Annual Report 2023

(Excerpts)

THE ALTHINGI
OMBUDSMAN

Contents

Published by
The Althingi ombudsman
Reykjavík
2024

Design & layout
Kolofon

Typefaces
Trade Gothic
Tuna

ISSN
2988–9995

Introduction by the Ombudsman[1]

1.1

Unity and co-ordination within the executive system

While the state is, under the constitution, a single and undivided entity with a single set of laws, the application of those laws by the executive falls to various public authorities, their responsibilities being limited to specific tasks, administrative levels or geographical areas. Article 14 of the Constitution states clearly that ministers are responsible for all administrative actions; under Article 11, by contrast, the president may not be held accountable for executive acts. Thus, ministers are in fact regarded as the highest-ranking executive officers, with ultimate responsibility for the application of the law and, consequently, no instance of the exercise of executive power lies outside ministerial responsibility.

The Constitution provides for the ministers' dividing tasks between themselves; in practice, however, their portfolios reflect the existing allocation of responsibilities between the various ministries at any given time. Under the Government Ministries Act, one of the main tasks of the prime minister is to ensure that the division of tasks within the cabinet, i.e. between different ministers, is as clear as possible. In the event of doubt or disagreement regarding the division, it is up to the prime minister to resolve the issue. The prime minister is also to ensure, where necessary, cohesion and harmonisation between the policies and actions of the various ministers in their respective areas. The law nevertheless prescribes that ministers themselves are to strive to coordinate the polices and functions of their ministries in cases where there is some overlapping between their fields of responsibility. Thus, while supreme executive power is invested in individual ministers, each of whom is accountable to the Althingi under the constitution, the executive is to function as a coordinated whole under the leadership of the prime minister. It follows that government ministers and their ministerial staff are the cornerstones of the executive system.

It is when a matter appears to fall under the purview of more than one ministry, or to lie outside the scope of any one of them, that collaboration and coordination between ministers is put to the test. It would be incompatible with constitutional principles for entities within the executive system to try to shift responsibility to another part of the system, or for no single authority

[1] This is a translation of the authentic Icelandic version which, in case of possible discrepancies, takes precedence.

to accept real responsibility for legislation that is intended to ensure specific rights for citizens. The same applies if there is no entity within the system that regards it as being its task to take appropriate measures to tackle an imminent challenge or problem, e.g. by adopting a policy and preparing draft legislation, or by issuing regulations. In the light of this, it need come as no surprise that the ombudsman has repeatedly brought up issues where collaboration and co-ordination of public agents is under the microscope.

At the beginning of 2023 I found reason to open an own-initiative investigation into a case which directly concerned collaboration between ministers within the cabinet. The background to the case was the issue of new rules by the minister of justice which expanded the power of the police to use electroshock weapons ('stun guns'). According to reports in the media, the minister had issued the new rules without consulting the prime minister or other members of the cabinet. In my subsequent correspondence with the prime minister, she expressed the view that the new rules had constituted a 'change of emphasis'. From this I inferred that the PM considered the new rules to have been an 'important government measure' in the sense that this term is used in the Constitution, which therefore should have been brought up in the cabinet prior to their promulgation.

Relations between ministers, particularly in a multi-party government, are essentially of a political nature and therefore lie outside the ombudsman's mandate. My concluding remarks on the case, in a letter to the PM, were therefore limited to noting that these relations nevertheless took place within a certain legal framework. I emphasised that any failure by ministers to observe these rules not only constituted a breach of strict formality but also undermined political consultation within the cabinet as provided for by the law and the Constitution. It was therefore of great importance that the cabinet ministers faithfully observed these rules and also kept in mind their aims. In this regard I said the following in my letter:

> *It could be expected that working procedures of this type would also mean that ministers would not find themselves exchanging opinions in public, as has happened in the present case, and that the public's image of the government would be one of a team of managers working together as one. This is therefore an issue with implications for whether citizens are able to trust that the government, at its highest level, will tackle matters professionally and with due deliberation.*

As I have pointed out before, the lack of collaboration and coordination within the public administrative system is not restricted to its supreme executive officers, i.e. cabinet ministers and their ministries. An example of another type is

the question of access by prisoners to emergency psychiatric units. It is clear from these cases that the lack of coordination between the prison administration and the healthcare system can result in the risk that individuals will not be given the health care they are entitled to by law. If the institutions in question, in this case the National Hospital and the Prison Service Agency, are not able find an acceptable solution on their own, as seems repeatedly to be the case, then the ministries and, perhaps, the ministers themselves, need to become involved. If all else fails, it is up to the PM to coordinate the workings of the ministers and their ministries with a view to ensuring the smooth and seamless application of the law.

If appropriate collaboration is lacking at the ministerial level, it cannot be expected that the ministries and subordinated institutions will be acting differently. Rather, it may be expected that the problem will 'trickle down the silos' of the government structure, with the risk that citizens' legally protected interests will be left in a no-man's land. Given such a state of affairs, there is also the risk that government actions, such as policymaking and the drafting of legislation, will not be based on adequate overall assessments. There is no need to reiterate that such a scenario is contrary to the rationale of the constitution, as has been mentioned above. Those who work within the administration, be it at a low or a high level, should in my opinion bear in mind that no government agency is an island, but rather a part of system which has been entrusted with upholding the laws of the land.

1.2 Supervision and surveillance by ministers

Another prerequisite for the efficient functioning of the law is the satisfactory supervision and surveillance by ministers of administration in the state bodies under their ministries. If this is lacking over long periods, a situation may develop where a state body comes to operate largely on its own terms without due regard to other parts of the administrative system. It should be impossible, under the constitution, for such 'autonomous entities' to exist, yet various cases dealt with by the ombudsman indicate weaknesses within the system in this regard.

It should be noted here that ministerial supervision and surveillance can take many different forms according to the matter at hand and the nature of the subordinated state body in question. This is a corollary of the executive system's being based on law, which means in turn that state bodies are of various types and have different functions as specified by law. Any involvement by a minister on the basis of his supervisory or surveillance powers must therefore respect the nature and responsibilities of the subordinated state agent as determined by law. Consequently, the scope for intervention may be considerably limited, particularly as regards decisions in individual instances. Nevertheless, even in the case of more or less independent admin-

istrative bodies, at the end of the day it is always the minister who is directly accountable to the Althingi, under the constitution, for the application of the laws that come under his or her ministry.

The powers and remedial measures available to ministers for supervision and surveillance of the matters under their portfolios are set out in further detail in the Government Ministries Act. However, these provisions are framed in general terms and entail mainly a codification of unwritten constitutional rules relating to ministerial functions. When considering practical cases and further interpretation of these statutory provisions, this constitutional basis has therefore to be kept in mind. To put it simply, however, this set of rules indicates that a minister is never able to say without reservation that a systemic problem relating to a state body under his mandate is none of his business.

Although the ombudsman regularly deals with cases which in one way or another touch upon the obligations of ministers (and their respective ministries) to supervise and surveil the public administrative sector, I find it appropriate to recall in particular one case from October 2023 which concerned the impartiality of the minister of finance and economic affairs when, in April that year, he took the final decision, on behalf of the state, on the sale of 22.5% of the shares in Íslandsbanki hf., a state-owned bank. It was undisputed in the case that when the minister took this decision, a company in the ownership of his father was one of the bidders. It was my conclusion on this aspect of the case, which there is no need to discuss in further detail here, that in doing this, the minister breached rules of administrative law pertaining to impartiality and conflicts of interest. Given this, however, the question remained why the bidding procedure preceding the sale had been organised in such a way that the minister had been exposed to the risk of unknowingly breaching these rules – a risk that had materialised, judging by the facts of the case. In this regard I recalled that the minister had repeatedly stated that the case would serve as lesson for the future, which I understood to mean that he considered the chain of events at least as something unfortunate.

It was clear from the case file that following the ministerial decision to initiate the procedure to sell the 22.5% share in the bank, Icelandic State Financial Investments (ISFI, the state agency responsible for its holdings in the banks) had been the principal actor in preparing and implementing the sale procedure. As the part played by the ISFI had been examined in a report by the auditor-general to the Althingi in autumn 2022, my attention was directed rather to the obligations of the ministry and its interaction with the ISFI. In this regard there was in principle no dispute about the sale's coming under the minister's mandate or that, in terms of the constitution, he was therefore responsible for it. Nevertheless, in his correspondence with me, the minister repeatedly referred to the nature and the legal functions of the ISFI. I under-

stood these references to mean that he had not considered it his role, or that of his ministry, to observe whether, and how, rules pertaining to impartiality were applicable to the organisation of the sale procedure. As I stated in my opinion on the case, I did not concur with this view:

> *In conformity with the general obligation of public authorities to respect the limits of their powers, the minister [...], when interacting with the ISFI, was to have due regard to its functions and tasks as determined by law. According to the law it was, for instance, for the ISFI, and not the minister, to take a certain initiative on the sale of the state-owned shares in Islandsbanki hf. and to implement proposals for the sale after obtaining the consent of the minister. Furthermore, when issuing any directions to the ISFI, the minister was to observe any limitations or instructions which followed from the applicable law. In my opinion this, however, did not alter the general obligation of the minister to observe whether the actions of the ISFI were in line with the law and good administrative practice. [/] All in all, I am compelled to conclude that it was part of the minister's duties to observe, as far as possible, whether and how the planned sales procedure satisfied the requirements of the rules pertaining to impartiality.*

In fact, my investigation into the case did not reveal that the ministry of finance and economic affairs had, during the preparation of the sale, at any time paid attention to issues concerning impartiality, for example by asking the agency how the proposed sales procedure would satisfy legal requirements in this regard. In view of this, it was my conclusion that the minister's actions had not been satisfactory in view of his legal and constitutional obligations to supervise administration under his mandate.

I mention this case here as one example of the consequences of what may happen if ministers and ministries do not fulfil their duties regarding supervision and surveillance of the administrative functions under their mandate. As is demonstrated by this case, a subordinated public agency may end up running, in a sense, "on autopilot". The other side of this coin is that certain state agencies lack the means needed to carry out their tasks in a satisfactory manner, sometimes without the ministry being fully aware of the problem or having taken any action to deal with it. From 2023 I can recall as an example of this my investigation into the reactions of the ministry of health with regard to delays at the directorate of health, sometimes running to years, in the processing of complaints – a case I closed with a letter to the ministry in May this year. I may also refer to several recommendations to ministries submitted in reports concerning the circumstances of persons deprived of their liberty, issued by the OPCAT unit of my office. While the Íslandsbanki

case made headlines in the media at the time, it was, in my opinion, first and foremost symptomatic of a more general weakness in public administration, and in particular at its highest level, i.e. in the ministries.

1.3 Complaint and appeal committees are executive authorities

In past annual reports, the ombudsman has discussed the trend over the past few decades in which supervision and surveillance of the executive has to some extent been taken out of the ministries and entrusted to complaint and appeal committees, which in turn are expected to function more or less independently. Thus, these committees are generally expected to take the place of the ministries regarding decisions that have been taken at the lower administrative levels. Some exceptions from this arrangement, in the form of appeal committees that are specially created to deal with private-law disputes between citizens, need not concern us here.

Regarding this trend, mention has been made in previous reports of the challenges involved in establishing the boundaries between the powers that the individual ministries have for carrying out supervision and surveillance. Concern has also been voiced regarding the danger of a tendency for ministries to wash their hands of responsibility where these boundaries are not clear with regard to supervision of the subject-matter in question. Broadly, this refers to situations in which a particular ministry may tend to take the view that certain matters are no longer its concern once an independent appeals committee has been established. The adoption of appeals and complaint committees for this purpose has also led to questions regarding how the committees themselves are appointed and how they function.

The main aim of establishing an appeals committee is usually to ensure that matters will be in the hands of an independent authority with the means to examine and resolve the issue objectively and professionally under the law. The committees are generally composed of qualified lawyers together with experts in the field relevant to the matter under examination. In practice, with few exceptions, the committees are under the chairmanship of a lawyer, who sometimes is required to meet the conditions for appointment as a district court judge. Understandably, for various reasons, lawyers who sit on these committees will to some extent be under the influence of civil law procedure; this applies particularly to those who have worked in the courts, either as judges or attorneys. It should also be mentioned that, up to now, cases involving administrative actions that have been brought before the courts have been heard according to the Code of Civil Procedure without any special rules governing these cases, e.g. as regards the adversarial principle and the power of the judge to gather evidence on his own initiative. Indeed, some of the basic principles of private law, for example regarding equality of status between the parties and the right to be heard,

may at first glance appear to be well suited to the handling of these cases by the complaints and appeals committees.

I think it appropriate to point out that while the committees certainly have some features in common with special courts, and even seem to play the same role in society as special courts do in other countries, they are nevertheless part of the executive. Consequently, they are bound to comply with the Administrative Procedure Act and the unwritten principles of administrative procedure unless they are subject to other provisions in special legislation. From this, it follows that some of the principles of civil law procedure are not at all applicable to procedure before the complaints and appeals committees. Consequently, if a case is brought before an appeals committee that is too greatly influenced by the principles of civil law procedure, the result may be that the committee will fail to discharge its role according to law. The unity of the administrative system may also be jeopardized if appeals committees define their roles too narrowly, with the result that overall supervision and control by a higher authority is lacking in a particular field.

It is important here to recall that there is a fundamental difference between civil law procedure before a court, on the one hand, and the procedure in administrative cases, on the other. Thus, in an administrative case the adversarial principle does not apply, which in turn implies that authorities, including appeals committees, are, unlike a civil law judge, under an obligation to make their own independent investigations. Hence, in administrative proceedings, it would be for the authority, and not the parties, to have the final say on whether a case has been fully investigated. Another fundamental difference is reflected in the lack of any obligation by the parties in administrative proceedings to disclose evidence. Therefore, if a new argument, or new evidence, is submitted to a hearing at a higher administrative level, it is admissible even though the party in question could possibly have submitted it earlier. In such circumstances, it would be for the higher authority to decide whether it is necessary to repeat the procedure by the lower authority or whether the issue can be resolved at the appeal level, taking into account new factors presented by the party.

Like other executive authorities, appeals committees are also under a far greater obligation to provide guidance to the parties than are judges in civil law proceedings. This must be borne in mind when an appeals committee decides to 'dismiss the case', as this wording means, in effect, that a citizen's case has been closed without the committee having adopted any position on its merits. In the harsh environment of civil law procedure, the parties to a case simply have to accept the conclusion reached by the court, including the reasoning on which it is based. However, such a situation is not always acceptable to those who seek redress of their position within the executive system.

In this connection I wish to recall a case from last year in which the welfare appeals committee had dismissed a case concerning the rejection by the Hafnarfjörður family and children's department of an application for special housing support. The committee cited as its reason the fact that the applicant should first have had the case examined by the municipal family council. In other words, the appeals committee took the view that as no final decision had been taken by the municipal authority, the committee was unable to examine the substance of the case at the appeal level. The applicant then tried to submit the case to the municipal family council so as to obtain a final decision at the municipal level. However, the municipal family council dismissed the case, saying the complaint had not been submitted within the applicable time-limit. The applicant then submitted an administrative appeal to the appeals committee. In its discussion of this new appeal, the committee upheld the dismissal by the family council, referring to the fact that the four-week window for appealing against the original dismissal had been closed when the applicant approached the council. In this new ruling, the committee therefore did not adopt a substantive position on the case any more than it had done in the previous one. The committee based both its rulings on the fact that no final decision had been taken on the matter by the competent authority at the municipal level. At no stage of the case, however, had the committee regarded it as its responsibility to take steps to have the case pass through the proper channels at the municipal level so that a lawful decision could be obtained. Consequently, the applicant was in the position of having no means of having a review made of any substantive conclusion reached by the municipal family and children's department, either at the municipal level or at a higher administrative level.

In my opinion on this case I discussed, amongst other things, the role of the welfare appeals committee in ensuring the effective protection of individuals' rights and the demands that should be made of the committee in this connection. I expressed the view that when it first discussed the matter, the committee should not have simply been content to dismiss the case on the grounds that no final decision had been taken by the municipality; instead, it should have discussed the legal status of the case within the municipality, i.e. whether it should be re-examined at the municipal level, and if so, how this should be done. In my view, this should have resulted in a substantive conclusion at the municipal level, which the applicant could then have referred to the appeals committee. My conclusion, however, was that in fact, that the applicant did not enjoy the protection under the law that is assumed in legislation.

It should be noted that the specific rules under which an appeals committee functions, and also the nature of the case, may involve certain variations on, and even deviations from, the ordinary procedures of administrative law. Those who sit on appeals committees, however, must, even under such

circumstances, bear in mind that they are exercising the role of a higher-level executive authority, with all the responsibilities for surveillance and ensuring protection of rights under the law that this implies. A situation where the ordinary citizen can fall through cracks in the system, as in the case discussed above, is incompatible with such a view.

1.4 Are appeals committees expected to act on the ombudsman's recommendations?

The ombudsman is not a regulator; he is not able to issue binding instructions on any government entity, either in general or in individual cases. Consequently, the ombudsman's resolutions are always presented as opinions, containing suggestions and recommendations to the authorities, pointing out how they can redress the position of someone whom he considers has been the victim of unjust treatment in the administrative system. Thus, the impact of the ombudsman's resolutions on the administrative sector will depend entirely on whether the authorities respect and act on these suggestions and recommendations. Obviously, a precondition for their doing so is that the ombudsman's conclusions must be well reasoned; in consequence, his opinions generally contain meaty legal arguments that are set out in detail and at length – too much so, for some people's taste! This is necessary, however, if his opinions are to have an effect. Unclear or sketchy reasoning would reduce their credibility and, consequently, undermine the likelihood that the authorities will act on his suggestions.

Experience shows that in the great majority of cases, the authorities do accept, and act on, the ombudsman's recommendations, and in this, his position is similar to that of the parliamentary ombudsmen in the other Nordic countries. In those exceptional instances where the authorities do not act on the ombudsman's recommendations, there is little he can do about it. Naturally he monitors what happens in response to his opinions (and letters and reports) and is able to ask for explanations from authorities where they have not acted on them. In the case of subordinate authorities, he may ask the ministry responsible for its view of the situation, and whether it intends to make any response. On the other hand, where an authority chooses not to heed the ombudsman's recommendations, and gives reasons for this position, then he is able to do little other than bring the matter to the attention of the Althingi. He is also able to recommend that individuals who intend to take their cases to court be granted legal aid.

It should be noted that when it comes to administration by the ministries, the Althingi has clearly-defined authority to investigate and take action, since the ministers are both legally and politically answerable to parliament. Generally, this also applies in the case of subordinate bodies, i.e., the Althingi can intervene directly in cases involving those bodies through the minister

responsible for the matter. On the other hand, the position of the Althingi and whether or not it can exercise its surveillance of the administration is not quite so clear when it comes to entities that are, by law, more or less independent vis-à-vis the minister. These include, for example, appeals committees, which are intended to be independent and are therefore neither legally nor politically responsible to the Althingi.

I mention all this here in connection with two cases that involved the environment and natural resources appeals committee. In one of them, which was concluded in 2022, the committee had upheld a decision by a municipal construction officer to halt the construction of a residential building on the grounds that it did not conform to the conditions of the local area plan and the revised plans for the building. The facts of the case were that the municipality had issued a construction licence for the building, but the construction officer later decided that the plans, which had been approved, were not in conformity with the local area plan. He then took the initiative on having new plans for the building drawn up and the construction licence amended to correspond to the new plans. In my opinion, I pointed out that it was the responsibility of the appeals committee to establish whether these changes had been made in a lawful manner so as to constitute a lawful basis for halting construction of the building. The point was that the holder of the construction licence claimed, during the hearing of the case, that he had not approved the amendments to the plan on which the municipality's decision to halt the construction had been based. My conclusion was that the committee had failed to take this into account in its examination. I therefore recommended that the committee re-examine the case, if it were requested to do so, and to resolve it in accordance with the considerations set out in my opinion. When I followed up the case last year, I found that the committee had nevertheless rejected an application from the holder of the construction licence for a re-examination of the case.

The other case, which was also concluded in 2022, involved the same appeals committee and a dispute concerning the enlargement of a parking garage in a multi-owner building. The municipality had ruled that no construction licence was needed for this project; all that was required was that the modifications be reported to the municipality. The complainant argued that this project resulted in a change in the utilisation of the building. The appeals committee, however, did not consider this aspect at all, but concentrated instead only on the modifications to the building. In my opinion I pointed out that the work on the garage had, from the outset, been aimed at changing the purpose for which the garage was used, i.e., conversion into a space for habitation. There was nothing in the case documents to indicate that the municipal authorities had adopted a position on whether this had in fact been the case. My conclusion was therefore that the committee had not been in a proper position to rule that the municipality's examination of the matter,

and its decision as to whether or not a construction licence was needed for the work, had been satisfactory. In the light of this, my opinion was that the committee's examination of the case was flawed. I therefore recommended that the committee re-examine the matter, if it were asked to do so, and then to resolve it in accordance with the considerations set out in my opinion. When I checked on the progress of the matter last year, however, I learned that the committee had decided not to comply with these recommendations.

In my report for the year 2022 I discussed the danger of a tendency for the ministries to dodge responsibility as soon as surveillance functions are transferred to independent appeals and complaints committees. In my view, the uncertainty regarding the powers of the Althingi vis-à-vis such committees is another manifestation of this problem, one that also may have indirect implications for the role of the ombudsman in dealing with the executive sector. In the two cases I have described above, it must be assumed that the ministry in charge of this branch of the executive had had only limited powers of intervention. This in turn means that it would have served little purpose if the Althingi's constitutional and supervisory committee had called on the minister in question to explain why the ombudsman's recommendations in these cases had not been followed.

Unlike government ministers, those who sit on appeals and complaints committees of the type in question are neither legally nor politically accountable towards the Althingi. In the light of the standing of such committees, as defined in law, it is therefore by no means certain that it would be appropriate to summon their members before a meeting of a parliamentary committee and have them explain their actions.

It has not so far happened that an independent government entity – an appeals committee, in this case – has systematically refused to comply with recommendations from the ombudsman. If this situation were to arise, an appropriate response by the ombudsman, and possibly by the Althingi, would depend on the circumstances. On the other hand, I would regard it as unfortunate if legislation providing for the independence of an appeals committee were to lead to a weakening of the power that the Althingi has conferred on the ombudsman to guarantee the rights of the citizenry vis-à-vis the executive. I think this is something that the members of appeals and complaints committees should bear in mind.

1.5 Use of legally-prescribed emergency remedies

The fundamental role of the state is generally seen as serving the public good. Within the Althingi, there will naturally be differences of opinion as to what form the public interest takes, both in general and in particular instances. Once these political disagreements have been resolved with the enactment of legislation according to the rules of the Constitution, however, then it is up

to the executive to implement the laws enacted. Thus, the executive is bound by law, and all actions taken by the administrative organs must have a basis in law and be in conformity with the law. Not least for this reason, there are limits to the extent to which the legislature is able to delegate to executive entities the power to make rules. In times of unforeseen and pressing circumstances, however, even this cornerstone of the rule of law may have to be set aside in a certain sense.

If an executive entity lacks an express basis in law to respond to such circumstances, or is hindered from responding by the current rules, then it is not impossible that 'necessity will justify breaking the law'. Obviously, caution must be employed when assessing when an entity is able to act in such a way, perhaps even involving the curtailment of citizens' constitutional rights. Bearing in mind the general considerations discussed above, situations of this type would have to entail an imminent and serious threat to important interests of the community, e.g. to the life and health of individuals, or their security, or to vital infrastructure. In addition, the circumstances must be such that there is not time for the entity in question to obtain, before acting, the necessary authorisation under legislation from the Althingi. An entity that takes measures on the basis of such emergency circumstances is therefore obliged to act as quickly as possible to restore the situation to the norms of the constitution by referring any points of doubt to the legislature. This will be done in recognition of the principle that it is up to the legislature, and not the entity involved, to assess the best way of securing the public interest in the light of specific circumstances, and to have the last word on the matter.

There have not been many instances where authorities have based their actions exclusively on unwritten principles pertaining to emergency. The reason for this is doubtless that legislation has been designed in such a way as to give them reasonable room to manoeuvre in various challenging situations. An example of this in current legislation is the authorisation in the Health Security and Communicable Diseases Act empowering the state epidemiologist and the minister of health to take a broad range of actions to combat the spread of dangerous diseases. This authorisation is based on the understanding on the part of the legislature that substantial room for manoeuvre on the part of the health authorities may be required in order to protect life and health, and that curtailment of citizens' constitutional rights may be necessary, notwithstanding the normal requirement that such curtailment must be introduced by legislation.

I discussed in my last two annual reports some of the measures taken by the authorities under the Health Security and Communicable Diseases Act in response to the covid-19 pandemic. The focus in my discussion was not on whether or not the measures were justified at the outset, but rather on the length of time they remained in force and the forms they took, these things

being viewed from the point of the various requirements normally made under the rule of law. In this context I noted that as the threat posed by a disease is perceived as receding, with more information available regarding its nature, it is natural to raise the demands regarding the authorities' duty to examine and assess whether it remains necessary to curtail constitutional rights and freedoms. I also pointed out that with the passing of time, the authorities could be expected to have greater room to manoeuvre to contain the threat posed by an epidemic by adopting other, and less far-reaching, measures than those that involved a curtailment of constitutional rights and freedoms. I also sounded a warning that in the wake of a long-lasting situation such as that which developed in the covid pandemic, there was a danger that governments could view the curtailment of fundamental rights as something of minor concern, or even as an obvious course of action, with the possible result that citizens' fundamental rights would be diminished in the long term.

I mention that discussion here in the light of a case involving a decision by the Suðurnes Commissioner of Police to prohibit children under a certain age from entering the area around the volcanic eruptions by the mountain Fagradalsfjall, in southwestern Iceland, in August 2022. Members of the public had submitted complaints and comments to my office following this decision, even though there was nothing to show that the police authorities had actually interfered in the freedoms of those submitting the complaints. I therefore decided to take the matter up on my own initiative, and issued my opinion in May last year.

At the outset, it was rather unclear whether the police commissioner's decision had been based on the Police Act or the Civil Defence Act; there are certain similarities between Article 15(2) of the former and Article 23(1) of the latter, both setting out broad authorisations for the authorities to issue instructions in times of danger, including prohibitions on being in, or moving through, specific areas. As with the measures taken by the authorities to combat the covid pandemic, my examination focussed not on whether there had been reason for restrictions at a particular point in time so as to respond to an imminent hazard, but rather on the fact that the police commissioner's orders had not stated that they were to apply for a limited period only nor had they included any provision on a possible review in response to a change in circumstances.

In my opinion on the 'prohibition on children' case, I noted that when faced by an imminent hazard, the authorities are not only empowered to take all measures necessary but are under an obligation to take the initiative in making an active response. I also noted that under such circumstances, the authorities must be allowed considerable scope to assess the need to take measures at any given time; more specifically, this means that this scope will increase as the threat becomes more serious or as uncertainty grows. I stated:

On this point, I have also mentioned in my discussion that different demands will apply to a government authority's examination of a situation, depending on the circumstances at any given time. As the hazard level is perceived as falling, as time passes and as more information becomes available, it is natural to make more stringent requirements regarding the authority's examination and assessment of the situation and whether there is an urgent need to continue to curtail constitutional rights and freedoms. Following on from this, it has also been pointed out that where measures have been taken in response to temporary circumstances, the authority should make regular assessments of whether the conditions for their prolongation are still met, this assessment taking account of the best available information at any given time. This means that measures taken in response to an imminent hazard cannot normally remain in force indefinitely.

Consequently, I concluded that it was not in conformity with the considerations applying to the authorisation under Article 23(1) of the Civil Defence Act to issue instructions prohibiting children's access to the eruption area indefinitely. I pointed out that the arguments granting the authorities the power to impose an emergency ban were based on a temporary hazardous situation and were not intended to serve as the basis for rules applying to citizen's activities more or less without a time restriction. If the police commissioner considered such rules to be necessary without a time restriction, then the minister of justice could, acting on his own initiative, propose the appropriate legislative amendments to the Althingi. I recalled that it was not up to an executive authority to have the final word on whether, and how, interventions are to be made in citizens' fundamental rights, even though they might certainly be permitted, and moreover obliged, to intervene in the short term so as to respond to an imminent hazard.

I fully appreciate the difficult position in which a state agent may find itself when it comes to determining whether it is necessary to restrict the rights of ordinary citizens in order to ensure public safety and security in the face of an imminent hazard. Nevertheless, I consider it important that the authorities bear in mind the reasoning on which such provisions in law are based and the limitations imposed by the rules of the constitution, written and unwritten.

1.6 Reinforcement of OPCAT monitoring

Under amendments made to the Parliamentary Ombudsman Act in 2018, the office was entrusted with monitoring the circumstances of persons deprived of their liberty under the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Punishment (OPCAT). It must be borne in mind that the protocol covers not only the plight of those who have been

deprived of their liberty by a formal decision, i.e. a ruling or judgment imposing detention or imprisonment, but all persons who are, in fact, prevented from determining their personal affairs themselves. The definition may therefore include persons in a very wide range of predicaments, often in very sensitive circumstances.

Experience shows, in my view, that OPCAT monitoring fits in well with other functions of the ombudsman's office. It is evident that the respect and trust that the ombudsman enjoys in the community and the professional skills that the office has built up are of great value in this work, and some of the issues that arise in the course of OPCAT monitoring are familiar from other, more traditional, parts of the ombudsman's work. Involvement in OPCAT monitoring and meeting those who have been deprived of their liberty gives us the opportunity to draw their attention to the possibility of submitting complaints to my office. This is important, since for various reasons these people are not always aware of the possibility of making formal complaints. In this context it should be noted that relatively few complaints are received from individuals in connection with some of the issues that are covered under OPCAT monitoring. In addition, other matters that come to our attention during monitoring may result in my instituting own-initiative investigations. Examples of this have been my examination of time-out rooms for junior-school children and the placement of inmates in a special security wing of the detention facility for those who lack criminal responsibility at the mental hospital Kleppur. It was with all this in mind that I expressed the view in my report for the year 2022 that own-initiative investigations, OPCAT monitoring and the examination of complaints constituted, collectively, the basis of the ombudsman's mandate, i.e. to secure the rights of the ordinary citizen vis-à-vis the authorities.

Unlike the position of those who are in prison, or under police detention, the legal position of others who have undergone deprivation of liberty tends to be rather scantily covered in law, even to the extent that they can be said to occupy a 'legal limbo'. In some cases they are in corners of society that have received little attention on the part of the legislature. When this is the case, a detailed analysis of their legal situation is a necessary pre-condition for monitoring under OPCAT. Legalistic work of this type, however, inevitably reduces the time available for active monitoring of the actual circumstances of the individuals involved.

In the preparation of the national budget in autumn 2021, the Althingi decided to make some further funding available for OPCAT monitoring. Combined with some internal structural changes, this made it possible to engage another member of staff to the regular OPCAT team, bringing the number up to three. This has made it possible for the office to tackle new and demanding challenges in addition to the traditional core of examinations connected with the prisons and police detention cells. Examples of this

broader spectrum include, from last year, visits to Klettabær and Vinakot, two privately-operated solutions for the placement by the child welfare authorities of children with complex problems. Another of last year's visits was to a closed ward in a nursing home which is mainly for elderly dementia sufferers. This was the first time the ombudsman had examined the situation of people in this category, notwithstanding that their numbers run to hundreds in Iceland. I should also mention the publication by my office of a report on the situation of female prisoners in Iceland and how serving prison sentences has different implications for women as compared with men. This was a 'theme report' which, unlike other OPCAT reports from my office, did not deal with any specific institution or concrete arrangement. The report, and other activities of the OPCAT unit of the ombudsman, are discussed in further detail elsewhere in this report.

In his reports on OPCAT monitoring, the ombudsman is able to point out where there is room for improvement, both in the legal framework and also in its implementation and the physical facilities involved. It is up to the executive authorities, and the Althingi, as appropriate, to act on these observations. I cannot avoid mentioning here that even though OPCAT monitoring by the ombudsman does not go back very far, quite some time has already passed since certain observations and recommendations were first set out without adequate measures having been taken to respond to them. Here I am thinking, for example, of our repeated discussion of the position of minors who have been deprived of their freedom, and of persons who are held in closed psychiatric wards.

Nevertheless there is, I think, no question but that OPCAT monitoring has produced some good results in recent years. What counts here is not only the immediate product of this monitoring in the form of the reports published, but also the trust in the process shown by the institutions and others who are the subject of the monitoring. In my view, both are important elements in improving and reinforcing the legal and material position of persons who are deprived of their liberty, which is the real aim of OPCAT. These results would never have been achieved without the support of the staff of the OPCAT unit of my office, who have done their work not only professionally but also with great interest and dedication. I therefore wish to thank them, and my other colleagues at the office, for their excellent work and collaboration in 2023.

The year in figures

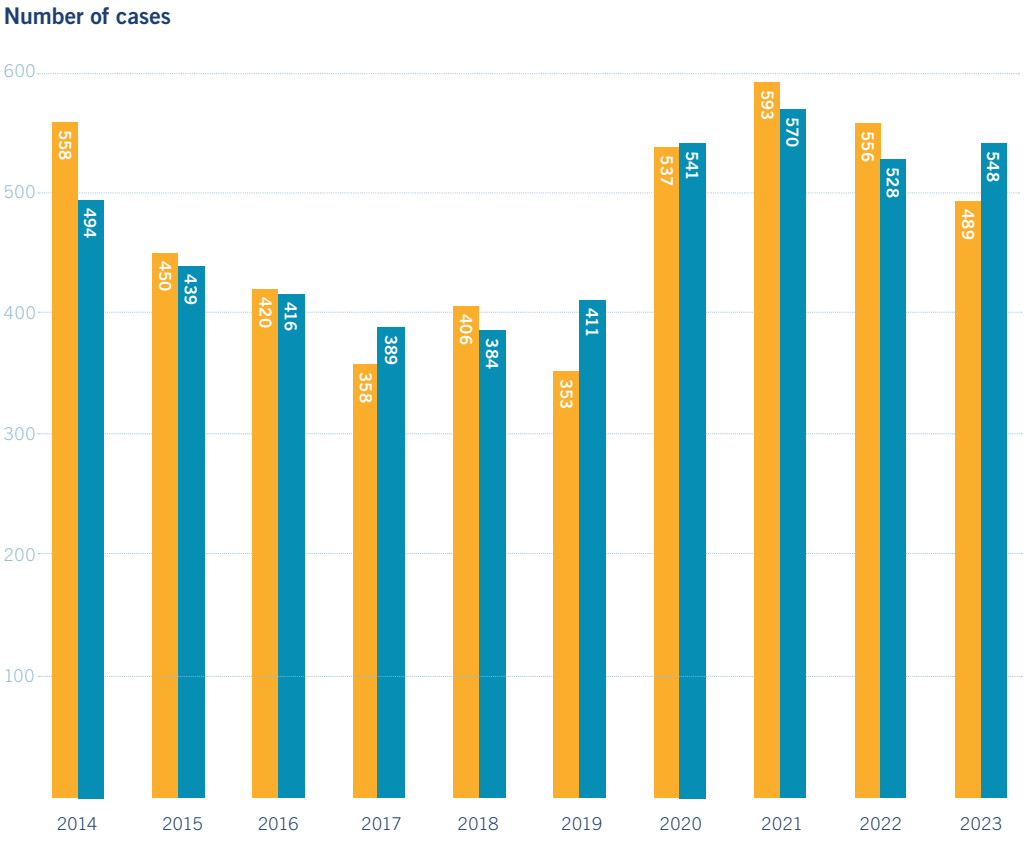
2.1 Complaints

Five hundred and forty-eight complaints were registered in 2023, twenty own-initiative inquiries were opened, seven visits were made as part of OPCAT monitoring and eighteen opinions were delivered. The number of complaints submitted was slightly lower than the record of 570 received in 2021.

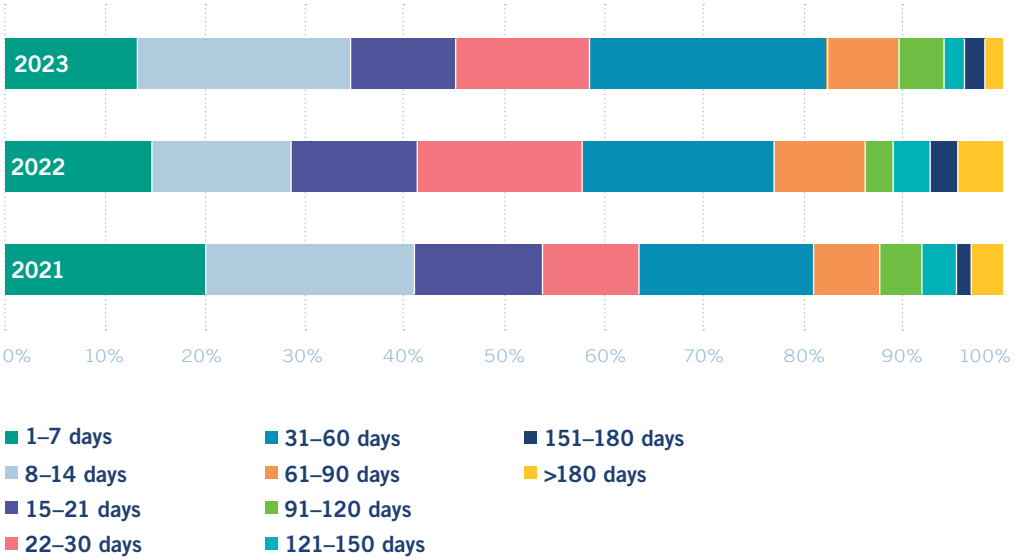
These figures cover registered cases only. In addition, a large number of informal tip-offs were received on various matters; these have been recorded by the division of the office dealing with own-initiative cases. Furthermore, many enquiries were received asking for information or guidance in connection with communications between the public and the authorities, including whether there were grounds for making formal complaints. It also happens that the authorities ask for guidance or information, without these requests being recorded in the case register.

Number of complaints registered and processed in past 10 years

Registered complaints
Processed complaints



Case processing time 2021–2023



Complaints monthly distribution

2023	Received	Processed	Pending at EOM (end of month)
Jan	46	51	73
Feb	39	42	70
Mar	56	39	87
Apr	38	37	88
May	50	42	96
Jun	54	39	111
Jul	44	33	122
Aug	33	43	112
Sep	38	46	104
Oct	49	39	114
Nov	45	46	113
Dec	56	32	137
Total	**548**	**489**	

Case outcomes

Outcomes	2023		2022	
Opinion	**17**	(3,5%)	**59/20**	(10,6%)
Recommendation to take dispute to court	**10**	(2%)	**15**	(2,7%)
Dropped following review or explanation from authority *(incl. 43 following review and 10 following reopening)*	**112**	(22,9%)	**72**	(13%)
Outside purview of the ombudsman				
a. Functions of the Althingi, its committees or institutions	**11**	(2,2%)	**16**	(2,9%)
b. Actions by the judiciary	**5**	(1%)	**8**	(1,4%)
c. Private law actions	**24**	(4,9%)	**26**	(4,7%)
d. Other matters	**4**	(0,8%)	**4**	(0,7%)
Case party intends to appeal to higher authority	**113**	(23,1%)	**113**	(20,3%)
One-year deadline past (see par. 2 of Art. 6 of Act 85/1997)	**9**	(1,8%)	**10**	(1,8%)
Complaint withdrawn or found not to warrant further action	**184**	(37,8%)	**233**	(41,9%)
Total	**489**		**556**	

OPCAT

Monitoring of facilities where persons deprived of their liberty reside

The Ombudsman conducted seven visits in 2023 to facilities where persons are deprived of their liberty and published four monitoring reports.

Security Housing in Akureyri

25 May 2022

Published 17 May 2023

The Althingi Ombudsman visited a security housing in Akureyri on 25 May 2022. This was the first visit by the Ombudsman to security housing, although in 2018 the Ombudsman visited the forensic psychiatric ward of the National University Hospital at Kleppur, where individuals can also be placed on the basis of a sentence. In the security housing in Akureyri, there are […] persons who have been sentenced to security detention based on Article 62 of the General Penal Code. Because of their situation, the legislation on disabled persons also applies to them.

The security housing is operated on the basis of a service contract between the Ministry of Social Affairs and Labour and the Municipality of Akureyri. The contract is concluded retroactively for one year at a time. For that reason, the Minister of Social Affairs and Labour and the Welfare Department of the Municipality of Akureyri are instructed to make sure that there is a valid service contract in force for the operations at all times.

In Iceland, no comprehensive legislation has been enacted on the implementation of security detention. The report points out that the lack of a legal framework has led to various problems that are reflected, among other things, in the fact that it is not fully clear how responsibility is divided between the enforcement authorities and the authorities of health and social affairs when it comes to various decisions on the implementation of sentences for security detention. Furthermore, it varies what legislation applies to persons who have been sentenced to security detention. As a result, different rules may apply to those in detention depending on whether the facility operates on the basis of a contract with local authorities or whether the person in question is held within the health care system, e.g. in a forensic psychiatric department. Some individuals are also covered by legislation on disabled persons while others are not, and this difference may affect the implementation of placement and details of the legal protection of the person in question. As a result, it is not clear either what authority is ultimately responsible for administration and supervision in each instance.

The Minister of Social Affairs and Labour has presented a draft bill for an Act on the implementation of security measures and secure placement. According to the revised parliamentary agenda, the Minister plans to present the bill in the current legislative session. The report urges the Minister to follow through on these plans, including clarifying which authority is responsible for the enforcement of judgments under Article 62 of the General Penal Code and for deciding on the detailed arrangements for detention.

The Act on the Protection of the Rights of Disabled Persons provides for a general prohibition of telemonitoring and the use of compulsion in dealing with disabled persons. The Act allows a service provider to apply for an exemption from the ban to an exemptions committee. In certain emergency cases, compulsion may be authorised without the committee's decision; however, the service provider must then send a description of the incident to a specialist team within a week of the compulsion being applied. The exemptions committee has not accepted applications from the facility for processing; however, during the visit it was revealed that new conditions have given rise to a new application. It was also revealed that no incident descriptions had been sent to the specialist team which operates under the Act. Therefore, the Ombudsman recommends to the Welfare Department of the Municipality of Akureyri that it follow through on its plans to send an application to the exemptions committee and also to send incident descriptions to the team.

There do not appear to be any authorisations for the use of force or intervention in the personal privacy of the sentenced persons except based on an exemption or rules on emergency defence measures and emergency actions. Therefore, the Ombudsman directs the Minister of Social Affairs and Labour to follow through on the plans to present a bill that meets the requirements for a legal grounding under the Constitution and human rights conventions regarding the compulsion that is considered necessary to authorise for security detention.

During the ombudsman's visit, it was revealed that the sentenced persons could be given sedatives, as the case may be, with forced administration of medication. However, such cases were very rare, and nothing during the visit gave reason to believe that the practice of such medication would be cause for censure. The Ombudsman did note, however, that the procedure did not provide for the involvement of a healthcare professional in the administration of the medicine in each individual case, nor for monitoring following it. In consideration of this, the recommendation is addressed to the Welfare Department that it review the procedure for forced administration of medication.

There is constant video surveillance in the common areas of the sentence persons' apartments, and their apartments are subject to audio surveillance for part of the day. In view of personal privacy considerations, the recommendation is addressed to the Welfare Department of the Municipality of Akureyri that it examine the implementation of video surveillance in the security housing on an individual basis. The Welfare Department is also instructed to keep a record of the telemonitoring in accordance with the provisions of the Act on the Protection of the Rights of Disabled Persons.

The sentenced persons' opportunities to communicate with the outside world are in some cases limited, for example, by their restricted access to their mobile phones. During the visit, it was learned that there were examples of this being done at the request of relatives [...]. The Ombudsman points out that during visits to psychiatric departments, such practices have raised questions regarding the requirement of necessity and proportionality. It should be kept in mind here that relatives themselves have the option of limiting calls, for example, through the settings on their phones. Therefore, the recommendation is addressed to the Welfare Department of the Municipality of Akureyri that it review the practice of restricting the sentenced persons' access to their phones in this way.

The Ombudsman noted that [...] of the [...] sentenced persons moved from their home district at the beginning of their placement in the security housing. The report points out that this raises questions about a person's right to live in contact with family and, as the case may be, friends. The suggestion is therefore made to the Minister of Social Affairs and Labour to consider whether the right of the sentenced persons to enjoy living in contact with family and friends, in cases where they are detained far from their home district, is adequately guaranteed.

Residents can generally get outdoor exercise accompanied by staff. [...] The suggestion was addressed to the Welfare Department to seek ways to provide all the sentenced persons with access to suitable outdoor exercise on a daily basis. According to recent information from the Department, the person is now given the opportunity for outdoor activity outside the town limits every day.

The ombudsman raises objections to the arrangement whereby the employees or managers of the facility are in charge of the personal finances of the sentenced persons. Although there was no indication during the visit

that any contentious issues related to this had arisen, such an arrangement can easily lead to conflicts of interest and endanger the independence and neutrality of the employee in question. For that reason, the Welfare Department is instructed to consider whether another arrangement for the management of funds is more desirable, e.g. based on the provisions of the Act on Legal Competence concerning so-called administrators.

The recommendation is made to the Welfare Department that it review procedures for the use of force with the aim of ensuring adequate information is provided about appeal and complaint channels and that issues related to the examining of incidents are adequately recorded, such as whether debriefing has taken place and whether the person concerned has been instructed on complaint channels.

Organised and continuous activities are not offered in the facility. Consideration must be given to the fact that residents live in a closed facility and have limited opportunities to choose a suitable pursuit. For that reason, the suggestion is made to the Welfare Department of the Municipality of Akureyri that it continue looking for ways to ensure that access to daily activities, such as work, school and leisure, is adequate for all sentenced persons staying in the facility.

All the sentenced persons have a service plan that sets out short-term and long-term objectives. According to specifications, the service plan is to be drafted in consultation with the user. Two service plans were not signed by the users, so it is difficult to see whether the person had been involved or accepted them. Therefore, the suggestion is made that the Welfare Department ensure that it is evident from the service plans that the sentenced persons were involved in making them and that they sign them.

The recommendation is addressed to the Welfare Department of the Municipality of Akureyri that it continue seeking ways to ensure that staff training in response and defence measures against violence is appropriate and takes sufficient account of the situation of the sentenced persons of the facility. There were conflicting reports as to whether summer replacement staff always had the opportunity to attend courses before they began work. Therefore, the suggestion is addressed to the Welfare Department that it ensure that the training of replacement staff is carried out in accordance with specifications, so that they always receive adequate training before starting work.

The report emphasises the importance of clear and efficient channels for complaints and appeals, not least in view of the vulnerable position of the sentenced persons. It points out that it can be difficult for them to find out where to go within the administration to present complaints or appeal individual decisions concerning the implementation of their detention. Although complaint and appeal channels exist, it is questionable whether they are a viable option for the persons in question when their framework is as complex as that discussed in the report. Since a draft of comprehensive legislation on

security measures and secure placement exists, which will be considered by the Althingi in the coming months, it is considered sufficient to direct the suggestion to the Minister of Social Affairs and Labour to keep these points of view in mind in the further processing of the bill.

The Ombudsman also directs the Welfare Department of the Municipality of Akureyri to analyse which decisions are considered administrative decisions and what complaint and appeal channels are available to the sentenced persons. A clear procedure for recording and handling comments and complaints must be established in order to ensure that they are processed in the manner that their presentation calls for and that appropriate instructions are provided.

At the meeting at the beginning of the detention, complaint and appeal channels are not explained specifically. Therefore, the Ombudsman directs the recommendation to the Welfare Department that it ensure that the sentenced persons and their relatives receive adequate information about complaint and appeal channels at the beginning of detention and regularly during detention, if deemed necessary. To that end, it is essential that staff are aware of the sentenced persons' rights in this respect and can thus provide instructions on them.

Security detention is indefinite and ends only by order of a judge. The supervisor appointed for the sentenced person is to monitor that their stay will not be longer than necessary; furthermore, the Minister can seek a ruling from a District Court in this regard if certain conditions are met.

A re-evaluation of the indefinite detention of a sentenced person in the security housing is generally carried out every five years; however, there are examples where a longer period has elapsed. During the visit, it was revealed that the need for re-evaluation depended on the individual and the sentenced persons could meet the conditions for relaxation of or release from security detention before re-evaluation. From the sentenced persons' supervisors it was learned, among other things, that their work lacked a framework, they had difficulty understanding their role and duties and believed that it was likely that understanding of the role varied among supervisors. The Ombudsman's report on a visit to the forensic psychiatric ward at Kleppur made various recommendations regarding the reassessment and the work of supervisors. With reference to the plans of the Minister of Social Affairs and Labour to present a bill in the coming months, which includes mention of the appointment, role and supervision of the work of supervisors, the Ombudsman does not see reason to direct recommendations to the Minister in this instance. On the other hand, it should be noted that the office will continue to follow these developments.

The Ombudsman will continue to monitor the development of these issues, but requests that the Minister of Social Affairs and Labour and the Municipality of Akureyri give an account of their responses to the report by 1 December 2023. The report is also sent to the Ministry of Justice for information purposes.

Contents of the report
Psychiatric Ward of Akureyri Hospital

Litla-Hraun Prison

28–30 November 2022

Published 4 December 2023

The Ombudsman visited Litla-Hraun Prison on 28-30 November 2022. This was the third visit by the Ombudsman to the prison for the purpose of the office's OPCAT mandate, but the first where the prison and its operations were examined in their entirety.

During the visit of the Ombudsman, it was found that the cabinet for defensive equipment was not sealed and that the employees had access to such equipment, including tear gas and batons, without the use being recorded or reported to the shift supervisor. Due to this, the recommendation is addressed to the Litla-Hraun Prison and the Prison and Probation Administration to clarify work procedures for the storage and use of defensive equipment and its registration. In addition, the recommendation is addressed to the Minister of Justice to follow up on plans to establish rules on the use of force by prison guards, as well as the handling and use of equipment involving the use of force and use of weapons.

Prisoners kept in security cells are generally separated from other prisoners. Their detention is never to last longer than is consistent with its purpose and the application of other measures. Considering the basic principle of proportionality, it is therefore necessary to periodically reassess whether there is a need for continued detention. In light of the fact that the harmful effects of isolation increase the longer it lasts, there are strong reasons for actively supervising detentions in security cells, especially in the case of long-term detention. However, the Execution of Sentences Act does not prescribe the maximum period of detention or systematic monitoring of it. Nevertheless, the recommendation is addressed to the prison to reassess regularly, at least daily, whether continued detention in a security cell is necessary and to ensure that this practice is adequately documented.

Laws and multinational standards stipulate certain safety measures for the use of solitary confinement, such as supervision by health care personnel. In actual practice, in some cases prisoners are neither examined by a doctor at the beginning of their placement in a security cell nor during their detention. Such a practice generally tends to increase the likelihood of inhuman and degrading treatment, and this applies especially if a prisoner is struggling with a mental health problem. The recommendation is directed to the prison to summon a doctor at the beginning of detention in a security cell to assess the prisoner's mental and physical condition. Furthermore, the general suggestion is made to the Minister of Justice to consider whether there is a reason to take the initiative to have the detention of prisoners in security cells given a more detailed framework in law or administrative provisions based on law.

The reports on cell searches of which the Ombudsman received a copy did not indicate that formal decisions had been taken by the director and recorded. It appeared from the reports that in the majority of cases prisoners were not given the opportunity to be present at the search and without this being based on a special decision by the director. In addition, prisoners were generally not informed of the reason for the search. With this in mind, the Ombudsman directs the prison to review the procedure for searching cells in order to comply with statutory provisions.

Body searches are carried out either due to individual incidents or systematically, e.g. after prisoners receive visits and when prisoners return to the prison after a stay outside it. Although the decision to systematically search prisoners can be based on objective considerations and fall within the limits set by the law and other basic principles for the practice, the suggestion is made to the prison to regularly reassess the need for systematic body searches in the prison.

Body searches in the prison are generally carried out by having prisoners undress completely, without a special assessment being made as to

whether a less extensive measure would suffice. The report points out that such a general practice may involve the risk of degrading treatment. In view thereof, the recommendation is addressed to the prison to make sure that the execution of body searches allows room for individual assessment of whether milder measures can be used during body searches, e.g. that it is carried out in stages.

When urine samples are taken, prisoners are always required to undress and are given the option of wearing a prison robe. In this context the Ombudsman points out that a decision on a physical examination is an onerous decision that must always be based on necessity and proportionality, both in terms of the need for it and its implementation. The recommendation is addressed to the prison that it review the procedure for taking urine samples so that there is scope for individual assessment of whether it is necessary to let prisoners strip completely or whether other and less extensive options are possible in that regard.

There were examples where the recording of the reasons for X-ray examinations was not adequate, and there was no formal decision by the director concerning them, as is required by law. For that reason, the recommendation is addressed to the prison to ensure that the implementation of these decisions accords with law.

Prisoners were generally not aware of the possibility of making calls in private in the prison's telephone rooms, for example, to attorneys, public institutions and the Althingi Ombudsman. For that reason, the prison is instructed to improve information provision in this regard.

The run-down condition of some parts of the prison's premises drew the Ombudsman's attention. The recommendation is made to the Ministry of Justice, the Prison and Probation Administration and the Litla-Hraun Prison to examine the general minimum maintenance of the prison's premises to ensure wholesome and decent conditions for prisoners, regardless of whether or when a new prison will be taken into use at Litla-Hraun.

The report comments on the air quality in the prison and directs recommendations to the prison to ensure that it is adequate, such as by checking the ventilation system and window frames. Poor air quality can also be attributed to the fact that smoking is allowed inside the cells. The suggestion is therefore made to the prison that it consider whether it is possible to house prisoners who so request in a non-smoking corridor.

With the exception of an exercise bike in the common area and a pull-up bar in the outdoor area, no visible improvements had been made to the security ward's facilities since the release of the Ombudsman's report on the ward in November 2021. For that reason, previous recommendations are repeated to the prison, the Prison and Probation Administration and the Minister of Justice to begin without delay the necessary renovations and maintenance of the security ward, such as to its outdoor areas and common spaces.

Hygiene was insufficient in the prison's common sanitary facilities, which prisoners see to cleaning. Some prisoners also described the discomfort that could follow from using the toilet facilities inside their cells, as they did not have access to shared sanitary facilities at night. Therefore, the suggestion has been made to find a way for prisoners to be able to use the toilet, also at night, without having to live and sleep with bad odours.

The children's visiting area Barnakot is a facility intended for prisoners and their children to spend time together and has a somewhat more relaxed feel than general visiting facilities in the prison. However, the facility is not fully utilised, which is explained by the fact that the opening hours of the facility are only from 13:00-15:30 on weekdays and it is closed on weekends. These opening hours can make it difficult for prisoners' families to use the facility, for example, due to school and work. Therefore, the suggestion is made to the Prison and Probation Administration that it look for ways to extend the opening hours of Barnakot or similar facilities for the families of prisoners, in part to take into account the activities of preschools and compulsory schools.

It could only be concluded that the food allowance, per diem allowance and payments for work and studies are generally insufficient to cover the expenses of prisoners in the prison. The Ombudsman's previous recommendation to the Prison and Probation Administration, that it publish information about prisoners' food allowance and the premises on which it is based, or to make this available by other means, is therefore reiterated. The Prison and Probation Administration is also advised to regularly re-evaluate the premises of the food allowance and assess whether it should rely on factors other than the consumption criteria of the Ministry of Social Affairs and Labour, e.g. by taking into account the development of consumer goods prices. The suggestion is also made to the Ministry of Justice to consider and assess whether there is a reason to revise the remuneration for study and work and the amount of the per diem allowance, taking into account the proposals of the steering group on prisoners' affairs.

At the time of the Ombudsman's visit, only one of the 48 prisoners serving time had an active treatment plan, and three treatment plans were in preparation. A recent report by the Ombudsman on the facilities and conditions of women in Icelandic prisons discussed how the criteria used as a basis by the Prison and Probation Administration in taking a decision as to whether there was a need for a treatment plan were too restrictive for the assessment that the institution was required to carry out according to law. Therefore, the recommendation was repeated, that the institution cease to apply only general criteria for the decisions in question and instead also assess the need for a treatment plan based on individual factors as required by law.

The majority of the inmates at Litla-Hraun struggle with substance abuse and appear to have easy access to illegal substances within the prison. Substance abuse generally has a major impact on prison activities and the order maintained within it. Violence among the group of prisoners and intervention by staff are often linked to prisoners' use of illegal substances. In this context, the Ombudsman draws attention to the fact that the problem of substance abuse is undisputed in the prison and that it stands apart from other prisons in terms of access to and consumption of illegal substances. Despite this, there are few treatment options in the prison and there does not appear to have been a specific response to comments of the CPT committee from 2019 about the lack of a holistic government policy regarding substance abuse problems in prisons. The plan for prisoners' healthcare services from 2019 assumed that a mental health team for prisons would be involved in providing targeted, continuous and individualised addiction treatment. In this regard, the Ombudsman emphasises that the team must be provided with appropriate facilities and given support to carry out treatment work so that the plans that have been made can be followed up on. The Ministers of Justice and Health, together with the Prison and Probation Administration, are also urged to draft a holistic policy on assistance to prisoners with substance abuse where the aim will be to reduce use of illegal substances in the prison, including by increasing the availability of treatment and support resources. The same ministers are instructed to examine, based on their powers as the senior management and supervisory authorities, whether the action plan on prisoners' healthcare services has been followed up on with appropriate actions.

Communication between prison guards and prisoners in the prison is mostly limited to formal requests, and prison guards generally do not have a presence inside the cell blocks except when drugs are given or cells are closed and opened in the evening and morning. For this reason, the Prison and Probation Administration and the prison are instructed to seriously improve the training of staff in active security, while regularly maintaining the training of staff in the use of force and physical restraint. The necessity of staff receiving regular training in first aid is also pointed out, together with the need to review arrangements for so-called training shifts, so that they will be more useful as training.

Due to the heavy workload of the transport team, inmates in need of healthcare may have to wait to be seen by a doctor. Therefore, the Ombudsman directs the Prison and Probation Administration and the prison to ensure ready access to healthcare services for prisoners due to unexpected pain or illness that requires treatment and to seek ways to prevent prisoners from being deprived of the services of specialist doctors due to incidents beyond their control, such as due to staff work loads or insufficient staffing. The Ombudsman also reiterates the importance of a medical examination being

carried out when prisoners begin serving their sentence and when solitary confinement, segregation, placement in a security cell and, as the case may be, placement in a security ward, are applied.

There can be a long wait for general dental care, even in cases where prisoners are in pain, and the service is dependent on the prisoner's finances. In accordance with the Ombudsman's previous discussion on prisoners' access to dental care, the recommendations to the Prison and Probation Administration are reiterated, that they ensure that all prisoners have access to necessary dental care regardless of their finances.

Prison guards are in charge of dispensing medicine in the prison. Administration of medication is an extensive task in the prison, as the vast majority of inmates take prescription drugs on a daily basis. Scheduled administrations of medicine occur four times a day. In general, prison guards have not received special training or education in relation to drug administration. Prescription medicines for daily use are dispensed in special medicine containers in a pharmacy. However, prison guards may administer medicine according to instructions from a doctor when a prisoner has been prescribed medicine as needed. For this reason, the prison is directed to seek ways to prevent prison guards or general workers from performing the work of medical personnel, such as administering medicine. If the situation is such that staff need to be involved in administering medication, the Ombudsman points out the need for the employees concerned having received appropriate instruction and training. The prison is directed to make sure that prisoners are informed when mistakes are made in administering medication.

Some prisoners with mental health problems have serious illnesses and therefore require extensive mental health services within the prison or, in some cases, in a psychiatric ward outside the prison. There is a general risk that these prisoners will not integrate well into the prison group, with the result that they are more likely to be separated from other prisoners, e.g. by placement in a security ward or a security cell. Such placement often means isolation, which can be particularly difficult for prisoners who suffer from mental illness of some kind. The prison's attention is drawn to the fact that in cases like this it is particularly urgent that the prisoner be medically examined and that their condition be monitored on a regular basis.

The introduction of the prisons' mental health team has improved mental health services for prisoners. In those cases where admission to a healthcare institution has been deemed necessary, for instance, by doctors or a mental health team, according to the information from the prison, prisoners only go to the relevant healthcare institution in exceptional cases, partly due to the reluctance of such institutions to accept prisoners. They point to a lack of facilities to ensure the safety of prisoners and staff. Detention of persons

in prison should not reduce their chances of admission to a psychiatric ward if it is deemed necessary. Therefore, the Ombudsman recommends that the Minister of Health ensure, in co-operation with the Minister of Justice, that prisoners have access to necessary mental health services comparable to that of other citizens.

In the case of foreign prisoners, the Prison and Probation Administration is directed to follow through on plans to have key information and documents translated into the languages which are most commonly spoken within the prison population. The prison is directed to always provide an interpretation service when prisoners are admitted who do not understand Icelandic or English, to ensure that the information is communicated, and also when communicating information that is clearly of great significance to them.

Prisoners serving sentences for sexual offences are at risk of being harassed by other prisoners and are reluctant, for instance, to go outdoors. There were examples of prisoners not going outdoors for months except for work or to go to a visiting facility. When the Ombudsman visited, a special outdoor time, intended for these prisoners, had been cancelled, on the grounds that they had not availed themselves of it. Interviews with prisoners revealed that despite having a special time for outdoor activities, they had been harassed by other prisoners, for example, through calls from windows. The prison is instructed to continue seeking ways to improve this, such as by increasing the presence of prison guards or with access to a special outdoor area where they can be safe from the harassment of other prisoners.

In view of the fact that the right of a remand prisoner, for example, to telecommunications, seems to be subject to the same restrictions as the right of a prisoner serving a sentence, the recommendation is repeated that the Prison and Probation Administration and the prison analyse the nature and content of those decisions taken in connection with the placement of remand prisoners, bearing in mind their legal status as remand prisoners.

Prisoners receive information about their rights and obligations in an admission booklet, which basically consists of a list of legal and administrative provisions regarding the serving of their sentence. Now, in addition, an admission booklet has been published in simpler language, which is delivered together with the aforementioned information, which is a positive step. In this connection, however, the Ombudsman points out that information about the laws and regulations that apply to detention may not always come to the attention of prisoners, for example, due to mental agitation or intoxication. Therefore, the Ombudsman recommends that the prison ensure adequate communication of information, e.g. by placing greater emphasis on following up on this written information with clear oral information in a manner the prisoner in question can understand, as appropriate, with the assistance of an interpreter upon admission or following it.

Prisoners were not given written confirmation of the queries and messages they submitted to the guard room, and there were examples of messages not being responded to specifically. It also proved to be difficult for prisoners to access information on the situation of their own cases. Therefore, the Ombudsman directs the prison to have the procedure for registering and handling queries from prisoners meet the requirements of the written and unwritten rules of administrative law regarding recording, the obligation to respond to written inquiries, and the right of parties to access information on the situation of their own cases.

Prisoners were either uninformed or poorly informed about complaint channels within the prison and generally had little faith in them. This was evident, inter alia in the fact that prisoners doubted that the content of the complaints would be kept strictly confidential and also that they would be acted upon. Prisoners also believed that complaining could affect their detention and pointed out that complaint forms had only been made available shortly before the Ombudsman's visit. There were examples of prisoners' complaints not being answered specifically or that they were not informed of the outcome of their handling. Since the prison's complaints procedure only covers complaints about the conduct and behaviour of prison guards and other prison employees towards prisoners the Ombudsman directs the Prison and Probation Administration and the prison to prepare a procedure that covers all complaints and rectifies the above-mentioned deficiencies. The prison is also instructed to cease its practice of inspecting prisoners' letters to certain parties which may not be inspected, such as to attorneys and the Althingi Ombudsman.

The Ombudsman recommends that the prison provide prisoners with appropriate instructions on complaint procedures and deadlines for their submission, regarding body searches, physical examinations and cell searches, and to ensure proper documentation of how the person was informed of the content of the decisions and appropriate complaint procedures.

During the preparation of this report, in September 2023, the Minister of Justice announced plans to build a new prison at Litla-Hraun and that preparations had already begun. The Ombudsman will closely monitor the progress of the plans for these projects. However, it must be kept in mind that the construction in question, if it happens, will take some time. Recommendations and suggestions regarding facilities are based on the state of affairs at the time the prison was visited.

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Litla-Hraun Prison

Women in prison

An examination of the facilities and conditions of women serving time 2023

Published 3 July 2023

This is the first thematic report of the Althingi Ombudsman on the basis of OPCAT monitoring of facilities where people deprived of their liberty reside. In it, attention is directed specifically at the facilities and conditions of women in prisons in Iceland and how the serving of sentences by this group compares with that of men. In preparing this report, the Ombudsman and his employees visited the prisons at Hólmsheiði and Sogn in February and March 2023 and interviewed female prisoners and staff.

Female prisoners are generally a small minority of the total prison population. In Iceland, the proportion has been around six percent in recent years. The report considers the special situation of female prisoners in the light of national and international research. In summary, this has indicated that their social status is generally worse than that of male prisoners.

The minority position of women in the penitentiary system in general tends to reduce their possibilities to avail themselves of a variety of alternatives in serving their time, and this can be of major significance for prisoners, for example, with regard to the location and level of security during their imprisonment. As things currently stand, female prisoners are only held in two of the four prisons run by the Prison and Probation Administration, Hólmsheiði Prison and Sogn Prison. In this connection it must be kept in mind that, in the case of men, Hólmsheiði Prison is generally used as a remand or reception facility, i.e. a short-term, high-security detention facility. In the case of women, however, it is utilised for long-term detention. In addition, women no longer have the option of serving time in Kvíabryggja Prison, which for various reasons is regarded as desirable.

In the 2004 report of the Prison and Probation Administration and the 2007 report of a committee on the future operation of the prison at Litla-Hraun, proposals were made for improvements to the prison facilities for women, including by increasing the number of detention options and meeting their needs better. The latter report also referred to the importance of formulating a comprehensive strategy for the detention of female prisoners. The proposals presented in the two reports were not implemented. Furthermore, a comprehensive strategy for the detention of female prisoners has not been formulated and the current situation reflects the lack of an overall view of the issue.

The report discusses in more detail the facilities, services and security in the two prisons where women are held. Accommodation in Hólmsheiði Prison is characterised by a high level of security and limited services and support for prisoners. This raises questions about whether the prison is suitable as a long-term solution. In addition, the Ombudsman has previously drawn attention to the conditions in Sogn Prison; a maximum of three women can be housed there at any given time, along with eighteen men. The women are therefore always a small minority. This, together with other factors, may mean that women choose not to serve their sentences at Sogn, which in turn means that they must be held long-term at Hólmsheiði. In view of this, the recommendation is addressed to the Ministry of Justice and the Prison and Probation Administration, that they take the necessary measures so that female prisoners have in practice the same opportunities as male prisoners to serve time in an open prison under suitable conditions.

According to the Act on Equal Status and Equal Rights Irrespective of Gender, the government must work towards equal possibilities and opportunities for the genders in all areas of society. In this regard, it is appropriate to bear in mind that Icelandic equality rules prohibit not only direct discrimination, but also indirect discrimination, i.e. the conditions that arise when certain criteria or measures are in force, which seem neutral, but in practice treat individuals of one gender worse than another without objective reasons justifying such a difference.

Facilities in prisons where women are placed must take into account their special needs. In the report, recommendations are addressed to the prisons at Hólmsheiði and Sogn to ensure the access of female prisoners to adequate menstrual products and to ensure that access to the products is arranged so that it is not awkward for the women to request them. The suggestion is also addressed to Hólmsheiði Prison to look for ways to enable the outdoor area of the women's section to be better utilised during the winter months.

The infrastructure of the prisons does not appear to meet the needs of young children who may be staying with their mothers during their sentences. Therefore, the recommendation is addressed to the Prison and Probation Administration that they consider whether the conditions in Icelandic prisons

are acceptable for prisoners with young children serving sentences and, as appropriate, ensure that there is a formal and clear response plan that covers what actions need to be taken for this purpose.

It is generally assumed that work and study can play an important role in the rehabilitation of prisoners and improve their chances to get back on their feet after prison. In the prisons at Hólmsheiði and Sogn, the possibilities for work are considerably less than, for example, at Litla-Hraun, and the work offered to women is mostly limited to handicrafts and cleaning. Therefore, the recommendation is addressed to the Prison and Probation Administration and the two prisons that they seek ways to increase employment options for female prisoners, with the objective of ensuring that the jobs offered to them are not limited to traditional women's work. The recommendation is also addressed to the Minister of Education and Children's Affairs, in consultation with the Prison and Probation Administration and the prisons, that they examine whether it is possible to improve the education of female prisoners, especially in Hólmsheiði, with a view to possibly offering on-site instruction and vocational training and in other respects increasing the variety of studies available to prisoners. The suggestion is also addressed to Hólmsheiði Prison to follow up on plans to promote organised activity for female prisoners.

A large proportion of female prisoners in Iceland struggle with serious substance abuse problems. In the prisons at Hólmsheiði and Sogn, prisoners are not offered places in a substance-free section. Furthermore, no treatment representative is permanently located there. In view of the circumstances, the only conclusion is that women are the group within the penitentiary system that receives the least help in getting a handle on their substance problem. Bearing this in mind, the recommendation is made that the Prison and Probation Administration and the two prisons improve their treatment work aimed at women, e.g. by increasing the involvement of professionals, and the suggestion is also made to the Administration that it seek ways to enable those female prisoners who need this, just like male prisoners, to be housed in a substance-free area if they meet the conditions for this.

The goal of a so-called treatment plan is to assess the prisoner's need for support and services and to work towards a successful integration into society after serving time. While there is no statutory obligation for the Prison and Probation Administration to prepare a treatment plan for each individual prisoner, according to the Execution of Sentences Act, the institution is to prepare such a plan in cooperation with prisoners if this is deemed necessary by its experts. In other words, a certain assessment of the necessity of such a plan is expected. According to information from the institute, however, the in-house criterion for this is that a prisoner has received a sentence of five years or more for a violent or sexual offence or a sentence for an offence against a child. As it is rare for women to receive sentences for the aforemen-

tioned crimes, as a result, the majority of female prisoners do not meet the said criteria. This must make it likely that the current arrangement is more detrimental to women in prison than to men in the same situation. Therefore, the recommendation is addressed to the Prison and Probation Administration that it cease applying only general criteria when deciding on the making of a treatment plan and instead also assess its necessity based on individual factors, in accordance with the requirements of the Execution of Sentences Act.

The report suggests that Sogn Prison and the Prison and Probation Administration try to arrange the gender composition of prison staff in such a way that it is generally possible to have both male and female staff on duty at all times. The recommendation is also addressed to the two prisons to have male prison guards show discretion to female prisoners during regular checks, e.g. by knocking and giving sufficient notice before opening doors. The suggestion is also directed to the prisons to arrange the work of prison guards in general so that male prison guards do not enter the women's wards without being accompanied by a female prison guard.

Mixed-gender prisons can threaten the safety of female prisoners, and therefore this is an issue that needs special attention. Due to the conditions in Sogn Prison gender mixing is unavoidable, but female prisoners are a small minority there. The recommendation is therefore addressed to the Prison and Probation Administration and the Ministry of Justice that they consider whether sufficient consideration is given to the situation, safety and needs of women by holding women and men together in the prison under the current conditions.

Prisoners have the same right to health care as others in society, even though they naturally cannot seek services on their own. The report suggests that an examination be made as to whether it is possible to accommodate female prisoners who wish to be cared for by a health worker of the same gender. It also discusses the importance of female prisoners having easy access to cancer screenings and the suggestion is addressed to the prison at Hólmsheiði and the Prison and Probation Administration that they ensure that notification of such screenings reach them quickly and securely.

Female foreign prisoners rarely accept the psychological services offered to prisoners. This is partly explained by the fact that some of the women did not know that the service was available to them. The suggestion is made to the two prisons and the prisons' mental health team that they improve the provision of information to foreign prisoners about the psychological and mental health services available to them.

Foreign prisoners are often at a disadvantage compared to other prisoners, for example, due to challenges related to language, culture, distance from home and lack of a network in the country of detention. When the Ombudsman visited Hólmsheiði Prison, a large number of the women placed

there were of foreign nationality. The report directs the recommendation to the prison authorities to always provide an interpretation service when prisoners arrive who do not understand Icelandic or English so that information can be communicated effectively, to improve generally the provision of information to foreign prisoners and to ensure that prisoners do not interpret for each other when it comes to sensitive private matters or information concerning their rights or obligations. The suggestion is also made that Hólmsheiði Prison seek ways to increase foreign prisoners' access to leisure material in a language they understand. According to information from Hólmsheiði Prison, foreign prisoners have more extensive access to video calls than other prisoners due to the distance from family and friends. However, from the interviews with prisoners, it could be concluded that this group was not always aware of this. Therefore, the recommendation is addressed to the prison to make sure that foreign prisoners are always informed that they have increased access to video calls.

Women who serve time in prisons with men are more vulnerable to violence or harassment by fellow inmates than those who serve time in women's prisons. It was noted that there is no response plan in prisons where women are detained in the case of incidents where there is suspicion of violence or harassment towards inmates, and the recommendation is made to the Prison and Probation Administration that this be rectified. The suggestion is also directed to the Prison and Probation Administration that it consider whether education about the special needs of female prisoners should be given a more important place in the curriculum of the Prison Guard School.

In consideration of all the above, the Ombudsman's conclusion is that the arrangements for female prisoners to serve their sentences in Iceland are generally conducive to making their position worse than that of males. The reasons are largely the result of fewer imprisonment options and the fact that women may be kept long-term in Hólmsheiði Prison, as the prisons at Litla-Hraun and Kvíabryggja are only intended for men. However, the poorer position of women is also reflected in the fact that, in many cases, their special situation when serving their sentences has not been taken sufficiently into account.

The Ombudsman will continue to monitor the development of these issues, but requests that authorities to whom recommendations and suggestions are directed report on their responses to the report no later than 1 February 2024.

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Women in prison

The Southern Iceland Commissioner of Police

Police Cells
July 2023

Published 30 November 2023

The Althingi Ombudsman visited the police detention facility of the Southern Iceland Commissioner of Police in Selfoss on 4 July and again in the night preceding 8 July 2023, on the basis of the office's OPCAT mandate. The exact timing of the second visit was not announced in advance. The Ombudsman's examination focused on the detention of individuals in police cells, the facilities there and the general procedure, as well as police practices in relation to the detention.

Persons arrested in the police district of Southern Iceland are usually kept in the police station in Selfoss, where there are six single-person cells. In 2022, 333 persons were arrested in the district and 126 of them were detained in the police cells.

The Ombudsman has emphasized the need for room for individual assessment of the necessity of single decisions. The report mentions, among other things, the confiscation of items in the possession of persons detained in police cells, as according to the current procedure, all belongings are removed from the person before they are taken to a cell. Due to this, the recommendation is made to the Southern Iceland Commissioner of Police that they ensure that the implementation of confiscation of items allows room for individual assessment of the need to remove individual items, for example, eyeglasses and hearing aids.

During the visit, it was learned that continuous video surveillance is maintained of all police cells. Due to this, the recommendation is addressed to the Southern Iceland Commissioner of Police that the implementation of video surveillance be reviewed and an assessment made in each individual case as to whether an arrested person needs to be subjected to continuous video surveillance. The recommendation is also made that the Commissioner remove a non-functional camera in the reception room of the detention facilities directed at the area where body searches take place. The recommendation in previous reports of the Ombudsman to the National Commissioner of Police, that it be examined whether there is cause to make proposals for a general procedure for video surveillance of police cells, is reiterated.

The premises of the police station in Selfoss place some limits on the police's activities, e.g. with regard to security, the privacy of detainees and work facilities. Considering this, as well as other comments made in the report, the recommendation is addressed to the Minister of Justice that they consider whether the building that currently houses the police station and the police cells meets the requirements set for the nature and scope of their activities.

The recommendation is addressed to the Southern Iceland Commissioner of Police that harmful items in the detention facility be stored in such a way that they are not accessible to arrested persons who may pass through the area and likewise to ensure disposal of refuse so that it does not pose a biohazard.

The report makes various recommendations regarding facilities in the police cells, such as concerning the possibilities of detainees to monitor the passage of time, the lighting control, lack of daylight in the cells and the location of emergency buttons.

The report mentions the mechanism on the door of the sanitary facility available to detainees, which is such that it does not exclude that staff can observe them. Therefore, the recom- mendation is addressed to the Commissioner of Police that they consider whether it is possible to have detainees use a toilet where privacy is guaranteed if there is no reason why the person needs to be in view during use of the toilet. Furthermore, the recommendation is directed to the Commissioner that they arrange proce-

dures in the detention area so that a request by detainees to use the toilet is acted upon without delay.

During the ombudsman's visit, it was learned that the police station lacks menstrual products specifically intended for women kept in police cells. In light of this, the recommendation is addressed to the Commissioner of Police that they ensure that menstrual products are available free of charge and to inform detainees that it is possible to request such products. It must also be ensured that the menstrual products that are available satisfy the different needs of women and that the products are accessible in a manner making it uncomplicated for women to request them and dispose of them after use.

Adequate supervision of persons kept in police cells is one of the basic prerequisites for the police to be able to guarantee their safety. Police procedures recommend that detainees be checked every twenty minutes or more often. However, in conversations with the staff of the police station, it was learned that, in general, checks on detainees do not take place on a regular basis. Instead, video surveillance is used to a large extent to monitor detainees. The report points out, among other things, that surveillance cameras do not replace actual supervision, although they can be an important part of ensuring the safety of those staying in police cells. The recommendation is made to the Commissioner of Police that they organize a procedure for active supervision by employees of individuals in police cells which ensures checking in on them no less frequently than every twenty minutes, and more often if deemed necessary according to the evaluation of employees at any given time.

The police cells have a buzzer system, which enable detainees to contact the staff of the police station, e.g. to request food or drink, to go to the toilet or if in need of emergency assistance. In one instance during the Ombudsman's visit, more than thirty minutes elapsed from the time the buzzer signal sounded until the person was attended to. The recommendation is made that the Commissioner of Police make sure that detainees are attended to without delay after an emergency signal is received from a cell, and that a clear procedure applies to this matter.

According to the regulation on the legal status of detainees, police questioning etc., a detention report must be written on the detention of every person in a police cell. The provisions of the regulation specify the information that must be included in the report, such as who made the decision on detention, whether the detainee was visibly injured when placed in a police cell, when the detainee was provided with food, etc. An examination of the detention reports received by the Ombudsman in connection with the visit indicates that the recording of aspects required in the regulation was lacking in many respects. This practice seemed to some extent to be explained by the fact that the employees did enter some of these aspects in the police system (LÖKE) instead of in the detention report. Therefore, the recommendation is

made to the Commissioner of Police that it be ensured that the aspects listed in the regulation are always recorded in detention reports. The recommendation is also made that the Commissioner see to it that all items confiscated from an arrested person are included in a personal property report and ensure that the person signs this report when the property is returned following the conclusion of detention.

The Ombudsman's report refers to the training and education of police officers, including weapons training and arrest exercises. It points out that substitute staff do not receive training or formal guidance in the supervision of persons held in police cells. The recommendation is made to the Commissioner of Police that they ensure, as appropriate in co-operation with the National Commissioner of Police and the Minister of Justice, adequate training, instruction and continuous and continuing education of police officers, so that they know the main human rights standards and legislation, methods of using force and first aid, and that sufficient consideration is given to the obligations incumbent on the police when detaining arrested persons.

Right at the beginning of detention, there may be a reason to seek the assistance of medical personnel to assess the detainee's health, for example, in order to ascertain whether hospitalization or other healthcare is needed. The report raises issues concerning the current procedure in relation to healthcare assistance for detainees, which does not specify, for example, which employee is responsible for assessing whether the condition of a detained person is such that a doctor's assistance should be requested. Due to this, the suggestion is made to the Southern Iceland Commissioner of Police, as appropriate together with the National Commissioner of Police, that work procedures regarding responsibility for and implementation of the assessment of the need for healthcare services of an arrested person be clarified. The recommendation is also made to the Southern Iceland Commissioner of Police that they ensure that an individual assessment is carried out as to whether the presence of the police is needed during medical consultations. In connection with the examination of the data received from the Commissioner on registration and administration in connection with suicides and suicide attempts, the Ombudsman also points out to the Commissioner to ensure the correct registration of incidents in the police cells and to take due note of the updated registration options that are available in this regard.

The authorities may be obliged to take the initiative in providing guidance to citizens, including on channels for complaints in the public administration. In this regard, the recommendation is made that the Police Commissioner ensure that information on appeal and complaint channels is presented systematically and that employees are specifically instructed on how to safeguard these rights of persons held in detention.

The procedures on which the operation of the police cells is based have not been updated since 1995. In preparing this report, information was received that their review was well advanced. The suggestion is made to the Southern Iceland Commissioner of Police that they follow up on the planned review.

The Ombudsman will continue to monitor the development of these issues, but requests that the Southern Iceland Commissioner of Police, and other authorities to whom recommendations are directed, account for their responses to the report by 1 June 2024.

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The Southern Iceland Commissioner of Police

Organisational chart 2023