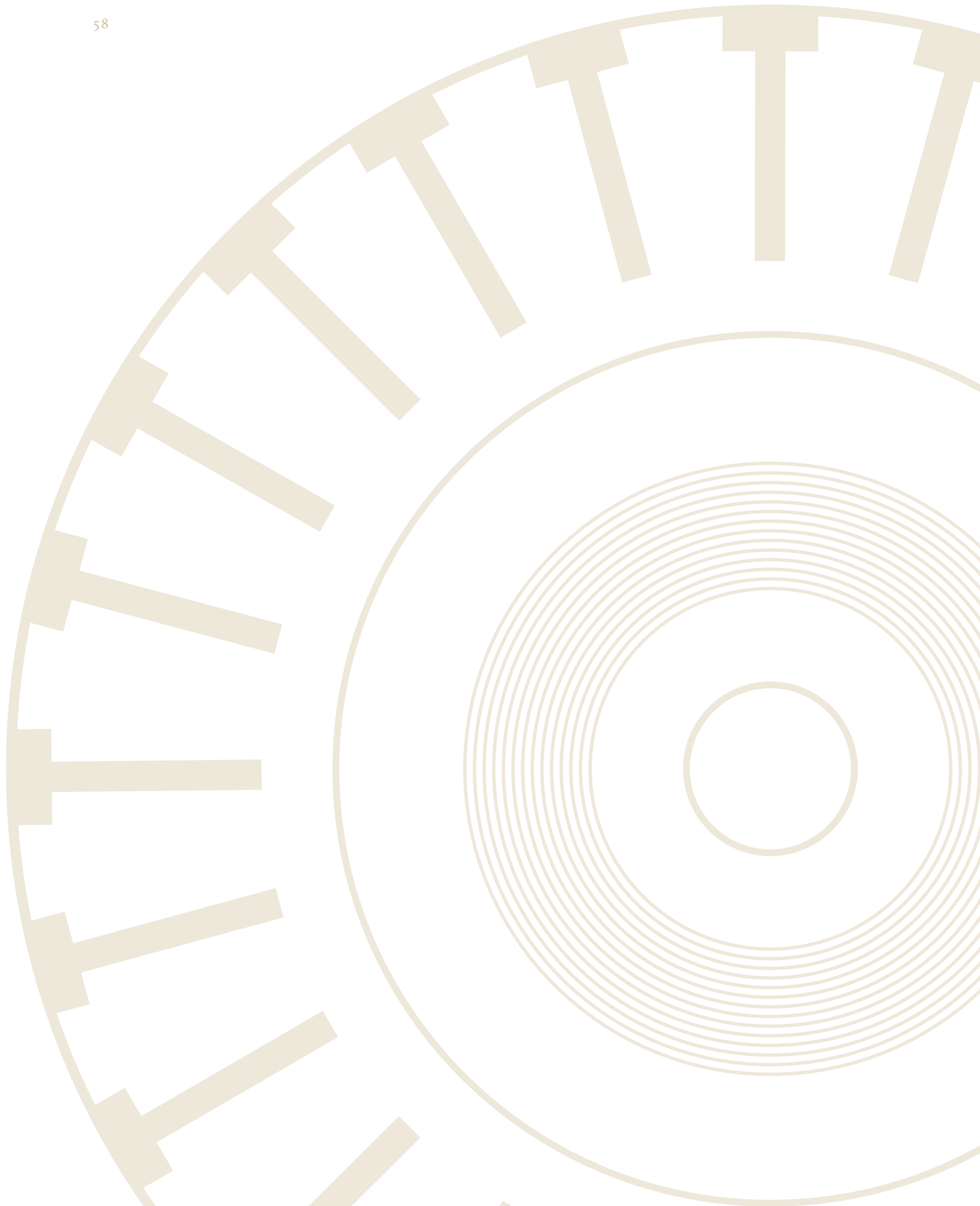
4.3 Concluding remarks by Parliamentary Ombudsman Katarina Påhlsson

During the 2020 and 2021 inspections, it emerged that the Prison and Probation Service had taken far-reaching measures to reduce the risk of the spread of COVID-19. Measures that affected the inmates and that entailed restrictions on the inmates' contacts with the outside world included missed leave and cancelled visits by relatives. While the pandemic was ongoing, occupancy in remand prisons and prisons remained high. In 2020 and 2021, inmates in remand prisons and prisons shared cells to a greater extent than in previous years. In summer 2019, there were 151 emergency beds, compared to about

47 See JO 2017/18 p. 131.

600 at the end of 2020. This meant that there were 1,200 beds in cells for more than one inmate (a permanent bed together with an emergency bed) in December 2020. These beds accounted for about 24 per cent of all beds in prisons. At the end of 2021, there was also around the same amount of beds in shared cells.[48] It is clear that the Prison and Probation Service will have a lack of space over time and that this situation seriously affects the situation for inmates in remand prison and prison. I see it as important that the Prison and Probation Service has a plan that ensures that double occupancy only occurs following individual assessments of the suitability of placing two inmates together. It is still important to monitor the often serious consequences of the occupancy situation for the inmates, e.g. that convicted persons remain in remand prison and that remand prisons cannot receive children who are arrested or detained. Despite the current situation, the Prison and Probation Service must ensure that the inmates' rights are met and are offered appropriate and relapse prevention content in the enforcement.

48 See the Prison and Probation Service's report on beds, occupancy and registrees, last updated on 4 February 2021. The report shows that there were approximately 640 emergency beds (a total of [640 x 2] 1,280 double occupancy beds) out of a total of approximately 5,200 beds in prison.



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The National Board of Institutional Care

The National Board of Institutional Care

The National Board of Institutional Care is responsible for the residential homes for compulsory care of substance abusers under the Care of Substance Abusers Act (SFS 1988:870). The National Board of Institutional Care is also the principal of the special residential homes for young people receiving care under Section 3 of the Care of Young Persons Act (1990:52) who need to be under particularly close supervision. Young persons who have been sentenced to secure youth care are also placed in special residential homes to serve their sentence in accordance with the Secure Youth Care Act (SFS 1998:603). In 2020 and 2021, there were 23 and 21 special residential homes for young people, respectively.[1] During the entire period, there were approximately 700 beds, of which 68 beds were intended for young persons sentenced to secure youth care. In addition, there were 11 residential homes for the compulsory care of substance abusers with about 400 beds.[2]

During 2020, the Parliamentary Ombudsmen inspected a residential home for the compulsory care of substance abusers and a special residential home for young people.[3] Both inspections were announced and carried out remotely. The inspections were part of the investigation of the situation for people deprived of their liberty during the COVID-19 pandemic. A summary of the investigation can be found in Section 10.

In 2021, the Parliamentary Ombudsmen inspected four special residential homes for young people. The purpose of the inspections was to investigate the safety and security at the National Board of Institutional Care's youth homes.[4] The investigation was a follow-up on the observations made during inspections of *the special residential homes for young people Sundbo* and *Vemyra* about serious shortcomings, including unwarranted force, that affected the safety and security of the incarcerated young people. [5] The inspections of the youth homes were followed up in the autumn of 2021 with an inspection at the National Board of Institutional Care's placement unit at the authority's head office. All inspections in 2021 were announced and carried out remotely, except for the on-site inspection of the placement unit.

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1 Lövsta special residential home for young people was temporarily closed in November 2019 and closed permanently in November 2021. Björkbacken special residential home for young people was closed at the beginning of December 2020.

2 SiS i korthet 2020 – En samling statistiska uppgifter om SiS [Briefly on the National Board of Institutional Care 2020 – A collection of statistical data on the National Board of Institutional Care].

3 Tysslinge special residential home for young people and Hornö residential home for the compulsory care of substance abusers.

4 See the Parliamentary Ombudsmen's reports, ref. no. O 9-2021 (Sundbo), O 10-2021 (Vemyra), O 11-2021 (Fagared), and O 12-2021 (Brättegården).

5 See the Parliamentary Ombudsmen's minutes in ref. no. 7107-2018 and report, ref. no. O 44-2019.

All inspections were carried out by or on behalf of Parliamentary Ombudsman Thomas Norling.

5.1 Observations during inspections of special residential homes for young people and the National Board of Institutional Care's placement unit

Sexual Assault Prevention

During the inspection of *the special residential home for young people Fagared*, it was noted that a male employee had recently been convicted of raping a girl in custody on the home's premises. The assault took place in December 2020. The management of the home had taken a number of measures as a result of the incident. These were mainly about ensuring that girls are not alone with male staff. However, it was found that a male staff member could take a girl on a car ride by himself. The Parliamentary Ombudsman therefore stated that the home should review how activities outside the home shall be carried out.

The residential home for young people Fagared needs to review how activities outside the home are carried out

The management of the home did not see it as a problem that the majority of the employees in the home's departments for girls were men. Furthermore, the management emphasised that girls tend to rely on male staff. The Parliamentary Ombudsman stated that he had consulted the Parliamentary Ombudsmen's expert in psychology in this regard and that the expert pointed out that there is nothing remarkable about a girl relying on male staff if they make up a majority of the employees. Furthermore, the expert emphasised the importance of male staff possessing sufficient ability and maturity to understand the role they have towards these girls. The Parliamentary Ombudsmen agreed with this assessment. Furthermore, the Parliamentary Ombudsman was very surprised that, as far as he understood, there had only been one exchange of experiences on the existence of employees' sexual abuse of young people within the scope of discussions between heads of departments at the National Board of Institutional Care.

Two employees at *the special residential home for young people Brättegården* have also been convicted of raping young people under care in the home in recent years. In conversations with staff, it emerged that some of the home's departments applied unwritten rules, which included that persons working as temporary substitutes may not be alone with young people and that male staff are not allowed to be alone with girls in their rooms. Following the inspection, the Parliamentary Ombudsman stated that there appeared to be a need to take measures in order to develop existing procedures relating to preventive measures against sexual abuse and to make them more uniform.

The National Board of Institutional Care needs to take measures to prevent sexual abuse in youth homes

Based on the observations made during the inspections of the two youth homes, the Parliamentary Ombudsmen stated that the National Board of

Institutional Care needs to review what measures should be taken to prevent sexual abuse from occurring in the youth homes.

The placement of young people

During the inspections of *the special residential homes for young people Vemyra, Fagared*, and *Brättegården*, it emerged that young persons not belonging to the correct target group had been placed in the homes. For example, school-age girls had been placed in wards for girls above school-leaving age. In Fagared, it emerged that girls who had been assessed to require particularly demanding care had been placed there despite the fact that the home lacked the capacity and competence to provide these young persons with safe and appropriate care and treatment. During the inspection of the National Board of Institutional Care's *placement unit at the head office,* it emerged that there was no requirement for the unit to follow up on individual placement cases, but that this could be done, for example, if a school-age young person was placed in a place intended for those of school-leaving age. Occasionally and for various reasons, young persons are placed in a place that does not meet their needs. If a suitable placement becomes available, the National Board of Institutional Care offers Social Services the opportunity to relocate the young person. However, according to representatives of the Planning Unit, Social Services often decline such transfers, arguing that it would be difficult for the young person to be relocated to a new institution and get to know a new team of staff.

Furthermore, the inspections of the youth homes revealed that the individual homes have very limited impact on which young people are placed there. In the discussions with the homes' staff and management, it was brought up that it is more difficult to initiate relocations of girls than boys because, unlike what applies to boys, there is no coordination within the National Board of Institutional Care, for the relocation of girls.

The residential homes for young people have limited impact on which youth are placed there

Following the inspections, the Parliamentary Ombudsmen stated, inter alia, that if a young person is placed in a youth home that is not suitable for their needs, there is good reason to assume that the care of the young person is threatened. It is also inevitable that the placement of a young person may affect the ability of other young persons to receive care and treatment if the resources of the home need to be used to provide care to a young person who has been placed there even though the activities of the home do not meet their needs.[6]

A few cases of placements were particularly noted during the inspections of the youth homes. One concerned a girl who was placed in *the special residen-*

6 See the Parliamentary Ombudsmen's reports, ref. no. O 10-2021, O 11-2021, and O 12-2021.

tial home for young people Fagared after an agreement with another youth home.[7] When the girl arrived at the home, the assessment was made that she could not be cared for in a regular place in a ward for girls. She was therefore placed as the only girl in an all-boys ward. Following the inspection, the Parliamentary Ombudsman stated that he understood the consequence was that the girl was given separate care without having any contact with other young persons. According to the Parliamentary Ombudsman, such a solution could complicate efforts to cease separate care and lead to the young person being isolated. He reminded of previous statements that the National Board of Institutional Care must ensure that a young person in separate care is activated and motivated to have contact with others and ensure the right conditions are created.

During the inspections, placements were also noted concerning young persons who belong to the category of people covered by the Act Concerning Support and Service for Persons with Certain Functional Impairments (SFS 1993:387) (LSS). According to representatives of the youth homes, many of these young persons are placed in so-called LSS housing with special services when they are discharged from a youth home. Following the inspections, the Parliamentary Ombudsmen stated that this raises questions about how the National Board of Institutional Care identifies that the young person is part of the category of people covered by the Act Concerning Support and Service for Persons with Certain Functional Impairments and how their care is planned and implemented.

Placement of young people under the Care of Young Persons Act and the Secure Youth Care Act

In January 2021, the National Board of Institutional Care announced that the authority intended to stop placements of young persons under the Secure act (LSU) alongside young persons in care pursuant to the Care of Young Persons Act (LVU). However, during the inspections of *the special residential homes for young people Fagared* and *Sundbo*, it emerged that these categories of young persons were still being cared for together in wards intended for boys requiring particularly demanding care. This may mean, for example, that young persons who are sentenced to secure youth care and live under threat are placed in the same ward as young persons in LVU care who are acting out. At *the special residential home for young people Brättegården*, girls serving sentences pursuant to the Secure Youth Care Act were cared for together with young persons in LVU care. Both young persons and staff at the homes questioned that the authority continued to care for these categories of young persons together, including from a safety and security perspective.

7 See the Parliamentary Ombudsmen's report, ref. no. O 11-2021.

The use of the coercive measure of segregation

It is clear from both the Care of Young Persons Act and the Secure Youth Care Act that the staff at the special residential homes for young people have the authority to take certain coercive measures provided by law against the young persons who stay at the homes. For example, a young person may be kept in segregation if it is particularly necessary because they behave violently or is under the influence of intoxicants to such an extent that they cannot be kept to order.[8] However, the coercive measure may only be used if it is proportionate to the purpose of the measure.[9]

The staff is also legally empowered to use force if an individual deprived of their liberty escapes or acts versus staff by using violence or threats of violence, or if they otherwise resists someone under whose supervision they are. The force must be justifiable in the circumstances.[10] In practice, an act of necessity is used in connection with inmates trying to leave the home, in connection with arguments and physical fights between young persons, and when children and young persons are to be taken to a segregation room.[11]

The National Board of Institutional Care may not take coercive measures in violation of Chapter 2, Section 6 of the Instrument of Government

For some time, the Parliamentary Ombudsman has monitored the application of the special powers set out in the Care of Young Persons Act (LVU) and the Care of Alcoholics and Drug Users Act (LVM). He has stated that there must, of course, not be a perception among the staff at the special residential homes for young people that they have, in addition to the special powers set out in the Care of Young Persons Act, other unwritten powers that in reality mean that the staff, in violation of Chapter 2, Section 6 of the Instrument of Government uses coercive measures against the incarcerated young persons. This applies, for example, to situations where staff pin down a young person instead of segregating them despite the fact that the conditions for a decision on segregation are met. [12]

Pinning down without a legal basis must not occur

During the inspections of the *special residential homes for young people* in 2021, decisions on segregation were reviewed and it was noted that a large proportion of the decisions described situations where young persons had been pinned down by staff. In many cases, the intervention was interrupted after a short period of pinning down when the young person had calmed down without being taken to, for example, a segregation room.

Following the inspections, the Parliamentary Ombudsmen stated that it is part of the staff's duties to ensure that order is maintained in a home.[13] Thus, the staff is responsible for intervening to avoid a fight, for example, and the

8 See Section 15 c of the Care of Young Persons Act (LVU) and Section 17 of the Enforcement of Custodial Youth Care Act (LSU).

9 See Section 20 a of the Care of Young Persons Act (LVU) and Section 18 b of the Enforcement of Custodial Youth Care Act (LSU).

10 See Chapter 24, Section 2 of the Swedish Criminal Code.

11 See Government Bill 2017/18:169 p. 55.

12 See the Parliamentary Ombudsmen's report, ref. no. O 12-2021.

13 See, e.g., the Parliamentary Ombudsmen (JO) 2008/09 p. 305.

staff must be able to pull an inmate aside if necessary to try to resolve the situation through dialogue. Although such intervention must sometimes be carried out with a certain degree of firmness, this must be regarded as a normal step in maintaining order. Segregation can, of course, be initiated by the staff pinning down the young person. When an intervention is interrupted after a short period of pinning down without the young person being taken to, for example, a segregation room because they have calmed down and there is no need for the staff to restrain them, it is not segregation. If, on the other hand, the juvenile is taken to a holding area where he or she is separated from other inmates and physical intervention is no longer necessary, this is segregation that covers the entire course of events.

The Parliamentary Ombudsmen concluded that decisions describing pinning down interrupted after a short period of time fall within the scope of legal authority. The provisions of the Care of Young Persons Act and Secure Youth Care Act are not applicable in these cases and therefore a decision on segregation should not be made, but the episode should be reported as an incident.

Because a young person in *the special residential home for young peopleBrättegården* had been pinned down on the floor of their resident room for 18 minutes, the Parliamentary Ombudsmen stated that the intervention in itself appeared to be a serious violation of the young person's privacy. One aggravating circumstance was that the measure was taken in the resident room where the young person has the right to feel safe. In this context the Parliamentary Ombudsmen also reacted to a decision on segregation in *the special residential home for young people Vemyra* in which it emerged that an employee had straddled and pinned down a girl lying on her stomach in a bed in a resident room. In *the special residential home for young people Fagared*, young persons had sometimes been segregated in a corridor-like space. According to the Parliamentary Ombudsmen, a youth home should use premises specifically intended for the purpose of such coercive measures, and it is therefore less appropriate to use some other space, such as a resident room or a corridor. The Parliamentary Ombudsmen also emphasised that there is a legal requirement that staff must keep the young person under constant supervision during segregation.

Youth homes need more premises that are adapted for segregation

During the inspection of *the special residential home for young people Brättegården*, it emerged that the staff in some cases had to transport the young people long distances to the segregation rooms. The segregation room used in one department was located in another building about 150 metres away. According to the staff, incidents had occurred during the transportation of young persons to the segregation room. During one such outside transport, the staff needed to put the young person down on the ground so that new staff could take over the transport. The Parliamentary Ombudsmen emphasised the National Board of Institutional Care's obligation to ensure that the

special residential homes for young people are designed in such a way that the staff have a real possibility to keep a young person segregated. Inadequate design must never lead to staff being forced to take measures that are not supported by the Care of Young Persons Act and Secure Youth Care Act, such as pinning down. The Parliamentary Ombudsman concluded that Brättegården is in need of more rooms for segregation. A similar problem was observed in *the special residential home for young people Vemyra.* This led the Parliamentary Ombudsman to conclude that this home is also in need of more rooms for segregation.

Finally, in view of the findings of the inspections, the Parliamentary Ombudsman stated he assumed that the National Board of Institutional Care would immediately review the application of the provisions on segregation in Care of Young Persons Act and Secure Youth Care Act. He also reminded that the National Board of Institutional Care had previously been encouraged to take measures in the form of training activities and general discussions about the limits of the special powers.

The use of the coercive measure of separate care

One important starting point is that a person under care at one of the National Board of Institutional Care's institutions has the right to associate with other inmates. The National Board of Institutional Care is able to limit this right in certain cases. It may prevent an individual from associating with others if this is required due to an individual's special care needs, their safety or the safety of other individuals (separate care). Separate care must be adapted to the individual's specific care needs. A decision on separate care must be reviewed continuously and always reviewed within seven days since the last review.[14]

A young person must be cared for with respect for their privacy and human dignity. A sleeping place on a mattress in a corridor is highly inappropriate

During the inspection of *the special residential home for young people Fagared*, it emerged that a young person in separate care had to sleep on a mattress in a corridor. The Parliamentary Ombudsman was provided a photograph that showed the young person's sleeping place. The Parliamentary Ombudsman stated that the arrangement was not only highly inappropriate but also incompatible with the basic rule in Section 1 of the Care of Young Persons Act that interventions for children and young persons must be characterised by respect for the young person's human dignity and privacy.

In *the special residential home for young people Vemyra*, a girl had been in separate care in a separate department for over a year. The placement had been made possible through a decision by the National Board of Institutional Care on a so-called bed reduction, which means that one or more regular beds cannot be occupied for a certain period of time. Furthermore, it emerged that the team of staff who worked in the department during the period in question

14 See Section 34 a of the Care of Alcoholics and Drug Users Act, Section 15 d of the Care of Young Persons Act, and Section 14 a of the Secure Youth Care Act.

had been about the same as when the department was filled to capacity. The Parliamentary Ombudsman expressed his concern about the possible consequences of such an arrangement. Above all, there is a risk that efforts to cease separate care will be made more complicated. According to the Parliamentary Ombudsman, the fact that the care had been ongoing for almost two years indicated that this was the case. Furthermore, there is a risk that the separate care may lead to the young person becoming isolated. The Parliamentary Ombudsman reminded of his previous statements that the National Board of Institutional Care must ensure that a young person in separate care is activated and motivated to have contact with others and ensure the right conditions are created.[15] The starting point must be that the young person can return to receiving care in a department together with other young persons in the home as soon as possible.

It is worrying that separate care can last for 2 years

During the inspection of *the special residential home for young people Vemyra*, it emerged that young person's receiving separate care were sometimes left alone. On one such occasion, a young person had been very close to taking their own life. The Parliamentary Ombudsman reminded of that he had previously stated that the assessments and considerations that the staff at a youth home must constantly make in order to be able to notice and stop conditions that may lead to a young person being injured are difficult. This places high demands on the care and the staff's ability to interpret signals. Furthermore, the Parliamentary Ombudsman stated that it is always a failure when a child or young person in social care custody takes their own life in a special residential youth home where they are receiving care. Of course, it is also a failure when, as in this case, a detained young person comes close to taking their own life.[16] The Parliamentary Ombudsman stated that he intended to follow up on the measures taken by the National Board of Institutional Care in connection with the incident.

It also emerged that only two young people had received care together during daytime in a department in *the special residential home for young people* Vemyra. The Parliamentary Ombudsman reiterated his previous statement that when a situation arises where fewer than three young people live together in a department, the basic requirement of association is not met. Association means that a young person stays with at least two other detainees during the daytime.[17] This is a basic right that must be respected in order to counteract the negative potential consequences of deprivation of liberty.

Information emerged in *the special residential home for young people Sundbo* that a decision on so-called separate care had been made after detained young persons expressed a desire for that form of care. The Parliamentary Om-

15 See JO 2019/20 p. 502.

16 See the Parliamentary Ombudsmen's report, ref. no. O 10-2021.

17 See the Parliamentary Ombudsmen's report, ref. no. 6204-2018.

budsman referred to his ongoing investigation into how the corresponding provision in residential homes for the compulsory care of substance abusers is applied, as information has come to light indicating that detainees in the National Board of Institutional Care's residential homes for the compulsory care of substance abusers receive separate care "voluntarily" and that they have the opportunity to "choose" this form of care.[18]

Electronic Communications

During the inspection of *the special residential home for young people Sundbo*, conversations with young persons and staff revealed that young persons' access to electronic communication services, especially their own mobile phones, can pose a security risk to other young person's receiving care at the home. In light of the findings of the inspection, the Parliamentary Ombudsman stated that there are grounds for him to continue monitoring the issue of which situations may justify restricting the use of the electronic services through a decision.

Notification of a follow-up inspection of the special residential home for young people Vemyra

During an inspection of the special residential home for young people *Vemyra* in 2019, it was noted that the National Board of Institutional Care still had several important matters of principle to deal with in order to ensure legal secure care for the inmates. Following the 2021 inspection, the Parliamentary Ombudsman found that many of the shortcomings noted during the previous inspection remained. Staff turnover at the home remains very high and there were difficulties in recruiting staff. Both staff and young persons questioned whether all employees have sufficient skills to carry out their duties. The Parliamentary Ombudsman was also very concerned about what emerged regarding the home's use of coercive measures and stated that the home's staff must not intervene against the young persons who are cared for there in a way that has no legal basis. In summary, the findings of this inspection were similar to those made during the previous inspection in 2019. The measures taken by the National Board of Institutional Care and the home have thus not ensured that young people receive safe and secure care. It is therefore urgent that the National Board of Institutional Care takes immediate action to ensure that young people at Vemyra have access to the care and treatment for which their placement is intended. The Parliamentary Ombudsman announced that he intended to carry out a follow-up inspection of the home.

18 See the Parliamentary Ombudsmen's case in ref. no. 2802-2020. Decision on the matter was made on 21 November 2022.

5.2 Concluding remarks by Parliamentary Ombudsman Thomas Norling

For a number of years, I have paid attention to the safety and security of young persons. In decisions and statements following inspections, I have pointed out serious shortcomings in the operation of the special residential homes for young people. Based on the information that emerged during the inspections carried out in 2020 and 2021, I find that it is important to continue to follow the issue of the situation of individuals deprived of their liberty in a placement in special residential home from a safety and security perspective. After the inspections were completed, I was able to establish that there are still serious shortcomings in the activities, including in connection with the inmates being restrained by the staff. I have previously launched a special review in an enquiry on the application of the provisions on the special powers of segregation and separate care and I will return to the outcome of that review in the 2022 Annual Report.

In light of what emerged about the prevalence of sexual abuse by staff at the *special residential homes for young people* Brättegården and Fagared, I find it urgent to follow up on how the National Board of Institutional Care works to prevent the occurrence of sexual abuse at the special residential homes for young people. I also intend to monitor whether young persons cared for under Care of Young Persons Act and Secure Youth Care Act continue to be placed together.

6 Compulsory psychiatric care

Compulsory psychiatric care

In Sweden, care pursuant to the Compulsory Psychiatric Care Act (SFS 1991:1128) and the Forensic Psychiatric Care Act (SFS 1991:1129) is almost exclusively provided by the regions. In 2020, there were an estimated 80 care facilities operating pursuant to the Compulsory Psychiatric Care Act and the Forensic Psychiatric Care Act with approximately 4,100 beds. Patients are also cared for voluntarily at these care facilities in accordance with the Health and Medical Services Act (SFS 2017:30).

In 2020, three inspections of organisations that provide care in accordance with the Compulsory Psychiatric Care Act and the Forensic Psychiatric Care Act were carried out. One of these was an unannounced on-site inspection.[1] The other two inspections were announced and conducted via telephone within the scope of the review of the situation for people deprived of their liberty during the COVID-19 pandemic.[2] A summary of this review can be found in Section 10. In 2021, five inspections were carried out as part of an enquiry. The inspections were announced and carried out remotely using image and video transmission.[3]

All inspections were carried out by or on behalf of Chief Parliamentary Ombudsman Elisabeth Rynning. She also made decisions in two enquiries. Chief Parliamentary Ombudsman Erik Nymansson made a decision in an enquiry that included inspections carried out in 2021. For more information on the enquiries, see Section 6.2.

6.1 Observations made during the inspection of Ryhov County Hospital

As in previous years, an on-site inspection of Ryhov County Hospital in Jönköping focused on issues relating to the staff's application of the provisions on coercive measures and issues relating to good care and systematic quality work.

1 Department of Psychiatry, Ryhov County Hospital, Parliamentary Ombudsmen's ref. no. O 9-2020.

2 The National Board of Forensic Medicine's investigation units in Gothenburg and Stockholm in the Parliamentary Ombudsmen's ref. no. O 24-2020 and O 25-2020.

3 See the Parliamentary Ombudsmen's reports, ref. no. O 4-2021 (Regional Forensic Psychiatric Clinic in Vadstena), ref. no. O 5-2021 (Forensic Psychiatric Services in Gothenburg, Rågården), ref. no. O 6-2021 (Regional Forensic Psychiatric Clinic in Växjö), ref. no. O 7-2021 (Rättspsykiatri Västmanland in Sala) and ref. no. O 8-2021 (Forensic Psychiatry Care Stockholm).

Use of psysical restraint and forced medication against a patient's will

If there is an immediate danger of a patient seriously injuring themselves or someone else, the patient may be briefly restrained physically with a belt or similar device.[4] Regarding the treatment during the length of stay, the patient must be consulted when possible. The treatment measures must be adapted to what is required to achieve the purpose of compulsory care, to enable the patient to voluntarily participate in necessary care and to receive the support the patient needs. If there are special reasons, the patient may, at the discretion of the Chief Medical Doctor, be given different kinds of forced treatment without consent.[5]

During the inspection, it was found that the clinic had made decisions on physcial restraints to a much greater extent than decisions on segregation. It also emerged that patients in many cases went to the restraints room themselves and that a decision on restraints could include a "short toilet break". The decision-making physician did not always conduct a personal examination of the patient before the initial decision on restraints. The decisions on restraints were generally not justified based on the conditions laid down in Section 19 of the Compulsory Psychiatric Care Act, and the staff used the term 'protective restraints' for the coercive measure.

Chief Parliamentary Ombudsman Elisabeth Rynning stated that in the event of an ex-post check, the grounds on which a decision on restraints was made must be completely clear. One condition for restraints is that there is an immediate danger that the patient will injure themselves or someone else, and there are good reasons to question whether this is the case when the patient has gone to the restraints room themselves or has been released to use the toilet. Furthermore, the Chief Parliamentary Ombudsman stated that restraints constitutes a serious restriction of a person's rights and freedom and that the use of the term 'protective restraints' risks leading to staff not understanding that it is a highly intrusive coercive measure. She urged the clinic to review its working methods and routines, as well as the everyday language so that the meaning of restraints is understood and communicated in a correct way and that the procedure is only done in accordance with the law and for as short a time as possible.

The term 'protective belting' risks leading to staff not understanding that restraint in belt is a highly intrusive coercive measure

Body search and external body examination

If necessary, a patient may be subjected to a body search or a superficial body search to check that they are not carrying, e.g., narcotics, alcoholic beverages, doping substances, syringes, or other objects that may be harmful to the

4 See Section 19 of the Compulsory Psychiatric Care Act.

5 See Section 17 of the Compulsory Psychiatric Care Act.

patient or to the detriment of the care or order of the care facility. A patient whose right to use electronic communication services is restricted may also be subjected to a body search or an external body examinations, if necessary, to check that the patient is not in possession of technical equipment that enables communication. The measure is decided by the Chief Medical doctor.[6] If necessary for upholding security in a health care facility or ward for secure psychiatric care with a heightened security classification, the care provider may decide that all persons entering the facility or ward shall be body searched (general entry check).[7] Heightened security classification refers to security level 1 or 2.[8]

The clinic's regular use of archway metal detector had no legal basis and the clinic therefore received serious criticism

During the inspection, it emerged that patients in some of the departments regularly had to enter through an archway metal detector when they had been outside the department. In such cases, no individual decision was made to carry out a search. The clinic, with all care wards classified as security level 3, had continued to use the archway metal detector in this way despite criticism from the Health and Social Care Inspectorate (IVO) in 2014. Chief Parliamentary Ombudsman Elisabeth Rynning stated that the clinic's regular use of the archway metal detector has no legal basis and the clinic therefore received serious criticism. Region Jönköping was urged to immediately cease any use in the manner that has come to light and to take measures to ensure that body searches are only carried out in accordance with law.

After the Chief Parliamentary Ombudsman criticised the use of archway metal detector, the care provider took measures deemed sufficient by the Health and Social Care Inspectorate to ensure that body searches are only carried out in accordance with applicable legislation.[9]

Good care and systematic quality work

Health and medical care activities must be conducted in such a way that the requirements for good care are met. This means that care must meet the patient's need for safety, continuity and security, and that it must be based on respect for the patient's self-determination and privacy.[10] Where healthcare activities are carried out, there must be the staff, premises, and equipment needed for good care to be provided.[11]

In health and medical care, the quality of the activities must be systematically and continuously developed and ensured.[12] This means that a follow-up and evaluation of the quality and results of the activities must be carried out. The

6 See Section 23 of the Compulsory Psychiatric Care Act.

7 See Section 8 b of the Forensic Psychiatric Care Act.

8 See the National Board of Health and Welfare's Regulations (2006:9) Concerning Security in Health Care Facilities which provide compulsory psychiatric care and forensic psychiatric care, as well as in units for forensic psychiatric examination.

9 See decision of 22 December 2021, ref. no. 3.5.1-34380/2021-4.

10 Chapter 5, Section 1 (2) and (3) of the Health and Medical Services Act.

11 See Chapter 5, Section 2 of the Health and Medical Services Act.

12 See Chapter 5, Section 4 of the Health and Medical Services Act.

care provider must also conduct systematic patient safety work. This means that the care provider must plan, manage, and control the activities in a way that meets the demand for good care.[13]

During the inspection, it was noted that all patients, including patients who were cared for voluntarily, were initially given a level of supervision that meant they were not allowed to leave the nursing ward. When a patient who was being cared for voluntarily wanted to leave, the staff tried to persuade him or her to stay on voluntarily until a doctor had made an assessment at the next doctor's round. Chief Parliamentary Ombudsman Elisabeth Rynning emphasised that the Health and Medical Services Act does not offer any legal basis for preventing a patient from leaving the clinic. The possibility of preventing a patient who is being cared for voluntarily from leaving is thus limited to what can be considered to follow from the general provisions of the Swedish Criminal Code on necessity and the status of a so-called guarantor of protection that the health professionals may be considered to have, taking into account the patient's maturity and health status.[14]

Furthermore, it emerged from the inspection that the clinic did not carry out any systematic follow-up of coercive measures taken or so-called informal coercion, e.g. medication against a patient's will. In addition, the supervision was not documented in such a way that it was possible to verify it ex post. Against this background, the clinic was urged to take measures to ensure that the use of coercive measures, including informal coercion, is continuously evaluated. The Chief Parliamentary Ombudsman was of the opinion that the clinic also needed to take measures to ensure that supervision that had been decided to prevent patients from self-harm and reduce the risk of suicide could be checked ex post.[15]

The use of informal coercion needs to be followed up and evaluated

6.2 Enquiries

The meaning of the term 'care facility' and the scope of apprehension

Following the inspection of *Northern Stockholm Psychiatry, Emergency Psychiatric Clinic and Department 1, Saint Göran Hospital* in September 2018, Chief Parliamentary Ombudsman Elisabeth Rynning decided to investigate, inter alia, Region Stockholm's way of organising psychiatric compulsory care, the meaning of the term 'care facility' and the scope of a decision on detention.[16]

During the inspection, it emerged that the emergency room at Saint Göran Hospital (Länsakuten) is the only adult emergency psychiatric clinic in Re-

13 See Chapter 3, Section 1 of the Patient Safety Act (SFS 2010:659).

14 See the Parliamentary Ombudsmen's minutes in ref. no. O 9-2020.

15 See also, e.g., the Parliamentary Ombudsmen's reports, ref. no. 4043-2017 and 3887-2018.

16 See the Parliamentary Ombudsmen's case in ref. no. 1732-2019 and National Preventive Mechanism – NPM, Report from the Opcat Unit 2018.

gion Stockholm. There, decisions on care certificate are made, while decisions on admission pursuant to the Compulsory Psychiatric Care Act are usually made at another unit within the Stockholm Health Care Services (SLSO). The guidelines for SLSO state that a detention decision made in psychiatric activities within SLSO is also valid in other activities within SLSO when the patient has been transported there. During the inspection, it also emerged that SLSO had accepted that a decision on detention constituted grounds for a request for judicial assistance from the Swedish Prison and Probation Service.

In the decision, the Chief Parliamentary Ombudsman stated that the scope of a care certificate is limited to the care facility where the decision was made. A patient who is the sole subject of such a decision and is therefore not yet admitted for treatment under the Compulsory Psychiatric Care Act cannot be regarded as deprived of their liberty when leaving the care facility in question. Therefore, the care certificate does not entitle health care professionals to take coercive measures outside the care facility based on the Compulsory Psychiatric Care Act and the provision on lawful authority does not apply. The Chief Parliamentary Ombudsman also stated that a prerequisite for the Swedish Prison and Probation Service to be engaged to transfer a patient is that a decision has been made to admit a patient to care in accordance with the Compulsory Psychiatric Care Act. She noted that compulsory psychiatric care within the Stockholm Region is organised in a way that is not compatible with the relevant provisions of the Compulsory Psychiatric Care Act and entails a risk of unlawful restrictions on the fundamental rights and freedoms of patients. The Chief Parliamentary Ombudsman considered that SLSO deserved serious criticism for its handling of these issues and assumed that measures would be taken immediately to ensure that all steps in the admission process are handled in a legally secure and correct manner within the region.[17]

Region Stockholm needs to review the admission process as it does not have a legal basis

The Chief Parliamentary Ombudsman also drew attention to the fact that the provisions on decisions on care certificate and admission in the Compulsory Psychiatric Care Act are not clearly defined, which may make it more difficult to apply them uniformly and legaly secure. The case also showed that there is a need to consider how the compulsory psychiatric care needs to be organised to ensure a legally certain admission process and meet the patient's need for safety and security in care. Against this background, a petition was made to the Government for a review of the legislation.[18]

Review of certain issues relating to use of coercive measures in psychiatric inpatient care of minor patients

Following an inspection of Child and Adolescent Psychiatry (BUP) in Stockholm in June 2017, observations were made about the conditions of a minor

17 See JO 2021/22 p. 165.

18 Such a request may be made pursuant to Section 4 of the Act with Instructions for the Parliamentary Ombudsmen (SFS 1986:765).

patient who was administered nutrition and medication via a feeding tube against their will. Chief Parliamentary Ombudsman Elisabeth Rynning decided to review certain issues relating to the legal status of children in compulsory psychiatric care.[19]

The Board of SLSO (Stockholm Health Care Services), the Regional Board of Region Skåne, the National Board of Health and Welfare, and IVO (the Health and Social Care Inspectorate) commented on certain issues. Both the National Board of Health and Welfare and the Health and Social Care Inspectorate stated that the legal position of the child in relation to the guardians' responsibility for the child's health and medical care is somewhat unclear, including the extent to which the guardians, based on the Children and Parents Code, can override the child's wishes to opt out of certain treatment and in what situations consent must be obtained.

The decision drew attention to the fact that there are ambiguities in several key aspects of the treatment of children, including the child's own attitude in relation to the guardians' responsibility for the child's health and medical care, the situations in which a decision on care under the Compulsory Psychiatric Care Act (LPT) is needed to care for a child against its will, and the detailed conditions for compulsory treatment of the child without consent pursuant to Section 17 of the LPT. The Chief Parliamentary Ombudsman also noted that it is not sufficiently specified what coercion the healthcare professionals are entitled to use in order to obtain treatment without consent under Section 17, third paragraph of the LPT and that the legal basis for the coercion actually used in compulsory care today can be questioned, which is deeply unsatisfactory.

Furthermore, the Chief Parliamentary Ombudsman stated that, from a legal secure perspective, it is of course important that healthcare legislation is clear and applied uniformly throughout the country. It is particularly important to have clear legal rules and indicative preparatory statements in cases where intrusive decisions, such as treatment without consent or even using physical coercion, cannot be appealed and further guidance cannot be obtained from case law in this area. The consequence of the scant regulation of the legal status of children in healthcare is that the assessment of difficult fundamental rights issues is left to the healthcare professionals, which is very unsatisfactory.

Overall, the Chief Parliamentary Ombudsman concluded that there is a need for further clarification regarding the conditions for the care and treatment of children in healthcare regardless of the will of the child and the guardians. Reference was made to the fact that the Government had recently commissioned a special investigator to review certain issues under the Compulsory

19 See the Parliamentary Ombudsmen's case in ref. no. 2782-2018.

Psychiatric Care Act, among others. Since the terms of reference only covered some of the issues raised in the case, the Government was made aware of the need for a review of the legislation that can more fully address the identified shortcomings.

Review of the Health and Social Care Inspectorate's supervision of compulsory psychiatric care

Over the years, the Parliamentary Ombudsmen have stated on several occasions that a dialogue with the *Health and Social Care Inspectorate (IVO)* should be initiated regarding the physical conditions in connection with patients being restrained with a belt, and how the authority supervises patients in long-term segregation and follows up on anomaly reports, etc.[20]

In 2019, dialogues were conducted with the Health and Social Care Inspectorate's six regional departments. Chief Parliamentary Ombudsman Elisabeth Rynning then held a dialogue meeting with the Director-General and raised issues such as follow-up of the use of coercive measures by care providers, review of reports under Lex Maria, follow-up of care providers' systematic patient safety work, checks of physical care environments, etc., as well as patients who are kept segregated for a long time. The Chief Parliamentary Ombudsman decided to open an initiative in which the Health and Social Care Inspectorate was given the opportunity to comment on the findings of the dialogues. In the decision, the Chief Parliamentary Ombudsman dealt with the following:[21]

Review of the Health and Social Care Inspectorate's supervision of compulsory psychiatric care

Follow-up of healthcare providers' use of coercive measures and systematic patient safety work

By law, a care provider must notify the Health and Social Care Inspectorate of, inter alia, decisions on physical restraints and segregation that have been going on for a certain period of time.[22] In addition, the Chief Medical Officer must continuously provide the Health and Social Care Inspectorate with information on measures taken in accordance with the Compulsory Psychiatric Care Act and the Forensic Psychiatric Care Act.[23] The Health and Social Care Inspectorate may issue regulations on how this reporting obligation is to be fulfilled.[24] The review revealed that the Health and Social Care Inspectorate did not have any collective knowledge of the extent to which care providers use coercive measures. The Health and Social Care Inspectorate also chose

20 See, e.g., the Parliamentary Ombudsmen's reports, ref. no. 5556-2016 and 2222-2016.

21 See JO 2021/22 p. 146.

22 See Section 19, third paragraph, Section 19 a, third paragraph, Section 20, third paragraph, and Section 20 a, third paragraph of the Compulsory Psychiatric Care Act, Section 8 of the Forensic Psychiatric Care Act, and Chapter 4, Section 7, first and second paragraphs, of the National Board of Health and Welfare's Regulations and General Guidelines (SOSFS 2008:18) on Psychiatric Compulsory Care and Forensic Psychiatric Care. SOSFS 2008:18 expired on 1 March 2023 and has been replaced by the National Board of Health and Welfare's regulations and general guidelines [HSLF-FS 2022:62] on compulsory psychiatric care and forensic psychiatric care.

23 See Section 49 of the Compulsory Psychiatric Care Act and Section 24 of the Forensic Psychiatric Care Act.

24 See Section 16 of the Ordinance (1991:1472) on Compulsory Psychiatric Care and Forensic Psychiatric Care.

not to apply the provision on the Chief Medical Officer's obligation to continuously provide the authority with information on the measures taken under the Compulsory Psychiatric Care Act and the Forensic Psychiatric Care Act. Nor had the Health and Social Care Inspectorate taken note of the reports of coercive measures that care providers submit to the National Board of Health and Welfare's patient register or regularly reviewed the care providers' systematic patient safety work or anomaly reports. The Chief Parliamentary Ombudsman noted that it is very serious that the Health and Social Care Inspectorate has not used the tools provided by the legislator to acquire a comprehensive knowledge of the care providers' use of coercive measures. Furthermore, she urged the Health and Social Care Inspectorate to take measures as soon as possible aimed at ensuring that the authority gets an overall picture of the care providers' systematic patient safety work.

It is very serious that the Health and Social Care Inspectorate does not use the legal tools to acquire a comprehensive knowledge of the use of coercive measures

Review of reports according to Lex Maria

A care provider must report incidents that have led or could have led to a serious healthcare injury (so-called Lex Maria) to the Health and Social Care Inspectorate.[25] The report must be made as soon as possible after the incident has occurred. Together with the report, or as soon as possible thereafter, the care provider must submit an investigation of the incident to the Health and Social Care Inspectorate.

The Health and Social Care Inspectorate stated that there was no agency-wide view on the deadlines for when a report and investigation under Lex Maria must be submitted to the authority. There have been instances where some of the authority supervisory departments have instructed care providers to submit a report and an investigation to the authority at the same time, and this has resulted in more than one year passing since the incident occurred.

The Chief Parliamentary Ombudsman emphasised that the primary purpose of the Lex Maria provision is for the Health and Social Care Inspectorate to become aware of, and disseminate knowledge about, serious risks in the health and medical care and for the authority to use it in its supervisory work. According to the Chief Parliamentary Ombudsman, it is important that the Health and Social Care Inspectorate receives information about such incidents as soon as possible. Furthermore, it is important that the Health and Social Care Inspectorate also disseminates knowledge about serious risks among care providers in order to prevent similar incidents from occurring again. A procedure in which the report and the investigation are submitted at the same time and which leads to a delay in the receipt of the report is therefore, in the opinion of the Chief Parliamentary Ombudsman, not compatible with the legislative intention of the provision.

25 See Chapter 3, Section 5 of the Patient Safety Act.

Patients segregated for lengthy periods

In its supervision, the Parliamentary Ombudsmen has drawn attention to the fact that there are patients in compulsory psychiatric care who have been kept in segregation for a very long time, in some cases for several years, without it being clear from the provision in the Compulsory Psychiatric Care Act that this may be done. In the enquiry, it emerged that the Health and Social Care Inspectorate considers a patient who is kept in segregation for more than four weeks in a row to be *long-term segregated*. The Health and Social Care Inspectorate did not have any agency-wide procedures for, inter alia, what documentation should be requested as a result of the notifications of segregation received by the authority or within what time and how an inspection of the conditions for these patients should be carried out. Nor was there any agency-wide view on the occurrence of patients in long-term segregation periodically associating with other patients during the period of segregation.

A specific legal provision for long-term segregation of patients should be introduced

Chief Parliamentary Ombudsman Elisabeth Rynning stated that so-called long-term segregation of patients should require a specific legal provision and that such an intrusive measure needs to be surrounded by comprehensive control measures, such as patients' opportunities to obtain a new medical assessment and to appeal a segregation decision. The Chief Parliamentary Ombudsman therefore petitioned the Government to revise the legislation regarding patients who are kept segregated for long periods of time. In the decision, the Chief Parliamentary Ombudsman emphasised that it is important for the Health and Social Care Inspectorate to pay attention to the conditions for these patients at an early stage, as there is a risk that they will become isolated. The authority was also urged to take measures to ensure ongoing supervision of the care of these patients.

Review of long periods of stay in secure forensic psychiatric care

In connection with inspections, the Parliamentary Ombudsmen have observed in several cases that there are patients with long periods of stay in forensic psychiatric care. In one enquiry, the circumstances that prevent patients with long periods of stay in forensic psychiatric inpatient care from being discharged to outpatient care were examined.[26] As part of the case, inspections were carried out of five forensic psychiatric clinics and the boards of the regions responsible for the clinics were given the opportunity to comment on what had emerged and were asked to answer a number of questions.

Care in accordance with the Forensic Psychiatric Care Act is provided to, inter alia, a person who is handed over by a court to secure forensic psychiatric care as a criminal sanction. The court may sentence the offender to forensic

26 See the Parliamentary Ombudsmen's ref. no. O 1-2021.

psychiatric care with a special discharge hearing if the offender's mental disorder means there is a risk that they will relapse into serious crime.[27] The treatment begins as inpatient care. The administrative court may, under certain conditions, decide on outpatient forensic psychiatric care. A report on outpatient forensic psychiatric care must be accompanied by a coordinated care plan that specifies what measures have been decided for the patient in outpatient care and who is to be responsible for them.[28] In order for a coordinated care plan to be established, coordinated care planning must take place between forensic psychiatry and the relevant units at the municipality and the region.

The investigation revealed that the timing of the start of coordinated care planning varies. It was also found that it can take a long time before a coordinated care plan is established due to the fact that the forensic psychiatric clinic and the municipality's social services make different assessments of what interventions a patient needs to be able to function in forensic psychiatric outpatient care. This was particularly true for patients in care with a special discharge review, where the risk of the patient relapsing into serious crime must be taken into account. Many patients are given forensic psychiatric care outside their home region, so-called out-of-county patients. The reasons for this may be a general shortage of beds in the home region or beds providing the level of security the patient needs. This means it is more difficult to achieve coordinated care planning for patients who are cared for outside their home region. This may, for example, lead to it being more difficult for the care facility to know of accommodation in the home municipality, thus making it more difficult to try short leaves.

In the decision, Chief Parliamentary Ombudsman Erik Nymansson stated that there may be as many as one in ten patients who cannot be discharged from inpatient forensic psychiatric care in connection with the clinic's assessment that they no longer need such care. The main reason for this is that patients need to have an ordered social situation, which in turn presupposes adequate accommodation. Access to adequate housing is often decisive for the assessment of the risk of relapse into serious crime. The Chief Parliamentary Ombudsman stated that the consequences for these patients are serious. This leads to a longer period of care than necessary in a form of care associated with deprivation of liberty and other coercion.

Longer periods of care than necessary in a form of care associated with deprivation of liberty and other coercion is a serious consequence for patients

The regions and representatives of the clinics also stated that the rules on payment liability in the Act regarding collaboration in relation to discharge from inpatient health and medical care (SFS 2017:612), the Collaboration Act, do not constitute an incentive for the municipalities to provide sufficient

27 See Chapter 31, Section 3 of the Swedish Criminal Code.

28 See Sections 16 a and 16 b of the Forensic Psychiatric Care Act compared with Sections 7 and 7 a of the Compulsory Psychiatric Care Act.

interventions. The assessment was based on the fact that the liability for payment only arises after the court has decided on inpatient forensic psychiatric care and the interventions the patients need are then already decided as part of the coordinated care plan. Based on the findings, the Chief Parliamentary Ombudsman shared this assessment. He stated that the paradox is that the regulation in the Collaboration Act only applies after the measures that the economic incentives are intended to promote have been taken. The Chief Parliamentary Ombudsman could therefore not see that the Collaboration Act in this regard has had any positive effect on patients receiving care in inpatient forensic psychiatric care.

In summary, the Chief Parliamentary Ombudsman considered that the review showed that measures need to be taken to ensure that patients in inpatient forensic psychiatric care with a special discharge review can be given forensic psychiatric outpatient care more quickly. The legislator has chosen to introduce financial incentives to promote this. According to the Chief Parliamentary Ombudsman, it is important that these incentives are effective. Other measures that increase the chances of patients getting suitable housing should also be investigated. Particular attention should be paid to the situation of out-of-county patients.

6.3 Concluding remarks by Chief Parliamentary Ombudsman Erik Nymansson

I welcome the fact that several of the issues where the Parliamentary Ombudsmen have alerted the Government to a need for oversight have been dealt with in investigations and government assignments. Among other things, the National Board of Health and Welfare has been commissioned to carry out a survey of compulsory psychiatric care and forensic psychiatric care.[29] In its final report, the National Board of Health and Welfare will submit proposals for measures that the authority can take to promote skills and quality development in the area and otherwise propose the development interventions that the authority deems important to create conditions for people who receive care in compulsory psychiatric care and in forensic psychiatric care to be offered equal, safe and secure care of good quality. The final report on the assignment shall be submitted to the Government no later than by 1 August 2023. On 20 May 2021, the Government decided to appoint a special investigator with the task of reviewing certain issues under the Compulsory Psychiatric Care Act and the Forensic Psychiatric Care Act. The assignment included submitting proposals on how the child rights perspective can be strengthened in legislation, e.g. that children receiving care under the Compulsory Psychiatric Care Act or the Forensic Psychiatric Care Act should not be receiving care alongside adults or only if it can be considered to be in the

29 See Government Decision of 18 March 2021, S2021/02640.

best interests of the child, and that patients over the age of 18 should also have the right to daily outdoor activities. The report was submitted to the Government in June 2022.[30] I have commented on the report and will return to it in the Parliamentary Ombudsmen's 2022 annual report on OPCAT activities.

The Health and Social Care Inspectorate has been commissioned by the Government to strengthen and develop the supervision and follow-up of compulsory psychiatric care and forensic psychiatric care.[31] The Health and Social Care Inspectorate shall take measures to ensure that the authority is able to conduct strategic, effective, and uniform supervision of compulsory psychiatric care (adults and children). The starting point should be to take into account the observations made by the Parliamentary Ombudsmen and the National Mental Health Coordinator. After the end of the assignment period, the interventions must be integrated into day-to-day activities. An interim report will be submitted to the Government annually on 31 May, starting in 2022, and a final report will be submitted on 31 May 2025.

I can thus conclude that the Parliamentary Ombudsmen's reviews and statements have contributed to the initiation of work aimed at improving legal certainty for patients in compulsory psychiatric care and forensic psychiatric care. However, the work will continue for a long time. It is therefore important that the Parliamentary Ombudsmen, in their role as National Preventive Mechanism, continue to carry out regular inspections of care facilities that provide care in accordance with the Compulsory Psychiatric Care Act and/or the Forensic Psychiatric Care Act and monitor the use of coercive measures, including informal coercion, and how these are continuously evaluated by the organisations. The conditions for children who are in compulsory care must also continue to be monitored during inspections, as well as the risk that patients in voluntary care are treated as deprived of their liberty. These are circumstances that have repeatedly led to statements from the Parliamentary Ombudsmen and that affect the legal security of individuals.[32]

30 See Good compulsory psychiatric care – safety, security and legal certainty in compulsory psychiatric care and forensic psychiatric care (SOU 2022:40).

31 See Government decision of 10 June 2021, S2021/04972 and the Health and Social Care Inspectorate's interim report ref. no. 23434/2021.

32 See, e.g., the Parliamentary Ombudsmen's reports, ref. no. 4043-2017 and O 18-2019.

7

The Swedish Migration Agency

The Swedish Migration Agency

The Swedish Migration Agency is tasked with, inter alia, operating detention centres where foreigners can be placed pending enforcement of a decision on expulsion or deportation from Sweden.[1] Foreigners may also be detained if it is necessary to investigate the identity of the foreign national. A detention decision may be made by the Swedish Migration Agency, the Swedish Police Authority, and the migration courts.[2] During the COVID-19 pandemic, the Swedish Migration Agency temporarily reduced the number of beds to about 300 in total throughout the country, compared to the normal 500, in order to be able to increase the physical distance inside the detention centres. The detention centres are distributed over six localities.

In 2020, the Swedish Migration Agency's detention units in Flen and Märsta were inspected. The inspections were announced and the conversations were conducted via audio and video transmission within the scope of the thematic review of the situation for people deprived of their liberty during the COVID-19 pandemic.[3] A summary of this review can be found in Section 10. In 2021, no inspection was carried out.

All inspections were carried out by or on behalf of Parliamentary Ombudsman Per Lennerbrant.

7.1 Matter regarding follow-up report

Following the inspection of *the detention centre in Ljungbyhed*, in September 2019, Parliamentary Ombudsman Per Lennerbrant requested a follow-up report on the measures taken by the Swedish Migration Agency to ensure that contacts with a detainee who has been placed in a prison, remand prison, or police detention facility will, as a starting point, take place through a visit.[4]

In June 2020, the Swedish Migration Agency submitted a statement to the Parliamentary Ombudsmen. The statement states that the authority has decided on an instruction on the procedure for visits of a detainee who has been placed in a prison, remand prison, or police detention facility. The new procedure states, inter alia, that detainees must be contacted as soon as possible after security placement in order for the Swedish Migration Agency to assess

1 See Section 3(4) of the Ordinance (SFS 2019:502) with instructions for the Swedish Migration Agency.

2 See Chapter 10, Sections 12–17 of the Aliens Act (SFS 2005:716).

3 See the Parliamentary Ombudsmen's reports, ref. no. O 22-2020 and O 23-2020, as well as the *Report from 2020 – Situation for people deprived of their liberty during the COVID-19 pandemic; The Parliamentary Ombudsmen's investigation of the measures taken by four public agencies.*

4 See the Parliamentary Ombudsmen's report, ref. no. O 52-2019.

whether the placement should continue and, if necessary, inform the detainee of the decision on placement. The starting point is that contact should take place through visits. Initially, the detainee must be visited on a weekly basis in order to assess whether they can be returned to the detention center. The visits may take place at more frequent intervals if there is reason to believe that a return to the detention centre can be expedited. After one month, it is possible to switch to visits at two-week intervals. If security placement lasts for longer than two months, or where there are other special reasons for not carrying out visits, the Swedish Migration Agency may instead have a contact via video link or, if this is not possible, by telephone. If the detainee does not want any contact with the Swedish Migration Agency, the agency must instead contact the Swedish Prison and Probation Service to ensure that the detainee has not changed their attitude towards contact or visits and to obtain information about their stay. The Parliamentary Ombudsmen found that the Swedish Migration Agency had taken appropriate measures.[5]

A detainee placed with the Swedish Prison and Probation Service for security reasons must be visited regularly by the Swedish Migration Agency

7.2 Concluding remarks by Parliamentary Ombudsman Per Lennerbrant

In 2020, the Swedish Migration Agency reduced the number of beds available in the detention centres and special procedures were introduced in order to limit the spread of infection. Also in 2021, the number of beds was lower than normal due to the pandemic.

The Swedish Migration Agency opened a new detention centre in Mölndal municipality in October 2022 and plans to open a new detention centre in northern Sweden in 2024.[6] There are grounds for the Parliamentary Ombudsmen to monitor how the Swedish Migration Agency uses the experience gained from the establishment of the detention centre in Ljungbyhed prior to the use of new detention facilities. It can be noted that the Swedish Migration Agency reduced the regular number of beds in that detention centre after the statements I made following the inspection in 2019 that the detention facilities did not have sufficient capacity.[7] Furthermore, it is important that the Parliamentary Ombudsmen continue to investigate the use of coercive measures such as segregation, the detainees' access to health and medical care, and the situation of detainees who are segregated for security reasons and placed with the Swedish Prison and Probation Service.[8]

5 See the Parliamentary Ombudsmen's decision of 12 January 2021 in ref. no. O 15-2020.

6 See the Swedish Migration Agency's Annual Report for 2021, p. 82.

7 See the Parliamentary Ombudsmen's report, ref. no. O 52-2019, and the Swedish Migration Agency's decision FV AC/002/2020 of 4 May 2020.

8 See also JO 2021/22 p. 221 on the situation of detainees within the Swedish Prison and Probation Service.

8

Municipalities' LSS activities

Municipalities' LSS activities

Each municipality is responsible for social services in its area, and has the ultimate responsibility for ensuring that individuals receive the support and help they need.[1] Unless otherwise agreed, each municipality shall also be responsible for, inter alia, housing with special services for adults or other specially adapted housing for adults in accordance with the Act Concerning Support and Service for Persons with Certain Functional Impairments (SFS 1993:387) (LSS).[2]

LSS means that a certain group of people are entitled to support and service from municipalities and regions. The intention is that with such help they will be able to create a dignified life for themselves, and that their lives will be as similar to other people's as possible and in association with other people. The interventions prusuant to LSS must be designed so as to strengthen the individual's ability to live an independent life and to actively participate in society. The overall purpose of the special interventions pursuant to LSS should be to achieve as equal conditions as possible between people with extensive disabilities and other people.[3] The activities must be based on respect for the individual's right to self-determination and privacy. To the greatest extent possible, the individual must be granted influence and co-determination over the initiatives. The quality of the activities must be systematically and continuously developed and ensured.[4]

On 5 February 2020, SVT aired an episode of Uppdrag granskning that dealt with conditions for a user at an LSS housing with special services in Gnosjö municipality (Skogsbo LSS home). After the TV programme was broadcast, a number of complaints were received by the Parliamentary Ombudsmen. Against this background, the Parliamentary Ombudsmen decided to conduct an inspection of the LSS home.[5]

The inspection was carried out on behalf of Parliamentary Ombudsman Thomas Norling.

8.1 Observations made during the inspection

During the inspection, the Parliamentary Ombudsmen's employees mainly paid attention to issues relating to the user's care environment, safety, treatment, and activities, as well as staffing and the staff's competence.

1 Chapter 2, Section 1 of the Social Services Act (SFS 2001:453).

2 Section 9 (9) of the Act Concerning Support and Service for Persons with Certain Functional Impairments (LSS).

3 See Prop. 1992/93:159 p. 50.

4 Sections 5 and 6 of LSS.

5 See the Parliamentary Ombudsmen's report, ref. no. O 10-2020.

Observations of the user's situation

Skogsbo LSS home was set up for a single user. Apart from the occasional visits from a relative, the user only socialised with the staff. The LSS home was staffed around the clock with two personal assistants. The organisation had eight permanent assistants and another eleven available when needed. The majority of the permanent employees had experience of working with people with disabilities. The staff had received training in autism and the municipality's values (participation and respect), and they had also been trained in pedagogy and low-arousal approach.

The user spent almost all his time at the home and he did not leave it to participate in a daily activity, for example. He had the opportunity to exert influence over his own days through the choice of activities. Based on the user's well-being, the staff made the assessment of which activities he would be able to choose from. His condition could cause him to do the same activities for several days or weeks in a row.

Following the inspection, the Parliamentary Ombudsman pointed out that the interventions pursuant to LSS are intended to offer such help that the person should be able to create a dignified life for themselves and that their lives should be as similar to other people's as possible and in association with other people. The interventions pursuant to LSS must be designed so as to strengthen the individual's ability to live an independent life and to actively participate in society.

The user was in fact deprived of his liberty

During the inspection, it emerged that the user was locked up for most of the day at the LSS home. He was only allowed to leave the housing accompanied by staff for short walks and car trips, among other things. The purpose of the confinement was to prevent the user from escaping or harming himself.

The user was locked up for most of the day

Following the inspection, the Parliamentary Ombudsman emphasised that each and every individual is protected against deprivation of liberty in respect of the acts of public bodies. However, this right may be limited by law.[6] Thus, an express legal basis is required for a person to be deprived of their liberty. The Parliamentary Ombudsman did not question that the confinement had taken place with the best of intentions and with care for the user. According to the Parliamentary Ombudsman, however, it was clear that he had de facto been deprived of his liberty. Without going into an assessment of whether the confinement constituted an unlawful deprivation of liberty, the Parliamentary Ombudsmen noted that LSS does not allow for such a measure. The activities had been conducted under these forms since 2013, which meant that the user had been deprived of his liberty without legal basis for several years**.** Gnosjö

6 Chapter 2, Section 8 and Section 20, first paragraph (3) of the Instrument of Government.

The Parliamentary Ombudsman directed serious criticism at the fact that the user was deprived of his liberty without legal basis for several years

Municipality was severely criticised by the Parliamentary Ombudsmen for allowing this to happen.

8.2 The review of the Health and Social Care Inspectorate's supervision

In connection with the inspection of the LSS housing with special services in Gnosjö, the Parliamentary Ombudsmen decided to review the Health and Social Care Inspectorate's supervision of the LSS home in a special enquiry.[7]

It emerged that the Health and Social Care Inspectorate had initiated an inspection of the LSS home Skogsbo after the authority received a complaint. It claimed, inter alia, that all areas of the home were locked, that the staff were unable to handle the user, and that he was under camera surveillance. In February 2019, the Health and Social Care Inspectorate carried out an inspection of the LSS housing. The inspection led to the conclusion that there were no shortcomings in the housing and that the user achieved good living conditions "in the parts covered by the supervision". In the decision in the enquiry, the Parliamentary Ombudsmen states that the Health and Social Care Inspectorate is obligated to investigate whether an LSS activity meets the requirements for good quality, regardless of the user's or the operator's opinion on the matter. Otherwise, there is a risk that an activity is considered to meet the requirements simply because no one is explicitly dissatisfied with it. That is, of course, unacceptable and risks leading to arbitrary assessments. The Parliamentary Ombudsman understood it as that the inspection lacked sufficient focus on the complaints that had been directed at the housing.

It was only in the consultation response to the Parliamentary Ombudsmen that the Health and Social Care Inspectorate considered the issue of whether the user was locked up or not

Furthermore, the Parliamentary Ombudsmen found that the findings of the investigation indicated that the Health and Social Care Inspectorate accepted that the user, at least to some extent, was subject to restrictions when he was in the home and that the Health and Social Care Inspectorate considered this to be a prerequisite for him to be able to live there. In its consultation response to the Parliamentary Ombudsmen, the authority had also stated that certain measures can be accepted as a safeguard measure if the individual has consented. According to the Parliamentary Ombudsmen, it was unclear whether the Health and Social Care Inspectorate meant that the user had given such consent and, if so, what the authority considered it to include. The Parliamentary Ombudsman pointed out that the user was placed in the home based on LSS and that this legislation is based on voluntary action and participation on the part of the user. Coercive measures taken without a legal basis constitute a violation of the fundamental rights and freedoms of the individual. The Parliamentary Ombudsmen found that the Health and Social Care Inspectorate had failed in its inspection of the LSS housing with special services.

7 See JO 2022/23 p. 399.

The Parliamentary Ombudsmen also stated that high demands must be placed on the Health and Social Care Inspectorate's supervisory activities. The authority's supervision plays an important role in ensuring that the individual is guaranteed good living conditions in accordance with the Act Concerning Support and Service for Persons with Certain Functional Impairments. Therefore, if the supervision is initiated after information has come to light on coercive or restrictive measures, it is important that these are properly investigated during the inspection. This is important, not least when the inspection concerns LSS housing with special services with only one user. Such a user is in a particularly vulnerable situation and must be able to rely on the supervision efforts to meet high standards. It is also important that the authority's documentation in a supervisory case is accurate and fair, and that the authority's decision is clear and well-prepared. The language should be proper, simple, and understandable. There must not be any uncertainty as to the circumstances on which the authority's assessment is based. It must therefore be clear from the inspection report how the authority has reasoned, regardless of whether or not it has found deficiencies in the reviewed activities.

It is not possible to take coercive measures based on the Act Concerning Support and Service for Persons with Certain Functional Impairments

8.3 Concluding remarks by Parliamentary Ombudsman Thomas Norling

The Parliamentary Ombudsmen's inspection of the LSS housing with special services in Gnosjö shows how important it is that those responsible for an LSS activity have a good knowledge of the legal conditions for the activity. This is necessary in order to ensure that measures are not taken in violation of the constitution or the law.

In December 2020, the Health and Social Care Inspectorate received an assignment from the Government concerning follow-up of LSS housing with special services.[8] The final report on this assignment was presented in December 2021.[9] In its report, the Health and Social Care Inspectorate highlights that the authority has opened more supervisory cases relating to coercive and restrictive measures within LSS activities. The report shows that the Health and Social Care Inspectorate believes there is a need to reach out to municipalities and principals with supervision to review the existence of such measures and that the Health and Social Care Inspectorate's work should be characterised by a patient and user perspective. During inspections of housing for children and adults, those who want and have the ability to talk to the Health and Social Care Inspectorate's inspectors must be given this opportunity and what emerges must be given the proper importance in assessments during the course of the case and before a decision is made. The Health and

8 Appropriation directions for the financial year 2021 regarding the Health and Social Care Inspectorate, S2020/09593. Government decision of 22 December 2020.

9 Follow-up of LSS housing with special services, final report of government assignments, article number IVO 2021-11, published in December 2021, www.ivo.se.

Social Care Inspectorate emphasises that the authority needs to work intensively to develop its supervision to become even more strategic, efficient, and uniform.

On the basis of, inter alia, reports in the media, there is reason to assume that actual deprivation of liberty without support in law occurs in several activities operated under the Act Concerning Support and Service for Persons with Certain Functional Impairments (LSS). There may be grounds to continue monitoring the supervision of LSS housing with special services.

9

Transportation

Transportation

In 2018 and 2019, the Parliamentary Ombudsmen's OPCAT activities had a thematic focus on the transport of individuals deprived of their liberty. During the period, 54 inspections were carried out within the scope of the theme. Issues related to transportation were also raised in a number of other inspections. In June 2019, the interim thematic report on *Transportation* was published. In September 2021, the final report *Transportation of individuals deprived of their liberty* was published. This section includes the summary included in the report of 2021.

Measures that can help counteract shortcomings in the transportation system

In order to address the shortcomings identified during the inspections, statements have been made on measures that needed to be taken:

- Ensuring there is a capacity within the Swedish Prison and Probation Service (tasked with executing assisted transportation) to perform assisted transportation within the timeframes established by the Parliamentary Ombudsmen's statements. This is to address the problematic situation where individuals deprived of their liberty are detained in more closed environments where they do not belong, e.g. in police custody facilities.
- The authorities that are able to turn to the Swedish Prison and Probation Service and the Swedish Police Authority for judicial assistance according to law, should have their own capacity to be able to carry out transports for which they can't request assistance according to law. Furthermore, there is a need for knowledge of how the legislation shall be applied. Only then can an overuse of the Swedish Prison and Probation Service's and the Swedish Police Authority's resources be avoided.
- The starting point for the planning and execution of assisted transportation for individuals deprived of their liberty under the healthcare laws is that they should not be placed in a remand prison in connection with transport. These categories of individuals deprived of their liberty should also not be transported together with the Swedish Prison and Probation Service's clients.
- There is a need for coordination between the authorities to enable individuals deprived of their liberty to have admission calls in case of assisted transportation. One possible way to achieve this is for the authorities to specify in their orders to the Swedish Prison and Probation Service who or which relatives a detainee may call during a transportation stopover in a remand prison.

- The Swedish Police Authority needs – in consultation with the Swedish Prison and Probation Service – to organise transportation stopovers at police custody facilities in such a way that the police custody facility staff have time to carry out all necessary checks and measures upon admission.
- The relevant authorities need to take measures to reduce the stigmatising elements in the performance of assisted transportation. Among other things, it is a matter of designing the transports in such a way that people taken into care under the healthcare laws are not made to feel like criminals. It is also a matter of ensuring that individual assessments are made of the need for security arrangements.
- The relevant authorities need to have a common understanding of what information is to be handed over by the ordering authority in connection with an order for an assisted transportation. Furthermore, there is an urgent need for a common understanding of what different types of data mean and what security arrangements they should lead to. This also means that the Swedish Prison and Probation Service's ordering system must be developed and adapted for ordering assisted transportation.

Measures taken

The interim thematic report on *Transportation* presented the measures that needed to be taken to rectify the identified shortcomings. The 2019 review shows that several measures were taken. Among other things, the Swedish Police Authority organised the transportation stopovers in the police custody facilities, which provided conditions for taking all necessary checks and measures upon admission. However, several shortcomings remained during the 2019 review. Among other things, the one concerning the capacity of the Swedish Prison and Probation Service to carry out assisted transportation within the time frames established by the Parliamentary Ombudsmen's statement. There were still stigmatising elements in the performance of assisted transportation and individuals deprived of their liberty under the healthcare acts were still placed in remand prisons and transported together with the Swedish Prison and Probation Service's clients.

The decision on priorities was in conflict with the Government's regulation

On 1 April 2017, the Swedish Prison and Probation Service was tasked with carrying out the transports handed over by the Swedish Police Authority and the Swedish Security Service in accordance with Section 29 a of the Police Act. The authority shall also, according to special regulations, provide other authorities assistance with transport. The final report highlights that the basis for the amendment of the law and the legislation on the transportation of individuals deprived of their liberty was not sufficiently substantiated. The

single most important factor that has affected the situation for the individuals deprived of their liberty is related to how the Swedish Prison and Probation Service organised its transportation assignment. This is highlighted in the decision of then Chief Parliamentary Ombudsman Elisabeth Rynning in March 2020. In the investigation in the case, it emerged that the Swedish Prison and Probation Service's transport organisation would be expanded in stages, and it was not until 2021 – i.e. four years after the regulations entered into force – that the authority expected to have the capacity required to be able to fulfil the expanded assignment. The Swedish Prison and Probation Service's focus on the transportation assignment has varied over time. Initially, the intention was for the authority to have the capacity to carry out round-the-clock transports. After some time, the Swedish Prison and Probation Service returned to the transport organisation that the authority had before the new rules entered into force. Subsequently, the transport organisation was expanded again. Throughout the process, the legal provisions that give a number of authorities the right to hand over transports to the Prison and Probation Swedish Prison and Probation Service have been in force. In the decision, the Chief Parliamentary Ombudsman directed serious criticism at the Swedish Prison and Probation Service. The criticism can be summarised as follows: The Swedish Prison and Probation Service's transport organisation was not prepared for the increase in the number of transport assignments that resulted from, among other things, Section 29 a of the Police Act. However, the Swedish Prison and Probation Service's attempt to deal with the problematic situation through the decision in December 2017 is in direct conflict with the authority's instructions announced by the Government in an ordinance. The purpose of the Government's governance of its authorities by means of, for example, ordinances is to provide transparency and predictability. The Swedish Prison and Probation Service's decision to only carry out transports handed over from the Swedish Police Authority to the extent allowed by their transport capacity, in the Swedish Prison and Probation Service's opinion, counteracted this purpose and thus one of the foundations of a state governed by the rule of law. The decision also had serious consequences for individuals deprived of their liberty.

The lack of capacity had a negative impact on individuals deprived of their liberty

The fact that the Swedish Prison and Probation Service was not prepared for the new assignment became apparent when the authority decided on 22 December 2017 to deprioritise the transports handed over by the Swedish Police Authority. In its decision, the Swedish Prison and Probation Service highlights that there is a significant risk that individuals will suffer if the authority does not solve its task. An inspection by then Parliamentary Om-

budsman Cecilia Renfors in March 2019 of the Swedish Police Authority, the Borlänge police custody facility showed this fear had been realised. During the inspection it emerged that 20 children and young people taken into care under the Care of Young Persons Act had been placed in the police custody facility awaiting transport to the National Board of Institutional Care's LVU home. Those in care were between 15 and 18 years old and had been placed in the police custody facility for between less than 24 hours and up to four and a half days. The Chief Parliamentary Ombudsman at the time, Elisabeth Rynning, referred to a previous statement that a police custody facility is generally an inappropriate place for the placement of young people who in many cases have no previous experience of such environments. If a young person is to be placed in a police custody facility, transportation must begin as soon as possible, but no later than 24 hours after they have been taken into custody. The Swedish Police Authority has drawn up anomaly reports and there are a number of cases during the second half of 2019 where children and young people who are cared for under the Care of Young Persons Act have remained in police custody facilities while waiting for transportation. The problems that arose immediately after the amendment entered into force thus persisted almost three years later, which the Chief Parliamentary Ombudsman considered very serious. In summary, the Chief Parliamentary Ombudsman concluded that the Swedish Prison and Probation Service had not been prepared for the expanded transport assignment.

In addition to what was previously identified, the Ombudsmen assessed that the following measures need to be taken:

The organisation of the Swedish Prison and Probation Service entails many and long transports

Shortcomings in the Swedish Prison and Probation Service's transport organisation have resulted in inmates being relocated between remand prisons. Long and frequent transports have been stressful for the inmates, who have been limited in their mobility, often been placed in restraints, and had limited access to toilets. In one case, the Parliamentary Ombudsmen noted that an inmate with special care needs had been transported over long distances between Skåne and Stockholm on several occasions in order to have the care needed at the country's only remand prison with care places in Stockholm.

- The Swedish Prison and Probation Service needs to review the appropriateness of the authority only having specially adapted care places for inmates held on remand in Stockholm.

Assisted transportation

The review showed that the Swedish Prison and Probation Service continued to have problems in 2019 with carrying out assisted transportation within a reasonable period of time. For this reason, the Ombudsmen made the following statements:

- Authorities entitled to request judicial assistance from the Swedish Prison and Probation Service should not abuse this possibility. If an authority requests judicial assistance even though it could have arranged the transport itself, this means that other transports are delayed or cannot be carried out by the Swedish Prison and Probation Service.
- The authorities need to have procedures in place to document the reasons for which a request for judicial assistance has been made. In this case, the request can be reviewed ex post and thus be included as part of follow-up and quality assurance of the authority's activities. An authority requesting judicial assistance should systematically follow up on the consequences of the Swedish Prison and Probation Service's transports being delayed.
- Authorities and others who may participate in judicial assistance need to have well-developed procedures in place for such a measure to be carried out in the best way for an individual deprived of their liberty regardless of the time of day. The authority requesting the judicial assistance must always be prepared to deal with the possibility that questions relating to the request may arise 24 hours a day.
- The relevant authorities need to have an overall plan for how the transportation shall be carried out and that there are conditions for the person requesting judicial assistance to book a trip if necessary and participate in the transport of a young person.

Transportation stopover

In 2019, it was observed that young people had to spend the night in police custody facilities in connection with transportation. That prompted a statement that:

- The National Board of Institutional Care has a responsibility to co-operate so that the judicial assistance is not more intrusive than necessary. The authority should therefore ensure that there are accommodation options available at its institutions.

10

Situation of individuals deprived of their liberty during the coronavirus pandemic

Situation of individuals deprived of their liberty during the coronavirus pandemic

In the spring of 2020, each of the Ombudsmen decided, within their respective areas of responsibility, to specifically investigate an agency that enforces deprivation of liberty, thus highlighting the consequences of COVID-19 for the inmates.[1] The Ombudsmen made their respective decisions in the summer or autumn of 2020.[2] This was followed by the publication of the thematic report *Situation for people deprived of their liberty during the Covid-19 pandemic – The Parliamentary Ombudsmen's investigation of the measures taken by four public agencies*. This section includes a summary of the report.

Shortcomings in the agencies' preparations

The Prison and Probation Service, the National Board of Institutional Care, the Swedish Migration Agency, and the National Board of Forensic Medicine carry out operations that are vital to society. In the decisions concerning the Swedish Prison and Probation Service and SiS, *Parliamentary Ombudsman Katarina Påhlsson* and *Parliamentary Ombudsman Thomas Norling* stated that it is of crucial that the agencies make preparations for any possible crises, such as a pandemic, and that they train staff and plan for measures to be taken. The purpose of such preparations is, inter alia, to ensure that any measures then taken can be considered as appropriate, proportionate, and legally secure.

In their investigations, the Ombudsmen have been able to establish a number of shortcomings in the agencies' crisis preparations. For example, *Parliamentary Ombudsman Katarina Påhlsson* stated that one of first measures taken by the Prison and Probation Service in mid-March 2020 restricted inmates' right to receive visits and take leave. However, this measure was part of a routine description introduced as an appendix to the Prison and Probation Service's health and medical care handbook. In the opinion of the Parliamentary

1 The Chief Parliamentary Ombudsman at the time, Elisabeth Rynning, investigated the conditions at the National Board of Forensic Medicine's two forensic psychiatric examination units. Parliamentary Ombudsman Thomas Norling investigated the conditions at one of the National Board of Institutional Care's residential homes for the compulsory care of substance abusers and one special residential home for young people. Parliamentary Ombudsman Katarina Påhlsson investigated the conditions at two of the Prison and Probation Service's remand prisons and four prisons. Parliamentary Ombudsman Per Lennerbrant investigated the conditions at two of the Swedish Migration Agency's detention centres.

2 See The Parliamentary Ombudsmen's decision, ref. no. O 12-2020, ref. no. O 13-2020, ref. no. O 18-2020, and ref. no. O 21-2020.

Ombudsman, the manner in which the Prison and Probation Service introduced the restrictions was problematic and she further stated: '[It should] be reasonably possible to demand that there is better preparation for how the Prison and Probation Service shall handle the spread of a disease that pose a danger to public or society. Well-prepared crisis management with clear rules and structures contributes to predictability for both inmates and staff regarding which measures may be taken in a crisis. I assume that the Prison and Probation Service will evaluate and analyse how the agency has handled the ongoing pandemic. This also ensures that any measures taken in relation to inmates in the next crisis are legally secure, appropriate, and proportionate.'

Parliamentary Ombudsman Thomas Norling made a similar statement in his decision following the investigation of the National Board of Institutional Care.

The possibilities to prevent the spread of infection

All the investigated agencies introduced, on short notice, procedures for how staff should act in the event of suspected or established infection of COVID-19. During the investigation, however, it emerged that there was some uncertainty concerning how the staff should act. Following the investigation of the National Board of Institutional Care, *Parliamentary Ombudsman Thomas Norling* stated that the starting point is that a decision on separate care must correspond to the individual's well-defined care need. He stated the agency had applied the provisions on separate care in a way that was very dubious. [3]

The inspection carried out by then *Chief Parliamentary Ombudsman Elisabeth Rynning* of the National Board of Forensic Medicine's forensic psychiatric examination units raised the question of how far the Communicable Diseases Act provisions on voluntary measures can be applied in situations where a person is deprived of their liberty, without risking to undermine the rule of law. In particular, this applies to agreements that can be perceived as the waiving of a continually protected right. Since a person deprived of their liberty is in a vulnerable situation, there is, in the opinion of the Chief Parliamentary Ombudsman, a significant risk in this context that voluntariness becomes an illusion. This applies not least in relation to people susceptible to, or with diagnosed, mental disorders that may affect their decision-making abilities.

It is possible for the agencies under investigation to separate inmates in certain situations. Following his inspection of the Swedish Migration Agency, *Parliamentary Ombudsman Per Lennerbrant* stated that he did not rule out that a situation may arise where an inmate, who is suspected or confirmed to be infected with a disease posing danger to the public and who, for example,

3 See the Parliamentary Ombudsmen's minutes, ref. no. O 21-2021.

displays behaviour that risks exposing others to infection, constitutes such a danger that there exists a legal basis for a decision on segregation. However, such a decision can only be aimed at averting a fast arising and potentially dangerous situation. In the Parliamentary Ombudsman´s view, it must not therefore be case that the agency routinely takes decisions on segregation as a measure to counteract infection. Nor can a decision on segregation replace the measures that may need to be taken in line with the Communicable Diseases Act. *Chief Parliamentary Ombudsman Elisabeth Rynning* and *Parliamentary Ombudsman Thomas Norling* made similar statements in their respective decisions.

Against this background *Chief Parliamentary Ombudsman Elisabeth Rynning* pointed out that an agency responsible for people deprived of their liberty is dependent on the existence of well-functioning cooperation with the regions' infectious diseases doctors who know the preconditions under which the agency operates and the measures it is able to take to prevent the spread of infection. In addition, Parliamentary Ombudsman Per Lennerbrant stated that a well-functioning crisis organisation is based on, inter alia, agencies' and other actors' abilities and preconditions for good cooperation.

Chief Parliamentary Ombudsman Elisabeth Rynning also stated that the details that emerged during the investigation of the National Board of Forensic Medicine highlighted the difficulties that may arise for agencies responsible for people deprived of their liberty in a situation where there exists a risk of spread of infection. In her view, neither the Communicable Diseases Act nor the laws governing the National Board of Forensic Medicine's activities provide sufficient support for the measures that may be necessary to prevent the spread of infection in a way that provides sufficient protection whilst simultaneously being proportionate and legally secure. In her view, it appeared obvious that the preconditions for such measures in activities where people are held deprived of their liberty should be urgently reviewed.

The issue of cooperation between agencies was also raised with regard to the possibility of testing for infection. Representatives of the Swedish Migration Agency, the National Board of Forensic Medicine, and the National Board of Institutional Care stated that, at the beginning of the pandemic, there were limited opportunities to test for COVID-19. In his decision following the inspection of the National Board of Institutional Care, *Parliamentary Ombudsman Thomas Norling* noted that, as recently as the beginning of June 2020, the agency experienced differences between the different regions in the extent to which staff were given the opportunity to be tested. Both *Parliamentary Ombudsman Katarina Påhlsson* and *Parliamentary Ombudsman Per Lennerbrant* stated in their decisions that testing is an important part of the work in preventing the spread of infection among people deprived of their liberty. *Parliamentary Ombudsman Per Lennerbrant* noted that the safety and security

of inmates during a pandemic largely depends on the capacity to test for infection and that such tests are carried out. The investigations of the Swedish Migration Agency, the National Board of Forensic Medicine, and the National Board of Institutional Care continued until the summer, and it was reported that testing possibilities had gradually improved over the course of the pandemic. In her decision, *Chief Parliamentary Ombudsman Elisabeth Rynning* pointed out that the Communicable Diseases Act is based on the premise that testing of suspected cases of diseases covered by the law can take place.

The lack of coordination was also made clear when state agencies were not subject to the mandate given by the Government to the National Board of Health and Welfare to secure protective equipment and other protective materials for use. In her decision, *Chief Parliamentary Ombudsman Elisabeth Rynning* stated that it was serious that it was not until the end of May that the National Board of Forensic Medicine had sufficient protective equipment. This led to – as she understood it – staff not being able to use protective equipment in all the situations recommended by the Public Health Agency of Sweden and Region Stockholm.

Physical distance

The strategy chosen by Sweden to limit the spread of COVID-19 is largely based on everyone taking individual responsibility and, inter alia, keeping a physical distance from other people. In their investigations, each Ombudsman found that it had been difficult for inmates and staff to maintain an acceptable physical distance in secure environments. During the investigation of the Swedish Prison and Probation Service, it emerged that the agency continued to double-occupy cells during the ongoing pandemic. *Parliamentary Ombudsman Katarina Påhlsson* stated that she believed that the Swedish Prison and Probation Service should take immediate measures to ensure that there is no double-occupancy of cells where it is not possible to maintain the necessary physical distance.

Parliamentary Ombudsman Per Lennerbrant also raised this issue, stating that, provided the Swedish Migration Agency took the necessary measures to enable detainees to maintain a physical distance, it should not be excluded that detainees are able to share living spaces during an ongoing pandemic. However, it became clear during the investigation that both staff and inmates found it difficult to maintain a physical distance from others in the detention centre. In the opinion of the Parliamentary Ombudsmen, the Swedish Migration Agency needed to consider these details and, for example, seek support from the different regions for assessments of what – from a disease control perspective – is an acceptable number of inmates in, for example, a residential room or how physical distance can be maintained in other ways.

Inmates belonging to an at-risk group

For people belonging to an at-risk group, Covid-19 infection and the onset of illness can have serious consequences. The Swedish Prison and Probation Service developed procedures for handling this category of inmates at an early stage. In her decision, *Parliamentary Ombudsman Katarina Påhlsson* made statements regarding how the agency had applied the procedures and stated, inter alia, that the Prison and Probation Service needed to have a long-term perspective in its planning for the handling of this group of inmates. When *Chief Parliamentary Ombudsman Elisabeth Rynning* began her investigation of the National Board of Forensic Medicine, the agency lacked a specific routine for the handling of inmates in at-risk groups. After the issue had been raised at the final dialogue meeting, the National Board of Forensic Medicine management announced that the agency had adopted such a routine. The investigations of the Swedish Migration Agency and the National Board of Institutional Care also highlighted a lack of agency-wide procedures. However, one of the Swedish Migration Agency's detention centres had adopted a local routine, and *Parliamentary Ombudsman Per Lennerbrant* stated that it was reasonable to require the agency to take measures which ensure that the routine was applied in all detention centres. *Parliamentary Ombudsman Thomas Norling* called on the National Board of Institutional Care to develop procedures for the protection of vulnerable inmates against infection.

Inmates' contacts with the outside world

All the agencies investigated took infectious disease control measures to limit inmates' contact with the outside world. These measures were varied in their extent. However, the investigations show that all the agencies had introduced some form of compensatory measures to reduce the negative effects of the restrictions. These measures included technical solutions which were quickly introduced to enable video calls (the Prison and Probation Service and the Swedish Migration Agency), and the possibility for inmates to receive visits outdoors (the National Board of Institutional Care). The National Board of Forensic Medicine also took measures and installed transparent screens to make it possible to conduct infectionsafe visits.

Although compensatory measures have been introduced, the Parliamentary Ombudsmen identified agencies that needed to take further measures. Following the investigation of the Prison and Probation Service, *Parliamentary Ombudsman Katarina Påhlsson* urged the agency to investigate whether it was possible to allow inmates to receive visits outdoors and to separate inmates and visitors from each other with screens to reduce the risk of infection. The Parliamentary Ombudsman also expressed concern that the possibility of making video calls to underage children was not sufficient to cover the need.

The investigation of the National Board of Institutional Care showed that it

had continually reviewed the need for visitor restrictions and, where possible, had eased restrictions. Initially, the visiting restrictions applied to all institutions. They expired on 7 July 2020. Since then, it has been up to each institution to examine whether there are grounds for continued visitor restrictions based on local conditions and needs. *Parliamentary Ombudsman Thomas Norling* stated that this change was in line with an ambition that restrictions to prevent the spread of infection should not exceed those which are necessary.

Information to inmates

Each Ombudsman found that there had been shortcomings in the way which the agenciees have provided people deprived of their liberty with information concerning COVID-19 and the measures to prevent the spread of infection. In the opinion of the Ombudsmen, the people deprived of their liberty should be provided with written information in the first instance, which may be supplemented with oral information. *Parliamentary Ombudsman Per Lennerbrant* stated that relevant information is a necessity for inmates to be able to claim their rights and to take appropriate measures to protect themselves and others against infection. *Parliamentary Ombudsman Katarina Påhlsson* pointed out that the lack of provision of information can create a general feeling of anxiety among inmates. She also pointed out that more serious is that a worry or an ignorance of what measures the Prison and Probation Service takes in the case of feared or confirmed infection can lead to inmates being reluctant to reveal that they have symptoms. *Chief Parliamentary Ombudsman Elisabeth Rynning* stated that the inmates and the agency can be seen as depending on one another in order to achieve the best results in the efforts that should be made to prevent the spread of infection. Such cooperation must be based on a sense of mutual trust that the parties concerned are taking the necessary measures. An important part of this, in the opinion to the Chief Parliamentary Ombudsman, is that inmates feel confident that the agency is doing what it can to protect them against possible infection.

One possible way to provide the inmates with accurate information is for the agencies to use the information material produced by, for example, the Public Health Agency of Sweden. *Parliamentary Ombudsman Thomas Norling* pointed out that, as a rule, individual agencies need to supplement this general material with information concerning the consequences of the outbreak of the disease in their own activities.

Annexes

Tables and summaries

ANNEX A

Participation in meetings

In 2020 and 2021, employees from the Parliamentary Ombudsmen's OPCAT Unit participated in the following meetings:

International meetings

- 23 and 24 Januari 2020, Oslo, Norge, *Nordic NPM-meeting*.
- 28 August 2020, *Nordic NPM-meeting*, via audio and video transmission.
- 20 November 2020, *Nordic NPM-meeting*, via audio and video transmission.
- 19 March 2021, *Nordic NPM-meeting*, via audio and video transmission.
- 27 October 2021, *Nordic NPM-meeting*, via audio and video transmission.

National meetings

- 5 March 2020, *Dialogue Forum with civil society stakeholders on the rights and situation of individuals deprived of their liberty*, Stockholm.
- 23 September 2020, *Dialogue Forum with civil society stakeholders on the rights and situation of individuals deprived of their liberty*, via audio and video transmission.
- 17 March 2021, *Dialogue Forum with civil society stakeholders on the rights and situation of individuals deprived of their liberty*, via audio and video transmission.
- 19 October 2021, *Dialogue Forum with civil society stakeholders on the rights and situation of individuals deprived of their liberty*, Stockholm.

Inspections carried out in 2020–2021

ANNEX B

Unannounced inspections

Police custody facilities	
Borås	Ref. no. O 1-2020
Västberga	Ref. no. O 21-2021
Karlstad	Ref. no. O 33-2021
Total 3	

Remand prisons	
Sollentuna	Ref. no. O 5-2020
Huddinge, dept. Nacka	Ref. no. O 20-2021
Karlstad	Ref. no. O 34-2021
Total 3	

Compulsory psychiatric care	
Department of Psychiatry, Ryhov County Hospital in Jönköping	Ref. no. O 9-2020
Total 1	

LSS housing with special services	
Skogsbo (Gnosjö)	Ref. no. O 10-2020
Total 1	

Total 8 unannounced inspections

Announced inspections

Police custody facilities	
Eskilstuna	Ref. no. O 3-2020
Varberg	Ref. no. O 8-2020
Malmö	Ref. no. O 27-2021
Total 3	

Remand prisons	
Färingsö	Ref. no. O 12-2020
Kronoberg	Ref. no. O 12-2020
Malmö	Ref. no. O 25-2021
Total 3	

Prisons	
Beateberg	Ref. no. O 12-2020
Färingsö	Ref. no. O 12-2020
Hall	Ref. no. O 12-2020
Svartsjö	Ref. no. O 12-2020
Total 4	

Residential homes for the compulsory care of substance abusers	
Hornö (Enköping)	Ref. no. O 20-2020
Total 1	

Special residential homes for young people	
Tysslinge (Södertälje)	Ref. no. O 19-2020
Sundbo	Ref. no. O 9-2021
Vemyra	Ref. no. O 10-2021
Fagared	Ref. no. O 11-2021
Brättegården	Ref. no. O 12-2021
Total 5	

National Board of Institutional Care	
Placement Unit	Ref. no. O 24-2021
Total 1	

Migration detention centres	
Flen	Ref. no. O 22-2020
Märsta	Ref. no. O 23-2020
Total 2	

Compulsory Psychiatric care	
National Board of Forensic Medicine, Forensic Phychiatric Examination Unit in Gothenburg	Ref. no. O 24-2020
National Board of Forensic Medicine, Forensic Phychiatric Examination Unit in Stockholm	Ref. no. O 25-2020
Region Östergötland, Forensic Psychiatric Clinic in Vadstena	Ref. no. O 4-2021
Region Västra Götaland, Forensic Psychiatric Clinic in Gothenburg	Ref. no. O 5-2021
Region Kronoberg, Regional Forensic Psychiatric Clinic in Växjö	Ref. no. O 6-2021
Region Västmanland, Department of Forensic Psychiatry Västmanland/Sala	Ref. no. O 7-2021
Region Stockholm, Stockholm County Healthcare Services, Forensic Psychiatric Care Stockholm	Ref. no. O 8-2021
Total 7	

Total 26 announced inspections

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