PARLIAMENTARY OMBUDSMAN OF FINLAND

SUMMARY OF THE ANNUAL REPORT 2021

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To the reader

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

The undersigned Mr Petri Jääskeläinen, Doctor of Laws and LL.M. with Court Training, served as Parliamentary Ombudsman throughout the year under review 2021. My term of office is from 1 January 2018 to 31 December 2021 (and from 1 January 2022 to 31 December 2025). Those who have served as Deputy Ombudsmen are Licentiate in Laws Ms Maija Sakslin (from 1 April 2018 to 31 March 2022 and 1 April 2022 to 31 March 2026) and Doctor of Laws and LL.M. with Court Training Mr Pasi Pölönen (from 1 October 2017 to 30 September 2021 and 1 October 2021 to 30 September 2025).

Licentiate in Laws and LL.M. with Court Training, Principal Legal Adviser Mr Mikko Sarja was selected to serve as the Substitute for a Deputy Ombudsman for the period 1 October 2017–30 September 2021 and 1 October 2021 to 30 September 2025. He performed the tasks of a Deputy Ombudsman for a total of 55 working days during the year under review.

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

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

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

I hope the summary will provide the reader with an overview of the Parliamentary Ombudsman's work in 2021.

Petri Jääskeläinen
Parliamentary Ombudsman of Finland

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PHOTOS

The photographs on the front pages of the sections feature shots of the steel statue deplating giant strawberries called "Oma maa mansikka" (2007) by sculptor Jukka Lehtinen, located at the front of the Finnish Parliament Annex. Photos: Office of the Parliamentary Ombudsman photo archive (p. 12, 30, 48, 161, 200, 219, 223).

Mikko Mäntyniemi p. 13, 21, 26.
Photo archive of the Parliament of Finland p. 43, 46.
Photo archive of the Parliamentary Ombudsman of Finland p. 96, 99, 103, 105.
Adobe Stock p. 162.
European Union p. 220.

1 General comments

Parliamentary Ombudsman
Mr Petri Jääskeläinen

Reform of Division of duties between the Parliamentary Ombudsman and the Chancellor of Justice

During the year under review 2021, a government proposal was submitted to Parliament for an Act on the Division of Duties between the Chancellor of Justice and the Parliamentary Ombudsman. Parliament adopted the bill on 19 April 2022, with amendments proposed by the Constitutional Law Committee.

This legislative reform is historic. The previous laws on the division of duties between the Parliamentary Ombudsman and the Chancellor of Justice were in force for almost 90 years, remaining the same in their key content. The new Act on the Division of Duties is one of the most important reforms that has taken place during the 100-year existence of the Ombudsman institution.

Background for division of duties

The division of responsibilities has been discussed since the 1920s when the position of the Ombudsman was established. The reason for this was that the Ombudsman had few cases to process, whereas the activities of the Chancellor of Justice was already out-dated at that time and they had a large workload.

In 1931, the Chancellor of Justice proposed that the division of labour be regulated so that complaints by prisoners would be referred to the Ombudsman. The Ombudsman at that time opposed the proposal, and said that he did not consider appropriate "a proposal suggesting that the responsibilities of the Parliamentary Ombudsman should be developed so that their principal responsibility would be taking care of resolving complaints made by persons held in the prison institution, which were often of a fairly secondary nature".

Subsequently, the Chancellor of Justice proposed that the Ombudsman's office be abolished, and it was proposed in the government proposal in 1932. However, the Constitutional Law Committee did not approve the proposal, and Parliament rejected the government proposal. Only then was the time ripe for the Act on the Division of Labour of 1933, wherein cases concerning prisoners and other persons deprived of their liberty, as well as military courts, the defence forces and the Ministry of Defence were primarily referred to the Ombudsman. The Act was laid down in the order of enactment of the Constitution, as it was considered to constitute an exception to the provisions on the Constitution of that time by entitling the division of labour between the Chancellor of Justice and the Parliamentary Ombudsman by ordinary law (HE 118/1932 vp).

In 1985 and 1987, the Constitutional Law Committee drew attention to the division of duties between the Ombudsman and the Chancellor of Justice and required that the overlap of their duties be thoroughly investigated and the necessary legislative measures be taken to clarify the situation and at the same time required the development of the position of the Ombudsman as an institution guaranteeing the legal protection of citizens (PeVM 1/1985 vp and 6/1987 vp).

The new Act on the Division of Duties adopted in 1990 introduced the mutual right of transfer of cases between the Parliamentary Ombudsman and the Chancellor of Justice when a transfer could speed up the processing of the case or when it was justified for some other special reason. However, the actual division of duties was not substantially improved on that time.

Despite its nature as an exceptional act, this Act was adopted under the ordinary order of enactment because it did not extend the initial exemption on the Constitution of that time, the Form of Government. However, its content conflicted in a similar manner with the provisions of the Form of Government as the previous exceptional act (PeVM 9/1990 vp).

Under section 110, subsection 2 of the new Constitution of year 2000, "provisions on the division of duties between the Chancellor of Justice and the Ombudsman may be laid down by an Act, without, however, restricting the competence of either of them in the supervision of legality". This provision forms the constitutional basis for legislation, which has become permanent in terms of the division of duties between the Chancellor of Justice and the Ombudsman, and removes the conflict described above between this legislation and the Constitution.

Under the Act on Division of duties adopted in 1990, the Chancellor of Justice was exempt from overseeing compliance with the law in matters falling within the remit of the Ombudsman that concern:

1) the Ministry of Defence (excluding oversight of the legality of the official duties of the Government and its members), the Finnish Defence Forces, the Border Guard, military crisis management personnel, the National Defence Training Association of Finland and military court proceedings;
2) apprehension, arrest, remand and travel ban, and taking into custody or other deprivation of a person's liberty meant in the Act on Coercive Measures;
3) prisons and other institutions where a person has been confined against his or her will.

The Chancellor of Justice was also exempt from handling a case filed by a person whose liberty had been restricted by imprisonment, arrest or other means. Under this provision, a complaint lodged by a person deprived of liberty was a case that went to the Ombudsman, regardless of whether the complaint concerned deprivation of liberty or something else.

In all of the above-mentioned cases falling within the division of responsibilities, the Chancellor of Justice had to, under the Act, transfer the case to the Ombudsman, "unless the Chancellor of Justice for special reasons deems it appropriate to resolve the matter himself or herself."

The Ombudsman and the Chancellor of Justice have transferred a total of less than 100 cases annually to one another, of which the majority have been cases transferred by the Chancellor of Justice to the Ombudsman. The number of transferred cases has been this small because, for example, prisoners, whose complaints formed the only large category in the Act on the Division of Duties, usually knew that their complaints would be handled by the Ombudsman.

Launch and preparation of reform

In my general comment in the Ombudsman's annual report for 2014, I discussed the development and present state of the then 95-year-old Ombudsman Institution. As a future development need, I brought up improving the way in which the work of the Ombudsman and the Chancellor of Justice is divided so that there would be as little overlap as possible. I believed a system that features overlap between the two supreme overseers of legality was not the most efficient or appropriate from the perspective of the public or society.

In the committee report (PeVM 7/2015 vp) issued on the basis of the annual report, the Constitutional Law Committee referred to the committee statement (PeVL 52/2014 vp) it had issued on the Government of Finland Human Rights Report. In the statement, the Committee considered it important that cooperation and the division of labour between the actors participating in the supervision and promotion of fundamental and human rights be improved and overlap in the activities be reduced so that their expertise in different sectors can be exploited in the most appropriate way possible. In its report, the Committee repeated the views it had expressed in the above-mentioned statement and considered it important that the possibilities for developing the division of work and opportunities for cooperation between the Ombudsman and the Chancellor of Justice be examined. In the committee report (PeVM 2/2016) issued on the basis of the Ombudsman's report for 2015, the Committee emphatically repeated its views.

As the examination work had not yet begun at that time, I explored the reasons why the development of division of duties was necessary in more detail in my comment for the Ombudsman's 2016 report. I addressed (1) the loss of time and effort, due, in particular to almost all new complaints requiring an examination on whether the same matter may be pending or a decision may already have been made on the same matter in the other agency to avoid a situation in which both the Ombudsman and the Chancellor or Justice investigate the same case. I referred (2) to a lack of awereness among complainants and the public in general as to which overseer of legality is more suited to dealing with certain case and which will eventually start investigating it. I brought up (3) problems with the uniformity of the decision-making practice. As the Ombudsman and the Chancellor of Justice handle the same sort of matters with equal competence, their outcome and the measures associated with them should be similar, regardless of which institution has dealt with the case. In practice, the differentiation and specialisation of the tasks of the Ombudsman and the Chancellor of Justice increased the risk of different solutions in similar cases. I also referred (4) to problems in the consistency of the decision-making practice, by which I meant that, in legal matters resolved by the same jurisdiction, the legal interpretation of laws should be the same. However, it may be difficult and uncertain to obtain information of the interpretation given by the other overseer of legality from a different agency. This involves a loss of time and there is the danger that different opinions will be issued by the overseers of legality.

In its report on the Ombudsman's report 2016, the Constitutional Law Committee (PeVM 2/2017 vp) emphatically reiterated its views on the development of the division of labour and pointed out that it had already taken a stand on the matter several times and urged that an evaluation be conducted as soon as possible. The committee stated that although there are long traditions in the different areas of oversight of legality that should be respected, the oversight of legality should also move with the times, and its development should be considered without prejudice. The committee reiterated its position on the following reports by the Ombudsman and the Chancellor of Justice up until 2019.

On 25 September 2018, the Ministry of Justice appointed a working group to prepare the division of duties between the Parliamentary Ombudsman and the Chancellor of Justice.[1)] The possibilities for such development had to be assessed within the framework laid down in the Constitution, i.e. without narrowing either party's competence concerning oversight of legality.

The working group's report published on 5 June 2019 proposed that the division of duties be revised to better reflect the specific tasks of the overseers of legality laid down in the Constitution and other legislation, as well as their areas of specialisation resulting from international agreements and actual areas of specialisation.

1) Ilkka Rautio, who previously acted as a Supreme Court Justice and as Deputy Ombudsman, served as the chair of the working group, and its members comprised both supreme overseers of legality and the Deputy Director General, subsequently Committee Counsel, Sami Manninen. Professor Tuomas Ojanen was the working group's permanent expert.

Further preparation of the matter was carried out by the Ministry of Justice in cooperation with the supreme overseers of legality. The Ministry of Justice organised two rounds of comments (20.6.–17.9.2019 and 16.11.–23.12.2020). As a result of the feedback given during these rounds, the legislative proposal dismissed proposals contained in the working group's report on centralising the supervision of courts, the National Courts Administration of Finland, the prosecution service and prosecutors as well as matters concerning the oversight of legality concerning the autonomy of Åland to the Chancellor of Justice. In addition, the working group's proposal to centralise to the Chancellor of Justice certain matters related to fundamental right to the environment was amended during further preparation.

Government proposal and its consideration in Parliament

The Government proposal (HE 179/2021 vp) was finally submitted to Parliament on 21 October 2021. The bill concerned the division of duties between the Parliamentary Ombudsman and the Chancellor of Justice under an ordinary Act referred to in section 110, subsection 2 of the Constitution. In the proposal, it was proposed that to the Chancellor of Justice would be concentrated matters concerning (section 2):

1) the Government and a member of the Government and the President of the Republic;
2) the legal conditions for safeguarding a healthy environment and biodiversity and the consideration of sustainable development in them, as well as opportunities to influence decision-making concerning these conditions;
3) the development and general basis for the maintenance of the administration's automated systems;
4) the organisation of anti-corruption activities;
5) public procurement, competition and State aid -related matters.

On the other hand, it was proposed that to the Ombudsman would be concentrated matters concerning (section 3):

1) the Finnish Defence Forces, the Finnish Border Guard, the crisis management personnel referred to in the Act on Military Crisis Management, the National Defence Training Association referred to in Chapter 3 of the Act on Voluntary National Defence, and military court proceedings;
2) police investigations and the powers laid down for the police or customs authorities as well as coercive measures and pre-trial investigation in criminal proceedings, excluding the failure to submit, the suspension and the restriction of the pre-trial investigation;
(3) secret gathering of information, secret coercive measures, civil intelligence, military intelligence and oversight of the legality of these intelligence activities;
(4) prisons and other institutions to which a person has been taken, irrespective of his or her will, and other measures that limit a person's right to self-determination;
(5) the tasks of the National Preventive Mechanism referred to in Article 3 of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment;
(6) the tasks of the national independent supervisory structure referred to in the Convention on the Rights of Persons with Disabilities and its Optional Protocol;
(7) the implementation of the rights of children, elderly people, persons with disabilities and asylum seekers;
8) the implementation of individual rights in social and health care and social insurance;
9) guardianship;
10) the implementation of rights guaranteed to the Sámi as an indigenous people;
11) the implementation of the rights to maintain and develop the language and culture guaranteed for the Roma and other groups.

According to the bill, the Chancellor of Justice and the Parliamentary Ombudsman may mutually transfer other cases falling within the competence of both parties when the transfer is believed to speed up the processing of a case or when this is appropriate for the joint processing of cases related to a certain entities or when it is justified for some other reason (section 4, subsection 3).

At the proposal of the Government, the Constitutional Law Committee submitted its report on 5 April 2022 (PeVM 3/2022 vp). The Constitutional Law Committee considered the proposed regulation necessary and appropriate, and proposed that it be adopted in such a way that paragraphs 1 and 2 of section 2 of the Act be deleted, i.e. the paragraphs concerning the Government and the President of the Republic and the fundamental right to the environment.

With regard to section 2, paragraph 1 of the bill, the Constitutional Law Committee stated that the regulation of the Constitution will entail parallel powers for the Parliamentary Ombudsman with the Chancellor of Justice in the oversight the legality of the official acts of the Government and the President of the Republic. In the view of the Constitutional Law Committee, the special provisions concerning the oversight powers and duties of the Chancellor of Justice in sections 108, 111 and 112 of the Constitution do not alter the premise that the oversight exercised by the Parliamentary Ombudsman also plays an important role in the oversight of legality as a whole. In addition, it is not insignificant that the duties of the Chancellor of Justice include the oversight of the legality of official acts of the Government and the President of the Republic (section 108, subsection 1 of the Constitution) and in providing legal advice (section 108, subsection 2 of the Constitution). As a whole, the Constitutional Law Committee did not consider it appropriate that the division of duties of the supreme overseers of legality should be regulated as proposed.

Secondly, the Constitutional Law Committee stated that the division of duties between overseers of legality must be sufficiently clear and unambiguous. In the view of the Constitutional Law Committee, the division of duties concerning the fundamental right to the environment laid down in section 2, paragraph 2, was rather unclear in light of the regulation and the reasoning behind it. For this reason, the committee proposed that the paragraph be deleted from the bill.

At the end of its report, the Constitutional Law Committee stated that a system with two supreme overseers of legality who process complaints with largely parallel powers is rare internationally. The Constitutional Law Committee considered an evaluation of the need for a comprehensive reform of the oversight of legality justified. Such an evaluation should also cover the relevant provisions of the Constitution. The evaluation should cover issues such as questions concerning the dual duties of the Chancellor of Justice as the legal advisor and overseer of legality of official acts by the President of the Republic and the Government, the oversight of legality of the activities of courts from the perspective of the independence of the court system and the content and guarantees of the independence of the supreme overseers of legality.[2)]

Evaluation

According to the government proposal, the areas of specialisation of both agencies and the special expertise acquired by them have been taken into account in the preparation of the reform. The main thrust was that cases related to monitoring the implementation of fundamental and human rights at the individual level and, in particular, to monitoring the implementation of the rights of vulnerable persons would be given more extensively than previously to the Ombudsman.

2) On these issues, I have discussed the oversight of legality of the courts in my article ”Oikeusasiamiehen tuomioistuinvalvonnan perusteet, rajoitukset ja sisältö”, which is included in the book commemorating the Parliamentary Ombudsman’s 90th anniversary.

On the other hand, the Chancellor of Justice's oversight of legality would focus more clearly on examining structural and systemic issues related to the implementation of fundamental and human rights when developing public administration. The proposal would reflect the specialisation areas formed in the practices of the supreme overseers of legality thus far and the priorities of oversight of legality that have been established in practice.

From the perspective of the Ombudsman, the reform is a natural continuation of long-term development, in which the Ombudsman's activities have focused on monitoring the rights and treatment of all persons in institutions and all vulnerable persons. Progress in this direction can be seen to have started with the Act on the Division of Duties of 1933, which referred prison matters primarily to the Ombudsman. Prisoners are not only perpetrators, but also persons in institutions and vulnerable people. These developments have culminated in specific tasks based on UN Conventions. Since 2014, the Ombudsman has had a special duty under the UN Convention to supervise all places where persons deprived of their liberty can be held. These may include not only prisoners, but also children, elderly people, persons with disabilities and psychiatric patients. As a second task under a UN Convention, the Ombudsman has been monitoring and promoting all the rights of persons with disabilities in cooperation with the Human Rights Centre since 2016. The establishment of the Human Rights Centre in connection to the Office of the Parliamentary Ombudsman also reflects this development.[3)]

On the other hand, the Ombudsman's activities have also focused on supervising the activities of the security authorities. In the previous 1990 Act on the Division of Duties, matters concerning the Defence Forces and the Border Guard were primarily referred to the Ombudsman. In addition, the oversight of information gathering and intelligence has been primarily assigned to the Ombudsman, who receives statutory annual reports on the use of secret information gathering methods and intelligence practices. In addition to what has been laid down previously, the new Act on the Division of Duties also assigns the Ombudsman case categories concerning the police, customs and intelligence authorities.

With regard to the Chancellor of Justice, the Act on the Division of Duties in its final form does not fully express the idea that the act reflects the specialisation areas of the supreme overseers of legality. Most importantly, section 2, paragraph 1 of the bill on the oversight of the legality of the acts of the Government and the President of the Republic laid down in the Constitution as a special task of the Chancellor of Justice was removed during parliamentary proceedings.

Under section 108 of the Constitution of Finland, the Chancellor of Justice is responsible for overseeing the legality of the acts of the Government and the President of the Republic. This duty is not specifically mentioned concerning the Ombudsman in the Constitution, even though the Ombudsman has the authority to carry out this duty. Under the same section, the Chancellor of Justice must provide the President, the Government and ministries with information and statements on legal issues upon request. The Ombudsman has not been assigned a similar task.

Under section 111 of the Constitution of Finland, the Chancellor of Justice "shall be" present at Government sessions and when matters are presented to the President of the Republic in the Government. According to the same section, the Ombudsman has "the right" to be present at these sessions and presentations.[4)]

Similarly, according to section 112 of the Constitution of Finland, the Chancellor of Justice "shall" present his/her comments with reasons if he/she finds that the legality of the decision or measure taken by the Government, a Minister or the President of the Republic gives rise to this. If this is ignored, the Chancellor of Justice "shall" record his/her comments in the minutes of the Government and, if necessary, undertake other measures. According to the same section, the Ombudsman has the corresponding "right" to make comments and undertake other measures.

3) I have highlighted this development in my general comment "The Parliamentary Ombudsman 100 years" in the Ombudsman's 2019 report.

4) The Ombudsman has apparently exercised this right only twice during the 100-year history of the institution.

Of the experts heard by the Constitutional Law Committee, the removal of section 2, paragraph 1 of the bill was proposed by Professor Veli-Pekka Viljanen.[5] In addition to the aforementioned constitutional provisions, he referred to sections 113 and 115 of the Constitution, according to which both the Chancellor of Justice and the Ombudsman can initiate a case concerning the criminal liability of a Minister or the President of the Republic. According to Viljanen, the fact that the oversight of the legality of the acts of the Government, its members and the President of the Republic by the Chancellor of Justice has been emphasised separately in the Constitution does not mean that this dimension of oversight of legality is irrelevant to the Ombudsman's activities. On the contrary, the Ombudsman's oversight of the Government and its members also plays an important role. The proposal in question could significantly change the oversight of legality by the Government compared to how it was intended to be carried out in the Constitution.

According to Viljanen, centralising the oversight of legality concerning the exercise of all government powers (section 3 of the Constitution) to the Chancellor of Justice would not be problem-free in practice. The Chancellor of Justice works in close cooperation with the Government and participates in the oversight of the Government's legality in various ways during the preparation and decision-making of cases. In this respect, it is problematic if the ex-post assessment of legality of the decisions, for example as a result of complaints, is, in practice, solely supervised by the same overseer of legality, who should have intervened in the possible unlawfulness of the decisions already during the preparation or decision-making phase. Particular attention must be paid to the dual role of the Chancellor of Justice in the Government and in the decision-making of the President. If the decision of the Government, a Minister or the President is based on a statement issued by the Chancellor of Justice in accordance with section 108 of the Constitution, credible oversight of legality cannot be left exclusively to the Chancellor of Justice. In Viljanen's opinion, in many cases the Parliamentary Ombudsman is a more credible overseer of legality than the Chancellor of Justice.

It is true that it would be more credible for the Ombudsman to carry out the ex-post oversight of legality of the Government's and the President's official duties, especially in the situation described above by Viljanen. However, the problem with this is that due to the similarity of the posts of the Parliamentary Ombudsman and the Chancellor of Justice, it has been established practice, and can be found in the preliminary works of the Constitution, that their duty is not to investigate one another's actions (HE 1/1998 vp p. 166). If the Ombudsman were to investigate the legality of a procedure or decision of the Government expressly approved by the Chancellor of Justice or based on an opinion of the Chancellor of Justice, the Ombudsman would in fact also be examining the legality of the actions of the Chancellor of Justice, which in turn does not fall within the Ombudsman's competence.

The Ombudsman has also received complaints in which it has been asked to investigate the actions of both the Government and the Chancellor of Justice in a certain case. For the aforementioned reason, such complaints have been referred to the Chancellor of Justice. This is understandably problematic both from the perspective of the complainant and that of the credibility of the oversight of legality. On the other hand, it would also be problematic if the Parliamentary Ombudsman seemed to restrict his investigation just into the actions of the Government, if in fact the issue also concerns the actions of the Chancellor of Justice.[6] There may be a need for constitutional debate on these situations.

5) Statement by Professor Viljanen to the Constitutional Law Committee on 18 November 2021.

6) As the Ombudsman and the Chancellor of Justice are not competent to investigate the legality of each other's official acts, it is my understanding that nor can they initiate a case concerning each other's legal liability within the meaning of Article 117 of the Constitution.

These problems are linked to the Chancellor of Justice's dual or triple role as the legal adviser to the Government and the President of the Republic, as the anticipatory overseer of the legality of their official acts and as the ex-post overseer of legality of the same official acts. In practice, it is difficult to avoid the emergence of tensions and conflicts between these different roles, even though the Office of the Chancellor of Justice has, in my opinion, sought to do so. This fault related to the various roles of the Chancellor of Justice was already in the previous Constitution, and it has also been expressly written into the current Constitution.

The proposal of the Constitutional Law Committee to delete section 2, paragraph 1 of the Act on the Division of Duties seems to be related to problems arising from the different roles of the Chancellor of Justice. The committee referred to these problems in connection with its statement as well as in its proposal to examine the need for a comprehensive reform of the oversight of legality.[7] These problems could have become emphasised if the supervision of the Government and the President of the Republic had been centralised to the Chancellor of Justice in the new Act on Division of Duties.

Even though this issue was in the preparation of the Act on the Division of Duties and in the Government proposal only seen as recording the special task of the Chancellor of Justice already included in the Constitution also into the Act on the Division of Duties, the issue also has broader significance in constitutional law. This concerns the division of state duties and relations between the highest organs of the state: that the Parliamentary Ombudsman also oversees the legality of the acts of the Government and the President of the Republic on behalf of Parliament.

Conclusion

The new Act on the Division of Duties will further strengthen the role of the Ombudsman, in particular as supervisor of the rights and treatment of vulnerable persons and also as supervisor of the activities of security authorities. The reform will reduce problems caused by overlapping duties of the Parliamentary Ombudsman and the Chancellor of Justice, improve the quality and effectiveness of oversight of legality, and support the uniformity and consistency of the decision-making practice.

A primary consequence of the new Act will be that a number of large groups of cases will be transferred to the Ombudsman. The government proposal estimated that about 450 cases would be transferred from the Chancellor of Justice to the Ombudsman on an annual basis. According to the government proposal, this required the creation of three new legal advisors' posts in the Office of the Parliamentary Ombudsman, for which Parliament has granted appropriations in the Office's budget for 2022.

These new posts will compensate for the immediate effects of the new division of duties, estimated by the number of cases in 2019 during the preparation of the government proposal. After this, without the effects of the new Act, the number of complaints sent to the Ombudsman has already increased annually by almost 1,500 cases (in total more than 7,700 cases). It should also be noted that according to the new division of duties, the future growth in the categories of cases assigned to the Ombudsman will mainly be directed to the Ombudsman.

The successful implementation of the reform will require that sufficient resources are secured for the Parliamentary Ombudsman. The Constitutional Law Committee has already drawn attention to the increase in the workload of oversight of legality. In its report on the bill on the division of duties, the Committee reiterated the importance of allocating sufficient resources for the oversight of legality.

7) Of the experts consulted by the Constitutional Law Committee, Professor Kaarlo Tuori proposed examining the need for a comprehensive reform of the oversight of legality, referring specifically to the diversity of the Chancellor of Justice's roles.

Deputy-Ombudsman
Ms Maija Sakslin

On the impact of the Ombudsman's activities

The evaluation of oversight of legality activities, allocating resources and choosing emphases for the oversight are mainly based on the evaluation of impact. Increasing the impact of the oversight of legality has been a goal guiding the Ombudsman's activities in the recent years. We have discussed the impact of the Ombudsman's activities both within the Office of the Ombudsman and, among other instances, with members of the Parliament in connection with the discussion on the annual report. One study, which was published in 2007, has been carried out on the impact of the Ombudsman institution. In the study, impact was divided in the impact on regulations, impact on authorities, and media visibility. As far as I know, no other impact research has been carried out on the activities of the Ombudsman in Finland. In international review, the impact of ombudsmen's activities is often described through the share of approved and implemented recommendations or proposals by the Ombudsman. In Finland, this number has remained very high according to the Ombudsman's own observations which are based on authority notifications. This is likely due to the commitment of those working in public tasks to the strong legislative tradition and the prestige of the Ombudsman institution.

The Ombudsman's activities are divided into four key activities. They are complaints, inspections, investigations based on own initiative, and statements. The aim has been that the impact of the oversight of legality would guide discretion regarding which complaints are taken under investigation, what kind of observations related to the promotion of basic and human rights act as starting points for investigations initiated by the Ombudsman, how inspections are targeted and to whom the overseer of legality gives statements. A complaint, investigation on own initiative or inspection might lead the Ombudsman to take action, forms of which are guidance, reprimand, or a warning. In addition, the Ombudsman can submit proposals. The proposal may be targeted at a competent authority to correct a mistake or a deficiency, amend legislation, rectify a violation of basic or human rights, and resolve a matter amicably. These measures are related to individual cases in the oversight of legality that have been solved by the Ombudsman.

At its most narrow, examining the impact is focused on the past in a temporal sense: on a violation of law that has already occurred, or another unlawful or incorrect procedure. The Ombudsman considers a violation to have occurred but often the situation cannot be remedied. However, even in these cases, the impact can be directed into the future. The Ombudsman's statement may be empowering for the violated party, and it may guide the future activities of the party under supervision to prevent the re-occurrence or continuation of the violation. However, the examination of the impact of the oversight of legality requires defining the impact of the Ombudsman's procedures and activities that extends beyond individual cases.

In the following, I will present one possible way of systematise the impact of the Ombudsman's activities. I have described different impacts with the awareness that they are not mutually comparable nor comprehensive, and named them. I hope that this classification can help specify both the external and internal evaluation of the impact of the highest oversight of legality.

Interpretative impact

Often the Ombudsman's solutions contain a statement on the correct interpretation of the law. The impact on interpretation is concerned when the Ombudsman bases their decision on the preliminary work on an act or established legal practice and presents their idea on how legislation should be interpreted. Such statements may have a significant long-term effect in guiding the activities of authorities especially in fields in which the law is applied by others than legal professionals. The task of the Ombudsman is to supervise the implementation of basic and human rights. In this task, the Ombudsman can in a significant manner outline the interpretation of laws regulating basic rights and promote an interpretation of law and fulfilment of rights which is favourable to basic and human rights. However, it is not the Ombudsman's task to take a stand on the interpretation of the law if solving the matter would fall within the competence of courts.

Normative impact

Legislation that is especially applied to social welfare and health care services often leaves much discretion to the applier of the law. In some cases, there is no applicable legislation, or it is unclear which laws should be applied to the matter under evaluation. In addition, it is typical to especially rights related to social welfare and health that matters concerning them often lack such legal remedy procedures which would guarantee a possibility to obtain a statement by a court of law in cases when legislation is open to interpretation or there are gaps in legislation. When there is no established legal practice or possibility to obtain a ruling from a court, the Ombudsman's statements on the oversight of legality have a significant impact on the legal status and interpretation of law. When authorities and other actors under the supervision of the Ombudsman rely on the Ombudsman's guidance to ensure the legality of their activities, the statements achieve a legal significance similar to a legal norm. I call this the normative impact. In such a case, the Ombudsman often submits a proposal in order to supplement or amend the legislation. However, sometimes the activities of an authority may be based on the Ombudsman's statement on the correct interpretation of law for a very long time. For example, statements related to the oversight of legality on the right to self-determination and the use of restrictive measures in social welfare and healthcare have had this kind of a long-term normative impact.

Procedural and organisational impact

The Ombudsman's statements often have impacts on authority procedures. For example, the content of the right to good administration and the appropriate and timely processing of a matter have largely been influenced by oversight of legality statements even before enacting the legislation that made the basic right regulations on good administration concrete. The Ombudsman's statements can also have an impact that affects authority institutions. The Ombudsman's decisions have affected the increase in the number of staff, the establishment of new supervision units, the improvement of the availability of services, safeguarding the free-of-charge nature of advice and automated decision-making, among other things.

Informative impact

What I call informative impact is primarily the impact of the Ombudsman's statements targeted at the subjects of supervision and the larger public. Through the publicity of decisions, the public, authorities and other subjects of supervision receive information about the content of the rule of law and individual's rights. In addition, published decisions spread information on how the realisation of rights is supervised and how individuals can participate in the supervision of their own as well as other people's rights. Discussions had in connection with inspections increase information about the rights of individuals and the obligations and oversight of legality of authorities. The Ombudsman's activities have more impact if decisions on the oversight of legality are easily available, accessible and visible.

Preventative impact

One of the main objectives of oversight of legality is to prevent and stop unlawful activities and the non-compliance with obligations. After the Ombudsman has submitted an opinion or a reprimand on unlawful actions or non-compliance by an authority, the decision usually has a broader impact than an individual case. The Ombudsman may also propose creating instructions and carry out training in order to ensure the legality of activities and to prevent further violations. Like informative impact, the preventative impact is the more effective the easier it is to access the decisions and the more visible the statements of the overseer of legality are. As oversight of legality mainly concentrates on the prevention of shortcomings, in my opinion, repressive impact does not play a role in guiding the Ombudsman's activities. However, if it is revealed that the subject of supervision has committed an offence, oversight of legality may be considered to have a repressive impact.

Impact on the quality of legislation

The number of statements the Ombudsman has given in different stages of the legislative process has risen in the recent years. Statements are given on the drafts of Government proposals to ministries and the Government's proposals to the Parliament's committees. This is an important form of activity, and the statements are estimated to have a significant impact on the quality of legislation, the rights of individuals and legal protection. However, what needs to be continuously assessed is whether there is a reason for the highest overseer of legality to submit a statement and what kind of issues the statement should focus on. The statutory task of the Ombudsman requires the assessment of legislative proposals at least from the perspective of basic and human rights. Especially restrictions, supervision and arrangements regarding legal rights that potentially target basic rights are important in the evaluation. The examination of basic rights is also closely connected to arrangements of competence that are important to the rule of law as well as the use of public authority and the evaluation of proposals related to the performance of public administrative tasks. The deep and extensive experience collected through the oversight of legality creates a good basis for the observation of internal conflicts and tensions in the legal order and, for example, the evaluation of the accuracy and timeliness of proposed regulations.

Impact on general principles of law

It may also be possible to indicate that the Ombudsman's activities can have an impact on the formation of general theories of jurisprudence and law in different sectors of the law. The oversight of legality has had this kind of an impact on, for example, the change of the fundamental rights paradigm and the understanding of the different legal effects of social rights.

According to the previous paradigm, the realisation of social, economic, and cultural rights requires active efforts and financial resources, and they usually cannot be applied directly or implemented comprehensively, and their implementation cannot be required of a court of justice or other authority. This previous paradigm stated that these features of rights meant that economic, social and cultural rights would not be legally binding. The oversight of legality procedure regarding social basic rights conducted by the Ombudsman has played a significant role in the change of this paradigm. After the basic rights reform in Finland, the Ombudsman began to implement their supervision task related to the implementation of basic rights to apply new constitutional provisions. Partly due to this oversight of legality procedure, the Finnish legal doctrine began to identify rather quickly different binding legal impacts in social basic rights such as directly applicable subjective rights, the obligation of the public authorities to actively implement social rights and the interpretative effect. The impact of the Ombudsman's activities has also partly been based on the fact that the traditional legal protection system does not provide access to court in many questions regarding social basic rights. Thus, the binding nature of social rights and their different legal impacts have been formed largely in the interaction between the Ombudsman's statements and legal research.

Political impact

According to the Constitution of Finland, the Ombudsman must supervise that courts and other authorities and officials, employees of public entities and others performing public tasks follow the law and fulfil their obligations. In the performance of their task, the Ombudsman monitors the realisation of basic and human rights. Ensuring the legality of the performance of public duties is important in this task established for the Ombudsman. The Ombudsman's statements are legal. Regardless, the Ombudsman's activities also have political impacts. The political impact may have been connected to individual statements by the overseer of legality and the Ombudsman's annual report. At its most efficient, the political impact on an individual matter has been concerned when the publicity of a matter of oversight of legality has launched a political discussion and the preparation of legislative reforms even before the Ombudsman's statements and proposals.

The Ombudsman submits an annual report to the Parliament on their activities and the state of the use of law as well as the shortcomings in legislation they have observed. The processing of the report in the Parliament and its committees creates an information base on political choices and decision-making, and acts as a platform for political discussion. The discussion of the annual report in the committees and the plenary session gives the members of Parliament much freedom to discuss questions that are important to them.

Impacts on the activities of a state governed by rule of law

According to the principle of the rule of law as stated in the Constitution of Finland, the use of public authority must be based on legislation. All public activities must follow the law carefully. The task of the Ombudsman is the supervision of the implementation of these principles of legality and the prohibition of arbitrariness that create the basis of a state governed by the rule of law. The success of the Ombudsman's supervision of the administration and courts strengthens trust in the use of public authority. The failure of the oversight of legality may be disastrous as it may undermine trust in the rule of law. Supervising compliance with the law in the performance of public duties and that all activities are based on legislation ensure that the will of the legislator is realised, which, in turn, is a prerequisite to functional democracy. The competence of the Ombudsman does not include the evaluation of the parliament's legislative activities but its own activities are based on the laws enacted by the democratically elected legislators. In a state governed by the rule of law, it is important from the perspective of the supervision of compliance with the Constitution that the Ombudsman can make proposals to amend or supplement the legislation after observing shortcomings in it to ensure the realisation of basic and human rights and constitutional principles. By making proposals to amend or supplement legislation, the Ombudsman also ensures that the legislator can use its competence in the matter. Even though the Ombudsman has not the power to determine whether the parliamentary laws are consistent with the Constitution, the Ombudsman can advise the complainant who has the chance to bring their case to be heard by the court and request the court to assess the constitutionality of the legislation that is applied in their individual case.

According to established oversight of legality practices, the independence of courts means that the Ombudsman does not act as an alternative to the court procedure or as a supplementary appellate authority nor otherwise interfere with the activity of independent courts. This is why the Ombudsman does not usually investigate matters that have a regular appeal procedure and does not assess the content of decisions by courts. However, the key impact from the perspective of the rule of law has come from the Ombudsman supervising the realisation of the prerequisites for the key elements of the rule of law, fair trials, independence of the court system and the accessibility of law.

Conclusion

The task of the Ombudsman is, in particular, to ensure the realisation of the rights of people in a vulnerable position. The examination of the different forms of impact that I have presented above does not mean that this task would receive less attention - vice versa. A statement that directly impacts the status of an individual also becomes stronger through these other forms of impact.

Pasi Pölönen

Strong rule of law requires strong courts

The Constitution and practices safeguard the rule of law

Finnish people have the privilege to live in a country where strong rule of law and democracy prevail and fundamental and human rights are respected. The principle of legality is an essential part of our constitutional tradition. Our Constitution is built on democracy and the rule of law, and it includes mechanisms to ensure that these principles are implemented, also through institutions that conduct oversight, such as the Parliamentary Ombudsman and the courts of law. The obligation to guarantee the implementation of fundamental and human rights applies to public powers as a whole.

The supreme oversight of legality has an active role in securing the rule of law, as is well described by Parliamentary Ombudsman Petri Jääskeläinen in his general comment in the Annual Report 2020.[1)] The Parliamentary Ombudsman must independently oversee the implementation of the constituents of the rule of law and intervene in activities that endanger it. The corresponding role of the courts of law is only passive and often limited to the demands and claims of the parties to the case in question.

However, the rule of law remains stable only when it is supported by all of its key pillars – democracy, legal protection and human rights. Each element must be in place and strong in itself. The constitutional structures of legal protection are essential, but it is equally essential that these structures are respected in practice.

At a seminar on the rule of law in November 2021, our human rights judge Pauliine Koskelo aptly stated that movement and commitment as well as the direction of will and action are essential. At the same seminar, Professor Tuomas Ojanen raised the question of whether our Constitution should contain special protection locks on matters for which the Constitution itself could not be changed. So far, there has been no debate on this kind of self-limitation of the constitutional legislature's competence in Finland.

The Chancellor of Justice has drawn attention to the fact that our legal protection structures are partly based on trust and established rules of convention.[2)] Fortunately, in my role, I have not seen signs indicating reason for any particular concern about these relations. However, no one can say anything certain about the future.

1) Parliamentary Ombudsman's report on his activities for the year 2020, pp. 13–19.

2) The Chancellor of Justice annual report 2020, pp. 112–113 (in Finnish.

If the majority of Parliament and consequently the Constitutional Law Committee, the Government and even the President of the Republic – who has the power to appoint but also to dismiss the Chancellor of Justice – fell into the hands of a political actor receiving supermajority and not respecting the rule of law, it would be possible to make in-depth changes to the very foundations of the rule of law even in Finland, especially through the activities of the Constitutional Law Committee. To prevent risks, the weaknesses in the structures of the rule of law in our country should be reinforced in advance, while hoping, of course, that they will never face a real test.

The less strong courts of the strong rule of law

Independent courts are a critical and necessary part of the system consisting of democracy, the rule of law and fundamental and human rights. As for the court system, the independence of the courts and comprehensive and effective access to legal protection are emphasised.

In the past few years, there has been debate on the guarantees of the independence of the courts in Finland as well. In the light of the Ombudsman's comments below, we could say “at last”. This debate is very welcome. It has been inspired by regrettable European examples and the work consequently launched in Sweden to better guarantee the independence of courts.

In both Sweden and Finland, more detailed constitutional regulation concerning especially the number of judges of the Supreme Court and their retirement age has been discussed. We may also need to carefully examine the so-called Venice Commission's Rule of Law Check-list (2016)[3] and its element on the extent to which the situation with the appropriations of courts can be freely determined by the executive and legislative powers, or whether there are some safeguard mechanisms in this respect.

According to the observations made by the supreme overseers of legality and the views of the representatives of the court system, jurisdiction in Finland is genuinely independent. In an international comparison, the rule of law in Finland has been ranked third best in the world. Our weaknesses are related to the administration of criminal justice, the risk of costs in civil matters and the resources of the courts.[4] In the EU Rule of Law Report, the rule of law in Finland is considered to be exemplary and the independence of the courts is also found to be at a very high level.

Our challenges today are therefore more related to access to justice than to independence. However, there is room for improvement and, as I already stated, we should try to protect ourselves against future risks in advance.

Concerns about access to justice relate particularly to the risk of being held liable for significant legal costs. In Finland, no ceiling has been laid down on legal costs in civil matters. This, together with the fact that the upper limit for the compensation in legal expenses insurances may be much less than the amount of legal costs incurred in cases other than minor ones, significantly increases the threshold for seeking justice in courts. Instead of the district court, people increasingly resort to the Consumer Disputes Board in civil matters. In the 21st century, the number of cases processed by the Consumer Disputes Board has doubled and the processing times are becoming longer.[5] From the perspective of the 90-day deadline requirement laid down in the Consumer Disputes Board Act, the situation is unbearable. The slowness and costs of legal proceedings may in some matters be the reason for the increase in the number of complaints received by the Parliamentary Ombudsman.

3) https://venice.coe.int/webforms/documents/default.aspx?pdffile=CDL-AD(2016)007-fin

4) World Justice Project Rule of Law index 2021. In the report, Denmark was ranked first, Norway second and Sweden fourth.

5) Parliamentary Ombudsman Jääskeläinen assessed the processing times of the Consumer Disputes Board on 26 October 2017 in his decision EOAK/4079/2017.

The Ombudsman has for a long time been concerned about the thinness of constitutional regulation on the court system and the regulation required to guarantee independence in general. In its 2010 report, the Constitutional Review Committee considered that the provisions on the court system in the Constitution do not require a revision. The Ombudsman took a different view and considered that more detailed provisions at the level of the Constitution to emphasise independence would be justified, especially because of the courts' legal protection and norm control tasks in defence of the rule of law.[6] At the same time, the Ombudsman proposed that the removal of the criterion of "evident conflict with the Constitution" in section 106 of the Constitution should be considered. It would be important for the constitutionality control carried out by the courts in concrete individual cases to be more flexible in implementing the primacy of the Constitution in situations where the application of an act reveals a conflict between the Constitution and provisions to which attention has not been paid in advance controls. A broader link between courts and ex-post constitutionality control of laws would be justified as part of the processes under the rule of law.[7]

Now, a little over a decade later, it can be noted that these themes brought up by the Ombudsman, which were not paid attention to at all in connection with the revision of the Constitution at the time, have become topical in a completely different way and with new significance.

Need for self-evaluation of the judicial system in the state authorities

I have recently assessed the independence of the courts, especially in the context of the Government property and premises strategies originating from the Ministry of Finance.[8] From the perspective of the overseer of legality, I have got the impression that all levels of central government have not understood that the independence of courts also includes the separation of their administrative status from the rest of the central government. The court system is not part of the central government. The wording of section 21 of the Constitution, in which the administrative authorities and the courts of law are bundled together in the same sentence, may contribute to this. I find it problematic from the perspective of the independence of the courts.

Very often, the Ombudsman has also drawn attention to the situation in the judicial system's resources. The basic funding of courts – and that of the police, prosecutors and the Criminal Sanctions Agency – is simply poor in Finland. Compared to Sweden, Finland invests one third less per inhabitant in courts, prosecutors and legal aid. This was already the case, for example, when the 2013 productivity programme for the administration of justice was being discussed (and also much earlier, of course). At the time, the official inquiry correctly stated that the tasks of the judicial system are the cornerstone of the rule of law. However, the conclusion from this was not the permanent increase in the resources of the judicial system proposed by the Ombudsman[9], but, on the contrary, the fact that legal protection must be provided "at lower overall costs".

6) Parliamentary Ombudsman Jääskeläinen's statement on 8 March 2010 (Record no 576/5/10).

7) The same view is also expressed in the Human Rights Centre's recent publication 5/2021: Primacy provision of Section 106 of the Constitution and the requirement of evident conflict – is it time for a change?

8) My statement of 16 March 2021 (EOAK/1678/2021) on the draft central government property strategy 2030 and my statement of 16 August 2021 (EOAK/4542/2021) on the working group's proposal for the central government premises strategy.

9) Parliamentary Ombudsman Jääskeläinen's opinion of 19 June 2013 (Record no 1892/5/13) on the programme reforming the administration of justice.

The plea bargaining system that was part of the judicial system at the time can also be mentioned as an example. It was estimated to achieve savings of EUR 1–2 million in the prosecution system and in the courts.[10] The Ombudsman's position that the foundations of our criminal justice system would thus be put on a destabilising basis that would jeopardise legal protection for purely economic reasons[11]– which were minimal in terms of the overall Budget – did not have any effect on the implementation of this practically irreversible reform of the system.

The independence of courts also includes the independence of the individual judges within the court system. The number of fixed-term judges in Finland is fairly high. This is not good for the independence of judges, as a fixed term may in different ways lead to the judge's dependence on the appointing body. Here, too, the scarcity of resources is in the background. With respect to the independence of the courts, it should already be considered alarming that, from time to time, it is necessary to rely on a supplementary budget to make the processing of a major criminal case possible.

A more fundamental problem with regard to independence is the system of lay members of district courts, in which local politicians are in practice selected as administrators of justice in municipal policymaking. Our system of lay members has not been examined in constitutional terms with regard to the independence of the courts or the constitutional separation of powers (section 3 of the Constitution). The Ombudsman has considered this system problematic and proposed that, in so far as the system is to be preserved, the National Courts Administration Finland should be involved in the appointment of lay members.

The establishment of the independent National Courts Administration Finland was gratifying and necessary for the rule of law. This development shows that concerns about maintaining the rule of law have been and are being heard in Finland. For a long time, the lack of a body separate from the ministry and responsible for the tasks of the central government authority for the entire court system was in principle a significant problem in terms of the independence of the courts. Unfortunately, this step forward remained incomplete at the time it was taken, in that the number of staff of the National Courts Administration Finland was far from the Nordic reference level and from what was considered necessary in the report of the public officials investigating the establishment of the agency.[12]

None of the numerous statements issued by the Parliamentary Ombudsman, the representatives of the courts or the Legal Affairs Committee of Parliament on the insufficient basic funding of courts have been realised in the Budget procedures.

During the year under review, the Ministry of Justice has launched the preparation of its first report on the administration of justice. I consider drawing up the report to be an extremely justified instrument for the self-assessment of the rule of law. In this context, the legislator will be able to assess not only the resources but also the need to review the Constitution’s provisions on the court system.

10) Ministry of Justice, Reports and guidelines 16/2013 (Programme reforming the administration of justice 2013–2025), p. 46.

11) Parliamentary Ombudsman Jääskeläinen’s opinion of 19 June 2013 (Record no 1892/5/13) and the Ombudsman’s opinion of 18 June 2012 (record no 1797/5/12) referred to in it.

12) Ministry of Justice, Reports and guidelines 23/2017 (Establishment of National Courts Administration Finland), pp. 12 and 58.

2 The Finnish Ombudsman institution in 2021

2.1
Review of the institution

The year 2021 was the Finnish Ombudsman institution's 102nd year of operation. The Parliamentary Ombudsman began his work in 1920, making Finland the second country in the world to adopt the institution. The Ombudsman institution originated in Sweden, where the office of Parliamentary Ombudsman was established in 1809. After Finland, the next country to adopt the institution was Denmark in 1955, followed by Norway in 1962.

The International Ombudsman Institute (IOI) currently has over 200 members, in around 100 countries. Some Ombudsmen are regional or local. For example, Germany and Italy do not have a Parliamentary Ombudsman. The post of European Ombudsman was established in 1995.

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

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

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

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

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

In 2021, Parliamentary Ombudsman Jääskeläinen made decisions on cases involving questions of principle, the Government, and other highest organs of state. In addition to this, his responsibilities also included, among others, matters concerning the police, the Emergency Response Centre Administration and rescue services, guardianship, language, the rights of foreigners and persons with disabilities, as well as covert intelligence gathering and intelligence operations. His responsibilities also included the prosecution service; however, not including the Office of the Prosecutor General. He was also responsible for handling matters concerning the coordination of tasks and reporting in the National Preventive Mechanism against Torture.

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

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

A detailed division of labour is provided in Annex 2.

If a Deputy-Ombudsman is prevented from performing their tasks, the Ombudsman can invite a Substitute for the Deputy-Ombudsman to stand in. The substitute for the Deputy-Ombudsman in 2021 was Principal Legal Adviser Mikko Sarja, who served as a substitute during the year under review for a total of 55 working days.

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

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

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

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

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

The two supreme overseers of legality, the Ombudsman and the Chancellor of Justice, have virtually identical powers. The only exception is the oversight of advocates, which falls exclusively within the scope of the Chancellor of Justice.

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

In October 2021, the Government submitted a proposal to Parliament for a new act on the division of duties between the Chancellor of Justice and the Parliamentary Ombudsman. Parliament adopted the bill on 19 April 2022, as proposed by the Constitutional Law Committee.

Parliamentary Ombudsman Jääskeläinen has discussed the new act on the distribution of duties in more detail in his article (see Section 1).

2.1.3
The values and objectives of the Office of the Parliamentary Ombudsman

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

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

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

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

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

2.1.4
OPERATIONS AND PRIORITIES

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

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

The values and objectives of the Office of the Parliamentary Ombudsman

Values

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

Objectives

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

Tasks

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

Emphases

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

Operating principles

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

Operating principles especially in complaint cases

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

The importance of achieving objectives

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

One of the priorities within the Parliamentary Ombudsman's remit is to monitor the implementation of the rights of persons with disabilities, the elderly and children.

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

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

Fundamental and human rights are relevant to the oversight of legality not only when individual cases are being investigated, but also in conjunction with inspections and when deciding on the focus of own-initiative investigations. Emphasising and promoting fundamental rights guides the thrust of the Ombudsman's activities. In connection with this, the Ombudsman engages with various bodies, including the main NGOs. The Ombudsman addresses issues in connection with the inspections, as well as on his own initiative, that are sensitive from the perspective of fundamental rights and that have broader significance than individual cases as such. In 2021, the special theme in the monitoring of fundamental and human rights was the provision of sufficient resources for authorities to ensure fundamental rights. The content of the theme is outlined in section 3.8, which discusses fundamental and human rights.

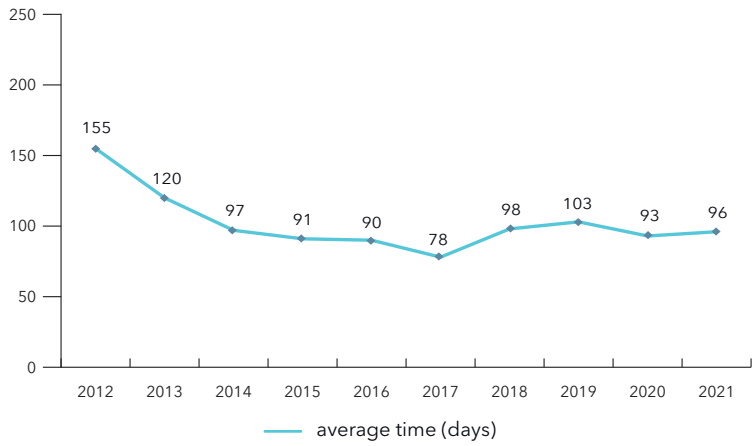
The Office of the Parliamentary Ombudsman is preparing the Parliamentary Ombudsman's operative strategy. The general strategic starting point has been to implement the constitutional task of the Parliamentary Ombudsman such, that its impact is as extensive as possible.

Complaints are processed within one year

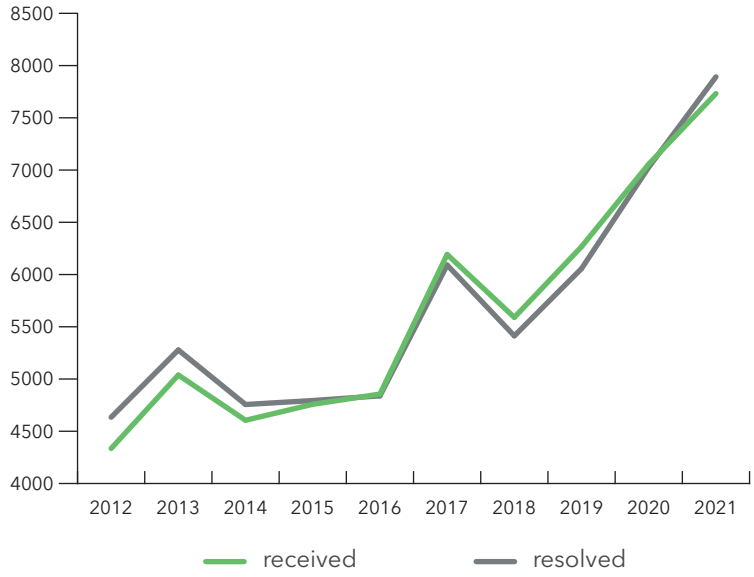
With the amendment to the Parliamentary Ombudsman Act, which entered into force in 2011, the oversight of legality was increased by giving the Ombudsman greater discretionary powers and a wider range of operational alternatives, and by a greater focus on the perspective of the citizen. The period within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

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

With the more effective processing of complaints, the Ombudsman achieved the target time – of one year for handling complaints – for the first time in 2013. It has also been achieved every year since then and at the end of the year under review. The average time taken to deal with complaints was 96 days at the end of 2021, compared to 93 days at the end of 2020.



Average time taken to deal with complaints in 2012–2021.



Complaints received and resolved in 2012–2021.

Complaints and other oversight of legality matters

Like the previous year, a record number of complaints were received in 2021, in total 7,732. This is almost 700 (9.5%) more than in 2020 (7,059). Case numbers rose in nearly all administrative branches. The highest number of complaints concerned health care 1,322 (802), social welfare 1,142 (1,196) and police 922 (852). The strongest growth was observed in complaints related to healthcare (65%). During the last three years (2019-2021), the number of complaints received by the Ombudsman has increased by 2,138 cases, or 38%.

During the year under review, a record number of 7,892 complaints were also resolved. This is almost 900 (12%) more than in 2020 (7,027).

The number of complaints submitted by letter or fax or delivered in person has decreased in recent years, while the number of complaints sent by email has increased correspondingly. In 2021, the majority of complaints, 86% (84% in 2020), were submitted electronically. The complainant also receives an immediate notification of the receipt of the email.

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

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

Some complaints are handled through an accelerated procedure. In 2021, a little more than half of all complaints (55%) were handled through the accelerated procedure. The purpose of the procedure is to identify immediately on receipt the complaints that require no further investigation. The accelerated procedure is suitable especially in cases where there is manifestly no ground to suspect an error, the time limit has been exceeded, the matter falls outside the Ombudsman's remit, the complaint is non-specific, the matter is pending elsewhere, or the complaint is a repeat complaint with no grounds for a reappraisal. If a complaint proves to not be suitable for the accelerated procedure, the matter is referred back for the normal distribution of complaints. A draft response is given within one week to the party deciding on the case. The complainant is sent a reply signed by the legal adviser taking care of the matter.

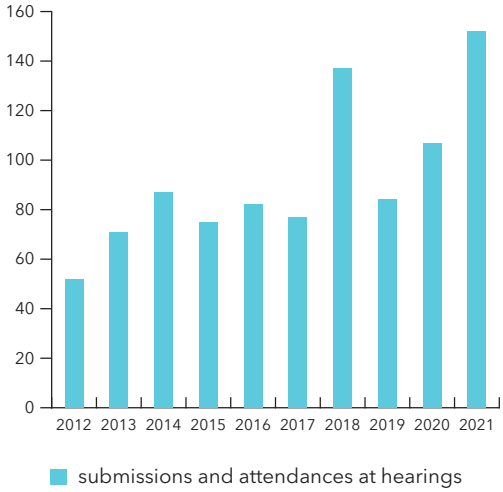
Legality matters received	2021	2020
Complaints	7,651	6,962
Transferred from the Chancellor of Justice	81	97
Taken up on own initiative	67	66
Requests for submissions and attendances at hearings	155	116
Total	7,954	7,241

Legality matters resolved	2021	2020
Complaints	7,840	6,982
Transferred to the Chancellor of Justice	52	45
Taken up on own initiative	91	78
Requests for submissions and attendances at hearings	153	107
Total	8,136	7,212

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

Communications and messages that were submitted for information only, that are not considered to have been sent for the purpose of initiating action and that are in no way related to any other matter under process, are not recorded. They are, however, always reviewed by the Substitute Deputy-Ombudsman or the Secretary General. Communications sent using the feedback form on the Office website are dealt with in accordance with the principles described above. In 2021, 9,647 written communications that had arrived for information were received (9,266 in 2020).

In addition, the oversight of legality extends to opinions and consultations on various parliamentary committees, for example. The number of statements and hearings increased to record levels in 2021.



Resolved requests for submissions and attendances at hearings between 2012 and 2021.

In 2021, 78% (77% in 2020) of all the complaints that arrived were related to the ten largest categories. Statistics on the Ombudsman's activities are provided in Appendix 6.

In 2021, a total of 91 (78 in 2020) matters investigated on the Ombudsman's own initiative were resolved. Of these, 42 (60) led to action on the part of the Ombudsman, meaning 46% (77%) of matters.

Measures

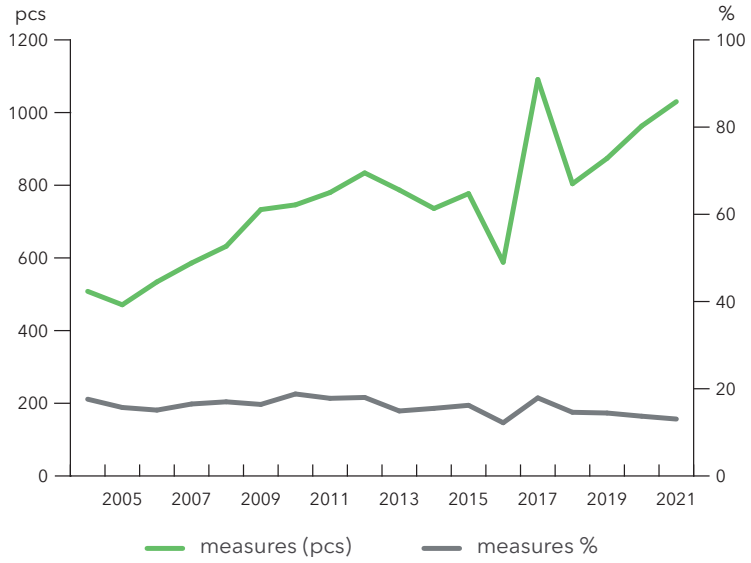
The most relevant decisions taken in the Ombudsman's work are those that lead to him or her taking measures. These measures include prosecution for breach of official duty, a reprimand, the expression of an opinion and a recommendation. A matter may also result in some other measure being taken by the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

A prosecution for breach of official duty is the most severe sanction available to the Ombudsman. This requires a pre-trial investigation and the processing of the matter in criminal proceedings. At the end of the proceedings, the Ombudsman may also make a reasoned reprimand of a criminal offence, the recipient of which has the right to bring a decision on guilt before a court (Article 10 of the Parliamentary Ombudsman Act). In the complaint procedure, the Ombudsman may issue a so-called administrative notice if the supervised party has acted unlawfully or failed to fulfil their obligations. He or she may also express an opinion as to what would have been a lawful course of action or draw the attention of the oversight subject to the principles of good administrative practice, or to aspects that are conducive to the implementation of fundamental and human rights. The opinion expressed may be formulated as a rebuke or intended for guidance.

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

MEASURES TAKEN BY PUBLIC AUTHORITIES	Prosecution	Assessment of the need for pre-trial investigation	Reprimand	Opinion	Recommendation	Rectiication	Other measure	TOTAL	Total number of decisions	Percentages*
Social welfare	0	1	15	191	8	14	43	272	1 321	20,59
Health	0	0	68	79	18	13	34	212	1 217	17,42
Police	0	1	3	87	4	2	41	138	931	14,82
Criminal Sanctions field	0	1	1	57	2	2	10	73	447	16,33
Social insurance	0	0	3	51	4	3	2	63	388	16,24
Administrative branch of the Ministry of Education and Culture	0	0	0	42	2	5	11	60	490	12,24
Administrative branch of the Ministry of Economic Affairs and Employment	0	0	0	53	0	1	1	55	299	18,39
Local government	0	0	3	19	1	5	6	34	305	11,15
Administrative branch of the Ministry of Transport and Communications	0	0	0	7	1	3	15	26	193	13,47
Taxation	0	0	2	14	1	3	2	22	137	16,06
Enforcement (distraint)	0	0	1	10	2	3	2	18	233	7,73
Administrative branch of the Ministry of Finance	0	0	0	10	1	1	5	17	70	24,29
Guardianship	0	0	1	7	1	0	5	14	113	12,39
Administration of Law	0	0	1	9	0	1	0	11	283	3,89
Administrative branch of the Ministry of Defence	0	0	0	10	0	0	0	10	74	13,51
Administrative branch of the Ministry of the Environment	0	0	2	6	0	1	1	10	203	4,93
Aliens affairs and citizenship	0	0	1	3	1	0	2	7	108	6,48
Administrative branch of the Ministry of Justice	0	0	0	5	1	0	1	7	126	5,56
Prosecutors	0	0	0	4	0	0	2	6	78	7,69
Customs	0	0	0	4	0	0	1	5	30	16,67
Highest organs of government	0	0	0	2	1	0	1	4	404	0,99
Administrative branch of the Ministry of Agriculture and Forestry	0	0	1	2	0	0	0	3	102	2,94
Administrative branch of the Ministry of the Interior	0	0	0	3	0	0	0	3	30	10,0
Administrative branch of the Ministry for Foreign Affairs	0	0	0	1	0	1	0	2	15	13,33
Other administrative branches	0	0	0	0	0	0	0	0	386	0,0
Total	0	3	102	676	48	58	185	1 072	7 983	13,4

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



In 2001–2021, the number of measures taken as a result of complaints increased from 320 to over 1,000. The number of resolved complaints within the same period increased from approximately 2,500 to almost over 8,000. The relative proportion of complaints leading to measures (measure %) has remained more or less unchanged.

Sometimes an authority may pre-emptively rectify an error at a stage when the Ombudsman has already intervened with a request for a report. The proposals for the development of regulations and instructions and for correcting errors are listed in Appendix 3.

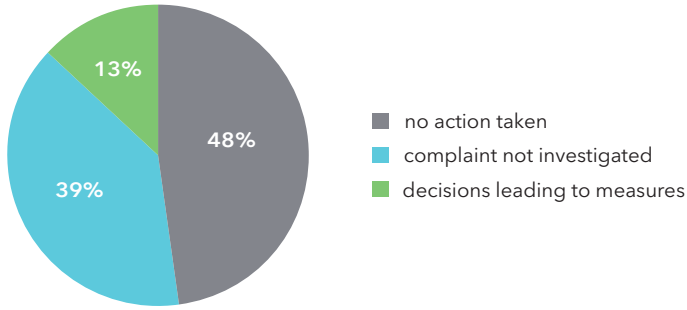
In 2021, decisions on complaints and investigations at the Ombudsman's own initiative that led to measures totalled 1,030 or 13% of all decisions (1,023 in 2020, i.e. 14 %). Approximately one fifth of complaints and investigations at the Ombudsman's own initiative were subject to a full investigation; in other words, at least one report and/or statement was obtained.

In about 44% of cases (3,497 in all), there was either no ground to suspect erroneous or unlawful behaviour or there was no reason for the Ombudsman to take measures. No erroneous action was found in 326 cases (approximately 4%). No investigation was conducted in 39% of cases (3,039).

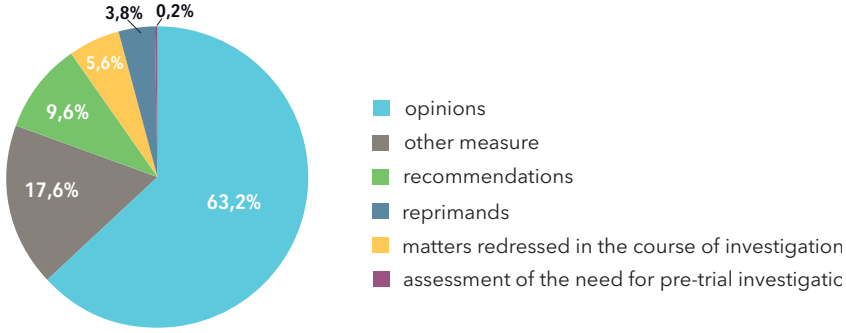
In most cases, the complaint was not investigated because the matter was already pending with a competent authority. An overseer of legality usually refrains from intervening in a case that is being dealt with at the appeal stage or by another authority. Matters pending with other authorities, and therefore not investigated, accounted for 12% (945) of all complaints dealt with. Other matters not investigated include those that fall outside the Ombudsman's remit and, as a rule, cases that are more than two years old.

The proportion of all investigated complaints that led to measures, when cases not investigated are excluded, was 21%.

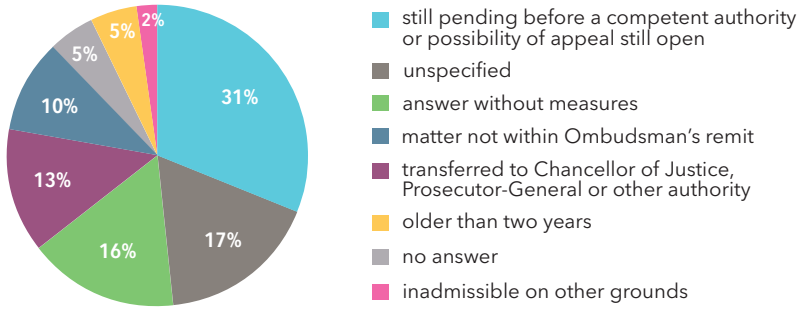
None of the matters handled in the year under review were brought to prosecution for breach of official duty. There were two matters that merited pre-trial investigation by the police. A total of 99 reprimands were given, and 651 opinions were expressed. Rectifications were made in 58 cases while under investigation. Decisions classed as recommendations numbered 39, although stances on development of administration that in their nature constituted a recommendation were included in also other decisions.



All cases resolved in 2021.



Decisions involving measures in 2021.



Complaints not investigated in 2021.

Other measures were recorded in 181 cases. In reality, the number of other measures that the decisions lead to is greater than the figure shown above, because only one measure is recorded under each case, even though several measures may have been taken.

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

The number of inspections between 2012 and 2021.

Inspection visits

Due to the coronavirus epidemic, the number of inspections continued to be low. In 2021, only 39 inspections were carried out (28 in 2020). A full list of all inspections is provided in Appendix 4.

Approximately half of the inspections were conducted under the leadership of the Ombudsman or the Deputy-Ombudsmen and the remainder by legal advisers and as documentation reviews because of the coronavirus epidemic. A total of 15 (16 in 2020) visits were made to places and facilities where individuals are or may be kept while deprived of their liberty; 2 (4) of these visits were unannounced. These visits were made in the capacity of the National Prevention Mechanism against Torture (NPM).

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

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

2.1.5 Cooperation in Finland and internationally

Events in Finland

Ombudsman Jääskeläinen and Deputy-Ombudsmen Sakslin and Pölönen submitted the Parliamentary Ombudsman's annual report 2020 to Speaker of the Parliament Anu Vehviläinen on 17 June 2021. The Ombudsman attended a preliminary debate on the report at a plenary session of Parliament on 7 September 2021. At the end of the reporting year, the committee reading of the 2020 report is still under way.

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

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

Parliamentary Ombudsman Petri Jääskeläinen, Deputy-Ombudsman Maija Sakslin and Deputy-Ombudsman Pasi Pölönen handed the Ombudsman's Annual Report for 2020 to Anu Vehviläinen, Speaker of the Parliament, on June 17th 2021.

Due to the continued coronavirus pandemic, participation in the events mainly took place remotely during the year under review.

On 8 October 2021, Parliamentary Ombudsman Jääskeläinen participated in the panel discussion organised by the Institute for the Languages in Finland on a thematic day on clear language use, titled "Does legal language have to be used in official texts?"

Parliamentary Ombudsman Jääskeläinen gave a statement prepared on 27 October 2021 at a round table discussion organised by the Speaker of the Parliament, Anu Vehviläinen, entitled "Is the plenary session of Parliament the right place to discuss legal issues related to MPs?" The event focused on the handling of issues related to ministerial responsibility and the immunity of a Member of Parliament.

On 15 November 2021, Parliamentary Ombudsman Jääskeläinen was heard in a working group appointed by the Ministry of Justice to prepare for the reform of the liability of public bodies.

On 2 March, Deputy-Ombudsman Sakslin and legal advisers from the Office discussed the development of health care prioritisation with the Ministry of Social Affairs and Service choices in healthcare (PALKO). A cooperation meeting with the Ombudsman for Children Elina Pekkarinen and representatives of the Office of the Ombudsman for Children, the Office of the Parliamentary Ombudsman and the Human Rights Centre was held on 25 March. The K-0 operating model was discussed with Aseman lapset ry on 7 April.

Deputy-Ombudsman Sakslin led the joint meeting on 28 April with Valvira and Regional State Administrative Agencies.

Deputy-Ombudsman Sakslin participated in the discussion on 18 May at the Ministry for Foreign Affairs. She gave a comment on 14 October at a seminar to launch the implementation of the Action Plan on Fundamental and Human Rights. Deputy-Ombudsman Sakslin gave a talk on 11 November in a rule of law seminar in the House of the Estates.

Deputy-Ombudsman Pölönen attended the seminar on 24 May on the impacts of the European Convention on Human Rights.

On 9 September, Deputy-Ombudsman Pölönen participated in the 20th anniversary seminar of the prosecutors of military trials. She gave a talk on 17 September at the seminar for the senior command of the Finnish Defence Forces and gave an interview on 30 November to the Ruotuväki newsletter, which is the newsletter of the Finnish Defence Forces.

On 10 November, Deputy-Ombudsman Pölönen gave a speech at the training event for Chief Legal Advisers of the Defence Forces on the topic "Parliamentary Ombudsman as the overseers of courts – the history and regulatory framework for legality oversight".

On 22 September, the Deputy-Ombudsman Pölönen and legal advisers of the Office held a cooperation meeting with the Social Insurance Institution of Finland on social assistance matters at Kela, and on 17 December a cooperation meeting with Valvira on topical issues related to the supervision of prisoner health care, the Defence Forces' health care and the supervision of services for the disabled.

During the year under review, several of the Office's legal advisers gave speeches and presentations on various topics on many occasions.

Deputy-Ombudsman Sakslin has been a member of the Human Rights Delegation since the first term of the delegation and also during the second period 2020-2024. The Office of the Parliamentary Ombudsman has expert representation in many working groups of ministries.

International cooperation

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

The Ombudsman has traditionally participated as a member of the International Ombudsman Institute (IOI) in the events of the institute and attended the related conferences and seminars, as well as those organised by the IOI's European chapter, IOI Europe. During the year under review, the Institute's World Conference "12th IOI World Conference and General Assembly" was organised remotely on 25-27 May. Parliamentary Ombudsman Jääskeläinen, Deputy-Ombudsman Sakslin, Deputy-Ombudsman Pölönen, Secretary General Marttunen, Principal Legal Adviser Länsisyrjä and Information Officer Dahl participated in the conference. The European Regional Meeting on 6 May, "Meeting of European Region - European Assembly", was attended by Parliamentary Ombudsman Jääskeläinen and Deputy-Ombudsman Sakslin.

The Parliamentary Ombudsman is a member of the European Network of Ombudsmen, the members of which exchange information on EU legislation and good practices at seminars and other gatherings as well as through a regular newsletter, an electronic discussion forum and daily electronic news services. Seminars intended for ombudsmen and other stakeholders of the network are organised every year. During the year under review, the network organised a webinar "ENO webinar on Artificial Intelligence" on 24 March, in which the principal legal advisers Riitta Länsisyrjä and Ulla-Maija Lindström participated. A second webinar entitled 'Institutional care, EU funds and lessons from the pandemic' was organised on 15 September. Principal Legal Adviser Minna Verronen and Senior Legal Adviser Juha-Pekka Konttinen participated in it.

On 20-22 September, the European Network of National Supervisory Bodies (NPM) organised remotely the conference "The role of NPMs in the effective implementation of ECtHR judgments and CPT recommendations – Police ill-treatment and effective investigations into alleged ill-treatment". The conference was attended by principal legal advisers Juha Haapamäki, Jari Pirjola and Iisa Suhonen, as well as assistant expert Maija Hirvi from the Human Rights Centre.

The Nordic NPMs meet regularly, twice a year. The Norwegian NPM held a remote meeting on 19 March 2021. The main theme of the meeting was inspection visits to units for persons with memory disorders and persons with disabilities. In addition, the participants discussed the impacts of the EU General Data Protection Regulation (GDPR) on the NPM's work and conducted a situation review of the impacts of the coronavirus pandemic on visits. The theme of the meeting organised remotely by the Finnish NPM on 22 September 2021 was the monitoring and effectiveness of the implementation of the recommendations and providing information on them. At the end of the meeting, Julia Korkman, Docent of Legal Psychology, gave a presentation on interview skills.

The Nordic parliamentary ombudsmen have convened on a regular basis every two years, at a meeting held in one of the Nordic countries. The meeting in Iceland which was planned for the reporting year was postponed to 2022 due to the coronavirus pandemic.

For several years, the Finnish Parliamentary Ombudsman has also engaged in dialogue with the Baltic ombudsmen. Due to the coronavirus pandemic, a meeting of ombudsmen related to Nordic Baltic cooperation was not organised in 2021.

Senior Legal Adviser Jari Pirjola has been Finland's representative on the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) since December 2011. This representative is elected for a term of four years. The Committee of Ministers of the Council of Europe elected Mr Pirjola for a third four-year term, ending on 19 December 2023.

Senior Legal Adviser Juha-Pekka Konttinen participated in the "Building Back Better - Disability Leadership and the Way Forward" webinar organised by the Nordic Welfare Centre on 9 February 2021. The webinar discussed the impacts of the coronavirus pandemic on persons with disabilities and disability leadership in the Nordic countries. In 2021, Finland chaired the Nordic Council of Ministers, which included chairing the Nordic Cooperation Council for the Disability Sector.

On 13 April, Principal Legal Adviser Jari Pirjola participated in the event "Border Police Monitoring in the OSCE Region".

On 13 April, Principal Legal Adviser Juha Haapamäki participated in the Board of IPCAN (Independent Police complaints authorities' network) meeting and their webinar on 3 December.

On 26-27 May, Senior Legal Adviser Kristiina Kouros participated in the online meeting of the European National Human Rights Institutions organised by the Ukrainian Parliamentary Commissioner for Human Rights, in which the topic was "State policy practices regarding Roma. The role of equality bodies in advocating for good public policies in relation to Roma communities."

On 9-10 November, Senior Legal Adviser Riitta Länsisyrjä participated in the "Manchester Memorandum" online meeting.

On 1 December, Deputy-Ombudsman Sakslin and Senior Legal Advisers Lotta Hämeen-Anttila and Pia Wirta participated in the seminar "Advancing the Rights of Older People".

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

International visitors

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

On 6 September, former Croatian Ombudsman Lora Vidovic visited the Office. Principal Legal Adviser Iisa Suhonen presented the activities of the Finnish NPM to the Ombudsman.

2.1.6 SERVICE FUNCTIONS

Client service

The objective of the Office of the Ombudsman is to make it as easy as possible to turn to the Ombudsman. Information on the Ombudsman's tasks and instructions on how to make a complaint can be found on the website of the Office and in a leaflet entitled "Can the Parliamentary Ombudsman help?", which contains a complaint form. A complaint may be sent by post, email or fax or by completing the online form.

The Office provides clients with services by phone, on its own premises and by email. Because of the coronavirus epidemic, client service at the Office was restricted with regard to visits by clients in 2020.

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

The Office's Registry receives and logs arriving complaints and responds to related enquiries, as well as documents requests and provides general advice on the activities of the Office of the Parliamentary Ombudsman. The Registry received around 3,100 (2,600) calls during the year. There were no physical customer visits due to the coronavirus situation. There were approximately 980 (900) orders for documents/requests for information.

The Finnish Parliament Annex.

Communications

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

In 2021, the Office published 20 (26) press releases on the Ombudsman's decisions, inspections and statements, if they were of particular legal or general interest. In addition, information was actively provided on the special tasks of the Office. The press releases are given in Finnish and Swedish and are also posted online in English. The Office has increasingly transferred to utilising Twitter when providing information.

The Office commissioned an analysis of its media visibility, which showed that the Ombudsman had been visible in the online media in the context of 2,311 (2,386) news items or articles during 2021. Almost 50% more posts linked to the Ombudsman were published on social media in 2021, a total of 15,369 (10,226).

A total of 337 (347) anonymous solutions were posted online. The website includes decisions and solutions that are of legal or general interest.

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

The Office and its personnel

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

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

At the end of 2021, the number of personnel in the Office was 69, including the Parliamentary Ombudsman and two Deputy Ombudsmen. At the end of the year under review, the share of women on the staff was 69.6%, including the personnel at the Human Rights Centre.

There were 67 permanent positions at the end of 2021. At the end of 2021, there were 4 vacancies. In addition to the Parliamentary Ombudsman and the Deputy-Ombudsmen, the permanent staff at the Office comprised the Secretary General, 16 principal legal advisers, 16 senior legal advisers, one on-duty lawyer and the Director, five specialists and an assistant of the Human Rights Centre. The Office also had an information officer, an information management specialist, two investigating officers, five notaries, an administrative secretary, a filing clerk, an assistant filing clerk, two departmental secretaries, two records management secretaries, an assistant for international affairs and six office secretaries.

At the end of the year, the share of personnel at least 45 years of age was 81.2% (82.9 %). The personnel's education level index was 6.6 (6.5). The share of personnel possessing a university-level degree was above 84.1% (81.4 %). Of this, the share of personnel with a Master's level university degree was 73.9% (72.9 %) and the share of those who have completed research training was 11.6% (12.9 %).

During a part of the year or the whole year, there were 15 persons working in the Office in fixed-term positions, including the fixed-term positions in the Human Rights Centre. A list of the personnel is provided in Appendix 5.

In accordance with its rules of procedure, the Office has a Management Group that includes the Parliamentary Ombudsman, the Deputy-Ombudsmen, the Secretary General, the Director of the Human Rights Centre and three staff representatives. The Information Officer was the secretary of the Management Group. The Management Group discusses in its meetings matters relating to, among others, the personnel policy and the development of the Office. The Management Group convened 4 times. A cooperation meeting for the entire staff of the Office was held on two occasions.

The Office had permanent working groups in the areas of education, wellbeing at work, and equitable treatment and equality. The Office also has a job evaluation working group, as required under the collective agreement for parliamentary officials. The Occupational Safety and Health Committee established at the Office in 2020 met four times during the year under review. Temporary work groups included the working group and steering group for case management and online service development projects.

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

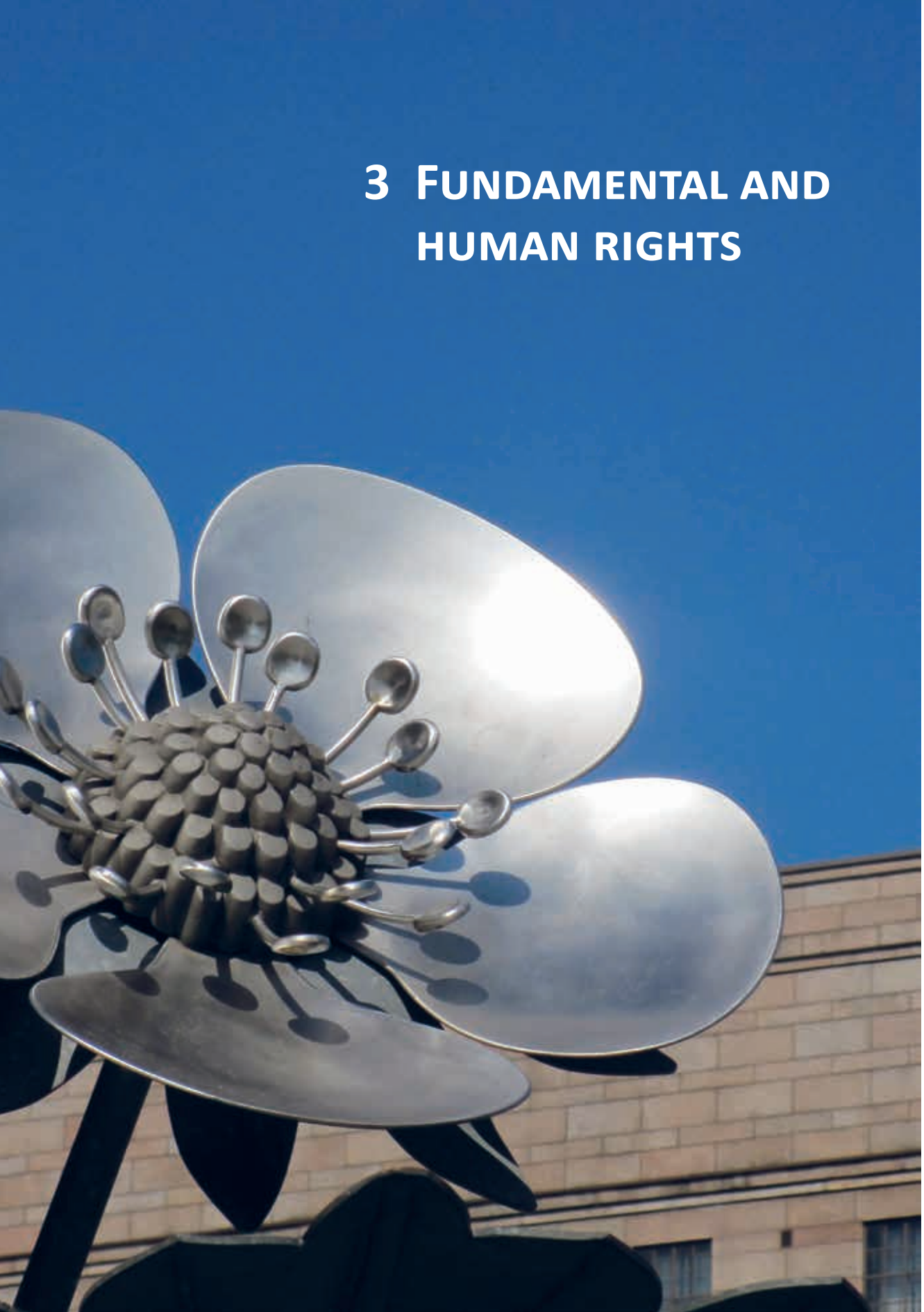
Office finances

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

The Office was given an appropriation totalling EUR 6,555,000 for 2021. A total of EUR 6,308,330 of this appropriation was spent in 2021, or 96.24% of the appropriation.

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

3 Fundamental and human rights



3.1 The Ombudsman's fundamental and human rights mandate

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

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

For example, this is provided for in the provision on the investigation of a complaint in the Parliamentary Ombudsman Act. Section 3 of the Act states that the Ombudsman shall take the measures arising from the complaint made that they deem necessary from the perspective of compliance with the law, protection under the law or the implementation of fundamental and human rights. It does not only involve monitoring the implementation of fundamental and human rights, but also promoting them. Similarly, section 10 of the Parliamentary Ombudsman Act states that the Ombudsman can, among other things, draw the attention of a subject of oversight to the requirements of good administration or to considerations of implementation of fundamental and human rights.

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

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

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

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

The fundamental and human rights chapter of the report has gradually become increasingly extensive, which is a good illustration of the way the emphasis in the Ombudman's work has shifted from overseeing the authorities' compliance with their duties and obligations towards promoting people's rights. The Parliamentary Constitutional Law Committee has welcomed this change in focus. In 1995, the Ombudsman had issued only a few decisions in which the fundamental and human rights dimension had been specifically deliberated and the fundamental and human rights chapter of the report was only a few pages long (see the Ombudsman's Annual Report for 1995 pp. 26–34). The chapter is nowadays the longest of those dealing with various groups of categories in the report, and implementation of fundamental and human rights is deliberated specifically in hundreds of decisions and in principle in every case.

3.2
The National Human Rights Institution of Finland

3.2.1
COMPOSITION, DUTIES AND POSITION OF THE HUMAN RIGHTS INSTITUTION

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

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

The tasks of the National Human Rights Institutions consist of diverse expert, advisory and investigation tasks related to the promotion and protection of human rights. The institutions must promote education, training and information related to human rights as well as the implementation of international human rights commitments. Institutions can also process complaints. Institutions must be as independent as possible from governments and be pluralistic, i.e. broadly representative of societal actors.

The Human Rights Centre and its Delegation were established under the aegis of the Ombudsman's Office with the aim of creating a structure which would meet the requirements of the Paris Principles to the best possible extent.

3.2.2
RENEWAL OF THE A STATUS

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

The A status not only has intrinsic and symbolic value but it also has legal relevance: a national institution with A status has, for example, the right to take the floor in the sessions of the UN Human Rights Council and to vote at GANHRI meetings.

Finland's National Human Rights Institution has been accredited with the A status twice already: between 2014–2019 and 2020–2025.

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

The Finnish Human Rights Institution has also joined the European Network of National Human Rights Institutions (ENNHRI). The Finnish institution was a member of the ENNHRI and GANHRI Bureaus until year 2019.

3.2.3
THE HUMAN RIGHTS INSTITUTION'S OPERATIVE STRATEGY

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

The strategy outlined the following main objectives for the Institution:

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

3.3
Human Rights Centre and Human Rights Delegation

3.3.1
THE HUMAN RIGHTS CENTRE'S MANDATE

The Human Rights Centre's (HRC) statutory tasks are:
- to promote information, education, training and research associated with fundamental and human rights
- to draft reports on implementation of fundamental and human rights
- to present initiatives and issue statements in order to promote and implement fundamental and human rights
- to participate in European and international cooperation related to the promotion and protection of fundamental and human rights
- to perform other comparable tasks associated with the promotion and implementation of fundamental and human rights.

The HRC does not handle complaints or other individual cases.

The HRC's budget proposal for 2021 stated a budget of EUR 962,000 for operational costs, of which EUR 769,000 was for personnel costs and EUR 193,000 for consumption expenses.

In 2021, the HRC had seven permanent posts (the director, five expert officials, and an administrative assistant). One permanent official working at the Office of the Parliamentary Ombudsman has been on leave of absence since 2019. In 2021, two experts in fixed-term employment relationships also worked at the HRC, one for the whole year and one for approximately nine months.

A call for applications for the Junior Experts Programme was announced in October 2021. In the process, the HRC sought two young, competent people interested in fundamental and human rights for 18 months' employment. The Centre received 239 applications which shows young people's great interest in human rights work. The programme was launched in February 2022.

The HRC's international "human rights advocate visit programme" also began in 2021. Each year, a current or former representative of a national human rights institution is invited to visit Finland to learn more about Finland's fundamental and human rights work and to share experiences. The former Croatian Ombudswoman Ms Lora Vidovic visited the HRC in summer 2021, although due to coronavirus restrictions, the visit was shorter than planned and not all meetings could be carried out during the programme.

3.3.2
THE HUMAN RIGHTS CENTRE'S OPERATION

The Human Rights Delegation adopted the Human Rights Centre's Action Plan for 2021 in December 2020. According to its assessment, the HRC has achieved the objectives set in the Action Plan for 2021 quite well despite the continued coronavirus pandemic.

Monitoring fundamental and human rights

Monitoring fundamental and human rights means collecting information on the implementation of fundamental and human rights, analysing the data and maintaining up-to-date knowledge of the situation. Based on the collected data, it is possible to assess how best to promote the fulfilment of rights. Monitoring is based on the utilisation of already existing information and on the Centre's own investigations which are carried out according to opportunities and needs.

During the year, the HRC continued to systematically develop monitoring. The long-term goal is for the HRC to have a comprehensive overview and knowledge base on the fundamental and human rights situation in Finland and to be able to report on it regularly and comprehensively. The HRC hopes that it will be able to submit its report also to the Parliament in the coming years, and not only for information to the committees. This is also required by the Sub-Committee on Accreditation of National Human Rights Institutions in its recommendations to the Finnish Human Rights Institution, which were received when the A status was confirmed in 2019.

In 2021, the HRC introduced a monitoring tool (Lempi) which creates technical preconditions for continuous and more systematic monitoring and reporting of fundamental and human rights.

During the year under review, the HRC monitored the development of the rule of law and the debate on it both in Finland and in Europe. Observations on Finland's current state of rule of law were submitted to the European Commission's rule of law review already for the second time in the State of The Rule of Law in Europe 2021 report, coordinated by ENNHRI, the European Network of National Human Rights Institutions.

A national Fundamental Rights Barometer carried out in cooperation with the Ministry of Justice was published in June 2021. The Fundamental Rights Barometer project produced new data on the situation of linguistic minorities (Arabic, Swedish and Russian speakers) and persons with disabilities in relation to the entire population. Two separate thematic summaries planned by the HRC on the realisation of the rights of persons with disabilities and general legal awareness will be published in 2022.

The results of the extensive SIHTI research project assessing the human rights responsibility of Finnish companies were published in January. Representatives of the HRC participated in the research project as experts. The results of the SIHTI project showed that Finland's largest companies in the care sector have not yet made much progress in the overall practical implementation of human rights responsibility. Based on this, the HRC conducted a survey on the state of human rights responsibility in the 13 largest care sector companies operating in Finland in spring and early summer 2021. Based on the report, the HRC assesses possible follow-up measures to promote the human rights responsibility of companies in the care sector.

In May, the Human Rights Centre published its report Primacy provision of Article 106 of the Constitution and the requirements of evident conflict - is it time to change? The report discusses the need for change related to the Primacy provision of Article 106 of the Constitution in relation to the requirements of evident conflict. The report examines court rulings in which the court has legally found an evident conflict between the Constitution and the application of the provision of the law. The report presents the findings that emerge from the solutions, such as that all solutions concern fundamental rights, half of the solutions were voted on, and that not many solutions have been made. The report also discusses the views expressed in connection with the preparation of the constitutional amendment that entered into force in 2011 and the views expressed in the legal literature on the necessity and justification of the requirement for evident conflict.

In March, the HRC launched a study on national operators involved in fundamental and human rights. The report discusses the supreme overseers of legality, the National Human Rights Institution, special ombudsmen and the National Non-Discrimination and Equality Tribunal. The purpose of the report is to produce comprehensive information on the current state of the fundamental and human rights structures in question and to submit proposals for clarifying and strengthening the structures. The report will be published in June 2022.

The HRC participated independently in the periodic reporting procedure for the human rights treaties by issuing statements and attending consultation events. It also provided information about the recommendations of the treaty bodies and monitored the implementation of recommendations of the treaty bodies. During 2021, the Centre issued a statement on i.e. the implementation of the UN International Covenant on Economic, Social and Cultural Rights, the implementation of the UN International Covenant on Civil and Political Rights, and the implementation of the UN Convention on the Elimination of All Forms of Discrimination Against Women.

Since 2021, the HRC has paid particular attention to delays in the national implementation of the decisions of the European Court of Human Rights (ECHR) and the European Committee of Social Rights (ECSR) concerning Finland. In June, the HRC asked the Ministry for Foreign Affairs to investigate the delays in implementation. At that time, a total of 19 judgments by the ECHR and seven by the Council of Europe Social Rights Committee concerning Finland were open. In September, the Ministry for Foreign Affairs responded to the request for information and communicated a plan to close the cases by the end of the year. The Human Rights Delegation discussed the matter at a meeting in September in which a representative of the Ministry for Foreign Affairs was consulted.

The promotion of fundamental and human rights

The task of the Human Rights Centre is to promote the implementation of fundamental and human rights through initiatives and statements. The HRC issues statements either on the basis of a request for a statement or on its own initiative on themes related to its activities and structural fundamental and human rights issues. A total of 20 statements were issued in 2021.

At the initiative and partial funding of the HRC, the teacher training of the faculty of educational sciences at the University of Helsinki still continued the Human Rights, Democracy, Values and Dialogue in Education project to strengthen competence in fundamental and human rights. The project ended on 31 July 2021. At the end of the project, thematic training packages on human rights education were produced on Article 24 of the Convention on the Rights of Persons with Disabilities (inclusive education) and the indigenous Sámi people. In particular, the thematic training material on the Sámi received a lot of attention and positive feedback, and it was introduced in widespread use.

The various events for the public and specialists are important for the HRC as a means of providing information and training related to topical fundamental and human rights themes. The coronavirus pandemic clearly continued to reduce the number of events compared to previous years in 2021.

HRC events and training events in 2021:
- HRC and the Finnish League for Human Rights webinar on economic, social and cultural human rights on 6 May 2021
- HRC webinar on the right to self-determination of older people in care services on 31 May 2021
- Education and training on the fundamental and human rights of older people in the “Magnet care sector” project (Vetovoimainen vanhustyö) (Savonia University of Applied Sciences Ltd and Savo Municipal Federation of Education) on 4 February 2021
- Training programmes on the right of older people to self-determination in 24-hour services on 18 May 2021, 20 May 2021, 1 June 2021 and 3 June 2021
- Training of the European Law Students’ Association Finland (ELSA) and the Human Rights Centre on human rights and rule of law issues on 27 April 2021
- Commissioned by the Human Rights Centre, Johanna Kare’s COVID-19-themed photography exhibition in the “Katso Ihminen” series (“Look Human”) on 11 June-31 July 2021 in the Temppeliaukio Church and Tripla Mall shopping centre

Press releases, statements, news and reviews of fundamental and human rights were published on the HRC website and on the Twitter and Facebook accounts. The news articles covered the HRC's activities as well as international and domestic fundamental and human rights themes and events. In 2021, a platform update of the website was carried out to improve accessibility. Information on various human rights themes, such as the rights of persons with disabilities and the rights of older people, was also disseminated using targeted communications.

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

The HRC's work with persons with disabilities focuses on increasing awareness of the rights of persons with disabilities, monitoring the implementation of the rights of persons with disabilities and promoting the social inclusion of persons with disabilities.

In 2021, the Disability Rights Committee (VIOK) discussed, among other things, the impacts of the coronavirus pandemic on persons with disabilities and the state of disability policy measures in the Government Programme. In 2021, the HRC, in cooperation with VIOK, published translations of CRPD Committee's General Comments No 6 and 7 on equality, non-discrimination and inclusion in Finnish and Swedish.

The reform of disability services legislation began in 2021 with consultations. In its consultation, the HRC highlighted in particular the comments of the CRPD Committee on supported decision-making, personal assistance and support services needed by the guardians of children with disabilities.

The HRC launched a joint project with the Non-Discrimination Ombudsman on promoting the working life rights of persons with disabilities. The objective of the project is to promote the right of persons with disabilities to work and to increase their employment in accordance with Article 27 of the UN Convention on the Rights of Persons with Disabilities.

For more information on the special task of the rights of persons with disabilities together with the Ombudsman, see section 3.4. The rights of persons with disabilities.

Promoting and monitoring the rights of older persons

The objectives of the HRC's work to promote the rights of older people include:
- strengthening a rights-based perspective in services for older people
- influencing values and attitudes
- influencing knowledge and understanding of the rights of older people and
- influencing the quality and content of legislative drafting related to the rights of older people.

During the year, the HRC cooperated closely on the rights of older people with the team handling matters related to older people within the Office of the Parliamentary Ombudsman. An interview study on the service needs and availability of services for older people living at home was commissioned in cooperation with Taloustutkimus.

The Centre continued its extensive cooperation with organisations representing older people, authorities, researchers, experts and human rights organisations. The HRC participated in the activities of the national VAASI network of experts in elder law. Cooperation with municipalities and service providers was emphasised more than in the previous year.

The HRC conducted a study on the implementation of the right to self-determination and fundamental and human rights of older clients in 24-hour housing services. The project was carried out in collaboration with providers of intensified assisted living services. A separate report on the results was published in spring 2021.

The HRC also published a report on the activities, good practices and potential challenges of municipal councils for older people. All Finnish older people's councils were sent a questionnaire analysing each council's practices and operating conditions.

One of the ways that minority groups and the diversity of older people were visible in the HRC's work on the rights of older people was reserving one of the meetings of the division for the rights of older persons for a discussion on the right of older persons speaking foreign languages on the basis of an introduction by representatives of the JADE Activity Centre.

During the year, the HRC issued several statements on the rights of older people. They concerned customer fees for social welfare and healthcare services, the quality recommendations for older people, palliative and terminal care and the establishment of the Ombudsman for Older Persons. During 2021, the HRC's experts organised several training events for social welfare and healthcare professionals on the fundamental and human rights of older people and the right to self-determination. In addition, the HRC experts spoke about the fundamental and human rights of older people at many events.

Ms Claudia Mahler, Independent Expert on the enjoyment of all human rights by older persons at the UN Human Rights Council, visited Finland from 26 October to 4 November 2021. This was the first visit of the mandate of an independent expert on older people's rights to the Nordic countries after its establishment in 2014. The purpose of the visit is to report to the UN Human Rights Council on legislation related to the rights of older people and the implementation of these rights in Finland. In the final statement, Ms Mahler emphasised, among other things, the heterogeneity of older people as a group and the importance of respecting their cultural, linguistic and other individual rights.

The UN Open-ended Working Group on Ageing held its 11th meeting in March-April 2021. The HRC had already issued written statements for the meeting in autumn 2019 before the beginning of the coronavirus pandemic. Close cooperation with the European Network of National Human Rights Institutions ENNHRI and the Global Network GANHRI took place prior to the OEWGA meeting and included the coordination of national human rights institutions' speeches and the exchange of information.

International and European cooperation

As a rule, the HRC represents the Finnish National Human Rights Institution in cooperation between national and European human rights institutions. The Centre was active in ENNHRI's thematic working groups. Questions of the rule of law and related concerns in Europe were often addressed during the year in institutional cooperation, reporting, events and training.

In addition, an expert from the HRC chaired the ENNHRI Legal Working Group. During 2021, the working group focused on promoting the implementation of the decisions of the European Court of Human Rights and creating tools to facilitate this. In addition, the Centre's experts participated actively in the ENNHRI working groups on economic and social rights, the rights of persons with disabilities, the rights of older people and corporate responsibility.

In December, the ENNHRI General Assembly elected the Human Rights Centre/Finnish National Human Rights Institution to the ENNHRI Board and the Centre's Director as the Chair of the Board as of 31 March 2022.

Close cooperation with the EU Agency for Fundamental Rights (FRA) and the Council of Europe was continued through ENNHRI and also separately. In particular, meetings and exchanges of information took place with the Council of Europe Commissioner for Human Rights. The Ombudsman was also the keynote speaker at the Human Rights Delegation meeting in June. The cooperation with FRA related to the Charter of Fundamental Rights, the rule of law and national human rights institutions and related standards. During the year, cooperation with the UN institutions focused in particular on the rights of persons with disabilities and the rights of older people, and as a new theme, on the environment and climate change.

3.3.3 THE HUMAN RIGHTS DELEGATION'S OPERATION

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

The Human Rights Delegation is part of the National Human Rights Institution and is the Centre's most important channel for cooperation, influence and communication.

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

The Human Rights Delegation met four times in 2021. Due to the coronavirus pandemic, all meetings were organised as remote meetings. The themes of the meetings included topical issues related to the international human rights policy in the Council of Europe and UN human rights activities, the state of the rule of law and human rights in Finland and Europe, and monitoring the implementation of fundamental and human rights. The recommendations received by Finland from international human rights bodies were also discussed by the delegation.

In early 2021, the HRC compiled and published the report The impacts of the coronavirus pandemic on the implementation of fundamental and human rights - recommendations of the Human Rights Delegation. The delegation also issued opinions on human rights education and training as well as inclusive teaching.

The third Human Rights Delegation began its four-year term on 1 April 2020. The Delegation has 38 members, including specially authorised actors and representatives of the supreme overseers of legality and the Sámi Parliament of Finland. The Human Rights Delegation and its working committee are chaired by the director of the HRC Ms Sirpa Rautio. Mr Esa Iivonen, member of the Delegation, is the deputy chairman.

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

3.4
Rights of persons with disabilities

3.4.1
SPECIAL MANDATE TO IMPLEMENT THE RIGHTS OF PERSONS WITH DISABILITIES

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

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

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

Decisions on cases in this category were made by Parliamentary Ombudsman Petri Jääskeläinen, the presenting officer was Principal Legal Adviser Minna Verronen, and the Senior Legal Adviser was Juha-Pekka Konttinen. Matters concerning persons with disabilities are also described in the sections concerning Opcat inspections (3.5) and coronavirus (4).

3.4.2
TASKS AND ACTIVITIES OF THE NATIONAL MECHANISM

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

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

Parliamentary Ombudsman

The Parliamentary Ombudsman protects, promotes and monitors the implementation of the CRPD within the limits of his or her specific mandate. The Ombudsman's tasks include overseeing legality in the exercise of public authority and supervising (protecting) the implementation of fundamental and human rights.

Over time, the Ombudsman's activities have evolved towards promoting fundamental and human rights. In decisions on complaints and during visits and inspections, instead of focusing solely on the legality of practices, an effort is made to guide authorities and other subjects of oversight towards adopting practices that implement fundamental and human rights as effectively as possible. Oversight and monitoring are interlinked in the Ombudsman's work, as observations of inadequacies in realising the rights of persons with disabilities made in the course of the oversight of legality are also part of general follow-up of how CRPD obligations are implemented in practice.

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

Other forms of cooperation with persons with disabilities and disability organisations have been and will continue to be increased.

Human Rights Centre

The statutory task of the Human Rights Centre (HRC) is to promote fundamental and human rights and monitor their realisation. The HRC does not investigate complaints or exercise oversight of legality. Rather than being limited to the activities of the authorities, the Human Rights Centre's competence also extends the activities of private stakeholders.

The HRC's work with persons with disabilities focuses on strengthening the legal perspective and increasing awareness of the rights of persons with disabilities, promoting the social inclusion of persons with disabilities, and developing oversight into the implementation of the rights of people with disabilities. Related to promoting the rights of persons with disabilities, this work has been reflected by a tool that supports monitoring (LEMPI) having been adapted to meet the reporting needs of the UN Convention on the Rights of Persons with Disabilities.

In general promotion work, one of the objectives of this term of the HRC has been to strengthen the fundamental and human rights competence of authorities and various professional groups. These efforts have been implemented especially in themes related to education and working life.

Results of the Fundamental Rights Barometer research project carried out jointly by the HRC and the Ministry of Justice were published on 22 June 2021. The HRC then launched the process of drafting two thematic reports based on the results of the Fundamental Rights Barometer. One thematic report further compares the responses of the overall population with responses given by persons with disabilities.

The HRC published human rights education material on inclusive education together with the Faculty of Educational Sciences at the University of Helsinki. The purpose of the material is to increase awareness especially in the field of education and training on topics such as Article 24 of the Convention on the Rights of Persons with Disabilities.

During the term, the HRC and its Human Rights Delegation published a statement on inclusive education.

The HRC published translations in Finnish and Swedish of two general comments of the CRPD Committee (General Comments Nos 6 and 7).

During the year under review, cooperation with the University of Tampere was launched on the use of legal remedies for persons with disabilities. Among other things, the purpose of the online survey is to find out how often persons with disabilities have to resort to legal remedies in relation to their subjective rights and what kind of problems they encounter with the implementation of legal protection.

The HRC issued an opinion to the Ministry for Foreign Affairs on the drafted additional protocol to the Convention on Human Rights and Biomedicine (the 'Oviedo Convention') of the Council of Europe regarding the protection of human rights and dignity of persons with mental disorders in the context of involuntary placement or treatment (IOK/8/2021). Other statements included an opinion on the Government proposal for an act establishing a special assignment company to support the employment of persons with impaired work ability, a statement on the proposals of the Ministry of Social Affairs and Health working group on the reform of disability services legislation (IOK/5/2021) and a statement to the CRPD Committee on the draft for a general comment by the Committee (IOK/44/2021). The general comment concerns Article 27 of the UN Convention on the Rights of Persons with Disabilities, which concerns disabled persons' right to work and become employed.

Disability Team

The Disability Team of the Office consisted of three experts from the Office of the Parliamentary Ombudsman, a notary and one expert from the Human Rights Centre. During 2021, the Disability Team worked in close cooperation with the Disability Sub-Committee. Matters highlighted in the Sub-Committee and Disability Team meetings were discussed fluently on both sides, since two members of the Disability Team also served as experts in the Sub-Committee.

The meetings of the Disability Team discussed the impact of the coronavirus epidemic on the selection of sites to visit and the performance of the visits, updated the strategy of the Disability Team and planned internal training related to the Office's theme of disability. As part of identifying the tasks of the national mechanism, the Team conducted discussions with the employees of the Office and assessed the scope of the concept of persons with disabilities in the administrative branches of the oversight of legality. The Disability Team also considered different ways of cooperating with and involving persons with disabilities.

The Disability Team published a self-assessment tool prepared during the project on fundamental and human rights in housing services. The self-assessment tool is intended to support service providers and producers offering special care in order to strengthen clients' right to self-determination. The tool consists of questions that guide special care providers to make an independent assessment on how well the activities and adopted operating methods of residential units support and strengthen clients' right to self-determination. The self-assessment tool is freely available on the HRC website. The tool is regularly updated, for example twice a year with regard to case law and the opinions of the overseers of legality.

On the initiative of the Disability Team, the Office organises annual training related to the theme of disability. During the year under review, this training focused on reasonable accommodation in the social security system (10 November 2021). The educator was Professor of Public Law Toomas Kotkas from the University of Helsinki. The members of the Disability Rights Committee also participated in the training.

Members of the Disability Team gave lectures on the rights of persons with disabilities at the following events:

– farewell seminar for the Director of the Finnish Association of People with Physical Disabilities Petri Pohjonen, titled "Towards an equal Finland", 20 January 2021

- seminar on human rights acts in the everyday life of children with disabilities, on 28 January 2021
- information event for new employees at the Office of the Parliamentary Ombudsman on taking accessibility into account during visits, 17 March 2021
- Right to self-determination and human rights in everyday life – training event organised by the Hospital District of Northern Ostrobothnia and Nuorten ystävät ry, 23 April 2021
- comments at two hearings organised by the Ministry of Social Affairs and Health, June 2021
- presentation at the meeting of the Advisory Board on Children's Affairs "Inclusion and the rights of the child"
- information event to Members of Parliament on the rights of persons with disabilities (HRC with the Non-Discrimination Ombudsman), 9 December 2021

Disability Rights Committee (VIOK)

The Disability Rights Committee (VIOK) – a permanent division under the Human Rights Delegation – met six times during the term. In accordance with the work programme prepared by the Committee for 2000–2024, the meetings heard external experts' presentations and discussed the impacts of the Covid-19 pandemic on persons with disabilities, the structural obstacles to working life inclusion, equality and discrimination, the entries related to persons with disabilities in the Education Policy Report, and the partial reform of the Non-Discrimination Act. In addition, the Committee closely monitored the implementation and progress of the disability policy measures of the Government Programme throughout the term. The Committee members and expert members participated as experts in the review of the terminology of the Finnish and Swedish translations of the CRPD Committee's general comments.

The Disability Rights Committee (VIOK) participated in the preparation of the polling station inspections by the Parliamentary Ombudsman of the 2021 municipal elections.

National cooperation

Cooperation with other authorities encompassed Valvira, regional state administrative agencies, the Office of the Non-Discrimination Ombudsman, the Ombudsman for Children, the National Non-Discrimination and Equality Tribunal and the Finnish Institute for Health and Welfare. Cooperation with Valvira and regional state administrative agencies included inspections and the selection of inspection sites.

The HRC launched a joint project with the Non-Discrimination Ombudsman on promoting the working life rights of persons with disabilities. The objective of the project is to promote the right of persons with disabilities to work and to increase their employment in accordance with Article 27 of the UN Convention on the Rights of Persons with Disabilities.

Two members of the Disability Team participated as separately invited experts in meetings of the legal team for the handbook on disability services (Vammaispalvelun käsikirja, maintained by the Finnish Institute for Health and Welfare), on topics including the latest case law relating to disability services and the monitoring of the reform of the Act on Disability Services and Assistance.

The Disability Team monitors the activities and communications of the parliamentary group on disability matters (VAMYT) and participates in events organised by VAMYT.

A member of the Disability Team (HRC) serves as an expert in the Advisory Board on the Rights of Persons with Disabilities (VANE) and in the Ministry of Justice expert group on monitoring discrimination.

International cooperation

As a result of the coronavirus pandemic, all meetings of the ENNHRI CRPD working group were remote meetings, and as in the previous year, the working group focused on assessing and monitoring the measures and impacts of the coronavirus pandemic. During the term, an expert from the HRC participated in a discussion event organised by the ENNHRI CRPD working group together with the European Disability Forum and Mental Health Europe and Equinet on the drafted additional protocol to the Convention on Human Rights and Biomedicine (the 'Oviedo Convention') of the Council of Europe regarding involuntary treatment measures.

The 14th Conference of States Parties to the UN Convention on the Rights of Persons with Disabilities was organised in June in a hybrid format, mainly virtually and partly on site in New York. The members of the Disability Team participated in a few events.

3.4.3 CURRENT LEGISLATIVE PROJECTS AND REPORTS

During the year under review, the Ministry of Social Affairs and Health prepared a reform of disability services legislation. The Ministry of Social Affairs and Health organised several consultation events that were open to everyone.

The development of legislation relating to the right of self-determination mentioned in the Government Programme was often brought up in discussions with authorities and organisations. The Ministry of Social Affairs and Health has appointed a monitoring group for strengthening the client's and patient's right to self-determination, with an expert from the Human Rights Centre participating as a member. The work of the monitoring working group will continue until 31 December 2023.

As agreed in Prime Minister Sanna Marin's Government Programme, a study (Signed Memories / Viitotut Muistot research project) was carried out in 2020–2021 on the violations – and the impacts thereof – against the rights of deaf people and the sign language community from the 20th century to the present day. The study found that the community had been discriminated against throughout this entire period. As a result of discrimination, many members of the community have internalised a negative image of themselves and of their community, which is why there needs to be a continued societal effort to process the injustices faced by the community. The study contains 9 recommendations for measures.

3.4.4 OVERSIGHT OF LEGALITY

The Ombudsman oversees the realisation of the rights of persons with disabilities concerning all authorities and private bodies performing public tasks, regardless of the administrative sector of the authority. Statistics on all complaint cases are primarily compiled into categories based on the authority and administrative branch (social welfare, social insurance, health care, education and culture authorities, etc.) reviewed in the case in question. Some decisions taken in the course of the oversight of legality relating to the rights of persons with disabilities involved several different administrative branches. This section deals with areas that are vital for the implementation of the rights of persons with disabilities regardless of which administrative branch the matter involved.

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

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

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

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

Complaints and own initiative investigations

The number of complaints and own-initiative investigations falling into this category on which decisions were issued was 300. This figure remained nearly the same compared to last year, with 306 issued decisions in 2020, 281 in 2019 and 257 in 2018.

The Ombudsman investigated 4 cases in total on his own initiative. Two decisions concerned restrictive measures for children in housing and institutional services (5030/2018 and 2757/2019), described in section 3.5. A larger number of investigations warranted further action than in previous years, 115 cases in total (38%). The percentage of cases warranting further action was higher than in the previous year (32%) and, as in previous years, higher than the average of the Office of the Parliamentary Ombudsman (13.5 %). A reprimand was issued in three cases and a proposal was made in seven cases (5 proposals for health care). Three reprimands were issued for social welfare. Two cases concerned disability service procedures (explained below) and the third case concerned a social services procedure for safeguarding the care of a person with a memory disorder 5849/2020. The Ombudsman gave his opinion on 64 (63) cases, and 19 (16) cases led to other measures. Due to the high number of cases that led to measures, it is not possible to give an account or mention of all decisions concerning disability rights. An increasing effort is being made to publish the decisions on the Ombudsman's website www.oikeusasiamies.fi.

As in previous years, the social welfare category had the highest number (218) of decisions concerning persons with disabilities (215 in 2020 and 179 in 2019). The reason is that local authorities are responsible for the provision of social services, such as special care for persons with intellectual disabilities, services and support measures provided on the basis of disability and services for persons with memory disorders. Of the services provided under the Act on Disability Services and Assistance (132 decisions), 40 decisions (35 in 2020 and 26 in 2019) concerned personal assistance, 44 cases (44 in 2020 and 30 in 2019) involved transport services, 28 cases (29 in 2020 and 25 in 2019) concerned the rights of persons with intellectual disabilities and 31 cases (43 in 2020) concerned the rights of elderly people with disabilities (memory disorders).

During the year under review, 23 decisions related to social insurance were made (32 in 2020 and 46 in 2019), 38 decisions related to health care (51 in 2020 and 57 in 2019) and 21 decisions related to education (15 in 2020 and 5 in 2019).

Complaints relating to service provision under the Act on Disability Services and Assistance concerned e.g. decision-making related to services and customer charges, guidance and advice related to services, complainant's treatment in a customer service situation or residential unit, assessment of service needs, delayed processing of an application or a complaint, and local authorities' service provision and application directives.

The practices of the Social Insurance Institution (Kela) were assessed as a body granting benefits, such as disability and rehabilitation allowances. In the health care sector, cases were related to the care and treatment of persons in mental health rehabilitation, the funding of a medical rehabilitation aid, the provision of medical rehabilitation and the patient's right to self-determination and adequate health care provision.

Inspection visits

During the year under review, due to the coronavirus pandemic, inspections of the housing and institutional services for the disabled were carried out as remote inspections, mainly by consulting the clients and their relatives by telephone and requesting documents and clarification from the inspected entity. The remote inspections focused on investigating the effects of the pandemic on the content and quality of services and the use of restraints. Remote inspections were carried out for the Purohovi unit in the City of Vaasa (3996/2021), the Central Ostrobothnia Joint Authority for Social and Health Services Soite (3995/2021), the Rekola Respiratory Paralysis Unit (4128/2021) and Jampankaari service yard of the Central Uusimaa Social and Health Care Authority (4060/2021). In addition, the Deputy-Ombudsman sent requests for clarification to the Niuvanniemi and Old Vaasa Hospitals.

The findings of the above-mentioned inspections conducted as a national preventive mechanism and the reports received are described in section 3.5 of this report.

Inspection observation on accessibility

Promoting accessibility and participation are cross-cutting themes of the CRPD covered in the Office's on-site inspection activities.

The ward of the Psychiatric Prison Hospital (Vantaa unit) had an accessible patient room/cell with a dedicated toilet and shower. There was a good amount of room for a wheelchair next to the bed and in the toilet. Because the call button for contacting a guard was only by the door, the Deputy-Ombudsman recommended considering measures such as purchasing of a wireless alarm device in for the space (6762/2021).

Advance polling stations

On the order of the Ombudsman, two officials of the Office of the Parliamentary Ombudsman carried out unannounced inspections at the advance polling stations for municipal elections in 8 municipalities in Southern Finland (Tampere, Akaa, Hämeenlinna, Janakkala, Siuntio, Kirkkonummi, Vantaa and Espoo). The Parliamentary Ombudsman decided to bring the observations and development proposals contained in the inspection record that relate to the visibility of signs, accessibility issues and voting arrangements of the polling stations to the attention of the inspected municipalities and their Central Election Boards.

The general observation was that there was still room for improvement in announcements related to the advance polling stations and their guidance. The Parliamentary Ombudsman welcomed the fact that advance polling stations are becoming increasingly accessible. The polling stations also have more accessible polling booths or spaces where voters using wheelchairs or other mobility aids can write down their vote while preserving their secrecy of election, as independently as possible (3250/2021).

Statements

The Ombudsman issued a statement on the proposals of the Ministry of Social Affairs and Health expert group on the reform of disability services legislation (8298/2020).

The Deputy-Ombudsman issued a statement to the Ministry for Foreign Affairs on a collective complaint against Finland in accordance with the European Social Charter (7992/2020). The complaint alleges that Finland has violated the rights of persons with disabilities living in housing units with restrictions to prevent the spread of the COVID-19 pandemic, including visiting bans.

The Deputy-Ombudsman issued an opinion to the Ministry for Foreign Affairs on the drafted additional protocol to the Convention on Human Rights and Biomedicine (the 'Oviedo Convention') of the Council of Europe regarding the protection of human rights and dignity of persons with mental disorders in the context of involuntary placement or treatment (1301/2021).

3.4.5 DECISIONS REGARDING SOCIAL WELFARE

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

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

Planning and organisation of services for a child injured in an accident

In case 877/2020, the Ombudsman gave a reprimand to the disability services of a joint municipal authority for welfare and health concerning unlawful practices in the planning of disability services for a child and the organisation of alterations to housing arrangements.

The Parliamentary Ombudsman found that the procedure of the disability services of the joint municipal authority for welfare and health had failed in many ways in the planning of services for a child who had become disabled in a skiing accident and in arranging alterations to the child's housing arrangements. In the case, the implementation of the decision on alteration work had been delayed, and in addition, disability services had neglected to supervise the service provider regarding the case.

The Ombudsman considered the entire procedure of the disability services of the joint municipal authority for welfare and health to be highly reprehensible. When assessing the reprehensibility of the proceedings, the Ombudsman took into account the fact that it was a question of organising services for a child of a sensitive age and in need of special support. In addition, the case concerned the service planning and guidance phase immediately after the person becoming disabled, which requires special attention, care and sensitivity from social work in mapping out the child's situation and in managing the situation of the child and the family.

Organising special care for a child in swedish

In case 488/2021, the City of Helsinki had not been able to arrange special care for a Swedish-speaking child with mild intellectual disabilities and psychiatric challenges in the child's mother tongue in the housing unit during the assessment period (guidance in the housing unit). According to the Parliamentary Ombudsman, the procedure had violated section 40 of the Social Welfare Act and violated the child's equality and social, cultural and linguistic rights guaranteed by the Constitution of Finland.

As the child was not able to have conversations in their mother tongue in guidance situations, the Parliamentary Ombudsman could not find that the quality of the service received by the child was good or that the child's mother tongue had been taken into account as required by the act on the status and rights of social welfare clients.

The Ombudsman emphasised that, from the perspective of the implementation of the right to self-determination and other rights of a child in need of special support, it is particularly important that the child's right to receive service in the language of their choice be realised. The language used plays an important role in encountering the child and in the mutual understanding of matters.

In its statement, the city considered that it had arranged the child's care in the best possible way despite having inadequate resources. From the context, it could be concluded that the lack of resources specifically concerned the organisation of services in Swedish and that the service could have been arranged for a Finnish-speaking child. The Ombudsman emphasised that inadequate resources are not a valid reason for not offering a client a service in the language of their choice.

In the Ombudsman's view, the city – as the entity providing and purchasing the service – should have taken the necessary measures in autumn 2019 to realise the child's right to special care in Swedish on an equal basis with Finnish-speaking children. In the view of the Ombudsman, the city, as the buyer of the service, could and should have used its influence so that the private service provider would have continued its possible efforts and measures to get Swedish-speaking personnel in the housing unit; alternatively the city itself should have taken the necessary measures to ensure that the right of the child to receive services in Swedish would have been realised.

The Ombudsman drew the city's attention to the fact that the implementation of fundamental rights requires active measures by public authorities to create effective preconditions for the implementation of fundamental rights. In practice, this means continuous measures from the service provider in a situation where the organised service does not implement the client's fundamental rights.

The Ombudsman asked the City of Helsinki to produce a report by 28 February 2022 on how the City of Helsinki intends to organise sufficient Swedish-speaking special care services and to ensure their availability for children with intellectual disabilities in the future.

– On 3 February 2022, the City of Helsinki announced that it had taken into account the need for development in Swedish-speaking services. With the health and social services reform, the operations of special care district and the provision of disability services in Swedish will be transferred to the wellbeing services counties and the City of Helsinki. This will increase the number of services provided by the City of Helsinki, and Uusimaa will also be carrying out both internal planning and cooperation to ensure the provision of services in Swedish in different ways.

Shortcomings in multidisciplinary cooperation

In case 1132/2020, the Ombudsman found that the planning of a child's services and the decision-making procedure concerning services were not in the interest of the child's family with regard to the city's early childhood education and education sector or the social welfare sector, and had not met the requirements of good governance in all respects. In the Ombudsman's view, this had been the case due to deficiencies in information flow within the city and cooperation issues between social services and early childhood education and care.

The Ombudsman found that the city's Swedish-language early childhood education and care should have made an appealable decision on the complainant's application for early childhood education and care and claims concerning day care at home. The Ombudsman emphasised that the right to receive an appealable decision and the right to appeal a decision are key legal safeguards of good governance. An authority may not delegate its duty to investigate and make decisions for example because a matter is complicated or difficult to resolve. Once a client's (child's) service needs become known to the social services (disability services), the individual service needs must always be assessed and the necessary assistance and treatment must be arranged, for example on the basis of the Social Welfare Act, the Act on Disability Services and Assistance, the Act on Special Care for Persons with Intellectual Disabilities and the Child Welfare Act.

The Ombudsman emphasised that confusion within the city and difficulties in cooperation between different sectors must not lead to loss of rights or delays in processing with regard to the organisation of services for a child in need of special support. In other words, social services cannot make the granting of a service conditional on another sector of the city making a negative decision on, for example, the provision of early childhood education and care. This course of action may lead to delays in decision-making and service provision that are contrary to a child's best interests.

The Ombudsman welcomed the proposal of the city's social welfare and health care sector to make Swedish-speaking service practices more client-oriented. As, according to the report received, the city's social work for the disabled had started to take measures to improve the availability of Swedish-speaking disability services, the Ombudsman was contented to drawing special attention to the equal availability of Swedish-speaking disability services and special care services in the city's social and health care sector and social work for the disabled.

Case 2254/2020 concerned the organisation of care for a disabled child during summer holiday from school in a situation where the child had not been granted special care for a person with intellectual disabilities. There was also a pending appeal in the Administrative Court relating to this case. In general, the Ombudsman drew the attention of the city's early childhood education and care to the fact that children in the age range of compulsory education can be entitled to early childhood education and care when special circumstances so require. Especially for single parents, situations may arise where it is most appropriate to arrange a child's care using early childhood education and care services.

Delays in decision-making and other negligence receive criticism once more

The most common shortcomings found in the oversight of legality by the Ombudsman involve delays in processing applications for benefits or services granted to persons with disabilities and neglecting the authority's duty to make decisions. These procedural errors jeopardise the implementation of legal protection of persons with disabilities, as the customer's appeal is delayed or cannot be realised. The decisions emphasise that support for persons in need of long-term support must be organised in such a way that the continuity of services is ensured.

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

In case 2490/2021, the Ombudsman issued a reprimand for future reference to municipal social services for unlawful delays in decision-making and repeated negligence in responding to contact requests. The Ombudsman took into account that, in an earlier decision, the Deputy-Ombudsman had already brought to the municipality's attention the unlawful failure of a social welfare office holder to respond to contact requests, but the situation had not been rectified. Repeated delays in the processing of social welfare matters may jeopardise the safeguarding of necessary care and adequate services for social welfare clients. For this reason, the Ombudsman found the procedure of the municipal social services highly reprehensible. The Ombudsman drew particular attention to the lawful handling of matters whose organisation was the duty of the municipal social services.

In case 8127/2020, the Ombudsman also drew serious attention to the lawful processing of applications for disability services by the city's disability services and the procedures of good governance. The Ombudsman considered delays in the processing of the application concerning the complainant's child to be in violation of the Act on Disability Services and Assistance and the Social Welfare Act.

The processing of the complainant's application concerning alterations to the child's housing arrangements with regard to a smart lock took in its entirety almost 10 months and with regard to a yard fence approximately one year and three months. The processing of a first application for autism guidance also took more than three months in 2020.

The city's disability services had not presented acceptable special reasons for clearly exceeding the three-month deadline laid down in the Act on Disability Services and Assistance. The city's disability services had not disputed the child's need for the above-mentioned alterations to the housing arrangements in the first place, but despite this, the processing of the applications and the investigation of the matters had taken an unreasonable time. When assessing the reprehensibility of the case, the Ombudsman took into account that the case concerned the organisation of necessary disability services of a child with a severe disability. The smart lock and the compensation for the yard fence also involved ensuring a safe living environment for the disabled child.

When it comes to safeguarding essential care or other fundamental rights – such as housing alterations and other subjective rights in accordance with the Act on Disability Services and Assistance – processing without delays must be given special importance in the activities of the authorities. In addition, the best interest of a person and child in need of special support must always be taken into account in the assessment of the order in which applications are processed and of their processing time.

The processing of a transport service application for commuting took over a month longer than the specified maximum period. The delay in processing was due to negligence and a recording error. The Ombudsman drew the attention of the City of Vantaa to recording applications carefully and appropriately and to the special maximum processing time laid down in the Act on Disability Services and Assistance (6961/2020).

In case 6604/2020, the Ombudsman brought his opinion on the unlawful delay in the application for disability services (housing alterations) to the attention of the city's social services and disability services. The processing of the complainant's application had only begun after they had reached out, at which point the initiation of matter had been delayed by about 10 months. The three-month deadline for processing an application laid down in the Act on Disability Services and Assistance had clearly been exceeded. The delay was apparently a result of oversight.

The Ombudsman drew the attention of the city's disability services to the careful recording and lawful processing of applications for disability services. The Ombudsman emphasised that the authority must start investigating matters immediately after an application has been initiated.

As a result of messages it had received, the rights enforcement unit of the Finnish Federation of the Visually Impaired criticised the disability service processes in Raisio in many ways. In addition, the criticism in the complaint was based on the experiences of rehabilitation instructors at Turku University Hospital in the management of the affairs of their visually impaired clients.

The Deputy-Ombudsman's substitute made the social welfare and health care services and disability services of the City of Raisio aware of the substitute's views on unlawful procedures in decision-making (taking over three months), the preparation of the service plan (records had not been made or had been delayed), the processing of claims for rectification (the claim for a revised decision was not referred to the City's Social and Health Services Board) and the notification of decisions (own-initiative revised decisions were not notified to the client). The Deputy-Ombudsman's substitute also drew the city's attention to what was said about justifying decisions and responding to contact requests.

The substitute asked for information on the measures that the decision has given rise to and how the organisational reform of disability services mentioned in the city's report has been implemented in practice (3560/2020).

– On 24 May 2021, the Raisio Social and Health Centre provided a detailed report on its measures in the matter and the implementation of the reform.

Obligation to make a mobility plan in special care

The Ombudsman considered that a joint municipal authority had neglected to draw up a mobility plan for clients under involuntary special care, even though the Act on Special Care for Persons with Intellectual Disabilities requires such a plan for clients who are subject to a decision on supervised movement. The plan must indicate how the client's mobility under supervision will be implemented (3882/2020).

Transport services provided under the Act on Disability Services and Assistance

According to Article 20 of the UN Convention on the Rights of Persons with Disabilities, the States Parties shall take effective measures to ensure personal mobility with the greatest possible independence for persons with disabilities, including by facilitating the personal mobility of persons with disabilities in the manner and at the time of their choice, and at affordable cost;

Temporary decision and guidance for making an extension application

In decisions 6961/2020 and 382/2021, the Ombudsman found the decision made by the City of Vantaa problematic in that a person with a temporary transport service application does not receive guidance on submitting an extension application similarly to other transport service decisions. A person with a severe disability may have a subjective right to additional transport. In the Ombudsman's view, it would be good to include similar guidance in decisions on additional transport or to individually ensure in some other way that the continuation of the service is ensured better than before.

The Ombudsman did not consider the practice in Vantaa to be unlawful as such, but he emphasised that, to follow good governance and legislation, the authority should act in such a way that the client's right to services would continue seamlessly.

In practice, this means that the office holder should make a temporary decision for a sufficiently long period of time and, if necessary, make a new decision early enough before the expiry of the previous decision.

The documents did not indicate that the complainant's need for additional transport services would have been individually assessed before the expiry of the temporary decision, thus ensuring the continuity of their services. The Ombudsman drew the attention of the City of Vantaa disability services to what was said about making temporary decisions and about guiding clients to apply for an extended decision.

Transport services in the Essote region

The Deputy-Ombudsman's substitute brought to the attention of the South Savo Social and Health Care Authority (Essote) and the municipality of Juva their understanding of a problem in the determination of customer fees for transport services (deductible) as well as their views on transport service practices and instructions related to the practices of organising transport services (one-way journey), payment of a transport service card, escort service related to transport services and cancellation practices and sanctions (4681/2020). The substitute asked Essote and the municipality of Juva to state what measures they had taken as a result of the decision by 15 October 2021.

– Essote reported that it would introduce the determination of deductibility based on zones in its region (excluding the municipality of Juva) from 1 December 2021. In addition, Essote announced that it would update its guidelines on one-way journeys, the payment of the transport service card, the escort service related to the transport service and the cancellation practices. The municipality of Juva announced that it would adopt the same updated customer instructions as Essote.

Advance order fee

A complainant had not been given a separate decision on customer charges for transport services, although the complainant had expressed their dissatisfaction with the collection of advance order fees. The Ombudsman brought to the attention of the city's disability services that in oversight practice, with regard to customer fees, the established minimum requirement is that social welfare customers should receive an appealable decision concerning the calculation basis and amount of customer fees, at least if the customer requests it (4520/2020).

Right to a familiar taxi

There are no separate provisions in legislation on the right to a familiar taxi or other individual means of organising transport services. In practice, the right to a familiar taxi enables the use of transport services in a situation where the general method of organising transport services decided by the municipality (such as combining journeys and using an order centre) restricts or prevents the actual use of the transport service by a person with severe disabilities.

In case 1273/2020, the Ombudsman assessed the application instructions concerning transport services in the Akaa cooperation area to the extent that it restricted the use of the right to a familiar taxi service so that the customer could not select a close family relation as the familiar taxi.

The Ombudsman found the general rule stated in the municipal application instructions problematic. He also considered the instructions unclear and open to interpretation regarding the instructions limiting the participation relatives. The Ombudsman informed his views to the city's disability services and social welfare services.

Re-opening cases

In decision 117/2021, the Deputy-Ombudsman's substitute considered that a joint municipal authority had acted incorrectly in that a case concerning transport services had not been re-opened on the basis of the complainant's contact request or the information contained in a request for clarification sent on the order of the Parliamentary Ombudsman. In addition, the Deputy-Ombudsman's substitute considered that the joint municipal authority had neglected its obligation to provide the complainant with relevant guidance and advice.

Personal assistance under the Act on Disability Services and Assistance

Determination and verification of the value of a service voucher

Based on a report submitted in a complaint by Kynnys ry, the Ministry of Social Affairs and Health estimates that the value of the service voucher for personal assistance has been lagging behind in several municipalities in relation to the increase in costs. Because this situation no longer met the requirements set by legislation, the Ministry of Social Affairs and Health informed in its statement to the Ombudsman that it had contacted the supervisory authorities and the Finnish Institute for Health and Welfare in order to improve supervision and guidance.

The Ombudsman also found that questioning the reasonableness of the value of the service voucher was justified on the basis of the complaint and the attached report. For this reason, the Ombudsman considered the measures taken by the Ministry of Social Affairs and Health important.

According to the Ombudsman, keeping the value of a service voucher sufficient and reasonable requires regular monitoring and checking of its value as necessary. The Ombudsman agreed with the Ministry that the requirement on the reasonableness of the value includes checking the adequacy of the value of the service voucher as costs increase and otherwise as necessary. The Ombudsman considered it important for the Regional State Administrative Agencies, as the primary authorities overseeing and supervising municipalities and private social service providers, to continue monitoring the reasonableness of the value of the service voucher in municipalities and, if necessary, take additional measures in the matter. The Act on Disability Services contains provisions on the arrangement of personal assistance with the service voucher, which is why it is important to ensure and monitor that this arrangement remains an actual option for persons with severe disabilities.

The Ombudsman's ruling practice has stated that the value of a service voucher should be set at a level that enables persons with severe disabilities to use it to factually meet their needs for assistance to the extent specified in the decisions concerning them and using the forms of services stated in the decisions and service plan. Although the municipality has the right to decide on the method of organising services, the chosen method of organising services may not prevent or reduce the realisation of the subjective right of an individual disabled person to the extent specified in the decision concerning them.

The Ombudsman emphasised that, according to section 22 of the Constitution of Finland, public authorities must safeguard the implementation of fundamental and human rights. The provision of personal assistance is a matter of the right to essential care and adequate social services under section 19 of the Constitution. Thus, section 22 of the Constitution requires monitoring the adequacy of the value of the service voucher and checking it when necessary.

The Ombudsman found it important, in connection with the reform of the Service Vouchers Act and the Act on Disability Services and Assistance, for it to be assessed how the adequacy and reasonableness of the value of the service vouchers could be better secured in the future.

The Ombudsman asked the Ministry to inform him by 31 December 2022 of the observations made in the supervision and guidance of the Regional State Administrative Agencies on the adequacy of the value of municipal service vouchers for personal assistance and the possible additional measures taken in the matter. At the same time, the Ombudsman asked the Ministry to assess the adequacy of possible measures taken by the Regional State Administrative Agencies in the matter (5684/2020).

Accident insurance payment

In case 482/2021, the Ombudsman considered that Siun sote had neglected to take out accident insurance for the complainant's personal assistant in accordance with its practices. The Ombudsman emphasised that if a joint municipal authority undertakes to help an employer with severe disabilities to fulfil their employer's obligations, the task must be carried out with the special care required of a social welfare authority. In addition, the Ombudsman drew the attention of Siun sote to the fact that it must ensure that the instructions concerning the employer model for personal assistance are clear and that they unambiguously indicate the responsibilities and obligations of all parties involved.

In another decision 6841/2020, the Ombudsman considered that the city's compensation for accident insurance payments had taken too long. As an employer of a personal assistant, a complainant had been put in a difficult situation due to ambiguities concerning accident insurance and partly due to the city's procedure.

Providing information after competitive tendering

After a tendering process for personal assistance, a joint municipal authority for health care and social services announced that a client could no longer select the service provider of their choice. Instead, the service provider would be assigned on the basis of the tendering process.

The Ombudsman found that the information provided to the client was open to interpretation and unclear. This may have caused uncertainty and confusion to the complainant and other clients of personal assistance.

The Ombudsman drew the joint municipal authority's attention to the comprehensibility and clarity of official language and documents. Authorities must use appropriate, clear and comprehensible language. The Ombudsman emphasised that the quality of language and the manner in which public servants express matters are important for the implementation of the guarantees of good governance referred to in section 21 of the Constitution of Finland.

In its report, the joint municipal authority for health care and social services had described the implementation of competitive tendering for personal assistance and how customers had been consulted and how their opinions had been taken into account in the selection of the personal assistant. In the light of the report received, the Ombudsman could not find that the joint municipal authority had acted unlawfully in the case concerning the selection and tendering of individual customers' personal assistance service providers (6302/2020).

Religious Christmas service in assisted housing for the disabled

A complainant criticised the fact that an Evangelical Lutheran Christmas service was "force fed" through the central radio into the apartments of an assisted housing facility for the disabled.

The Ombudsman stated that the last sentence of section 11 of the Constitution, "no one is under the obligation, against his or her conscience, to participate in the practice of a religion" specifies certain dimensions of so-called negative religious freedom.

The Ombudsman considered that if religious events are broadcast via the public central radio of an assisted housing facility, the residents should have the possibility – from within their apartments – to turn off the central radio or alternatively change the channel of the central radio.

The Ombudsman did not find it an acceptable arrangement for the staff of the assisted housing facility for the disabled to move residents not attending religious events to other premises outside their homes for that period. The Ombudsman justified his view with the ECHR's ruling practice and by the fact that persons with disabilities enjoy the protection of domiciliary peace and private life when living in rental apartments in assisted housing for disability services.

In the light of the letter of complaint and the report received on the matter, the Ombudsman considered that the Validia house had violated the complainant's freedom of religion and conscience protected by the Constitution for having had to participate in a religious Christmas service on the central radio at the apartment against the resident's will. This procedure had also violated the protection of domiciliary peace and private life guaranteed by the Constitution. At the same time, in violation of the Social Welfare Act and the Act on the Status and Rights of Social Welfare Clients, the assisted housing facility had neglected to implement the complainant's social welfare in a manner that respects their beliefs and privacy.

The Ombudsman brought to the attention of the Validia house and the city his views on the unlawful procedure in the implementation of the Christmas service. The Ombudsman asked Validia Oy to report by 30 November 2021 on the actions it has taken as a consequence of the decision (8265/2020).

– On 25 October 2021, Validia Oy announced that it had specified its guidelines for the implementation of religious events and that it would take into account the implementation of religious freedom.

3.4.6 DECISIONS REGARDING SOCIAL INSURANCE

Procedure of social insurance institution Kela in providing guidance and information for disability allowance

In case 682/2020, the Ombudsman did not find the guidance provided by Kela on disability allowance matters to be fully successful. He drew the attention of Kela to the fact that it is more necessary for the authorities to provide guidance on their own initiative when a person is in a weaker position in terms of taking care of their own affairs. In the complainant's view, they should have been granted disability allowance retroactively for a longer period than what had happened because Kela had not advised them to apply for disability allowance, and it was not clear on Kela's website that a person with a mental illness could receive disability allowance.

The Ombudsman found it a good starting point that Kela stated that it would change its website if necessary based on the feedback received.

In the Ombudsman's view, Kela had room for improvement in the provision of information on disability allowance on its website, especially in the section on support and who can receive it. In the Ombudsman's view, Kela should examine its website critically because disability support for a person with a long-term mental disorder may not become apparent as a form of support that they could receive.

The Ombudsman drew Kela's attention to the fact that the implementation of effective equality between different persons receiving disability support may require the authority to take specific measures on their own initiative in an appropriate manner. Basically, it is a question of how to secure equality in access to information and to ensure the potential right of customers to benefits in the best way possible.

The Ombudsman also stated that he agrees with the complainant in that the Kela website referencing "a young person" is inaccurate, because the benefit is not only available for young people but also for adults (working age). In this respect, the Ombudsman drew Kela's attention on a general level to the accuracy and correctness of online communications.

– Kela reported that it had corrected its website during summer 2021 and added a piece of text to the website that had been left out in an earlier website update due to human error. In addition, Kela stated that the disability benefits team is endeavouring to amend the texts on the Disability page so that they would contain more information about the fact that people with varying illnesses and injuries may be entitled to disability benefits. This work will be carried out in the next update on disability benefits on kela.fi, estimated for early 2022.

Delay in processing a disability allowance

In decision 7273/2021, the Deputy-Ombudsman criticised Kela for an undue delay in processing an application for disability allowance. The Deputy-Ombudsman considered that Kela had neglected its obligation to process the complainant's application without delay as referred to in the Administrative Procedure Act.

If the processing time of a case does not fit within the framework that is considered to constitute the average processing time and there are no valid grounds for the length of the processing time, for example because of additional clarifications or additional work required by the case, the Deputy-Ombudsman considers that the authority may be found to have neglected to process the case without undue delay. In this case, the processing time (53 days) exceeded the average processing time (26 days). Kela had not provided acceptable grounds for the delay in processing the complainant's application and the related decision-making.

3.4.7 Decisions regarding early childhood education and teaching

Requiring a decision on special support as formal precondition is problematic

In decision 6398/2020, the Deputy-Ombudsman stated on a general level that requiring a decision on special support as a formal precondition for obtaining a service (morning and afternoon activities for schoolchildren) may be problematic and endanger the realisation of the rights of the child. Children with ADHD symptoms and children on the autism spectrum, among others, may be entitled to special support and reasonable accommodation in education under the UN Convention on the Rights of Persons with Disabilities, even if they have not been granted a decision on special support in pre-primary education or basic education.

3.4.8 Decisions regarding health care

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

Right to adequate time outdoors in a psychiatric hospital

In decision 4702/2020, the Ombudsman emphasised a hospital's obligation to also safeguard the right of psychiatric patients requiring challenging care to adequate time outdoors in a safe way. If a hospital does not have a fenced outdoor exercise yard, sufficient human resources are required for the safe implementation of outdoor activities.

The Ombudsman considered the hospital's procedure in the implementation of outdoor activities of the patient in question, who was ordered to receive involuntary care, to be incorrect. The hospital was aware of the patient's perception of having no illness and likelihood of escaping. The hospital did not have a fenced outdoor exercise yard. The Ombudsman stated that allowing outdoor exercise carried a risk and that the patient's outdoor activities should have been started in the hospital area accompanied by one or more nurses and not with a family member. It is the hospital's responsibility to make decisions on how a patient's outdoor activities can be carried out safely and to reserve an adequate number of staff for securing outdoor activities. The hospital's procedure had resulted in the patient escaping and being left without necessary treatment.

Termination of involuntary treatment

In decision 4702/2020, the Ombudsman found that HUS had neglected to make an assessment of the fulfilment (termination) of the prerequisites for involuntary treatment in the manner referred to in the Mental Health Act. According to the Ombudsman, the decision on a patient's discharge cannot be based solely on time elapsed after leaving the hospital and the fact that reaching the patient not been possible. In the case, the hospital had made a decision to end involuntary care after the patient had escaped and stayed away for a week.

The Ombudsman emphasised that the termination of involuntary care must be based on an assessment of whether the prerequisites for involuntary care laid down in the Mental Health Act are met.

The situation highlights the hospital's obligation to ensure adequate health services for patients in a particularly vulnerable position due to their illness as referred to in the Constitution and the patient's right to good health and medical care in accordance with the Patient Act.

Involuntary assessment period in a city hospital

In decision 7866/2020, the Deputy-Ombudsman emphasised that, despite a possible decline in cognition, a person has the right to make decisions which, in the opinion of the health care professionals, would not match the decision that is most advantageous for them in a situation. The Deputy-Ombudsman also stressed that the staff should be aware of what respecting the right to self-determination means and what constitutes restricting a patient's fundamental rights and under what conditions this is permitted. In the Deputy-Ombudsman's view, a visually impaired complainant, who had lived independently at least at the end of the assessment period, had been in hospital against their will, which was apparent from the patient record entries made.

In the case, the complainant had been kept in hospital against their will in order to provide services according to the complainant's wishes, the need for which had already been known to social services before the assessment period in hospital. The Ombudsman considered that the procedure was not in the complainant's interest and that cooperation between social welfare and health care had not been carried out in the best possible way. The procedure had not complied with the Health Care Act and the Social Welfare Act. The Deputy-Ombudsman further stressed that a patient has the right to refuse hospital care at any time, in which case it must be reassessed whether other alternatives are available.

Assistive device for medical rehabilitation

Medical rehabilitation includes assistive equipment services. Medical rehabilitation is part of the medical care referred to in the Health Care Act, and a patient's need for rehabilitation must be assessed according to their individual needs.

In the Ombudsman's established oversight of legality, it has been considered that guidelines concerning the organisation of health services can only be complementary to the provisions of an act and decree, and they cannot restrict or exclude the right to rights secured by an act or decree. Guidelines that do not leave room for taking into account the individual needs of a person in need of the service are in conflict with legislation.

In decision 5445/2020 on the cost liability of cochlear implants' power sources and spare parts, the Deputy-Ombudsman considered it justified to amend the national guidelines of the Ministry of Social Affairs and Health on the issuing criteria for medical rehabilitation aids so that a child using a cochlear implant is given the water covers of a speech processor when the child needs this protection for swimming lessons at school or for other similar activities. This would be in line with the provisions of the CRPD and the Convention on the Rights of the Child. These conventions safeguard the right of a disabled child to recreational, leisure and sports activities and, for example, swimming and water rescue skills that are part of the national core curriculum for basic education on an equal basis with other children.

According to the complaint, batteries of the cochlear implant sound processor should have been compensated in full to all users of the implant.

In the Deputy-Ombudsman's view, it was necessary for the Ministry of Social Affairs and Health's further work on the criteria for the issuing of medical rehabilitation aids to actively monitor and assess the cost development of the batteries used in assistive devices and the financial burden to customers arising from the purchase of batteries and, if necessary, to amend the guidelines. The Deputy-Ombudsman brought this view to the attention of the Ministry of Social Affairs and Health and asked it to state by 4 February 2022 what measures the proposal had given rise to.

– The Ministry of Social Affairs and Health announced that it would set up a working group in early 2022 to review the need to update the guidelines for hearing aids and that the working group would take into account the Deputy-Ombudsman's decision in its work. The updated guidelines will be published in early 2023.

In case 7004/2020, the Deputy-Ombudsman found that the Pirkanmaa Hospital District had acted unlawfully when it had not handed issued the complainant with an assistive device (electric moped) needed in the complainant's work for medical rehabilitation. Under the Health Care Act, municipalities must allocate sufficient resources to health and welfare promotion and health care services that are the basis of central government transfers for basic municipal services. Health services are not budget dependent. The Deputy-Ombudsman made this view known to the Pirkanmaa Hospital District.

In decision 2917/2020, it was stated that a service dog, such as a guide dog, meets the definition of an assistive device for medical rehabilitation laid down in the Assistive Devices Decree. In the opinion of the Deputy-Ombudsman's substitute, HUS should have considered the complainant's application to acquire a service dog as an assistive device for medical rehabilitation. Granting service dogs as assistive devices for medical rehabilitation would promote their actual availability and be part of the implementation of the CRPD.

Like Valvira, the Deputy-Ombudsman's substitute did not consider the general operating model of the city to be appropriate, in which the participation of any clients in the rehabilitation group meeting is categorically prohibited, citing the limited amount of time available. In the opinion of the Deputy-Ombudsman's substitute, the matter could have been dealt with differently, i.e. by inviting the complainant to a meeting of the rehabilitation group and hearing them personally. In the view of the Deputy-Ombudsman's substitute, this would have promoted the implementation of the service principle of the Administrative Procedure Act (3124/2020).

In case 3558/2020, assistive equipment services had considered that participating in bike rides with children was not essential for everyday life, which is why no assistive equipment was issued for this purpose as an assistive device for medical rehabilitation.

The Deputy-Ombudsman stated that, in the case of the complainant or in any procedural way, the assistive equipment services had no grounds to refuse issuing the assistive device for medical rehabilitation on such grounds.

The Deputy-Ombudsman considered that the assistive equipment services did not assess the complainant's need for an assistive device individually in a user-oriented manner as required by legislation. The complainant should have been informed of the options related to the selection of assistive devices, and the assistive equipment services should have worked with the complainant to assess the various options for assistive devices. The Deputy-Ombudsman informed HUS and the assistive equipment services of the Deputy Ombudsman's views on the incorrect interpretation of the statutory grounds for issuing medical rehabilitation aids and the shortcomings in the evaluation for the complainant's need for assistive devices.

3.5
National Preventive Mechanism against Torture

3.5.1
THE OMBUDSMAN'S TASK AS A NATIONAL PREVENTIVE MECHANISM

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

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

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

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

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

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

For this reason, too, it is important that those members of the Office's personnel whose area of responsibility covers facilities within the scope of the OPCAT also participate in the tasks of the NPM. In practice, this means the majority of the Office's legal advisers, more than 30 people.

The OPCAT requires the States Parties to make available the necessary resources for the functioning of the NPM. The Government proposal concerning the adoption of the OPCAT (HE 182/2012 vp) notes that in the interest of effective performance of obligations under the OPCAT, the personnel resources at the Office of the Parliamentary Ombudsman should be increased. These resources were not provided when the National Supervisory Body was established in the Office of the Parliamentary Ombudsman or at a later date despite the increase in the workload brought about by the task. The UN Committee against Torture has expressed its concern about the Ombudsman's insufficient resources for the tasks of the NPM.

During 2019, several cases of negligence were identified in service units for the elderly. Some units had to be closed because of this. The Parliament granted additional funding for the Office of the Parliamentary Ombudsman for 2019 to step up the supervision of the rights of the elderly. Additional funding was granted for the establishment of new posts in 2020. Three of these posts focused on overseeing the rights of the elderly. This also increases the resources of the NPM to some extent because a large part of the visits conducted to units for the elderly are carried out under the NPM's mandate.

3.5.2 OPERATING MODEL

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

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

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

3.5.3 INFORMATION ACTIVITIES

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

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

3.5.4 PARTICIPATION IN TRAINING AND EVENTS

In the year under review, employees of the Office of the Parliamentary Ombudsman participated in the following events and courses as part of their duties under the NPM:

- Hearing and assessing the reliability of statements, trainer: Julia Korkman, Docent of Legal Psychology, Åbo Akademi University, internal training of the Ombudsman's Office
- Safe pharmacotherapy guide, trainers: project coordinator Emilia Laukkanen from the Finnish Medicines Agency (Fimea) and Senior Officer Irja Hemmilä from the National Supervisory Authority for Welfare and Health (Valvira), internal training of the Ombudsman's Office
- Right to self-determination of the elderly in 24-hour services, a webinar organised by the Human Rights Centre
- An open lecture organised by the Finnish Association of Criminal Law and Criminology on the topic "A decline in court ordered forensic assessments – reasons and consequences", lecture given by Professor Tapio Lappi-Seppälä, University of Helsinki, Institute of Criminology and Legal Policy
- The European NPM Conference on the topic "The role of NPMs in the effective implementation of ECtHR judgements and CPT recommendations – police ill-treatment and effective investigations into alleged ill-treatment"
- An international discussion event organised by the NPM of Tunisia on the topic "Monitoring conditions of arrest, custody, and pre-trial detention"

In addition to the above, a separate induction into the NPM's mandate and duties is always organised to new employees. New employees are also informed about the rights of persons with disabilities and taking these into account on inspection visits.

The full-time coordinator of the NPM was interviewed in the SILE project, one of the objectives of which is to create new practices for hearing silent agents in legislative drafting. Related development work concerning hearing prisoners had been launched in autumn 2021 in cooperation with the Ministry of Justice. As a starting point for the development, information was needed on factors that it would be important to consider when hearing prisoners. Interviews were also conducted with persons who had experience in discussions conducted with prisoners.

3.5.5 INTERNATIONAL COOPERATION

Nordic cooperation

The Nordic NPMs meet regularly, twice a year. Themes topical at the time have been discussed in each meeting. During the coronavirus pandemic, cooperation has continued through a remote connection. It has been considered important to share information between the different Nordic countries on how the coronavirus pandemic has affected the work of the NPM of each country. At the same time, information has been obtained on new monitoring methods. The advantage of remote meetings has been the opportunity for several persons from each NPM to participate in them.

In March 2021, the remote meeting was organised by the Norwegian NPM. The main theme of the meeting was inspection visits to units for persons with memory impairment and persons with disabilities. In addition, the participants discussed the impacts of the EU General Data Protection Regulation (GDPR) on the NPM's work and conducted a situation review of the impacts of the coronavirus pandemic on visits.

In October 2021, the main theme of the remote meeting organised by the Finnish NPM was the monitoring and effectiveness of implementing the recommendations and communicating about them. The aim was to find out how the NPMs supervised the practical implementation of the recommendations given during the visits. In addition, it was discussed how each NPM communicates its activities and recommendations and ensures that information about them is disseminated as widely as possible. Finally, the level of impact of the NPM's work on legislation, guidelines, resources, and institutional culture was assessed. At the end of the meeting, Julia Korkman, Docent of Legal Psychology, gave a presentation on interview skills.

Other international cooperation

The 2020 report of the Finnish NPM was submitted for information to the UN Subcommittee on Prevention of Torture (SPT).

In March 2021, the SPT sent a message to all NPMs, requesting information related to Article 4 of the Optional Protocol (OPCAT). In Articles 19 and 20 of the Optional Protocol, the NPMs have been granted the power to regularly examine the treatment of persons deprived of their liberty in places of detention as defined in Article 4. The Protocol does not define deprivation of liberty on the basis of places, but on the basis of form (any kind of deprivation of liberty). The SPT had received a request from several NPMs to further define the scope of Article 4. The Finnish NPM submitted its reply to the SPT on 26 May 2021 (163/2021).

3.5.6 VISITS

The impact of the COVID-19 pandemic on the work of the NPM

On 16 March 2020, a state of emergency was declared in Finland over the coronavirus outbreak. The Parliamentary Ombudsman considered that it was not possible to ensure the safety of the persons deprived of their liberty and the staff working in the units or of the employees of the Ombudsman/NPM sufficiently to make site visits riskless during the state of emergency. Therefore, all site visits by the NPM were suspended until further notice in March 2020. As Finland has not had separate quarantine facilities during the entire pandemic, there has been no need to visit any.

Visits were continued in other ways, until site visits were gradually started again as from summer 2021. For this purpose, guidelines for conducting inspections with attention to health security during the coronavirus pandemic were drawn up at the Office of the Parliamentary Ombudsman on 19 March 2021.

New methods for visits

Because of the restrictions caused by the coronavirus pandemic, new methods were introduced for conducting visits. In some administrative branches, the NPMs visiting mandate took place by collecting information and requesting information from the units concerned. Documents have been inspected in the social welfare sector.

Visits have also been carried out through a secure remote connection. Documentation inspections may have included remote discussions with the management and staff of the unit. The final discussion of the site visit may have been carried out remotely. For this purpose, the Office of the Parliamentary Ombudsman acquired a secure remote connection, eTUVE, which is provided by Valtori, an agency providing ICT services for the central government.

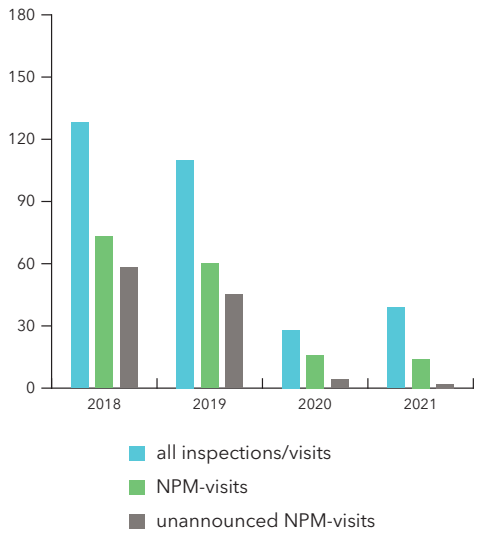
It is considered important to hear persons with disabilities and the elderly because they make few complaints. For this purpose, an opportunity to contact the NPM team by telephone in a confidential manner during remote visits may have been reserved to the residents in the unit, their families, and the employees.

Questionnaires for prisoners and prison staff were introduced on visits to prisons in the year under review. Responding is voluntary and the surveys are carried out anonymously. The purpose of the surveys is to obtain information, for example, on the treatment of prisoners belonging to vulnerable groups, i.e., on matters that it may not be possible to perceive during the visit. The aim is to better target the NPM's visits based on the information obtained from the responses. The use of the surveys has been explained in more detail in section 3.5.10.

All the above-mentioned methods will continue to be employed even after the pandemic. On the other hand, visits conducted remotely can never replace site visits. The same applies to interviews with persons.

Visits by the NPM in 2021

The NPM conducted 14 visits in the year under review. The total number of site visits carried out by the Office of the Parliamentary Ombudsman was 39. One half (7) of the NPM's visits were on-site visits. In addition, three of the Parliamentary Ombudsman's inspections were related to the task of the NPM. They included visits to the National Police Board and to Health Care Services for Prisoners.



Visits in 2018–2021.

Special themes to be considered during visits

In 2021, the special fundamental and human rights theme of the Office of the Parliamentary Ombudsman was the provision of sufficient resources for authorities to ensure fundamental rights. Further details on the theme of fundamental and human rights are provided in section 3.8. In addition to the special theme, the special duties of the Parliamentary Ombudsman, namely, the rights of children, the elderly, and the disabled, are considered on each visit. The visits also involve the "oversight of oversight", meaning the realisation of the other supervisory authorities' oversight responsibility.

Immunity of preventive mechanisms when conducting a visit

The Central Administration of the Criminal Sanctions Agency requested a statement from the Parliamentary Ombudsman on a draft concerning the guideline for security checks at prisons (4958/2021). In the draft, the staff of closed prisons were given instructions on how to conduct a security check on persons other than prisoners when they arrive in the prison. According to the guideline, the condition for entering the prison was consenting to a security check. The intention was to also apply the guideline to the Parliamentary Ombudsman and the NPM and, for example, the members of the CPT. Leaving their overclothes and other belongings they have with them to be stored in the way determined by the prison could also be set as a condition for the NPM team's entry into the prison. Once inside the prison, however, they would be allowed to carry with them the equipment required for conducting the inspection visit.

The Ombudsman issued a statement on the draft on 28 September 2021. As his opinion, he stated that the Criminal Sanctions Agency does not have the powers to intervene in or prevent the activities of the officials of the Office of the Parliamentary Ombudsman or the members of the CPT when they are performing tasks under their mandate to inspect prisons. He therefore did not consider it possible that the Criminal Sanctions Agency could use its internal instructions to set additional conditions for the visit of the Parliamentary Ombudsman or the CPT, as they could violate the immunity of the person conducting the visit and endanger or even prevent the inspection from being carried out. The draft guideline contained wrong information and guided prisons to take unlawful actions in connection with the visits of the Parliamentary Ombudsman and the CPT. However, the Parliamentary Ombudsman considered it obvious that when the NPM team arrive in the prison, they must present the appropriate inspection order and identity documents.

The Ombudsman stated that the draft had to be changed to state that the guideline does not apply to the officials of the Office of the Parliamentary Ombudsman and the members of the CPT when they are visiting prisons. Similarly, the SPT and the Chancellor of Justice should also be mentioned. In addition, the part laying down provisions on the equipment required to be handed over during the visits had to be removed. The Ombudsman also stated he was not aware of any previous attempts by prisons or the Central Administration to intervene in the visits conducted by the Parliamentary Ombudsman. The Ombudsman took seriously any action aimed at weakening, complicating, or preventing the Ombudsman's visits. The Criminal Sanctions Agency had to ensure that prisons did not have an incorrect understanding of their powers to restrict the visits conducted by the Parliamentary Ombudsman and the CPT.

– The Central Administration of the Criminal Sanctions Agency issued a guideline as of 1 November 2021 until further notice on performing security checks at the prison entrance on persons entering Riihimäki Prison. According to the guideline, the security check does not need to be performed on the officials of the Office of the Parliamentary Ombudsman, or members of the CPT or other international supervisory bodies.

3.5.7
THE IMPACT OF NPM'S PREVENTIVE MANDATE

Regardless of the number or frequency of visits, their impact will be inconsequential if recommendations made based on the visits do not lead to improved treatment and conditions of persons deprived of their liberty at the respective institutions. If tangible results cannot be documented, the visits will reduce their corrective impact.

Overall, the opinions and recommendations of the Ombudsman lead to positive actions. Often, the dialogue during the actual visit alone helps establish mutual understanding on how operations could be improved, and issues addressed. Following the visit, a draft visit report is sent to the visited facility, which has the opportunity to comment on the provisional opinions and recommendations made by the Ombudsman. In many cases, the visited unit reports on the measures it has taken on the basis of the preliminary recommendations already at this stage. An official request for information is sometimes enough incentive to take the necessary actions. On the other hand, it sometimes takes time to take through and implement the recommendations. The visits made by the NPM may also lead to changes to the legislation.

The Parliamentary Ombudsman's annual report 2020 has comprehensively reviewed the NPM's visits and their effectiveness between 2015 and 2020, the period during which the Parliamentary Ombudsman has acted as the NPM. Themes that the NPM has had to draw attention to year after year are presented from each administrative branch, as well as more uncommon themes that have played an important role in the treatment of persons deprived of their liberty. Measures taken at the institutions visited or at the national level after the NPM's visits and the Ombudsman's recommendations have also been brought up.

3.5.8
POLICE

It is the duty of the police to arrange for the detention of persons deprived of their liberty not only in connection with police matters, but also as part of the activities of Customs and the Border Guard. The largest number of people are apprehended because they are intoxicated: slightly under 50,000 every year. The second largest group is formed by persons suspected of an offence, numbering approximately 19,000. A small number of people detained under the Aliens Act are also held in police prisons.

The NPM visit reports are always sent to both the National Police Board and the visited police department. Internal oversight of legality at police departments is conducted by separate legal units. Each year, the National Police Board provides the Parliamentary Ombudsman with a report on the oversight of legality.

According to the information received from the National Police Board, the focus areas of its oversight of legality in 2021 included training in the use of force and recording the use of force. In addition, the National Police Board intended to carry out unannounced legality inspections on police detention facilities.

The police currently have 45 police prisons in use. The NPM visits are usually carried out at police detention facilities unannounced. However, in the year under review, the institutions visited were exceptionally informed of the visits in advance. This was done because of the coronavirus epidemic so that the institution to be visited could make preparations to ensure the health security of the visit.

Inspection visits

The coronavirus pandemic also affected the inspection visits to police detention facilities by the Parliamentary Ombudsman and the NPM in 2021. Only two site visits to police prisons were conducted:

– Pasila Police Prison, Helsinki Police Department (Helsinki Police Prison as of 27 September 2021) on 17 June 2021 (4225/2021), previous visit on 7 March 2018 (849/2018)
– Vantaa Police Prison, Eastern Uusimaa Police Department on 17 June 2021 (4226/2021), previous visit on 18 November 2016 (4721/2016)

In addition to the above, the Ombudsman's inspections of the National Police Board (8409/2021) and the Eastern Finland Police Department (4245/2021) were carried out remotely. The visit to the National Police Board revealed that, due to the coronavirus pandemic, the Board's own legality inspections of police prisons had had to be cancelled. In addition, it was found out that the principle of separating investigation and detention had not yet been realised as desired. The visit to the police department is explained later to the extent it was related to the operation of the police prison.

Conditions in detention rooms

In Helsinki (former Pasila) Police Prison, approximately one half of the cells do not have a toilet. However, the interviewed detainees told the NPM that they could get to the toilet quickly by pressing the call button in the cell.

In connection with the previous inspection visit to the Vantaa Police Prison in 2016, it had been stated that there were not enough even surfaces in the cells of the remand prisoners for the detainees to keep their belongings on. The situation had not changed. Both persons who were in custody on the day of the visit kept some of their belongings on the cell floor. The NPM team also paid attention to the fact that there was still no suitable place for drying the towels. The Ombudsman recommended that at least temporary storage solutions be acquired to the cells on a case-by-case basis for the belongings of remand prisoners. In addition, he recommended that a space be organised in police prisons where remand prisoners can dry their washing and towels if necessary.

– The Eastern Uusimaa Police Department reported that a solution for temporary and secure storage and places for drying laundry is being discussed at the Police Department. The National Police Board is responsible for the approval procedure for any alteration work carried out in detention facilities, for which reason its opinion regarding alterations related to detention security must be asked.

Training of members of supervising staff

In both police prisons inspected, there were police custodial officers, who had not completed the guard training for the police administration.

– However, Helsinki Police Department reported that all guards in its police prison met the qualification requirements for a police custodial officer.

In Vantaa police prison, each new police custodial officer had a personal induction card, in which the areas they had been familiarised with were marked, such as catering, outdoor exercise, the prison rules and information systems. Many of the officers were trained in using a taser and each time one is used, a report on the use of force is recorded. Training entitling to carry a service pistol had been started for officers who carried out transport tasks.

The Police University College organises training to police custodial officers in the police administration. Each police department have their own quota for the training. The Ombudsman stated that the Police Department should take care of the missing training within the limits of what is possible and the training quotas.

– The Helsinki Police Department reported it would make sure that all guards employed by the Police Department would participate in the training within the limits of the training quotas. The Eastern Uusimaa Police Department reported it had used the training quota allocated to it for the guard course every year. In November 2021, two police custodial officers were due to complete their training.

The new police custodial officers had not all received first aid training. During the coronavirus pandemic, the training courses had been put on hold. The Ombudsman recommended that the first aid training should be started again as soon as possible. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has in its latest report on Finland recommended that regular first aid training be made possible for everyone working in police prisons.

– The Helsinki Police Department reported that the guards working in the police prison would participate in first aid training as soon as the training courses can be arranged. The Eastern Uusimaa Police Department reported that it organises first aid training to all of its staff – also to those working in the police prison – and the training is repeated regularly every couple of years.

Information on rights and obligations

In its latest report on Finland, the CPT has recommended that informing persons who have been deprived of their liberty of their rights should be improved. Based on the observations made by the CPT, there were still delays in providing written information on their rights to those deprived of their liberty in police prisons. The delay concerned especially information provided in languages other than Finnish. Furthermore, not everyone could take the written information with them into their cell. Under the Act on the Treatment of Persons in Police Custody, the information must be available in the most commonly used languages.

The National Police Board has issued instructions on the treatment of persons in police custody. According to the instructions, a person deprived of his or her liberty must immediately after arrival at the detention facility be informed of the conditions in the detention facility by giving the person a form explaining the rights and obligations of persons deprived of their liberty, the rules of the police prison and the National Police Board's instructions in question. Despite this, the Ombudsman has during NPM visits had to draw the attention of police prisons to matters such as the obligation under the Criminal Investigation Act to give the detainee written information on his or her rights.

Based on what the detainees interviewed in the police prisons visited said, is seemed that there were deficiencies in providing information on the rights and obligations.

– The Helsinki Police Department reported that the person deprived of his or her liberty is given the prison rules on his or her arrival. The person is also told about the conditions in the detention facility orally and familiarised with the technical systems in the detention room. The informing of the person about the rights and obligations is always entered in the apprehension record. However, the guidance letter from the National Police Board has not been automatically given to each customer. At the time of the inspection visit, the prison rules were being translated into 17 different languages.

– The Eastern Uusimaa Police Department reported that a person who has been apprehended on the basis of an offence and has arrived in the police prison is given written information on the rules of the detention facility, his or her rights and obligations, and the daily programme. At the time of the visit, the forms were available only in Finnish. In addition, the apprehended person is told about the functionalities in the cell, such as how to use the water point and the alarm button. The informing of the person is entered in the apprehension record.

In the NPM visit report, the Ombudsman recommended that the Eastern Uusimaa Police Department ensure the availability of the information to detainees in Vantaa police prison not only in Finnish but also in the other languages most commonly spoken by persons detained in the police prison.

– The Police Department informed the Ombudsman that the rights and obligations of persons deprived of their liberty had been available in the police prison in 21 different languages at the time of the inspection visit. Police custodial officers have been instructed to inform those deprived of their liberty of them. According to the Police Department, the rules of the police prison in their entirety are also available in the domestic languages and in English.

Notification of custody

In its latest report concerning Finland, the CPT has stated its observation that notifying of custody to a family member, or some other person, is often delayed and widespread. According to the CPT, this was not caused by the investigation of the offence because in that case, any such delay must be duly reasoned. According to the CPT, this seemed to happen especially when the apprehended person was a foreign national without residence in Finland. Deficiencies related to this were not detected in the police prisons visited in the year under review.

Minors deprived of their liberty

Information on minors who had been deprived of their liberty was also requested in connection with the NPM visits. In the cases dealt with the Helsinki Police Department in 2020, a total of 159 persons under the age of 18 had been deprived of their liberty. According to the Eastern Uusimaa Police Department, the number of minors who had been deprived of their liberty during the year was a few dozens. More detailed information on their number was not available at the time of the visit. It also remained unclear to the NPM team how long the minors had been detained for.

Under the Act on the Treatment of Persons in Police Custody (the Police Custody Act), a medical examination by a doctor or other health care professional should be conducted on a person aged under 18 years without undue delay unless it is obviously unnecessary to carry out the examination.

– According to the report of Helsinki Police Prison, a minor brought to the prison is always reported to the nurse, who will conduct an interview on arrival with each minor. In Vantaa Police Prison, on the other hand, the deprivation of liberty of a minor is not automatically reported to a doctor, but it is reported to social services.

The Ombudsman stated that minors belong to the vulnerable group that should always be reported to a health care professional so that the professional can visit the minor who has been deprived of his or her liberty. Apparently, this was not possible in Vantaa, as a health care professional visited the police prison only twice a week. The Ombudsman found this problematic. In its 2021 report on Finland, the CPT also states that the situation in almost all police prisons is still the same as before, that is to say that they lack sufficient health care. The CPT has recommended all police prisons to improve access to a doctor and to ensure that a nurse visits the prison regularly.

Reporting the need for care of a vulnerable person

In November 2020, the Helsinki Police Department issued internal instructions concerning the need for care of a person deprived of his or her liberty. The instructions include a separate protective guarantee, which means a mandatory obligation set to the authorities to report to a health care professional. Protective guarantees are applied to persons in a vulnerable position and persons deprived of their liberty who have been subjected to the use of force by the authorities. According to the instructions, protective guarantees shall also apply to persons deprived of their liberty who have been subject to restraining or isolation. The report is made regardless of the will of the detainee or whether the matter has previously been reported to another health care professional. The instructions separately specify persons belonging to groups in a vulnerable position, which include minors, persons with disabilities, older people, pregnant women, persons with severe diseases and victims of human trafficking. According to the instructions, the supervising staff use individual consideration and other available information to identify a detainee who is in a vulnerable position. The Parliamentary Ombudsman had found the instructions drawn up by the Police Department a good practice.

The right of a detainee to see a doctor

A doctor visited both the police prisons inspected two or three times a week. In addition, a nurse visited Helsinki police prison every working day.

In both NPM visit reports, the Ombudsman has referred to the guidance letter sent by the National Police Board in November 2017 reminding police departments that all detainees must be informed on their arrival of their right to receive health care in the detention facility at their own expense with permission from the doctor organised by the police. The CPT has also required that the detainees be allowed access to their own doctor. Based on the Ombudsman's observations, this did not seem to happen in practice in either police prison. The Ombudsman stated that police departments should ensure that, on their arrival, detainees are provided with information on the possibility to see their own doctor.

– The Helsinki Police Department reported that the right of a person deprived of his or her liberty to health care is explained in the appendix to the guidance letter from the National Police Board, which is given to the person on his or her arrival. In connection with care procedures, the health care staff of the police prison also tell the detainees about their right to health care at their own expense while in police prison. The Eastern Uusimaa Police Department reported that, after the NPM visit, supervising staff had been instructed to inform the detainee during the arrival check of the possibility to use his or her own doctor

Unlike in the police prison in Helsinki, the health care professionals working in the police prison in Vantaa had not been given an induction into the legislation concerning police administration and the issued regulations and instructions. The Ombudsman stated that a health care professional working in the detention facilities of the police should know at least those provisions in the Police Custody Act that affect their work and those instructions issued by the National Police Board that also apply to health care provided in police prisons. The Ombudsman recommended that the Police Department provide the doctor working in the police prison in Vantaa with an induction into the necessary parts of legislation and the regulations and instructions issued in police administration.

– The Eastern Uusimaa Police Department reported that it would provide the doctor working in the police prison with training on the necessary parts of legislation and the relevant regulations and instructions.

Health examination

In its 2021 report on Finland, the CPT required health examinations to be conducted on detainees (including remand prisoners) within 24 hours of their arrival in the police detention facilities. In practice, this is not achieved in any police prison at the moment. This requirement has not been included in the guidance letter issued by the National Police Board in 2017, either. In both visited police prisons, the Ombudsman recommended that police detention facilities should try to ensure that all persons deprived of their liberty for longer than 24 hours get to see a health care professional.

– According to the Helsinki Police Department, the police prison has not been able to conduct regular health examinations on detainees arriving in the police prison because the prison has not had permanent health care staff. The operations of Helsinki Police Prison and the Töölö custodial facilities merged on 27 September 2021 and the City of Helsinki sobering-up station also moved to the police station building in Pasila. The Police Department estimates that the relocation of the sobering-up station to the same facilities with the police prison will make it possible to reorganise the health care in the police prison and, at the same time, conduct health examinations on detainees of the police prison. The matter will be discussed between the Helsinki Police Department and the City of Helsinki.
– Vantaa Police Prison also reported that it does not conduct health examinations on persons deprived of their liberty within 24 hours of their arrival, neither does a doctor automatically see all detainees who arrive in the police prison. The Eastern Uusimaa Police Department reported that recommendations concerning health care will be assessed as a whole at the Police Department. According to the information received from the Police Department, extending health examinations to everyone detained for more than 24 hours would require reviews and competitive tendering of agreements related to health care.

Reporting a person placed in observation to health care

Vantaa Police Prison does not automatically inform health care when a detainee is placed in observation. If necessary, a police custodial officer can order an emergency care unit to check the state of health of a person placed in observation. The doctor visiting the police prison meets detainees on the basis of the work list drawn up by the custodian officers in advance.

The Ombudsman stated that according to the Police Custody Act, a health care official must be notified without delay when a detainee is placed in observation (isolation under observation for safety purposes) or isolation under observation (isolation under observation for the purposes of detecting prohibited substances). A doctor or other health care official must examine the state of health of a detainee as soon as possible. Reporting is therefore not discretionary. The CPT's standards require health care to be informed of an isolated prisoner and require health care staff to see the prisoner immediately and then regularly at least once a day.

In connection with NPM's visit to the health care of the detention facilities of Helsinki Police Department (1488/2018), the Deputy-Ombudsman stated that the lack of health care staff is not sufficient grounds for neglecting to examine the state of health of a detainee once the person has been placed in observation. However, according to the Deputy-Ombudsman, it is not possible to set any specific time limits for the examination, as situations vary. There are also no separate provisions in law on how often health care staff should visit a person who has been placed in observation or isolation under observation. However, the Deputy-Ombudsman has considered the CPT's view of daily regular visits to be a step in the right direction when considering the harmful impact of isolation on the mental health of the detainee.

The Parliamentary Ombudsman recommended that the Eastern Uusimaa Police Department go through the practices of Vantaa Police Prison concerning reporting of placement in observation and isolation under observation and examining the state of health of persons deprived of their liberty.

– The Police Department reported that it has emphasised the importance of reporting to health care staff.

Confidentiality in health care

In both police prisons visited, the appointment with the patient was carried out in the cell of the detainee. According to the information received, health care staff have found this procedure the safest option. The guard usually stays waiting outside the cell. However, it has remained unclear during the visits whether the guard can hear the discussion between the health care professional and the detainee.

The Helsinki Police Department has issued instructions on the matter, which the Ombudsman considers to be a step in the right direction. The Ombudsman has emphasised to both police prisons that the primary aim should always be to arrange the care situation in such a way that the violation of the right to privacy would be as small as possible (visual contact vs. hearing contact) even if there is a need for guarding because of security or other necessary reasons in the situation. In addition, the opinion of the detainee should be determined. The person should always have the possibility to refuse the care situation. Alternatively, the person can give his or her permission to the health care professional to express confidential information in the presence of the police custodial officer. The doctor/nurse should record appropriate entries in the patient documents regarding the outsider present during the appointment and the patient's permission for this. In its opinions, the CPT has stated that there may be situations in which special safeguards are needed during the medical examination. As an example, the Committee has mentioned a situation in which health care staff feels that their safety is at risk. However, according to the Committee, this does not mean that guards can always be present during appointments.

– The Helsinki Police Department reported it had instructed the health care staff of the police prison to ask the person deprived of his or her liberty whether he or she agrees to the guard being present in the care situation, if the guard's presence is considered necessary. In addition, if a guard has been present during a care procedure, the health care staff have been instructed to record this in the patient documents.

Medicinal treatment

In its statement issued to the Parliamentary Ombudsman, the National Supervisory Authority for Welfare and Health (Valvira) has emphasised that, when police custodial officer distribute medicines, patient safety should be ensured by following the instructions of the Safe pharmacotherapy guide regarding the participation of a person not trained in pharmacotherapy in the implementation of medicinal treatment. It is also essential that the police custodial officers receive an appropriate and sufficient induction to the task. According to the information received from the National Police Board, guards working in police prisons have received training in medication. It has not been possible for the Ombudsman to assess whether this training is sufficient.

The Safe pharmacotherapy guide (last updated on 12 February 2021) also states that every unit implementing pharmacotherapy must have a pharmacotherapy plan. Police departments have not drawn up a pharmacotherapy plan although medicinal treatment is carried out in police prisons. An exception to this is the Helsinki Police Department, which submitted a pharmacotherapy plan dated 1 December 2020 to the Ombudsman after the previous NPM inspection visit (1488/2018).

During the NPM visit to Helsinki Police Prison, it was found that the staff at the police prison was not aware of the pharmacotherapy plan. The Ombudsman considered that the plan should be brought to the attention of the entire supervising staff.

– According to the Helsinki Police Department, a summary of the plan had been brought to the attention of everyone working in the police prison in May 2021. After the NPM visit, the pharmacotherapy plan was sent once more to all guards, this time entire plan.

Like other police departments, the Eastern Uusimaa Police Department did not have a pharmacotherapy plan. The Deputy Ombudsman recommended that the Police Department draw up a pharmacotherapy plan for the police prison and bring it to the attention of the health care professional visiting the detention facility and the entire supervising staff.

– After the NPM visit, the Police Department reported to the Ombudsman that the preparation of a pharmacotherapy plan concerning the police prison had begun.

Impact of the coronavirus pandemic on the rights of persons deprived of their liberty

In connection with the NPM visits, both police prisons were requested to provide their instructions related to the coronavirus pandemic. The Eastern Uusimaa Police Department had issued instructions on the operation of police prisons during the pandemic on 14 April 2020. According to the instructions, an information sheet drawn up by the National Police Board on COVID-19 had to be given to persons deprived of their liberty in connection with the examination upon their detention. On 9 March 2021, the Helsinki Police Department had in turn issued a regulation on restricting the activities in police prisons and locking the premises. The Ombudsman stated that the internal regulation about restricting the activities in the police prison and locking the premises was not in accordance with the Police Custody Act in all respects. The Police Department had to make sure that the regulation would be brought in line with the Act.

In 2020, the Ombudsman investigated as his own initiative the activities of the police in connection with detaining foreigners and holding them in detention during the coronavirus pandemic. In his decision concerning the actions of the police, the Ombudsman considered that the pandemic had also been taken into account in the detention of foreigners. In practice, this meant that the threshold for detaining had been raised and that mostly only foreigners who were a danger to public order and security had been detained (2615/2020). The Ombudsman's decision of 8 March 2021 has been explained in more detail in section 4.2.6 of the Annual Report.

Inspection of the Eastern Finland Police Department

At the beginning of the coronavirus pandemic, the Eastern Finland Police Department made the decision to centralise the detention of those exposed to the virus to Kuopio, Joensuu and Mikkeli. However, the facilities of the Kuopio Police Station posed challenges of their own because the space reserved for outdoor exercise can be accessed only by using a public lift of stairs, in which case persons deprived of their liberty could have exposed others. For this reason, the detainees held in the police prison who had been exposed to the virus were not provided with an opportunity for outdoor exercise. The NPM team was informed that when the decision was made, consideration was given to the right to outdoor exercise of a detainee and to the protection of the lives and health of others.

Under the Police Custody Act, a person deprived of his or her liberty must be given an opportunity to have outdoor exercise for at least one hour per day, unless the state of health of the person or a particularly serious reason related to order or security in the detention facility prevents it.

The Ombudsman stated that daily outdoor exercise had been denied to prevent coronavirus exposure of other persons in the public spaces of the Police Department. The procedure has therefore obviously not been related to order and safety in the detention facility. The Ombudsman doubted whether coronavirus exposure alone was a situation in which daily outdoor exercise could be denied on the basis of the detainee's state of health in the first place. Even the outdoor exercise of a person ordered to official coronavirus quarantine is not prohibited as long as the person ordered to quarantine keeps a safe distance from other people.

The Ombudsman emphasised the importance of organising daily outdoor exercise. He stated that enabling adequate outdoor exercise is about taking care of the basic needs and also about respecting human dignity. Outdoor exercise of persons deprived of their liberty may be restricted only on grounds laid down by law. The Ombudsman is of the view that efforts should be made to arrange outdoor exercise to those persons deprived of their liberty who have been exposed to coronavirus by organising it at times when there is no one else in the common areas. In any case, outdoor exercise should be arranged at least to those whose deprivation of liberty lasts several days.

Reform of the Act on the Treatment of Persons in Police Custody

According to the Government's legislative plan, the aim is to submit a government proposal during the spring session 2022 to reform the legislation concerning the treatment of persons deprived of their liberty in police custody. On 16 June 2021, in connection with this reform, the Ombudsman issued a statement (2523/2021) to the Ministry of the Interior on the report of a working group proposing that a new Act on the Treatment of Persons in Police Custody be enacted. The aim of the proposal is to take into account, in particular, the decisions and opinions of national and international supervisory bodies overseeing the implementation of fundamental rights and human rights, case-law and the practical applicability of provisions. The Police Custody Act would be applied to the treatment of all persons detained by the police under the law.

The report also proposes further specification of the responsibility to organise sobering-up treatment and the provisions on human and technical supervision of detention facilities and persons deprived of their liberty. In addition, it is proposed that new provisions on using intensified supervision at the beginning of the deprivation of liberty where necessary be added to the Act. The report also proposes that the minimum staff resources for the supervision of persons deprived of their liberty in detention facilities be separately laid down. If realised, this would mean that guarding alone would be given up in police detention facilities.

The Ombudsman stated, among other things, that even though the maximum detention period of a remand prisoner in a police prison has now been brought down to seven days, remand prisoners may still be placed in a police prison for up to months. The plan is that by 2025, remand prisoners will no longer be held in police prisons. In any case, even after the entry into force of the new Act, remand prisoners will be placed in police prisons. According to the Ombudsman, the conditions and treatment of remand prisoners must not depend too much on where they have been placed. It should therefore be assessed whether special provisions on remand prisoners should remain in the Act.

The Ombudsman found it highly desirable that the reform will bring about a functioning solution for sobering-up treatment, in which case only some of the intoxicated persons would be held in police custody. He considered it obvious that a sufficient network of sobering-up stations would significantly reduce deaths in police custody in Finland. According to the Ombudsman, however, it remained unclear what kind of measures would be taken to ensure that the current unsatisfactory situation will be rectified, both with regard to sobering-up stations and the health care provided in police prisons.

According to the Ombudsman, several justified reforms are proposed in the report – one example being the separation of the responsibilities for detention and investigation. However, the Ombudsman expressed doubts as to whether sufficient resources were available for the implementation of all improvement proposals, such as giving up having only one guard in charge of the entire detention unit. The Ombudsman considered allocation of sufficient resources a precondition for the effective protection of the rights of persons deprived of their liberty in practice, not just on paper.

In his statement, the Ombudsman also brought up the health care available in police prisons. The Ombudsman considered it important to establish a well-functioning arrangement for implementing the requirements in the international rules for the treatment of prisoners as well as those expressed in CPT's opinions that Finland ensure regular visits by a nurse to every police prison operating in Finland and access to a doctor to persons deprived of their liberty. If this is not considered possible, the reasons for this solution should be stated clearly. In the Ombudsman's view, very serious consideration should be given to whether provisions should be laid down on an assessment by a health care professional to be carried out on all intoxicated persons before they are placed in a police detention facility. Ultimately, this is about the right to life of the person deprived of his or her liberty.

3.5.9 DEFENCE FORCES, BORDER GUARD AND CUSTOMS

The NPM did not conduct any inspection visits to the detention facilities of the Defence Forces, the Border Guard or Customs in the year under review.

In 2020, the Ombudsman investigated as his own initiative the activities the Border Guard in connection with detaining foreigners and holding them in detention during the coronavirus pandemic. In his decision of 8 March 2021, the Ombudsman considered that according to the report, the Finnish Border Guard had after individual consideration released foreigners held in custody if their removal from Finland had not succeeded (2807/2020). The Ombudsman's decision is explained in more detail in section 4.2.6 of the Annual Report.

3.5.10 THE CRIMINAL SANCTIONS FIELD

The Criminal Sanctions Agency operating under the Ministry of Justice is responsible for the enforcement of prison sentences. There are 26 prisons in Finland. Prisoners serve their sentences either in a closed prison or an open institution. Of the prisons, 15 are closed and 11 open institutions. In addition, certain closed prisons also include open units. The inspection visits mainly focus on closed prisons. The average number of prisoners has remained stable at around 3,000 prisoners for several years now. During the coronavirus pandemic, efforts have been made to reduce the number of prisoners in prison by postponing the implementation of certain groups of prisoners.

In the field of criminal sanctions, NPM visit reports are sent for information to the visited prison, the Central Administration of the Criminal Sanctions Agency, the management of the criminal sanctions region in question, and the Department for Criminal Policy and Criminal Law at the Ministry of Justice. In addition, the prison and the central and regional administrations are often requested to report measures taken as a result of the observations. The Ombudsman receives reports on the facilities visited, drawn up for the internal oversight of legality in the criminal sanctions field.

The Criminal Sanctions Agency provides the Ombudsman with statistics on the number of prisoners twice a month. Among other things, these statistics indicate the number of remand prisoners, the proportions of male and female prisoners, and the proportion of prisoners under the age of 21.

In addition, the Parliamentary Ombudsman receives the prison leave statistics once a month. The information obtained from them gives an indication of the processing practices concerning prison leave applications in each prison, or in other words, how many prisoners have applied for leave and how often, and how much leave is granted.

Questionnaires to prisoners and staff

During the year under review, the Office of the Parliamentary Ombudsman introduced questionnaires for prison staff and prisoners as a new tool. The surveys include questions about their views on the relationship between prisoners and staff, safety and security, discrimination, and equal treatment. Prisoners are also asked about their arrival, the induction provided to them and their time outside the cell. Staff are asked about the sufficient number of staff, staff training and changes in the amount of violence taking place in prison. Both respondent groups also have the opportunity to express their views in their own words in the open-ended answers.

The aim is to carry out the surveys before the visit to the prison. Responding to the surveys is voluntary and the answers are given anonymously. The survey drawn up for the staff is intended for all employees working in the prison – including special employees and the management.

Inspection visits

In the year under review, visits to prisons were conducted to the Naarajärvi open prison on 15 June 2021 (2933/2021) and to Kuopio Prison between 3 and 4 November 2021 (6769/2021). Both visits were announced in advance. The inspection visit to Naarajärvi Prison was carried out remotely, and the Prison was asked to submit documents before the inspection. The visit to Kuopio Prison was carried out on site and the final discussion was held remotely on 29 November 2021. Both visit inspections involved anonymous surveys, which were sent to the prison staff and prisoners in advance. The results of the responses were reviewed with both prisons at a general level. In addition, two visits were made to prisoner health care. They are described in section 3.5.11 below.

For more information on the impacts of the COVID-19 pandemic on the criminal sanctions field, see section 4.2.4 of the Annual Report.

Inspection visit to Naarajärvi Prison

During the inspection visit to Naarajärvi Prison, attention was paid to, among other things, the prison's procedure for segregating a prisoner. The documents showed that after a positive test, four prisoners had been segregated from other prisoners for two days. In the Deputy-Ombudsman's view, there no longer seemed to be anything to investigate in the matters. Urine tests had already been given and were about to be sent for verification. The starting point in legislation is that segregation must be necessary. It seemed that there were no statutory preconditions for segregation. If there had been any, they should have been recorded in the documents.

The Deputy-Ombudsman also found it a problem in principle that the prison anticipated a disciplinary punishment by determining the length of the segregation to be what was assumed to be the length of the punishment. This way, the punishment is already completed in advance before the disciplinary procedure and the disciplinary judgement. This practice adopted by the prison prevented genuine decision-making in the disciplinary procedure. In the Deputy-Ombudsman's opinion, the possibility of a false positive result in the quick test also had to be considered.

– The prison informed the Deputy-Ombudsman that it would end this practice.

Surveys of staff and prisoners of Naarajärvi Prison

Based on the responses to the questionnaires sent to the prisoners and staff, the system of personal officers seemed to be working well in Naarajärvi Prison. The prison officer receiving the arriving prisoner is the personal officer for the prisoner. Based on the feedback given by the prisoners, they knew who their personal officer was. However, their responses expressed clear dissatisfaction with the prisoner health care services, including oral health care. In the staff's responses, the prisoner health care resources were considered too small. The staff were separately asked whether prisoners requiring special support had been identified in the prison and whether sufficient attention was paid to them. Almost one half of the respondents were of the opinion that such prisoners had been only partly identified and paid attention to.

Neither respondent group found the prison unsafe. However, the open-ended answers given by the staff revealed concerns about working alone, especially at night-time. The answers given by the prisoners in turn revealed that they were not willing to report violence targeted at themselves or intervene in ill treatment between other prisoners, for example.

– According to the prison director, this reinforced the understanding of the hierarchy between prisoners and prevailing in prisons and the challenges these phenomena posed on the operation of the prison.

The answers of both the prisoners and the staff revealed observations of a racist and discriminatory attitude especially towards prisoners with a foreign background, prisoners with mental health problems and Roma prisoners. Based on the responses, the prisoners also had doubts about whether the prison intervened in such cases.

– The prison brought up the fact that the number of Roma prisoners and foreign prisoners was exceptionally high at the time of the survey.

Inspection visit to Kuopio Prison

The Deputy-Ombudsman stated that Kuopio Prison acted unlawfully when remand prisoners were placed in the same ward with prisoners serving sentences. The Central Administration of the Criminal Sanctions Agency had already drawn attention to this in the inspection conducted on the prison in 2017 and stated that the prison must comply with the Remand Imprisonment Act. The Deputy-Ombudsman now required the prison to change its practice of placing remand prisoners in the ward to comply with the Act without delay. During the NPM visit, it was revealed that some remand prisoners had even been accommodated in the same cell with a prisoner serving a sentence. The Deputy-Ombudsman did not consider this possible even if the remand prisoner consented to it. The visit also revealed that none of the senior criminal sanctions officials responsible for making decisions on the placement of prisoners was separately responsible for the placement of remand prisoners. The Deputy-Ombudsman considered it possible that this may have contributed to the prison not having taken into account the requirements of the Remand Imprisonment Act.

During the NPM visit, it was also observed that there were not enough opportunities for prisoners to spend time engaging in meaningful activities outside their cells. This was also strongly highlighted in the responses the prisoners gave in the survey. The Deputy-Ombudsman stated that this is one of the most serious problems in most prisons.

International recommendations have for a long time been based on the premise that prisoners and remand prisoners should be permitted to spend a reasonable amount of time outside their cells: at least eight hours each day. During that time, they should be able to engage in rewarding and stimulating activities. According to the Deputy-Ombudsman, the obligations and objectives laid down in legislation as well as international recommendations on time and meaningful activities outside the cell were not sufficiently implemented in Kuopio Prison, even though the problem has already been known for a long time. At this point in the NPM visit report, reference was made to the prison action plan, which stated an almost continuous and already partly chronic shortage of human resources that is challenging especially for the supervising staff.

– According to the prison, increasing the number of wards in the prison has forced the activities to be organised by ward. This has contributed to a decline in the activities offered to the wards.

In connection with the visit, the Deputy-Ombudsman drew attention to a recent international recommendation that was included in the reformed European Prison Rules. According to it, prisoners who are separated shall be offered at least two hours of meaningful human contact a day. On the NPM visit, it was found that this recommendation was not realised with segregated prisoners – of whom a clear majority were remand prisoners.

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) visited Finland in September 2020. In its opinions, the CPT recommended that further efforts be made in order to provide all prisoners in the establishments visited with purposeful activities tailored to their needs (including work, vocational training, education and targeted rehabilitation programmes). The CPT stressed that the longer the restrictions continue, the more resources should be made available to ensure that the prisoners concerned benefit from a programme of purposeful, and preferably out-of-cell, activities and are offered at least two hours of meaningful human contact every day (and preferably more). In the NPM visit report, the Deputy-Ombudsman stated that, like the CPT, he was also concerned about the mental and physical well-being of segregated prisoners. He was particularly concerned about those remand prisoners who, under the Coercive Measures Act, are subject to strict long-term restrictions imposed by a court.

It was also noted during the visit that the prison facilities were poorly suited to the modern objectives and needs in the implementation of imprisonment. In the Deputy-Ombudsman's view, space solutions make it difficult to increase the time spent outside the cell, organise activities outside the cell, and place prisoners serving a sentence and remand prisoners in different wards.

Surveys conducted with the staff and prisoners at Kuopio Prison

Based on the anonymous responses from the prisoners, it appeared that there was a lot of room for improvement in the information and induction given to prisoners. This also applied to first-time prisoners. A clear majority of the respondents reported that they did not know who the personal officer for them was. Despite this, the responses given by both groups gave the impression that the relationships between the staff and the prisoners were appropriate.

In their responses, both groups considered Kuopio Prison a safe prison. However, in the open-ended answers regarding changes they wished to see, staff members expressed a wish that safety and security would be invested in. It was noteworthy that, according to the responses, prisoners would not be very likely to report it if another prisoner subjected them or another prisoner to ill treatment. The prisoners who responded were also unsure about whether they would report it if a member of staff subjected them or another prisoner to ill treatment.

Answers about the treatment of prisoners belonging to minorities and vulnerable groups revealed that racist comments were made especially to foreign prisoners and Roma prisoners in the prison. According to the responses, this was done specifically by other prisoners. A majority of the staff that responded were of the opinion that prisoners who need special support are not sufficiently identified and paid attention to in the prison.

Annual theme

The annual theme selected by the Office of the Parliamentary Ombudsman was "Sufficient resources for authorities to ensure fundamental rights". In the criminal sanctions field, sufficient resources are related above all to the sufficient number of staff. An example of this is the opportunity for prisons to organise activities to prisoners outside their cells or meetings with their families by using a remote connection. It is also a question of unsuitable and insufficient facilities and scarce financial resources for carrying out different repairs and changes. For observations and comments related to the annual theme, see section 3.8 of the Annual Report.

Own-initiative investigations

The Deputy-Ombudsman has conducted own-initiative investigations on the availability of trained supervising staff in prisons (4153/2019). Based on observations such as those made by the Deputy-Ombudsman during the NPM visits, it seemed obvious that the lack of trained guards meeting the qualification requirements was a serious and acute problem. In connection with its latest visit to Finland, the CPT also drew attention to the fact that all prisons should have enough appropriately trained staff (supervising staff, in particular).

– The Central Administration of the Criminal Sanctions Agency informed the Deputy Ombudsman of measures that had been taken to improve the situation. These include increasing the number of available student places for qualifications in the criminal sanctions field.

3.5.11 PRISONER HEALTH CARE

Inspection visits

NPM visits to prisoner health care services were directed to the Vantaa unit of the Psychiatric Hospital for Prisoners on 13 October 2021 (6762/2021) and Health Care Services for Prisoners' Kuopio outpatient clinic on 3 –4 November 2021 (6832/2021). Both were on-site inspection visits. The Psychiatric Hospital for Prisoners had been informed of the fact that the Vantaa unit would be visited within a certain period, whereas Kuopio outpatient clinic was notified of the visit in advance. This made it possible to have discussions with not only the clinic's staff, the charge nurse, and the regional chief physician but also the director of the Health Care Services for Prisoners, chief medical officer of the outpatient clinic, chief dentist, senior coordinator and senior nursing officer of the outpatient care.

In addition to these visits, the management system of a unit of the Health Care Services for Prisoners was inspected remotely under the leadership of the Deputy-Ombudsman on 16 March 2021 (1185/2021).

Visit to the Vantaa unit of the Psychiatric Hospital for Prisoners

The psychiatric ward of the Vantaa unit has 14 beds for male prisoners and remand prisoners. The ward is located on the premises of Vantaa Prison. The ward does not provide involuntary treatment. The unit also conducts court ordered forensic assessments, among other things. The prison officers at Vantaa Prison are present on the ward between 7:00 and 17:00 on weekdays and between 8:00 and 17:00 at weekends. Health care personnel are available in the ward between 7:00 and 19:00.

Once the staff have left, the patients are locked in their cells, and they can contact the prison officers using a call button.

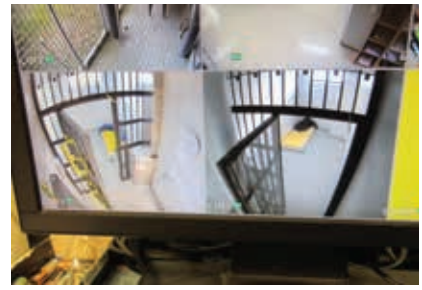
The Deputy-Ombudsman found it highly problematic that patients who have been assessed to be in need of specialised psychiatric care spend almost one half of each day without immediate supervision and attention of health care personnel. In addition, the mental state of a person undergoing a court ordered forensic assessment is not observed 24 hours a day. Ten patients are forced to share a cell with another patient and remain in a locked cell for 11 to 12 hours each day. The Deputy-Ombudsman finds that leaving the patients without immediate supervision for long periods may risk patient safety. The absence of health care personnel also has an impact on the medical treatment of patients, as medicines administered for the night must be distributed by 19:00. In the Deputy-Ombudsman's opinion, this is not only a question of patient safety but also of good care. The Deputy-Ombudsman stated that a nurse trained in psychiatric care should be continuously present in the unit. This statement was also brought to the attention of the Finnish Institute for Health and Welfare (THL) and the Ministry of Social Affairs and Health.

The Deputy-Ombudsman noted that having health care personnel available in the evenings and at night may also require an increased presence of prison officers in the ward. The absence of guards during the night already came to light in 2019 as the Deputy-Ombudsman visited the Turku unit of the Psychiatric Hospital for Prisoners (2570/2019). A discussion on this matter covering the entire Psychiatric Hospital for Prisoners was to take place on a follow-up visit to the Turku unit. This visit has been delayed because of the COVID-19 pandemic.

After the NPM visit, the Psychiatric Hospital for Prisoners was asked to submit to the Deputy-Ombudsman an account of the hospital's waiting list as a whole. As it did not have sufficient physician resources, the Vantaa unit had a waiting list for treatment periods. During the visit, it was noted that this situation had increased the responsibility and workload of the ward's nursing staff. Once a new physician had been recruited, the waiting lists for treatment could be eliminated within two months of the NPM visit.

In addition to personnel resources, the Deputy-Ombudsman commented on the facilities available to the Vantaa unit. The Deputy-Ombudsman found that the ward facilities do not promote spontaneous interaction between the staff and patients that is not related to regular interaction situations. The Deputy-Ombudsman agreed with what was stated in the self-monitoring plan of the Psychiatric Hospital for Prisoners and noted that the hospital facilities inside the prison do not meet the needs of modern psychiatric hospital care.

The hospital ward had two seclusion rooms with camera surveillance connected to the central control room of the prison. The Deputy-Ombudsman found this problematic and noted it was unclear if the prison can also use camera surveillance in situations where the prisoner has been secluded by a decision of Health Care Services for Prisoners. The Deputy-Ombudsman asked the Ministry of Justice to consider if provisions on camera surveillance in these situations should be laid down in the Imprisonment Act and the Remand Imprisonment Act. The Deputy-Ombudsman's view was that, if this right was to be given to prison officers, it should be laid down in a legal provision.



Visit to Kuopio outpatient clinic

The Deputy-Ombudsman drew attention to the adequacy of the resources available to the outpatient clinic. Kuopio Prison serves as a remand prison, which is why the number of prisoners directly deprived of their liberty is high. This had a significant impact on the work of the outpatient clinic, and especially on carrying out interviews with prisoners on arrival. Following its visit to Finland in September 2020, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) reiterated its long-standing recommendation to take effective measures ensuring that new prisoners systematically have a medical screening within 24 hours of arrival. Health Care Services for Prisoners has requested additional financing, for example to fund interviews with incoming prisoners at the outpatient clinics conducted on weekdays within 24 hours of their arrival. However, unpredictable arrivals of prisoners made it difficult in Kuopio to plan the work and carry out medical screenings within 24 hours of the prisoner's arrival.

The large number of remand prisoners also meant that the outpatient clinic did not use mechanical distribution of medicines. The precondition for introducing such a system is regular medication prescribed to the prisoners, and this is not possible when the prisoners have been newly deprived of their liberty. Distributing and double-checking the medicines for prisoners created a significant workload for the outpatient clinic, and the work input of one nurse was taken up solely by the distribution of medicines.

The Deputy-Ombudsman found it appropriate that Health Care Services for Prisoners had tried to support the work of the Kuopio outpatient clinic by means of a fixed-term nurse's position. However, the Deputy-Ombudsman was concerned over the adequacy of the outpatient clinic's resources once the fixed-term employment relationship comes to an end.

In connection with the visit to the outpatient clinic, the Criminal Sanctions Agency's project on fine default prisoners was also discussed. The aim of the project is that, rather than putting them in prison, fine default prisoners and other short-term prisoners who have a substance abuse problem can be placed in an institution providing substance abuse services located outside the prison. Health Care Services for Prisoners would remain responsible for the prisoner's care even after such placements. The Health Care Services for Prisoners and the Criminal Sanctions Agency were currently working on a common guideline to ensure that the practices would be consistent throughout the country. When they arrive in the prison, the prisoners will be interviewed at the outpatient clinic to assess their state of health and any reasons for not placing them in the rehabilitation institution. Once their eligibility has been assessed, the prisoner could be transferred to a rehabilitation institution outside the prison. The Deputy-Ombudsman welcomed this project, however stressing that Health Care Services for Prisoners had a statutory obligation to also take care of the health and medical care of prisoners placed outside prisons. Responsibility laid down in law cannot be eliminated or transferred by a mutual agreement with other actors.

Inspection of Health Care Services for Prisoners' management system

During this inspection, challenges related to human resources were reported to the Deputy-Ombudsman. The workload of outpatient clinics has not decreased during the COVID-19 pandemic, even if the execution of short-term and fine default sentences was suspended for a significant part of years 2020 and 2021. Due to the pandemic, it had been necessary to increase the number of nursing staff by two nurses and one practical nurse. In specialised medical care, recruiting physicians to the Vantaa unit of the Psychiatric Hospital for Prisoners and the Prison Hospital providing somatic care in Hämeenlinna had proven difficult. In oral health care, it had been necessary to rely on outsourced dentist's services. However, each outpatient clinic had access to an on-site physician at the time of the inspection, eliminating any need to resort to remote medical services.

The numbers of physicians visiting the outpatient clinics who were public officials and those who provided outsourced services were not discussed specifically during the inspection.

On visits to Health Care Services for Prisoners' units, it has emerged that the staffing ratio of guards has a significant impact on the work of the Health Care Services for Prisoners and its efficiency. The management system of the Health Care Services for Prisoners reported that in oral health care, for example, the lack of prison officer resources is seen as delayed or cancelled surgery visits when the guards are unable to transport the prisoner to the surgery. Similar observations were also made regarding appointments with physicians and nurses in outpatient care. The Deputy-Ombudsman did not find it acceptable that the provision of health and medical care that meets the prisoners' medical needs is dependent on the availability of guard resources.

The Deputy-Ombudsman welcomed the fact that all possible external signs of abuse and head injuries are currently examined and recorded as arriving prisoners are interviewed and undergo a medical screening. Another positive observation was that Health Care Services for Prisoners has provided training on the organisation and methods of transport for a suicidal prisoner and reminded outpatient clinic physicians of the possibility of consulting the Turku unit of the Psychiatric Hospital for Prisoners.

Impacts of COVID-19 on Health Care Services for Prisoners

The COVID-19 situation has contributed to increasing the challenges faced by the Health Care Services for Prisoner regarding the provision of health and medical care for prisoners and especially the making of quarantine and isolation decisions. As of 1 December 2020, in practice all incoming prisoners were quarantined for 14 days as the epidemic situation deteriorated to safeguard prisoners' health and prevent institutional outbreaks. This was considered important as a large proportion of prisoners are in the at-risk groups of a severe coronavirus disease. The Health Care Services for Prisoners prepared written instructions for prisoners on being put in quarantine and their rights and obligations related to this practice.

According to information received during the inspection of the Health Care Services for Prisoners' management system, some 6,000 administrative quarantine or isolation decisions had been made by 23 April 2021. Issuing written notifications of the quarantine decisions was fraught with challenges. The service of the notification could be delayed by a period extending from a few days to as much as a week. Particular challenges were encountered by small outpatient clinics whose personnel resources have been scaled to only being open a few days a week. The Health Care Services for Prisoners also noted that, as the pandemic becomes less virulent, the outpatient clinics will experience additional pressure as fine default prisoners and similar will again be taken in.

The Deputy-Ombudsman stressed that when a prisoner is placed in quarantine, these decisions must be made individually, and each prisoner's state of health must be taken into account. The Deputy-Ombudsman drew attention to the fact that the relevant persons should be notified of quarantine decisions without delay and that they have the right to appeal the decision. The Deputy-Ombudsman found it important that prisoners are informed of being placed in quarantine in a manner that they can understand. Particular attention should be paid to adequately informing prisoners who speak a language other than the national languages.

3.5.12 ALIEN AFFAIRS

Finland had 20 reception centres for adults and families at the end of 2021. In addition, there were seven units intended for unaccompanied minors. Some asylum seekers are also housed in private accommodation. Under section 121 of the Aliens Act, an asylum seeker may be held in detention for reasons such as establishing their identity or enforcing a decision on removing them from the country. There are two detention units for foreign nationals in Finland. One of the detention units is located in Metsälä, Helsinki (40 places), and the other in Konnunsuo, adjacent to the Joutseno reception centre (68 places). Both units operate under the Finnish Immigration Service.

The Ombudsman does not oversee return flights in its role as the NPM, although this would fall under its jurisdiction. This is because the Non-Discrimination Ombudsman has been assigned the special duty of overseeing the removal of foreign nationals from the country. However, the Ombudsman has received complaints, such as the conduct of the police, regarding issues related to return flights for asylum seekers.

Until now, visits to reception centres have been made under the jurisdiction of the Parliamentary Ombudsman.

Assistance system for victims of human trafficking

Some of the residents in reception centres and detention units may be victims of human trafficking and recognising them is a challenge. The assistance system for victims of human trafficking operates in connection with Joutseno reception centre. According to information released by the Finnish Immigration Service, 243 new customers were admitted to the assistance system in 2021, which was the same number as in the previous year. Together with the new clients, 48 underage children were also included as clients in the system. Of the new clients, 97 were estimated to have become victims of exploitation indicative of human trafficking in Finland. It was estimated that most of the victims exploited in Finland were subjected to forced labour. A total of 1,132 people were receiving the assistance system's services at the end of 2021.

The annual report of the Assistance System for Victims of Human Trafficking shows that the number of underaged human trafficking victims has more than doubled. In 2021, 28 children and young people were admitted to the assistance system, of whom 27 had been subjected to exploitation indicative of human trafficking abroad and one in Finland. In previous years, approximately 10 to 14 minor clients have been admitted to the assistance system. Trafficking in minors has been related to forced labour, sexual exploitation and forced marriage. The same child may have been subjected to more than one form of human trafficking. Minors admitted to the assistance system in 2021 were usually asylum seekers by their background.

In connection with a visit to Joutseno detention unit conducted on 16 June 2021, the NPM also examined the Assistance system for victims of human trafficking. On this visit, the NPM was also informed of a working group appointed by the Ministry of Social Affairs and Health to prepare a proposal for a new act on assisting victims of human trafficking. The working group's term of office ends on 31 December 2022.

Inspection visits

The NPM aims is to make regular visits to both detention units. Due to the COVID-19 pandemic, no on-site visits to the detention units took place in 2020. In March 2021, the units were instead asked to submit reports on clients detained in isolation since 1 August 2020. The units were also asked to report on measures referred to in section 24 of the Act on the Treatment of Detained Aliens and on Detention Units during the same period. These measures include prohibiting visits, checking mail, preventing the use of telephone, various inspections, confiscation of a prohibited object or substance as well as using force and instruments of force. Both detention units were also asked to provide information on how the detainees' health care had been arranged on weekends and how many suicide attempts or cases of other self-destructive behaviour had occurred in the unit in 2020.

Joutseno detention unit had made six decisions on placing a detainee in segregation. At its longest, a detainee had been kept in isolation for approximately 3.5 days and, at its shortest, less than two hours. No cases of segregation had been heard by the District Court, as each incident had ended before the first District Court hearing. The unit had carried out 81 measures referred to in section 24 of the Act on the Treatment of Detained Aliens and on Detention Units. In 2020, there were no cases of suicide, attempted suicide, or self-harm. In two cases, a person was found to have injured themselves during transport before arriving in the unit. On weekends, the unit's health care staff are on call. The centre's four nurses take turns to be on call at weekends from Friday afternoon until Monday morning, and they are prepared to come in within two hours of being called (7392/2020).

No clients had been placed in segregation at Helsinki detention unit. The unit had carried out 142 measures referred to in section 24 of the Act on the Treatment of Detained Aliens and on Detention Units. While there had been no suicide attempts in 2020, one case that can be classified as self-harm had been recorded. On Saturdays a nurse is present, sees clients with acute health problems without an appointment and conducts health examinations. On Sundays, urgent cases and those requiring emergency assistance are handled at an emergency health care centre outside the detention unit (7605/2020).

In 2021, the detention unit of the Joutseno reception centre was visited in June (4149/2021) and Helsinki detention unit in November (7238/2021). Both were on-site visits. Joutseno detention unit was informed of the visit in advance, while the visit to Helsinki detention unit was carried out unannounced.

Treatment and reporting on mistreatment

No allegations of improper treatment of clients came up in interviews with detainees at either detention unit. The observations on the treatment of clients made during the visit were consistent with the information received in interviews with clients. According to information received on a visit in November, the Finnish Immigration Service had introduced an internal confidential reporting channel based on the EU's Whistleblower Directive since 28 October 2021, even though the national implementation of the directive was still pending. In addition, both units have a system through which clients can file complaints, both with an external monitoring body and within the unit or the Finnish Immigration Service.

Access to outdoor exercise

On the visit to Joutseno detention unit, it emerged that the clients' access to outdoor exercise depends on the part of the unit where the client is accommodated. Clients placed in the north wing have access to outdoor exercise for an hour a day, whereas those placed in the south wing had free access to the covered football pitch between 6:00 and 19:30. In addition, they had access to a smaller uncovered outdoor recreation area connected to the exercise yard at certain times.

According to the detention unit regulations, detainees have the right to an hour of outdoor exercise every day. In this context, the detention unit's attention was drawn to the fact that such bodies as the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) recommends in its standards (Fact Sheet on Immigration Detention) giving detainees access to outdoors for more than an hour. In principle, detainees should have an unlimited right to spend time outdoors.

– After the visit, Joutseno detention unit reported to the Ombudsman that, based on the observations made during the NPM's visit, a second opportunity for outdoor recreation (from 9:00 to 10:00) had been arranged for clients placed in the north wing.

Health care

Both detention units strive to arrange a medical screening for each detainee within 24 hours of their arrival. For this purpose, a new arrival interview form with a broader scope has been introduced. It contains a specific section for recording any signs of violence observed in the arrival interview. At both detention units, all clients brought into detention after a failed attempt at removal from the country are met by a nurse.

A review of documentation at Joutseno detention centre showed that, as a rule, a detainee placed in segregation was met by the health care staff soon after they were isolated. However, the documents created the impression that if the detainee was kept in isolation for several days, they were not visited by the health care staff every day. The Ombudsman found it important that persons kept in isolation should be visited by the health care staff each day.

– The detention unit reported that health care staff visit detainees kept in isolation daily on weekdays. At weekends, instructors visit detainees kept in isolation several times a day and report to the nurse or public health nurse on duty if the detainee's situation appears to have changed. The current personnel structure does not, without compromising on the organisation of statutory duties, make it possible to create a system in which a person kept in isolation would be routinely visited also at weekends if no specific need for this has emerged. According to the unit, experience has shown that a daily visit to a detainee kept in isolation by the health care staff usually produces relatively little added value.

It should be noted that the CPT visited Finland and Helsinki detention unit in autumn 2021. In the context of health care, the CPT recommended that both detention units introduce a practice of carrying out rapid and systematic medical screenings of all clients arriving at the detention unit. The CPT encouraged the detention unit to aim for providing its clients with access to a nurse also on Sundays. The CPT also referred to its recommendations on health care in police prisons, in which it recommended that persons deprived of their liberty should be given an effective right to be examined by a doctor. In addition, they should be given the possibility of being examined by a doctor of their own choice.

Conditions in isolation and camera surveillance

Since the previous visit, safety beds of 30 cm in height, a soft cube table for eating on and a digital clock fixed to the wall had been purchased for the isolation rooms at Joutseno detention unit as recommended by the Ombudsman. The NPM team still considered camera surveillance of the isolation rooms to be problematic from the perspective of privacy protection. There had been no change in this situation since the previous visit, despite the recommendations made by the Ombudsman in the NPM visit report (5145/2018). The Ombudsman again drew the unit's attention to protection of privacy in sanitary facilities.

– The detention unit emphasised in its statement that, among other things, camera surveillance of the sanitary facilities is lawful. The structural solutions of the detention unit do not make possible a practice in which the safety issues brought up previously (including the risk of vandalism resulting in water damage) could be solved through structural changes. The Ombudsman's opinion was taken into account, however, and the detention unit stated that it had discovered a way of improving the situation. A new version of the camera surveillance software used by the centre had been released, which makes it possible to pixelate moving objects (blurring them by technical means). Customers to be placed in isolation will be informed of this. Funds for implementing this reform had been set aside in the budget.

Impact of the COVID-19 pandemic on the detention unit's work and conditions

Both detention units had limited the number of detainees they took in during the COVID-19 pandemic. Helsinki detention unit had 20 places. The number of clients in the unit during the pandemic was at minimum only 3 and at maximum 25. Joutseno detention unit had had 15 to 20 clients during the pandemic.

By the date of the visit, no COVID-19 infections had been diagnosed among the clients of Helsinki detention unit. The detention unit had a separate block for clients who had been detained after recently arriving in Finland, in which they were kept separate from others for ten days. While they were isolated, they were given opportunities for outdoor recreation, smoking, and visiting the gym. Getting a COVID-19 vaccination has not been possible at the detention unit, but if the client so wished, they had the opportunity to get the vaccination through public health care.

Throughout the pandemic, Joutseno detention unit had only had one positive COVID-19 test result by the date of the visit. The unit had two quarantine blocks. On the day of the visit, three clients had been placed in quarantine-like conditions in the separate block.

The units followed the pandemic instructions issued by the Finnish Immigration Service. In the initial phase and before the instructions had been issued, new detainees stayed in voluntary quarantine in their own rooms for 14 days. Once the Finnish Immigration Service's instructions had been issued, the practice of quarantining each client entering the detention unit in their own rooms was followed. Persons arriving from Finland were placed in quarantine for 10 days and those arriving from abroad for 14 days. While in quarantine, detainees are entitled to daily outdoor exercise. No COVID-19 test is organised for new detainees if they have no symptoms. For occupational safety reasons, an initial medical screening is only carried out on clients placed in quarantine after the quarantine period is over. However, a detainee in quarantine has also received help for acute health problems during the quarantine period.

Joutseno detention unit has not allowed outside visitors during the pandemic. This rule was based on the Act on the Treatment of Detained Aliens and on Detention Units and guidelines issued by the Finnish Immigration Service. Visits were only permitted for certain humane reasons. Outsiders' visits to the detention unit were again permitted at the beginning of June 2021. Clients have the right to use their phones. All activities were also suspended during the pandemic.

For more information on the impacts of the COVID-19 pandemic on alien affairs, see section 4.2.6 of the Annual Report.

3.5.13 SOCIAL WELFARE UNITS FOR CHILDREN AND ADOLESCENTS

Before the pandemic, the NPM's visits to child welfare institutions had an extremely high impact. Among other things, observations made on such visits led to an urgent amendment to the Child Welfare Act. For example, systematic measures will be required in the future to help minimise the use of restrictive measures. Each child welfare institution will be required to present a plan for the good treatment of children as part of their self-monitoring plan. The institutions will also be required to involve and engage the children placed in them in the creation of the plan. If restrictive measures are used, they must be discussed with the child in a mandatory debriefing. When an institution draws up a care and education plan for a child, it must discuss ways in which the use of restrictive measures could be avoided in advance with a social worker and the child. The amendments entered into force on 1 January 2020.

Following visits by the NPM, many child welfare institutions have reviewed their practices and rules as recommended in the visit reports. The findings of these visits have also attracted a great deal of public attention, and awareness has been raised among children placed in institutions of their rights. Complaining about shortcomings in substitute care has been made easier for children by offering them the possibility of also contacting the Office of the Parliamentary Ombudsman orally in order to initiate a matter. Visits to child welfare institutions, the simplified complaint procedure and awareness-raising described below have been seen as a clear increase in the number of complaints filed by children.

More attention has also been paid to the effectiveness of the work carried out by supervisory authorities responsible for monitoring child welfare institutions. The monitoring efforts fall, in some cases, far short of satisfactory. Following the NPM's visits, amended legislation entered into force on 1 January 2020 under which the Regional State Administrative Agency must, when conducting its own inspection, give the children placed in a unit an opportunity to be heard in person.

CPT'S VISITS TO TWO STATE RESIDENTIAL SCHOOLS

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) visited Finland in September 2021. At that time, the CPT also visited two state-run residential schools for the first time in Finland. In February 2020, the NPM had made a three-day visit to one of the facilities visited by the CPT.

The CPT's report shows that in some cases, the residential school visited by the NPM had taken the measures required by the Deputy-Ombudsman. An example of this is the obligation to draw up a care and education plan for each child. According to the CPT's observations, the school had drawn up individual plans for each young person and updated them regularly. The CPT's report also explicitly mentioned that the residential school had allowed more freedom of movement for the young people only two weeks before the Committee's visit. The facility had formerly followed stricter practices regarding freedom of movement, which the Deputy-Ombudsman had considered unlawful in the NPM's report completed in June 2020.

On the other hand, the CPT's report found that the freedom of movement of young people who had been placed in a special care unit was continuously restricted. According to information received by the CPT, these children were sometimes allowed to go out for no more than about half an hour a day. The CPT stated that young people should be offered at least two hours' access to outdoor areas per day. The Committee therefore recommended that the management of State Residential School take the necessary steps to ensure that this precept is implemented in practice

Raising children's awareness during the COVID-19 pandemic

The Office of the Parliamentary Ombudsman has refrained from on-site visits in all administrative branches during the COVID-19 pandemic as the health security of the visits could not be sufficiently guaranteed. Private discussions with children placed in child welfare units have been an important part of these visits. This opportunity cannot be replaced by hearings through remote connections or reviews of documentation. For this reason, no visits were made to child welfare units during the reporting year.

Instead of visits, the Office of the Parliamentary Ombudsman introduced new methods of informing children with the aim of raising their awareness of their statutory rights in substitute care. At children's initiative, two remote discussion events were organised in a residential school in the summer and autumn. The participants in these discussions were children placed in the residential school, the facility's staff members and children's social workers. Representatives of the Office of the Parliamentary Ombudsman responded to questions put by the children to the Ombudsman concerning the rights and legal protection of children in substitute care. The Deputy-Ombudsman also participated in the first event. A representative of the Office of the Parliamentary Ombudsman has also participated in four virtual chat events. Three of these events were organised by social workers who were social media influencers, and each of them attracted an audience of more than 3,000. In addition, the young influencers of SOS Children's Village organised a chat event with over a thousand participants. At all these events, questions asked by children and young people were answered, and the legal remedies they were entitled to were explained. They were also familiarised with the Ombudsman's work and previous decisions.

The Ombudsman has a website intended for children, and its contents were updated in the year under review. Children and young people as well as experts by experience in child welfare were engaged in this work.

Complaining about shortcomings in substitute care has been made easier for children by also offering them the possibility of contacting the Office of the Parliamentary Ombudsman orally in order to initiate a matter, instead of the written complaint procedure, which has at times been found challenging. The children wrote to or contacted the Office of the Parliamentary Ombudsman by telephone and criticised their treatment at the place of substitute care, the educational practices of child welfare facilities, the restrictive measures used, the passive approach of their social workers and shortcomings in the decision-making concerning substitute care.

For information on the impacts of the COVID-19 pandemic on restricting children's fundamental rights in child welfare units, see section 4.2.7 of the Annual Report.

3.5.14 SOCIAL WELFARE UNITS FOR OLDER PEOPLE

The NPM's visits to units providing care for older people primarily target closed units providing full-time care for people with memory impairment and psycho-geriatric units. Few complaints are made about these units, which stresses the importance of the inspection visits. During the COVID-19 pandemic, highlighting the goal of protecting lives in housing service units for older persons brought up questions about the realisation of other fundamental and human rights. The Deputy-Ombudsman's opinions on the treatment of older people with memory disorders in units providing care and attention as well as prohibiting visits by relatives and loved ones have strongly guided the activities of the units, and they have been discussed extensively in the public sphere.

On the NPM's visits to care units for older people, special attention is paid to the use of restrictive measures. Under the Finnish Constitution, the use of restrictive measures must be based on law. The Deputy-Ombudsman has stressed the need for a legislative reform and also emphasised that using restrictive measures is not allowed if their objective can be achieved by other means.

This section only discusses the NPM's visits. For more information on oversight of care for older people during the COVID-19 pandemic, see section 4.2.10 of the Annual Report.

Minimum staffing ratios entered into force

At the beginning of 2021, an amendment to the Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons concerning minimum staffing ratios entered into force. The amendment applies to both public and private services. Staffing ratios will gradually increase. The staffing ratio of 24-hour residential service and long-term institutional care units must be at least 0.7 employees per client by 1 April 2023. The ratio must be higher than this if the clients' functional capacity and service needs and ensuring the quality of services so require.

Inspection visits

During the year under review, one visit was made to units providing 24-hour care for older persons under the NPM's mandate. This visit was motivated by information received in connection with the oversight of legality, according to which certain units had followed a practice that resembled isolation during the COVID-19 epidemic. In this practice a new resident, a resident discharged from hospital, or a resident who goes shopping or enjoys outdoor exercise with a family member without wearing a mask can be ordered to undergo 'room care'. 'Room care' means that the resident is kept in their private room for 10 to 14 days, and the services they need are provided in this room. It was unclear how the unit ensured that 1) the resident can leave their room if they wish to do so, 2) the resident is supervised sufficiently, 3) the resident's functional capacity is maintained, and 4) their right to interact with other people is realised.

To investigate the matter, the Deputy-Ombudsman took the initiative to investigate the use of 'room care' in care units for older people across the area of the Central Uusimaa Joint Authority for Health and Social Services (Keu-sote) (3360/2021). As part of this investigation, an inspection of the service housing units with 24-hour assistance in Jampankaari service area maintained by Central Uusimaa Joint Authority for Health and Social Services was conducted on 21 June 2021 (4060/2021). The inspection was carried out by using a secure remote connection and by requesting documents from the inspected unit. In addition, a request to contact the Ombudsman was sent to family members of 15 residents. A total of five relatives got in touch.

Deputy-Ombudsman's statements on 'room care' in care for older people

Service housing units with 24-hour assistance in Jampankaari service area had striven to prevent the spread of COVID-19 infections by placing new residents in quarantine for two weeks or, following updated instructions, ten days. This procedure has since been called room care. The Deputy-Ombudsman found that Jampankaari service unit had acted incorrectly and unlawfully. The procedure in place may have been effective in preventing the spread of the disease, but they were not based on valid legislation.

According to the Deputy-Ombudsman, the manner in which the two-week isolation is organised is of crucial importance. The precautions can be taken before the resident moves into the unit; for example, the person with memory impairment could have lived at home and enjoy outdoor exercise with their relatives without having their freedom of movement restricted. This, according to the Deputy-Ombudsman, does not mean that the resident's fundamental rights are restricted. On the other hand, if the precautions mean that a resident is transferred to another service housing unit and that they are required to remain exclusively in their own room, the Deputy-Ombudsman finds that this procedure corresponds to isolation. The use of a restrictive measure like this is only permitted in situations specifically defined in the Communicable Diseases Act. The decision-making must follow the procedure laid down by law. Nursing home staff do not have a right to make decisions pursuant to the Communicable Diseases Act.

Based on the inspection findings, the factors resulting in unlawful and incorrect practices included the management having no knowledge of to what extent it was possible for the nursing staff to follow the instructions issued to them in practice. The Deputy-Ombudsman noted that the staff had acted correctly when they did not prevent a person with memory impairment from moving around when they were able to get out of their room independently. The practice was incorrect to the extent that residents who were not able to leave their rooms without assistance had not been helped or allowed to leave the room and access other areas of the unit. The Deputy-Ombudsman emphasised the management's responsibility to ensure that staff shortages do not prevent the staff from carrying out their tasks. The management is also responsible for ensuring that instructions are lawful and that they cannot be misinterpreted in the practical work, leading to violations of the law. The Deputy-Ombudsman requested the unit to ensure that the management's, and employees' knowledge of legislation is improved. She welcomed the fact that the care unit has since been taken care of that employees are aware of their obligation to report any shortcomings they have noticed in compliance with section 48 of the Social Welfare Act. The Deputy-Ombudsman also recommended that staff have the opportunity to provide feedback on work-related shortcomings anonymously.

Proposals to authorities

The Deputy-Ombudsman's decisions (3115/2020 and 4180/2020) have contained proposals to the Ministry of Social Affairs and Health stating that the ministry should start drafting legislation on older persons' rights without delay. The Deputy-Ombudsman considered it essential that legal provisions are enacted on the restrictions to which older person may be subjected and the preconditions for such restrictions as well as the practices to be followed. Even before such legislation is completed, the Deputy-Ombudsman considered it necessary for the National Supervisory Authority for Welfare and Health (Valvira) and the Finnish Institute for Health and Welfare (THL) to issue national guidelines on ways in which restricting the fundamental rights of older persons can be avoided. The guidelines could also be used to review the application of general principles regarding restrictive measures in practical situations.

In a proposal on supplementing the Mental Health Act (164/2021), the Deputy-Ombudsman also stated that the most urgent step would be adopting legislation for those sectors where it is completely lacking. This includes restricting the client's fundamental rights in somatic health care and care for older people.

3.5.15 UNITS FOR PERSONS WITH DISABILITIES

When visiting institutional care and housing service units for persons with disabilities, particular attention is paid to the use of restrictive measures as well as to the making decisions on and keeping records of these measures. The extent to which the right to self-determination and privacy of persons with disabilities is respected and whether the unit has adequate resources are also examined on the visits. During the COVID-19 pandemic, the Ombudsman also wished to find out how the pandemic has affected the unit's work and the clients' conditions.

With the ratification of the UN Convention on the Rights of Persons with Disabilities (10 June 2016), the Parliamentary Ombudsman became part of the mechanism referred to in Article 33(2) of the Convention designated to promote, protect, and monitor the implementation of the rights of persons with disabilities. This special task of the Ombudsman is discussed further in section 3.4 (Rights of persons with disabilities). In addition, the monitoring of the rights of persons with disabilities during the COVID-19 pandemic is discussed in section 4.2.11 of the Annual Report.

No on-site visits to residential units for persons with disabilities took place during the pandemic. Persons with disabilities have an increased risk of becoming seriously ill as a result of a COVID-19 infection. Consequently, the NPM has refrained from carrying out on-site visits at units for persons with disabilities. During the pandemic, remote inspections were used, mainly in form of reviews of documentation. In addition, clients and their legal representatives and family members were consulted by telephone more frequently during the COVID-19 pandemic. Experiences gained through reviews of documentation have shown that sometimes on-site inspection visits are a more effective way of investigating issues. In these cases, it has been considered important to conduct an on-site visit to the unit after the pandemic (4128/2021 Rekola group home).

Inspection visits

During the year under review, two residential service units for persons with intellectual disabilities and a respiratory paralysis unit, which is a health care unit, were inspected. All three inspections were conducted as reviews of documentation. The inspected units were:

- Residential units of the Central Ostrobothnia Joint Municipal Authority for Social and Health Services Soite for persons with intellectual disabilities and severe disabilities (especially Maria-Katariina House in Kokkola) 16 June – 15 September 2021 (3995/2021)
- Purohovi residential service unit for persons with intellectual disabilities, City of Vaasa 16 June – 17 December 2021 (3996/2021)
- HUS Respiratory paralysis unit for heart and lung diseases, Rekola group home 16 June – 13 December 2021 (4128/2021)

In addition, six reviews of documentation started in 2020 were completed. These inspections were carried out as reviews of documentation. Some of them also included a hearing for clients and their families. The inspected units were:

- Rinnekoti, Helsinki Deaconess Foundation 1 June 2020 – 11 June 2021 (3649/2020)
- Vaalijala Joint Municipal Authority, Savo Special Care District 1 June 2020 – 16 June 2021 (3650/2020)

- Antinkartano rehabilitation centre, Satakunta Hospital District Joint Municipal Authority 1 June 2020 – 11 June 2021 (3651/2020)
- Pajukoti residential unit for people with intellectual disabilities, municipality of Loppi 1 June 2020 – 15 June 2021 (3652/2020)
- Institutional and residential services for persons with intellectual disabilities in the City of Pietarsaari 22 June 2020 – 27 September 2021 (3653/2020)
- Lahden Validia-talo, Validia Oy's residential services in Lahti 1 June 2020 – 15 June 2021 (3654/2020)

Restrictive measures

Where restrictions are placed on the personal freedom or self-determination of a person with a disability, it must always be ensured that no other, less restrictive methods are available. Restrictions should never be applied to a greater extent or for a longer period of time than is necessary. The Ombudsman finds it important that the use of restrictive measures is supervised.

According to decisions on restrictive measures, the inspected units had subjected the clients to various restrictive measures referred to in the Act on Special Care for Persons with Intellectual Disabilities (the Intellectual Disabilities Act):

- short-term isolation (3649/2020 Rinnekoti/Majakkayksikkö, 3650/2020 Vaalijala/Maininki and Kaisla)
- use of a security room (3650/2020 Vaalijala/Satama)
- preventing a resident from leaving the unit (3650/2020 Vaalijala/Kaisla)
- holding on to a resident (3649/2020 Rinnekoti/Majakkayksikkö, 3650/2020 Vaalijala/Kaisla)
- administering essential health care involuntarily (3650/2020 Vaalijala/Kaisla, 3652/2020 Pajukoti, 3996/2021 Purohovi)
- use of restrictive equipment and clothing in daily activities (3650/2020 Vaalijala/Kaisla, 3653/2020 Pietarsaari, 3995/2021 Soite, Kokkola/Maria-Katariina)
- repeated use of restrictive equipment and clothing in situations involving a serious risk (3650/2020 Vaalijala/Kaisla, 3995/2021 Soite, Kokkola/Maria-Katariina)
- supervised movement (3649/2020 Rinnekoti/Majakkayksikkö, 3650/2020 Vaalijala/Kaisla, 3653/2020 Pietarsaari, 3995/2021 Soite, Kokkola/Maria-Katariina)
- confiscation of substances and objects (3649/2020 Rinnekoti/Majakkayksikkö, 3650/2020 Vaalijala/Kaisla, 3653/2020 Pietarsaari, 3996/2021 Purohovi, 3995/2021 Soite, Kokkola/Maria-Katariina)
- raising the sides of the bed for the night (3996/2021 Purohovi)

In some cases, the unit had been able to agree with the client on raising the sides of the bed. The Ombudsman has commented on the significance of consent in special care for persons with intellectual disabilities. He noted that if the client is able to understand the significance of the matter, they may give their valid consent to the use of restrictive equipment (such as a bed siderail) or clothing, or to confiscation of their property. This is not a restrictive measure. However, if the client is unable to make decisions about their care and attention and does not understand the consequences of their behaviour, they cannot legally give their consent to the use of restrictions. In this case, their use is a restrictive measure, and a decision referred to in the Intellectual Disabilities Act must always be issued to the client. If restrictive measures are used regularly and over a long term, a written decision must be issued (3653/2020 Pietarsaari).

In 2016, detailed provisions on the prerequisites and procedures for using restrictive measures were added to the Intellectual Disabilities Act. Despite this, it is still necessary to draw the units' attention on the NPM's visits to the fact that their practices do not meet all legal requirements. **Among other things, the Ombudsman issued the following opinions on restrictive measures** to the inspected units:

- In addition to describing how the general prerequisites for using a restrictive measure are met, the decisions on restrictive measures must detail how the specific prerequisites for the restrictive measure are met for the customer subject to the decision. Restrictive measures may not be used merely because the general preconditions are met. For example, a precondition for the confiscation of substances and objects is specifying in the decision how the properties of the confiscated substance or object put the client's health or safety at serious risk or cause significant damage to property (3995/2021 Soite, Kokkola/Maria-Katariina).
- Before spring 2021, the city's social welfare and health care services did not have the capacity to make decisions on restrictive measures. The legal requirements are still not met for the part of the expert team required under the Intellectual Disabilities Act (3996/2021 Purohovi).
- Careful records must be kept of restrictive measures as required by law (3650/2020 Vaalijala/Kaisla, 3996/2021 Purohovi).
- The precondition for using some restrictive measures is defining the maximum period for which a piece of restrictive equipment or clothing can be used at a time. At the same time, the Ombudsman stressed that the decision must indicate why other means have not been suitable and adequate (3995/2021 Soite, Kokkola/Maria-Katariina).
- The statutory appeal instructions must be attached to a decision on a restrictive measure compliant with the Intellectual Disabilities Act (3996/2021 Purohovi).

The Ombudsman has also drawn attention to the fact that a decision on restrictive measures issued to one person may not restrict the rights of other clients, such as their freedom of movement. An example of this is a situation where the unit's self-monitoring plan states that the kitchen refrigerator always contains food to which the clients can help themselves. The documents showed, however, that the kitchen door was kept locked because of an individual client's behaviour (3995/2021 Soite, Kokkola/Maria-Katariina).

Under the Intellectual Disabilities Act, the use of restrictive measures must always be followed by a debriefing, which must be documented. The inspection observations indicate that the debriefing and its documentation have not always been carried out appropriately in the unit (3996/2021 Purohovi).

Expert team's role

One precondition for using restrictive measures is that a residential unit with 24-hour assistance or an institution have access to sufficient expertise in medicine, psychology and social work for delivering and monitoring demanding care and attention. In his previous decisions, the Ombudsman has found that while the Intellectual Disabilities Act does not as such require a continuous presence of experts in an operating unit, in order to achieve the objectives of the Act, an expert group must systematically and regularly monitor and assess the use of restrictive measures and alternative methods in the operating unit.

The Ombudsman has also stated that a member of the expert team cannot be a person who makes decisions on restrictive measures. The reason for this is that the same person cannot both assess the need for restrictive measures as an expert team member and make decisions on their use. The responsibility for obtaining an expert team rests with the unit (3649/2020 Rinnekoti).

Safety

The Ombudsman drew a unit's attention to ensuring the clients' pharmaceutical safety and taking particular care when providing medical treatment to clients. In the light of the documents, medication errors appeared in many cases to have been caused by the staff's carelessness (3650/2020 Vaalijala/Kaisla, 3651/2020 Satakunta Special Care District/Antinkartano rehabilitation centre, 3654/2020 Validia).

Reports of situations that put patient and occupational safety at risk and adverse events (HaiPro) revealed that a unit encountered several situations involving violence, in which the clients could use violence against themselves, other clients or staff members. The reports made by the unit's personnel created the impression that the threat of violence was always present in the unit. The Ombudsman found this situation worrying (3650/2020 Vaalijala/Kaisla). In the inspection report on another unit, the Ombudsman found it important that efforts are constantly made to reduce the threat of violence and that all situations involving violence are discussed thoroughly as described in the unit's self-monitoring plan (3651/2020 Satakunta Special Care District/Antinkartano rehabilitation centre).

One occupational safety report showed that the staff of the unit did not have enough (safety) phones for work use. In the situation described in the report, a staff member had gone out to look for a client but could not call for help or ask other staff members to secure the situation because both work phones of the unit were in other use. The report claimed that the staff are not allowed to use their personal phones during the working hours. The measure recorded in the report form noted that in the future, staff members have permission to use their personal phones for safety reasons. In the Ombudsman's view, institutional and residential units should have a sufficient number of work phones for staff use to secure the safety of clients and staff (3650/2020 Vaalijala/Kaisla).

Self-monitoring and quality assurance of services

In several inspections, the Ombudsman's general comment has been that continuous discussion, development and supervision are needed to safeguard and effectively realise the fundamental and human rights of persons with disabilities in residential services.

Under the Social Welfare Act, social welfare personnel members or persons performing similar tasks in a contractual relationship or as independent traders must notify the person in charge of the operation without delay if, while performing their tasks, they notice or become aware of a shortcoming or obvious defect in the delivery of the client's social welfare services.

The Ombudsman has recommended that residential service units supplement and add detail to their self-monitoring plans, among other things to ensure that the plans clearly set out the staff's reporting obligation and matters related to its fulfilment (3653/2020 Pietarsaari, 3995/2021 Soite, Kokkola/Maria-Katariina, 3996/2021 Purohovi).

From the perspective of clients with severe disabilities, the Ombudsman found the waiting times for assistance indicated in a unit's documents unreasonably long. The Ombudsman drew the unit's attention to the fact that a precondition for realising the right of clients with severe disabilities to good care and attention is the service provider's ability to secure sufficient assistance in performing daily activities within a reasonable time. In the Ombudsman's view, it cannot be considered acceptable that a client must wait for over an hour to use the toilet, for example. Under the Act on Private Social Services, a unit must have enough personnel in relation to the need for services and the number of clients. The Ombudsman noted that sufficient staffing enables the provision of timely assistance that meets individual needs. Excessive waiting times may lead to health harms, put patient safety at risk, and reduce the opportunities for participation of a person with severe disabilities as well as impair their quality of life (3654/2020 Validia).

Feedback collected in a group home over three years revealed some dissatisfaction with the delivery of care, visiting practices during the COVID-19 pandemic and the protection of privacy as well as the realisation of communication and the functioning of communication devices. The Ombudsman found it important that the group home hears the clients and regularly collects feedback from them on their care and the unit's activities. The Ombudsman stressed that carefully analysing the feedback is an essential part of the unit's quality assessment (self-monitoring) and plays an important role in efforts to develop the care (4128/2021 Rekola group home).

Annual theme

The annual theme selected by the Office of the Parliamentary Ombudsman was "Sufficient resources for authorities to ensure fundamental rights". Among other things, the Ombudsman has noted that a special care unit must have enough social welfare and healthcare professionals and other personnel considering its activities and the specific needs of the people under its special care (3653/2020 Pietarsaari, 3996/2021 Purohovi). For observations and comments related to the annual theme, see section 3.8 of the Annual Report.

Self-assessment tool for organisers and providers of residential services for persons with intellectual disabilities

The Human Rights Centre and the Parliamentary Ombudsman have produced a self-assessment tool to support special care operators' measures aiming to strengthen clients' right to self-determination. The tool consists of questions that guide special care organisers to self-assess how well the activities of residential units and the operating methods adopted by them support and strengthen clients' right to self-determination. The self-assessment tool is easy to integrate into existing structures and self-monitoring work (self-monitoring plan).

The Ombudsman has generally recommended that the organisers and providers of residential services for persons with intellectual disabilities use the self-assessment tool to support their self-monitoring. The self-assessment tool has been attached to the NPM's inspection report, and it is available to download on the website of the Human Rights Centre. The website also contains instructions for using the self-assessment tool (3996/2021 Purohovi).

Impacts of the COVID-19 pandemic on residential units' activities and clients' rights

In connection with the NPM's visits, the Ombudsman has stressed that in group housing for persons with disabilities, the primary concern in all circumstances is safeguarding the health and safety of each client. Despite this, the clients' right to movement and communication and their other fundamental and human rights cannot be restricted without a legal basis or otherwise excessively, not even in such exceptional circumstances as the COVID-19 pandemic.

In all inspected units, visits to the residential unit had been restricted, at least in the early days of the pandemic. No visits had been allowed in some units, whereas others had permitted clients to leave the unit or spend periods in their homes. In this respect, the Ombudsman drew the units' attention to the fact that, as the COVID-19 pandemic continued, residential service units for persons with disabilities must in the changing circumstances individually and continuously assess how and to what extent visits, for example, and the customer's right to keep in contact are realised lawfully.

A prohibition of, or recommendation to avoid, visiting may have led to unlawful restrictions (3649/2020 Rinnekoti, 3650/2020 Vaalijala / Kaisla, 3651/2020 Satakunta Hospital District joint municipal authority, 3652/2020 Pajukoti, 3653/2020 Pietarsaari).

In decisions on older persons' rights (incl. 3232/2020), the Deputy-Ombudsman has found that the instructions issued by the Ministry of Social Affairs and Health during the emergency conditions (spring 2020) were incorrect and led to prohibiting or unlawfully restricting visits to health care and social welfare residential units. After the emergency conditions ended on 16 June 2020, the instructions and recommendations of the Ministry of Social Affairs and Health and the Finnish Institute for Health and Welfare were updated to correspond to the pandemic situation better.

In the NPM's reports and in the Ombudsman's decisions concerning residential and institutional units for persons with disabilities (incl. 3602/2020), the Ombudsman has emphasised that the responsibility for a decision on an individual visit and communication lies with the residential unit management or other competent office holder or employee. The party responsible for the activities must be familiar with the legislation in their field and comply with the Constitution and international human rights conventions. The management responsible for the operations must always take care of and ensure that the instructions given to the staff are compliant with the law and that the staff can and know how to work in compliance with legislation by following the instructions.

Pursuant to the case law of the Administrative Courts, a case (decision or instructions) concerning restrictions on visits and communication in a residential unit can be appealed to the Administrative Court. Consequently, in individual cases the court ultimately decides whether visits or, for example, a client's contacts with their loved ones have been unlawfully restricted in a certain situation.

In connection with a hearing of clients and their families, it emerged that in the early stages of the COVID-19 pandemic in spring 2020, relatives would have liked more accurate and timely information. Family members claimed that the information always came late. The impacts of the pandemic on the operation of units and services were unclear. The Ombudsman noted in general that, especially in spring and summer 2020, it could be noticed that the information provided by residential units often came with some delay as – partly conflicting – instructions and recommendations were issued by different authorities and other parties, forcing the units to respond to a changing situation. In a time of crisis, the importance of accurate information and its successful dissemination are emphasised (3650/2020 Vaalijala/Kaisla).

Statutory services and support measures granted on the basis of individual needs must also be arranged for persons with disabilities in exceptional circumstances (3651/2020 Satakunta Special Care District/Antinkartano rehabilitation centre, 3653/2020 Pietarsaari, 3996/2021 Purohovi). The Ombudsman stated that, rather than restricting them categorically, clients' outdoor exercise and services should have been assessed individually. According to the account received, no one was able to use the services, which indicated that no individual assessment had been carried out for clients (3652/2020 Pajukoti).

In a hearing of clients and their family members, it emerged that some clients had felt that their movements had been restricted in spring 2020. It was reported that one unit had a 'quiet hour' twice a day, during which it was not possible to go out. Concerns over a reduction in different daytime activities during the pandemic were also raised in the discussions. The Ombudsman noted that a client who does not live in a residential unit with 24-hour assistance or an institutional unit may only be prevented from leaving the unit to prevent the spread of an infectious disease if an order concerning quarantine and isolation has been issued in compliance with the Communicable Diseases Act (3649/2020 Rinnekoti).

The COVID-19 pandemic and issues associated with it have invoked anxiety and fear in some clients. In addition, masks worn by the personnel have hampered communication. For example, the masks prevented a client with hearing impairments from lip reading. The masks worn by the staff have also confused clients with autism spectrum disorders. Children's units have seen situations where a child has tried to remove an employee's mask because it has made the child afraid and prevented them from reading the adult's facial expressions (3650/2020 Vaalijala/Kaisla).

The inspection also looked at vaccine protection. The personal assistant of a patient in a respiratory paralysis unit had a COVID-19 infection, as a result of which the patient was exposed to the infection and placed in quarantine. The report provided did not state if the assistant or exposed patient had had vaccine protection (4128/2021 Rekola group home). On 30 April 2021, the Deputy-Ombudsman issued a decision on a complaint (1291/2021) concerning an assistant of a respirator patient in another unit who refused to be vaccinated. In the Deputy-Ombudsman's view, no one in a high-risk group should have to face a situation in which they are forced to accept that the person assisting them does not have the best protection available against a life-threatening disease. The Deputy-Ombudsman found that the obligation of public authorities to protect the life and health of everyone requires that the necessary services can be organised without endangering the health or life of a person dependent on them.

The impacts of the COVID-19 pandemic on the rights of persons with disabilities are also discussed in section 4.2.11 of the Annual Report.

Decisions on matters investigated separately

The Parliamentary Ombudsman issued two decisions on matters that had been separately examined on the basis of observations made on the NPM's visits. Both concerned the use of restrictive measures:

In a case he investigated on his own initiative, the Ombudsman noted that a general observation made on the NPM's visits to institutional and residential units of intellectual disability services is that the line between a measure that is a part of normal upbringing of children and a restrictive measure is not always clear. Identifying these measures has emerged as a problem in both public and private service providers' units. The Ombudsman also noted that the Intellectual Disabilities Act does not contain any exceptions applicable to minors regarding the use of restrictive measures. If, in an individual case, it is assessed that a minor is subjected to a restrictive measure referred to in the Intellectual Disabilities Act, the same procedures required by law must be carried out as for an adult. They include service and care plans, client records, decisions as well as notifications and debriefings. As an exception to this, under the Intellectual Disabilities Act the best interests of the child as well as their age and level of development must be considered in the use of restrictive measures. Other acts also contain special provisions on the hearing and representation of children.

The Ombudsman additionally stressed that if a child in need of special support or with a disability is not considered to be in need of-special care (intellectually disabled) and, consequently, no individual special care programme is drawn up for them, they cannot be subjected to restrictive measures under the Intellectual Disabilities Act. The Intellectual Disabilities Act also limits the scope of using restrictive measures, for example prohibiting their use at school or in morning or afternoon club activities for schoolchildren (5030/2018).

Another separate investigation concerning restrictions to the right to self-determination was motivated by the observation made on an NPM visit that for none of the children concerned, measures restricting the children's movements had been regarded as restrictive measures referred to in the Intellectual Disabilities Act (supervised movement). The unit had regarded the restrictions as being related to the normal care and supervision of a child. The written decisions required by the law had not been made on supervising their movements. This was due to the fact that the procedures and principles to be followed with all children had been individually agreed with the customer municipality and clients' family members.

– After the NPM's visit, the service provider announced that the director of the unit will in the future make a decision on supervised movement for each client separately (2757/2019).

3.5.16 HEALTH CARE

Due to the COVID-19 pandemic, the NPM's and Parliamentary Ombudsman's visits to health care units were completely or partially suspended in 2020 and 2021. The Ombudsman regarded the health security risk of visiting units with a large number of people in at-risk groups as too high. The strong increase in the number of complaints about health care, which has partly resulted from complaints related to COVID-19, has also contributed to the low number of inspection visits.

For more information on the impacts of the COVID-19 pandemic on health care and patients' fundamental rights, see section 4.2.8 of the Annual Report.

Inspection visits

During the year under review, two remote inspections were conducted in state-run forensic psychiatric hospitals by sending similar requests for information to Niuvanniemi Hospital (3565/2021) and Old Vaasa Hospital (3566/2021). The aim of the requests was to obtain information about the impacts of the pandemic on patients' rights and treatment.

Under the Communicable Diseases Act, a decision on placing a person in quarantine may be made for a maximum of one month, and it can also be made against the person's will. A decision on isolating a person may be made for a maximum period of two months if there is an obvious risk of the spread of the disease and it cannot be prevented by other means. The doctor deciding on the isolation must provide the isolated person and the treating personnel instructions necessary to prevent the spread of the infection. The decision may also be made against the person's will. Decisions on quarantine and isolation may be appealed to the Administrative Court.

Among other things, the hospitals were requested to provide information on the use of restrictive measures, ensuring and safeguarding the realisation of fundamental rights, and the flow of information. While the hospitals submitted the requested information, the processing of their reports had not been completed at the time of the writing of this Annual Report, and the Deputy-Ombudsman's comments are not available. However, the following are some comments on the accounts provided.

COVID-19 prevention

On a positive note, prevention of the COVID-19 epidemic has been successful, as so far no one being treated for a psychological illness has been infected in either hospital. The vaccination coverage among patients is approximately 90% at Old Vaasa Hospital and about 70% to 80% at Niuvanniemi Hospital. Neither hospital puts any pressure on patients to accept the vaccination.

The report of Old Vaasa Hospital notes that the hospital has made sustained efforts to offer a private room for as many patients as possible. As the pandemic set in, the hospital attempted to make more private rooms available as soon as possible. A prefabricated ward was set up in the hospital area, which provided single rooms and enough nursing staff for eight patients. An area which had previously served as a patient ward but now housed the hospital's financial administration was again used as a ward as the financial administration moved to other premises. These measures ensured that most of the hospital's patients had private rooms.

Quarantines and isolation compliant with the Communicable Diseases Act

Both hospitals have had to quarantine patients. At Niuvanniemi Hospital, patients were also isolated under the Communicable Diseases Act. At both hospitals, the quarantine periods were clearly shorter than what is allowed under the Communicable Diseases Act. According to the report, isolation periods referred to in the Communicable Diseases Act at Niuvanniemi Hospital usually lasted approximately 24 hours, or the time it required to receive the test result. Niuvanniemi Hospital reported that outdoor exercise for patients placed in quarantine or isolation in compliance with the Communicable Diseases Act is organised following the same principles as for patients secluded in compliance with the Mental Health Act. This means that the hospital strives to enable daily outdoor exercise while taking into account the patient's physical health, which may be a contraindication to outdoor recreation. The account provided by Old Vaasa Hospital notes that if it has been necessary to quarantine a patient behind locked doors in compliance with the Communicable Diseases Act, it has been agreed that the patient is monitored in the same way as when a patient is secluded in compliance with the Mental Health Act. A separate monitoring form has been provided for this purpose.

Restrictive measures compliant with the Mental Health Act during the pandemic

According to the report, incidents requiring seclusion and restraints at Old Vaasa Hospital have not increased in number due to the pandemic. Variations in the number or duration of these measures are explained by the situation of individual patient(s) who are particularly challenging to treat, not by the pandemic. While the number of incidents requiring seclusion and restraints at Niuvanniemi Hospital has increased somewhat during the pandemic compared to previous years, the numbers partly returned to the pre-pandemic levels in summer 2021.

Activities during the pandemic

Based on the reports, the pandemic has not prevented the activities offered to patients in either hospital. According to Old Vaasa Hospital, efforts have been made to continue and secure the activities with various arrangements and to organise compensatory activities. For example, group sizes have been reduced and indoor exercise has been replaced by outdoor exercise. According to the account provided by Niuvanniemi Hospital, any changes have mainly affected group activities. They have also been continued, however, trying to ensure that the infection risk remains low.

Visits and keeping in contact with loved ones during the pandemic

Visits were cancelled or restricted to some extent at Old Vaasa Hospital while the pandemic situation was particularly serious or, for example, if the visitor had symptoms of infection. Some visits were postponed in a mutual understanding until such a time that the epidemic situation becomes less severe. Visits to patients were restricted at Niuvanniemi Hospital, especially in the early stages of the epidemic in spring 2020. The report notes that the instructions issued by the authorities were possibly misinterpreted at that time to mean that no visits should be allowed. In case of minors, however, active efforts were made to arrange visits using a movable space ('meeting prefab').

Both hospitals have striven to arrange different possibilities for patients to keep in touch with their families and friends. Separate, more spacious rooms have been set aside for visits, and the number of visitors arriving at the hospital at one time has been limited (Old Vaasa).

At the most difficult stages of the pandemic, remote connections were favoured for keeping in touch, and patients were also otherwise encouraged to contact their loved ones by remote means.

Patients' leaves and outside visits have been possible with careful planning and individual consideration at both hospitals. In this context, the patient's functional capacity and judgement as well as their ability to protect themselves against a COVID-19 infection were also taken into account. At Old Vaasa Hospital, an effort was made to organise transport by family members or in a car provided by the hospital when a patient went on a leave, avoiding the need to use public transport. While being vaccinated has not been imposed as a condition for such privileges as leaving the hospital, accepting the vaccine has been one of the factors affecting the overall consideration at Niuvanniemi. According to Niuvanniemi Hospital, patients have not been routinely placed in quarantine after going on a leave. As a rule, patients return to the normal hospital routines after a leave, unless they are known to have had a significant risk of exposure.

Information activities related to the pandemic

Both reports state that the patients have been informed of issues related to the COVID-19 pandemic in different situations. As a rule, information has been provided orally. However, neither hospital had actively informed patients' families or friends about the impacts of the pandemic on the patient's rights or, for example, keeping in contact. Information on the arrangements has been provided either by the patient's personal carer or in connection with other routine contacts.

Personnel resources

The pandemic has had little impact on the personnel resources of either hospital. They have also had enough staff for organising activities for the patients. As a temporary ward was set up at Old Vaasa Hospital, however, additional nursing staff were required. The reports state that the pandemic period was mentally stressful and demanding for the staff, which has been recognised by the hospitals. The pandemic situation has made it necessary for different professional groups to acquire knowledge and learn about practices and regulations that are partly outside their core competence areas. Efforts have been made to support the coping of the staff with instructions that are as clear as possible. The staff have been offered possibilities to participate in work guidance and training remotely. Niuvanniemi Hospital provided an internal service line ('worry line') in form of an on-call telephone service which the staff could contact about stressful issues related to the pandemic. This service was discontinued, however, as there were no contacts.

Particular challenges

Both hospitals mentioned in their reports that the national guidelines issued by the authorities in the early stages of the pandemic were a challenge. They were considered inconsistent, and they created confusion when planning and providing instructions for the work. In the early stages of the pandemic, the availability and adequacy of personal protective devices was also a cause for concern.

In the early days, organising appropriate COVID-19 testing for both patients and staff was a major challenge (Old Vaasa). According to the report, an impression was created during the pandemic that a patient group in a vulnerable position and suffering from serious mental illnesses may be overlooked in decision-making and planning if their needs and rights are not taken care of separately (Old Vaasa). It was noted that state-run forensic psychiatric hospitals played an active role in including psychosis patients in the risk groups defined by the Finnish Institute for Health and Welfare.

Getting the patients vaccinated also proved extremely challenging at first and required a great deal of fact-finding and negotiations before the party responsible for delivering the vaccines could be identified and vaccinations could start (Old Vaasa). The hospital found that when it came to staff vaccinations, for example, its staff were not treated equally with the personnel of the Kuopio University Hospital or the psychiatric staff of that hospital, for instance. The hospital had set up a unit prepared to treat patients with a COVID-19 infection, and while it managed to get its staff vaccinated as a group, no vaccination protection could be obtained for the rest of the hospital's staff, including doctors on call, despite the attempts to do so (Niuvanniemi Hospital).

Proposals to authorities

As a measure related to his decision on a complaint, the Ombudsman asked during the reporting year the National Supervisory Authority for Welfare and Health (Valvira) to investigate the responsibility of a psychiatric hospital for a patient ordered to undergo treatment when the patient has left the hospital without permission. The Deputy-Ombudsman proposed that Valvira consider, based on its report, issuing a national guideline on the hospital's obligations and measures in a situation of this type (4702/2020).

On 27 May 2021, the Deputy-Ombudsman submitted to the Ministry of Social Affairs and Health a proposal on supplementing the Mental Health Act. The proposal summarised problems observed by the Deputy-Ombudsman in the Mental Health Act, to which the Ministry was asked to pay attention when developing legislation. The observations were based on patient complaints and inspection visits to psychiatric hospitals by the Ombudsman and the NPM. Among other things, the Deputy-Ombudsman found it important in this proposal that the right to outdoor exercise of patients undergoing involuntary treatment be safeguarded by law. The Deputy-Ombudsman also drew attention to developing the patient's legal remedies based on the CPT's opinions. Whereas some of the proposals had been submitted to the Ministry on a previous occasion, they had not yet led to any action. The Deputy-Ombudsman also noted that there is no legislation on restricting the client's fundamental rights in somatic health care or care for older persons. Under the Constitution of Finland and the European Human Rights Convention, restrictive measures of this type must be based on an act that is sufficiently unambiguous and sets down precise limits as well as contains the appropriate legal remedies. In the Deputy-Ombudsman's view, passing legislation for those sectors where it is completely lacking is the most urgent concern (164/2021).

– In its reply dated 30 September 2021, the Ministry of Social Affairs and Health stated that it would use the Deputy-Ombudsman's proposal as a basis for drafting legislation. The legislation is to be prepared in stages, however, as this is a very extensive theme. In addition, the ministry has a backlog of legislative work owing to the COVID-19 pandemic as its drafting resources had to be allocated elsewhere. Consequently, the ministry will not be able to effectively continue the drafting of legislation on the client's and patient's right to self-determination until October 2021. In this context, the Ministry will assess if the drafting of the most urgent amendments proposed by the Deputy-Ombudsman could be included in the first-stage Government proposal to be submitted in 2022.

It should be noted that the Government's legislative plan for autumn 2022 foresees a government proposal aimed at rectifying the shortcomings in legislation concerning legal remedies related to medication administered in connection with involuntary psychiatric treatment. The plan also states that the drafting of legislation on strengthening the client's and patient's right to self-determination and the prerequisites for using restrictive measures will also continue in other respects as set out in the Government Programme.

3.6 Shortcomings in implementation of fundamental and human rights

The Ombudsman's observations and comments in conjunction with oversight of legality often give rise to proposals and expressions of opinion to authorities as to how they could promote or improve the implementation of fundamental and human rights in their actions. In most cases, these proposals and expressions of opinion have had an influence on official actions, but measures on the part of the Ombudsman have not always achieved the desired improvement. The way in which certain shortcomings repeatedly manifest themselves shows that the public authorities' reaction to problems highlighted in the implementation of fundamental and human rights has not always been adequate.

Since 2009, following a recommendation by the Constitutional Law Committee (PeVM 10/2009 vp), the Ombudsman's Annual Report has included a section outlining observations of certain typical or persistent shortcomings in the implementation of fundamental and human rights. As per the request of the Constitutional Law Committee, (PeVM 13/2010 vp) this section has become a permanent feature of the Ombudsman's Annual Report.

Since 2013, this section has been presented as a list of ten critical problems identified in the implementation of fundamental and human rights in Finland. The list was first presented in 2013 by the Ombudsman at an expert seminar on the evaluation of Finland's first national action plan on fundamental and human rights, and was thereby integrally linked to the implementation of the action plan. As the same ten problems consistently appear on the list each year, a revised list has been published in subsequent years describing potential changes and progress made in each area.

In 2021, separate mention of restriction practices violating the right of self-determination in institutionalized care was removed from the list of ten critical problems. The removal does not mean that there are no longer problems related to self-determination. Instead, these problems are addressed in other parts of the list. Problems in the implementation of good governance and public access were added to the list as a new item. These problems occur widely in all administrative branches, including ones that are not covered by the list of ten central problems.

When evaluating the list, it is important to note that it includes typical or ongoing problems that have been identified specifically through the observations compiled by the Ombudsman under his remit. The Ombudsman mainly obtains information on failures and shortcomings through complaints, inspection visits and own initiatives. However, not all fundamental and human rights problems are revealed by the Ombudsman's actions.

The Ombudsman's oversight of legality is primarily based on complaints, which typically concern individual cases. Broader phenomena (such as racism and hate speech) do not clearly come up in the Ombudsman's activities. What is more, some matters that reflect shortcomings are directed towards other supervisory authorities, such as special ombudsmen (including the Non-Discrimination Ombudsman). Because some problems rarely surface in the Ombudsman's activities, they have not been included on the list (such as the rights of the Sámi people).

Some even clearly identified problems relating to fundamental and human rights may be absent from the list if they have not been encountered in the Ombudsman's work. And some problems may be absent from the list because they are, at least in some respects, related to the private sector or the actions of individuals to the extent that they do not come under the Ombudsman's oversight.

For the above reasons, the list cannot provide an exhaustive picture of the various problems relating to fundamental and human rights in Finland. Also, the order of the problems on the list does not reflect their seriousness in relation to each other.

There can be several reasons for possible defects or delays in redressing a legal situation. In general, it is fair to say that the Ombudsman's statements and proposals are complied with very well. When this does not happen, the explanation is generally lack of resources or defects in legislation. Delays in legislative measures also often appear to be due to insufficient resources for law drafting.

Some of the listed problems are perpetual to some extent by their nature. This does not mean, however, that such problems should not be addressed through continuous effort. Most of the listed problems could be eliminated through sufficient resourcing and legislative development. In fact, significant improvements have been made with regard to some issues. On the other hand, some shortcomings have become more common.

3.6.1 TEN CENTRAL FUNDAMENTAL AND HUMAN RIGHTS PROBLEMS IN FINLAND

Shortcomings in the living conditions and treatment of the elderly

Tens of thousands of elderly customers in Finland live in institutional care and assisted living units. Shortcomings are continuously being identified in relation to nutrition, hygiene, change of adult nappies, rehabilitation and access to outdoor recreation. Shortcomings have also been identified in relation to the frequency of doctor's visits, medical treatment and dental care. Shortcomings are often due to insufficient personnel numbers or flawed management.

Measures limiting the right to self-determination in the treatment and care of the elderly should be based on law. However, the required legislative foundation is still entirely lacking. Restrictive measures are also used even when they are not necessary, and situations could be solved by other means. During the coronavirus pandemic, inappropriate operating practices have been found in different nursing units. There is still a risk that the rights of the elderly are unnecessarily restricted on the basis of health safety.

Digitalisation of services may endanger the availability of services for elderly persons.

There are also shortcomings in terms of the adequacy and quality, safety, access to outdoors and support services for elderly people living at home.

Self-monitoring and retrospective oversight of the adequacy and quality of services provided to customers at home is insufficient, and new supervision methods are required.

Despite applications, authorities do not always make decisions on services provided at home or sheltered housing to increase the amount of services provided at home or to arrange care in an assisted living facility or residential home for the elderly. When authorities do not make decisions on the organisation of services, the right to refer a matter concerning the scope of the municipality's organisation obligation to the consideration of an administrative court is not realised.

Supervision of service quality by local authorities is insufficient, and problems in private care homes can go on for long periods before any interventions. The guidelines issued by Regional State Administrative Agencies are not always followed, and issues sometimes take an unreasonably long time to rectify. Local authorities are not always able to provide substitute services, even in severe problem situations.

Shortcomings in the implementation of child welfare

The general lack of resources allocated by local government to child welfare services and, in particular, the poor availability of qualified social workers and the high turnover of employees have a negative impact on the standard of child welfare services.

There are shortcomings in the implementation of the multidisciplinary services needed by children, in the cooperation between different administrative branches and in the coordination of service systems. Major problems have existed for a long time in the cooperation between child welfare substitute care and psychiatric care, but also in the cooperation between pupil and student welfare, services for children with disabilities and child welfare, to name a few. The incompatibility of the care and services needed by children weakens treatment outcomes and may lead to a worsening of a child's symptoms. A child presenting serious symptoms or having a disability may also remain completely untreated or unnoticed in child welfare services. The available services are particularly insufficient in relation to the need for mental health care.

There are few units or services in child welfare substitute care that could be used to effectively address serious substance abuse problems in children, for example by offering mental health services linked to substance abuse treatment if necessary or by breaking a cycle of substance abuse harming a child.

Children who are in poor health or have severe symptoms and therefore temporarily need demanding substitute care with a wide range of integrated services and support, or children who need other individual substitute care may have to wait in queue for several months, up to a year, to access periods of special care or other substitute care that matches their specific needs.

Children's mental health problems are increasingly treated with strong antidepressants primarily intended for adults. The joint service structure of child welfare and child psychiatry lacks suitable placement for children who need not only child welfare substitute care but also intensive psychiatric care. The services needed by these children cannot be provided satisfactorily in a children's home or psychiatric hospital alone.

Repeated changes in the place of substitute care endanger the permanent relationships and stable conditions that are particularly important for children placed in substitute care. Alternatives to substitute care have not been fully implemented with the child's needs in mind. Child welfare services do not have the correct types of substitute care placements available for children who are in the poorest condition and are the most difficult to treat.

The child's right to practise their religion, the right to have their identity respected in terms of background and culture and the right to have the development of their mother tongue preserved have not always been sufficiently taken into account in substitute care.

The reunification of a child and their family is often not planned and its implementation is not assessed in connection with reviewing the client plan. The reunification of a child and their family can be promoted by drawing up a client plan for the parents to support their parenthood, but these plans are often not done.

Children who have been taken into care and are in substitute care often do not know their own rights or the obligations and rights of child welfare institutions concerning children. The children also do not always know that the social workers responsible for their affairs are also responsible for supporting and helping them and that they have the right to meet their social workers in person. The children are also not always informed of the legal remedies they are entitled to as required by the Child Welfare Act.

Child welfare institutions continue to take restrictive measures in violation of the Child Welfare Act by, for example, using restrictive measures in situations or in ways not permitted by the Act.

The supervision of substitute care under child welfare services is largely inadequate. Regional State Administrative Agencies still do not have sufficient resources to carry out the inspections they are responsible for. The supervision of family care in child welfare, which is only the responsibility of municipal social welfare authorities, is also insufficiently implemented.

Shortcomings in the implementation of the rights of persons with disabilities

Equal opportunities with regard to participation are not being realized for persons with disabilities. There are shortcomings in the accessibility of premises and services, and the implementation of reasonable accommodation.

Practices vary with regard to the restriction of the self-determination right of people in institutionalised care. The amendment to the restrictive measures provision of the act on special care for persons with intellectual disabilities (381/2016) has improved the situation, but there are unawareness, shortcomings and negligence around its implementation.

Statutory service plans and special care programmes are not always prepared, they are inadequate, or there are delays in their preparation. Decisions regarding services and the implementation of such decisions are often delayed without just cause.

Application practices regarding disability services are inconsistent between municipalities, and the adopted policies may prevent customers from accessing statutory services.

The competitive tendering of services for persons with disabilities may have jeopardized the rights to services for special individual needs.

Inspections ordered by the Ombudsman at polling stations revealed deficiencies in terms of the accessibility of the voting premises themselves or the routes for accessing the premises. In addition, the lack of accessible polling booths or stations may have jeopardised the preservation of the secrecy of the ballot. However, the Ombudsman has welcomed the fact that, according to inspection findings, more polling stations are starting to be accessible.

Long processing times of alien affairs and the insecurity of undocumented immigrants

The Finnish Immigration Service is unable to meet the deadlines for processing asylum applications, residence permit applications based on family ties and residence permit applications based on employment as laid down in the Aliens Act. Certain new deadlines have further lengthened the processing times of old applications that were not subject to the new deadlines. The Ombudsman has issued numerous reprimands to the Finnish Immigration Service in relation to the unlawful delays in processing cases, but processing times have remained poor.

Shortcomings have been identified in meeting the basic needs such as health and social care services, of undocumented immigrants. A government bill was submitted to the Parliament in 2014 (HE 343/2014 vp) that would have improved the right to health services of certain groups among undocumented immigrants (including pregnant women and minors), but the bill lapsed. Municipalities have adopted different policies on what types of social and health services are still offered to persons who no longer have the right to reception services.

Flaws in the conditions and treatment of prisoners and remand prisoners

For many prisoners, lack of activity is a serious problem. The Council of Europe Committee for the Prevention of Torture (CPT) recommends that prisoners be allowed to spend at least eight hours per day outside their cells. In closed units, prisoners get to spend less than eight hours outside their cells in many cases. Some prison facilities have begun to pay more attention to increasing outside time and, in some cases, providing more activities, and the situation has improved in such facilities.

When prisoners are placed in units, the legal principle of placing remand prisoners in separate locations from prisoners serving sentences is not always observed. Under the law, minors should also be placed separately from adults in prison, which is largely not implemented.

However, the performance targets of the Criminal Sanctions Agency for 2022–2025 include an agreement on the establishment of new departments for minors and young prisoners.

The CPT has criticized Finland for more than 20 years for its excessive detention of remand prisoners in police prisons. The Remand Imprisonment Act was amended by an act (103/2018) that entered into force on 1 January 2019 with the effect that remand prisoners must not be kept in a police detention facility for longer than seven days without an exceptionally weighty reason. According to information obtained during the Ombudsman's inspections, detention periods for remand prisoners in police prisons are now shorter.

There have also been positive developments in the fact that the Government proposal for an act on the treatment of persons in police custody and certain related acts will be submitted to Parliament in 2022.

Shortcomings in the availability of health care services and the relevant legislation

There are shortcomings in the provision of statutory health care services. For example, there are problems with the distribution of care supplies and the handing over of assistive devices for medical rehabilitation. For financial reasons, sufficient quantities of supplies and assistive devices are not always distributed.

Serious shortcomings in fundamental rights regarding health care exist in the access to treatment and contact (access to a doctor's assessment, queues for treatment and healthcare debt). A new shortcoming has emerged in the resource situation of gender identity examinations both at HYKS and at TAYS.

The requisite legal basis for restrictive measures is still lacking in somatic health care. Some emergency and care units have secure rooms, in which aggressive and intoxicated patients can be placed. There is no legislation governing secure rooms and the authority to use them. The grounds for and the duration of loss of liberty, the person making the decision, the decision-making process and the legal protection of patients should be provided for in legislation in compliance with the criteria for restricting fundamental rights.

The Mental Health Act includes no provisions on the use of coercive measures by care personnel to restrict a patient's freedom of movement outside a hospital area or to bring a patient to the hospital from outside the hospital area. Nor does the Mental Health Act include any provisions on patient transport to destinations aside from health-care service units, such as courts of law, or on the treatment and conditions of the patient during transport or the competencies of the accompanying personnel. The lack of a legislative framework repeatedly results in situations that are problematic and dangerous.

Private security guards may be used in psychiatric hospitals in duties for which the security guards are not authorised.

Shortcomings in learning environments and decision-making processes in primary education

The right of schoolchildren to a safe learning environment is not always observed. The means available for schools to identify and intervene with bullying are not always sufficient, and there are problems with indoor air quality.

There are shortcomings that cause legal protection problems in the legal knowledge, administrative processes and decision-making of education providers and schools. For example, administrative decisions that are open to appeal are not always made, are not based on law or do not meet the requirements of the Administrative Procedure Act.

Long processing times in legal processes and shortcomings in the structural independence of courts

Delays in legal proceedings remain a problem in Finland, and the coronavirus epidemic has exacerbated the situation. Despite legislative reforms to improve the situation, court cases can still take an unreasonably long time. This can be a serious problem in particular for matters that require urgent handling.

In criminal cases, the total duration of the process depends on the length of the pre-trial investigation, which may be exceptionally long in many complex cases, such as financial crimes. The number of exceptionally extensive cases and sets of cases has increased. It has become clear that the current criminal process and appeal system are not designed to handle such cases. Delays in the processing of criminal cases are also partly caused by under-resourcing across the criminal process system – the police, prosecutors and courts. The project to enhance criminal proceedings (OM046:00/2020) set by the Ministry of Justice has assessed ways of improving the efficiency of criminal proceedings and speeding up the processing of criminal cases as well as the need to amend the Criminal Investigations Act. The project ended on 31 December 2021.

High trial costs and court fees can prevent due legal protection.

With regard to the structural independence of the courts, the situation has improved with the establishment of the National Courts Administration. Despite this, executive powers continue to try to steer the operations of the independent court system by, for example, including the courts within the scope of the central government premises strategy, despite statements by the National Courts Administration and the Deputy-Ombudsman emphasising the independence of the courts.

However, the large number of temporary judges and the fact that, in practice, local councils select jury members for District Courts on the basis on political quotas, remain problematic issues from the perspective of the independence of courts.

Problems in the implementation of good governance and public access

The Ombudsman often has to draw attention to the implementation of good governance and the principle of public access in different administrative branches. Related problems are often also addressed through own initiatives in the context of processing complaints.

During the year under review, unreasonably long processing times (16–18 months) were for example discovered in the Tax Administration regarding claims for revised decisions concerning income taxation for individual customers. The delivery times of genealogical reports and the processing times of matters related to guardianship in the Digital and Population Data Services Agency were also often unreasonably long. Delays in the processing times of cases also occur with many other authorities.

Unlawful conduct in the processing of information requests under the Act on the Openness of Government Activities is also a constant in the oversight of legality.

Shortcomings have also emerged in the provision of digital e-services, especially for persons in a vulnerable position. In the Suomi.fi portal, it has for example not been possible to use the authorisation service when acting on behalf of an older person or a disabled person if the authorisation could not be granted using strong identification. The rights of foreigners may also have been realised inadequately if they have not had access to means of strong identification.

The Ombudsman's oversight of legality has included the processing of financial management problems of persons in a vulnerable position in municipalities, joint municipal authorities, financial and debt advisory services and enforcement proceedings. Problems have been discovered in decision-making related to invoicing and enforcement and in informing customers about their rights.

For example, health care services do not have sufficient knowledge of the possibility of reducing or eliminating payments instead of resorting to social assistance. Creditor communities have not always sufficiently supervised the practices of private debt collection companies in the collection of payments. This may have resulted in additional indebtedness, especially for people who use health care services frequently.

Municipalities have problems with official bodies processing matters in secret. With the exception of confidential matters, municipalities must use the public information network to publish cases that are processed by official bodies. Information necessary for public access to information must be published.

Shortcomings in the prevention and compensations of violations of fundamental and human rights

Awareness of fundamental and human rights can be lacking, and authorities do not always pay sufficient attention to their implementation and promotion. Education and training on fundamental and human rights are insufficient, even though there have been some positive developments.

The Ombudsman has for long now drawn attention to the fact that the legislative foundation for the recompense for basic and human rights violations is inadequate. During the year under review, the Ministry of Justice has appointed a working group tasked with examining how the liability for damages of public employees and those exercising public authority should be reformed and the necessary legislative amendments prepared. The working group must particularly examine whether specific provisions on compensation for violations of fundamental or human rights caused by the activities of public employees should be included in the legislation. In addition, the working group will examine whether damage caused by incorrect or neglected guidance by public employees should be compensated in more cases. The working group is operational from 17 August 2021 to 31 May 2022.

3.6.2 EXAMPLES OF POSITIVE DEVELOPMENT

This section of Parliamentary Ombudsman's reports for 2009–2014 has usually contained examples of cases in different branches of administration where, as a result of a statement or proposal issued by the Ombudsman or otherwise, there has been favourable development with respect to fundamental or human rights. The examples have also described the impact of the Ombudsman's activities. In the current report, this section no longer contains such cases.

For the Ombudsman's recommendations concerning recompense for mistakes or violations and measures for the amicable settling of matters, see section 3.7. These proposals and measures have mostly led to positive outcomes.

3.7 The Ombudsman's proposals concerning recompense and matters that have led to an amicable solution

The Parliamentary Ombudsman Act empowers the Ombudsman to recommend to authorities that they correct an error or rectify a shortcoming. Making recompense for an error or a breach of a complainant's rights on the basis of a recommendation by the Ombudsman is one way of reaching an amicable settlement in a matter.

Over the years, the Ombudsman has made numerous recommendations regarding recompense. These proposals have in most cases led to a positive outcome. In its reports (PeVM 12/2010, 2/2016 and 2/2019 vp), the Constitutional Law Committee has also taken the view that a proposal by the Ombudsman to reach an agreed settlement and effect recompense is in clear cases a justifiable way of enabling citizens to enjoy their rights, bring about an amicable settlement and avoid unnecessary legal disputes. In the latter two reports, the Committee has considered it a positive development that the focus of the Parliamentary Ombudsman's tasks have shifted even more clearly from the oversight of authorities to promoting of people's rights. The grounds on which the Ombudsman recommends recompense are explained more extensively in the 2011 and 2012 annual reports (p. 84 and p. 65).

Making recompense was recommended by the Ombudsman in 16 cases in the reporting year. In addition, during the handling of complaints, communications from the Office to authorities often led to the rectification of errors or insufficient actions and therefore contributed to reaching an amicable settlement. For example, as a result of a complaint, the police took up a case for reconsideration in 15 cases in the year under review and started a pre-trial investigation in at least six cases. Consideration is still in progress in some of the cases. In numerous other cases, guidance was provided to complainants and authorities by explaining the applicable legislation, the practices followed in the administration of justice and oversight of legality, and the means of appeal available.

3.7.1 PROCESSING OF CLAIMS AT THE STATE TREASURY

Under the act on state indemnity operations, the majority of claims for damages addressed to the State are processed by the State Treasury. The act is applied to the processing of a claim for damages from the central government if the claim is based on an error or neglect by a central government authority. As agreed with the State Treasury, the State Treasury will annually send all decisions on recompense under the act on state indemnity operations to the Ombudsman for the Ombudsman's information.

According information obtained from the State Treasury, 1,319 decisions were issued on claims based on the State's general liability in the year under review. There was a considerable increase in the number of the decisions as the State Treasury issued 837 decisions in the preceding year 2020. In 2021, the amount of the compensations paid was large, totalling EUR 5,604,200, while it was EUR 753,220 in 2020. A significant part of the compensations paid were based on advice provided by the Finnish Transport and Communications Agency Traficom on the scrapping premiums of passenger cars. In the administrative branch of the Ministry of Transport and Communications, the compensations paid totalled EUR 4,230,000 and 329 claims were presented. The next highest amounts of compensation were paid in the administrative branches of the Ministry of Defence (EUR 480,000), the Ministry of the Interior (EUR 440,000) and the Ministry of Justice (EUR 315,000).

During the periods 1 December 2020–4 April 2021 and 18–25 January 2021, the Finnish Transport and Communications Agency Traficom had provided advice, according to which more than one scrapping premium could be used to purchase one car. In a decision involving one of the largest compensation amounts, the client had scrapped 33 cars and applied to the Finnish Transport and Communications Agency for the scrapping premium for them. The Agency paid the premium for only one car. In its decision on the claim for compensation, the State Treasury referred to chapter 3, section 2 of the Tort Liability Act, under which a public corporation is liable for damage caused through an error or negligence in its exercise of public authority. However, the liability of the corporation arises only if the performance of the activity or task, in view of its nature and purpose, has not met the reasonable requirements set for it. Under chapter 5, section 1 of the Tort Liability Act, damages shall constitute compensation for personal injury or damage to property and, under the conditions laid down in sections 4a and 6, for anguish. According the to State Treasury's decision, the Agency's advice and communication about using the scrapping premium to purchase more than one car had been incorrect until 25 January 2021. Furthermore, it was clear that the person submitting the claim had scrapped more than one car and had claimed scrapping fees for them. According to the decision, a justification had been presented for the claim and a credible explanation had been provided for the financial amount in the claim. The State Treasury paid the compensation of EUR 64,000 demanded by the client. The amount of compensation paid in the other decisions taken by the State ranged from a few thousand euros to several tens of thousands of euros.

In the administrative branch of the Ministry of Defence, the State Treasury paid compensation among other things for damages to property that had been caused to vehicles by aircraft jet currents or the air flow of helicopter rotors during military aviation exercises. The backwash of the Navy's missile boat in turn had caused damage to a boat moored at a pier on the shore. Compensation was also paid for the financial damage caused by the Defence Forces as a result of cancelled refresher training exercises at the end of 2020 and in 2021. The exercises had been cancelled because the prevailing COVID-19 pandemic. The claims demanded compensation to the amount corresponding to the reservist salary and daily allowance. The claimants had applied and been granted unpaid leave for the duration of the refresher training exercise. The State Treasury paid the compensations according to the claims.

In the administrative branch of the Ministry of the Interior, the State Treasury made recompense for a violation of fundamental and human rights on the basis of the Parliamentary Ombudsman's recommendation in two cases. Recompense was also made on the basis of the European Court of Human Rights' ruling against Finland (Kotilainen and Others v. Finland) on 17 September 2020. The matter concerned procedures and negligence in the local police concerning the firearms permit of a young man guilty of the school shooting in Kauhajoki in 2008. Based on the ruling, the State Treasury recompensed 22 complainants and households for immaterial damages, i.e., suffering caused by the violation of Article 2 of the European Convention on Human Rights. In addition, the legal costs of the complainants were reimbursed.

A total of 543 claims for damages concerning the administrative branch of the Ministry of Justice were filed with the State Treasury in the year under review. The large number of the matters filed was caused especially by the claims for damages concerning the office of guardianship services of the state's legal aid and public guardianship districts. Based on them, decisions on damages were issued in which the amounts paid varied from a few euros in delinquency charges of bills and taxes to thousands of euros. In the latter, the compensations were related to issues such as failure to apply for care and housing allowances or retirement pension, or a telephone subscription left uncancelled, for example. Damages were also claimed in the criminal sanctions field. They largely concerned items and clothing that were lost or broken in prison.

One of the decisions issued by the State Treasury concerned damages claimed for the PRISON'S actions. The Deputy-Ombudsman's decision of 23 March 2018 and of 30 October 2018 were used as grounds for the claim for damages. In the first decision, the Deputy-Ombudsman had considered the prison guards' actions unlawful as they had checked the prisoner's groin area with a mirror placed on the floor. In the latter decision, the Deputy-Ombudsman had considered it wrong to handcuff the prisoners during transport to the sample collection facilities for substance testing. According to the State Treasury's decision, the issue was whether the actions of the prison established the client's right to compensation for suffering and other damages. According to the State Treasury, there was no reason to assess the use of the mirror to check the groin area differently from the Deputy-Ombudsman assessment. As the matter did not have sufficient prerequisites for a body search, the requirements reasonably set for the activity or task has been violated. The case therefore had grounds for compensation for damages. However, according to the decision, there had been grounds for the monitoring of substance use and the handcuffing had only lasted five minutes. In this respect, this was not a violation that could be considered to establish grounds for compensation for immaterial damage as a result of a violation of fundamental or human rights. The State Treasury considered EUR 500 a fair compensation for the immaterial damage caused to the applicant. In addition, the applicant was compensated for the deliquency charge and the application costs.

3.7.2 RECOMMENDATIONS FOR RECOMPENSE

The following gives an overview of the recommendations for recompense made by the Ombudsman during the year under review. Some of the cases are still waiting for a response from the authority.

RIGHT TO PERSONAL INTEGRITY AND LIBERTY

Treatment of the patient and involuntary medication

The claimant had been brought to the emergency clinic in an ambulance with executive assistance from the police. As the intention was to transport the claimant to Vantaa, the claimant had to wait for the transfer in the facilities of the joint emergency services of Turku. The physician on call at the emergency clinic had given the permission to use the isolation facility on the basis of a consultation call because the claimant had been distressed and unpredictable and would have severely risked their own safety. The claimant says they called the nurses and asked for toilet paper while in the isolation facility, but no one answered. It has not been possible to clarify in what way contact between the patient in the isolation facility and the nursing staff had been organised and why the staff had not answered the claimant's calls. On the basis of the report received by the Deputy-Ombudsman, the Deputy-Ombudsman could not be convinced that the complainant's right to good care and treatment respectful of human dignity in the isolation facility had been implemented in compliance with the Act on the Status and Rights of Patients (Patient Act).

According to the monitoring form for isolation, the patient had been walking around the room, sitting on the mattress and walking back and forth. The patient had been given Serenase medicine. According to the entries recorded in the security report by Tyks Acute, security stewards secured the administration of medication to the aggressive patient who resisted the treatment. According to the entries, the patient was confused and therefore entirely incapable of cooperation and resisted treatment physically, for example, using the mattress. Security wardens had had to pull the patient down on the mattress and restrain the patient to enable the medication. According to the Deputy-Ombudsman, the patient records or the received information did not reveal in what way the doctor had examined the patient before the medication was given.

It was not possible to verify the grounds for giving the medication or the existance of an emergency situation that would have justified involuntary medication from the patient records or other documents. The Deputy-Ombudsman was of the view that the Hospital District of Southwest Finland acted unlawfully when it gave the medication to the complainant against their will.

The complainant's right to treatment respectful of human dignity while isolated in the safety facility was not realised. The complainant was in the isolation facility for more than three hours, it was not possible for them to contact the nursing staff and they were not given toilet paper. The complainant had been medicated against their will. Involuntary medication without grounds to justify it violated the complainant's right to personal integrity. The Deputy-Ombudsman proposed that the Hospital District of Southwest Finland consider in what way it can recompense the complainant for the fundamental and human rights violations imposed on them (8349/2020*).

– According to its report, the hospital district has reminded its staff about the importance of making specific entries in patient documents especially in procedures in which the patient's fundamental rights are restricted. The hospital district has reported that is will specify its guidelines for the use of restrictive measures and their more detailed recording. Special attention will be paid to the use of involuntary medication and recording of special situations. The hospital district apologised for the unfair treatment of the claimant. In addition, the hospital district considered it fair to pay EUR 200 to the claimant in recompense for the violation of their fundamental and human rights.

Restriction of the right to self-determination during hospitalisation

The patient had Alzheimer's disease and a vascular memory disorder and used a rollator to move about. They lived in a care home with 24-hour assistance and returned there after the hospitalisation. During the hospitalisation, the patient´s right to self-determination was restricted. During the episode of care, the reason behind the patient's confusion was most likely delirium, a sudden state of confusion in which the memory disorder, the hospital environment and an infection were predisposing factors. According to the information received by the Ombudsman, physical restriction was not used until as the last resort and it was continued because the patient repeatedly fell on the ward. It was stated in the account that the hospital's instructions on physical restriction of patients were complied with.

In the practice of legal oversight, the Ombudsman has considered that because there is no legislation on restricting the patient's fundamental rights, the use of restrictions may be possible in an emergency or as self-protection, the provisions on which are laid down in the Criminal Code. Restrictions must be necessary to achieve an acceptable outcome and also otherwise in compliance with the proportionality requirement. This means that restricting a fundamental right can be allowed only if an acceptable outcome cannot be achieved by means that affect the fundamental right less. The justifications for restricting and the possibility to act otherwise must be assessed separately every time that restricting in carried out. From the point of view of monitoring the use of restrictive measures and the legal protection of the parties involved, it is important that the entries concerning the measures are made carefully.

According to the Deputy-Ombudsman, the patient's freedom of movement and right to self-determination had been restricted several times. In some situations, the restraining measures had been used more extensively than enabled by the decision on restrictive measures. Although an emergency may justify the use of a restrictive measure in an urgent situation, situations were revealed in which the patient had been restricted but which could not be justified with an emergency. In addition, rush or a lack of staff cannot be a reason to use a restrictive measure such as a crotch belt. Restricting should be recorded in the patient documents in a view in which it can be read as part of the medical records and from where it is also transferred to the Patient Data Repository. The justifications and the discussions with the patient and the family members must be recorded. The city's instructions were not complied with in the decision-making in all respects.

The periods of restrictive measures were longer than recommended and very severe forms of restricting movement had been used on the patient. As a rule, no entries were found for the start and end times of the restrictive measures in the patient records, nor justifications for the need for the restrictive measure. A magnetic belt had been used on several nights although the patient had been sleeping peacefully according to the records.

According to the Deputy-Ombudsman, the city had acted unlawfully in restricting the patient's right to self-determination and freedom of movement as a fundamental right. The Deputy-Ombudsman therefore proposed that the city's social welfare and healthcare services consider how it can recompense the patient for the violation of rights caused by its wrongful and unlawful actions (4180/2020*).

– In their official decision, the manager of the social welfare and healthcare services unit decided to pay the complainant EUR 700 as a compensation for the suffering caused by the restriction of their freedom of movement during their hospitalisation. In addition, the complainant was apologised for the suffering this had caused to them.

Involuntary assessment period in hospital

The elderly complainant is an independently living visually impaired person aged 89 who receives personal assistance referred to in the Act on Disability Services and Assistance. An assistant visits them once a week. They also wear an alarm wristband. The relatives help the complainant with shopping. The complainant considered that they had been hospitalised against their will between 31 July and 14 August 2020. According to the complaint, the complainant was not told the reason for the treatment or medication, nor were any decisions made on their treatment. The complainant also criticised the conditions in the hospital. After having returned home, the complainant received an invoice for more than EUR 600 for the episode of care in hospital. The complainant did not consider themselves ill or in need of medical care.

According to the information received, the complainant had on 27 July 2020 expressed their consent to an assessment period on the assessment ward in the city hospital, but was not willing to have a doctor's appointment. The doctor had therefore referred the complainant to an assessment period. According to the information, the complainant had been unwilling to leave for hospital at the beginning of the episode of care on 31 July 2020, but had been successfully persuaded to agree to the episode of care. It had been suspected that the complainant had a memory disorder, and the complainant had wanted a medical statement for applying to service housing.

The matter under consideration was challenging and the patient was not explicitly treated against their will. Instead, an effort had been made to treat the patient in agreement with them, but it had required persuasion. No decision on involuntary treatment was made for the complainant because the complainant was not in involuntary treatment referred to in the Mental Health Act, nor can such treatment be organised at a city hospital. Towards the end of the assessment period, the complainant had been in hospital against their will. On the basis of the recorded entries, the complainant had felt that they had been forced to stay in hospital without any a real opportunity to leave the hospital without assistance.

The Deputy-Ombudsman considered it positive that the complainant's comments had been recorded but, based on the entries, they had been repeatedly ignored. Despite a possible decline in cognition, a person has the right to make decisions which, in the opinion of the health care professionals, would not match the decision that is most advantageous for them in a situation. In the senior ward physician's view, discharging the complainant without the assistance they needed would have met the criteria of abandonment. During the assessment period in hospital, the complainant's need for services had been investigated as referred to in the Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons, and an effort had been made to ensure the availability of sufficient services to the complainant on discharge.

Against this background, it could be considered that, towards the end of the assessment period, the hospitalisation had been continued regardless of the person's will in order to secure adequate social services for the patient on discharge. According to the entries made in documents after discharge, the complainant had refused to let home care workers into their home and had continued to use the old assistance and support. The assessment period in hospital or its length thus did not affect the services that the complainant had been willing to accept immediately after being discharged.

According to the Deputy-Ombudsman, cooperation between social welfare and health care was not realised in the situation. It had not been in the complainant's interests to be kept in hospital against their will in order to provide services according to the complainant's wishes, the need for which had already been known to social services before the assessment period in hospital. According to the Deputy-Ombudsman, the city's wellbeing services had acted wrongly when keeping the complainant on the city hospital's assessment ward against their will towards the end of the period without statutory grounds justifying it. The reprehensibility of the actions was reduced by the fact that the staff had aimed to act in the best interest of the complainant. The examinations carried out in hospital were aimed at providing information for both the complainant's healthcare and the implementation of social services. The Deputy-Ombudsman proposed that the city's wellbeing services consider how it can recompense the complainant for the violation of rights caused by its wrongful actions (7866/2020*).

Identification of the applicant in the customer service of the Finnish Immigration Service

The official at the customer service point of the Finnish Immigration Service had made a mistake in the identification of a customer. One of the reasons leading to this was that the name and nationality of the applicant visiting the service point were the same as those of another person found in the case management system for immigration matters (UMA). Because of the mistake made by the Finnish Immigration Service, the applicant was taken to the police station where they had to stay for approximately two and a half hours.

Appropriate handling of matters involves a general duty of care, i.e. that work tasks are handled carefully and correctly. Because the mistake made had led to a violation of the customer's personal liberty guaranteed by the Constitution of Finland, the Parliamentary Ombudsman found the mistake a serious one even though it had been an unintentional lapse. The Finnish Immigration Service must look after the working methods in its customer service and the training of the personnel to ensure that such serious mistakes will not take place. In this case, the appropriateness of the processing of the matter was not implemented and, because of the mistake made by the Finnish Immigration Service, the applicant was taken to the police station after having been identified as a wrong person who had committed offences. The Ombudsman considered it obvious that what happened had caused anxiety and experiences of unfairness to the injured parties. The Ombudsman proposed that the applicant be recompensed for the violation of personal freedom and integrity caused by the mistake made by the Finnish Immigration Service (5732/2020*).

– The State Treasury compensated the applicant for the anguish caused by the violation of privacy and personal liberty to the amount of EUR 200 and for the travel expenses to the amount of EUR 200, a total of EUR 400. The State Treasury rejected the separate claim of EUR 2,000 for the violation of personal liberty and integrity for the part exceeding the EUR 200.

Protection of privacy

Sending invoices to a client with a non-disclosure for personal safety reasons

According to the complainant, after having been granted a non-disclosure for personal safety reasons in 2016, they had not received invoices for social welfare services in their new home address that was subject to the non-disclosure apart from some cases, when the due dates of the invoices had already passed. Because of the properties of the patient information system and invoicing systems of the town of Pieksämäki, it was no longer possible to check to which address the invoices had been posted before the year 2020 and whether the complainant had received the invoices in time. In June 2020, the invoicing information system had been updated so that the persons sending the invoices for social welfare services always check the address of persons with a non-disclosure for personal safety reasons before sending the invoice. In practice, the employees carrying out the invoicing request the address from the data protection officer, who verifies the up-to-date address from the Population Information System.

The complainant had been asked about the possibility to cancel the non-disclosure because the invoicing details were not visible to home care. The details of the client with the non-disclosure had not transferred from the patient information system to the ERP system of home care because no address information for the client with the non-disclosure was visible in the basic information of the patient information system.

The Deputy-Ombudsman stated that a non-disclosure for personal reasons is granted only because of a threat to health and safety and the authorities are therefore responsible for handling the address information with the required care. The Deputy-Ombudsman considered it obvious that it is not in accordance with the requirement of appropriateness of the activities of the authorities to even enquire about the possibility give up the non-disclosure for personal safety. The town must make sure that its information systems are appropriate so that the client receives the information about their invoices in time.

The town of Pieksämäki was responsible for ensuring that clients receive their invoices in the right address at the right time. However, based on the received information, it was obvious that the complainant had not been informed of all the invoices appropriately in the address subject to the non-disclosure for personal safety reasons. The Deputy-Ombudsman proposed that the complainant be recompensed for the harm caused to them by the error and the expenses that resulted from investigating the matter (4582/2020).

– According to the information provided by the town of Pieksämäki, unlike reported in its earlier reply, the number of the invoices sent to the wrong address had been determined. The error had been made in 32 invoices, of which 25 had been forwarded to enforcement. An effort had been made to determine the expenses resulting from the error together with the complainant and to determine a reasonable compensation for them. In addition, EUR 300 had been paid to the complainant for the harm and inconvenience caused by the error.

Right to sufficient social and health care services

Health station’s procedure for making an appointment

The health station of the City of Helsinki had responded to the complainant’s request for an appointment saying that at the health station, the assessment for removing a mole is made by a physician and that at the time, there were no appointments available for such assessments. The complainant had been recommended to contact the health station again later. In this kind of situation, the electronic service system of the health centre does not make it possible to place the patient in the queue.

Under the Act on the Status and Rights of Patients, the patient must be informed of the date of access to care or treatment. If that date is altered, the patient must be immediately informed of the new date and the reason for the alteration. This provision means that the patient cannot be left waiting for access to treatment for an unspecified time. When the date of access to treatment is notified, it will also be found out whether treatment for the patient may also have to be purchased from other service providers. According to the Deputy-Ombudsman, the City of Helsinki acted unlawfully because it did not inform the patient of the date of access to treatment. If it was not possible to give the exact date of access to treatment, an estimated date should have been given. As the complainant incurred expenses from a visit to a private physician because of this unlawful action, the Deputy-Ombudsman proposed that the City consider how it could recompense the complainant for the violation of their rights (6217/2020).

– According to the reply from the City of Helsinki, a letter had been sent to the complainant requesting them to provide the receipts or the corresponding documents of the visits to the private physician. The complainant did not reply to the letter. Because of the violation of the right, a decision to pay EUR 500 as compensation had been made on 20 September 2021.

A health centre physician's actions regarding vision examination

The complainant had made an appointment with physician A at the health centre. The complainant explained their concern about their declined vision and requested a referral to specialised medical care. Health centre physician A did not examine the complainant's vision or refer the complainant to an examination. Instead, the physician advised the complainant to make an appointment with a private ophthalmologist. According to the statement by the National Supervisory Authority for Welfare and Health, the complainant's symptoms met the criteria for a referral to an assessment for cataract surgery.

According to the Deputy-Ombudsman, health centre physician A acted unlawfully by not examining the complainant's vision or referring the complainant to an examination, by not drawing up a referral to specialised medical care and by advising the complainant to see a private ophthalmologist at their expenses. A's actions led to extra costs to the complainant from the visit to a private ophthalmologist. The complainant's rights to the adequate health services and the high-quality health and medical care referred to in the Act on the Status and Rights of Patients were not realised.

The Deputy-Ombudsman proposed that the South Karelia Social and Health Care District consider how it can recompense for the violation of the complainant's rights (5303/2020).

– With its decision of 21 December 2021, the South Karelia Social and Health Care District compensated the cost of EUR 167.50 for the visit to a private ophthalmologist to the complainant according to the copy of the invoice submitted to it.

Discontinuation of deep brain stimulation treatment (DBS)

Despite long-term psychiatric treatments, psychotherapeutic and other treatment and rehabilitation methods or medications, the complainant's symptoms had been difficult and significantly weakened their functional capacity and work ability. The deputy chief physician of Tampere University Hospital (TAYS) recorded an examination and treatment programme for assessing suitability to DBS treatment. In the programme, the complainant`s symptoms as a whole were taken into account. Based on the examinations carried out, a stand was also taken on the complainant's medical treatment and need for rehabilitation, and cooperation was carried out with the care team responsible for the psychiatric outpatient care of the complainant at the Psychiatric Outpatient Clinic of the City of Tampere.

After the deputy chief physician had resigned from their position, it was found out in June 2018 that the Neuropsychiatry and Geriatric Psychiatry Outpatient Clinic no longer had a physician in charge of DBS treatment and post-surgery psychiatric follow-up could therefore no longer be implemented. The deputy chief physician did not draw up the final medical opinion concerning the complainant's episode of outpatient care between 19 February and 25 July 2018 until on 13 September 2018, which is in violation of the Decree on Patient Documents. The final medical opinion was not sent to the complainant or the party responsible for their further treatment. The deputy chief physician entered the final visit of the assessment period as a visit in outpatient care and not as the final medical opinion ending the episode of care as they should have done under the Decree on Patient Documents. Because the deputy chief physician did not send a final medical opinion to the complainant, the complainant did not find out about the termination of their treatment. The party responsible for the complainant's further treatment did not receive this information, either, nor any clear and specific instructions for the implementation of the follow-up and further treatment of the complainant. Because no final medical opinion was sent to the complainant, they were still under the impression that their DBS treatment continued.

The complainant had not received the sufficient and appropriate information on the experimental nature of the DBS treatment planned for them, the grounds for the treatment, its possible adverse effects and the alternatives. Because the treatment was experimental, the complainant's right to receive information was particularly important. The complainant did not receive sufficient and appropriate information on the actual possibilities to implement DBS treatment or changes in these possibilities at the different stages of the treatment. The complainant also had the right to be informed of who was the physician in charge of the DBS treatment and the treatment decisions concerning it at any given time. In this respect, the entries in the patient documents were unclear.

The complainant did not have a right to receive treatment that under law could not be given to them. A rechargeable DBS device without a CE marking could not be used to treat an obsessive-compulsive disorder without a clinical trial on medical devices, which had to be notified to the National Supervisory Authority for Welfare and Health (Valvira) before starting the trial. It was not possible to get an exemption for the rechargeable device because the corresponding non-chargeable device has CE marking.

According to the Deputy-Ombudsman, the actions had been in violation of the Constitution. The complainant's matter was not handled appropriately, nor according to the service principle. The complainant was not informed of the termination of their DBS treatment. Therefore, for nine months, they had the false impression that their DBS treatment at TAYS still continued. The complainant's right to receive information as a patient was violated. In their replies to the complainant's objection, the director of department and the director of the area of responsibility at Pirkanmaa Hospital District had already apologised to the complainant for what had happened. The Deputy-Ombudsman proposed that the joint municipal authority for the hospital district assess how, in addition to the apologies, it can otherwise recompense the complainant for the violation of the fundamental right, the anguish caused to them and the extra costs of having had to use private health services (3744/2020).

– According to the report from Tampere University Hospital, the office of the chief medical officer had contacted the complainant and apologised for what had happened. The complainant had submitted a claim for damages to the hospital district on 26 January 2022. The hospital district will process the complainant's claim for damages and the intention is to recompense the complainant in accordance with the Parliamentary Ombudsman's guidance.

Failure to distribute medical supplies

The authorities at the City of A had come to a conclusion that the complainant would be compensated for the costs of the diapers purchased during the time their spouse had under the law been entitled to get the diapers for free but had not been given them in spite of an assessment by the doctor treating the spouse. The payment of the compensation had not been considered until the processing of the request for clarification sent by the Office of the Parliamentary Ombudsman on 19 August 2020 had begun. According to the Deputy-Ombudsman, the case should have been dealt with immediately after the City of A had received the decision of the Regional State Administrative Agency for Southern Finland dated 6 March 2018 stating that the instructions and actions of the City of A were incorrect.

According to the Deputy-Ombudsman, the right good-quality health care and medical care in accordance with the client's needs would have required providing advice, instructions and assistance at the latest when the City of A's social welfare and healthcare services had been informed in a request for clarification sent from the Office of the Parliamentary Ombudsman of the fact that no diapers had been delivered to the complainant's wife. The Deputy-Ombudsman found it particularly reprehensible that the City of A's social welfare and healthcare services had not contacted the complainant, even though the request for clarification sent from the Office of the Parliamentary Ombudsman was aimed at directing the city's officials to take appropriate action in the matter. The social welfare and healthcare services of the City of A have acted incorrectly and unlawfully. The complainant felt they had been treated unfairly and had purchased medical supplies on their own expenses for a long period of time although their spouse would have been entitled to get them for free. In addition to these extra costs, the complainant's work as an informal carer became more difficult and caused them unnecessary distress. The Deputy Ombudsman proposed that the social welfare and healthcare sector of the City of A consider how it can recompense the complainant for its incorrect and unlawful actions (3279/2020).

– In their official decision, the director of the social welfare and healthcare services decided to compensate the complainant and their spouse EUR 6,000 in recompense. According to the calculations made by the complainant, the costs of purchasing the diapers had totalled EUR 5,216. Taking into consideration the work this caused to the complainant, the recompense of EUR 6,000 was considered reasonable in the decision.

Legal protection and good governance

Processing of executive assistance concerning a child maintenance agreement

A case of executive assistance concerning the child maintenance agreement of the complainant's child was received by the City of Espoo's Family Law Services on 20 February 2020. On 21 April 2020, the complainant had called the child welfare officer, who had told them that there were queues of at least three months, but had promised to hurry things up. According to the complaint and the information provided, the other parent had been to sign the contract on 30 April 2020. On 26 May 2020, the child welfare officer had gone to check whether the agreement had been signed. Because the agreement had apparently been in the folder of unsigned documents, they had concluded that the parent had not yet been to sign it. This information had been given to the complainant when they rang the Family Law Services on 27 May 2020. The child's other parent had visited the Family Law Services again on 28 May 2020 at the request of the complainant, and the agreement was found as signed on 30 April 2020.

The Deputy-Ombudsman stated that the executive assistance task given to the City of Espoo's Family Law Services was delayed unnecessarily for a reason caused by the COVID-19 pandemic because the operating conditions of the office taking care of the signatures had not been looked after sufficiently. The executive assistance case was processed by the City of Espoo's Family Law Services at least between 20 February and 28 May 2020. It is not known exactly when the agreement found signed on 28 May 2020 was sent to the complainant's municipality of residence. In any case, the complainant's child was left without child maintenance or maintenance support because of the delay. The full child maintenance support in 2020 had been EUR 167.01 per month. The Deputy-Ombudsman therefore proposed that the City of Espoo's Family Law Services recompense the complainant because of the child maintenance they did not receive as a result of the unnecessary delay (3817/2020).

– According to the City of Espoo, the director of social welfare had on 24 September 2021 decided to pay the complainant EUR 334.02 because of the child maintenance they did not receive as a result of the delay in executive assistance.

Queueing time to child welfare officers' services

The booking of appointments to the child welfare officers at the joint municipal authority for Kymenlaakso social and health services (Kymsote) had been badly congested and the waiting time for an appointment could sometimes be up to six months. According to the Deputy-Ombudsman, parents usually need the services of a child welfare officer when families separate and issues related to the custody, housing, right of access to the children and their maintenance become topical. Agreements often need to be reviewed when there are changes in the child's or a parent's circumstances or a change becomes necessary for some other reason. Although there are no specific provisions on the organisation of the services of child welfare officers in the current legislation, the services are so essential to the realisation of the rights of children that they must be available within a reasonable time even without specific binding provisions.

The complainant had booked an appointment in early October for the conclusion of a new fixed-term child maintenance agreement. The previous agreement ended at the end of 2020 and in terms of the family's finances, it was important to confirm the new agreement. The delay in confirming the new agreement had a direct effect on the family's financial position because the confirmed child maintenance agreement required for the payment of Kela's maintenance support expired and the new one could not be confirmed.

According to the Deputy-Ombudsman, Kymsote had acted unlawfully when it neglected the provision of the services of child welfare officers in a manner that meets the rights and needs of children and families with children. For this reason, the complainant had suffered an obvious material damage. The Deputy-Ombudsman proposed that Kymsote should consider how it could recompense the complainant for the loss and inconvenience caused by the violation of their rights (602/2021).

– Kymsote informed the Ombudsman that, as a recompense, it had apologised by letter to the complainant for the long waiting time. However, the parents had since then been able to make arrangements so that no breaks had arisen. Kymsote also reported on the improvements in making an appointment to a child welfare officer and in other arrangements as well as on increases in the resources which had significantly improved the situation.

Cash available paid to a child in substitute care

When a child or a young person has been placed outside the home as a measure supporting open care or in accordance with the provisions on substitute care or after-care, the municipality must ensure that their studies and hobbies are supported financially, if necessary. In addition to the financial support, the child or young person must be given cash every calendar month for their personal needs depending on their age and growth environment.

Based on the report the Deputy-Ombudsman's substitute received from the joint municipal authority for Kymenlaakso social and health services (Kymsote), it could be concluded that all children placed outside the home were paid EUR 500 per year as a clothing allowance. The report also revealed that this money could be used for other purposes, as well. Apparently, the clothing allowance paid to the children as described above had ultimately been part of the contractual compensation paid to the service provider by the municipality placing the child. In the information submitted by Kymsote, it was stated only that the complainant had been paid clothing money to the amount of EUR 649.50 during their placement.

According to the Deputy Ombudsman's substitute, Kymsote should recompense the complainant for the cash they had not received and also determine what action should be taken with regard to the clothing allowance belonging to but possibly not received by the complainant (2742/2020).

– According to the information submitted by Kymsote, the complainant had received all the cash they were entitled to during the time they had been placed in substitute care.

Actions of the Tax Administration in imposing advance tax

The complainant was a guardian. The complainant's client owned a property together with two other persons. On 4 March 2020, the client and another partial owner sold their shares of the property to the third owner. After the sale, this person owned the property alone. The Tax Administration imposed advance tax to the guardian's client on the sale of the property.

According to the calculation in the request for clarification sent to the complainant by the Tax Administration, the amount of the capital gains was slightly over EUR 3,000. After that, the Tax Administration issued a decision in which the amount of the capital gains was slightly over EUR 13,000. In the latest decision by the Tax Administration, the capital gains amount was slightly over EUR 9,000. The last two decisions did not include a calculation of the grounds for calculating the capital gains and the complainant had therefore not been appropriately heard with regard to them, either. Despite the numerous written demands the complainant had sent to the Tax Administration contesting the Tax Administration's calculations and decisions on the advance tax and demanding removal of the tax, and despite the complainant's several phone calls in which they repeated the demands, the complainant was not issued an appealable decision and given an appropriate account of the grounds for calculating the capital gains. The information provided by the Tax Administration does not reveal why and on what grounds the accounts and demands sent by the complainant were not processed and why no answers to them were given to the complainant.

The grounds for calculating the capital gains and the amount were explained to the complainant incorrectly and deficiently and they did not receive appropriate guidance and advice. According to the information obtained from the taxation unit, the method for calculating the capital gains had been discussed with the complainant over the telephone several times and the hearing for determining the advance tax had been conducted over the telephone. However, the complainant had presented new written demands and had contacted Tax Administration by phone again. In spite of this, the complainant was not given appropriate guidance or an appealable decision for which they could have applied for a revised decision and request a prohibition of the implementation of the imposed tax.

Only after the complainant had submitted a complaint to the Parliamentary Ombudsman did the Tax Administration send a calculation of the grounds for calculating the capital gains to the complainant and issued an appealable decision.

According to the Deputy-Ombudsman, the grounds for calculating the capital gains and the amount were explained to the complainant incorrectly and deficiently and the complainant did not receive appropriate guidance and advice. The actions of the Tax Administration in determining the advance tax did not meet the legal protection guaranteed in the Constitution of Finland nor the requirements for good governance. According to the Deputy-Ombudsman, a clear error and a violation of the complainant's fundamental rights had taken place. The Deputy-Ombudsman therefore proposed that the Tax Administration should somehow recompense the complainant for the harm, inconvenience and concern caused by its unlawful actions (6936/2020).

Processing of a driving ban

The delay in processing a case concerning a fine had been caused by an error in the processing of the fine at the police department. The error that caused the delay had occurred when no entry had been made in the police system on the provision of notification of the order for a fine, for which reason the order did not proceed to the prosecutor to be reviewed for issuing the summary penal order. Based on the material available, the complainant had been subject to a temporary driving ban for about nine months. When the penal order that was the precondition for resolving the driving ban had been issued, the driving ban was considered to be fully completed because of the length of the temporary driving ban.

According to the National Police Board's instructions for the processing of a crime-based driving ban, the normal driving ban for driving while intoxicated would normally be approximately 5 months for a first-timer. In this case, the total length of the driving ban was therefore clearly longer than the flexibility in the instructions. According to the Parliamentary Ombudsman, the complainant had actually been subject to a driving ban for an unduly long time because of a delay in processing the fine. Based on the instructions issued by the National Police Board, the driving ban had been approximately 3–5 months too long. The complainant says they had "lost jobs" because of the delay.

The Parliamentary Ombudsman is of the view that the requirement of effective implementation of fundamental and human rights in this case necessitated that the complainant be entitled to appropriate recompense for the harm incurred from negligence of diligence. The Parliamentary Ombudsman sent its decision to the State Treasury and asked it to contact the complainant in an appropriate way and settle the matter on the basis of the Act on State Indemnity Operations (3814/2020).

– The State Treasury reported that it had paid the complainant EUR 350 because the complainant's driving ban had become clearly longer than would have been required by the instructions of the National Police Board.

Neglecting after-care in child welfare

Under the Child Welfare Act, those children and young people aged 18 or over who have been taken into care and been in substitute care are entitled to after-care after their placement into care has ended. The same applies to children who have been placed as a measure supporting open care for at least six months. The municipality placing the child has the obligation to provide after-care for five years from the end of the client relationship in child welfare after substitute care, however, at most until the young person turns 25. The complainant's right to after-care will continue until 2025, which is when they turn 25.

The after-care in child welfare must ensure that the child or young person also receives the services they need from other authorities and parties. According to the Deputy-Ombudsman, the pregnancy and parenthood of a young person in after-care must be seen from this point of view, as well. The task of after-care is thus to ensure that an expectant young person in after-care also receives all the services, allowances and benefits related to pregnancy and parenthood. The object of the support given in after-care is thus above all the young parent receiving after-care, not the child due or already born to them. Special support of their own must naturally be organised to the child in addition to the normal services where necessary. Therefore, the pregnancy and parenthood of a child or young person in after-care cannot under any circumstances be even partly a justification for ending the child's need for after-care. On the contrary, it must mean a particularly active phase in the young person's after-care.

The complainant's social worker had apparently not considered the complainant's pregnancy a matter that would be significant in terms of after-care. According to the complainant, the social worker had proposed cancelling the after-care agreement. The grounds for it were that the complainant did not need after-care. According to the Deputy-Ombudsman, the joint municipal authority had neglected the support measures the young person had been entitled to and, alongside other things, the need to provide the young person with information they had a right to receive. The Deputy-Ombudsman proposed that the joint municipal authority should consider how it could recompense the young person for the financial losses and violations of rights that had occurred (2723/2020).

– According to its report, the joint municipal authority had apologised to the complainant for the bad treatment received and experienced by them. In addition, it had been agreed that the remaining study loan amounting to approximately EUR 3,000 would be paid in recompense.

Unfounded payment default entry as a result of the actions of the enforcement agency

A prohibition on payments had been issued to two different companies that were the complainant's employers. The complainant's employment relationship with both companies had ended during the time that the complainant was a client of enforcement. One of these companies had not made any payments to enforcement during the more than nine months that the enforcement had been in force. The other company in turn had made the payments until May, after which the payments from the employer in question had ended. After this, the prohibition on payments had been in force for more than four months without any payments being made.

According to the Deputy-Ombudsman, the requirement for appropriateness laid down in the Enforcement Code should have been taken into account and the bailiffs should have contacted the recipients of the prohibitions on payment so that the correct status of the employment relationships would have been found out. When the bailiffs responsible for the complainant's matters changed, the status of the complainant's employment relationships should have been determined at least through the monitoring of the prohibition of payment. In this case, the prohibitions on payment had both been valid for approximately four months during the new bailiffs responsible for the complainant's matter without any payments having been made to enforcement. The fact that the bailiff responsible for the complainant changed had possibly affected the monitoring of the prohibition on payment issued for the other company as no action had been taken to follow up the request for clarification the previous bailiff had sent to the employing company. The shortcoming in monitoring the prohibition on payment had in this case led to the prohibition being valid unnecessarily for a considerably long time. The prohibition on payment issued for the company had also affected the credit reference entries for long-term enforcement.

In addition to monitoring the prohibitions on payment, the case concerned the enforcement agency's actions with regard to information on the termination of the complainant's employment relationships.

The enforcement agency had not contested the complainant's statement that the complainant had informed the agency of the termination of their employment relationship with one of the companies concerned or that the agency had been aware of the termination of the complainant's employment relationship with one of these companies. According to the Deputy-Ombudsman, appropriate handling of the matter required the enforcement agency to verify the status of the debtor's employment relationship without delay if it received information on the termination of the debtor's employment relationship. For example, this had been the case when the debtor informed the enforcement agency of the termination of their employment relationship. The reason for why this had not been done after the complainant's notification had not been determined.

The Deputy-Ombudsman proposed that the Office of the Director General of the National Enforcement Authority of Finland consider how it could recompense the complainant for the damage caused by the actions of the enforcement agency (978/2020).

– According to the information obtained from the Office of the Director General of the National Enforcement Authority of Finland, based on the equity principle and because of the mistake made in enforcement, the Office considers it right to pay the complainant two hundred (200) euros in recompense for the costs of managing the matter. According to the Office, there were no grounds for paying a higher compensation. The complainant's demand for recompense to the amount of EUR 5,000 and EUR 300 for the costs of phone calls, photocopies and other expenses including the appropriate interests for late payments was rejected in excess of this.

3.7.3 CASES RESULTING IN AN AMICABLE SETTLEMENT

In numerous cases, communications from the Office of the Parliamentary Ombudsman during the processing of the complaint to authorities often led to the rectification of errors or insufficient actions and therefore contributed to reaching an amicable settlement. The Parliamentary Ombudsman may also make proposals to authorities for the amicable settlement of a matter. The following describes certain examples of such cases.

Monitoring the completion of compulsory education

The complainant's child was a pupil who had completed basic education in special education and was in grade 10 of voluntary additional basic education. The education had begun on 19 August 2021. On 31 August 2021, the teacher had informed the guardian that the child did not attend school. On 2 September 2021, the school had contacted the guardian again to inform them that the child was not at school. At the time, the child had told the guardian that they would not go to school. According to the information received by the guardian, the child had participated in the studies during the autumn term on perhaps two days. A meeting with the guardian and the representatives of the school had been organised about the matter at the institute in September. For example, they had talked about what studies the child could transfer to and agreed that the child could visit the psychologist of the educational institution. The guardian was not aware of whether this had happened. On 1 November 2021, the guardian had sent a message to the guidance counsellor to enquire what had happened in the matter. They had not received a reply by 11 November 2021.

Because of the complaint, the referendary of the matter contacted the guidance counsellor of the institute on 15 November 2021. The discussion revealed that the predecessor of the guidance counsellor had taken leave of absence and the matters had been transferred to the new guidance counsellor with some delay. Having heard about the child's situation, the guidance counsellor promised to investigate it and contact the complainant without delay.

The referendary of the matter said they would next call the complainant about the matter and, if the complainant agreed to it, they would propose an amicable solution in which the educational institution would continue the supervision of the child's completion of their compulsory education in cooperation with the child and the complainant, and a decision ending the processing of the case would be issued on the complaint. The complainant accepted the proposed procedure.

Under the Parliamentary Ombudsman Act, the Ombudsman can in a case within their oversight of legality recommend to a competent authority that they correct an error or rectify a shortcoming. Under this provision, the Parliamentary Ombudsman may also submit a proposal for an amicable settlement of the matter to the authority. Based on a preliminary report received by telephone and the complainant's consent, the Deputy-Ombudsman's substitute proposed, without taking any further measures in this context, that the institute investigate the attendance, the completion of studies and the support measures of the person subject to compulsory education, and work together with the guardian to ensure the supervision of the pupil's compulsory education without delay. The proposal for settlement does not prevent the complainant from renewing their complaint if a reason for this arises later.

The Deputy-Ombudsman informed the institute of the amicable solution they had proposed. At the same time, they informed the institute of the legal instructions concerning the supervision of compulsory education, which were compiled for the reply (7783/2021).

Intervention in bullying at school

The child sent a letter to the Parliamentary Ombudsman telling the Ombudsman about bullying in a secondary school in the city. According to the child, they and their siblings had already been bullied at school for several years. According to the letter, the school had tried to put an end to the bullying but had not succeeded because the headteacher had turned their back to the situation.

The child's letter did not reveal when and how the bullying had taken place or how the school had investigated the matter. It was therefore difficult to start to investigate the matter on the basis of the letter. According to the Deputy-Ombudsman, the matter should primarily be further investigated by the school and the city. The referendary therefore contacted the headteacher in charge of education in the city. It was agreed with them that the child may call the telephone numbers of the deputy head or the director of education, stated in the reply, to get help for resolving the situation. The city's headteacher in charge considered it very important that all schools in the city intervene sufficiently in bullying.

At least not at this stage, the matter did not result in any other measures to be taken by the Deputy-Ombudsman. According to the reply, if the bullying continues, the child can write to the Parliamentary Ombudsman again and explain in more detail what has happened. In the end, the Deputy-Ombudsman also emphasised that, under the Basic Education Act, a pupil participating in education is entitled to a safe learning environment. The provision obliges the school to make sure that, among other things, pupils are not subjected to violence or other bullying at school or in other activities of the school. In practice, the provision requires teachers and the headteacher to take the required measures in their power to investigate and rectify the situation (6117/2021).

The actions of a headteacher

The complainant expressed their concern about how the matters of their child will be managed at school in future. They also told about a lack of trust in the school's headteacher. Having familiarised themselves with the case the Deputy-Ombudsman considered that the case concerned events and actions that would be justified to primarily investigate in the internal administration of the authority.

Because of the letter, the referendary of the matter called the head of basic education of the city's service area of growth and learning. The heads of basic education are supervisors of the headteachers of the schools in the city. According to the head of basic education, they had the capacity to investigate the matter in the manner that could be agreed with the complainant, for example, under their leadership. If they wished, the complainant could turn directly to the head of basic education by phone or by email. In this context, the complainant could present the aspects that they informed the Parliamentary Ombudsman of, and discuss, present their views and obtain a clarification in the matter in cooperation with the city's basic education.

At this stage, the matter was not investigated as a complaint. However, the complainant can write to the Parliamentary Ombudsman again if they consider that there is still reason to do so. A copy of the reply given to the complainant was sent to the basic education services in the city's service area of growth and learning (1740/2021).

Bingel services to schoolchildren

According to the complainant, there had been obstacles in the use of the Bingel service during the autumn term. The complainant wanted to make sure that the service would be available to their children during the spring term. According to the Deputy-Ombudsman, the Parliamentary Ombudsman does not under the law have the rights to investigate the actions of private companies, such as the actions of SanomaPro Oy criticised by the complainant. However, the Ombudsman may assess whether the education provider, the city, has appropriately made an effort to investigate the situation if using the Bingel service is an essential part of the teaching material used by schools.

When asked about this, the head of information management of the city's service area of growth and learning had explained that a non-disclosure for personal safety should not be an obstacle to using the Bingel service as the pupil can be individualised on the basis of the series of numbers separately created for them. According to what the complainant wrote, the school and the IT support had already tried to clarify the matter. The head of information management stated that they would still personally ensure that the material used in teaching is equally available to everyone. According to the Deputy-Ombudsman, because the city had tried to clarify the matter, at least at this stage, it will not be investigated further (8308/2020).

The actions of the police

The complainant told that their former tenant had threatened to kill them. The threats had been mad over the telephone and in text messages. The superintendent had taken the decision that there was not a reason to suspect an offence and a pre-trial investigation would therefore not be conducted. In their request for clarification, the Parliamentary Ombudsman asked the police department to take a stand on the superintendent's decision that the injured party did not have a justified reason to fear for their personal safety as the threat had not been made face to face. According to the request for clarification, if the police department considered that there was reason to take some kind of measures, they should avoid any delay and take those measures immediately, without waiting for the decision on the complaint.

The complainant informed the Ombudsman in a letter that they were cancelling their complaint addressed to the Ombudsman because the police had already started a pre-trial investigation. For this reason, the processing of the complaint at the Office of the Parliamentary Ombudsman could be terminated (8491/2020).

Storage of cars confiscated by the police

According to the complainant, the Central Finland Police Department keeps the vehicles confiscated by it on a public road without paying the parking fee. According to a preliminary report obtained from the police department, the vehicle identified in the complaint had not been confiscated. The vehicle had been object to a search of premises by the police, after which the vehicle had most obviously been moved to the street to wait for actions by the owner. According to the preliminary report, the practices related to the storage of vehicles had been questioned in the complaint, apparently for the first time. The police department reported it would investigate the matter in cooperation with the City of Tampere and give additional instructions in the matter if necessary.

The Parliamentary Ombudsman considered that, based on the available material, the procedure was not one in which there was reason for the Ombudsman to intervene any further, at least for the time being. The Parliamentary Ombudsman requested that the Central Finland Police Department inform them what concrete measures it has taken with regard to the matter (3859/2021).

– According to information obtained from the Central Finland Police Department, the vehicles that had been taken into possession or confiscated by the police department had been moved to Sorrinkatu in Tampere to wait for their owners to come and pick them up. The City of Tampere is changing the parking arrangements on Sorrinkatu and it is likely that parking spaces will be reserved for the police to be used when a vehicle that has been in the possession of the police department is handed over to the owner. The police department notified that it will need three parking spaces. Extensive roadwork is currently under way on Sorrinkatu and the new parking practices will probably be introduced when the roadwork is completed.

Processing of an application for a disability service

The complainant was dissatisfied with the city's decision-making regarding the granting of additional hours of personal assistance. The complainant had received a message from the social worker, according to which the decision on the additional hours the complainant had applied for would be negative because their need for assistance had recently been reassessed. The complainant was of the opinion that their legal protection was not implemented.

The referendary of the matter discussed the situation with the complainant's social worker by telephone. According to the received information, the complainant had applied for additional hours for the needs of the following few days. According to the report, it had not been possible to make the decision with such a fast timetable. The complainant had therefore been advised to discuss the organisation of the hours of assistance with the service provider producing the personal assistance. The social worker estimated that an official decision eligible for a claim for a revised decision would be made in approximately one week's time, after which the decision would be posted to the complainant.

According to the Parliamentary Ombudsman, there was not reason to suspect the authority's unlawful actions in light of the received information. If the complainant does not receive an official decision within a reasonable time, they can turn to the Parliamentary Ombudsman again (681/2021).

Next-of-kin as a personal assistant

The complainant was dissatisfied with the Espoo Disability Services having interpreted that the complainant had cancelled their application in which they demanded that a family member act as their personal assistant. The referendary of the complaint had contacted Espoo Disability Services. According to the information received, the manager of Espoo Disability Services had instructed social work to re-initiate the complainant's application. The complainant will receive a decision that is eligible for a claim for a revised decision.

According to the Parliamentary Ombudsman, what the complainant had written did not require further measures within the Ombudsman's oversight of legality regarding the application at this stage. If the complainant does not receive a decision eligible for a claim for a revised decision within the time required time (without undue delay and in three months at the latest) from the city's disability services (763/2021).

Personal data in the minutes of the environmental committee

Termination of a public-service employment relationship was discussed in section 68 of the meeting of the municipality's environmental committee on 7 October 2020. In accordance with the legal instructions in the Local Government Act, the meeting agendas and minutes of municipal bodies must be published in a public information network, unless otherwise provided on their secrecy. The Deputy-Ombudsman's substitute stated that section 68 of the minutes of the environmental committee on 7 October 2020 do not reveal confidential information referred to in provisions on secrecy. However, the minutes contained personal data concerning the complainant. Under the Local Government Act, only the personal data necessary for the provision of information is published in the minutes of meetings and it has to be deleted from the public information network at the end of the period for claims for a revised decision and for appeals.

According to the Deputy-Ombudsman's substitute, no reason to suspect publication of secret information in the public information network was revealed, nor did they have any reason to suspect that the published personal data was not essential personal data for obtaining information. In this respect, there was no reason to suspect any unlawful actions or negligence of obligations that would require the Deputy-Ombudsman´s substitute to take action.

However, the Deputy-Ombudsman's substitute stated that, because the complainant's personal data in the minutes does not seem to have been deleted from the public information network by the end of the period for claims for a revised decision and for appeals, the Deputy-Ombudsman´s substitute informed the municipality of their decision and so that it could be taken into account in the manner required by the Local Government Act. The Deputy-Ombudsman's substitute requested that the municipality report on the measures that have been taken in the matter (1810/2021).

– On the same day, the municipality announced that, as a result of a decision by the Deputy-Ombudsman´s substitute, section 68 of the minutes of the environmental committee on 7 October 2020 containing the personal data had been removed from the publication and was thus no longer available for viewing on the public information network.

3.8
Special theme in 2021: Sufficient resources for authorities to ensure fundamental rights

3.8.1
OVERVIEW OF THE ANNUAL THEME

For the second year, as planned, the annual theme of the Office of the Parliamentary Ombudsman was "sufficient resources for authorities to ensure fundamental rights". Perspectives related to the annual theme were emphasised in the processing of complaints and when considering the office's own initiatives as well as in audits, which remained relatively few due to the pandemic.

The annual theme is related to several constitutional rights. The Constitution safeguards everyone's right to have their case dealt with appropriately and without undue delay by a legally competent court of law or other authority, as well as to have a decision pertaining to their rights or obligations reviewed by a court of law or other independent organ for the administration of justice (section 21). Further, according to the Constitution, public authorities must safeguard the observance of fundamental rights and human rights (section 22), and the use of public powers must be based on an Act (section 2).

The Ombudsman's task is not to monitor the sufficiency of the authorities' resources. However, if a lack of resources leads to a failure to observe fundamental rights, for example by making it more difficult, delayed, or even impossible to fulfil the statutory obligations imposed on the authority, the oversight of legality cannot ignore issues related to resourcing.

The perspectives and focuses related to the annual theme were highlighted especially in the handling of complaints concerning delays. The traditional legal praxis of the oversight of legality considers that an authority cannot ignore its statutory obligations due to a congestion, lack of resources or, for example, problems related to the organisation of work. In general, a lack of resources has not been considered an acceptable reason for delays. Instead, it has been stated that the authorities must ensure that processing times are kept reasonable through effective supervision, the organisation of work and the development of operating methods, and by other means at their disposal that improve the workflow. In recent years, however, it has been observed that these methods are not always sufficient, as the problem might rather be the lack of balance between the requirements that legislation lays down for authorities' activities and the resources allocated to them.

From the perspective of oversight of legality, it is essential that the resources provided to the authority correspond to the order the legislator has made for the authority's activities. The oversight of legality that is centred on the annual theme focuses on the assessment of whether the authority can implement the requirements imposed on it that relate to safeguarding fundamental rights in practise, at least under normal conditions. If the requirements laid down in legislation are excessive in relation to the resources available to the authorities and the realistic opportunities for action, instead of reprimanding and blaming the actors, efforts should be made to find the level of responsibility that is equivalent to the resourcing and ensuring appropriate opportunities for action.

In a situation where a statutory order cannot be fulfilled within the limits of the resources provided, it is necessary to either increase the resources or reduce the order by amending the law. For example, the procedural requirements related to criminal proceedings in a fair trial have become significantly more stringent in the recent decades. As the characteristics of a fair trial include not only procedural requirements but also the expeditiousness of the proceedings, it has not been possible to implement all the requirements simultaneously due to lacking resources.

The resources available have not corresponded to the order, so the legislator has been forced to regulate concessions and shortcuts to laws, such as a written criminal procedure in the district court, a continued consideration permit system in courts of appeal, the introduction of plea bargaining, and the extension of the administrative fine procedure.

Under unpredictable and exceptional circumstances, it may be inevitable that an authoritative sector is unable to operate within the framework of the resources allocated to it and answer to the exceptional increase in demand for the services it provides. In pandemic conditions, particular concern has been expressed about the capacity of medical care and especially intensive care. Under exceptional circumstances, the administrative resources of infectious disease physicians have proved inadequate at times and, for example, there was not enough time to make the isolation and quarantine decisions required by the Communicable Diseases Act at the end of the operating year. Basically, the annual theme is not related to exceptional circumstances. Above all, it is related to normal legislative projects that have failed to assess the impact of resources and the resource shortcomings detected after regulations have become effective and for which adequate corrective measures have not been taken. During the pandemic, however, it has been noted that when the requirements set for healthcare have been tuned to the limits of the available resources already under normal conditions, even minor unexpected additional strain will hinder and slow down the system for a long time.

Sufficient human resources for authority activities are of primary importance in the protection of fundamental rights. If the human resources are limited from the start, for example unexpected sick leaves will have a significant impact on the smooth functioning of the authority activities. Problems related to the availability of skilled personnel are also very relevant in many administrative branches.

3.8.2
LONG PROCESSING TIMES AND OTHER OBSERVATIONS RELATED TO THE ANNUAL THEME

The continuous delays at the Office of the Data Protection Ombudsman and the Consumer Disputes Board based on observations made during and before the year under review constitute a situation in which insufficient resources allocated to authorities endanger the implementation of fundamental rights.

As a result of the EU's General Data Protection Regulation (GDPR) that entered into force on 25 May 2018, the number of cases handled by the Office of the Data Protection Ombudsman has increased considerably, which was not fully predicted. Under the new legislation, decision making requires considerably more human resources than previous steering. The processing times of the Office of the Data Protection Ombudsman have been too long, and the registry has been very congested. It has been impossible to handle matters as required by the Constitution and the Administrative Procedure Act.

In its decision on 27 December 2021 (OKV/123/70/2020), the Deputy Chancellor of Justice requested that the Ministry of Justice notify them by 31 May 2022 of how the resources of the Office of the Data Protection Ombudsman will be ensured to guarantee the lawful processing of matters.

There were several complaints concerning long processing times at the Consumer Disputes Board. This is a long-term problem to which the Parliamentary Ombudsman, the Deputy-Ombudsman and the Deputy Chancellor of Justice have drawn attention several times. The main reasons for the long processing times are the resources that are insufficient for the Board's workload and procedure.

According to section 17 a of the Act on the Consumer Disputes Board, the Board must issue its recommendation with justifications in writing no later than 90 days after all the material necessary for resolving the matter has become available to the Board. In highly complex disputes, the Board may, at its discretion, extend the period of 90 days.

This deadline comes from the directive 2013/11/EU of the European Parliament and of the Council on alternative dispute resolution for consumer disputes (ADR Directive). The Board is unable to comply with this deadline.

In recent years, both the Parliamentary Ombudsman and the Deputy Chancellor of Justice have brought their views on the inadequate resourcing of the Consumer Disputes Board to the attention of the Ministry of Justice, and they have asked for announcements of measures that bring the Board's processing times to the level laid down in legislation. The Ministry of Justice has prepared an action plan containing development proposals for solving the problem. In the 2020–2023 performance agreement negotiations between the Ministry of Justice and the Consumer Disputes Board, they agreed on targets that will be monitored biannually. The situation may partially have been eased by the fact that the Consumer Disputes Board only received 5,694 new requests for solutions in 2021. The corresponding figure was 6,872 in the previous year, and in 2019, there were 6,944 requests for decisions.

The Deputy-Ombudsman will conduct an inspection visit to the Consumer Disputes Board in 2022.

There have also been frequent complaints about delays in matters processed by THE DIGITAL AND POPULATION DATA SERVICES AGENCY. The delays were mainly due the scarcity of resources allocated to the Agency's various tasks. The Deputy-Ombudsman criticised the Agency's proceedings, particularly in the delay of issuing reports on family relationships and extracts from the civil register (see section 5.27.2).

In a number of decisions, the Deputy-Ombudsman stated that the long processing times in THE TAX ADMINISTRATION in claims for a revised decision concerning income taxation of individual-customers still did not fulfil the constitutional right to have your matters dealt appropriately and without undue delay. This is a question of deficient resources and resource allocation in accordance with the annual theme (see section 5.20.3).

In several consecutive years, the Parliamentary Ombudsman's reports have paid attention to structural problems in CHILD WELFARE as one of the shortcomings in the implementation of fundamental and human rights. In connection to this, they have also repeatedly paid attention to shortcomings in municipalities' resources for child welfare and the supervision of substitute care in child welfare. In 2021, the parliamentary Audit Committee (TrVL 1/2021 vp) and the Constitutional Law Committee (PeVM 16/2021 vp), which also took into account the Social Affairs and Health Committee's statement on the matter (StVL 8/2020 vp), drew attention to shortcomings in child welfare resources when discussing the Parliamentary Ombudsman's 2019 report. On the basis of the report, the committees highlighted the shortcomings in the resources for the supervision of substitute care and the general lack of resources for child welfare in municipalities, and especially the high turnover of social workers and the difficulties in the availability of qualified social workers.

The scrutiny related to COURTS of appeal that was initiated by the Deputy-Ombudsman on its own initiative (2472/2020) on whether the insufficient resources or other structural matters have contributed to delays in handing out judgments in the courts of appeal that exceed the 30-day deadline referred to in Chapter 24, section 17, subsection 2 of the Code of Judicial Procedure was still pending at the end of the operative year, as was the scrutiny on administrative courts (8164/2020) and the extent to which the deadline the legislator has appointed for processing matters of certain topics urgently was realised in practise. According to a report the National Courts Administration issued on 14 May 2021 concerning the above-mentioned administrative courts matter, roughly half of the cases received by the administrative courts were deemed urgent.

With regard to THE POLICE, resource issues were raised again in the handling of several complaints. Resource issues concerning the police have also been discussed in section 5.3.

The Deputy-Ombudsman's decision on the criminal investigation of the Eastern Uusimaa Police Department (5275/2020) found that one head of investigation may have as many as 1,000 cases to deal with at the same time. The situation cannot be considered satisfactory. In the Deputy-Ombudsman's view, the situation with pre-trial investigations at the Eastern Uusimaa Police Department has led to delays that already affect the legal protection of people. However, the report received by the Deputy-Ombudsman did not exclude the possibility that active supervision of work, allocation of human resources, and more accurate prioritisation of cases could not achieve better results than currently to improve the police department's general situation with investigations.

In THE CRIMINAL SANCTIONS SECTOR, the lack of human resources affected the prisoners' possibility to contact their close relatives and to manage matters related to their property.

In their report for a complaint about being unable to have a Skype meeting between the prisoner and their close relatives as referred to in the Imprisonment Act and its preliminary work, the Director of Turku Prison stated that they would also find a quantitative increase of Skype meetings highly desirable, but the prison could not arrange them with the current resources. The number of devices for Skype and human resources did not allow for more meetings. In its decision (6911/2020), the Deputy-Ombudsman stated that the human resources available to the prison had been reduced considerably. According to the report, the resources of the prison made it impossible to increase the number of Skype meetings, but the prison nevertheless carried out development work to increase them.

In its decision on Turku prison (6268/2020), the Deputy-Ombudsman drew attention to the concerning human resources situation in the prison. The two-month waiting period for visiting the reception department could be considered extremely problematic and unreasonably long. During that period, the complainant had not been given the opportunity to inspect and acquire their property transferred from another prison.

In its decision on Turku Prison (7996/2020), the Deputy-Ombudsman stated that the prison's human resources in property maintenance and supervision had been reduced, and property maintenance was outsourced to a limited liability company. Due to the scarcity of resources and problems in prioritising property maintenance tasks, it took about two weeks to replace a lamp in a cell toilet.

The Deputy-Ombudsman's decision (8240/2020) on locking the leisure facilities' toilets in the Turku Prison was also at least partly related to human resources. The Deputy-Ombudsman stated that they had no reason to doubt the restrictive effects that the limited number of personnel had on prisoners' leisure activities. The Deputy-Ombudsman considered it degrading treatment prisoners that the prisoners could not access toilets from outdoors or during leisure activities when needed.

The human resources of Pyhäselkä Prison were not sufficient for organising all of the evening activities they used to organise before making the changes related to security. The Deputy-Ombudsman had no reason to suspect the prison director's report about how the prison's human resources no longer allowed keeping the cells open in the evenings for as long as before under the new circumstances. In its solution (6885/2020), the Deputy-Ombudsman found it problematic that the lack of resources clearly weakens the prison's ability to organise evening activities for prisoners.

In its decision on Pyhäselkä Prison (1419/2021), the Deputy-Ombudsman stated that it is not the duty of the overseer of legality to supervise the adequacy of the authorities' resources. However, the question of resources will concern the oversight of legality if the situation leads to a failure to implement fundamental rights. The Deputy-Ombudsman found it problematic that the lack of resources affects the prison's ability to organise physical activity for prisoners and thus also the number of activities organised outside their prison cells.

In general, the Deputy-Ombudsman found it very concerning that the oversight of legality repeatedly revealed clear indications of significant weakness and downright inadequacy of the resources for the criminal sanctions sector that they need to implement legal rights.

However, in all complaint cases, the authorities' explanations of insufficient resources were not accepted as elements that remove or reduce the weight of criticism on the authorities themselves.

In its decision (2490/2021), the Parliamentary Ombudsman considered that the individual SOCIAL WELFARE matters mentioned in a letter of complaint had not been handled without undue delay as required by the Social Welfare Act and the Administrative Procedure Act. In this case, the lack of personnel did not justify delays in the processing of service applications or other matters. The municipality had not presented acceptable reasons for the delays of processing matters related to social welfare and disability services. Repeated delays in the processing of social welfare matters may have jeopardised the safeguarding of necessary care and adequate services for social welfare clients (such as people with disabilities). For this reason, the Ombudsman found the procedure of the municipal social services highly reprehensible. The Parliamentary Ombudsman also considered that a social worker had acted in violation of the Administrative Procedure Act because the complainant's attempts to contact had not been answered in accordance with the requirements of good administration. With regard to the resources of municipal social services and social work, the Parliamentary Ombudsman emphasised that, under the Constitution, public authorities are obliged to implement fundamental and human rights. This means that the authorities must allocate resources to their statutory tasks by increasing or allocating human resources, if necessary, so that they can cope with their statutory tasks. As a measure, the Parliamentary Ombudsman reprimanded a municipality's social services for unlawful delays in decision making and repeated negligence in responding to attempts to contact.

In its solution (488/2021), the Parliamentary Ombudsman emphasised that inadequate resources were not a valid reason for not offering a client a service in the language of their choice. In its statement, the city considered that it had arranged the child's special care in the best possible way despite having inadequate resources. In the Parliamentary Ombudsman's opinion, it could be concluded from the context that the lack of resources specifically concerned the organisation of services in Swedish and that the service could have been arranged for a Finnish-speaking child.

The Deputy-Ombudsman issued a reprimand to the Joint Authority for Health Care and Social Services in Kymenlaakso (Kymsote), which had acted unlawfully in neglecting the proper organisation of child welfare services (602/2021 and 6380/2020). Schedules of child welfare officers were so busy that the client should have made the appointment as early as the beginning of August 2020 to be able to confirm the support agreement before the beginning of 2021. The Deputy-Ombudsman requested that the joint authority notify the Ombudsman of the actions it has taken in the matter by 28 February 2022.

In its decision on the Helsinki Court of Appeal (1952/2020), the Deputy-Ombudsman stated that the decision of the court of appeal in a case concerning an attempted rape should have been issued within 30 days of the main hearing on 12 March 2019, but it was only issued on 20 January 2020. According to the report, the workload of the member responsible for the preparation was the main reason for the delay in issuing the judgment.

With regard to HEALTHCARE, resource issues were raised again in the handling of several complaints.

The Deputy-Ombudsman considered it the duty of HUS to ensure that the assistive equipment services has the resources to carry out its statutory task, that is, to provide assistive equipment for medical rehabilitation. Resources must be allocated not only to vital assistive equipment referred to in the common criteria for non-urgent care of 2019, but also to other necessary assistive equipment for medical rehabilitation (3129/2020).

Once again, the Deputy-Ombudsman drew attention to the inadequate resources of research and treatment of gender change at HYKS and TAYS, where its research and treatment are centralised at in Finland. The lack of resources has led to unreasonably long waiting times, which seriously jeopardises patients' rights. The Deputy-Ombudsman's decision 2119/2020 is discussed in section 5.11.

As isolation and quarantine decisions under the Communicable Diseases Act significantly restrict the freedom of the individual, the cities of Vantaa and Oulu should have allocated sufficient resources for devising and mailing the decisions so that they could have notified the parties concerned without delay. The Deputy-Ombudsman's decisions 3535/2020 and 8324/2020 are discussed in section 4.2.8.

3.8.3 AUDIT OBSERVATIONS RELATED TO RESOURCES

Remote inspections of garrisons revealed some resource shortcomings related to the healthcare of conscripts (8002/2021 and 8003/2021).

As a result of the inspection on the Health Care Services for Prisoners (1185/2021), the Deputy-Ombudsman emphasised the responsibility of their operative management and management of operations in the organisation of activities and the sufficiency of resources. The Deputy-Ombudsman considered it unacceptable that prisoners might not receive the health and medical care they need due to the lack of security resources. The Deputy-Ombudsman also expressed concern about the adequacy of the resources of somatic medical care for female prisoners and the appropriateness of the facilities available.

A number of resource issues were revealed during an inspection of a psychiatric hospital for prisoners (6762/2021). The Deputy-Ombudsman will comment on the impact healthcare resources have on patient safety in the final report after receiving the views of the Health Care Services for Prisoners and the Psychiatric Prison Hospital on the matter.

In connection with the audit of customer guidance for older people in the City of Hämeenlinna (3143/2021), the Deputy-Ombudsman made a general note that the lack of resources cannot justify violations of rights in authoritative activities, such as delays or negligence. In addition to the correct allocation of human resources, attention should also be paid to matters related to personnel availability, stability and wellbeing at work.

3.9 Statements on fundamental rights

This section discusses certain statements on fundamental rights made in the course of the Ombudsman's oversight of legality. The section focuses exclusively on individual decisions that involve a new aspect of fundamental rights or are of importance in principle. They are also included in section 3.7, which describes the Ombudsman's decisions leading to a recommendation for compensation, and in section 4, which discusses matters related to the coronavirus pandemic.

3.9.1 DECISIONS

Equality in digital services (section 6 of the Constitution)

The implementation of equality in digital services was featured in several cases during the year under review. In a decision on the use of the Suomi.fi e-Authorizations service, the Deputy-Ombudsman stated that although the Act on the Provision of Digital Services aims to promote the primacy of digital services in public authorities' e-services, it is not in accordance with the administrative service principle or the Non-Discrimination Act that there are no attempts made in individual circumstances to provide services with other means of contact as stipulated in the Administrative Procedure Act. The opportunities for using services must meet the needs of special groups, such as older and disabled persons, in the best possible way (3665/2020).

In a case concerning the submission of a customs clearance, the Deputy-Ombudsman suggested that, although e-services are expressly provided for in the directly applicable European Union Customs Code as the only form of transaction in this case, the issue must be assessed from the point of view of the implementation of fundamental rights. Therefore the authority must arrange the services in such a way that everyone can have their case heard by the authority under equal conditions, regardless of whether they have had the opportunity to use the means of strong identification that the authority has approved for electronic services (4892/2020).

Child's right to social services in Swedish (sections 6, 17, 19 and 22 of the Constitution)

Equality, the right to one's language, the right to sufficient social and health care services and the safeguarding of fundamental and human rights were discussed in a case in which the City of Helsinki had not been able to arrange special care during an assessment period (guidance in a housing unit) in Swedish for a Swedish-speaking child with a mild intellectual disability, psychiatric challenges and a need for special support.

According to the Ombudsman, the procedure at the housing unit had violated the Social Welfare Act and the child's equality and social, cultural and linguistic rights guaranteed by the Constitution of Finland.

The Ombudsman emphasised that, from the perspective of the implementation of the right to self-determination and other rights of a child in need of special support, it is particularly important that the child's right to receive service in the language of their choice be realised. The language used plays an important role in encountering the child and in the mutual understanding of matters.

The Ombudsman emphasised that inadequate resources are not a valid reason for not offering a client a service in the language of their choice. In the Ombudsman's view, the city – as the entity providing and purchasing the service – should have taken the necessary measures in time to realise the child's right to special care in Swedish on an equal basis with Finnish-speaking children.

The Ombudsman highlighted the fact that the implementation of fundamental rights requires active measures by public authorities to create effective preconditions for the implementation of fundamental rights. In practice, this means continuous measures from the service provider in a situation where the organised service does not implement the client's fundamental rights (488/2021).

Remand prisoner's protection of privacy (sections 7 and 10 of the Constitution)

A decision by the Ombudsman concerned the failure to maintain supervised communications for a remand prisoner and whether the supervision of communications would have been the responsibility of the prison or the pre-trial investigation authority, and what would have been the content of the supervision.

Based on the communication restrictions in the detention decision, it remained unclear how the supervision of the remand prisoner complainant's meetings and calls should have been arranged. Communication was prevented by the police and the prison authorities having differing views on which of them was responsible for the supervision.

The Ombudsman noted that the restriction of the remand prisoner's communications significantly interferes with their freedoms and protection of privacy, which are laid down in sections 7 and 10 of the Constitution and Articles 5 and 8 of the European Convention on Human Rights, for example. The regulation on restricting communications must be precise and delimited. In addition, the communication restrictions imposed by the court must be sufficiently clear in terms of their content to be unambiguously enforceable. In terms of the content and clarity of communication restrictions, it is essential that proposals concerning restrictions made by a prison director or an official with the power of arrest are also specific and clear (7510/2020).

Equality, freedom of expression, combating racism (sections 6, 12, 22 of the Constitution)

The Ombudsman received 17 complaints when two police officers who supervised a Black Lives Matter demonstration took photographs while holding demonstration signs. The Ombudsman found this problematic for the emphasised impartiality required of the police due to the nature of their duties.

According to the Parliamentary Ombudsman, the police officer in charge of supervising the demonstration should not take a stand in favour or against the demonstration, but should remain neutral. In this case, too, the police were in uniform not only to safeguard the exercise of the freedom of assembly, but also to ensure that the organiser fulfilled their obligations under the law. The Ombudsman emphasised that it is not a question of what the subject of the demonstration was and how it might be generally considered worth supporting. Although it is the duty of the police to combat racism, this does not entitle police officers to deviate from the role of an impartial supervisor. The police must act in such a way that the activities also look neutral from the outside.

For the sake of clarity, the Ombudsman emphasised that combating racism is the duty of the police. Among other things, the Ombudsman cited Finland's commitment to the International Convention on the Elimination of All Forms of Racial Discrimination (SopS 37/1970), according to which States Parties condemn racial discrimination and undertake to pursue by all appropriate means and without delay a policy of eliminating racial discrimination in all its forms and promoting understanding among all races while condemning all practices of segregation (4428/2020).

Protection of privacy in insurance claim investigations (section 10 of the Constitution)

The Deputy-Ombudsman examined the legal basis of insurance claim investigation activities carried out by insurance institutions and the nature of these activities. Insurance claim investigations are used in examining cases of suspected insurance fraud, among other things. In an investigation, either an insurance claim investigator employed by the institution or an external claims detective may, for example, follow and photograph the insured person in public places in order to ascertain the person's functional capacity.

The Workers' Compensation Act and the Motor Insurance Act include provisions on the insurance institutions' obligation to obtain sufficient clarification of matters. However, no express provisions are laid down on the insurance claim investigations carried out by the institutions.

Under the case-law of the European Court of Human Rights (ECHR), the activities of a claims detective are considered to be the responsibility of the State in situations where the insurance company implements the State's insurance system. Provisions on interference with the protection of private life must be laid down at the level of legislation and with sufficient precision.

According to the Deputy-Ombudsman, the current statutes and the needs to change them from the point of view of privacy protection of insured persons must be assessed in Finland as well. The assessment would concern the requirements that must be met before it is possible to interfere with the insured person's privacy protection by means of insurance claim investigations. In addition, the decision-making process, the procedures applied, the scope of the measures and the storage of the obtained information would also be assessed.

The Deputy-Ombudsman was also of the view that the activities of insurance claim investigators in obtaining evidence and clarifications on matters concerning a statutory and obligatory motor liability or accident insurance constitute a public task and fall under the competence of both the Financial Supervisory Authority and the Parliamentary Ombudsman (1672/2019).

– On 17 December 2021, the Ministry of Social Affairs and Health announced its preliminary view that it was necessary to add provisions to the Workers' Compensation Act and the Motor Insurance Act as a basis for organising insurance claim investigation operations in insurance companies. The Ministry announced its intention to launch preparatory work on the legislation as soon as possible.

Freedom of religion and conscience in assisted housing facilities (section 11 of the Constitution)

A complainant criticised the fact that an Evangelical Lutheran Christmas service was "force fed" through the central radio into the apartments of an assisted housing facility for the disabled. The Ombudsman stated that the last sentence of section 11 of the Constitution, "no one is under the obligation, against his or her conscience, to participate in the practice of a religion" specifies certain dimensions of so-called negative religious freedom. According to the justifications of the provision, this means that no one is under the obligation to participate in a church service or some other religious event against their conscience. However, the purpose of the sentence is not to prevent other people's positive freedom to practise religion.

The Ombudsman did not find it an acceptable arrangement for the staff of the assisted housing facility for the disabled to move residents not attending religious events to other premises outside their homes for that period. The Ombudsman justified his view with the ECHR's ruling practice and by the fact that persons with disabilities enjoy the protection of domiciliary peace and private life when living in rental apartments in assisted housing for disability services.

The Ombudsman considered that if religious events are broadcast via the public central radio of an assisted housing facility, the residents should have the possibility – from within their apartments – to turn off the central radio or change the channel of the central radio (8265/2020, see section 3.4).

Protection of property during seizure of assets (section 15 of the Constitution)

When assessing the police procedure for seizing a bank account, the Ombudsman stated that seizure, like other coercive measures, interferes with suspects' fundamental rights. The legislation on coercive measures must be precise and delimited. The Ombudsman emphasised that the protection of fundamental rights enshrined in the Constitution is watered down if the prerequisites for using coercive measures that intervene with these fundamental rights are not interpreted in an appropriately strict manner. Broader interpretations are very problematic. In this context, the Ombudsman stated that, if the conditions are met, the police may use confiscation for security if necessary; the scope of confiscation must not be extended to an area where confiscation for security is intended (7777/2020).

Treatment of indigenous Sámi people in internal border control (section 17.3 of the Constitution)

According to complaints, the closure of border crossing points and border crossing permit procedures related to the temporary reintroduction of internal border control had prevented and hampered reindeer herding by Sámi people and the Sámi culture in general in violation of the Constitution.

The question was whether the rights secured for the Sámi people by the Constitution required the Border Guard to take more extensive measures to take into account the status of the Sámi people and to safeguard Sámi livelihoods. As a result of the Constitution and international treaties, there is a prohibition of undermining the Sámi culture, which means that official actions may not undermine the rights of the Sámi as an indigenous people to practise and maintain their culture.

According to the Deputy-Ombudsman, as a result of the temporary reintroduction of internal border control, the restrictive measures concerning border crossings had an impact on the Sámi people, particularly in the form of negative effects that were reflected on Sámi livelihoods but also on the Sámi community and culture in a more comprehensive manner. On the other hand, the effects of the restrictive measures were not only directed at the Sámi people but also at other people crossing the border. However, the impacts on the Sámi people could be understood to be somewhat more comprehensive.

According to the Deputy-Ombudsman, the border control and permit procedures were due to a change caused by the prevention of a communicable disease, and this change could not be regarded as a far-reaching or significant measure that could directly and in a special way affect the status of the Sámi as an indigenous people and significantly undermine the Sámi culture. While the right of an indigenous people to health and life must be safeguarded, the measures taken in this regard had to accommodate the fact that the spread of the serious communicable disease varied from one region to another. Taking these considerations into account, the proactive requirement of border crossing permits for crossings outside the border crossing points had not violated the provisions of the Constitution concerning the Sámi people. It had merely been a matter of controlling border crossings and of the procedure for authorising or prohibiting border crossings (5597/2020, see section 4.2.3).

Psychiatric patient's right to treatment and possibilities for outdoor recreation (sections 7, 19 of the Constitution)

The Ombudsman commented on the termination and discharge practice of a patient who had left involuntary treatment without authorisation, and on the safe organisation of the patient's outdoor recreation.

The Ombudsman highlighted the hospital's obligation to ensure adequate health services for patients in a particularly vulnerable position due to their illness as referred to section 19(3) of the Constitution and the patient's right to good health and medical care in accordance with the Patient Act. The Parliamentary Ombudsman considered that HUS should supplement its discharge instructions for patients who leave the hospital without authorisation. In the Ombudsman's opinion, the matter would also require national guidelines.

The Ombudsman also considered that the hospital had acted incorrectly when granting a permit for outdoor recreation and arranging the outdoor recreation with a family member. With this procedure, the hospital had compromised the patient's safety and the continuity of care and the right to the treatment the patient needed (4702/2020).

Right to treatment aiming at gender transition (sections 19 and 22 of the Constitution)

Examinations and treatment aiming at gender transition is nationally centralised in two university hospitals (HYKS and TAYS). Examinations aimed at gender transition had become overburdened in a way that seriously endangered patients' rights. In this situation, the Deputy-Ombudsman considered it necessary to notify the Ministry of Social Affairs and Health of the state of the operational resources. She asked the Ministry of Social Affairs and Health to state by 31 December 2021 what measures her decision had given rise to. The Deputy-Ombudsman issued a reprimand to HUS on non-compliance with a statutory obligation (2119/2020, also 8482/2020).

– On 24 January 2022, the Ministry of Social Affairs and Health announced that it had investigated current access to treatment and availability of resources at the gender identity research outpatient clinics at HYKS and TAYS and that it had launched a cross-administrative programme in November 2021 to ensure the sufficiency and availability of social and health care personnel. In addition, the Ministry is preparing a reform of trans legislation.

Missing instructions for appeal (section 21 of the Constitution)

The rectification and disciplinary board of the Emergency Services Academy had not attached instructions for appeal to its decision concerning the temporary dismissal of a student. The Deputy-Ombudsman stated that the right to have a decision pertaining to one's rights or obligations reviewed by a court of law or other independent judicial body is one of the elements of legal protection. At worst, missing instructions for appeal required by law may in fact leave a citizen without the option to appeal, thus preventing the implementation of a fair trial (6492/2020).

Compliance with deadlines (Section 21 of the Constitution)

The processing of a request for information concerning a pre-trial investigation record was delayed when a request was submitted by an attorney of a person suspected of a crime. The Ombudsman stated that proper compliance with procedural provisions must also be ensured during annual holidays or other absences. Holidays, busy schedules, work-related pressures and unclear substitute practices do not justify deviating from compliance with statutory deadlines or other appropriate handling of matters. It is problematic for the implementation of a fair trial if, when preparing for a trial, the party concerned does not have access to all materials that affect or may affect their position in the trial (2374/2020).

Several decisions by the Deputy-Ombudsman drew the attention of the Digital and Population Data Services Agency to the timely processing of matters. In particular, the delivery times of genealogical reports were unreasonably long and caused significant harm in estate management matters (5591/2020).

Principle of being heard (Section 21 of the Constitution)

The right to be heard in one's case is one of the key administrative principles of legal protection, as enshrined in section 21 of the Constitution. Deviations from the principle of being heard must be based on legislation, and even then it must be possible to justify it in an acceptable manner. The Deputy-Ombudsman considered that the principle of being heard and the right to receive a reasoned decision concern the decision-making of the Finnish Orthodox Church Bishops' Conference even when a matter is criticised and appropriately resolved only on the basis of canonical rules (8366/2020).

3.10 Complaints to the European Court of Human Rights against Finland

A total of 91 new applications were brought against Finland at the European Court of Human Rights (ECHR or the Court) in 2021 (120 in the previous year). A response from the Finnish Government was requested in three cases (5 in 2020). At the end of the year, 16 (35) cases concerning Finland were pending.

Complaints to the ECHR must be lodged using the form prepared by the ECHR Registry, and the requested information must be provided, along with copies of all documents relevant to the case. If an application is not properly filed, the case will not be investigated. The decision on the admissibility of an application is made by the ECHR in a single-judge formation, in a Committee formation or in a Chamber formation (7 judges). The Court's decision may also confirm a settlement, and the case is then struck out of the ECHR's list. Final judgments are given either by a Committee, a Chamber or the Grand Chamber (17 judges). In its judgment, the ECHR resolves an alleged case of a human rights violation or confirms a friendly settlement.

Most of the applications lodged with the ECHR are declared inadmissible. In 2021, a total of 109 (103) complaints concerning Finland were declared inadmissible or struck out of the case list. In 2021, the ECHR issued one judgment on Finland (one in 2020, and two in 2019).

The only judgment issued on Finland in 2021 concerned the decision ruled against Finland on 14 November 2019 (N.A. v. Finland, 25244/18). The case concerned the return of an asylum seeker to Iraq where the asylum seeker was allegedly killed, but it has since been proven that the information was not correct. At the request of Finland, the ECHR reviewed the matter again and rejected the complainant's application as an abuse of the right to appeal. The ECHR considered that the complainant had deliberately misled the Court with the false facts presented. If the information had come to the attention of the court before deciding the case, the complainant's application would have been inadmissible under Article 35, 3(a) of the European Convention on Human Rights.

The total number of judgments issued by the ECHR to Finland by the end of 2020 was 142. The number also includes the previously mentioned reviewed decision. Of these, 99 were judgments confirming a violation of rights relating to the duration of court proceedings or shortcomings in the implementation of a fair trial. The number of judgments in recent years has been very low every year.

3.10.1 MONITORING OF THE EXECUTION OF ECHR JUDGMENTS AT THE COMMITTEE OF MINISTERS OF THE COUNCIL OF EUROPE

The Committee of Ministers of the Council of Europe supervises the execution of ECHR judgments. Provisions on the enforcement of EIT judgments are contained in Article 46 of the European Convention on Human Rights. It states that the final judgment of the Court of Justice will be forwarded to the Committee of Ministers, which will supervise its execution. Judgments shall remain under the control of the Committee of Ministers until the necessary measures have been taken to implement them. Enforcement will then be decided by a resolution. In practice, the monitoring carried out by the Committee focuses on three different aspects: the payment of compensation, individual measures, and general measures taken as a result of a judgment. The monitoring primarily takes place by diplomatic means.

On 17 September 2020, the ECHR ruled against Finland on a matter involving a school shooting, the case Kotilainen and others v. Finland (no. 62439/12). According to Article 44 of the European Convention on Human Rights, the judgment has become final on 17 December 2020. On 17 June 2021, the Agent of the Finnish Government before the ECHR submitted to the Committee of Ministers an action report in accordance with its procedures, in which the Government notified the Committee of Ministers of the measures it had taken as a result of the above-mentioned judgment. In its resolution of 8 December 2021, the Committee of Ministers stated that it had examined the Government's action report and considered that the necessary measures had been taken to enforce the judgment. The Committee of Ministers ended the supervision of the execution of the judgment.

No new cases became pending in the supervision process during the year under review. 18 pending judgements concerning Finland (31 in the previous year) remained in supervision for their enforcement. In most of these cases national enforcement measures have been implemented, but the action reports are not fully completed. In all cases, the compensation ordered has been duly paid.

A significant case that is still under supervision is X. v. Finland (34806/04), which concerns the procedure for ordering involuntary psychiatric treatment and the treatment carried out regardless of willingness, especially forced medication. In its judgment of 3 July 2012, the ECHR considered the right to freedom under Article 5 of the European Convention on Human Rights and the right to private life under Article 8 to have been violated. In connection with the same case, the ECHR has a new appeal case pending against Finland, E.S. v. Finland (23903/20), which also concerns forced medication. Enforcement of the judgment X. v. Finland (34806/04) has been pending for more than nine years. The matter has been referred to enhanced enforcement by the Committee of Ministers.

4 Issues related to coronavirus

4.1 Overview

4.1.1 DESCRIPTION OF THE SITUATION

In December 2019, cases of pneumonia were diagnosed in China that were caused by the new coronavirus SARS-CoV-2. The virus disease COVID-19 started spreading around the world rapidly. On 11 March 2020, the World Health Organisation (WHO) declared the COVID-19 epidemic a pandemic.

In Finland, the coronavirus epidemic began in March 2020 and still continued throughout the year under review. In the year under review, the number and incidence of COVID-19 cases increased rapidly after the beginning of February and on 1 March 2021, the Government decided to declare a state of emergency in Finland. After the epidemic situation had calmed down, the state of emergency was declared to have ended on 27 April 2021. The Government considered it possible to manage the still continuing coronavirus epidemic with the authorities' regular powers. The epidemic situation worsened again towards the end of the summer and, after a calmer situation in the autumn, again in December along with Omicron, a coronavirus variant that spreads very easily.

The coronavirus epidemic has already continued for a couple of years and it has had enormous health, social and economic impacts worldwide. The impacts and their extent and severity may not even be fully known, yet. Even though Finland has survived the pandemic well from an international point of view, the disease has also greatly affected Finland on many levels.

The COVID-19 epidemic has put society and the authorities in an unprecedented situation. At the beginning of the epidemic, the situation progressed rapidly and the fight against serious threats required prompt measures from the authorities to protect the lives and health of the population. There was very little time left for the authorities to plan and implement the measures required by the epidemic. Decisions also had to be made and instructions given in a situation where research data on the disease and its spread was limited and inadequate. As the epidemic progressed, more research data, experience and guidance has been accumulated and over the time, the authorities have been better placed to make decisions and plan their actions. On the other hand, rapid changes in the epidemic situation have caused uncertainty, for example, because the spread of new virus variants and the severity of the disease caused by them have not been known.

Due to its nature and the transmission mechanism of the virus, the epidemic has required strong interference with people's lives and fundamental rights. It has been necessary to restrict the freedom of movement and trade in an unprecedented manner. In their activities, the authorities have had to assess the prerequisites for restricting fundamental rights and weigh up the different fundamental rights. In this situation too, the authorities have only been able to use their legal powers, even if many other means could have been effective in combating the epidemic.

Over the course of the epidemic, it became evident that the legislation in force was not fully satisfactory and did not allow the necessary measures to combat the epidemic in the best possible way. Legislation has been amended and developed in many respects and on several occasions over the course of the epidemic. The aim has been to ensure that the epidemic can be managed with the authorities' regular powers.

In the oversight of legality, it was observed at the beginning of the epidemic that the legal nature of the instructions, recommendations and regulations sometimes remained unclear, and both citizens and other authorities were therefore uncertain about their binding nature. In this respect, the situation can be estimated to have improved during the epidemic.

At the beginning of the epidemic, the protection of life and health was often emphasised at the expense of other fundamental rights, especially in the case of older people and persons with disabilities. As the epidemic continues, society has begun to weigh the different fundamental rights and the advantages and disadvantages of their restrictions more diversely.

4.1.2 IMPACT ON THE ACTIVITIES OF THE OFFICE OF THE PARLIAMENTARY OMBUDSMAN

The situation caused by COVID-19 has also been exceptional in the Office of the Parliamentary Ombudsman and in the oversight of legality. The epidemic has caused extensive changes in the matters handled and in the working methods. From the very beginning of the epidemic, the Ombudsman began to receive complaints about the activities of the authorities. The epidemic also gave grounds for clarifying matters on the Ombudsman's own initiative. Matters related to the coronavirus epidemic have been filed for handling throughout the epidemic, and the number of complaints has remained fairly even and high.

In addition to matters related to the epidemic, the Office naturally had other so-called usual cases of oversight of legality. All in all, the Parliamentary Ombudsman received a record number of complaints in the year under review and over the past three years, the number of complaints has increased by more than 38 per cent.

During the entire coronavirus epidemic (2020–2021), more than two thousand cases of oversight of legality related to the epidemic (complaints or own initiatives) have been filed with the Ombudsman. In that time, the largest number of cases filed have concerned matters related to health care, the highest organs of government and education.

Received	Resolved	Decisions leading to measures	Percentage of cases leading to measures
2 046	1 806	335	18,54

Legal oversight matters related to the COVID-19 epidemic 2020–2021 (complaints + own initiatives)

During the year under review, more than one thousand (1,120) cases of oversight of legality became pending that were somehow related to the COVID-19 epidemic. The issues were very diverse and included questions related to almost all administrative branches.

Received	Resolved	Decisions leading to measures	Percentage of cases leading to measures
1 120	1 082	226	18,91

Legal oversight matters related to the COVID-19 epidemic 2021 (complaints + own initiatives).

The coronavirus epidemic and related restrictive measures have created new types of sometimes challenging legal questions in the oversight of legality. Many of the restrictions to combat the epidemic, such as movement restrictions and visiting bans on various institutions, have significantly influenced people's fundamental rights.

Restrictions have often had the biggest impact on the most vulnerable groups of people, such as the elderly or persons with disabilities, by making their position even more difficult. The importance of oversight of legality has been emphasised under these circumstances. The oversight of legality has therefore been focused on the control issues related to the epidemic in those areas where the likelihood of endangering fundamental and human rights was high. The aim was to identify these situations and intervene promptly.

As the coronavirus epidemic has affected all of society very extensively, it has required more exchange of information, cooperation and agreeing on the division of labour between different authorities in several administrative branches. The Office of the Parliamentary Ombudsman has also participated in international cooperation, in which issues such as the challenges posed by the epidemic situation and the operating methods used in inspections have been discussed.

Due to coronavirus, the customer service of the Office of the Parliamentary Ombudsman has been limited so that no personal meetings with customers were arranged during the year under review. Documents have been received and customers have been otherwise served normally. The staff of the Office of the Parliamentary Ombudsman largely continued to work remotely during the year under review. Remote work was technically and productively successful.

4.1.3 COMPLAINTS

A total of 1,106 complaints related to the COVID-19 epidemic were received in the year under review. A total of 1,178 complaints filed with the Ombudsman in the year under review or the previous year were resolved. Almost one half (501) of them concerned activities in the administrative branch of health care. The next largest number of complaints concerned the activities of the highest organs of government and the criminal sanctions field. However, complaints were directed at almost all administrative branches (see table on the following page). For a sector-specific description of the content and special features of complaints in different administrative branches, see section 4.2.

4.1.4 THE PARLIAMENTARY OMBUDSMAN'S OWN INITIATIVES

The COVID-19 epidemic has given rise to investigation of several questions on the Ombudsman's own initiative. A total of 14 own initiatives were taken in different administrative branches in the year under review and 17 were resolved. For a more detailed description of cases dealt with on an own initiative basis, see section 4.2.

4.1.5 INSPECTIONS

Inspections are an important part of the oversight of legality. The epidemic had a significant impact on the inspections by the Office of the Parliamentary Ombudsman. A total of 39 inspections were carried out during the year under review, while the number was over one hundred in 2019, the year preceding the epidemic.

Because of the safety of the inspected sites and the inspectors, the opportunities to visit the inspection sites were limited during the entire year under review. However, some inspections could be carried out on site at the inspection sites. Such on-site inspections totalled seven, two of which were carried out in a police prison and two in a detention unit.

Administrative branch	Received	Resolved
Health	501	383
Highest organs of government	167	162
Criminal sanctions field	112	115
Administrative branch of the Ministry of Education and Culture	75	198
Police	62	78
Local government	60	59
Social welfare	39	68
Administrative branch of the Ministry of Transport and Communications	26	21
Administrative branch of the Ministry of Defence	20	27
Administrative branch of the Ministry of Economic Affairs and Employment	11	34
Other administrative branches	10	9
Social insurance	8	8
Administrative branch of the Ministry of Finance	5	4
Administration of law	2	3
Administrative branch of the Ministry of Justice	2	1
Enforcement (distraint)	2	2
Administrative branch of the Ministry of the Interior	4	1
Aliens affairs and citizenship	3	1
Administrative branch of the Ministry for Foreign Affairs	2	3
Taxation	1	1
Total	1 106	1 178

Complaints related to the COVID-19 epidemic by administrative branch in 2021.

In these situations, special attention was paid to the safe implementation of the inspection. When conducting the inspections, efforts were made to carefully pay attention to safe distances, the use of face masks and other practical measures necessary from the point of view of combatting the epidemic. Before the visit, the inspection team had a coronavirus test or performed a so-called home test.

The epidemic situation has led to consider the possibilities of carrying out inspections in a manner other than the traditional physical visits to the inspection site. Some inspections were carried out remotely, using a secure video connection if necessary. Information was also obtained by telephone or in writing from the inspected sites or different stakeholders, such as the family members of elderly clients.

In future, inspection activity will be increased to the extent and within the timetable that is safely possible. The development of alternative and safe inspection methods will continue, and international experiences will also be used in the development work.

The realised sector-specific inspection activities are described in more detail in section 4.2. The inspection activities are also described in section 3.5 (National Preventive Mechanism against Torture).

4.1.6 STATEMENTS

The Ombudsman issued a statement on the Government's proposal on the temporary restriction of the freedom of movement and close contacts (HE 39/2021 vp) to the Constitutional Law Committee (2226/2021) and the Administration Committee (2228/2021). The Ombudsman found it problematic that the proposed regulation would prohibit something else (movement and stay) than what needs to be prohibited (gatherings and close contact). In the areas subject to the prohibition, all movement and stay other than those specifically permitted by the proposed act would be prohibited. This regulation structure would result in also prohibiting such movement and stay that do not involve a risk of infection and are not reprehensible in any other way, either. Such movement and stay would still be punishable, as well. The Ombudsman found these situations problematic from the point of view of both the preconditions for restricting fundamental rights and the principles of criminalisation.

The Constitutional Law Committee was of the opinion (PeVL 12/2021 vp) that the bill could not be processed in the order of enactment of normal laws. The bill had to be changed, among other things, to focus the prohibition on the sources of infection mentioned in the grounds for the bill, not on all movement. Because of the statement of the Constitutional Law Committee, the Government withdrew its legislative proposal on 31 March 2021.

Two other statements related to the COVID-19 epidemic were also issued by the Office of the Parliamentary Ombudsman during the year under review.

4.2
Issues related to coronavirus by authorities

4.2.1
COURTS OF LAW

The pandemic continued to significantly affect the operation of the courts of law in 2021. The processing of cases already became congested in spring 2020, especially in the district courts where the majority of cases are processed in oral hearings. The number of the cases filed with the Ombudsman increased because the measures taken to prevent the spreading of the virus and to ensure health security limited the organisation of oral hearings. The National Courts Administration published statistics on cases that had been interrupted because of the pandemic and were still pending. The statistics was updated at intervals of a few months. At the end of 2021, the total number of such cases was 700 in the district courts, 11 in the courts of appeal and 9 in the administrative courts. Especially the number of criminal matters pending in district courts was considerably higher than usual. At the end of 2021, a total of 27,256 (20,381 in 2019) criminal matters were pending in the district courts.

The effects of the pandemic were also reflected in the courts of law as increased use of remote connections, and process management measures and recommendations related to safe distances and the use of masks.

The pandemic was mentioned in one way or another in a few complaints against courts, but it was essentially discussed in only two cases. In one of them, the chairperson of the District Court had required the party concerned and their counsel to observe safety distances in the court room, in which case the counsel and the client had not been able to whisper to each other during the hearing. In the other case, according to the complainant, the Administrative Court should have resolved an appeal against a decision on restrictive measures issued by the Regional State Administrative Agency under section 58 of the Communicable Diseases Act within the three-week validity period of the decision. The Deputy-Ombudsman did not find any reason to suspect unlawful actions or negligence of obligations by the court in either of the cases.

However, it was revealed that the cancelling and postponing of sessions had had a negative impact on the length of court proceedings, which has contributed to an increase in the number of complaints about delays.

4.2.2
POLICE

There were some sixty complaints about police activities in relation to the coronavirus epidemic. Almost all complaints concerned police activities in the supervision of coronavirus restrictions, especially in demonstrations, which from time to time were subject to very strict restrictions. Individual complaints were also made about the fact that the use of services had become difficult. Only some of the cases were resolved during the year under review. Several complaints were transferred to the prosecutor because the complainant considered that the police had committed a crime.

The oversight of legality concerning the police was most influenced by the fact that inspections could not be carried out on site. An essential part of inspections, the visits to police prisons, were therefore mainly postponed to the future.

However, when the epidemic slowed down slightly in summer 2021, the police prisons of Pasila and Vantaa were inspected (see Section 3.5 regarding these). The inspections of the Eastern Finland Police Department and the National Police Board were carried out as documentation reviews and with a remote connection. During the inspections, it was examined how they had prepared for the coronavirus epidemic and how it had affected their activities. According to the information received by the Parliamentary Ombudsman, the police had been able to perform their duties fairly well despite COVID-19, for example, by differentiating the activities and through other preparedness. However, the renovations of police premises have partly been delayed because of the virus. The pandemic has been considered to have had a more general impact on police duties: in 2020, for example, the number of homicides and attempted homicides increased by nearly 15 per cent and home alerts by 26 per cent.

The inspection of the Eastern Finland Police Department revealed that the police prison in Kuopio had had to partly restrict the outdoor exercise of those deprived of their liberty. According to the Ombudsman, efforts should be made to arrange outdoor exercise to those exposed to coronavirus at times when there is no one else in the common areas. In any case, outdoor exercise should be arranged at least to those whose deprivation of liberty lasts several days.

Police activities in a demonstration

17 complaints were submitted to the Parliamentary Ombudsman concerning the actions of the police in Helsinki in March 2021 when a demonstration of hundreds of people against the coronavirus restrictions was allowed, even though the Regional State Administrative Agency's restrictions on gatherings (maximum of six persons) were essentially violated at the time. In his decision 3994/2021*, the Ombudsman considered that the police had not exceeded their discretion when they had not started to use force but first ordered the demonstration to be discontinued and still allowed the speakers present at the demonstration to give their speeches. The police considered this to be the most appropriate way to disperse the crowd of hundreds of people. The Ombudsman emphasised that demonstrations are at the core of the freedom of assembly and the police must give the organisers an opportunity to correct the lawfulness of the situation. They must primarily use advice and requests and, in general, observe the principle of proportionality. In his decision, the Ombudsman also discussed the relationship between the provisions on general meetings in the Communicable Diseases Act and the Assembly Act. For example, he stated that even if a general meeting is interrupted or discontinued under the Communicable Diseases Act, the Assembly Act must also be taken into account.

Police activities in the Black Lives Matter demonstration

Seventeen complaints were submitted to the Parliamentary Ombudsman when two policemen supervising the Black Lives Matter demonstration joined photographs while holding demonstration signs. The police were also criticised for not intervening in the demonstration even though the limit for the number of participants was violated (4428/2020).

At least 3 000 people took part in the demonstration held in June 2020, while the restrictions at that time would have allowed only 500 participants. Both the police and the organiser of the demonstration seemed to have been surprised, as many times more people arrived than expected. According to the Parliamentary Ombudsman, the police's actions to conclude the meeting were not delayed in a manner that would have given him cause for action.

4.2.3 NATIONAL DEFENCE AND BORDER SURVEILLANCE

Ordering to quarantine using a military command

A military command issued by the Army had been used to place to quarantine persons who because of the coronavirus pandemic had been ordered to return to Finland from crisis management tasks in Iraq. The quarantine lasted for two weeks and was implemented in closed and supervised conditions in the premises of the Defence Forces. The procedure was justified by Finland's participation in the crisis management operation and the resulting obligations to be available to the operation.

It had to be assessed whether a military command is suitable for ordering a contingent to quarantine conditions or whether it is a measure within the scope of the Communicable Diseases Act that cannot be ordered using a military command.

Under the Communicable Diseases Act, the decision on quarantining can be made only by the physician in charge of communicable diseases in a public service relationship with the municipality or the hospital district, and in the Defence Forces, by the Surgeon General under the Communicable Diseases Act and based on the internal instructions of the Defence Forces. The quarantine decision is based on an individual, case-specific, personal assessment by the physician.

In the case referred to in the complaint, such a quarantine decision by a health care professional had not been made by the said officeholders with regard to the complainants. As such, the legal effects on the complainants had been similar to those of the quarantine referred to in the Communicable Diseases Act. The operational needs of the crisis management operation identified in the reports were in favour of using the observed military command. On the other hand, this was not a quarantine in the legal sense of the word. This had naturally caused uncertainty and the conditions of the persons in this contingent who were ordered to quarantine-like conditions had actually corresponded to quarantine conditions. In some respects, the conditions had been even stricter because it was not possible for them to be at home during the quarantine-like arrangement. Instead, the period in question was carried out in a facility assigned and supervised by the Defence Forces.

According to the Deputy-Ombudsman's assessment, a person or the contingent in crisis management tasks could be ordered to quarantine-like conditions with a military command during their service relationship if it can be shown to have a direct link to the service task or the performance of the task. According to the report received, the case referred to was this kind of situation.

However, the organisation of the Defence Forces as a whole has a considerable number of different tasks even within the military service and the voluntary military service for women alone. The Communicable Diseases Act specifically lays down that the Defence Forces is responsible for making official decisions under the Communicable Diseases Act. According to the internal guidance in the Defence Forces, these decisions are made by the Surgeon General. The existance of this provision in the Act indicates the legislator's intention that the decisions on quarantine and isolation referred to in the Act can also be made in the Defence Forces. In the Deputy-Ombudsman's view, it may well be possible to find situations within the Defence Forces in which the connection with the performance of a service task is weaker and the quarantine referred to in the Communicable Diseases Act, including the legal protection factors included in it, would be legally more appropriate than taking care of the matter as a whole through the straightforward military command institution. It is not possible for the overseer of legality to try to specify such tasks. The task is the responsibility of the Defence Forces (396/2021). The Deputy-Ombudsman requested the Ministry of Defence to report the measures it may take as a result of the decision.

– The Ministry of Defence reported that the Defence Command justifies using military commands to control the risk of the spread of the communicable disease among the conscripts particularly from operational points of view, such as the fact that the entire service time spent by conscripts in the garrison is military activity and controlled by military commands.

A military command is considered an agile and fast instrument and according to the provisions in the Communicable Diseases Act, the Act must be applied as the last resort when other measures are not sufficient. The Defence Command requires that, if the situation permits, possible needs to change the practice be investigated. The Ministry of Defence considered these measures sufficient at this stage.

Treatment of the Sámi in internal border control

According to complaints submitted to the Ombudsman, the closure of border crossing points and border crossing permit procedures related to the temporary reintroduction of internal border control had prevented and hampered reindeer herding by Sámi people and the Sámi culture in general in violation of the Constitution.

The question was whether the rights secured for the Sámi people by the Constitution required the Border Guard to take more extensive measures to take into account the status of the Sámi people and to safeguard Sámi livelihoods. As a result of the Constitution and international treaties, there is a prohibition of undermining the Sámi culture, which means that official actions may not undermine the rights of the Sámi as an indigenous people to practise and maintain their culture.

According to the Deputy-Ombudsman, as a result of the temporary reintroduction of internal border control, the restrictive measures concerning border crossings had an impact on the Sámi people, particularly in the form of negative effects that were reflected on Sámi livelihoods but also on the Sámi community and culture in a more comprehensive manner. On the other hand, the impacts of the restrictive measures did not focus only on the Sámi but also on others crossing the border. However, the impacts on the Sámi people could be understood to be somewhat more comprehensive.

According to the Deputy-Ombudsman, the border control and permit procedures were due to a change caused by the prevention of a communicable disease, and this change could not be regarded as a far-reaching or significant measure that could directly and in a special way affect the status of the Sámi as an indigenous people and significantly undermine the Sámi culture. While the right of an indigenous people to health and life must be safeguarded, the measures taken in this regard had to accommodate the fact that the spread of the serious communicable disease varied from one region to another. Taking these considerations into account, the proactive requirement of border crossing permits for crossings outside the border crossing points had not violated the provisions of the Constitution concerning the Sámi people. It had merely been a matter of controlling border crossings and of the procedure for authorising or prohibiting border crossings (5597/2020).

4.2.4 CRIMINAL SANCTIONS FIELD

The coronavirus epidemic has widely affected the operation of the Criminal Sanctions Agency. The legislation on prisoners and remand prisoners was not prepared for situations such as the pandemic. The legislative basis was corrected on 7 June 2021 when the Act on Temporary Measures in the Enforcement of Punishments and the Enforcement of Remand Imprisonment because of the COVID-19 Epidemic (452/2021) entered into force. The Act remained in force until 31 October 2021. The Act laid down provisions on a possibility to deviate from the provisions in the Imprisonment Act and the Remand Imprisonment Act. It was possible to make decisions to restrict and discontinue the prison activities, meetings and prison leaves to the extent this was necessary, if other measures taken by the prison to prevent the spread of the COVID-19 epidemic were not sufficient.

The Central Administration of the Criminal Sanctions Agency had the competence to make decisions on restriction and discontinuation.

Efforts were also made to facilitate the operation of prisons by postponing the enforcement of certain shorter imprisonments for a fixed period of time. By postponing the enforcement, an effort was made to reduce the number of prisoners in prisons and the risk of infection.

It was possible to restrict the enforcement of community sanctions by decree of the Ministry of Justice issued under the above-mentioned temporary act if this was necessary to ensure appropriate enforcement of the sanctions. These were situations in which the enforcement of community sanctions had been prevented or become unreasonably difficult because of the coronavirus epidemic. With the decree, the Ministry of Justice limited the beginning of the enforcement of a community service and a monitoring sentence.

Because of the coronavirus epidemic, no inspections were carried out in prisons at the beginning of the year. In June, Naarajärvi Prison was inspected remotely. The inspection findings were based on the documents requested from the prison in advance, questionnaires to which the prisoners and staff could respond anonymously and remote discussions with the prison management. In November, Kuopio prison was inspected on site. The inspections are discussed in more detail in Section 3.5.

Ninety-five complaints (66 in 2020) concerning the coronavirus-related measures taken by the Central Administration of the Criminal Sanctions Agency were received in the year under review. The figures 112 (filed) and 115 (resolved) mentioned above in subsection 4.1.3 in the context of the criminal sanctions field also include those complaints that focused on the Health Care Services for Prisoners (VTH), which operates under the Finnish Institute for Health and Welfare in the administrative branch of the Ministry of Social Affairs and Health. After the expiry of the above-mentioned temporary act on 1 November 2021, only two complaints about the coronavirus-related measures taken by the Central Administration of the Criminal Sanctions Agency were received by the end of the year under review.

The complaints concerning the Agency's coronavirus-related measures were mostly either not investigated or they were referred to the Agency. This was done with complaints concerning the time before the entry into force of the temporary act on 7 June 2021 because the Deputy-Ombudsman was already investigating the lawfulness of the restrictions on his own initiative (2606/2020). It would therefore not have been appropriate to handle individual complaints separately. After the entry into force of the temporary act, the complaints were mainly about whether the prisons applied the restrictive decisions made by the Central Administration of the Criminal Sanctions Agency under the above-mentioned act in the way intended by the Central Administration. The assessment of such complaints was considered to be suitable for the Central Administration, to which they were transferred. The Central Administration's decisions on restrictions and suspensions in turn could be appealed against to administrative courts and, as a rule, the Parliamentary Ombudsman does not investigate a complaint about a case that can be appealed against.

However, the Deputy-Ombudsman handled a few individual complaints, mainly those in which the issues raised were not included his own initiative.

The Deputy-Ombudsman criticised the instructions according to which prisoners exposed to COVID-19 and living in the same cell could continue living together. Prisoners who have been ordered to quarantine by the Health Care Services for Prisoners with a decision based on the Communicable Diseases Act should under no circumstances be accommodated in the same cell, but alone. It is possible that not all of the persons exposed have been infected, in which case the infected person could infect the others when living together with them (7933/2020).

In July 2021, the Deputy-Ombudsman issued a decision on own his initiative on the actions of the Criminal Sanctions Agency during the coronavirus epidemic. The legal opinions presented in the initiative apply to the time before 7 June 2021, when the above-mentioned Act on temporary measures entered into force. The Deputy-Ombudsman stated that the procedure had been incorrect in the following respects.

As regards prisoners' right to meet, unlawful actions were taken when supervised meetings were suspended. Prisoners and remand prisoners have a statutory right to receive guests under supervision. Apart from exceptions to certain individual situations, there is no provision in legislation under which this right could be denied. Suspending meetings between minors and their parents was particularly problematic. On the other hand, as regards unsupervised meetings, the Deputy-Ombudsman considered it possible that the pandemic situation could be a reason referred to in law to refuse an unsupervised meeting.

According to the Deputy-Ombudsman, when considering prison leave applications, it was possible to take into account the risk to health and safety arising from the possible spread of the epidemic to the prison. It had therefore been possible to use the coronavirus epidemic as a justification for negative decision on prison leave applications. The actions were not unlawful. However, the consideration of prison leave applications should have been carried out on a case-by-case basis, weighing the factors in favour and against each prisoner and prison leave (2606/2020).

The Deputy-Ombudsman also investigated the actions of the Health Care Services for Prisoners on his own initiative during the coronavirus epidemic and found that there was no reason to take action in the matter (2736/2020).

4.2.5
ECONOMIC ACTIVITIES, DISRUPTION IN PAYMENTS AND ENFORCEMENT

After March 2020, the Office of the Parliamentary Ombudsman had received more than thirty complaints concerning business subsidies that had been granted because of the COVID-19 pandemic from appropriations of supplementary Budgets and based on the necessary regulations. Most of the complaints concerned Business Finland, which in this context refers to Business Finland Oy (hereinafter the company), which had granted the aids, and Innovation Funding Agency Business Finland (hereinafter the Funding Agency), which directed and supervised the activities. In the decision issued in April 2021, three of these complaints had been used as a basis for the report. However, clarification had also been requested more widely for issues that were significant from the point of view of the Ombudsman's oversight of legality. There were also complaints about subsidies granted by the ELY Centres, the State Treasury and municipalities. Decisions will be made on all of the complaints in due course.

It had not been shown that the company had acted in violation of the principle of legitimate expectations in administration when the application had been processed according to the published conditions that had been in force when the application was submitted. Because the tasks of the Funding Agency in the inspection, rectification procedure and recovery proceedings partly take place later than the tasks of the company and were still ongoing at the time the report was submitted, the Deputy-Ombudsman did not have a reason to investigate the resource situation in more detail at that time. However, in the light of the reports commissioned by the Ministry, there were concerns about whether the level of the resources reserved for the authority's activities was sufficient. The Deputy-Ombudsman therefore drew the attention of Business Finland to sufficient allocation of resources for the authority's statutory tasks at a general level. As for ELY Centres, the Deputy-Ombudsman stated that it had not been proven in the matter that an authority or an official had behaved in violation of the law or neglected their duty in the processing of the aid application in a manner that would require him to intervene in the matter as an overseer of legality (2273/2020).

As a result of complaints, the Deputy-Ombudsman later intervened in some of the issues related especially to the beneficiaries. In a case concerning the right of foundations and associations to receive funding for business development in disruptive circumstances, the complainant reported its member associations did not submit applications for the funding to Business Finland because Business Finland announced on its home page that associations and foundations among others were not entitled to the support. The Deputy-Ombudsman informed Innovation Funding Agency Business Finland and the Ministry of Economic Affairs and Employment that the exclusion of foundations and associations from the funding for business development in disruptive circumstances was not in accordance with the Act on Discretionary Government Transfers, and Business Finland of his understanding that making profit cannot be set as a precondition for granting aid under the Act on Discretionary Government Transfers. According to an established interpretation of the EU's rules on State aid, economic activities refer to the provision of goods and services on the market, regardless of the legal form of the operator and the way in which it is financed. In the definition of the nature of the aid as State aid, not profit criterion has been set for it in these rules. However, Business Finland had set additional criteria for the aid granted to associations and foundations. The criteria concerning making a profit was particularly problematic as it is not based on law or other statutes and would require an exact definition for the concept (3843/2020).

In the case concerning granting funding for business development in disruptive circumstances to fur farmers, the Deputy-Ombudsman assessed Annex 1 to Article 38 of the TFEU, which defines primary agricultural production. The complainant had paid attention to the fact that the authorities had interpreted the concepts referred to in the Annex in different ways. Unlike other parties granting government support, Business Finland had not considered fur farming to be primary agricultural production at all if the animals were sold dead. In accordance with the provisions applying to it, Business Finland did not grant support to primary agricultural producers. As the classification in Appendix 1 does not place selling animals alive or dead in a different position (cf. groups 1 and 5), the Deputy-Ombudsman found Business Finland's interpretation incorrect. When granting the aid, it should be required that the activities to which the aid is granted be differentiated in accordance with the de minimis Regulation. In the light of the received report, the development of the industry targeted by the aid had been identified only at a general level. The activities had not been differentiated, at least based on the report. The Deputy-Ombudsman considered that Business Finland Oy and the Innovation Funding Centre Business Finland steering its operations should have assessed the preconditions for paying government support differently from the way they did. The Deputy-Ombudsman also informed the Ministry of Economic Affairs and Employment, which steers and supervises Business Finland's operations, of his view (6493/2020).

4.2.6 ALIEN AFFAIRS

During the inspections carried out at the detention units in Joutseno and Helsinki in the year under review, attention was paid to how the coronavirus situation had affected the operation of the detention units. At the detention unit in Joutseno, three clients had been placed in quarantine-like conditions in a separate department at the time of the inspection in June 2021. During the COVID-19 pandemic, there had been only one positive coronavirus test result in the detention unit.

During the inspection, it was revealed that everyone arriving at the detention unit was placed into quarantine (in rooms of their own) according to the instructions given by the Finnish Immigration Service. Persons arriving from Finland were placed into quarantine for 10 days and those arriving from abroad for 14 days. During the quarantine, the detainees are entitled to daily outdoor exercise.

The unit has two quarantine departments. In accordance with the instructions at the time of the inspection, no coronavirus test was organised to new detainees if the person did not have any symptoms. Both the staff and the clients wore a mask (4149/2021).

Based on the information obtained during the inspection carried out in November, there were no COVID-19 infections among clients at the detention unit in Helsinki. A few staff members had had the disease. The detention unit in Helsinki had a separate department for new clients who have arrived in Finland and been detained. The clients lived in the department separated from the others for ten days. During the ten-day period, they were given access to the outdoors, an opportunity to smoke and visit the gym. It was not possible to get a vaccination at the detention unit, but if the client so wished, they could have the vaccination through public health care (7238/2021).

In 2020, the Ombudsman started investigating as his own initiative the activities of both the police and the Border Guard in connection with detaining foreigners and holding them in detention. He asked the above-mentioned authorities the following questions: 1) What has the significance of the coronavirus pandemic been in terms of deportation measures? 2) Have individual assessments been made during the coronavirus pandemic to ensure that the detention of each foreigner is necessary and proportionate? and 3) If the police has considered continued detention of the foreigner necessary and proportionate, were the detained person and their assistant informed of the possibility to bring the matter before the District Court for reconsideration due to changes in the circumstances.

In his decision concerning the actions of the police, the Ombudsman considered that the pandemic had also been taken into account in the detention of foreigners. As of March 2020, the Helsinki Police Department had regularly ensured that the preconditions for keeping each foreigner in detention were met in this changed situation. This meant that the threshold for detaining had been raised in practice and that mostly only foreigners who were a danger to public order and security had been detained.

However, the Helsinki Police Department considered that the prevailing coronavirus pandemic alone was not a significant change in the circumstances that would oblige the authorities to categorically inform the detainees of the possibility to have the matter reviewed by the District Court in accordance with section 128, subsection 2 of the Aliens Act. The Southeast Finland Police Department had informed the assistants of all detainees of the possibility of submitting the matter before the District Court for reconsideration due to the changed circumstances and delays in deportations. The police had also sent this message to all detainees through the staff of the detention unit in Joutseno.

In the Ombudsman's view, the operating method of the Southeast Finland Police Department meets the objectives of the Aliens Act. He considered the COVID-19 pandemic and the resulting delay in deportations to be a change in circumstances that should be reported to the detainees and their assistants. He stated that it is clearly the duty of the police to continuously assess whether the conditions for detention existed, and if this is not the case according to the police's own assessment, the police must order the detainee's immediate release. In the Ombudsman's view, the objective of section 128 of the Aliens Act is to ensure that assessing the effect of the changed circumstances on the conditions for detention is not limited to the assessment of the police only, but the change in circumstances is notified to the detained person and their assistant so that they can themselves consider the need to bring the matter before the District Court for reconsideration. The Parliamentary Ombudsman considered it to be important and in accordance with the Aliens Act that a foreign detainee and their assistant be informed of any changes in the circumstances that may affect the conditions for holding the person in detention and thus give cause for a reconsideration of the case in a District Court, even if the police do not consider this to be the case (2615/2020).

In his decision concerning the Border Guard, the Ombudsman stated that, according to the information received, the Gulf of Finland Coast Guard District had carried out a new individual case-specific consideration for each foreign detainee in the changed situation and ensured that the conditions for detention were met. Detained foreigners had been released if their deportation from Finland had not been successful. The Border Guard had also informed the assistants of the detainees that they could bring the detention decision before the District Court for reconsideration due to the changed circumstances. This message had also been sent to all detainees through the staff of the detention unit in Joutseno. In the Ombudsman's opinion, the Finnish Border Guard had managed the detainee's access to information appropriately (2807/2020).

4.2.7 SOCIAL WELFARE

A total of 39 complaints related to the COVID-19 epidemic were initiated in the social welfare category. This section deals with the oversight of legality in relation to child protection, social assistance and homelessness. Social welfare matters are also included later in the sections on the rights of the child, the rights of older persons and the rights of persons with disabilities (4.2.9, 4.2.10 and 4.2.11).

Child protection

A considerable proportion of oversight of legality matters resolved in 2021 in the social welfare sector were related to the rights of the child (578/1321). In these decisions, the pandemic has not been so visible. This has probably been influenced by the fact that in the early stages of the pandemic, on 1 April 2020, the Ministry of Social Affairs and Health already confirmed the principle that the coronavirus pandemic alone does not justify restricting the child's fundamental rights in substitute care units in child welfare. The decision issued on the matter by the Substitute for the Deputy-Ombudsman was also published at the same time (2130/2020). This principle has later been confirmed in the instructions issued by the National Supervisory Authority for Welfare and Health (*Valvira*) and the Regional State Administrative Agencies. If necessary, a child living in a substitute care unit has also been able to keep in touch with their family by other means than visiting them. The same principle has also applied to the right of access between children and parents.

However, in 2021, 24 cases of oversight of legality containing allegations about the impact of the coronavirus pandemic on the realisation of the rights of children were resolved in the social welfare category. The allegations were mostly related to contact between children and their families or the realisation of children's freedom of movement in substitute care in child welfare. Five of the complaints led to measures that also included statements related to the pandemic.

As a result of the complaints, attention was paid to matters such as the use of masks in substitute care units. Children and young people who have been placed outside the home have the right to a safe growth environment in substitute care, and the use of masks ensures their own safety and that of others. Although there is no obligation to use a mask, the substitute care unit must ensure that both the children placed in the unit and the employees have access to protective equipment that can be used in accordance with their individual needs and capacities (2296/2021, 2266/2021, 3212/2020). The Deputy-Ombudsman also drew the attention of the substitute care unit and the municipality that had placed the child to good communication of information about issues related to the pandemic (3212/2020).

Social assistance

The new pending complaints (12) concerned decision-making regarding social assistance during the state of emergency and payments of temporary epidemic compensation.

Two decisions concerned problems with visiting Kela during the state of emergency.

The Deputy-Ombudsman considered it necessary that Kela's services, especially with regard to last-resort social assistance, be organised in a manner that is accessible to the client. Difficulties in using the services must not prevent or endanger the realisation of the person's rights. Furthermore, Kela must provide the client with sufficient information about its services and the different possibilities to use the services (1945/2021).

The complainant criticised Kela for not enabling social assistance clients to make an appointment at any of Kela's offices in Vantaa. Clients can book only telephone appointments in Kela's appointment booking system. The Deputy-Ombudsman considered that Kela had neglected its obligation to provide advice. Incorrect advice and difficulties in using the services prevented the realisation of the complainant's rights in a timely manner. The Deputy-Ombudsman emphasised Kela's obligation and responsibility to ensure the accessibility and usability of its services, taking into account the challenges, abilities and needs of different client groups (3496/2020).

Homelessness

The Deputy-Ombudsman decided to investigate on her own initiative municipalities' activities to reduce homelessness and to organise health and social services for homeless persons during the state of emergency.

The situation of persons who have been homeless during the pandemic caused by COVID-19 has been difficult as daytime services have been closed and it has been even more difficult for them to find temporary accommodation. Homeless people have also been at a greater risk of the disease.

Based on both the reports and the received complaints, the living conditions in temporary accommodation have posed a clear risk of infection in spite of the precautions taken. The risk increases when the likelihood of contacts between people increases. The Deputy-Ombudsman therefore considered it likely that, as the pandemic continues, new and more infectious variants of the virus will pose a greater risk to homeless persons than to others.

The Constitution does not guarantee accommodation as an individual right. However, section 19, subsection 1 of the Constitution imposes on the public authorities the obligation to ensure indispensable care to everyone. Under subsection 4, the public authorities shall promote the right of everyone to housing and the opportunity to arrange their own housing. The Deputy-Ombudsman emphasised that, during the pandemic, reducing homelessness is the primary means of improving everyone's health security. Although municipalities had set reducing homelessness as their target, the Deputy-Ombudsman did not consider the results achieved to be sufficient. The number of long-term homeless people continued to be high. On the other hand, the Deputy-Ombudsman welcomed the fact that municipalities had also considered ways to prevent homelessness especially during the pandemic.

In the Deputy-Ombudsman's opinion, the increased risk of an infectious disease due to the housing conditions in temporary accommodation should be taken into account when determining the vaccination order. This should be done particularly in situations where a person is unable to influence their situation and homelessness is associated with a disease that significantly weakens the person's immunity and ability to protect themselves against the disease.

The Deputy-Ombudsman considered that the same applies to all persons whose permanent or temporary treatment or care must be carried out in circumstances where the number of contacts inevitably increases.

The responses received also mentioned the ban on visiting housing units based on the national guidelines used during the pandemic. The Deputy-Ombudsman stated at a general level that if there are house rules in temporary accommodation that contain restrictions not based on existing legal norms, the municipality must ensure that the person has a real opportunity to stay elsewhere if they so wish.

The Deputy-Ombudsman drew attention to the fact that improving the situation of homeless people also requires the development of legislation and guidelines as well as monitoring the implementation of the Cooperation Programme to Halve Homelessness referred to in the Government Programme (2446/2020).

4.2.8 HEALTH CARE

A total of 501 complaints related to the coronavirus pandemic were initiated in the year under review. The number of resolved complaints was 383. Among other things, the complaints concerned the coronavirus strategy, the introduction of the vaccination passport, COVID-19 vaccination certificates, the imposition of quarantine and isolation, compulsory use of a mask, the safety and adverse effects of coronavirus vaccines, coronavirus restrictions, vaccination of minors, postponing non-urgent surgeries, the so-called adapted quarantine and ordering to work, the procedure used by coronavirus trackers, restricting the presence of a support person at childbirth, interrupting family coaching, and bans on visiting acute wards of hospitals and inpatient wards of health centres.

Proposals

The Deputy-Ombudsman submitted two proposals to the Ministry of Social Affairs and Health to supplement the legislation. The Deputy-Ombudsman noted that by restricting the presence of fathers or support persons at childbirth, significant interference was made with the rights of the parturient, father or mother, and the child, especially with the right to self-determination and the protection of private and family life. On the other hand, consideration must also be given to the right of these people and other patients and staff to life and safety and sufficient health services.

The Deputy-Ombudsman stated that fundamental rights are not organised hierarchically or according to any predetermined order of priority. This means that if, in a situation where the decision is made, different fundamental rights or the fundamental rights of different persons would appear to point in different directions, an effort must be made to find a solution in which all fundamental rights of all persons are implemented as well as possible. If a person's fundamental right must be restricted in order to protect another person's fundamental rights, it must always be assessed whether the restriction would mean interference in the core area of the fundamental right. In addition, it must be assessed whether the restriction is necessary or whether another approach could be found that would limit the fundamental right less. Sufficient legal remedies must also be offered to the person subject to the restriction.

However, weighing between fundamental rights is primarily the responsibility of the legislator. In the Deputy-Ombudsman's opinion, the conditions for restricting or banning visits and the legal protection related to it should therefore be laid down in an act. In her decision (3232/2020), the Deputy-Ombudsman had already proposed that the Ministry of Social Affairs and Health should immediately start careful preparation of legislative amendments concerning restrictions focusing on older people.

She considered it necessary that the act should also explicitly provide for the conditions under which visits can be restricted or banned in health care units. Legislative measures would also be necessary regarding the presence of a support person at childbirth. Furthermore, the act should provide for sufficient legal remedies (7771/2020 and 2463/2020).

– According to the news item it published on 24 February 2022, HUS (Joint Authority of the Helsinki and Uusimaa Hospital District) expanded the presence of support persons in the Gynecology and Obstetrics Unit.

Own-initiative investigation

Vaccination order and the implementation of vaccinations during the coronavirus pandemic

Because of several complaints and contact requests, the Deputy-Ombudsman began to investigate on her own initiative possible shortcomings related to the implementation and order of COVID-19 vaccinations.

According to the Deputy-Ombudsman, it would have been justified to revise the order of vaccination in accordance with the Decree on Voluntary COVID-19 Vaccinations for persons working in home nursing referred to in the Health Care Act, in home services and home care referred to in the Social Welfare Act, and in personal assistance referred to in the Act on Disability Services and Assistance. From the perspective of the obligation to promote public health and equality laid down in the Constitution, it had to be considered necessary to supplement legislation with regard to these occupational groups.

The explanatory memorandum to the Decree on Voluntary COVID-19 Vaccinations states:

"Under section 7 of the Communicable Diseases Act, THL as a national expert institution in the control of communicable diseases supervises and supports the control of communicable diseases in municipalities.

With its guidelines, THL would further specify the definition of population groups into subgroups based on age, risk factors, susceptibility to the severe form of the disease or other relevant factors in accordance with medical evidence and approved indications of vaccines. In addition, the prioritisation recommendation should be changed, if necessary, according to the schedule and quantities of vaccines received in the country.

If necessary, the vaccination order could be flexible according to local conditions to ensure smooth operation and prevent vaccine loss. For example, elderly people living in the same household could be vaccinated at the same time, regardless of the exact age limits, or the vaccinations of consecutive groups could be allowed to overlap if it has been assessed locally that it would be appropriate and would reduce vaccine loss."

According to the Deputy-Ombudsman, the text of the explanatory memorandum had to be considered open to interpretation. It gave the impression that the "vaccination order" was meant to refer to the order of vaccination referred to in the Decree, in which case the paragraph could be considered to conflict with the text of the Decree. Provisions on allowing flexibility in the vaccination order are not laid down in the Decree. The Deputy-Ombudsman stated that it is not appropriate to lay down provisions with an explanatory memorandum. Any flexibility possibly allowed to the party applying the statute must be indicated in the statute itself. If, on the other hand, the "vaccination order" mentioned in the latter paragraph was intended to refer to THL's guidelines on the order of coronavirus vaccinations in risk groups, the matter should have been expressed unambiguously in such a way that it did not give rise to misunderstandings.

According to the Deputy-Ombudsman, leaving the precise definition of population groups referred to in the Decree on Voluntary COVID-19 Vaccinations to rely on the instructions issued by THL had to be considered an understandable solution as such in the exceptional circumstances. In the situation caused by the coronavirus pandemic, decisions affecting the entire society had to be made without delay. Furthermore, it was difficult to predict the progress of COVID-19 and the availability of vaccines, which is why it was expected that changes to the provisions of the Decree would have to be made very quickly. However, the Deputy-Ombudsman noted that specifying the vaccination order laid down in the Decree by means of official instructions is not entirely unproblematic from the perspective of the fundamental rights system.

In the explanatory memorandum of the Decree on Voluntary COVID-19 Vaccinations, the scope of the assignment given to THL was fairly extensive and partly open ("other relevant factors"). In addition, the importance of the vaccination order was linked to the equality, the right to life and the obligation imposed on the public authorities to promote the population's health laid down in the Constitution.

According to the Deputy-Ombudsman, decisions on the vaccination order are significant from the point of view of several fundamental rights. The starting point of the Constitution is that the principles governing the rights of private individuals shall be governed by acts. The Decree on Voluntary COVID-19 Vaccinations is based on the authorisation to issue decrees in the Communicable Diseases Act. The explanatory memorandum of the Decree states that in its guidelines, THL would specify a more specific definition of population groups into subgroups and, if necessary, change the prioritisation recommendation according to the timetable of receiving vaccines in the country and the amount of the received vaccines. The Deputy-Ombudsman emphasised the fact that the explanatory memorandum of the Decree does not, however, provide a legal norm that could be set as the basis for the authorities' activities.

Because decisions on the vaccination order were relevant for several fundamental rights, the Deputy-Ombudsman considered that it would have been justified from a constitutional point of view to lay down exhaustive provisions on the vaccination order by decree. When issuing the Decree, the Government's task was to assess whether the impacts of the vaccination order on the implementation of fundamental rights would require provisions to be laid down in an act.

After THL's guidelines on the order of vaccination published on 22 December 2020, it became clear that in some hospital districts, vaccinations were focused on social welfare and health care personnel in violation of the Decree on Voluntary COVID-19 Vaccinations. As a result, the vaccination coverage of older people and persons belonging to risk groups remained lower than intended. On 19 February 2021, after having detected this on the basis of the data in the vaccination register, THL issued instructions to the Regional State Administrative Agencies, hospital districts and health management of regional centres, according to which the vaccination of new groups in social welfare and health care personnel had to be suspended. The vaccines had to be given to older people and medical risk groups who were at the greatest risk of the severe form of the disease. According to THL, the need to issue instructions was also due to the fact that fewer vaccines had been obtained and more slowly than expected, in which case the precise targeting of vaccinations played a greater role than anticipated in the disease situation prevailing at the time.

According to the Deputy-Ombudsman, the fact that THL sought to correct the distorted vaccination situation in such a way that the situation would actually correspond to what was intended in the Decree on Voluntary COVID-19 Vaccinations did not play a decisive role in the legal assessment of the matter. THL would have had at its disposal the powers laid down to it in the Communicable Diseases Act to guide municipalities and hospital districts that had deviated from the vaccination order.

The Deputy-Ombudsman considered THL to have exceeded its powers because it issued instructions that contradicted the provisions laid down in the Government Decree. The Deputy-Ombudsman informed the Government, the Ministry of Social Affairs and Health and THL (1043/2021) of her understanding of the shortcomings related to the procedure.

Inspection visits

The Deputy-Ombudsman sent requests for clarification to the hospitals of Niuvanniemi and Old Vaasa. The aim was to investigate the impacts of the COVID-19 epidemic on the status and conditions of patients and on the operation of hospitals. Requests for clarification and the reports received are explained in the section dealing with Opcat (Section 3.5).

Decisions

THL's recommendations to airlines, transport companies and shipping companies

The Office of the Parliamentary Ombudsman received 12 complaints criticising the measures THL recommended to transport companies and shipping companies for preventing the spread of SARS-CoV-2 and its easily spreading variants. In the complaints, the procedure was considered to violate the constitutional right of Finnish citizens to enter the country.

On 22 January 2021, THL issued a recommendation to all airlines to combat the considerable threat posed by the new virus variant. It strongly recommended that airlines require all passengers arriving in Finland to present a certificate of a negative COVID-19 test before boarding their flight. On 17 February 2021, THL issued a new recommendation to transport and shipping companies operating to Finland, according to which a certificate was not necessary if the passenger could present a certificate of COVID-19 that they had already had and recovered from. On 10 June 2021, THL issued a new recommendation, according to which the passenger could alternatively present a certificate of a COVID-19 vaccination.

The Deputy-Ombudsman noted that by preventing communicable diseases, the public authorities carry out their statutory task to promote the health of the population and the individual's right to life and health and their effective protection as part of fundamental and human rights. As the authority referred to in the Communicable Diseases Act, THL has the obligation to take action to prevent communicable diseases.

The Deputy-Ombudsman considered that THL's recommendation indicated its legal nature, i.e. that it was not a binding order but a recommendation from the authority. The recommendation was aimed at private companies, i.e. transport companies that can determine their transport conditions themselves. Based on the recommendation concerned, the authorities did not prevent Finnish citizens from arriving in or leaving the country.

Taking into account matters such as the nature of the document, the acceptable purpose of preventing the epidemic and the possibility for a Finnish citizen to travel by presenting a certificate, the Deputy-Ombudsman considered that, when issuing the recommendation, she had no reason to suspect that THL would have exceeded its discretion as a national expert institution for the prevention of infectious diseases or otherwise acted in an unlawful manner requiring the Ombudsman's actions or neglected its obligations.

However, the Deputy-Ombudsman noted that issues related to entering the country are very relevant from the point of view of several fundamental rights and considered that the recommendation in question was not entirely unproblematic in terms of the freedom of movement guaranteed as a fundamental right. Although the recommendations were not a matter of an authority preventing entry into the country or a mandatory order to do so, as a result of the recommendation, the arrival of a Finnish citizen in Finland may in fact have been prevented or at least significantly complicated by the fact that they have not been able to board the means of transport without the required certificate.

In the Deputy-Ombudsman's view, it is justified from the perspective of the legal protection of all parties to lay down provisions on this kind of restrictions in an act because they effectively and significantly affect the movement of persons and fundamental rights (e.g., 1022/2021). The Act on Temporarily Amending the Communicable Diseases Act (701/2021) entered into force on 12 July 2021.

Issuing and serving a decision on isolation

The Deputy-Ombudsman considered that the Communicable diseases and Hygiene Unit of the City of Vantaa had acted lawfully when issuing an oral decision on isolation and serving the decision on the complainant. However, according to the Administrative Procedure Act, an oral decision shall also be issued in writing without delay. The time limit for requesting a judicial review begins from the receipt of the written decision.

On 5 May 2020, the physician responsible for communicable diseases issued a written official decision on isolating the complainant between 30 April 2020 and 13 May 2020 because of a communicable disease (COVID-19) defined as generally hazardous in the Communicable Diseases Act in order to prevent the spread of the disease. The Deputy-Ombudsman noted that the written decision was not made until the fourth day after the oral decision had been issued.

The Deputy-Ombudsman considered that a written decision on isolating should have been issued faster. Issuing a written decision guarantees that a complainant who is unhappy with the decision will have access to the grounds for the decision and can consider whether they want to bring the decision before a court of justice to be investigated. The provisions are based particularly on what has been laid down on the right of appeal in the Constitution.

The Deputy-Ombudsman stated that, according to the Administrative Procedure Act, an authority shall serve its decision on the party concerned without delay. The provision contains a general time requirement according to which the authority must undertake the measures requiring the service without delay after it has made a decision on the matter. This aims to ensure that the period between the issuance of the decision and the service is not unduly prolonged. Although section 21, subsection 1 of the Constitution does not directly impose requirements on anything other than the length of the proceedings, it can be considered to be closely linked with the requirement that the service of the decision, which is essential for the person subject to the decision, be carried out without delay.

The officeholder's decision on isolating the complainant was not posted until 11 May 2020. The delays in posting the decisions were caused by the large number of decisions in spring 2020 when the COVID-19 epidemic was spreading rapidly.

The Deputy-Ombudsman stated that the obligation laid down in the Constitution for public authorities to safeguard the implementation of fundamental and human rights means that sufficient resources must be allocated to safeguarding the implementation of fundamental rights, such as the right to legal protection. It has been consistently considered in the Ombudsman's decision-making practice that matters related to the organisation and the resources cannot, in principle, justify deviations from statutory obligations.

The Deputy-Ombudsman understood that the City had not been able to prepare in advance for the need to organise the activities caused by the pandemic and allocate sufficient human resources for issuing and posting written decisions on isolation. However, as this was a significant restriction on the liberty of the individual, the Deputy-Ombudsman considered that, despite the exceptional circumstances, the City of Vantaa should have allocated sufficient resources for posting isolation decisions so that the decisions could have been served on the parties concerned without delay. The written isolation decision was not received by the complainant until after the isolation period had ended. Consequently, the complainant's fundamental right to legal protection was not realised in practice as appealing against the isolation decision would have had no actual effect.

The Deputy-Ombudsman brough her opinion to the attention of the City of Vantaa and the physician responsible for communicable diseases. With the COVID-19 epidemic still continuing, the Deputy-Ombudsman requested the City of Vantaa to provide her with an account of how the written decisions since then been delivered (3535/2020).

– On 31 January 2022, the City of Vantaa reported the following. During the COVID-19 pandemic, the number of daily cases has varied considerably due to the fluctuating nature of the epidemic. In addition to tasks related to the pandemic, health care has also had to fulfil the obligations laid down in the Health Care Act. For this reason, it has not been possible to allocate at each peak of infections the number of personnel required to deliver the isolation decisions to the parties concerned without delay as it would have affected the other activities specified in legislation. We have therefore developed our activities so that the infected person receives the information on their infection without delay and the instructions for isolating to prevent further infections by text message.
– We are aware that this text message is not legally binding, in other words, if someone has refused to isolate on the basis of the message, sanctions under criminal law have not been imposed on them. A legally binding oral service on isolating has been given by phone. After the decision had been served, the physician responsible for communicable diseases has issued a written decision as soon as possible, mainly within 1 or 2 days. The written decision by the physician responsible for communicable diseases has been sent as an e-letter to the person ordered to isolate. If the person ordered to isolate has wished to receive the decision more quickly, with their permission, we have sent it to them as an attachment to a secure email, if necessary.
– The number of COVID-19 infections began to increase fast in December 2021. As a result of this development, the delays in tracing infections became unreasonably long, and the tracing of infections proved to be an ineffective way to limit the epidemic. For this reason, Vantaa and many other municipalities no longer order people with COVID-19 to isolate, apart from exceptional cases, in other words mainly in social welfare and health care units. In these exceptional cases, the physician usually issues the written decisions on the same day or on the following day at the latest, and they are sent to the persons ordered to isolate as an e-letter on the same day.
– Due to the rapid multiplication of cases, Vantaa has several thousand people who were infected in January and were advised by text message to stay isolated. Although this guidance is not legally binding, we make the decisions on isolation retrospectively to safeguard their rights to the allowance on account of an infectious disease.

Issuing decisions referred to in the communicable diseases act and provision of advice

The Deputy-Ombudsman stated that the City of Oulu had acted unlawfully when it did not draw up and serve quarantine decisions in accordance with the Communicable Diseases Act. It was the practice of the City that a written decision was issued only to those ordered to isolate. No written decision was issued to those ordered to quarantine unless the person had been suspended from work or studies. In such cases, a certificate for the quarantine could be obtained only on separate request.

The Deputy-Ombudsman noted that failure to issue a written decision effectively prevented the possibility to appeal against quarantine decisions, which is secured as a fundamental and human right. Furthermore, because of the procedure, the person ordered to quarantine did not have the opportunity to submit a request to the appeal authority to have the enforcement of the decisions prohibited or suspended in connection with the appeal. The city justified its actions with a large number of decisions under the Communicable Diseases Act.

The Deputy-Ombudsman stated that, as isolation and quarantine decisions under the Communicable Diseases Act significantly restrict the freedom of the individual, the City should have allocated sufficient resources for devising up and posting the quarantine and isolation decisions so that they could have been served on the parties concerned without delay. The Deputy-Ombudsman referred to her decision 3535/2020 on the delay in issuing a written decision to isolate.

In addition, the Deputy-Ombudsman drew the City's attention to the fact that persons assigned to quarantine and isolate must be given clear instructions on the importance of the decisions and contact details for requesting further information.

The Deputy-Ombudsman found it concerning that the City did not recognise its violation of the complainant's fundamental right to legal protection. The Deputy-Ombudsman issued a reprimand to the city for the future. The Deputy-Ombudsman asked the City to report by 28 February 2022 on what actions it had taken as a result of her decision (8324/2020).

– On 28 February 2022, the City of Oulu reported the following. The City of Oulu changed its practices of ordering to isolate and tracing infections in February 2022 in accordance with the instructions of the Ministry of Social Affairs and Health and the Northern Ostrobothnia Hospital District, which is why fewer quarantine and isolation decisions are now made. All administrative decisions are also served in writing, including the appeal instructions.

Organising family coaching

In spring 2020, the Päijät-Häme Joint Authority for Health and Wellbeing cancelled all family coaching and antenatal groups, even for first-time mothers.

The Substitute for the Deputy-Ombudsman stated that the Emergency Powers Act laid down provisions on powers that could be implemented in emergency conditions and on practices to be complied with when implementing them. Under the Act, a municipality may waive compliance with the deadlines laid down in the Health Care Act in organising non-urgent care if this is necessary for organising urgent care and if exceeding the deadline does not endanger the patient's health. The provision was applied between 18 March and 15 June 2020 (government decrees 127/2020, 197/2020, 363/2020 and 444/2020).

On the basis of the government decrees, a municipality could waive compliance with the deadlines laid down in the Health Care Act in the organisation of non-urgent care in emergency conditions during the period 18 March–15 June 2020 if this was necessary to organise necessary urgent treatment and if exceeding the deadline did not put the patient's health at risk. According to the Substitute for the Deputy-Ombudsman, with the exceptions laid down in the decrees, the statutory requirements concerning the organisation of social welfare and health care services were also valid in exceptional circumstances.

This meant that the municipality had to organise the maternity and child health clinic services laid down in the Health Care Act and the support for parenthood and other well-being of the family included in them. Under the Government Decree on maternity and child health clinic services, school and student health services and preventive oral health services for children and youth, families expecting their first baby shall be provided with multi-professional family training including parents' group activities.

The Joint Authority for Health and Wellbeing cancelled the family training groups because of the coronavirus pandemic in accordance with the national instructions prohibiting group activities. The Substitute for the Deputy-Ombudsman stated that THL did not instruct to stop group activities or issue instructions prohibiting such activities.

On 18 March 2020, THL issued instructions to organise group-based meetings, such as family training, only as digital services. THL issued these instructions in a situation in which the number of infections increased rapidly and not much was known about the new disease. For example, there was insufficient information about the danger caused by the disease to expectant women and unborn children at that stage. It was difficult to give instructions for organising physical meetings safely at the time because very little was known about how the virus was transmitted and how effective the different means of preventing infections were. There was also a worldwide shortage of protective equipment and other supplies. THL updated its instructions on 18 May 2020 and stated that clients entitled to all statutory preventative services even in emergency conditions. In addition, THL stated the following: "It is recommended that group-based meetings, such as family training, other parents' groups and group-based support in student welfare be primarily organised virtually. If the group meets in the same space, the general instructions concerning gatherings are taken into account: the participants must not attend the meeting if they are ill, not even with mild symptoms, and safety distances must be observed."

The Substitute for the Deputy-Ombudsman stated that THL's updated instructions took into account the possibility of a group meeting in the same space and stated compliance with the general instructions applying to gatherings. Issuing instructions was one of THL's statutory tasks.

The Substitute for the Deputy-Ombudsman stated that the Päijät-Häme Joint Authority for Health and Wellbeing failed to meet its statutory duty when it cancelled the family training groups. However, the Substitute for the Deputy-Ombudsman considered it appropriate that, after having cancelled the family coaching groups, the Joint Authority for Health and Wellbeing enhanced the work of public health nurses during appointments and made individual virtual service packages available. The Substitute for the Deputy-Ombudsman brought her view on neglecting the statutory duty to the attention of the Joint Authority for Health and Wellbeing (3021/2020).

Access to non-urgent dental care

Deputy-Ombudsman stated that on the basis of government decrees (127/2020, 197/2020, 363/2020 and 444/2020), a municipality could waive compliance with the deadlines laid down in the Health Care Act in the provision of non-urgent care in emergency conditions between 18 March and 15 June 2020, if this was necessary for arranging urgent care and if exceeding the deadline did not put the patient's health at risk. Apart from the exceptions laid down in the decrees, the statutory requirements concerning the provision of health and social services were also in force in emergency conditions.

This meant that the provision in section 4 of the Patient Act on informing the patient of the time of access to treatment had to be applied also in emergency conditions. This provision means that the patient must be informed of when they will be treated and they can no longer be left waiting for treatment for an indefinite period of time. In the Parliamentary Ombudsman's ruling practice, it has been considered sufficient to inform the patient of the time of access to treatment with one month's accuracy.

The Substitute for the Deputy-Ombudsman was of the view that the oral health care of the joint municipal authority for Kymenlaakso social and health services (Kymsote) should have informed the complainant of the dates of access to oral and dental examinations and treatment in accordance with section 4 of the Patient Act and not leave the complainant to wait for the examination and treatment for an indefinite period of time.

The Substitute for the Deputy-Ombudsman informed Kymsote of his understanding of the statutory obligation to inform the complainant of the dates of oral and dental examination and treatment. He also made Kymsote aware of his views on an alternative procedure for booking an appointment with the complainant.

It could not be considered good practice to remain waiting until the complainant's need for treatment became urgent. The care instructions given to the complainant on the purchase and use of temporary filling material were not appropriate, especially as the complainant was an older person aged 78 (3335/2020).

4.2.9 RIGHTS OF THE CHILD

As is well known, the coronavirus pandemic has made children's lives more difficult in many ways. The Parliamentary Ombudsman's Annual report 2020 referred to an assessment made by the COVID-19 working group of the Child Strategy and its proposals for the implementation of the rights of the child (Children, youth and the Covid-19, Publications of the Finnish Government 2021:2, Abstract in English). It stated that the COVID-19 pandemic had had a severe impact on the well-being of children and young people. The pandemic was said to have worsened the position of vulnerable children and families in particular.

In the year under review, concerns about the impacts of the coronavirus pandemic on children have been repeatedly brought up in public. In 2021, the Finnish Institute for Health and Welfare (THL) published research findings that gave cause for concern. In the School Health Promotion study conducted in spring 2021, approximately 30% of girls and 8% of boys in their teens reported having experienced moderate or severe anxiety. Anxiety had increased in both boys and girls from the 2019 survey, but the increase had been stronger among girls. Approximately one in ten boys and one quarter of girls also reported having experienced loneliness fairly often or continuously. The experiences of loneliness had become more common since the 2019 survey. (The pandemic and young people's mental health, The School Health Promotion study 2021, THL 55/2021). The same data from the School Health Promotion study also served as a basis for another study, which specifically concerned the school attendance and well-being of children and young people placed outside the home (School attendance and well-being of children and young people placed outside the home in the shadow of the coronavirus in 2021, THL 72/2021, in Finnish). The most alarming result of the study was that 40% of the teenagers who had been placed outside the home had had self-destructive thoughts, more than one third (35%) had harmed themselves, and 14% had tried to commit a suicide several times during the preceding year. According to the study, small children placed outside the home had also been worried, most of all about their family members becoming infected with coronavirus.

A survey targeted at child welfare in municipalities revealed that the number of child welfare clients in municipalities had increased in 40% of the municipalities and the number of child welfare notifications in 47% of them. The increase in child welfare notifications had most often concerned the education services (51%). Based on the same survey, it was found that compared to autumn 2020, it had been increasingly challenging for child welfare clients to receive the health and social services they needed. It had been particularly difficult to obtain education services or pupil welfare services (in 56% of municipalities) and child and adolescent psychiatry services (in 62% of municipalities, Impacts on COVID-19 on child welfare part 2, THL 16/2021, in Finnish).

The serious shortcomings in the well-being of children and services intended for children identified in the studies have not – at least not immediately – been reflected in the complaints received by the Office of the Parliamentary Ombudsman. The number of complaints related to the coronavirus pandemic in different subject categories has remained relatively low and, for example, they do not seem to explain the increase in the number of complaints related to the rights of the child. However, it cannot be excluded that the effects of the coronavirus pandemic on the increased malaise of children and families with children have also increased dissatisfaction with the social welfare and health care services, among other things, and the resulting dissatisfaction may also have contributed to the increase in the number of complaints.

However, direct impacts of the coronavirus pandemic on the realisation of children's rights have been assessed in the decisions made in 2021 as well. Some of the decisions have been described in the subject categories specific to the administrative sectors in this section dealing with the coronavirus pandemic, for example, child protection matters in subsection 4.2.7 (Social welfare) and basic education in subsection 4.2.16 (Education and culture). Section 4.2.4 dealing with the criminal sanctions field also describes a case concerning the restrictive measures taken by the Criminal Sanctions Agency due to the coronavirus epidemic and investigated by Deputy-Ombudsman Pölönen on his own initiative. The restrictions also made it more difficult for children to meet their parents who were in prison (2606/2020). The explanatory report on the cancelling of family training groups because of the coronavirus pandemic (3021/2020) in section 4.2.8 dealing with health care is also related to the realisation of the rights of the child. Article 24 of the Convention on the Rights of the Child ensures the right to appropriate health care, not only for children themselves, but also for prenatal and postnatal mothers (Article 24(d)). It also ensures the right of everyone and particularly the right of parents and children to have basic knowledge of child health and, for example, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents (Article 24 (e)).

4.2.10 RIGHTS OF OLDER PERSONS

During the coronavirus pandemic, the public target set by the highest organs of government has been to ensure the adequacy of health care resources and protect particularly the risk groups from infection. The emphasised aim of protecting life in the care of older persons has raised questions about the implementation of other fundamental and human rights.

Reports on the impacts of the coronavirus pandemic reveal older people's experiences of loneliness and the low level of outdoor activities. According to the results of the THL's client satisfaction survey targeted at the clients of home care and 24-hour care in elderly care (Kehusmaa S, Siltanen S, Leppäaho S, 2021, Well-being during the coronavirus epidemic – results of the client satisfaction survey in services for older people. In Finnish), approximately one half of the respondents reported they had seen their family and friends less than they would have wanted to or not at all during the pandemic. Many of the clients of services for older people who responded lived their life completely indoors.

A survey carried out by the Parliamentary Ombudsman and the Human Rights Centre in early 2021 on people aged over 70 shows that the respondents' use of all home care services increased during the coronavirus pandemic in comparison to the time before the pandemic. On the other hand, the use of all other social welfare and health care services decreased. The greatest decrease was in the use of medical services, oral health care, rehabilitation services and assistive equipment services at health stations. Municipalities had offered less than a fifth assistance with shopping, for example, due to the coronavirus pandemic.

In total, there were some 110 complaints concerning the coronavirus pandemic and older persons. The majority of them were in the administrative branches of social welfare and health care. In the year under the review, 116 complaints concerning the pandemic and older people were resolved. A majority of the complaints concerning the COVID-19 pandemic concerned coronavirus vaccinations. For example, 61 complaints concerning vaccinating persons aged between 65 and 69 only with the AstraZeneca vaccine were resolved. Twenty-seven complaints concerning restrictions on visits to social welfare and health care units were resolved.

Inspection findings related to the pandemic have been reported in section 3.5.

Four own initiatives related to the pandemic and older people were resolved. The initiatives concerned the main shortcomings that had been detected in the oversight of legality.

Decisions

Limiting the use of AstraZeneca's covid-19 vaccine to persons aged 65–69

The Deputy-Ombudsman considered that the press release published by the Finnish Institute for Health and Welfare (THL) on 24 March 2021 led to treatment that violated the right to self-determination of the age group of 65–69-year-olds and put them in a less favourable position than others. The press release was misleading and deficient, which led to many municipalities complying with it as if it had been a decision or regulation binding municipalities. According to the Deputy-Ombudsman, the action taken by these municipalities was incorrect. Municipal bodies and officials must be responsible for the lawfulness of the decisions and other measures they take within their competence.

THL acted against the requirements of conformity to law of public administration when it did not conduct a legal assessment while preparing the guidelines on the use of AstraZeneca's coronavirus vaccination.

The Ministry of Social Affairs and Health neglected its statutory responsibility to guide and supervise an institution subordinate to it to ensure that THL takes into account the provisions laid down in the Constitution when preparing the guidelines.

The Deputy-Ombudsman issued a reprimand for future reference to THL and the Ministry for their unlawful actions. The Deputy-Ombudsman informed the cities of Espoo, Helsinki, Lahti, Tampere and Vantaa and the Central Uusimaa Social and Health Care Authority of her understanding that their actions had been unlawful (3432/2021).

– The Ministry of Social Affairs and Health has reported that it will together with THL assess how the lawfulness of the guidelines to be published will be ensured in similar situations in the future. THL has reported that it will assess the Deputy-Ombudsman's decision and take the necessary corrective measures among other things by modifying the texts in its guidelines again. According to THL, the guidelines issued by it were by nature recommendations, not regulations, and this must be clearly indicated in them.

Implementation of informal care during the coronavirus pandemic

During the coronavirus epidemic, municipalities cut down services such as daytime activities and short-term episodes of care, which are implemented as part of support for informal care. Based on the information received during an inspection (1389/2020), sufficient replacement services were not available. The Deputy-Ombudsman noted that the closure of the services may have caused unreasonable circumstances for the families under support for informal care because some of the families may have accumulated service needs already before the coronavirus outbreak due to the long intervals between the updates of their care and service plans. The Deputy-Ombudsman emphasised that municipalities and joint municipal authorities must organise the required social welfare and health care services even during a state of emergency and the services already granted to the client must be organised (3372/2020).

Monitoring the quality of institutional and sheltered housing in the care for older persons during the coronavirus epidemic

In 2019 and 2020, the Deputy-Ombudsman investigated on her own initiative (4944/2019) how municipalities could preventatively ensure that an individual older person with a memory disorder is not mistreated. The Deputy-Ombudsman considered it justified to take the initiative of investigating how the municipalities involved in the report had changed their operations during the coronavirus pandemic.

The Deputy-Ombudsman emphasised the responsibility of municipalities in monitoring the services of clients in a vulnerable position. The municipal authority responsible for organising the services has the primary responsibility for preventing any shortcomings. The importance of the actions taken by municipalities has been emphasised during the emergency conditions as it has been more difficult for relatives and family members to observe the care and treatment received by an older person with a memory disorder.

Municipalities' practices regarding services for older people have been partly incorrect during the coronavirus epidemic. The actions have prevented mass deaths, but emphasising the protection of life and health has led to excessive narrowing of other fundamental rights that has not been based on law, especially in the case of persons with memory disorders. The rapidly changing and inadequate instructions and deficiencies in legislation have made the activities of social welfare and health care professionals more difficult. There have also been shortcomings in the knowledge of current legal norms and in their application.

Despite the new national corrected instructions, the Deputy-Ombudsman still considered it a risk that elderly care units unnecessarily limit the rights of older people on the basis of health security.

The Deputy-Ombudsman stated that it has been possible to enhance the implementation of the rights of older people by observing current legislation and introducing best practices from different municipalities. However, based on the observations made in the oversight of legality, it must be assessed what parts of the legislation should be clarified and supplemented in future so that protecting life and health will not cause unnecessary suffering to older people in a vulnerable position in the future.

The efforts of institutions and service housing units in Finland to protect the health of their residents has in practice meant different kinds of restrictions in terms of their activities and other interaction. For this reason, the Deputy-Ombudsman considers it extremely important that there are also other alternative ways to organise housing in addition to large housing units. However, several reports also highlight the efforts of large units to avoid restrictions and to take individual situations into account. Efforts have been made to promote encounters with family members by means of various technical solutions, and services that bring content to life have been organised remotely or by the staff of the unit.

The Deputy-Ombudsman emphasises that municipalities must as part of self-monitoring continue to ensure that staff are familiar with the valid legal norms they must observe in their work. Despite national press releases, the Deputy-Ombudsman has noticed a phenomenon in which local operating practices have been unlawful either because the instructions have originally been unlawful or open to interpretation, or because the management has not followed up what compliance with the instructions has led to in practice (2688/2020).

Implementation of meetings and movement of older people in care units during the coronavirus pandemic

According to the information received, several municipalities had issued instructions that they had required to be followed strictly. This had either been explicitly stated in the report provided or it emerged from the report as permits were mentioned that could be granted on a discretionary basis, or certain conditions on which home holidays or visits to a resident's room were allowed. The Deputy-Ombudsman stated that instead of instructions and recommendations, these were orders that could not have been ignored. Such orders are unlawful.

The Deputy-Ombudsman stated that the Communicable Diseases Act does not include a provision that would justify a unit for sheltered housing with 24-hour assistance to proactively limit the duration of meetings of all residents, prohibit meetings in the resident's own room or require the presence of staff when residents meet people.

The Deputy-Ombudsman found it understandable that the Finnish Institute for Health and Welfare had attempted to issue guidelines on health grounds to effectively prevent the spread of COVID-19. The guidelines can also be considered to have played a major role in preventing infections and deaths in care units.

However, the Deputy-Ombudsman emphasised that the units do not have the right to order residents or their families to comply with restrictions that are not based on law. A good practice has been to provide residents and their families and friends with information on the means available for carrying out meetings safely and the opportunity to implement them in practice. Residents may also be informed of recommendations in this regard.

The Deputy-Ombudsman stated that, to extent health security experts consider it strictly necessary to comply with the instructions in use in order to safeguard life and health in situations involving communicable diseases, the necessary changes should be made by means of legislation.

Municipalities have not complied with the statutory obligation to ensure that a professional acting as a municipal officeholder has been appointed as a personal worker for an older person with a memory disorder living in an institution or a sheltered housing unit. During the coronavirus epidemic, this shortcoming has resulted in family members having felt that they have been left on their own in situations where the activities of the sheltered housing unit have been illegal in individual situations and/or it has been more difficult than usual for them to monitor the quality of care and care received by their loved one (5463/2020).

– The Government has submitted a proposal to Parliament (HE 231/2021 vp.), in which it is proposed that the tasks of a personal worker be specified in the Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons.

Implementation of contact with a family member

The complainant criticised the actions of the infections ward of Tampere University Hospital (Tays) in implementation of contact with the complainant's spouse who had coronavirus. The complainant themselves was in quarantine because of exposure to coronavirus and did not consider it possible to visit the hospital. The complainant's spouse died of coronavirus on the ward.

A seriously ill patient or the patient's family do not necessarily think of the possibility to talk with each other over the telephone in the acute phase of the disease and that they should specifically ask for this. If the patient's prognosis for recovery is poor, the Deputy-Ombudsman considered it important for respect for the patient's family life that the nursing staff also ask the patient on their own initiative, if the patient's situation so permits, about their willingness to contact a family member or a person close to them.

Similarly, in the Deputy-Ombudsman's view, when a family member contacts the nursing staff, they should also be asked about this, especially if it is known that the family member or the person close to the patient themselves has special challenges with coming to visit the patient at the hospital. Furthermore, the Deputy-Ombudsman considered that the family member or the person close to the patients in terminal care should be informed of the possibility to visit when there is one and in such a way that they understand the procedures that may be associated with it (1531/2021).

4.2.11 THE RIGHTS OF PERSONS WITH DISABILITIES

During the year under review, 50 cases of legal oversight matters concerning the rights of persons with disabilities and related to the coronavirus epidemic were resolved. Most of the cases concerned the administrative branches of social welfare and health care. It was necessary for the Ombudsman to take action in a total of 22 decisions and in 7 of them, the authority was considered to have acted unlawfully.

A considerable number of the resolved cases were related to restrictions on visiting and movement in housing units for persons with disabilities or to deficiencies in ensuring services. Especially at the beginning of the epidemic, the authorities and parties responsible for the operation of housing units for persons with disabilities made categorically restrictive decisions that directly affected the realisation of the fundamental and human rights of persons with disabilities. In addition, the authorities did not always otherwise take sufficient care of an individual client's right to receive the services granted to them, either (e.g., daytime activities). Individual complaints concerned the vaccination passport, the allowance on account of an infectious disease, the use of a mask and communication of information.

The Deputy-Ombudsman issued a statement (7992/2020) concerning a collective complaint made in accordance with the European Social Charter. In the complaint, it was claimed that Finland had violated the rights of persons with disabilities living in housing units through the restrictions imposed to prevent the spread of the coronavirus pandemic, including bans on visits.

Decisions

Restrictions concerning visits in a residential service unit for persons with disabilities

In his decision 5944/2020, the Ombudsman emphasised that the health and safety of every resident must be ensured in group housing of disability services in all circumstances. Despite this, the residents' right to movement and communication and their other fundamental and human rights cannot be restricted even in exceptional circumstances (COVID-19) without a legal basis or excessively in some other way. In the changing circumstances during the current pandemic, the responsibility for assessing and making a decision concerning an individual situation and resident rests with the management of the housing unit or other competent officeholder or employee. In addition, the Ombudsman emphasised in general that the management responsible for the operations must always take care of and ensure that the instructions given to the staff are legal and that, on the basis of the instructions, the staff can and know how to act as required by legislation. In this context, the case did not lead to other actions by the Ombudsman. This was because according to case law, the complainant had the opportunity to bring the matter (decision or instructions) concerning the visiting restrictions at the housing unit before the Administrative Court as an appeal.

Quarantine regulations at a care home

In his decision 6353/2020, the Ombudsman considered the actions of the care home unlawful when it obliged the resident to 2-week quarantine or self-isolation because the resident had been outside the housing unit and met people other than those living in the housing unit in autumn 2020. The Ombudsman considered that the obligation to quarantine was not in accordance with the Communicable Diseases Act, and the procedure had interfered with the residents' rights laid down in the Constitution.

The Ombudsman stressed that a resident can only be isolated or quarantined by a decision made by a physician in charge of communicable diseases in a public-service employment relationship in accordance with the Communicable Diseases Act. There is no right to restrict residents' freedom of movement or other fundamental and human rights without a basis laid down in legislation, and quarantine or other isolation based on instructions is thus not legal.

In the same case, the Ombudsman considered it an inappropriate procedure to have a categorical policy according to which the personal carer carries out the resident's shopping. According to the Ombudsman, the care home should have assessed on an individual basis whether the shopping carried out by the resident themselves could be done safely.

Using a personal assistant during emergency conditions

In case 4247/2020, the Deputy-Ombudsman informed social welfare services that the services had acted reprehensibly when restricting the client's right to a personal assistant in spring 2020, even though the client's possibility to participate in recreational and daytime activities had been secured in other ways. A personal assistant had not been able to enter the housing unit and could not participate in the activities outdoors either. As a result, the Deputy-Ombudsman drew the attention of social welfare services to the fact that, during exceptional circumstances, a person with a disability must be provided with the services that they have been granted on the basis of an individual need. The management responsible for the operations must always take care of and ensure that the instructions given to the staff are in accordance with the law and that, on the basis of the instructions, the staff can and know how to act in accordance with legislation.

In addition, the Deputy-Ombudsman emphasised at a general level that, in the changing circumstances during the coronavirus pandemic, the housing units for persons with disabilities must individually and continuously assess how and to what extent the client's right to services and communication can be lawfully implemented. The Deputy-Ombudsman stressed that a resident's fundamental and human rights, such as communication and movement, cannot be restricted without grounds laid down in law, such as in the Communicable Diseases Act or the Act on Persons with Intellectual Disabilities, or excessively in some other way.

A patient on a ventilator gets an assistant who refuses the vaccination

In the Deputy-Ombudsman's view, no one in the highest risk groups should have to face a situation in which they are forced to accept that the person assisting them does not have the best protection available against a life-threatening disease. The obligation of public authorities to protect the life and health of everyone requires that the necessary services can be organised without endangering the health or life of a person dependent on them. The Deputy-Ombudsman considered supplementing legislation necessary in this respect 1291/2021.

– The legislative amendment was implemented by adding section 48 a to the Communicable Diseases Act. The section entered into force on 1 January 2022 and will remain in force until 31 December 2022.

Other decisions

In case 3882/2020, the resident's opportunities to go shopping had been restricted in involuntary special care. The Ombudsman emphasised at a general level that, in the changing circumstances during the coronavirus pandemic, housing units for persons with disabilities must assess individually and continuously how and to what extent the client's right to movement can be lawfully implemented and, if necessary, to develop alternative methods for enabling the use of services. For other aspects of this decision, please see Section 3.14 The rights of persons with disabilities.

In case 6781/2020, the Ombudsman brought to the attention of the services for the disabled the views he had presented on the obligation to secure services for persons with disabilities and determining the individual need for services during exceptional circumstances. Because of the coronavirus pandemic, not all services have been available for health security reasons. In spite of that, a person with a disability must be provided with the daytime activities granted to that person – in an appropriate form.

In case 4628/2020, the complainant's medical rehabilitation (pool therapy) was not implemented due to the state of emergency in spring 2020. After this, Kela considered that it no longer had to provide the complainant with rehabilitation once the complainant had turned 65.

When assessing the matter afterwards, the Substitute for the Deputy-Ombudsman felt that it would have been a justified procedure for Kela to issue an appealable decision on the rehabilitation matter to the complainant. This should have been done even though in Kela's view, the age limit laid down in law does not allow for case-by-case consideration and that the coronavirus pandemic would therefore not be significant when assessing the right to rehabilitation. In the Substitute for the Deputy-Ombudsman's opinion, Kela should at least have asked the complainant, within its procedural obligation to provide advice, whether the complainant wished to resubmit their case orally as permitted by Kela.

Other decisions concerning persons with disabilities (such as persons with memory disorders) are described in this section under the subject categories specific to the administrative branches, such as 4.2.10 (Rights of the older persons) and 4.2.8 (Health care).

Inspection visits

In the year under review, the remote inspections started in the preceding year and focusing on a housing unit for persons with severe disabilities and five institutional and housing service units for persons with intellectual disabilities were completed (3649-3654/2020). In these mainly document-based inspections, the Ombudsman investigated how the coronavirus epidemic had affected the activities of the operating units and the treatment and conditions of residents during the epidemic.

In the year under review, the sites inspected were the City of Vaasa (Purohovi housing unit) 3996/2021, the Central Ostrobothnia Joint Authority for Social and Health Services Soite 3995/2021 and the Rekola Respiratory Paralysis Unit 4128/2021.

The above-mentioned inspections are discussed in more detail in section 3.5.

The Parliamentary Ombudsman carried out unannounced visits to the advance polling stations of municipal elections in eight different municipalities in the south of Finland. The visits focused on the exceptional arrangements at the polling stations due to COVID-19. Based on the observations, the polling stations had acknowledged the current exceptional circumstances well and taken care of the related health safety matters 3250/2021. In his decision 5758/2021, the Ombudsman considered it important at a general level that, when organising future training for election boards and electoral commissions, the central municipal election boards pay particular attention to health security issues (COVID-19) and other unusual voting arrangements.

4.2.12 GUARDIANSHIP

No guardianship matters related to the coronavirus pandemic were filed during the year under review. One such case was resolved and did not lead to any action. The case concerned extending the period for submitting a guardian's annual accounts due to the coronavirus outbreak (4479/2020).

4.2.13 SOCIAL INSURANCE

The impact of the coronavirus pandemic on the number of complaints in the social insurance sector has always been very small, and fewer than ten complaints related to emergency conditions were handled in the year under review. The criticism in them mainly focused on Kela. In the decision 3933/2021, Kela had informed the complainant of having postponed the decision on the complainant's housing allowance to be able to take into account a provision in the exceptive act concerning an increase in the exempt amount of the unemployment benefit. As a result, the statutory deadline for processing the complainant's housing allowance was exceeded. Kela had adopted the procedure from the point of view of the smooth functioning of its own decision-making process and reported that it considered carefully in whose case it waits for the entry into force of the exceptive act. However, the Deputy-Ombudsman reminded Kela of the need to comply with the statutory deadline.

In early spring 2021, the number of applications for the allowance on account of an infectious disease received by Kela began to increase dramatically. Only a few complaints concerning them was received and they did not lead to measures. However, the amount of work required at Kela to process matters related to the allowance on account of an infectious disease was a key factor contributing to the severe congestion in the processing of sickness allowance matters before Kela managed to recruit new employees in May. In December, the Deputy-Ombudsman issued his decision on complaints concerning the processing times of sickness allowance matters.

4.2.14 LABOUR AND UNEMPLOYMENT SECURITY

In 2021, the number of unemployed jobseekers fell clearly, being at almost the same level at the end of the year as before the pandemic. In the subject category, five complaints were filed and five were resolved. Three of the decisions concerned the actions of TE Offices (Employment and Economic Development Offices), one a city's employment services and one the actions of the occupational safety and health authority.

Two of the decisions on the complaints led to actions by the Deputy-Ombudsman, both of which concerned the processing time of a matter concerning unemployment benefit at the TE Office. The number of complaints in this category decreased clearly from 2020, when there were 44 complaints and decisions.

4.2.15 GENERAL MUNICIPAL AFFAIRS

In the year under review, the Office of the Parliamentary Ombudsman received numerous complaints, slightly over 70, criticising the coronavirus restrictions imposed by municipalities and Regional State Administrative Agencies. Because the restrictions subject to criticism were based on provisions in the Communicable Diseases Act, laid down by Parliament's decisions, and the lawfulness of the decisions of the Regional State Administrative Agencies could be resolved by appealing to administrative courts, the complaints did not lead to any action by the Deputy-Ombudsman.

4.2.16 EDUCATION AND CULTURE

The continuing coronavirus pandemic continued to have an effect on school attendance and the provision of education at all levels of education. As the situation with the pandemic varied regionally, some of the pupils and students have been without contact teaching for a long time. Concerns about the gaps in the learning and well-being of children and in the implementation of support for learning emerged in the public debate.

In this category, 75 complaints related to the coronavirus epidemic were filed in the year under review and 198 were resolved. A considerable number of the resolved cases concerned universities' actions when the criteria for student selections were changed in spring 2020. A large part of the other complaints related to the COVID-19 pandemic concerned the obligations or recommendations to use a mask set by different actors and the requirement that the vaccination passport had to be presented in different contexts.

Decisions

Changing over to exceptional teaching arrangements

The Deputy-Ombudsman stated that the decision made by the City's director of education to move grades 6–9 in basic education to distance learning, or to the exceptional teaching arrangements referred to in the Basic Education Act, did not meet the conditions laid down in the Act. The decision had been based only on a recommendation issued by the joint municipal authority of the hospital district, and it had not been appropriately preceded by a decision on the closure of educational institutions issued under the Communicable Diseases Act by the municipal body responsible for combating communicable diseases or the Regional State Administrative Agency (1965/2021).

Changing the criteria for student admissions

According to the Deputy-Ombudsman, universities did not act unlawfully when changing their student admission criteria in spring 2020 and using an electronic pre-selection examination. The joint application to universities took place at the outset of the coronavirus pandemic and a national a state of emergency. Traditional entrance examinations were not organised and universities changed the already announced admission criteria after the deadline for applications in the joint application process.

An exceptionally large number of complaints about student admissions were received (107). The complaints concerned, in particular, increasing the proportion of certificate-based admissions, communication about the changes, the necessity to cancel the physical examinations and problems related to the electronic pre-selection examination, especially the possibility of cheating. The Deputy-Ombudsman considered it important to investigate the matter at a general level, even though he did not take a stand on individual student admission decisions or the appropriateness of the admission criteria for individual fields due to the regular possibility of appealing.

The Deputy-Ombudsman examined changes to the admission criteria from the perspectives of universities' examination duty, legitimate expectations, equality, proportionality requirement and information provision. In addition, he examined matters related to electronic pre-selection and universities' preparedness for emergency conditions with regard to student admission. The Deputy-Ombudsman considered universities to have properly investigated alternative ways of organising student admissions and to have provided information on the changes as soon as possible and to the extent this had been possible under the prevailing circumstances and based on their knowledge. Furthermore, universities had not misused their discretion. The Deputy-Ombudsman also considered the use of electronic pre-selection acceptable under the prevailing conditions (2628/2020, etc.).

DECISIONS ON MANDATORY USE OF MASKS

The Parliamentary Ombudsman received several complaints about the obligation to wear a face mask set by different actors.

Obligating a student to wear a face mask or a respirator in the premises of the higher education institution was ultimately a question of restricting and securing fundamental rights and weighing them. The Constitutional Law Committee had stated that the proposed limited obligation to use a face mask or respirator to mitigate the coronavirus pandemic was a relatively minor restriction on fundamental rights. In spite of this, according to the Deputy-Ombudsman, the obligation interfered with the person's right to self-determination and personal liberty in higher education institutions. Therefore, the matter should have been assessed on the basis of the general preconditions for restricting fundamental rights, which would have been above all the task of the legislator. However, there was no explicit regulation on the matter, for example, in the Communicable Diseases Act or in legislation on education.

Even before the pandemic, safety-based protective equipment (including masks) had been required in higher education institutions in certain teaching situations and facilities on the basis of regulations on a safe learning environment and occupational safety. Some of the higher education institutions had concluded that these regulations provided sufficient legal grounds for extending the obligation to wear a face mask or respirator during the coronavirus pandemic so that they still applied to limited situations and facilities. The Deputy-Ombudsman considered this interpretation possible, especially if the student had had the opportunity, for example, for health reasons to use a space where a mask was not required.

In the majority of the higher education institutions, a recommendation to use a mask had been issued instead of an obligation, at least formally. However, the difference between an obligation and a recommendation was not always clear in the communication of higher education institutions. The Deputy-Ombudsman found the possible confusion between the recommendation and the obligation problematic. Higher education institutions had specified the communication on the basis of recommendations given by the health authorities and when knowledge related to the management of the pandemic had increased. The Deputy-Ombudsman found this good. As regards the cost of masks, the Deputy-Ombudsman stated that the legal basis was not unambiguous. It was significant whether the masks were protective clothing that were part of teaching and required for organising the teaching or protective equipment required by occupational safety regulations, which in turn depended on how the teaching had been organised. In any case, the Deputy-Ombudsman considered the practice mainly implemented by higher education institutions good as they offered students masks in situations where masks were required (4732/2020).

The Deputy-Ombudsman also assessed the requirement to wear a mask in a City's libraries. The decisions had been duly justified with the principles guiding and restricting the discretionary power laid down in the Administrative Procedure Act. An effort had been made to organise the services fairly, taking into account everyone's possibility to use the services in the coronavirus situation. Requiring a mask was proportionate compared with having to completely close the libraries. The severity of the epidemic situation, the vaccination coverage in the population and knowledge of the usefulness of masks played an important role. However, the decisions may in principle have been subject to criticism because the exercise of public authority must be based on law and there was no norm base clearly justifying the obligation to wear a mask. Mandatory use was later changed into a recommendation and legal protection routes in accordance with the Local Government Act had been available to determine the lawfulness of the decisions. The complaints did not lead to any action (270/2021, 400/2021, 814/2021 and 1039/2021).

The actions taken by an art museum in a case concerning the use of face masks did not lead to any action by the Deputy-Ombudsman, either (7529/2020).

Communication of travel information

The Deputy-Ombudsman assessed the information provided by a university of applied sciences to its students and staff about travelling during the coronavirus pandemic in spring 2020. According to the bulletin, staff and students could travel abroad only with the rector's permission, and domestic travel should also have been avoided so that travelling would be limited to what was necessary. The primary purpose of the bulletin had been to centralise the decisions on students' study trips and staff's work trips to the rector and, while following the development of the COVID-19 situation, restrict if necessary the study trips abroad that were supported by the educational institution. In this respect, the wordings in the bulletin had failed. As the university of applied sciences had corrected the bulletin to correspond to its original purpose and no harm had been caused by the bulletin, the Deputy-Ombudsman was satisfied with drawing the institution's attention to carefulness in its communications (1934 and 1937/2020).

4.2.17 LANGUAGE ISSUES

Language of the COVID -19 vaccination certificate

The Ombudsman assessed the language of the COVID-19 vaccination certificate that can be downloaded from the My Kanta system. The text sections of the certificate are in English before the sections in Finnish and Swedish, and the text in English has been printed in bold letters. In addition, the following text is only in English at the end of the certificate. "This certificate is not a travel document. The scientific evidence on COVID-19 vaccination, testing and recovery continues to evolve, also in view of new variants of concern of the virus. Before traveling, please check the applicable public health measures and related restrictions applied at the point of destination."

The COVID-19 vaccination certificate is a certificate granted by a Finnish authority. Its model or pattern has not been separately confirmed in EU legislation in a manner that binds the Member States, although the information contained by it has been determined in the relevant EU regulation. Under the regulation, the information in the certificates must be presented at least in the official language or languages of the Member State and in English. The regulation does not take a stand on the order of the language versions or the methods of presenting them, neither has it been required or even recommended at the level of the EU that the information related to the EU's COVID-19 vaccination certificate would be primarily in English and only secondarily in the national languages. In this respect, the decision on the matter has been made nationally.

As such, the national languages had been treated equally to the extent that the same information was available in both national languages. However, the national languages had been treated as secondary languages in relation to a foreign language. Considering the constitutional status of the national languages, the Ombudsman was of the opinion that if the same document contains text not only in the national languages but also in a foreign language or languages, the texts in the national languages take precedence over texts in the foreign languages. This starting point is not changed by the fact that the EU's COVID-19 vaccination certificate has two purposes, i.e. it functions as a vaccination passport in Finland, but it can also be used when travelling.

With regard to the text of the coronavirus vaccination certificate in English only, the Ombudsman stated that EU legislation does not seem to require that the text be in English only. Therefore, in principle, the national constitution and language legislation were to be complied with in the matter. The importance of the national languages was emphasised because the information in question was intended specifically for the holder of the certificate, i.e. the person travelling, and was essential information related to the purpose of the COVID-19 vaccination certificate and travelling, required to be explicitly mentioned in the certificate at the level of the EU regulation.

The Ministry of Social Affairs and Health informed the Ombudsman it was investigating the possibility to also add texts in the national languages for the above-mentioned section. The Ombudsman did not consider it necessary to investigate the matter further. However, he sent his reply to the Ministry for information and asked the Ministry to report what measures it had decided to take in the matter not only as a result of the investigation already announced by the Ministry, but also as a result of the Ombudsman's view of how other information on the vaccine certificate should be presented (primacy of national languages). After this information has been received from the Ministry, the Ombudsman will assess separately whether it is necessary to continue processing the matter on his own initiative (7210/2021).

Other decisions

Only the English expression “drive-in” was used in the signs at the coronavirus sample collection sites of a bilingual hospital district. The national languages had not been entirely disregarded by using the foreign language. Instead, a single foreign-language expression, which from the point of view of language guidance is an established expression and part of standard language, had been used in the signposts written in the national languages. According to the Ombudsman, from the perspective of the good language use referred to in the Administrative Procedure Act and obligations related to the use of national languages under the Language Act, it would in principle be justified for the authorities to use national-language equivalents for expressions or words of foreign origin insofar as they exist in standard language. On the other hand, it was not unlawful for the authority to use a word of foreign origin that was part of standard language. The matter was not investigated (1153/2021).

A bilingual city acted unlawfully in making a quarantine decision when the language the client used in the services was not checked and the decisions had not been made in the language chosen by the client, which was Swedish (3939/2020).

4.2.18 TRANSPORT AND COMMUNICATIONS

The complaints related to the pandemic concerned particularly the compulsory use of a mask on flights and public transport and the recommendations issued by the Finnish Institute for Health and Welfare (THL) to airlines, transport companies and shipping companies. Decisions concerning THL’s actions when issuing recommendations are described in section 4.2.8. There were also complaints concerning the news reporting related to coronavirus by Yleisradio Oy and the instructions issued by Posti on practices during the pandemic.

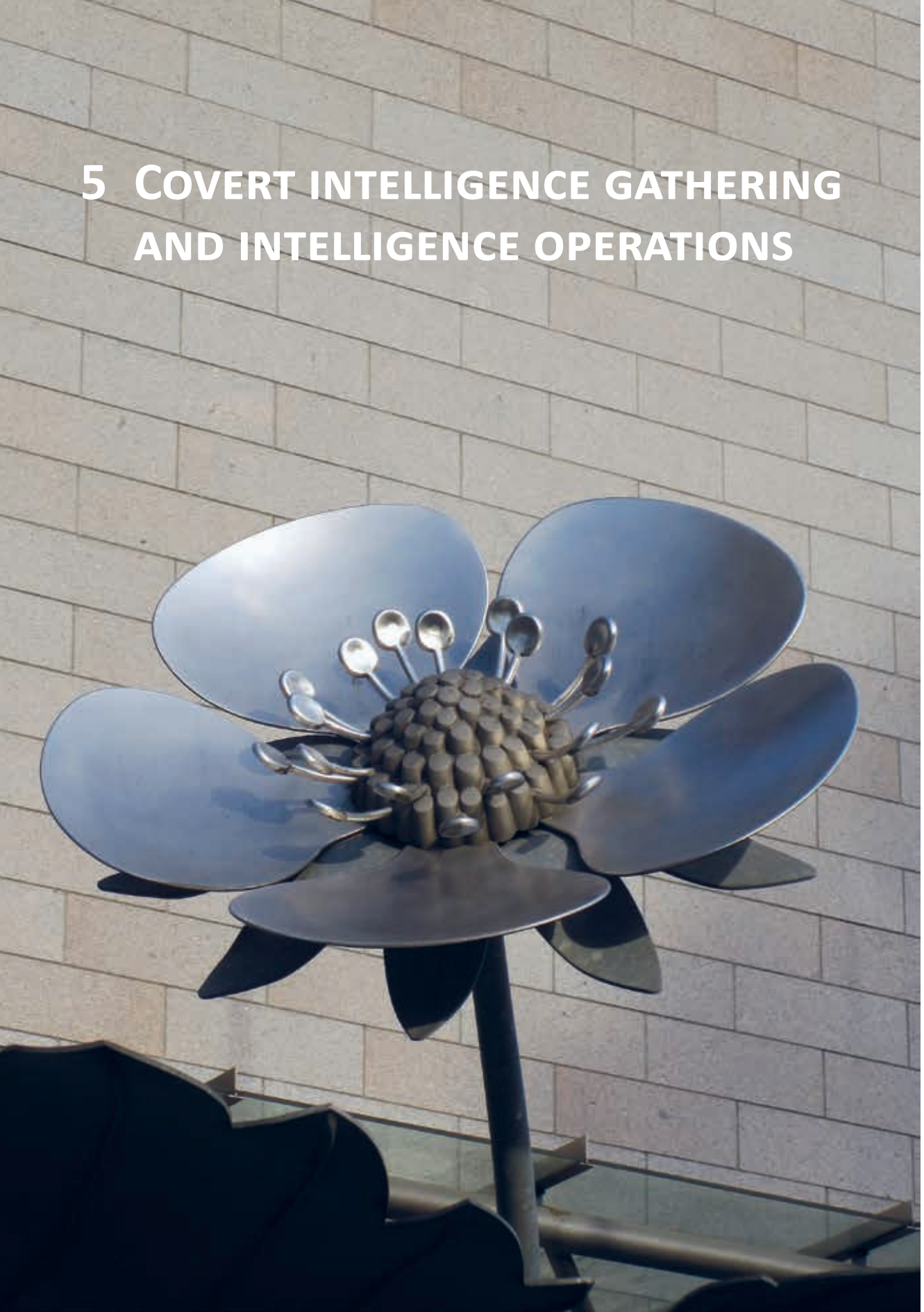
Two of the complaints related to the pandemic led to measures being taken. Both of them concerned the renewal of the driving licence of a complainant belonging to the risk group of the pandemic. In her decisions, the Deputy-Ombudsman stated that the Finnish Transport and Communications Agency had in its press release recommended that clients over the age of 70 and others in the risk groups cancel or postpone their visit to the service point or authorise someone to act on their behalf. Reducing the physical use of services by risk groups during the pandemic had thus been the aim of the Finnish Transport and Communications Agency as well. According to the Deputy-Ombudsman, the Agency should have emphasised to Ajovarma Oy that Ajovarma Oy should also in its own activities and in the customer service provided to the said risk groups make efforts to achieve this aim during the pandemic. This meant that Ajovarma Oy should have aimed to act in such a way that a person in the risk group would not need to make a physical visit to its service point unless the matter specifically required it. The decisions have been explained more extensively in section 5.23 dealing with transport and communications (1417/2021 and 1527/2021).

4.2.19
HIGHEST ORGANS OF GOVERNMENT

As in the previous year, the total number of complaints in this subject category was higher than usual due to the large number of complaints related to the coronavirus pandemic. The large number of complaints is in turn explained by the Government's central role in the management of the pandemic and by the fact that they concerned many measures that had a strong impact on fundamental rights and everyday life, be it individuals or entrepreneurs.
The majority of the complaints related to the pandemic concerned the vaccination passport and the restrictions on gatherings. Complaints were also filed about the preparation of the planned mandatory use of a mask and the Government's measures regarding coronavirus in general.

The complaints did not lead to any action by the Ombudsman. This is largely explained by the general nature of the complaints and the fact that the concrete coronavirus measures were based on law and on appealable official decisions based on law. For example, provisions on the vaccination passport are laid down in the Communicable Diseases Act, and different regional and local restrictive measures are based on decisions made by the Regional State Administrative Agencies and municipalities – not the Government – which can be appealed against to an administrative court. The Ombudsman does not have the power to investigate Parliament's use of legislative powers, nor does the Ombudsman in principle investigate a matter in which there is a regular possibility of appeal. The Chancellor of Justice's explicit duty to oversee the legality of the decisions made by the Government in the management of the coronavirus pandemic also plays a role.

5 Covert intelligence gathering and intelligence operations



5
Covert intelligence gathering and intelligence operations

The oversight of covert information gathering and intelligence operations fell within the remit of Parliamentary Ombudsman Petri Jääskeläinen. The principal legal adviser responsible for the area was Mikko Eteläpää. Themes included in this area are also presented by Legal Adviser Minna Ketola (until 24 January 2021) and Principal Legal Adviser Juha Haapamäki.

Covert intelligence gathering refers first of all to the covert coercive measures used in criminal investigations and to the corresponding covert methods of gathering intelligence that may be used to prevent or detect offences or avert danger. Such methods include, for example, telecommunications interception and traffic data monitoring, technical listening and surveillance as well as undercover operations and pseudo purchases. The use of these methods is kept secret from their targets and to some extent they may, based on a court decision, remain permanently undisclosed to the targets.

The police have the most extensive powers to use covert intelligence gathering, but the Finnish Customs also have access to a wide range of covert methods of gathering intelligence with respect to customs-related offences. The powers of the Finnish Border Guard and the Defence Forces are clearly more limited.

This chapter also discusses a report on the witness protection programme submitted to the Parliamentary Ombudsman. The witness protection programme act (laki todistajansuojeluohjelmasta 88/2015) entered into force on 1 March 2015. According to the act, the Ministry of the Interior must annually report to the Parliamentary Ombudsman on decisions and measures taken under the act.

In 2019, a new regulatory framework for intelligence gathering was adopted. The Act on the Oversight of Intelligence Gathering (121/2019) entered into force on 1 February 2019. The amendment to the Police Act, Chapter 5a (civilian intelligence, 581/2019), Act on Telecommunications Intelligence in Civilian Intelligence (582/2019) and Act on Military Intelligence (590/2019) entered into force on 1 June 2019. The legislation includes the obligation of the authorities to submit an annual report to the Ombudsman on their operations.

The amendments to the Parliament's Rules of Procedure and Section 9 of the Act on Parliamentary Civil Servants concerning parliamentary oversight of intelligence operations entered into force on 1 February 2019.

5.1
SPECIAL NATURE OF COVERT INTELLIGENCE GATHERING

Covert intelligence gathering involves secretly intervening in the core area of several fundamental rights, especially those concerning privacy, domestic peace, confidential communications and the protection of personal data. Its use may also affect the implementation of the right to a fair trial. For intelligence gathering to be effective, the target must remain unaware of the measures, at least in the early stages of an investigation. Thus, the parties at whom these measures are targeted have more limited opportunities to react to the use of these coercive measures than is the case with "ordinary" coercive measures, which in practice become evident immediately or very soon.

Due to the special nature of covert intelligence gathering, questions of legal protection are of accentuated importance from the perspective of those against whom the measures are employed and more generally the legitimacy of the entire legal system.

The secrecy that is inevitably associated with covert intelligence gathering exposes the activity to doubts about its legality, whether or not there are grounds for that. Indeed, an effort has been made to ensure legal protection through special arrangements both before and after intelligence gathering. Their key components include the court warrant procedure, the authorities' internal oversight and the Ombudsman's oversight of legality.

5.2 OVERSIGHT OF COVERT INTELLIGENCE GATHERING

Courts

To ensure legal protection, it has been considered important that telecommunications interception and mainly also traffic data monitoring can only be carried out under a warrant issued by a court. These days, undercover operations during a criminal investigation also require authorisation from a court (Helsinki District Court). Depending on the target location, technical surveillance can in some cases also be carried out on the basis of the authority's own decision without court control. The same applies to the majority of other forms of covert intelligence gathering. The decision-making criteria laid down by law are partly rather loose and leave the party making the decision great discretionary power. For example, the "reason to suspect an offence" threshold that is a basic precondition for issuing a warrant for telecommunications interception is fairly low.

Requests concerning coercive measures must be dealt with in the presence of the person who has requested the measure or by using a video conference – written procedures are only allowed under limited circumstances when renewing an authorisation. When considering the prerequisites for using a coercive measure, a court is dependent on the information it receives from the criminal investigation authority, and the object of the utilisation of the method is not present at the hearing. The only exception is on-site interception in domestic premises: in these cases, the interests of the target of the coercive measure are overseen (naturally without his or her knowing) by a public attorney, usually an advocate or public legal aid.

The Supreme Court stressed the responsibility of a civil servant requesting a covert coercive measure in its decision KKO:2020:95. The matter concerned a breach of office where the police officer on charge had deceived the District Court into granting unlawful traffic data monitoring and telecommunications interception permits on the basis of false and misleading information. According to the Supreme Court, the reprehensibility of the acts was heightened by the fact that the matter concerned covert coercive measures, in which the court may not be able to ascertain the accuracy of the information the applicant has reported to it and in which trust in the appropriateness of the activities of the civil servant is emphasised. In addition, the acts had been detrimental to the trust of the police responsible for investigating crimes.

According to law, a complaint may be lodged with a Court of Appeal against a District Court's decision concerning covert intelligence gathering, with no time limit. Thus, a suspect may even years later refer the legality of a decision to a Court of Appeal for assessment, and some people have done so. In such cases, courts of higher instances establish case law on covert intelligence gathering. The importance of the courts' role in ensuring a suspect's legal protection and in examining the grounds for the requested coercive measure has been highlighted, for example, in the Supreme Court's decisions KKO:2007:7 and KKO:2009:54.

The courts also play a key role with respect to the parties' right of access to information concerning covert intelligence gathering. As a rule, the target of covert intelligence gathering must be notified of the use of the method no later than one year after the use has ceased. Based on the grounds laid down by law, a court may grant permission to postpone the notification or an exemption from the notification obligation.

However, it is important to ensure that the total exemption, in particular, is only granted when it is absolutely necessary. In a state governed by the rule of law, measures that interfere with fundamental rights and are kept completely secret can only be allowed to a very limited extent. The Supreme Court has considered the issue of parties' right to obtain information on undercover operations in its decision KKO:2011:27 concerning the Ulvila homicide case, which was widely covered in the media.

On 28 September 2016, the Supreme Administrative Court issued two decisions on public access to documents on covert intelligence gathering by the police (4077, 62/1/15 and 4078, 2216/1/15). The decisions concerned a request for information about regulations concerning the use of covert human intelligence sources by the police and the SALPA system. In its decisions, the Supreme Administrative Court was of the view that the information contained in the regulations regarding the use of covert human intelligence sources, the related safety and security measures and the organisation of the protection of intelligence gathering must be kept secret because, if these were disclosed in public, there is a risk that the identities of human intelligence sources and the police officers involved in the operations would be revealed.

Authorities' internal oversight

The oversight of the use of covert intelligence gathering primarily involves normal supervision by superior officials. Moreover, provisions separately emphasise the oversight of covert intelligence gathering.

Under law, the use of covert intelligence gathering methods by the police is overseen by the National Police Board (apart from the Finnish Security Intelligence Service, Supo) and the heads of the police units using such methods. Responsibility for overseeing the covert intelligence gathering methods used by Supo was transferred to the Ministry of the Interior at the beginning of 2016. At the Finnish Border Guard, the special oversight duties fall within the responsibility of the Border Guard Headquarters and the administrative units operating under it. At Finnish Customs, covert intelligence gathering is overseen by supervisory personnel of Customs and the units employing the methods in their respective administrative branches. At the Finnish Defence Forces, records drawn up on the use of covert intelligence gathering must be sent to the Ministry of Defence.

In addition to various acts, a government decree has been adopted on criminal investigations, coercive measures and covert intelligence gathering (122/2014). The decree lays down provisions on, for example, drawing up records on the use of different methods and reports on covert intelligence gathering. The authorities have also issued internal orders on covert intelligence gathering.

The Ministry of the Interior, the Headquarters of the Finnish Border Guard (which is a department of the Ministry of the Interior), the Ministry of Finance (which governs Finnish Customs) and the Ministry of Defence report annually by 15th March to the Parliamentary Ombudsman on the use and oversight of covert intelligence gathering in their respective administrative branches.

The authorities reporting to the Parliamentary Ombudsman receive a substantial part of their information on the use of covert intelligence gathering from the SALPA case management system. The only exception is the Finnish Defence Forces, which do not – at least yet – use the SALPA system. SALPA is a reliable source of statistical data. However, it does not cover all methods of covert intelligence gathering, such as undercover operations, pseudo purchases and the use of covert human intelligence sources. The superior agencies also receive information on the activities through their own inspections and contacts with the heads of investigation.

The police have centralised all intelligence gathering from telecommunications operators to be conducted through the SALPA system maintained by the National Bureau of Investigation (NBI). The NBI's telecommunications unit oversees the quality of activities and provides guidance to the heads of investigation when necessary. Centralising the activities under the NBI has improved the quality of the functions.

In the police administration, several officials have been granted supervisory rights in SALPA for the oversight of legality. These officials work mainly in the legal units of police departments. Their task is to oversee activities in accordance with the unit's legality inspection plan and by conducting spot checks.
In addition to internal oversight at police departments, the National Police Board also oversees the units operating under it through the SALPA system and by conducting separate inspections.

In accordance with the previously mentioned decree, the National Police Board has established a working group to monitor the use of covert coercive measures and covert intelligence gathering methods. The members of the group may include representatives from the National Police Board, the National Bureau of Investigation, the Finnish Security Intelligence Service and police departments. Moreover, representatives of the Ministry of the Interior, the Border Guard, the Defence Forces and Customs are also invited to participate as members of the group. The group is tasked with monitoring the authorities' activities, collaboration and training, discussing issues that have been identified in the activities and collaboration or that are important for the oversight of legality and reporting them to the National Police Board, proposing ways to improve activities, and coordinating the preparation of reports submitted to the Parliamentary Ombudsman.

Parliamentary Ombudsman's oversight of legality

Overseeing covert intelligence gathering has been one of the special tasks of the Parliamentary Ombudsman since 1995. At the time, it was provided that the Ministry of the Interior would give the Ombudsman an annual report on telecommunications interception, traffic data monitoring and technical listening by the police as well as on technical surveillance in penal institutions. The National Board of Customs submitted a report on the use of the methods by Finnish Customs. The Ministry of Defence and the Finnish Border Guard prepared similar reports on the methods they had used. In 2001, the scope of the Ombudsman's special oversight was extended to also include undercover operations and in 2005 to cover pseudo purchases. Both measures were only available to the police.

It was not until the beginning of 2014 that the Ombudsman's special oversight duties were extended to cover all covert gathering of intelligence. In addition to the extended powers, the use of these methods has also significantly increased over the years.

The annual reports obtained from various authorities improve the Ombudsman's opportunities to follow the use of covert intelligence gathering on a general level. Where concrete individual cases are concerned, the Ombudsman's special oversight can, for limited resources alone, be at best of a random check nature. At present and in the future, the Ombudsman's oversight mainly complements the authorities' own internal oversight of legality and can largely be characterised as "oversight of oversight".

Complaints concerning covert intelligence gathering have been few, with no more than approximately ten complaints received a year. This is most likely due, at least in part, to the secret nature of the activities. However, it should be noted that covert intelligence gathering operations remain completely unknown to the target only in very rare and exceptional cases. On inspection visits and in other own-initiative activities, the Ombudsman has striven to identify problematic issues concerning legislation and the practical application of the methods. Cases have been examined, for example, on the basis of the reports received or inspections conducted. However, opportunities for this kind of own-initiative examination are limited.

5.3 LEGISLATION

At the beginning of 2014, the Coercive Measures Act and the Police Act underwent a complete reform, including a significant expansion in the scope of regulation concerning covert intelligence gathering. The provisions on the previously used methods were also complemented and specified in the reform.

With respect to the Defence Forces, the act on military discipline and crime prevention in the Defence Forces (laki sotilaskurinpidosta ja rikostorjunnasta puolustusvoimissa 255/2014) entered into force on 1 May 2014. Under the act, when the Defence Forces conduct a criminal investigation they may use certain, separately determined methods of covert intelligence gathering as referred to in the Coercive Measures Act, such as extended surveillance and technical observation and listening. In the prevention and detection of crimes, the Defence Forces similarly only have access to certain methods of covert intelligence gathering, although the range is wider than in criminal investigations. However, the Defence Forces cannot use, for example, telecommunications interception, traffic data monitoring, undercover operations or pseudo purchases. If these measures are needed, they are carried out by the police.

The act on the prevention of crime by Finnish Customs (laki rikostorjunnasta Tullissa 623/2015) entered into force on 1 June 2015. In the act, the powers of Customs were harmonised with those laid down in the new Criminal Investigation Act, Coercive Measures Act and Police Act. One significant change was that Customs were given powers to conduct undercover operations and pseudo purchases, even though the measures are in practice implemented by the police at Customs' request. Moreover, the use of covert human intelligence sources in the prevention of customs-related offences was harmonised with the provisions of the Police Act and the Coercive Measures Act.

The act on crime prevention by the Finnish Border Guard entered into force on 1 April 2018. The crime prevention provisions currently included in the Border Guard Act were transferred to the new act. In addition to the previous powers, the right to use a basic form of human intelligence source was added to the powers of the Finnish Border Guard.

5.4 REPORTS ON COVERT INFORMATION GATHERING SUBMITTED TO THE PARLIAMENTARY OMBUDSMAN

The following presents certain information on the use and oversight of covert intelligence gathering obtained from the reports submitted by the Ministry of the Interior, the Headquarters of the Finnish Border Guard, the Ministry of Finance and the Ministry of Defence. The precise figures are partly confidential. For example, the covert intelligence gathering activities of the Finnish Security Intelligence Service are not included in the figures presented below.

Use of covert intelligence gathering in 2021

Coercive telecommunications measures under the Coercive Measures Act

The police were granted 2,924 telecommunications interception and traffic data monitoring warrants for the purpose of investigating an offence (3,279 in 2020). However, in the statistical evaluation of covert coercive measures the most important indicator is perhaps the number of persons at whom coercive measures were targeted.

In 2021, simultaneous telecommunications interception and traffic data monitoring activities carried out by the police under the Coercive Measures Act were targeted at 440 (507) suspects, of whom 88 were unidentified. The use of traffic data monitoring was targeted at 1,678 (1,604) suspects.

Simultaneous telecommunications interception and traffic data monitoring activities carried out by Customs were targeted in 2021 at 96 (101) persons, and the number of warrants issued was 556 (625).

The traffic data monitoring activities carried out by the Customs were targeted at 151 (149) persons, with 601 (627) warrants issued.

The most common grounds for simultaneous telecommunications interception and traffic data monitoring by the police were aggravated narcotics offences (60%) and violent offences (11%). Within the administrative branch of Customs, the most common grounds were aggravated narcotics offences (89%) and aggravated tax frauds (9 %).

The Finnish Border Guard used telecommunications interception and traffic data monitoring much less frequently than the police and Customs. One simple reason for this is that under the law the Border Guard can only use coercive telecommunications measures in the investigation of a few specific types of offences (mainly aggravated arrangement of illegal immigration and the related offence of human trafficking). As a whole, the use of covert coercive measures and covert intelligence gathering methods by the Border Guard decreased compared to 2021. Similarly, the number of offences the measures were based on also declined, probably due to the situation caused by the coronavirus pandemic.

In the Finnish Defence Forces, the use of covert intelligence gathering is even less frequent.

Telecommunications interception and traffic data monitoring under the Police Act

Telecommunications interception and traffic data monitoring under the Police Act was targeted at two (twelve) persons. Mere traffic data monitoring was targeted at 131 (149) persons. The method was used most frequently to avert a danger to life or health and to investigate the cause of death.

Traffic data monitoring under the Act on the Prevention of Crime by Finnish Customs

In total, 29 (19) traffic data monitoring warrants were issued to prevent and detect customs offences, most typically on the grounds of an aggravated tax fraud or an aggravated narcotics offence.

Technical surveillance

In 2021, the police used technical surveillance under the Coercive Measures Act 26 times with respect to premises covered by domiciliary peace, technical surveillance 202 times, on-site interception 200 times and technical tracking 336 times. On-site interception in domestic premises was used 12 times. Data for the identification of a network address or a terminal end device were obtained 65 times. The most common reason for using these surveillance methods was an aggravated narcotics offence. According to the National Police Board, the relatively small proportion of property offences as grounds for surveillance and technical surveillance in 2020 and 2021 may be due to the movement restrictions related to combating the coronavirus pandemic, as they have also reduced cross-border crime.

Under the Police Act, technical observation was used 13 times, on-site interception seven times and technical tracking 32 times.

Customs used technical tracking under the Coercive Measures Act in 52 (43) instances. On-site interception was used 26 (12) times and technical surveillance 33 (28) times.

Technical tracking under the act on the prevention of crime by Finnish Customs was used 10 (eight) times. One (0) decision was issued on on-site interception and one (0) on technical surveillance.

Extended surveillance

Extended surveillance means other than short-term surveillance of a person who is suspected of an offence or who, with reasonable cause, might be assumed to commit an offence. The National Police Board has interpreted this to mean several individual and repeated instances of surveillance (approximately five times) or one continuous instance of surveillance lasting approximately 24 hours.

According to the report that the Parliamentary Ombudsman received from the Ministry of the Interior, the police made 260 (277) decisions on the use of extended surveillance in 2021. Customs took 50 (44) similar decisions.

Special covert coercive measures

In 2021, a few new decisions were taken to use undercover operations and to continue the validity of previously issued decisions on undercover operations. Undercover operations performed in data networks are more frequent than such operations in real life. Pseudo purchases were also mainly used to detect and investigate aggravated narcotics offences, although property offences also featured as grounds for the use of this investigation method.

The prerequisites for controlled delivery are very strict which in practice has restricted the use of this method. The police have performed a few controlled deliveries during the time the act has been in force. Customs reported having used controlled deliveries 12 (five) times in 2021.

Rejected requests

There was no significant change in the number of rejected requests for the use of coercive telecommunications measures. In 2021, courts rejected 22 requests for coercive telecommunications measures submitted by the police. As for Customs, one further request for telecommunications interception and traffic data monitoring and one request for traffic data monitoring were rejected in court.

Notification of the use of coercive measures

As a rule, the use of a covert intelligence gathering method must be notified to the target no later than one year after the gathering of intelligence has ceased. A court may under certain conditions authorise the notification to be postponed or decide that no notification needs to be given.

During the year under review, there were some individual police cases in which the notification was delayed. As for Customs, there were no cases in which the notification was delayed.

Internal oversight of legality

The oversight carried out by the National Police Board on the use of covert intelligence gathering methods was conducted as part of the oversight of legality as one of the priority areas for 2021. Because of the coronavirus pandemic, the inspections of police units were carried out remotely.

As a general observation, the National Police Board states that the quality of the operative processes of organising, using and overseeing covert intelligence gathering is good. The quality of the decisions issued and requests made is good. The detected errors were most commonly related to compliance with the deadlines for drawing up records and diligence in making the entries and, to a smaller extent, to the concreteness of the justifications. Deviations from the general good quality were isolated cases and no commonly repeated errors or qualitative deviations emerged.

The majority of the qualitative deviations concerned an incomplete or missing report on the connection between the person subject to traffic data monitoring and the network address. There were some shortcomings in consent-based traffic data monitoring in the entries related to giving consent. To a minor extent, inaccuracies were observed in the descriptions of the suspected offence and in the grounds for the role of the person subject to the information gathering in the suspected offence or event.

The observation made in the inspection activities carried out by police units were similar to those made in inspections conducted by the National Police Board. There were shortcomings in determining the connection between the target person and the telecommunications connection or the vehicle that in the decision or request was reported to be used by the person. There were shortcomings in the recording of consent in consent-based traffic data monitoring and in compliance with the deadlines for drawing up records on information gathering.

The telecommunications unit of the National Bureau of Investigation (NBI) carries out daily monitoring of the use of coercive telecommunications measures by checking the prerequisites for the requests for coercive telecommunications measures and requests for access to information submitted in the Salpa system and the content of these requests. The applicant is informed of the observed shortcomings and requested to correct the errors, for example, by submitting a new request for access to information or to modify the request. The check is carried out before the requests are sent to telecommunications companies. According to the NBI's telecommunications unit, the problems observed in urgent decisions in previous years have been successfully reduced through training.

The oversight of the Finnish Security Intelligence Services falls under the remit of the Ministry of the Interior, not the National Police Board. The Ministry of the Interior has assessed the lawfulness and relevance of covert intelligence gathering methods on the basis of a report issued by the Finnish Security Intelligence Service.

According to the Ministry, the Finnish Security Intelligence Service has a recognised fundamental and human rights perspective. The practical organisation of internal oversight of legality in the Finnish Security Intelligence Service has been the responsibility of a full-time internal overseer of legality, who is independent of operational activities.

According to the Ministry of the Interior, the report provided by the Finnish Security Intelligence Service on the use and oversight of covert intelligence gathering methods and their protection is appropriate.

During the year under review, Customs has carried out continuous and systematic monitoring of all covert intelligence gathering and its protection.

The eight regional Salpa officials at Customs are responsible for monitoring the use of these methods and drawing up a report on the oversight carried out and the related findings to a specific customs officer. The task of this customs officer is to oversee the use and organisation of covert intelligence gathering and the implementation of supervision by superior officers at the national level.

According to the Finnish Customs, it has been observed during inspections carried out in the Salpa system and during visits to investigating units that the number of errors and negligence in the processes related to the use of covert intelligence gathering methods has declined year by year. Few errors were found for the year under review. There were no serious deficiencies.

In the light of the report received from Customs, the Ministry of Finance considers the methods of oversight of legality focusing on the use of covert coercive measures and intelligence gathering methods by Customs to be well-established and notes that good practices and processes of oversight of legality have strengthened the understanding of the Ministry of Finance that a careful and appropriate operating culture in the use of covert coercive measures and information gathering methods has successfully been put in place at Customs.

In the Finnish Border Guard, the oversight of Salpa is performed by the Border Guard Headquarters and administrative units. In the administrative units, overseeing Salpa is the responsibility of a public official who does not participate in operational crime prevention himself or herself. The inspection and the observations made during the oversight activities are recorded in the supervisor field of the Salpa system. As from the beginning of 2022, the oversight of legality unit of the Legal Division is responsible for oversight at the Border Guard Headquarters.

On-site interception and gathering of data other than through telecommunications interception are only used by the Gulf of Finland Coast Guard District and the Southeast Finland Border Guard District.

As a general observation, the Finnish Border Guard states that the requests were mainly well-founded and comprehensive.

The Ministry of Defence has not identified any unlawful conduct in the use of covert coercive measures and covert intelligence gathering methods of the Finnish Defence Forces in 2021. In addition, the Ministry of Defence found the internal legality oversight in the Defence Forces effective, comprehensive and appropriately organised.

5.5 PARLIAMENTARY OMBUDSMAN'S OVERSIGHT OF LEGALITY

During the year under review, the decisions made by the Eastern Finland Police Department on covert coercive measures and intelligence gathering methods were inspected. Because of the COVID-19 epidemic, the inspections were carried out as documentation review. In addition, the documentation review was supplemented with a discussion session organised through video connections. For the inspection, the Police Department was asked to provide requests for coercive telecommunications measures from the period preceding the inspection, including the related decisions of the district courts, and decisions on technical surveillance and so-called limited pseudo purchases.

Based on the inspection, the Ombudsman decided to investigate on his own initiative three decisions on technical observation made by officials with the power of arrest and one decision on on-site interception made by an official with the power of arrest. After the inspection, the question remained whether the target of the actions had been specified in sufficient detail in these decisions. The case was pending at the end of the year under review.

In 2016, the Parliamentary Ombudsman requested that the National Police Board inform him of cases in which a warrant for covert coercive measure has been applied for and it has been granted to investigate, prevent or detect an offence for which it is not possible under the law to grant the warrant in question. The Ombudsman has considered it important that, in such cases and possibly other cases that appear to be manifestly unlawful, the need for legality oversight measures be also assessed with regard to the actions of the court.

Based on such information received from the National Police Board, the Ombudsman decided to conduct an own-initiative investigation on a decision concerning telecommunications interception and traffic data monitoring issued by a district court.

The warrant had been granted to prevent the preparation of an aggravated offence against life or health. The justification for the warrant was that it was considered necessary to avert an immediate serious danger to life or health.

The Ombudsman issued a reprimand to the district judge because this was not a question of preventing an immediate threat referred to by the legislator as, according to the request for the warrant, the objective of the intelligence gathering was to obtain advance information on the plans of the person subject to the intelligence gathering had made in the preparation of an aggravated offence against life or health. In addition, the Ombudsman criticised the grounds for the decision because the decision did not reveal the facts that the preconditions for using the intelligence gathering method had been considered to be based on under the Police Act. The grounds for the decision referred to what had been presented in the request and also stated in general that the warrant for telecommunications interception can be considered necessary to avert immediate danger to life and health. The decision thus did not explain in more detail the facts on which the decision-making was actually based. Furthermore, had the facts been recorded in the decision, it would probably have helped the maker of the decision to realise that the grounds for granting the warrant for telecommunications interception in accordance with the Police Act did not exist. (EOAK/7688/2020)

In an own-initiative investigation based on the Finnish Border Guard's inspection of covert coercive measures and intelligence gathering methods, the Ombudsman stated that the facts on which the suspicion of the offence was based should have been recorded more concretely in the decision on technical tracking. In this case, facts would have had to be presented that apparently could not have been revealed to the suspects later if and when they would have possibly been informed of the covert coercive measures used. However, this is not an obstacle to making a decision in accordance with the requirements of the Coercive Measures Act. What information the suspect would have been entitled to receive on that decision is a different matter. Secrecy considerations do not justify not providing the grounds for the decision in the manner expressly required by the Coercive Measures Act. The oversight of legality has consistently emphasised the importance of providing the grounds for requests for covert coercive measures and intelligence gathering methods and the decisions issued on them.

This is particularly important when it comes to measures that are based on decisions taken by the pre-trial investigation authority itself because in such cases the decision is not made by an external and independent authority like in cases concerning measures authorised by a court. (EOAK/1762/2020)

5.6 EVALUATION

General problems in oversight

Resources must be invested in internal oversight

The Ombudsman's oversight of the legality of covert intelligence gathering focuses on overseeing the internal oversight of authorities. The inspections of the legal units of police departments are used for emphasising the units' internal oversight of the covert intelligence gathering methods used by the police departments.

The authorities using covert intelligence gathering have in recent years invested resources and efforts in internal oversight.

According to the National Police Board, the operation of the legal units of police departments has become established and the scope of activities has become clear, although the constantly expanding task description does take time away from inspection activities.

In its report, the National Police Board brings up what has for several years been proposed by the police departments regarding the possibility for pre-trial investigation authorities to obtain through an information system the decision data from the judicial administration system to be used to implement and monitor the destruction of information obtained through covert intelligence gathering measures. So far, this has not been achieved, and the transfer of data between the Salpa system and the AIPA system used by the courts is limited to documents dealing with a coercive measure.

At the Finnish Customs, Border Guard and Defence Forces, internal oversight has functioned very well according to the authorities' own assessment. In these authorities, oversight is easier because the volume of operations is much smaller than in the police.

The Ombudsman conducts retrospective oversight of a fairly general nature. The Ombudsman is remote from the actual activities and cannot begin directing the authorities' actions or otherwise be a key setter of limits, who would redress the weaknesses in legislation. Annual or other reports submitted to the Ombudsman are important but do not solve the problems related to oversight and legal protection.

The oversight of covert coercive measures is partly founded on trust in the fact that the person conducting the oversight activities receives all the information he or she wants. Due to the nature of the activities, precise documentation is a fundamental prerequisite for successful oversight.

Real-time active recording of events and measures also helps operators to evaluate and develop their own activities, to ensure the legality of their operations and to build trust in their activities. Keeping records is also an absolute precondition for the Ombudsman's retrospective oversight of legality.

In the oversight of legality, the Ombudsman has continuously emphasised the importance of providing justifications for requests and decisions. The grounds and justifications should be recorded, for example, to enable the control of decisions. If a court does not require the applicant to provide sufficient justifications or if the court neglects to provide sufficient justifications, there is a risk that warrants will be issued for cases other than those intended by the legislator.

5.7 INTELLIGENCE

Intelligence gathering methods

Intelligence operations may be used to gather information on military operations or other operations that form a clear threat to national security.

Chapter 5a (civilian intelligence) of the Police Act provides for information gathering conducted by the Finnish Security Intelligence Services and the utilisation of information to protect national security, support government decision-making and the statutory national security duties of other authorities and state agencies.

According to the Act on Military Intelligence, the purpose of military intelligence is to gather and analyse information about military operations targeted against Finland or significant to Finland's security environment or the activities of a foreign state or other such activities that place a significant risk on the military defence of Finland or threaten the essential functions of society. The purpose of information gathering is to support government decision-making and the execution of the specific statutory duties of the Defence Forces.

Network traffic intelligence refers to technical gathering of information that crosses the national boundaries of Finland on the information network, based on automated analytical tools, and the processing of the information gathered.

Differences between intelligence gathering and secret information gathering methods

There are certain decisive distinctions to be made between intelligence gathering and secret information gathering.

The same secret information gathering methods may be used in intelligence gathering under less restrictive criteria, because intelligence gathering is not offence-based and its targeting can be less accurate.

The targets of intelligence gathering may be quite vague compared to the targets of secret information gathering. According to Chapter 5 of the Police Act, secret information gathering may be utilised only on a named person when there are reasonable grounds to believe that he or she would commit an offence. However, in intelligence gathering, it can remain unclear under which authorisation, which circumstances and within which limits an intelligence gathering method may be targeted at other than an individual who is personally engaging in or associated with military operations or operations forming a substantial threat to national security.

For example, traffic data monitoring, when conducted as part of secret information gathering, can only be targeted at a person when there are reasonable grounds to believe that he or she would commit an offence referred to. In the military intelligence context, the use of these methods need not be limited to a person; it is sufficient that traffic data monitoring can be shown to have a significant role in gathering information necessary for an intelligence operation. In civilian intelligence gathering, the legal provisions on traffic data monitoring, personalised targeting is not mentioned.

With many intelligence gathering methods, the permission can be issued for up to six times as long (1 months/6 months) than is possible in secret information gathering. These methods include telecommunications interception, traffic data monitoring, technical surveillance, technical surveillance of devices and pseudo purchases.

The scope of secret information gathering methods in intelligence operations has been expanded both in terms of content and methods. In secret information gathering, the target of telecommunications interception must be a named network address or terminal device, while in intelligence gathering, the target may be a person (in which case the connection between a network address or terminal device and the target of information gathering remains outside the control of the courts). In intelligence gathering, many of the methods can be targeted at groups of individuals while in secret information gathering, the same methods must be targeted at a named individual. In secret information gathering, the technology enabling the obtaining of the identifying data of a network address or terminal device must not be suited for telecommunications interception, whereas in intelligence gathering no such limitations exist. In intelligence gathering, telecommunications interception may be carried out using the intelligence agency's own equipment whereas in secret information gathering, an external operator is used as a rule. The methods of secret information gathering can be used on a court order or other official authorisation within Finnish territory only, whereas in intelligence operations, the same methods can also be used abroad, subject to the decision of the Finnish Security Intelligence Service or the Chief of Intelligence for the Defence Command and without the legal remedies available in Finland, even if the target is a Finnish individual.

In addition to the methods available for secret information gathering, intelligence gathering methods also include methods that cannot be adopted in secret information gathering. These include intelligence gathering on specific locations, reproduction, intercepting a shipment for the purpose of reproduction, gathering of information from a private organisation and network traffic intelligence.

Oversight of intelligence

The domain of the oversight of intelligence includes the following elements: the parliamentary oversight, the oversight of legality, court proceedings on intelligence powers, internal supervision of authorities and supreme oversight of legality.

The parliamentary oversight of intelligence is conducted by the Parliamentary Intelligence Oversight Committee. The duties of the Committee are provided for in Section 31 b of the Parliament's Rules of Procedure.

According to Section 2(3) of the Act on the Oversight of Intelligence Gathering, the legality oversight of intelligence gathering is the responsibility of the Intelligence Ombudsman. The Intelligence Ombudsman also supervises the non-intelligence operations of the Finnish Security Intelligence Service. This supervision is provided for in Chapter 3 of the Act on the Oversight of Intelligence Gathering where applicable. Hence, the Intelligence Ombudsman has all the powers referred to in the act for the purpose of overseeing all other operations of the Finnish Security Intelligence Service excepted for intelligence operations, with the exception of powers specifically concerning intelligence gathering methods. Thereby, the jurisdiction of the Intelligence Ombudsman, for example, also covers the activities of the Finnish Security Intelligence Service including the non-intelligence activities.

An independent court of law is a central instrument in the control of intelligence gathering methods. That the use of certain intelligence powers requires the authorisation by a court is of vital importance when ensuring that their application remains within the law and for the purpose of honouring fundamental and human rights.

The responsibility for internal legality oversight of authorities in civilian intelligence gathering is divided between the Finnish Security Intelligence Service and the Ministry of the Interior, where the legality oversight of the police is carried out by the Police Department. Military intelligence is overseen by the Chief of Defence Command. The Chief Legal Advisor of the Defence Forces is responsible for the internal legality oversight of military intelligence gathering. Military intelligence gathering is also supervised by the Ministry of Defence (the Legal Unit and the Permanent Secretary).

The Parliamentary Ombudsman and the Chancellor of Justice have, by virtue of their powers, an equal authority to oversee civilian and military intelligence authorities as well as courts of law and the Intelligence Ombudsman.

In practice, however, the supreme legality oversight must be exercised in line with the established practice according to which the oversight of secret information gathering and secret coercive measures is a special duty of the Parliamentary Ombudsman. This division of duties is based on the obligation by which the ministries responsible for the operations of the authorities exercising these methods must submit an annual report on the use of these methods as well as their protection and oversight to the Parliamentary Ombudsman. According to the regulations in force, the reports must be submitted every year by 15 March.

The same practice has been adopted with intelligence legislation. Therefore, the legality oversight has concentrated on the Parliamentary Ombudsman. Moreover, attention should be paid to Section 1 (1)(1) of the Act on the Division of Responsibilities between the Chancellor of Justice of the Government and the Parliamentary Ombudsman, under which the Chancellor of Justice is released from the obligation of legal oversight in such matters as those within the jurisdiction of the Parliamentary Ombudsman related to the Ministry of Defence and the Finnish Defence Forces. This, in turn, has practical implications on the supreme legality oversight on military intelligence.

With the intelligence legislation, the expansion of the scope of supervision under the remit of the Ombudsman, including the reports on intelligence submitted to the Ombudsman shall, in part, increase the share of oversight directed by the Ombudsman at the 'secret methods' during the oversight of legality exercised by the Ombudsman.

The operations of the Parliamentary Intelligence Oversight Committee do not fall under the jurisdiction of the Parliamentary Ombudsman.

Parliamentary Ombudsman's oversight of legality

The purpose of supreme oversight of legality in intelligence is the same as in that of secret information gathering. In the oversight of secret information gathering and secret coercive measures, the Ombudsman's attention has, in practice, focused on the "oversight of supervision", that is, that the internal legal oversight exercised by authorities adopting these methods would be as effective as possible. However, the Ombudsman's "direct" oversight is of particular importance with methods that the authorities can use without a court order.

Within the scope of the Ombudsman's jurisdiction, the legality oversight of intelligence gathering is important with respect to methods that fall outside the jurisdiction of the Intelligence Ombudsman. One such aspect is the secret information gathering conducted by the Defence Forces, which is provided for in Chapter 9 of the Act on Military Discipline and Combating Crime in the Defence Forces. This oversight is important because of, for example, the boundary between secret information gathering and intelligence. During the year under review, there was an ongoing inspection of covert intelligence gathering and partly of intelligence operations by the Defence Forces.

The Intelligence Ombudsman falls partly under the oversight of the Ombudsman. However, the oversight of the Intelligence Ombudsman takes mainly the form of collaboration rather than inspection in the traditional sense, although the latter is not ruled out. Complaints filed on the Intelligence Ombudsman are processed following the normal procedure.

The oversight of courts of law is by virtue of their independence always mainly based on dialogue. However, the oversight of courts carried out by the Ombudsman is important in that the jurisdiction of the Intelligence Ombudsman does not extend to the courts of law.

During the year under review, the Ombudsman did not receive complaints related to intelligence operations that would have been cause for inspection.

The intelligence oversight system is illustrated in the table on the following page.

The Parliamentary Ombudsman issued his decision on a matter concerning the interpretation of the so-called firewall provision, which he had investigated on his own initiative. The matter had arisen from the interpretation of law presented in the annual report 2019 of the Intelligence Ombudsman.

Based on the grounds specified in more detail in his decision, the Ombudsman stated that

1. The Intelligence Ombudsman's interpretation that firewall provisions do not restrict the disclosure of intelligence data on offences within the remit of intelligence authorities to crime prevention is contrary to the legislator's intention.
2. The firewall provisions on civil and military intelligence also apply to the use of intelligence data in the intelligence authorities' own activities to prevent or detect offences. 3. Firewall provisions indicate the preconditions under which information obtained through intelligence gathering methods may be disclosed to crime prevention.
4. Disclosure of information obtained through intelligence gathering methods to crime prevention is an exception
   to purpose limitation. These exceptions are expressly laid down in the firewall provisions of the intelligence legislation, which are special provisions in relation to the general provisions of the Act on the Processing of Personal Data in Criminal Matters and in Connection with Maintaining National Security or the acts on the processing of personal data by the Police or by the Defence Forces. Firewall provisions indicate under what conditions information obtained through intelligence gathering methods on an offence that has already been committed or is being prepared may or must not be disclosed to crime prevention. In addition, information may always be disclosed as evidence to support innocence and to prevent certain kinds of risks and damage.
5. The definitions of the tasks of the Finnish Security Intelligence Service and military intelligence authorities cannot be used to justify or provided as grounds for deviations from the purpose limitation of personal data. Explicit regulation at the level of an act is required.

OVERSEEING SYSTEM

SUBJECTS OF OVERSIGHT	Parliamentary Ombudsman	Chancellor of Justice of the Government	Intelligence Oversight Committee	Intelligence Ombudsman
Finnish Security and Intelligence Service Chapter 5a of the Police Act and the Act on Telecommunication Intelligence in Civilian Intelligence	O + A + R	O + A	O + A + R	O + A + R
Finnish Security and Intelligence Service Chapter 5 of the Police Act	O + A + R	O + A	O + A	O + A
Finnish Security and Intelligence Service Other activities	O + A	O + A	O + A	O + A
The Finnish Defence Forces Act on Military Intelligence	O + A + R	O* + A	O + A + R	O + A + R
The Finnish Defence Forces Chapter 9 of the Act on Military Discipline and Combating Crime in the Defence Forces	O + A + R	O + A	–	–
The Finnish Defence Forces Other activities	O + A	O* + A	–	–
Intelligence Ombudsman	O + A + R	O + A	A +R**	
Court	O + A	O + A	A	A + P
Public administrative task	O + A	O + A	A	A
Public task	O + A	O + A	A	–

O = oversight
A = access to information
R = report
P = procedural powers

* see Section 1 of the Act on the Division of Duties between the Chancellor of Justice of the Government and the Parliamentary Ombudsman
** Report to the Parliament; Section 19 of the Act on the Oversight of Intelligence Gathering

6. The fact that the guarantees of legal protection are linked to the application of firewall provisions when intelligence data results in a criminal procedure is an indication of the legislator's intention to apply firewall provisions in all situations in which information obtained through intelligence gathering methods is disclosed to crime prevention.
7. Also, the fact that the storage and recording of information obtained through intelligence gathering methods for purposes other than intelligence purposes is by law bound to cases referred to in the firewall provisions proves the legislator's intention that the exhaustive provisions on the disclosure of intelligence data to the needs of crime prevention have been laid down in the firewall provisions. (EOAK/289/2021)

During the year under review, the Parliamentary Ombudsman was heard in the Intelligence Oversight Committee regarding the Intelligence Ombudsman's report for 2020. In his statement, the Ombudsman found it regrettable that the public report cannot contain secret information, which means that the information on the actual observations made by the Intelligence Ombudsman is rather limited and that it has not been possible to present much statistical information. In addition, the description of the concrete implementation of oversight remains rather thin in the annual report, probably because of the secrecy provisions. The Parliamentary Ombudsman – as well as the Intelligence Oversight Committee – receives detailed statistics on the annual reports submitted to the Ombudsman by the authorities, but the information the rest of society receives on the matter will inevitably remain quite general. This may have negative impacts from the perspective of public trust in the lawfulness of intelligence operations.

As in the previous year, the Ombudsman considered the current lack of resources to be very problematic from the point of view of the vulnerability of the Intelligence Ombudsman's function. Sufficient resources are a prerequisite for the function of the Intelligence Ombudsman to be able to carry out all the oversight tasks laid down for it by law. According to the Parliamentary Ombudsman, sufficient resources are also linked to the Intelligence Ombudsman's function having all the expertise needed for its tasks, instead of obtaining ICT expertise independent of the intelligence authorities through cooperation arrangements, as described in the report. With regard to resources, the Parliamentary Ombudsman also notes that when the activities of the Intelligence Ombudsman are further developed, attention should also be paid to the oversight of activities other than intelligence operations in the Finnish Security Intelligence Service. (EOAK/5849/2021)

Reports submitted to the Parliamentary Ombudsman

The Ministry of the Interior has as one of its duties to evaluate the legality and relevance of civilian intelligence operations based on the report submitted by the Finnish Security Intelligence Service.

The report submitted to the Ministry by the Finnish Security Intelligence Service covers the implementation of internal oversight of legality of civilian intelligence. According to the Ministry of the Interior, the internal monitoring at the Finnish Security Intelligence Service has been as timely as possible with respect to methods of civilian intelligence gathering and any findings have been addressed as necessary. Where necessary, a report has been submitted to the Intelligence Ombudsman and the matter has been brought to the attention of the Ministry of the Interior. In the view of the Ministry of the Interior, the report provided by the Finnish Security Intelligence Service is appropriate.

The Ministry of the Interior finds it appropriate to assess the development needs in legislation with regard to covert intelligence gathering as a whole. The Government submitted a report on legislation concerning intelligence gathering (VNS 11/2021 vp) to Parliament on 16 December 2021.

The Ministry of Defence notes in its report that it has reviewed all decisions and minutes made in 2021 by the military intelligence authority. In addition, the Ministry of Defence has reviewed all inspection reports prepared by the Defence Command Legal Division.

During the review of the documents, legal issues and other development needs and topical issues have been discussed with representatives of the military intelligence authority. The COVID-19 pandemic did not have any significant impacts on the planned oversight of legality of military intelligence operations. The oversight of legality could be carried out well, and the Ministry of Defence has not identified any special areas of development or unlawful actions in the oversight of the legality of military intelligence in 2021.

Unlike intelligence authorities, the Intelligence Ombudsman is not under any deadline for submitting an annual report to the Parliamentary Ombudsman. For this reason, the report of the Intelligence Ombudsman was not available for this report by the Parliamentary Ombudsman. As intelligence authorities submit their reports to the Intelligence Ombudsman at the same time as to the Parliamentary Ombudsman, it is difficult to reconcile the schedule for completing the Intelligence Ombudsman's annual report with the timetable for the Parliamentary Ombudsman's annual report. However, it would be useful for the Intelligence Ombudsman's report to be available when preparing the Parliamentary Ombudsman's annual report.

5.8 WITNESS PROTECTION

The witness protection programme act (laki todistajansuojeluohjelmasta 88/2015) entered into force on 1 March 2015. The act constitutes a major reform in terms of fundamental rights and the rights of the individual. It safeguards the right to life, personal liberty and integrity and the right to the sanctity of the home, as enshrined in the Constitution.

A person may be admitted to a witness protection programme in order to receive protection if there is a serious threat against the life or health of the person or someone in their family, because the person is being heard in a criminal matter or for some other reason and the threat cannot be efficiently eliminated through other measures. Together with the protected person, the police will draw up a personal protection plan in writing that includes the key measures to be implemented as part of the programme. They may include, for example, relocating the protected person to another region, arranging a new home for the person, installing security devices in their home and providing advice on personal safety and security. The programme focuses on the protection of the individual, not the criminal investigation.

If necessary for the implementation of the witness protection programme, the police may make and create false, misleading or disguised register entries and documents to support the protected person's new identity. The police may also monitor the person's home and its surroundings. Protected persons may also receive financial support to ensure their income security and independent living.

The National Bureau of Investigation (NBI) is responsible for the implementation of the witness protection programme together with other authorities. The director of the NBI makes decisions about beginning and terminating witness protection programmes and certain related measures. The Ministry of the Interior submits annual reports to the Parliamentary Ombudsman on decisions and measures taken under the act.

According to the National Police Board's report appended to the Ministry of the Interior's annual report, the annual report on the witness protection programme issued by the NBI has comprehensively discussed matters relevant to the oversight of legality in connection with the implementation of the witness protection programme. The annual report has brought up some of the challenges in the witness protection programme.

The inaccuracies and problems identified by the NBI in the witness protection act are the significant scope of the act in relation to the available resources; the "high" threshold for terminating a protection programme; binding the temporary identity to the validity of the programme and the failure to examine the need to change the powers in technical surveillance related to witness protection as required by the parliamentary reply EV 248/2014. According to the National Police Board, it is important to examine the existing legislation in the light of the highlighted challenges and consider the need for a legislative reform on the basis of the observations.

The Ombudsman received no complaints regarding witness protection.

6 Issues relating to EU law

6
Issues relating to EU law

6.1
STATEMENTS

Parliamentary Ombudsman Jääskeläinen issued a statement on the government proposal on amending the Credit Information Act to the Constitutional Law Committee. Among other things, he stated that in the government proposal, the nature of carrying out credit information activities as a task of public interest had been used as an argument to demonstrate that the processing of person-al data in credit information activities is necessary for the performance of a task of public interest in accordance with Article 6(1)(e) of the General Data Protection Regulation. The said legal basis for the processing of personal data was wanted because it enables flexibility in national regulation and thus makes possible the desired provisions on the processing of personal data in the Credit In-formation Act.

The Ombudsman stated that, as such, he agreed with the nature of carrying out credit information activities as a task of public in-terest. However, the same arguments concerning the public interest also support the view that credit information activities should also be regarded as a public administrative task. In the Ombudsman's view, Article 6(1)(e) of the General Data Protection Regulation should, at least in principle, only apply to the activities of public authorities or other parties performing public administration tasks at the national level, even if the General Data Protection Regulation itself enables the subsection to be also used as the legal basis for a task of public interest carried out by a private party (see Recital 45 of the Regulation). (6918/2021)

Parliamentary Ombudsman Jääskeläinen issued a statement to the Ministry of Justice on the draft government proposal for an act on the protection of persons who report breaches of EU and national law. In his statement on the draft Directive on this matter, he had already stated that it would be justified at the national level to be prepared, in conjunction with the implementation of the Directive, to extend the perspective beyond the scope of the Directive and not only to certain EU policies. It is not appropriate to build a large-scale reporting and protection system only for breaches in certain areas of activity. This is also very problematic from the point of view of the legal protection of the person reporting the breach, as the person reporting the breach will not be protected under the law if the abuse reported by them falls outside the scope of the fields of legislation listed in the proposed act. It is obvious that not all persons reporting breaches are familiar with or understand the scope of the act.

The Ombudsman also drew attention to the fact that the draft bill had been drawn up on the basis of an incorrect concept of legal entity. Unlike European Union agencies in general, government agencies in Finland are not separate legal entities. Therefore, for example, the Chancellor of Justice, who had been intended as a centralised external reporting channel, was in fact a centralised internal reporting channel, as the Chancellor of Justice is not a separate legal entity but a part of the State. Government agencies cannot, contrary to the basic principles of Finnish law, be called legal entities, which they are not.

The Ombudsman also drew attention to the fact that most of the abuses and breaches referred to in the draft bill that are reported are likely to meet the criteria for an offence. Therefore, it must be assessed whether a report received in the reporting channel must be submitted to the police for the purpose of conducting a pre-trial investigation. However, the draft bill did not consider at what stage the information received in the reporting channel is transferred to the police, in what form it is transferred and who decides on the matter. (4731/2021)

The government proposal on the matter has not yet been submitted to Parliament, even though the implementation period of the Directive has already expired. The Directive should have been transposed into national law and the European Commission notified of the implementing measures by 17 December 2021.

6.2 State aid

In several of his decisions on complaints, Deputy-Ombudsman Pölönen assessed the criteria for granting financial support in disrup-tive circumstances under the de minimis rules in EU law and the allocation of this benefit. From the point of view of EU competition law, it is essential that all companies in the internal market have a level playing field so that the more innovative and most efficient companies will be successful. As defined in the Treaty, the support and its limitation must have cross-border impacts. The Deputy-Ombudsman considered that assessing the impact of the limitation in question on the permissibility of State aid is primarily the responsibility of the Commission and, ultimately, of the Court of Justice of the European Union. Regardless of this, it is essential from the point of view of the acceptability of the procedure to assess whether the procedure has been carried out in accordance with the principles of justice and non-discrimination in good governance. As a fundamental right, the principle of equality requires the authority and, in this case, the person performing a public administrative task to apply the law without making any differences other than those arising from the law. According to an established interpretation of the EU's rules on State aid, economic activities refer to the provision of goods and services on the market, regardless of the legal form of the operator and the way in which it is financed. When determining the nature of the aid as State aid, the rules do not set a profit criterion. However, Business Finland had set additional criteria for the aid granted to associations and foundations. It could be asked to what extent the European Commission would consider acceptable an aid that might place the economic activities of associations or foundations in a different position under com-petition law. The Deputy-Ombudsman considered that the exclusion of foundations and associations from financing granted in disruptive circumstances was not lawful and that making a profit could not be made a precondition for the aid. (3843/2020)

In the case concerning financing granted to fur farmers in disruptive circumstances, Deputy-Ombudsman Pölönen assessed the concept of primary agricultural production in accordance with Annex 1 to Article 38 of the TFEU. Financing in disruptive circumstances is about granting de minimis aid, which is provided for in Commission Regulation (EU) No 1407/2013 on the application of Articles 107 and 108 of the Treaty on the Functioning of the European Union to de minimis aid (later referred to as the de minimis Regulation). According to Article 1(1)(b) of the Regulation, the Regulation does not apply to aid granted to undertakings active in the primary production of agricultural products, for which there is a separate de minimis Regulation (1408 2014). Granting this aid does not fall within the competence of Business Finland. According to the definition provision in Article 2 of the de minimis Regulation, 'agricultural products' means products listed in Annex 1 to the Treaty, with the exception of fishery and aquaculture products (para-graph 1 (a)). The European Commission has expressed its opinion on the inclusion of fur farming in primary agricultural production, for example in the State aid decision mentioned by the Ministry of Agriculture and Forestry. As the classification in Appendix 1 does not place selling animals alive or dead in a different position (cf. groups 1 and 5), the Deputy-Ombudsman finds Business Finland's interpretation wrong. When granting the aid, it should be required that the activities to which the aid is granted be differentiated in accordance with the de minimis Regulation. The development of the livelihood targeted by the aid had only been identified at a general level. The Deputy-Ombudsman considered that Business Finland Oy and the Innovation Funding Centre Business Finland steering its operations should have assessed the preconditions for paying government support differently from the way they did (6493 /2020).

6.3 AGRICULTURE AND FORESTRY

Suomen Hippos performs a public administrative task in the registration of equine species entered in a stud book or otherwise regis-tered and in issuing an identification document for them. At the regulatory level, the task is based on the EU Horse Passports Regu-lation and the regulations governing food safety and animal breeding. Deputy-Ombudsman Sakslin was of the view that the Ministry of Agriculture and Forestry had acted unlawfully in the sense that provisions on public fees related to the registration and identification of horses had not been laid down until a decree based on the Act on Criteria for Charges Payable to the State entered into force at the beginning of 2019. She gave a reprimand to the Ministry and drew the attention of the Ministry of Agriculture and Forestry, the Finnish Food Authority and Hippos to the obligation to ensure the good governance and protection under the law guaranteed by the Constitution and to ensuring that public service fees and their categories are sufficiently clear and that no additional fee is incurred by customers in administrative matters dealt with through telephone services. (4804/2018)

6.4 INSURANCE SUPERVISION AND A TRAFFIC ACCIDENT ABROAD

A legal act of the Union may require the national legislator to take implementation measures to ensure that EU law is implemented effectively. Deputy-Ombudsman Pölönen's decision included, among other things, a question relating to the implementation of the Motor Insurance Directive. The purpose of the provisions of the Motor Insurance Directive has been, among other things, to improve the position of injured parties in the EU so that the injured party has the opportunity to claim in their Member State of residence against a claims representative appointed there by the insurance company of the responsible party. The directive also obliges Member States to set up or approve a compensation body to which the injured party may take their case if the claims representative fails to fulfil their obligations. In the complainant's case, the Finnish Motor Insurers' Centre acted as the claims representative appointed by the foreign company. However, the Motor Insurance Act also designates the same Centre as the compensation body referred to in the Directive in case of negligence by the claims representative. The Deputy-Ombudsman found this dual role of the Finnish Motor Insurers' Centre problematic for the effective implementation of EU law and for the rights of the parties to the motor insurance event. He brought his views to the attention of the Ministry of Social Affairs and Health and to be considered in the possible future amendments to the Motor Insurance Act (783/ 2020)

7 Appendixes

Appendix 1
Constitutional Provisions pertaining to Parliamentary Ombudsman of Finland

11 June 1999 (731/1999), entry into force 1 March 2000

Section 27
Eligibility and qualifications for the office of Representative

Everyone with the right to vote and who is not under guardianship can be a candidate in parliamentary elections.

A person holdin military office cannot, however, be elected as a Representative.

The Chancellor of Justice of the Government, the Parliamentary Ombudsman, a Justice of the Supreme Court or the Supreme Administrative Court, and the Prosecutor-General cannot serve as representatives. If a Representative is elected President of the Republic or appointed or elected to one of the aforesaid offices, he or she shall cease to be a Representative from the date of appointment or election. The office of a Representative shall cease also if the Representative forfeits his or her eligibility

Section 38
Parliamentary Ombudsman

The Parliament appoints for a term of four years a Parliamentary Ombudsman and two Deputy Ombudsmen, who shall have outstanding knowledge of law. A Deputy Ombudsman may have a substitute as provided in more detail by an Act. The provisions on the Ombudsman apply, in so far as appropriate, to a Deputy Ombudsman and to a Deputy Ombudsman's a substitute. (802/2007, entry into force 1.10.2007)

The Parliament, after having obtained the opinion of the Constitutional Law Committee, may, for extremely weighty reasons, dismiss the Ombudsman before the end of his or her term by a decision supported by at least two thirds of the votes cast.

Section 48
Right of attendance of Ministers, the Ombudsman and the Chancellor of Justice

Minister has the right to attend and to participate in debates in plenary sessions of the Parliament even if the Minister is not a Representative. A Minister may not be a member of a Committee of the Parliament. When performing the duties of the President of the Republic under section 59, a Minister may not participate in parliamentary work.

The Parliamentary Ombudsman and the Chancellor of Justice of the Government may attend and participate in debates in plenary sessions of the Parliament when their reports or other matters taken up on their initiative are being considered.

Section 109
Duties of the Parliamentary Ombudsman

The Ombudsman shall ensure that the courts of law, the other authorities and civil servants, public employees and other persons, when the latter are performing a public task, obey the law and fulfil their obligations. In the performance of his or her duties, the Ombudsman monitors the implementation of basic rights and liberties and human rights.

The Ombudsman submits an annual report to the Parliament on his or her work, including observations on the state of the administration of justice and on any shortcomings in legislation.

Section 110
The right of the Chancellor of Justice and the Ombudsman to bring charges and the division of responsibilities between them

A decision to bring charges against a judge for unlawful conduct in office is made by the Chancellor of Justice or the Ombudsman. The Chancellor of Justice and the Ombudsman may prosecute or order that charges be brought also in other matters falling within the purview of their supervision of legality.

Provisions on the division of responsibilities between the Chancellor of Justice and the Ombudsman may be laid down by an Act, without, however, restricting the competence of either of them in the supervision of legality

Section 111
The right of the Chancellor of Justice and Ombudsman to receive information

The Chancellor of Justice and the Ombudsman have the right to receive from public authorities or others performing public duties the information needed for their supervision of legality.

The Chancellor of Justice shall be present at meetings of the Government and when matters are presented to the President of the Republic in a presidential meeting of the Government. The Ombudsman has the right to attend these meetings and presentations.

Section 112
Supervision of the lawfulness of the official acts of the Government and the President of the Republic

If the Chancellor of Justice becomes aware that the lawfulness of a decision or measure taken by the Government, a Minister or the President of the Republic gives rise to a comment, the Chancellor shall present the comment, with reasons, on the aforesaid decision or measure. If the comment is ignored, the Chancellor of Justice shall have the comment entered in the minutes of the Government and, where necessary, undertake other measures. The Ombudsman has the corresponding right to make a comment and to undertake measures.

If a decision made by the President is unlawful, the Government shall, after having obtained a statement from the Chancellor of Justice, notify the President that the decision cannot be implemented, and propose to the President that the decision be amended or revoked.

Section 113
Criminal liability of the President of the Republic

If the Chancellor of Justice, the Ombudsman or the Government deem that the President of the Republic is guilty of treason or high treason, or a crime against humanity, the matter shall be communicated to the Parliament. In this event, if the Parliament, by three fourths of the votes cast, decides that charges are to be brought, the Prosecutor-General shall prosecute the President in the High Court of Impeachment and the President shall abstain from office for the duration of the proceedings. In other cases, no charges shall be brought for the official acts of the President.

Section 114
Prosecution of Ministers

A charge against a Member of the Government for unlawful conduct in office is heard by the High Court of Impeachment, as provided in more detail by an Act.

The decision to bring a charge is made by the Parliament, after having obtained an opinion from the Constitutional Law Committee concerning the unlawfulness of the actions of the Minister. Before the Parliament decides to bring charges or not it shall allow the Minister an opportunity to give an explanation. When considering a matter of this kind the Committee shall have a quorum when all of its members are present.

A Member of the Government is prosecuted by the Prosecutor-General.

Section 115
Initiation of a matter concerning the legal responsibility of a Minister

An inquiry into the lawfulness of the official acts of a Minister may be initiated in the Constitutional Law Committee on the basis of:

1) A notification submitted to the Constitutional Law Committee by the Chancellor of Justice or the Ombudsman;

2) A petition signed by at least ten Representatives; or

3) A request for an inquiry addressed to the Constitutional Law Committee by another Committee of the Parliament.

The Constitutional Law Committee may open an inquiry into the lawfulness of the official acts of a Minister also on its own initiative.

Section 117
Legal responsibility of the Chancellor of Justice and the Ombudsman

The provisions in sections 114 and 115 concerning a member of the Government apply to an inquiry into the lawfulness of the official acts of the Chancellor of Justice and the Ombudsman, the bringing of charges against them for unlawful conduct in office and the procedure for the hearing of such charges.

Appendix 1
Parliamentary Ombudsman Act 14 March 2002 (197/2002)

CHAPTER 1
OVERSIGHT OF LEGALITY

Section 1
Subjects of the Parliamentary Ombudsman's oversight

(1) For the purposes of this Act, subjects of oversight shall, in accordance with Section 109 (1) of the Constitution of Finland, be defined as courts of law, other authorities, officials, employees of public bodies and also other parties performing public tasks.

(2) In addition, as provided for in Sections 112 and 113 of the Constitution, the Ombudsman shall oversee the legality of the decisions and actions of the Government, the Ministers and the President of the Republic. The provisions set forth below in relation to subjects of oversight apply in so far as appropriate also to the Government, the Ministers and the President of the Republic.

Section 2
Complaint

(1) A complaint in a matter within the Ombudsman's remit may be filed by anyone who thinks a subject has acted unlawfully or neglected a duty in the performance of their task.

(2) The complaint shall be filed in writing. It shall contain the name and contact particulars of the complainant, as well as the necessary information on the matter to which the complaint relates.

Section 3
Investigation of a complaint (20.5.2011/535)

(1) The Ombudsman shall investigate a complaint if the matter to which it relates falls within his or her remit and if there is reason to suspect that the subject has acted unlawfully or neglected a duty or if the Ombudsman for another reason takes the view that doing so is warranted.

(2) Arising from a complaint made to him or her, the Ombudsman shall take the measures that he or she deems necessary from the perspective of compliance with the law, protection under the law or implementation of fundamental and human rights. Information shall be procured in the matter as deemed necessary by the Ombudsman.

(3) The Ombudsman shall not investigate a complaint relating to a matter more than two years old, unless there is a special reason for doing so.

(4) The Ombudsman must without delay notify the complainant if no measures are to be taken in a matter by virtue of paragraph 3 or because it is not within the Ombudsman's remit, it is pending before a competent authority, it is appealable through regular appeal procedures, or for another reason. The Ombudsman can at the same time inform the complainant of the legal remedies available in the matter and give other necessary guidance.

(5) The Ombudsman can transfer handling of a complaint to a competent authority if the nature of the matter so warrants. The complainant must be notified of the transfer. The authority must inform the Ombudsman of its decision or other measures in the matter within the deadline set by the Ombudsman. Separate provisions shall apply to a transfer of a complaint between the Parliamentary Ombudsman and the Chancellor of Justice of the Government.

Section 4
Own initiative

The Ombudsman may also, on his or her own initiative, take up a matter within his or her remit.

Section 5
Inspections (28.6.2013/495)

(1) The Ombudsman shall carry out the onsite inspections of public offices and institutions necessary to monitor matters within his or her remit. Specifically, the Ombudsman shall carry out inspections in prisons and other closed institutions to oversee the treatment of inmates, as well as in the various units of the Defence Forces and Finland's military crisis management organisation to monitor the treatment of conscripts, other persons doing their military service and crisis management personnel.

(2) In the context of an inspection, the Ombudsman and officials in the Office of the Ombudsman assigned to this task by the Ombudsman have the right of access to all premises and information systems of the inspection subjeft, as well as the right to have confidential discussions with the personnel of the office or institution, persons serving there and its inmates.

Section 6
Executive assistance

The Ombudsman has the right to executive assistance free of charge from the authorities as he or she deems necessary, as well as the right to obtain the required copies or printouts of the documents and files of the authorities and other subjects.

Section 7
Right of the Ombudsman to information

The right of the Ombudsman to receive information necessary for his or her oversight of legality is regulated by Section 111 (1) of the Constitution.

Section 8
Ordering a police inquiry or a pre-trial investigation (22.7.2011/811)

The Ombudsman may order that a police inquiry, as referred to in the Police Act (872/2011), or a pre-trial investigation, as referred to in the Pretrial Investigations Act (805/2011), be carried out in order to clarify a matter under investigation by the Ombudsman.

Section 9
Hearing a subject

If there is reason to believe that the matter may give rise to criticism as to the conduct of the subject, the Ombudsman shall reserve the subject an opportunity to be heard in the matter before it is decided.

Section 10
Reprimand and opinion

(1) If, in a matter within his or her remit, the Ombudsman concludes that a subject has acted unlawfully or neglected a duty, but considers that a criminal charge or disciplinary proceedings are nonetheless unwarranted in this case, the Ombudsman may issue a reprimand to the subject for future guidance.

(2) If necessary, the Ombudsman may express to the subject his or her opinion concerning what constitutes proper observance of the law, or draw the attention of the subject to the requirements of good administration or to considerations of promoting fundamental and human rights.

(3) If a decision made by the Parliamentary Ombudsman referred to in Subsection 1 contains an imputation of criminal guilt, the party having been issued with a reprimand has the right to have the decision concerning criminal guilt heard by a court of law. The demand for a court hearing shall be submitted to the Parliamentary Ombudsman in writing within 30 days of the date on which the party was notified of the reprimand. If notification of the reprimand is served in a letter sent by post, the party shall be deemed to have been notified of the reprimand on the seventh day following the dispatch of the letter unless otherwise proven. The party having been issued with a reprimand shall be informed without delay of the time and place of the court hearing, and of the fact that a decision may be given in the matter in their absence. Otherwise the provisions on court proceedings in criminal matters shall be complied with in the hearing of the matter where applicable. (22.8.2014/674)

Section 11
Recommendation

(1) In a matter within the Ombudsman's remit, he or she may issue a recommendation to the competent authority that an error be redressed or a shortcoming rectified.

(2) In the performance of his or her duties, the Ombudsman may draw the attention of the Government or another body responsible for legislative drafting to defects in legislation or official regulations, as well as make recommendations concerning the development of these and the elimination of the defects.

CHAPTER 1 a
NATIONAL PREVENTIVE MECHANISM (NPM)
(28.6.2013/495)

Section 11 a
National Preventive Mechanism (28.6.2013/495)

The Ombudsman shall act as the National Preventive Mechanism referred to in Article 3 of the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (International Treaty Series 93/2014).

Section 11 b
Inspection duty (28.6.2013/495)

(1) When carrying out his or her duties in capacity of the National Preventive Mechanism, the Ombudsman inspects places where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence (place of detention).

(2) In order to carry out such inspections, the Ombudsman and an official in the Office of the Ombudsman assigned to this task by the Ombudsman have the right of access to all premises and information systems of the place of detention, as well as the right to have confidential discussions with persons having been deprived of their liberty, with the personnel of the place of detention and with any other persons who may supply relevant information.

Section 11 c
Access to information (28.6.2013/495)

Notwithstanding the secrecy provisions, when carrying out their duties in capacity of the National Preventive Mechanism the Ombudsman and an official in the Office of the Ombudsman assigned to this task by the Ombudsman have the right to receive from authorities and parties maintaining the places of detention information about the number of persons deprived of their liberty, the number and locations of the facilities, the treatment of persons deprived of their liberty and the conditions in which they are kept, as well as any other information necessary in order to carry out the duties of the National Preventive Mechanism.

Section 11 d
Disclosure of information (28.6.2013/495)

In addition to the provisions contained in the Act on the Openness of Government Activities (621/1999) the Ombudsman may, notwithstanding the secrecy provisions, disclose information about persons having been deprived of their liberty, their treatment and the conditions in which they are kept to a Subcommittee referred to in Article 2 of the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

Section 11 e
Issuing of recommendations (28.6.2013/495)

When carrying out his or her duties in capacity of the National Preventive Mechanism, the Ombudsman may issue the subjects of supervision recommendations intended to improve the treatment of persons having been deprived of their liberty and the conditions in which they are kept and to prevent torture and other cruel, inhuman or degrading treatment or punishment.

Section 11 f
Other applicable provisions (28.6.2013/495)

In addition, the provisions contained in Sections 6 and 8–11 herein on the Ombudsman's action in the oversight of legality shall apply to the Ombudsman's activities in his or her capacity as the National Preventive Mechanism.

Section 11 g
Independent Experts (28.6.2013/495)

(1) When carrying out his or her duties in capacity of the National Preventive Mechanism, the Ombudsman may rely on expert assistance. The Ombudsman may appoint as an expert a person who has given his or her consent to accepting this task and who has particular expertise relevant to the inspection duties of the National Preventive Mechanism. The expert may take part in conducting inspections referred to in Section 11 b, in which case the provisions in the aforementioned section and Section 11 c shall apply to their competence.

(2) When the expert is carrying out his or her duties referred to in this Chapter, the provisions on criminal liability for acts in office shall apply. Provisions on liability for damages are contained in the Tort Liability Act (412/1974).

Section 11 h
Prohibition of imposing sanctions (28.6.2013/495)

No punishment or other sanctions may be imposed on persons having provided information to the National Preventive Mechanism for having communicated this information.

CHAPTER 2
REPORT TO THE PARLIAMENT AND DECLARATION OF INTERESTS

Section 12
Report

(1) The Ombudsman shall submit to the Parliament an annual report on his or her activities and the state of administration of justice, public administration and the performance of public tasks, as well as on defects observed in legislation, with special attention to implementation of fundamental and human rights.

(2) The Ombudsman may also submit a special report to the Parliament on a matter he or she deems to be of importance.

(3) In connection with the submission of reports, the Ombudsman may make recommendations to the Parliament concerning the elimination of defects in legislation. If a defect relates to a matter under deliberation in the Parliament, the Ombudsman may also otherwise communicate his or her observations to the relevant body within the Parliament.

Section 13
Declaration of interests (24.8.2007/804)

(1) A person elected to the position of Ombudsman, Deputy-Ombudsman or as a substitute for a Deputy-Ombudsman shall without delay submit to the Parliament a declaration of business activities and assets and duties and other interests which may be of relevance in the evaluation of his or her activity as Ombudsman, Deputy-Ombudsman or substitute for a Deputy-Ombudsman.

(2) During their term in office, the Ombudsman the Deputy-Ombudsmen and the substitute for a Deputy-Ombudsman shall without delay declare any changes to the information referred to in paragraph (1) above.

CHAPTER 3
GENERAL PROVISIONS ON THE OMBUDSMAN, THE DEPUTY-OMBUDSMEN AND THE DIRECTOR OF THE HUMAN RIGHTS CENTRE (20.5.2011/535)

Section 14
Competence of the Ombudsman and the Deputy-Ombudsmen

(1) The Ombudsman has sole competence to make decisions in all matters falling within his or her remit under the law. Having heard the opinions of the Deputy-Ombudsmen, the Ombudsman shall also decide on the allocation of duties among the Ombudsman and the Deputy-Ombudsmen.

(2) The Deputy-Ombudsmen have the same competence as the Ombudsman to consider and decide on those oversight-of-legality matters that the Ombudsman has allocated to them or that they have taken up on their own initiative.

(3) If a Deputy-Ombudsman deems that in a matter under his or her consideration there is reason to issue a reprimand for a decision or action of the Government, a Minister or the President of the Republic, or to bring a charge against the President or a Justice of the Supreme Court or the Supreme Administrative Court, he or she shall refer the matter to the Ombudsman for a decision.

Section 15
Decision-making by the Ombudsman

The Ombudsman or a Deputy-Ombudsman shall make their decisions on the basis of drafts prepared by referendary officials, unless they specifically decide otherwise in a given case.

Section 16
Substitution (24.8.2007/804)

(1) If the Ombudsman dies in office or resigns, and the Parliament has not elected a successor, his or her duties shall be performed by the senior Deputy-Ombudsman.

(2) The senior Deputy-Ombudsman shall perform the duties of the Ombudsman also when the latter is recused or otherwise prevented from attending to his or her duties, as provided for in greater detail in the Rules of Procedure of the Office of the Parliamentary Ombudsman.

(3) Having received the opinion of the Constitutional Law Committee on the matter, the Parliamentary Ombudsman shall choose a substitute for a Deputy-Ombudsman for a term in office of not more than four years.

(4) When a Deputy-Ombudsman is recused or otherwise prevented from attending to his or her duties, these shall be performed by the Ombudsman or the other Deputy-Ombudsman as provided for in greater detail in the Rules of Procedure of the Office, unless the Ombudsman, as provided for in Section 19 a, paragraph 1, invites a substitute for a Deputy-Ombudsman to perform the Deputy-Ombudsman's tasks. When a substitute is performing the tasks of a Deputy-Ombudsman, the provisions of paragraphs (1) and (2) above concerning a Deputy-Ombudsman shall not apply to him or her.

Section 17
Other duties and leave of absence

(1) During their term of service, the Ombudsman and the Deputy-Ombudsmen shall not hold other public offices. In addition, they shall not have public or private duties that may compromise the credibility of their impartiality as overseers of legality or otherwise hamper the appropriate performance of their duties as Ombudsman or Deputy-Ombudsman.

(2) If the person elected as Ombudsman, Deputy-Ombudsman or Director of the Human Rights Centre holds a state office, he or she shall be granted leave of absence from it for the duration of their term of service as as Ombudsman, Deputy-Ombudsman or Director of the Human Rights Centre (20.5.2011/535).

Section 18
Remuneration

(1) The Ombudsman and the Deputy-Ombudsmen shall be remunerated for their service. The Ombudsman's remuneration shall be determined on the same basis as the salary of the Chancellor of Justice of the Government and that of the Deputy-Ombudsmen on the same basis as the salary of the Deputy Chancellor of Justice.

(2) If a person elected as Ombudsman or Deputy-Ombudsman is in a public or private employment relationship, he or she shall forgo the remuneration from that employment relationship for the duration of their term. For the duration of their term, they shall also forgo any other perquisites of an employment relationship or other office to which they have been elected or appointed and which could compromise the credibility of their impartiality as overseers of legality.

Section 19
Annual vacation

The Ombudsman and the Deputy-Ombudsmen are each entitled to annual vacation time of a month and a half.

Section 19 a
Substitute for a Deputy-Ombudsman (24.8.2007/804)

(1) A substitute for a Deputy-Ombudsman can perform the duties of a Deputy-Ombudsman if the latter is prevented from attending to them or if a Deputy-Ombudsman's post has not been filled. The Ombudsman shall decide on inviting a substitute to perform the tasks of a Deputy-Ombudsman. (20.5.2011/535)

(2) The provisions of this and other Acts concerning a Deputy-Ombudsman shall apply mutatis mutandis also to a substitute for a Deputy-Ombudsman while he or she is performing the tasks of a Deputy-Ombudsman, unless separately otherwise regulated

CHAPTER 3 a
HUMAN RIGHTS CENTRE (20.5.2011/535)

Section 19 b
Purpose of the Human Rights Centre (20.5.2011/535)

For the promotion of fundamental and human rights there shall be a Human Rights Centre under the auspices of the Office of the Parliamentary Ombudsman.

Section 19 c
The Director of the Human Rights Centre (20.5.2011/535)

(1) The Human Rights Centre shall have a Director, who must have good familiarity with fundamental and human rights. Having received the Constitutional Law Committee's opinion on the matter, the Parliamentary Ombudsman shall appoint the Director for a four-year term.

(2) The Director shall be tasked with heading and representing the Human Rights Centre as well as resolving those matters within the remit of the Human Rights Centre that are not assigned under the provisions of this Act to the Human Rights Delegation.

Section 19 d
Tasks of the Human Rights Centre (20.5.2011/535)

(1) The tasks of the Human Rights Centre are:

1) to promote information, education, training and research concerning fundamental and human rights as well as cooperation relating to them;
2) to draft reports on implementation of fundamental and human rights;
3) to present initiatives and issue statements in order to promote and implement fundamental and human rights;
4) to participate in European and international cooperation associated with promoting and safeguarding fundamental and human rights;
5) to take care of other comparable tasks associated with promoting and implementing fundamental and human rights.

(2) The Human Rights Centre does not handle complaints.

(3) In order to perform its tasks, the Human Rights Centre shall have the right to receive the necessary information and reports free of charge from the authorities.

Section 19 e
Human Rights Delegation (20.5.2011/535)

(1) The Human Rights Centre shall have a Human Rights Delegation, which the Parliamentary Ombudsman, having heard the view of the Director of the Human Rights Centre, shall appoint for a four-year term. The Director of the Human Rights Centre shall chair the Human Rights Delegation. In addition, the Delegation shall have not fewer than 20 and no more than 40 members. The Delegation shall comprise representatives of civil society, research in the field of fundamental and human rights as well as other actors participating in the promotion and safeguarding of fundamental and human rights. The Delegation shall choose a deputy chair from among its own number. If a member of the Delegation resigns or dies midterm, the Ombudsman shall appoint a replacement for him or her for the remainder of the term.

(2) The Office Commission of the Eduskunta shall confirm the remuneration of the members of the Delegation.

(3) The tasks of the Delegation are:

1) to deal with matters of fundamental and human rights that are far-reaching and important in principle;
2) to approve annually the Human Rights Centre's operational plan and the Centre's annual report;
3) to act as a national cooperative body for actors in the sector of fundamental and human rights.

(4) A quarum of the Delegation shall be present when the chair or the deputy chair as well as at least half of the members are in attendance. The opinion that the majority has supported shall constitute the decision of the Delegation. In the event of a tie, the chair shall have the casting vote.

(5) To organise its activities, the Delegation may have a work committee and sections. The Delegation may adopt rules of procedure.

CHAPTER 3 b
OTHER TASKS (10.4.2015/374)

Section 19 f (10.4.2015/374)
Promotion, protection and monitoring of the implementation of the Convention on the Rights of Persons with Disabilities

The tasks under Article 33(2) of the Convention on the Rights of Persons with Disabilities concluded in New York in 13 December 2006 shall be performed by the Parliamentary Ombudsman, the Human Rights Centre and its Human Rights Delegation.

CHAPTER 4
OFFICE OF THE PARLIAMENTARY OMBUDSMAN AND THE DETAILED PROVISIONS

Section 20 (20.5.2011/535)
Office of the Parliamentary Ombudsman and detailed provisions

For the preliminary processing of cases for decision by the Ombudsman and the performance of the other duties of the Ombudsman as well as for the discharge of tasks assigned to the Human Rights Centre, there shall be an office headed by the Parliamentary Ombudsman.

Section 21
Staff Regulations of the Parliamentary Ombudsman and the Rules of Procedure of the Office (20.5.2011/535)

(1) The positions in the Office of the Parliamentary Ombudsman and the special qualifications for those positions shall be set forth in the Staff Regulations of the Parliamentary Ombudsman.

(2) The Rules of Procedure of the Office of the Parliamentary Ombudsman shall contain more detailed provisions on the allocation of tasks among the Ombudsman and the Deputy-Ombudsmen. Also determined in the Rules of Procedure shall be substitution arrangements for the Ombudsman, the Deputy-Ombudsmen and the Director of the Human Rights Centre as well as the duties of the office staff and the cooperation procedures to be observed in the Office.

(3) The Ombudsman shall confirm the Rules of Procedure of the Office having heard the views of the Deputy-Ombudsmen and the Director of the Human Rights Centre.

CHAPTER 5
ENTRY INTO FORCE AND TRANSITIONAL PROVISION

Section 22
Entry into force

This Act enters into force on 1 April 2002.

Section 23
Transitional provision

The persons performing the duties of Ombudsman and Deputy-Ombudsman shall declare their interests, as referred to in Section 13, within one month of the entry into force of this Act.

Entry into force and application of the amending acts:

24.8.2007/804:
This Act entered into force on 1 October 2007.

20.5.2011/535:
This Act entered into force on 1 January 2012 (Section 3 and Section 19 a, subsection 1 on 1 June 2011).

22.7.2011/811:
This Act entered into force on 1 January 2014.

28.6.2013/495:
This Act entered into force on 7 November 2014 (Section 5 on 1 July 2013).

22.8.2014/674:
This Act entered into force on 1 January 2015.

10.4.2015/374:
This Act entered into force on 10 June 2016.

Appendix 1
Act on the Division of Duties between the Chancellor of Justice and the Parliamentary Ombudsman

21 December 1990 (1224/1990)

SECTION 1

The Chancellor of Justice is released from the obligation to monitor compliance with the law in issues within the remit of the Parliamentary Ombudsman concerning:

1) the Ministry of Defence, excluding the oversight of legality of the official activities of the Government and its members, the Defence Forces, the Border Guard, the crisis management personnel referred to in the Act on Military Crisis Management (211/2006), the National Defence Training Association of Finland (MPK) referred to in chapter 3 of the Act on Voluntary National Defence (556/2007) as well as military court proceedings; (11.5.2007/564)
2) the apprehension, arrest, remand and travel ban as well as taking into custody or other deprivation of liberty referred to in the Coercive Measures Act (806/2011);
3) prisons and other institutions, to which persons have been admitted against their will. (22.7.2011/813)

The Chancellor of Justice is also released from handling an issue within the remit of the Ombudsman initiated by a person, whose liberty has been restricted by remand or arrest or by other means.

SECTION 2

In cases referred to in section 1, the Chancellor of Justice must refer the matter to the Ombudsman, unless there are special reasons for deeming it appropriate to resolve the matter him-/herself.

SECTION 3

The Chancellor of Justice and the Ombudsman may also mutually transfer other issues within the remit of both parties, when the transfer can be considered to speed up the processing of the issue or if it is justified for other special reasons. In cases related to complaints, the complainant must be notified about the transfer.

SECTION 4

This act shall enter into force on 1 January 1991.

This act repeals the Act on the Principles of the Division of Duties between the Chancellor of Justice and the Parliamentary Ombudsman, issued on 10 November 1933 (276/33), as well as the Act on Releasing the Chancellor of Justice from Certain Duties issued on the same day (275/33).

When this act enters into force, it shall apply to the cases pending in the Office of the Chancellor of Justice as well as the Office of the Parliamentary Ombudsman.

Appendix 1
Rules of Procedure of the Parliamentary Ombudsman
5 March 2002 (209/2002)

Under section 52(2) of the Constitution of Finland, the Finnish Parliament has approved the following rules of procedure for the Parliamentary Ombudsman:

Section 1
Staff of the Office of the Parliamentary Ombudsman

The potential posts in the Office of the Parliamentary Ombudsman include the post of secretary general, principal legal adviser, senior legal adviser, legal adviser, on-duty lawyer, investigating officer, information officer, notary, departmental secretary, filing clerk, records clerk, assistant filing clerk and office secretary. Other officials may also be appointed to the Office.

Within the limits of the budget, officials may be employed by the Office of the Parliamentary Ombudsman in fixed-term positions.

Section 2
Qualification requirements of the staff

The qualification requirements are:

1) the secretary general, principal legal adviser, senior legal adviser and legal adviser have a Master of Laws degree or a different master's degree as well as the experience in public administration or working as a judge required for the task; and
2) those working in other positions have a master's degree suitable for the purpose or other education and experience required by their duties.

Section 3
Appointing officials

The Ombudsman appoints the officials of his/her office.

Section 4
Leave of absence

The Ombudsman grants a leave of absence to the officials of the Office of the Parliamentary Ombudsman.

Section 5
Entry into force

These rules of procedure shall enter into force on 1 April 2002.

These rules of procedure repeal the rules of procedure of the Parliamentary Ombudsman issued on 22 February 2000 (251/2000).

Appendix 2
Division of labour between the Ombudsman and the Deputy-Ombudsmen

OMBUDSMAN MR PETRI JÄÄSKELÄINEN decides on matters concerning:
- the highest organs of state
- questions involving important principles
- the police, the Emergency Response Centre and rescue services
- public prosecutor, excluding matters concerning the Office of the Prosecutor General
- legal guardianship
- language legislation
- asylum and immigration
- the rights of persons with disabilities
- covert intelligence gathering and intelligence operations
- the coordination of the tasks of the National Preventive Mechanism against Torture and reports relating to its work
- matters concerning statements issued by the administrative branch of the Ministry of Justice

DEPUTY-OMBUDSMAN MS MAIJA SAKSLIN decides on matters concerning:
- social welfare
- children's rights
- rights of the elderly
- health care
- municipal affairs
- the autonomy of the Åland Islands
- taxation
- traffic and communications
- environmental administration
- agriculture and forestry
- Sámi affairs
- Customs
- church affairs

DEPUTY-OMBUDSMAN MR PASI PÖLÖNEN decides on matters concerning:
- courts, judicial administration and legal aid
- the Office of the Prosecutor General
- Criminal sanctions field
- distraint, bankruptcy and dept arrangements
- social insurance
- income support
- early childhood education and care, education, science and culture
- labour administration
- unemployment security
- military matters, Defence Forces and Border Guard
- data protecton, data management and telecommunications

Appendix 3
Proposals for the development of regulations and instructions and for correcting errors

The Financial Supervisory Authority

– Deputy-Ombudsman Pölönen issued a note to LocalTapiola General Mutual Insurance Company concerning unlawful practices in the transfer of a public administrative task laid down in the Motor Liability Insurance Act to another private party. In addition, the Deputy-Ombudsman drew the attention of the Financial Supervisory Authority to the fact that it should continue to draw up more detailed policies (3360/2020).

The City of Hämeenlinna

– Deputy-Ombudsman Sakslin stated that the instructions issued by the City of Hämeenlinna to harmonise the practice of taking out and inserting the hormonal intrauterine device were illegal because it excluded patients who needed the treatment (5025/2020).

To Kela

– Deputy-Ombudsman Pölönen stated that legislation on the reimbursement of occupational health care costs should be reviewed for employees aged over 68 who continue to work. In its report, Kela announced that it would take the necessary measures to initiate legislative development work (2246/2020).

Municipalities, Ministry of Social Affairs and Health, National Institute for Health and Welfare

– Deputy-Ombudsman Sakslin emphasised that the municipalities must, as part of their self-monitoring, ensure that the personnel are familiar with the valid legal norms of care for the elderly that are observed in their work. The Deputy-Ombudsman also drew the attention of the Ministry of Social Affairs and Health and the National Institute for Health and Welfare to the guidelines and legislation (2688/2020).

The Ministry of Transport and Communications

– Deputy-Ombudsman Sakslin stated that it would be important to have an unambiguous decision on the legal nature of the tasks laid down in the Postal Act, and that public administrative tasks be analysed and defined. The Deputy-Ombudsman proposed to the Ministry of Transport and Communications that an assessment be made of whether and to what extent the tasks referred to in the Postal Act are public administrative tasks in accordance with section 124 of the Constitution of Finland (1069/2019).

The Ministry of Justice

- Deputy-Ombudsman Pölönen stated that the prison in Vantaa had acted incorrectly when requesting an appointment of a defense counsel from each defendant coming to a meeting. The Deputy-Ombudsman also informed the Ministry of Justice (2406/2020) that there were ambiguities in the interpretation of the provision concerning the meeting with defendants.
- Deputy-Ombudsman Pölönen found that the information available on the Helsinki District Court website regarding fees was partly misleading and incomplete. The Deputy-Ombudsman relayed its decision to the Ministry of Justice and the working group appointed by it that is preparing the update of the Act on the Openness of Government Activities (4051/2020).
- The Parliamentary Ombudsman Jääskeläinen criticised the Central Election Board of the City of Espoo for an incorrect procedure that endangers the ballot secrecy when voting in a car. The Ombudsman also stated that it would be appropriate for the Ministry of Justice to compile guidelines on exceptional voting arrangements from different parties into a clear package for future elections (4197/2021).
- Deputy-Ombudsman Pölönen thought it to be a concern if a prison cannot perform its statutory duties due to a shortage of personnel. The Deputy-Ombudsman's decision was sent to the Ministry of Justice for legislative work (6533/2020).
- Parliamentary Ombudsman Jääskeläinen emphasised that the protection of fundamental rights enshrined in the Constitution is watered down if the prerequisites for using coercive measures that intervene with these fundamental rights are not interpreted in an appropriately strict manner. The Ombudsman considered it necessary that the questions concerning the application of the confiscation provisions discussed in the decision are taken into account in the development of the Coercive Measures Act, and made these observations known to the Ministry of Justice (7777/2020).

The Ministry of Justice and the Ministry of Finance

- Parliamentary Ombudsman Jääskeläinen stated that credit institutions may refuse to grant strong electronic authentication to persons under guardianship only if they have an objective legal basis for it. The Ombudsman also asked the Ministry of Justice and the Ministry of Finance to assess whether the matter requires measures related to the regulation that fall within the scope of their competence (2065/2019).

The Ministry of Education and Culture

- Deputy-Ombudsman Pölönen stated that proper recording of the use of restrictive measures on a pupil is a prerequisite for ensuring afterwards that fundamental rights are safeguarded. The decision was sent to the Ministry of Education and Culture for consideration in the forthcoming legislative drafting (3176/2020).

The National Police Board

- Parliamentary Ombudsman Jääskeläinen proposed to the National Police Board that it take measures without delay to ensure that notifications made under section 63 of the Animal Welfare Act are recorded in a uniform manner in all police departments and stated the need to increase the offering of training on animal welfare offences (3971/2020)

The Ministry of the Interior

- Parliamentary Ombudsman Jääskeläinen stated that the National Police Commissioner acted in violation of the prohibition laid down in Chapter 1, section 10, subsection 3 of the Police Act when granting the Minister of the Interior permission to use a police reflector vest. The Ombudsman proposed that the Ministry of the Interior take immediate action to review the enforcement of the regulation on police uniforms (2354/2020).
- Parliamentary Ombudsman Jääskeläinen stated that the court's communication restrictions and the requirements of the competent officials concerning them should be specified and clear. The Ombudsman stressed the importance of supplementing and specifying legislation (7510/2020).

The Ministry of Social Affairs and Health

- Deputy-Ombudsman Pölönen urged the Ministry of Social Affairs and Health to take the necessary measures to produce sufficiently precise legislation on insurance investigation activities (1672/2019).
- Deputy-Ombudsman Pölönen considered the provisions of the Motor Liability Insurance Act to be partly inaccurate, for example as regards Fiva's supervisory powers. The decision was sent to the Ministry of Social Affairs and Health for consideration in any future amendment to the Motor Liability Insurance Act (783/2020).
- Deputy-Ombudsman Sakslin collected the problems observed in the Mental Health Act, which the Ministry was asked to consider when developing legislation. The observations were based on complaints from patients and inspections at psychiatric hospitals (164/2021).
- Deputy-Ombudsman Sakslin stated that the legislation should be amended so that the COVID-19 vaccine would, where applicable, be subject to the same regulation as the influenza vaccine, which means that certain work tasks could require vaccination protection regulated by law (1291/2021).
- Deputy-Ombudsman Sakslin stated that the task of HUS is to ensure that the assistive equipment services have the resources to carry out their statutory task. She asked the Ministry of Social Affairs and Health to assess whether the regulation on assistive equipment may need to be specified in terms of the concept of "everyday activities" (3129/2020).
- Deputy-Ombudsman Sakslin stated that the interpretation of the impact of the Aliens Act underlying the policies and guidelines on city decisions and organising temporary accommodation was partly incorrect regarding the application of social welfare legislation. The ministry's guidelines should be supplemented to avoid interpretation errors (4354/2020).
- Deputy-Ombudsman Sakslin stressed that taking into account the need for consultation in health care and how commissioned consultation reduces the obligation of secrecy, the right to consult should be under more detailed regulation. The Deputy-Ombudsman submitted the decision to the Ministry of Social Affairs and Health for an examination of any needs to amend the legislation (6465/2020).
- Deputy-Ombudsman Sakslin stated that the current regulation puts other persons studying to be a licensed professional in a less favourable position than those who have completed a vocational qualification in medicine abroad. According to the Deputy-Ombudsman, it should be assessed whether existing legislation should be supplemented (7414/2020).
- Deputy-Ombudsman Sakslin stated that it is problematic that there is no legislation on restricting visits to social welfare and health care units. She stressed that the Ministry of Social Affairs and Health should begin preparing legislative amendments concerning restrictions on the elderly and the conditions under which visits can be restricted or prohibited in health care units (7771/2020).

– Deputy-Ombudsman Sakslin stated that the legislation in force provides poor support in situations in which discharging a patient can in practice mean abandoning the patient and threaten the patient's life and health. The report was sent to the Ministry of Social Affairs and Health for the preparation of legislative amendments and to Valvira and THL for updating the guidelines (7866/2020).

The Ministry of Social Affairs and Health and the Finnish Institute for Health and Welfare

– Deputy-Ombudsman Sakslin required that instructions on visiting elderly patients and implementing physical activity in care units be made available on an equal and clear basis in a way that does not restrict the residents' and their family members' fundamental rights, especially their right to self-determination (5463/2020).

The Ministry of Social Affairs and Health and Valvira

– Deputy-Ombudsman Sakslin proposed that the Act on the Status and Rights of Patients should be specified in such a way that it would clearly address taking do-not-resuscitate decisions (DNR) and that national and international law be taken into account in the decisions. Valvira's DNR guidelines should also be specified and clarified (6027/2020).

The Ministry of Social Affairs and Health, Valvira and the Finnish Institute for Health and Welfare

– Deputy-Ombudsman Sakslin stressed that a personnel shortage does not justify restricting the patient, and the possibility of using less stringent methods to ensure the patient's safety must be assessed in situations. The decision was sent to the Ministry of Social Affairs and Health for the preparation of legislative amendments and to Valvira and THL for implementing national guidelines (3115/2020).
– Deputy-Ombudsman Sakslin stated that the City acted incorrectly when restricting the patient's freedom of movement but that the legislation on the matter was inadequate. The decision was sent to the Ministry of Social Affairs and Health for the preparation of legislative amendments and to Valvira and THL for implementing national guidelines (4180/2020).

Ministry of Finance

– According to Deputy-Ombudsman Pölönen, the operations of Senate Properties had been based on an inadequate and incorrect legal basis in parts described in the decision. The Deputy-Ombudsman asked the Ministry of Finance to state what measures the Ministry and the Senate Group have taken to dismantle the monopoly status and reform the state's internal in-house agreement position, and to what extent the Administrative Procedure Act is applied in the Senate Group's operations (6870/2019).

Valvira

- Deputy-Ombudsman Sakslin stated that the systematic practice of denying a couple fertility treatment only on the basis of the cancer treatments of the other partner is not legal. The Deputy-Ombudsman asked Valvira to guide university hospitals to lawful practices in the matter (1587/2020).
- Parliamentary Ombudsman Jääskeläinen asked Valvira to clarify the responsibility of the psychiatric hospital for the patient assigned to treatment when the patient has left the hospital without permission. The Ombudsman proposed that Valvira consider issuing national guidelines on the basis of the report (4702/2020).

City of X, municipality of Y

- Deputy-Ombudsman Sakslin stated that the child welfare services of the child's municipality of residence include organising the necessary and adequate services and support measures. If the customer relationship is transferred to another municipality, the necessary provisions required by law must be taken into account in the agreement. The Deputy-Ombudsman emphasised that the transfer must always be in the child's best interests (3400/2021).

Appendix 4
Inspections

#) = unannounced inspection

Finnish Prosecution Service

– 30 September Prosecution District of Eastern Finland, Kuopio office – documentation review (4903/2021)

Police administration

– 17 June Helsinki Police Department, Pasila police prison (4225/2021)
– 17 June Eastern Uusimaa Police Department, Vantaa police prison (4226/2021)
– 30 September Eastern Finland Police Department – remote inspection (4245/2021)
– 30 September Eastern Finland Police Department, covert coercive measures and intelligence gathering – documentation review (6819/2021)
– 8 December National Police Board (8409/2021)

Defence Forces and Border Guard

– 9 June Karelia Brigade – remote inspection (3779/2021)
– 1 December Pori brigade, in Niinisalo – remote inspection (8002/2021)
– 2 December Pori brigade, in Säkylä – remote inspection (8003/2021)

Criminal Sanctions

– 16 March Unit of Health Care Services for Prisoners – remote inspection (1185/2021)
– 15 June Naarajärvi Prison – remote inspection (2933/2021)
– 13 October the Vantaa unit of the Psychiatric Hospital for Prisoners#) (6762/2021)
– 2–4 November Kuopio Prison (6769/2021)
– 3–4 November Health Care Services for Prisoners, Kuopio Prison Outpatient Clinic (6832/2021)

Aliens affairs

– 16 June Joutseno detention unit (4149/2021)
– 8 November Detention Unit in Helsinki#) (7238/2021)

Social welfare/Persons with disabilities

- 1 June 2020 –15 June 2021 Lempäälä municipality, Pajukoti residential unit for people with intellectual disabilities – documentation review (3652/2020)
- 16 June – 15 September the Central Ostrobothnia Joint Municipal Authority for Social and Health Services Soite, Housing units for persons with intellectual disabilities and severe disabilities, especially Maria-Katariina House in Kokkola – documentation review (3995/2021)
- 13 December 2021 HUS Respiratory paralysis unit for heart and lung diseases, Rekola group home – documentation review (4128/2021)
- 16 June – 17 December 2021 City of Vaasa, Purohovi housing service unit for persons with intellectual disabilities – documentation review (3996/2021)
- 22 June 2020 – 27 September 2021 City of Pietarsaari, Institutional and housing services for persons with intellectual disabilities (3653/2020, in Swedish)

Social welfare/Elderly units

- 21 June the Central Uusimaa Joint Authority for Health and Social Services (Keu-sote), service housing units with 24-hour assistance in Jampankaari service area – remote inspection, documentation review (4060/2021)
- 16 August City of Hämeenlinna, Customer guidance in services for older people – remote inspection (3143/2021)
- 31 August City of Kangasala, Services for the elderly – remote inspection (1252/2021)

Health care

- Niuvanniemi Hospital – remote inspection (3565/2021)
- Old Vaasa Hospital – remote inspection (3566/2021)

Other inspections

- 18 February Southeastern Finland TE Office (346/2021)
- 18 February A joint municipal authority for Kymenlaakso social and health services (Kymsote), employment services (348/2021)
- 31 May – 1 June Advance polling stations for municipal elections:
  - City of Tampere[#)] (3250/2021 includes all inspected polling stations)
  - Akaa[#)] (4004/2021)
  - City of Hämeenlinna[#)] (4005/2021)
  - Janakkala[#)] (4006/2021)
  - Siuntio[#)] (4007/2021)
  - Kirkkonummi[#)] (4008/2021)
  - City of Vantaa[#)] (4009/2021)
  - City of Espoo[#)] (4010/2021)
- 2 June Ministry of Social Affairs and Health, supervision and administration of occupational safety and health (3567/2021)
- 24 September the Saami Parliament (6254/2021)
- 11 November Uusimaa ELY Centre, Legal services (6634/2021)

Appendix 5
Staff of the Office of the Parliamentary Ombudsman

Parliamentary Ombudsman
Mr Petri Jääskeläinen, LL.D., LL.M. with court training

Deputy-Ombudsmen
Ms Maija Sakslin, LL.Lic.
Mr Pasi Pölönen, LLD., LL.M. with court training

Secretary General
Ms Päivi Romanov, LL.M. with court training (till 31 January)
Ms Riitta Länsisyrjä, LL.M. with court training (on fixed term till 28 February)
Mr Matti Marttunen LLD., LL.M. with court training (since 1 March)

Principal Legal Advisers
Mr Mikko Eteläpää, LL.M. with court training
Mr Juha Haapamäki, LL.M. with court training
Mr Jarmo Hirvonen, LL.M. with court training
Mr Erkki Hännikäinen, LL.M. (till 30 November)
Ms Kirsti Kurki-Suonio, LL.D
Ms Ulla-Maija Lindström, LL.M.
Ms Riitta Länsisyrjä, LL.M. with court training (on leave till 28 February)
Mr Juha Niemelä, LL.M. with court training
Mr Jari Pirjola, LL.D., M.A.
Mr Pasi Pölönen, LL.D., LL.M. with court training (on leave)
Ms Anu Rita, LL.M. with court training
Mr Tapio Räty, LL.M.
Mr Mikko Sarja, LL.Lic., LL.M. with court training
Mr Håkan Stoor, LL.Lic., LL.M. with court training (till 31 March)
Ms Iisa Suhonen, LL.M. with court training
Ms Kaija Tanttinen-Laakkonen, LL.M.
Ms Minna Verronen, LL.M. with court training

Senior Legal Advisers
Ms Terhi Arjola-Sarja, LL.M. with court training
Ms Riitta Burrell, LL.D.
Mr Kristian Holman, LL.M., M.Sc. (Admin.)
Ms Lotta Hämeen-Anttila, M.Soc.Sc.
Ms Anne Ilkka, LL.M. with court training
Ms Riikka Jackson, LL.M (on leave 1 February–7 March and 1 June–31 August)
Ms Minna Ketola, LL.M. with court training (till 30 June, on leave 25 January–30 June)
Ms Johanna Koli, M.Soc.Sc.
Mr Juha-Pekka Konttinen, LL.M.
Ms Heidi Laurila, LL.M. with court training
Ms Päivi Pihlajisto, LL.M. with court training
Ms Piatta Skottman-Kivelä, LL.M. with court training
Ms Mirja Tamminen, LL.M. with court training (till 31 August)
Mr Matti Vartia, LL.M. with court training
Ms Pia Wirta, LL.M. with court training
Ms Susanna Wähä, M.Sc. (Admin.)

Legal Advisers
Mr Jukka Anttila, LL.M. with court training (on fixed term 8 March–31 December)
Mr Peter Fagerholm, M.Sc. (Admin.) (on fixed term 25 January–31 December)
Ms Kouros Kristiina LL.M. (on fixed term 1 January–31 December)
Ms Leena-Maija Vitie, LL.M. with court training (on fixed term 1 February–31 December)

On-duty lawyer
Ms Jaana Romakkaniemi, LL.M. with court training

Information Officer
Ms Citha Dahl, M.A.

Information Management Specialist
Mr Janne Madetoja, M.Sc. (Admin.)

Investigating Officers
Mr Birger Eriksson, LL.M. (on fixed term 25 January–30 September)
Mr Peter Fagerholm, M.Sc. (Admin.) (on leave 25 January–31 December)
Mr Joel Hyväri, M.Sc. (Admin.) (on fixed term 1 October–31 December)
Mr Reima Laakso

Notaries
Ms Sanna-Kaisa Frantti, B.B.A.
Ms Taru Koskiniemi, LL.B.
Ms Kaisu Lehtikangas, M.Soc.Sc.
Ms Eeva-Maria Tuominen, M.Sc.(Admin.), LL.B.
Ms Riina Tuominen, M.Sc. (Admin.)

Administrative secretary
Ms Eija Einola

Filing Clerk
Ms Helena Kataja (till 31 October)
Ms Anna-Liisa Tapio, B.B.A. (since 1 November, on fixed term 10 June–31 October)

Assistant Filing Clerk
Ms Anu Forsell

Case Management Secretary
Ms Anna-Liisa Tapio, B.B.A.
(on leave 10 June–31 October)
Mr Taneli Palmén, M.A., B.A.

Departmental Secretaries
Ms Bergman Andrea, Master of Culture and Arts (since 1 August)
Mr Matti Rautala
(on fixed term 1 January–30 June)
Ms Mervi Stern

Assistant for International Affairs
Ms Tiina Mäkinen

Office Secretaries
Ms Minna Haapaniemi
Ms Johanna Hellgren
Ms Sari Holappa
Mr Mikko Kaukolinna
Ms Krissu Keinänen
Ms Ira Nyberg
(on fixed term 7 June–31 December)
Ms Virpi Salminen

Staff of the Human Rights Centre

Director
Ms Sirpa Rautio, LL.M. with court training

Experts
Ms Sanna Ahola, LL.M.
Ms Maria Fagerholm, M.Pol.Sc. (on fixed term 1 September–31 December)
Ms Elina Hakala, M.Soc.Sc. (on fixed term 18 March–31 December)
Mr Mikko Joronen, M.Pol.Sc.
Ms Kouros Kristiina LL.M. (on leave)
Ms Leena Leikas, LL.M. with court training
Ms Susan Villa, M.Soc.Sc. (on leave 1 Septemver–31 December)

Assistant expert
Ms Maija Hirvi, LL.M. (on fixed term 1 February–31 December)
Ms Kupiainen Emmi LL.M, LL.B. (on fixed term 1 January–31 December)

Assistentti
Ms Katariina Huhta

Appendix 6
Statistical data on the Ombudsman's work in 2021

OVERSIGHT-OF-LEGALITY CASES UNDER CONSIDERATION

CASES INITIATED IN 2021	7 954
Complaints to the Ombudsman	7 651
Complaints transferred from the Chancellor of Justice	81
Taken up on the Ombudsman's own initiative	67
Submissions and attendances at hearings	155

CASES RESOLVED	8 136
Complaints	7 840
Transferred to the Chancellor of Justice	52
Taken up on the Ombudsman's own initiative	91
Submissions and attendances at hearings	153

OTHER MATTERS UNDER CONSIDERATION	1 194
Inspections	39
Administrative matters in the Office	1 132
International matters	23

RESOLVED CASES BY PUBLIC AUTHORITIES

COMPLAINT CASES	7 892
Social welfare	1269
Health	1211
Police	924
Administrative branch of the Ministry of Education and Culture	489
Criminal sanctions field	445
Highest organs of government	404
Other administrative branches	386
Social insurance	386
Local government	303
Administrative branch of the Ministry of Economic Affairs and Employment	299
Administration of law	281
Enforcement (distraint)	232
Administrative branch of the Ministry of Environment	203

Administrative branch of the Ministry of Transport and Communications	191
Taxation	137
Administrative branch of the Ministry of Justice	124
Guardianship	112
Aliens affairs and citizenship	104
Administrative branch of the Ministry of Agriculture and Forestry	101
Prosecutors	77
Administrative branch of the Ministry of Defence	74
Administrative branch of the Ministry of Finance	68
Administrative branch of the Ministry of the Interior	29
Customs	28
Administrative branch of the Ministry for Foreign Affairs	15
Subjects of oversight in the private sector	0

Taken up on the Ombudsman's own initiative	**91**
Social welfare	52
Police	7
Health	6
Aliens affairs and citizenship	4
Local government	2
Administration of law	2
Administrative branch of the Ministry of Transport and Communications	2
Administrative branch of the Ministry of Justice	2
Criminal sanctions field	2
Social insurance	2
Customs	2
Administrative branch of the Ministry of Finance	2
Guardianship	1
Administrative branch of the Ministry of Agriculture and Forestry	1
Administrative branch of the Ministry of Education and Culture	1
Administrative branch of the Ministry of the Interior	1
Prosecutors	1
Enforcement (distraint)	1

Total number of decisions	**7 983**

MEASURES TAKEN BY THE OMBUDSMAN

COMPLAINTS	**7 892**
Decisions leading to measures	**1 030**
– prosecution	0
– assessment of the need for pre-trial investigation	2
– reprimands	99
– opinions	651
– as a rebuke	433
– for future guidance	218
– recommendations	39
– to redress an error or rectify a shortcoming	3
– to develop legislation or regulations	21
– to provide compensation for a violation	14
– to rech an agreed settlement	1
– matters redressed in the course of investigation	58
– other measure	181
No action taken	**3 823**
– no incorrect action found	326
– no grounds	3497
– to suspect illegal or incorrect procedure	1919
– for the Ombudsman's measures	1578
Complaint not investigated	**3 039**
– matter not within Ombudsman's remit	318
– still pending before a competent authority or possibility of appeal still open	945
– unspecified	524
– transferred to Chancellor of Justice	52
– transferred to Prosecutor-Genera	8
– transferred to Regional State Administrative Agency	103
– transferred to ELY Centre	1
– transferred to other authority	238
– older than two years	157
– inadmissible on other grounds	59
– no answer	141
– answer without measures	493

MEASURES TAKEN BY THE OMBUDSMAN

TAKEN UP ON THE OMBUDSMAN'S OWN INITIATIVE	**91**
Decisions leading to measures	**42**
– prosecution	0
– assessment of the need for pre-trial investigation	1
– reprimands	3
– opinions	25
– as a rebuke	11
– for future guidance	14
– recommendations	9
– to redress an error or rectify a shortcoming	1
– to develop legislation or regulations	8
– to provide compensation for a violation	0
– to rech an agreed settlement	0
– matters redressed in the course of investigation	0
– other measure	4
No action taken	**45**
– no incorrect action found	0
– no grounds	45
– to suspect illegal or incorrect procedure	6
– for the Ombudsman's measures	39
Own initiative not investigated	**4**
– no answer	4

INCOMING CASES BY AUTHORITY

Health	1 322
Social welfare	1 142
Police	922
Criminal sanctions field	477
Highest organs of government	403
Other administrative branches	399
Administrative branch of the Ministry of Education and Culture	397
Social insurance	381
Local government	302
Administrative branch of the Ministry of Economic Affairs and Employment	274
Administration of law	254
Enforcement (distraint)	217
Administrative branch of the Ministry of Transport and Communications	202
Administrative branch of the Ministry of Environment	192
Taxation	136
Guardianship	124
Administrative branch of the Ministry of Justice	123
Administrative branch of the Ministry of Agriculture and Forestry	90
Aliens affairs and citizenship	90
Prosecutors	80
Administrative branch of the Ministry of Finance	75
Administrative branch of the Ministry of Defence	66
Administrative branch of the Ministry of the Interior	28
Customs	19
Administrative branch of the Ministry for Foreign Affairs	17
Subjects of oversight in the private sector	0

PARLIAMENTARY OMBUDSMAN OF FINLAND

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