PARLIAMENTARY OMBUDSMAN OF FINLAND

SUMMARY OF THE ANNUAL REPORT 2023

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To the reader

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

The undersigned Mr Petri Jääskeläinen, Doctor of Laws and LL.M. with Court Training, served as Parliamentary Ombudsman throughout the year under review 2023. My term of office is 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 2022 to 31 March 2026), Doctor of Laws and LL.M. with Court Training Mr Pasi Pölönen (from 1 October 2021 to 31 March 2023) and Licentiate in Laws and LL.M. with Court Training Mr Mikko Sarja (from 1 June 2023 to 31 May 2027). Sarja performed the tasks of the Subsitute for a Deputy Ombudsman for a total of 55 working days during the year under review from 1 January to 31 May 2023.

Doctor of Laws, Secretary General Mr Jari Råman was selected to serve as the Substitute for a Deputy Ombudsman for the period 16 June 2023 to 15 June 2027. He performed the tasks of a Deputy Ombudsman for a total of 34 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 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 about 300 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.

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 2023.

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. 9, 31, 49, 132).

Photo archive of the Parliament of Finland p. 10, 17, 23, 44.
Photo archive of the Parliamentary Ombudsman of Finland p. 47, 91.

1 General comments

Parliamentary Ombudsman
Mr Petri Jääskeläinen

Ombudsman's own initiatives

Under section 4 of the Parliamentary Ombudsman Act, the Ombudsman may, on his or her own initiative, take up a matter within his or her remit. In addition to processing complaints and carrying out on site inspections, own initiatives are a third avenue open to the Ombudsman's oversight of legality.

In my general comment on the Ombudsman's annual report for 2022, I discuss the Ombudsman's inspection activities. In this general comment, I focus on own initiatives.

1. Criteria for own initiatives in general

According to section 109 of the Constitution the Ombudsman shall ensure that the courts of law, the other authorities and civil servants, public employees and other persons, when the latter are performing a public task, obey the law and fulfil their obligations. In the performance of his or her duties, the Ombudsman monitors the implementation of basic rights and liberties and human rights.

Because the Constitution of Finland states that the Ombudsman's task is to oversee compliance with the law and the implementation of fundamental and human rights, also the goal of own initiatives is to implement and enhance these oversight tasks.

There are no specific legislative provisions on the criteria for own initiatives. Instead, there are provisions on the processing of complaints, for example as follows (Parliamentary Ombudsman Act, section 3):

> 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. (subsection 1)
>
> 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. (subsection 2)

Own initiatives are mainly taken up using the same criteria as for complaints. The most typical criterion is suspected unlawful conduct, but the investigation of a complaint or own initiative may also be for "another reason".

The Parliamentary Ombudsman is not merely tasked with overseeing legality; moreover, the Ombudsman can for example "draw the attention of the subject to the requirements of good administration or to considerations of promoting fundamental and human rights" (Parliamentary Ombudsman Act, section 10, subsection 2). This does not necessarily mean that the subject has acted unlawfully.

In such situations, typically the subject has not acted unlawfully per se but could have better promoted the implementation of fundamental and human rights by acting in some other way. In line with the principle adopted in the fundamental rights reform, when authorities face different options for interpreting legislation, they should choose the interpretation that best promotes the implementation of fundamental and human rights. This principle is expressly stated in several laws, for example in section 2 of the Police Act.

In addition, the Parliamentary Ombudsman may, "in the performance of his or her duties, 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" (Parliamentary Ombudsman Act, section 11, subsection 2). Again, this does not necessarily mean the authority in question has acted unlawfully in cases which has led to the Ombudsman submitting a legislative proposal. Typically, the shortcoming or inaccuracy observed in legislation is problematic in terms of individuals' legal protection or the implementation of fundamental and human rights.

With regard to the Ombudsman's key tasks, the regulation concerning the annual report offers some further insight as well. Under section 109 of the Constitution of Finland, 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" (subsection 2). Similarly, section 12 of the Parliamentary Ombudsman Act states that the Ombudsman shall submit to the Parliament an annual report on his or her activities, but also on "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" (subsection 1). The state of administration of justice, public administration and the performance of public tasks mentioned in the provisions may for example concern various structural problems.

In line with the above, the most important criteria for an own initiative – the general criteria for assessing the investigative interest for the oversight of legality – can be summarised as follows:

The Ombudsman will investigate an own initiative if he deems it appropriate for
(1) compliance with the law;
(2) the implementation of legal protection;
(3) the implementation of fundamental and human rights;
(4) the state of administration of justice, public administration and public tasks; or
(5) possible deficiencies in legislation.

Compared to investigating complaints, own initiatives often address matters that involve structural issues or that otherwise hold a wider significance than individual cases.

The procedure for complaints laid down in the Parliamentary Ombudsman Act also applies to own-initiative investigations.

2. Procedural own initiatives

In some situations, an own initiative can be taken for procedural reasons. In these situations, it is either more appropriate to investigate a matter as an own initiative than as a complaint, or the matter cannot be investigated as a complaint.

(1) One possibility is that there have been numerous complaints about the same issue or set of issues. Complaints can be addressed to the Ombudsman even in matters that do not concern the complainant personally, and in these situations, it is typical that some or all of the complainants are outsiders, for example when an issue has received widespread public attention.

Instead of investigating each complaint separately, it may be appropriate to investigate the matter as a single own initiative. This achieves several benefits.

Firstly, it is a more efficient use of resources and a more clear-cut process to investigate a single own initiative than a number of complaints separately and prepare a separate response to each one.

Secondly, an own initiative allows for putting together all the facts, allegations and questions relevant to the Ombudsman's investigation. If the investigations were separate cases, the overall picture might not become as clear. In addition, different events and aspects related to the same theme may support one another and also affect the overall assessment of the reprehensibility of an authority's actions. An own initiative also allows for the inclusion of aspects and questions considered relevant by the Ombudsman, which have not been raised in any complaint. All these elements will enhance the efficiency of the investigation of a matter brought up in several complaints.

In situations such as the above, the investigation of individual complaints as separate matters is discontinued, which is communicated to the complainants. The complainants are also informed that a copy of the eventual decision on the own initiative will be sent to them for information. If the number of complaints is very high, the complainants may be informed that the decision on the own initiative will be published on the Ombudsman's website in due course.

One example where an own initiative may be an appropriate procedure is when the Ombudsman receives numerous complaints about police conduct during a demonstration. Some complaints may be submitted by outsiders and some by persons who took part in the demonstration. In such situations, it is also possible for a separate own initiative to be formed from some of the complaints while other complaints are investigated separately. An individual investigation may, for example, be necessary if the complainant is a person who was subjected to police measures and there is reason to suspect unlawful conduct by the police in this matter.

(2) Another type of a procedural own initiative is when the Ombudsman receives an anonymous complaint. Under legislation, a complaint must include the complainant's name and contact details (Parliamentary Ombudsman Act, section 2, subsection 2). For this reason, an anonymous submission cannot be investigated as a complaint.

However, a matter presented in an anonymous submission may involve significant investigative interest for the oversight of legality. It might be very understandable that a person writing to the Ombudsman may not want to reveal their identity.

In such situations, a matter presented in an anonymous submission can be investigated as an own initiative.

(3) A third type of a procedural own initiative is when a complainant withdraws their complaint. In this case, the investigation of the matter can no longer be continued as a complaint. Instead, the investigation can be continued as an own initiative.

When considering an own initiative in these situations, the reason for withdrawing the complaint is taken into account. For example, if an authority has already rectified the procedure or negligence criticised in a complaint independently or as a result of a request for clarification sent by the Ombudsman due to a complaint, it is possible that it will no longer be necessary to continue investigating the matter as an own initiative.

Another factor may be the stage of the investigation in question. If the authority has already provided an explanation to the complaint, it may be appropriate for the Ombudsman to issue a decision regardless of the withdrawal of the complaint.

One key factor in all of these cases is the investigative interest for the oversight of legality, in which the complainant's view is only one element. If a matter is of a more serious nature or has significance beyond the individual case, it may be justified to continue investigating it as an own initiative.

3. Substantive own initiatives

Most own initiatives are initiated on substantive grounds and not for procedural reasons.

(1) One of the typical justifications for taking an own initiative is that the matter relates to the annual theme of the Office of the Parliamentary Ombudsman.

Each year, the Office has a special theme related to fundamental and human rights or otherwise central to the Ombudsman's duties. The theme is brought up at every inspection visit and taken into account when focusing on own initiatives. In practice, each theme has been used for two years in a row.

During this reporting year, the theme was "oversight of oversight". The purpose of the theme is to examine and supervise how the internal oversight of authorities and each administrative branch, as well as the special supervisory authorities, such as special ombudsmen, have carried out their supervisory tasks. The Parliamentary Ombudsman is the supreme overseer of legality who also oversees other supervisory authorities. The Ombudsman is not intended to be the sole overseer of legality for any authority.

Previous annual themes have included "provision of sufficient resources for authorities to ensure fundamental rights", "right to effective legal remedies" and "right to privacy".

(2) At the Office of the Parliamentary Ombudsman, teams focusing on the supervision of certain authorities or administrative branches also have their own team-specific themes that are central to the administrative branch in question, and matters related to these themes are investigated as own initiatives.

For example, the team focusing on police oversight typically focuses on the use of coercive measures and other police powers affecting fundamental rights. Teams may also have changing themes – for example, during the year under review, one special theme of the police team was the supervision of private security services. The theme was also featured in public discourse due to suspected criminal offences by private security guards.

(3) In practice, the largest number of own initiatives are taken on the basis of inspections.

Many of the flaws or deficiencies detected during inspections are discussed during the inspection with the management of the inspected target and in the inspection report. However, if the observed deficiency is of a serious nature or otherwise requires a more detailed investigation, the matter will be investigated separately as an own initiative. One inspection may lead to several own initiatives.

Doing so better highlights the investigated issues, so that relevant opinions and measures do not get drowned out by a plethora of more minor inspection findings. This serves to promote the effectiveness of the Ombudsman's measures and opinions.

Another benefit is that it becomes possible to draw up inspection reports more quickly, as the process is not slowed down by matters that have to be inspected separately. This allows the inspected target to act quickly in taking possible corrective action based on the inspection findings even though no decisions have yet been made concerning own initiatives. At the Office of the Parliamentary Ombudsman, the target time for the completion of an inspection report is three months after the inspection.

(4) Own initiatives are taken in connection with the investigation of complaints.

In practice, it is not unusual that some deficiency other than the actual object of the complaint is detected in connection with an investigation of a complaint. In these situations, it is possible that the other detected problem is investigated alongside the complaint. However, if the identified problem is clearly a separate one and not relevant to the resolution of the complaint, the matter is investigated as an own initiative.

(5) Own initiatives are taken on the basis of information that has surfaced in the media or based on other publicly available information or observations if the matter is thought to have a significant investigative interest for the oversight of legality.

In the past, issues that received public attention were an important source of own initiatives. However, the situation has changed now that sharing information online has become the norm and, as a result, submitting a complaint has become quick and easy. Nowadays, when a matter that the Ombudsman could justifiably investigate as an own initiative surfaces in public discourse, there will subsequently be several complaints that arrive in quick succession. In this case, there is no longer any need to take a substantive own initiative. Instead, these situations will typically involve considering a procedural own initiative described in section 2(1) above.

(6) Own initiatives are targeted at areas of oversight that produce no complaints or are otherwise blind spots in respect of oversight.

Usually, the Ombudsman becomes aware of shortcomings through complaints. However, not all people are able, or willing, or have the wherewithal to submit complaints about violations they have experienced or shortcomings they have observed. Own initiatives are particularly important – alongside inspections – in safeguarding the rights and treatment of such people. These include children, older people, persons with disabilities and psychiatric patients.

Another typical example is covert information gathering and intelligence activities. These measures take place without the knowledge of the target, so the target is in no way able to complain. For this reason, own initiatives and inspections are key sources of information and forms of oversight of legality in these situations.

(7) It is also possible that an issue or a larger range of issues is put under monitoring on the Ombudsman's initiative. In such cases, information will first be collected, after which it will be decided whether an actual investigation should be initiated.

4. Number of own initiatives and measures

Over the past ten years, the Ombudsman's own initiatives have had an annual average of 70 cases. The minimum has been about 50 and the maximum 95.

The relatively low number of own initiatives is especially due to the high number of complaints and the continuous rise in that number. Over the past decade, the annual number of complaints has risen from some 4,500 to over 7,000.

However, own initiatives tend to be very fruitful. In the past 10 years, almost 70% of all own initiatives have led to measures taken by the Ombudsman. The corresponding percentage of complaints is much lower – on average, about 14% of all complaints lead to measures.

The fruitfulness of own initiatives is natural in itself – own initiatives are only taken in cases involving an investigative interest for the oversight of legality that can be assumed to lead to measures. For complaints, comparative cases are mainly the cases that are investigated in full, which means getting at least one report and/or statement from an authority.

In fact, for complaints that are investigated in full, the percentage of cases where measures are taken reaches about 50%. About a quarter of all complaints are investigated in full.

It is also noteworthy that own initiatives and their measures are more likely to go beyond the individual case in question, or carry greater significance in terms of principle.

5. Example

The Ombudsman's role as the National Preventive Mechanism (NPM) for the Optional Protocol to the UN Convention against Torture (OPCAT, Parliamentary Ombudsman Act, chapter 1a) involves inspecting places where persons deprived of their liberty can be held. The competence of the NPM also includes the detention facilities for persons deprived of their liberty on board a ship.

On my order, an inspection of the detention facilities of a passenger car ferry operating between Finland and Sweden was carried out in November 2022. The flag state of the vessel is Finland and the home port is Mariehamn. The inspection was the first of its kind, and it revealed issues related to detention facilities, procedures and the oversight of operations such as:

- The police had not inspected and approved the detention facilities before their use, as would have been required by the Private Security Services Act.
- Detention notifications concerning detained persons had not been delivered to the police department as required by the Private Security Services Act after the ship had arrived in port.
- The cells on the vessel did not have an alarm button that a detainee could have used to call for help.
- Detained persons had not always been examined by a health care professional as required by decree.
- The inspected detention notifications revealed two cases where women who were thought to be suicidal had been detained on board the ship and male ship security stewards had ordered them to remove all their clothing. This was contrary to the so-called gender rule laid down by decree, and treating people with dignity includes the right to keep appropriate clothing on during detention.

In addition, the inspection raised the question of how police departments have carried out their oversight duties of security stewards on board ships and how the National Police Board has carried out its oversight and supervisory duties related to this. The inspection also revealed a number of legislative problems and shortcomings.

The inspection report was completed in February 2023. Some of the inspection findings were discussed in the inspection report, and on the basis of the other inspection findings, I took four own initiatives, subsequently sending requests for information and opinions to the Ministry of the Interior, the Ministry of Economic Affairs and Employment, the Ministry of Transport and Communications, the Government of Åland, the shipping company and the security stewards who had been involved in the cases where detainees were forced to undress.

The own initiatives in this example case are a concrete portrayal of fulfilling all the five common criteria of taking own initiatives mentioned above in part 1. In addition, some of the own initiatives were related to the annual theme of the "oversight of oversight" of the Office of the Parliamentary Ombudsman as described in section 3(1), some were related to the "supervision of private security services" theme of the Office's police team explained in part 3(2), all the own initiatives were taken on the basis of an inspection as explained in part 3(3), and the matter addressed a blind spot that had not produced any complaints, as described in part 3(6). Many of the issues addressed in the own initiatives also carry a wider significance than the individual cases in question.

6. Conclusions

Own initiatives are an important form of the Ombudsman's oversight of legality in addition to processing complaints and carrying out inspections. Although there are relatively few own initiatives, their significance is greater than their numbers.

Procedural own initiatives can be used to intensify the investigation of issues presented in complaints and, in the case of anonymous or withdrawn complaints, to enable the investigation or continued investigation of presented issues.

Substantive own initiatives can be used to direct the oversight of legality to selected focus areas both in the activities of the Office as a whole and in the activities of the Office's teams. In this way, it is possible to get deeper and more multifaceted information on the selected themes to promote the effectiveness of the oversight of legality.

When flaws or deficiencies detected in inspections are investigated separately as own initiatives, it speeds up the completion of inspection reports and highlights the investigated issues more clearly. This serves to enhance the effectiveness of the Ombudsman's measures and opinions related to inspections.

Own initiatives enable the Ombudsman to intervene in matters that have emerged in the investigation of a complaint, issues that have arisen in public discourse or other matters that the Ombudsman has observed that are considered to involve a significant investigative interest for the oversight of legality. Own initiatives are also targeted at aspects of oversight that produce no complaints or are otherwise blind spots for oversight.

Own initiatives also tend to be very fruitful. On average, almost 70% of all own initiatives lead to action taken by the Ombudsman.

For these reasons, increasing the number of the Ombudsman's own initiatives would be very justified. However, due to the availability of resources, there is only limited potential to do so. This is especially due to the large number of complaints and the continuous rise in that number. Each complaint must be investigated to the extent required by the case, and a reply must be issued to each complaint, whereas taking own initiatives is up to the Ombudsman's descretion.

Nevertheless, one of the objectives of the Office of the Parliamentary Ombudsman for 2024 is to increase the number of both procedural and substantive own initiatives within the limits of possibilities.

Deputy-Ombudsman
Ms Maija Sakslin

Right to sufficient health services

Oversight of legality in healthcare

In my general comment in this annual report, I discuss the Parliamentary Ombudsman's oversight in healthcare. The Parliamentary Ombudsman oversees that everyone performing a public task complies with the law and fulfils their obligations. In the performance of his duties, the Parliamentary Ombudsman oversees the realisation of the right to health services, which is secured to everyone in the Constitution of Finland. The Parliamentary Ombudsman oversees public healthcare, but also private healthcare operators when they perform a public task.

Based on the number of the complaints received, healthcare has for several years been one of the largest categories of matters in the Ombudsman's oversight of legality. Complaints usually concern access to treatment, the right to good care and treatment, the right to be given information, and responding to requests, enquiries and reminders. During the year under review, 795 health-related complaints were resolved. Several factors may explain the large number of matters: they often concern the patient's fundamental rights, which are considered extremely important, and every day, there are a large number of encounters that may give rise to a complaint. In addition, the patient might not have any other effective legal remedy at their disposal.

Because the oversight carried out by the Ombudsman is oversight of legality, the Ombudsman does not comment on issues related to medicine or dental medicine. When medical expertise is needed for assessing the legality of the actions, the Ombudsman usually requests an opinion from the Regional State Administrative Agency or the National Supervisory Authority for Welfare and Health (Valvira), which have the expertise required for the assessment. In the oversight of legality by the Ombudsman, it has been considered that when the Ombudsman requests a comment from the Regional State Administrative Office, the Regional State Administrative Office must also obtain the required opinions from external experts if it does not itself have expertise in the medical field in question.

However, from the point of view of oversight of legality, good care of the patient does not involve only medical appropriateness: the realisation of the patient's fundamental rights and the fulfilment of the other obligations laid down in legislation are also always required.

The Parliamentary Ombudsman's special task is to oversee the legality of prisoner healthcare, healthcare in the Defence Forces and psychiatric medical care. In these sectors, inspections play a key role in the oversight of legality. When the inspections are part of monitoring the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the Ombudsman may also use external healthcare experts, such as experts in nursing, psychiatry and medical care of people with an intellectual disability.

Inspection visits to psychiatry wards are conducted especially to assess the realisation of the patient's right to self-determination and the protection of privacy, procedures related to seclusion and use of coercive measures, the functionality and appropriateness of the facilities, and their utilisation rates and possible overcrowding, personnel resources and the presence of nursing staff. The Parliamentary Ombudsman also oversees the conditions and treatment of patients and the realisation of their fundamental rights by investigating how patients are advised, how they are informed of their rights and how their families and other people close to them are taken into account. These inspections usually last for several days.

The aim is to conduct the visits unannounced, but in practice, to enable their appropriate implementation and to obtain the material required in advance, some kind of time range for the visit is notified to the organisation that will be inspected. The inspection records are published on the Ombudsman's website.

Shortcomings in implementation of fundamental and human rights

The Parliamentary Ombudsman's annual report contains a list of the ten main long-term shortcomings or deficiencies related to the realisation of fundamental and human rights problems. Shortcomings in the availability of health services and the relevant legislation have repeatedly been on in this list. To rectify the shortcomings he or she has observed in legislation, the Ombudsman submits proposals for amending the legislation to ministries.

There have been serious deficiencies in access to examinations and treatment and the waiting list may be long and contacting the healthcare unit may be difficult. Because the regional state administrative offices and Valvira are the primary supervisors of access to treatment and the availability of services, the Parliamentary Ombudsman as the supreme overseer of legality usually transfers complaints concerning these issues to the regional state administrative offices or Valvira for processing.

For example, problems are constantly detected in the distribution of care supplies and the handing over of assistive devices for medical rehabilitation. It has been consistently considered in the Parliamentary Ombudsman's decision-making practice that the supply of care supplies must always be based on the individual need determined by a doctor, without categorical restrictions to the quantity of the supplies.

Shortcomings in legislation repeatedly cause serious problems and hazards and endanger the legal protection of patients and personnel. For example, in somatic health care, restrictive measures may have to be imposed on a patient. In practice, there are situations in emergency services where an intoxicated or aggressive patient may have to be locked into a so-called security room. Restricting the freedom secured in fundamental rights requires legislation in which the prerequisites for restriction, the procedures complied with in restricting, decision-making and legal protection are defined, among other things.

The list of serious shortcomings related to fundamental rights in our legislation also includes the fact that the Mental Health Act does not include any 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 it. Our legislation also does not include provisions on the transport of a psychiatric patient and the patient's treatment during transport when the patient is transported to a place other than a healthcare unit. The Ombudsman has issued a proposal for supplementing the legislation to rectify these shortcomings, as well.

Challenges related to the sufficiency of healthcare and nursing staff and problems in the availability of personnel concern almost all professional groups in the whole country. Especially the psychiatric wards of hospitals are extremely overwhelmed and the number of patients exceeds the number of beds on the wards. There are only very limited possibilities to intervene in problems related to the adequacy of the resources by means of oversight of legality.

However, the Ombudsman has emphasised that the structure and number of personnel responsible for healthcare must correspond to the need for healthcare services in the population of the area. According to the Ombudsman's established opinion, inappropriate facilities, too high a number of patients in relation to the facilities or insufficient personnel are not acceptable grounds for deviating from the requirements laid down in the Constitution or other legislation.

In the past few years, several matters resolved in the oversight of legality have concerned taking photographs or filming in different healthcare or other units. The legal state is problematic from the point of view of the realisation of the rights of patients and personnel. The Parliamentary Ombudsman has also made a proposal for supplementing legislation in order to remove this shortcoming.

Insufficient actions are often observed in compliance with the Act on the Status and Rights of Patients. The patient must be given information about matters related to their treatment and they must be cared in mutual understanding with them. The right to self-determination referred to in the Act means that the patient's informed consent is required for treatment. If the patient refuses a certain treatment or measure, they have to be cared, as far as possible, in other medically acceptable way in mutual understanding with them.

Right to health services in the Constitution

Provisions on the right to health services and on health promotion are laid down in section 19, subsection 3 of the Constitution of Finland. According to it, public authorities shall guarantee for everyone adequate health services and promote the health of the population. According to section 22 of the Constitution, public authorities shall guarantee the observance of basic rights and liberties. Together these provisions lay a strong legal foundation for the Parliamentary Ombudsman's oversight of legality.

A certain legal content for the right to adequate health services and the criteria for assessing it have become established in the practice of the Constitutional Law Committee.[1)] The Constitution states that adequate services must be provided.[2)] More detailed provisions must be laid down in legislation to equitably secure sufficient availability and provision of the services to people living in different parts of Finland. The adequacy of the healthcare services must be assessed on an individual basis.[3)] According to the Committee, a level of services that provides each individual with the capacities to act as a full member of society can be considered sufficient.[4)] However, the Constitution does not determine how the services should be organised.[5)] Nevertheless, the wording of the provisions on fundamental rights has been formulated with the aim of making the actual implementation of the rights and taking into consideration the financial circumstances possible.[6)]

The right to adequate health services interacts closely with several other fundamental rights. On the one hand, health services secure the right to life. On the other hand, several other fundamental rights, such as human dignity, the right to self-determination, the right to privacy and protection of family life impose requirements on the quality of health services. The Parliamentary Ombudsman's oversight of legality therefore concerns especially the realisation of these fundamental rights in health services.

1) PeVL 17/2021 vp, paragraph 71—72.
2) PeVL 26/2017 vp, p. 32 and 36—41, PeVL 12/2015 vp, p. 3 and PeVL 11/1995 vp, p. 2.
3) PeVL 30/2013 vp, p. 3/I.
4) HE 309/1993, p. 71/II.
5) PeVL 26/2017 vp, p. 32 and 36—41, PeVL 12/2015 vp, p. 3 and PeVL 11/1995 vp, p. 2.
6) HE 309/1993 vp, p. 19/I, see e.g., PeVL 13/2024 vp, paragraph 4 and PeVL 16/2023 vp, paragraph 6.

Right to health and health services as a human right

The task imposed on the Parliamentary Ombudsman in the Constitution is to oversee the realisation of fundamental and human rights. The rights secured in human rights agreements play a central role in the oversight of healthcare. Oversight is supported by the supervisory bodies' interpretation practice of the content and obligatory nature of the rights.

The right to health is special among human rights. It is a precondition for the full exercise of other rights, but also depends on the realisation of other rights. Under the UN's Universal Declaration on Human Rights, everyone has the right to a standard of living adequate for the health, well-being and medical care of himself and his family. Everyone also has the right to security in the event of sickness and accident.

The UN International Covenant on Economic, Social and Cultural Rights secures the right to enjoy the highest attainable standard of physical and mental health to everyone. The Convention obliges the states parties to gradually implement this right. The right to health does not mean only the right to healthcare, but the preconditions for a healthy life more generally. For example, these include nutrition, housing, clean water, sanitation, healthy working conditions and a healthy environment.

The right to health can be implemented with health policy and health programmes, but it also includes elements that are legally binding. In legal examination, it is essential that the right to health ensures freedom to make decisions on one's own health and body and freedom from interventions, such as inhuman or degrading treatment and involuntary treatment or experimentations. In addition, it obliges to maintain a healthcare system that secures timely and appropriate health services and equal opportunities to enjoy the highest attainable standard of health and also implements non-discrimination, equitable treatment, privacy and the right to receive information. Health services must be equally accessible physically, financially and in terms of the available information, medically of a high quality, and ethically and culturally acceptable. It has also been considered in international interpretation practice that the state has an obligation among others to ensure access to healthcare and prevent contagious diseases. States must also ensure appropriate education of doctors and other healthcare personnel and the adequacy of hospitals, clinics and other healthcare units.

According to the view adopted in international monitoring practice, the obligation to gradually implement the rights secured by the Convention is based on the idea that the development of health policy and healthcare systems requires time. On the other hand, measures that would weaken the right to health are not permitted. If the state carries out such measures, it has an obligation to show that they are based on very careful consideration of different options and are appropriately justified from the point of view of the set of rights secured by the Convention and all full resources available to the state. It has been considered to be in violence of the Convention if the state has not taken measures to reduce unequal provision of healthcare units, services and products.

A central question in the debate on the right to health services also in the international context is how different treatments can be prioritised by respecting all fundamental and human rights. From the point of view of equitability, it is important to ensure that resources are not directed only to expensive treatments available only to a small group of people while at the same time endangering the availability of basic care intended for everyone. The right to health and health services is a right, not a privilege.

The quality and availability of healthcare have also been examined in the practice of monitoring compliance with Article 11 of the Revised European Social Charter of the Council of Europe. The Article secures equitable access to quality health services and obligates the state to refrain from intervening indirectly or directly in the right to exercise the right to health. The right to protection of health includes the right to access healthcare and the availability of healthcare for everyone without discrimination. The European Committee of Social Rights has considered this to mean that healthcare must be effective and its price such that also persons in a vulnerable position, such as older people, homeless people, persons with disabilities, persons living in institutional housing, prisoners or immigrants can afford appropriate treatment.

The costs of healthcare must not become unreasonable for the individual. States must reduce the financial burden of underprivileged patients in society. Language must also not be an obstacle to access to appropriate healthcare.

When reforming healthcare systems, states must assess the success of the reform from the point of view of how effectively the availability of health services has been ensured to everyone as an equitable human right. Arrangements related to the availability of healthcare must not lead to unnecessary delays in access to treatment. This must be assessed by monitoring the management of the queues to treatment and the waiting times. Access to treatment must be based on open criteria that have been agreed on at the national level. When drawing up these criteria, attention must also have been paid to the risk of a decline in the state of health and quality of life.

The number of personnel and hospital beds must be sufficient and the conditions in hospital, especially in psychiatric units, must be appropriate and dignified.

According to the European Committee of Social Rights, and many other human rights bodies, any medical procedure performed without free mutual agreement based on information (except for some strictly defined exceptions) constitutes intervention with the person's physical and mental integrity. Informed consent is an essential precondition for the implementation of the right to self-determination, human dignity and the right to health.

In the practice of monitoring the Convention, the Convention has been considered to oblige the provision of regular free consultations with a doctor and examinations for children and pregnant women everywhere in Finland. In addition, free health checks must be organised for schoolchildren.

The European Convention on Human Rights has also consistently been considered to secure rights related to health services. Especially the right to life secured by Article 2 of the Convention, the prohibition of torture, inhuman and degrading treatment contained in Article 3 and the right to privacy and family life secured in Article 8 require that the parties to the Convention create an effective regulatory framework that obliges public and private hospitals and healthcare professionals to adopt the appropriate procedures and methods to protect the dignified treatment, privacy and integrity of patients and to secure access to a procedure assessing whether the patient is entitled to receive compensation for a possible medical malpractice. However, only in very exceptional conditions has the European Court for Human Rights found that a violation of the rights secured by the European Convention on Human Rights has been based on activities or negligence in healthcare. A violation was found in a situation where the patient's life had been knowingly put at risk when a life-saving medical procedure had been denied from the patient because of systemic or structural dysfunctional of medical services and the authorities were aware or should have been aware of the related risk but had not undertaken sufficient measures to prevent it.

Recompenses

In straightforward cases, the Parliamentary Ombudsman may issue a proposal to the authority for a settlement of the matter or compensation to find an amicable solution and to avoid unnecessary legal disputes. Proposals for recompense are made when it is no longer possible to rectify the violation of the right or the error. During the year of the review, three proposals for recompense concerning healthcare were made, while the number was eight in 2022.
The starting point for the proposals for recompense has been the fact that the right for health services of an adequate quality, ensured as a fundamental and human right, has not been realised. The proposals have usually concerned especially the availability of treatment or its quality.

For example, recompense has been proposed in a matter, in which an insufficient examination of the patient and the deficient referral to specialised medical care based on it had led to the referral being returned. As a result, the patient's specialised medical care was delayed. On the Ombudsman's proposal, the patient was compensated for the extra effort and costs incurred by them.

Recompense was also proposed in a matter in which the continuity of a child's treatment was neglected after the child had moved to a new place of residence. Despite seven requests, no referral for the child was sent from the health service provider of the original place of residence. When the child moved back to the original place of residence, treatment was still not organised. The Ombudsman considered it unlawful that the continuity of the child's psychiatric treatment was not ensured appropriately, for which reason the child did not have a treatment contact for several months. The child's fundamental right to adequate health services and good treatment was not realised and the child's best interests were not taken into account as required by the Convention on the Rights of the Child.

Recompense was proposed to a patient who had not received good, dignified care when the patient had had to suffer severe pain during an operation. Furthermore, it had taken a long time to process the patient's matter. The Ombudsman also proposed compensation to a patient with a severe intellectual disability to whom unnecessary pain and suffering was caused because of negligence in organising the urgent oral healthcare required by the patient. Their rights to the dignified treatment, indispensable care and adequate health services enshrined in the Constitution were not implemented.

In addition, the Parliamentary Ombudsman has also proposed that the authority consider how it could compensate to a client for the fact that their right to good treatment was not realised when the distribution of the client's care supplies was discontinued without a medical assessment of their state of health.

Self-monitoring and Act on the Supervision of Healthcare and Social Welfare Services

The aim of the Act on the Supervision of Healthcare and Social Welfare Services (741/2023), which entered into force at the beginning of 2024, is to ensure the safety of clients and patients in healthcare and social welfare and the good quality of healthcare and social welfare services. Under section 23, subsection 1 of the Act, the service provider must through self-monitoring ensure that its healthcare and social welfare duties are carried out in compliance with the law. The service provider must supervise its operations in such a manner that the content, extent and quality of the healthcare and social welfare services correspond to the need and safety of clients and patients. The service provider must also ensure that the services of social welfare clients and patients are implemented in an equitable manner.

A patient who is not satisfied with their healthcare or medical care has the right to submit an objection to the director responsible for healthcare in the unit. It has been considered appropriate in the supreme oversight of legality to direct the complainant to first submit an objection when the complaint concerns matters such as the patient's treatment, interaction in the healthcare unit or an individual care event, such as administration of medication. Submitting an objection does not restrict the patient's right to submit a complaint later. Matters in which the complainant was directed to submit an objection totalled approximately 150 in the year of the review.

The Ombudsman's visits and inspections have involved familiarisation with different arrangements adopted in self-monitoring and assessment of their functioning and effectiveness in supervising the realisation of fundamental rights. The aim has been to assess how the wellbeing services county, responsible institution for organising the services, uses the means of self-monitoring to ensure that its services are organised lawfully and that the service provider has sufficient operational and financial capacities to provide the services.

From the point of view of the supreme overseer of legality, self-monitoring is the primary form of statutory supervision. However, it is still too early to assess what the significance of the Act on the Supervision of Healthcare and Social Welfare Services will be from the point of view of the Ombudsman's oversight of legality.

Deputy-Ombudsman
Mr Mikko Sarja

What is a public task overseen by the Ombudsman?

Framing the question

For the topic of my first general comment, I have chosen to address the competence of the Ombudsman and, in particular, the notion "public task" that determines it. The first sentence of section 109(1) 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. A close concept is contained in section 124 of the Constitution, stating that a public administrative task may be delegated to others than public authorities only by an Act or by virtue of an Act, if this is necessary for the appropriate performance of the task and if basic rights and liberties, legal remedies and other requirements of good governance are not endangered. However, a task involving significant exercise of public powers can only be delegated to public authorities.

From these starting points, I am reflecting on the relationship between a public task and a public administrative task and the scope of the concept of a public task, which is independent of the concept of a public administrative task.

Regulatory development

The Ombudsman has overseen public tasks since 1991, when the powers of oversight were separated from the concept of civil servant in the Criminal Code. At that time, "public task" was not specified in any detail. However, the legislative drafting material indicated that it was usually linked to indirect public administration, which is managed by bodies such as independent public law institutions, associations subject to public law, and companies where the state has a controlling interest. A mentioned example was the management of compulsory insurance policies, civil defence tasks, delivery of postal items in accordance with the Postal Services Act and performance of the public broadcasting task. The privatisation of traditional public services was also found to have an impact on the Ombudsman's activities, and those services were found to fall within the Ombudsman's competence regardless of who produced them.[1)]

The fundamental rights reform of 1995 did not extend the powers of the overseers of legality or provide any increased right of oversight of the private sector.

1) On the development of jurisdictional regulation, see e.g. HE 129/1997 vp.

When enacting our Constitution, which entered into force in 2000, the government-proposal referred to the proposed section 124 – in the reasoning of the proposed provision on the duties of the Chancellor of Justice – and stated that the powers of the Chancellor of Justice would be expanded accordingly if public tasks were transferred outside the actual authority. With regard to the provision on the Ombudsman's competence, reference was mainly made to the provision concerning the Chancellor of Justice and the linguistic harmonisation of the definition of tasks. The report of the Constitutional Law Committee did not assess the matter of competence.[2)]

The role of a public administrative task in interpreting competence

Public administrative tasks include tasks related to the implementation of laws and decision-making concerning the rights, duties and interests of private individuals and organisations. They may include tasks that has conventionally been assigned to an authority, but also new tasks that included in administration. They can also be public service tasks, often involving actual and performative administrative activities.[3)] The assessment of section 124 of the Constitution is the responsibility of the Constitutional Law Committee (section 74 of the Constitution), whose statements are case-specific.[4)] As general features, the Committee takes notice of 1) the nature and characteristics of the task, 2) whether the task is regulated by law, 3) whether a certain party acts within the scope of official authority, steering or supervisory powers, and 4) the legal effects of the task and related decision-making.[5)]

Occasionally, even the Ombudsman refers to section 124 of the Constitution to assess activities subject to a complaint. This is particularly necessary when a complaint concerns compliance with general administrative laws whose scope of application is linked to the concept of a public administrative task (such as the Administrative Procedure Act and the Language Act). In many cases, assessments under section 124 of the Constitution also include a legislative proposal to the competent ministry to clarify the legal situation.

One example is the Parliamentary Ombudsman assessing the legal nature of the tasks of state-owned company Finavia Oyj and finding that legislation on the aviation sector should indicate in more detail which provisions involve public administrative tasks (1634/2/12). The subsequent government proposal on the Aviation Act included a detailed assessment of the legal nature of the company's tasks.[6)]

Another task that has been considered a public administrative task is the provision of government-subsidised rental homes for application to the public and selecting residents for them (1930/2/13). In the past, resident selection was assessed as a public task.

2) HE 1/1998 vp, p. 165 and 166, and PeVM 10/1998 vp. The notion of a public task is also contained in section 111 of the Constitution on the Ombudsman's right to receive information, and in section 118(3) of the Constitution, which provides for the right of an injured party to request that a civil servant public official or other person in charge of a public task be held liable for damages. According to the explanatory memorandum to the provision, this right does not depend on whether the performance of a public task has been entrusted to a civil servant or outside the actual authority (HE 1/1998 vp, pp. 172–173).

3) HE 1/1998 vp, p. 178–179.

4) For example, PeVL 26/2017 vp (pp. 47–51) contains an extensive summary of the Committee's statements.

5) E.g. PeVL 5/2014 vp.

6) HE 79/2014 vp, p. 111–114.

The Constitutional Law Committee has referred to this later decision and subsequently considered resident selection a public administrative task when assessing the transfer of resident selection from municipalities to right-of-occupancy communities, which was included in the government proposal for acts on right-of-occupancy housing and amending the act on interest subsidies for rental housing loans and right-of-occupancy loans.[7] Other tasks that the Parliamentary Ombudsman has also considered public administrative tasks include the public account of bankruptcy (2665/2017), the maintenance of the postcode system (1069/2019), FinnHEMS Oy's medical helicopter operations (7308/2021), decision-making by Alko Oy concerning introduction of retail sales of alcoholic beverages, their removal from retail sales and their pricing (5474/2021), and the operations of Finnish Innovation Fund Sitra (4770/2015). The latter had previously been assessed as a public task.

The question of a public administrative task is sometimes also assessed in statements. For example, in his statement to the Employment and Equality Committee of the Parliament, the Ombudsman considered that the proposed state-owned company (Työkanava Oy), in its proposed form, was carrying out a public administrative task and recommended referring the matter to the Constitutional Law Committee for evaluation (7734/2021). As a result of the Constitutional Law Committee statement, any tasks that the Committee considered to be public administrative tasks were removed from the tasks planned for the company. It was notable that, according to the government proposal, the tasks proposed to the company were not public administrative tasks.[8]

Does a public task also carry independent practical significance?

As a rule, a public task has an independent legal significance based on the Constitution; the Ombudsman's competence is based on it. Instead, from the Ombudsman's point of view, a public administrative task can be understood as a kind of additional feature of a public task and a public task can be understood as an umbrella term with relation to a public administrative task: a public administrative task is always also a public task, whereas a public task is not always a public administrative task. In most cases, the Ombudsman's competence is, in practice, directly linked to the concept of a public administrative task, even though section 124 of the Constitution is not a provision on competence. In practice, it is not necessary to assess the issue of competence if the legislator has already clearly indicated that an activity is a public administrative task.

Nevertheless, some activities may still be assessed as a public task only, without the characteristics of a public administrative task. This particularly applies to certain universal services or public service tasks. These services, which are important not only for citizens but also for the functioning of society in general, might not be produced by the market to a satisfactory extent. In this case, an authority specified in legislation may lean on legislation to impose a nation-wide or regional universal service obligation on a company. The service obligation can also be based directly on a law.

The Ombudsman has traditionally assessed that one public task is the universal service obligation of a postal undertaking imposed on it by a decision made by the Finnish Transport and Communications Agency under the Postal Act. Defining the location of mailboxes and releasing postage stamps, as laid down in the Postal Act, have also been seen to be public tasks. At the same time postal undertakings have also been considered to have public administrative tasks under the Postal Act and other legislation, such as managing the statutory notification procedure, maintaining the postal code system and opening postal packages, and tasks related to receiving change-of-address notifications and acting as an advance polling station (e.g. 1069/2019).

7) PeVL 5/2021 vp – HE 189/2020 vp.

8) PeVL 6/2022 vp and HE 98/2021 vp.

Another public task has been assessed to be the public service task referred to in section 7 of the Act on the Finnish Broadcasting Company, which includes the obligation to make available versatile and comprehensive television and radio programming, including related ancillary and additional services, to everyone on equal terms.

The interpretation of competence regarding the general obligation for postal services raises a question of the relationship that certain other, similar services have in relation to public tasks. The regulatory structure for the universal service of telephone and telecommunications services is the same in the Act on Electronic Communications Services: the Act defines a universal service and an authority that can impose a universal service obligation on a private company. Similarly, pursuant to the Act on Transport Services, a public service obligation may be imposed on air transport by decision of the Finnish Transport and Communications Agency. The similarity of this regulation could be in favour of the Ombudsman overseeing telecommunications companies subject to universal service obligations and air transport operators subject to public service obligations. However, no oversight of legality statements has been issued on these sectors. It should be noted that the Ombudsman has not ruled out the possibility of considering the public service obligation imposed on VR (state-owned rail transport company) as a public task, which was based on the concession contract on the exclusive right of passenger train traffic concluded between the Ministry of Transport and Communications and VR.

The Ombudsman has also interpreted certain activities as public tasks without necessarily excluding the possibility them being public administrative tasks. Examples of such cases include exhibition activities in the Finnish National Gallery (7529/2020) and on-demand training organised by the universities of applied sciences (5930/2023). On the other hand, the general and special tasks of student unions derived from the Universities Act have been considered to form a set of public tasks, the latter of which are also public administrative tasks (5930/2016). Some more examples of public tasks include the activities of insurance investigators in insurance companies in obtaining evidence and reports on statutory compulsory traffic or accident insurance cases (1672/2019), the granting of Finnvera Oyj's female entrepreneur loan (2957/09), mediators ordered by a district court under the Act on the Enforcement of Decisions on Child Custody and Right of Access (2726/07), and private debt collection agencies when they collect fees under public law (1964/4/03).

As it has not always been necessary to take a stand on whether some activity is a public administrative task, I find it very possible that some of the public tasks mentioned above could also prove to be public administrative tasks in closer examination.

By my observations, the Constitutional Law Committee hardly assesses the provision on the Ombudsman's competence, as the relationship between legislative proposals and the Constitution is specifically assessed by the Committee from the perspective of section 124 of the Constitution. Still, the theme has been discussed occasionally. In its assessment, the Committee has drawn attention to matters such as whether a government proposal contains specific contractual provisions or legislative proposals on restricting the powers of the supreme overseers of legality separately. If this has not been the case, the Committee has not considered it necessary to examine the competence of the supreme overseers of legality in advance with categorical definitions. Instead, the scope of oversight of legality is determined by the interpretation of the provisions of the Constitution in each specific situation of application, with consideration to the special features of each situation.[9)] In another case I am aware of, the Ombudsman recommended for the Constitutional Law Committee to take a stand on credit information activities as a public task if the committee did not regard said activities as a public administrative task (6918/2021).

9) PeVL 2/2024 vp – HE 90/2023 vp.

The Constitutional Law Committee did not consider credit information activities to be a public administrative task, and according to the Committee, there was no immediate need to assess the activities as a public task, which would have run contrary to established practices.[10)]

Even legislation contains mixed use of concepts

There are still laws that came into force before the Constitution was enacted that still use the concept of a public task (e.g. the Act on the Openness of Government Activities and the Archives Act) in the same sense as in the competence provision of the supreme overseers of legality. On the contrary, general administrative acts that entered into force after the Constitution was enacted (e.g. the Administrative Procedure Act and the Language Act) use the expression "public administrative tasks" found in section 124 of the Constitution more consistently. Still, even the enactment of the Constitution is not a clear watershed in the use of concepts. There are laws (e.g. the Chamber of Commerce Act) that still use the concept of a public task even though they were enacted after the Constitution.

A good example of the use of concepts is in section 5 of the Act on Joint Administrative e-Service Support Services, titled "Using support services in a public task". The provision specifies who is obligated to use the support services referred to in the Act. Subsection 1 of this section only lists authorities. Subsection 2 lays down provisions on parties that are appointed to independently perform a public administrative task, imposed by an act or a decree issued under the law, or a decision issued by an administrative authority of the state. Subsection 3 lays down provisions on parties performing a public task under an agreement based on law or on grounds other than those referred to in subsection 2. According to the government proposal, such parties are "more loosely connected" to public administration than, for example, the authorities referred to in that section and other bodies performing public administrative tasks.[11)]

As it is, this provision reflects the basic premise that there are authorities, parties performing public administrative tasks and parties performing public tasks. However, it remains open to interpretation which parties exactly are "more loosely connected", given that, pursuant to section 124 of the Constitution, a public administrative task may also be delegated to others than public authorities by virtue of an agreement based on law, which would cover such "more loosely connected" parties. Even in these cases, the task constitutes a public administrative task.

My second example concerns the intelligence sector. In the Act on the Oversight of Intelligence Gathering, the Parliamentary Intelligence Oversight Committee has the right of access to information and the right to receive reports from parties performing public tasks, whereas the corresponding rights of the Intelligence Ombudsman and the Intelligence Ombudsman's right of access extend only to parties performing public administrative tasks. In the government proposal on the Act, this difference has been justified to some extent, but the difference between a public task and a public administrative task has not been assessed in concrete terms. However, it can be inferred from the Act and the government proposal that the terms have been observed and intended to have a legislative difference, even though said difference has not been made very apparent.[12)]

10) PeVL 8/2022 vp.

11) HE 59/2016 vp, p. 42

12) See HE 199/2017 vp, p. 43–46. The difference is justified by the different nature of parliamentary oversight and the oversight of legality. The stance is that the parliamentary committee's right to receive information cannot be limited to the performance of a public administrative task.

Conceptual difference is not insignificant

The difference between a public task and a public administrative task is evident in the application of general administrative laws. There are three ways how complaints particularly concerning the application of the Administrative Procedure Act and the Language Act may lead to difficult assessments. The first step is to decide whether a case falls within the Ombudsman's competence as a public task. The next step is to assess from the perspective of section 124 of the Constitution whether the task is also a public administrative task, which determines whether general administrative laws are applicable to the activities. If it is a matter of a public administrative task, only then it will be possible to assess the actual question how to apply the general administrative laws to the case. For example, in a case concerning Posti, the assessment started with the application of the Administrative Procedure Act to Posti's telephone counselling, ending with an extensive assessment of the legal nature of the tasks referred to in the Postal Act and a legislative proposal to the Ministry of Transport and Communications. Similar assessments concerning medical helicopter operations (FinnHEMS Oy), Alko's decision-making procedure and the resident selection procedure for government-subsidised rental housing started from individual questions concerning the application of the Language Act.

From the perspective of a public task and a public administrative task, the Language Act still poses a special challenge compared to e.g. the Administrative Procedure Act. The scope of application of the Language Act is broader than that of the Administrative Procedure Act: it applies not only to private parties performing public administrative tasks (section 25) but also, for example, to state-owned companies producing services (section 24)[13]. If such a service can be defined as a public task on a company-specific basis, the Ombudsman can also oversee compliance with the Language Act in the service in question – but not compliance with the Administrative Procedure Act, because the Administrative Procedure Act does not state that it is directly applicable to state-owned companies providing a service.

The scope of application of the Act on the Openness of Government Activities, on the other hand, is linked to private parties performing a public task that involves exercising public authority. In 2023, a working group of the Ministry of Justice proposed an amendment to the Act on the Openness of Government Activities to harmonise the areas of application of general administrative laws by linking the scope of application of the Act on the Openness of Government Activities to the concept of public administrative task. From the Ombudsman's perspective, a more interesting proposal to extend the scope of application is related to the fact that the Act on the Openness of Government Activities would, with certain limitations, also apply to corporations controlled by public bodies, and the obligation to apply the Act on the Openness of Government Activities would be a public administrative task entrusted to the corporation. This way, the Ombudsman could oversee the processing of requests for information in the activities of these corporations, but not the actual activities in which those documents were created. This would be quite exceptional in the oversight of legality.[14]

13) A similar provision is in section 17 of the Sámi Language Act.

14) See Julkisuuslain ajantasaistaminen (Updating the Act on the Openness of Government Activities), Publications of the Ministry of Justice 2023:32 and the Ombudsman's statement on the report (7975/2023).

Summarising perspectives

A public task and a public administrative task are independent legislative concepts that have been established for their respective purposes; the former to define the powers of the supreme overseers of legality, the latter to outsource official tasks. The concept of a public administrative task was adopted in the Constitution enacted in 2000, which is nine years after the concept of a public task was introduced in the competence provisions of the supreme overseers of legality (the Parliamentary Ombudsman and the Chancellor of Justice of the Government). During this period, the overseers of legality had adopted interpretations that, in my understanding, were not intervened in by the enactment of section 124 of the Constitution – let alone specifically link competence to it afterwards.

The differences in concepts are discovered case-by-case through individual interpretations. There is still a need for the concept of a public task and its interpretation that is independent of the concept of a public administrative task, which is especially evident in the oversight of certain universal services.

However, discerning the difference between a public task and a public administrative task is difficult, which may be at least because:

1) of the history of the legislative drafting concerning these concepts and the fact that these concepts were open to interpretation from the start, not only separately but in relation to each other;
2) of whether an individual ordinary law where the concepts are used was enacted before or after the Constitution;
3) of the partially inconsistent use of the concepts in ordinary legislation drafted after the Constitution was enacted;
4) legislation does not always clearly indicate public administrative tasks;
5) an activity has been or will be brought within the scope of oversight of legality so that it is first assessed as a public task and later as a public administrative task, which reduces the independent scope of use for the concept of public task;
6) a public administrative task has been assigned quite extensive meaning in the statements of the Parliamentary Constitutional Law Committee, which is likely to narrow the difference to a public task;
7) of the possible different interpretations of competence between the Parliamentary Ombudsman and the Chancellor of Justice, or if the difference between the concepts is not recognised in the oversight of legality.

The independence of the supreme oversight of legality is emphasised by the fact that the competence of the overseers of legality is not linked by law to how the Parliament (the Constitutional Law Committee) or the Government interprets section 124 of the Constitution. Not all government proposals are even submitted to the Constitutional Law Committee for assessment, in which case a potentially inaccurate or even incorrect interpretation of section 124 of the Constitution could ultimately affect the scope of the Ombudsman's competence. On the one hand, if a legislative proposal has been evaluated by the Constitutional Law Committee and contains an explicit statement in favour of a public administrative task, the Ombudsman can always base his assessment of competence (directly) on it. On the other hand, an exclusive interpretation of a public administrative task by the Constitutional Law Committee does not yet mean that something could not still constitute a public task. Interpretations of section 124 of the Constitution may also change over time, which may be de facto reflected on the Ombudsman's interpretations of competence.

The impacts of legislative amendments on the Ombudsman's competence and previous interpretations have to be continuously assessed. Competence particularly has to be under constant reassessment because public administrative tasks are entrusted to the private sector in many ways, it is commonplace, widespread and has been a standard practice for a long while now. As a rule, the Ombudsman's powers of oversight are aligned with the changes in how official tasks are organised: the activities of a private service provider can become subject to oversight due to a commitment based on legislation on the organisation of services, and a private service provider can similarly fall out of the scope of oversight after such a commitment concludes.

It is important that operators are aware of their role, at least in the performance of a public administrative task, and of the obligations arising from said role. Sometimes, fortunately very rarely, an operator refuses to admit that it is performing a public administrative task, let alone being subject to the Ombudsman's oversight. This is understandable as such, not only because of the ambiguity of the concepts, but also because there may be a fear of an increased administrative burden due to having to comply with general administrative laws and be subject to related oversight. In this case, the Ombudsman has to be particularly able to justify his competence and, if necessary, clarify the distinction between a public task and a public administrative task.

The Ombudsman strives to use the observations he has made in the oversight of legality and, where possible, lean on the statement practices of the Constitutional Law Committee, in order to define and demonstrate parties performing public administrative tasks and to communicate related information for the purposes of legislative drafting. However, it is essential that public administrative tasks – and, if necessary, public tasks – are identified, assessed and demonstrated unprompted already in legislative drafting and government proposals. Ultimately, the matter concerns legal protection, both for customers and operators.

2 The Finnish Ombudsman institution in 2023

2.1 Review of the institution

The year 2023 was the Finnish Ombudsman institution's 104th 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). According to the Constitution of Finland, "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." (section 109, subsection 1)

In other words, the scope of the Ombudsman's extensive oversight includes all public administration bodies but also private persons and organisations performing public tasks, such as social welfare and health care providers. However, the Ombudsman does not 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. In a well-functioning state governed by the rule of law, one of the key tasks of the supreme oversight of legality is to monitor that the primary systems of oversight and regulatory legal remedies are working 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 the year under review, **Parliamentary Ombudsman Jääskeläinen** made decisions on cases involving questions of principle, the Government, and other highest organs of state. His responsibilities also included matters concerning the police, the Emergency Response Centre Administration, rescue services, military matters, the defence administration and the Border Guard, Customs, the prosecution service, guardianship, language, foreigners, covert intelligence gathering and intelligence operations as well as freedom of expression. He was also responsible for handling matters concerning the coordination of tasks and reporting in the National Preventive Mechanism against Torture.

Deputy-Ombudsman Sakslin addressed matters such as healthcare, social welfare, children's rights and rights of older people, regional and local government, the autonomy of Åland, and the Church. In addition, she assumed responsibility for matters relating to the environment, agriculture and forestry, traffic and communications as well as Sámi affairs.

Deputy-Ombudsman Pasi Pölönen (until 31 March 2023) and **Sarja** (as of 1 June 2023) were 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. They also resolved matters concerning taxation, social insurance, social assistance, early childhood education and care services, education, science and culture as well as labour force and unemployment security. Their responsibilities also included matters concerning economic activities, late payments and distraint as well as data protection, data management and telecommunications.

The Ombudsman changed the division of duties so that, as of 19 June 2023, Parliamentary Ombudsman Jääskeläinen resolved matters concerning courts, justice administration and legal assistance. Deputy-Ombudsman Sakslin was assigned tasks such as matters concerning economic activities, late payments, distraint and taxation, and Deputy-Ombudsman Sarja was assigned matters concerning foreigners, children's rights, language and public guardianship. A detailed division of labour is provided in Appendix 2.

If a Deputy-Ombudsman is prevented from performing their tasks, the Ombudsman can invite a Substitute for the Deputy-Ombudsman to stand in. The Substitute for the Deputy-Ombudsman in 2023 was Principal Legal Adviser Mikko Sarja, who served as a substitute until 31 May 2023 during the year under review for a total of 55 working days. The substitute for the Deputy-Ombudsman starting 16 June 2026 was Secretary General Jari Råman, who served as a substitute during the year under review for a total of 34 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 and licenced legal counsels, which falls exclusively within the scope of the Chancellor of Justice.

Despite having mostly similar powers, there are differences in the duties of overseers of legality. The new Act on the Distribution of Duties, which entered into force on 1 October 2022, reformed the division of duties between the supreme overseers of legality to correspond to the special tasks laid down in the legislation on the overseers of legality and the specialisation that has been established in practice. The Parliamentary Ombudsman oversaw more extensively the implementation of fundamental and human rights at the individual level and, in particular, the implementation of the rights and treatment of vulnerable persons. Matters that were centralised to the Ombudsman included ones concerning the rights of the individual in social and health care and social insurance, as well as the oversight of the rights of children, older people and persons with disabilities. Matters concerning pre-trial investigation authorities and security authorities were centralised to the Parliamentary Ombudsman in addition to matters concerning prisons and other closed institutions to which a person was taken against their will that have been centralised already earlier. The act on the division of tasks between the Parliamentary Ombudsman and the Chancellor of Justice can be found in Appendix 1.

Parliamentary Ombudsman Jääskeläinen discussed the new Act on the Distribution of Duties in more detail in his speech to the 2021 report.

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

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

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

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

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

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

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.

2.1.4 OPERATIONS AND PRIORITIES

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

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

The Ombudsman's special task is to oversee the covert intelligence gathering and intelligence activities of security authorities (the police, the Customs, the Finnish Border Guard and the Finnish Defence Forces). For this purpose, the ministries concerned report annually to the Ombudsman on the use of covert intelligence gathering and intelligence methods.

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 2023, the special theme for the monitoring of fundamental and human rights was the oversight of oversight. 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 so that its impact is as extensive as possible.

2.1.5 OPERATION IN THE REPORTING YEAR

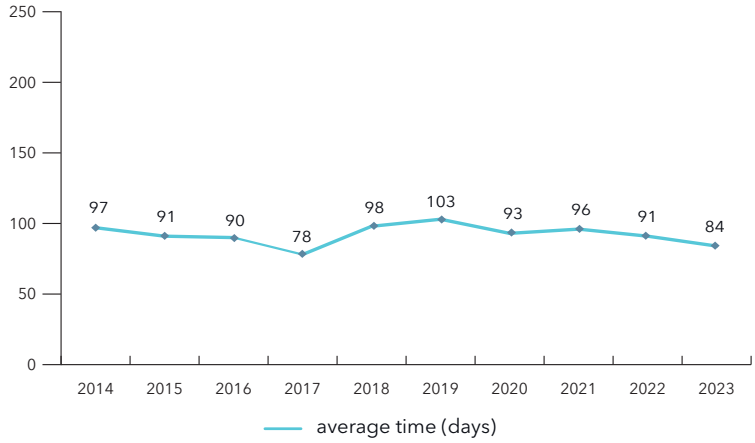
Complaints are processed within one year

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.

The Office of the Parliamentary Ombudsman has had the target of processing all complaints within a maximum of one year. This target was reached already in 2013, after which no complaints pending for more than one year have been transferred to the following year at the turn of the year. The average time taken to process complaints was 84 days at the end of 2023, compared to 91 days at the end of 2022.



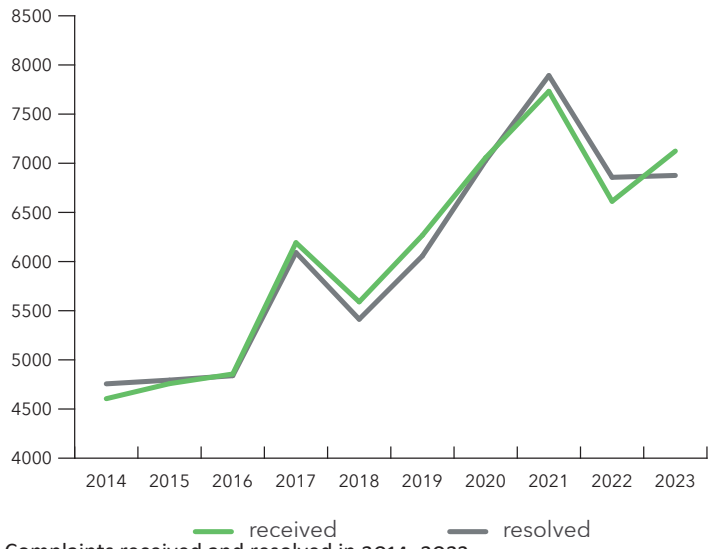
Average time taken to deal with complaints in 2014–2023.

Complaints and other oversight of legality matters

In 2023, there were a total of 7,124 complaints (6,613 in 2022). This is just over 500 (7.7%) more than in the previous year and just over 600 fewer than the peak year 2022 caused by the coronavirus pandemic. The largest number of resolved complaints concerned social welfare 1,136 (997), the police 885 (821), healthcare 803 (751) and criminal sanctions 591 (672). In the reporting year, 6,876 complaints were resolved. The corresponding figure in 2022 was 6,857.

The number of complaints submitted by letter or fax or delivered in person has decreased in recent years, and the number of complaints sent by email has stabilised. In 2023, the majority of complaints, 83% (82% in 2022), were submitted electronically. The complainant also receives an immediate notification of the receipt of the email.

Some complaints are handled through an accelerated procedure. In 2023, slightly over half (57%) (54% in 2022) of all complaints were processed with 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. In the accelerated procedure, a draft response is given within one week to the party deciding on the case in accordance with the instructions of the Office. The complainant is sent a reply signed by the legal adviser taking care of the matter.



Complaints received and resolved in 2014–2023.

The accelerated procedure is also used to process complaints that are so-called other communications, such as letters from citizens containing enquiries, clearly unfounded communications, matters that fall outside the Ombudsman's remit, and communications with unclear content. As a rule, the Substitute Deputy-Ombudsman or the Secretary General refer these communications to notaries or investigating officers for processing. The replies are reviewed by the Substitute Deputy-Ombudsman or the Secretary General. In 2023, approximately 14% of complaints in the accelerated procedure were other communications.

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. However, they are checked by an administrative assessor. Communications sent using the feedback form on the Office website are dealt with in accordance with the principles described above. In 2023, 12,933 written communications that had arrived for information were received (10,518 in 2022).

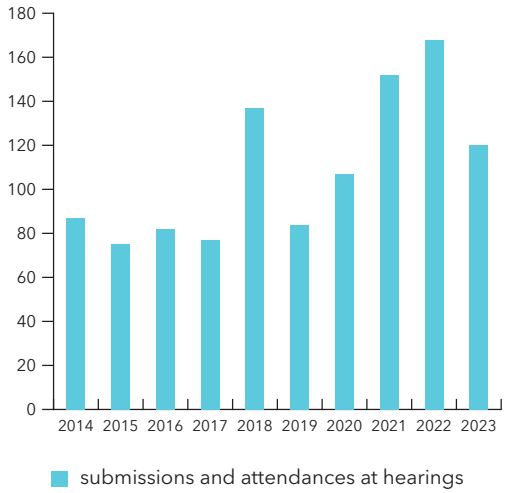
Received oversight of legality matters	**2023**	**2022**
Complaints	6,843	6,512
Complaints referred by the Chancellor of Justice	281	101
Own-initiative investigations	54	47
Requests for statements and hearings	133	157
Total	7,311	6,817

Resolved oversight of legality matters	**2023**	**2022**
Complaints	6,840	6,814
Complaints referred to the Chancellor of Justice	36	43
Own-initiative investigations	39	47
Requests for statements and hearings	120	168
Total	7,035	7,072

In addition, the oversight of legality extends to opinions and consultations on various parliamentary committees, for example. The number of statements and hearings decreased from the previous year's figures in both received and resolved cases.

In 2023, 74% (78% in 2022) of all the complaints that arrived were related to the ten largest categories. Figures for the case categories are in Appendix 4.

In 2023, a total of 39 (47 in 2022) matters investigated on the Ombudsman's own initiative were resolved. Of these, 26 (35) led to action on the part of the Ombudsman, meaning 67% (75%) of matters.



Resolved requests for statements and hearings between 2014 and 2023.

Measures

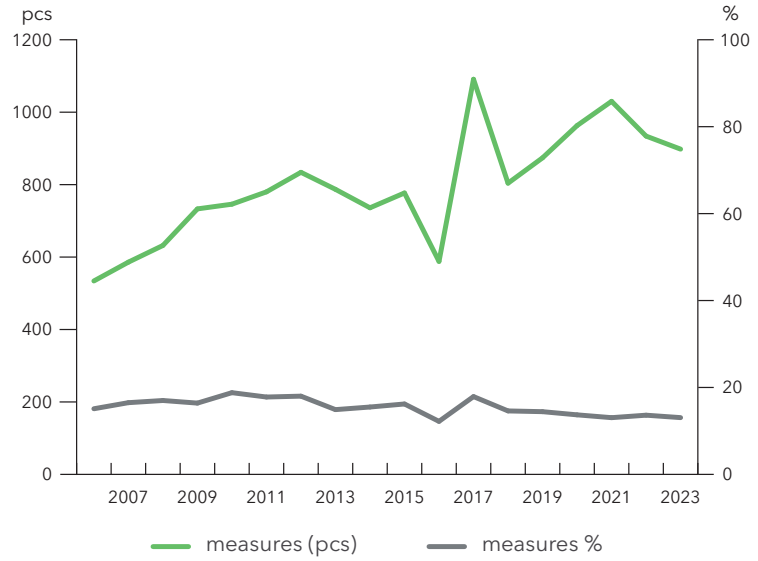
The most relevant decisions taken in the Ombudsman's work are those that lead to him or her taking measures. These measures include prosecution for breach of official duty, a reprimand, the expression of an opinion and a recommendation. A matter may also result in some other measure being taken by the 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 (section 10(3) 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. Sometimes an authority may pre-emptively rectify an error at a stage when the Ombudsman has already intervened with a request for a report.

In 2023, decisions on complaints and investigations at the Ombudsman's own initiative that led to measures totalled 925 or 13.4% of all decisions (967 in 2022, i.e. 14%). Approximately one fourth 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 43% of complaints (2,966), there were no grounds to suspect erroneous or unlawful action, or there was no reason for the Ombudsman to take action. A total of 133 cases (approximately 2%) were found not to involve erroneous action. No investigation was conducted in 42% of the cases (2,876).



Since 2006, the number of measures taken as a result of complaints increased from 500 up to over 1,000. The number of resolved complaints within the same period increased from approximately 3,500 up to nearly 8,000. The relative proportion of complaints leading to measures (measure %) has remained more or less unchanged.

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 13% (892) 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.

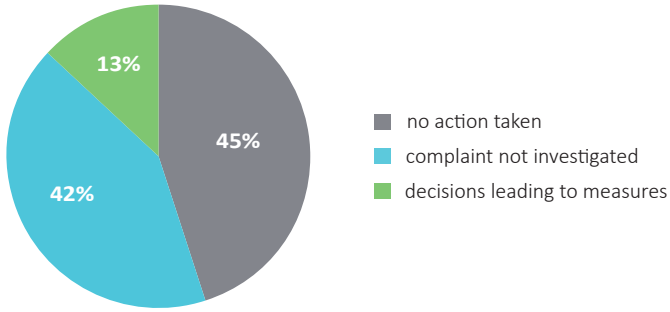
The proportion of all investigated complaints that led to measures, when cases not investigated are excluded, was 22.5%. For complaints that are investigated in full, the percentage of cases where measures are taken reaches about 50%.

None of the matters handled in the year under review were brought to prosecution for breach of official duty. There were four complaints that merited pre-trial investigation by the police. A total of 28 reprimands were given, and 629 opinions were expressed. Rectifications were made in 23 cases while under investigation. Decisions classed as recommendations numbered 30, although opinions regarding the development of governance that count as recommendations were also included in other types of decisions. Other measures were recorded in 184 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.

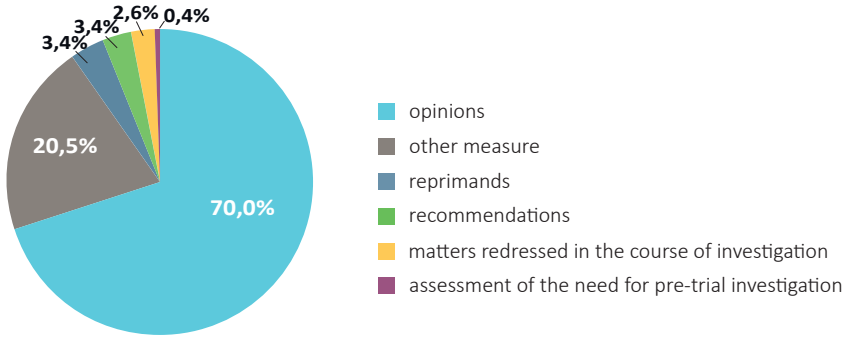
Statistics on the Ombudsman's activities are provided in Appendix 4.

MEASURES TAKEN BY PUBLIC AUTHORITIES	Prosecution	Assessment of the need for pre-trial investigation	Reprimand	Opinion	Recommendation	Rectification	Other measure	TOTAL	Total number of decisions	Percentages*
Social welfare	0	0	6	127	10	4	40	187	1,136	16,5
Criminal Sanctions field	0	1	1	85	8	3	61	159	591	26,9
Administrative branch of the Ministry of Economic Affairs and Employment	0	0	0	103	1	0	2	106	347	30,5
Police	0	3	4	65	4	3	25	104	885	11,8
Health	0	0	1	58	5	3	25	92	803	11,5
Social insurance	0	0	5	37	0	2	2	46	371	12,4
Administrative branch of the Ministry of Education and Culture	0	0	0	35	1	4	4	44	267	16,5
Administrative branch of the Ministry of Justice	0	0	2	11	1	1	9	24	144	16,7
Regional and local government	0	0	0	19	2	0	2	23	229	10,0
Taxation	0	0	0	20	0	1	0	21	139	15,1
Enforcement (distraint)	0	0	1	12	0	1	2	16	184	8,7
Administrative branch of the Ministry of the Environment	0	0	3	8	0	0	4	15	153	9,8
Administration of Law	0	0	0	8	0	1	3	12	278	4,3
Guardianship	0	0	1	10	0	0	0	11	104	10,6
Administrative branch of the Ministry of Transport and Communications	0	0	1	7	1	0	2	11	110	10,0
Aliens affairs and citizenship	0	0	2	6	0	0	3	11	105	10,5
Administrative branch of the Ministry of Defence	0	0	0	9	0	0	1	10	69	14,5
Customs	0	0	0	9	0	0	0	9	30	30,0
Administrative branch of the Ministry of Agriculture and Forestry	0	0	1	4	0	0	3	8	78	10,3
Administrative branch of the Ministry of Finance	0	0	0	7	0	1	0	8	64	12,5
Prosecutors	0	0	0	4	0	0	0	4	58	6,9
Administrative branch of the Ministry of the Interior	0	0	0	3	0	0	0	3	15	20,0
Highest organs of government	0	0	0	0	0	0	2	2	184	1,1
Other administrative branches	0	0	0	0	0	0	0	0	550	0,0
Administrative branch of the Ministry for Foreign Affairs	0	0	0	0	0	0	0	0	16	0,0
Subjects of oversight in the private sector	0	0	0	0	0	0	0	0	5	0,0
Total	0	4	28	647	33	24	190	926	6,915	13,4

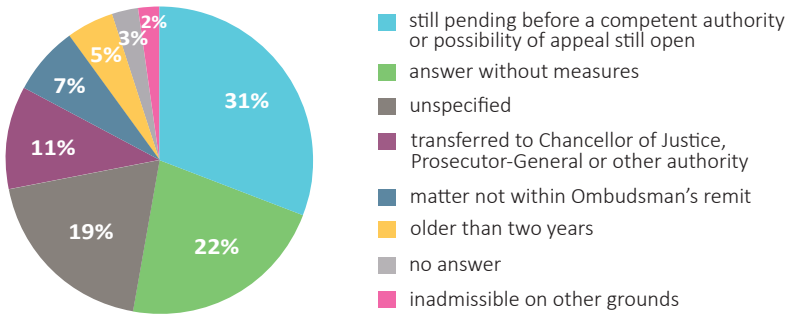
* Percentage share of measures in decisions on complaints and own initiatives in a category of cases.



All cases resolved in 2023.



Decisions involving measures in 2023.



Complaints not investigated in 2023.

Inspection visits

The number of inspections was still below the pre-pandemic level. In 2023, 83 inspections were carried out (76 in 2022). The inspections are described in more detail in connection with the respective topic.

Of the inspections, 24% were conducted under the leadership of the Ombudsman or the Deputy-Ombudsmen and 76% were carried out by legal advisers. A total of 39 (29 in 2022) visits were made to places and facilities where individuals are or may be kept while deprived of their liberty; 19 (15) of these visits were unannounced. These visits were made in the capacity of the National Prevention Mechanism against Torture (NPM).

The number of inspections between 2014 and 2023.

The NPM visits are made, in particular, in prisons and other detention facilities for persons deprived of their liberty, 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.

2.1.6 COOPERATION IN FINLAND AND INTERNATIONALLY

Events in Finland

Parliamentary Ombudsman Jääskeläinen attended the only parliamentary debate on the Parliamentary Ombudsman's report for 2021 at the plenary session on 6 February 2023. Ombudsman Jääskeläinen and Deputy-Ombudsmen Sakslin and Sarja submitted the Parliamentary Ombudsman's annual report 2022 to Deputy Speaker of the Parliament Juho Erola on 15 June 2023. Ombudsman Jääskeläinen attended a preliminary debate on the report at a plenary session of Parliament on 19 September 2023. At the end of the reporting year, the committee reading of the 2022 report is still under way.

Several Finnish authorities and other guests visited the Office of the Parliamentary Ombudsman, and topical issues and the work of the Ombudsman were discussed with them. Visitors to the Office included directors of the Regional State Administrative Agencies' Legal Protection and Permits Division on 1 February, the police crime team of the Office of the Prosecutor General on 16 March, the Ombudsman for Children Elina Pekkarinen on 23 March, course attendees of the Police University College on 5 September, the Sámi truth and reconciliation commission on 3 October and students of the Border and Coast Guard Academy on 14 December.

Parliamentary Ombudsman Petri Jääskeläinen, Deputy-Ombudsman Maija Sakslin and Deputy-Ombudsman Mikko Sarja handed the Ombudsman's Annual Report for 2022 to Juho Eerola (on left), Deputy Speaker of the Parliament, on 15 June 2023.

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 Jääskeläinen gave a speech on intelligence legislation at a training day organised by the Judicial Training Board on 22 March.

Deputy-Ombudsman Sakslin participated in a Cultural Policy Research Project event on 23 March and in a celebratory symposium of the University of Eastern Finland on 20–22 September.

Deputy-Ombudsman Pölönen gave a presentation on the Ombudsman's activities at the Halku2021 course on 13 January and participated in training for the management of the Criminal Sanctions Agency on 12 January and a discussion on the country visit on 15 March.

The Office's legal advisers participated in several cooperation and development events, including: a co-development event of the Hatkassa project on 24 January, a stakeholder cooperation meeting of child welfare experts on 28 March, a cooperation meeting for early childhood education and care with the Regional Management Agencies on 8 May, a conference and virtual event organised by influencer social workers in connection with the virtual days project package organised with different customer groups of children and young people on 23 May and 16 June, a meeting of the authorities supervising the health care of prisoners and the Defence Forces at Valvira on 29 May, a meeting about school home issues on 7 June, a discussion event on the Committee's recommendations on the UN rights of the child on 30 August, and a virtual Tik Tok event organised by influencer social workers related to the virtual days project package organised with different customer groups of children and young people on 27 November and 19 December

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

Deputy-Ombudsman Sakslin has been a member of the Human Rights Delegation since the first term of the delegation and also during the period 2020-2024. In addition, 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.

The Parliamentary Ombudsman is a member of the **European Network of Ombudsmen ENO**. ENO members 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 reporting year, the network organised a conference in Brussels on 9–10 November, attended by Senior Legal Adviser Riikka Jackson.

On 14–15 February, the European NPM Forum organised a webinar workshop titled "Monitoring mental health care in prisons", which was attended by Principal Legal Adviser Iisa Suhonen.

The **Nordic NPMs** meet regularly, twice a year. The first meeting was held on 23 May with the theme of "Monitoring selfharm incidents and deaths under the NPM mandate" and was attended by Principal Legal Adviser Iisa Suhonen. The second meeting took place in Sweden on 4–5 September, attended by Principal Legal Adviser Jari Pirjola and Senior Legal Adviser Pia Wirta.

The Nordic parliamentary ombudsmen have convened on a regular basis every two years, at a meeting held in one of the Nordic countries. A meeting on administrative matters was held in Oslo on 24–25 August, attended by the Substitute Deputy-Ombudsman, Secretary General Jari Råman and Administrative Assessor Astrid Geisor-Goman.

For several years, the Finnish Parliamentary Ombudsman has also engaged in dialogue with the Baltic ombudsmen. The meeting of **Ombudsmen for Nordic and Baltic cooperation** was held in Copenhagen on 14–28 September. Parliamentary Ombudsman Jääskeläinen, Deputy-Ombudsman Sarja and Administrative Assessor Astrid Geisor-Goman attended the meeting.

Principal 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 Pirjola for a third four-year term, which ended on 19 December 2023.

Other international events

- Deputy-Ombudsman Pölönen was heard in the 2nd country assessment related to the UN Convention Against Corruption on 15 March
- Deputy-Ombudsman Sakslin participated in the hearing of the European Commission's preparatory Rule of Law Report meeting on 17 March
- Principal Legal Adviser Minna Verronen, Senior Legal Adviser Riikka Jackson and Expert Sanna Ahola from the Human Rights Centre participated in the 16th Session of the Conference of States Parties to the CRPD (COSP) on 13–15 June
- Deputy-Ombudsman Sakslin participated in the celebratory symposium of 100 years of religious freedom in Finland on 21 September
- Deputy-Ombudsman Sakslin and Senior Legal Adviser Riikka Jackson participated in ENNHRI's 10th anniversary event on 9–10 October

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.

Visitors to the Office included:
- President of the EN Parliamentary Assembly Tiny Kox 12 January
- NPM Unit of the Estonian Chancellor of Justice 24–26 January
- Department of the execution of ECtHR judgements 25 January
- OSCE High Commissioner on National Minorities Kairat Abdrakhmanov and his entourage 13 February
- Delegation from Uzbekistan 1 June
- IT Directors of Nordic police on 8 June
- Frontex Fundamental Rights Officers Amina Sihvo and Giulio Morello 27 June
- Deputy Minister Dr Juanda Jaya of the State of Sarawak, Malaysia with delegation 23 August
- Delegation of the Lithuanian Seimas Ombudsperson's Office 27 September
- UN Special Rapporteur on the right to education Ms. Farida Shaheed 22 November

In addition, the Ukrainian Parliament Commissioner for Human Rights and representatives of the Parliament visited the Human Rights Centre on 7 June. The event was attended by Parliamentary Ombudsman Jääskeläinen, Deputy-Ombudsman Sakslin, Deputy-Ombudsman Sarja and Senior Legal Adviser Riikka Jackson.

2.1.7 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.

Clients are always offered advice in line with the Administrative Procedure Act in a manner that is appropriate for each situation. Such advice includes, for example, visiting the Office of the Parliamentary Ombudsman, opening hours, filing a complaint and handling a complaint. The Office does not provide legislative or legal advice on any individual case. During the year under review, telephone client service was enhanced by introducing a telephone system with call recording. Advice by telephone at the Office is mainly provided by a team consisting of an on-duty lawyer, notaries and inspectors.

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. With the improved efficiency of client service, the number of calls decreased considerably. The Registry received around 1,800 (2,800) calls during the year. There were still a few client visits, approximately 20 (20). There were approximately 760 (910) orders for documents/requests for information.

Communications

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

In 2023, the Office published 10 (18) 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 using messaging service X for sharing 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 1,359 (1,635) news items or articles during 2023. There were more social media posts linked to the Ombudsman compared to the previous year, with a total of 12,917 (9,206) posts.

A total of 290 (296) anonymous decisions were posted online. The website includes decisions that are of legal or general interest as well as statements and inspection records.

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. The Ombudsman and the Deputy-Ombudsmen each lead 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. The HRC is located at Aurorankatu 6.

At the end of 2023, the number of personnel in the Office was 83 (78), 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% (70.5%), including the personnel of the Human Rights Centre.

The Finnish Parliament Annex.

There were 75 permanent positions at the end of 2023. There was 1 vacant post at the end of 2023. In addition to the Parliamentary Ombudsman and the Deputy-Ombudsmen, the permanent staff at the Office comprised the Secretary General, administrative assessor, 16 principal legal advisers, 21 senior legal advisers and one on-duty lawyer, and the staff of the Human Rights Centre: the Director, 7 specialists, 3 younger experts and an assistant. The Office also had an information officer, a data management specialist, 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 77.8% (79.5%). The personnel's education level index was 6.5 (6.7). The share of personnel with a university-level degree was 85.2% (88.5%). Of this, the share of personnel with a Master's level university degree was 75.3% (79.5%) and the share of those who have completed research training was 9.9% (11.5%).

During a part of the year or the whole year, there were 21 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 3.

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 administrative assessor, the Director of the Human Rights Centre and three staff representatives. The Management Group discusses in its meetings matters relating to, among others, the personnel policy and the development of the Office. The Management Group convened seven times in the reporting year. A cooperation meeting for the entire staff of the Office was held on seven 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 Office's Occupational Safety and Health Committee met four times during the year under review.

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, no documents have been archived in paper format. At the end of the year, the Office introduced a new version of the electronic case management system.

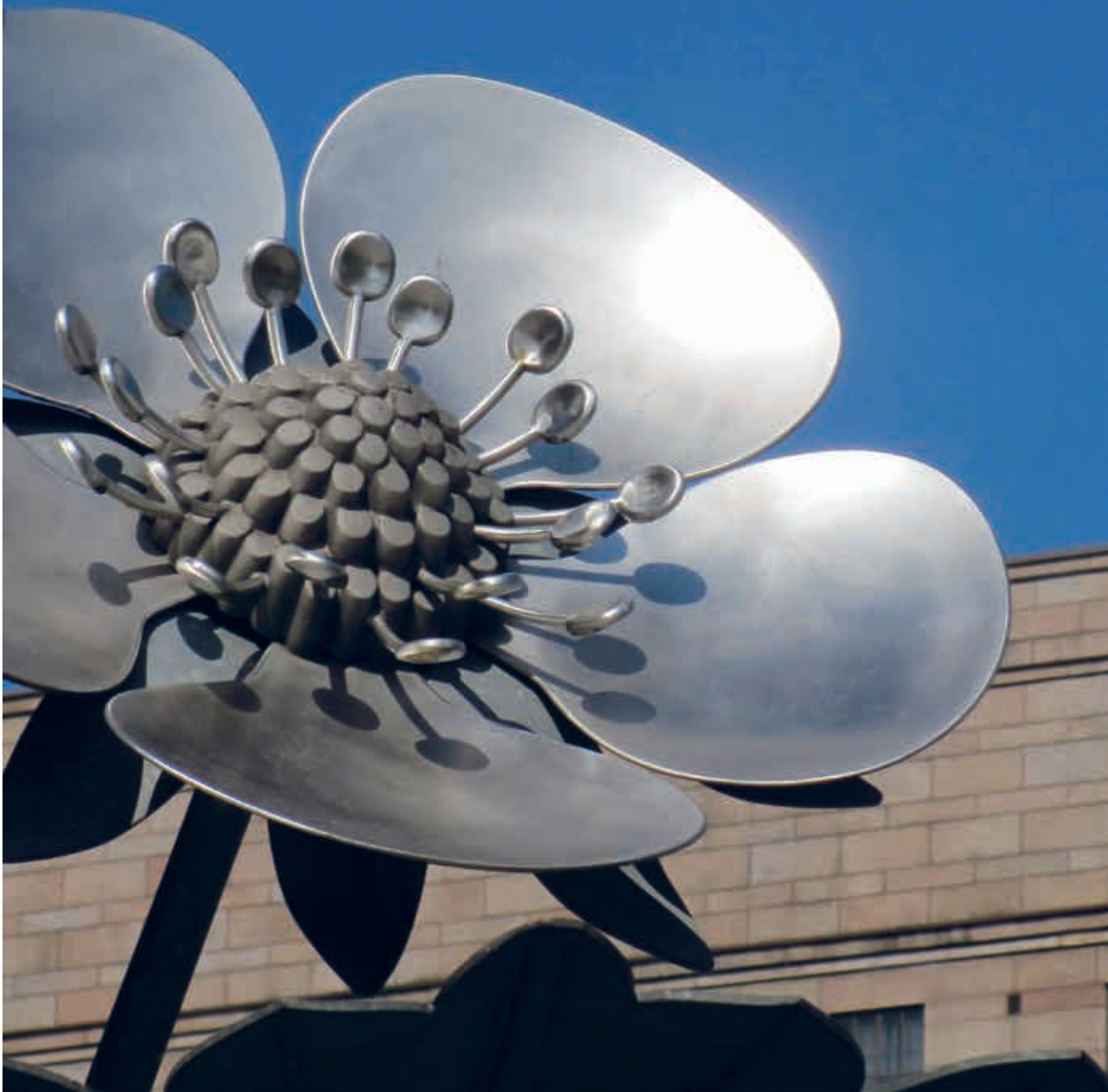
Office finances

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 7,459,000 euros for 2023. A total of EUR 7,354,908.91 of this appropriation was spent in 2023, or 98.60% 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 English summary of 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 English summary of the 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). As of 31 March 2022, the Finnish Human Rights Institution (Ms Sirpa Rautio, Director of the Human Rights Centre) has been the Chair of the ENNHRI Board and a member of the GANHRI Board for a period of three years.

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 2023 stated a budget of EUR 1,072,000 for operational costs, of which EUR 910,312 was for personnel costs and EUR 161,688 for consumption expenses. EUR 36,000 of the consumption expenses were service purchases.

In 2023, the HRC had eight permanent posts (the director, an administrative assistant, six expert officials of which one post was vacant) and two fixed-term employment relationships for junior experts under the Young Experts Programme. In addition, the HRC employed an international affairs advisor with a fixed-term employment relationship as well as fixed-term experts and junior experts for various development projects and as substitutes.

3.3.2
THE HUMAN RIGHTS CENTRE'S OPERATION

The Human Rights Delegation adopted the Human Rights Centre's Action Plan for 2023 in December 2022. The HRC has achieved the objectives set in the Action Plan rather well. The Human Rights Delegation is tasked with the final assessment on the implementation of the Action Plan.

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 available information and on inquiries that are, when possible and appropriate, carried out by the HRC itself.

As part of its monitoring work, the HRC can prepare reports on the implementation of fundamental and human rights. In January 2023, the HRC published a report on the case law on the circumvention of entry provisions. The report examines situations where the Administrative Courts and the Supreme Administrative Court have found that an applicant has circumvented entry provisions and whereby the court has upheld the Finnish Immigration Service's decision not to grant the applicant a residence permit.

In November, the HRC published a report on human rights foresight, resilience and preparedness during transformations in society. The report maps the field of human rights foresight and describes the methods of operating foresight and the Finnish foresight system. It offers tools for developing human rights actors' foresight capabilities and resilience as well as insights on how human rights may be considered in national foresight.

Human Rights Centre regularly reports to international and European human rights actors based on its monitoring data. The HRC participates independently in the periodic reporting procedures for international human rights treaties by issuing statements and attending consultation events. It also provides information about the recommendations of the treaty bodies and monitors the implementation of these recommendations. The HRC also promotes the NGOs' participation in reporting in different ways. In 2023, the HRC issued a statement on the implementation of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention), the UN International Covenant on Civil and Political Rights (ICCPR) and the UN Convention on the Rights of the Child (CRC). In addition, the Human Rights Centre issued a statement in connection with the processing of Finland's Universal Periodic Review (UPR) at the UN Human Rights Council.

Over the year, Human Rights Centre paid particular attention to delays in the national implementation of the decisions of the European Court of Human Rights (ECtHR) and the European Committee of Social Rights (ECSR) concerning Finland. At the end of the year, 54 human rights complaints against Finland were pending at the ECtHR. The execution of judgments was still in process for six ECtHR rulings and eight ECSR rulings. There has been a particularly difficult implementation process concerning ECtHR's decision on case **X v. Finland**, on which the HRC issued a follow-up statement to the Committee of Ministers of the Council of Europe in February 2023. The Council of Europe's department responsible for monitoring the execution of ECtHR judgements visited Finland early in the year to address this case and other matters.

The promotion of fundamental and human rights

One 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 2023.

In the first half of 2023, the HRC's communications and advocacy focused on influencing the Government Programme. The starting point was to have the Government Programme commit to safeguarding and promoting fundamental and human rights and respecting the rule of law. Advocacy also involved further promoting the implementation of recommendations received by Finland from international treaty monitoring bodies. The focus of stakeholder work was on building cooperation networks in national foresight networks. During the year under review, the HRC's communications and advocacy were strengthened by recruiting a permanent communications expert to the communications and advocacy team in the autumn.

As part of the work to promote fundamental and human rights, the HRC also organises human rights education and training. During 2023, HRC staff members were active in giving lectures in national and international contexts and organised several events on various human rights topics. Target groups have included young people, different working groups, councils for older people, networks, organisations and forums.

The HRC's events in 2023:
- Round table on the rights of older people, 22 March 2023
- Webinar by the HRC, Mobile Futures and SILE on circumventing entry regulations, 26 April 2023
- Human rights event for young people, 25 May 2023

- "Implementation of the rights of vulnerable people: challenges and results of research" seminar in cooperation with the Center of Law and Welfare of the University of Eastern Finland, 7 June 2023
- Visit of the representatives of the Ukrainian High Commissioner for Human Rights and events organised in connection with the visit, 7 June 2023
- "Besök hos Människorättscentret" (Visit at the Human Rights Centre), event for participants in the Nordic Moot Court Competition, 9 June 2023
- Introduction on the HRC's activities for the representatives of the Office of the Lithuanian Ombudsman, 25–29 September 2023
- Joint event of the HRC and the Finnish League for Human Rights titled "The right to make do – social security as a human right in Finland", 17 October 2023
- Publication event: "Report on human rights foresight and resilience during transformations in society", 23 November 2023

Young Experts Programme

The first term of the Young Experts Programme, launched at the Human Rights Centre on 1 February 2022, came to a conclusion on 31 July 2023. The programme aims to strengthen the voices of young people in the overall discourse on fundamental and human rights and in the HRC's activities and to offer the experts selected for the programme an opportunity to develop their competence.

In spring 2023, the junior experts met young people with an asylum seeker background, young people with disabilities and young mental health rehabilitees. In addition, a human rights event for young people was organised in Helsinki in May. The events involved discussion on human rights from the perspective of young people and collecting information on what human rights problems young people have noticed and what they would like from human rights actors.

At the end of their programme term, the junior experts prepared a review of young people and human rights, published by the HRC in November. The review compiles the most important observations of the first programme term, which have been collected from sources such as the aforementioned meetings with young people. The review also addresses the status of young adults in the international human rights system on a more general level.

In December, two new experts were recruited to the HRC for the second term of the Young Experts Programme. The new programme term will last two years (from 1 December 2023 to 30 November 2025).

Monitoring the implementation of the UN Convention on the Rights of Persons with Disabilities (CRPD)

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.

For more information on the special task of the rights of persons with disabilities together with the Ombudsman, see section 3.4. 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 2023, the HRC promoted awareness of the recommendations in the report published in 2022 by the UN independent expert on the rights of older people. The report discusses the implementation of the rights of older people in Finland and contains 40 recommendations for measures for the Government to safeguard the rights of older people. The HRC has translated the report into Finnish and Swedish.

The Division for the Rights of Older Persons of the HRC's Human Rights Delegation invited various ministries and authorities to discuss the implementation of the recommendations in the report. In addition, a round table event was organised with civil society and researchers to consider how the recommendations of the report could be better implemented both locally and nationally among different actors.

In April 2023, the HRC participated in a meeting of the UN Open-ended Working Group on Ageing (OEWGA), for which the HRC issued two written statements. One of the statements addressed social inclusion, the right to health and access to health care services, the other addressed the participation of older people in sustainable development measures and the financial security of older people.

In 2023, the HRC also participated in the steering groups of the University of Eastern Finland SOLDEX project on the exclusion of elderly people in home care and the "Access to justice for marginalized groups of older people in aging society" (AMIS) project funded by the Research Council of Finland.

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 HRC participates actively in the European Network of National Human Rights Institutions (ENNHRI). The Director of the HRC chaired ENNHRI and served as a member of the board of the Global Alliance for National Human Rights Institutions (GANHRI).

In addition, an expert from the HRC chaired the ENNHRI Legal Working Group. During 2023, the working group focused on promoting the implementation of the decisions of the European Court of Human Rights (ECtHR) and creating tools to facilitate this and participating in the implementation enforcement process (Rule 9). Promotion efforts also included participating in the oral session of the Grand Chamber of the ECtHR for third-party interventions in two climate cases. The HRC's experts also 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.

During the year under review, the HRC continued to strengthen the rule of law perspective and preparedness for various changes in its international and European cooperation on human rights. The HRC also continued to offer support for national human rights institutions in difficult situations. The HRC cooperated with the Ukrainian High Commissioner for Human Rights both bilaterally and through ENNHRI. There was also cooperation with other European human rights actors, such as the Council of Europe, the Organisation for Security and Cooperation in Europe (OSCE) and the EU Agency for Fundamental Rights (FRA).

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 Action Plan and annual report every year (see www.humanrightscentre.fi). The report of the Parliamentary Ombudsman contains a summary of the HRC's report.

The Human Rights Delegation is part of the National Human Rights Institution and is the HRC's most important channel for cooperation, advocacy 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 2023. Themes included the current discussion culture and hate speech and their impacts on society, support for human rights defenders, the rights of young people, the reforms of the Disability Services Act and the Border Guard Act, and delays in the implementation of decisions concerning Finland by the European Court of Human Rights and the European Committee of Social Rights. In addition, a separate foresight workshop was organised to discuss the foresight report that was being prepared at the Human Rights Centre.

The third Human Rights Delegation began its four-year term on 1 April 2020. The Delegation has 38 members, including special ombudsmen as well as representatives from the supreme overseers of legality and the Sámi Parliament of Finland. The Human Rights Delegation and its working committee were chaired by HRC Director Sirpa Rautio, while Esa Iivonen, a member of the Delegation, served as deputy chair.

3.4
Rights of persons with disabilities

Under the Parliamentary Ombudsman Act, the Ombudsman, together with the Human Rights Centre and its Human Rights Delegation, is responsible for promoting, protecting and monitoring the implementation of the UN Convention on the Rights of Persons with Disabilities. These aforementioned actors of the independent national mechanism constitute the Finnish National Human Rights Institute. The content of the first special task jointly assigned to the Institute was described more extensively in the report for 2022.

During the year under review, decisions on cases in this category were made by Deputy-Ombudsman Maija Sakslin; the presenting officer was Principal Legal Adviser Minna Verronen and Senior Legal Adviser Juha-Pekka Konttinen and Notary Sofie Roininen (as of 1 April 2023) acted as legal advisers.

3.4.1
ACTIVITIES OF THE NATIONAL MECHANISM

Disability Team

During 2023, the Disability Team of the Office worked in close cooperation with the Disability Rights Committee (VIOK). Matters highlighted in the meetings of the Committee and the Disability Team were discussed fluently on both sides, since two members of the Disability Team also served as experts in the Disability Rights Committee.

The Disability Team updated the inspection form used in all of the Ombudsman's inspections by adding a point for assessing the accessibility of the information and communication environment.

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

- meeting of an accessibility working group appointed by the Ministry of the Environment, 13 January 2023
- Barnahus and THL webinar on supporting children and young people with intellectual disabilities after experiences of violence, 15 January 2023
- THL conference on services for persons with disabilities, 9 February 2023
- Webinar by autism association Autismiliitto, titled Kuormitus ja kaaos (Workload and chaos), 26 September 2023
- Personal assistance day, 15 November 2023
- Meeting with Careeria Vocational College students, 4 December 2023
- Information event for new employees at the Office of the Parliamentary Ombudsman on taking accessibility into account during visits, 18 December 2023

Human Rights Centre

The HRC issued statements to the Ministry of Social Affairs and Health on the postponement of the entry into force of the Disability Services Act (IOK/37/2023) and on limiting its scope of application (IOK/8059/2023). In addition, the HRC issued a statement to the European Commission on the European Disability Card (IOK/25/2023).

The HRC also commented on the implementation of the rights of persons with disabilities, including its statement on the interim report on the implementation of the Istanbul Convention (IOK/21/2023), its additional statement to the UN Committee on the Rights of the Child (IOK/23/2023) and its statement to the parliamentary Social Affairs and Health Committee on freezing index amendments and on amending the Child Allowance Act (IOK/7300/2023).

Together with the Disability Rights Committee (VIOK) acting under the Human Rights Delegation, the HRC participated in the work of the UN Committee on the Rights of Persons with Disabilities in preparing the processing of Finland's first periodic report. The HRC also participated in a discussion organised by the Committee on the List of Issues in Geneva on 11–15 September 2023.

In cooperation with the Parliamentary Ombudsman, the HRC issued a statement to the UN Committee on the Rights of Persons with Disabilities (HRC/39/2023).

Disability Rights Committee (VIOK)

The Disability Rights Committee (VIOK) – a permanent division under the Human Rights Delegation – met five times during the year. In these meetings, topics included issues concerning the rights of persons with disabilities that are pending in the European Union, preparations for processing the Finnish periodic report on the UN Convention on the Rights of Persons with Disabilities, the rights of persons with disabilities in employment, the impacts of the Government Programme on the livelihoods of persons with disabilities, and corporate responsibility issues. Most meetings were introduced by an external expert. All the meetings also involved presenting new decisions by the Parliamentary Ombudsman that had been published online.

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.

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, the Finnish Institute for Health and Welfare and various stakeholders. Cooperation with Valvira and regional state administrative agencies included inspections and the selection of inspection sites.

During the year under review, a representative of the Disability Team participated as an expert in the Government's fundamental and human rights network (PIO), the Advisory Board on the Rights of Persons with Disabilities (VANE) and in the Swedish-speaking expert group on the handbook on disability services by the Finnish Institute for Health and Welfare. In addition to the above, members of the Disability Team also participated in the monitoring group for the preparation of legislation relating to the right of self-determination, and in the monitoring committee of the European Social Fund for the EU Regional and Structural Policy Programme.

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

International cooperation

The HRC and the Parliamentary Ombudsman attended the UN Conference of States Parties to the CRPD in New York in June 2023. The Human Rights Centre participated in the ENNHRI CRPD working group meetings.

Representatives of the Disability Team regularly observed the decision policies of the UN Committee on the Rights of Persons with Disabilities and the European Court of Human Rights as well as other discourse on the rights of persons with disabilities.

3.4.2 OVERSIGHT OF LEGALITY

The UN Convention on the Rights of Persons with Disabilities (CRPD) 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.

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, healthcare, 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 addresses areas that are vital for the implementation of the rights of persons with disabilities regardless of which administrative branch the matter involved. The oversight of the legality of the rights of persons with disabilities has been examined in its own section as of 2014.

The oversight of legality related to the rights of persons with disabilities focuses, in particular, on fundamental rights, such as essential income and care, access to adequate social welfare and healthcare services, equality, legal protection and accessibility, as well as individual autonomy and inclusion in society. As specified by the Constitution, public authorities must secure adequate social welfare and healthcare services for everyone and promote the health of the population.

Disability services provided by wellbeing services counties 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. As a rule, inspections are carried out without prior notice. 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 wellbeing services counties responsible for the provision and supervision of services. A private service provider is considered to perform a public task when it provides its services under an authority's order either as a purchased service or for a service voucher. The Ombudsman also oversees other special supervisory authorities, such as Valvira and the regional state administrative agencies.

The Ombudsman, in its capacity as the National Preventive Mechanism (NPM) under the Optional Protocol to the UN Convention against Torture (OPCAT), may rely on the assistance of experts appointed by the Ombudsman, who have expertise significant for the NPM mandate. These experts include, among others, healthcare 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.

Complaints and own-initiative investigations

The number of complaints and own-initiative investigations falling into this category on which decisions were issued in different administrative branches was 265 (247 in 2022). A total of 58 cases led to measures (22%). The percentage of cases warranting further action was smaller than in the previous year (33%) but, as in previous years, higher than the average of the Office of the Parliamentary Ombudsman (13%). A reprimand was issued in three cases concerning disability services.

An opinion was stated on 50 (44) cases, and 5 (22) cases led to other measures. An increasing effort is being made to publish the decisions on the Ombudsman's website www.oikeusasiamies.fi.

As in previous years, the administrative branch of social welfare had the highest number (170) of decisions concerning persons with disabilities (189 in 2022). Since 1 January 2023, wellbeing services counties have been 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 Disability Services Act (121 decisions), 29 decisions concerned personal assistance (27 in 2022) and 29 cases concerned transport services (27 in 2022). Moreover, 13 decisions concerned the rights of persons with intellectual disabilities (24 in 2022) and 13 decisions concerned the rights of older persons with disabilities (memory disorders) (29 in 2022). Interpreting services for persons with disabilities were also included in the social welfare category, in which Kela, the Social Insurance Institution of Finland, serves as the service provider. During the year under review, no complaints were resolved concerning interpretation services that would have led to measures.

During the reporting year, 24 decisions were made related to social insurance (16 in 2022), 37 decisions related to healthcare (42 in 2022) and 15 decisions related to education (16 in 2022).

Complaints relating to service provision under the Disability Services Act concerned issues such as decision-making related to services and customer charges, multisectoral and professional cooperation, opportunities for people with disabilities to participate in the planning and preparation of service reforms, 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 wellbeing services counties' 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, and as an organiser of interpreting services.

Recommendation

In decisions 2319/2023* and 6109/2023, the Deputy-Ombudsman recommended that the Ministry of Justice consider whether legislation should be passed on the duties and obligations of institutions such as psychiatric hospitals in voting at special advance voting facilities. The Parliamentary Ombudsman asked the Ministry of Justice to state by 30 April 2024 what measures the recommendation may have given rise to.

In the Deputy-Ombudsman's view, it would be appropriate to assess whether legislation should contain provisions on the duties and responsibilities of institutions as special advance voting facilities, as neither the Election Act nor any other Act expressly lays down provisions on the tasks and responsibilities of institutions or their staff for voting arrangements at special advance voting facilities. In reality, especially in closed institutions, staff conduct may have a significant impact on the successfulness of voting at special advance voting facilities and on enabling patients to exercise their right to vote.

The decision is explained in more detail in section 3.4.8 below.

Inspection visits

Practically all visits to psychiatric hospitals and residential and institutional units for persons with disabilities combine the two special mandates that the Ombudsman has under international conventions (CRPD and OPCAT). A total of 12 such visits were carried out during the year under review. The visits focused on housing and institutional units (6), housing units for older people (with memory disorders) (3), units providing hospital care (1) and operating units providing psychiatric hospital care (3).

During the year under review, the following housing and institutional units for persons with disabilities were inspected on the order of the Deputy-Ombudsman:

- Maria-Katariinan talo, Kokkola 2324/2023*
- Mattilakoti, Kokkola 2942/2023*
- Keski-Pohjanmaan Hoitopalvelu Oy's Karelia-koti, Kokkola 2810/2023*
- Kasarminportti, Lappeenranta 3110/2023*
- Kotimäki, Lappeenranta 3515/2023*
- Examination and rehabilitation unit Tutka, Lappeenranta 5357/2023*.

In addition, the Deputy-Ombudsman inspected disability services' activities and client guidance for at-home services at the Wellbeing Services County of South Karelia 3992/2023*.

Inspection findings of NPM visits are described in section 3.5 of this report, and findings related to the oversight of oversight are in section 3.8.

Statements

The Deputy-Ombudsman issued a statement to the Ministry of Social Affairs and Health on the draft government proposal to Parliament for legislation on the postponement of the Disability Services Act and certain related acts (4332/2023*).

The Deputy-Ombudsman issued a statement to the Social Affairs and Health Committee on the government proposal (HE 9/2023 vp) to Parliament for legislation on the postponement of the entry into force of the Disability Services Act and certain related acts (5658/2023*).

The Deputy-Ombudsman issued a statement to the Constitutional Committee on the government proposal (HE 9/2023 vp) to Parliament for legislation on the postponement of the entry into force of the Disability Services Act and certain related acts (5813/2023*).

The Deputy-Ombudsman issued a statement to the Parliamentary Social Affairs and Health Committee on the Parliamentary Ombudsman's report for 2022 (7783/2023*).

The Deputy-Ombudsman issued a statement to the Finnish Institute for Health and Welfare, which organised a hearing on the scope of application of the new Disability Services Act at the request of the Ministry of Social Affairs and Health (7414/2023*).

In her statement, the Deputy-Ombudsman noted that the preparation of possible amendments to the provisions on the scope of application of the new Disability Services Act is justified insofar as the purpose is to clarify the regulation on the personal scope of application of the Act, the conditions for accessing services and the relationship of the Disability Services Act with legislation concerning other services and assistance.

In cooperation with the HRC, the Deputy-Ombudsman issued a statement to the UN Committee on the Rights of Persons with Disabilities (HRC/39/2023).

3.4.3 INSPECTION FINDINGS AND DECISIONS ON ACCESSIBILITY

Promoting accessibility and participation are cross-cutting themes of the CRPD covered in the Office's on-site inspection activities. Article 9 of the CRPD provides for accessibility and full participation and equal access to, inter alia, physical environment. Article 19 provides for inclusion in a community and that community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

An accessible, unimpeded environment for people with disabilities is an absolute requirement if they are to lead an independent life and enjoy equal status. The Convention on the Rights of Persons with Disabilities is based on the notion that all activity must take account of the demands of accessibility across society, because this is often a requirement for the implementation of other rights. Promoting accessibility and inclusion requires continuous work.

Findings from inspections

Social welfare

Child protection

The main entrance to the unit for unaccompanied minors 5775/2023* of the Ostrobothnia Immigration Centre was accessible by wheelchair to the floor that had an accessible room, toilet and bathroom. However, there was no accessible route to the upper floor of the house, where the other children's bedrooms were located.

Housing units for persons with intellectual and other disabilities

The outdoor area of Karelia-koti by Keski-Pohjanmaan Hoitopalvelu Oy 2810/2023* was level, paved ground, and the door was accessible with a wheelchair and other mobility aids. The inspectors considered it a shortcoming that there was no designated accessible parking space.

The entrance to Mattilakoti 2942/2023* in Kokkola was accessible. The interior of the housing unit was mainly accessible, and there was room to move around with mobility aids. The corridors had handrails. At least one resident had a shower stretcher in their toilet/bathroom, which made the space cramped. There were parking spaces in front of the building, and designated accessible parking spaces were available next to the entrance.

The indoor spaces of the Kotimäki Housing Unit 3513/2023 in Lappeenranta were accessible, and there was enough room to use even large mobility aids. The facilities at the housing unit are not suitable for bed patients, as the residents' personal toilets and bathrooms do not have room for shower stretchers, and the rooms also do not have hoists or enough space for a possible hoist. The residents at Kotimäki had the opportunity to spend time outdoors in an accessible and pleasant courtyard.

The indoor spaces were mainly accessible at the examination and rehabilitation unit Tutka of the Wellbeing Services County of South Karelia, and there was enough room to move around with mobility aids. The car park in front of the building had designated accessible parking spaces that were located near the entrance 5357/2023*.

Healthcare

In the inspection of the psychiatric wards of the Kainuu Central Hospital in the Wellbeing Services County of Kainuu 5780/2023*, the Deputy-Ombudsman welcomed the fact that the facilities were new, modern, had an overall tidy appearance and were appropriately accessible. Next to the hospital was a Health Forest for outdoor activities, which included accessible nature trails.

In the inspection of the City of Helsinki sobering-up station, the Deputy-Ombudsman recommended that the city take the necessary measures to adjust the premises of the sobering-up station, including the entrance ramp, to meet the requirements of patient safety and employee safety 6562/2023*.

Education

Digital accessibility was ensured for the staff and students at Diaconia University of Applied Sciences with the help of an internal expert group and an accessibility guideline 5455/2023*.

The Kankarepuisto Comprehensive School 1940/2023 and the Lauttasaari Upper Secondary School 1941/2023 of the City of Helsinki had accessible parking spots in their yard areas.

Prisons and police detention facilities

The Hämeenlinna police prison (detention facility) had 27 cells for apprehended and detained persons, one of which was an accessible cell 1176/2023. There was no accessible cell in the detention facility of the Mikkeli Police Department 2868/2023*.

The Ombudsman found the accessible cell at the detention facility of the Pasila police department to be appropriate. According to the Ombudsman, people with reduced mobility had also been taken appropriately into account in the facilities in general, both in terms of unobstructed access and in terms of equipment intended for this purpose 6432/2023*.

A particular purpose of inspection 6259/2023* at Riihimäki Prison was to map out and assess the accessibility of the prison's meeting facilities, access routes and environment, mainly from the perspective of the mobility of prisoners' disabled visitors.

The Deputy-Ombudsman stated that although there was an alternative route to the supervised meeting facilities of the prison building, the route could not be considered accessible. In the Deputy-Ombudsman's view, it was clear that safe and unobstructed access should be provided to visitors with reduced mobility.

The Deputy-Ombudsman recommended that a specialised accessibility expert be consulted for the accessibility solutions of the prison building and its surroundings so that the accessways can be designed to be suitable and functional for everyone at once.

There was no accessible toilet in the unattended meeting room or in its vicinity. The Deputy-Ombudsman considered it a good practice that crossing low thresholds was facilitated by easily implemented ramp solutions. In the Deputy-Ombudsman's opinion, this is a good example of how the accessibility of a building can be improved with relatively little effort and at reasonable cost.

In general, the Deputy-Ombudsman recommended issuing communications about prison accessibility at least in situations where the prison's meeting rooms and environment do not allow the independent movement of persons with reduced mobility and functional capacity and may require special arrangements.

The Deputy-Ombudsman asked the prison and the legal unit of the Prison and Probation Service of Finland to report no later than 29 March 2024 on the measures that the observations and opinions have given rise to in the prison and the Prison and Probation Service.

General advance polling stations and special advance voting facilities

Unannounced inspections 1545/2023* and 1546/2023* by the Parliamentary Ombudsman revealed deficiencies in arrangements for advance polling and voting at special advance voting facilities. Legal advisers of the Office of the Parliamentary Ombudsman conducted unannounced inspections of general advance polling stations in five municipalities in Southwest Finland. It was not possible to independently access some of the general polling stations with a wheelchair. The arrangements at general advance polling stations were mainly in order.

Observations concerning the election bus were positive, but an election bus was considered problematic as a general advance polling station from an accessibility perspective.

For the first time, inspections were also conducted at three special advance voting facilities at social welfare institutions in Uusimaa. The inspection pointed out that older people, especially those with poor vision, could benefit from a better magnifying glass or a magnifying reader at the special advance voting facility. Voting at special advance voting facilities took place in housing units that were mainly accessible. The voting facilities had also been selected so that people using different mobility aids could access them.

Other authorities (agencies)

During an inspection of the Finnish Transport Infrastructure Agency, the Deputy-Ombudsman found it important to take a systematic approach on improving the accessibility of station environments, especially old ones, with regard to the provision of information and communications and renovating the physical environment.

The Finnish Transport Infrastructure Agency had prepared an accessibility statement, and the accessibility of digital services had been tested by external parties. The Agency did not offer an alternative e-service, but support for the use of digital services was available if necessary. The Agency also was not using induction loops or other similar aids or plain-language instructions/bulletins or digital systems 754/2023*.

In an inspection of the Social Insurance Institution of Finland (Kela) 5838/2023, Kela reported that it had prepared accessibility statements on its online services and that the statements were updated regularly. Kela has a usability and accessibility team that conducts accessibility assessments of online services. Additionally, Kela cooperates with external accessibility experts when necessary. In addition to using e-services, clients can use Kela services at service points or via the telephone service.

In the inspection form, Kela stated that it offers a comprehensive range of digital support to customers. Digital support is available by telephone, appointment and at service points, so it is geographically comprehensive over the entire Kela service network. Disabled persons' right to digital support is also ensured with Kela's sign language website; for example, the use of MyKela is supported with both sign language videos and written instructions on the website.

Disabled clients have the right to use an interpreter if necessary. According to Kela, service points will independently order an induction loop if they discover a need for an induction loop or some other similar aid.

The Kela website contains information on benefits in plain language. There are eight published plain-language brochures on benefits, available as printed versions at service points and on the Kela website.

Decisions on complaints

Accessibility of a hospital and health station

In case 1620/2022*, the Deputy-Ombudsman was not satisfied that the right of persons with disabilities to use the primary healthcare services of the City of Espoo and the services of the HUS Diagnostic Centre had been realised equally and without discrimination.

According to complaints received by the Office of the Parliamentary Ombudsman and according to publicly available information, there were no hoists available at the City of Espoo health stations and HUS Diagnostics Centre facilities in Espoo that could be used to lift a wheelchair user on to an examination table. Patients had been asked to bring their own hoist or go to a unit that had a hoist. For one patient, an examination had not been performed due to the lack of a hoist.

Public healthcare services are meant for all residents. Public health services must be designed so that everyone who needs and is entitled to them can access and use them. Taking people's special needs into account is a part of good care.

Making accommodations for accessibility is central to service planning. If equal access to services is not realised without special measures, the authority has to make due and appropriate adjustments necessary for each situation for a person to be able to deal with the authority equally with others.

In addition to the measures already taken, the Deputy-Ombudsman considered it necessary that the Wellbeing Services County of Western Uusimaa and HUS Group actively monitor the realisation of the rights of persons with disabilities and gather information on any detected problems. The Deputy-Ombudsman requested the Wellbeing Services County of Länsi-Uusimaa and the HUS Group to provide a report on the measures taken and the development targets set for improving service access for persons with disabilities by 28 February 2024.

The Wellbeing Services County of Länsi-Uusimaa reported that several health stations had improved accessibility, for example by procuring lifts, wheelchair scales, hoists, induction loops and information boards. The phone number of the health stations' SMS service for persons with hearing impairments has been added to the website. In 2024, the aim is to further improve accessibility, for example by updating instruction signs and removing thresholds. Accessibility will be taken into account already in the construction stage of future renovations and in the design of new properties.

Accessibility of shelter services

In decision 5820/2022*, the Deputy-Ombudsman considered it a deficiency that not all shelters under the responsibility of the Finnish Institute for Health and Welfare were accessible by the end of 2022, even though various measures had been taken to correct accessibility problems.

The Deputy-Ombudsman considered that improving the general accessibility situation of shelters and shelter services without delay is necessary to ensure equal treatment of persons with disabilities and to safeguard the rights laid down in legislation.

Under the Non-Discrimination Act, a shelter service provider must provide due and appropriate adjustments necessary in each situation for a person with disabilities to be able to use shelter services equally with others.

The Deputy-Ombudsman emphasised that having an accessible environment and service system creates the preconditions for persons with disabilities to live life as independently as possible equally with others. In addition, accessible environments and services are functional and safe for everyone – and they promote easy everyday life for everyone.

The Deputy-Ombudsman asked the Ministry of Social Affairs and Health to submit by 31 January 2024 a report from the Finnish Institute for Health and Welfare and a statement from the Ministry on the state of accessibility at shelters and the measures taken to ensure the accessibility of shelter services.

Based on a notification received from the Ministry of Social Affairs and Health and the Finnish Institute for Health and Welfare on 30 January 2024, measures had been taken, and the importance of continuous development had been recognised. The matter did not give rise to any further measures by the Deputy-Ombudsman.

Institutional and ward placement of a prisoner with reduced mobility

In case 4646/2022, the Deputy-Ombudsman considered that the rights of a prisoner with reduced mobility had not been fulfilled equally with other prisoners due to the accessible cell being located in a prison ward intended for short-term placement only. According to the Deputy-Ombudsman, the cell in question should not be used for housing prisoners with reduced mobility unless the conditions of the cell can be made compliant with legislation. The Deputy-Ombudsman considered it justified that the appropriateness of the equipment in an accessible cell is always assessed separately with healthcare services, based on the needs of each prisoner housed in the accessible cell.

The Deputy-Ombudsman asked the Prison and Probation Service of Finland to report no later than 30 September 2024 on the measures that the observations and opinions have given rise to.

Contact options at the patient insurance centre

In case 4310/2022*, the Deputy-Ombudsman considered that the Patient Insurance Centre had acted unlawfully by not offering everyone in all situations the option to send messages related to its advice or information requests via digital services or other electronic data transfer methods and, in this respect, not clearly communicating how each person could handle their matters electronically with the Patient Insurance Centre. The procedure was also not likely to promote the equality of customers, considering that customers of the Centre may also include persons who are only able to use services electronically.

In addition, the Patient Insurance Centre had failed to comply with the Administrative Procedure Act by not responding to a complainant's request for advice. The complainant's request for advice should have been responded to without delay, as doing so would not have required any special measures from the Patient Insurance Centre.

The Patient Insurance Centre reported that they had started using a general email address where clients can send enquiries and requests for advice. The Patient Insurance Centre also reported that their future development work would include the option of potentially sending them voice recordings electronically.

In another decision 2219/2023, the Deputy-Ombudsman stated that a matter had been handled lawfully in the sense that using services had still been possible in person, by phone and by letter in addition to using the Maisa client portal.

However, the Deputy-Ombudsman found it unclear whether all social welfare clients had been provided information as required by the Status and Rights of Social Welfare Clients on the introduction of the Maisa client portal and electronic notifications and whether all social welfare clients had been asked for their consent to receiving notifications of social welfare decisions via electronic message.

In addition, for the sake of clarity, the Deputy-Ombudsman stated that the Maisa client portal is subject to the provisions of the Digital Services Act on the planning and maintenance of digital services and the accessibility requirements that service providers are obliged to comply with.

The Deputy-Ombudsman also emphasised that clients may not suffer any loss of rights, such as the loss of the appeal period, due to errors in the authority's digital services.

The Deputy-Ombudsman asked the social welfare, healthcare and rescue services of the city to report by 1 February 2024 on measures that they had taken on the Deputy-Ombudsman's decision, how they will ensure and document explicit consent to receiving notifications of decisions as electronic messages, and how the usability and accessibility of the Maisa client portal will be further developed.

On 30 January 2024, the city announced that it had taken the measures proposed in the decision but that it would take some time before the necessary system changes could be made.

Visiting a health station as a hearing-impaired person

In case 4629/2021, the Deputy-Ombudsman had asked the City of Helsinki to report on the measures the city had taken to ensure that information on the contact options for persons with disabilities were presented more clearly for persons with hearing impairments on the website. The Deputy-Ombudsman considered it essential for the rights of persons with disabilities that they have sufficient information on how to contact health services.

On 15 September 2023, the social welfare, healthcare and rescue services of the City of Helsinki announced that they had updated their website so that all health stations' pages feature a separate section with guidance for persons with hearing and speech impairments on different ways of contacting the services. Accessibility had been taken into account in the design of the pages.

3.4.4 THE PARLIAMENTARY OMBUDSMAN'S OWN INITIATIVES

Ensuring social services for persons with disabilities in disruptive circumstances

As an own initiative, the Deputy-Ombudsman investigated how the wellbeing services counties and the social, health and rescue services of the City of Helsinki had ensured that the functional capacity and well-being of persons with disabilities could be safeguarded in case of possible disruptions during which some necessary services could not be used or were only usable to a limited extent.

The Deputy-Ombudsman drew the attention of the wellbeing services counties to the fact that the preparedness plans of different sectors, including private service providers and potential other parties, have to be coordinated. She stressed that, for regional cooperation, the wellbeing services county must have a cooperation group required by the Government Decree, also including representatives of rescue services in addition to local social welfare and healthcare services and expertise in at least environmental healthcare and the preparedness of local authorities.

The Deputy-Ombudsman emphasised that, under the Act on the Organisation of Social Welfare and Healthcare, the preparedness of a wellbeing services county includes ensuring the continuity of services also when services are provided by procuring them from private service providers. In addition, the Deputy-Ombudsman emphasised that the responsibilities and obligations of different actors specified in preparedness plans must be clear and known to the responsible actors in such a way that taking action on the basis of the plans is seamless in practice. It is also important for staff members to be familiar with the contents of the plans.

The Deputy-Ombudsman found it particularly important that the disability advisory council and service users with different disabilities are given a real opportunity to influence and participate in the planning and implementation of preparedness for disruptive circumstances and exceptional situations and to be involved in other stages related to preparedness.

However, the Deputy-Ombudsman noted that preparedness planning may contain confidential information, which in turn restricts the participation of larger groups and public discussion. In this case, it should be taken into account that not all preparedness information can be widely shared for security reasons if sharing such information may cause harm or danger.

The Deputy-Ombudsman considered it a shortcoming that the individual client preparedness plan was only mentioned in a few received reports. In general, the Deputy-Ombudsman drew attention to the fact that the individual social services client plan has to indicate the measures for each specific client in different disruptions and exceptional situations. One especially vulnerable group are people with severe disabilities living at home for whom the wellbeing services county has organised services that meet their individual needs.

The Deputy-Ombudsman emphasised that, even in disruptions to normal conditions and in emergencies, persons with disabilities must be provided with services that meet their individual needs and that have been granted to them as services organised by the wellbeing services county. This means that, during disruptions and emergencies, the wellbeing services county must constantly assess that the right of a disabled client to adequate services is realised in compliance with the law as required by the Constitution and that necessary care is safeguarded.

In general, the Deputy-Ombudsman also noted that preparedness measures should pay special attention to persons with disabilities who need support in accessing information and communicating during disruptions. This kind of need for support during crisis communications should be taken into account in advance in client plans or individual preparedness plans.

The Deputy-Ombudsman considered it important that wellbeing services counties check the agreements concluded with service providers on preparedness for disruptions and, if necessary, provide preparedness guidance to private service providers even outside inspection visits.

The planning and implementation of services provided at home for persons with disabilities requires securing the functioning of disability social services during disruptive circumstances and exceptional situations. The Deputy-Ombudsman emphasised that it is important that self-monitoring plans not only assess service production but also the risks of disability social services and how activities are secured in changed circumstances.

The Deputy-Ombudsman emphasised that, in preparing for disruptions, it is important to plan different options for responding to possible personnel shortages and for ensuring and organising statutory services so that the fundamental and human rights of persons with disabilities are realised even in disruptive circumstances and exceptional situations.

Procedures for restraining measures and preparation of special care programmes

In another own-initiative case 73/2022*, the Deputy-Ombudsman considered that the social welfare and healthcare services of the City of Vaasa had neglected to draw up special care programmes for adults who live in city housing units and require special care in accordance with the Act on Special Care for Persons with Intellectual Disabilities. In assessing the reprehensibility of the procedure, the Deputy-Ombudsman took into account the fact that the Parliamentary Ombudsman had already issued a reprimand to the City of Vaasa for failing to draw up a special care programme.

The Deputy-Ombudsman requested that the Wellbeing Services County of Ostrobothnia submit by 31 October 2023 a report (situational picture) on how the county has implemented the procedures, practices and structures concerning the use of restraining measures on persons with intellectual disabilities and the preparation of special care programmes.

The Wellbeing Services County of Ostrobothnia submitted the requested report on 31 October 2023.

3.4.5 DECISIONS IN THE SOCIAL WELFARE SECTOR

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

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

In case 1357/2023*, the Deputy-Ombudsman issued a reprimand to a wellbeing services county for unlawfully neglecting to provide care assistance and personal assistance services to the girls of a family in full accordance with the decisions of an official and in line with special care programmes. The wellbeing services county had also not supervised that outsourced services are implemented as planned.

The reprehensibility of the procedure was worsened by the fact that the realisation of the disability services for the girls of the family had not improved to any significant extent after the Deputy-Ombudsman's earlier decision. In addition, problems with the implementation of services had continued for an unreasonably long time from the family's perspective – for more than two years.

The Deputy-Ombudsman emphasised that even though a wellbeing services county can organise social welfare and healthcare by procuring services from a private service provider, the county cannot transfer its responsibility for monitoring and organising services to a private service provider or an individual client or to a client's legal representative. If services granted to a disabled person cannot be fully organised through outsourced services, the wellbeing services county must consider other ways of organising the services, for example directly by the wellbeing services county.

In case 6841/2022*, the Deputy-Ombudsman considered that the social services of a city had failed to fully fulfil a decision in a situation where service was interrupted: a change in circumstances had first caused an interruption in a child's services, and the city had subsequently organised temporary care periods that only lasted a few days instead of a week. The Deputy-Ombudsman found the actions by social services to be reprehensible.

The Deputy-Ombudsman drew the attention of the city's social services and service provider to ensuring that procedures are carried out in accordance with the principles of good governance and social welfare and that timely communications are realised in a crisis client situation. The Deputy-Ombudsman emphasised that the parties providing and implementing social welfare services, especially the authority, have a responsibility to take initiative in investigating the different options available to the client in the service system and, in particular, the conditions under which the client is entitled to receive services.

In case 4664/2022*, the Deputy-Ombudsman considered that the reassessment and planning of the service needs of a severely symptomatic child with intellectual disabilities had been unlawfully delayed as the child's situation had fallen into crisis. Emergency situations must be responded to as quickly as possible, and immediate assistance must be arranged if necessary. The best interests of the child must be a primary consideration in all social welfare activities involving children. This obligation is also included in the Convention on the Rights of the Child.

The constitutional right to necessary and adequate social welfare and healthcare services must not be delayed because authorities cannot agree on which authority should primarily organise the services. This provision of the Constitution obliges public authorities to safeguard the availability of social services as laid down in law. The challenges posed by the child's special care rehabilitation and crisis period services were largely due to neglect and deficiencies in the authorities' communication, which had led to confusion in the division of responsibilities between the municipality organising the service, specialised medical care services and B (service provider, joint municipal authority of the special care district).

As the party responsible for the child's services, the municipal social services should have ensured access to services that meet the child's needs, despite the fact that the authorities (healthcare and social welfare) were unsure who had the obligation to provide the services. The Deputy-Ombudsman found it inappropriate that the operating unit of the special care district that was involved in the child's care had not taken initiative to start network cooperation, even though they had been well aware of the child's crisis situation and the lack of implementation of the child's specialised medical care.

The municipality should have made a decision on the crisis period that had the child had started to undergo. The child and the complainant should have had the opportunity to appeal a decision in the manner stated in the appeal instructions. The neglect in decision-making may have jeopardised the implementation of the rights and legal protection of the complainant and their client.

In decision 1668/2022, the Deputy-Ombudsman considered that the child welfare services of a city had neglected their duties under the Child Welfare Act by failing to draw up a plan for the after-care of a child with severe disabilities after the child had been transferred to after-care. The plan not been drawn up until seven months after the end of the placement.

Organisation of disability services and decision-making

Each year, the oversight of legality by the Parliamentary Ombudsman repeatedly addresses authorities' deficiencies and negligence in decision-making or delays in the processing of matters in decisions concerning disability services or special care for persons with intellectual disabilities.

In case 6889/2022*, the Deputy-Ombudsman brought to the attention of a wellbeing services county her understanding of a city's unlawful practices in organising personal assistance and the wellbeing services county's neglect in decision-making and providing advice.

The Deputy-Ombudsman considered it a serious deficiency that the city's social services had not taken immediate measures after a decision by the Regional State Administrative Agency. In the view of the Deputy-Ombudsman, despite challenges in client cooperation, the social services of the city should have sooner started to actively solve the challenges in the realisation of the complainant's personal assistance, the multidisciplinary reassessment of service needs and, if necessary, the investigation of alternative forms of service.

The disability services of the wellbeing services county had acted in violation of the Social Welfare Act and the Administrative Procedure Act because they had not made an appealable official decision on the basis of the individualised application by the complainant's client. An official should also have issued a written decision in the situation where the official had orally changed the content and conditions of a valid decision as regards access to personal assistance.

In the same decision, the Deputy-Ombudsman considered that the communications and advice by the wellbeing services county's disability services were not compliant with good governance, as the official had neglected to provide the complainant with timely and clear information and advice on the organisation of transitional services.

The Deputy-Ombudsman further drew the attention of the wellbeing services county to the fact that the social welfare authority is responsible for the functioning of its information systems and ensuring that information on notifications of concern is communicated to the right parties without delay.

In decision 6119/2022*, the Deputy-Ombudsman did not consider a municipal procedure to be compliant with the Disability Services Act, as a decision on personal assistance had been made more than five months after receiving the application, and investigation revealed that resolving the application had not required a longer processing time for any special reason. Decision-making on social work support had also been delayed, even though the implementation of the service had started as agreed, but the decision on support had not been entered in the information system.

The Deputy-Ombudsman considered that, in the complainant's situation, it would have been justified to draw up a multiprofessional and multidisciplinary client plan where the responsibilities and contact persons of different operators were clearly defined. The Ombudsman also considered that the appointment of a personal worker in disability services was justified and necessary.

The starting point for organising disability services must always be respect for the client's right to self-determination and strengthening their independence. In this case, the investigation revealed that there had been no assessment or offer for the complainant of alternative means of arranging personal assistance in a situation where service provision had failed to start with the employer model.

As the official had neglected to make an appealable decision, the social welfare authority must process the application concerning the provision of social welfare regardless of which social welfare service sector the application is submitted. The administrative and service structures of a social welfare authority may not prevent or restrict a social welfare client from applying for or receiving the social welfare services and support measures they need.

In addition, the Deputy-Ombudsman considered it important for the social worker acting as the personal worker to actually participate in the assessment of the service needs of a person in need of special support and in the preparation of the client plan 6944/2022*.

Other decisions

In decision 3026/2022*, the Deputy-Ombudsman emphasised that the method of reimbursement of occupational healthcare fees must not result in inability to use the personal assistance services stipulated by the Disability Services Act. The wellbeing services county must ensure that the chosen method of arranging or paying for personal assistance for a person with a severe disability acting as an employer does not effectively restrict the subjective right to personal assistance of the person with a severe disability acting as an employer.

Discontinuation of the right to a standard taxi right

In decision 1983/2022*, the Deputy-Ombudsman emphasised that the authority responsible for organising transport services must regularly monitor and oversee what is recorded in its client profiles and the client profiles of its service provider.

As such, the city's disability services were justified in removing the entry concerning the right to a standard taxi from the complainant's client profile, as this entry was not based on a valid official decision. In the Deputy-Ombudsman's opinion, this procedure by the city's disability services was not good governance or in the interest of the client, as the complainant did not have enough time to react to the removal of the entry concerning the right to a standard taxi so that their use of an individual transport service (standard taxi) would not have been interrupted.

In the Deputy-Ombudsman's view, when setting the deadline for removing the right to a standard taxi, it should have been ensured that there would not be an undue interruption in the complainant's way of organising an individual transport service (standard taxi) due to the processing of an application by the authorities.

Deficiencies in recording practices and personnel situation

In case 3248/2022*, the Deputy-Ombudsman considered the procedure of a housing unit seriously reprehensible, as the staffing level specified in the permit of the housing unit had not always been met, so client safety could have been compromised, or in the least, the clients had been forced to wait for service. In assessing the reprehensibility of the procedure, the Deputy-Ombudsman had taken into account the fact that deficiencies in the number of staff members and failure to report deviations may have endangered the right of persons with disabilities to safe disability services. In the same instance, the constitutional right to essential care and adequate social services may have been compromised.

The Deputy-Ombudsman considered it important that the city regularly monitors – for example in connection with updating client plans – whether the assistance (service class) granted to a disabled person is sufficient in the light of their current functional capacity. While doing so, it is often justified to assess whether a disabled client is entitled to personal assistance outside the home, for example. In 24-hour assisted housing, a disabled person has the right to receive the amount of assistance and support for their daily activities that meets their individual needs as specified in their client plan and decision made by an official.

The Deputy-Ombudsman welcomed the fact that the city had reacted quickly to the criticism of the private housing unit (notification of shortcoming) that had emerged from the complaint. The Deputy-Ombudsman found it particularly important that the city continues to regularly steer and oversee the activities of outsourced service providers through reports of shortcomings and self-initiated monitoring and oversight.

The Deputy-Ombudsman asked the city to submit an oversight report by 31 January 2024 on the inspection visit to the city unit to assess the implementation of staffing and other measures in the housing unit.

On 20 October 2023, the city announced that the inspection report on the guidance and supervision meeting prepared by the outsourced disability services unit includes assessments of the requested matters.

Use of a visual monitoring device in special care

In the Deputy-Ombudsman's view, an appealable decision should have been made in case 5880/2022* on stopping the use of a visual monitoring device in a situation where the guardian and the client's family member had opposed the removal of the monitoring device from the room of a client with intellectual disabilities living in assisted housing. Issuing an appealable decision would have better ensured the constitutional appeal right of the family member (and guardian). The Deputy-Ombudsman informed the Wellbeing Services County of North Ostrobothnia of her understanding of the unlawfulness of the procedure. The Deputy-Ombudsman emphasised that the authority must process any request within its decision-making powers and provide an appropriate decision to it. When a request concerns the interest, right or obligation of the party concerned, the authority is obliged to make an administrative decision on the matter as a result of the request or application.

The authority must use the service plan to record the client's (or guardian's) opinion on the manner in which a service is organised and any related restraining measures that are used, especially when the client and the authority are not in agreement. The view of the client (guardian or family member) recorded in the service plan may be important in a conflict situation if the client applies for a change to the authority's decision.

In general, the Deputy-Ombudsman additionally drew attention to recording client entries without delay after processing a client's case.

Involuntary coronavirus sample in special care for persons with intellectual disabilities

In decision 2154/2022*, the Deputy-Ombudsman considered that a social services housing unit of a joint municipal authority had acted unlawfully when taking a coronavirus test sample from a resident and neglecting to notify the physician treating the client of the use of restraints. The Deputy-Ombudsman informed the wellbeing services county that there would have been grounds for issuing a reprimand to the social services of the joint municipal authority.

The Deputy-Ombudsman drew the attention of the authority to the fact that the provision of the Act on Special Care for Persons with Intellectual Disabilities concerning involuntarily healthcare procedures does not entail that, when a resident in a 24-hour special care unit opposes sampling, involuntary procedures (restraining) can be used systematically or automatically in all situations related to healthcare; instead, each individual case must be carefully considered whether the general and special conditions laid down for restraining measures in the Act on Special Care for Persons with Intellectual Disabilities are met. The Act on Special Care for Persons with Intellectual Disabilities lays down the conditions that must be met in order for a restraining measure to be used. The Deputy-Ombudsman also emphasised that instructions issued by the Finnish Institute for Health and Welfare in relation to the prevention of infectious disease or instructions issued by a hospital district are not legally binding and cannot be used as a basis for justifying taking a coronavirus test involuntarily.

Taking a coronavirus sample from a resident must be voluntary, and the coronavirus test must be taken in agreement with the resident in the manner required by the Act on the Status and Rights of Patients and the Act on Special Care for Persons with Intellectual Disabilities. In the Deputy-Ombudsman's view, the provision in the Act on Special Care for Persons with Intellectual Disabilities on involuntary treatment does not justify taking an involuntary coronavirus sample (by using restraints) because an oral sample is not the only way to test for coronavirus, and the situation would have allowed for more lenient methods.

The Deputy-Ombudsman considered it clear that the resident had been subjected to unnecessary fear and suffering from being restrained and having an oral sample taken and that the procedure carried some institution-like tones. The Deputy-Ombudsman also considered that the procedure had been unlawful in that the physician treating the resident had not been immediately notified of the restraining.

The Deputy-Ombudsman brought her views on the flow of information between authorities to be taken into account in future activities. Due to inconsistencies in the reports, the Deputy-Ombudsman found it clear that the flow of information between healthcare services and the housing unit had been seriously deficient because the housing unit had incorrectly thought that the testing was part of mass-testing ordered by an infectious disease physician. This deficiency in the flow of information had partly contributed to the unlawful conduct in taking the sample. The Deputy-Ombudsman drew the authorities' serious attention to being careful and precise in ensuring that the flow of information between authorities is correct.

In general, the Deputy-Ombudsman stated that, since the testing of the client was based on individual consideration, this individual consideration by a physician must be reflected in the resident's patient documents.

The Deputy-Ombudsman drew the wellbeing services county's attention to the need to rectify incorrect instructions and any operating practices based on them.

Finally, the Deputy-Ombudsman emphasised that the social welfare unit must be able to comply with relevant legislation and the Constitution in its procedures. It is the employer's duty to train its staff in the prevention of situations preceding the use of restraining measures. Ultimately, the authority responsible for organising the services is obliged to ensure that the interest of clients with intellectual disabilities in special care comes first in all activities.

In the same case, the Deputy-Ombudsman considered that the complainant's request for information had not been processed in accordance with the Act on the Openness of Government Activities.

The Deputy-Ombudsman drew the attention of the wellbeing services county to the fact that, in refusing to provide requested information, the official responsible for the matter must proceed in the manner specified in the Act on the Openness of Government Activities and provide legal guidance in their response.

The Parliamentary Ombudsman asked the wellbeing services county to state by 29 September 2023 what measures the decision has given rise to.

On 29 August 2023, the Wellbeing Services County of South Ostrobothnia announced that attention had been paid to the flow of information, the availability of instructions and the uniformity of infection control in the wellbeing services county.

Partial coronavirus closure of an activity centre for people with disabilities

In case 627/2022* Substitute Deputy-Ombudsman Sarja considered that decisions concerning the partial suspension of operations at an activity centre had not been justified as required by the Administrative Procedure Act. The Substitute Deputy-Ombudsman found the procedure to be reprehensible because the decision on a partial coronavirus closure of the activity centre for people with disabilities had resulted in a significant change to the established situation. In his assessment, the Substitute Deputy-Ombudsman took into account the fact that the decisions may have had an impact on the implementation of the rights of individual persons with disabilities.

The purpose of the obligation to provide justification to a decision is to ensure that parties concerned are informed not only of the outcome of the decision but also of its grounds. Clear justifications and appropriate references to legislative provisions strengthen trust in authorities' decisions and exercise of public authority being based on law. The correctness of an authority's decision can only be verified afterwards through appropriate justifications.

The partial closure of the activity centre was partly – in addition to safety concerns and a staff shortage caused by coronavirus – due to the fact that there simply were no substitutes available for the activity centre.

The Deputy-Ombudsman emphasised that it is the responsibility of the social welfare authority to ensure that it is always able to organise the statutory services for which it is responsible and that it has sufficient professional staff at its disposal to produce the services. 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.

3.4.6 DECISIONS IN THE TEACHING SECTOR

Frequent complaints in the Ombudsman's oversight of legality include shortcomings in support for learning and school attendance as well as related administrative procedures and decision-making.

During the year under review, inspections of different levels of education (1940/2023, 1941/2023, 1939/2023, 5455/2023*, 5604/2023*, 5457/2023*) focused especially on the status and legal protection of pupils with disabilities and other pupils in need of special support, including the equal right of pupils in basic education to receive education and adequate support, and the obligation of the education and training provider to ensure that the rights of children and young people are safeguarded by administrative and decision-making procedures.

In case 6456/2022*, a city had not arranged transport services for a child with intellectual disabilities in accordance with the Basic Education Act when short-term institutional care had been organised for the child as special care at a temporary care place in another municipality every two weeks. The different sectors of the city should have agreed early enough on how the transports and the necessary accompanying services would be arranged and how the division of costs between the city's sectors would be agreed upon if necessary.

The Deputy-Ombudsman emphasised the importance of systematic multidisciplinary and multiprofessional cooperation in addressing the individual needs of a disabled child and safeguarding the child's best interests when planning, organising and deciding on their services.

3.4.7 DECISIONS IN THE HEALTHCARE SECTOR

Article 25 of the UN Convention on the Rights of Persons with Disabilities safeguards the right of persons with disabilities to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability and ensures access to healthcare services for persons with disabilities. According to the Article, health-related rehabilitation also falls under healthcare services. The States Parties have agreed to provide persons with disabilities with the same range, quality and standard of healthcare as other persons.

In case 876/2022*, the Deputy-Ombudsman considered that the fitting and procurement of essential accessories for a complainant's wheelchair should have been carried out without delay for reasons related to health and safety. The Deputy-Ombudsman further emphasised that, due to the sensory deficiencies caused by a spinal cord injury, it had been particularly important that the assistive device (e.g. wheelchair) of a person with severe disabilities would be made usable, suitable and safe for the user as quickly as possible. Doing so would prevent health hazards caused by the wrong kind or otherwise unsuitable assistive device.

Under the Assistive Devices Decree, the need for an assistive device must be assessed in a way that is user-oriented, timely and individual. This also applies to essential accessories such as pads that enable the safe long-term use of a wheelchair.

In another decision 3072/2022* on a referral for an assistive device, Substitute Deputy-Ombudsman Sarja considered that a wellbeing services county's intellectual disability outpatient clinic had acted in violation of the Administrative Procedure Act, the Health Care Act and the Decree on Patient Documents, resulting in a situation where a child's constitutional right to adequate health services and the good quality of healthcare and medical care laid down in the Act on the Status and Rights of Patients had not been realised at the time.

The Substitute Deputy-Ombudsman emphasised that compliance with the provisions concerning the preparation of patient documents ensures the realisation of the fundamental right to legal protection and the implementation of adequate health services secured as basic rights.

The Substitute Deputy-Ombudsman considered this serious neglect. In the assessment of reprehensibility, the Substitute Deputy-Ombudsman took into account that the matter concerned issuing a referral for an essential assistive device for a vulnerable disabled child. The Substitute Deputy-Ombudsman also drew attention to the fact that the failure in the client process of the disabled child was due to both the lack of clarity in authorities' practices (referral practices) and negligence in preparing a referral.

In decision 5574/2022 concerning a child's occupational therapy, the Deputy-Ombudsman noted that the deadlines for access to treatment had been exceeded when a child's occupational therapy did not start until just over one year after the need for treatment had been established. The delay in the start of occupational therapy had been justified by the fact that there was a national shortage of occupational therapists and that the situation in the municipality had been difficult. The Deputy-Ombudsman could not be satisfied that the municipality had duly fulfilled its obligation to oversee the implementation of health services that it had outsourced but was still responsible for organising.

3.4.8
DECISION IN THE REGIONAL AND LOCAL GOVERNMENT SECTOR

Arrangements for a special advance voting facility at a psychiatric ward

In case 2319/2023*, the Deputy-Ombudsman issued a reprimand to a city's election authority (electoral commission) for future reference for a procedural error in the provision of information and communications on voting at a special advance voting facility. In addition, for future reference, the Deputy-Ombudsman drew the attention of the wellbeing services county and the central hospital to the general obligation of personnel to contribute to the proper implementation of voting at special advance voting facilities.

The Deputy-Ombudsman stated that the personnel of the central hospital and the wellbeing services county have an obligation to promote fundamental rights. In addition, the Deputy-Ombudsman drew the attention of the wellbeing services county and the central hospital to authorities' obligation to cooperate when arranging voting at special advance voting facilities.

The Deputy-Ombudsman considered that not all patients in the acute psychosis ward of the central hospital were able to vote at the special advance voting facility in the parliamentary elections in 2023. At the request of the electoral commission, the hospital had informed the ward patients in advance of the day of voting at the special advance voting facility. In the Deputy-Ombudsman's view, the key reason for the failure to implement the special advance vote was that the electoral commission had not agreed on or announced in advance the exact time at which the electoral commission would arrive at the psychiatric ward.

The Deputy-Ombudsman concluded that the loss of the complainants' access to voting at the special advance voting facility was primarily due to a procedural error by the responsible election authority – the electoral commission. The Deputy-Ombudsman considered the error to be serious because, as a result, some patients in the psychiatric ward had not been allowed to exercise their fundamental right to vote at the special advance voting facility.

The practices and procedures of an institution where voting takes place cannot result in a resident of the institution being prevented from exercising their constitutional right to vote. The report did not indicate that the hospital staff would have informed the election authorities that they had noticed problems with the implementation of the special advance vote.

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 NPM has the power to make recommendations to the authorities with the aim of improving the treatment and the conditions of persons deprived of their liberty and preventing actions that are prohibited under the Convention against Torture. It must also have the power to submit proposals and observations concerning existing or draft legislation.

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

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

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

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

3.5.2 OPERATING MODEL AND INFORMATION ACTIVITIES

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 NPM has provided induction training for external experts regarding the related visits. During the reporting year, the NPM had a total of 22 specialists available. Of them, 11 are healthcare specialists from the fields of care work, psychiatry, youth psychiatry, geriatric psychiatry, forensic psychiatry and intellectual disability medicine. Two social welfare experts are available for inspection visits focusing on child welfare. A further four 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 healthcare inspection visits.

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 shares information on inspection visits and related matters on social media.

3.5.3 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:

- The SPT organised a conference on 9 February 2022 to celebrate the 20-year-old OPCAT and the 15-year-old SPT. The topics discussed included good practices for the effective implementation of OPCAT and cooperation between all actors in the field and the sharing of ideas on future challenges
- The workshop organised for NPMs by the European NPM Forum and the Association for the Prevention of Torture (APT) on 14–15 February 2023 was titled "Monitoring mental health care in prisons"
- Internal training of the Office of the Parliamentary Ombudsman with "The reducing number of psychiatric assessments – causes and consequences" and "Assessment of the risk of violence and dangerousness of prisoners" as topics, LL.D Jussi Pajuoja, Director of Research, and Mika Rautanen, Specialist in Forensic Psychiatry, as instructors on 12 April 2023
- Seminar organised by the HRC titled "Implementation of the rights of vulnerable groups; challenges and results of research" with Professor Rosie Harding from Birmingham University as keynote speaker on 7 June 2023

- Discussion event held at the Little Parliament on 7 June 2023 focused on the work of the Ukrainian High Commissioner for Human Rights and practical preparedness in conflict situations
- Seminar organised by the Finnish Institute for Health and Welfare, the Health Care Services for Prisoners and the Prison and Probation Service of Finland titled "Health and well-being of prisoners 2023" (publication of the research report) on 21 September 2023
- Conference and symposium titled "Promoting autonomy in mental healthcare" organised by the Steering Committee for Human Rights in the Fields of Biomedicine and Health (CDBIO), the Latvian Ombudsman and the University of Latvia in Riga on 13–14 November 2023
- Webinar organised by Valvira on the topic "Monitoring and self-monitoring" on 15 December 2023.

In 2023, the Psychotraumatology Centre of the Helsinki Deaconess Institute launched a training project in compliance with the Istanbul Protocol. It was also attended by the coordinator of the NPM from the Office of the Parliamentary Ombudsman. The Istanbul Protocol is a manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment. The objective of the training project is to raise awareness of the use of the protocol to identify, investigate and document victims of torture. The meetings will continue in 2024. In addition, an e-learning course on the topic and a Finnish translation of the revised protocol are underway.

A separate induction into the NPM's mandate and duties is always organised to new employees of the Office of the Parliamentary Ombudsman. New employees are also informed about the rights of persons with disabilities and taking these into account on inspection visits. An induction with the same content is also arranged for new external experts before their first inspection visit.

3.5.4 INTERNATIONAL COOPERATION

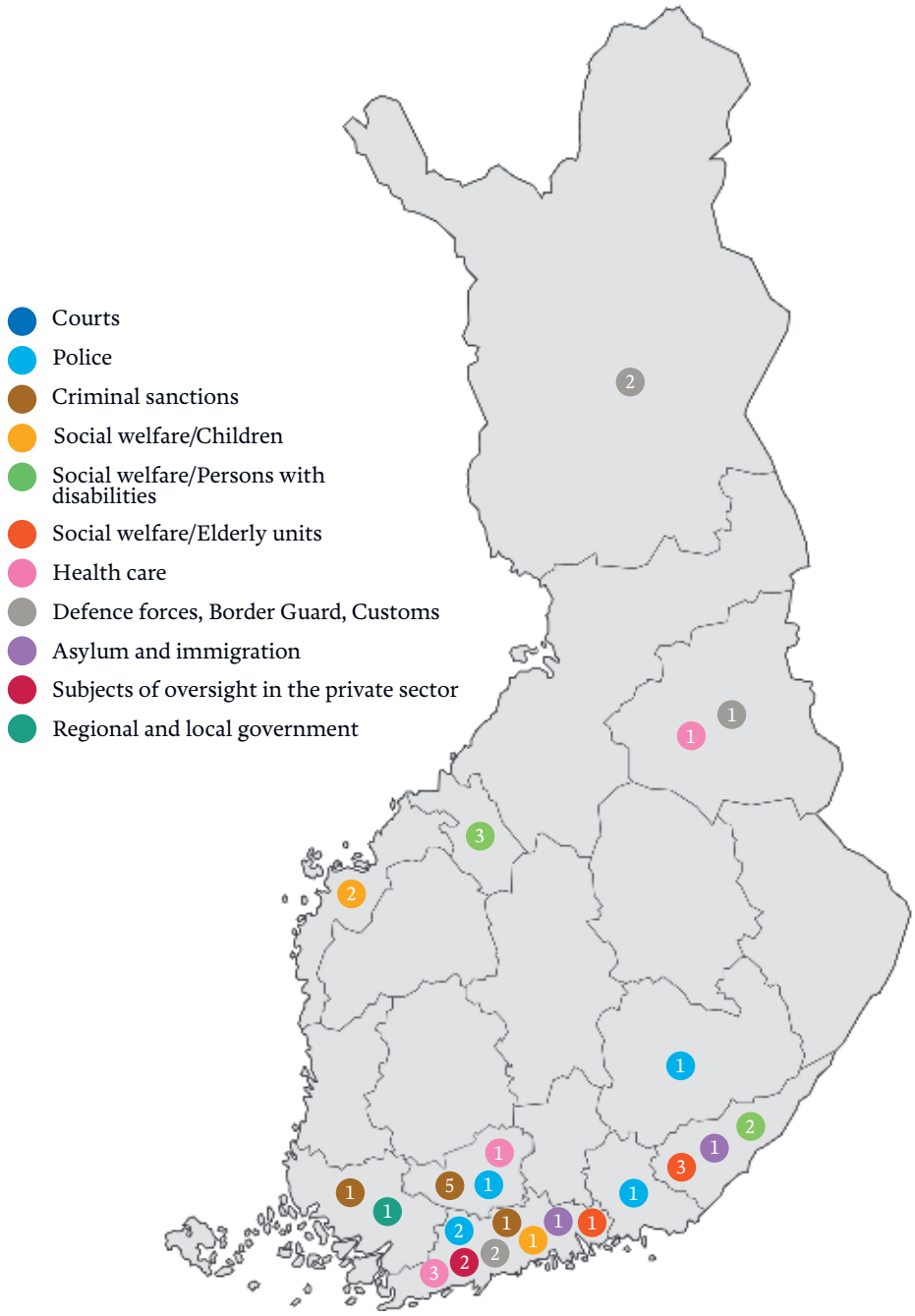
The NPMs of the Nordic countries meet regularly every year. Themes topical at the time have been discussed in each meeting. At the meeting held in Stockholm in September 2023, the themes included the effectiveness of the preventive work of the NPMs and minors and young prisoners as targets of supervisory measures.

During the year under review, cooperation was also carried out with the Baltic countries. On 24–26 January 2023, representatives of the Chancellor of Justice and the NPM of Estonia made a study visit to get acquainted with the activities of the Finnish NPM and the involuntary psychiatric treatment provided in Finland. Their programme included visits to the state forensic psychiatric clinic at Niuvanniemi Hospital in Kuopio and to the acute psychiatric ward of the City of Helsinki's Aurora Hospital. In September 2023, representatives of the Lithuanian Ombudsman also visited the Finnish NPM and Helsinki Prison to learn about their activities.

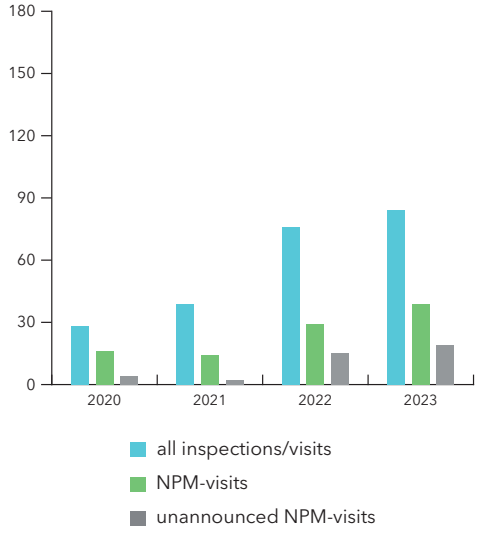
3.5.5 VISITS

Visits by the NPM in 2023

The NPM conducted 39 visits in the year under review (29 in the previous year). All inspections were carried out on site. The total number of inspection visits carried out by the Office of the Parliamentary Ombudsman was 84 (76 in the previous year). In addition, three of the Parliamentary Ombudsman's visits were related to the task of the NPM (see in paragraph 3.5.6 of this section).



NPM visits by region in 2023.



Visits in 2020–2023.

Half of the visits (19) were unannounced in advance. A total of 13 external experts were involved in 8 visits, which means that more than one expert was used on some visits.

Special themes to be considered during visits

For the second year in a row, the special fundamental and human rights theme of the Office of the Parliamentary Ombudsman was "oversight of oversight". The theme is discussed in more detail 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.

3.5.6 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 majority of apprehensions are due to intoxication, totalling approximately 42,200 cases in 2022. The second largest group is formed by persons suspected of an offence. In 2022, they numbered around 20,000, and almost 1,800 of them were imprisoned. In addition, some persons detained under the Aliens Act are kept in police detention facilities (also referred to as police prisons below).

Since the beginning of 2019, the detention of remand prisoners in police detention facilities for longer than seven days has been prohibited without an exceptionally weighty reason considered by a court. The aim is to have the responsibility for the custody of all remand prisoners transferred to the Prison and Probation Service of Finland by 2025. After this, those suspected of an offence would not be deprived of their liberty in police prisons for more than 96 hours at most.

Some fifty police prisons are used by the police. The NPM visits are usually carried out at police detention facilities unannounced.

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. The National Police Board carries out legality inspections on police detention facilities without prior notification. During the year under review, it inspected three police prisons.

Inspection visits

Date of Inspection	Target	Number of Places	Case Number	Other / Previous Inspection
16 February 2023	Hämeenlinna police prison	47 cells	1176/2023	previous visit in 2014
16 February 2023	Hyvinkää police prison	18 cells	1177/2023	previous visit in 2016
26 April 2023	Mikkeli police prison	17 cells	2868/2023	previous visit in 2011
7 June 2023	Kouvola police prison	27 cells	3669/2023	previous visit in 2017
21 November 2023	Helsinki police prison	132 cells	6432/2023	previous visit in 2018 (849/2028)
21 November 2023	Healthcare of Helsinki police prison	–	6434/2023	previous visit in 2018 (1488/2028)

With the exception of the Helsinki police prison, all other inspections were unannounced.

In addition to the above, the Ombudsman carried out an inspection visit at the National Police Board (6435/2023). The issues raised included the steering, supervision and development of the private security sector and the internal oversight of legality of the police.

In the year under review, the NPM also inspected the detention facilities of private security companies for the first time. These visits are described in paragraph 3.5.7 of this section. Inspections related to the supervision of the private security sector were carried out on the supervision of the private security sector conducted by the Helsinki Police Department (6431/2023), the Southeast Finland Police Department (2440/2023) and the National Police Board and its supervision unit of the private security sector (2235/2023).

The focus areas of the NPM inspections of **police detention facilities** included the following:

Working alone in detention facilities

In police prisons where the number of apprehended persons is small, custodial officers often have to work alone (see e.g. 2868/2023). The Ombudsman has found this very problematic, for example in terms of detention and occupational safety. Despite the Ombudsman's statements on the matter, no change is apparently possible until working alone is prohibited by legislation. The comprehensive reform of the act on the treatment of persons deprived of their liberty in police custody has been pending since 2015. It has still not been implemented since the Government proposal was not submitted to Parliament before the end of the parliamentary term in 2022. The main reason for this was apparently the fact that the funding required by the reform could not be arranged (see The Annual Report of the Parliamentary Ombudsman 2022, p. 91). The overall reform of the Act is not included in the current Government Programme.

Information on rights and obligations

In its recommendations to Finland, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has recommended improving the procedures of informing detainees of their rights.

The Ombudsman noted that almost all police prisons inspected had taken good care of informing those deprived of their liberty orally and providing written information on material that contains sufficient information on the practices of the detention facility. This had also been recorded as required by the instructions of the National Police Board. In some police prisons previously inspected, written material had not been kept on display in detention rooms. The explanation given for this was that it could be used to block the toilet. On the inspections carried out during the year under review, the detention facility staff had not identified such a risk to safety in detention (1177/2023, 2868/2023, 3669/2023, 6432/2023).

Health care for detainees and their right to see a doctor

Health care for detainees in police detention facilities has in most cases been arranged so that the police custodial officers of the detention facility ensure that detainees receive their medication prescribed for them outside the detention facility and that an emergency care unit is called to the facility in acute situations. This was the procedure in three units in the police prisons inspected (1177/2023, 2868/2023, 3669/2023). The Ombudsman recommended that police departments at least assess the need for regular visits by a nurse. He also recommended that all police departments should try to ensure that all persons deprived of their liberty for longer than 24 hours would get to see a healthcare professional. The same has also been recommended by the CPT.

The Eastern Uusimaa Police Department announced that it would at least assess the need for regular visits by a nurse (1177/2023).

The Eastern Finland Police Department reported that the arrangements would result in significant additional costs. According to its report, the recommendations may also affect the activities of other police departments, which is why they also sent their statement on the matter to the National Police Board for information (2868/2023).

During the inspections, the Ombudsman has still had to remind some police prisons of the guidance letter issued by the National Police Board in 2017. According to the letter, upon arrival, all persons deprived of their liberty must be informed of their right to receive healthcare in the detention facility at their own expense with the permission of the physician arranged by the police. The CPT has also required that the detainees be allowed access to their own doctor.

Medication

Police detention facilities have different ways of managing the medications of detainees. At Helsinki police prison, pharmacotherapy is provided entirely by healthcare professionals. The Ombudsman has also welcomed the practice used at the Hämeenlinna police prison. There, a nurse pre-doses the medicines to pill dispensers on weekdays and distributes the medicines to detainees. On the other hand, in other police prisons inspected, the custodial officers had to take care of the daily medication of the detainees.

The Safe pharmacotherapy guide requires that each unit providing pharmacotherapy has a pharmacotherapy plan. During his inspections, the Parliamentary Ombudsman recommended that police departments draw up a pharmacotherapy plan for their detention facilities. Of the police prisons inspected, only Helsinki police prison had such a plan.

The Ombudsman also recommended that all custodial officers participating in pharmacotherapy complete training on the distribution of medicines. In the police prisons inspected, this had been managed well. On the other hand, there was need for training related to the distribution and preservation of drugs classified as narcotics (2868/2023, 3669/2023).

In its statement, the Eastern Finland Police Department stated that it is not responsible for preparing training on the distribution of medicines and is thus unable to influence the content of the training. It announced that it would contact the National Police Board and investigate the matter.

Inspection visit of healthcare at Helsinki police prison

At the time of inspection, the responsibility for providing healthcare services in the police prison lied with the healthcare professionals employed by the police department and the nurses and practical nurses of the City of Helsinki sobering-up station, which operates in connection with the police prison. However, the employees at the sobering-up station did not participate in the healthcare of suspects of a crime. The inspection found out that the plan was to transfer the organisation of healthcare at the police prison in its entirety to the City of Helsinki in spring 2024. After this, the sobering-up station will be responsible for healthcare services in the police prison as a whole. In the preliminary view of the Deputy-Ombudsman, the arrangement promotes the patient safety and equality of persons deprived of their liberty better than the current system.

The police department expressed its support for reorganising the healthcare of persons deprived of their liberty. The current practice of the police prison in which two separate healthcare actors are responsible for the healthcare of detainees is not satisfactory in all respects, nor is it the most efficient or safest way of providing patient care.

On the previous visit by the NPM (1488/2018), it had remained unclear how the prison deals with minors deprived of their liberty. The new inspection visit revealed that training on the matter had been provided for the supervising staff and healthcare providers. According to the instructions, the police prison staff must report all minors deprived of their liberty to healthcare, after which a healthcare professional will meet the minor as soon as possible. In addition, the NPM was told that a healthcare professional meets all minors deprived of their liberty every day. The police contact the parents of a minor and file a child welfare notification. The Deputy-Ombudsman was satisfied that the responsibility and procedures for minors have become clearer.

After the inspection, the police department reported that training has been organised for supervisory staff and care personnel of the police prison on how to identify vulnerable persons. The purpose of the instructions given has been to create a mandatory notification procedure in which a physician or other member of nursing staff at the police prison is notified by email of any minors or other vulnerable persons deprived of their liberty.

The final opinions and recommendations of the Deputy-Ombudsman related to the visit of the NPM can be found in the visit report (6434/2023).

Measures following the inspection visit of passenger car ferry detention facilities

In November 2022, the detention facilities of a passenger ship were inspected for the first time under the NPM's mandate (6559/2022, see paragraph 3.5.6 of the Annual Report of the Parliamentary Ombudsman 2022). The inspection visit revealed a number of problematic issues concerning the vessel's facilities and the procedures followed there as well as the state of legislation – but also how the police supervise the activities. After the NPM visit, the shipping company announced having taken the following measures:

- police authorities have inspected and approved the detention facilities of the passenger car ferry
- instructions have been drawn up on submitting detention notifications to the police
- new mattresses have been procured for the detention facilities
- alarms have been ordered for the detention facilities to allow persons deprived of their liberty to contact security stewards.

In addition to the above, the inspection visit gave rise to four cases the Ombudsman took the initiative to investigate. These concerned, among other things, security steward activities on board ships and police supervision of these activities, as well as two cases in which women detained on board the ship had been ordered to remove all their clothes.

3.5.7 DETENTION FACILITIES OF PRIVATE SECURITY COMPANIES

During the year under review, the detention facilities of private security companies were inspected at the Kamppi shopping centre (Securitas Oy, 1488/2023) and Helsinki Central Railway Station (Avarn Security, 1974/2023) for the first time. These inspection visits were announced in advance.

The Ombudsman drew the attention of both companies to the careful recording of incident notifications. For example, an incident notification must be recorded of all situations involving use of force. He also stated that even though security stewards have the right of apprehension, they do not have the right to detention. Although no prohibited detentions were discovered, the Ombudsman emphasised that placing an apprehended person in a closed space alone should only be done out of necessity or in self-defence. He also stressed the importance of self-monitoring by companies.

3.5.8 DEFENCE FORCES

The treatment of person deprived of their liberty in the detention facilities of the Defence Forces is subject to the provisions of the Act on the Treatment of Persons in Police Custody. During these NPM visits, attention is paid to the conditions and treatment of detainees, their access to information and their security. During the year under review, the following four inspection visits were carried out, all of which were notified in advance:

Date of Inspection	Target	Case Number	Other / Previous Inspection
28 March 2023	Guard Jaeger Regiment detention facilities	1768/2023	previous visit in 2018
24 May 2023	Jaeger Brigade, Sodankylä detention facilities	3510/2023	previous visit in 2017
24 May 2023	Jaeger Brigade, Rovaniemi detention facilities	3511/2023	–
30 October 2023	Kainuu Brigade, detention facilities for persons deprived of their liberty	6866/2023	previous visit in 2017

The detention facilities of the Defence Forces are used quite rarely. During visits, they are usually not holding any persons deprived of their liberty. This was also the case in the year under review. In the inspected units, the number of detention rooms for detainees varied from one room (Sodankylä) to five rooms (Kainuu). On the annual level, the number of persons deprived of their liberty was about the same in all inspected units (10–20 persons) except in the Guard Jaeger Regiment. In 2022, their detention facilities had held a total of 100 detainees. In addition, there had been a significant increase in the number of persons deprived of their liberty in Kainuu.

The most common grounds for deprivation of liberty were desertion and intoxication. The duration of the deprivation of liberty is usually a few hours and seldom more than 24 hours.

When visiting detention facilities, the NPM pays particular attention to the following matters:
- standard of equipment of the detention facility and its safety
- arrival check, including inquiring about illnesses and injuries
- supervision of detainees
- information provided to detainees on their rights and obligations, language versions of the information
- access to outdoor activities
- basic maintenance (meals, shower, and toilet visits)
- number of supervisory staff and their training (use of force and first aid training, etc.)
- healthcare and first aid preparedness
- entries to records
- fire alarm system.

During the year under review, the furnishings of detention rooms were found to be very scarce in all units, except in one. The rooms only had a thin mattress on the floor. Based on the findings, those deprived of their liberty had their meals in the detention room. The Ombudsman stated that when it is necessary to serve a meal to a person deprived of their liberty, the conditions for eating should be such that they do not need to eat their meal either sitting on the floor or standing up (1768/2023, 3510/2023, 3511/2023).

The Jaeger Brigade reported that in Sodankylä the operative division had been given the task of organising decent conditions for having meals for those deprived of their liberty. This could mean, for example, providing a foldable table and chair that are moved to the detention room for mealtimes or arranging meals in other facilities. On the other hand, in Rovaniemi the detainees eat under supervision in the Main Guard kitchen, where they have a table and benches.

3.5.8 BORDER GUARD AND CUSTOMS

The Act on the Treatment of Persons in Police Custody applies to the treatment of persons deprived of their liberty detained in the facilities of the Border Guard and Customs.

No visits to the Customs detention facilities were made in the year under review. Instead, the NPM carried out an unannounced inspection visit of the Helsinki Border Control Department's detention facilities of persons deprived of their liberty at the Helsinki Airport on 11 December 2023 (6655/2023). The detention facilities were only intended for temporary and short-term detention (less than 12 hours). The matters in need of improvement detected during the visit included the way the detainees are provided information on their rights and obligations and the conditions in the detention facility.

3.5.9 THE CRIMINAL SANCTIONS FIELD

The Prison and Probation Service of Finland operating under the Ministry of Justice is responsible for the enforcement of prison sentences. Finland has 28 prisons, 15 of which are closed and 13 open institutions. The average number of prisoners has remained stable at around 3,000 prisoners for several years now. However, there have been signs of an increase in the number of prisoners in recent years, which manifests itself as overcrowding of closed prisons.

The Judicial Unit of the Prison and Probation Service of Finland (hereinafter the Judicial Unit) carries out its own oversight of legality in prisons. The Parliamentary Ombudsman receives an annual report from the Judicial Unit, which indicates, among other things, the oversight of legality inspections carried out by the Judicial Unit and self-monitoring measures of prisons. During the year under review, the Judicial Unit carried out inspections in four prisons and documentary inspections in three prisons. All decisions issued by the Parliamentary Ombudsman on the oversight of legality are processed in the Judicial Unit. The summaries of these decisions are sent to the personnel for information. The matrix group of legal guidance prepares proposals for measures related to, inter alia, the Ombudsman's opinions and the recommendations of the European Committee against Torture and Inhuman or Degrading Treatment or Punishment (CPT).

Surveys of staff and prisoners

The Office of the Parliamentary Ombudsman has introduced surveys 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. 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. Information provided by the responses helps the Ombudsman and the NPM to focus their inspection activities better than before. In the final discussion of the site visit, the prison is usually given feedback on its responses. The discussion focuses especially on issues the prison should pay attention to.

When visiting prisons, in addition to the surveys, usually both prisoners and staff are given an opportunity to come and talk to the NPM. The NPM also try to interview prisoners who do not volunteer to discuss matters or who may belong to vulnerable groups, such as minors, the elderly or disabled people. In the prison environment in particular, vulnerable groups also include women and those who belong to linguistic and cultural minorities or sexual and gender minorities. If necessary, interpretation is used.

Inspection visits

During the year under review, five prison inspection visits were carried out:

Date of inspection	Target	Number of prison places	Case number	Other / Previous inspection
13–14 March 2023	Riihimäki Prison, F and D wards	–	1186/2023	–
25 April 2023	Riihimäki Prison, C wards	–	2330/2023	–
1 June 2023	Hämeenlinna Prison	100	2868/2023	previous visit in 2014 and 2015 (family ward)
26 September 2023	Kerava prison	130	5747/2023	previous visit in 2018 (448/2018)
3 October 2023	Riihimäki Prison, accessibility inspection	206	6259/2023	–

Except for the accessibility inspection, the visits were announced in advance. The inspection of Riihimäki prison was divided into three parts. The first of them targeted the wards A and C1 on 17 November 2022 (5672/2022). A previous visit to Riihimäki prison had been carried out in 2016. The staff and prisoners in Riihimäki and Kerava prisons were sent a survey in advance.

Observations related to the accessibility inspection are discussed in section 3.4 on the rights of persons with disabilities. Two visits were made to Health Care Services for Prisoners; these are described below in paragraph 3.5.10 of this section. At the time of writing, the Deputy-Ombudsman's final opinions and recommendations concerning Kerava prison were not yet available.

Inspection visits carried out at Riihimäki Prison

During the inspections carried out at Riihimäki prison, the NPM paid attention to several issues. These observations can be read in the visit reports published on the Ombudsman's website. The Prison and Probation Service of Finland's Judicial Unit reported having held a meeting with the management of Riihimäki prison to discuss the findings of the second NPM visit. At the time of writing, no notifications of the measures taken after the third visit have been received yet from the prison and the Judicial unit.

Lack of resources

A particular issue that was raised during the visits to Riihimäki was lack of resources. It is common to the entire criminal sanctions sector, impacting the activities of prisons, the conditions of prisoners and the well-being of staff. It has been consistently considered in the Parliamentary Ombudsman's decision-making practice that the lack of resources cannot justify violations of rights in authoritative activities. Furthermore, the Ombudsman's task is not to monitor the sufficiency of the authorities' resources. However, this cannot be ignored if the lack of resources clearly affects, for example, the appropriate conditions and treatment of prisoners.

According to the Government report on the administration of justice (Publications of the Finnish Government 2022:67), the Prison and Probation Service of Finland is unable to fulfil its obligations. The Prison and Probation Service of Finland should be allocated an additional resource of 400 person-years by 2027. Raising the level of operations to the level required by legislation would require a significantly larger number of personnel by 2030 and the reform of the prison network.

After the NPM inspection visits, Riihimäki prison notified the Deputy-Ombudsman of its measures and generally stated that the resourcing of prisons was far from satisfactory. In Riihimäki, this was above all manifested as deficiencies in the activities offered to prisoners and their cancellations, in keeping cell doors closed and in the opening hours of the wards. It was known that savings measures would be targeted to Riihimäki prison in 2024, which would affect the use of substitutes. According to the prison, these measures had an impact on how the activities are organised. According to the prison, in overall arrangements, it should also be considered that the occupational safety of the personnel can be ensured.

In the NPM inspection visits carried out at Riihimäki prison during the year under review, the lack of resources – specifically the human resources – was reflected in how cell doors are kept open and how functions and leisure activities are organised, especially in the remand prison ward, the intensified supervision wards, and the high-security ward. The 8-hour minimum recommendation concerning time spent outside the cell was not realised and there was no meaningful and developmental activity available outside the cell.

After the NPM inspection visit, the prison reported that small-scale activities have been organised for prisoners living in the remand prison ward for a long time, but the number of personnel resources does not allow for sensible and meaningful activities for eight hours a day. It should also be noted that the institution has places for 20 remand prisoners, but, in reality, the institution had 50 remand prisoners on a daily basis.

According to the Prison and Probation Service of Finland's Judicial Unit, it was not possible to arrange visits to the sports hall for prisoners in the remand prison ward, as the current number of personnel did not enable it. Furthermore, it was not possible to increase the time outside the cell. On the other hand, it had been possible to increase study opportunities from October 2023 forward by providing higher education students with new computers. In addition, it has been possible for them to promote their studies in the library. It has not been possible to plan activities for the intensified supervision wards because the prison has not been given more personnel that would arrange activities.

The Judicial Unit also considered the situation worrying. However, the Judicial Unit considered it positive that, despite the difficult resource situation, efforts had been made to increase the activities and the time of keeping the cells doors open.

The Deputy-Ombudsman considered that the quantity and quality of activities for prisoners and leisure activities required by law were an extensive problem throughout the Prison and Probation Service of Finland, not just in Riihimäki prison. The Deputy-Ombudsman found it extremely worrying that he has had to repeatedly criticise the small amount of time allowed outside the cell and the fact that prisoners are not offered enough meaningful and developmental activities (e.g., 2066/2008 and 2336/2017). However, no change appears to have taken place. CPT-has also repeatedly and for a long-time paid attention to the importance of diversified activities as a guarantee of the welfare and dignity of prisoners.

Taking children into consideration – good practice

A picture book had been prepared for the small children of prisoners visiting the prison that described life in prison at the child's level. The Deputy-Ombudsman considered this a good example other prisons could follow. The Prison and Probation Service of Finland's Judicial Unit stated that it had forwarded the matter to the relevant unit.

Inspection visit carried out at Hämeenlinna Prison

Hämeenlinna Prison is intended for female prisoners and remand prisoners. The prison was opened in new premises in November 2020. It is Finland's first smart prison in which every prisoner has a personal cell terminal. This enables distance learning for prisoners, flexible contact with family and friends and increased rehabilitation opportunities. More information on the smart prison system and digital services can be found in the visit report.

Despite many positive observations made during the inspection visit, it was observed that in certain wards of the Hämeenlinna prison (remand prison and intoxicant-free contract ward) the time spent outside the cell was less than the recommended 8 hours. There was also room for improvement in the provision of meaningful and developmental activities.

Prison management said that they were aware of the lack of activity in the most closed wards. They were very positively inclined towards finding solutions to improve the situation. The prison actively develops new forms of activity, especially for the needs of female prisoners. In addition, efforts will be made to further increase access to shared facilities and classrooms.

In addition to the above, it was noted that the possibilities of prisoners placed in the youth ward to engage in social contacts remained very limited, even when they had plenty of time outside the cell. The Deputy-Ombudsman urged the prison to take measures to improve the situation. Separating minor prisoners from adult prisoners should not mean keeping them entirely alone. If there is only one or no more than a few minors in a facility and they lack other social contacts, activities can be arranged for them with adult prisoners in a selective manner, so that they would not need to be kept in conditions similar to isolation. In such matters, the child's best interests and adequate supervision must be considered.

Like in other prisons, challenges related to personnel resources also emerged in Hämeenlinna. The Deputy-Ombudsman found it worrying that the staff often had to work alone, which had an impact on occupational safety.

Prison management reported that it had identified priority areas to be developed in this respect and taken immediate action. For example, the prison had drawn up a timetable for closing certain activities if the number of personnel was critical. Concern about the overall situation of the prison had also been expressed to the management of the Prison and Probation Service of Finland.

3.5.10 PRISONER HEALTHCARE

Prisoner healthcare falls within the administrative branch of the Ministry of Social Affairs and Health. Health Care Services for Prisoners operates in connection with the Finnish Institute for Health and Welfare. In addition to the visits of the Parliamentary Ombudsman and the NPM, the National Supervisory Authority for Welfare and Health Valvira and the Regional State Administrative Agency for Northern Finland carry out guidance and supervision visits to outpatient clinics and hospitals of Health Care Services for Prisoners. The reports of the visits are sent for the information of the Ombudsman.

In September 2023, The Health and Wellbeing of Finnish Prisoners 2023 (WATTU IV), a joint health examination study between the Finnish Institute for Health and Welfare, the Prison and Probation Service of Finland and the Health Care Services for Prisoners, was published. The report takes a more diverse approach to the health and wellbeing of prisoners than earlier studies, discussing it from several different perspectives. In addition to the research results, the report presents several data-based recommendations and suggestions for further measures.

Inspection visits

Two inspection visits announced in advance were carried out in the Health Care Services for Prisoners:

- Health Care Services for Prisoners outpatient clinic at Riihimäki, 14 March 2023 (1107/2023)
- Psychiatric Prison Hospital of Health Care Services for Prisoners, Turku unit, 12–13 June 2023 (3067/2023), previous visit in 2019 (2570/2019)

Inspection visit at Riihimäki outpatient clinic

The greatest challenge in the operation of the outpatient clinic was related to the shortage of prison officer resources at the Prison and Probation Service of Finland. It could even prevent patients from being transported to an outpatient clinic inside the prison or for examinations or treatment outside the prison. This also concerned oral health care and was particularly related to the transport of patients from Jokela prison to their appointments at Riihimäki prison.

According to both Riihimäki and Jokela prisons, transport tasks outside the prison had increased considerably in recent years. This, combined with a continuous shortage of prison officer resources, has caused some appointments to be postponed. Both prisons sought to find a solution to the situation together with the Health Care Services for Prisoners.

The Deputy-Ombudsman stated that prisons must contribute to ensuring that prisoners receive the healthcare and medical care their state of health requires when a healthcare professional has assessed it as necessary. The shortage of prison officer resources had also emerged during inspection visits carried out at other Health Care Services for Prisoners outpatient clinics. Deputy-Ombudsman Pölönen paid attention to the matter, for example, when visiting the Health Care Services for Prisoner' management system in 2021 (1185/2021). The Deputy-Ombudsman emphasised in the visit report that the implementation of prisoners' healthcare must be treated with the appropriate gravity and immediate action must be taken to change the situation. The report was also submitted to the Ministry of Justice and the Prison and Probation Service of Finland.

Another important issue that was raised during the inspection visit was the outpatient clinic's concern about the adequacy of psychiatric services.

The Prison and Probation Service of Finland's management system announced that psychiatric services are being developed nationally and the aim is to introduce remote services throughout the country.

The Deputy-Ombudsman emphasised the importance of access to psychiatric services for those needing them. He considered the Health Care Services for Prisoners' plan to use remote connections to be worthwhile as such, but also stressed that patients should also have the opportunity to meet a psychiatrist in person. The Deputy-Ombudsman decided to take the own initiative to investigate access to psychiatric treatment in prisons (64/2024, pending). The report The Health and Wellbeing of Finnish Prisoners 2023 shows that prisoners suffering from psychosis are more likely to be subjected to isolation measures during their imprisonment. The report considers it important to ensure that prisons do not become an inappropriate place to put away people with serious mental illnesses.

Inspection visit of a psychiatric prison hospital

At the time of writing this report, the Deputy-Ombudsman had not yet prepared his final opinions and recommendations on the visit. The inspection visit findings included the following issues:

- it was possible to access psychiatric treatment without waiting time, whereas the waiting times to different examinations may be up to one year
- the duties and powers of the guards working in the hospital did not seem to be clear in all respects, and the Prison and Probation Service of Finland had not provided instructions on this
- the instructions on restricting the patient's right to self-determination seemed unclear, and there were also errors and inconsistencies regarding it

In addition to the above, the Deputy-Ombudsman presented a preliminary opinion on a matter concerning the possibility of a prisoner patient with a minor intellectual disability to initiate an application for a leave of absence. The NPM visit revealed challenges in this matter.

In this respect, the Deputy-Ombudsman gave a preliminary recommendation that the hospital discuss more generally how patients in need of special support could be helped to exercise their rights without having to rely on other patients. The patient may also need help in understanding the contents of bulletins, rules, and other similar documents if, for example, they do not know how to read well or do not understand well enough what they have read.

3.5.11
DETENTION UNITS FOR FOREIGNERS

Under section 121 of the Aliens Act, a foreign national may be held in detention for enforcing a decision on removing them from the country. The detention period may not exceed 12 months.

There are two detention units for foreign nationals in Finland. One is in Metsälä, Helsinki (40 places), and one in Konnunsuo, in connection with the Joutseno reception centre (69 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. The inspection visits carried out at reception centres have been carried out under the Ombudsman's mandate, because people are not prevented from leaving the reception centre.

The NPM strives to carry out regular visits to both detention units at about one-year intervals. In the reporting year, an inspection visit announced in advance was made to both units:

– Inspection visit to Helsinki detention unit, 26 April 2023 (2745/2023), previous visit in November 2021 (7238/2021)
– Inspection visit to the detention unit of the Joutseno reception centre, 12 December 2023 (7813/2023), previous visit in December 2022 (7487/2022)

There were two nurses working full-time at the **Helsinki detention unit**. Approximately 90% of the initial health examinations of persons deprived of their liberty could be carried out within 24 hours of arriving at the unit. No attempted suicides or more serious self-destructive behaviour had occurred in the unit among the detainees. At the time of the previous NPM visit, the unit had plans for psychological first aid training for staff, which had still not been implemented.

The **detention unit in Joutseno**, on the other hand, had experienced some self-destructive behaviour among those deprived of their liberty. In some cases, it was reported to have been related to the use of drugs in the unit. In the staff's view, the Act on the Treatment of Detained Aliens cannot properly intervene in the smuggling of drugs. Customs officials had carried out a special inspection at the detention unit in autumn 2023 at the request of the unit.

Based on the inspection findings, the Deputy-Ombudsman decided to take the initiative to investigate the legality of the decision on the isolation of a person deprived of their liberty (311/2024, pending).

3.5.12
Social welfare units for children and adolescents

The visits made to child welfare facilities by the NPM have been proven to have a far-reaching impact. The observations made during the visits have also led to an urgent amendment to the Child Welfare Act. Following the visits, many child welfare institutions have also reviewed their practices and rules as recommended in the visit reports. The findings of these visits have attracted a great deal of public attention, and awareness of rights has been raised among children placed in institutions.

Visits to child welfare institutions, the simplified complaint procedure and active awareness-raising have manifested themselves 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. In some cases, the monitoring efforts fall far short of satisfactory. Amended legislation has entered into force 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.

Inspection visits

Date of inspection	Target	Number of places	Case number
3 October 2023	Youth Psychiatric Residential Home Puro, units Skogsbacken 1 and 3, Vähäkyrö, private service provider	14 places in total	4480/2023
21–22 August 2023	Naulakallio Children's Home, Helsinki, maintained by the municipality	–	4983/2023
5 October 2023	Lagmansgården residential school, Pedersöre, state-run	11 substitute care places	5758/2023

Children gone missing from Child Welfare Services

The number of children and adolescents who leave substitute care provided by child welfare without permission and fail to return (hereinafter also referred to as runaways) has clearly increased over the past ten years. This has also been reflected in inspection visits carried out at child welfare institutions by the Ombudsman and the NPM.

In March 2023, Pesäpuu ry, a community developing the national child welfare work, published a report in Finnish "Kohti kansallista tilannekuvaa lastensuojelun sijaishuollosta kadonneista lapsista" ["Towards a national situational picture of children gone missing from child welfare substitute care"]. There are hundreds of children gone missing, i.e. runaways, from substitute care provided by child welfare in Finland each year. This extensive study shows that, when they go missing from substitute care, adolescents are at a significant risk of encountering serious violations of their rights. The young runaways may, for example, become victims of crime or end up committing crimes themselves, use intoxicants, encounter different types of pressure, threats and exploitation, which, at its most serious, meets the definition of human trafficking. Young runaways may even be in mortal danger. Despite this, it may happen that no one is looking for these young people.

The report states that cooperation that would be needed to find the adolescents gone missing and return them to the place of substitute care is prevented by the insufficient resources of child welfare institutions, social welfare and the police. Problems in the legislation also pose challenges. There is no common understanding between the actors on issues related to such matters as authority, responsibilities and operating models. In March 2024, the Hatkassa.fi website was launched to provide information for young people, their families and professionals.

At the beginning of 2024, based on the report, an analysis was also published with an aim to, for example, produce information to support decision-making, development work and practices (Hatkassa lapsen silmin – Analyysi lastensuojelun sijaishuollosta luvatta poistuneiden lasten kyselytutkimuksesta [In Finnish with English summary; Runaway experiences: An analysis of a survey of runaways from substitute care provided by child welfare], Outi Kekkonen & Elina Pekkarinen, Publications of the Office of the Ombudsman for Children 2024:1). The report states that by preventing young people from running away we can also reduce the use of intoxicants among children, and by preventing the use of intoxicants we can reduce experiences that may harm children. At the moment, not all places of substitute care are able to provide high-quality substance abuse and addiction treatment for children. Therefore, children using intoxicants are transferred from one place of substitute care to another. The report presents seven recommendations for measures that could be used to affect this phenomenon.

Inspection visits findings and measures

Children gone missing from the institution and the challenges related to finding them were discussed on every NPM visit. In **Naulakallio Children's Home**, the NPM was told that if a child leaves the institution without permission or fails to return to it, the employee on night shift does not have any opportunities to go and look for the child. The NPM was told that attempts had repeatedly been made to remedy this problem by requesting additional resources for the supervision of children at night. No such resources had been provided.

The units also experienced difficulties in obtaining executive assistance from the police to return a child to the institution. The **youth psychiatric units of Skogsbacken** reported to the NPM that the police were reluctant to look for runaway children. The **Lagmansgården reform school** reported that the police only provided executive assistance if the child who had run away from substitute care was in acute danger. The recommendations for measures in the above-mentioned report highlighted the question of whether any of the children that had run away from substitute care would not be in acute or concrete danger. At the same time, report called for the examination and renewal of operating instructions and official practices as well as the review of competences.

The Deputy-Ombudsman asked the City of Helsinki to clarify what measures child welfare will take due to observations made during the inspection visit of the Naulakallio Children's Home. A statement on the measures was requested not only for the visited children's home, but also more generally for all child welfare institutions run by the city. Among other things, a statement was requested on the following issues:

- **training and induction** of employees in child welfare institutions – training on the use of restrictive measures in particular and induction of new employees
- **sufficient resourcing** to ensure the presence of staff in daily life and enable stimulating activities for the child, especially when the child's freedom of movement continues to be restricted for a long time – the adequacy of resources also had to be taken into account at night, because, for example, the search for a missing child cannot be postponed to wait until sufficient resources become available
- **organising children's school attendance** during long restrictive measures (restriction of the freedom of movement) and substance abuse treatment
- the development of **detoxification and rehabilitation** for children placed in placement – how children's substance abuse problems are addressed in other units run by the City of Helsinki

Following an inspection visit of the **Lagmansgården reform school**, the school submitted a notification of the measures it had taken. At the same time, the school expressed concerns about children running away from the reform school and their drug use. These affected their ability to attend school and their unauthorised absence from school.

The school hoped for more effective means for substance abuse treatment of children. During the NPM visit, the seriousness of children's substance abuse problems was also revealed in the documents concerning children.

On the basis of the observations made during the NPM inspection visit of the reform school, the Deputy-Ombudsman decided **to take the initiative** to investigate the conditions and the protection of privacy in the isolation room at the institution, and the treatment of the child placed there.

3.5.13 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 to the Ombudsman about these units, which stresses the importance of the visits.

The basic rights of older people are continually restricted in social welfare service units, even though this is not regulated by law. The Deputy-Ombudsman has considered this a significant deficiency and proposed to the Ministry of Social Affairs and Health that the ministry should start drafting legislation on older people's rights without delay (3115/2020 and 4180/2020). 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 people can be avoided (3014/2022). In a proposal on supplementing the Mental Health Act (164/2021), the Deputy-Ombudsman additionally stated that the most urgent step would be adopting legislation for those sectors where it is completely lacking. This includes restricting a client's fundamental rights in somatic healthcare and care for older people.

Inspection visits

Date of inspection	Target	Case number
15 February 2023	Service Centre Mäntyrinne (24-hour service housing facility), Askola, service provider the wellbeing services county of East Uusimaa	1003/2023
23 May 2023	Kasarminportti Service Home (24-hour service housing facility for the elderly and persons with disabilities), Lappeenranta, service provider wellbeing services county of South Karelia	3110/2023
22 May 2023 24 May 2023	Pienniemenkatu Service Home (24-hour service housing facility), Lappeenranta, service provider wellbeing services county of South Karelia, inspection carried out during the evening hours and inspection carried out at the same facility in daytime	3353/2023

In addition to the above, inspection visits were carried out at the internal medicine and trauma rehabilitation wards of the City of Helsinki's Laakso Hospital on 9 March, 30 March and 27 April 2023 (1497/2023). The visits examined the treatment of elderly patients and the quality of service. An external expert was present during the visits.

All above-mentioned visits were unannounced. At the time of writing, the Deputy-Ombudsman's final opinions on all inspected sites are not yet available. They can be read in the final visit reports published on the Ombudsman's website (only in Finnish).

Observations and opinions concerning care units for older people

Resources – the lack of human resources was reflected in the quality of care and rehabilitation of the residents, end-of life care and night-time care as follows:

The staff felt that they do not always have the opportunity to take a rehabilitative approach to work. Due to shortage of staff, the staff did not always have time to assist people to get up from the bed, so they were left "to spend their day" in bed. The resident's shower day also had to be postponed every now and then, and the morning wash could not be started before midday (1003/2023). In the Deputy-Ombudsman's view, the staff should have the opportunity to spend time with the residents, monitor their condition and observe any changes in behaviour. In her preliminary opinion, the Deputy-Ombudsman considered it very important that the residents have a means of contacting the staff whenever necessary. On the other hand, she also emphasised that technical aids, such as safety bracelets, cannot replace staff presence and direct contact (3110/2023).

When it comes to locking the door of a resident's room, as her preliminary opinion the Deputy-Ombudsman stated that safety alone is not an acceptable reason for doing that. With insufficient staffing, locking the door of a resident's room may cause a serious fire hazard, even if the resident has asked for their door to be locked (3351/2023).

The visited units had few night nurses. One unit had one night nurse with 17 residents present (3110/2023). Another unit had one night nurse and 30 places (1003/2023). In her preliminary opinion, the Deputy-Ombudsman emphasised the employer's obligation to ensure that the operating unit has sufficient staff in relation to the needs and number of residents in each shift. The Deputy-Ombudsman expressed her concern about the sufficiency of night-time staff due to the residents' need for assistance (residents requiring two nurses for handling) and the special features of the building (three floors). The Deputy-Ombudsman also paid attention to the employer's obligation to ensure the safety of employees (3110/2023).

According to the staff, no additional staff was used in end-of-life care – not even at night when the unit had only one night nurse (3110/2023). In her statements concerning end-of-life care, the Deputy-Ombudsman stated that high-quality end-of-life care is an essential part of good care. End-of-life care poses demands on personnel competence and on the number of personnel (see, e.g., 2788/2022).

Outdoor activities – enabling outdoor activities for residents of service homes seems to be a constant challenge. This was also the case in the visited facilities during the year under review, although this varied.

In one unit, the staff carried out guided walking trips with residents, and the realisation of outdoor activities was monitored (3110/2023). In another unit, based on entries made, the amount of outdoor activities appeared to be low (3351/2023). Based on inspection visit's findings, not even an environment well suited for outdoor activities guaranteed that the residents would spend time outdoors. Outdoor activities were mainly carried out in the summer and even then, only once a week by volunteers. The unit also did not monitor the amount or realisation of outdoor activities (1003/2023).

In her statement concerning outdoor activities, the Deputy-Ombudsman referred to the guidelines of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), according to which residents should be provided with daily opportunities for outdoor activities, and the goal should be unrestricted access to outdoor activities. According to the Deputy-Ombudsman, daily outdoor activities are part of good care, and their realisation should be monitored.

It is a question of taking care of basic human needs and thus also about respecting human dignity. Special attention must be paid to those residents who are unable to move independently and cannot clearly express their views. Enabling outdoor activities must not depend solely on family members or volunteers (1003/2023).

Restrictive measures – a restrictive measure is a measure that interferes with a person's fundamental rights, such as the right to self-determination and freedom of movement. The Deputy-Ombudsman has commented on the use of restrictive measures in several decisions and visit reports (e.g. 3187/2020, 1129/2022).

Restrictive measures were also used in all visited units during the year under review. Restrictive measures include raised bedrails, the use of an anti-strip jumpsuit (a garment that a person cannot take off by themselves) and a pelvic belt, and locking the door of a resident's room so that the person cannot open the door themselves.

Shortcomings were detected in all visited units in recording the use of restrictive measures, such as writing down the time when the use of a restrictive measure started and ended. Other shortcomings were also identified. For example, the unit did not monitor the use of restrictive measures even though there was a ready-made form for this purpose. In her preliminary opinion, the Deputy-Ombudsman stated that based on the NPM inspection visit's findings, the unit did not comply with the wellbeing services county's instructions for recording and assessing the use of restrictive measures. The Deputy-Ombudsman also considered it a worrying finding that the unit's personnel considered accurate recording of the use of restrictive measures unnecessary. She underscored that 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 (3351/2023).

The Deputy-Ombudsman required that in the treatment of each elderly resident the number of restrictive measures used, the situations resulting in the use of restrictive measures and the intended outcomes and disadvantages related to the use of restrictive measures should be monitored. The Deputy-Ombudsman also considered it important that units draw up a plan containing concrete measures to prevent the use of restrictive measures. The plan should also contain information on options that could be used in different situations instead of restrictive measures (1003/2023).

Inspection visit of internal medicine and trauma rehabilitation wards at Laakso Hospital

Both wards visited were treating many elderly patients among whom a state of confusion (delirium) was common. The wards may have multiple delirium patients at the same time. Restrictive measures were routinely used in the treatment of these patients if the medication did not help in the situation or until it generated a response. Although the hospital had required that all staff members read the hospital's instructions on the use of restrictive measures, it appeared that both nurses and physicians were poorly aware of them.

The legality oversight authorities have considered that a plan for reducing the use of restrictive measures and monitoring their use are important if there is a genuine desire to reduce the use of coercive measures. This theme should be highlighted at all times so that the amount of restrictive approaches could also be kept as low as possible. The Deputy-Ombudsman recommended that the wards particularly review practices that are contrary to the hospital's own instructions. From the perspective of reducing the use of restrictive measures, the Deputy-Ombudsman also considered it important that, after each time a restrictive measure is used, consideration be given to how the situation could be avoided in the future and what other means would be available. The Deputy-Ombudsman emphasised that restrictive measures can only be used as a last resort. The lack of sufficient amount of personnel does not justify the use of restrictive measures.

The Deputy-Ombudsman considered it important that all employees using the system for reporting patient safety incidents (HaiPro) are aware that the notifications matter. This helps to ensure that notifications are made. The Deputy-Ombudsman considered it important that the management assess its own activities with regard to what the reception and processing of reports leads to. In addition, the management was to inform employees clearly about how notifications are processed, why filing notifications matters and what they lead to.

The Deputy-Ombudsman paid attention to the fact that hospital employees were under the impression that nothing could be done about these matters. The Deputy-Ombudsman decided to investigate separately on her own initiative how the hospital ensures that patients will not be restricted unnecessarily and in a degrading manner in the future, as had been done based on the NPM's findings.

3.5.14 UNITS FOR PERSONS WITH DISABILITIES

When visiting institutional care and residential service units for persons with disabilities, particular attention is paid to the use of restrictive measures as well as to the decision-making and record-keeping of these measures. Other important themes include the right to self-determination and privacy of persons with disabilities.

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.

Inspection visits

Date of inspection	Target	Case number
25 April 2023	Maria-Katariinatalo (institutional care, housing, temporary childcare, crisis and rehabilitation units for persons with intellectual disabilities), Kokkola, service provider wellbeing services county of Central Ostrobothnia	2324/2023
26 April 2023	Karelia home, Kokkola (residential unit with 24-hour assistance for persons with disabilities), private service provider Keski-Pohjanmaan hoitopalvelu Oy	2810/2023
26 April 2023	Mattila home (housing unit for persons with intellectual disabilities), Kokkola, service provider wellbeing services county of Central Ostrobothnia	2942/2023
24 May 2023	Kotimäki (housing unit for persons with intellectual disabilities), Lappeenranta, service provider wellbeing services county of South Karelia	3513/2023
27 August 2023	Examination and rehabilitation unit Tutka, Lappeenranta, service provider wellbeing services county of South Karelia	5357/2023

All of the inspection visits were unannounced. Three visits were joined by an expert in intellectual disability medicine.

The visit carried out at Maria-Katariinatalo was a continuation of a documentation inspection of the unit done between 16 June 2021 and 25 January 2022 (3995/2021). Observations and opinions given on the accessibility of the visited facilities are described in section 3.4 on the rights of persons with disabilities.

In addition to the above, during the year under review inspection visits were carried out at special advance polling stations in parliamentary elections located at the housing units of persons with disabilities and older people on 24 March 2023 (1546/2023). The visit aimed to examine, for instance, how the voting rights of the residents of the units were realised. The Deputy-Ombudsman decided to take the initiative to investigate procedures leading to a person denied the right to vote because their ability to make a mark in the ballot is considered essentially weakened (section 58(3) of the Election Act) or because it is considered that the person is unable to vote (Ministry of Justice guidelines).

Strengthening and restricting the right to self-determination

During the year under review, one of the important themes of the visits was how the sites consider the right to self-determination of persons with disabilities and how it is restricted. The culture of care adopted and the basic rights training provided to staff or the lack of such training affect how the operational units providing treatment and care in social welfare respect the right to self-determination and what is their attitude towards using restrictive measures. The visit reports describe in more detail the factors that should be taken into account if restrictive measures must be taken. Ultimately, the question of the legality of the use of restrictive measures falls within the competence of courts.

One of the units visited was intended for persons with disabilities other than intellectual disabilities. Thus, it was not possible to impose restrictive measures on residents in accordance with the Act on Special Care for Persons with Intellectual Disabilities (2810/2023). The unit's self-monitoring plan stated that the unit does not use restrictive measures or equipment. Despite this, the unit used raised bedrails and wheelchair seat belt restraints. Their use was justified with the resident's safety. In addition, the entrance doors of the unit were kept locked. The unit was examining whether employees could use a controlled physical restraint (HFR) technique if, for example, a resident refuses to shower (2810/2023).

The Deputy-Ombudsman emphasised that, in general, the realisation of the right to self-determination of persons with disabilities should be promoted and strengthened in the implementation of housing services. The Deputy-Ombudsman recommended that the service provider organise training for the staff on promoting the residents' right to self-determination and solving challenging situations. In addition, the Deputy-Ombudsman drew the service provider's attention to what has been stated in the visit report on restricting fundamental rights in operating units providing treatment and care in welfare services.

In other units visited, the use of restrictive measures was permitted, provided that a decision on special care had been issued for the person concerned and that the statutory requirements for the restrictive measure used were met. These units could say to the NPM that they did not use restrictive measures or equipment at all or that they were not being used at the time of the inspection visit. However, during or after the visit the NPM was informed that restrictive measures had been used on some residents in all units. For example, one unit had encountered situations requiring restrictive measures in case of individual residents (3513/2023). In another unit, a large number of decisions concerning confiscation of substances and objects had been made. Decisions on restrictive measures had also been made concerning the use of anti-strip jumpsuits (a garment that a person cannot take off by themselves), raised bedrails and pelvic belts on wheelchairs (2942/2023), etc.

A unit that produced examination and rehabilitation periods for special care clients also had to resort to using restrictive measures. Decisions on restrictive measures had been issued for one customer to allow forcible holding for the purpose of taking a blood sample and the use an anti-strip jumpsuit (5357/2023).

The Deputy-Ombudsman stressed that clients' right to self-determination cannot be restricted without an assessment of the need for the use of restrictive measures and a decision to use restrictive measures (5357/2023).

After the NPM inspection visit, the wellbeing services county reported that the update of the guidelines on strengthening the right to self-determination and the use of restrictive measures will be completed by summer 2024. In addition, the intention was to immediately focus on the procedures concerning the use of restrictive measures and corrections needed in them.

Agreeing on restrictive measures

The inspection visits also revealed that a lot of efforts were made to agree on matters with the residents to thus avoid using restrictive measures. For example, in one case it had been agreed with the residents that there would be a separate treat day and at other times treats would be kept out of the reach of the residents (2810/2023, 2942/2023 and 3513/2023). In addition, an agreement had been made with a resident that their wardrobes would be kept locked (3513/2023).

The Deputy-Ombudsman has emphasised (e.g. 1130/2022) that when agreeing with a vulnerable person on practices restricting their right to self-determination that are not laid down in the law, special attention should be paid to the fact that the person's consent is authentic and truly voluntary. If necessary, the expert group on demanding multiprofessional support must assess the client's ability to understand the significance of the agreements they have made (3513/2023).

Staff induction and training

The Act on Special Care for Persons with Intellectual Disabilities requires that the personnel of a special care unit be inducted to working methods and techniques that support and promote the realisation of the right to self-determination of persons in special care. It must be ensured that personnel are trained to prevent situations that would require the use of restrictive measures and to use restrictive measures in an appropriate manner. Training is relevant to ensuring good treatment and minimising the use of coercive measures. If the use of a restrictive measure proves necessary, the training aims to ensure that the measure is implemented in accordance with the human dignity of the person concerned and taking care of their health and safety.

The NPM inspection visit revealed that the unit's staff had not been given training on the right to self-determination (2810/2023). The Deputy-Ombudsman recommended that the service provider organise training for the staff of the unit on promoting the residents' right to self-determination and solving challenging situations.

The staff were not certain about how far the right to self-determination of persons with intellectual disabilities can be respected so that this does not lead to neglecting treatment and care. It remained unclear whether all staff members had received training in matters concerning the right to self-determination (3513/2023). At the examination and rehabilitation unit of the same wellbeing services county it was found out that the wellbeing services county made it possible for the personnel to participate in different training courses, but not all the employees of the unit had received training on the right to self-determination (5357/2023).

The Deputy-Ombudsman considered it important that sufficient induction and training be organised for the staff of the housing unit on how to strengthen the residents' right to self-determination and identify restrictive measures. The Deputy-Ombudsman also considered it necessary that the guidelines and self-monitoring plan concerning the strengthening of the right to self-determination and the use of restrictive measures be discussed with the personnel.

The wellbeing services county announced that extensive training on the right to self-determination will be held for all personnel in March 2024.

Measures following the NPM's inspection visit

In the visit report, the Deputy-Ombudsman urges the service provider to discuss the observations and opinions presented in the visit report together with the staff of the unit. In addition, it is required that the report be made available to the staff and residents and their families, for example, by displaying it in an easily accessible place, such as on the bulletin board of the unit.

The Human Rights Centre and the Parliamentary Ombudsman have produced a self-assessment tool to support special care operators' measures aiming to strengthen residents' right to self-determination. The tool consists of questions that guide housing service units to self-assess how well their activities and the operating methods adopted support and strengthen residents' right to self-determination. The self-assessment tool is sent as an appendix to the final report to the unit. It can also be downloaded from the HRC's website.

3.5.15 HEALTH CARE

Inspection visits

- Psychiatric wards at Pitkäniemi Hospital, Tampere, wellbeing services county of Pirkanmaa, 15–17 May 2023 (1234/2023), previous visits in April 2016 and in geriatric psychiatry in October 2019 (5592/2019)
- Psychiatric wards at Kainuu Central Hospital, Kajaani, wellbeing services county of Kainuu, 16–17 November 2023 (5780/2023), previous visit in March 2018 (727/2018)

Healthcare inspection visits were also carried out at the healthcare services of the Helsinki police prison (see in paragraph 3.5.6 of this section) and the Health Care Services for Prisoners (see in paragraph 3.5.10 of this section). In addition, an inspection visit in three parts was made at the City of Helsinki's Laakso Hospital with the focus on the treatment of elderly patients and the quality of service (see in paragraph 3.5.13 of this section).

The visit to Pitkäniemi Hospital was joined by three external experts. The inspection visit at Kainuu Central Hospital was joined by two experts. Both wellbeing services counties had been informed in advance that an unannounced visit to psychiatry would be carried out during 2023.

At the end of both visits, a discussion session was held to present preliminary findings and have a constructive dialogue. The sessions were attended by wellbeing services county management and hospital staff as well as by a representative of the Regional State Administrative Agency at the invitation of the Office of the Parliamentary Ombudsman. At the time of writing, the final report of the visit in Kainuu has not been drawn out yet, so NPM's findings have been presented for that part. The Deputy-Ombudsman's final opinions, recommendations and any other measures can be read in the report published in due course. Below are some inspection visit findings and (for Pitkäniemi) opinions and recommendations.

Overcrowding situation

The mental health and substance abuse units for adults were almost continuously overcrowded. It had been necessary to place two patients to almost all single rooms. When the room was shared with another patient, it was not possible to use it for treatment negotiations with the patient or for meetings with family members. A similar overcrowding situation could also be observed in the youth psychiatry ward. During the visit, the staff raised concerns about the continuous increase in patient numbers (5780/2023).

Lack of physician resources and its consequences

In the mental health and substance abuse ward for adults, the nursing staff felt that the lack of physician resources was visible, for example, in the fact that the use of restrictive measures had increased. According to the NPM's observations, the shortage of physicians also led to using restrictive measures for longer periods, as the physician did not have time to assess whether using them was necessary. This also resulted in unclear situations related to the use of restrictive measures. For example, the on-call physician had taken a stand on whether to continue the use of restraints by telephone, without coming on site to assess the patient.

Already back in 2019, the lack of physician resources had also led to adopting a practice, in which the observation of adult patients and their commitment to involuntary treatment is carried out at Oulu University Hospital. The patient is transported from Kajaani with an M1 referral to Oulu for observation. If the patient is committed to involuntary treatment after the observation period, they will be transported back to Kainuu Central Hospital. The ambulance drive from Kajaani to Oulu is about 180 km, and the journey takes about 2.5 hours in one direction (5780/2023).

"Outpatient care" of patients in involuntary care

The mental health and substance abuse ward for adults had a practice that allowed patients in involuntary care to stay on home leaves for several weeks or even months at a time and only come to the hospital for treatment negotiations or to receive injection medication. A person on home leave could be subject to a valid restriction on freedom of movement decision. According to the information received by the NPM, the practice was based on the fact that if the patient's condition deteriorated during home leave, they could be easily readmitted to the hospital. Therefore, there was no need to transport the patient to Oulu for a new observation period to get a decision to commit the person to treatment. At the time of the NPM's visit, a similar practice was also observed at the youth psychiatry ward. The ward had some 'day patients', of whom at least one had been committed to involuntary treatment. They went to upper secondary school independently and stayed at home but came to the ward for meals (5780/2023).

Long-term seclusion and restraining

The mental health and substance abuse wards for adults used restraining (limb restraints) more often than seclusion in one's room. One patient had remained continuously restrained for several hundred hours (5780/2023).

In her decision (4277/2019), the Deputy-Ombudsman proposed to the state forensic psychiatric hospital that, if seclusion continues for a long time, several professionals should be involved in assessing the preconditions for continuing the use of the measure.
The Deputy-Ombudsman recommended that the psychiatry of the wellbeing services county of Pirkanmaa should also carefully consider whether long seclusion periods were necessary and, if seclusion or restraining were prolonged, whether there should be several doctors involved in assessing whether it is necessary (1234/2023).

The Deputy-Ombudsman has considered it extremely important to improve the legal remedies for isolated and restrained patients and proposed that the legislation be supplemented in this respect (164/2021). She has also taken the initiative to investigate how the long-term seclusion and restraining of psychiatric patients is supervised by the Regional State Administrative Agencies (6408/2021, pending).

Use of magnetic belt as a restrictive measure

Magnetic belts were used in the geriatric psychiatry ward and in the memory disorder ward. The Mental Health Act does not contain separate provisions on the use of a magnetic belt to prevent the patient from moving if, for example, they are assessed to have a high risk of falling.

According to the standards of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), all types of restrictive measures and the criteria for their use must be laid down by law. The Deputy-Ombudsman considered it problematic that the psychiatric hospital uses restrictive measures in geriatric psychiatry that are not based on the Mental Health Act. On the other hand, the Mental Health Act does not take into account the safety equipment used in the care for older people, the use of which may sometimes be justified. There are no provisions on the use of such equipment in somatic care either.

The Deputy-Ombudsman considered it positive as such that effort are made to safeguard the safety of patients and that milder measures than limb restraints are used in connection with treatment. She also finds it good that the use of a magnetic belt is made visible so that it is recorded in the lists of restrictive measures. There are also risks associated with the use of a magnetic belt. Its use requires monitoring of the patient and inducting the personnel in the correct use of the device.

There have been plans to amend the provisions of the Mental Health Act on restricting the patient's fundamental rights during involuntary care for a long time. The Deputy-Ombudsman decided to send the visit report to the Ministry of Social Affairs and Health responsible for legislative drafting so that it can take into account the aspects related to the use of magnetic belts presented in the report (1234/2023).

Monitoring and reducing the use of restrictive measures

As an inspection visit observation, it was noted that the Kainuu Central Hospital did not systematically monitor the use of restrictive measures and did not have a plan for reducing the use of coercive measures. This was the case despite the fact that the Parliamentary Ombudsman had recommended this in the visit report of the psychiatric wards of Kainuu healthcare and social welfare in 2018 and that Kainuu healthcare and social welfare had announced that they had prepared a programme for reducing the use of coercive measures. This also included the monitoring of the use of restrictive measures. Pitkäniemi Hospital did not have a plan to reduce the use of coercive measures either and it did not monitor the use of restrictive measures. Instead, all wards used the Safewards method. The purpose of the model is to reduce the violence of patients and the restrictive measures used to control it.

The Ombudsman's oversight of legality has considered that systematic monitoring of the use of restrictive measures is important if the aim is to genuinely reduce the use of coercive measures. Monitoring the use of coercive measures without information on realised restrictive measures and the number of their use is difficult or impossible. The theme of the use of coercive measures should be highlighted at all times so that the amount of restrictive approaches could be reduced or kept as low as possible.

The Deputy-Ombudsman recommended that measures be taken in the psychiatry sector of the wellbeing services county to obtain statistics on the matter and to systematically monitor the use of restrictive measures. She also recommended that a separate plan be drawn up to reduce the use of restrictive measures. The Deputy-Ombudsman welcomed the use of the Safewards model. She also considered it important to be able to demonstrate its effects. If the effects cannot be verified, the use of the model may be forgotten or at least become superficial (1234/2023).

Access to outdoor exercise

The Deputy-Ombudsman has proposed to the Ministry of Social Affairs and Health that the right of patients in involuntary care to outdoor exercise be safeguarded by law (164/2021).

The Deputy-Ombudsman also considered that access to outdoor activities should be made possible for patients under observation or in seclusion to the extent possible. Routine practices on restricting outdoor exercise during observation are not acceptable. The Deputy-Ombudsman emphasised the importance of outdoor exercise as part of good care. She also urged service providers to take care of access to outdoors in new facilities where the urban environment poses different challenges for outdoor recreation (1234/2023).

During the inspection visit carried out in Kainuu healthcare and social welfare in 2018, the Ombudsman had already drawn the attention of the wards to the fact that patients' outdoor activities should not be restricted any more than necessary. After the NPM visit, Kainuu healthcare and social welfare reported that guidelines had been issued on outdoor activities and that the realisation of outdoor activities was monitored. However, on the basis of the inspection visit carried out during the year under review, a doubt remained whether the patients' access to outdoors was realised as instructed and whether the realisation of outdoor activities was monitored (5780/2023).

Prevention of inappropriate treatment

Neither of the hospitals visited during the year under review had a uniform procedure by which a patient, family member or staff member could report abuse of a patient within the hospital. The Ombudsman has encouraged healthcare units to establish such a procedure, which would be known to everyone and through which they could report abuse without negative consequences.

The visited hospitals used the HaiPro system for reporting safety incidents. However, the NPM was told in both units that the staff did not always bother to submit notifications because they felt that it was of no use. In Kainuu, it was also reported that the notifications were not always reviewed with the staff, so the staff were not informed of what the notifications led to.

In previous visit reports, the Deputy-Ombudsman has emphasised at a general level the management's responsibility for clearly defining what mistreatment of patients entails and informing the staff that this is not permitted and that there will be consequences for anyone committing such actions. According to the Deputy-Ombudsman, the hospital would benefit from clear staff guidance on the concept of mistreatment and on the process by which reports are handled. Patients and their families should also be provided with instructions on the matter. At the same time, it should also be made clear that reporting mistreatment or deficiencies will never lead to any negative consequences for the person filing the report.

In her statement concerning the Pitkäniemi Hospital, the Deputy-Ombudsman considered it important that the wards submit HaiPro notifications. The motivation to submit notifications is increased by the fact that the staff are aware of the significance of the notifications and the manner in which they are handled. The Deputy-Ombudsman recommended that the staff be encouraged to file notifications and that they are reminded of the purpose of the notifications, how the notifications are handled and what they can lead to.

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

More than 50,000 elderly people live in units providing 24-hour care. The shortage of care and nursing staff and problems in leadership erode the quality of the services provided by care homes. Shortcomings in nutrition, rehabilitation, assistance with using the bathroom, taking care of nappy changes and other hygiene, social interaction and outdoor activities have been a problem. Shortcomings have also been identified in relation to the frequency of doctor's visits, medical treatment and dental care. The customer capacity of care homes is not sufficient.

Hospitals and inpatient wards of health centres have older people queueing for a housing service for several months without opportunities to engage in outdoor activities and to sufficiently maintain their functional capacity and physical activity. Elderly people who are in an increasingly poor condition are cared for at home. Sufficient services to support living at home are not available and there are shortcomings in their quality and safety. Elderly people do not have sufficient opportunities to go out or to run errands and there are serious shortcomings in the availability of services such as home care, daytime activities, substance abuse services and mental health services for older people, rehabilitation at home, social work and social guidance.

The most vulnerable elderly persons have been left without the necessary care, sufficient nutrition and a living environment that does not endanger the person's health. Elderly persons with a memory disorder or a mental illness have repeatedly been placed in temporary accommodation for homeless people in the wellbeing services counties.

There are older clients with no dedicated worker appointed for them to monitor changes in their service needs and, if necessary, to contact the parties responsible for organising and providing social welfare and health care services. Social welfare professionals do not recognise those elderly persons who would be entitled to special support to get the healthcare and social welfare services they need.

There are no services applicable to special groups of older people. Elderly persons with chronic schizophrenia have been left without the housing services meeting their needs. There are not any appropriate service units for older people with substance abuse disorders.

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 almost entirely lacking. The rights of the elderly are unnecessarily restricted on the basis of health security and as a result of incorrect practices. Restrictive measures are used even if they endanger the customer's safety or even if there are other measures or actions available that interfere less with the freedom of movement or other implementation of self-determination. The Deputy-Ombudsman has repeatedly intervened in the inhuman treatment of older people and the use of strong restrictive measures during physical pain or end-of-life care.

Problems in a private care home may have continued for a long time before the situation is intervened in. The guidelines issued by Regional State Administrative Agencies have not always been followed, and issues have sometimes taken an unreasonably long time to rectify. Self-monitoring and retrospective oversight of the adequacy and quality of services provided to customers at home has also been insufficient. Now that the monitoring responsibility of municipalities has ended, the self-monitoring by wellbeing services counties has only just been launched and sufficient coverage and competence have not yet been reached.

There are still deficiencies in decision-making and in taking into account and recording the opinion of an elderly person. The authorities are not familiar with the social welfare legislation concerning the elderly, and older people and their families are not given information about their rights and the consequences of different options in a way that they can understand. For example, spouses are not told about their right to live together or about the different options in the implementation of housing services. The legal protection of elderly persons is violated by not issuing a negative decision, for example, on admission to service housing with 24-hour assistance or increasing home services, even though an application has been submitted. When a public authority does not make decisions on organising the services, the wellbeing services county does not receive information on services that are lacking. As a result, the customer's right to bring a matter concerning the scope of the wellbeing services county's responsibility to organise services in the municipality to be investigated by an administrative court is not realised.

Digitalisation of the authorities' services may endanger the availability of services for elderly persons in all administrative branches.

Shortcomings in the implementation of child welfare

The general lack of resources allocated by wellbeing services counties to child welfare services and, in particular, the poor availability of qualified employees and the high turnover of employees impact negatively 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 provisions of the Child Welfare Act and the Police Act on searching children who have left the place of substitute care without permission and the provisions of the Act on the Status and Rights of Social Welfare Clients on executive assistance contain deficiencies that may seriously endanger the interests of children who have been placed into care. Children who have gone missing from their place of substitute care are in practice left without the safety net provided by society and the people close to them. These children placed in substitute care are in a vulnerable position and may be in concrete danger when they leave without permission. For example, they are at a great risk of becoming victims of abuse or offences.

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 the social welfare authorities of the wellbeing services counties, 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, services and digital services and in the implementation of reasonable accommodation.

Practices vary with regard to the restriction of the self-determination right of people in institutionalised care and in the housing units of service housing with 24-hour assistance. 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 wellbeing service counties, 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. In the year under review, inspections ordered by the Deputy-Ombudsman were for the first time conducted at special advance voting facilities. A number of problems that may have limited the actual use of the right to vote were detected in the practices of the electoral authorities and the institutions in which the voting was organised.

Long processing times of the Finnish Immigration Service

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. The processing of citizenship applications by the Finnish Immigration Service is also congested and the processing times are very long. For example, the Parliamentary Ombudsman has in his decisions considered the situation in the processing of residence permit applications based on family ties to be very unsatisfactory.

According to the reports received from the Finnish Immigration Service, the processing of the cases has been delayed for reasons such as an increase in the number of applications as well as insufficient resources.

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.

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.

The Government proposal for an act on the treatment of persons in police custody and certain related acts was meant to be submitted to Parliament in 2022, but this did not happen. Many parts of the act have become outdated and it would be necessary to reform it.

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

There are shortcomings in the provision of statutory health care services. The Parliamentary Ombudsman's oversight of legality repeatedly reveals shortcomings in organising services and patients' difficulties with access to treatment within a reasonable time. The patient may not receive the appropriate examination or treatment or access to treatment may be delayed.

The adequacy and availability of healthcare personnel is a nationwide problem in almost all the professional groups. In particular, there is a shortage of specialists in psychiatry. The psychiatric wards of hospitals are often overwhelmed and the number of patients exceeds the number of beds on the wards.

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.

The requisite legal basis for restrictive measures is still lacking in somatic health care. There is therefore no legislation on restraining, for example, in connection with pre-hospital emergency care, urgent and emergency health services or care of elderly persons on inpatient wards. Some emergency and care units have secure rooms, in which aggressive and intoxicated patients can be placed. There is no legislation governing them or the authority to use them, either. The lack of unambiguous legislation that sets down precise limits for the necessary restrictive measures used in healthcare units is unsatisfactory from the point of view of legal protection of both the patient and the staff.

The provisions on involuntary treatment in the Mental Health Act are also partly deficient. The Act does not lay down any 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 Act lay down 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 provisions on the competencies of the accompanying personnel. The lack of a legislative framework repeatedly results in situations that are problematic and dangerous. There are also other deficiencies in the Mental Health Act, for example, in terms of the legal remedies available to patients.

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 and sufficient support for learning and school attendance is not always observed. Many pupils still continue to experience bullying, violence and harassment at school.

The personnel resources in student welfare are insufficient in many places. This means that pupils do not receive the individual support they need and that there is no time for the collective pupil welfare services that promote wellbeing and safety in the study environment.

The legislation governing primary and lower secondary education is partly open to interpretation, and shortcomings in administrative procedures and decision-making are highlighted in the organisation of support for learning.

Long professing times in legal processes and shortcomings in the structural independence of the judicial system

Delays in legal proceedings remain a problem in Finland. This is because of insufficient resources, but also because not all of the corrective measures that have had to be taken since the process reforms of the 1990s have been completed yet.

As noted in a statement by the Deputy Ombudsman (471/2023), issuing provisions on the small claims procedure would make up an important part of these corrective measures. Delays in the courts of appeal give particular cause for concern. Although the relevant acts have been approved, it has still not been possible to introduce into use the admission of evidence based on watching videos in the courts of appeal because the courts have not managed to acquire the technical equipment required for it in their court rooms.

A positive development is that, every year, the level of the appropriations allocated to the administrative branch of the Ministry of Justice is always higher than previously in the central government spending limits included in the General Government Fiscal Plan. The higher level of appropriations is based on the first ever Government Report on the Administration of Justice and its operating conditions (VNS 13/2022 vp). According to the report, a total of approximately 1,200 person-years will be needed by 2030 to secure the operating conditions of administration of justice. This requires that the basic funding for the administration of justice is increased permanently by EUR 90 million per year on average.

High trial costs and court fees can prevent due legal protection. Finland has the lowest number of civil cases going to court in Europe.

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. The most recent example of the constitutional problems caused by the premises strategy is the government proposal (HE 63/2023 vp.) according to which the security checks of the courts should also be made to apply, for example, to clients of debt counselling or public guardianship offices because they have to use the shared entrance of courts and other agencies to enter the shared premises referred to in the Government Premises Strategy.

The regulation of the independence of courts at the constitutional level in Finland is limited. The independence of the courts can easily be undermined by legislative changes that appear to be technical in nature or by indirect administrative arrangements. The work of judges depends on matters such as continued pay, the availability of offices, the functioning of ICT systems and occupational safety. If these matters are left to administration outside the court system, the executive powers have, in principle, dangerous means at their disposal to influence the work of the court system.

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.

The prosecution service is part of the judicial system. However, the position of the independent prosecution service has not been expressed at the level of the Constitution in the same way as that of judges, and the right of the Prosecutor General and other prosecutors to remain in office is not equal to that of judges.

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.

The oversight of legality has focused on matters such as unreasonably long processing times (21–26 months) in the Tax Administration regarding claims for revised decisions concerning taxation. The processing times of matters related to guardianship and the registration times related to changes of names and changes in family relationships that have taken place abroad are also often unreasonably long in the Digital and Population Data Services Agency. 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 a constant in the oversight of legality.

With the digitalisation of services, shortcomings have emerged in the provision of services and communication, especially for persons in a vulnerable position.

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 for example been discovered in decision-making related to invoicing and enforcement and in informing customers about their rights.

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. In 2021, the Ministry of Justice 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 was particularly meant to 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 examined whether damage caused by incorrect or neglected guidance by public employees should be compensated in more cases. The report of the working group was completed in early 2023. It is not known whether the report of the working group will lead to legislative action.

3.6.2 Examples of positive development

This section of Parliamentary Ombudsman's reports for 2009–2014 has usually contained examples of cases in different branches of administration where, as a result of a statement or proposal issued by the Ombudsman or otherwise, there has been favourable development with respect to fundamental or human rights. The examples have also described the impact of the Ombudsman's activities. The cases are no longer included in this section.

For the Ombudsman's recommendations concerning recompense for mistakes or violations and measures for the amicable settling of matters, see section 3.7. These proposals and measures have mostly led to positive outcomes.

3.7
The Ombudsman's recommendations for recompense

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. In most cases, they have 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 the complainant to enjoy their rights, bring about an amicable settlement and avoid unnecessary legal disputes. The Committee has considered it a positive development that the focus of the Parliamentary Ombudsman's tasks has shifted even more clearly from the oversight of authorities to promoting fundamental and human rights. The grounds on which the Ombudsman recommends recompense are explained more extensively in the 2011 and 2012 annual reports (p. 88 and p. 71).

Recompense was recommended in 13 cases in the reporting year. In several 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. The State Treasury sends all decisions on recompense under the Act on State Indemnity Operations to the Ombudsman for the Ombudsman's information, as agreed.

In the year under review, a total of 1,324 claims based on the State's general liability were filed with the State Treasury. Three cases were initiated as a result of a proposal for recompense made by the Parliamentary Ombudsman. In the year under review, no cases were initiated in which compensation would have been paid on the basis of a ruling of the European Court of Human Rights.

A total of 1,036 decisions were issued during the year under review. The number of decisions was almost the same as in the previous year (1,039 decisions). During the year under review, a total of approximately EUR 820,000 was paid in compensation. The amount of compensation paid decreased considerably from the previous year, when the compensations amounted to approximately EUR 1.4 million. The largest amount of compensation was paid in the administrative branch of the Ministry of Justice (EUR 507,000). The next highest amounts of compensation were paid in the administrative branches of the Ministry of Economic Affairs and Employment (EUR 121,500) and in the administrative branch of the Ministry of Justice (EUR 70,000).

During the year under review, the largest number of claims filed concerned the administrative branch of the Ministry of Justice (797). Similarly to the previous years, the large number of filed matters was caused especially by the claims for damages concerning the office of guardianship services of the state's legal aid and public guardianship districts. The compensation amounts paid varied from a few euros in delinquency charges of bills and taxes to thousands of euros. In addition to unpaid invoices, compensations were based especially on social security benefits that had not been applied for and insurances and telephone or electricity contracts that had not been terminated or transferred, among others.

In the administrative branch of the Ministry of Justice, compensation was also paid for extra legal costs (EUR 21,685.81) resulting from a matter concerning unjustified dismissal from an employment relationship having been processed twice in a district court for a reason caused by the chairperson. In another case, compensation was paid for the unreasonably long processing time in a district court (3 years and 1 month) in a civil matter concerning a defect in a property transaction. Compensation for financial damages was paid to the amount of EUR 3,396.87. Compensation was also paid in a case in which a public legal aid attorney had neglected to invoke the time limitation of a debt in court proceedings when attending a case allocated to them. The damages amounted to EUR 23,124.09.

In the administrative branch of the Ministry of Economic Affairs and Employment, compensations were paid for erroneous actions of the Employment and Economic Development Offices. In one of the cases, the TE Office recovered a pay subsidy on incorrect grounds, which resulted in a total compensation amount of EUR 20,713.62. In another case, the compensation for financial damages amounted to EUR 7,713.29 as, when making the decision on the unemployment benefit, the TE Office had not taken into account that the applicant had been working as a family carer. The applicant had received incorrect advice from the TE Office and an incorrect labour policy statement, as a result of which the applicant's unemployment fund was recovering the overpaid unemployment allowance. Compensation was also paid in a case in which the Social Security Appeal Board had detected at the appeal stage that the TE Office had in its actions neglected its usual procedures in investigating the continuation of the applicant's job search. In addition, the appropriate labour policy statement had not been issued on time. The compensation amounted to EUR 3,308.91.

In the administrative branch of the Ministry of Defence, the State Treasury paid compensation for damages caused to a parked car by the air current from a Defence Forces helicopter. Compensation was also paid for the damages caused to a boat and fishing nets by a Defence Forces drone and for the broken windscreen of a car which was a result of the shock wave from an overflying Air Forces fighter plane. Compensation totalling EUR 8,750 for pain and suffering and other temporary harm was paid to a conscript in a case in which the conscript fell under an all-terrain tracked carrier in a competition that was part of the service duty. The conscripts participating in the competition had not been given instructions on how big a distance they should leave to the car of the all-terrain tracked carrier, nor how close to the car it was safe to be during the towing. Instructions had also not been provided on whether the all-terrain carrier should have had a driver/brakeman during towing. After the accident, the task related to towing an all-terrain tracked carrier was removed from the competition programme.

In the criminal sanctions field, compensations were most commonly paid in cases concerning objects that had been lost or broken in prison (e.g., an electric toothbrush, pair of glasses, earphones and a phone). In one case, compensation was paid for a completed community service that had been exceeded by four hours. In another case, a prisoner was compensated for suffering after his release was delayed because of an error in the computer system. In a third case, a prisoner was compensated for the fact that, because of a fault in the Roti system of the Prison and Probation Service of Finland, the prisoner ended up in a closed prison instead of an open prison. Because of the fault, a sentence plan could not be drawn up for the prisoner. The prisoner could therefore not participate in the work or training activities approved by the prison, for which the prisoner could have been paid an activity allowance. Because of the fault in the system, the prisoner could not be transferred from the closed prison to an open prison on time. The prison had made several repair and service requests during the autumn and winter in order to have the discovered faults in the Roti system repaired. The faults were not repaired until January the following year. A total of EUR 996.45 was paid to the prisoner as compensation for the activity allowance that they had not received.

In the administrative branch of the Ministry of the Interior, compensations were paid, for example, for the Finnish Immigration Service having forgotten to take the applicant's fingerprints in connection with submitting a residence permit application. As a result, the applicant had to travel to the office of the Immigration Service again.

In another case, compensation was paid because the Finnish Immigration Service had unduly cancelled a person's Finnish passport, which was noticed at the airport. The person had to get a temporary passport and a new flight and lost some of the reservations that had been made for at the destination.

EUR 1,580 was paid in compensation for the actions of the Finnish Customs when the claimant's car was damaged in the X-ray scan performed in connection with border crossing. Compensation for the actions of the police were paid (for example) to the amount of EUR 300 for an unjustified search of a home and EUR 220 for unfounded deprivation of liberty. In the administrative branch of the Finnish Transport Infrastructure Agency, compensation was paid, for example, for slipping accidents in winter weather.

3.7.2 RECOMMENDATIONS FOR RECOMPENSE

The following itemises recommendations for recompense for the reporting year, some of which have not yet received a response from the relevant authority.

Decisions concerning the proceedings of the Criminal Sanctions Agency and the Police

Treatment of a prisoner

A complainant was placed in a cell with a prisoner who subsequently attempted to commit suicide and was stopped by the complainant. The complainant had to remain in the cell, and it was possible that the complainant had to clean up after the suicide attempt. The complainant's constitutional right to safety had been violated. The Deputy-Ombudsman recommended that the Criminal Sanctions Agency and the State Treasury consider how the violation of the complainant's right could be recompensed (7663/2022).

The State Treasury paid EUR 2,000 in recompense for the violation of fundamental and human rights. The Criminal Sanctions Agency reported that the Ombudsman's opinion has been addressed at internal training events and that employees have been informed of it extensively.

Excessive length of a pre-trial investigation

The Ombudsman issued a reprimand to the head of an investigation and investigator when the pre-trial investigation of a case concerning procuration and human trafficking had been on hold for almost four years without an acceptable reason. The prosecutor had decided not to prosecute due to the absence of evidence. The Ombudsman also criticised the police department's procedure for the supervision of delayed cases. The Ombudsman recommended to the State Treasury that the injured party be recompensed for the pre-trial investigation having lasted unreasonably long due to a reason that was caused by the police (388/2022).

The State Treasury reported that it had paid the injured party EUR 4,500 in recompense.

Decisions on social welfare and social insurance

Misuse of emancipation funds

Emancipation funds accumulated during substitute care referred to in the Child Welfare Act had been used for expenses (such as buying food) that should have been part of the aftercare support arranged by authorities. This resulted in financial loss for a young person. The Deputy-Ombudsman recommended that the authority recompense its incorrect actions to the young person (4836/2023).

The social welfare, healthcare and rescue services of the City of Helsinki reported that they had paid the young person EUR 5,024.50 in recompense.

Deficiencies in the processing of a social assistance application

There were several errors and deficiencies in the processing of an application for social assistance: Kela had not assessed a complainant's need for urgent social assistance for medicines and did not take into account their individual circumstances, counselling had been incorrect and incomplete, an application had not been resolved within the statutory deadline, and the granting of a one-time payment commitment to the complainant for the purchase of medicines had not been assessed. The complainant's constitutional right to appropriate handling of a matter had not been realised. The Deputy-Ombudsman recommended that Kela consider recompensing the violation of the complainant's right (2057/2022).

Kela reported that it had sent the complainant an apology letter and paid EUR 25 in recompense.

Referral to food aid instead of resolving an application for social assistance

The urgency of a complainant's social assistance application had not been assessed in a timely manner due to a backlog in urgent services, and Kela had referred the client to food assistance. Kela could have granted urgent assistance with a payment commitment. The complainant's right to receive medicines prescribed to treat an illness in a timely manner with a payment commitment issued by Kela was also compromised. The Deputy-Ombudsman proposed that Kela consider how it could recompense for the delay in securing subsistence caused by its procedure (2852/2022).

Kela reported that it had paid EUR 50 in recompense and apologised for its procedure.

Requirement of a new child maintenance agreement

Kela's referral to have a new child maintenance agreement confirmed by a child welfare officer was unnecessary and contrary to the Administrative Procedure Act. The referral delayed the decision-making on social assistance and was likely to cause confusion as to why Kela would not accept existing, confirmed child maintenance agreements. In addition, Kela had also disclosed confidential information in the hearing letter to the person liable for child maintenance by including the information that the complainant's family were receiving social assistance. The Deputy-Ombudsman reprimanded Kela for the unlawful and incorrect procedure and recommended that Kela consider how it can recompense the complainant and the complainant's underage children for endangering their social security (1670/2022).

Kela stated that changing the procedure and emphasising the role of social assistance would not be in line with the Child Maintenance Act or the Act on Social Assistance or in the best interest of the child. Kela will investigate a person's current ability to provide maintenance if it is clear that a person liable for child maintenance has income or funds that they could use to participate in the maintenance of their child. However, Kela will stop referring clients to a child welfare officer in decisions on social assistance. Kela paid the complainant EUR 50 in recompense.

Delayed and careless processing of a social assistance matter

Kela's actions were in many ways negligent and in violation of the Act on Social Assistance and the Administrative Procedure Act: an application for social assistance was not processed within the statutory deadline, the complainant was asked to provide unnecessary additional information, the additional information provided by the complainant was not taken into account in the decision-making, the decisions were inadequately justified, and all the individual circumstances of the matter and the complainant's life situation were not appropriately taken into account in the decision-making. The decision on sickness allowance did not involve individual consideration of the reasonableness of the recovery of funds. The Deputy-Ombudsman reprimanded Kela for unlawful conduct. As the conduct by Kela was likely to weaken the complainant's trust in official actions and the credibility of the exercise of public authority, the Deputy-Ombudsman recommended that Kela consider how it could recompense the complainant and their child for endangering their social security due to the unlawful procedure (677/2022).

Kela reported that it had paid EUR 150 in recompense and apologised for its incorrect procedure.

Delay in processing a travel compensation complaint

The Deputy-Ombudsman's substitute reprimanded Kela for undue delay in processing a complainant's travel compensation complaint and for neglecting the service principle. The complainant had appealed against a travel compensation decision in February. Kela had already decided in March that the appeal could be approved, and the matter had been referred for processing as a revised decision. However, Kela did not issue the compensation decisions until December. In its decisions, Kela paid almost EUR 4,000 in compensation to the complainant. The Deputy-Ombudsman's substitute recommended to Kela that it recompense the complainant for the undue delay in processing the matter and for the additional concern and trouble caused to the complainant (6801/2022).

Kela reported that it had apologised to the complainant for the delay in processing the matter and for the additional concern and trouble caused to the complainant, and that it had paid EUR 100 in recompense.

Decisions concerning healthcare

Failure of pain relief during surgery

A complainant suffered severe pain during an operation and did therefore not receive good care and treatment respectful of human dignity as laid down in the Act on the Status and Rights of Patients. In addition, the processing times of the complainant's request for medical records and objection and claim for compensation were too long. The Deputy-Ombudsman recommended that the authority consider how it can recompense for the violation of the complainant's rights (543/2022).

The authority reported that the complainant was paid a recompense of EUR 1,000 for the very severe and longer than momentary sensation of pain caused by the surgery. The authority had also apologised for its incorrect procedure.

Discontinuing the delivery of medical supplies

A client's right to good quality healthcare and medical care was not realised when their individual state of health was not assessed medically before discontinuing the delivery of medical supplies. The medical supplies had been used by the client free of charge and without interruption for more than 10 years.

After the free medical supplies had been discontinued, the client had to purchase the medical supplies at their own expense. The Deputy-Ombudsman considered that the authority had acted incorrectly and violated the client's constitutional right to adequate healthcare services. The Deputy-Ombudsman recommended that the authority consider how it can recompense for the incorrect procedure (3042/2022).

Good governance

Processing a claim for a revised decision

The processing of a claim for a revised decision concerning a complainant's healthcare customer fee had lasted for 1.5 years in the hospital district. The complainant had received a notice of initiation from an enforcement authority concerning the customer fee in question. The notice stated that the complainant had to pay for collection, interest and enforcement costs in addition to the customer fee. The Deputy-Ombudsman reprimanded the Administrative Counsel in charge of preparing the claim for a revised decision and informed the wellbeing services county of the unlawfulness of the procedure. The complainant would have avoided the enforcement fee and other collection and interest costs if the hospital district had processed the claim for a revised decision as an urgent matter. The Deputy-Ombudsman recommended that the wellbeing services county consider how it can recompense for the violation of the complainant's rights (6273/2022).

The wellbeing services county reported that it had paid the costs incurred by the complainant, EUR 127.80. In addition, an apology had previously been presented to the complainant for the delay in processing the matter.

Processing of an unemployment benefit matter

The TE Office acted in violation of good governance when it did not investigate with sufficient diligence the interruption of a complainant's work trial and the related unemployment benefit matter, and the processing of the matter became delayed. The Deputy-Ombudsman stated 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 and the long processing time. The Deputy-Ombudsman asked the State Treasury to resolve the matter on the basis of the Act on State Indemnity Operations (6108/2022).

The State Treasury reported that it had paid the complainant EUR 250 in recompense.

Payment of support for informal care

The incorrect conduct of two cities in a matter concerning support for informal care caused a client to not receive a decision on support for informal care based on their need for support for more than a year (from 1 May 2020 to 30 June 2021). Due to the neglect in making decisions and preparing service plans, both the complainant and the client in need of special support remained without sufficient support for a long time. The Deputy-Ombudsman considered that the city had violated the client's constitutional right to adequate social and healthcare services, endangered the implementation of legal protection and neglected its obligation to safeguard the implementation of fundamental and human rights. The Deputy-Ombudsman recommended that the city recompense the complainant and the client for the damage caused by the incorrect procedure for the period of 1 May to 27 September 2020 (2602/2022).

The city reported that it had made a positive decision on support for informal care for the period of 1 May to 27 September 2020.

3.8
Special theme in 2023: Oversight of oversight

3.8.1
OVERVIEW

For the second year in a row, the special theme of the Office of the Parliamentary Ombudsman was "Oversight of oversight". Perspectives related to the theme were emphasised in all of the Ombudsman's activities, but especially in inspections. Although the theme of the Office will change for 2024, the practices concerning the oversight of oversight will continue to be part of the oversight of legality, as the oversight of the primary overseers is closely linked to the Ombudsman's basic task as a supreme overseer of legality.

The task of the Parliamentary Ombudsman – the supreme overseer of legality – as laid down in the Constitution of Finland is to ensure that parties subject to the Ombudsman's oversight act lawfully and fulfil their obligations. In the performance of his duties, the Ombudsman also monitors the implementation of fundamental and human rights. The Parliamentary Ombudsman's oversight of legality operates outside the powers of state and independently of them and intervenes in the abuse of public powers if necessary. In a well-functioning state governed by the rule of law, the key task of the supreme oversight of legality is to monitor that primary supervisory systems are in place and fully operative.

Parliament's Constitutional Law Committee has welcomed the shift in the focus of the Ombudsman's activities from the oversight of authorities to the promotion of individuals' rights. However, in addition to helping individual complainants and focusing on safeguarding their rights, the oversight of legality also has another dimension, which focuses on the fact that, in order to increase the effectiveness of the supreme oversight of legality, there should be a stronger emphasis on the oversight of oversight. In fact, the Constitutional Law Committee has also stated that other overseeing authorities are under the oversight of the supreme overseers of legality.

The special theme is linked to the rule of law and the fundamentally related principle of conformity to law of public administration, as laid down in section 2(3) of the Constitution of Finland. The Constitution states that the exercise of public powers shall be based on an Act. In all public activity, the law shall be strictly observed. The theme is also linked to the provision on legal protection in section 21(1) of the Constitution, according to which everyone has the right to have his or her case dealt with appropriately and without undue delay by a legally competent court of law or other authority. According to section 22 of the Constitution, public authorities shall guarantee the observance of basic rights and liberties and human rights. Under section 68(1) of the Constitution, each Ministry, within its proper purview, is responsible for the appropriate functioning of administration. This includes the steering and oversight of the administration under each Ministry's authority.

3.8.2
PERSPECTIVES ON THE SPECIAL THEME IN OVERSIGHT OF LEGALITY

Oversight of legality within the administration can be regarded to include organisations' self-monitoring and hierarchical oversight where subordinate bodies are overseen by higher organisation levels. This kind of hierarchical oversight involves investigating administrative complaints concerning the operation of a subordinate body. External oversight refers to oversight by an external and independent organisation.

In the rule of law, the external oversight of the legality of administration is based on court control. External oversight is complemented by general oversight of legality by the supreme overseers of legality.

From the perspective of the special theme, the aim of the Parliamentary Ombudsman's oversight of legality is to ensure that the internal oversight by the actors overseen by the Ombudsman and the parties overseeing them (e.g. special authorities, special ombudsmen and councils responsible for oversight) are effective in the oversight of legality and the promotion of fundamental and human rights. Another aim is to identify possible structural shortcomings and gaps in oversight. One more aim is to strengthen the effectiveness of the Ombudsman's oversight and to allocate the resources at the Ombudsman's disposal to questions within the purview of the supreme overseer of legality.

Inspections carried out on the Parliamentary Ombudsman's initiative can be used to obtain information on the state of official activities and their shortcomings affecting the implementation of oversight and fundamental and human rights that is not directly made available by the processing of complaints. Direct oversight during inspections also provides information on the state of the oversight of other parties responsible for monitoring the activities. These inspections can therefore be used to address infringements of rights, but they also provide invaluable information for the oversight of primary overseers.

The Parliamentary Ombudsman acts as a last-resort overseer in sectors that have a special ombudsman or another special oversight authority dealing with individual complaints. For his investigations, the Parliamentary Ombudsman may lean on the special expertise of these authorities, either by transferring complaints or by requesting statements. The follow-up of complaint processes and measures transferred to the primary overseer is also included in the focus area of the special theme. If there are no competent special authorities investigating certain complaints, the Parliamentary Ombudsman becomes the primary overseer of these activities, which is not expedient from the perspective of the functioning and effectiveness of the oversight of legality.

3.8.3 THEME OBSERVATIONS

Overview

During the year under review, inspections and visits to authorities were conducted to examine the implementation and structures of internal oversight of legality in organisations. Inspections focused on practices concerning ex-ante and ex-post verification of the legality of operations. The inspections were also used to monitor how the primary oversight authorities in charge of oversight had overseen and guided the inspected organisation.

In his special task of overseeing covert intelligence gathering, the Ombudsman focused on the functioning of the internal oversight of legality of the authorities that use intelligence gathering methods. Covert intelligence gathering is used by the police, Customs, the Border Guard and the Defence Forces. All these organisations submit a report to the Ombudsman each year on the resources used to acquire intelligence. The Ombudsman's visit to the Southeastern Finland Police Department on covert intelligence gathering revealed that internal oversight at the police department had clearly had an impact, as the quality of the decisions had improved significantly over the years (5411/2023).

Oversight of social welfare and healthcare

The responsibility for organising social welfare and healthcare services was transferred from municipalities and joint municipal authorities to wellbeing services counties on 1 January 2023. At the same time, the importance of self-monitoring has become further emphasised in legislation. Internal oversight in social welfare and healthcare is primarily implemented through the self-monitoring of the wellbeing services county (service organiser) and the service provider. During inspections, the Deputy-Ombudsman emphasised that self-monitoring is the primary form of legislative oversight, and service organisers must carry out self-monitoring to ensure that their social welfare and healthcare duties are carried out lawfully. In addition, service organisers must steer and oversee the service production that they are responsible for organising (7172/2023).

In the inspection of a sheltered housing unit for the elderly, the Deputy-Ombudsman found it a significant shortcoming that, based on the inspection findings, there had been serious deficiencies in the implementation of self-monitoring. Serious problems were found in the implementation of residents' fundamental rights, such as shortcomings in outdoor recreation and activities supporting participation. The Deputy-Ombudsman emphasised that, for self-monitoring and the implementation of a client's legal protection, it is essential that the person responsible for self-monitoring in an operating unit is familiar with current laws, regulations and recommendations. Legislation has to be followed in the planning and implementation of self-monitoring (1003/2023).

During the year under review, the Deputy-Ombudsman's inspections have addressed the preparation of statutory documents that are part of self-monitoring. The Deputy-Ombudsman drew the attention of an assisted living unit for persons with disabilities to the fact that a private service provider must also draw up a self-monitoring programme for the tasks and services that they are responsible for (2810/2023). An inspection at the Kainuu wellbeing services county revealed that a self-monitoring programme had already been approved in 2022, and a self-monitoring plan was to be approved in January 2024. In the wellbeing services county, self-monitoring was part of the ISO 9001 quality management system (7172/2023).

In the inspection of a housing unit for persons with intellectual disabilities, the Deputy-Ombudsman drew the wellbeing services county's attention to the fact that self-monitoring plans must be up-to-date and updated as planned and whenever necessary. In addition, the self-monitoring plan of a housing unit for special care must include appropriate descriptions of the grounds and procedures for the use of restrictive measures pursuant to the Act on Special Care for Persons with Intellectual Disabilities. After the inspection, the wellbeing services county informed the Deputy-Ombudsman that the self-monitoring plans of all service units for persons with disabilities will be updated in early 2024 (3513/2023). The unit-specific pharmacotherapy plan of the examination and rehabilitation unit will also be updated to the new wellbeing services county template in January 2024 (5357/2023).

In the inspection of a sheltered housing unit for the elderly, the Deputy-Ombudsman stated that the person responsible for overseeing the self-monitoring plan must ensure that the practices recorded in the plan are implemented in practice. The Deputy-Ombudsman found it worrying that no incident reports of adverse or hazardous situations had been made in the unit in six months, even though one of the inspection findings was a discrepancy in medication. The Deputy-Ombudsman emphasised the responsibility of wellbeing services counties in overseeing the services of clients in a vulnerable position. The self-monitoring plan is a key tool for overseeing client safety and the quality of operations (1003/2023).

Inspections made during the year under review have addressed the operating practices at wellbeing services counties' social welfare and healthcare monitoring units. The Deputy-Ombudsman found it positive and important that the unit for outsourced services and oversight of the Wellbeing Services County of Ostrobothnia systematically and regularly oversees the outsourced service units in its area and monitors the implementation of measures.

The inspection of a sheltered housing unit for persons with disabilities revealed that the head of outsourced services and oversight of the wellbeing services county and previously of the joint municipal authority made an annual inspection visit to the unit (2810/2023).

The self-monitoring of the Wellbeing Services County of South Karelia is included in the work of the heads and personnel of various units at the wellbeing services county. In addition, for self-monitoring and the oversight of social welfare and healthcare services, work resources have been allocated to an oversight unit led by the head of self-monitoring. A self-monitoring team has been formed around the oversight unit, including a medication safety specialist, a client and patient safety specialist, a lawyer and a chief administrative physician (3513/2023). The oversight unit of the wellbeing services county finds the oversight of self-monitoring particularly important, where risk awareness holds an important role. The oversight unit carries out preventive, systematic and reactive oversight. The inspection revealed that a national working group on self-monitoring has been set up, including one person responsible for oversight from each wellbeing services county (3992/2023).

During the inspection of an overnight shelter for homeless people, discovered deficiencies resulted in a planned inspection visit to the unit by officials of the Wellbeing Services County of Southwest Finland. The Deputy-Ombudsman emphasised that the wellbeing services county is obliged to ensure that any discovered deficiencies are rectified and that oversight is carried out regularly. The unit had not been properly overseen in years. The Deputy-Ombudsman considered the deficiencies in oversight to be very serious due to the fact that the service ensures necessary last-resort care. In order to improve the effectiveness of oversight, the Deputy-Ombudsman sent the minutes for information to the wellbeing services county and the Regional State Administrative Agency (1016/2023).

The tasks of external authority oversight are primarily carried out by the competent supervisory authorities in social welfare and healthcare, which are the Regional State Administrative Agencies and the National Supervisory Authority for Welfare and Health (Valvira). An inspection revealed that Valvira and the Regional State Administrative Agency for Northern Finland had carried out a joint guidance and assessment visit to the Wellbeing Services County of Kainuu, aimed to promote successful self-monitoring (7172/2023). The inspection of an immigration unit for minors revealed that the Regional State Administrative Agency for Western and Inland Finland monitors units' operations with regard to children who have received a residence permit (5775/2023).

According to the personnel of the City of Helsinki Detoxification Centre, the city's inspection office and inspection board do carry out inspections at healthcare units, but they have not carried out inspection visits to the Detoxification Centre in a few years. The Deputy-Ombudsman emphasised that the city is responsible for organising health services in its area and is primarily responsible for the oversight and steering of the services (6595/2023).

An inspection of a family rehabilitation centre ordered by the Deputy-Ombudsman was carried out in a new way by organising a joint event to meet the parents of the children placed there, the personnel of the institution and the children's responsible social workers. The parents were given an opportunity to express their opinions on their children's substitute care, its possible shortcomings and any development needs. During the inspection, addressed topics included the organisation of substitute care, the statutory tasks of social workers, problems and development ideas related to oversight and the tasks of the substitute care facility. An inspection is also planned for 2024 (1709/2023).

In connection with the Deputy-Ombudsman's own-initiative oversight of residential schools, Valvira submitted supervisory and complaint decisions concerning state-run residential schools of the Regional State Administrative Agencies and Valvira in 2021–2023. The Deputy-Ombudsman aims to assess more extensively how and in what matters oversight is carried out by the Regional State Administrative Agencies and Valvira. Two negotiation events were held in the matter, where the participants consisted of Valvira, the Regional State Administrative Agencies and the legal advisers for child-related matters from the Office of the Parliamentary Ombudsman.

The events involved assessing decisions submitted by Valvira and the Regional State Administrative Authorities and the decisions made by the Deputy-Ombudsman concerning state residential schools for the same period. Valvira's and the Regional Administrative Agencies' preliminary inspection plans concerning residential schools were also discussed at the event (4251/2023).

An inspection at the Riihimäki outpatient clinic of the Health Care Services for Prisoners (VTH) revealed that each VTH location has a self-monitoring plan that is updated annually. The Deputy-Ombudsman considered the implementation of self-monitoring very important and encouraged its continuous development and implementation. The functioning of self-monitoring requires that the organisation receives information on detected incidents and quality deviations. The Deputy-Ombudsman encouraged personnel members to actively submit these notifications (1107/2023).

In its complaint, SuPer ry issued the criticism that the oversight of a private residential service provider had failed both at the level of self-monitoring and at the level of official oversight. The Deputy-Ombudsman did not take on the complaint for investigation at this stage because Valvira had announced that it had started national oversight of the service provider in spring 2023, and the Regional State Administrative Agencies have had relevant individual enforcement cases pending. The Deputy-Ombudsman requested Valvira to report on the situation of the oversight by 31 May 2024, including the measures that the oversight had given rise to so far (2073/2023).

After the Deputy-Ombudsman's request for information on a complaint, the city department for outsourced disability services had carried out an inspection visit to the private residential service unit that was the subject of the criticism. The Deputy-Ombudsman welcomed the fact that the city had addressed the observed shortcomings quickly. The Deputy-Ombudsman found it particularly important that the city continues to regularly steer and oversee the activities of outsourced service providers through reports of shortcomings and self-initiated monitoring and oversight. The Deputy-Ombudsman requested that the city provide her with an oversight report on the city's inspection visit, assessing the implementation of personnel allocation and other measures in the residential unit (3248/2022).

Oversight of the private security sector

The inspection of Avarn Security Oy at the Central Railway Station and the inspection of Securitas Oy at the Kamppi centre did not reveal that the city's police department would have carried out separate inspections of security stewards' operations. Avarn Security supplies daily activity reports to the police. In addition, there have been recent efforts to develop Avarn Security's self-monitoring. According to the Parliamentary Ombudsman, the development of self-monitoring is justified. The Ombudsman asked the company to report on how and on what schedule this work would proceed. According to Avarn Security, the aim is to prepare new guidelines and make the operations part of the company's normal processes during the autumn. From then on, the appropriateness of operations will be controlled through self-monitoring. This will be achieved with audits carried out by the security unit and a reporting channel (1974/2023). The representatives at Securitas were not aware of how the police process their daily reports. Securitas has an internal auditing system, and especially all situations of using force are reviewed internally. An internal incident report is submitted on situations involving violence or use of force. The report indicates details such as the events that occurred, the use of force and possible injuries and damages (1488/2023).

The purpose of the Ombudsman's inspection was to get an overall understanding of how the Helsinki Police Department has arranged the practical oversight, observations and any issues of the private security sector. During the inspection, the Ombudsman reported on complaints against security stewards and guards, some of which will be referred on a discretionary basis to police departments in the future as well. A separate firearms and security sector team operates in the licence supervision of the police department, which follows a separate oversight plan. The oversight is carried out in a targeted manner and in connection with daily operations.

Licence supervision performs continuous violation and integrity oversight as well as oversight based on external tips. During the year under review, 21 targeted inspections had been carried out, covering a total of 83 inspection targets (6431/2023).

During the inspection, the private security supervision unit of the National Police Board pointed out that the supervision of the private security sector should be part of police departments' daily operations. However, practices vary between police departments. Police departments are responsible for supervising the operations of private security services in their respective areas. The oversight of oversight for police departments is the responsibility of the National Police Board's supervision unit. The self-monitoring of operators would also be important, but the oversight unit has not issued instructions for operators on self-monitoring. The Ombudsman decided to conduct a separate own-initiative investigation whether the division of labour between the National Police Board's licence administration and the oversight unit is clear in terms of the oversight and steering of the private security sector. In addition, it will be examined whether there are sufficient resources in the area of responsibility of the National Police Board's licence administration to steer, oversee and develop the oversight of the private security sector (2235/2023).

Other theme observations

An inspection of the Emergency Response Centre Agency carried out by the Parliamentary Ombudsman revealed that the Ministry of the Interior inspects the Agency annually. The Emergency Response Centre Agency receives about 50 complaints each year. The amount of feedback is annually between 800 and 900 messages, which are mainly addressed by the emergency response centres. According to the Ombudsman, it would be justified not to leave the registry to process citizens' messages by itself. The oversight of legality is better equipped to assess whether a message should be classified as feedback or a complaint (6839/2023). As a result of the inspection of the Kerava Emergency Response Centre, the Ombudsman emphasised in general that there should be a low threshold for referring a message received through the feedback channel to the complaint procedure if the message contains even minor criticism of an official at the Emergency Response Centre Agency or if it is open to interpretation whether something is a complaint or feedback (6838/2023).

The Ombudsman familiarised himself with the internal oversight of legality of the Border Guard Headquarters. In addition to the oversight of general legality in daily operations, key methods of oversight of legality include processing administrative complaints, carrying oversight of legality inspections and overseeing the processing of personal data. Lawyers at the oversight of legality unit issue military lawyers' statements referred to in section 33 of the Act on Military Discipline and Combating Crime in the Defence Forces in pre-trial investigations conducted in the units of the Border Guard. This was considered an exceptional arrangement in terms of the objective of independence in the oversight of legality (407/2023).

According to information received from the Finnish Transport Infrastructure Agency, efforts have been made to develop internal oversight, and said oversight is working well. Internal openness and flow of information is encouraged in everything. Internal auditing has been outsourced, and the resulting observations are used to develop operations. The Finnish Transport Infrastructure Agency has found the performance guidance and its relationship with the relevant ministry very effective (754/2023).

An inspection of the Ministry of Defence carried out by the Parliamentary Ombudsman revealed that each operational unit of the ministry is responsible for overseeing the operations of the Defence Forces in its respective area of operations (oversight of legality and appropriateness). The legislative drafting and legal affairs unit oversees the legal sector of the Defence Forces. The oversight is based on section 68 of the Constitution of Finland.

On the order of the Minister or the Secretary General, the legal affairs and legislative drafting unit of the Ministry of Defence carries out inspection tasks that are separate from general oversight, either as the Minister's own-initiative oversight of legality or as the investigation or resolution of complaints. The targeting of inspections takes place in other activities, such as oversight observations made in legislative drafting or written questions (6595/2023).

The inspection of the Northern Finland extensive enforcement unit of the National Enforcement Authority revealed that inspections are reported to the Office of the Director General. The right balance for self-monitoring is still being sought after the organisational reform. The enforcement inspector carries out self-monitoring once a month and submits the report to the district bailiff. The joint services' operating unit does not carry out separate inspection activities; instead, inspections are carried out and reports are prepared by the Office of the Director General. There had been fewer complaints compared to the previous year. Instead of complaints arriving directly to the operating unit of the National Enforcement Authority, they go through the Office of the Director General. Liaison with the Office of the Director General is close and cooperation works well (796/2023).

During an inspection of financial and debt counselling at the Oulu Legal Aid Office, the implementation of internal oversight of legality was discussed. The Northern Finland Legal Aid and Public Guardianship District oversees the agencies within its scope, including the Oulu Legal Aid Office. Any complaints and feedback are addressed by the Senior Public Legal Adviser, and the responses are also sent to the Director of the Legal Aid and Public Guardianship District. There have been very few complaints concerning financial and debt counselling (797/2023).

The Deputy-Ombudsman carried out an inspection at the legal protection unit of the Regional State Administrative Agency for Western and Inland Finland concerning the statutory oversight of local government pilots on employment. An oversight group has been established for 2023 and 2024, and the Regional State Administrative Agency has drawn up an oversight plan for local government pilots. The Regional State Administrative Agency reports to the Ministry of Economic Affairs and Employment on the implementation of the oversight plan, the measures taken and the relevant results. The oversight of local government pilots is an oversight pilot that will be organised by the Regional State Administrative Agency when the organisation of employment services is transferred to municipalities at the beginning of 2025 (1390/2023).

During a visit to the Ministry of the Interior, the Parliamentary Ombudsman noted that the Ministry website should offer information on how to submit a complaint. The Ombudsman noted that there was variance in the structure and content of the reports delivered to the Ombudsman. Ministries have discretion in what kind of report they provide, but the Ombudsman considered it desirable that reports include some kind of assessment or analysis by the ministry on the use of methods in the reporting year (1725/2023).

An inspection of the childhood and education sector of the City of Helsinki and two comprehensive schools addressed the oversight of basic education. It was noted that the forms of self-monitoring include participation in external evaluation of education and self-assessment as well as the monitoring of different plans. The Deputy-Ombudsman has found that there are national problems in the availability of psychologist services in pupil welfare due to issues such as workforce shortages. The government has attempted to address the problem by increasing their numbers in higher education. The Deputy-Ombudsman stated that Regional State Administrative Agencies and Valvira are competent to oversee the provision of pupil welfare and its services. The minutes were sent to the Regional State Administrative Agency for Southern Finland for appropriate consideration in future operations (1939/2023). The Deputy-Ombudsman stated that, as part of oversight of legality, he will also pay particular attention to how the oversight of student welfare is implemented (1940/2023). Subsequently, the Regional State Administrative Agency for Western and Inland Finland announced that it had surveyed the implementation of psychologist services in pupil welfare in the wellbeing services counties of its operating area in 2023. The Regional State Administrative Agency has released a publication on the matter.

The inspection of a private comprehensive school revealed that the school has channels for reporting shortcomings. If necessary, the school receives support from the city's regional manager of childhood and education services and other persons in the sector (1941/2023).

During an inspection visit, the Deputy-Ombudsman investigated the quality system of the Diaconia University of Applied Sciences, which covers all operations from the quality management of core tasks to support services and management. There is a system called Falcony for reporting deviations; students and staff can use it to reach out and report shortcomings and inappropriate activities. The university of applied sciences must regularly participate in the evaluation of its external activities and quality systems and publish the results of the evaluation it arranges (5455/2023).

An inspection of the Riihimäki Reception Centre revealed that the Finnish Immigration Service, which oversees the activities of the centre, visited the reception centre's apartments in March 2023. According to the information received, the Regional State Administrative Agency would be making an inspection visit to the reception centre (3901/2023). A self-monitoring plan had not been confirmed for the Joutseno detention unit, even though the plan was already "in progress" during the inspection carried out the year before. During 2023, the Finnish Immigration Service had not carried out inspection visits to the Joutseno unit. The Deputy-Ombudsman asked the detention unit to notify the Office of the Parliamentary Ombudsman of the completion of the self-monitoring plan (7813/2023).

3.9 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 2023 (170 in the previous year). A response from the Finnish Government was requested in two (2) cases. At the end of the year, 54 (36) cases concerning Finland were pending, nine of which had been communicated to the Government for a response, and a decision on admissibility had been made for one case.

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 2023, a total of 72 (150) complaints concerning Finland were declared inadmissible or struck out of the case list. In 2023, the ECHR issued two judgments on Finland (0 in 2022, one in 2021).

On 9 May 2023, the ECHR issued a judgment concerning Finland (31172/19) on the processing of personal data. According to the ECHR, Finland did not violate the right to a fair trial or the freedom of thought, conscience and religion as enshrined in the European Convention on Human Rights in a case concerning the right of Jehovah's witnesses to collect lists of names and to use notes of their visits in connection with door-to-door preaching without the consent of the parties concerned. The ECHR found that it was a correct balance of freedom of thought, conscience and religion and respect for private and family life. The ECHR considered it relevant and necessary for ensuring the protection of privacy that individuals are asked for their consent to draw up and use name lists and notes.

In its judgement of 9 November 2023 (46131/19), the ECHR found no violation of Article 6 of the European Convention on Human Rights when the Court of Appeal decided to refer a case of revoking a lawyer's trial counsel licence to the extended composition of the court. The ECHR found that the conditions for transferring the case to the extended composition were clear from the law. The purpose of the provision was to ensure that there would be a solid and far-reaching basis for a decision that was of considerable importance to the court regardless of whether a previous composition had processed the matter or not. Furthermore, the applicant had not lost the opportunity to participate in the decision-making process as a result of the transfer. There were also other procedural safeguards in the case. In addition, the Supreme Court had full competence to investigate the applicant's case because it had granted the applicant leave to appeal. The Supreme Court could have also rectified any procedural deficiencies in the previous procedure. The ECHR also considered that there was no evidence of personal bias on the part of the Chief Justice Court of Appeal who took the decision to transfer the case to the extended composition. The ECHR referenced the detailed explanation of the Supreme Court's legal framework and its application in the applicant's case and stated that there were no grounds for doubting that the conditions for a transfer had not objectively been met. According to the ECHR, it was satisfied that the proceedings provided sufficient guarantees to exclude any legitimate doubt in respect of the impartiality of the Court of Appeal.

The total number of judgments issued by the ECHR to Finland by the end of 2023 was 142. Most of the judgments were related to the duration of court proceedings or other shortcomings in the implementation of a fair trial. The annual number of judgments has been very low in recent years.

On 13 April 2023, the ECHR issued an advisory opinion (P16-2022-001) to the Supreme Court in accordance with Protocol No. 16 of the European Convention on Human Rights in an adoption case leading to decision KKO 2024:18. Requesting opinions has been possible since August 2018, but this possibility only applies to national supreme courts. The request was the first of its kind in Finland, and for the time being, the ECHR has only issued few of such opinions on matters of principle related to the interpretation or application of the Convention on Human Rights.

3.9.1 MONITORING OF THE EXECUTION OF JUDGMENTS IN THE COMMITTEE OF MINISTERS OF THE COUNCIL OF EUROPE

The Committee of Ministers of the Council of Europe supervises the execution of ECHR judgments. According to Article 46 of the European Convention on Human Rights, "The final judgment of the Court shall be transmitted to the Committee of Ministers, which shall supervise its execution". The monitoring process is based on legal analysis, but it also involves political considerations. The parties to the ECHR monitor the execution of judgments in the form of peer support and pressure in legitimate political discourse.

The effective execution of the Court's judgments is the cornerstone of the European Convention on Human Rights. The judgments shall remain subject to the supervisory procedure until the Committee of Ministers explicitly decides to end the supervision. The basic form of supervision is called standard procedure. In addition to standard supervision, there is also the enhanced procedure, which applies to some of the cases under supervision. Such cases include: 1) judgments that require urgent individual action for enforcement; 2) pilot judgments; 3) judgments that indicate structural or complex problems in a Member State; and 4) judgments on inter-State applications. The Committee of Ministers always decides whether a judgment will be handled under the enhanced procedure.

In Finland, the supervision of the execution of ECHR judgments has been relatively unproblematic. The cases have been dealt with in writing with the standard procedure and the dialogue between the Registry and the Government has been effective. Finland has paid the financial compensation ordered by the ECHR on time and implemented the other measures required for enforcement quickly or at least within a reasonable time.

In autumn 2021, the situation changed so that the first case concerning Finland was transferred to enhanced supervision. In its resolution, the Committee of Ministers urged Finland to implement urgent legislative measures to complete the execution of the judgment. The resolution concerned the 2012 judgment in case X v. Finland (34806/04). In its judgment, the ECHR considered the right to liberty under Article 5 of the European Convention on Human Rights and the right to respect for private life under Article 8 to have been violated. The latter was related to medication given to a patient against their will. In this context, the ECHR concluded that there are no adequate legal safeguards.

On 30 March 2022 and 21 September 2022, the Government submitted an updated action plan on case X v. Finland to the Committee of Ministers and an appendix to the action plan on 21 November 2022. The Human Rights Centre (HRC) issued a statement to the Committee of Ministers on 21 October 2021 and again on 27 January 2023. Rule 9 of the Rules of Procedure of the Committee of Ministers allows National Human Rights Institutions an opportunity to submit a statement to the Council of Europe for enforcement purposes. In its latest statement, the HRC criticised the fact that the implementation of the measures required by the case had again been delayed after the Ministry of Social Affairs and Health announced that the Government proposal could not be submitted during the current government term.

National courts have also dealt with cases of medication given to a patient against their will. In its April 2022 judgment (S 21/1053), the Turku Court of Appeal considered that the objection and complaint procedure specified after the X v. Finland judgment gave the patient sufficient legal protection. In May 2022, on the other hand, the Vaasa Court of Appeal considered (S 21/871) that the patient did not have access to effective legal remedies because no new remedies had been regulated after the X v. Finland judgment. In the latter case, the Supreme Court granted the leave to appeal and issued precedent KKO 2023:93 on 29 November 2023, in which it considered that the remedies available to the patient had been deficient because the patient had not had the right to bring the legality or proportionality of the involuntary medication or the termination of the medication for review by a court or other independent judicial body. The government was ordered to pay compensation for the violation of fundamental and human rights.

The above-mentioned lack of legal remedies was rectified after the Parliament adopted in December 2023 the amendments to the Mental Health Act and the Administrative Courts Act (15/2024) on the basis of Government proposal HE 14/2023 vp, which will enter into force on 1 April 2024. The Mental Health Act was amended so that the implementation of the medical treatment of a patient's mental illness requires an administrative decision if the treatment cannot be carried out in agreement with the patient. In such case, medically acceptable pharmacotherapy for a mental illness is carried out on the basis of an administrative decision regardless of the patient's will. An administrative decision should also be issued if a patient requests one. After the legislative amendment, patients have the opportunity to appeal such decisions to the Administrative Court. Appeals against these decisions must be heard in court as matters of urgency.

No new cases became pending in the supervision process during the year under review. Monitoring of execution remained pending in six judgements concerning Finland. Case X. v. Finland will be discussed at the meeting of the Committee of Ministers in March 2024.

4 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 of the Government and the Parliamentary Ombudsman (330/2022)

SECTION 1
PURPOSE OF THE ACT

This Act lays down provisions on the division of the duties between the Chancellor of Justice of the Government and the Parliamentary Ombudsman without curtailing the powers of either of them with regard to oversight of legality.

SECTION 2
DUTIES TO BE CENTRALISED TO THE CHANCELLOR OF JUSTICE OF THE GOVERNMENT

The Parliamentary Ombudsman is exempted from the obligation to carry out the duties of the supreme guardian of legality in matters falling within the remit of the Chancellor of Justice of the Government concerning:

1) the development and general bases for the maintenance of the automated public administration systems;
2) the organisation of anti-corruption activities;
3) public procurement, competition and state aid-related matters.

SECTION 3
DUTIES TO BE CENTRALISED TO THE PARLIAMENTARY OMBUDSMAN

The Chancellor of Justice of the Government is exempted from the obligation to carry out the duties of the supreme guardian of legality in matters falling within the remit of the Parliamentary Ombudsman concerning:

1) the Finnish Defence Forces, the Finnish Border Guard, the crisis management personnel referred to in the Act on Military Crisis Management (211/2006), the National Defence Training Association referred to in chapter 3 of the Act on Voluntary National Defence (556/2007) 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 waiver, discontinuation and restriction of the pre-trial investigation;
3) covert intelligence gathering, covert coercive measures, civilian intelligence, military intelligence and oversight of the legality of intelligence activities;
4) prisons and other institutions to which a person is involuntarily committed as well as other measures restricting 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 (Finnish Treaty Series SopS 93/2014);
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 (Finnish Treaty Series SopS 27/2016);

7) the implementation of the rights of children, the elderly, persons with disabilities and asylum seekers;
8) the realisation of individual rights in social and health care and social insurance;
9) public guardianship;
10) the realisation of rights guaranteed to the Sámi as an indigenous people;
11) the realisation of the rights to maintain and develop the language and culture guaranteed for the Roma and other groups.

SECTION 4
MUTUAL TRANSFER OF CASES

In the cases referred to in section 3, the Chancellor of Justice refers the matter to the Ombudsman unless they deem it appropriate to resolve the matter themselves due to special reasons. Notwithstanding the provisions of section 3, the Chancellor of Justice supervises the general conditions for the realisation of fundamental and human rights and other rights in the exercise of executive power and in matters for which the government is responsible.

In the cases referred to in section 2, the Ombudsman refers the matter to the Chancellor of Justice unless they deem it appropriate to resolve the matter themselves due to special reasons.

The Chancellor of Justice and the Parliamentary Ombudsman may mutually transfer other cases falling within the remit 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 set of issues or when it is justified for some other reason.

The complainant must be informed of the transfer of the complaint.

SECTION 5
MUTUAL EXCHANGE OF INFORMATION

The Chancellor of Justice and the Ombudsman exchange information with each other in order to promote the effectiveness of the supreme oversight of legality and the uniformity of decision-making practice.

SECTION 6
ENTRY INTO FORCE

This Act shall enter into force on 1 October 2022.

This Act repeals the Act on the Division of Duties between the Chancellor of Justice of the Government and the Parliamentary Ombudsman (1224/1990).

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 from 1 January to 18 June 2023

OMBUDSMAN MR PETRI JÄÄSKELÄINEN decides on matters concerning:
- the highest organs of state
- questions involving important principles
- military matters, Defence Forces and Border Guard
- the police, the Emergency Response Centre and rescue services
- Customs
- public prosecutor
- legal guardianship
- language legislation
- asylum and immigration
- covert intelligence gathering and intelligence operations
- the coordination of the tasks of the National Preventive Mechanism against Torture and reports relating to its work
- statements concerning the administrative branch of the Ministry of Justice
- freedom of expression

DEPUTY-OMBUDSMAN MS MAIJA SAKSLIN decides on matters concerning:
- social welfare
- children's rights
- rights of the elderly
- the rights of persons with disabilities
- health care
- municipal affairs
- the autonomy of the Åland Islands
- traffic and communications
- register administration
- environmental administration
- agriculture and forestry
- Sámi affairs
- church affairs

DEPUTY-OMBUDSMAN MR PASI PÖLÖNEN (till 31 March) and SUBSTITUTE FOR A DEPUTY OMBUDSMAN MR MIKKO SARJA (from 1 April) decides on matters concerning:
- courts, judicial administration and legal aid
- Criminal sanctions field
- distraint, bankruptcy and dept arrangements
- taxation and Customs taxation
- social insurance
- income support
- early childhood education and care, education, science and culture
- labour administration and unemployment security
- data protecton, data management and telecommunications

Appendix 2
Division of labour between the Ombudsman and the Deputy-Ombudsmen from 19 June to 31 December 2023

OMBUDSMAN MR PETRI JÄÄSKELÄINEN decides on matters concerning:
- the highest organs of state
- questions involving important principles
- courts, judicial administration and legal aid
- public prosecutor
- the police, the Emergency Response Centre and rescue services
- military matters, Defence Forces and Border Guard (including conscript health care)
- Customs (excluding Customs taxation)
- covert intelligence gathering and intelligence operations
- the coordination of the tasks of the National Preventive Mechanism against Torture and reports relating to its work

DEPUTY-OMBUDSMAN MS MAIJA SAKSLIN decides on matters concerning:
- distraint, bankruptcy and dept arrangements
- social welfare
- health care
- rights of the elderly
- the rights of persons with disabilities
- regional and local government
- the autonomy of the Åland Islands
- taxation
- Customs taxation
- environmental administration
- agriculture and forestry
- traffic and communications
- register administration
- religious communities
- Sámi affairs

DEPUTY-OMBUDSMAN MR MIKKO SARJA decides on matters concerning:
- Criminal sanctions field (including prisoner health care)
- asylum and immigration
- children's rights
- legal guardianship
- social insurance
- income support
- labour administration and unemployment security
- early childhood education and care, education, science and culture
- language legislation

Appendix 3
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 (till 31 March)
Mr Mikko Sarja, LL.Lic., LL.M. with court training (from 1 June)

Secretary General

Mr Jari Råman, LL.D.

Administrative assessor

Ms Astrid Geisor-Goman, LL.M.

Principal Legal Advisers

Ms Terhi Arjola-Sarja, LL.M. with court training (from 1 February, on fixed term till 31 January)
Mr Mikko Eteläpää, LL.M. with court training
Mr Juha Haapamäki, LL.M. with court training
Mr Jarmo Hirvonen, LL.M. with court training (on fixed term)
Mr Kristian Holman, LL.M., M.Sc. (Admin.)
Ms Lotta Hämeen-Anttila, M.Soc.Sc, LL.M.
Ms Kirsti Kurki-Suonio, LL.D.
Ms Heidi Laurila, LL.M. with court training (from 1 January)
Mr Juha Niemelä, LL.M. with court training
Mr Jari Pirjola, LL.D., M.A.
Ms Anu Rita, LL.M. with court training
Mr Tapio Räty, LL.M.
Mr Mikko Sarja, LL.Lic., LL.M. with court training (on leave from 1 June)
Ms Piatta Skottman-Kivelä, LL.M. with court training (from 1 December)
Ms Iisa Suhonen, LL.M. with court training
Ms Minna Verronen, LL.M. with court training
Ms Susanna Wähä, M.Sc. (Admin.)

Senior Legal Advisers

Mr Jukka Anttila, LL.M. with court training
Ms Riitta Burrell, LL.D.
Ms Elina Castrén, LL.M. with court training
Mr Peter Fagerholm, M.Sc. (Admin.)
Ms Katja Harakka, LL.Lic., MBA (from 1 April)
Ms Sanna Hyttinen, LL.M. (from 1 May)
Ms Anne Ilkka, LL.M. with court training
Ms Riikka Jackson, LL.M.

Ms Heli Karjalainen-Michel, LL.M.
Ms Johanna Koli, M.Soc.Sc.
Mr Juha-Pekka Konttinen, LL.M.
Ms Päivi Lahtinen, LL.M. (from 16 January)
Ms Anu Lempiäinen, LL.M.
Ms Päivi Pihlajisto, LL.M. with court training
Ms Johanna Pomell, LL.M. (from 1 April, on leave from 13 November)
Ms Johanna Rantala, LL.M. (from 1 February)
Mr Matti Vartia, LL.M. with court training
Mr Jyri Vesanto, LL.M. (from 1 April)
Ms Leena-Maija Vitie, LL.M. with court training
Ms Pia Wirta, LL.M. with court training

Legal Advisers

Ms Katja Harakka, LL.Lic., MBA (till 31 March)
Ms Sanna Hyttinen, LL.M. (on fixed term till 30 April)
Ms Pirjo Kainulainen, LL.M. (on fixed term from 1 March)
Ms Anne Kohvakka, LL.M. (on fixed term from 13 November)
Ms Johanna Rantala, LL.M. (on fixed term till 31 January)
Ms Eeva-Maria Tuominen, M.Sc.(Admin.), LL.B. (on fixed term)

On-duty lawyer

Ms Jaana Romakkaniemi, LL.M. with court training

Information Officer

Ms Citha Dahl, M.A.

Information Technology Specialist

Mr Tapio Kaikkonen, MBA (from 1 April)

Information Management Specialist

Mr Janne Madetoja, M.Sc. (Admin.)

Investigating Officers

Mr Reima Laakso
Mr Antti Perälä, B.Sc. (Admin.), Bachelor of Police Services

Notaries

Ms Sanna-Kaisa Frantti, B.B.A.
Ms Taru Koskiniemi, LL.B.
Ms Kaisu Lehtikangas, M.Soc.Sc.
Ms Sofie Roininen, M.Pol.Sc., Th.M. (on fixed term from 1 April)
Ms Eeva-Maria Tuominen, M.Sc.(Admin.), LL.B. (on leave)
Ms Riina Tuominen, M.Sc. (Admin.)

Administrative secretary

Ms Eija Einola

Filing Clerk

Ms Anu Forsell (from 1 March, on fixed term till 29 February)

Assistant Filing Clerk

Mr Taneli Palmén, M.A., B.A. (from 1 June)

Departmental Secretaries

Ms Andrea Bergman, M.A.
Ms Annimari Laakkonen (from 20 March)
Ms Anja Mattila-Lempinen (till 31 March)

Case Management Secretary

Ms Ira Nyberg Ira
Mr Taneli Palmén, M.A., B.A. (till 31 May)
Ms Katri Paukku (on fixed term from 27 December)

Assistant for International Affairs

Ms Tiina Mäkinen

Office Secretaries

Ms Minna Haapaniemi (on leave till 31 August)
Ms Sari Holappa
Ms Johanna Hörkkö-Petroff
Mr Mikko Kaukolinna
Ms Krissu Keinänen
Ms Virpi Salminen
Ms Riikka Saulamaa, BBA (from 1 November, on fixed term till 30 October)

Staff of the Human Rights Centre

Director

Ms Sirpa Rautio, LL.M. with court training

Experts

Ms Sanna Ahola, LL.M.
Ms Elina Hakala, M.Soc.Sc. (on fixed term)
Mr Mikko Joronen, M.Pol.Sc. (on leave)
Ms Leena Leikas, LL.M. with court training
Mr Nitin Sood, M.Pol.Sc. (on fixed term 1 June – 31 December, on leave from 19 September)
Ms Susan Villa, M.Soc.Sc.

Communications Specialist

Mr Miro Järnefelt, M.Sc., BA (from 1 September)

Junior experts

Ms Klara Fält, M.Soc.Sc. (on fixed term from 1 December)
Ms Elsa Korkman, LL.M., LL. B. (on fixed term till 31 July)
Ms Emmi Kupiainen, LL.M, LL.B (on fixed term till 31 December)
Ms Sanni Myllyaho Sanni, M.Pol.Sc. (on fixed term till 31 July)
Mr Mikko Pursimo, LL.M. (on fixed term from 1 December)

Assistant

Ms Minna Orkokari (from 1 September, on fixed term till 31 August)

Appendix 4
Statistical data on the Ombudsman's work in 2023

OVERSIGHT-OF-LEGALITY CASES UNDER CONSIDERATION

CASES INITIATED IN 2023	7,311
Complaints to the Ombudsman	6,843
Complaints transferred from the Chancellor of Justice	281
Taken up on the Ombudsman's own initiative	54
Submissions and attendances at hearings	133

CASES RESOLVED	7,035
Complaints	6,840
Transferred to the Chancellor of Justice	36
Taken up on the Ombudsman's own initiative	39
Submissions and attendances at hearings	120

OTHER MATTERS UNDER CONSIDERATION	1,045
Inspections	84
Administrative matters in the Office	933
International matters	28

RESOLVED CASES BY PUBLIC AUTHORITIES

COMPLAINT CASES	6,876
Social welfare	1,124
Police	881
Health	795
Criminal sanctions field	591
Other administrative branches	549
Social insurance	370
Administrative branch of the Ministry of Economic Affairs and Employment	347
Administration of law	277
Administrative branch of the Ministry of Education and Culture	266
Regional and local government	226
Highest organs of government	184
Enforcement (distraint)	184
Administrative branch of the Ministry of Environment	152
Administrative branch of the Ministry of Justice	143

Taxation	139
Administrative branch of the Ministry of Transport and Communications	107
Guardianship	104
Aliens affairs and citizenship	104
Administrative branch of the Ministry of Agriculture and Forestry	78
Administrative branch of the Ministry of Defence	69
Administrative branch of the Ministry of Finance	62
Prosecutors	58
Customs	30
Administrative branch of the Ministry for Foreign Affairs A	16
dministrative branch of the Ministry of the Interior	15
Subjects of oversight in the private sector	5

Taken up on the Ombudsman's own initiative	**39**
Social welfare	14
Health	9
Police	4
Regional and local government	3
Administrative branch of the Ministry of Transport and Communications	2
Administrative branch of the Ministry of Finance	2
Administration of law	1
Administrative branch of the Ministry of Justice	1
Administrative branch of the Ministry of Education and Culture	1
Aliens affairs and citizenship	1
Administrative branch of the Ministry of Environment	1

Total number of decisions	**6,915**

MEASURES TAKEN BY THE OMBUDSMAN

COMPLAINTS	**6,876**
Decisions leading to measures	**899**
– prosecution	0
– assessment of the need for pre-trial investigation	4
– reprimands	28
– opinions	629
– as a rebuke	458
– for future guidance	171
– recommendations	31
– to redress an error or rectify a shortcoming	1
– to develop legislation or regulations	17
– to provide compensation for a violation	13
– to rech an agreed settlement	0
– matters redressed in the course of investigation	23
– other measure	184
– to rech an agreed settlement	4
No action taken	**3,099**
– no incorrect action found	133
– no grounds	2,966
– to suspect illegal or incorrect procedure	1,411
– for the Ombudsman's measures	1,555
Complaint not investigated	**2,876**
– matter not within Ombudsman's remit	210
– still pending before a competent authority or possibility of appeal still open	891
– unspecified	545
– transferred to Chancellor of Justice	38
– transferred to Prosecutor-Genera	3
– transferred to Regional State Administrative Agency	78
– transferred to ELY Centre	1
– transferred to other authority	209
– older than two years	130
– inadmissible on other grounds	38
– no answer	85
– answer without measures	620

MEASURES TAKEN BY THE OMBUDSMAN

TAKEN UP ON THE OMBUDSMAN'S OWN INITIATIVE	**39**
Decisions leading to measures	**25**
– prosecution	0
– assessment of the need for pre-trial investigation	0
– reprimands	0
– opinions	17
– as a rebuke	13
– for future guidance	4
– recommendations	2
– to redress an error or rectify a shortcoming	0
– to develop legislation or regulations	2
– to provide compensation for a violation	0
– to rech an agreed settlement	0
– matters redressed in the course of investigation	1
– other measure	5
No action taken	**13**
– no incorrect action found	0
– no grounds	13
– to suspect illegal or incorrect procedure	0
– for the Ombudsman's measures	13
Own initiative not investigated	**1**

INCOMING CASES BY AUTHORITY

Social welfare	1,167
Police	888
Health	758
Criminal sanctions field	712
Other administrative branches	576
Administrative branch of the Ministry of Economic Affairs and Employment	400
Social insurance	381
Administration of law	294
Administrative branch of the Ministry of Education and Culture	275
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