PARLIAMENTARY OMBUDSMAN OF FINLAND

SUMMARY OF THE ANNUAL REPORT 2022

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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 2022. 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) and Doctor of Laws and LL.M. with Court Training Mr Pasi Pölönen (from 1 October 2021 to 30 September 2025).

Licentiate in Laws and LL.M. with Court Training, Principal Legal Adviser Mr Mikko Sarja was selected to serve as the Substitute for a Deputy Ombudsman for the period 1 October 2021 to 30 September 2025. He performed the tasks of a Deputy Ombudsman for a total of 77 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 330 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 2022.

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, 25, 43, 139).

Mikko Mäntyniemi p. 10, 16, 22.
Photo archive of the Parliament of Finland p. 38.
Photo archive of the Parliamentary Ombudsman of Finland p. 40, 42, 82, 85, 89, 92, 95, 100, 105.

1 General comments

Parliamentary Ombudsman
Mr Petri Jääskeläinen

Ombudsman's inspections

The Ombudsman oversees the legality of actions taken by the authorities by investigating complaints received, investigating matters on his or her own initiative and carrying out inspections. In this review, I will give an overview of the Ombudsman's inspection activities.

Inspection mandate of the Ombudsman

Under section 5 of the Parliamentary Ombudsman Act, the Ombudsman shall carry out the on-site inspections of public offices and institutions necessary to monitor matters within his or her remit. Specifically, the Ombudsman shall carry out inspections in prisons and other closed institutions to oversee the treatment of inmates, as well as in the various units of the Defence Forces and Finland's military crisis management organisation to monitor the treatment of conscripts, other persons doing their military service and crisis management personnel.

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 subject, as well as the right to have confidential discussions with the personnel of the office or institution, persons serving there and its inmates.

The Parliamentary Ombudsman also acts as the National Preventive Mechanism (NPM) for the UN Optional Protocol to the Convention Against Torture (OPCAT). When carrying out his or her duties in capacity of the NPM, 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). In its duties as the NPM, 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 b).

The Ombudsman may conduct inspections at the sites of all bodies under its control, that is, all courts of law, authorities and private sector parties performing public tasks. As the NPM, the Ombudsman's competence also extends to other private parties maintaining places where persons deprived of their liberty are held or may be held as mentioned above. These include 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.

The Ombudsman can use all the powers laid down in the Constitution of Finland and the Parliamentary Ombudsman Act to perform the inspection duties.

Forms and methods of inspections

Inspections can be carried out with or without prior announcement, that is, as surprise visits. The majority of inspection visits performed as the NPM are unannounced, which the Subcommittee on Prevention of Torture (SPT) considers important.

The Ombudsman may acquire documents, such as various decisions and administrative instructions, from the inspection target before making a pre-announced visit. This way, the Ombudsman's observations concerning the documents can be discussed with the site's personnel already during the visit. The prior announcement is also a way to ensure that the management is present on site during the inspection.

In the case of unannounced inspections, the inspectors are unable to familiarise themselves with the documents in advance, which means that they can only go through them during the visit or acquire the documents after it. However, it is important to obtain an authentic picture of the conditions, particularly at places of detention, which is only possible with unannounced inspections.

In some cases, the Ombudsman informs the site to be inspected that there will be an inspection visit in the near future, but at an unannounced time. This way, they can obtain documents in advance but keep a partial element of surprise for the inspection visit.

A specific questionnaire form with questions related to prison conditions and the treatment of inmates has been developed for inspecting prisons. The form is sent to the prison in advance, and the inmates and staff are asked to answer questions anonymously. Based on the responses, the inspection can focus on issues that have drawn criticism, and the inspectors can discuss them with the prison management already during the visit.

The possibility to have confidential discussions with the inspectors is a central part of the inspection visits. This possibility is regularly reserved for inmates of a closed institution and conscripts and other persons performing military service. With consideration, this possibility may also be reserved for the site's staff.

The confidential discussions usually take place individually, but in some cases, several people can participate in the discussion at the same time. For example, garrison inspections regularly involve group discussions with all conscripts belonging to the Conscript Committee. Similarly, the garrison's priest, doctor and social welfare officer are also usually part of the same discussion.

During the coronavirus pandemic, when normal on-site inspections were not possible due to the risk of infection, the Ombudsman developed different remote inspection methods. In these, it is possible to talk with the management and staff of the site under inspection using a secure video connection. Confidential discussions can also be held by telephone so that the inspection site is told the telephone numbers and times when they can reach the inspectors of the Office of the Parliamentary Ombudsman. The opportunity for discussion can be reserved not only for the persons in the institution or housing unit themselves, but also for the relatives of older people or persons with disabilities, for example.

The identity of the participants in confidential discussions is disclosed to the management or staff of the inspected site only if the person has given their prior consent. In cases where the identity is shared with the inspected site, the site shall not take retaliatory action against the person who provided the information to the inspectors. The Parliamentary Ombudsman Act explicitly provides immunity for inspections carried out as the NPM: in accordance with the Act, no punishment or other sanctions may be imposed on persons having provided information to the National Preventive Mechanism for having communicated this information (section 11 h).

For inspections carried out as the NPM, the Ombudsman may appoint third party experts who have particular expertise relevant to the inspection duties of the NPM (section 11 g). There are currently 22 experts. The majority of them are medical experts in fields such as youth psychiatry, geriatric psychiatry, forensic psychiatry or intellectual disability medicine. Multiprofessionalism has recently been increased by appointing social workers working in child welfare as experts.

Experts may also be experts by experience. The members of the section for disability rights under the Human Rights Delegation at the Human Rights Centre, which operates in connection with the Office of the Parliamentary Ombudsman, have been appointed as experts for inspections related to monitoring the rights of persons with disabilities. They are not only experts on the rights of persons with disabilities, but also persons with disabilities themselves. Similarly, experts who were once themselves placed in a closed institution for children and young people in social welfare can participate in inspections carried out at child welfare institutions.

If there are foreign inmates at the inspection site, interpreters are also provided. These sites include detention units for foreigners, reception centres and prisons.

Inspections may be carried out under the leadership of the Ombudsman or the Deputy-Ombudsman, but they may also order legal advisers of the Office of the Parliamentary Ombudsman to perform them alone. Currently, legal advisers perform approximately half of all inspections and the majority of the inspections carried out as the NPM. In these cases, the observations made during the inspections are presented to the Ombudsman or Deputy-Ombudsman, who ordered the inspection, to decide on the comments and measures that the inspection warrants.

Inspection themes

In addition to the general oversight of legality and monitoring the implementation of fundamental and human rights, the inspections also gather information on several special themes.

The Office of the Parliamentary Ombudsman has traditionally selected a special annual theme that is taken into account in each inspection and when directing its own initiatives and other activities. The annual theme is typically related to some fundamental and human rights issue or other issues relevant to the Ombudsman's duties. During this reporting year, the theme was "oversight of oversight". The inspection was focused on the functioning of authorities' internal oversight of legality and the activities of the special supervisory authorities in different fields. Oversight of oversight belongs to the Parliamentary Ombudsman as the supreme overseer of legality, and it is also important for other oversight by the Ombudsman and for appropriate allocation of resources of the Ombudsman: as the supreme overseer of legality, the Ombudsman should not be the sole overseer of any authorities' actions or public tasks, as they should have effective internal monitoring and monitoring of other supervisory authorities.

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

In addition to the annual theme, all inspections focus on the implementation of the rights of persons with disabilities, as the Ombudsman has a special task (together with the Human Rights Centre and its Human Rights Delegation) to act as a national mechanism in accordance with the UN Convention on the Rights of Persons with Disabilities. The monitoring of the rights of elderly people is also a focus area in the Ombudsman's activities, for which the Parliament has granted additional resources. Specific forms have been drawn up for monitoring the rights of both persons with disabilities and elderly people containing questions that will be raised during the inspections.

Principally, all inspections also pay attention to the realisation of linguistic rights. It may be a question of monitoring that the national languages (Finnish and Swedish) laid down in the Constitution are implemented equally, meaning that services are available and any signs, instructions and information are provided in both national languages in accordance with the Language Act. It may also be a question of a foreigner's right to obtain the information they need in a language that they understand when the law entitles them to it.

In addition to the aforementioned themes, different inspection sectors have certain established special themes (such as the use of restrictive measures in closed institutions) and also other changing, special themes, depending on how current the theme is or on the special features of the inspected site.

Selection of inspection sites

The strategic objective of the inspections, like in all other activities of the Parliamentary Ombudsman, is to maximise the impact of the activities, which also affects the selection of inspection sites. When the Ombudsman has thousands of inspection sites to oversee and only a very small number of them can be inspected for practical reasons, targeting inspections is a very important issue.

One starting point for this consideration is to target inspections at places where fundamental rights are a sensitive issue and which include vulnerable people. The Parliamentary Ombudsman Act already requires that inspections are targeted especially at prisons and other closed institutions and different units of the Defence Forces. Similarly, the NPM is responsible for inspecting places where persons deprived of their liberty are held. These include places where the people cannot leave the premises upon their will.

From these starting points, the inspections focus on prisons, detention facilities for persons deprived of their liberty maintained by the police and other authorities, garrisons and psychiatric hospitals, but also on housing units or institutions for children, elderly people or persons with disabilities from which the occupants cannot leave when they want.

It is reasonable to target inspection visits also to places from where complaints are not received, as the Ombudsman usually receives information on issues through complaints. With the exception of prisons, the above-mentioned places may also be valid inspection targets from this perspective – conscripts, psychiatric patients, children, elderly people and persons with disabilities make up only few complaints.

There are also activities around which no complaints are made. Typical examples are covert intelligence gathering and intelligence operations that take place without the target's knowledge – the target is thus unable to complain about these. For this reason, inspections are a key source of information for the Ombudsman.

The existence and effectiveness of other supervision also affects the targeting of Ombudsman's inspections. For example, as the oversight of intelligence operations is a special task of the Intelligence Ombudsman, it is reasonable for the Parliamentary Ombudsman to focus its inspections mainly on covert intelligence gathering, for which the Ombudsman is practically the only external overseer of legality. The Act on the Division of Duties between the Chancellor of Justice and the Parliamentary Ombudsman (330/2022) is also taken into account when targeting inspection visits. In the Act, the categories centralised to the Parliamentary Ombudsman are special tasks of the Parliamentary Ombudsman from the perspective of the supreme oversight of legality.

Following these starting points, there is still a huge number of sites that can be selected for an inspection visit. The aim is to select the most important sites and sites where the Ombudsman conciders that an inspection would have the greatest impact. Each inspection sector also has certain key sites that are inspected alternately, as a rule. However, there may be grounds to carry out a follow-up visit at the same site to ensure that the recommendations issued after the previous visit have been implemented. Closed institutions are also inspected in the evening and at night, in order to make observations of activities and conditions that would not be apparent during the daytime.

The Ombudsman also aims to identify shortcomings and gaps in supervision. For example, during this reporting year, the detention facilities of a passenger ferry operating between Finland and Sweden were inspected for the first time. The inspection of such premises is part of the mandate of the NPM and the private security guards on board the ship are performing a public administrative task, which falls under the Ombudsman's competence. The inspection revealed significant deficiencies not only in the ship's detention facilities and operating methods, but also in the police supervision related to them and the vessel's security guard operation, as well as in legislation (see section 3.5.6 of this report for more details).

According to the Parliamentary Ombudsman Act, the Ombudsman also carries out on-site inspections to get acquainted with matters within his or her remit. These kinds of inspections concern different authorities, but the number of these inspections is not very high at present.

Measures and visit reports

The Ombudsman's inspection visits – as well as its other activities – are not only ex-post oversight of legality, as they also promote the implementation of fundamental and human rights. A key aspect is the perspective that prevents violations and guides and develops the activities of authorities.

A report is drawn up after each inspection visit, presenting the observations made and the Ombudsman's comments, recommendations and other measures. Some of these can already be discussed during the inspection with the site's staff and management. If the inspection reveals issues requiring more extensive investigation, they will be investigated as separate own initiatives.

The inspected site will be given an opportunity to comment on the information and observations presented in the draft visit report and usually on the Ombudsman's preliminary opinions. The inspected site is also asked whether it considers that the report contains confidential parts that should be removed from the published report.

The aim is to increase the effectiveness of the inspections and the Ombudsman's comments related to them by means of extensive distribution and publication of the report.

The finished visit report is delivered not only to the inspected site but also to the relevant supervisory agency (such as the National Police Board) and other supervisory authorities in the administrative branch (such as Valvira and the Regional State Administrative Agency) and to other parties if considered necessary.

The reports of inspection visits carried out as the NPM are published regularly on the website of the Office of the Parliamentary Ombudsman and the reports of other inspections are published at the discretion of the Ombudsman.

The observations and measures of the NPM inspections are described in section 3.5 of this report and the measures of the other inspections for each category in section 4 (not included in this English Summary).

Number of inspection visits

According to OPCAT, the NPM should make regular visits to the sites covered by the scope of the Protocol. This is not possible in practice because there are thousands of sites.

Before the coronavirus pandemic, 100–150 sites were visited annually. During the pandemic, only a few dozen sites were inspected annually. Due to the strong increase in the number of complaints, we have not yet reached the number of inspections made before the pandemic. During the reporting year, there were 76 inspection visits, 29 of which were carried out as the NPM.

The preparation for the visit, the inspection visit itself and the related work afterwards including all their stages are rather burdensome. The Office of the Parliamentary Ombudsman has estimated that approximately 10% of the Office's resources are spent on inspections, except during the coronavirus pandemic.

Conclusion

In practice, the investigation of complaints is the most important means of the Ombudsman's oversight of legality. It would be practically impossible for the Ombudsman alone to obtain information on all the shortcomings or errors in public administration that may require the Ombudsman's measures in terms of compliance with the law, legal protection or the implementation of fundamental and human rights. I have therefore stated that the Ombudsman's activities are largely based on the fact that the Ombudsman has 5.5 million agents in Finland who, by making complaints, bring these shortcomings or errors to the attention of the Ombudsman.

However, not all people are able, willing or aware enough to submit complaints about violations or shortcomings they have experienced. It is particularly important to conduct inspections to ensure the rights and treatment of such people, such as children, the elderly, persons with disabilities, persons deprived of their liberty and foreigners. Inspections are also important in other areas of authority activities where complaints are typically rarely made. These include the treatment of conscripts and other persons performing military service, as well as covert information gathering by security authorities.

The inspection 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.

The complaint procedure is always in written format, which often limits the possibility of obtaining a versatile picture of the matter under investigation. The inspection visit, on the other hand, provides an opportunity for oral interactive dialogue with the management and staff of the site and with the persons who have been placed there. The inspection provides an authentic picture of the inspected site and its conditions. For these reasons, the inspections provide a good opportunity not only for monitoring legality, but also for the Ombudsman's measures that prevent violations and to guide and develop the activities of the authorities.

From many perspectives, inspection visits are a very important part of the Ombudsman's oversight of legality and the promotion of the implementation of fundamental and human rights.

Deputy-Ombudsman
Ms Maija Sakslin

What measures have my decisions given reason for

Measures taken by the Parliamentary Ombudsman

The content of a large part of the complaints received for processing by the Parliamentary Ombudsman – 40% in the year of the review – is such that they will not be investigated. There are many different reasons for this. The text written by the complainant may be unspecified to the extent that investigating it is not possible. The events referred to in the complaint may have taken so long ago that investigating them is no longer justified, the Parliamentary Ombudsman can no longer help the complainant, or the complainant no longer needs legal protection. The reason for not investigating the complaint is often that the criticism is targeted at activities or an actor that the Ombudsman is not authorised to supervise, the matter is pending before a competent authority or it is still appealable through regular appeal procedures. In some matters, the Ombudsman advises the complainant to turn to some other competent authority or transfers handling of a complaint to another supervisory authority. On the other hand, the outcome in matters on which an investigation has been started may also be that the matter did not give reason for the Ombudsman to take any measures or that there was no reason to suspect unlawful action, negligence of responsibilities or exceeded authority or discretion.

When the Ombudsman observes incorrect actions by the subject of oversight in the investigated matters, he may present criticism of different strengths and guide the subject of oversight in acting lawfully and implementing fundamental and human rights.

Provisions on the measures at the Ombudsman's disposal have been laid down in the Parliamentary Ombudsman Act. According to the Act, the Parliamentary Ombudsman may issue a reprimand for future guidance if he concludes in his oversight of legality that the subject of oversight has acted unlawfully or failed to fulfil its obligations, but the Ombudsman considers that bringing criminal charges is not necessary. The Parliamentary Ombudsman may bring to the attention of the subject of oversight his opinion concerning what constitutes proper observance of law through reprimand or guidance, draw attention to the requirements of good governance or to considerations of promoting fundamental and human rights. In addition, the Ombudsman may propose to the competent authority how the mistake that has taken place could be corrected or the shortcoming rectified.

From the point of view of the oversight of legality, the fact that the Parliamentary Ombudsman can draw the attention of the Government or the ministry to defects observed in the provisions or regulations and propose their development, or the elimination of the defects has a greater impact than a decision on an individual complaint. A proposal for the development of regulations was made in about six percent of the matters solved in the year of the review. The proposals are brought to the attention of Parliament in the Annual Report.

Measures being taken by the Ombudsman are typically not targeted at an individual public official or person performing a public task. Instead, the guidance and criticism are targeted at the authority or its leading body. Oversight of legality is aimed at addressing the harm caused to an individual by unlawful actions, exceeded discretion or negligence of obligations regardless of whether a single person can be found responsible for the action.

Notifications of the measures taken

Our legislation does not set out an obligation for the Parliamentary Ombudsman to monitor or supervise what measures the subject of oversight has undertaken as a result of the Ombudsman's opinion. However, at a very early stage, the Ombudsman requested information on the measures that his view had given reason for in some individual cases.

The general understanding is that the implementation of the opinions, recommendations and proposals presented in the Ombudsman's decisions is very effective. This understanding is based on the thought that principle of legality and lawfulness have traditionally been respected in the Finnish legal and administrative culture. This has created an operating environment for the supreme overseer of legality in which there has not been any specific need for comprehensive, systematic follow-up monitoring or follow-up supervision. The assessment of the need for follow-up monitoring is also affected by what kind of authorities or actors are involved. When the authority has functioning internal guidance in terms of lawfulness and the oversight of legality, the implementation of the opinions of the overseer of legality is usually effective. On the other hand, there may be more uncertainty about private actors subject to the Ombudsman's oversight or about very small or dispersed organisations. It is likely that the Parliamentary Ombudsman's oversight of legality will in future focus increasingly on private actors performing public tasks or public administrative tasks, which in turn is likely to increase the need for follow-up monitoring.

The monitoring of the effects of the Ombudsman's measures has largely been based on the complainant monitoring how the authority acts in the matter. In addition, the complaints submitted by other complainant's may reveal that the authority has not corrected its actions. The media also participate in the monitoring by conveying information on the Ombudsman's opinions on the one hand, and by reporting on defects in the implementation of the Ombudsman's guidance or recommendations, on the other. Awareness of the Ombudsman's decisions and the participation of private persons in their supervision is based on media publicity and decisions on measures published by the Ombudsman.

In 2022, of the 7,072 cases of oversight of legality in which a decision was made, 967 led to a measure taken by the Ombudsman. In the past few years, follow-up monitoring has been increased and a request to report the measures that the Ombudsman's opinions and proposals have given reason to has increasingly been added to decisions leading to measures. Based on the notification of the measures taken, it is possible to assess whether the measures have been adequate. In addition, the request alone may speed up and increase the effectiveness of the measures. In 2022, the Parliamentary Ombudsman received 468 notifications of the measures taken. In 2021, 435 notifications were received and in 2020, 355 notifications. Although the Ombudsman's decisions on measures to be taken and the notifications on the measures taken are not statistically allocated to the same year, the number of notifications indicates a slight increase in follow-up monitoring. However, it is not possible to use them to estimate comprehensively how the Ombudsman's proposals, recommendations and other opinions have been implemented. The number of notifications of the measures taken is also increased by the fact that matters are transferred to another supervising authority for processing or, for example, to the reprimand procedure, in which case a request is always made to report how the matter has been solved. Still, it is possible to assess the effectiveness and focus of oversight of legality to some extent on the basis of the notifications of the measures taken.

The proposals for recompense and the related notifications of the measures taken constitute a specific category of the Ombudsman's measures. A notification of the measures taken is without exception requested in connection with proposals for recompense. The Parliamentary Ombudsman may make proposals for recompense for a violation of fundamental or human rights in an individual case when the unlawful or erroneous action can no longer be corrected. In them, it is proposed that the subject of oversight should consider how it can recompense the immaterial harm or the unfairness experienced as a result of the violation of the rights. The recompense may be an apology, but it is often a sizeable amount of money. Because the Ombudsman's proposals usually leave it to be considered by the subject of oversight how the violation of rights that has occurred can be recompensed, it is requested that the subject of oversight report what measures the proposal has given reason to. Only in exceptional cases have the notifications of the measures taken given reason for the Ombudsman to take further measures. In the year under review, the Ombudsman made 22 proposals for recompense. They are reported to Parliament in the Parliamentary Ombudsman's Annual Report.

In several countries, deadlines have been set in the legislation concerning the Parliamentary Ombudsman by which the authorities subject to oversight must report what measures have been taken on the basis of the opinions issued by the Ombudsman or justify why the measures have not been taken. The deadlines are often fairly short, from thirty to sixty days. Parliamentary Ombudsmen also publish information on how large a proportion of their recommendations have led to the desired measures.

For example, the Regulation of the Parliament on the performance of the European Ombudsman's duties expressly lays down provisions on the interaction of the Ombudsman and the EU's institutions. Under the Regulation, if the Ombudsman observes instances of maladministration in an inquiry, the Ombudsman will inform the Union institution, body, office or agency concerned of the findings of the inquiry without undue delay and, where appropriate, will make recommendations. The Union institution to which recommendations have been issued must submit a detailed opinion to the Ombudsman within three months. The European Ombudsman can on reasoned request grant an extension to that deadline for a maximum of two months.

In addition, at the end of each annual session, the European Ombudsman submits to the European Parliament a report on the outcome of the inquiries that he or she has carried out. The report includes an assessment of compliance with the European Ombudsman's recommendations, proposals for solutions and suggestions for improvement. The Annual Report of the Parliamentary Ombudsman does not include a similar assessment or proposals and suggestions.

Legislative recommendations

It is the Parliamentary Ombudsman's statutory duty to draw the attention of the Government or another body responsible for legislative drafting to defects in legislation or official regulations and make recommendations concerning the development of these and the elimination of the defects.

The Ombudsman's recommendations concern defects, missing provisions or inaccuracies in an act or decree or defects in the interpretation of an act, found when exercising the oversight of legality. The monitoring of the progress of legislative recommendations is systematic and the Parliamentary Ombudsman usually requests a report of what measures the recommendation has given reason to. The measures are considered sufficient even when planned measures that have not been completed by the given deadline are reported in the notification.

However, there are situations in which the Parliamentary Ombudsman does not make specific legislative recommendations but may leave the decision on the need for legislative amendments to the discretion of the ministry responsible for the legislative drafting. A request made even in connection with such a recommendation may enhance the implementation of the recommendation, but usually a report of the measures is not requested.

The procedure adopted for assessing the notifications of the measures taken received by the Ombudsman is relatively established. The Parliamentary Ombudsman or the Deputy-Ombudsman who has made the recommendation decides on whether the planned or implemented measures give reason to further measures. Further measures are seldom undertaken. This is mainly because the planned measures may be extremely diverse, which is why assessing their adequacy is not straightforward and ultimately, deciding on the need to make amendments to legislation is the responsibility of Parliament as the legislator. The more specified the legislative proposal is, the more likely it will lead to initiation of legislative drafting.

It is very rare for a legislative recommendation not to lead to legislative measures. Sometimes there are acceptable reasons for this, for example, with regard to the legal order as a whole. Sometimes legislative amendments are not implemented until several years after the recommendation made by the Parliamentary Ombudsman.

The Parliamentary Ombudsman's powers do not include ordering the Ministry to prepare a legislative proposal and the Ombudsman cannot obligate the Government to decide on submitting to Parliament a government proposal included in a legislative proposal. If there is a desire to increase the effectiveness of the follow-up monitoring of legislative recommendations, it could take place in closer interaction with Parliament, for example, in connection with the discussion on the Annual Report. Currently, the different sections of the Annual Report may include descriptions of what measures the legislative recommendations made during the year of the review have given reason to, less often descriptions of how the recommendation has not resulted in a change.

Under the Parliamentary Ombudsman Act, in connection with Annual Reports, the Ombudsman could also submit proposals for the elimination of the defects observed in legislation to Parliament. The first Staff Regulations governing the operation of the Parliamentary Ombudsman's activities, issued in 1920 already, gave to the Ombudsman the task of reporting to Parliament the defects and any unclear or conflicting provisions found in acts and decrees. Under the current Parliamentary Ombudsman Act, if the observed deficiency is related to a matter that is being discussed in Parliament, the Ombudsman may also bring his observations to the attention of the relevant body within the Parliament in other ways. From the point of view of the constitutionality of acts, it is significant that this authority has already been traditionally interpreted to give the Ombudsman the right to report the non-constitutionality of the provisions of an act to Parliament regardless of whether the conflict is linked to the narrowing of a basic right of an individual person in an individual case.

Proposals for the implementation of human rights

In addition to the traditional oversight of legality, the Ombudsman's constitutional task has been to monitor the realisation of fundamental and human rights. Under section 22 of the Constitution of Finland, public authorities have the obligation to guarantee the observance of basic rights and liberties and human rights, and under section 109 of the Constitution, the Parliamentary Ombudsman has the duty to monitor the implementation of basic rights and liberties and human rights. These provisions provide the Ombudsman with exceptionally strong powers in the oversight of human rights, even by international comparison. The Ombudsman's Annual Report must pay special attention to implementation of fundamental and human rights.

Human rights conventions are considered to be part of the national legal system, and the interpretations and opinions by the international monitoring bodies of human rights conventions are considered to apply to all exercise of public power. Promoting consideration of the judgements of the European Court of Human Rights and the opinions issued by the other monitoring bodies of human rights conventions by making proposals on actions, training and instructions, and similar is therefore part of the Ombudsman's everyday work.

Legislative recommendations and other proposals for taking into account the requirements of human rights conventions are made especially in matters investigated as own initiatives and opinions given to the ministries or to the Parliament. In addition, the Ombudsman has special duties in the supervision of the UN Convention of the Rights of the Child and the UN Convention on the Rights of Persons with Disabilities and as the National Preventive Mechanism of the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The observations made in the supervision of these conventions and the proposals made by the Parliamentary Ombudsman are widely reported to Parliament in the Annual Report.

The Ombudsman does not otherwise systematically monitor the realisation of human rights or report to Parliament how the judgements of human rights courts or other monitoring bodies have been implemented in Finland. However, since 2009, the Annual report of the Parliamentary Ombudsman has at the request of the Constitutional Law Committee included a description of such defects in the realisation of basic and human rights that the Ombudsman has in his oversight of legality addressed several times without achieving the desired improvement. This section is currently a list of the ten main fundamental and human rights problems in Finland. The short section does not include the proposals made by the Parliamentary Ombudsman to eliminate the defects.

In February 2022, a study was published stating that the implementation of the decisions and recommendations issued by the monitoring bodies of international human rights conventions was slow in Finland. The objective of the study was to support the creation of such national structures and operating models that would promote the monitoring of the interpretation practice of the human rights monitoring bodies in legislative drafting and in the implementation of acts.[1)]

In the study, Parliament's access to information was considered inadequate and it was proposed that reports on the opinions issued by the bodies monitoring human rights should be regularly reported to Parliament and to its committees. The judgments of the European Court of Human Rights on Finland have at the Constitutional Law Committee's request been explained in the Parliamentary Ombudsman's Annual Report, but the report does not include an overview of the opinions of other Human Rights monitoring bodies or judgements of the Court of Justice of the European Union concerning basic rights or their implementation.

In the internal division of work at the National Human Rights Institution, monitoring the implementation of human rights is the duty of the Human Rights Centre. The Human Rights Centre has since 2021 paid special attention to the monitoring of national implementation of the decisions and recommendations of the treaty bodies concerning Finland. Parliament's access to information would improve if the legislation concerning the National Human Rights Institution were changed so that the Annual Report of the Human Rights Centre would be submitted to Parliament.

From the point of view of the Parliamentary Ombudsman's oversight of legality, assessing the adequacy of the implementation of the judgements of the European Court of Human Rights and the opinions and recommendations of other human rights monitoring bodies is complicated by the fact that the opinions and recommendations have very often not been formulated precisely and unambiguously. On the other hand, even unambiguous opinions such as the judgements of the European Court of Human Rights leave a great deal of discretion to the Member State in the implementation of the judgements.

1) Jukka Viljanen, Tarja Seppä, Petra Järvinen, Nelli Keskilammi: Euroopan neuvoston ihmisoikeussopimusten kansallinen täytäntöönpano ja seuranta, Valtioneuvoston kanslia Helsinki 2022

For the first time, the Committee of Ministers of the Council of Europe has subjected Finland to intensified monitoring of the implementation of the judgements of the European Court of Human Rights because of delays in implementation of the judgement in the case X v. Finland. Deep concern has been expressed in the monitoring that, although more than ten years have passed since the 2012 judgements, the decision on involuntary medication is still made by the physician and it is not possible to have the physician's decision re-evaluated. The Finnish authorities were asked to prevent by all means at their disposal any delay in the necessary legislative changes and to immediately create a review procedure for decisions in close cooperation with the Secretariat of the Council of Europe.

Before the start of intensified monitoring, I had made several proposals to the Ministry of Social Affairs and Health on supplementing the Mental Health Act, especially with regard to the legal remedies available to the patient. I have also pointed out that there is still no legislation on restricting fundamental rights and human rights in somatic health care or care for the elderly, and proposed prioritising the drafting of legislation. Because the provisions of the Mental Health Act concerning appeals do not fully correspond to the current understanding of the patient's need for legal protection, I had proposed to the Ministry of Social Affairs and Health, with reference to the European Court of Human Rights' judgement X v. Finland, that it should be determined what kind of support measures would improve the patient's opportunities to improve their right to appeal. The Ministry prepared the legislative amendments. In the draft, it was proposed that the Mental Health Act be amended so that a written decision on regular medication should be made if the patient is opposed to medication or the patient's will is not known. Decisions could be appealed to the Administrative Court. Especially because of a statement issued by the Supreme Administrative Court, the bill did not proceed to a discussion by Parliament', but the drafting process was continued.

Finland has received numerous recommendations from human rights monitoring bodies to guarantee the Sámi people's right to self-determination by amending the definition of a Sámi and by enacting an obligation for the authorities to negotiate with the Sámi Parliament on matters directly affecting the status of the Sámi people. In a number of opinions I have issued, I have tried to rush through legislative changes to implement these recommendations. During the year under review, Parliament was given a government proposal for amending the Act on the Sámi Parliament, but the processing of the proposed Act expired.

These two examples are intended to illustrate the Ombudsman's role in monitoring and promoting the implementation of the judgements of the European Court of Human Rights and other monitoring bodies when legislative changes are needed. The Parliamentary Ombudsman acts within the limits of his own competence and tasks by making proposals and by monitoring and hurrying up the implementation of the necessary changes. In my view, the examples also show that there is sometimes a great deal of friction in the implementation of human rights even in a democratic country governed by the rule of law such as Finland. In exercising his duties, the Parliamentary Ombudsman aims to eliminate this friction.

In addition, these examples show that it is highly necessary to create a mechanism to effectively promote the implementation of decisions and recommendations of the human rights monitoring bodies Finland has received.

Deputy-Ombudsman
Mr Pasi Pölönen

Changes and challenges in the criminal sanctions field

Oversight of the treatment of prisoners as a special task of the Ombudsman

Oversight of the treatment of persons serving an unconditional sentence of imprisonment and those remanded in custody has been included in the Ombudsman's duties from the very beginning of the institution. The first complaint to the Ombudsman in February 1920 was made by a remand prisoner. The Parliamentary Ombudsman has had a specific legal duty to oversee the treatment of prisoners since the 1930s. The act on the division of duties with the Chancellor of Justice, which entered into force in October 2022, did not change this state of affairs; prison complaints are still handled by the Parliamentary Ombudsman.

Conducting prison inspections is based on section 5 of the Parliamentary Ombudsman Act: it concerns overseeing the treatment of inmates. The Ombudsman also has an obligation to inspect prisons due to the international law commitments made by the state of Finland. The Parliamentary Ombudsman is the national preventive mechanism (NPM) under the Optional Protocol to the Convention against Torture (OPCAT, Chapter 1a of the Parliamentary Ombudsman Act). Compared to the Ombudsman's traditional role as an overseer of legality, the perspective in this role is more forward-looking, focusing on developing the legal status. The aim is to engage in constructive dialogue and cooperation with the Criminal Sanctions Agency and to issue recommendations aimed at improving the treatment and conditions of persons deprived of their liberty.

Precise regulation in a limited framework

The provisions of the Imprisonment Act are quite detailed. In their lives, prisoners face the same issues as any other individual, and there must be solutions available to these issues even within the framework of having been deprived of one's liberty. Legally, this framework particularly includes the constitutional regulations on the conditions for restricting fundamental rights – which highlight the precision and delimitation of regulation – and the so-called principle of normality, which is the basis of prison legislation. It stipulates that prison conditions must be arranged to match the conditions prevailing in society as far as possible. The content of imprisonment is the loss of liberty or its limitation. No restrictions on the rights or circumstances of a prisoner other than those laid down by law or which will inevitably result from the punishment itself may occur. The days of institutional power are long gone.

The Constitutional Law Committee has specifically emphasised the importance of compliance with the Administrative Procedure Act in prisons (PeVL 20/2005 vp). It is one manifestation of the principle of normality. Just as any "normal" authorities, prison authorities routinely make administrative decisions falling within the scope of the Administrative Procedure Act. In a prison environment, however, the difference with many other authorities is the wide spectrum of matters that have to be decided. Additionally, the principles of good governance must be observed in the actual administrative activities of prisons.

All of this places quite high demands on the expertise and resources of prisons. However, rising to this challenge is complicated by several factors: a lack of resources at prisons, the obsolescence of institutions, continuous overcrowding, the scarcity of trained personnel and challenges in the use of the new ROTI customer information system introduced in the reporting year.

It is clear that having criminal sanctions efforts be effective and meet legal requirements requires sufficient human resources and an appropriate framework for action in other respects. However, the amount of personnel at the Criminal Sanctions Agency has been reduced by more than 500 person-years between 2005 and 2016 by way of productivity programmes and personnel adjustment measures. At the same time, several amendments have been made to sanctions legislation, which have made the work even more challenging.

In these circumstances, it is not surprising that the Parliamentary Ombudsman constantly finds points of criticism and need for improvement in the operations of prisons. In the oversight of legality in the criminal sanctions sector, the percentage of measures taken by the Ombudsman is consistently the highest at approximately 25–30%, with the average for all administrative branches being approximately 13–14%. Nonetheless, there is no reason to direct special reprimands against the criminal sanctions sector; the operations are responsible, professional and guided by the principle of legality. A significant part of the deficiencies observed in criminal sanctions are resource-based. Some are structural in the true sense of the word as they relate to the physical conditions of a facility. In such situations, it is not necessarily or usually meaningful to criticise an individual prison or public servant, but to seek to bring attention to the matter at a higher level, such as the Criminal Sanctions Agency or the Ministry of Justice.

Organisational and operational development

In the case of closed institutions, the challenge of having differing practices in different prisons is inevitable. Efforts should however be made to eliminate unfounded differences. In fact, the harmonisation of operations was one of the key inspirations in the organisational reform of the Criminal Sanctions Agency that entered into force on 1 September 2022 (so-called Rise 2.0). The reform abandoned previous divisions into geographical areas and shifted to a national agency model. We still need to gather experiences of the new organisation, but the reform seems to have been initially successful. In any case, the development is meant to be ongoing, with Rise 3.0 already underway.

The duties of the overseer of legality do not usually focus on assessing the practical organisation of an authority organisation. However, to the extent that the methods of organisation have an impact on the legality of operations and the oversight of legality, the supreme overseer of legality, including as the above-mentioned NPM for OPCAT, plays a role in bringing forth recommendations that promote the operations. Indeed, the views I presented to the Ministry of Justice in the draft stage were observed quite well in the Government proposal HE 57/2021 vp concerning the organisation of the Criminal Sanctions Agency. I especially emphasised the need to separate legal services into a distinct area of responsibility or unit that would be independent of other activities, a centralised entity for resolving complaints and claims for revised decisions and other matters concerning the oversight of legality (7961/2020); and this was in fact the eventual solution.

In the administration of justice as a field of operation, administrative dialogue with the Parliamentary Ombudsman institution is a genuinely utilised resource. There is regular judicial dialogue, and it is not limited to the above-mentioned organisational reform. Over the past seven years, the Parliamentary Ombudsman has submitted nearly 40 legislative recommendations for the development of the criminal sanctions sector and its regulation. Dozens of the Ombudsman's recommendations have contributed to the current Imprisonment Act that entered into force in 2006. This is not only an indication of our state administration being strongly committed to the rule of law, but I also believe that it is sensible in the context of limited resources.

How are resources meeting the demands set by the legislator?

In my statement on the organisational reform of the Criminal Sanctions Agency, I drew the attention of the Legal Affairs Committee to whether the organisational reform would be enough to achieve all the objectives of the Government proposal (3862/2021). Although the Ombudsman's task is not to oversee the sufficiency of authorities' resources, in recent years it has repeatedly been necessary to comment on the lack of resources for the administration of justice in different contexts. When a lack of resources leads to a failure to observe fundamental rights, for example by making it more difficult, delayed, or even impossible to fulfil the statutory obligations imposed on the authority, the oversight of legality cannot ignore issues related to resourcing.

The resourcing of prisons is far from satisfactory. This is 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. On the contrary, the quality standards of the European Committee for the Prevention of Torture (CPT) have recently been made even stricter in terms of meaningful activities and interaction. The lack of resources also has a causal link to violence between prisoners and security threats, and there is a clear link to otherwise available healthcare services and other activities going to waste solely because there are no guards to escort prisoners to them.

In its most recent report on Finland for 2021, the CPT finds that significant developments should be made in the financial and human resources of prisons in order to enable the implementation of the CPT's recommendations in the first place. The latest report also includes a threat of issuing a public statement. Finland has not been issued one so far, but it is clear that the threshold for this will lower over time and as issues persist.

The Government report on the administration of justice (VNS 13/2022 vp) highlights the lack of resources in the criminal sanctions sector. On the basis of numerous observations made in the oversight of legality, I must concur with the views expressed in the report on the serious inadequacy of resources in the criminal sanctions sector. The report states, rather straightforwardly, that compliance with the law in the criminal sanctions sector is not possible in all respects at the current resource level. This would not even be achieved with the approximately 400 person-year increase proposed in the report. Instead, it would require significant additional investments as well as a reform of the prison network (7148/2022).

The Ombudsman's task is to inform Parliament of the state of the administration of justice and on any shortcomings in legislation. In addition to the Government and its responsibility for preparation, the final responsibility for deficiencies in legislation and the state of administration lies with Parliament, which exercises legislative and budgetary powers.

2 The Finnish Ombudsman institution in 2022

2.1 Review of the institution

The year 2022 was the Finnish Ombudsman institution's 103rd year of operation. The Parliamentary Ombudsman began his work in 1920, making Finland the second country in the world to adopt the institution. The Ombudsman institution originated in Sweden, where the office of Parliamentary Ombudsman was established in 1809. After Finland, the next country to adopt the institution was Denmark in 1955, followed by Norway in 1962.

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

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

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

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

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

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

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

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

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

As of 1 October 2022, the Ombudsman changed the division of duties so that Parliamentary Ombudsman Jääskeläinen resolved matters concerning the military, the defence administration and the Border Guard, matters concerning the Office of the Prosecutor General and matters concerning freedom of expression. Matters concerning the rights of persons with disabilities were transferred to Deputy-Ombudsman Sakslin and matters concerning taxation and customs taxation to Deputy-Ombudsman Pölönen. 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 2022 was Principal Legal Adviser Mikko Sarja, who served as a substitute during the year under review for a total of 77 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 oversees 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 general comment for the Ombudsman's 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.

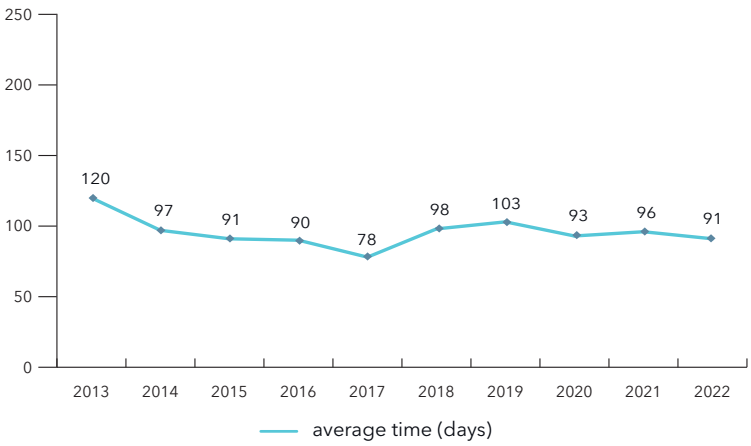
Fundamental and human rights are relevant to the oversight of legality not only when individual cases are being investigated, but also in conjunction with inspections and when deciding on the focus of own-initiative investigations. Emphasising and promoting fundamental rights guides the thrust of the 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 2022, 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.



Average time taken to deal with complaints in 2013–2022.

Complaints received and resolved in 2013–2022.

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

With the more effective processing of complaints, the Ombudsman achieved the target time – of one year for handling complaints – for the first time in 2013. It has also been achieved every year since then and at the end of the year under review. The average time taken to deal with complaints was 91 days at the end of 2022, compared to 96 days at the end of 2021.

Complaints and other oversight of legality matters

In 2022, there were a total of 6,613 complaints (7,732 in 2021). This is more than 1,000 (14.5%) fewer complaints than in the previous year, but still the third largest number of complaints ever, even though the coronavirus pandemic no longer had a significant impact on it. The largest number of complaints concerned social welfare 997 (1,142), the police 821 (922), healthcare 751 (1,322) and criminal sanctions 672 (477). The strongest growth was observed in complaints related to criminal sanctions (40%). In the reporting year, 6,857 complaints were resolved. The corresponding figure in 2021 was 7,892.

The number of complaints submitted by letter or fax or delivered in person has decreased in recent years, while the number of complaints sent by email has increased correspondingly. In 2022, the majority of complaints, 82% (86% in 2021), were submitted electronically. The complainant also receives an immediate notification of the receipt of the email.

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

With the introduction of the electronic case management system in 2016, communications that were previously filed under category 6 "Other communications", are now filed under complaints. The processing of these communications, however, remains the same: they are forwarded to the Substitute Deputy-Ombudsman or Secretary General for further distribution and handling. The replies are reviewed by the Substitute Deputy-Ombudsman or the Secretary General.
Some complaints are handled through an accelerated procedure. In 2022, slightly over half (54%) of all complaints were dealt with in this way. The purpose of the procedure is to identify immediately on receipt the complaints that require no further investigation. The accelerated procedure is suitable especially in cases where there is manifestly no ground to suspect an error, the time limit has been exceeded, the matter falls outside the Ombudsman's remit, the complaint is non-specific, the matter is pending elsewhere, or the complaint is a repeat complaint with no grounds for a reappraisal. If a complaint proves to not be suitable for the accelerated procedure, the matter is referred back for the normal distribution of complaints. A draft response is given within one week to the party deciding on the case. The complainant is sent a reply signed by the legal adviser taking care of the matter.

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

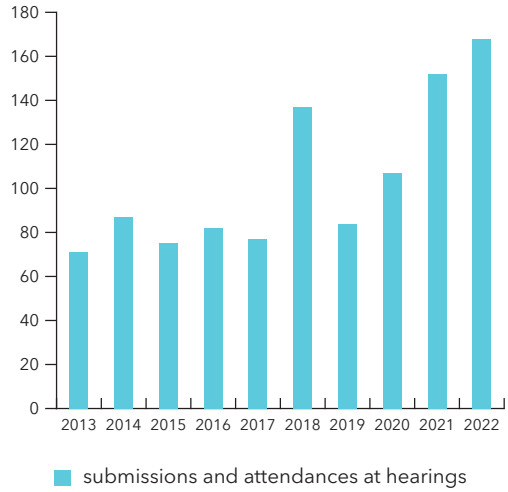
Received oversight of legality matters	2022	2021
Complaints	6,512	7,651
Complaints referred by the Chancellor of Justice	101	81
Own-initiative investigations	47	67
Requests for statements and hearings	157	155
Total	6,817	7,954

Resolved oversight of legality matters	2022	2021
Complaints	6,814	7,840
Complaints referred to the Chancellor of Justice	43	52
Own-initiative investigations	47	91
Requests for statements and hearings	168	153
Total	7,072	8,136

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 2022, 10,518 written communications that had arrived for information were received (9,647 in 2021).

In addition, the oversight of legality extends to opinions and consultations on various parliamentary committees, for example. The number of statements and hearings increased to record levels again in 2022.

In 2022, 78% (78% in 2021) of all the complaints that arrived were related to the ten largest categories. Statistics on the Ombudsman's activities are provided in Appendix 6.

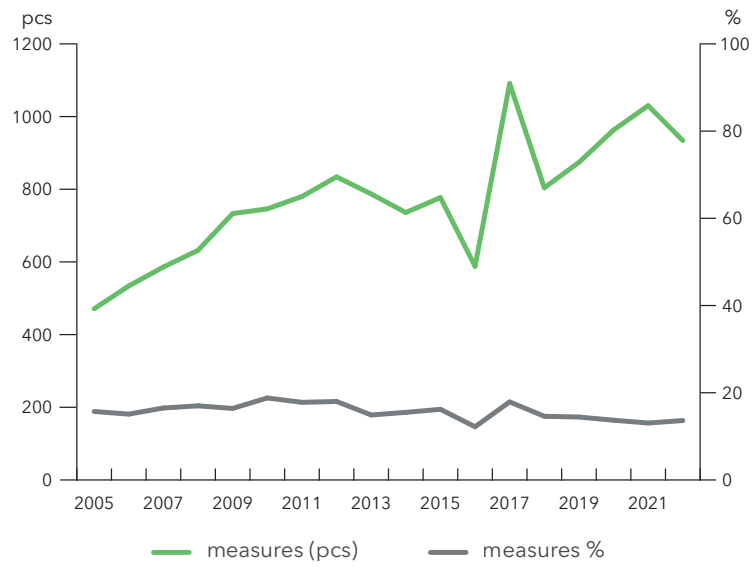


Resolved requests for statements and hearings between 2013 and 2022.

In 2022, a total of 47 (91 in 2021) matters investigated on the Ombudsman's own initiative were resolved. Of these, 35 (42) led to action on the part of the Ombudsman, meaning 75% (46%) of matters.

Measures

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



In 2001–2022, the number of measures taken as a result of complaints increased from 320 up to over 1,000. The number of resolved complaints within the same period increased from approximately 2,500 up to nearly 8,000. The relative proportion of complaints leading to measures (measure %) has remained more or less unchanged.

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

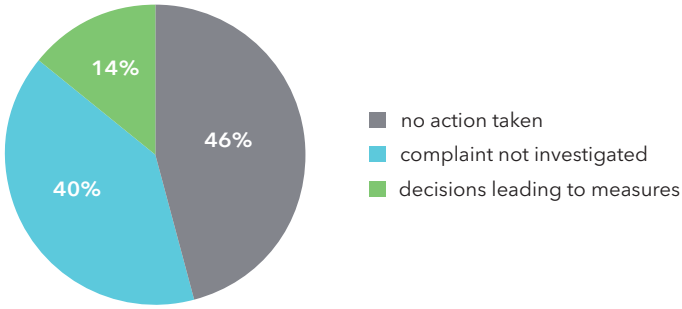
In addition, the Ombudsman may recommend the rectification of an error or draw the attention of the Government or other body responsible for legislative drafting to shortcomings that he has observed in legal provisions or regulations. The Ombudsman may also suggest compensation for an infringement that has been committed or make a proposal for an amicable solution on a matter. Sometimes an authority may pre-emptively rectify an error at a stage when the Ombudsman has already intervened with a request for a report. The proposals are listed in Appendix 3.

In 2022, decisions on complaints and investigations at the Ombudsman's own initiative that led to measures totalled 967 or 14% of all decisions (1,030 in 2021, i.e. 13%). Approximately one fifth of complaints and investigations at the Ombudsman's own initiative were subject to a full investigation; in other words, at least one report and/or statement was obtained.

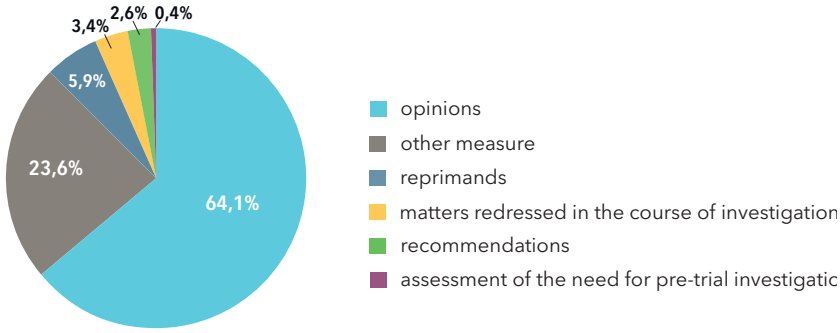
In about 43% of the cases (2,953), there were no grounds to suspect erroneous or unlawful action, or there was no reason for the Ombudsman to take action. A total of 197 cases (approximately 3%) were found not to involve erroneous action. No investigation was conducted in 40% of the cases (2,773).

MEASURES TAKEN BY PUBLIC AUTHORITIES	Prosecution	Assessment of the need for pre-trial investigation	Reprimand	Opinion	Recommendation	Rectiication	Other measure	TOTAL	Total number of decisions	Percentages*
Social welfare	0	0	10	117	19	7	52	205	1 031	19,9
Health	0	0	7	89	12	7	42	157	952	16,5
Criminal Sanctions field	0	0	1	108	7	5	26	147	634	23,2
Police	0	4	2	77	7	3	12	105	856	12,3
Administrative branch of the Ministry of Education and Culture	0	0	1	36	6	2	42	87	319	27,3
Social insurance	0	0	2	39	3	3	12	59	364	16,2
Administrative branch of the Ministry of Economic Affairs and Employment	0	0	0	37	2	0	2	41	277	14,8
Local government	0	0	1	23	0	3	7	34	233	14,6
Enforcement (distraint)	0	0	0	14	1	3	1	19	179	10,6
Taxation	0	0	0	11	0	0	4	15	105	14,3
Administrative branch of the Ministry of the Environment	0	0	0	4	0	0	10	14	175	8,0
Administrative branch of the Ministry of Justice	0	0	0	10	0	1	1	12	108	11,1
Administration of Law	0	0	0	7	0	0	4	11	258	4,3
Administrative branch of the Ministry of Defence	0	0	2	7	0	0	0	9	97	9,3
Guardianship	0	0	2	6	0	0	2	8	66	12,1
Administrative branch of the Ministry of Agriculture and Forestry	0	0	1	4	0	0	3	7	158	4,4
Administrative branch of the Ministry of Transport and Communications	0	0	0	7	0	0	0	7	81	8,6
Administrative branch of the Ministry of Finance	0	0	0	4	0	0	0	4	67	6,0
Prosecutors	0	0	0	3	0	0	1	4	93	4,3
Aliens affairs and citizenship	0	0	0	2	1	0	1	4	290	1,4
Highest organs of government	0	0	0	2	0	0	0	2	20	10,0
Administrative branch of the Ministry of the Interior	0	0	0	1	1	0	0	2	22	9,1
Customs	0	0	0	0	0	0	1	1	453	0,2
Administrative branch of the Ministry for Foreign Affairs	0	0	0	1	0	0	0	1	16	6,3
Other administrative branches	0	0	0	0	1	0	0	1	1	0,0
Total	0	4	27	618	61	34	223	967	6 904	14,0

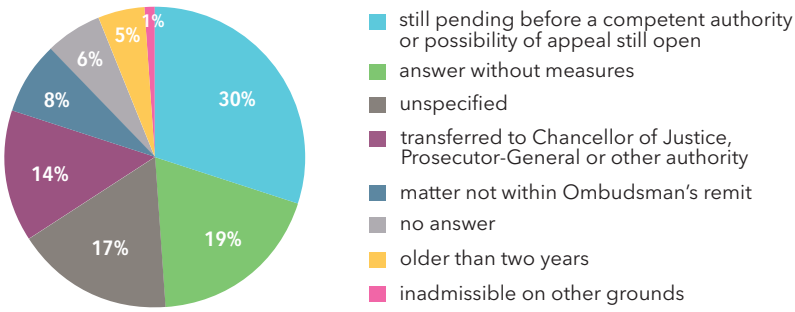
* Percentage share of measures in decisions on complaints and own initiatives in a category of cases.



All cases resolved in 2022.



Decisions involving measures in 2022.



Complaints not investigated in 2022.

In most cases, the complaint was not investigated because the matter was already pending with a competent authority. An overseer of legality usually refrains from intervening in a case that is being dealt with at the appeal stage or by another authority. Matters pending with other authorities, and therefore not investigated, accounted for 12% (841) 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 22.9%.

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 24 reprimands were given, and 597 opinions were expressed. Rectifications were made in 32 cases while under investigation. Decisions classed as recommendations numbered 55, although opinions regarding the development of governance that count as recommendations were also included in other types of decisions. Other measures were recorded in 220 cases. In reality, the number of other measures that the decisions lead to is greater than the figure shown above, because only one measure is recorded under each case, even though several measures may have been taken.

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

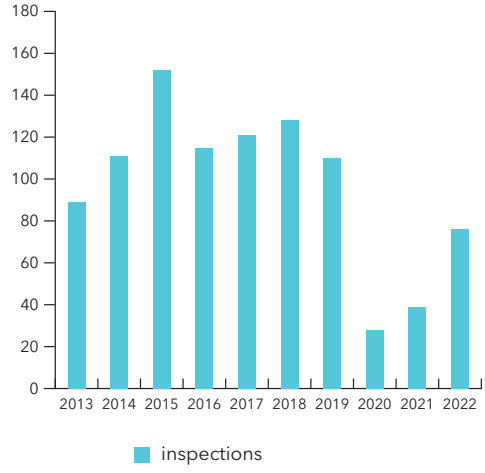
Inspection visits

Due to the coronavirus epidemic, the number of inspections continued to be lower than usual. In 2022, 76 inspections were carried out (39 in 2021). A full list of all inspections is provided in Appendix 4. The inspections are described in more detail in connection with the respective topic.

Approximately half of the inspections were conducted under the leadership of the Ombudsman or the Deputy-Ombudsmen and the remainder by legal advisers and as documentation reviews because of the coronavirus epidemic. A total of 29 (15 in 2021) visits were made to places and facilities where individuals are or may be kept while deprived of their liberty; 15 (2) of these visits were unannounced. These visits were made in the capacity of the National Prevention Mechanism against Torture (NPM).

The NPM visits are made, in particular, in prisons 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.



The number of inspections between 2013 and 2022.

2.1.6 COOPERATION IN FINLAND AND INTERNATIONALLY

Events in Finland

Ombudsman Jääskeläinen and Deputy-Ombudsmen Sakslin and Pölönen submitted the Parliamentary Ombudsman's annual report 2021 to Speaker of the Parliament Matti Vanhanen on 21 June 2022. The Ombudsman attended a preliminary debate on the report at a plenary session of Parliament on 13 October 2022. At the end of the reporting year, the committee reading of the 2021 report is still under way.

As the coronavirus epidemic eased, several Finnish authorities and other guests and groups visited the Ombudsman's Office, and topical issues and the work of the Ombudsman were discussed with them. For example, lawyers responsible for the oversight of legality at the Criminal Sanctions Agency visited the Office on 11 April, Päivi Topo, who started as the Ombudsman for older people, visited on 26 August, a group from the Police University College visited on 31 August, the legal unit of the Tax Administration visited on 7 December and students of the Border and Coast Guard Academy visited on 15 December.

The Ombudsman's inspection activities were presented to representatives of the Office of the Non-Discrimination Ombudsman on 22 August. The legal advisers of the Office's team handling matters related to older people held a cooperation meeting with Valvira's legal advisers on 6 October. On 10 November, students of Laurea University of Applied Sciences visited Deputy-Ombudsman Pölönen and interviewed him on the subject Legal Design and Expertise. A cooperation meeting was held with representatives of the Association of Finnish Local and Regional Authorities on 8 December to discuss matters related to the education sector.

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

Parliamentary Ombudsman Jääskeläinen gave a talk at the Human Rights Centre's 10th anniversary celebration on 9 June and at the seminar for the senior command of the Finnish Defence Forces on 16 September.

On 19 January, Deputy-Ombudsman Sakslin and the legal advisers of the team handling matters related to older people held a remote cooperation meeting with Päivi Topo, who was selected as the Ombudsman for older people.

Parliamentary Ombudsman Petri Jääskeläinen, Deputy-Ombudsman Maija Sakslin and Deputy-Ombudsman Pasi Pölönen handed the Ombudsman's Annual Report for 2021 to Matti Vanhanen, Speaker of the Parliament, on 21 June 2022.

On 21 January, Deputy-Ombudsman Sakslin participated in the ethical perspective on the right to self-determination event and on 9 May in the Forge research project event. On 27 September, Deputy-Ombudsman Sakslin participated in the panel discussion "Uniform principles, from hidden prioritisation to openness" at the social welfare and healthcare prioritisation forum 2022.

On 28 March, Deputy-Ombudsman Sakslin and Deputy-Ombudsman Pölönen held a cooperation meeting remotely with the legal advisers of the Ombudsman for Children Elina Pekkarinen and the Office of the Ombudsman for Children.

On 28 April, Deputy-Ombudsman Pölönen and the Office's legal advisers held a cooperation meeting with the Social Insurance Institution of Finland (Kela) on topical issues at Kela.

Deputy-Ombudsman Pölönen participated in the consultation and discussion event for the stakeholders of the report on administration of justice on 24 May and in the stakeholder event of the Administrative Courts on 13 October.

Deputy-Ombudsman Pölönen gave a speech "A strong rule of law requires strong courts" at the XXII Judge Day: independence and credibility of the court on 14 October. On 11 November, he held a presentation at the induction event for junior judges of the National Courts Administration on the topic "Parliamentary Ombudsman as the overseers of courts – the history and regulatory framework for legality oversight" and on 18 November, he presented the activities of the Parliamentary Ombudsman to higher education interns of the Parliament's information and communications department.

Legal advisers of the Office met with representatives of the Office of the Non-Discrimination Ombudsman on 25 August to discuss matters related to education and on 10 October about matters related to persons with disabilities. A cooperation meeting with Valvira and AVI Northern Finland was held on 28 November on matters related to the healthcare of inmates and the Defence Forces.

Principal Legal Adviser Tapio Räty participated in the negotiation and virtual events for influencer social workers held in connection with the virtual days work package organised with different customer groups of children and young people on 23 February and 16 December at Tampere.

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. 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, the members of which exchange information on EU legislation and good practices at seminars and other gatherings as well as through a regular newsletter, an electronic discussion forum and daily electronic news services. Seminars intended for ombudsmen and other stakeholders of the network are organised every year. During the reporting year, the network organised a conference on 27–28 April in Strasbourg, to which Parliamentary Ombudsman Jääskeläinen, Deputy-Ombudsman Sakslin, Deputy-Ombudsman Pölönen and Principal Legal Adviser Riitta Länsisyrjä attended remotely. The network also organised a webinar on 12.10. "Web accessibility and the ENO queries procedure", to which Legal Adviser Petri Lehtonen attended.

On 7 October, the European Network of National Supervisory Bodies (NPM) organised a webinar titled "Monitoring the rights of specific groups of people deprived of their liberty", to which Principal Legal Adviser Iisa Suhonen participated.

The Nordic NPMs meet regularly, twice a year. The first meeting was held remotely on 1 March. The second meeting was held in Copenhagen on 22–23 August.

The Nordic parliamentary ombudsmen have convened on a regular basis every two years, at a meeting held in one of the Nordic countries. The meeting in Iceland, which was planned for 2021, was postponed to 2022 due to the coronavirus pandemic. The meeting was held on 16–17 August in Reykjavik, and Parliamentary Ombudsman Jääskeläinen, Deputy-Ombudsman Sakslin, Deputy-Ombudsman Pölönen and Secretary General Råman attended.

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 27–28 September in Tallinn. The meeting was attended by Parliamentary Ombudsman Jääskeläinen and Secretary General Råman.

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, ending on 19 December 2023.

On 19–21 September, Senior Legal Adviser Riikka Jackson participated in the "COE-FRA-ENNHRI-EQUINET platform on social and economic rights" event in Bratislava.

On 16 December, Deputy-Ombudsman Sakslin participated in the "Nordic Workshop on Law and Crises" event organised at the University of Turku.

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

International visitors

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

On 5 May, Deputy-Ombudsman Pölönen and Director of the Human Rights Centre Sirpa Rautio met Robert Spanon, the President of the European Court of Human Rights.

Deputy-Ombudsman Pölönen met with judges of the Moldovan delegation, representatives of the Ministry of Justice and the Local Register Office on 14 September and a delegation of Members of Parliament from the United Kingdom on 27 September.

Deputy-Ombudsman Sakslin met with the delegation of Turkmenistan on 15 December.

The importance of national human rights institutions was the focal point of the discussions with Robert Spano, President of the European Court of Human Rights (positioned at the center-left).

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. Because of the coronavirus epidemic, client service at the Office was restricted with regard to visits by clients in 2020.
An on-duty lawyer at the Office is tasked with advising clients on how to make a complaint. The Legal Advisers of the Office also provide advice on matters that concern their field of activity.

The Office's Registry receives and logs arriving complaints and responds to related enquiries, as well as documents requests and provides general advice on the activities of the Office of the Parliamentary Ombudsman. The Registry received around 2,800 (3,100) calls during the year. Due to the coronavirus pandemic, there were only 20 customer visits. There were approximately 910 (980) 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 new brochure published by the Office on elderly care is also available online.

In 2022, the Office published 18 (20) press releases on the Ombudsman's decisions, inspections and statements, if they were of particular legal or general interest. In addition, information was actively provided on the special tasks of the Office. The press releases are given in Finnish and Swedish and are also posted online in English. The Office has increasingly transferred to utilising Twitter when providing information.

The Office commissioned an analysis of its media visibility, which showed that the Ombudsman had been visible in the online media in the context of 1,635 (2,311) news items or articles during 2022. A total of 9,206 (15,369) posts linked to the Ombudsman were published on social media.

A total of 296 (337) anonymous solutions 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.

The Finnish Parliament Annex.

At the end of 2022, the number of personnel in the Office was 78 (69), including the Parliamentary Ombudsman and two Deputy Ombudsmen. At the end of the year under review, the share of women on the staff was 70.5% (69.6%), including the personnel at the Human Rights Centre.

There were 67 permanent positions at the end of 2022. There were 5 vacant posts at the end of 2022. In addition to the Parliamentary Ombudsman and the Deputy-Ombudsmen, the permanent staff at the Office comprised the Secretary General, administrative assessor, 15 principal legal advisers, 20 senior legal advisers, one on-duty lawyer and the Director, five specialists and an assistant of the Human Rights Centre. The Office also had an information officer, an information management specialist, two investigating officers, five notaries, an administrative secretary, a filing clerk, an assistant filing clerk, two departmental secretaries, two records management secretaries, an assistant for international affairs and six office secretaries.

At the end of the year, the share of personnel at least 45 years of age was 79.5% (81.2%). The personnel's education level index was 6.7 (6.6). The share of personnel possessing a university-level degree was 88.5% (84.1%). Of this, the share of personnel with a Master's level university degree was 79.5% (73.9%) and the share of those who have completed research training was 11.5% (11.6%).

During a part of the year or the whole year, there were 26 persons working in the Office in fixed-term positions, including the fixed-term positions in the Human Rights Centre. A list of the personnel is provided in Appendix 5.

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

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

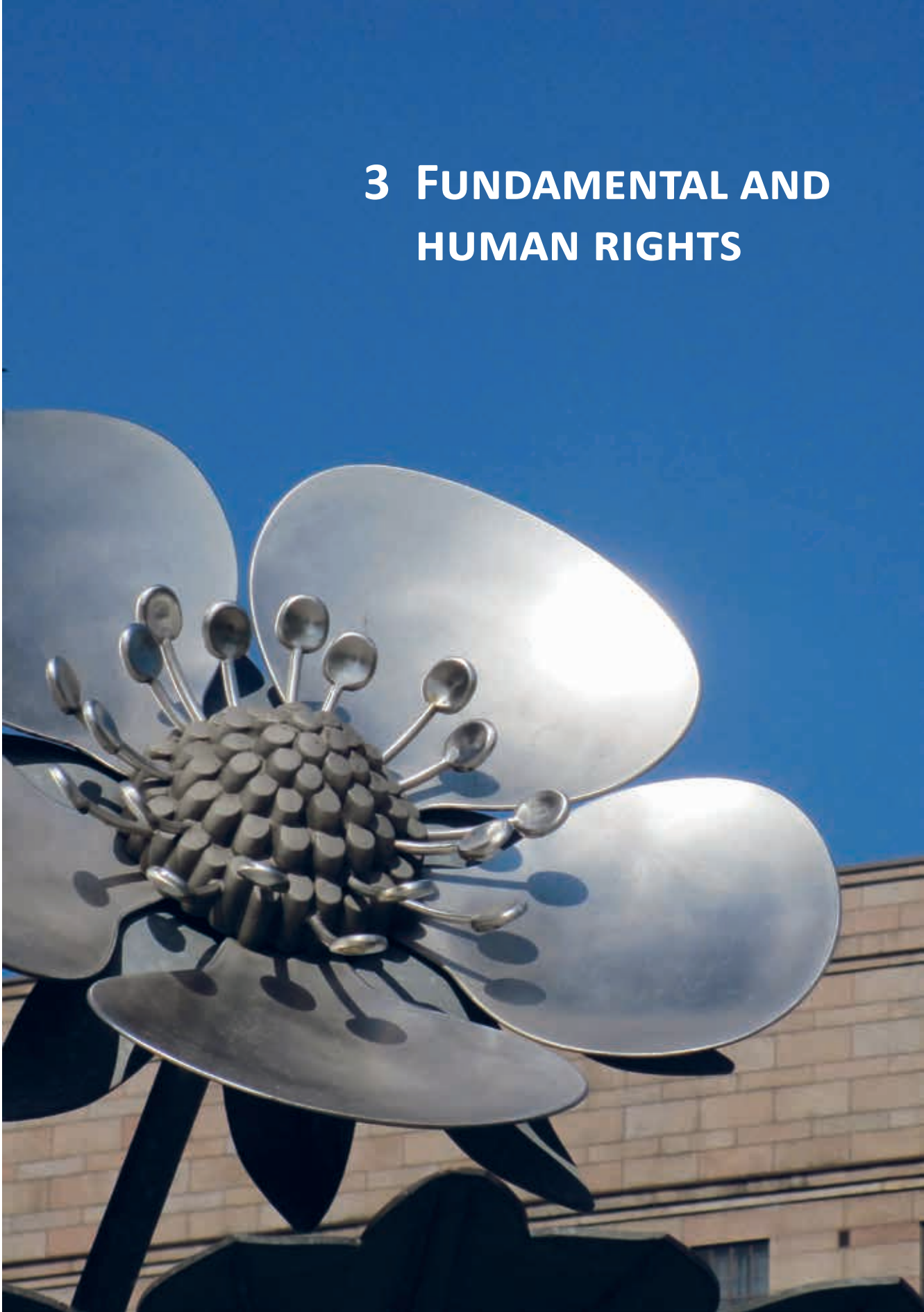
The electronic case management system introduced in 2016 allows for the electronic handling and archiving of matters related to the oversight of legality and administration. This has significantly shortened handling times and the manual handling of papers at the Office. With the new system, none of the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

Office finances

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

The Office was given an appropriation totalling 7,090,000 euros for 2022. A total of 6,969,434.03 euros of this appropriation were spent in 2022, or 98.30% of the appropriation. The Human Rights Centre drew up its own action and financial plan and its own draft budget.

3 Fundamental and human rights



3.1 The Ombudsman's fundamental and human rights mandate

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

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

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

For a more extensive discussion of the Ombudsman's duty to promote the implementation of fundamental and human rights, see Parliamentary Ombudsman Jääskeläinen's article on this subject in the Annual Report for 2012 (pp. 22–26).

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

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

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

The fundamental and human rights chapter of the report has gradually become increasingly extensive, which is a good illustration of the way the emphasis in the Ombudman's work has shifted from overseeing the authorities' compliance with their duties and obligations towards promoting people's rights. The Parliamentary Constitutional Law Committee has welcomed this change in focus. In 1995, the Ombudsman had issued only a few decisions in which the fundamental and human rights dimension had been specifically deliberated and the fundamental and human rights chapter of the report was only a few pages long (see the Ombudsman's Annual Report for 1995 pp. 23–26). 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 2022 stated a budget of EUR 997,000 for operational costs, of which EUR 775,930 was for personnel costs and EUR 193,000 for consumption expenses. EUR 185,070 of the consumption expenses were service purchases.

In 2022, the HRC had seven permanent posts (the director, five expert officials and an administrative assistant) and two fixed-term employment relationships for young experts under the Young Expert Programme. Additionally, an international affairs advisor was hired for a fixed-term employment relationship as well as fixed-term experts and young experts for various development projects and as substitutes.

In February 2022, the Young Expert Programme was launched with two competent young people interested in fundamental and human rights for 18 months' employment relationship. The Centre received 239 applications which shows young people's great interest in human rights work.

3.3.2
THE HUMAN RIGHTS CENTRE'S OPERATION

The Human Rights Delegation adopted the Human Rights Centre's Action Plan for 2022 in December 2021. 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 on the basis of the Annual Report.

Monitoring fundamental and human rights

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

During the year, the HRC continued the systematic development of monitoring. The aim of monitoring is to ensure that the HRC has a comprehensive understanding of Finland's fundamental and human rights situation and to create a report that could be submitted to Parliament every four years, for example. This is also required by the Sub-Committee on Accreditation of National Human Rights Institutions in its recommendations to the Finnish Human Rights Institution in 2019.

The HRC's monitoring tool (Lempi) has created technical facilities for more systematic continuous monitoring of fundamental and human rights. In 2022, the use of Lempi was established as part of the Centre's monitoring work and it provides the Centre with a comprehensive overview of the human rights situation in Finland.

As part of its monitoring work, the HRC may also prepare reports on the implementation of fundamental and human rights. In June 2022, the Centre published an in-depth report on national fundamental and human rights actors. The actors included in the report were the supreme overseers of legality, the National Human Rights Institution, special Ombudsmen and the National Non-Discrimination and Equality Tribunal. Each actor was examined with regard to their tasks and powers, independence and objectiveness, effectiveness and conspicuousness, operating environment and resilience, cooperation and coordination as well as observations on the entity of fundamental and human rights actors. The purpose of the report is to produce comprehensive information on the current state of the fundamental and human rights structures in question and to submit proposals for clarifying and strengthening the structures.

The HRC also published a background paper on European human rights institutions, equality bodies and relevant standards. National models for establishing human rights institutions, equality bodies and other specialised human rights bodies vary in European countries. The background paper discusses the strengths and weaknesses of different models and standards related to their structures.

In autumn 2022, the Finnish public discussed the rights of the Sámi and the reform of the Act on the Sámi Parliament. The HRC prepared a background paper on the reform of the Act on the Sámi Parliament providing background information and answers to key questions (Saamelaiskäräjälain uudistus – taustatietoa ja vastauksia keskeisiin kysymyksiin). The publication discusses human rights issues related to the reform of the Act on the Sámi Parliament and the background to its development. The aim is to provide a factual basis for the debate on the legislative reform.

During 2022, the HRC also started working on the application of the Aliens Act in administrative courts concerning its section 36, subsection 2 regarding evading provisions on entry into the country. The aim of the report is to create an overall picture of the different situations to which the prohibition of circumvention of entry provisions is currently applied. Based on this, we can examine what kind of regulation would be appropriate in future.

The HRC regularly reports to international and European human rights actors based on its monitoring data. The HRC participates independently in the periodic reporting procedure for the 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 recommendations of the treaty bodies. In 2022, the Centre issued a statement on the implementation of the UN Convention on the Rights of the Child and the UN Convention on the Elimination of All Forms of Discrimination against Women. The Centre also participated in the Universal Periodic Review (UPR) reviewing human rights in Finland under the UN Human Rights Council by issuing statements.

In 2022, the HRC paid particular attention to delays in the national implementation of the decisions of the European Court of Human Rights (ECHR) and the European Committee of Social Rights (ECSR) concerning Finland. At the end of 2022, 11 human rights complaints against Finland were pending at the ECHR. Of the judgments issued, 18 remain partially unimplemented and nine of them are leading cases. The average implementation period for leading cases in Finland was 11 years and 11 months at the end of 2022.

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 34 statements were issued in 2022. The HRC aims to promote the implementation of fundamental and human rights through statements, initiatives and by informing the public of current human rights issues.

One focus point for promotion work in 2022 was the national fundamental and human rights structures and their effectiveness based on a report published by the Centre. For example, many statements mentioned the fundamental and human rights structures. In addition to fundamental and human rights structures, the Centre's promotion work focused on other topical human rights issues and legislative projects. By issuing statements and sharing information about the topic, the Centre influenced the reform of the Trans Act paying particular attention to the status of transgender youth. In addition, the Centre closely monitored amendments to the Border Guard Act, issued statements and cooperated nationally and internationally to highlight the problem areas of the legislative amendments. The HRC also promoted the work of human rights defenders, highlighting the need for protection mechanisms for human rights defenders at risk and a rapid and flexible visa procedure so that human rights defenders could also enter Finland.

The various events for the public and specialists are important for the HRC as a means of providing information related to topical fundamental and human rights themes. During the coronavirus pandemic, the number of events decreased significantly, but in 2022, the HRC had several events on various human rights themes. Some of the events were also held outside the Helsinki Metropolitan Area.

HRC events and training events in 2022:

- Combatting antisemitism in Finland and Europe, an event in connection with Katharina von Schnurbein's, EU coordinator on combating antisemitism, visit to Finland on 6 April 2022
- Meeting of fundamental and human rights actors, 25 April 2022
- Networking event for young influencers on human rights and the approachability of human rights debate, 24 May 2022
- Human rights, dreams and pizza, meetings for Roma youths aged 18–29 in Mikkeli, Tampere, Kajaani and Helsinki, in cooperation with the Ministry of Justice, May–June 2022
- The Human Rights Centre 10 years – cooperation to promote the implementation of fundamental and human rights, an event where the Human Rights Centre's report on national fundamental and human rights actors was published, 9 June 2022
- Lunch discussion on topical human rights issues in connection with the ENNHRI Board meeting in Helsinki, 14 September 2022
- Side event in connection with the 51st session of the UN Human Rights Council in Geneva on the rights of older people belonging to minorities and indigenous people, a hybrid event on 20 September 2022
- Building the future of Sámi youth, an event on the Act on the Sámi Parliament in cooperation with the Youth Council under the Sámi Parliament, 11 October 2022
- Discussion with Swedish-speaking law students about safety and human rights, 18 October 2022
- Arctic dimensions of human rights and the security environment, an online event in cooperation with the Arctic Centre of the University of Lapland, the Institute for Northern Institute for Environmental and Minority Law (NIEM) and the UArctic Network on Arctic Law, 26 October 2022

- Online workshop to develop the Human Rights Centre and Parliamentary Ombudsman's right to self-determination tool, 23 November 2022
- Kalle Könkkölä Symposium, a hybrid event in cooperation with the Disability Rights Committee under the Human Rights Delegation (VIOK) and the Parliamentary Ombudsman, 12 December 2022

Press releases, statements and reviews were published on the HRC's website and shared on the Centre's social media channels. The news provided information about the HRC's activities and Finnish and international fundamental and human rights themes and events. An Instagram account for the Human Rights Centre was a new channel, the content of which is produced by the Centre's Young Expert Programme. The HRC also used other media for communications. For example, during the Helsinki Pride week, the Centre's young expert wrote a guest column to Helsingin Sanomat together with the lawyer of the Ombudsman for Children, defending the rights of transgender youth.

Young Expert Programme

In February 2022, the Human Rights Centre launched the Young Expert Programme for those in the early stages of their career. The first term of the programme is 1.5 years (1 Feb. 2022–31 July 2023), and its aim is to strengthen the voice of young people in the debate on fundamental and human rights and the activities of the Human Rights Centre. The programme focuses on the rights of young people and human rights issues of interest to them. Young experts also carry out expert work related to other themes in order to introduce the perspective of young people with different human rights issues in a cross-cutting manner.

In March 2022, young experts set up an Instagram account for the HRC to communicate from young people to young people. In the channel, the Young Expert Programme communicates about human rights issues in general and in a manner approachable to young people. In December, the channel broadcast an Instagram live event on climate and human rights during the Human Rights Week. In addition to Instagram, the Centre has highlighted young people's perspectives and observations on human rights in its other communication channels, such as the blog.

In May 2022, young experts met young influencers to get their views on young people's participation in the human rights debate. In the meeting, young people pointed out that the language of human rights is difficult and they barely dare to speak it. The discussion identified several ways with which the Young Expert Programme could lower the threshold for participation. In particular, young people wished for more communications about human rights in a way that is simplified and appealing to the youth.

One observation made at the meeting of young influencers was that mental health is not recognised as a human rights issue. However, mental health is a very important issue for many young people. During autumn 2022, the Young Expert Programme focused on mental health as a human rights issue as its communications theme. The Young Expert Programme also participated in the preparation of the youth welfare programme of MIELI Mental Health Finland, in which the HRC sought to raise awareness of human rights in mental health issues and to strengthen the human rights base of the welfare programme.

Through the Young Expert Programme, the HRC hears the views and experiences of young people on different human rights issues. In spring 2022, the Ministry of Justice and the Young Expert Programme organised four discussion events around Finland where they met Roma youth and discussed the racism and discrimination they experienced. Roma young people spoke about how experiences of racism and discrimination were common, about the discrimination they face in different services and about the inappropriate behaviour of security guards. The Young Expert Programme highlighted these observations in its statement issued in autumn 2022 on the draft for the third National Roma Policy.

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

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

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

Promoting and monitoring the rights of older persons

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

During the year, the HRC cooperated closely with organisations representing older people, authorities, researchers, experts and human rights organisations. The Centre also invited the new Ombudsman for older people to become a member of the Human Rights Delegation and cooperated with the Ombudsman by, for example, inviting her to join the UN Human Rights Council meeting in Geneva in autumn 2022.

Minority groups and the diversity of older people stood out in the HRC's work on the rights of older people. The Centre paid particular attention to the rights of older Sámi, Roma and foreign-language speakers. The Centre has created website content on their rights and actively cooperated with representatives of these population groups and their organisations.

In April 2022, the HRC participated in a meeting of the UN Open-ended Working Group in Ageing (OEWGA), for which the HRC issued two written statements. The HRC also participated in various working groups of ENNHRI and GANHRI to discuss a possible international instrument for the rights of older people. In August 2022, the Centre participated in the UN Multi-stakeholder meeting on the human rights of older persons.

At the 51st session of the UN Human Rights Council on 19 September 2022, Claudia Mahler, an independent expert on the rights of older persons, issued a report on Finland's situation based on her visit to Finland. The HRC has translated the report into Finnish and Swedish. The HRC gave a talk at the Human Rights Council in connection with the processing of the report under the mandate of the Human Rights Institution. In connection with the session of the Human Rights Council, the HRC also organised the first side event in its history on the rights of older minority and indigenous people.

International and European cooperation

As a rule, the HRC represents the Finnish National Human Rights Institution in cooperation between national and European human rights institutions. The Centre is active in the European Network of National Human Rights Institutions (ENNHRI). On 31 March 2022, the Director of the Human Rights Centre became the chair of ENNHRI.

The Russian invasion of Ukraine in February 2022 and its consequences, especially in the neighbouring countries, and the dramatic change in the security situation dominate European human rights cooperation. In spring 2022, the Director of the Human Rights Centre visited Poland and the Poland–Ukraine border to learn about the situation and reception of refugees. In August 2022, the Director of the Human Rights Centre visited Lviv and Kyiv as a guest of the Ukrainian Parliament Commissioner for Human Rights. The purpose of the visit was to support the Commissioner's office.

In addition, an expert from the HRC chaired the ENNHRI Legal Working Group. During 2022, the working group focused on promoting the implementation of the decisions of the European Court of Human Rights (ECHR) and creating tools to facilitate this. The promotion work included the preparation of third-party interventions in four cases concerning climate change and a case concerning abortion rights under investigation at the ECHR. The Centre'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, corporate responsibility and immigration.

Close cooperation with the EU Agency for Fundamental Rights (FRA) and the Council of Europe was continued through ENNHRI and also separately. The Centre met and exchanged information particularly with Dunja Mijatovic, Council of Europe Commissioner for Human Rights, and Michael O'Flaherty, Director of the EU Agency for Fundamental Rights. During the year, cooperation with the UN institutions focused in particular on the rights of persons with disabilities and the rights of older people, and as a new theme, on the environment and climate change.

3.3.3 THE HUMAN RIGHTS DELEGATION'S OPERATION

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

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

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

The Human Rights Delegation met four times in 2022. The themes included the impacts the war in Ukraine has on the human rights situation, the Human Rights Centre's new Young Expert Programme, the assessment of the fundamental and human rights impacts of government proposals, the situation of human rights defenders in Finland (special focus on Afghanistan), the need for a humanitarian visa, amendments to section 16 of the Border Guard Act (centralisation of international protection at certain border crossing points), the reform of the Act on the Sámi Parliament and the implementation of the Government Programme's fundamental and human rights and the priorities for influence in the upcoming 2023 Government Programme. In October, the delegation issued a statement on human rights defenders.

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

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

3.4 Rights of persons with disabilities

3.4.1 SPECIAL MANDATE TO IMPLEMENT THE RIGHTS OF PERSONS WITH DISABILITIES

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

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

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

Parliamentary Ombudsman Petri Jääskeläinen (until 30 September 2022) and Deputy-Ombudsman Maija Sakslin (as of 1 October 2022) made the decisions in this category and Principal Legal Adviser Minna Verronen and Senior Legal Adviser Juha-Pekka Konttinen acted as the presenting officers. Matters concerning persons with disabilities are also described in sections concerning the visits conducted by the NPM (3.5), the Ombudsman's recommendations for compensation (3.7) and the special theme (3.8).

3.4.2 TASKS AND ACTIVITIES OF THE NATIONAL MECHANISM

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

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

Parliamentary Ombudsman

The Parliamentary Ombudsman protects, promotes and monitors the implementation of the CRPD within the limits of his or her specific mandate. The Ombudsman's tasks include overseeing legality in the exercise of public authority and supervising (protecting) the implementation of fundamental and human rights. Over time, the Ombudsman's activities have evolved towards promoting fundamental and human rights. In decisions on complaints and during visits and inspections, instead of focusing solely on the legality of practices, an effort is made to guide authorities and other subjects of oversight towards adopting practices that implement fundamental and human rights as effectively as possible. Oversight and monitoring are interlinked in the Ombudsman's work, as observations of inadequacies in realising the rights of persons with disabilities made in the course of the oversight of legality are also part of general follow-up of how CRPD obligations are implemented in practice.

For the main part, the Ombudsman exercises oversight of legality by investigating complaints, but he or she also examines shortcomings on his or her own initiative and when conducting inspections. In addition to the oversight of legality, the Ombudsman also serves as the National Preventive Mechanism (NPM) under the Optional Protocol to the UN Convention against Torture (OPCAT). The NPM visits places where persons are or may be deprived of their liberty, including residential units for persons with intellectual disabilities or memory disorders. When performing this task, the Ombudsman may rely on the assistance of experts appointed by the Ombudsman, who have expertise significant for the NPM mandate. These experts include, among others, 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. During the reporting year, external experts participated in several visits.

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

Human Rights Centre

The HRC's work with persons with disabilities focuses on strengthening the legal perspective and increasing awareness of the rights of persons with disabilities, promoting the social inclusion of persons with disabilities, and developing oversight into the implementation of the rights of people with disabilities. The HRC's monitoring tool (LEMPI) was further modified to meet the reporting needs of the UN Convention on the Rights of Persons with Disabilities and to analyse information in a phenomenon-based manner.

The HRC continued to promote the fundamental and human rights competence of the authorities and various professional groups. In spring 2022, the HRC trained the authorities assessing EU projects on compliance with the EU Charter of Fundamental Rights and the Convention on the Rights of Persons with Disabilities in the EU Regional and Structural Policy Programme period 2021–2027. In autumn 2022, an expert of the HRC participated in the implementation of the education package on the rights of the child set out in the national Child Strategy where one of the focus points concerned the rights of children with disabilities. The education package was targeted at professionals working with children. The HRC and the Non-Discrimination Ombudsman published a handbook on promoting the employment of persons with disabilities and strengthening their rights at work.

The HRC issued statements to the Ministry of Social Affairs and Health on the draft proposal concerning the national implementation of the EU directive European Accessibility Act (IOK/9/2022) and the draft proposal for the Act on Disability Services and Assistance (IOK/33/2022).

The HRC also discussed the rights of persons with disabilities in its additional statement to the committee monitoring the implementation of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in Finland (IOK/59/2022) and in its statement for the processing of the periodic report of Finland's Government concerning the implementation of the Convention on the Rights of the Child (CRC) (IOK/53/2022).

Disability Team

The Disability Team of the Office consisted of three experts from the Office of the Parliamentary Ombudsman, a notary and experts from the Human Rights Centre. At the end of the year, another expert and a younger expert from the Human Rights Centre also participated in the meetings.

During 2022, the Disability Team worked in close cooperation with the Disability Rights Committee. Matters highlighted in the Committee or Disability Team meetings were discussed fluently on both sides, since two members of the Disability Team also served as experts in the Disability Rights Committee (VIOK).

The Disability Team worked on the tool created in the project on fundamental and human rights in housing services by organising a workshop to develop the tool further. In addition to the members of the Disability Team, other authorities and representatives of organisations, service providers and service users participated in the workshop. The self-assessment tool for actors organising special care, which is available on the HRC's website, was updated with new decisions by the Parliamentary Ombudsman.

The Disability Team prepared a brochure on the special task of the Finland's National Human Rights Institution related to the rights of persons with disabilities.

On the initiative of the Disability Team, the office organises annual training related to the theme of disability. During the reporting year, Professor Michael Stein from Harvard Law School gave a lecture on Articles 33.2 and 33.3 of the United Nations Convention on the Rights of Persons with Disabilities. The members of the Disability Rights Committee also participated in the training.

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

- THL's conference on services for persons with disabilities, 11 February 2022
- Right to self-determination training organised by the Finnish Association on Intellectual and Developmental Disabilities, 23 March 2022
- Information event for new employees at the Office of the Parliamentary Ombudsman on taking accessibility into account during visits, 20 May 2022
- OPCAT training for VIOK members, 12 October 2022, Finnish Parliament Annex
- University of Tampere thesis group visit, 4 November 2022, Finnish Parliament Annex
- Self-assessment tool development workshop, 23 November 2022
- The Finnish CP Association's stakeholder event, 28 November 2022, Helsinki
- The State of Turkmenistan delegation of experts visit, 15 December 2022, Finnish Parliament Annex

Disability Rights Committee (VIOK)

The Disability Rights Committee (VIOK) – a permanent division under the Human Rights Delegation – met three times during the year. The meetings discussed the status and rights of persons with disabilities in the midst of the war in Ukraine, planned a second Kalle Könkkölä symposium and followed the Government's new proposal on the Act on Disability Services and Assistance and its progress.

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. OPCAT training was also organised for VIOK members, after which the participants can now participate in the Parliamentary Ombudsman's inspection visits to closed institutions and housing units. During the reporting year, two VIOK members participated in the Ombudsman's visits.

National cooperation

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

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

A representative of the Disability Team participated as an expert in the activities and meetings of the Government's fundamental and human rights network.

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

The HRC and the Non-Discrimination Ombudsman published a handbook on promoting the employment of persons with disabilities and strengthening their rights at work. The purpose of the handbook is to promote the right of persons with disabilities to work and to increase their employment in accordance with Article 27 of the UN Convention on the Rights of Persons with Disabilities.

The Human Rights Centre, the Disability Rights Committee under the Human Rights Delegation (VIOK) and the Parliamentary Ombudsman jointly organised the Kalle Könkkölä symposium that discussed how persons with disabilities can access their rights in crisis situations. The symposium was organised for the second time to commemorate Kalle Könkkölä's life's work as a defender of the rights of persons with disabilities (the first symposium was held in 2019). The event was organised as a hybrid event with an estimated 180 participants. Gerard Quinn, UN Special Rapporteur on the rights of persons with disabilities, was one of the speakers at the event.

International cooperation

An expert of the HRC participated in ENNHRI's CRPD WG meetings remotely.

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 debate on the rights of persons with disabilities.

3.4.3 OVERSIGHT OF LEGALITY

The Ombudsman oversees the realisation of the rights of persons with disabilities concerning all authorities and private bodies performing public tasks, regardless of the administrative sector of the authority. Statistics on all complaint cases are primarily compiled into categories based on the authority and administrative branch (social welfare, social insurance, 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 deals with areas that are vital for the implementation of the rights of persons with disabilities regardless of which administrative branch the matter involved. The 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 local authorities are an important area from the perspective of the oversight of legality. Many complaints relate to shortcomings in service plans and special care programmes, the advice and guidance given in relation to services, as well as delays and procedural errors in decision-making and other aspects of case management.

Inspections are vital for the oversight of legality, as persons with disabilities are not always able to file complaints themselves. On inspection visits to housing and institutional services, supervisory measures are targeted at public and private actors providing disability services and their self-monitoring systems, and the local authorities responsible for the provision and supervision of services. 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.

Complaints, proposals and own initiative investigations

The number of complaints and own-initiative investigations falling into this category on which decisions were issued was 247 (300 in 2021). The number of cases resolved showed a decrease in the number of complaints related to the coronavirus epidemic. A total of 81 matters led to measures (33%). The percentage of cases warranting further action was smaller than in the previous year (38%) but, as in previous years, higher than the average of the Office of the Parliamentary Ombudsman (13%). A reprimand was issued in four cases, three of which concerned the social welfare procedure and one Kela's procedures in a social insurance matter.

Four compensation proposals were made in matters concerning persons with disabilities during the reporting year. The grounds for the compensation proposal concerning disability services was an infringement by the city's social services on the right to necessary care and sufficient social and health services and the right of the family's parents to constitutional support from public authorities in safeguarding the child's wellbeing and individual growth (6084/2021). This decision and other compensation proposals from the Parliamentary Ombudsman are summarised in section 3.7.

The Ombudsman gave his opinion on 44 (64) cases, and 22 (19) cases led to other measures. Due to the high number of cases that led to measures, it is not possible to give an account or mention of all decisions concerning disability rights. An increasing effort is being made to publish the decisions on the Ombudsman's website www.oikeusasiamies.fi.

As in previous years, the social welfare category had the highest number (189) of decisions concerning persons with disabilities (218 in 2021). The reason is that local authorities were responsible for the provision of social services, such as special care for persons with intellectual disabilities, services and support measures provided on the basis of disability and services for persons with memory disorders. Of the services provided under the Act on Disability Services and Assistance (118 decisions), 27 decisions concerned personal assistance (40 in 2021), 27 cases concerned transport services (44 in 2021), 24 cases concerned the rights of persons with intellectual disabilities (28 in 2021) and 29 cases concerned the rights of older people with disabilities (memory disorders) (33 in 2021).

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. Six of these cases were addressed during the reporting year. The monitoring and promotion of the rights of older people with memory disorders or other disabilities are described also in section 4.13 of this report.

During the reporting year, 16 decisions related to social insurance were made (23 in 2021), 42 decisions related to healthcare (38 in 2021) and 16 decisions related to education (21 in 2021).

Complaints relating to service provision under the Act on Disability Services and Assistance concerned e.g. 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 local authorities' service provision and application directives.

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

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 (4), housing units for older people (with memory disorders) (5) and operating units providing psychiatric hospital care (3).

During the reporting year, the Eteva joint municipal authority's psychiatry unit for intellectual disabilities in Lahti was visited twice (children's unit, 4119/2022 and the psychiatry for intellectual disabilities unit, 1686/2022). The Ruusuhaka housing unit of the City of Vantaa was also visited (2816/2022).

An inspection visit was also carried out at the HUS respiratory paralysis unit for heart and lung diseases, Rekola group home (5196/2022).

For details of the observations from the above visits made by the Ombudsman in its role as the National Preventive Mechanism, see section 3.5 of this annual report.

Observations on accessibility and promotion of social inclusion

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.

Shortcomings in the accessibility of premises and services and the implementation of adaptation measures have been detected on the Ombudsman's inspection visits. Individual observations made primarily in connection with visits and inspections are discussed below.

Regarding social welfare

The facilities of the Espoo group home and supported housing unit for unaccompanied minors in Finland were accessible and there was an elevator between the floors (2873/2022).

Housing units for persons with intellectual and other disabilities

The visit to the respiratory paralysis unit for heart and lung diseases (HUS) at the Rekola group home did not raise any particular issues regarding the accessibility or functionality of the facilities. When talking to the employees, the inspectors considered it appropriate to raise awareness of preparedness for potential power outages with patients and their families (5196/2022).

During the inspection visit to Eteva joint municipal authority's psychiatry unit for intellectual disabilities in Lahti, no special comments were made on the accessibility of facilities and the environment (1686/2022 and 4119/2022).

Care and assisted living facilities for older people

During the visit to the Mainiokoti Andante in Espoo (1127/2022*), the Deputy-Ombudsman drew attention to the maintenance of the yard area during the winter too, as the outdoor recreation areas must be accessible and suitable for customer mobility. The Deputy-Ombudsman did not find it acceptable that some of the clients of the unit were effectively prevented from outdoor activities due to the poor winter maintenance of the property.

Other authorities (agencies)

The entrance door of the Consumer Disputes Board was heavy and somewhat narrow. When entering the premises, a buzzer had to be pressed to open the door. There was also a small threshold at the entrance, which may be a hindrance for a person using a wheelchair, for example. There is an accessible toilet at the Board's premises. No induction loop was available. The Board's premises were accessible (1949/2022).

The facilities of the employment services in the City of Vantaa were not accessible for persons with disabilities, as the entrance door was so narrow that a wheelchair could not get through it properly (2596/2022).

Education

According to information received during the visit to the Lapland Education Centre REDU, solutions that took accessibility into account had to be built in the original building afterwards, but the accessibility of the facilities will be taken into account in renovations and as the starting point for planning (4780/2022).

The Criminal Sanctions field, the prosecution authority and the police

Prisons

Kylmäkoski Prison

The accessible toilet in the corridor of the prison's meeting rooms had been converted into a urine sampling room and was no longer suitable for its original use after the changes. According to the Deputy-Ombudsman, a prison cannot decommission an accessible toilet originally constructed in accordance with regulations and instructions and change its intended use for another purpose entirely, pleading to its minor need for use.

The Deputy-Ombudsman found that the prison had weakened the realisation of the rights of persons with reduced mobility by making this change. The Deputy-Ombudsman required that the necessary measures be taken to rectify the situation.

Persons with reduced mobility arriving at the prison had been taken into account in parking and entrances. An accessible parking space was closest to the main entrance to the prison and the gate's call button was located so that it could also be pressed from a wheelchair.

There was a ramp at the entrance to the prison that enabled the entry of a person with reduced mobility. The prison ward had an accessible cell and a prisoner with reduced mobility was able to move between different operating points and facilities.

Turku Police Prison

The Ombudsman found the construction of accessible cells in connection with renovations a positive matter in itself. The Ombudsman recommended that the police department commission an accessibility survey, which would assess the accessibility of accessible cells and their suitability for shorter and/or longer-term stay in general, and that the police department take appropriate measures to improve the level of equipment in accessible cells.

The police department announced that it would commission an accessibility survey for the accessible cells. As a result of the observations made during the visit and the measures taken by the police department, the Ombudsman noted that the visit did not give him cause for further measures (4771/2022).

During a visit to the prison hospital, the Deputy-Ombudsman encouraged the healthcare services for prisoners to be active in making prisoners' living and activities as accessible and available as possible, so that prisoners with a more severe disability could handle everyday life in the prison independently. The Deputy-Ombudsman emphasised the importance of accessibility when planning the facilities of the new hospital so that prisoners who have disabilities or are older are also taken into account (2555/2022).

Statements

In its statement to the Ministry of Social Affairs and Health (8732/2021), the Ombudsman found it important that the assessment of the impacts of obligations related to the built environment is sufficiently comprehensive and that they take into account the implementation and costs of the obligations set in the directive when finding out alternatives to regulation. The Ombudsman's oversight of legality has found that not all measures promoting accessibility are unreasonably expensive, as long as the accessibility issues are properly investigated and repairs are planned and carried out by experts.

In its statement to the working group for three regulations concerning the accessibility requirements for certain products and services, coordinated by the Ministry of Social Affairs and Health, the Ombudsman considered it important that the authorities and other actors increase information on the rights of persons with disabilities and promote a positive impression of persons with disabilities and also raise awareness of accessibility 2247/2022.

Complaints

In case 5511/2021, the Ombudsman took into account the child's severe disability in the assessment of the delay in processing the application and that the application concerned home alteration work as a subjective right of a child in need of special support with the purpose of ensuring an accessible and safe living environment for the severely disabled child.

Complaints concerning accessibility issues may also include allegations of discrimination against persons with disabilities and the application of the Non-Discrimination Act. In some cases, the Ombudsman has informed the complainant that the allegation of discrimination can first be referred to the competent supervisory authorities (the Non-Discrimination Ombudsman and the National Non-Discrimination and Equality Tribunal) (6403/2022 and 3610/2022).

In case 5885/2022, the Ombudsman referred the matter concerning the lowness of the railway platforms at Haapamäki station to the Office of the Non-Discrimination Ombudsman, as the complainant had referred to the provisions of the Non-Discrimination Act.

On 5 January 2023, the Office of the Non-Discrimination Ombudsman announced that it did not process the case in question further, but it will promote it as a general matter of promoting equality and will discuss the accessibility of railway stations in general together with the Ministry of Transport and Communications and the Finnish Transport Infrastructure Agency.

Statements

The Ombudsman issued a statement to the Ministry of Social Affairs and Health on a draft Government proposal to Parliament on legislation implementing the directive on accessibility requirements for products and services (8732/2021).

The Ombudsman issued a statement on the reform of disability services legislation (1243/2022).

The Ombudsman issued a statement to the Ministry of Social Affairs and Health on three Government decrees concerning accessibility requirements for certain products and services (2247/2022).

3.4.4 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.

Organising assisted housing and care for children with severe disabilities at home

In case 2920/2021, the Ombudsman issued a reprimand to the city's social welfare and healthcare services for unlawful negligence in organising care in the child's best interests, in order to avoid a similar situation in future. The city had not been able to organise a child's essential services fully (assisted housing in accordance with the Act on Disability Services and Assistance) and 24-hour care at home after the service provider had suddenly resigned. The Ombudsman found the procedure of social welfare and healthcare services seriously reprehensible in this respect. In the assessment of reprehensibility, the Ombudsman took into account the fact that the case concerned a vulnerable child with intellectual disabilities who required care that supports breathing as well as the guaranteeing of necessary care.

The Ombudsman also drew the attention of the social welfare and healthcare services to what the decision stated about the responsibility for organising and supervising social welfare and healthcare services, ensuring the continuity of the service, implementing multidisciplinary cooperation and assessing the service needs of children with disabilities in need of special support.

The Ombudsman emphasised that, as the authority responsible for organising the services, the city must oversee and ensure that the service provider's activities meet the requirements set for good social welfare and health care in legislation. The city must intervene in the activities of a private outsourced service provider if the activities endanger the realisation of the customer's rights and interests. This responsibility for supervision and organisation cannot be transferred to an individual customer or to the customer's legal representative (guardian).

In the Ombudsman's view, the social welfare and healthcare services should have assessed and planned in good time – and with multidisciplinary cooperation – how the service package granted to a child could be implemented at the child's home even in exceptional situations. In the Ombudsman's opinion, the child's care and service plan should have included proceedings for what to do if the child's essential care is interrupted or in case of a sudden lack of carers. This procedure would probably have prevented a complete interruption of services in the event of a surprising service disruption.

In the Ombudsman's view, the challenges related to the coordination of the service provided at the child's home and the exchange of information had at least partly been caused by inadequate communication and an unclear division of responsibilities between different actors (family, service provider, city social welfare and healthcare services, specialised medical care). In the Ombudsman's opinion, the city's social welfare and healthcare services should have organised – as the party responsible for the child's services – closer communications with the actors and persons who had an impact on the functioning of the child's service package.

The Ombudsman considered it necessary and important that a social worker working as a personal worker always participates in the home visits, service needs assessments and the preparation of a service plan that concern a child in need of special support.

The Ombudsman requested that the city's social welfare and healthcare services report on which measures they have taken as a result of the decision within the deadline.

On 30 September 2022, the city announced that after spring 2021, regular monthly meetings had been held between the family, service provider, disability services and health services, and at the time of the notification, they were able to provide the service at home in accordance with the decision on service housing, ensuring the child's best interests. At the time of the notification, the employee responsible for the child's affairs was a social worker. Multiprofessional cooperation was successful and the child's affairs were taken care of together.

Implementation of an Administrative Court decision in a case concerning disability services

In case 4937/2021, the Ombudsman brought to the attention of the social welfare and healthcare sector of the City of Helsinki his understanding of the unlawful delay in the implementation of the Administrative Court decision and in the making of the decision on service housing of a child with severe disabilities. The reprehensibility of the procedure was increased by the fact that the case concerned disability services for a child in a vulnerable position and in need of special support. The city's services for disabled people had made a decision on service housing for the child almost six months after the Administrative Court had referred the case back to the city, even though the decision had not required further clarification. An official of disability services had only made a decision on the child's case after the city had received the Ombudsman's request for information on the matter. The Ombudsman stressed that authorities must take measures to enforce a court decision without delay. Social welfare clients have the right to rely that the authority ensures, on its own initiative, that the court's decision is enforced and that the authority goes through the required decision-making process.

The Ombudsman also brought to the attention of the social welfare and healthcare sector the views he presented concerning the initiation of a disability services case and the validity of the decision. In the Ombudsman's opinion, the official should have registered the date on which the application concerning the child's service housing had been submitted and recorded to the client information system for social welfare as the date on which the decision on the child's service housing was made instead of the date of the Administrative Court decision.

Other decisions

Two decisions issued by the Ombudsman emphasised the implementation of multidisciplinary and multiprofessional cooperation in addressing the individual needs of a child in need of special support.

In the first decision 1688/2021, the Ombudsman considered it important that the municipality continues to implement and develop multidisciplinary and multiprofessional cooperation in a case where the complainant seemed to have had continuous disagreements and ambiguities with the municipal social and healthcare services and education services regarding the planning and organisation of their children's services. In the Ombudsman's view, more systematic implementation of multidisciplinary cooperation in the services for the complainant's family and children in particular could have helped them find and implement suitable and timely forms of service and service packages.

In the second decision 8687/2021, the Deputy-Ombudsman emphasised that a multidisciplinary and multiprofessional client plan that is drawn up with the consent of the social welfare client or their legal representative may help acknowledge the individual needs of persons in need of special support and promote cooperation between authorities in different administrative sectors.

In its decision 5511/2021, the Parliamentary Ombudsman found that the delay of the municipal disability services in processing an application regarding the complainant's child was in violation of the Act on Disability Services and Assistance and the Social Welfare Act. The municipality had not presented acceptable special reasons for clearly exceeding the three-month processing period laid down in the Act on Disability Services and Assistance. The Ombudsman drew the attention of the municipality's disability services to the lawful processing of applications and the procedure in accordance with good administration. In its assessment, the Ombudsman took into account the fact that the case concerned a support measure that the complainant applied for as a subjective right for a child with severe disabilities and in need of special support.

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

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

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

In case 6384/2021, the Deputy-Ombudsman considered that the processing of the complainant's case concerning alterations to an apartment had taken unreasonably long (more than one and a half years) without finding any solution for the disputed matter. The Deputy-Ombudsman also found it lacking that the report did not indicate that the complainant had been adequately advised on taking the matter forward and on the use of legal remedies.

Case 5862/2021 also concerned an unlawful delay in decision-making regarding an application concerning alterations to a dwelling (wheelchair ramp), which the Ombudsman considered to be reprehensible.

Case 8637/2021 concerned a delay in processing a claim for a revised decision related to alteration work on a dwelling. The Substitute for a Deputy-Ombudsman considered that the Central Uusimaa joint municipal authority for health and social services had neglected to process the claim for a revised decision urgently as required by law and that the processing was thus delayed in an unlawful manner.

The Parliamentary Ombudsman's oversight of legality has customarily considered it important that the appeal instructions attached to a decision clearly describe the collection of a court fee and that appeal is free of charge, as informing of the fees promotes the good administration and the implementation of a fair trial under section 21 of the Constitution. The guidance provided in appeal instructions enforces the obligation to provide services and advice, which is part of the basics of good governance.

In case 1950/2022, the Ombudsman considered it sufficient to inform the city's social welfare and healthcare services that the instructions for appeal attached to the decision of the social services division, which also mentioned the court fee, were misleading in terms of court fees. This was due to the fact that, on the basis of instructions for appeal, the appellant might have justifiably understood that complaints in social welfare matters are subject to a court fee.

As challenges related to the processing of invoices and the number of personnel have are not customarily considered justified reasons for a delay, the Substitute for a Deputy-Ombudsman considered that the City of Turku neglected to process the invoicing of customer fees of a transport service without undue delay after the calculation basis for the deductible in transport services changed on 1 July 2021 (7548/2021).

Authorities' negligence in decision-making

In case 5389/2021, the Parliamentary Ombudsman informed the joint municipal authority of its view on the negligence of decision-making in the case of discontinuing the payment of maintenance compensation for a respiratory paralysis patient. In the Ombudsman's view, the joint municipal authority should have, on request – in accordance with the requirements of good administration – made a decision that can be appealed after discontinuing the payment of maintenance compensation and other claims concerning maintenance compensation. The negligence of decision-making may have jeopardised the legal protection of the complainant's client in the case. The Ombudsman stressed that for the legal protection of respiratory paralysis patients, it is important that they can, if they so wish, bring a matter concerning maintenance that is determined as free of charge in the Act on Client Charges in Healthcare and Social Welfare to be investigated ultimately by a court of law.

The Ombudsman also considered that the joint municipal authority should have given the respiratory paralysis patient instructions for how to use legal remedies. The Ombudsman drew the joint municipal authority's attention to the use of legal remedies and the advice related to them.

The Ombudsman requested that the joint municipal authority report on which measures they have taken as a result of the decision within the deadline.

On 14 October 2022, the joint municipal authority announced that it had made a decision on the patient's case.

Neglect of decision-making was also a matter in case 8202/2021, in which no decision that was claimable for a correction had been made on the application to reimburse the amount paid for a psychologist's statement. The Substitute for a Deputy-Ombudsman informed the joint municipal authority for social Affairs and healthcare of its opinion on the neglect of the decision.

In its decision 2692/2021, the Ombudsman emphasised that under the Act on Special Care for Persons with Intellectual Disabilities, the management team of special care makes the decision on discontinuing special care, unless otherwise provided in the rules and regulations of the special care district. The Ombudsman considered that the joint municipal authority had neglected its duty to make a decision on the complainant's case regarding the termination of the exemplary employment granted as special care. An official had made a decision on the work activities in accordance with the Act on Disability Services and Assistance while the employment granted as special care was in force. The Ombudsman found the procedure of disability services in decisions concerning exemplary employment unclear, problematic and weakening to the legitimate expectations and legal protection because the terminology used by the disability services to describe different services had been unclear, for example. In the complainant's situation, receiving the decision on discontinuing work without delay and in a timely manner would have been of particular importance, as the complainant and the authority had disagreed on whether the service had been granted as special care in the first place or under the Act on Disability Services and Assistance, for example.

The Ombudsman emphasised that the authority must ensure that the social welfare client does not suffer any loss or reduction of their interests as a result of the authority's procedure and that the authority is obliged to comply with the decisions it has made and any commitments included in them so that the procedure does not violate the principle of legitimate expectations.

On a general level, the Ombudsman emphasised that the party concerned must be given an opportunity to provide an explanation of all reports that may affect the decision on the matter before the decision is made.

Personal assistance under the Act on Disability Services and Assistance

Delays in reimbursement of a personal assistant's salary costs

In decision 5892/2021, the Substitute for a Deputy-Ombudsman informed the Central Satakunta Joint Municipal Social and Health Care Authority of their view of the unlawful delay in compensating the costs of hiring a personal assistant. In assessing the reprehensibility of the delay in the payment of the joint municipal authority's compensation, the Substitute for a Deputy-Ombudsman acknowledged that in the employer model for personal assistance, an employer with a severe disability has a special need to receive compensation for hiring an assistant on time as agreed. The timely payment of compensation is a prerequisite for an employer with a severe disability to be able to pay the salary to a personal assistant on time.

The Substitute for a Deputy-Ombudsman considered it an issue that the complainant's decision on personal assistance did not include clear, up-to-date written records concerning the payment of personal assistance allowance and the application for compensation. In the Substitute for a Deputy-Ombudsman's view, the official must clearly and comprehensively record the payment of the assistant's compensation and compensation practices in the decision concerning the organisation of personal assistance.

The complainant had not received separate appealable decisions on changes made to the payment date and practices, which is why the Substitute for a Deputy-Ombudsman found that the joint municipal authority had not acted in accordance with the Act on Disability Services and Assistance and the Social Welfare Act in this respect.

Case 7415/2021 concerned negligence in decision-making and the delay in the processing of a case, where a case concerning the compensation of costs incurred by hiring a personal assistant for the complainant had been under investigation in the joint municipal authority for more than two years without a final decision. The joint municipal authority had also not made an appealable decision to the complainant on discontinuing the compensation for the costs of hiring a personal assistant. The Deputy-Ombudsman noted that if there had been a disagreement on the compensation paid to the assistant, the joint municipal authority should have made a decision that could be appealed without undue delay on the basis of the complainant's application or claim. The Deputy-Ombudsman found the procedure particularly reprehensible, as in the employer model for personal assistance, an employer with a severe disability has a special need to receive compensation for hiring an assistant on time as agreed.

Changes to the service require a decision

In case 5168/2021, the Ombudsman found the procedure of a joint municipal authority to be reprehensible because the decision on the complainant's personal assistance had not been revised, even though the joint municipal authority had made home care responsible for the evening visits for personal assistance at the end of 2020. The Ombudsman stressed that for the legal protection of social welfare clients, it is particularly important that they receive a decision by an official eligible for a claim for a revised decision when the amount of services is reduced or the manner in which the services are organised is changed.

Ensuring the continuity of services for people with disabilities

The Deputy-Ombudsman drew the attention of the joint municipal authority to carefulness when investigating the service needs and that the flow of information is organised appropriately, as the continuity of the client's disability services (day activities and personal assistance) had not been ensured due to negligence and shortcomings in the information flow. The Deputy-Ombudsman also drew the attention of the joint municipal authority for well-being to the fact that the client's service plan must be reviewed if there are changes in the circumstances of a disabled person and otherwise as necessary. The Deputy-Ombudsman drew the joint municipal authority's special attention on the fact that under the Social Welfare Act, the task of the client's own employee is to ensure and promote the continuity and implementation of the client's services 8321/2021.

Determination and verification of the value of a service voucher

In its decision concerning a complaint of Kynnys ry issued on 30 November 2021, the Ombudsman considered that a service voucher's adequate and reasonable level of value requires regular monitoring and review of the value of the service voucher if necessary. When a municipality has arranged a service with a service voucher, it must ensure that the service fulfils the customer's requirements in accordance with the decision and service plan. The municipality cannot be released from its responsibility for organising the service by transferring the entire responsibility to the service voucher provider. Instead, as a service organiser, the municipality must monitor and supervise the actual implementation of the service. The chosen method of organisation may not prevent or reduce the realisation of the customer's rights.

In his decision, the Ombudsman required that the Ministry of Social Affairs and Health informs him by 31 December 2022 of the observations they have made in the supervision and guidance of the Regional State Administrative Agencies regarding the adequacy of the value of municipal service vouchers for personal assistance and the possible additional measures taken.

At the same time, the Ombudsman asked the Ministry to assess the adequacy of possible measures taken by the Regional State Administrative Agencies in the matter (5684/2020).

Based on the Regional State Administrative Agencies' report on the matter and the guidance letter for the wellbeing services counties prepared by the supervisory authorities (Regional State Administrative Agencies and Valvira) as well as development measures otherwise prepared in connection with the matter, the Ministry of Social Affairs and Health assesses that the steering measures in this matter are sufficient to ensure that the requirements and objectives set by legislation are met and that the rights of customers are realised. In order to ensure the realisation of the client's fundamental rights in individual situations, the ministry also considered it important that municipalities and, in the future, wellbeing services counties implement their obligation to increase the value of the service voucher laid down in section 8 of the Service Vouchers Act if the client's or their family's livelihood or statutory maintenance obligation is compromised.

Transport services provided under the Act on Disability Services and Assistance

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

Transport services provided under the Act on Disability Services and Assistance in Kessote

In case 8942/2021, the Deputy-Ombudsman informed the Central Satakunta Joint Municipal Authority for Social Welfare and Health Care Authority (Kessote) of its understanding of the joint municipal authority's failure to organise and implement transport services. The Deputy-Ombudsman also drew the joint municipal authority's attention to what was said about ensuring the opportunities for persons with disabilities and the Council on Disability to influence and participate.

The Deputy-Ombudsman found the procedure of Kessote to be reprehensible because the issues and shortcomings in the implementation of transport services might have undoubtedly affected the possibility of individual customers with severe disabilities to use the transport service granted to them as a subjective right. However, in the assessment of reprehensibility, the Deputy-Ombudsman took into account the fact that Kessote had continuously sought to remedy the situation through various measures described in the report.

The Deputy-Ombudsman drew Kessote's attention to the fact that the manner and practices chosen by the joint municipal authority for organising transport services may not in fact restrict or prevent the use of statutory transport services and the mobility and participation of persons with severe disabilities outside the home. The Deputy-Ombudsman stated that the municipality (and the joint municipal authority) must acknowledge the individual needs and life situation of the person with severe disabilities, taking into account that the services granted for the disabled person will also be arranged in the event of an interruption or disruption of the service. The Deputy-Ombudsman stressed that the municipal body and its subordinate officials must take appropriate measures without delay if there are deficiencies in the quality of the service provided or if the provision of the service compromises the individual interest of the client.

The Deputy-Ombudsman stressed that even though a municipality can organise social welfare and healthcare by procuring services from a private service provider, it cannot transfer its own responsibility for organising services to a private service provider or an individual client. Municipalities must also supervise the organisation and quality of the services they purchase.

The municipality must thus intervene in the activities of a private outsourced service provider if the activities endanger the realisation of the customer's rights and interests.

When assessing the hearing of persons with disabilities and the Council on Disability about the tendering and procurement procedure, the Deputy-Ombudsman was not convinced that Kessote has provided persons with disabilities with sufficient opportunities to influence and participate – for example, through the Council on Disability – in the planning and preparation of the reform of transport services as required by the UN Convention on the Rights of Persons with Disabilities and the Local Government Act. For this reason, the Deputy-Ombudsman drew Kessote's attention to ensuring the opportunities for persons with disabilities to exert influence and participate in municipal activities.

In the Deputy-Ombudsman's view, the competitive tendering and organisation of transport services in accordance with the Act on Disability Services and Assistance is a matter that affects the rights of persons with disabilities and is of particular importance for their inclusion, mobility and performance of daily activities. Transport services in accordance with the Act on Disability Services and Assistance contribute to the realisation of many other fundamental and human rights. Functional transport services allow persons with severe disabilities to access work, training and leisure activities, for example. For this reason, the Deputy-Ombudsman considered it particularly important that the Council on Disability and service users with disabilities are given a real opportunity to influence and participate in the planning, preparation, implementation and monitoring of transport service reforms.

Informing of the separate right concerning transport services and cancellation practices

In case 1707/2021, the Substitute for a Deputy-Ombudsman drew the City of Kuopio' attention to the authority's obligation to provide advice, information and clarification. The Substitute for a Deputy-Ombudsman stressed that if the municipality has separate rights for transport services, the authority must also communicate and instruct the client clearly and comprehensibly about the procedure for applying for these rights. The Substitute for a Deputy-Ombudsman did not find the practice mentioned in the city's report sufficient, in which the client is only informed of the separate right when applying for a transport service if the client is found to need it.

The Substitute for a Deputy-Ombudsman found the City of Kuopio's transport service instructions problematic in light of the customer fee legislation, because the report did not indicate whether Kuopio's authorities issue decisions for customers of transport services on the collection of costs for uncancelled travel that is eligible for rectification. According to the Substitute for a Deputy-Ombudsman's understanding, the customer must be able to submit the matter concerning the loss of a service journey to the social welfare services for assessment and decision.

Termination of daytime activities for persons in mental health rehabilitation

In its decision 2719/2021, the Ombudsman considered it a shortcoming that those participating in the day centre activities organised by healthcare (Central Finland Regional Health Care Centre) or the disability organisations representing them had not been able to participate in the change in the service structure prepared by the Central Finland Regional Health Care Centre and the City of Keuruu. When the day centre activities ended, some patients had found it challenging to switch to services in accordance with the Act on Disability Services and Assistance. The Ombudsman considered it important that when an authority draws up policies on service structures, service users and/or organisations representing them should be involved in the preparation. The Ombudsman drew attention to the implementation of the right of persons with disabilities to participate.

The Ombudsman drew the attention of the City of Keuruu and the Central Finland Regional Health Care Centre to the authority's responsibility for ensuring that service users and residents (municipal residents) receive essential information about the planned service changes that were significant for them and the reasons that led to them. In this case, the City of Keuruu's responsibility for notifying was emphasised, as the responsibility of organising a service to replace the discontinued service (day centre activities) was transferred to it in the service structure reform. The Ombudsman stressed that according to the Local Government Act, adequate informing does not only concern the solutions and their impacts, but that the municipality must also inform its residents of matters pending in the municipality and the plans concerning them. When changes in the activities affect the rights and obligations of an individual client, the social welfare personnel must explain to the client their rights and obligations as well as different options and their impacts and other matters that are relevant to them.

The Ombudsman was left with a strong impression that cooperation between healthcare and social welfare (disability services) had not worked seamlessly after the service structure reform. In the Ombudsman's view, the social welfare (basic social security) and healthcare authorities should have cooperated significantly more to secure seamless service chains for patients and clients than what the report revealed. The Ombudsman considered it a shortcoming that the aforementioned multiprofessional working group had not included a representative of social welfare services where necessary. The lack of cooperation might have contributed to the fact that when the service ended, services based on the customer's individual needs did not form a solution in the customer's best interest, as the customer might have been left completely without the service they needed.

In the Ombudsman's view, the basic security of the City of Keuruu should have acknowledged the continuity of services in its operations well in advance when planning the service change, also in other ways than by "investing in service guidance" after the termination of the service. In this case, it has ultimately been the responsibility of the City of Keuruu to ensure that the services replacing the discontinued service are implemented in accordance with the individual needs and interests of persons with disabilities in terms of content and scope, and that people in mental health rehabilitation receive the services they need in cooperation between social welfare and healthcare services.

Patients with schizophrenia are not provided with statutory social services

The Deputy-Ombudsman issued two decisions on social services for people with chronic schizophrenia.

The first case concerned a violation of private life because a place of residence was chosen for the client (intensified service housing) far from their close relatives, thus effectively restricting the meetings between the mother and the daughter. The Deputy-Ombudsman stated that she could not avoid getting the impression that contact with the daughter and grandchildren was not considered important when the assessment for the best place of residence was carried out (1942/2021).

In the other case, social welfare professionals did not identify the right of persons with chronic schizophrenia to free disability services. The starting point in legislation is that social welfare professionals ensure through their own actions the necessary care for persons in a vulnerable position. Under the Act on Disability Services and Assistance, wellbeing services counties, previously municipalities, have a special obligation to organise the service housing required by mental health rehabilitees who are considered to be severely disabled. Service housing referred to in the Act on Disability Services and Assistance is an entity that is free of charge to the client even if it consists of paid services organised under various acts, such as home care and assistance with cleaning the flat (6600/2021).

3.4.5 DECISIONS IN THE SOCIAL INSURANCE SECTOR

Processing time of applications for demanding medical rehabilitation

The three cases resolved by the Ombudsman concerned Kela's negligence to process an application for demanding medical rehabilitation for a client with severe disabilities without undue delay.

In the first case 7676/2021, the Ombudsman reprimanded Kela for an unlawful procedure in processing an application for the complainant's child to avoid similar cases in future. The Ombudsman found that Kela had neglected to process an extension application concerning demanding medical rehabilitation (physiotherapy and speech therapy) for a severely disabled child without undue delay. The Ombudsman stressed that Kela should have sought to act without delay at all stages of processing the matter.

The UN Convention on the Rights of Persons with Disabilities and the UN Convention on the Rights of the Child require that the best interests of the child must be a primary consideration in all actions concerning children with disabilities. This case concerned the rehabilitation of a child, in which the speed of processing the extension application is particularly important for the child so that the rehabilitation can continue without interruption.

However, due to the delay, the physiotherapy and speech therapy organised by Kela for the developing child was interrupted for almost two months, even though Kela should have sought to deal with the matter as quickly as possible.

In case 8525/2021, the Deputy-Ombudsman also considered that Kela had neglected its obligation to process the complainant's rehabilitation application appropriately and without undue delay. The processing of the application had a long passive period at the start, despite the customer's request to hurry, when it seemed that the application had not progressed at all. The delay in processing the matter was significant. The Deputy-Ombudsman stressed that Kela should have sought to act without delay at all stages of processing the matter. In the processing of applications, they should ensure that the processing does not stop and that the period without any measures to process the application is as short as possible.

Similarly in the third case 5637/2021, the Deputy-Ombudsman considered that Kela had neglected its obligation to process the complainant's application without undue delay. Kela announced that it would develop a national process for handling demanding medical rehabilitation benefits. The Ombudsman considered the development work carried out by Kela to be necessary, as the continuity of demanding medical rehabilitation granted by Kela and the prompt resolution of the extension application are of great importance for the rehabilitee's everyday life, which Kela should take into account in all its decision-making.

Deficiencies in justifying decisions and receiving family rehabilitation in your mother tongue

In case 8525/2021, the Deputy-Ombudsman found Kela's decision on the application for family rehabilitation unclear and a danger to the complainant's legal protection. The grounds for the decision were also incomplete. The grounds for the decision did not include any opinion on how significant it was, for the application's assessment, that the complainant had acquired the service from Sweden because Kela had not arranged family rehabilitation in Swedish. In addition, Kela had not rejected the claim for compensation presented by the applicant, nor had the decision justified the reasons why the complainant had not been granted family rehabilitation in Finland. The Deputy-Ombudsman also considered it an issue that the decision did not address the psychologist's costs at all, even though they were also included in the application. The Deputy-Ombudsman drew Kela's attention to carefully justifying its decisions.

In the Deputy-Ombudsman's view, the procedure that would better safeguard the complainant's legal protection would have been that Kela decides on the application, assessing whether to grant the complainant discretionary rehabilitation (family rehabilitation) for which they applied. Kela should also have made a separate decision assessing whether the course and psychology services purchased by the complainant are reimbursable. This time, the decision denied the family rehabilitation and also assessed the compensation matter without considering the complainant's possibility of accessing family rehabilitation and, on the other hand, without the complainant having had the right to appeal the decision insofar as it concerned reimbursement of costs. In the Deputy-Ombudsman's view, if Kela had resolved the complainant's claim as a matter of reimbursement of rehabilitation costs, the normal complaint procedure should have been available for the decision.

The Deputy-Ombudsman considered the decision issued by Kela a severe threat to the complainant's legal protection, as the decision did not contain instructions for appealing. For this reason, the complainant could not complain nor receive a decision to a question, in connection with the appeal, on whether they would have been entitled to receive compensation for the service if it is acquired from another EU country on the basis of EU legislation.

The Deputy-Ombudsman asked Kela to report by 20 February 2023 (extended date 31 March 2023) on the measures that the Deputy-Ombudsman's opinion may have initiated.

On 17 March 2023, Kela reported that it had issued a new, more justified and appealable deci-sion for the customer on the costs they had applied for. Kela announced that it would pay more attention to giving justifications for rejected rehabilitation decisions in future. Kela also announced that it would improve the internal cooperation between its different benefit schemes so that the benefit process takes the customer's situation and their right to compensation under different provisions into account more comprehensively in future, regardless of the grounds based on which the customer applied for compensation.

Despite Kela's attempts, it had failed to obtain a Swedish-speaking service provider through public or direct procurement in order to organise discretionary family rehabilitation. In the Deputy-Ombudsman's opinion, it is justified to state that rehabilitation services provided with interpretation are not fully comparable with a service provided in the person's mother tongue. In such situations, it is particularly important for children with disabilities to receive services in their mother tongue. The complainant did not have the opportunity to receive family rehabilitation in their mother tongue on an equal basis with Finnish speakers.

The Deputy-Ombudsman considered the situation concerning. The Deputy-Ombudsman requested a report from Kela by 30 May 2023 on how it intends to ensure the availability of family rehabilitation in future.

On 17 March 2023, Kela announced that it would introduce a registration procedure outside the Act on Public Procurement and Concession Contracts as a method to implement the LAKU family rehabilitation during 2024. The registration procedure gives service providers more flexibility and with it, Kela can continuously provide information of and market the possibility of registering as LAKU family rehabilitation service providers to Swedish-speaking rehabilitation service providers.

3.4.6 DECISION IN THE TEACHING SECTOR

In the Ombudsman's oversight of legality, frequently repeated complaints include questions related to learning support as well as the status and rights of children and young people in a vulnerable position, persons with disabilities and others in need of support.

In its decision 3927/2021 on the complaint submitted by the Trade Union of Education in Finland, the Deputy-Ombudsman emphasised that everyone's secured right to basic education is supported by the fact that special needs education is provided by a teacher who meets the eligibility criteria.

The Deputy-Ombudsman proposed that the Ministry of Education and Culture assess whether the provisions on teaching qualifications should be clarified.

The Deputy-Ombudsman emphasised that the pupil has the right to receive the special support education provided in those subjects in which the pupil has been found to need special support education, regardless of the place of education or the teaching group. The Deputy-Ombudsman proposed that the Ministry of Education and Culture and the Finnish National Board of Education assess whether the legal protection of children and the equal right to education require that the content and organisation of intensified and special support be clarified in legislative terms, and whether the Basic Education Act should be supplemented by an obligation to issue an appealable administrative decision on intensified support.

The Deputy-Ombudsman requested both the Finnish National Board of Education and the Ministry of Education and Culture to report by 28 February 2023 on the measures that have been taken in response to the decision.

The Finnish National Board of Education announced that it had corrected its instructions and prepared additional support material for organising special support.

The Ministry of Education and Culture stated that legislation and the national core curriculum should clarify when and on what grounds the syllabus for the subject can be individualised. In this respect, the ministry had asked the Finnish National Board of Education to review its guidelines, and the preparations for clarifying legislation have begun in the ministry. The Ministry of Education and Culture emphasised that it is particularly important that the decision on special support defines further how the special education included in the special support is organised at the local level. The ministry announced that it had requested the Finnish National Board of Education to review its guidelines from this perspective.

3.4.7 DECISIONS IN THE HEALTHCARE SECTOR

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

Organisation of care for a child with intellectual disabilities

In the Deputy-Ombudsman's view, the hospital district had neglected its obligation when it failed to provide specialised medical care that meets the needs of a child with a severe intellectual disability. The hospital district should have cooperated more with the different units of the hospital district and with other university hospital districts to find a suitable place for care for the child. The child had received several referrals to specialised medical care, but the hospital district had considered that the hospital's different departments did not have the skills needed to meet the child's needs. Instead, the child needed special expertise in intellectual disability services. Neither did primary healthcare have sufficient competence to respond to the situation. In services for people with disabilities, on the other hand, the need for services was primarily seen as a responsibility of healthcare. The area did not have enough institutional facilities for persons with intellectual disabilities, especially for acute crisis situations.

The Deputy-Ombudsman stressed that the Constitutional right to necessary and adequate social welfare and healthcare services must not be delayed because the authorities have different views on which authority should primarily organise the services.

The Deputy-Ombudsman noted that the special care district should pay particular attention in its activities to cooperation with other authorities in the region and ensure that its operation is able to meet the needs of its residents. The special care district must take measures to secure adequate institutional rehabilitation facilities so that they can meet the service need also in acute crisis situations.

In the Deputy-Ombudsman's view, the reassessment of service needs should have started earlier. The city's services for disabled people considered the child's worsened situation to be primarily a matter belonging to healthcare, and therefore the actual assessment of the need for services under the Social Welfare Act was not initiated at that time. The assessment of service needs only started one year later on the basis of child welfare notifications submitted by the child's parents and employees caring for the child.

The Deputy-Ombudsman informed the hospital district, special care district and the city of their views on the illegality of the procedure and asked them to report on their actions by 28 February 2023 (2888/2021).

The wellbeing services county of Central Finland reported that the services and service need assessment of persons with intellectual disabilities have been made a focus area in the county during the year 2023 to ensure the provision of equitable and timely services.

Visiting a health station as a hearing-impaired person

In case 4629/2021, the Deputy-Ombudsman considered that it would be necessary that the City of Helsinki's website presents information on the contact methods for persons with hearing impairments more clearly. The Deputy-Ombudsman considered it essential for the rights of persons with disabilities that they have sufficient information on how to contact health services.

The Deputy-Ombudsman informed the City of Helsinki of the decision and asked the city to report on any measures they may have taken by 31 January 2023.

Home hospital procedure

In decision 1869/2021, the Deputy-Ombudsman considered that the joint municipal authority's home hospital had proceeded incorrectly after a physician had discussed matters related to patient care with the patient's family member only after the referral had been prepared. The patient's consent was incorrectly recorded in the referral even though they did not have the prerequisites for giving such consent. Due to their state of health and intellectual disability, the adult patient was not able to independently decide on their treatment regarding health matters for which they were referred to a hospital.

The Deputy-Ombudsman noted that it was important to provide the patient with an explanation of matters related to their treatment even when the patient has particular difficulties in understanding the information received. It is equally important that the nursing staff recognise when the patient is unable to understand the significance of the medical solution or express their will. When making patient document entries, the entry should clearly indicate whether an effort was made to provide information or whether the patient understood what was going on and was able to express their opinion.

The Deputy-Ombudsman stressed that if the patient is unable to decide on their treatment, the implementation of the right to equal and high-quality health services guaranteed by the Constitution and the UN Convention on the Rights of Persons with Disabilities requires that the patient's treatment complies with the provisions of the Act on the Status and Rights of Patients. In order to determine what kind of treatment would best correspond to the patient's will and interest, cooperation must be carried out with the patient's legal representative, a close relative or other person close to them.

On 12 December 2022, the head of service announced that the joint municipal authority had taken into account the issues raised in the Deputy-Ombudsman's decision and had informed the parties in the organisation whose task is to ensure that the problems related to the realisation of the right to self-determination of persons with disabilities and the quality of health services are not repeated.

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

The NPM has provided induction training for external experts regarding the related visits. During the reporting year, the NPM had 11 external health care specialists available from the fields of care work, psychiatry, youth psychiatry, geriatric psychiatry, forensic psychiatry and intellectual disability medicine. A further four external experts represent the Sub-Committee on the Rights of Persons with Disabilities operating under the Human Rights Delegation at the Human Rights Centre. Their joint expertise will benefit visits carried out at units where the rights of persons with disabilities may be restricted. In addition, the NPM has trained five experts by experience to support this work. Three of them have experience of closed social welfare institutions for children and adolescents, while the expertise of the other two is used in health-care inspection visits.

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:

- webinar titled "Torture – Assessing and Documenting using the Istanbul Protocol" on 19 April 2022
- conference organised by the European NPM Forum for national preventive mechanisms (NPM), titled "Monitoring the rights of specific groups of people deprived of their liberty" from 5 to 6 October 2022 where Deputy-Ombudsman Maija Sakslin gave a talk
- a discussion workshop for developing the right to self-determination tool on 23 November 2022 (organised by the Human Rights Centre)
- Kalle Könkkölä symposium: Access of persons with disabilities to their rights in crisis situations on 12 December 2022 (organised by the Human Rights Centre, the Parliamentary Ombudsman and the Disability Rights Committee under the Human Rights Delegation)

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 NORDIC COOPERATION

The Nordic NPMs meet regularly, twice a year. Themes topical at the time have been discussed in each meeting. During the coronavirus pandemic, cooperation continued through a remote connection. After the coronavirus pandemic subsided, an in-person meeting could finally be held in autumn 2022.

A remote meeting was organised by the Icelandic NPM in March 2022. At the meeting, the NPMs exchanged experiences on topics such as how expert opinions address the freedom or private life of persons deprived of their liberty. The NPMs also discussed the difficulties faced by services or institutions in complying with NPM recommendations, for example due to a lack of resources or a shortage of staff. Participants at the meeting were also treated to a presentation by psychologist Sigríður Karen J. Bárudóttir. The presentation was about confidential discussions in closed psychiatric wards with patients who have been assessed to be dangerous or who are held in a high-security unit.

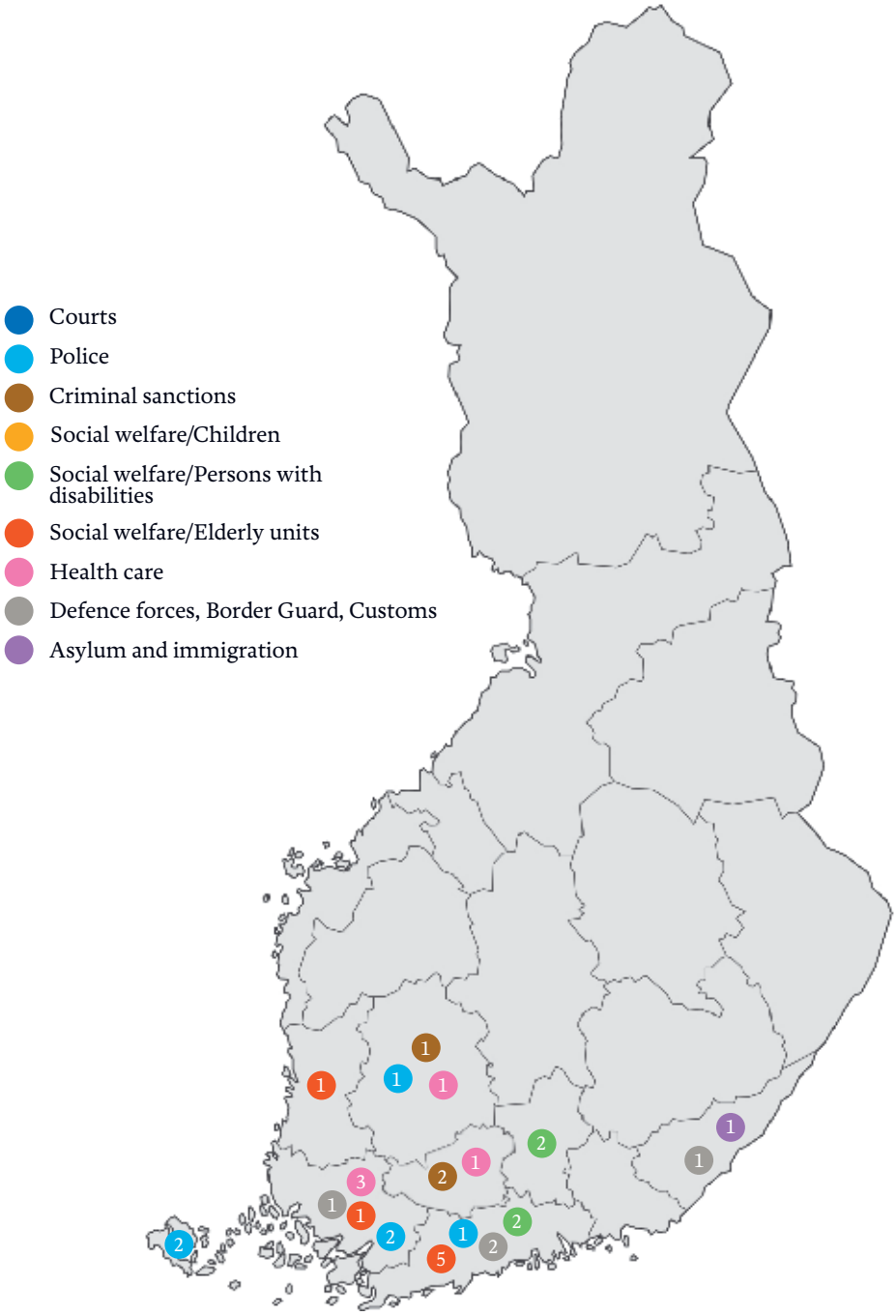
In August 2022, the meeting took place in Copenhagen. The meeting featured a presentation by a representative of the Danish Institute Against Torture (DIGNITY), discussing which themes and administrative areas NPMs should focus on. The main theme chosen by the Danish NPM was the oversight of prisons located abroad. In connection with this theme, there were presentations titled "Denmark's experiences – participation in drafting a law on the oversight of prisons in Kosovo" and "Establishment of a prison in Kosovo". Another topic was the mandate of the Norwegian NPM in a situation where a foreign state is holding persons deprived of their liberty at bases located on Norwegian soil. There was also discussion on the oversight of military bases and the security checks of NPM members.

3.5.5 VISITS

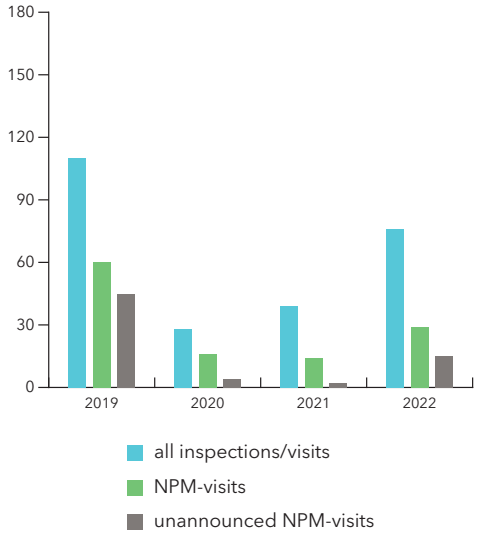
Visits by the NPM in 2022

The NPM conducted 29 visits in the year under review. All inspections were carried out on site. The total number of inspection visits carried out by the Office of the Parliamentary Ombudsman was 76. In addition, three of the Parliamentary Ombudsman's visits were related to the task of the NPM. They included visits to the National Police Board and to the Criminal Sanctions Agency.

Of the inspections, 14 were unannounced and 12 were announced in advance. In addition, three inspections were carried out with a notification of a specific period during which the inspection would be carried out without indicating the exact date. The Parliamentary Ombudsman or the Deputy-Ombudsman participated in five inspections. External experts were used in nine inspections. These inspections involved a total of 16 experts, which means that some inspections had several experts participating.



NPM visits by region in 2022. A full list of all visits and inspections is provided in Appendix 4.



Visits in 2019–2022.

Special themes to be considered during visits

The oversight of oversight was the special theme for 2022 in the field of fundamental and human rights at the Office of the Parliamentary Ombudsman. 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, with slightly under 50,000 cases every year. The second largest group is formed by persons suspected of an offence, numbering approximately 20,000. In addition, some persons detained under the Aliens Act are kept in police detention facilities (also referred to as police prisons below).

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. In 2022, the Board carried out four inspections in police prisons.

Inspection visits

In the reporting year, the NPM carried out five inspections in police detention facilities and one inspection in the detention facilities of a passenger car ferry (see table on the following page).

All above-mentioned inspections of police detention facilities were carried out without prior notice. The inspection visit to the detention facilities on the passenger car ferry was announced in advance.

In addition to the above, the Ombudsman carried out an inspection visit at the National Police Board (5819/2022*). The focus areas of the NPM inspections of police detention facilities included the following:

Detention facilities

Many of the buildings used by the police are between 40 and 60 years old, which is why it has been necessary to renovate police stations and their detention facilities or to build completely new facilities. This also applies to the police detention facilities inspected during the year under review.

Date of Inspection	Target	Number of Places	Case Number	Other / Previous Inspection
23 May 2022	Helsinki Police Department detention facilities	–	3174/2022	previous visit on 17 June 2021 (4225/2021)
27 September 2022	Tampere Central Police Station	62 cells	5682/2022	previous visit on 12 July 2019 (2982/2019)
29 September 2022	Southwestern Finland Police Department's detention facilities in Turku	68 cells	1950/2019	previous visit on 17 April 2018 (1963/2018)
29 September 2022	Southwestern Finland Police Department's detention facilities in Salo	8 cells	4772/2022	previous visit on 22 September 2015 (3996/3/15)
8 November 2022	Åland Police Authority's detention facilities in Mariehamn	7 cells	6392/2022	previous visit on 12 September 2016 (3474/2016)
7 November 2022	detention facilities of the M/S Baltic Princess passenger car ferry	6 cells	6559/2022	–

Working alone in detention facilities

In police prisons where the number of apprehended persons is small, staff members have to regularly work alone (see e.g. 4772/2022). The Ombudsman has found this very problematic, for example in terms of occupational safety and the effectiveness of supervision. Despite the Ombudsman's statements on the matter, no change is apparently possible until working alone is prohibited by legislation.

Supervision of detainees

Inspections particularly focus on how the supervision of detainees has been implemented in police detention facilities and how detainees can contact the supervisory staff. Supervision may however not compromise the privacy of detainees when they use the toilet. Deficiencies related to these issues were also identified in some of the inspected detention facilities during the year under review.

With regard to the detention facilities in Salo, the Ombudsman required for the supervision of the detention facilities to be fixed without delay so that the audio connection to the control room works and so that privacy is ensured when using the toilet. The police department reported that it initiated measures to obstruct the view from the toilet seats in the detention facilities and to fix the audio connection from the detention facilities to the control room (4772/2022).

In the detention facilities in Mariehamn, detainees were occasionally mainly supervised via camera feed at the emergency response and situation centre, which was on a different floor than the detention facilities. The Ombudsman found it problematic that detainees are supervised by persons who are not physically at the detention facilities. An audio and video connection is not a substitute for physical supervision. The Ombudsman recommended for the police authority to review their procedures and guidelines concerning the supervision of detainees.

The police authority reported that its limited personnel resources forced them to use staff efficiently, so it was not possible to resolve the issue with the current financial resources.


Detention facility for intoxicated persons in Salo police prison.

The Ombudsman still found it problematic that supervision of detainees has been delegated to a person who does not work physically in the detention facilities, at least at certain times. However, he thought it understandable that this is largely due to the resources allocated to the police authority, which the authority cannot decide. The Ombudsman asked the police authority to report any possible measures by 31 December 2023 (6392/2022).

Other duties of persons involved in the supervision of detention facilities

The inspections revealed that the police custodial officers of some detention facilities had also been given other tasks in addition to the supervision and care of detainees. This was particularly the case for detention facilities with few detained people. The Ombudsman stated that, for example, registration tasks must not interfere with the proper performance of supervision duties (4772/2022).

The police custodial officer in the detention facilities of the Åland Police Authority was responsible for the supervision and care of detainees but also for customer service, lost property, taking eyewitness evidence as well as receiving and recording simple reports. In addition, the duty officer at the emergency response and situation centre on the 3rd floor was occasionally responsible for supervising and taking care of detainees in addition to performing the duty officer's actual tasks, such as taking emergency calls. The Ombudsman found this problematic. Although there are two persons working at the emergency response and situation centre, one of them is not always a police officer and not trained for the supervision of detention facilities. The division of responsibilities between different employees also remained unclear (6392/2022).

Training of persons involved in the supervision of detainees

Custodial officer training by the police administration

In all the inspected units, the police custodial officers of the detention facilities had a qualification required for the post, i.e. a degree from the security sector. On the other hand, not all of the police custodial officers had completed the custodial officer training organised by the Police University College. In the Ombudsman's view, the custodial officer training organised by the police administration clearly improves police custodial officers' ability to perform supervision tasks at a detention facility. For this reason, the Ombudsman has recommended that police departments should, within the limits of possibilities and training quotas, make sure that police custodial officers have access to this training.

The police departments reported that they would aim to ensure that all police custodial officers would complete the custodial officer training organised by the police administration. However, this aim was hampered by the training quotas set for police departments (4771/2022, 4772/2022 and 5682/2022).

The Åland Police Authority informed the Ombudsman that no Swedish-language custodial officer training was available at the Police University College. For this reason, the police department has been developing its own training programme whose content matches the custodial officer training provided by the Police University College.

Another aim is to continue discussions with the Police University College to resolve this availability issue. In this respect, the Ombudsman noted that if police officers also have to be used as custodial officers in police prisons, it would be justified for them to receive the same training that is arranged for custodial officers, at least covering the main topics (6392/2022).

First aid training

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has in its latest report on Finland from 2021 recommended that regular first aid training be made possible for everyone working in police prisons. During the coronavirus pandemic, these training courses had been put on hold. The Ombudsman has in fact recommended that the first aid training of employees supervising detention facilities be started again as soon as possible.

For the police departments whose custodial officers' first aid training situation remained unclear, the Ombudsman recommended that the missing training be undertaken as soon as possible. The Ombudsman also considered it justified for the facilities to keep up-to-date records of police custodial officers' first aid training. According to reports from police departments, training has been resumed after the coronavirus pandemic. Training for the most recent police custodial officers had been agreed for early 2023. In the future, the senior police custodial officer will keep a record of personnel's first aid training (4771/2022 and 4772/2022).

Police custodial officers' training on pharmacotherapy

In its statement issued to the Parliamentary Ombudsman, the National Supervisory Authority for Welfare and Health (Valvira) has emphasised that, when police custodial officers distribute medicines, patient safety should be ensured by following the instructions of the Safe pharmacotherapy guide regarding situations where a person not trained in pharmacotherapy is participating in the implementation of medicinal treatment. It is also essential that police custodial officers receive an appropriate and sufficient induction to the task.

All police custodial officers at the detention facilities in Tampere and Mariehamn had completed online training on pharmacotherapy. However, in the police detention facilities in Turku and Salo, there were new custodial officers who had not received this training. With regard to these custodial officers, the Ombudsman recommended that all of them complete the medicine administration training without delay. The need for this was particularly emphasised in police prisons where police custodial officers had to work alone. The Southwestern Finland Police Department reported that the matter will be resolved for both police prisons by the end of 2022.

Information on rights and obligations

In its recommendations to Finland, the CPT has also recommended improving the procedures of informing detainees of their rights. The National Police Board has issued instructions on the treatment of persons in police custody. According to these instructions, a person deprived of their liberty must immediately after their arrival at the detention facility be informed of the conditions in the detention facility by giving them a form explaining the rights and obligations of detainees, the rules of the police prison and the National Police Board's instructions in question. Despite this, the Parliamentary Ombudsman has had to draw the police prisons' attention to the provision of information on rights and obligations.

Deficiencies were also found in some of the police prisons inspected during the year under review. Written material has not been kept on display in detention rooms, with the argument that a sheet of paper could be used to block the toilet.

However, other inspections have revealed that detention rooms have had printed documents, which, according to the detention facility staff, had not posed a risk to safety in detention (e.g. 4772/2022). The police department announced that it would ensure that, in future, detainees would be given the required materials and that records would be made of this (4771/2022).

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 all the inspected police prisons except for one.

The Ombudsman has recommended that police departments at least assess the need for regular visits by a nurse. This has also been recommended by the CPT. However, the Southwestern Finland Police Department has stated that it considers the current practice sufficient for the detention facilities in Turku and Salo. Health care for detainees in the detention facilities of the Tampere Central Police Station is provided by the sobering-up station near the facilities. The station has a nurse available 24 hours a day and a doctor during office hours.

During the inspections, the Ombudsman has reminded police prisons of the guidance letter by the National Police Board in 2017, according to which all detainees must be informed on their arrival of their right to receive health care in the detention facility at their own expense with permission from the doctor organised by the police. The CPT has also required that the detainees be allowed access to their own doctor.

Health examination

In its latest report on Finland, the CPT has required health examinations to be conducted on persons deprived of their liberty (including remand prisoners) within 24 hours of their arrival in the police detention facilities. In practice, this is not achieved in any police prison at the moment. The requirement has also not been included in the guidance letter issued by the National Police Board in 2017. The Ombudsman has issued a recommendation to police departments that police detention facilities should try to ensure that all persons deprived of their liberty for longer than 24 hours would get to see a health care professional. The Southwest Finland Police Department, which has not considered it necessary for a nurse to visit the police detention facilities on a regular basis, has also not taken action to carry out health examinations. Instead, police custodial officers will be instructed that persons detained for longer than 24 hours will be informed orally about the possibility of seeing a health care professional (4771/2022 and 4772/2022).

Medical care

Police detention facilities have different ways of managing the medications of detainees. In the inspected police prisons, the custodial officers no longer had to administer medicines for detainees. Instead, the medicines could be retrieved from a pharmacy pre-dosed in pill dispensers (4771/2022, 4772/2022 and 6392/2022). When a sobering-up station oversees the health care of the police prison, medicines have come from the sobering-up station in pill dispensers, and custodial officers have administered them from a lockable medicine cart (5682/2022).

The Safe pharmacotherapy guide requires that each unit providing pharmacotherapy has a pharmacotherapy plan. Police departments have not drawn up a pharmacotherapy plan although medicinal treatment is carried out in police prisons. This has started to change with the Helsinki Police Department preparing a pharmacotherapy plan first in 2020.

The Eastern Uusimaa Police Department has also announced after the Parliamentary Ombudsman's inspection in 2021 that it has started preparing a pharmacotherapy plan for the police prison.

The Ombudsman has recommended that pharmacotherapy plans also be drawn up for the police prisons inspected during the year under review. Supervisory personnel should also be introduced to the contents of the pharmacotherapy plan where necessary. The Southwestern Finland Police Department has announced that a plan for police prisons at the Southwestern Finland Police Department will be prepared by 31 December 2022 on the basis of the pharmacotherapy plan of the Helsinki Police Department. Orientation for personnel will be implemented in January 2023.

Inspection visit to detention facilities at a passenger car ferry

During the year under review, the detention facilities of a ship were also inspected for the first time under the NPM's mandate. The flag state of the inspected vessel is Finland. The shipping line reported that it uses its own security stewards who also manage the detention facilities.

It was found during the inspection that personnel usually attempts to take persons to their cabins instead of the detention facility. The reports examined did not indicate that detentions had been made without legal grounds. The relevant records were also found to be appropriate. Instead, the Ombudsman commented on the following issues in particular:

Approval of detention facilities. The police have not inspected or approved the cell facilities of the vessel. Under the Private Security Services Act (hereinafter the PSS Act), a police department must inspect this type of detention facility and approve it before the facility is used. The Ombudsman stressed that the provision on police approval is an absolute special provision for security proceedings (also on vessels). However, it remained open to interpretation which particular police authority could grant the approval. Nevertheless, this ambiguity does not justify the fact that the detention facilities have not been approved by the police at all.

Detention notifications to the police. Notifications had not been submitted to the police unprompted, only after separate request from the police. However, according to the PSS Act, a notification must be submitted to the police immediately after the vessel arrives in port. After the inspection, the shipping line asked for instructions on how the reports should be submitted and to which police department. The Ombudsman stressed that detention notifications are one way for the police to oversee security proceedings on board vessels. It is another matter that there is room for interpretation as to which port the law refers to. This issue should be resolved jointly by the police and shipping lines.

The passenger ferry M/S Baltic Princess had six detention facilities, of which two can be seen in the pictures.

The Ombudsman announced that he would conduct a separate investigation on the issues related to security on board vessels and its supervision, which may bring clarification to these interpretations as well.

Supervision of persons deprived of their liberty. All cells had a surveillance camera but no voice or audio connection. None of the cells had an alarm button that a detainee could have used to call for help. Furthermore, there was nobody on board that could have continuously focused solely on the supervision of detained persons. After the inspection, a monitor was installed on the bridge of the vessel, from which the officer of the watch can supervise detainees round the clock. The Parliamentary Ombudsman welcomed this measure. Nevertheless, he was apprehensive of how efficiently the officer of the watch could carry out adequate supervision, which had to be continuous, in addition to the officer's other important duties. In the Ombudsman's opinion, there should in any case be an alarm device in cells that could be used by detainees to immediately reach personnel. In addition, supervision would be improved if there was a voice line to the cells. He recommended investigating whether such a technological solution could be arranged.

Ensuring privacy when using the toilet. All cells also had a toilet seat that was visible in the surveillance camera feed. From the perspective of ensuring privacy, the Ombudsman found it problematic that the view of the surveillance camera had not been covered by technological means or otherwise at the toilet seat. The Ombudsman recommended that the shipping line investigate whether it would be possible to improve privacy without compromising detention safety with structural changes or by other means. Regardless, he considered it problematic having structures in the cells that a person could use to hang themselves.

Treatment of persons deprived of their liberty. Detention notifications revealed two cases where all clothes had been removed from a woman who had behaved in a self-destructive way. The Ombudsman stated that treatment respectful of human dignity includes the right to wear appropriate clothing. The problem was accentuated by the fact that all the security stewards on board the vessel were men. According to a decree by the Ministry of the Interior (hereinafter referred to as the MI decree), the security officer conducting a security check must be of the same sex as the person being checked if the person subject to the check has to remove clothing other than outdoor clothes for the purposes of the check. The Ombudsman decided to investigate the two cases separately on his own initiative.

Health checks. According to the MI decree, before an apprehended person is detained, a health care professional must establish that they do not have an injury or illness that may endanger the health of the detained person during detention. This had not always been done. The Ombudsman stated that the provision of the MI decree is absolute in this respect as well. The Ombudsman found it positive that, after the NPM's inspection, a regular health examination, investigation of medications and assessment of illnesses were added to the detention report.

The Ombudsman requested the shipping line to report any action it will take by 15 December 2023. Additionally, he took the initiative to investigate the development of legislation and police procedure for the oversight of security aboard vessels. He has requested statements from the Ministry of the Interior, the Ministry of Economic Affairs and Employment, the Ministry of Transport and Communications and the Government of Åland.

Detention of intoxicated persons

At the moment, sobering-up treatment for intoxicated persons has not been arranged even in all large cities with there being no statutory obligation to do so. However, from the perspective of police work, a sobering-up station located in the immediate vicinity of police detention facilities plays an important role. Police do not need to get involved when these stations take care of intoxicated persons who are acting calmly. In addition, the health care personnel at a sobering-up station offer assistance related to the health of apprehended persons who are in police custody.

An example of this is the sobering-up station maintained by the City of Tampere, located next to the police detention facilities. The inspection visit at the detention facilities revealed that the sobering-up station had reduced the number of police detentions by as much as 2,000 a year.

Reform of the Police Custody Act

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

One proposal of the report was that the minimum staff resources for the supervision of persons deprived of their liberty in detention facilities be separately laid down. If implemented, this would mean that the police detention facilities would no longer allow having only one custodial officer in charge of the entire detention unit. In his statement, the Ombudsman however expressed doubts as to whether sufficient resources were available for the implementation of all the improvement proposals, such as custodial officers not working alone. The Ombudsman considered allocation of sufficient resources a precondition for the effective protection of the rights of persons deprived of their liberty in practice, not just on paper.

The Ombudsman also found it highly desirable that the reform will bring about a functioning solution for sobering-up treatment, in which case only some of the intoxicated persons would be held in police custody. He considered it obvious that a sufficient network of sobering-up stations would significantly reduce deaths in police custody in Finland. However, the Ombudsman noted that the report did not specify how the current unsatisfactory situation would be rectified.

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

The overall reform of the Police Custody Act that had been pending since 2015 was eventually not implemented, as the Government proposal was not submitted to Parliament before the end of its parliamentary term. The main reason for this was apparently that the funding required for the reform could not be arranged.

3.5.7 DEFENCE FORCES

The treatment of persons deprived of their liberty in the detention facilities of the Defence Forces is subject to the provisions of the Police Custody Act. During these visits, attention is paid to the conditions and treatment of detainees, their access to information and their security. During the year under review, an unannounced inspection was carried out in the detention facilities of the Coastal Fleet on 12 October 2022 (6123/2022) and a pre-announced inspection visit at the detention facilities of the Coastal Brigade on 9 December 2022 (7438/2022).

Detention facilities of the Coastal Fleet

The detention facilities were used very little. By the date of the inspection, three persons had been deprived of their liberty in 2022 and 12 in the previous year. The average duration of the deprivation of liberty is a few hours, in practice always less than 12 hours.

It was found during the inspection that the camera surveillance in the detention rooms made it possible to supervise detainees even when using the toilet of the detention room. This has been considered a violation of privacy and humiliating in the Ombudsman's oversight of legality. There may also be other detainees in the same room. The Ombudsman proposed for consideration whether it would be possible to change the camera surveillance so that the privacy of a person deprived of their liberty could be safeguarded when they are using the toilet. There was no furniture in the storage rooms, and detainees had to eat their meals either standing up or sitting on the mattress on the floor. The Ombudsman stated that when it is necessary to serve a meal to a person deprived of their liberty, the facilities should be appropriate for eating.

Coastal Brigade detention facilities

The detention facilities were taken into use on 1 April 2022 and were located in the new main surveillance building of the Coastal Brigade. In the past year from 1 January to 31 October 2022, there were 18 detainees. In the previous year, there were 5 detainees. No person had been deprived of their liberty for longer than 12 hours.

There was no furniture in these inspected detention facilities either. In connection with the inspection, it was reported that meals can be arranged in such a way that detainees eat at the countertop used for arrival checks. In this case, the meal is had standing up. The Ombudsman stated that when a meal must be served to a person deprived of their liberty, the conditions in the cell should be such that the person does not have to eat while sitting on the floor or standing up.

Another inspection finding was that, before placing persons in the detention facility, glasses are taken away from all detainees who wear ones. According to the Police Custody Act, the rights of persons deprived of their liberty must not be restricted more than is necessary, taking into account factors such as safety during detention. In the Ombudsman's view, removing property from detainees should be considered on a case-by-case basis, and glasses should not be considered a safety risk in all cases. In addition, a decision is required if a person is not given glasses in the detention facility even if they request them.

3.5.8 BORDER GUARD AND CUSTOMS

During the year under review, an unannounced inspection was carried out at the detention facilities of the Nuijamaa border crossing point on 15 December 2022 (7489/2022*) and a pre-announced inspection was carried out at the Customs detention facilities in Itä-Pasila on 7 December 2022 (7326/2022*). As a rule, the Police Custody Act applies to the treatment of persons deprived of their liberty detained in the facilities of both the Border Guard and Customs.

Inspection visit to the detention facilities at the Nuijamaa border crossing point

Based on the inspection findings, the detention facilities at the border crossing point were rarely used and detention times were short. Despite this, the Ombudsman recommended that the Border Guard ensure without delay that all border guards who take part in placing persons in the detention facilities and supervising detainees at border crossings are familiarised with the provisions of the Police Custody Act and the contents of the rules of procedure. In addition, the Border Guard should ensure that detainees have access to the material specified in the rules of procedure.

The detention rooms of the passenger traffic centre had a toilet seat that was not covered in the camera feed. The rules of procedure of the detention facility addressed the protection of privacy when using the toilet. The Ombudsman doubted whether the process described in the rules of procedure ensured sufficient protection of privacy. Among other things, the process required that the person deprived of their liberty notifies in advance when they intend to use the toilet so that the rules of procedure could be followed. The Ombudsman referred to how protection of privacy has been implemented in police detention facilities in a manner that does not endanger safety in detention. The solution in these facilities has mainly been to obscure the toilet seat by blurring it in the video feed. The Ombudsman recommended the same for the Border Guard's detention facilities.

The Ombudsman also drew attention to the fact that apprehensions should be justified thoroughly. He also recommended that the notifications to detainees concerning their rights and obligations and the conditions of the detention facilities be recorded in the apprehension record.

After the inspection, the Southeast Finland Border Guard District announced that it would ensure without delay that their personnel were aware of and familiarised with the Police Custody Act and the rules of procedure. In addition, it will ensure that detainees have the necessary materials available in print at the detention facility. The Border Guard also announced that it would immediately start investigating the change of camera surveillance in the detention facility so that the feed is blurred at the toilet seat. In the future, the facility will also pay closer attention to noting the grounds for detention in the apprehension record, and the notifications made to detainees will be entered in the records.

A toilet seat in a detention room at Nuijamaa border control post, photographed from inside the room. In the second picture the same space is shown through a camera surveillance screen.

Inspection visit to Customs detention facilities in Itä-Pasila

The inspected detention facility was only used for short-term detention of persons deprived of their liberty. The rules of procedure at the facility state that the maximum detention time is 12 hours. Based on the observations made during the inspection, the Ombudsman found that the facility in question was only suitable for very short-term detention of an apprehended person, a few hours in practice.

No apprehension forms had been drawn up when placing persons in the detention facility. The Ombudsman stressed that records must always be made of the deprivation of liberty and many other related matters. Customs were required to ensure compliance with the provisions on drawing up records of the deprivation of liberty.

The Ombudsman also required that Customs ensure that there is a functioning alarm device in the detention facility that allows detainees to immediately contact personnel. In addition, appropriate supervision requires the presence of staff members who can immediately go check the status of a person deprived of their liberty. There was a surveillance camera in the detention facility, but its functioning remained unclear during the inspection. According to the rules of procedure of the detention facility, camera surveillance is not generally used.

The oversight of legality has emphasised that the responsibilities for investigation and detention should be kept separate administratively and in practice. However, with regard to the Customs detention facility, the Ombudsman noted that, taking into account the short-term and occasional nature of the detentions, it would not be feasible to have separate security personnel who were responsible for detention. However, Customs must ensure that officials working at the detention facility are familiar with the provisions of the Police Custody Act and other provisions on the treatment of persons deprived of their liberty. They must also be familiar with the facilities, related equipment and conditions in other respects as well.

After the inspection, Customs reported that the alarm system in the storage facility has been restored to working order. In addition, there will always be a criminal investigation representative from Customs near the detention facility if a person is being detained in the facility. Customs will also change their guidelines on the practices for recording information. The Ombudsman also drew Customs' attention to the fact that it is also necessary to ensure that the Customs detention facilities and the practices followed in them are appropriate.

3.5.9 THE CRIMINAL SANCTIONS FIELD

The Criminal Sanctions Agency 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.

Several significant changes were made in the criminal sanctions field during the year under review. One of the changes was the enhanced supervision departments (Teva) established in the prisons of Riihimäki, Turku, Sukeva and Mikkeli (a total of 12 departments). This aims to increase prison safety and prevent criminal activity from continuing during imprisonment. The introduction of the Teva departments has not been without its issues. The conditions and deficiencies in the departments were discussed during the inspection visit at the Criminal Sanctions Agency in November 2022. Changes and challenges concerning the Teva departments and the rest of the criminal sanctions field are discussed more in section 4.7 and in the review by Deputy-Ombudsman Pölönen (section 1).

Surveys to prisoners and staff

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.

Inspection visits

During the year under review, inspections were carried out at Kylmäkoski Prison between 25 and 27 April 2022 (1621/2022) and at Riihimäki Prison on 17 November 2022 (5672/2022). The latter inspection only focused on certain wards and themes. The plan is to continue the inspection of the prison in 2023. The inspection visits were announced in advance. Both inspections involved surveys that were sent to the prison staff and prisoners in advance.

Two visits were made to Health Care Services for Prisoners; these are described in section 3.5.11. The same section discusses the guard services in the Prison Hospital of Hämeenlinna Prison.

In addition, inspections were carried out at the Criminal Sanctions Agency on 24 November 2022 (7020/2022) and the Department for Criminal Policy and Criminal Law at the Ministry of Justice on 1 December 2022 (7131/2022). One of the themes for these inspections was the availability of trained personnel in prisons. The Deputy-Ombudsman has investigated this matter as on own initiative investigation (4153/2019). The European Committee for the Prevention of Torture (CPT) has also drawn attention to this in connection with its latest visit in Finland. To increase the number of trained prison officers, the Criminal Sanctions Agency organised, for the first time, an internal degree programme application process in autumn 2022 for prison officers working at the Criminal Sanctions Agency without relevant training. At the time of application, there were around 220 such persons. According to a press release by the Criminal Sanctions Agency, 47 people applied for the training programme starting in January 2023. The second programme application is scheduled for 2023.

Inspection visit to Kylmäkoski Prison

Kylmäkoski Prison is a closed institution for 113 male remand prisoners and prisoners serving sentences. The observations made during the inspection concern the same themes on which the Ombudsman has issued statements and recommendations year after year to prisons and the authorities responsible for overseeing the legality of prison operations. In the visit report, the Deputy-Ombudsman drew attention to the following issues, among other things:

Using the temporary cell ward for housing. A temporary cell is only intended for short-term accommodation when a prisoner enters or leaves prison. A temporary cell is also used when a prisoner has to stay overnight when travelling for court or to another prison. The inspection revealed that prisoners were placed to live in the temporary cell ward for long periods, even though the conditions of the ward were only suitable for short-term placement. In addition, too many prisoners were placed in each cell considering the surface area of the cells. Attention was also drawn to the dirtiness of large temporary cells.

Conditions of remand prisoners. The placement of remand prisoners did not fully comply with the law. Remand prisoners and prisoners serving sentences had not only been placed in the same ward but even in the same cell. In addition, remand prisoners with restricted contact had very little access to activities outside their cell. This is one of the issues the CPT has drawn attention to during its most recent visit to Finland.

Administrative decisions concerning prisoners. Significant deficiencies were identified in various administrative decisions concerning prisoners and the appropriate justifications of these decisions.

Prisoner induction at arrival. The induction of prisoners when they arrived in prison was insufficient.

Endangerment of privacy. The telephones intended for prisoners were located in ward corridors without any soundproofing. In some residential wards, the prisoners' names were on the cell doors.

Treatment of foreign prisoners. At the time of the inspection, there were 10 foreign prisoners at the prison, five of whom were interviewed with an interpreter. The interviews created the impression that the prisoners would have needed more interpretation assistance than they had received. They had also not applied for video meetings (via Skype) to maintain family relations. The reason for this was that the video meetings were only available at times when family members were at work and school. This also applied to other prisoners.

Surveys of staff and prisoners of Kylmäkoski Prison

Based on the prisoners' responses, there were clear shortcomings in the induction at arrival. A clear majority of the respondents reported that they had not received any induction in the residential ward, and almost all of them had also not received a guidebook for newly-arrived prisoners. At the same time, the respondents stated that relations between prisoners and staff were appropriate and good. Responses from staff indicated that closely working with the prisoners was implemented well. On the other hand, a clear majority of the responding prisoners did not know who their responsible official was, or, if they did, the prisoner had not necessarily met them.

The staff responses highlighted a strong concern that there were not enough staff members in the prison. Respondents considered the staff shortage to be chronic, which caused insecurity and issues with coping. The observations made during the inspection visit indicated that staff members could not avoid working alone, for example at prison wards. The majority of the respondents felt that substitutes do not have sufficient competence and that they are not given adequate orientation. Based on conversations had during the inspection, it appeared that first aid training had not been organised for staff in years and that there had also been a long pause in rescue training.

Based on the responses, the prison seemed to have room for improvement in the flow of information. Both groups of respondents were uncertain about where they could report abuse.

Partial inspection visit to Riihimäki Prison

The view over the prison courtyard.

Riihimäki Prison is a closed institution for 223 male prisoners serving sentences and remand prisoners. The inspection focused on the A wards and ward C1 where the isolation cells, penalty cells and temporary cells are located. In the visit report, the Deputy-Ombudsman drew attention to the following issues, among other things:

Use of a ward intended for short-term housing. At the time of the inspection, several prisoners were living long-term in the ward meant for incoming prisoners – for months or even over a year. The ward is however intended for short-term housing for persons arriving in prison until a suitable residential ward is found for them. The ward operates separately from the rest of the prison community.

The time prisoners spend outside the cell (less than 8 hours) and the possibility of activities and leisure time were only planned for the needs of short-term housing.

Using interpretation and translation services. The Deputy-Ombudsman considered that attention should be paid to access to information in prison, especially when prisoners arrive. The prison's rules of procedure and guidebook for new prisoners had only been translated into English and Russian. However, many of the foreign prisoners do not speak English at all or only poorly. Interviews with foreign prisoners revealed that interpretation and translation services in general were used little at the prison. It did not seem appropriate that prisoners had to use a fellow prisoner to help with interpreting or finding out answers in Finnish.

Privacy for phone calls. The Ombudsman has consistently considered that even prisoners have the right to privacy when they talk on the phone. The telephones intended for prisoners were located in the corridors of A wards without any soundproofing covers.

Enabling the use of a phone. During the inspection, it remained unclear what kind of actual opportunity prisoners had to make phone calls while their ward was closed. Prisoners were not usually able to reach their loved ones during the hours that the residential ward was open. The Deputy-Ombudsman stated that prisoners should have the option to make calls in the evening if necessary.

Conditions in isolation. The cells used for observation and isolation under observation were unfurnished. In the oversight of legality, it has been considered that the reason for placing a prisoner under observation and the behaviour of the prisoner determine the furniture that can be placed in the cell. It was found during the inspection that there were plastic tables and chairs intended for furnishing the cell in the storage room of the isolation ward. However, it remained unclear during the inspection what the prison's policy was for furnishing the cell when a prisoner is placed in an isolation cell. Placement in observation should not automatically lead to the prisoner having to eat while sitting on the floor. According to information received during the inspection, the prison was in the process of acquiring 50 cm thick mattresses for these cells. The Deputy-Ombudsman found this appropriate.

Conditions of temporary cells. The maximum number of beds in traveller's cells should be checked for the minimum permissible area per prisoner. According to information received during the inspection, the number of penalty cells was too high compared to demand, and there was a need for single-person temporary cells. Due to this reason, there was a plan to convert some of the penalty cells into single-person traveller's cells. The Deputy-Ombudsman found this plan appropriate.

Treatment of Roma prisoners. During the inspections, claims were made that Roma prisoners were not given the possibility to live in a ward where prisoners work or study. The issue hinged on how other prisoners in these wards react to Roma prisoners. The Deputy-Ombudsman considered it necessary to monitor the placement of Roma prisoners in wards. If necessary, measures should be taken to ensure that such issues do not prevent prisoners belonging to minorities from being placed to specific wards. The responses of the anonymous prisoners' survey revealed that racist comments or comments otherwise degrading Roma prisoners had been made by both prisoners and staff members. The Deputy-Ombudsman stated that the prison should consider procedures for intervening in discriminatory language and attitudes.

Special theme for 2022 "Oversight of oversight"

As an inspection finding at Kylmäkoski Prison, it was noted that the prison had not corrected all the practices that the Central Administration Unit of the Criminal Sanctions Agency had considered incorrect. In this respect, the oversight of the prison operations in the Regional Centre and the Central Administration Unit of the Criminal Sanctions Region could not be considered successful.

3.5.10 PRISONER HEALTH CARE

Inspection visits

Two inspection visits were made to prisoner health care, both of which were announced in advance to the inspected locations:

– Health Care Services for Prisoners Unit, Kylmäkoski Outpatient Clinic on 25 and 26 April 2022 (1623/2022)
– Health Care Services for Prisoners: Prison Hospital, Medicines Centre and Dental Clinic and the operations of Hämeenlinna Prison at the Prison Hospital on 20 May 2022 (2555/2022)

Inspection visit to the Kylmäkoski Outpatient Clinic

At the time of writing this, there is no final inspection report available yet. The inspection findings included these issues:

The special features of Kylmäkoski Prison posed challenges to health care. The prison also serves as a remand prison, which is why the number of prisoners newly deprived of their liberty is high. The police bring apprehended persons to the prison regardless of the time of the day. These apprehended persons may be intoxicated. It takes a lot of time to investigate the medical treatment and examine the health of prisoners newly deprived of their liberty.

The adequacy of human resources was also a cause for concern. Substitutes were scarcely available and there was no substitute system in use. The outpatient clinic had not been able to hire a resident doctor, which is why the prison had to outsource doctors' services. Inspectors were told that nurse resources did not allow the double-checking of medicines. However, double checks are important for patient safety so that any discrepancies in medicines can be detected in advance. This importance is highlighted in prison conditions, as the prison officers involved in pharmacotherapy do not have the competence of health care professionals to detect issues – and they do not even always have the opportunity to do so if a prisoner has not consented to the prison officers accessing their health information.

The outpatient clinic is also highly dependent on the prison officer resources at the prison, as prison officers are needed to escort a prison patient to the outpatient clinic or to transport a patient outside the prison for examination or treatment. During the inspection, it was noted that the outpatient clinic is usually not able to give prisoners an exact appointment time, as the timing of appointments depends on whether there are prison officers available. However, according to the Act on the Status and Rights of Patients, patients must be given an exact date and time. Due to a lack of prison officer resources, doctors' and dentists' appointments may become very delayed as they are forced to wait for patients. Health care visits outside the prison have also been cancelled for the same reason. The lack of prison officer resources and its impacts on matters such as access to care outside the prison have been highlighted through inspections carried out at both Kylmäkoski Prison and the Criminal Sanctions Agency.

Inspection visit to the Prison Hospital

The Prison Hospital is the national primary health care hospital of Health Care Services for Prisoners that provides services for somatically ill male and female prisoners. Doctors are only present at the Prison Hospital during office hours on weekdays. Hämeenlinna Prison is responsible for the oversight and safety of the Prison Hospital.

Health care personnel can only make decisions related to the health care of prisoners. Patient prisoners are locked in their rooms in accordance with the daily programme confirmed by the prison.

The Deputy-Ombudsman found the scarcity of health care personnel worrying. It appears to be a continuous, daily issue that will necessarily affect the interaction of nursing staff and patients as well as the activities that maintain patients' functional capacity. The scarcity of prison officer resources was also evident at the Prison Hospital. According to the hospital's guidelines, nurses may not go to the ward if there is no prison officer present. The women's ward has even had to be closed for a certain period of time due to the lack of prison officers.

A patient's room at the Prison Hospital.

The Deputy-Ombudsman found it understandable that the Prison Hospital has not been able to provide emergency medical services with the current doctor resources. However, the prison may have prisoners with care needs that cannot be considered to be included in the duties of prison officers, who also may not have sufficient competence or training to attend to these needs. The Deputy-Ombudsman considered it untenable if such a prisoner has to be held in prison for example over the weekend only because there is no agreed procedure at the Prison Hospital for taking patients to hospital outside office hours. The Prison Hospital should have a backup system for exceptional situations such as those described above so that a prisoner could also be admitted to the hospital outside office hours.

A patient can be placed under camera surveillance for the purposes of treatment at the Prison Hospital when the patient's state of health requires closer monitoring. There is no legislation on the camera surveillance of somatic patients. The Deputy-Ombudsman considered it understandable that there may be a need for continuous monitoring of patients at the hospital. Instead, the operating environment and the prison status of patients pose obstacles to care staff attending to the patients freely regardless of time to assess a patient's state of health or otherwise carry out observations. On the other hand, camera surveillance intervenes in the protection of a patient's privacy. According to the Deputy-Ombudsman, the Prison Hospital has acknowledged this problem. Based on the observations made during the inspection, camera surveillance for the purposes of treatment is only used when there is a clear treatment-linked or health-related reason for it and the patient has given their consent. However, the patient must be given sufficient and appropriate information on what camera surveillance for treatment purposes means and why it is considered necessary in their case. Without this information, the Deputy-Ombudsman finds it impossible to interpret that the patient has given informed consent. In order to assess this afterwards, it is recommended that the staff be instructed to record the information provided to the patient.

Operations of Hämeenlinna Prison at the Prison Hospital

The Imprisonment Act does not contain a specific provision on who decides on admitting a prisoner to a ward at the Prison Hospital. This also involves the question of what matters will be taken into account when deciding on the admittance. Based on the inspection, it became apparent that the current facilities of the Prison Hospital did not enable the admittance to account for both patient care and the safety issues related to the placement of prisoners. The Deputy-Ombudsman brought to the attention of the Ministry of Justice and for the purposes of drafting legislation the shortcomings and ambiguities of legislation concerning ward placement.

The Deputy-Ombudsman recommended that the prison investigate the possibilities of increasing the opening hours of a more closed male ward despite the lack of prison officers. The Head of Unit at Hämeenlinna Prison reported that it would be possible to extend the opening hours of the ward to some extent. The preparations for this started in October 2022.

It seemed that the lack of prison officers and transport equipment significantly hampered the operation of the hospital and caused safety risks. This was also reflected in the activities of the prison, as prison officers have to occasionally be transferred from there to supervisory duties at the hospital. The Deputy-Ombudsman stated that the problems caused by the staff shortage should be carefully investigated. This investigation should be the basis for assessing the number of personnel and taking measures to remedy the situation. The Head of Unit reported that, based on discussions with both the hospital and supervision, it became apparent that it would not really be possible to modify the current facilities to make them safer. The situation should therefore be improved by increasing human resources and by reviewing practices. This will be discussed with Health Care Services for Prisoners and the Criminal Sanctions Agency.

The Deputy-Ombudsman also informed the Ministry of Justice and the Criminal Sanctions Agency of her observations on the inadequacy of supervising personnel and equipment and the inappropriateness of the facilities.

Meals at the Prison Hospital

Meal services of the Prison Hospital are organised by Leijona Catering Oy, who also produce meal services to prisons. The inspection revealed that there had been problems with the quality and quantity of food served to patients. For example, there was not always enough food for persons following a special diet. In addition, patients only had a single warm meal on weekends. After the inspection, the Ombudsman received a complaint from a prisoner concerning the same matters. The Deputy-Ombudsman issued a decision on the matter on 14 September 2022 (3386/2022*) in which the Ombudsman asked the Criminal Sanctions Agency to report on the measures it has taken to eliminate the problems and shortcomings that have arisen. As concrete measures, the Agency reported that two warm meals will be served at the Prison Hospital also on Saturdays and Sundays.

3.5.11 ALIEN AFFAIRS

Under section 121 of the Aliens Act, a foreign national may be held in detention for reasons such as establishing their identity or 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 of the detention units is located in Metsälä, Helsinki (40 places), and the other in Konnunsuo, adjacent to the Joutseno reception centre (69 places). Both units operate under the Finnish Immigration Service. According to the 2023 performance plan of the Service, an average of 37 places per day of the detention capacity was available between January and October 2022, meaning that the utilisation rate was 34%. The utilisation rate is determined by the actions of the authorities deciding on detention (police, border control, district courts).

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

During the year under review, the detention unit of the Joutseno Reception Centre was inspected on 16 December 2022 (7487/2022). The unit was notified of the inspection in advance about a week before the inspection. The previous inspection was carried out on 16 June 2021 (4149/2021).

Inspection visit to the Joutseno detention unit

At the time of the inspection, there were 15 persons deprived of their liberty in detention. The longest detention had lasted 324 days. The inspection reviewed the measures taken by the unit following the recommendations issued since the previous inspection:

- the security camera in the shower of the isolation room had been blurred to protect the privacy of the person in the shower
- the unit had improved detained persons' possibility to file a complaint
- the possibility of outdoor exercise for detained persons had been increased
- the pharmacotherapy plan had been reviewed and updated
- the nurse's role had been specified in the process of placing a detained person into isolation.

Conditions in isolation and camera surveillance

The Ombudsman's previous inspections at the Joutseno detention unit had drawn attention to the camera surveillance of the toilets and showers in the isolation facilities. The Ombudsman considered camera surveillance of the isolation rooms to be problematic from the perspective of privacy protection. There had been no change in this situation since the inspection visit in 2018, despite the recommendations made by the Ombudsman in the visit report (5145/2018). The Ombudsman also drew the unit's attention to the protection of privacy in sanitary facilities after an inspection carried out in 2021.

One of the things emphasised by the detention unit in its report was that the camera surveillance of the sanitary facilities is lawful. The structural solutions of the detention unit did not enable a practice where the safety issues brought up previously (including the risk of vandalism resulting in water damage) could be solved through structural changes. The Ombudsman's opinion was taken into account, however, and the detention unit stated that it had discovered a way of improving the situation. A new version of the camera surveillance software used by the centre had been released, which makes it possible to blur objects by technical means. This was to be communicated to detained persons being placed in isolation. In the course of the inspection carried out during the year under review, it was found that the surveillance feed of the sanitary facilities had been blurred.

Special theme for 2022 "Oversight of oversight"

The inspection revealed that no separate self-monitoring plan had been confirmed for the detention unit. The Finnish Immigration Service had carried out a guidance and assessment visit to the Joutseno detention unit on 23 November 2021. The findings and observations of the Ombudsman's inspection visit on 16 June 2021 had also been discussed in connection with the visit. In addition, the Division of Occupational Safety and Health of the Regional State Administrative Agency for Southern Finland had inspected the detention unit on 23 November 2021.

The Finnish Immigration Service has prepared an internal audit plan to confirm the appropriateness and adequacy of internal oversight procedures. The internal auditor has for example carried out inspections at the Helsinki detention facility (2021) and the Joutseno reception centre and detention facility (2022).

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 the awareness-raising described below have been seen as a clear increase in the number of complaints filed by children. The complainants have criticised their treatment at the place of substitute care, the practices of child welfare institutions, the restrictive measures used, the passiveness of assigned social workers and the shortcomings in decision-making concerning substitute care.

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. Following the NPM's visits, amended legislation 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.

During the coronavirus pandemic, on-site inspections had to be put on pause. Other forms of working and new communication methods were introduced instead. The aim has been to increase children's awareness of their statutory rights in substitute care. During the year under review, a representative of the Office of the Parliamentary Ombudsman has participated about once a month in online events ("virtuaalilive") organised by "influencer social workers" ("TikToksossut"). Each event has had 2500 to 4000 attendees, with social workers answering questions from children and adolescents and sharing information about legal remedies in substitute care. During these events, social workers have also presented the Ombudsman's work and previous decisions.

The Ombudsman also has a website for children. Its content update has been started. Children and young people as well as experts by experience in child welfare were engaged in this work.

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 about these units, which stresses the importance of the visits.

On visits to care units for older people, special attention is paid to the use of restrictive measures. Under the Finnish Constitution, the use of restrictive measures must be based on law. The Deputy-Ombudsman has considered it a significant shortcoming that there is still no legislation on restricting fundamental rights in somatic health care or in the care for older people. However, the Constitutional Law Committee has defined the general grounds for restricting fundamental rights. On the basis of these grounds, it is already possible to determine the kinds of situations where restriction is not allowed and cannot be authorised. Restriction is not permitted if it is possible to meet an objective by some other lenient means. The lack of personnel does not justify the use of restrictive measures. In addition, measures must not be excessive in relation to the sought objective. In order to implement the principle of proportionality in the care of older people, social welfare and health care personnel need sufficiently clear instructions on how to act in different situations.

The Deputy-Ombudsman considered it essential that legal provisions are enacted on the restrictions to which older persons may be subjected and the preconditions for such restrictions as well as the practices to be followed.

The Deputy-Ombudsman's decisions have contained proposals to the Ministry of Social Affairs and Health stating that the ministry should start drafting legislation on older persons' rights without delay (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 persons can be avoided. 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 health care and care for older people.

This section only discusses the NPM's visits.

Inspection visits

During the year under review, six inspection visits were made to units providing 24-hour care for older persons under the NPM's mandate. All inspected sites were residential units with 24-hour assistance, and one of them was a psychogeriatric unit. In addition, an inspection was carried out at a nursing home intended for older mental health and substance abuse patients. The inspected sites were the following:

Date of Inspection	Target	Case Number
3 March 2022	Mainiokoti Andante, Espoo, service provider Mehiläinen hoivapalvelut Oy	1127/2022*
17 March 2022	Toivokoti, Nummela, service provider Kuntayhtymä Karviainen	1128/2022*
31 March 2022 5 May 2022	Simonkylä care home (psychogeriatric unit), Vantaa, service provider the City of Vantaa and an evening inspection visit at the same unit	1129/2022 2317/2022
18 August 2022	Valko care home, Loviisa, service provider Kulta-ajan Koti	1130/2022*
24 May 2022	Mainiokoti Jussoila, Rauma, service provider Mehiläinen Oy	2787/2022*
23 May 2022	Mainiokoti Timantti, Kaarina, service provider Mehiläinen Oy	2788/2022*

All of the inspections were unannounced. One unit was notified in advance of the period during which the inspection was to be carried out without indicating the exact date. Two inspection visits were joined by an external expert. After the daytime inspection, a separate inspection was carried out at the Simonkylä care home in the evening. The inspection of Mainiokoti Timantti was carried out in two parts – the first inspection was during the day, and the second was carried out during the evening and night shifts on the same day from 20:30 to 23:00. The inspections carried out in care units for older people raised issues such as:

Special expertise of personnel. Personnel competence and training have a major impact on the quality of residential services. Residents had been transferred from other city units to the psychogeriatric unit because their behaviour had been experienced as challenging at the previous place of care. However, it remained unclear to the inspectors how the psychogeriatric unit differed from other residential units with 24-hour assistance for older people, for example when it came to the competence of nursing staff. These kinds of special units should ensure that nursing staff and doctors have special expertise to care for older persons with mental illness.

In the Simonkylä care home, photos of different pets, like cats and dogs, have been put up to add to the well-being of the residents.

According to the information received during the inspection, few of the nurses had training for caring for mentally ill people. The unit also did not have the opportunity to consult a geropsychiatrist (1129/2022).

Night-time care. Night-time care for older people with memory impairment must be arranged so that they are not left unattended. The unit had a practice where two group homes were without a nurse for most of the night, which was in conflict with the guidelines of the unit. The Deputy-Ombudsman was not convinced that the residents' safety could be ensured at night. She recommended that the unit ensure a sufficient number and placement of night nurses, instruct staff on the use of surveillance cameras and consider the introduction of technological solutions such as motion sensor mats (2787/2022). At another unit, one night nurse was responsible for the care of 22 residents. The nurse had to occasionally go assist the night nurses on other floors of the building, in which case the residents of one unit were practically unsupervised. The Deputy-Ombudsman considered that night-time care should be arranged so that residents receive care that meets their individual needs. Some of the residents were bedbound and some needed support for mobility and for monitoring their mental state. The Deputy-Ombudsman also stated that residents' night-time fast should not exceed the recommended 11-hour limit (2317/2022).

Enabling outdoor activities. Sufficient and regular outdoor activities must be arranged based on the residents' needs. Outdoor activities should be monitored daily and recorded (2787/2022). The Deputy-Ombudsman did not find it acceptable that some of the residents at the unit were effectively barred from outdoor activities due to the poor winter maintenance of the property (1127/2022). The Deputy-Ombudsman drew the unit's attention to the accessibility of the property and the maintenance of the yard area at all times of the year (2787/2022, 1129/2022).

Limitation of fundamental rights. During the coronavirus pandemic, the oversight of legality observed that staff members at residential services have had difficulties in knowing in practice when their actions constitute restriction of fundamental rights. It has also been unclear whether the units' guidelines imposing restrictions on residents are based on legislation. An example of this is the Deputy-Ombudsman's decision on the implementation of so-called room care in a service unit for older people (3360/2021). During the inspection, it was noted that individual residents had been subjected to restrictive measures concerning so-called self-quarantine, which were not based on legislation.

In the Deputy-Ombudsman's view, the main reason for the shortcomings in the implementation of "self-quarantine" was that staff members had different views on the content and binding nature of the guidelines in force at the time (1127/2022, 2787/2022). The Deputy-Ombudsman considered it important that all care units for older people hold a meeting with all staff members to go through any changes to procedures implemented during the coronavirus pandemic and to clarify which of these changes are still in use. This would make it possible to eliminate practices where compliance is no longer justified (2788/2022).

Monitoring and reducing restrictive measures. In the care of an older resident, the use of restrictions should be monitored on an individual basis, and the methods used to support the resident's right to self-determination and how to reduce the restrictive measures should be assessed (1127/2022, 1129/2022).

Terminal care. The decision on terminal care must be made at the right time. Terminal care poses demands on personnel competence and on the number of personnel. The Deputy-Ombudsman was not convinced that a categorical hourly visit by a nurse at night is sufficient treatment and care for all residents in terminal care (2787/2022). At another unit, it was revealed that the unit's doctor made terminal care decisions based on phone consultation with a nurse without meeting the resident. Terminal care decisions did not contain descriptions of the limitations of treatment to be implemented for each patient. The Deputy-Ombudsman decided to conduct a separate investigation on the practices related to making decisions on end-of-life care and DNRs (Do Not Resuscitate orders) (2788/2022).

Valko care home

The Valko care home provided residential services for mental health and substance abuse patients. The residents of the unit were mostly ageing mental health patients. One of the purposes of the inspection was to determine how the residents' right to self-determination was realised. At the time of the inspection, residents' movement was restricted with raised bedrails and pelvic belts in wheelchairs. In addition, one resident wore anti-strip jumpsuits at night (overalls that a person cannot take off by themselves). The unit recorded the restrictive measures ordered by the doctor to be valid until further notice. During the inspection, it was discussed that the doctor had not recorded or otherwise expressed any time limit for the restrictive measures. The documents received after the inspection indicated that the unit had started noting down time limits for restrictive measures.

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. The extent to which the right to self-determination and privacy of persons with disabilities is respected and whether the unit has adequate resources are also examined on the visits.

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

During the year under review, four inspection visits were carried out, all of which were notified in advance to the inspected sites. One of the sites was a health care unit. The sites visited were:

Date of Inspection	Target	Case Number
30 June 2022	Lahti Psychiatric Unit for Persons with Intellectual Disabilities (residential unit with 24-hour assistance for persons with intellectual disabilities), Lahti, service provider Eteva Joint Municipal Authority	1686/2022
30 June 202	Lahti Psychiatric Unit for Children, Lahti, service provider Eteva Joint Municipal Authority	4119/2022
22 November 2022	Ruusuhaka unit (residential unit with 24-hour assistance for persons with intellectual disabilities), Vantaa, service provider City of Vantaa	2816/2022
7 October 2022	Rekola group home, Vantaa, Respiratory paralysis unit for the Heart and Lung Centre of the Helsinki and Uusimaa Hospital District (HUS)	5196/2022

The inspection of the Ruusuhaka unit and the inspections of the Eteva joint municipal authority units were carried out as documentation inspections and as pre-announced inspection visits on site. The inspection carried out at the Rekola group home was a continuation of a documentation inspection of the unit done in the previous year (4128/2021). Three inspection visits were joined by an external expert from the Disability Rights Committee operating under the Human Rights Delegation of the Human Rights Centre.

Inspection visit to the Lahti Psychiatric Unit for Persons with Intellectual Disabilities

The inspection found that there was an increased number of involuntary stays at the unit but no clear reason for this increase. One reason could be that involuntary special care is provided in very few places. The Lahti unit is often the last-resort crisis unit if a patient has not coped anywhere else due to experiencing varied challenges.

Due to a shortage of personnel, the unit had seven empty patient beds while there were 16 patients on a waiting list. Patients arriving for involuntary care are however prioritised as urgent cases in the waiting list. This has led to a situation where the persons on the waiting list have no other option than to get temporarily referred to the emergency clinic, to psychiatric units and then back home. On a general level, the Deputy-Ombudsman found it worrying that, due to labour shortages in social welfare and health care, services for persons with intellectual disabilities and the number of patients in the psychiatric unit for persons with intellectual disabilities have had to be reduced. The Regional State Administrative Agency for Southern Finland is monitoring the Lahti Psychiatric Unit for Persons with Intellectual Disabilities with regard to the amount of personnel and related issues. The monitoring concerns matters such as whether the unit has had to restrict clients' right to self-determination due to the insufficient number of staff members.

The unit used a security service, and the guards regularly had to engage in challenging customer situations. The Deputy-Ombudsman drew the unit's attention to the fact that guards from private security services may not participate in client care by carrying out duties tasked to the nursing staff. Measures restricting a client's right to self-determination must also be considered care-related tasks that do not fall under guards' authority. Instead, guards' authority extends to ensuring that nursing staff are able to perform their duties safely, for example. Legislative projects concerning the strengthening of clients' and patients' right to self-determination have also aimed to lay down provisions on the authority of guards and security stewards in social welfare and health care. These projects have not led to new legislation yet.

Inspection visit to the Ruusuhaka unit

Before the on-site inspection, the residents of the unit and their legal representatives and family members were given the opportunity to have a confidential conversation by telephone with the representatives of the Office of the Parliamentary Ombudsman. The report of the inspection was not yet finished at the time of writing this, so the Deputy-Ombudsman's comments were not available. However, the inspection made the following findings:

One resident was not allowed to go outdoors alone for safety reasons and was accompanied by a counsellor instead. However, the resident had not been issued a decision on the monitoring of movement as required by the Act on Special Care for Persons with Intellectual Disabilities, even though the resident's movement was monitored as referred to in the Act.

The inspection revealed that a resident's medicine had been hidden in their food after the resident had refused to take the medicine. Not taking this specific medicine would not seriously jeopardise health. It appeared that the resident's pharmacotherapy was not implemented in mutual agreement, and the resident's right to refuse treatment was not respected.

According to the unit's self-monitoring plan, the unit used raised bedrails and wheelchair seat belts as restrictive measures. Although these are safety equipment, using them requires a written decision. According to the information received during the inspection, the unit was not using restrictive measures with the residents at the time of the inspection.

The inspection revealed that the counsellors were also tasked with support service duties. They prepared food and washed dishes. The time required for such support service duties should not be included when assessing how much staff is needed in relation to the amount of assistance and support needed.

Inspection visit to the Rekola group home

In the report on the documentation inspection of the unit (4128/2021), the Ombudsman considered it important that the group home consults its residents and regularly collects feedback from them. This is an essential part of the quality assessment of the unit's operations and the development of care. According to information received from HUS, this matter has been addressed immediately after the inspection visit.

The Deputy-Ombudsman found it positive that the HUS Rekola group home had taken improvement measures to enable collecting feedback and wishes from residents. She recommended putting up the patient ombudsman's contact details on the notice board alongside information on the materials on the rights of the patient available on the HUS website. It is important for the purpose of securing patients' rights that patients and their families are aware of patients' rights and the legal remedies and other means of influence available to them.

The Deputy-Ombudsman found it positive that the number of staff members and their well-being at work seemed to have improved after the Ombudsman's documentation inspection. The Deputy-Ombudsman recommended that the adequacy of staff and their well-being at work be monitored regularly at the group home.

The documentation inspection had drawn HUS's attention to the procedures concerning visits to the group home. The inspection revealed that visiting procedures had become less stringent just before the Deputy-Ombudsman's on-site inspection. For example, the two-hour time limit for visits and the restriction on the number of visitors had been removed. The Deputy-Ombudsman did not initiate an investigation of the legality of HUS's visiting practices and related guidelines, as the Ombudsman was already investigating the legality of the restrictions on visits to health care units (3643/2021).

The inspection revealed that all patient rooms in the group home had a surveillance camera, which was always on. Patients are asked for their consent to this. Inspectors were told that patients' requests to turn off the camera, for example when having visitors over, are met positively. The Deputy-Ombudsman stated that there is no separate legislation on camera surveillance or other filming in health care units. Camera surveillance in patient rooms always interferes with the patient's privacy. The Deputy-Ombudsman stated that camera surveillance should not be used unless absolutely necessary. For example understaffing is not an adequate basis for camera surveillance. The patient and their family must always be informed of camera surveillance. In 2020, the Deputy-Ombudsman proposed legislative measures to the Ministry of Social Affairs and Health and the Ministry of Justice concerning filming in health care units. This includes filming by patients but also filming done by the operating unit. The Ministry of Justice announced that it would set up an investigative project where the legal status and possible legislative needs related to filming pointed out by the Deputy-Ombudsman would be examined in cooperation with the Ministry of Social Affairs and Health.

The Deputy-Ombudsman considered it important for safety that all patients in the group home have an easy and quick way to contact the staff. The Deputy-Ombudsman found it positive and important that a working alarm system was being acquired for the patient rooms of the group home for all respiratory paralysis patients.

Another topic discussed during the inspection was how the unit had prepared for crises such as power outages. This was particularly important for patients at the unit because they rely on respiratory assist devices that use electricity. According to the information received, the unit had prepared for possible power outages with measures such as an emergency generator that is tested weekly. Preparedness had not been discussed specifically with patients. The Deputy-Ombudsman considered it important that the unit provides information on various exceptional situations, crises and related preparedness measures and that these matters are discussed with the residents and their families.

Special theme for 2022 "Oversight of oversight"

In connection with the inspection of a psychiatry unit for people with intellectual disabilities, the Deputy-Ombudsman refrained from assessing the adequacy of the amount of personnel, as this question was already under enforcement at the Regional State Administrative Agency. However, the Deputy-Ombudsman assessed how the unit had taken into account the opinions of the Regional State Administrative Agency's previous inspection and enforcement decision. The Deputy-Ombudsman had to draw the attention of the service provider to the same matters (e.g. self-monitoring plan and privacy protection) that the Regional State Administrative Agency had already commented on (1686/2022).

3.5.15 HEALTH CARE

Inspection visits

During the year under review, the psychiatric hospital care and joint emergency services provided in the Hospital District of Southwest Finland were inspected. The inspected units were:

Date of Inspection	Target	Case Number
7 June 2022	Tyks Halikko Hospital adult psychiatry wards	2431/2022
13 to 15 June 2022	Tyks psychiatry wards at the former Kupittaa hospital	2432/2022
13 June 2022	Tyks Turku joint emergency services' mental health and substance abuse unit	3635/2022

Inspection visits to psychiatry wards

At the time of writing, the final reports of the inspections have not been drawn out yet, so the Deputy-Ombudsman's statements on the inspections findings are consequently not available. The inspection findings were presented to the inspected site at the end of the second inspection visit. Present were representatives of the hospital district, employees from each inspected hospital ward and two officials of the Regional State Administrative Agency for Southwestern Finland. Below are some inspection findings from the wards of the former Kupittaa hospital:

Facilities and ward workload. The hospital had a continuous bed shortage, which resulted in patients living in overcrowded conditions. In many wards, even the geriatric psychiatry ward, patients occasionally have to lie on camping beds or mattresses placed on the floor. At least one ward was using a seclusion room as a patient room due to the overcrowding. The inspectors also drew attention to the fact that cleanliness of the facilities and the condition of furniture was not up to par. The seclusion facilities were found to be cell-like. During the final discussion, the inspectors were told that the number of patients arriving at the wards was not declining and that the hospital district was unable to do anything about it. Attention has however been paid to the overcrowding.

The bed shortage at Tyks psychiatry wards could be seen at the geriatric psychiatry ward, were up to three patients had to be placed in the same room.

For example, the plans for the new hospital to be completed in autumn 2024 have had to be changed because it has been anticipated that the originally planned number of patient beds will not be sufficient. Intensified outpatient care has been introduced for psychosis patients who keep returning to treatment. There are additionally plans for a so-called three-day unit for acute crises.

Human resources. Some wards were not able to get substitutes when nursing staff took unexpected sick leave. Incident reports included situations where patient safety had been compromised either because substitutes were not available or because substitutes were not familiar with the practices of a ward or the patients. A major problem in the entire psychiatry sector was the high turnover and poor availability of doctors. Many wards did not have a doctor specialised in psychiatry, with the ward doctor still doing their training for specialisation. During the summer holidays, specialising doctors were not available and Bachelors of Medicine had to be used instead. In the final discussion, the hospital district stated that one ward had had to reduce patient beds due to the severe shortage of doctors.

Presence of nursing staff. In adult wards, the inspectors drew attention to the fact that the work of nursing staff was mostly done in the office and not in direct interaction with patients. This was also visible in departments with a sufficient amount of staff. The matter also came up in discussions with patients.

Patient information. Deficiencies were found in the information provided to patients and their families and friends in all the inspected wards. The wards' guidelines and leaflets seemed confusing and did not always indicate the patient group they were intended for. It appeared that written information was only available in Finnish. Patient interviews also revealed dissatisfaction with the lack of sufficient information on care. In the final discussion, the hospital district acknowledged the need to update the leaflets. THL's leaflet had been translated into several languages.

Restriction of the right of self-determination. Patients had to occasionally be placed in the seclusion room of another ward. The division of responsibilities for the patient's supervision and care and record-keeping seemed unclear. The possibility of a secluded patient to take a shower and get outdoor exercise seemed to be poorly realised. The wards carrying out involuntary pharmacotherapy were not always aware that prescribing involuntary treatment does not automatically mean that the patient can be given medication against their will. The findings suggested that, in some wards, patient movement was restricted without a doctor's decision or even without a legal basis. The restriction instructions for psychiatry did not include instructions on the outdoor exercise possibility of a patient placed under observation and in seclusion.

Duration of seclusion. Based on the inspection findings, seclusion was not usually long-term. However, certain wards had used seclusion periods of several days, at most 12 to 15 days. Restraining was less frequent, with a maximum duration of nearly 4 days during the inspected period. The Deputy-Ombudsman has considered it extremely important to improve the legal remedies for secluded and restrained patients and proposed that the legislation be supplemented in this respect. 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.

Monitoring and reducing the use of coercive measures. The inspectors were left with the impression that the psychiatry branch does not systematically monitor the use of restrictive measures. Therefore the hospital district would not have accurate information on how much restrictive measures are used in the branch. The hospital district also did not have a separate plan for reducing restrictive measures. Instead, the restriction instructions for the psychiatry branch included a separate section on the operating models for reducing involuntary measures. The final discussion revealed that the hospital had had a programme to reduce restrictive measures some years ago. Reducing the use of coercive measures will be taken into account in the planning of the new hospital.

Care agreements. Some wards had different kinds of care agreements and commitments whose content seemed very questionable. It seemed that the agreements and commitments in use were not always based on the patient's genuine and informed consent. Ending seclusion with "open seclusion" also appeared to be based on an agreement between the patient and the unit, and the patient had to agree to it if they wanted to leave seclusion. The restriction guidelines of the branch did not identify such a procedure, and there were no guidelines for the procedure either.

Right to privacy. Patients seemed to lack the option of peace and privacy when they were taken to overflow beds in already packed patient rooms. The confidentiality of care discussions is also compromised if they are held in these rooms. The shared spaces of one ward were visible from outdoors. Not all patients had access to a lockable locker where they could store their property.

Inspection visit to joint emergency services' mental health and substance abuse unit

The Deputy-Ombudsman's statements on the emergency services' inspection were not yet available at the time of writing this. Among other things, the inspection revealed the following:

The TYKS joint emergency services in Turku have a separate mental health and substance abuse unit where patients in crisis can seek help independently or with a referral. Police officers also bring patients there as executive assistance or on their own initiative. During on-call hours, the unit serves as the admitting unit to psychiatric hospitals. This means that a patient can be placed under observation at the mental health and substance abuse unit, after which they will be transported to a psychiatric hospital ward regardless of their will. The joint emergency clinic could also diagnose or exclude somatic illnesses or conditions for psychiatric patients before they were referred to somatic or psychiatric treatment. Nevertheless, when examining the documents, no patient data indicated that attention had been paid to patients' possible injuries at the emergency clinic. Some patients however arrive at the emergency clinic intoxicated, and there was a mention in the documents for at least 14 patients that they had been brought in by the police.

The mental health and substance abuse unit had two seclusion rooms with decisions on use made by a doctor. The rooms were equipped with camera surveillance and a telephone to allow the patient to contact nurses. The insulation rooms had thin mattresses on the floor and the inspectors were told that patients eat sitting on the mattress on the floor. It has been the Ombudsman's established view that seclusion rooms should have facilities that prevent patients from having to eat while standing up or sitting on the floor.

The inspectors were told that cooperation with security stewards worked well. In general, situations can be anticipated well, and security stewards are only used as a last resort. A security steward on shift said that his task was to safeguard the patients' care and the personnel and to prevent violence. Security stewards can for example hold a patient still when limb restraints are being applied to ensure that the patient is not able to hit or kick anyone. There were weekly incidents where a patient was stopped from leaving. Security stewards do not place patients in safety seclusion on their own initiative, but when placing a patient in seclusion, it is checked that the patient does not have dangerous objects or substances in their possession. If the patient behaves in a very disoriented way, a security steward will hold them until a nurse comes to assess the situation.

In the Ombudsman's decision-making practice, it has often been necessary to draw attention to the authority and role of guards and security stewards when they are used in a health care unit. The inspection visit at the joint emergency service also revealed matters where the Deputy-Ombudsman will for example have to assess whether security stewards have the authority to act.

3.6 Shortcomings in implementation of fundamental and human rights

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

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

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

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

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

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

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

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

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

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

3.6.1 TEN CENTRAL FUNDAMENTAL AND HUMAN RIGHTS PROBLEMS IN FINLAND

Shortcomings in the living conditions and treatment of the elderly

Tens of thousands of elderly customers in Finland live in institutional care and assisted living units. Shortcomings in nutrition, hygiene, change of adult nappies, rehabilitation and access to outdoor recreation have been persistent issues. Shortcomings have been identified in relation to the frequency of doctor's visits, medical treatment and dental care. There have also been shortcomings in management, and the number of staff has not been sufficient.

Compliance with the new statutory personnel allocations has been overseen nation-wide, and the number of staff in service housing with 24-hour assistance has increased somewhat in proportion to the number of customers. However, the required customer capacity is not sufficient. There are older people living at home who are in very poor condition, and inpatient wards at health centres have elderly people waiting for access to housing services. There are social welfare clients with no dedicated worker appointed for them to monitor changes in their client's service needs and, if necessary, to contact the parties responsible for organising and providing their social welfare and health care services.

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

There are also shortcomings in terms of the adequacy and quality of services, safety, access to outdoors and support services for elderly people living at home. Self-monitoring and retrospective oversight of the adequacy and quality of services provided to customers at home has been insufficient, and new supervision methods are required.

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

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

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

Shortcomings in the implementation of child welfare

The general lack of resources allocated by local government to child welfare services and, in particular, the poor availability of qualified social workers

and the high turnover of employees have a negative impact on the standard of child welfare services.

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

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

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

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

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

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

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

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

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

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

Shortcomings in the implementation of the rights of persons with disabilities

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

Practices vary with regard to the restriction of the self-determination right of people in institutionalised care 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 municipalities, and the adopted policies may prevent customers from accessing statutory services.

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

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

Long processing times of the Finnish Immigration Service and the insecurity of undocumented immigrants

The Finnish Immigration Service is unable to meet the deadlines for processing asylum applications, residence permit applications based on family ties and residence permit applications based on employment as laid down in the Aliens Act. The Ombudsman has issued numerous reprimands to the Finnish Immigration Service in relation to the unlawful delays in processing cases, but processing times have remained poor. The processing of citizenship applications by the Finnish Immigration Service is also badly congested and the processing times are very long. In many of his decisions, the Parliamentary Ombudsman has considered the processing times of various permit applications by the Finnish Immigration Service to be very unsatisfactory.

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

There has been a positive development as the Parliament confirmed legislative amendments (HE 112/2022 vp) that improved the right of undocumented people to health care on 20 December 2022. Wellbeing services counties, the City of Helsinki and the HUS Group are obliged to not only arrange urgent care but also organise essential health care services for certain foreign persons who do not have a municipality of residence in Finland or who do not have the right to other public health care services other than emergency care under other national legislation or international legislation or agreement binding on Finland. This regulation firstly applies to persons who do not have a residence permit for legal residence in Finland. It secondly applies to persons residing legally in Finland under a temporary residence permit who do not have a municipality of residence in Finland or who are not legally equivalent to a resident of a wellbeing services county.

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.

When prisoners are placed in units, the legal principle of placing remand prisoners in separate locations from prisoners serving sentences is not always observed.

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. Nevertheless, the Government proposal was not submitted during this parliamentary term even though it was included in the Government's legislative plan.

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

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

Serious shortcomings in fundamental rights regarding health care exist in the access to treatment and contact (access to a doctor's assessment, queues for treatment and healthcare debt).

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

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

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

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

The right of schoolchildren to a safe learning environment and support for learning and school attendance is not always observed. The means available for schools to prevent and intervene in bullying are not always sufficient.

Legislation is partly open to interpretation, and shortcomings in administrative procedures and decision-making are highlighted in the organisation of support for schoolchildren. There are issues in the multidisciplinary cooperation between different administrative branches when identifying children's need for support and providing timely support. In student welfare, psychologist services are insufficient in particular.

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

Delays in legal proceedings remain a problem in Finland, and the coronavirus epidemic has exacerbated the situation. Despite legislative reforms to improve the situation, court cases can still take an unreasonably long time. This can be a serious problem in particular for matters that require urgent handling.

In criminal cases, the total duration of the process depends on the length of the pre-trial investigation, which may be exceptionally long in many complex cases, such as financial crimes. The number of exceptionally extensive cases and sets of cases has increased in recent years. It has become clear that the current criminal process and appeal system are not designed to handle such cases. Delays in the processing of criminal cases are also partly caused by under-resourcing across the criminal process system – the police, prosecutors and courts – which has also been stated in the Government report VNS 13/2022 vp to Parliament on 17 November 2022. When examining the length of pre-trial investigations on his own initiative (1510/2021), the Ombudsman found the situation of police pre-trial investigations very worrying, which may undermine the credibility of the criminal justice system and trust in the police.

High trial costs and court fees can prevent due legal protection. Finland has the lowest number of civil cases going to court in Europe. The potential impacts of the amendments to the provisions on legal costs (HE 201/2022 vp) in Chapter 21 of the Code of Judicial Procedure are not yet evident.

With regard to the structural independence of the courts, the situation has improved with the establishment of the National Courts Administration. Despite this, executive powers continue to try to steer the operations of the independent court system by, for example, including the courts within the scope of the central government premises strategy, despite statements by the National Courts Administration and the Deputy-Ombudsman emphasising the independence of the courts.

Constitutional regulation on the functioning of the judicial system is sparse. In Finland, the courts have been given little room to handle constitutional issues. 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.

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 (16–18 months) in the Tax Administration regarding claims for revised decisions concerning income taxation for individual customers. The delivery times of genealogical reports and the processing times of matters related to guardianship in the Digital and Population Data Services Agency are also often unreasonably long. Delays in the processing times of cases also occur with many other authorities.

Unlawful conduct in the processing of information requests under the Act on the Openness of Government Activities is a constant in the oversight of legality.

With the digitalisation of services, shortcomings have emerged in the provision of e-services, 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.

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. These cases are no longer included in this section, as they are available in section 4 "Oversight of legality by category" of this Annual Report.

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

3.7 The Ombudsman's proposals concerning recompense and matters that have led to an amicable solution

The Parliamentary Ombudsman Act empowers the Ombudsman to recommend to authorities that they correct an error or rectify a shortcoming. Making recompense for an error or a breach of a complainant's rights on the basis of a recommendation by the Ombudsman is one way of reaching an amicable settlement in a matter.

Over the years, the Ombudsman has made numerous recommendations regarding recompense. These proposals have in most cases led to a positive outcome. In its reports (PeVM 12/2010, 2/2016 and 2/2019 vp), the Constitutional Law Committee has also taken the view that a proposal by the Ombudsman to reach an agreed settlement and effect recompense is in clear cases a justifiable way of enabling citizens to enjoy their rights, bring about an amicable settlement and avoid unnecessary legal disputes. 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).

Making recompense was recommended by the Ombudsman in 22 cases in the reporting year. In addition, during the handling of complaints, communications from the Office to authorities often led to the rectification of errors or insufficient actions. For example, during the year under review, the police decided to reassess the matter in several cases and started a pre-trial investigation in some of them. 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. As agreed with the State Treasury, the State Treasury will annually send all decisions on recompense under the Act on State Indemnity Operations to the Ombudsman for information.

According to information obtained from the State Treasury, 1039 decisions were issued on claims based on the State's general liability in the year under review. There was a slight decrease in the number of decisions as the State Treasury issued 1,319 decisions in the previous year. During the year under review, a total of approximately EUR 1.4 million was paid in compensation. The amount of compensation paid decreased significantly from the previous year, when approximately EUR 5.6 million was paid out. The largest amount of compensation was paid in the administrative branch of the Ministry of Transport and Communications (EUR 711,000). The next highest amount of compensation was paid in the administrative branches of the Ministry of Justice (EUR 333,000), the Ministry of Economic Affairs and Employment (EUR 130,000) and the Ministry of the Interior (EUR 92,000).

During the year under review, the largest number of claims filed concerned the administrative branch of the Ministry of Justice (661). Like the previous year, a large number of claims for damages concerned the office of guardianship services of the state's legal aid and public guardianship districts.

Based on the claims, several hundreds of decisions on damages were issued in which the amounts paid varied from a few euros in delinquency charges of bills and taxes to thousands of euros. In addition to unpaid invoices, compensation was based on social security benefits that had not been applied for and on telephone or electricity contracts which had not been terminated or transferred, among others. Several persons were also compensated for funds that belonged to persons under guardianship and that were misused and embezzled by a person working in guardianship services. Other claims concerning the administrative branch of the Ministry of Justice were related to procedural errors made by district courts.

In the administrative branch of the Ministry of Transport and Communications, the largest compensation was paid in matters concerning the procedure of the Finnish Transport and Communications Agency Traficom. During the periods 1 December 2020–4 January 2021 and 18–25 January 2021, Traficom had provided erroneous advice, according to which more than one scrapping premium of old cars could be used to purchase a new car. In 2021, a large number of all compensation decisions concerned situations in which the customer had scrapped several cars in order to receive scrapping premiums, but the premium had only been paid for one car. In 2022, the State Treasury still paid a significant amount of compensation in more than 20 cases to clients who had trusted the authorities' advice and scrapped several cars in order to receive scrapping premiums. The compensation amounts varied between EUR 1,000 and EUR 103,000. Other compensation paid in the administrative branch of the Ministry of Transport and Communications was related, among other things, to falls and slipping caused by shortcomings in the maintenance of pedestrian and cycle paths as well as other accidents.

In the criminal sanctions sector, compensation was mainly paid in cases in which objects and clothing were lost or broken in prison. In a few cases, the case revolved around compensation for damage caused by a person serving a community service punishment. In one case, compensation for suffering was paid due to a delay in releasing the person from prison.

In the administrative branch of the Ministry of Defence, the State Treasury paid compensation for damages to property caused to cars parked in the area of the Defence Forces. The backwash of the Navy's ships had also caused damage to a boat moored at a pier on the shore. A few applicants were also compensated for the loss of earnings caused by the Defence Forces due to the cancellation of the 2021 refresher training exercises due to the COVID-19 pandemic situation at the time.

The State Treasury made recompense for a violation of fundamental and human rights on the basis of the Parliamentary Ombudsman's recommendation in two cases. The decisions concerned the procedures of the Finnish Tax Administration and Customs. Recompense was also made on the basis of the European Court of Human Rights' ruling against Finland (Kotilainen and Others v. Finland) on 17 September 2020 to two more families that were not previously involved in the Court's appeal process. The State Treasury paid compensation for intangible damage, i.e. suffering, as a result of the violation of Article 2 of the European Convention on Human Rights. In addition, the legal costs were partly reimbursed.

In the administrative branch of the Ministry of the Interior, compensation was paid for cases relating to physical injuries caused by a police dog, unjustified search of homes and overpaid fines. In one case, the State Treasury paid a child more than EUR 3,000 in compensation for the temporary harm caused by a fractured humerus. The humerus of the girl, who was placed in a residential school, fractured when two police officers physically moved her to the isolation room within the residential school. In its decision, the State Treasury considered that the use of force by police officers was not in accordance with the principles of proportionality and minimum harm. In its decision, the State Treasury referred to the requirement of sensitivity required under section 4 of the Child Welfare Act. According to the State Treasury, the use of force by the police did not comply with the reasonable requirements set for the use of force. Thus, according to the State Treasury, the police acted erroneously and there was justification for compensating the child for the damage caused.

In addition, compensation was paid in the administrative branch of the Ministry of the Interior for the fact that the children applying for a residence permit had to travel a second time to the Finnish diplomatic mission in Nairobi to give missing fingerprints. With regard to the procedure of the Finnish Immigration Service, compensation was paid due to unnecessary costs (a tuition fee, rent for student housing) caused by delays in processing a student's residence permit application.

One of the decisions issued by the State Treasury concerned a claim for damages due to the procedure of debt advisory services. The claim was based on a decision issued by the Deputy-Ombudsman on 10 May 2021. In its decision, the Deputy-Ombudsman had found the debt advisory procedure incorrect to the extent that the complainant's access to debt advisory services had taken unreasonably long and the debt counsellor had acted negligently. In its decision, the State Treasury considered that it had no reason to deviate from the Deputy-Ombudsman's conclusions and considered that the damage to be compensated in accordance with Chapter 3, section 2 of the Tort Liability Act was causal to the negligence of the legal aid office. The State Treasury considered EUR 550 a fair compensation for the financial damage caused to the applicant.

3.7.2 RECOMMENDATIONS FOR RECOMPENSE

The following gives an overview of the recommendations for recompense made by the Ombudsman during the year under review. Some of the cases are still waiting for a response from the authority.

Proposals concerning recompence related to the rights of the child

Safeguarding the child's linguistic rights and planning the reunification of the family during substitute care

After the end of the placement as an open care support measure, the complainant's child had been taken into care. This had been justified with the complainant's consent without referring the matter to the Administrative Court. The Deputy-Ombudsman was of the view that the genuineness of the complainant's consent could be questioned, considering that the complainant was a person requiring special support who was in an extremely vulnerable position, unable to speak the language and not familiar with the system, whose psychological condition was poor when the child was taken into care and who had on doctor's orders been taking several different psychological medicines. The complainant had also been identified as a victim of human trafficking and had been given a negative decision on a residence permit and a decision to refuse entry. Despite the complainant's position, the authority did not make sure that the complainant had a legal counsel to supervise the complainant's rights when the child was taken into care.

The Deputy Ombudsman did not consider acceptable a procedure in which the authority justifies the decision on taking a child into care with consent from the parent in the circumstances described above. To ensure the realisation of legal protection in the complainant's circumstances, taking the child into care should have been referred to the Administrative Court as a case concerning involuntary taking into care.

The complainant's child, whose mother tongue was English, was placed into a Finnish-speaking family after having been taken into care. Despite repeated requests from the complainant, the social welfare authority did not support the child's skills in the mother tongue at all, which led to the complainant and the child no longer having a common language. The Deputy-Ombudsman stated that, when placed outside home, a child has the right to receive substitute care meeting the child's needs. This also includes safeguarding the child's linguistic rights.

The Deputy-Ombudsman referred to previous decisions by the European Court of Justice emphasising the positive obligation of states to ensure that taking a child into care is as a rule considered a temporary measure. The Deputy-Ombudsman emphasised that the authority placing a child outside home has the obligation to aim at ending the care and reuniting the family. However, the social worker had not taken the aim of reuniting the family into account in their work and the planning of reunification had been neglected. The client plan offering parenting support for the parents, referred to in the Child Welfare Act, had also not been drawn up for the complainant.

Furthermore, contact between the complainant and the child had been unlawfully and heavily restricted for a long time without an appealable decision. As a result of these actions, the complainant lost the opportunity to use effective legal remedies. The social welfare authority's negligence and unlawful actions especially in restricting contact and neglecting the child's linguistic rights, but also in planning the reunification of the family severely endangered the realisation of the complainant's and the child's rights laid down in law.

The Deputy-Ombudsman also considered the placement in open care preceding the taking into care and the decision-making procedure concerning it to be in violation of the Child Welfare Act and found that it severely endangered the realisation of the complainant's and the child's legal protection. The legal effects of the placement in open care were not explained to the complainant, nor was the complainant informed of the fact that placements in open care are voluntary and that consent for them can be withdrawn. The complainant was unaware of their rights.

The Deputy-Ombudsman further drew attention to the fact the complainant's position as a person requiring special support referred to in the Social Welfare Act was not identified and not taken into account at all in the social welfare authority's work. In addition, the right to participate in the child's matters, which the complainant has on the basis of the custody of the child, was severely restricted and the authority did not take care of its explaining and interpreting obligations so that the complainant would have fully understood their own and the child's rights.

The realisation of the complainant's legal protection was also weakened by negligence in providing a reply to the objection, in conducting multidisciplinary cooperation, in processing the child welfare notifications and in the payment of compensations for the child's visits relating to keeping in contact with the child. There were also shortcomings in the monitoring of family care, and the authority did not comply with the principles of good governance. The Deputy-Ombudsman stated that the actions of the social worker had contributed to weakening the complainant's trust in the impartiality of the authority's activities.

The Deputy-Ombudsman issued a reprimand to the authority and the social worker responsible for the child' matters for their unlawful and incorrect actions. The Deputy-Ombudsman proposed that the authority and the wellbeing services county responsible for the substitute care reflect on how the complainant and the child can be recompensed for the violations of fundamental rights that have taken place (3166/2021*).

The wellbeing services county stated that it would pay the complainant and the child EUR 10,000 both in compensation. In addition, the wellbeing services county stated that it would personally apologise to the complainant and the child. The other measures taken by the welfare services county were the following: discussing the case with the social worker and investigating the possible supervisory actions, going through the case with family carers as a monitoring case, investigating the actions of the guardian appointed to the child as a monitoring case, and assessing the need for additional training for the child welfare social workers in the wellbeing services county.

The action taken when substitute care for the complainants' child was organised had been unlawful and insufficient as safeguarding the child's linguistic rights and planning the reunification of the family had been neglected and contact between the complainants and their child had been restricted without an appealable decision. In addition, the Deputy-Ombudsman paid attention to other serious negligence that included insufficient preparation of client plans and neglecting the drawing up of the plan supporting parenthood, not responding to repeated enquiries from the attorney and delayed responses to document requests made by the attorney, ignoring the complainant's vulnerable position, and neglecting the planning and offering of services and support.

Especially the negligence related to safeguarding the child's linguistic rights, to planning the reunification of the family and to negligence related to decision-making severely risked the realisation of the rights laid down in law. The Deputy-Ombudsman reprimanded the authority for unlawful actions for future reference. In addition, the Deputy-Ombudsman proposed that the authority recompense the complainants and the child for the violations of fundamental rights (3502/2021*).

The authority stated that, in addition to apologising, it had paid both complainants EUR 1,000 and the child EUR 3,000 in compensation.

Abuse of a child in family care

The complaint was about organising after-care and about the child's traumatic experiences in substitute care. The authority did not process the child's demands for changing the place of substitute care and did not issue any written decisions in the matter, which the child could have appealed. Based on the reports received, the child had experienced both physical and mental abuse in family care and the child's rights and right to self-determination had been unlawfully restricted. The realisation of the child's rights was not looked after and the child's repeated requests for help were not investigated.

The monitoring of the actual organisation of substitute care and its quality is the task of the municipality placing the child and especially of the social worker responsible for the child's matters. The social worker must specifically supervise the upbringing methods and practices of family carers. Taking a child into care and placing the child into substitute care is not a punishment for the child. Instead, the aim of child welfare measures is to protect the child and at the same time ensure that the child's childhood and youth are as normal as possible. The Child Welfare Act does not give the place of substitute care the right to use inappropriate, unjustified, or arbitrary upbringing methods. The authority admitted inappropriate treatment of the child in family care and actions in violation of the Child Welfare Act. The authority had also neglected the monitoring of family care.

Because of the authority's negligence regarding its obligation to issue decisions, the child lost the opportunity referred to in the Constitution of Finland to bring a matter concerning them in front of a court of justice. Inappropriate and subjugating treatment of the child severely endangered the best interest and rights of the child who was in a vulnerable position and had the right to receive special protection. The Deputy-Ombudsman proposed that the authority responsible for the implementation of the fundamental rights of the child recompense the complainant for the violations of their fundamental rights (1421/2022*).

The authority stated that it had paid the complainant, who was the child, EUR 6,000 as recompense for the violation of fundamental rights.

Restricting a child's rights without decision-making

The complainant had been transferred without a legal decision to a period of special care. The decision on starting the period was made in the residential school, which was in violation of the provision laid down in the Child Welfare Act. The authority did not draw up a written decision until afterwards, four days after the beginning of the period.

The Substitute for the Deputy-Ombudsman considered the incorrect actions serious and to be in violation of the child's rights. The rights belonging to the child were restricted without a mandate granted by law and had been intervened in without the child having had an opportunity to be heard at the time, appeal the decision or request a prohibition of its enforcement. The child's right to legal protection was not realised when the child was not given a new legal counsel to replace the counsel who had considered themselves biased. Neither the social worker nor the residential school fulfilled their obligation laid down in the Child Welfare Act to explain to the child their rights and how to act in a situation where the child suspects that the authority or the place of substitute care has acted unlawfully.

The Substitute for the Deputy-Ombudsman considered it particularly reprehensible in this case that an effort had been made in the residential school to persuade the complainant to give up their statutory legal remedies by offering a (possible) monetary compensation for this. The Substitute for the Deputy-Ombudsman proposed that the authority responsible for the placement consider how it can recompense for the violations of the child's rights (7944/2021).

The authority stated it had paid the child EUR 3,000 in compensation and apologised for having violated the child's rights.

Right to effective legal remedies

The complainant's right to legal protection was not realised when the notification of appealable decisions concerning the complainant was delayed so that, in practice, the complainant lost the opportunity to effectively exercise the legal remedies secured to them under the Constitution. The reprehensibility of the procedure was increased by the fact that the child in question was in a vulnerable position and the realisation of the child's rights and legal protection relied on measures taken by the authority and the parties commissioned by it. Other kinds of negligence in decision-making had also taken place in the case.

The Deputy-Ombudsman paid attention also to the manner in which the child was restrained, the general principles of usual upbringing of children, the (lack of) monitoring of the place of substitute care and to the role of the social worker as the actual implementer of the monitoring. The Deputy-Ombudsman reprimanded the residential school and proposed that the authority that was responsible for implementing the complainant's fundamental rights recompense the complainant for the violations of the complainant's fundamental rights (5985/2021).

The authority stated it would pay the complainant EUR 3,500 for having violated their fundamental rights, admitted that the procedure had violated the Child Welfare Act and apologised for the harm caused by its actions.

Organising services to children with intellectual disabilities and supporting the family in a situation that had developed into a crisis

The authority failed in organising the personal assistance for the family's children with intellectual disabilities, in organising care assistance and monitoring the realisation of the services. The Deputy-Ombudsman's view was based on the fact that the services granted to the children on the basis of their disability were not implemented in accordance with their needs as indicated in the service plans nor in line with the officeholder's decisions and the special care programmes. The authority also neglected to fully implement the officeholder's decisions and the special care programmes. In the changing situation that had developed into a crisis, the authority was not able to assess and solve the family's matters without undue delay. The authority neglected its obligation to issue decisions regarding the requests the family made for substitutive services and their demands to have the way of organising the services changed.

The Deputy-Ombudsman could not be convinced that correctly timed services or support for the realisation of the parents' upbringing task had been planned or provided to the parents to the extent required, also known to the authority. The situation of the adults in the family had developed into a crisis. Because of the authority's negligence in decision-making, the discharge of the other guardian of the children from hospital was prolonged and led to an increasing burden for the other parent, who was in practice responsible for the care at home alone. In the view of the Deputy-Ombudsman, this burden exceeded the usual care responsibility of parents.

Negligence in organising social welfare services, in the authorities' cooperation, in the decision-making and especially in implementing decisions issued to the family led to a situation in which the family's oldest child became a child welfare customer. The Deputy-Ombudsman did not consider it acceptable that, because of the actions of the authority, an underage child had to take care of the daily care of their siblings in a manner that did not correspond to the child's development and age. What makes the matter even more reprehensible is that the child in question was also a person in need of special support.

The officeholder's decisions securing necessary care should have been implemented urgently and without delay. The Deputy-Ombudsman found the authorities' actions seriously reprehensible. The reports received gave the impression that the authority had knowingly ignored the family's circumstances and needs as well as the problems in implementing the selected way of organising the services. The authority did not take sufficient, immediate, and urgent measures, which in the Deputy-Ombudsman's opinion could have been provided and implemented to secure the best interest of the family and its children.

The Deputy-Ombudsman issued a reprimand to the authority for further reference. The social services had through its actions violated the constitutional right of the family's children to necessary care and sufficient social and health care services and the right of the family's parents to support from public authorities in safeguarding the child's wellbeing and individual growth. The authority had neglected its obligation under the Constitution to secure the implementation of fundamental and human rights. The Deputy-Ombudsman proposed that the authority consider how it can recompense for the violation of fundamental rights (6084/2021).

The authority announced that they have paid the family 8000 euros in recompense. In addition, according to the authority's announcement, services tailored to the family's needs will be continued and multidisciplinary teams will be used in the evaluation and allocation of services.

Right to sufficient health services

The continuity of the child's treatment was not ensured in accordance with the law

After the child who had been taken into care had moved from Vaasa to Helsinki, a referral concerning the child from the Vaasa Hospital District to the Hospital District of Helsinki and Uusimaa was requested a total of seven times. However, no referral was received by the Helsinki and Uusimaa Hospital District before the child moved back to the area of the Vaasa Hospital District. The Vaasa Hospital District did not organise the child's treatment even after the child had moved back.

The Deputy-Ombudsman considered that the Adolescent Psychiatry Outpatient Clinic of the Vaasa Hospital District acted unlawfully when appropriate care was not taken of the continuity of the child's psychiatric treatment and no referral was written for the child within the maximum time of five days required in the Decree on Patient Documents. As a result, the child remained without the psychiatric treatment contact determined necessary for the child for more than eight months and the child's motivation for the treatment declined.

The child's right to sufficient health services and the good treatment secured by the Act on the Status and Rights of Patients was not realised and the child's best interest was not taken into account as required in the Convention on the Rights of the Child.

The Deputy-Ombudsman stated that the right to sufficient health services is a fundamental right, the realisation of which public authorities are required to safeguard. The child's right to receive the treatment considered necessary for the child was not realised because of the negligence of the Vaasa Hospital District. For this reason, the Deputy-Ombudsman proposed that the Hospital District consider how it can recompense the violation of the child's fundamental rights (2767/2021).

Treatment of a pain patient

The complainant criticised the procedure of the Pain Clinic of the hospital district for the clinic's actions when treating pain in the complainant's hand after the complainant had been injured in 2012. The pain clinic refused to refer the complainant to further treatment for receiving a pain stimulator because the court process related to the injury was still under way.

The Deputy-Ombudsman was of the view that although ongoing legal processes may have different effects for different patients, an ongoing legal process does not as such automatically mean bad response to treatment. The complainant's right to good care was not realised to the extent that the care decision was made without individual discretion, based only on the systematic practice followed in the healthcare unit. According to an assessment by the National Supervisory Authority for Welfare and Health Valvira, the negligence led to treatment being delayed by several years. In the Deputy-Ombudsman's view, the complainant's right to sufficient health services and good care was not realised when the complainant had had to experience uncertainty about the treatment and probably had also had to suffer additional pain. In the complainant's case, it was no longer possible to rectify the violation. The Deputy-Ombudsman proposed that the hospital district consider how it can recompense for the violation of the complainant's rights (3257/2021).

The authority announced that they had apologised to the complainant and given them instructions to contact the Patient Insurance Centre regarding the possible malpractice in their case.

Procedural errors in social services

The person had a chronic psychiatric disease that severely limited functional ability. However, the authority did not identify the person's right to receive special support under the Social Welfare Act, and the person had not been given the social worker services as required under the Act. The assessment of the need for services and the decision-making procedure in the matter were incorrect and unlawful. In situations where the person's ability to manage their matter has weakened because of an illness there is an emphasis on the authorities' responsibility to ensure the accuracy of their actions and to make sure that the realisation of the need-based services are not at risk. The Deputy-Ombudsman proposed that the authority recompense its incorrect and unlawful actions (1942/2021).

The authority stated it had apologised to the client and the complainant for its incorrect actions. The authority has also refunded the home care fees paid by the client since 2018. A dedicated social worker was designated for the client.

The processing of the matters of the complainant and the complainant's mother was unlawful as the assessment of the need for services was made inadequately, no client plans were drawn up, no dedicated worker was designated for the complainant, decisions were not made by the deadline, they were inadequately justified and partly not made at all. Their implementation had also been delayed. Sufficient guidance and advice had not been given to the complainant, either. The constant drafting of applications and requests for rectified decisions related to the authority's procedural errors burdened the complainant and made the complainant's recovery from a neurological disease more difficult. In addition, it became more difficult for the complainant to act as an informal carer.

The quality of the service was not good because of the procedural errors. The Deputy-Ombudsman proposed that the authority recompense the violations of rights to the complainant (2036/2021).

The authority stated it would compensate for its incorrect and unlawful actions with a written apology.

Decisions relating to social assistance

Taking into account rental costs and the costs of moving in social assistance

The complainant and their child moved to Finland and entered into a fixed-term rental agreement for an apartment. Regardless of the fixed-time nature of the rental agreement, in which there was a penalty for violating the contract, Kela still demanded that the family moves to a more affordable apartment. Kela did not grant social assistance to the complainant for the contractual penalty. In addition, Kela considered that the rent of the complaints new apartment was also unreasonably high and therefore reduced the level of social assistance granted. Kela did not grant any social assistance for moving costs. Kela directed the complainant to apply for supplementary social assistance from the municipality, which was not granted. Kela's actions resulted in a situation where the complainant needed social assistance.

Based on the report received, the Deputy-Ombudsman considered that the moderation of the housing costs, taking the housing costs into account and assessing the costs of moving did not take place in accordance with Kela's own benefit guidelines. Kela's report did not explain how Kela had used its discretion in the matter and why the guidelines for benefits had not been followed. The Deputy-Ombudsman got the impression that the individual circumstances of the complainant had not been taken into account appropriately, for example, that this was a family in a vulnerable position. Kela did not correct its actions with regard to the housing costs and assistance for moving costs until after the complaint had been filed with the Parliamentary Ombudsman. Kela still did not grant social assistance for the contractual penalty.

The Deputy-Ombudsman was of the view that Kela's incorrect actions caused harm, concern and financial losses to the complainant. The Deputy-Ombudsman therefore proposed that Kela recompense the harm caused by its incorrect actions to the complainant (1198/2021).

Kela reported it had paid a recompense of EUR 2,110 to the complainant.

Termination of social assistance was not based on law

Kela changed the decisions on social assistance issued to the complainant and implemented the decisions in a manner that no longer corresponded to the content of the decisions made previously. Kela demanded repeatedly that the complainant move to more affordable rented accommodation with their underage child.

Kela's procedure was in violation of the Act on Social Assistance, the Administrative Procedure Act and Kela's guidelines on benefits. It was also careless. The complainant had to apply for social assistance several times for the same period of time, was asked to provide unnecessary additional information and sometimes no additional information was requested when it would have been necessary. The additional information submitted by the complainant was not considered in the decision-making. No decision was made on some of the applications for social assistance and the justifications for the decisions were incorrect or inadequate. The individual circumstances and the complainant's life situation were not appropriately considered in the decision-making. The Deputy-Ombudsman drew Kela's attention to its obligation to issue a decision on a pending application and reminded Kela that it cannot dismiss an application on the grounds that a decision on another benefit on which it must issue a decision is still pending.

The Deputy-Ombudsman also drew Kela's attention to the fact that the Act on Social Assistance does not contain a provision that would give Kela the right to terminate social assistance. Kela's decision on terminating the assistance had been justified with the provision on reviewing social assistance in the Act on Social Assistance. Terminating the complainant's social assistance was in violation of the Act on Social Assistance and the principle of legitimate expectations laid down in the Administrative Procedure Act.

The Deputy-Ombudsman proposed that Kela considers how it can recompense the complainant and the complainant's underage child the endangering of their social security because of its unlawful actions (7615/2021).

Kela reported it had paid the complainant EUR 50 in compensation.

Good governance

Responding to a request for a document and an enquiry

The complainant submitted a request for a document on 24 August 2019. No response to the request had been received by 5 January 2022. According to the report, the document request had been forwarded from the registry to the social and health care document centre, where it was no longer found, so it was not possible to verify whether the request had been answered.

The Deputy-Ombudsman considered that the request for a document was not processed in a manner required by law as the complainant had not received an answer by the time two years and four months had passed from the request. The city had neglected its obligation to implement good information management practices when the request for the document could no longer be found in the information system. It was particularly reprehensible that the complainant's request for the document was not answered even after the request had been submitted to the city as an attachment to the Parliamentary Ombudsman's request for clarification and opinion.

The Deputy-Ombudsman stated the city also acted unlawfully when it had not responded to the complainant's request for clarification for unlawful viewing of information on prescriptions. More than five months after the first message sent by the complainant, the complainant was informed that the matter was being processed as an objection. The Deputy-Ombudsman stated that the provisions of the Act on the Status and Rights of Patients were also not complied with in processing the objection despite the social services and healthcare services having informed the complainant in April and May 2021 that the complainant had the right to receive an answer without delay and a promise was given to do this. The Deputy-Ombudsman proposed that the city consider how it can recompense the complainant for the unlawful actions (1500/2021).

Processing a claim for a revised decision

The complainant was in substance abuse rehabilitation at an alcohol and drug rehabilitation centre. The complainant felt they needed an extension to the rehabilitation period, but it was not granted. The complainant's mother submitted a claim for a revised decision on the matter to the supervisor of drug abuse treatment services. A reply to the request was sent promptly, but the decision was not changed.

The Deputy-Ombudsman stated that, instead of sending a claim for a revised decision to the social welfare and healthcare committee as advised in the instructions for requesting a review, the complainant's mother submitted the request to the officeholder who had made the negative decision. The officeholder answered to the request with a "response" and had not transferred the matter to the committee to be processed as a claim for a revised decision. The Deputy-Ombudsman considered that the city had acted unlawfully and incorrectly when the complainant did not receive a decision on the claim for a revised decision.

The Deputy-Ombudsman also considered the mistakes serious because the complainant had a chronic disease, and the authorities were aware of the complainants reduced ability to manage their matters. The Deputy-Ombudsman proposed that the authority consider how it could recompense for the violation of the complainant's rights (856/2021).

The authority reported that the instructions for appealing to the municipal social welfare and healthcare committee are always enclosed to an officeholder's written decision concerning a social welfare service. In the complainant's case, the service manager and the supervisor of the operating unit had by accident and incorrectly answered to the claim for a revised decision submitted by the complainant's mother like to an objection. The same had happened in another case. Both cases were taken to be processed by the next possible division of the committee. The officeholders had contacted the complainant and apologised for their incorrect actions. The complainant was instructed about the opportunity to submit a separate claim for damages to the city.

Compliance with the principle of legitimate expectations in employment services

The complainant had applied for the opportunity for self-motivated study with unemployment benefit. The complainant received the labour policy statement sent to the unemployment fund by the TE Office, according to which the self-motivated studies would be supported with unemployment benefit for the periods 29 March 2021–9 October 2022 and 1 August 2023–19 January 2024. In between these supported periods of time, the complainant had a paid work placement from 10 October 2022 to 31 July 2023, during which the studies would not be supported with the unemployment benefit. The decision was recorded in the employment plan dated 8 March 2021. In March 2022, the complainant contacted the TE Office. On 24 March 2022, the complainant was told over the telephone that the labour policy statement issued earlier was incorrect and that the months of supported studying cannot be split.

The Deputy-Ombudsman considered that the specialist at the TE Office had neglected sufficient diligence, which is part of the basics of good governance, when not paying sufficient attention to the provisions and instructions on self-motivated studies supported with unemployment benefit while advising the complainant in matters related to support during studies and issuing a labour policy statement.

The principle of legitimate expectations means that the authority must take into consideration the legitimate expectations protected on the basis of legal order. A private person must be able to trust that the actions of the authority do not suddenly, and at least not retrospectively, change in a way that restricts or otherwise has a negative effect on the right or benefit of a private person. According to the principle of legitimate expectations, the authority has the obligation to comply with the decisions they have made, and the commitments and promises included in them. Legitimate expectations can be considered one of the guarantees of legal certainty.

The complainant made the decision on their studies and on moving to another city after receiving the information about support for the duration of the studies. The information that the labour policy statement issued on 9 March 2021 was incorrect came as a surprise to the complainant in March 2022. As a result of the officeholder's negligence of diligence, the complainant lost the unemployment benefit promised for the period 1 August 2023–19 January 2024.

The Deputy-Ombudsman considered the actions of the TE Office to be in violation of the complainant's legitimate expectations; the incorrect information had quite obviously contributed significantly to the complainant's choice of studies and the complainant had no reason to suspect the validity of the information given. Diligence in the processing of cases is essential in securing subsistence. The requirement of effective implementation of fundamental and human rights necessitates that the complainant be entitled to appropriate recompense for the harm incurred from negligence of diligence and violation of legitimate expectations.

The Deputy-Ombudsman sent their decision to the State Treasury and asked it to contact the complainant in an appropriate way and settle the matter on the basis of the Act on State Indemnity Operations (2541/2022*).

The State Treasury stated that it had paid the complainant a gross amount of EUR 3 633.01 for the loss of unemployment benefit plus EUR 100 in compensation.

Other proposals concerning recompense

Disposal of dental prosthesis

The complainant's valuable dental bridge, which was in a usable condition, was thrown to the bin at the hospital without checking with the complainant and the response to the objection did not answer the complainant's question about the reasons that the disposal was based on. The complainant considers themselves entitled to a full compensation for the damage.

The Deputy-Ombudsman considered that the hospital acted wrongly when the complainant's dental bridge was disposed of without checking the complainant's opinion. The Deputy-Ombudsman proposed that the hospital consider how it could recompense the complainant for the violation of the complainant's rights and requested that the hospital contact the complainant in a suitable manner for this purpose (3903/2021).

Treatment of a psychiatric patient

The complainant said they had made an appointment with a psychiatrist for renewing their therapy and rehabilitation subsidy The complainant was not informed of the cancellation of the appointment and came to the appointment in vain.

The Deputy-Ombudsman stated that the complainant did not get a new appointment until a month after the cancelled appointment although the appointment was needed for renewing the complainant's medication and therapy and for getting the allowance. The seriousness of the negligence was increased by the fact that the complainant suffered from severe depression. The Deputy-Ombudsman proposed that the hospital district consider how it can recompense the suffering caused to the complainant, the harm caused by the delayed processing of the rehabilitation subsidy and the violations of rights found in the decision (804/2021).

The hospital district stated that the client's visit to the outpatient clinic in vain had partly been caused by a communication breakdown between the city and the hospital district. Because of the severe shortage of physicians in psychiatry, it was not possible to give the client a new appointment until a month later. In spring 2021, a queue manager had been added to the field of psychiatry, among other things. The hospital district did not consider the payment of monetary recompense possible because the situation had been caused by reasons that the hospital district had not been able to fully influence. The hospital district apologised to the client for the cancellation of the appointment.

Delay in returning a confiscated object

Entries made by Customs regarding the confiscation were inadequate and the recorded entries did not indicate the officer authorised to make an arrest who was responsible for the confiscation. Because Customs had issued a regulation on decision-making to clarify the procedure, the Deputy-Ombudsman considered that the matter did not give rise to anything else but proposing a recompense for the harm and costs caused by the delay.

The decision was sent for information to the State Treasury, which was requested to contact the complainant for specifying the claim for compensation and resolve the matter on the basis of the Act on State Indemnity Operations (943/2021).

The State Treasury reported it had paid the complainant EUR 100 in compensation for damages.

Recompense was also proposed in the following cases: 7901/2021 (organising health care for a child welfare client), 8070/2021 (urgent placement), 8167/2021 (reasonable adjustments) and 8547/2021 (driving ban).

3.8
Special theme in 2022: Oversight of oversight

3.8.1
OVERVIEW

For the first time, the special annual 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. The same theme will be carried on to 2023. Deputy-Ombudsman Sakslin has also discussed the oversight of oversight in the annual report for 2017.

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 his work, the Ombudsman also monitors the implementation of fundamental and human rights. The Parliamentary Ombudsman's oversight of legality is exercised outside the domain of the government and independent of it and, when necessary, the mechanism allows for intervention in cases where public authority is abused. In a well-functioning state governed by the rule of law, the supreme overseers of legality must ensure that primary supervisory systems are in place and fully operative.

Parliament's Constitutional Law Committee commends the Ombudsman for refocusing its attention from the supervision of authorities' actions 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 authorities exercising oversight are subject, in every case, to the supreme oversight 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 oversight of the external 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 and special ombudsmen 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 utilise the expertise of these special 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

Inspections and visits

During the year under review, inspections of various authorities and visits to agencies were conducted to examine the implementation 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 oversight of covert intelligence gathering is detailed in section 4.6. of this annual report.

With regard to police matters, the Ombudsman examined the activities of the legal unit of the National Bureau of Investigation (NBI) and its oversight of legality. The inspection revealed that complaints and compensation for damages had been handled appropriately and justified fairly thoroughly. No significant deficiencies were found in the legality inspections carried out by the NBI. The inspection also addressed how the provision of legal support from the legal unit is compatible with the oversight of legality carried out by the legal unit. In 2022, the external inspection of the NBI was carried out by the National Police Board's internal inspection and oversight of legality and the Data Protection Ombudsman (5818/2022).

During the inspection visit, the Ombudsman noted that, in his opinion, it would be important to develop the internal oversight of legality by the Finnish Security Intelligence Service. The Parliamentary Ombudsman states that the Intelligence Ombudsman currently mainly only oversees the intelligence operations of the Finnish Security Intelligence Service, even though the Intelligence Ombudsman is responsible for overseeing the Service as a whole. The Ombudsman has explained his observations in his statements to the Parliamentary Intelligence Oversight Committee. According to the department head of the Finnish Security and Intelligence Service, legality is important for the success of the unit's operations, and the unit is subject to continuous oversight of legality. In addition to the agency's own oversight of legality, the Data Protection Ombudsman carried out an inspection of the unit in 2020. In addition, inspections on the security clearance unit of the Finnish Security and Intelligence Service were carried out by the Ministry of the Interior's oversight of legality and internal inspection (5702/2022).

The Parliamentary Ombudsman's inspection of the Eastern Uusimaa Police Department addressed the operations of the legal unit. According to the regulation on the internal oversight of legality of police departments, the legality of operations is based on the duty of each person working at a police department to ensure the lawfulness of their own actions. In addition to the responsibilities of the legal unit, the police department's oversight of legality plan for 2022 highlights the obligation of other civil servants in supervisory positions to carry out oversight of legality in their areas of responsibility (2583/2022). The inspection of the National Police Board especially focused on the internal oversight of legality and the situations that occur in criminal investigation and licence administration. The National Police Board had carried out planned inspections in all police departments and, for the first time, also in the Åland Police Authority (5819/2022).

The inspection of the detention facilities of the passenger car ferry revealed, among other things, that the police had not approved these facilities and that detention notifications had not been delivered to the police as required by law (6559/2022). On the basis of the observations made during the inspection, the Parliamentary Ombudsman decided to take the initiative to investigate some more general questions that concerned keeping order on board vessels and, in particular, its oversight (813/2023).

In the criminal sanctions sector, it was noted during the inspection of Kylmäkoski Prison that the prison had not addressed all the incorrect practices discovered by the inspections carried out by the Central Administration Unit of the Prison and Probation Service of Finland between 2018 and 2020. In this respect, the oversight of the prison operations in the Regional Centre and the Central Administration Unit could not be considered successful. The Deputy-Ombudsman found it very positive that systematic internal oversight has been introduced in prisons with well-selected themes that are regularly assessed (1621/2022).

The organisational reform of the Prison and Probation Service of Finland was among the topics discussed during the visit of the Legality Oversight Officers of the Prison and Probation Service of Finland. Centralising the processing of complaints and developing the self-monitoring of prisons emerged as key issues (2260/2022).

Internal and external oversight of legality was assessed during the inspection of the prison hospital, pharmaceutical centre and dental clinic of the Prisoners' Health Care Unit. Each prison hospital location of the Prisoners' Health Care Unit has a self-monitoring plan, which is updated annually. The Regional State Administrative Agency and National Supervisory Authority for Welfare and Health carried out a joint guidance and assessment visit to the hospital in 2017. The Deputy-Ombudsman drew attention to the fact that the Director of the Pharmaceutical Centre selects the internal inspectors for the internal oversight of the Pharmaceutical Centre. The opinion of the Deputy-Ombudsman was that it would be better for the target of inspection not to participate in the selection of inspectors. The Prisoners' Health Care Unit was also encouraged to self-monitor dental care services (2555/2022).

The internal oversight of legality of the National Prosecution Authority was addressed during the inspection of the Office of the Prosecutor General by the Parliamentary Ombudsman. Monitoring and oversight at the agency level produces a national situational picture of the general legality of the agency's operations, the quality of prosecutors' decisions and the uniformity of prosecutors' decision-making and the operational arrangements by which the Prosecution Districts ensure the quality and legality of their prosecution operations. The main theme of the Prosecution Districts' regional oversight has been to investigate the causes of work backlog, the matters that promote and hinder the flow of the prosecution process and the matters related to the well-being of personnel at work (7478/2022).

The implementation of the oversight of legality of the Finnish Defence Forces and the administration of military justice were examined in the inspection of the Defence Command Finland (Deputy-Ombudsman) and the Navy Headquarters (Ombudsman). The oversight of legality of the Legal Division of the Defence Command carries out inspections in different units of the Defence Forces, and the Defence Forces' Chief Legal Advisor also carries out annual sectoral and steering visits to the branches of Defence Headquarters. The Defence Forces have a legality oversight channel (as part of the national implementation of the Whistleblower Directive), which has been in national use in all administrative units of the Defence Forces since 2020. The initial experiences of the legality oversight channel had been positive (408/2022 and 5666/2022).

The implementation of the internal oversight of legality by Finnish Customs was discussed during the inspection carried out by the Parliamentary Ombudsman. The processing of administrative complaints and the processing of statements issued to other overseers of legality have been centralised to the Customs Headquarters. The Customs Enforcement Department carries out crime prevention and control and the ex-post monitoring of the legality of criminal intelligence units of Police, Customs and Border Guard. Oversight of the use of Customs' personal data registers takes place on a case-by-case basis and is based on a risk assessment. In mass oversight, one entity is selected each year for making log reports. The report may for example focus on a topic that has received significant media attention (5667/2022).

The inspection of the National Courts Administration discussed the enforcement of data protection legislation in judicial matters. It was found that the National Courts Administration is within the oversight purview of the Data Protection Ombudsman, but the supervisory authority is not competent to oversee the processing operations carried out by the courts in their judicial capacity. Information received during the inspection revealed that, with regard to the oversight of the processing of personal data, it is unclear which processing operations are related to a court's judicial activities in general. It is also unclear how the courts should act in cases of data breaches that are reported elsewhere to the Data Protection Ombudsman (1329/2022).

In the inspections of education services, it was noted that the forms of self-monitoring in the basic education sector include participation in external evaluation of education and self-assessment as well as the monitoring of different plans. It is important that an education provider receives information about shortcomings from schools and staff to be able to assess the legality of their own activities. Discovered development targets included improving cooperation and the flow of information between administration and schools and increasing training for school staff. The Deputy-Ombudsman will monitor the situation as the responsibility for organising student welfare services is transferred to the wellbeing services counties, paying particular attention to how student welfare oversight is implemented in future oversight of legality. (3521/2022 and 5690/2022).

The inspection of the education and culture services in Rovaniemi revealed that the city had taken into account the decisions of the Regional State Administrative Agency and administrative steering by developing the coordination of special support and by changing decision-making practices. The decision-making processes to support learning had been changed to ensure the legality of procedures. The city conducts inspections of basic education institutions on the basis of the quality criteria for basic education drawn up by the Ministry of Education and Culture to assess and develop the operations.

Internal oversight involves plans and annual assessments of aspects such as information security and protection as well as compliance with legal provisions, regulations, and decisions (4778/2022).

During the inspection of the University of Lapland, university representatives told the Deputy-Ombudsman that there was still room for improvement in the self-monitoring of legality. At the moment, self-monitoring is largely based on existing procedures under the Universities Act. It was estimated that administrative employees having a clearer role in the school group would promote more efficient self-monitoring (4777/2022).

In social welfare sector, the Deputy Ombudsman's inspection of a sheltered housing unit for the elderly 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 and takes them into account in the planning and implementation of self-monitoring. The Deputy-Ombudsman found it advisable for the self-monitoring plan to be placed on each unit's website. (2787/2022). In another inspection of elderly care, the Deputy-Ombudsman found it positive that a self-monitoring plan was available at the unit and on the unit's website and that it was updated at least annually (1127/2022).

The key objective of the self-monitoring of municipalities and elderly care units as well as the oversight by the Regional State Administrative Agencies has been to ensure that these units have the amount of personnel required by law. During the inspection of the elderly care unit, the Deputy-Ombudsman found it positive that the municipalities had carried out oversight visits to the unit and that the unit had complied with municipal guidelines. The Deputy-Ombudsman emphasised that compliance with the amount of personnel is reflected in the oversight of legality as good quality of service (2788/2022).

In connection with the inspection of a psychiatry unit for persons with intellectual disabilities, the Deputy-Ombudsman refrained from assessing the adequacy of the amount of personnel, as this question was already under enforcement at the Regional State Administrative Agency. However, the Deputy-Ombudsman assessed how the unit had taken into account the opinions of the Regional State Administrative Agency's previous inspection and enforcement decision. The Deputy-Ombudsman had to draw the attention of the service provider to the same matters (e.g. self-monitoring plan and door windows in residents' rooms) that the Regional State Administrative Agency had already commented on (1686/2022).

As a result of the inspection of a reception centre for minors, the Deputy-Ombudsman asked the Finnish Immigration Service to report on how agency oversees the suitability of its outsourced services, especially facilities in this case, for children and young people. According to a report by the Finnish Immigration Service, it oversees reception centres in accordance with the oversight programme for the reception system prepared by the agency, and the agency requires that reception centres, detention units and units for minors draw up a self-monitoring plan. The Finnish Immigration Service required that the service provider of the reception centre find new premises for the unit and pay attention in general to the safety of the workspaces, the occupational safety of personnel and lock systems (2874/2022).

The Deputy-Ombudsman investigated the conditions of unaccompanied children seeking international and temporary protection in a group home and supported housing unit. The Deputy-Ombudsman recommended that the notice board of the unit should have an explanation of the possibility to file a complaint. The Finnish Immigration Service reported that, during its guidance and assessment visits, it has recommended that the notice boards of reception centres and units for minors should have information on how to file complaints about the services and the operations of the reception centre. The Finnish Immigration Service instructed the unit to supplement its self-monitoring plan and operations with regard to the matter (2873/2022).

In the inspection of the Lahti Reception Centre and its intensified unit, the Ombudsman considered it somewhat unclear what kind of measures had been taken by the Finnish Immigration Service, which oversees and steers reception operations, or by the intensified support unit to prevent serious situations, such as those related to self-harm. The Finnish Immigration Service provided a response to the Ombudsman's request for action (3263/2022, 3235/2022).

During the inspection of the employment services by City of Vantaa, the implementation of internal oversight of legality was discussed. Six complaints concerning the Vantaa-Kerava pilot area had been filed with the Regional State Administrative Agency for Western and Inland Finland, which oversees the local government pilot on employment promotion. In addition, the Regional State Administrative Agency had taken the initiative to investigate the organisation of personnel resources and employment services in the City of Vantaa pilot to match the tasks referred to in the act concerning the pilot. During the local government pilot, five complaints concerning the procedure of Vantaa's employment services had been submitted to the Office of the Parliamentary Ombudsman, one of which had been referred to the Regional State Administrative Agency (2596/2022).

During the inspection of the National Enforcement Authority, the Deputy-Ombudsman investigated the activities of the Office of Director General and the oversight carried out by it. The internal oversight of the Office of Director General consists of internal auditing, self-monitoring of units, a risk management evaluation report, instructions, performance targets and the Baro survey by the Ministry of Finance. The organisational reform has taken a lot of time, and the development of the internal oversight of the operating units is still ongoing (679/2022).

The inspection of the Regional State Administrative Agency for Southern Finland focused on the role of the Regional State Administrative Agency as the overseer of debt collection activities. According to the Deputy-Ombudsman, the personnel resources for the oversight of debt collection seemed rather limited. Limited resources have an impact not only on other aspects, but also on the possibilities of carrying out own-initiative oversight – including oversight campaigns. The exchange of information and other forms of cooperation between the collection control team of the Regional State Administrative Agency and the Office of the Ombudsman were discussed (4649/2022).

The Deputy-Ombudsman's inspection at the Finnish Transport and Communications Agency addressed the entity of internal oversight based on a management system, consisting of internal oversight, risk management and self-monitoring. The Ministry's relationship with the agency was understood more as guidance rather than oversight. The Finnish Transport and Communications Agency oversees the operation of the postal service by means of regular annual oversight, investigations and reports. The aim of the oversight measures is to correct identified problems as efficiently as possible (3324/2022).

During a cooperation meeting, the Social Insurance Institution of Finland (Kela) presented their internal oversight activities and the processing of administrative complaints to the Deputy-Ombudsman. In recent years, inspections have focused most on topics such as management, strategy and IT services. Kela strives to provide a written decision on administrative complaints within a target period of one month (1178/2022).

The Deputy-Ombudsman collects inspection reports from the courts of appeal on their oversight of sub-courts. From the perspective of the Ombudsman`s theme, observations made in the inspection protocols of the courts of appeal can be utilised for purposes such as targeting own initiatives and inspections (7785/2022).

Complaints

The Parliamentary Ombudsman investigates complaints concerning the procedures of primary supervisory authorities in the handling of complaints. These matters are often related to procedural errors in the handling of complaints, such as long processing times. In his decision, the Substitute Deputy-Ombudsman found that the processing time of a complaint in Valvira (almost two years) had been unreasonably long, and the processing had been delayed in violation of section 21 of the Constitution and section 23 of the Administrative Procedure Act (5855/2021).

The Deputy-Ombudsman found that a private care home for the elderly had acted unlawfully when carrying out care and treatment. The Deputy-Ombudsman emphasised the importance of the role of municipalities and Regional State Administrative Agencies in overseeing public and private units producing social welfare services. The Deputy-Ombudsman stated that she had no reason to disagree with the Regional State Administrative Agency's assessment of enforcement by the joint municipal authority, having found that the joint municipal authority had appropriately overseen the operation of the care home (5677/2021).

In her decision on disability services, the Deputy-Ombudsman emphasised that, as the authority responsible for organising the services, the city must oversee and ensure that the service provider's activities meet the requirements set for good social welfare and health care in legislation. The Deputy-Ombudsman considered that the city had neglected to oversee that the private service provider would be able to implement the procured service package in the first place. The Deputy-Ombudsman issued the city a reprimand for negligence in the organisation of services and the oversight of their implementation. As a result of the fundamental rights violation, the Deputy-Ombudsman proposed that the city consider paying compensation to the family (6084/2021).

The Deputy-Ombudsman found it good and important for the uniform practices of disability services that the Regional State Administrative Agency actively guides and oversees municipal procedures and practices in its area (1707/2021). In another decision, the Deputy-Ombudsman drew the joint municipal authority's attention to the fact that the authority must oversee and ensure that an outsourced service provider (transport service call centre) responds appropriately to service users' enquiries and messages (8942/2021).

In her decision on the organisation of student welfare, the Deputy-Ombudsman stated that, in the light of the annual theme, she will monitor the situation as the responsibility for organising student welfare services is transferred to the wellbeing services counties. In her future oversight of legality, the Deputy-Ombudsman will also pay particular attention to how the oversight of student welfare is implemented (8623/2021).

In his decision on the refusal to grant permissions to leave at the Riihimäki Prison, the Deputy-Ombudsman found it justified and important that the Regional Centre for the Criminal Sanctions Region of Southern Finland should pay attention to the uniformity of permit practices in training organised for prisons and at other occasions. The Deputy-Ombudsman found that, having transpired in a fairly short period of time, the significant change in the prison's practices with permissions to leave was a cause for concern, and in addition to the prison director, the Deputy-Ombudsman related his findings to the Regional Centre for the Criminal Sanctions Region of Southern Finland and the Criminal Sanctions Agency's Central Administration Unit so that they could take the necessary measures (7701/2021).

Own-initiative investigations

On her own initiative, the Deputy-Ombudsman investigated the procedure of church authorities in submitting reports on family relationships. As a result of the special theme, the Deputy-Ombudsman considered it justified to carry out four inspections on the oversight of legality related to this matter (Espoo diocesan chapter, Helsinki diocesan chapter, Turku archdiocese and the Church Council). One of the central themes of the inspection was the operation and tasks of the chapters under the oversight of the diocese parishes. The Deputy-Ombudsman found that the submission of official certificates had been delayed in a significant part of the regional centre registers in violation of good administrative practice and that the situation had been ongoing for quite a long time. At the same time, the chapters were found to have limited opportunities to oversee or influence the situation. The Deputy-Ombudsman also decided on her own initiative to investigate the activities of the chapters with regard to oversight (1849/2022).

In her decision on an own-initiative investigation of the implementation of room care for older people, the Deputy-Ombudsman expressed concerns about the rise of an operating culture during the pandemic in which the rights of vulnerable older persons who have difficulty expressing their own will are strongly restricted on the basis of various guidelines. The Deputy-Ombudsman drew attention to the need to take the problems raised in the report into account when reforming legislation and guidelines and when implementing oversight. For this purpose, the Deputy-Ombudsman sent the decision for information to the Ministry of Social Affairs and Health, the Finnish Institute of Health and Welfare (THL), the National Supervisory Authority for Welfare and Health (Valvira) and the Regional State Administrative Agencies (3360/2021). The annual theme also relates to another initiative of the Deputy-Ombudsman concerning the avoidance of restrictive measures and the preparation of national guidelines for the care and treatment of older persons (3014/2022). The decision is discussed in this report in section 4.13 on the rights of the elderly.

The national social welfare and health care monitoring programme for 2020–2023 by the National Supervisory Authority for Welfare and Health and Regional State Administrative Agencies had been supplemented as proposed by the Deputy-Ombudsman so that one of the targets of the monitoring programme was basic mental health and substance abuse services for children and young people (including mental health and substance abuse services by student health care). For this reason, the Deputy-Ombudsman no longer found cause for action in this matter (8501/2020).

The Deputy-Ombudsman took the initiative to investigate situations where a prisoner or a remand prisoner dies in prison. The purpose is to particularly investigate how the Prison and Probation Service of Finland monitors deaths, how they are investigated and what measures are taken to prevent them (2054/2022).

3.9 Complaints to the European Court of Human Rights against Finland

A total of 170 new applications were brought against Finland at the European Court of Human Rights (ECHR or the Court) in 2022 (91 in the previous year). A response from the Finnish Government was requested in two (3) cases. At the end of the year, 36 (16) cases concerning Finland were pending.

Complaints to the ECHR must be lodged using the form prepared by the ECHR Registry, and the requested information must be provided, along with copies of all documents relevant to the case. If an application is not properly filed, the case will not be investigated. The decision on the admissibility of an application is made by the ECHR in a single-judge formation, in a Committee formation or in a Chamber formation (7 judges). The Court's decision may also confirm a settlement, and the case is then struck out of the ECHR's list. Final judgments are given either by a Committee, a Chamber or the Grand Chamber (17 judges). In its judgment, the ECHR resolves an alleged case of a human rights violation or confirms a friendly settlement.

Most of the applications lodged with the ECHR are declared inadmissible. In 2022, a total of 150 (109) complaints concerning Finland were declared inadmissible or struck out of the case list. In 2022, the ECHR issued no judgments on Finland (one in 2020, and one in 2021).

The total number of judgments issued by the ECHR to Finland by the end of 2022 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 number of judgments in recent years has been very low every year.

3.9.1 SUPERVISION OF THE EXECUTION OF ECHR JUDGMENTS AT THE COMMITTEE OF MINISTERS OF THE COUNCIL OF EUROPE

The Committee of Ministers of the Council of Europe supervises the execution of ECHR judgments. 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 supervision process is based on legal analysis, but it is also political in nature. The parties to the ECHR supervise the execution of judgments in the form of peer support and pressure in legal-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 measures; 2) pilot judgments; 3) judgments that reveal 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 compensations 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 (complaint No. 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 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. The latter case is pending in the Supreme Court after it granted leave to appeal in the case (S2022/361, VL:2022-102).

No new cases became pending in the supervision process during the year under review. As was in the previous year, 18 pending judgements concerning Finland remained in supervision for their enforcement. Apart from the case mentioned above, these are cases in which the majority of national enforcement measures have been implemented, but in which the action reports are not fully completed. In all cases, the compensation ordered has been duly paid.

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 30 September 2022

OMBUDSMAN MR PETRI JÄÄSKELÄINEN decides on matters concerning:
- the highest organs of state
- questions involving important principles
- the police, the Emergency Response Centre and rescue services
- public prosecutor, excluding matters concerning the Office of the Prosecutor General
- legal guardianship
- language legislation
- asylum and immigration
- the rights of persons with disabilities
- covert intelligence gathering and intelligence operations
- the coordination of the tasks of the National Preventive Mechanism against Torture and reports relating to its work
- statements concerning the administrative branch of the Ministry of Justice

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

DEPUTY-OMBUDSMAN MR PASI PÖLÖNEN decides on matters concerning:
- courts, judicial administration and legal aid
- the Office of the Prosecutor General
- Criminal sanctions field
- distraint, bankruptcy and dept arrangements
- social insurance
- income support
- early childhood education and care, education, science and culture
- labour administration
- unemployment security
- military matters, Defence Forces and Border Guard
- data protecton, data management and telecommunications

Appendix 2
Division of labour between the Ombudsman and the Deputy-Ombudsmen from 1 October to 31 December 2022

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

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 decides on matters concerning:
- courts, judicial administration and legal aid
- Criminal sanctions field
- distraint, bankruptcy and dept arrangements
- taxation
- 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 3
Proposals for the development of regulations and instructions and for correcting errors

TO KELA

- Deputy-Ombudsman Pölönen and Valvira urged Kela to assess eye examinations carried out by non-health professionals and, in this context, also its own policies on the reimbursement of examination costs under the Health Insurance Act (4723/2021).
- Deputy-Ombudsman Pölönen drew attention to the need to update the social assistance benefit instructions. It could be justified for Kela to request the client's consent for issuing a decision using the information available before the deadline for submitting the additional information has expired if the client has clearly stated that they will not submit the additional information (5108/2021).

TO KOTKA'S IMMIGRANT WORK, KYMSOTE CHILD WELFARE SERVICES, ETC.

- Deputy-Ombudsman Sakslin proposed that, for example, immigrant work and child welfare – if necessary, together with the child's health and mental health services and education provider – prepare a cooperation plan for unaccompanied immigrant children who are in a particularly difficult position to prevent their exclusion and to safeguard the realisation of the child's rights (5155/2022).

THE MINISTRY OF TRANSPORT AND COMMUNICATIONS

- Parliamentary Ombudsman Jääskeläinen proposed specifying and revising the provisions on the right to appeal driving ban decisions (8085/2021).

TO THE MINISTRY OF JUSTICE

- Parliamentary Ombudsman Jääskeläinen proposed that the Ministry of Justice consider whether the Security Clearance Act should be specified with regard to the obligations of the Finnish Security and Intelligence Service in the acquisition of information from registers kept by foreign authorities (644/2021).
- Parliamentary Ombudsman Jääskeläinen sent his decision on the processing and legal nature of the police uniform camera recordings to the Ministry of Justice for information and proposed that the matter be referred to the working group preparing the update to the Act on the Openness of Government Activities in order to assess whether legislative measures are needed in the matter (2017/2021).
- Deputy-Ombudsman Pölönen stated that the Act does not provide for the possible primacy of estate settlement debts in relation to the debts of the deceased that are in debt recovery proceedings and that the enforcement authorities have the discretion on whether to give priority to the estate settlement debts in relation to the debts in the recovery proceedings and on which grounds. The Deputy-Ombudsman submitted his decision to the Ministry of Justice for information for the assessment of the need to amend legislation (7704/2021).

- Deputy-Ombudsman Pölönen brought to the attention of the Ministry of Justice the following observations related to the activities of the Criminal Sanctions Agency for legislative work:
  - The Remand Imprisonment Act does not contain provisions on matters to be taken into account in the remand prisoner's ward placement or on who has the authority to decide which ward the remand prisoner is placed in (2739/2022).
  - The Act does not contain provisions on reading messages received and sent by prisoners when communication takes place via the Internet. The Act only allows reading emails as well as text messages sent by mobile phone (7939/2021).
  - The Act does not contain sufficiently precise and clearly defined restrictions on whether the prisoner may delete text messages from the mobile phone in their use due to the preconditions of restricting fundamental rights and the legislative process. The prohibition on deleting text messages cannot be set as a condition for using the mobile phone (1328/2021).
  - Regulation on restricting the use of prisoners' own clothes in prisons or in their wards is open to interpretation and, in terms of its precision and clear definition, problematic. The term "limits" in the act does not mean a total ban, but rather, for example, a reduction or decrease (445/2021).
  - The power to decide to grant unsupervised visits to prisoners in different prisons is unclear. The decision on short-term transfers is made in the receiving prison. It is open to interpretation whether an application for an unsupervised visit is processed separately from this and who is competent in this case (8931/2021, 2860/2022).
- Deputy-Ombudsman Sakslin informed the Ministry of Justice of the following observation. After the complainant's spouse died, the children of the complainant's spouse remained alone in the custody of their other parent. The children had lived in the same family as the complainant for years. Under the law, the complainant did not have the right to apply to the District Court for the custody of the children. Yet, the case law of the ECHR also protects actual family life (7829/2021).

TO THE MINISTRY OF EDUCATION AND CULTURE

- Parliamentary Ombudsman Jääskeläinen proposed to the Ministry of Education and Culture to specify the provisions on the language proficiency requirements laid down in the Decree on the exemption of students (1493/2022, 2177/2022).
- Deputy-Ombudsman Pölönen proposed to the Ministry of Education and Culture that the equal right to early childhood education and care of children seeking protection in Finland should be safeguarded with legislative amendments (1992/2022).
- Deputy-Ombudsman Pölönen proposed that the Ministry of Education and Culture and the Finnish National Board of Education assess whether the legal protection of children and the equal right to education require that the content and organisation of intensified and special support be clarified in legislative terms and the national core curriculum for basic education be specified. The Deputy-Ombudsman also proposed that the need to clarify the provisions on the qualification requirements of teaching staff be assessed (3927/2021).
- In the matter of deciding on studies that are not tied to grades, Deputy-Ombudsman Pölönen presented the Ministry of Education and Culture and the Finnish National Board of Education with an assessment of the need to amend the Basic Education Act and Decree as well as the National Core Curriculum for Basic Education (4355/2021).

TO THE NATIONAL POLICE BOARD

- Parliamentary Ombudsman Jääskeläinen proposed a revision of the guidelines related to the enforcement of bans on business operations (7371/2021).
- Parliamentary Ombudsman Jääskeläinen proposed a revision of the instruction "Decision-making process in pre-trial investigation" (656/2021).
- The Parliamentary Ombudsman Jääskeläinen drew the National Police Board's attention to the delays in pre-trial investigations and asked the Board to continue to actively consider methods for speeding up pre-trial investigations and to take care of monitoring and supervising the duration of pre-trial investigations. In the Parliamentary Ombudsman's view, it should be assessed whether the legal regulation of prioritising investigations would have any benefits. In addition, the parties must have access to legal remedies if the pre-trial investigation is delayed. One possibility is to recompense for a violation of fundamental and human rights caused by a delayed pre-trial investigation, the possibility of which the authorities should actively provide information on (1510/2021).

TO THE MINISTRY OF SOCIAL AFFAIRS AND HEALTH

- The Ombudsman proposed taking legislative measures concerning the state-owned company FinnHEMS Oy, which carries out medical helicopter operations. According to the Ombudsman, the medical helicopter's activities concerned the performance of a public administrative task (7308/2021).
- The Ombudsman proposed that the regulation concerning the public administration duties of the state-owned alcohol company should be clarified in the Alcohol Act. The Ombudsman considered that decision-making procedure of Alko Oy concerning selection of alcoholic beverages for the assortment in retail outlets, removing them from the assortment in retail outlets, and their pricing to be a public administrative task (5474/2021).
- Deputy-Ombudsman Pölönen considered that Vahinkojaosto, an advisory section in connection with the Finnish Motor Insurers' Centre, participated in the implementation of the motor insurance system and in the performance of the public administration task with its statements. He brought to the attention of the Centre and the Ministry of Social Affairs and Health his opinion that the assignment of a public administrative task to Vahinkojaosto should not have been carried out without the legal provision entitling this (127/2021).
- Deputy-Ombudsman Sakslin stated that the legislation in force and the practices followed in voluntary psychiatric hospital care conflict with each other. Legislation should unambiguously and precisely specify what can be agreed in care agreements and under what conditions (1924/2021).
- In the view of Deputy-Ombudsman Sakslin, provision should be made for a situation in which 24-hour crisis accommodation should be provided and for whom, in order to safeguard the constitutional right to the necessary care. She drew the attention of the Ministry of Social Affairs and Health to the need to specify legislation (8646/2021).
- Deputy-Ombudsman Sakslin considered it problematic that restrictive measures are used in voluntary substance abuse services without the procedure being laid down in legislation. During the drafting of legislation, both methods for committing substance abusers to treatment and their legal protection when implementing services should be assessed (2686/2021).
- Deputy-Ombudsman Sakslin drew the attention of the Ministry of Social Affairs and Health to the fact that the legislation on the care guarantee should also apply to referrals made within specialised medical care (1224/2021).

- Deputy-Ombudsman Sakslin considered that the substitutability of medicines used for the treatment of generalised epilepsy concerned indirect discrimination as referred to in the Non-Discrimination Act and direct gender-based discrimination referred to in the Equality Act. She asked the Ministry of Social Affairs and Health to state what measures her decision had given rise to (7819/2021).
- The Ombudsman considered that the division of responsibilities between the state and wellbeing services counties in decision-making concerning medical helicopters should be clarified in separate legislative drafting. He considered it justified that decision-making on helicopter bases would be based on specific regulation. The Ombudsman proposed that legislative measures be taken (2635/2021).
- Deputy-Ombudsman Sakslin suggested that the Ministry of Social Affairs and Health would take steps to determine how the legislation should be specified with regard to the procedures for notifying quarantine and isolation decisions referred to in the Communicable Diseases Act (6200/2021).
- Deputy-Ombudsman Sakslin stated that the legislation did not provide an unambiguous answer to how patient data should be disclosed in a situation in which the documents did not indicate the child's decision-making capacity and opinion on the disclosure of the data to their guardian. She proposed that the Ministry of Social Affairs and Health take action to clarify the legislation (3723/2021).
- Deputy-Ombudsman Sakslin brought to the attention of the Ministry of Social Affairs and Health her observation that the child's right to receive psychiatric treatment intended for children with severe psychological symptoms in Finnish or Swedish on equal grounds does not appear to be realised. The treatment has only been centralised in Finnish-speaking units by decree (EVA unit / Tays and NEVA department / Niuvanniemi Hospital) (448/2021).
- Deputy-Ombudsman Sakslin proposed that the Ministry of Social Affairs and Health prepare instructions on child welfare support services for children and their parents during and after difficult custody disputes. The instructions had to take into account the court procedure to safeguard the independence of the courts. The Ministry of Social Affairs and Health had to contact the Ministry of Justice for this reason (4063/2022).
- Substitute Deputy-Ombudsman Sarja asked the Ministry of Social Affairs and Health to assess whether the duties of the mediator ordered for the implementation of the decision on the child's custody and right of access should include an obligation to submit a child welfare notification and whether the Child Welfare Act should be supplemented accordingly (7352/2021).

TO THE MINISTRY OF SOCIAL AFFAIRS AND HEALTH AND THE MINISTRY OF JUSTICE

- Deputy-Ombudsman Pölönen considered that the Health Care Services for Prisoners (VTH) could not impose binding instructions to prohibit patients and examination subjects from wearing their own clothes or take possession of their property. The Deputy-Ombudsman brought this to the attention of the Ministry of Justice and the Ministry of Social Affairs and Health for consideration in the drafting of legislation (6338/2021).

TO MINISTRY OF ECONOMIC AFFAIRS AND EMPLOYMENT AND SOUTHWEST FINLAND CENTRE FOR ECONOMIC DEVELOPMENT, TRANSPORT AND THE ENVIRONMENT

– Deputy-Ombudsman Pölönen asked the ELY Centre for Southwest Finland and the Ministry of Economic Affairs and Employment to report on the measures they had taken to deal with the secondary occupation matter in the ELY Centre's rules of procedure and the use of job titles (1006/2022).

TO THE FINNISH DEFENCE FORCES AND THE BORDER GUARD

– Deputy-Ombudsman Pölönen proposed that the Finnish Defence Forces and the Border Guard take measures to determine which authority is responsible for health care when conscripts participate in the entrance examinations of the Border Guard's special forces (46/2021).

Appendix 4
Inspections

#) = unannounced inspection

COURTS AND JUSTICE ADMINISTRATION

- 9 March National Court Administration (1329/2022)
- 12 May The Intelligence Ombudsman (2996/2022)
- 16 May The Consumer Disputes Board (1949/2022)

FINNISH PROSECUTION SERVICE

- 4 May The Prosecution District of Southern Finland, office in Vantaa (2188/2022)
- 8 December Office of the Prosecutor General (7478/2022)

POLICE ADMINISTRATION

- 2 February Finnish Security and Intelligence Service, document inspection of intelligence (592/2022)
- 9 March Helsinki Police Department (8615/2021)
- 4 May Eastern Uusimaa Police Department (2583/2022)
- 4 May Eastern Uusimaa Police Department, secret coercive measures and the resources used to acquire intelligence (3180/2022)
- 23 May Helsinki Police Station, Police Custody (3174/2022)
- 27 SeptemberTampere Main Police Station, detention facilities#) (5682/2022)
- 29 September Southwestern Finland Police Department, Salo Police Custody#) (4772/2022)
- 29 September Turku Main Police Station, Police Custody#) (4771/2022)
- 2 November Finnish Security and Intelligence Service (5702/2022)
- 7 November M/S Baltic Princess detention facilities (6559/2022)
- 8 November Emergency Response Centre Agency#), Åland Islands (6393/2022)
- 8 November Police Authority of Åland Islands, detention facilities in Mariehamn#) (6392/2022)
- 16 November National Bureau of Investigation (5818/2022)
- 12 December National Police Board of Finland (5819/2022)
- 8 December Police Authority of Åland Islands (6391/2022)

DEFENCE FORCES AND BORDER GUARD

- 10.2. Defence Command (408/2022)
- 24 March Defence Command military administration of justice, Inspection of documents (2014/2022)
- 12 October Coastal Fleet, detention facilities for persons deprived of their liberty (6123/2022)
- 12 October Navy Command (5666/2022)
- 12 October Coastal Fleet (5541/2022)
- 9 December Coastal Brigade (6638/2022)
- 9 December Coastal Fleet, unit at Upinniemi Base (7507/2022)
- 9 December Coastal Brigade, detention facilities for persons deprived of their liberty (7438/2022)
- 15 December Nuijamaa border control post, detention facilities#) (7489/2022)

CUSTOMS

- 24 November Customs (5667/2022)
- 7 December Customs, covert intelligence gathering, Document inspection (6157/2022)
- 7 December The detention facilities of the customs in Itä-Pasila (7326/2022)

CRIMINAL SANCTIONS

- 25-27 April Kylmäkoski Prison (1621/2022)
- 20 May Hämeenlinna Prison's operations in the Prison Hospital (2555/2022)
- 17 November Riihimäki Prison (5672/2022)
- 24 November Criminal Sanctions Agency (7020/2022)
- 1 December Ministry of Justice, Department for Criminal Policy and Criminal Law (7131/2022)

INDEBTEDNESS AND DISTRAINT

- 1 March Office of Director General (679/2022)
- 1 November Regional State Administrative Agency for Southern Finland, Oversight of debt collection agencies (4649/2022)

ALIENS AFFAIRS

- 23 May Reception centre for underage asylum seekers, group home Nuorten Isola[#)], Vantaa, JST Aves Oy (2874/2022)
- 23 May City of Espoo, group homes and supported housing services units[#)] (2873/2022)
- 30 May Lahti reception centre (3263/2022)
- 30 May Lahti reception centre, unit for intensified support (3235/2022)
- 31 May Tampere reception centre (3241/2022)
- 15 December Kouvola reception centre[#)] (7488/2022)
- 16 December Joutseno reception centre, detention unit (7487/2022)

SOCIAL WELFARE/PERSONS WITH DISABILITIES

- 30 June Eteva joint municipal authority, Lahti psychiatric unit for people with disabilities (1686/2022)
- 30 June Eteva joint municipal authority, Lahti psychiatric unit for children with disabilities (4119/2022)
- 7 October HUS Heart and Lung Center, Respiratory Paralysis Unit, Rekola group home, Vantaa (5196/2022)
- 22 November City of Vantaa, Ruusuhaka housing services unit (2816/2022)

SOCIAL WELFARE/ELDERLY UNITS

- 3 March Mehiläinen Hoivapalvelut Oy, Mainiokoti Andante[#)], in Espoo (1127/2022)
- 17 March Joint Municipal Authority for Health Care and Social Services Karviainen, Toivokoti, sheltered housing unit with 24-hour assistance, Karkkila (1128/2022)
- 31 March City of Vantaa, Special housing, Simonkylä Centre for the Elderly, Simonkylä nursing home 3, sheltered housing with 24-hour assistance, psychogeriatric unit, Vantaa (1129/2022)
- 23 May Sheltered housing unit with 24-hour assistance, Mehiläinen Mainiokoti Timantti[#)], Kaarina (2788/2022)
- 24 May Sheltered housing unit with 24-hour assistance for older people, Mehiläinen Mainiokoti Jussoila, Rauma (2787/2022)

- 5 May City of Vantaa, Simonkylä sheltered housing services#) (2317/2022)
- 18 August Valko nursing home, Loviisa#) (1130/2022)

HEALTH CARE

- 25-26 April Prisoners' health care unit, Kylmäkoski outpatient clinic (1623/2022)
- 20 May The Prison Hospital, the Medicine Dispensary, the Dental Clinic in the Prison Hospital (2555/2022)
- 7 June TYKS, Halikko Hospital#) (2431/2022)
- 13-15 June TYKS, Psychiatric wards (former Kupittaa Hospital)#) (2432/2022)
- 13 June TYKS, Turku joint emergency services' unit for emergency services for mental illness and addiction problems#) (3635/2022)

LABOUR AND UNEMPLOYMENT SECURITY

- 8 September The city of Vantaa, employment services (2596/2022)

EDUCATION AND EARLY CHILDHOOD EDUCATION

- 15 September City of Turku, Education Services (3521/2022)
- 15 September City of Turku, Mikael school (5690/2022)
- 11 October City of Rovaniemi, Education and Cultural Services (4778/2022)
- 11 October University of Lapland (4777/2022)
- 12 October Lapland University of Applied Sciences, remote inspection (4781/2022)
- 12 October Lapland Education Centre Redu, remote inspection (4780/2022)
- 15 November Finnish National Agency for Education (4759/2022)
- 7 December Ministry of Education and Culture (4760/2022)

THE CHURCH

- 2 June Espoo diocesan chapter (1955/2022)
- 3 June Helsinki diocesan chapter (1954/2022)
- 13 June Remote inspection visit: Turku archdiocese (1956/2022)
- 30 August Church Council (1957/2022)

OTHER INSPECTIONS

- 24 March Government ICT centre Valtori, remote inspection (1330/2022)
- 3 October The Finnish Transport and Communications Agency Traficom (3324/2022)

Appendix 5
Staff of the Office of the Parliamentary Ombudsman

Parliamentary Ombudsman

Mr Petri Jääskeläinen, LL.D., LL.M. with court training

Deputy-Ombudsmen

Ms Maija Sakslin, LL.Lic.
Mr Pasi Pölönen, LLD., LL.M. with court training

Secretary General

Mr Matti Marttunen LLD., LL.M. with court training (till 4 February)
Ms Riitta Länsisyrjä, LL.M. with court training (on fixed term 7 February - 30 April)
Mr Jari Råman, LL.D. (from 11 May)

Administrative assessor

Ms Astrid Geisor-Goman, LL.M. (since 1 October)

Principal Legal Advisers

Ms Terhi Arjola-Sarja, LL.M. with court training (on fixed term 1 May - 31 Dece)
Ms Riitta Burrell, LL.D. (on fixed term 1 September – 31 December)
Mr Mikko Eteläpää, LL.M. with court training
Mr Juha Haapamäki, LL.M. with court training
Mr Jarmo Hirvonen, LL.M. with court training
Mr Kristian Holman, LL.M., M.Sc. (Admin.)
Ms Lotta Hämeen-Anttila, M.Soc.Sc, LL.M.
Ms Kirsti Kurki-Suonio, LL.D.
Ms Ulla-Maija Lindström, LL.M. (till 30 November)
Ms Riitta Länsisyrjä, LL.M. with court training (till 30 November)
Mr Juha Niemelä, LL.M. with court training
Mr Jari Pirjola, LL.D., M.A.
Mr Pasi Pölönen, LL.D., LL.M. with court training (on leave)
Ms Anu Rita, LL.M. with court training
Mr Tapio Räty, LL.M.
Mr Mikko Sarja, LL.Lic., LL.M. with court training
Ms Iisa Suhonen, LL.M. with court training
Ms Kaija Tanttinen-Laakkonen, LL.M. (till 31 December)
Ms Minna Verronen, LL.M. with court training
Ms Susanna Wähä, M.Sc. (Admin.) (since 1 January)

Senior Legal Advisers

Mr Jukka Anttila, LL.M. with court training (since 1 August)
Ms Terhi Arjola-Sarja, LL.M. with court training (on leave 1 May – 31 December)
Ms Riitta Burrell, LL.D.
Ms Elina Castrén, LL.M. with court training (since 1 February)
Mr Peter Fagerholm, M.Sc. (Admin.) (since 1 January)
Ms Anne Ilkka, LL.M. with court training (since 1 December)
Ms Riikka Jackson, LL.M. (on leave 30 January – 8 December)
Ms Heli Karjalainen-Michael, LL.M. (since 1 October)
Ms Johanna Koli, M.Soc.Sc. (since 22 June)
Mr Juha-Pekka Konttinen, LL.M.
Ms Heidi Laurila, LL.M. with court training
Ms Anu Lempiäinen, LL.M. (since 15 August)
Ms Päivi Pihlajisto, LL.M. with court training
Ms Piatta Skottman-Kivelä, LL.M. with court training
Mr Matti Vartia, LL.M. with court training
Ms Leena-Maija Vitie, LL.M. with court training (since 1 August)
Ms Pia Wirta, LL.M. with court training

Legal Advisers

Ms Katja Harakka, LL.Lic., MBA (on fixed term 1 April – 31 December
Ms Sanna Hyttinen, LL.M. (on fixed term 1 September – 31 December)
Ms Niina Kolju, LL.M. (on fixed term 1 May – 31 December)

Ms Kristiina Kouros, LL.M (on fixed term 1 January – 30 September)
Mr Petri Lehtonen, LL.M (on fixed term 1 May – 31 December)
Ms Minna Mättö, LL.M. with court training (on fixed term 10 January – 31 May)
Ms Johanna Rantala, LL.M. (on fixed term 11 April – 31 December)
Ms Marika Riekki, LL.M, VT (on fixed term 18 August – 31 December)
Ms Leena-Maija Vitie, LL.M. with court training (on fixed term 1 January – 31 July)

On-duty lawyer

Ms Jaana Romakkaniemi, LL.M. with court training

Information Officer

Ms Citha Dahl, M.A.

Information Management Specialist

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

Investigating Officers

Mr Joel Hyväri, M.Sc. (Admin.) (on fixed term 1 January – 31 March)
Mr Reima Laakso
Mr Antti Perälä, B.Sc. (Admin.), Bachelor of Police Services (since 19 April)

Notaries

Ms Sanna-Kaisa Frantti, B.B.A.
Ms Taru Koskiniemi, LL.B.
Ms Kaisu Lehtikangas, M.Soc.Sc.
Ms Eeva-Maria Tuominen, M.Sc.(Admin.), LL.B.
Ms Riina Tuominen, M.Sc. (Admin.)

Administrative secretary

Ms Eija Einola

Filing Clerk

Ms Anu Forsell (on fixed term 1 September – 31 December)
Ms Anna-Liisa Tapio (on leave 1 September – 31 December, till 31 December)

Assistant Filing Clerk

Ms Anu Forsell

Case Management Secretary

Ms Ira Nyberg Ira (since 1 January)
Mr Taneli Palmén, M.A., B.A.

Departmental Secretaries

Ms Andrea Bergman, M.A. (on leave 20 August – 20 December)
Ms Anja Mattila-Lempinen (on fixed term 1 April – 31 December)
Ms Mervi Stern (till 31 August)

Assistant for International Affairs

Ms Tiina Mäkinen

Office Secretaries

Ms Minna Haapaniemi (on leave since 1 December
Ms Johanna Hörkkö-Petroff
Mr Mikko Kaukolinna
Ms Krissu Keinänen
Ms Virpi Salminen
Ms Riikka Saulamaa (on fixed term, part-time, since 7 December)

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 since 18 March)
Mr Mikko Joronen, M.Pol.Sc. (on leave since 15 March)
Ms Kristiina Kouros, LL.M. (till 30 September)
Ms Leena Leikas, LL.M. with court training
Mr Nitin Sood (on fixed term since 15 September)
Ms Susan Villa, M.Soc.Sc.

Junior experts

Ms Jasmin Airinen, M.Sc. (Health Sci.) (on fixed term 1 July – 31 December)
Mr Rasmus Johnson, LL.M., LL. B. (on fixed term 20 June – 31 December)
Ms Elsa Korkman, LL.M., LL. B. (on fixed term 1 February – 31 July)
Ms Emmi Kupiainen, LL.M, LL.B (on fixed term since 1 March)
Ms Sanni Myllyaho, M.Pol.Sc. (on fixed term since 1 February)

Assistant expert

Ms Emmi Kupiainen, LL.M, LL.B (on fixed term 1 January – 28 February)

Assistants

Ms Minna Haapaniemi (on fixed term since 1 December)
Ms Katariina Huhta (on leave since 1 December)

Appendix 6
Statistical data on the Ombudsman's work in 2022

OVERSIGHT-OF-LEGALITY CASES UNDER CONSIDERATION

CASES INITIATED IN 2022	6,817
Complaints to the Ombudsman	6,512
Complaints transferred from the Chancellor of Justice	101
Taken up on the Ombudsman's own initiative	47
Submissions and attendances at hearings	157

CASES RESOLVED	7,072
Complaints	6,814
Transferred to the Chancellor of Justice	43
Taken up on the Ombudsman's own initiative	47
Submissions and attendances at hearings	168

OTHER MATTERS UNDER CONSIDERATION	1,198
Inspections	76
Administrative matters in the Office	1,107
International matters	15

RESOLVED CASES BY PUBLIC AUTHORITIES

COMPLAINT CASES	6,857
Social welfare	1,017
Health	940
Police	849
Criminal sanctions field	633
Other administrative branches	453
Social insurance	364
Administrative branch of the Ministry of Education and Culture	315
Highest organs of government	290
Administrative branch of the Ministry of Economic Affairs and Employment	275
Administration of law	257
Local government	233
Enforcement (distraint)	179
Administrative branch of the Ministry of Environment	175
Administrative branch of the Ministry of Transport and Communications	156

Administrative branch of the Ministry of Justice	107
Taxation	104
Guardianship	96
Aliens affairs and citizenship	93
Administrative branch of the Ministry of Finance	80
Prosecutors	67
Administrative branch of the Ministry of Agriculture and Forestry	66
Administrative branch of the Ministry of Defence	49
Customs	22
Administrative branch of the Ministry of the Interior	20
Administrative branch of the Ministry for Foreign Affairs	16
Subjects of oversight in the private sector	1

Taken up on the Ombudsman's own initiative	**47**
Social welfare	14
Health	12
Police	7
Administrative branch of the Ministry of Education and Culture	4
Administrative branch of the Ministry of Transport and Communications	2
Administrative branch of the Ministry of Economic Affairs and Employment	2
Guardianship	1
Administration of law	1
Administrative branch of the Ministry of Justice	1
Criminal sanctions field	1
Taxation	1
Administrative branch of the Ministry of Finance	1

Total number of decisions	**6,904**

MEASURES TAKEN BY THE OMBUDSMAN

COMPLAINTS	**6,857**
Decisions leading to measures	**932**
– prosecution	0
– assessment of the need for pre-trial investigation	4
– reprimands	24
– opinions	597
– as a rebuke	396
– for future guidance	201
– recommendations	55
– to redress an error or rectify a shortcoming	3
– to develop legislation or regulations	31
– to provide compensation for a violation	21
– to rech an agreed settlement	0
– matters redressed in the course of investigation	32
– other measure	220
No action taken	**3,150**
– no incorrect action found	197
– no grounds	2,953
– to suspect illegal or incorrect procedure	1,520
– for the Ombudsman's measures	1,433
Complaint not investigated	**2,773**
– matter not within Ombudsman's remit	231
– still pending before a competent authority or possibility of appeal still open	841
– unspecified	467
– transferred to Chancellor of Justice	43
– transferred to Prosecutor-Genera	6
– transferred to Regional State Administrative Agency	86
– transferred to ELY Centre	1
– transferred to other authority	254
– older than two years	128
– inadmissible on other grounds	38
– no answer	160
– answer without measures	518

MEASURES TAKEN BY THE OMBUDSMAN

TAKEN UP ON THE OMBUDSMAN'S OWN INITIATIVE	**47**
Decisions leading to measures	**35**
– prosecution	0
– assessment of the need for pre-trial investigation	0
– reprimands	3
– opinions	21
– as a rebuke	9
– for future guidance	12
– recommendations	6
– to redress an error or rectify a shortcoming	2
– to develop legislation or regulations	3
– to provide compensation for a violation	1
– to rech an agreed settlement	0
– matters redressed in the course of investigation	2
– other measure	3
No action taken	**7**
– no incorrect action found	1
– no grounds	6
– to suspect illegal or incorrect procedure	2
– for the Ombudsman's measures	4
Own initiative not investigated	**5**
– no answer	5

INCOMING CASES BY AUTHORITY

Social welfare	997
Police	821
Health	751
Criminal sanctions field	672
Other administrative branches	449
Social insurance	394
Highest organs of government	271
Administrative branch of the Ministry of Education and Culture	269
Administration of law	265
Administrative branch of the Ministry of Economic Affairs and Employment	264
Local government	235
Enforcement (distraint)	194
Administrative branch of the Ministry of Environment	159
Administrative branch of the Ministry of Transport and Communications	141
Taxation	116
Aliens affairs and citizenship	110
Administrative branch of the Ministry of Justice	106
Guardianship	94
Prosecutors	70
Administrative branch of the Ministry of Finance	66
Administrative branch of the Ministry of Agriculture and Forestry	64
Administrative branch of the Ministry of Defence	48
Customs	24
Administrative branch of the Ministry of the Interior	18
Administrative branch of the Ministry for Foreign Affairs	14
Subjects of oversight in the private sector	1

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