PARLIAMENTARY OMBUDSMAN OF FINLAND

SUMMARY OF THE ANNUAL REPORT 2018

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To the reader

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

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

Licentiate in Laws and LL.M. with Court Training, Principal Legal Adviser Mr *Mikko Sarja* was selected to serve as the Substitute for a Deputy-Ombudsman for the period 1 October 2017–30 September 2021. He performed the tasks of a Deputy-Ombudsman for a total of 54 days during the year under review.

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

The original annual report is about 370 pages long. This brief summary in English has been prepared for the benefit of foreign readers. The longest section of the original report, a review of oversight of legality and decisions by the Ombudsman by sector of administration, has been omitted from it. However, the chapter dealing with the oversight of covert intelligence gathering as well as the chapter of European Union law issues are included in this summary.

I hope the summary will provide the reader with an overview of the Parliamentary Ombudsman's work in 2018.

Helsinki 20 May 2019

Petri Jääskeläinen
Parliamentary Ombudsman of Finland

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Decisions marked with an asterisk * (for example 123/4/18*) can be found as press releases on the Ombudsman's web site: www.ombudsman.fi/english.

Photos

The photographs on the front pages of the sections feature shots of the steel statue deplating giant strawberries called "Oma maa mansikka" (2007) by sculptor Jukka Lehtinen, located at the front of the Finnish Parliament Annex. Photos: Office of the Parliamentary Ombudsman photo archive (p. 10, 24, 43, 151, 165, 170).

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1 General comments

Parliamentary Ombudsman
Mr Petri Jääskeläinen

The Ombudsman supervises the rights of the elderly

The elderly population of Finland grows rapidly. At the same time, the need for and amount of social welfare and health care services as well as other services and support measures for the elderly increase. This in turn also increases the need for monitoring and promoting the rights of the elderly.

The Office of the Parliamentary Ombudsman has been preparing for this development in a variety of ways. In 2017, the rights of the elderly were collected into a dedicated category, while previously the issues related to the rights of the elderly were divided between several different categories depending on the administrative sector of each issue. The separate and dedicated category makes it easier to obtain a general picture and facilitates the monitoring of and reporting on the rights of the elderly. The Ombudsman's Annual Report for 2017 included a sector-specific section on the rights of the elderly for the first time; it describes the Ombudsman's decisions on complaints and other activities in the field.

The category was also assigned its own principal legal adviser, whose tasks include monitoring the activities, legislation and case law in the field in particular, as well as preparing and coordinating the Office's activities in the field. The amount of activities on the Ombudsman's own initiative concerning the monitoring and promotion of the rights of the elderly have been increased by focusing more inspections on residential units for the elderly than previously.

These measures were implemented through a rearrangement of duties within the Office without new resources. In practice, only a few other human resources in addition to the principal legal adviser could be assigned to the duties in the category.

During the year under review, severe deficiencies in certain residential units for the elderly became public. The existence of deficiencies as such was not a new issue – for example, the list "Ten essential fundamental and human rights problems in Finland" in the Ombudsman's annual report stated as follows already in 2013:

"Tens of thousands of elderly customers in Finland live in institutional care and assisted living units. Shortcomings related to nutrition, hygiene, change of diapers, rehabilitation and access to outdoor areas are identified continuously as is substi-

tuting medication for insufficient staffing. There are also shortcomings in safety, outdoor recreation arrangements and services for running errands. Measures limiting the right to self-determination in the care of the elderly should be based on law. However, the required legislative foundation is entirely lacking. A legal reform is underway, but its preparation has been delayed. Resources for internal oversight of the public administration are insufficient. Regional state administrative agencies have no realistic means of supervising care provision comprehensively." Mainly the same deficiencies are still topical (see the corresponding list in section 3.6.1 of this annual report).

Making the monitoring of the rights of the elderly more effective requires increasing the resources for monitoring. In fact, the deficiencies that became public during the year under review led to the Parliament granting an additional appropriation for the 2019 budget of the Office of the Parliamentary Ombudsman for enforcing and promoting the rights of elderly people. This appropriation made it possible to hire three legal advisers for the Ombudsman as well as one expert and one information officer for the Human Rights Centre until the end of 2019. The additional appropriation is also used for the fees of external experts, inspection tours, reports, education and information. More resources were also allocated to the special supervisory authorities for social welfare and health care, that is, Valvira and the Regional State Administrative Agencies.

The activities and observations of the Ombudsman with regard to the monitoring and promotion of the rights of the elderly have been described in section 3.5.14 of this report. In this address, I discuss the rights of the elderly *from the point of view of the Ombudsman institution*. What are the powers and duties of the Ombudsman in monitoring and promoting the rights of the elderly? How do they differ from the powers and duties of other supervisory authorities?

The Ombudsman supervises the realisation of all rights of the elderly

The Ombudsman is a general overseer of legality. While the power of other supervisory authorities is limited to certain services in e.g. social welfare and health care, the Ombudsman also supervises the realisation of all other rights of the elderly in addition to them.

For example, the Ombudsman monitors the right of the elderly to equal treatment, self-determination, personal liberty and integrity, protection of privacy, freedom of religion and conscience, their participatory rights, linguistic rights and protection under the law, even when they are not connected to social welfare and health care services.

The Ombudsman supervises the rights of the elderly in all administrative sectors

The Ombudsman shall ensure that all authorities and private bodies who are performing a public task, obey the law and fulfil their obligations. The private bodies who perform public tasks within the Ombudsman's jurisdiction include, for instance, private companies offering services for the elderly as outsourced municipal services.

The task of the Ombudsman as a general overseer of legality is also evident in the Ombudsman monitoring the realisation of the rights of the elderly concerning all authorities and private bodies performing public tasks regardless of the administrative sector of the authority or other party. For example, changing the services of the authorities to electronic format may endanger the availability of services for elderly persons in all administrative sectors. Therefore, the duties and perspective of the Ombudsman are more extensive than those of the special supervisory authorities.

The Ombudsman supervises other supervisory authorities

The Ombudsman is the supreme overseer of legality. This means that the Ombudsman supervises not only the providers of services for the elderly and their self-monitoring, but also all supervisory authorities. For example, with regard to the social welfare and health care services for the elderly, the Ombudsman monitors both the municipalities responsible for the organisation and monitoring as well as the special supervisory authorities, i.e. Valvira and the Regional State Administrative Agencies, in addition to the Ministry of Social Affairs and Health.

Only the Ombudsman can supervise the functionality and scope of the supervisory mechanism as a whole. With regard to the special supervisory authorities, this often involves cooperation and coordinating the monitoring, but the Ombudsman also constantly processes complaints related to them.

The Ombudsman can use a wide range of measures and methods

The effective monitoring and protection of the rights of the elderly requires investigating individual complaints concerning the rights of the elderly and the possibility of investigating matters on one's own initiative, as well as carrying out inspections in residential units for the elderly and on authorities handling matters related to the elderly, for example. These matters are a part of the Ombudsman's duties, and the Ombudsman has a comprehensive right of access to information and extensive powers to take measures in order to remove shortcomings he has discovered. Because the elderly or their family members only rarely file complaints, the Ombudsman's power to carry out inspections and investigate matter either based on them or for other reasons on the Ombudsman's own initiative is essential.

In the statements given on various bills, the Ombudsman can also call attention to the realisation of the rights of the elderly, and the Ombudsman has the power to make proposals to improve legislation and remove deficiencies.

In addition, The Ombudsman has the right to institute criminal proceedings and the powers of a prosecutor in issues related to the Ombudsman's oversight of legality. This means that the Ombudsman can assess the issues under consideration comprehensively. The Ombudsman can not only give reprimands or present an opinion as a rebuke or intended for guidance, but also assess the need for penal measures. For example, during the year under review, the Deputy-Ombudsman ordered a pre-trial investigation to be carried out based on observations made during the inspection of a residential school.

The Human Rights Centre takes care of the general duties in promoting the rights of the elderly

The Human Rights Centre it is part of the Office of the Parliamentary Ombudsman but it operates autonomously and independently. The duties of the Human Rights Centre include providing information, education, training and research associated with fundamental and human rights, as well as drafting reports, presenting initiatives and issuing statements in order to promote and implement fundamental and human rights.

With regard to the rights of the elderly, the duties of the Human Rights Centre are largely similar to the general duties of the Ombudsman for Children related to promoting the rights of children, and correspondingly, they would also be similar to the duties of a potential Ombudsman for the Elderly. In contrast, investigating complaints and other individual cases as well as carrying out inspections in connection with the monitoring of the rights of both children and the elderly are the duty of the Ombudsman alone.

The duties of the Ombudsman and the Human Rights Centre are complementary and they support each other very well. The information and expertise accumulated through each party's activities can be used not only separately in the other party's activities, but also in joint informa-

tion, education and investigation projects. For example, in 2017 the Ombudsman and the Human Rights Centre commissioned the survey "Assessment of customers and family members on the home care of senior citizens". The information gathered in the survey is used in targeting and developing the oversight of legality.

The Human Rights Delegation acts as a cooperative body

The Human Rights Centre has a Human Rights Delegation, appointed by the Ombudsman for four years at a time. The Delegation is composed of representatives of civil society, research into fundamental and human rights as well as other bodies that participate in promoting and safeguarding these rights. At the moment, the Delegation has 38 members, most of whom are people active in various non-governmental organisations, but the Delegation also includes parties such as representatives of the supreme overseers of legality and all special ombudsmen (such as the Non-Discrimination Ombudsman).

The effective monitoring and promotion of the rights of the elderly requires cooperation by different parties and coordinating the activities. The Human Rights Delegation of the Human Rights Centre functions as a national cooperative body for actors in the sector of fundamental and human rights, and it deals with matters of fundamental and human rights that are of far-reaching significance and important in principle.

The special duties of the Ombudsman derived from UN Conventions support the monitoring of the rights of the elderly

The Ombudsman is the National Preventive Mechanism (NPM) in accordance with *the UN Optional Protocol to the Convention against Torture* (OPCAT). The NPM is responsible for conducting visits to places where persons are or may be deprived of their liberty. The scope of application of the Optional Protocol is intended to be very extensive. It applies, for instance, to the residential units for the elderly where doors may be kept locked or different kinds of restrictive measures may be used on the elderly.

In practice, the activities of the NPM involve conducting visits to, for example, elderly care homes for those suffering from dementia and similar conditions in order to prevent mistreatment and/or any abuse of the right to self-determination. In carrying out this task, the Ombudsman may use the assistance of experts. At the moment the Ombudsman has, for example, nine external experts in the field of health care available; one of them is a specialist in geriatric psychiatry and another is a specialist in geriatrics.

Together, the Ombudsman, the Human Rights Centre and the Human Rights Delegation act as the body in accordance with *the UN Convention on the Rights of Persons with Disabilities* (CRPD) tasked with promoting, protecting and monitoring the implementation of the rights guaranteed by the Convention. Many elderly people, such as elderly persons with memory disorders, are within the scope of this convention.

The purpose of the CRPD is to promote, protect and ensure the enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. The leading principles of the CRPD are non-discrimination and accessibility. The Convention emphasises the right of persons with disabilities to self-determination and their right to participate in decision-making that concerns them.

The duties in accordance with both conventions include international cooperation, training and exchange of information that support the activities of the Ombudsman and the Human Rights Centre in monitoring and promoting the rights of the elderly.

Possible legal reforms

With regard to the international conventions mentioned above, the monitoring and promotion of the rights of the elderly are already special tasks of the Ombudsman and the Human Rights Centre. However, the tasks could be highlighted

by laying them down as a specific special task in the Parliamentary Ombudsman Act. The powers required by the task are already included in the provisions of the Parliamentary Ombudsman Act that apply to the Ombudsman and the Human Rights Centre.

The monitoring and promotion of the rights of the elderly could also be centralised on the Ombudsman in the Act on the Division of the Duties of the Chancellor of Justice and the Parliamentary Ombudsman. The working group appointed by the Ministry of Justice to prepare the development of the division of duties of the Ombudsman and the Chancellor of Justice made such a proposal in the report it gave in the spring of 2019.

Conclusion

All authorities and private bodies performing public tasks, whose tasks include services for the elderly or with whom elderly people deal with, are primarily responsible for the implementation of the rights of the elderly.

In addition, external monitoring is needed. The special supervisory authorities, i.e. Valvira and the Regional State Administrative Agencies, are responsible for monitoring the social welfare and health care services for the elderly, and it must be ensured that they have sufficient resources for the task. Among others, the Non-Discrimination Ombudsman also monitors the rights of the elderly in their own area of responsibility.

In addition, the Parliamentary Ombudsman is needed. The key difference between the Ombudsman and other supervisory authorities is that as the general overseer of legality, the Ombudsman monitors and promotes the realisation of all rights of the elderly in all administrative sectors, with all authorities and private bodies who perform public tasks. As the supreme overseer of legality, the Ombudsman also monitors other supervisory authorities.

Together, the Ombudsman, the Human Rights Centre and its Human Rights Delegation form the Finnish National Human Rights Institution (NHRI). This institutional structure is very well suited for purposes such as promoting and monitoring the rights of the elderly. The Ombudsman investigates complaints related to the rights of the elderly, takes own initiatives and carries out inspections, and the Ombudsman has extensive powers to address any shortcomings he has discovered. The Human Rights Centre takes care of general tasks related to promoting the rights of the elderly, such as providing information, education, and drafting reports and presenting initiatives. As for the Human Rights Delegation, it functions as the national cooperative body for actors in the sector of fundamental and human rights and deals with matters of fundamental and human rights that are of far-reaching significance and important in principle. In addition, the Ombudsman and the Human Rights Centre have special tasks based on international conventions that support the monitoring and promotion of the rights of the elderly.

I am very glad that the Parliament granted an additional appropriation for the 2019 budget of the Office of the Parliamentary Ombudsman for enforcing and promoting the rights of elderly people. Making this appropriation permanent would be very important for ensuring that the rights of the elderly are realised.

Deputy-Ombudsman
Ms Maija Sakslin

Monitoring of the rights of the child

The Finnish Constitution includes special provisions on the fundamental rights of children. The rights of children as independent individuals are emphasised in the equality provision of section 6 of the Constitution. According to the provision, children shall be treated equally and as individuals and they shall be allowed to influence matters pertaining to themselves to a degree corresponding to their level of development. Equality must be secured both between children and between children and adults. Discrimination based on age is prohibited by the Constitution, and no one shall be treated differently on the ground of age.

This provision reflects the principle that fundamental rights belong to everyone without regard to age, children included, and minority does not constitute acceptable grounds for restricting the fundamental rights of a child.

According to the Constitution, the public authorities shall support families and others responsible for providing for children in such a way that they are able to ensure the well-being and personal development of the children. This provision highlights the role of the family in safeguarding the well-being of a child and the duty of the public authorities to support parents.

In 1993, the rationale of the Government proposal on the fundamental rights reform specifically referred to the fact that international developments emphasise the special recognition of the rights of children. The purpose of the provision on fundamental rights was to demonstrate that every child should be treated as an individual, not merely as a passive object.

The UN Convention on the Rights of the Child safeguards the right of children to protection and care, adequate provision of resources by society, and participation in civic life and decision-making concerning themselves. The Convention specifies that, in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration. The Convention on the Rights of the Child provides for both civil and political rights and economic, social and cultural rights. The right of children to influence their own affairs in accordance

with their level of development is perhaps the most important of the rights safeguarded by the Convention.

Finland acceded to the Convention on the Rights of the Child in 1991. According to the Convention, a child who is capable of forming his or her own views has the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child. Children have the right to express themselves and obtain information. The child's right to privacy and the freedom of thought, conscience and religion must be respected. The Convention safeguards children from arbitrary treatment and abuse. Children also have the right to education, play, rest and free time.

The Convention provides children taken into custody with the right to regular oversight of their treatment and other conditions of custody.

The Convention on the Rights of the Child reinforced the autonomy and right to self-determination of children, as well as their position as holders of their own rights.

Parliamentary Ombudsman

The Constitution assigns the Parliamentary Ombudsman the duty of monitoring the realisation of the fundamental and human rights of children. In the performance of this duty, the Ombudsman places great importance on discussions with the children, particularly those taken into custody.

The Parliamentary Ombudsman has been paying particular attention to the enforcement of the rights of the child for more than two decades now. Legality oversight related to the rights of the child is one of the special duties of the Ombudsman. This oversight was strengthened in 1998 with the establishment of the new office of Deputy Parliamentary Ombudsman, when legality oversight related to the rights of the child was assigned to one of the two Deputy Ombudsmen. Also the establishment of the office of Ombudsman for Children was discussed at the same time.

According to the rationale of the government proposal for the appointment of a second Deputy Parliamentary Ombudsman, the development of the Parliamentary Ombudsman institution should be aimed towards improving the supervision of the realisation of the rights of the child. Issues involving the rights of the child would be appointed to one of the Deputy Parliamentary Ombudsmen.

The Constitutional Law Committee seconded the motion, noting that centralising responsibility for the child-related issues falling under the remit of the Parliamentary Ombudsman to one of the Deputy Parliamentary Ombudsmen cannot be taken as a statement on the necessity of a dedicated Ombudsman for Children in Finland. At that time, the Parliamentary Ombudsman was not given specific tasks for the promotion and enforcement of the rights of the child. The position of children's rights in the oversight of legality has been consolidated, however. This duty could be designated as a special duty of the Parliamentary Ombudsman in law.

In an article published a few years later, in 2001, Deputy Parliamentary Ombudsman Riitta-Leena Paunio stated the opinion that the enforcement of the rights of the child at the individual level is a natural part of the Parliamentary Ombudsman's duty of enforcing fundamental and human rights. However, the promotion of the rights of the child on a general level would be better suited to a dedicated Ombudsman for Children.

The Ombudsman's primary task is to resolve complaints. However, the number of complaints filed by children is small. For this reason, it is important that the Parliamentary Ombudsman be able to intervene in illegal or otherwise reprehensible treatment on the Ombudsman's own initiative.

Approximately 300–400 legality oversight matters involving children are resolved each year. The majority of these decisions apply to the social welfare services. The second-highest number of decisions involving the rights of children were issued in the early and basic education sectors. Other matters related to the rights of the child involved health care, the criminal sanctions service, the courts, foreign nationals, the police, social insurance, enforcement and the activities of register offices.

From 2013, the Annual Report of the Parliamentary Ombudsman has presented key problems related to fundamental and human rights in Finland that have come up in connection with the Ombudsman's enforcement activities. The key concerns have not changed much over the years.

Child welfare services have no appropriate care places for the most challenging or troubled children. Children placed into care are not aware of their rights or the duties of the institution. Children often do not get the support from social workers that they are entitled to by law.

Restrictive measures are imposed in violation of the Child Welfare Act. Such measures are employed in unlawful situations and manners. Restrictive measures are used without the decisions required by law. The distinction between normal, acceptable boundaries and the restriction of a child's fundamental and human rights is not clear. Children and young people do not have access to sufficient mental health services. There are gaps in the service system between child welfare and psychiatric care. The service system lacks suitable places for children suffering from serious behavioural disorders.

Inspections

In order to promote children's rights and participation, the Parliamentary Ombudsman's inspections have, more than before, included confidential discussions with the children, which has also improved the efficiency of enforcement. Children have the right to express their views regardless of their age or level of development. The views of the child must also be taken into account. This right to be heard applies to children collectively as well.

As the supreme overseer of legality, the Parliamentary Ombudsman also supervises the activities of all other supervisory authorities. Through supervision during inspections and interviews with children, the Parliamentary Ombudsman also obtains information on the functionality of the supervision performed by other supervisory authorities. The inspections are also essential for the enhanced supervision of the activities of social workers, the municipality that placed the child into care and the State Regional Administrative Agency.

As a rule, inspections of the care places of children taken into custody are conducted without advance notice. The purpose of this has been to determine how the children are being treated, what types of restrictive measures are being used and how they are being implemented.

The inspections have uncovered serious shortcomings and received much publicity. I have initiated several investigations on my own initiative based on them. In addition to issuing a reprimand opinion as a rebuke or for guidance, the Ombudsman can also assess the need for criminal sanctions. Indeed, I have ordered criminal investigations to be conducted as a result of the observations made during the inspections of two child welfare institutions.

Ombudsman for Children

The tasks of the Ombudsman for Children are to reinforce the status and rights of children in society and promote the realisation of the UN Convention on the Rights of the Child. The office of Ombudsman for Children was established in 2004. Making the opinions of children heard in public discussion and, in particular, informing children themselves of the rights of the child are key duties of the Ombudsman. The Ombudsman for Children is tasked with promoting the realisation of the interests and rights of children and the UN Convention on the Rights of the Child and general awareness of them.

In the preparatory documents for the Act on the Ombudsman for Children, it is noted that the key supervisory authority for the realisation of the rights of children is the Parliamentary Ombudsman. The Parliamentary Ombudsman supervises the legality of the exercise of public authority and compliance with the Constitution and other legislation in the discharge of official duties. The Constitution also assigns the task of enforcing the realisation of fundamental and human rights to the Parliamentary Ombudsman.

Together, the Parliamentary Ombudsman and the Ombudsman for Children are considered to constitute the independent national supervisory body under the UN Convention on the Rights of the Child.

The duties of the Parliamentary Ombudsman and Ombudsman for Children complement each other. Enforcement of the rights of the child is a special duty of the Parliamentary Ombudsman. For the most part, the Ombudsman's activities consist of retrospective enforcement related to individual cases. The task of the Ombudsman for Children is to promote the interests and rights of all children in Finland and make these perspectives heard in public debate and decision-making.

The Human Rights Centre operates in connection with the Office of the Parliamentary Ombudsman. The tasks of the Human Rights Centre have much in common with those of the Ombudsman for Children. Indeed, in the preparatory documents for the Act on the establishment of the Human Rights Centre, it was stated that overlap with, for example, the Ombudsman for Children's duties concerning the promotion of the rights of the child should be avoided when setting the focus for the Centre's activities. The task of the Human Rights Centre is to promote communications, training, education and research on fundamental and human rights, as well as cooperation in these issues. The Human Rights Centre has much of discretionary leeway in choosing which fundamental and human rights, issues or situations to focus on.

The Parliamentary Ombudsman and Human Rights Centre have implemented a joint project intended to reinforce and promote education and training related to fundamental and human rights in schools. The project has included school visits and drawing up training materials for principals. Improving competencies related to the rights of children in teacher education is essential from the children's perspective.

Conclusion

The primary concern of the Committee charged with the enforcement of the implementation of the Convention on the Rights of the Child has been that the institution enforcing the implementation of the Convention should be able to supervise, promote and safeguard the rights of children in an independent and efficient manner, and with the broadest authority possible. The Parliamentary Ombudsman has extensive rights to obtain information as well as a broad mandate. During the past year, the Parliamentary Ombudsman has developed the methods for improving the efficiency of enforcement and sought to consolidate cooperation with both the Human Rights Centre and Ombudsman for Children, as well as other parties working to promote the rights of the child.

According to one survey, children placed into care wish for greater and more focused enforcement. It is the Parliamentary Ombudsman's objective to reinforce the rights of the child, improve the legal protection of children and ensure that children have access to assistance for filing complaints. For this purpose, the Ombudsman has increased information directed to children, for example in the form of webpages targeted at children and the young people.

Deputy-Ombudsman
Mr Pasi Pölönen

Overseeing the rights of persons deprived of their liberty – a traditional and evolving special task of the Parliamentary Ombudsman

Oversight since the days of Russian rule

Finland has an extensive tradition of overseeing the rights and conditions of persons deprived of their liberty. During the period of Russian rule (1809–1917), inspecting prisons to ensure that they were appropriately managed was the official duty of the only supreme overseer of legality at the time, the Procurator (now the Chancellor of Justice). According to the 1812 ordinance, the Procurator himself was to visit the prison and spinning room at Turku Castle at least once a month and to inspect the prisoner rosters on a regular basis. By contrast, inspecting the other prisons in Finland was the duty of junior civil servants reporting to the governors.

The office of Parliamentary Ombudsman was established in independent Finland in 1920, but its function was minor for a considerable period of time. In the first year, only 39 complaints were received; but 22 inspections were made, eight of them at closed institutions.[1)] Later, in the 1930s, overseeing the rights of all persons deprived of their liberty – not just prisoners – was defined as principally being the duty of the Parliamentary Ombudsman, removing it from the remit of the Chancellor of Justice. Neither of the aforementioned supreme overseers of legality actually wanted this duty at the time, and the end result was the enactment of what was known as the 'Act on the Division of Duties'. With this Act, which entered into force in 1934, the Chancellor of Justice was released from handling matters concerning prisoners and forcible means affecting personal liberty, and indeed any complaints concerning persons deprived of their liberty. The Chancellor of Justice was also released from overseeing the legality of the Defence Forces.[2)]

1) See Paunio, Riitta-Leena: 'Objectives and challenges – 90 years of the Ombudsman's oversight of legality.' In: Parliamentary Ombudsman 90 years, p. 9.

2) See Pajuoja, Jussi – Pölönen, Pasi: Ylin laillisuusvalvonta. Oikeuskansleri ja oikeusasiamies. [Supreme overseers of legality. The Chancellor of Justice and the Parliamentary Ombudsman.] Tietosanoma 2011, pp. 33–35, 42 and 135–136. See also Kuusikko, Kirsi: Oikeusasiamiesinstituutio [The Parliamentary Ombudsman institution], Suomalaisen Lakimiesyhdistyksen julkaisuja, E-sarja N:o 22, 2011, pp. 115–117

This basic policy decision made decades ago had far-reaching repercussions. As the overseer of the rights of persons deprived of their liberty, the Parliamentary Ombudsman was the better placed of the two high officials to adopt the duties that emerged much later in the field of human rights oversight (overseeing the rights of children, the human rights institution, the national preventive mechanism against torture, the rights of disabled persons). These new duties continue to shape the profile of the institution of the Parliamentary Ombudsman and current emphases in the oversight of legality.

Oversight under several mandates

The Parliamentary Ombudsman's duty of oversight of legality comprises two strands: overseeing compliance with the law (traditional oversight of legality) and overseeing the enjoyment of fundamental and human rights. Both types of oversight are mainstreamed in all of the activities of the Parliamentary Ombudsman. This plurality is particularly apparent in the inspections undertaken.

The traditional duties are described in section 5 of the Act on the Parliamentary Ombudsman, according to which the Ombudsman shall carry out the on-site inspections of public offices and institutions necessary to monitor matters within his or her remit. Specifically, the Ombudsman shall carry out inspections in prisons and other closed institutions to oversee the treatment of inmates, as well as in the various units of the Defence Forces and Finnish peacekeeping contingents to monitor the treatment of conscripts, other military personnel and peacekeepers.

The first sentence of this provision is broad in its obligation ("[as] necessary") and refers on a general basis to visits to public offices and institutions. Keeping contact with operators in various administrative sectors is justifiable in promoting the exchange of information. Visits agreed in advance also have an inspection component to them (e.g. processing times at various agencies).

The part of the provision referring to closed institutions is more peremptory ("shall carry out"). This applies to actual inspections under a special duty of the Parliamentary Ombudsman that goes back to the aforementioned Act on the Division of Duties. In the oversight of closed institutions, the fundamental and human rights aspect is prominent alongside the traditional legality aspect. The enjoyment of fundamental rights has actually been addressed even in the early years of the Parliamentary Ombudsman's office, although fundamental and human rights obligations as we know them today have mostly emerged since the Second World War. After the fundamental rights reform of 1995, observance of fundamental and human rights were provided for by law as a specific duty of the Parliamentary Ombudsman, and this is to be addressed in inspections too.

Another new consideration in the oversight of closed institutions is the Parliamentary Ombudsman's role as the National Preventive Mechanism against torture (the OPCAT role, see section 3.5). This role was provided for in the Act on the Parliamentary Ombudsman in 2013. As the National Preventive Mechanism, the Parliamentary Ombudsman is required to inspect places where persons are or may be deprived of their liberty, either by virtue of an order given by a authority or at its instigation or with its consent or acquiescence (place of detention). It includes prisons, police departments and remand prisons, but also places like detention units for foreigners, psychiatric hospitals, residential schools, child welfare institutions and, under certain conditions, care homes and residential units for the elderly and persons with intellectual disabilities. The mandate also extends to the private sector to include detention facilities on passenger vessels, for instance. The role goes beyond simple inspections, but the inspections themselves underwent certain minor changes with the addition of this duty; constructive dialogue and a preventive approach are of the essence. In other words, oversight is now not just about evaluating the legality of operations after the fact.

A third aspect in the inspecting of closed institutions comes from the mandate of the national human rights institution (the Parliamentary Ombudsman, the Human Rights Centre and its Human Rights Delegation) in overseeing the rights of disabled persons. This special duty applies to

more than just closed institutions, but it is of direct relevance in the inspecting of closed institutions. In inspections of OPCAT institutions, a separate protocol on obstacle-free access is written up by default, unless the topics of obstacle-free access and the enjoyment of the rights of disabled persons are specifically addressed in the inspection programme and protocol.

Great importance of inspections

Although the number of inspections only amounts to about 2% of the annual number of complaints, the Parliamentary Ombudsman's office spends considerably more than 1,000 person-days per year on inspections, about 10% of the referendaries' total person-days. This function also takes up a considerable percentage of the working hours of the decision-makers, i.e. the Parliamentary Ombudsman and Deputy-Ombudsman, and of the administrative staff of the office. Also, external OPCAT experts are employed particularly in inspections in the social welfare and health care sector (on 19 occasions in the past year).

Generally, inspections yield broader-based information on matters relevant for the oversight of legality than individual complaints. Information is obtained for instance by having conversations with inmates and personnel, by observing the premises and by presenting requests for information to the institution, either on site or immediately after the inspection. The office sometimes undertakes to investigate matters at its own initiative, and most of the office's own initiatives in fact originate from an inspection. Inspections allow the Parliamentary Ombudsman to allocate the available legality oversight resources flexibly and independently according to needs.

The protocol drawn up on an inspection of a closed institution is generally very comprehensive and may include several dozen comments by the Parliamentary Ombudsman. Yet in the annual statistics each inspection appears only as the entry 'Inspection completed'. The main thing is of course not the statistics but the steering impact, which is in fact considerable. Even though the Parliamentary Ombudsman's comments do not have legal force, they are generally complied with well. The inspection protocols are also regularly posted online, and they can thus have an impact more widely than just on the institution inspected.

Broad domain presents a challenge

An inspection is carried out under a decision-maker as part of the office's inspection team or by the referendaries of the office. Out of the 128 inspections carried out in 2018, a decision-maker was present in person in 46 of them and the remaining 82 were led by referendaries. More than half of the inspections (73) were at closed institutions; of these, 15 were led by a decision-maker.

By far the largest number of inspections of closed institutions concern the social welfare sector (children's homes, residential schools, service centres, group homes, disabled care units, nursing homes, etc.). In 2018, 32 institutions were inspected in this sector; 23 of the inspections were unannounced. The next largest groups of institutions inspected were police detention units (14), prisons (13) and health care facilities (10). The inspections of police detention units were unannounced in almost every case. Unannounced inspections of health care facilities were also common. Most of the prison inspections, by contrast, were announced and scheduled in advance; this allows for greater potential for discussions with the inmates.

It is the duty of the national oversight authority to inspect all closed institutions "on a regular basis". In practice, this is not possible, because there are several thousand such institutions all around the country. Inspections are planned with regard to the special characteristics of each sector, and the institutions inspected are generally selected on the basis of a longer-term strategy laid out in advance. For instance, regular inspections can be maintained for police detention units, major prisons and state forensic psychiatric clinics. Beyond that, the selection of sites to inspect and decisions on the duration of the inspections and the use of an external OPCAT expert (if any) are made on the basis of available background information. This information comes from complaints, from other oversight authorities (the National Super-

visory Authority for Welfare and Health, the National Institute for Health and Welfare, Regional State Administrative Agencies, the National Police Board, the Central Administration of the Criminal Sanctions Agency) and from various NGOs such as organisations of patients and family members.

Yet despite all of the above, the role of the Parliamentary Ombudsman in the oversight of the rights of persons deprived of their liberty can be no more than that of an overseer of overseers. Self-monitoring by operators in any particular administrative sector is of crucial importance. How much need there is for direct inspections by the Parliamentary Ombudsman depends to a great extent on how comprehensive the coverage of self-monitoring in a particular administrative sector is. In the criminal sanctions system, the Parliamentary Ombudsman traditionally has an exceptionally active role. But the Parliamentary Ombudsman can underline the importance of investing in self-monitoring through inspections of closed institutions in all administrative sectors. Also, the Parliamentary Ombudsman can convey information on best practices between institutions and, conversely, report on unjustifiable differences between institutions.

Shifts in focus in the oversight of closed institutions?

Previously, the Parliamentary Ombudsman's inspections have focused on traditional sites such as prisons, police detention units and psychiatric hospitals. Inspections of this 'hard core' of closed institutions will certainly remain an important part of the operations of the Parliamentary Ombudsman in the future.

On the other hand, there is also a clear ongoing trend towards investing in inspections of closed institutions of other kinds. The resources of the office of the Parliamentary Ombudsman have increasingly been channelled towards inspecting institutions for children and the elderly (for more on this, see the remarks by Parliamentary Ombudsman Jääskeläinen and Deputy-Ombudsman Sakslin above). This trend in the oversight of closed institutions – inspections of units in the social welfare sector – is relatively new even in the international context. For instance, the European Committee for the Prevention of Torture has only been carrying out inspections of social welfare institutions for quite a short period of time.

It is perhaps not immediately obvious that the operations of institutions for the elderly and for children may also involve depriving persons of their liberty. For this reason alone – and more besides – they require effective oversight. In Finland, the Parliamentary Ombudsman, working with the Human Rights Centre, now has better potential for improving inspections and other oversight of operations concerning the elderly in particular, thanks to additional appropriations provided.

2 The Finnish Ombudsman institution in 2018

2.1 REVIEW OF THE INSTITUTION

The year 2018 was the Finnish Ombudsman institution's 99th year of operation. The Parliamentary Ombudsman began his work in 1920, making Finland the second country in the world to adopt the institution. The Ombudsman institution originated in Sweden, where the office of Parliamentary Ombudsman was established in 1809. After Finland, the next country to adopt the institution was Denmark in 1955, followed by Norway in 1962.

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

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

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

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

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

In addition to the Parliamentary Ombudsman, Parliament elects two Deputy-Ombudsmen; their term of office is four years. The Ombudsman decides on the division of labour between the three. The Deputy-Ombudsmen decide on the matters they are given responsibility for independently and with the same powers as the Ombudsman.

Parliamentary Ombudsman Petri Jääskeläinen made decisions on cases involving questions of principle, the Government, and other of the highest organs of state. In addition to this, his responsibilities also included, among others, matters concerning courts and justice administration, health care, guardianship, language, the rights of foreigners and persons with disabilities, as well as covert intelligence gathering. Parliamentary Ombudsman Jääskeläinen was also responsible for handling matters concerning the coordination of tasks and reporting in the National Preventive Mechanism against Torture.

Deputy-Ombudsman Maija Sakslin dealt with matters such as social welfare, children's rights and early childhood education and care services, rights of the elderly, regional and local government, the Church, and debt enforcement. In addition, she assumed responsibility for matters relating to taxation, the environment, agriculture and forestry, defence administration, as well as the Customs and the Border Guard.

Deputy-Ombudsman Pasi Pölönen was responsible for matters relating to the police, the prosecution service, criminal sanctions, meaning matters relating to the treatment of prisoners, the enforcement of sentences, and prisoner after-care services. He also resolved matters concerning social insurance, social assistance, education, science and culture as well as labour affairs and unemployment security.

The Parliamentary Ombudsman's decision to change the division of tasks took effect on 1 September. Hence, Parliamentary Ombudsman Jääskeläinen resolved matters concerning the police, the Emergency Response Centre Administration and rescue services, as well as the prosecution service; however, not including the Office of the Prosecutor General. Matters concerning, among others, health care were transferred to Deputy-Ombudsman Maija Sakslin and matters concerning the courts, justice administration and legal assistance as well as military affairs, defence administration and the Border Guard were transferred to Deputy-Ombudsman Pasi Pölönen. A detailed division of labour is provided in Annex 2.

If a Deputy-Ombudsman is prevented from performing their tasks, the Ombudsman can invite a Substitute for the Deputy-Ombudsman to stand in. The substitute for the Deputy-Ombudsman in 2018 was Principal Legal Adviser Mikko Sarja, who served as a substitute during the year under review for a total of 54 working days.

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

The Parliamentary Ombudsman is part of the National Human Rights Institution of Finland as set forth in the so-called Paris Principles defined by the UN (A/RES/48/134) together with the Human Rights Centre established in 2012 and its Delegation. For more information on the Human Rights Centre and the National Human Rights Institution of Finland, refer to sections 3.3 and 3.2.

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

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

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

The two supreme overseers of legality, the Ombudsman and the Chancellor of Justice, have virtually identical powers. The only exception is the oversight of advocates, which falls exclusively within the scope of the Chancellor of Justice. Only the Ombudsman or the Chancellor of Justice can decide to bring legal proceedings against a judge for unlawful action in an official capacity.

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

the division of tasks between the Parliamentary Ombudsman and the Chancellor of Justice can be found in Appendix 1.

In its statement (PeVL 52/2014) on the Government Report on Human Rights Policy, and in several of its reports when processing the reports of the supreme overseers of legality, the Parliament's Constitutional Law Committee has considered it important that the division of tasks between the Parliamentary Ombudsman and the Chancellor of Justice is defined and clarified and their cooperation improved. The committee has also submitted its opinion on the matter when processing reports of the overseers of legality from 2016 and 2017, and expedited the making of an examination (PeVM 3/2018 vp, PeVM 2/2017 vp, PeVM 1/2017 vp). Parliamentary Ombudsman Jääskeläinen dealt with the development of the division of tasks in his Parliamentary Ombudsman's address in the summary of the annual report for 2016 (pp. 12–20).

On 25 September 2018, the Ministry of Justice appointed a working group to determine and evaluate the current status, development needs and possibilities of the division of tasks between the Parliamentary Ombudsman and the Chancellor of Justice, and to prepare policy suggestions on the basis of the evaluation. The instruction was to evaluate the division of tasks and the possibilities for improving cooperation within the boundary conditions as set forth in the Constitution. Ilkka Rautio, Master of Laws trained on the bench, was appointed Chairman of the working group and Parliamentary Ombudsman Petri Jääskeläinen, Tuomas Pöysti, Chancellor of Justice, and Sami Manninen, Chief Director, as members of the working group. Professor Tuomas Ojanen was appointed permanent expert and special expert Anu Mutanen as secretary. The term of the working group is from 1 October 2018 to 30 April 2019.

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

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

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

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

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

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

The values and objectives of the Office of the Parliamentary Ombudsman

Values

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

Objectives

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

Tasks

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

Emphases

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

Operating principles

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

Operating principles in especially complaint cases

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

The importance of achieving objectives

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

2.5 OPERATIONS AND PRIORITIES

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

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

Following a legislative amendment that entered into force at the beginning of 2014, the Ombudsman's remit concerning the special monitoring of covert intelligence gathering was ex-tended to cover all methods of covert intelligence. The amended legislation has also expanded the scope of supervision accordingly. Covert intelligence gathering is used by the police, Customs, the Border Guard and the Defence Forces.

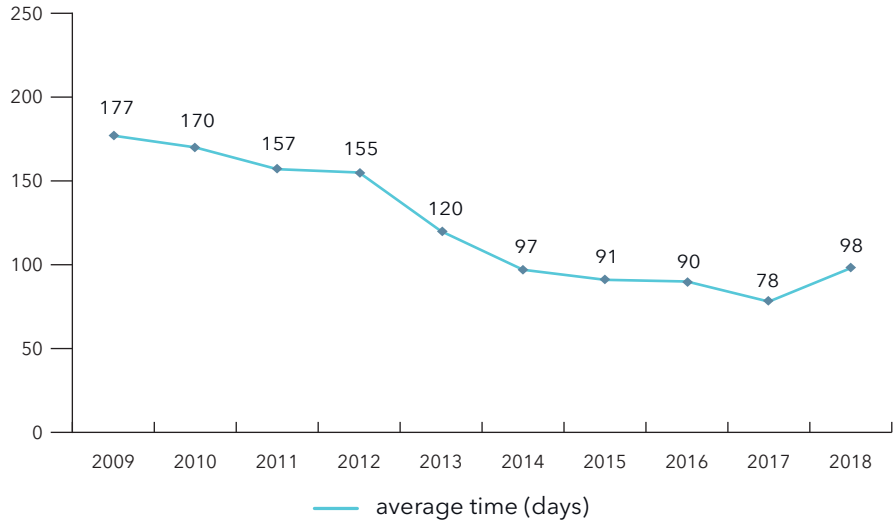
Covert intelligence gathering involves interfering with several constitutionally guaranteed fundamental rights and liberties, such as the right to privacy, confidentiality of communications and protection of domestic peace. The use of covert intelligence gathering is usually subject to the permission of a court; this ensures that it is used lawfully. However, the Ombudsman also plays a vital role in the appropriate monitoring of the use of such intelligence gathering, which must be kept secret from the subject of investigation at the time. The oversight of covert intelligence gathering is detailed in section 4.

Fundamental and human rights are relevant to the oversight of legality not only when individual cases are being investigated, but also in conjunction with inspections and when deciding on the focus of own-initiative investigations. Emphasising and promoting fundamental rights guides the thrust of the Ombudsman's activities. In connection with this, the Ombudsman engages with various bodies, including the main NGOs. The Ombudsman addresses issues in connection with the inspections, as well as on his own initiative, that are sensitive from the perspective of fundamental rights and that have broader significance than individual cases as such. In 2018, the special theme for the monitoring of fundamental and human rights is the right to privacy. The content of the theme is outlined in section 3.8, which discusses fundamental and human rights.

In the year under review, the preparation of the Parliamentary Ombudsman's operative strategy was initiated. The general strategic starting point has been to implement the constitutional task of the Parliamentary Ombudsman such, that its impact is as extensive as possible.

COMPLAINTS ARE PROCESSED WITHIN ONE YEAR

With the amendment to the Parliamentary Ombudsman Act, which entered into force in 2011, the oversight of legality was enhanced by giving the Ombudsman greater discretionary powers and a wider range of operational alternatives, and by a greater focus on the perspective of the citizen. The period within which complaints can be made was reduced from five to two years. The Parliamentary Ombudsman was granted the possibility of referring a complaint to another competent



Average time taken to deal with complaints in 2009–2018

authority. The amendment of the Act also enables the Parliamentary Ombudsman to invite a Substitute Deputy-Ombudsman to discharge the duties of the Deputy-Ombudsman as and when required.

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

With the more effective processing of complaints, the Ombudsman achieved the target time – of one year for handling complaints – for the first time in 2013. The target has subsequently been met each subsequent year, including 2018, when there were no complaints older than one year pending a decision.

The average time taken to deal with complaints was 98 days at the end of the year, compared to 78 days at the end of 2017.

Complaints and other oversight of legality matters

The number of complaints received in 2018 was 5,594. This is around 650 (11%) fewer than in 2017 (6,256). At the time, the large number of complaints was due to the transfer of matters concerning basic social assistance from the municipalities to Kela (the Social Insurance Institution of Finland) which was not able to process them within the time limit prescribed in the law. Due to this, the number of complaints concerning Kela alone increased in 2017 by approximately 700, but decreased close to the previous number during the year under review. In the year under review, a total of 5,410 complaints were resolved. The corresponding number in 2017 was 6,094.

The number of complaints submitted by letter or fax or delivered in person has decreased in recent years, while the number of complaints sent by email has increased correspondingly. In 2018, the majority of complaints, 76%, where submitted electronically.

Before the introduction of the electronic case management system, complaints received by the Ombudsman were recorded under their own sub-

Complaints received and resolved in 2009–2018

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

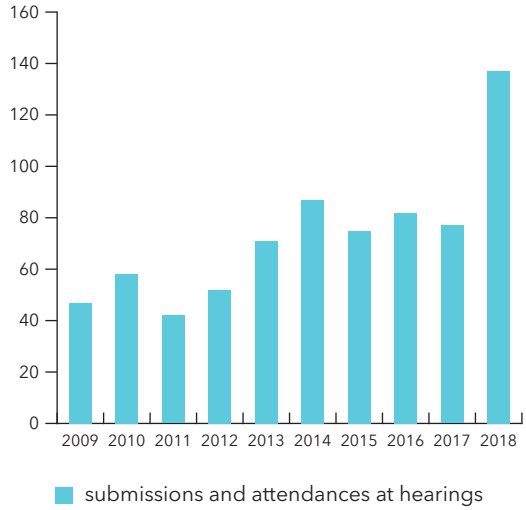
With the introduction of the electronic case management system in 2016, communications that were previously filed under category 6 "Other communications", are now filed under complaints. The processing of these communications, however, remains the same: they are forwarded to the Substitute Deputy-Ombudsman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

Once a complaint has been filed with the Office, a confirmation of receipt is sent to the complainant within approximately one week. The complainant also receives an immediate notification of the receipt of the email.

Some complaints are handled through an accelerated procedure. In 2018, 2,842 complaints, which is 52% of the total, were handled through the accelerated procedure. The purpose of the procedure is to identify immediately on receipt the complaints that require no further investigation. The accelerated procedure is suitable especially in cases where there is manifestly no ground to suspect an error, the time limit has been exceeded, the matter falls outside the Ombudsman's remit, the complaint is non-specific, the matter is pending elsewhere, or the complaint is a repeat complaint with no grounds for a reappraisal. In the accelerated procedure, the complainants do not receive a notification letter. If a complaint proves un-suitable for the accelerated procedure, the matter is referred back for the normal distribution of complaints, and the complainant will receive the letter of acknowledgement from the Registry Of-

■ received ■ resolved	2017	2018
Complaints	6,192 6,094	5,561 5,410
Transferred from the Chancellor of Justice	64	33
Taken up on own initiative	77 81	79 82
Requests for submissions and attendances at hearings	82 77	145 137
Total	6,415 6,252	5,818 5,629

Oversight-of-legality matters received and resolved in 2017–2018



Resolved requests for submissions and attendances at hearings between 2009 and 2018

fice. A draft response is given within one week to the party deciding on the case. The complainant is sent a reply signed by the legal adviser taking care of the matter.

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

Communications and messages that were submitted for information only, that are not considered to have been sent for the purpose of initiating action and that are in no way related to any other matter under process, are not recorded. They are, however, always reviewed by the Substitute Deputy-Ombudsman or the Secretary General. Communications sent using the feedback form on the Office website are dealt with in accordance with the principles described above. In 2018, a total of 4,757 written communications that had arrived for information were received.

In addition, submissions and attendances at hearings in various committees of Parliament are counted belonging to oversight of legality. In the year under review, the number of statements almost doubled.

In 2018, 76% of all the complaints that arrived were related to the ten largest categories. Statistics on the Ombudsman's activities are provided in Appendix 3.

In 2018, a total of 82 matters investigated on the Ombudsman's own initiative were resolved. Of these, 45 (55%) led to action on the part of the Ombudsman.

Measures

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

A prosecution for breach of official duty is the most severe sanction available to the Ombudsman. However, if the Ombudsman takes the view that a reprimand will suffice, he may choose not to bring a prosecution, even though the subject of oversight has acted unlawfully or neglected to ful-

MEASURES TAKEN BY PUBLIC AUTHORITIES	Measures								Total number of decisions	Percentages*
	Prosecution	Assessment of the need for pre-trial investigation	Reprimand	Opinion	Recommendation	Rectification	Other measure	Total		
Social welfare			16	149	1	11	16	193	1046	18,4
Criminal Sanctions field			4	118	10		15	147	434	33,9
Police		5	3	64	2	1	5	80	626	12,8
Health			6	47	8	2	9	72	589	12,2
Administrative branch of the Ministry of Economic Affairs and Employment			1	67	1			69	274	25,2
Social insurance			1	37	1	1	2	42	419	10,0
Local government			5	26	2		5	38	192	19,8
Administrative branch of the Ministry of Education and Culture			1	15	5	2	13	36	200	18,0
Aliens affairs and citizenship		1	6	10			2	19	134	14,2
Administrative branch of the Ministry of the Environment			1	13		1		15	126	11,6
Taxation			1	9	1	1	2	14	107	13,1
Enforcement (distraint)				8	3		3	14	152	9,2
Administration of law				7	2		2	11	176	6,2
Highest organs of government				9	1			10	157	6,4
Administrative branch of the Ministry of Finance			1	8				9	41	21,9
Administrative branch of the Ministry of Transport and Communications				2	3	1	3	9	139	6,5
Guardianship				7				7	82	8,5
Prosecutors				3			1	4	50	8,0
Administrative branch of the Ministry of Agriculture and Forestry				3				3	73	4,1
Administrative branch of the Ministry for Foreign Affairs				3				3	12	25,0
Customs				3				3	17	17,6
Administrative branch of the Ministry of Justice				2			1	3	62	4,8
Administrative branch of the Ministry of Defence				2				2	33	6,1
Administrative branch of the Ministry of the Interior				1				1	24	4,2
Total	–	6	46	613	40	20	79	804	5 492	14,6

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

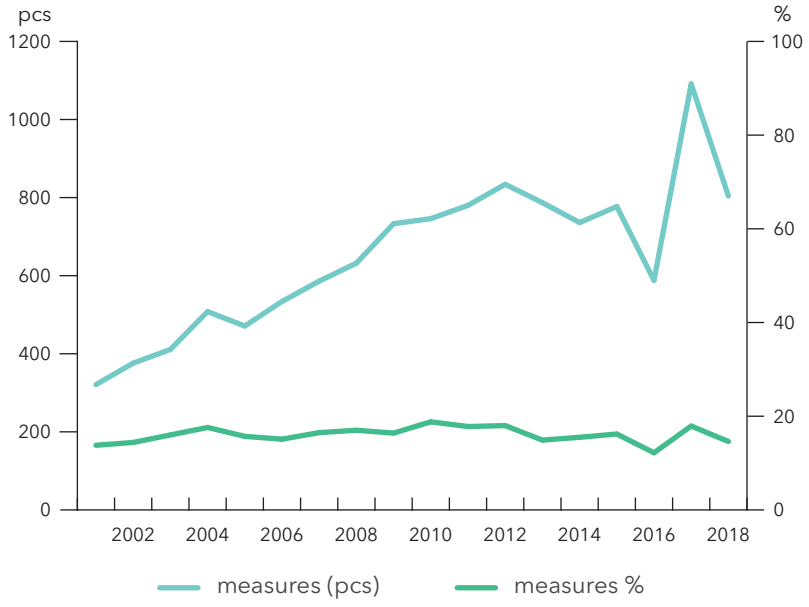
fil their duty. He may also express an opinion as to what would have been a lawful course of action or draw the attention of the oversight subject to the principles of good administrative practice, or to aspects that are conducive to the implementation of fundamental and human rights. The opinion expressed may be formulated as a rebuke or intended for guidance.

In addition, the Ombudsman may recommend the rectification of an error or draw the attention of the Government or other body responsible for legislative drafting to shortcomings that he has observed in legal provisions or regulations. The Ombudsman may also suggest compensation for an infringement that has been committed or make a proposal for an amicable solution on a matter. Sometimes an authority may preemptively rectify an error at a stage when the Ombudsman has already intervened with a request for a report. The proposals are listed in Appendix 4.

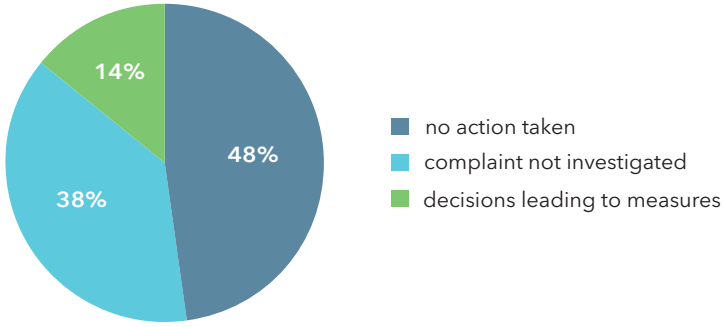
Decisions on complaints and investigations at the Ombudsman's own initiative that led to measures totalled 804 in 2018, which represented nearly 15% of all decisions. Approximately one fourth of complaints and investigations at the Ombudsman's own initiative were subject to a full investigation; in other words, at least one report and/or statement was obtained.

In about 44% of the cases (2,404), there were no grounds to suspect erroneous or unlawful action, or there was no reason for the Ombudsman to take action. A total of 213 cases (approximately 4%) were found not to involve erroneous action. No investigation was conducted in 38% of the cases (2,034).

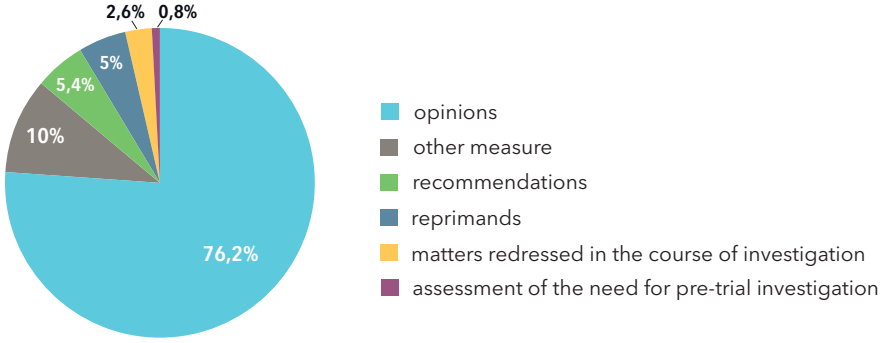
In most cases, the complaint was not investigated because the matter was already pending with a competent authority. An overseer of legality usually refrains from intervening in a case that is being dealt with at the appeal stage or by anoth-



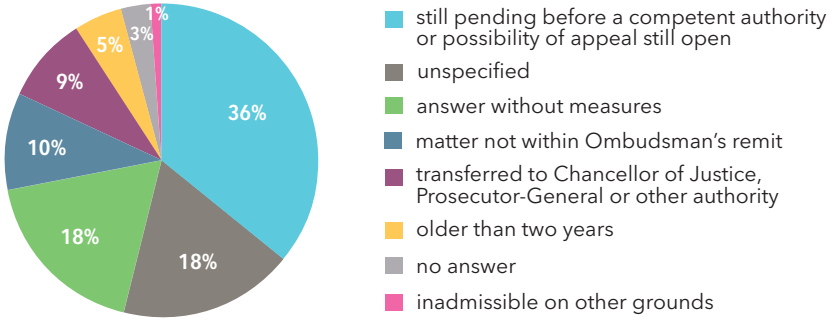
In 2001–2018, the number of measures taken as a result of complaints increased from 320 up to over 1,000. The number of resolved complaints within the same period increased from approximately 2,500 up to over 6,000. Despite the increase in the number of complaints, the relative proportion of complaints leading to measures (measure %) has remained unchanged.



All cases resolved in 2018



Decisions involving measures in 2018



Complaints not investigated in 2018

er authority. Matters pending with other authorities, and therefore not investigated, accounted for 13% (723) of all complaints dealt with. Other matters not investigated include those that fall outside the Ombudsman's remit and, as a rule, cases that are more than two years old.

The proportion of all investigated complaints which led to measures, when cases not investigated are excluded, was 22%.

None of the matters handled in the year under review were brought to prosecution for breach of official duty. There were six matters that merited pre-trial investigation by the police. A total of 46 reprimands were given, and 613 opinions were expressed. Rectifications were made in 20 cases while under investigation. Decisions classed as recommendations numbered 40, although opinions regarding the development of governance that count as recommendations were also included in other types of decisions. Other measures were recorded in 79 cases. In reality, the number of other measures that the decisions lead to is greater than the figure shown above, because only one measure is recorded under each case, even though several measures may have been taken.

Statistics on the Ombudsman's activities are provided in Appendix 3.

Inspections

A total of 128 inspections were carried out during 2018. A full list of all inspections is provided in Appendix 5.

36% of the inspections and visits were headed by the Ombudsman or Deputy-Ombudsmen, and the remaining 64% were conducted under Legal Advisers. A total of 73 visits were made to places and facilities where individuals are or may be kept while deprived of their liberty; the majority of these visits were unannounced. These visits were made in the capacity of the National Prevention Mechanism against Torture (NPM).

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

The number of inspections between 2009 and 2018

The annual report of the NPM details the observations listed in section 3.5.7 and recommendations given and measures taken by authorities as a result. Shortcomings, which are often observed in the course of inspections, are subsequently investigated on the Ombudsman's own initiative. Inspection visits also fulfil a preventive function.

2.6 COOPERATION IN FINLAND AND INTERNATIONALLY

Events in Finland

Ombudsman Jääskeläinen and Deputy-Ombudsmen Sakslin and Pölönen submitted the Parliamentary Ombudsman's annual report 2017 to Speaker of the Parliament Paula Risikko on 15 June 2018. The Ombudsman attended a preliminary debate and a parliamentary debate on the

Deputy-Ombudsman Pasi Pölönen, Deputy-Ombudsman Maija Sakslin and Parliamentary Ombudsman Petri Jääskeläinen handed the Ombudsman's Annual Report for 2017 to Paula Risikko, Speaker of the Parliament, on 15 June 2018.

report in plenary sessions of the Parliament on 19 June 2018 and on 4 October 2018 respectively.

Several Finnish authorities and other guests visited the Ombudsman's office, and topical issues and the work of the Ombudsman were discussed with them. In addition, the Office was also visited by students from the Nakkila Senior Secondary School and pupils from the Pyörö School in Kuopio attending the prize trip for a competition on children's rights called 'I know my basic rights', organised by the Office of the Parliamentary Ombudsman.

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

Ombudsman Jääskeläinen selected the winner for the competition to award the most articulate communicator of the year organised by the Institute for the Languages of Finland, and presented the award on 11 October on a theme day for articulate language. The winner was 'Kela-tärpit' (Kela Tips) which provides clear and understandable information especially in social media on the various Kela benefits.

Deputy-Ombudsman Sakslin was awarded a prize recognizing her work concerning security at old age called 'Turvallisen vanhuuden puolesta – Suvanto ry:n Valontuojapalkinto' on 28 November. This prize is awarded annually to an individual person or community who or which has significantly promoted the safety and wellbeing of the elderly.

International cooperation

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

The Ombudsman has traditionally participated as a member of the International Ombudsman Institute (IOI) in the events of the institute and attended the related conferences and seminars, as well as those organised by the IOI's European chapter, IOI Europe. In the year under review, Ombudsman Jääskeläinen participated in a seminar called 'Human Rights in the Digital Age' organised in Tallinn, Estonia, on 23–24 January,

The winners of the competition regarding children's rights visited the Parliament.

where he gave a speech on the topic 'Secret surveillance activities and Ombudsmen's supervisory experiences'. The Ombudsman also participated in an IOI Europe conference 'The Ombudsman in an open and participatory society' held on 1–3 October in Brussels where he lectured on the topic 'The Ombudsman as a guarantor of international commitments'.

The Parliamentary Ombudsman is a member of the European Network of Ombudsmen, the members of which exchange information on EU legislation and good practices at seminars and other gatherings as well as through a regular newsletter, an electronic discussion forum and daily electronic news services. Seminars intended for ombudsmen and other stakeholders of the network are organised every year. The network conference held in Brussels on 8–9 March was attended by Riitta Länsisyrjä, Principal Legal Adviser and network contact person; Citha Dahl, Information Officer; and Pia Wirta, on-call lawyer. Ms Länsisyrjä and Ms Dahl also participated in the network conference in Brussels on 5–6 September.

The Nordic parliamentary ombudsmen have convened on a regular basis every two years, at a meeting held in one of the Nordic countries. In the year under review, the meeting was held on 22–24 August in Helsinki. The themes of the meeting included, among others, the Ombudsman's competence, children's rights, EU's General Data Protection Regulation, digitalisation of administration, and the processing methods of complaints. The meeting was attended by Parliamentary Ombudsman Jääskeläinen, Deputy-Ombudsmen Sakslin and Pölönen, Substitute Secretary General Länsisyrjä, Principal Legal Adviser Håkan Stoor and on-duty lawyer Wirta.

For several years, the Finnish Parliamentary Ombudsman has also engaged in dialogue with the Baltic ombudsmen. The meeting for Nordic and Baltic ombudsmen was held in Riga, Latvia, on 19–20 September. The theme of the meeting was data protection in relation to other fundamental rights. The meeting was attended by Pasi Pölönen and Principal Legal Adviser Jarmo Hirvonen.

The Nordic countries have established a Nordic network for NPMs, with meetings organised on 3–4 January in Copenhagen, Denmark, and on 29–30 August in Lund, Sweden. The first was attended by Senior Legal Adviser Iisa Suhonen and Inspector Reima Laakso. The latter was attended by Wirta and Notary Kaisu Lehtikangas.

The activities of the National Preventive Mechanism also included a workshop of the International Ombudsman Institute arranged on 6–9 November in Copenhagen, with attendees including Senior Legal Adviser Riikka Jackson and Notary Taru Koskiniemi.

Senior Legal Adviser Jari Pirjola has been Finland's representative on the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) since December 2011. This representative is elected for a term of four years. This is Mr Pirjola's second term on the Committee. On 8 July 2015, the Committee of Ministers of the European Council re-elected him for an additional term of four years.

On 26 April Parliamentary Ombudsman Jääskeläinen attended a diplomatic dinner held at the Presidential Palace.

On 27 November, Deputy-Ombudsman Sakslin attended a meeting organised by the European Parliament on the enforcement of the position of national parliaments in executing and applying EU law. She held a speech in the meeting on the role of the Parliamentary Ombudsman in the implementation of EU law and the rights of the citizens.

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

Deputy Prosecutor General, Chief Judge Jorma Kalske, accompanied by his spouse, at the awarding ceremony of the ombudsman sculpture.

International visitors

During the year, the Office received a number of visitors and delegations from other countries, who came to familiarise themselves with the Ombudsman's activities. Some of these were working visits, during which the visitors were given a practical introduction to the work and procedures of the Office as well as the administration, and met employees working at the Office. One of the reasons for which the Finnish Parliamentary Ombudsman institution and its activities attract international interest lies in the fact that the Finnish institution is the second oldest of its kind in the world.

Below is a list of the individuals and delegations that visited the Office in the year under review.

- 15 February UN Expert Mechanism on the Rights of Indigenous Peoples
- 16 March Delegation of the Kenyan parliament
- 21 March Representatives of the Mongolian parliament
- 7 June Deputy Minister for Human Rights and Ambassador of Egypt
- 23 October The Ombudsman for Children of Lithuania
- 6 November Delegation of the Parliamentary Ombudsman of Georgia
- 15 November Delegation of the Parliamentary Ombudsman of Sweden
- 21 November Chairman and head of cabinet of the Parliamentary Assembly of the Council of Europe

2.7 OMBUDSMAN SCULPTURE

In 2009, the Ombudsman commissioned a work from sculptor Hannu Sirén to celebrate the 90th anniversary of the establishment of the Parliamentary Ombudsman institution. It is a serially produced piece used like a medal.

The Parliamentary Ombudsman may award the sculpture to a Finnish or a foreign person, authority or an organisation for commendable work that promotes the rule of law and the implementation of fundamental and human rights.

On 18 June, Ombudsman Jääskeläinen presented Deputy Prosecutor General, Chief Judge Jorma Kalske an ombudsman statue upon his retirement. In total, Mr Kalske has acted as the Deputy Prosecutor General and in numerous other prosecutor positions for more than 40 years. In his speech, Ombudsman Jääskeläinen commended Mr Kalske for his actions and statements that have promoted legality, the legal protection of individuals and fairness, and stated that Mr Kalske's contributions were widely recognised and highly valued.

2.8 SERVICE FUNCTIONS

Client service

The objective of the Office of the Ombudsman is to make it as easy as possible to turn to the Ombudsman. Information on the Ombudsman's tasks and instruction on how to make a complaint can be found on the website of the Office and in a leaflet entitled 'Can the Ombudsman help?'. A complaint may be sent by post, email or fax or by completing the online form. The Office provides clients with services by phone, on its own premises and by email.

Two on-duty lawyers at the Office are tasked with advising clients on how to make a complaint. In addition, the Legal Advisers of the Office have also provided advice on matters that concern their field of activity.

The Office's Registry receives and logs arriving complaints and responds to related enquiries, as well as documents requests and provides general advice on the activities of the Office of the Parlia-mentary Ombudsman. The Registry received around 2,400 calls during the year. There were approximately 120 visits from clients and 550 requests for documents/information.

Communications

During the year under review, the Office of the Parliamentary Ombudsman introduced a new website with the goal of being more customer-oriented. The new solution is also compliant with the Directive on Web Accessibility.

In 2018, the Office published 32 press releases on the Ombudsman's decisions, inspections and statements, if they are of particular legal or general interest. In addition, information was actively provided on the special tasks of the Office. The press releases are given in Finnish and Swedish and are also posted online in English. The Office has increasingly transferred to utilising Twitter when providing information at a fast pace.

The Office commissioned an analysis of its media visibility, which showed that the Ombudsman had been visible in the online media in 2018 in the context of 2,405 news items and articles. Use of Twitter and visibility in social media were increased significantly. In 2018, there was a total of 6,770 media hits, i.e., more than 3,123 more than in 2017 (3,647). There were 235% more Tweets generated from the Ombudsman's Twitter account in 2018 than in 2017.

A total of 291 anonymous solutions were posted online. The website includes decisions and solutions that are of legal or general interest.

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

The Office and its personnel

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

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

At the end of 2018, there were 60 permanent positions in the Office, including the Ombudsman and two Deputy-Ombudsmen. At the end of the year under review, the share of women in the staff was 66.1%, including the personnel at the Human Rights Centre.

At the end of 2018, there were no vacant posts at the Office. In addition to the Parliamentary Ombudsman and the Deputy-Ombudsmen, the permanent staff at the office comprised the Secretary General, 14 principal legal advisers, 14 legal advisers, two on-duty lawyers and the Director and three specialists of the Human Rights Centre. The Office also had an information officer, an infor-

The Finnish Parliament Annex.

mation management specialist, two investigating officers, five notaries, an administrative secretary, a filing clerk, an assistant filing clerk, two departmental secretaries, a records management secretary, an assistant for international affairs and six office secretaries.

The share of personnel at least 45 years in age was 86.4%. The personnel's education level index was 6.6. The share of personnel possessing a university-level degree was above 83%. Of this, the share of personnel with a Master's level university degree was 74.6% and the share of those who have completed research training was almost 12%.

During a part of the year or the whole year, there were five persons working in the Office in fixed-term positions, including the fixed-term positions in the Human Rights Centre. A list of the personnel is provided in Annex 6.

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

The Office had permanent working groups in the areas of education, wellbeing at work, and equitable treatment and equality. The Office also has a job evaluation working group, as required under the collective agreement for parliamentary officials. Temporary work groups included the working group and steering group for case management and online service development projects.

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

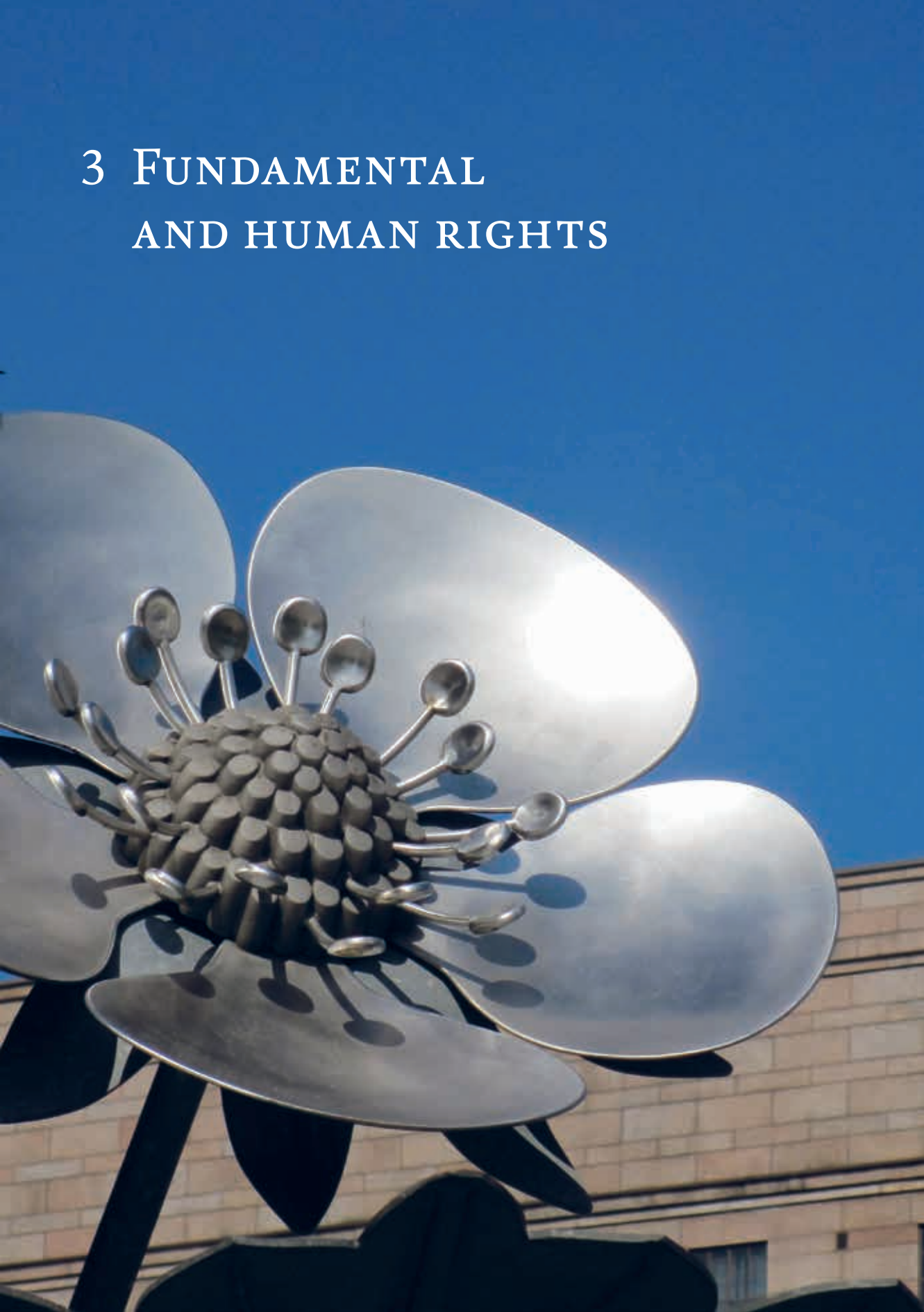
OFFICE FINANCES

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

The Office was given an appropriation of EUR 5,468,000 for 2018. Of this, EUR 5,461,440, i.e., 99.8%, was used in 2018. When taking the realised costs of the Human Rights Centre into consideration, the appropriation of the entire Office was exceeded by approximately EUR 22.000, for which an overrun permission was applied from the Parliament's Office Commission. The main cause of the overrun was hiring costs.

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

3 Fundamental and human rights



3.1 The Ombudsman's fundamental and human rights mandate

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

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

For example, this is provided for in the provision on the investigation of a complaint in the Parliamentary Ombudsman Act. Under Section 3 of the act, arising from a complaint made to him or her, the Ombudsman shall take the measures that he or she deems necessary from the perspective of compliance with the law, protection under the law or implementation of fundamental and human rights. Similarly, section 10 of the Parliamentary Ombudsman Act states that the Ombudsman can, among other things, draw the attention of a subject of oversight to the requirements of good administration or to considerations of implementation of fundamental and human rights.

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

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

Both the Constitution and the Parliamentary Ombudsman Act state that the Ombudsman must give the Eduskunta an annual report on his activities as well as on the state of exercise of law, public administration and the performance of public tasks, in addition to which he must mention any flaws or shortcomings he has observed in legislation. In this context, special attention is drawn to implementation of fundamental and human rights.

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

The fundamental and human rights section of the report has gradually grown longer and longer, which is a good illustration of the way the em-

phasis in the Ombudman's work has shifted from overseeing the authorities' compliance with their duties and obligations towards promoting people's rights. In 1995 the Ombudsman had issued only a few decisions in which the fundamental and human rights dimension had been specifically deliberated and the fundamental and human rights section of the report was only a few pages long (see the Ombudsman's Annual Report for 1995 pp. 26–34). The section is nowadays the longest of those dealing with various groups of categories in the report, and implementation of fundamental and human rights is deliberated specifically in hundreds of decisions and in principle in every case.

Information concerning various human rights events and ratification of human rights conventions are no longer included in the Ombudsman's annual report, because these matters are dealt with in the Human Rights Centre's own annual report.

3.2
The National Human Rights Institution of Finland

Finland's National Human Rights Institution consists of the Ombudsman and the Human Rights Centre and its Delegation.

3.2.1
THE HUMAN RIGHTS INSTITUTION IS ACCREDITED WITH A STATUS

The Human Rights Institution and its Delegation were established under the aegis of the Ombudsman's Office with the aim of creating a structure which, together with the Ombudsman, would meet, as satisfactorily as possible, the requirements of the Paris Principles, adopted by the UN in 1993. This process, which started in the early 2000s, achieved its objective when the Finnish Human Rights Institution was awarded an A status for 2014–2019 in December 2014.

National human rights institutions must apply to the UN international coordinating committee for human rights institutions, the Global Alliance of National Human Rights Institutions or GANHRI) for accreditation. The accreditation status shows how well the relevant institution meets the requirements of the Paris Principles. A status means that the institution fully meets the requirements while B status indicates some shortcomings. The accreditation status is reassessed every five years.

The granting of an A status may be accompanied by recommendations on how to improve the institution. The recommendations given to Finland stressed, among other things, the need to safeguard the resources necessary to ensure that the tasks of the Finnish National Human Rights Institution are effectively discharged. The full text of the recommendations is provided in Annex 5 to the summary of the Ombudsman's annual report for 2014.

Besides its intrinsic and symbolic value, the A status also has legal relevance: a national institution with A status has, for example, the right to take the floor in sessions of the UN Human Rights Council and to vote at GANHRI meetings. A status is considered highly significant in the UN and, in more general terms, in international cooperation. The Finnish Human Rights Institution has also joined the European Network of National Human Rights Institutions (ENNHRI). Finland's National Human Rights Institution is a member of the ENNHRI and GANHRI Bureaus.

3.2.2
THE HUMAN RIGHTS INSTITUTION'S OPERATIVE STRATEGY

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

The strategy outlined the following main objectives for the Institution:

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

3.3 The Human Rights Centre and the Human Rights Delegation

3.3.1 MANDATE OF THE HUMAN RIGHTS CENTRE

The Human Rights Centre (HRC) began operating in 2012. It works autonomously and independently, although it is part of the Office of the Parliamentary Ombudsman in administrative terms. The HRC's duties are laid down in the Parliamentary Ombudsman Act. According to the Act, the HRC has the following tasks:

- to promote information provision, training, education and research on fundamental and human rights, as well as cooperation in these issues
- to draft reports on the implementation of fundamental and human rights
- to propose initiatives and give statements for the promotion and implementation of fundamental and human rights
- to participate in European and international cooperation related to the promotion and protection of fundamental and human rights, and to perform other comparable tasks associated with the promotion and implementation of fundamental and human rights
- to promote, protect and monitor the implementation of the UN Convention on the Rights of Persons with Disabilities.

The HRC does not handle complaints or other individual cases.

3.3.2 OPERATION OF THE HUMAN RIGHTS CENTRE IN 2018

Education and training on fundamental and human rights

The particular goal for 2018 was to leverage cooperation to improve the availability of training concerning fundamental and human rights. The Human Rights Centre distributed information on training provided by various actors on its website, in targeted e-mail shots and in social media.

The series of video training sessions produced by the Human Rights Centre detailing the basics of fundamental and human rights was published online and also in the eOppiva digital learning environment, a spearhead project of the Government of Finland. The project launched with the Parliamentary Ombudsman to strengthen competence in fundamental and human rights in the education sector involved the Regional State Administrative Agencies, the Finnish National Agency for Education, the Trade Union of Education in Finland (OAJ), the Finnish Association of Principals (SURE) and the Finnish Association of Educational Directors and Experts (OPSIA). In the course of the year, preparation was started for a new training project with the Parliamentary Ombudsman to reinforce the right to individual autonomy of persons with intellectual disabilities in housing services.

The Faculty of Education at the University of Helsinki launched a one-year project to improve competence in fundamental and human rights in teacher training, at the initiative of and with partial funding from the Human Rights Centre.

Information activities and events

Bulletins, statements, news items and reviews on fundamental and human rights were published regularly on the Human Rights Centre website and on social media channels. The website was completely overhauled in 2018. In December, Members of Parliament and officials were provided with information on current topics in fundamental and human rights during Human Rights Week in Parliament.

The Human Rights Centre organised and participated in various events, such as the Educa event for education and training sector professionals , the seminar 'Standing up for Human Rights in a Multipolar World', a session on the rights of transgender individuals, and an expert seminar on Finland's EU Presidency and fundamental rights.

Statements and publications

The Human Rights Centre issues statements on request or on its own initiative on themes relevant to its operations. Statements are issued mainly to domestic actors, but also directly to international oversight bodies and organisations in the form of regular reports and various surveys. For instance, in 2018 the Human Rights Centre issued statements about the land rights of indigenous peoples to the UN Permanent Forum on Indigenous Issues, about the draft Roma policy programme, about the need to revise transgender legislation, about violence against women and domestic violence to GREVIO at the Council of Europe, and about the draft of the UN Guiding Principles on Business and Human Rights.

In the year under review, the Human Rights Centre issued six international reviews compiling key events, research and news from international human rights actors. A report related to the transgender legislation reform was also published, *Sukupuolen oikeudellinen vahvistaminen – Tilanne Suomessa ja lainsäädännön kehityslinjoja Euroopassa* [Legal recognition of gender – Situation in Finland and legislative trends in Europe]. The study presents materials, viewpoints, recommendations and legal practice related to gender recognition, produced by international human rights instruments and mechanisms. The publication also discusses the reform of transgender legislation in Finland and legislative amendments concerning legal recognition of gender in Malta, Denmark, Norway, the Netherlands and Ireland.

Monitoring the implementation of fundamental and human rights

The Human Rights Centre continued to develop a monitoring process for the enjoyment of fundamental and human rights. The HRC will pay particular attention to themes or rights for which no special ombudsman has been appointed with respect to their implementation and monitoring. This monitoring largely relies on cooperation and existing knowledge, but the Human Rights Centre also conducts studies of its own, such as the report on the rights of transgender people published in 2018.

In 2018, the Human Rights Centre began preparation of a national barometer for fundamental rights, together with the Ministry of Justice and the European Union Agency for Fundamental Rights. The purpose of the barometer is to gauge public awareness of fundamental rights, popular conceptions of the importance of various rights and experiences of how these rights are enjoyed in everyday life. Alongside the European fundamental rights barometer, Finland is developing an addendum to the fundamental rights barometer intended for disabled persons and language minorities (Swedish, Russian and Arabic), being the first EU Member State to do so.

The Human Rights Centre, an autonomous body independent of the Government, participates in periodic reporting under human rights' treaties and monitors the implementation of recommendations issued by treaty monitoring bodies. The HRC communicated extensively on individual and collective complaints that are being considered by judicial and investigative bodies that operate under the UN and the Council of Europe.

The HRC participated in national hearings organised by the Ministry for Foreign Affairs regarding the Council of Europe's Framework Con-

vention for the Protection of National Minorities (FCNM) and the UN Convention on the Rights of Persons with Disabilities (CRPD), and regarding the visits by the ECRI and GREVIO committees.

Promoting and monitoring the implementation of the UN Convention on the Rights of Persons with Disabilities

According to Article 33(2) of the Convention on the Rights of Persons with Disabilities (CRPD), States Parties shall designate or establish an independent mechanism to promote, protect and monitor the implementation of the CRPD. The tasks of this independent mechanism are performed by the Human Rights Centre and its Human Rights Delegation, together with the Parliamentary Ombudsman. Operations having to do with the special task during 2018 are reported in detail in section 3.4.

Under Article 33(3) of the CRPD, persons with disabilities and their representative organisations must be involved and participate fully in the monitoring process of CRPD implementation. For this reason, a permanent sub-committee, the Disability Rights Committee operates under the Human Rights Delegation at the Human Rights Centre. The Sub-Committee may submit proposals and express its views to the Parliamentary Ombudsman and the Human Rights Centre on how they might develop the realisation of the rights of persons with disabilities and the performance of tasks related to CRPD implementation. The Sub-Committee can also raise issues related to the rights of persons with disabilities for the Human Rights Delegation to address. The operations of the Disability Rights Committee (VIOK) are discussed in section 3.4.

International cooperation

The Human Rights Centre participated in international and European cooperation on the boards and in the working groups of the Global Alliance for National Human Rights Institutions (GANHRI) and the European Network of National Human Rights Institutions (ENNHRI).

The Human Rights Centre boosted public awareness of the European Union Agency for Fundamental Rights (FRA) and the European Charter of Fundamental Rights in Finland and pursued closer cooperation with the FRA inter alia in research and publicity. The director of the Human Rights Centre is the chairman of the supervisory board of the FRA until July 2020.

3.3.3 MANDATE AND OPERATIONS OF THE HUMAN RIGHTS DELEGATION

The HRC has a Human Rights Delegation, which functions as a national cooperative body for fundamental and human rights actors. Delegation deals with fundamental and human rights matters of far-reaching significance and principal importance, and approves the HRC's plan of action and annual report each year.

The term of office of the current Delegation is from 1 April 2016 to 31 March 2020. The Delegation has 38 members including special ombudsmen and representatives of the supreme overseers of legality and the Sámi Parliament. The members are appointed by the Parliamentary Ombudsman and the Delegation is chaired by the Director of the HRC. A permanent Working Committee and a permanent sub-committee, the Disability Rights Committee operate under the Human Rights Delegation.

The Delegation convened four times during the year under review. Matters discussed at meetings included violence against women, data protection and current issues with fundamental and human rights in the work of overseers of legality and special ombudsmen. In October 2018, the Human Rights Delegation adopted a statement calling for more effective measures to prevent violence against women and domestic violence. The statement noted that work in this area must be guaranteed augmented resources and that a special national body should be set up to oversee the work.

3.4 Rights of persons with disabilities

3.4.1 SPECIAL MANDATE TO IMPLEMENT THE RIGHTS OF PERSONS WITH DISABILITIES

The ratification of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and its Optional Protocol on 10 June 2016 brought the Parliamentary Ombudsman a new special task, which is laid down in the Parliamentary Ombudsman Act. The tasks laid down in Article 33.2 of the CRPD are attended to by the Parliamentary Ombudsman, the Human Rights Centre and its Human Rights Delegation, which together form Finland's National Human Rights Institution.

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

3.4.2 TASKS OF THE NATIONAL MECHANISM

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

Promotion refers to future-orientated active work, such as the provision of guidance, advice, training and information. The purpose of monitoring is to find out how effectively the rights of persons with disabilities are being protected formally and in practice. Monitoring also means compiling information on the practical implementation of the contractual obligations arising from the CRPD and using that information to correct any shortcomings in the implementation of those contractual obligations. Protecting refers to the Government's obligation to directly and indirectly protect individuals against potential violations of the rights laid down in the CRPD.

Parliamentary Ombudsman

The Parliamentary Ombudsman protects, promotes and monitors the implementation of the CRPD within the limis of his or her specific competence e. The Ombudsman is responsible for overseeing legality in the exercise of public authority and supervising (protecting) the implementation of fundamental and human rights. Over the decades, the Ombudsman has assumed an increasingly proactive role in promoting fundamental and human rights. The Ombudsman's decisions on complaints and inspections no longer simply address the legality of practices but also aim to encourage the authorities and supervised entities to adopt policies that implement fundamental and human rights as effectively as possible. The Ombudsman's practices combine supervision and monitoring, as any failings to implement the rights of persons with disabilities discovered in connection with the oversight of legality also help to monitor how effectively contractual obligations are being observed in practice.

The Ombudsman's oversight of legality is largely based on complaints, but the Ombudsman also investigates non-conformances on his or her own initiative and in connection with inspections. In addition to overseeing legality, the Ombudsman acts as Finland's National Preventive Mechanism (NPM) under the Optional Protocol to the UN Convention against Torture (OPCAT). The NPM is responsible for regularly examining the

treatment of persons who have been deprived of their liberty in places of detention, including care homes and residential units for persons with intellectual disabilities or memory disorders. The Ombudsman can, when carrying out duties in his or her capacity as the NPM, rely on expert assistance by appointing as an expert any person who has particular expertise relevant to the inspection duties of the NPM. The Ombudsman's experts include, among others, health care specialists, including two physicians who specialise in intellectual disabilities. The Ombudsman also relies on the expert assistance of disabled persons themselves. Three members of the Disability Rights Committee, which operates as a permanent division under the Human Rights Delegation, were trained to provide expert assistance in connection with the NPM's inspections in November of 2018. Two members of the Committee had completed the training during the previous year. The Ombudsman can invite the trained individuals to participate in OPCAT inspections as experts. Cooperation with persons with disabilities and organisations representing persons with disabilities has been, and will continue to be, promoted in other ways as well.

Human Rights Centre

The Human Rights Centre's primary mission is to promote and monitor the implementation of fundamental and human rights. Unlike the Ombudsman, the Human Rights Centre does not handle complaints or oversee legality. The Human Rights Centre's mandate is not limited to public authorities, and it can also promote and monitor the implementation of the CRPD in respect of private sectors.

As in previous years, the Human Rights Centre's strategy in respect of the rights of persons with disabilities was to prevent overlaps with the work of other operators and to add value by cooperating systematically with a range of public authorities and non-governmental organisations.

This operating model has helped the Human Rights Centre to establish itself and to find its place among the extensive and diverse group of actors involved in the promotion of the rights of persons with disabilities. The Human Rights Centre has tweaked its approach so as to focus more unequivocally on the objectives arising from its statutory role and especially on monitoring and promotion.

The Human Rights Centre's priorities in respect of persons with disabilities include promoting the inclusion of disabled persons in society and increasing the general public's awareness of the rights of persons with disabilities. The inclusion of disabled persons in the labour market and in decision-making processes that affect them personally were chosen as special themes for the year 2018.

The Human Rights Centre was one of the organisers of an event held at the Messukeskus Helsinki, Expo and Convention Centre to promote equal opportunities in the labour market. The event addressed current issues affecting the inclusion of persons with disabilities in the labour market. Both lack of information and people's attitudes were identified as obstacles to ensuring equal opportunities in the labour market, and the changing nature of the labour market was seen as a factor creating more challenges. Changing people's attitudes by means of education was identified as a key means to promote employment and self-employment among persons with disabilities.

The Human Rights Centre ran a media campaign called *Monday belongs to everyone* with the Non-Discrimination Ombudsman in 2018. The aim of the campaign was to advocate more positive attitudes towards persons with disabilities and to increase disabled persons' inclusion in the labour market. The campaign ran for a period of three weeks and involved posting videos and information on social media. An article written by Sirpa Rautio, Director of the Human Rights Centre, and Non-Discrimination Ombudsman Kirsi Pimiä on employment among persons with disabilities was published in *Helsingin Sanomat* to mark the launch of the campaign on 22 October 2018.

The Human Rights Centre and the Advisory Board for the Rights of Persons with Disabilities co-hosted an event for members of Municipal Councils on Disability in the Finnish Parliament

Annex in Helsinki on 10 December 2018. The event's agenda focused on the inclusion of persons with disabilities and their chances of influencing municipal decision-making. A keynote speech delivered by a representative of the Swedish Agency for Participation (*myndigheten för delaktighet*) on the social inclusion of persons with disabilities in Sweden brought a new perspective to the debate. The participants were encouraged to share their experiences of both achievements and challenges that they had encountered as members of Councils on Disability. The participants considered it important to communicate about the General Comment issued by the Committee on the Rights of Persons with Disabilities (CRPD Committee) regarding inclusion to the general public.

To celebrate the UN's international Human Rights Day and the International Day of Disabled Persons, the Human Rights Centre hosted a week-long event in the Parliament of Finland. Triangular table cards, providing information about the 70th anniversary of the Universal Declaration of Human Rights, the Human Rights Centre's role in promoting human rights education, and disabled persons' right to accessibility, were placed in the Parliament's cafeterias. In respect of the latter, the Human Rights Centre urged candidates standing for the parliamentary elections to ensure that their election campaigns would be accessible.

The Human Rights Centre's most important monitoring measures in 2018 were two surveys. The first was an online survey designed in cooperation with the Finnish Disability Forum, which focused on the rights of persons with disabilities. The second is a national fundamental rights survey, which the Human Rights Centre is preparing in collaboration with the Ministry of Justice.

The Human Rights Centre began to collate and analyse the results of the online survey conducted in cooperation with the Finnish Disability Forum towards the end of the year. The findings are presented in a report drawn up by the Human Rights Centre to complement the Finnish Government's periodic report to the CRPD Committee. The results will also be used to support the Human Rights Centre's promotional efforts and especially in educational resources relating to the rights of persons with disabilities.

The national fundamental rights survey complements the Fundamental Rights Survey of the European Union Agency for Fundamental Rights (FRA). The national survey is targeted at persons with disabilities and specific linguistic minorities. The aim is to collect comparable data on the status of persons with disabilities and linguistic minorities versus the general population in respect of certain fundamental rights.

The Disability Rights Committee convened six times in 2018. The Committee has drawn up a statement to accompany the Finnish Government's periodic report to the CRPD Committee. The Committee was also commissioned by the Human Rights Centre to issue an expert opinion in response to the Chancellor of Justice's consultation on personal hygiene in the context of residential services for persons with disabilities. Moreover, the Committee contributed to the work of the Human Rights Delegation by compiling a summary of problems that persons with disabilities are currently facing in respect of fundamental and human rights. The Committee also submitted a proposal to organise an annual symposium in memory of Kalle Könkkölä to the Human Rights Centre and the Parliamentary Ombudsman.

Disability Team

The Disability Team at the Office of the Parliamentary Ombudsman consisted of three experts representing the Ombudsman and one expert from the Human Rights Centre. The Disability Team worked in close cooperation with the Disability Rights Committee throughout 2018. It became natural to share issues raised in the meetings of the Disability Rights Committee on the one hand and in the meetings of the Disability Team on the other, as two members of the Disability Team also served as experts on the Disability Rights Committee.

The Human Rights Centre and the Ombudsman began preparations for a new training project aimed at promoting the right of persons with intellectual disabilities to individual autonomy in the context of residential services. To this end, experts from the Human Rights Centre accompa-

nied the Ombudsman on inspection visits to residential units for persons with intellectual disabilities. The objective was to find out about the views and experiences of the staff and management of these residential units regarding the right of persons with intellectual disabilities to individual autonomy. The Human Rights Centre held further meetings relating to the topic with ASPA, a foundation that provides housing to persons with disabilities, the Association of Finnish Local and Regional Authorities, the Regional State Administrative Agency for Southern Finland, the National Supervisory Authority for Welfare and Health and the Service Foundation for People with an Intellectual Disability towards the end of the year. The meetings focused on discussing key problems and shortcomings in the implementation of the right to individual autonomy and possible ways to increase the competence of providers of residential services.

The Disability Team's meetings focused on agreeing on residential units to be inspected and the inspection procedure, reviewing the Disability Team's strategy and planning training relating to persons with disabilities within the Office of the Parliamentary Ombudsman as well as information about the rights of persons with disabilities to be added to the websites of the Human Rights Centre and the Parliamentary Ombudsman. The Disability Team contributed to a review of the tasks of the national mechanism by discussing and analysing the breadth of the concept of *persons with disabilities* in government departments related to the oversight of legality. The Disability Team's meetings also involved planning the new shared training project aimed at promoting the right of persons with intellectual disabilities to individual autonomy in the context of residential services.

The Disability Team's public-sector partners include the National Supervisory Authority for Welfare and Health, Regional State Administrative Agencies and the National Non-Discrimination and Equality Tribunal of Finland. Cooperation with Regional State Administrative Agencies mostly relates to inspections and the choice of residential units to be inspected.

Members of the Disability Team attended events hosted by the Parliament of Finland's Committee for Disabled Affairs relating to the rights of persons with disabilities. Two members of the Disability Team attended meetings of the National Institute for Health and Welfare's legal team for the Handbook on Disability Services to discuss, among other topics, the latest case law relating to disability services and the progress of the reform of the Act on Services and Assistance for the Disabled.

At the Disability Team's proposal, the Office of the Parliamentary Ombudsman organised two internal training events relating to persons with disabilities, the first of which focused on promoting the right to individual autonomy and the use of restraints on persons with intellectual disabilities (on 9 May 2018) and the second on the current status of disability services and the associated practices (on 26 September 2018). Two referendaries from the Supreme Administrative Court also spoke at the events. The Research Manager of the Finnish Association on Intellectual and Developmental Disabilities talked about the right of persons with intellectual disabilities to individual autonomy from a researcher's perspective, and a lawyer from the Finnish Association of People with Physical Disabilities focused the status of disability services from a legal point of view.

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

- Launch of the national action plan for the implementation of the CRPD in Helsinki on 13 March 2018
- Audience with guests from Tajikistan in the Finnish Parliament Annex in Helsinki on 16 May 2018
- Seminar of the Satakunta Council on Disability in Kankaanpää on 30 August 2018
- National seminar on special care for persons with disabilities in Helsinki on 14 September 2018
- #homeward-bound seminar hosted by the Housing Finance and Development Centre of Finland, the Finnish Association on Intellectual and Developmental Disabilities and Inclu-

sion Finland FDUV in Helsinki on 2 October 2018
- ENNHRI CRPD working group – training seminar in Riga on 3 October 2018
- Speech to a delegation from Japan in Helsinki on 8 October 2018
- Meeting of the Church Council's working group on disabled affairs focusing on the Evangelical Lutheran Church of Finland's programme of services for persons with disabilities in Helsinki on 22 October 2018
- Status and implementation of services for persons with disabilities – a forum hosted by the National Supervisory Authority for Welfare and Health and the Regional State Administrative Agency for Southern Finland in Järvenpää on 23 October 2018 to allow users of services for persons with disabilities to have a say in the coordination and regulatory control of the services
- 40 years of research by the Finnish Association on Intellectual and Developmental Disabilities – anniversary conference in Helsinki on 7 November 2018
- Seminar on the right to individual autonomy for Special Care Districts in Oulu on 9 November 2018
- Study visit by the Swedish Parliamentary Ombudsman in the Finnish Parliament Annex in Helsinki on 15 November 2018
- Seminar for members of the Finnish Association on Intellectual and Developmental Disabilities in Helsinki on 19 November 2018
- National seminar for Municipal Councils on Disability in Helsinki on 10 December 2018

International cooperation

International cooperation helps the Human Rights Centre to deepen its understanding of the rights of persons with disabilities and identify best practices. The Director of the Human Rights Centre and one of its experts, a legal adviser of the Parliamentary Ombudsman and the chair person of the Disability Rights Committee attended GANHRI's annual seminar in Geneva. One of the themes of the conference was the role of national human rights institutions in the promotion of the rights of persons with disabilities, and it was co-hosted by the Committee on the Rights of Persons with Disabilities, which monitors the implementation of the CRPD.

The Human Rights Centre attended the Conference of CRPD States Parties in New York as well as a Day of General Discussion that preceded the conference and focused on the CRPD Committee's draft General Comment on Articles 4.3 and 33.3. The Human Rights Centre had prepared a joint statement on the draft General Comment together with the ENNHRI CRPD working group and GANHRI. On the Day of General Discussion, a representative of the Human Rights Centre gave a speech on key areas of development from Finland's perspective. The Human Rights Centre was represented in a panel discussion at a side event of the Conference of States Parties, which was hosted by GANHRI and focused on monitoring.

The Human Rights Centre also attended a training event hosted by the ENHHRI CRPD working group in Riga. The theme of the event was cooperation with the CRPD Committee.

3.4.3 OPERATING ENVIRONMENT AND CURRENT LEGISLATIVE PROJECTS

The competitive tendering of services for persons with disabilities raised a lot of criticism in 2018. One of the most important triggers for the debate was a citizens' initiative called *Not for sale*, which seeks to exempt contracts for services catering for the essential care and support of persons with disabilities in housing and day-to-day life from the provisions of the Act on Public Procurement and Concession Contracts (139/2016).

The legislature is seeking to amalgamate the Act on Services and Assistance for the Disabled and the Act on Special Care for the persons with intellectual disabilities into a new law on special social welfare services for persons with disabilities, which would apply equally to all persons with disabilities. The Government gave its proposal for the new law to the Parliament of Finland on 27 September 2018. The law would implement the

principles of the United Nations Convention on the Rights of Persons with Disabilities and the Convention on the Rights of the Child. It would guarantee access to special services for all persons with disabilities according to their individual needs in the event that services provided under other laws proved inadequate or unsuitable. Such special services would be available for individuals who rely on help or support on a regular basis due to a long-term disability resulting from an injury or an illness. Eligibility would not require a diagnosis. The responsibility for providing services for persons with disabilities would be transferred from local authorities to Regional Councils in connection with the health and social services reform. The new law is intended to enter into force on 1 January 2021.

A goal set in the 2012 Government Resolution on the independent living and services for persons with intellectual disabilities is that no disabled person will be living in an institution after 2020. It has been estimated that there are some 40,000 persons with intellectual disabilities in Finland. A trend favouring assisted living over the institutional care of persons with intellectual disabilities has continued throughout the 21st century. One of the targets set in respect of reducing institutional care was that, by 2016, no more than 500 persons with intellectual disabilities would be living in institutions. This has not happened, however.

A total of 739 persons with intellectual disabilities were living in institutions at the end of 2017, a drop of some 20% on the previous year. Assisted living services were provided to 8,484 persons with intellectual disabilities at the end of 2017 (according to the National Institute for Health and Welfare's statistical report No 41/2018 of 14 December 2018).

The Government issued a new decree on the accessibility of buildings (241/2017). It applies to all planning applications submitted after 1 January 2018. According to the Ministry of the Environment, the decree helps to clarify the requirements of accessible construction and reduce differences between local authorities' interpretations. The new decree lays down several measurements relating to accessible construction that were previously open to interpretation.

Finland introduced the EU Disability Card in June of 2018. The EU Disability Card allows persons with disabilities to prove their disability and need for a carer in Finland and other EU countries. Applying for the card is voluntary and applications are subject to a fee, but the card is useful, for example, when travelling on different modes of transport or attending sporting or cultural events.

Finland's first national action plan on the implementation of the United Nations' Convention on the Rights of Persons with Disabilities was published in 2018. The aim of the action plan is to increase awareness about the rights of persons with disabilities and to ensure that all government departments know how to take those rights into consideration in their services. Persons with disabilities were consulted on the action plan.

Statements

The Ombudsman gave two statements to the Ministry for Foreign Affairs. The statements related to a draft of Finland's first-ever report on the implementation of the CRPD (1557/2018) and a draft Additional Protocol to the Council of Europe's Convention on Human Rights and Biomedicine and an associated explanatory report (2164/2018).

The Ministry of Social Affairs and Health was given a statement on the status of Special Care Districts in the context of the health and social services reform (4519/2018).

The Ombudsman's other statements also dealt with issues that related to the implementation of the rights of persons with disabilities (including the reform of the Act on Client Fees for Social Welfare and Health Care (3377/2018), legislation on the freedom of choice in the context of social welfare and health care (1501/2018) and a proposal for a new Client and Patient Act (3519/2018).

3.4.4 OVERSIGHT OF LEGALITY

The oversight of legality relating to the rights of persons with disabilities extends to all authority and administrative branch. In statistics, complaints are primarily compiled into categorises based on the authorities and administrative branch (social services, social insurance, health care, education and cultural authorities, etc.) that are discussed in the decisions. Some decisions taken in the course of the oversight of legality relating to the rights of persons with disabilities involve several different administrative branches. This section deals with areas that are vital for the implementation of the rights of persons with disabilities regardless of which administrative branch the matter involved.

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

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

The disability services provided by local authorities are an important area from the perspective of the oversight of legality. Many complaints relate to shortcomings in service plans and special care programmes, the advice and guidance given in relation to services, as well as delays and procedural errors in decision-making and other aspects of handling the matter. Inspections are vital for the oversight of legality, as persons with disabilities are not always able to submit complaints themselves.

In 2018, decisions in this category were taken by Parliamentary Ombudsman *Petri Jääskeläinen*, with Senior Legal Adviser *Minna Verronen* acting as the principal referendary. Other referendaries for cases involving the social welfare of persons with disabilities included Principal Legal Adviser *Tapio Räty* and Senior Legal Adviser *Juha-Pekka Konttinen*. Inspections in residential units and institutions for persons with disabilities were also attended by Specialist *Mikko Joronen* and Notary *Sanna-Kaisa Frantti*.

Complaints and own-initiative investigations

The Ombudsman delivered decisions on a total of 257 complaints and cases investigated on his own initiative relating to the rights of persons with disabilities. The number of decisions was up on the previous year (242) and the year 2016 (171). The Ombudsman investigated seven cases on his own initiative. Three of these involved deficiencies in accessibility and securing the secrecy of the polls at certain advance polling stations. The same number of cases as in the previous year, i.e. 62 (28%), warranted further action. The percentage of cases warranting further action was higher than the average of the Office of the Ombudsman (18%). Three cases led to the Ombudsman's issuing a reprimand and six to a recommendation. The Ombudsman also communicated his opinion on what would be the legal course of action in 42 (41) cases and took other action in 12 (13) cases. Due to the high number of cases that warranted further action, it is not possible to give an account or even mention anywhere near all of the decisions taken in 2018 that related to the rights of persons with disabilities in this report.

Most of the decisions (150) concerning the rights of persons with disabilities related to social services, similarly to previous years (150 in 2017 and 130 in 2016). This is due to the fact that the provision of social services, such as special care for persons with intellectual disabilities and services and support based on disability, is the responsibility of local authorities. A total of 38 cases (40 in 2017) related to personal assistance within the meaning of the Act on Services and Assistance for the Disabled, 19 (34) to transport services and 28 (22) to the rights of persons with intellectual disabilities.

Cases relating to social insurance numbered 28 in 2018 (34 in 2017), while cases relating to health care amounted to 55 and cases relating to education to seven (12).

Cases relating to services within the meaning of the Act on Services and Assistance for the Disabled concerned, among other things, decision-making in respect of services and customer charges, advice and guidance relating to services, the treatment of individuals in the context of customer service or in residential units, the assessment of service needs, delays in the processing of applications and complaints, local authorities' guidelines on the implementation of services, and practical aspects of the provision of services. The Ombudsman also examined the role of the Social Insurance Institution of Finland as a provider of interpreters for persons with disabilities and as the authority in charge of benefits, such as disability benefits and rehabilitation benefits. Cases involving health care related to the care and treatment of individuals recovering from mental illness, reimbursement of the costs of medical rehabilitation aids, the provision of medical rehabilitation, and the provision of adequate health care services.

Inspection visits

Practically all inspections of residential and institutional units for persons with disabilities and psychiatric hospitals combine the two special mandates that the Ombudsman has under international conventions (CRPD and OPCAT). These kinds of inspections numbered 25 in 2018. A total of 11 of the inspections were conducted in residential and institutional units for persons with intellectual disabilities and 11 in residential units for the elderly (persons with memory disorders). The providers of psychiatric hospital care inspected in 2018 included Niuvanniemi Hospital and its Neva Ward, which treats minors with especially complex conditions, and the psychiatric services of the North Karelia Joint Authority for Social Welfare and Health Care Services (Siun sote).

The Ombudsman's inspections focus, in particular, on the implementation of the rights that persons with disabilities have under the United Nations' Convention on the Rights of Persons with Disabilities in respect of, for example, individual autonomy, the use of restraints, opportunities for participation and the accessibility of facilities. In his capacity as Finland's National Preventive Mechanism under the Optional Protocol to the UN Convention against Torture, the Ombudsman also strives to prevent the ill treatment of persons who have been deprived of their liberty and violations of the right to individual autonomy. The inspectors talk to the management, staff and clients of the residential units, inspect documents and the communal areas of the units, the surrounding area as well as clients' private rooms with their permission.

The residential units for persons with intellectual disabilities and persons with severe disabilities inspected during the year included both local authorities' (Kuumaniemi Group Home in Kemijärvi) and joint authorities' (Kolpene Service Centre) units and hospital districts' (Hospital District of North Ostrobothnia) own units in Oulu and Rovaniemi. Several service units run by private service providers (such as Esperi Care's nursing home in Järvenpää, Validia Housing's assisted living unit in Lintukorpi, Espoo, Attendo's Valkamahovi assisted living home in Helsinki and an assisted living unit called Pipolakoti in Karjalohja) to whom local authorities had outsourced services were also inspected.

Key issues addressed in connection with inspections of residential and institutional units for persons with intellectual disabilities included the new provisions introduced to the Act on Special Care for the persons with intellectual disabilities, which obligate service providers to revise and reassess their practices. The inspections of residential services for persons with memory disorders and the elderly focus, in particular, on the right to dignity in old age, elderly people's right to individual autonomy and measures to support and promote the participation of elderly people. Inspections in units providing psychiatric hospital care are aimed, above all, at ensuring the proper conditions and treatment of patients committed to psychiatric care and the implementation of their fundamental rights.

The observations made by the Ombudsman in his capacity as the National Preventive Mechanism in connection with the aforementioned inspections are discussed in section 3.5 of this report.

Findings on accessibility and the promotion of inclusion

Promoting accessibility and inclusion are among the horizontal themes of the CRPD, which are factored into all inspections carried out by the Office of the Parliamentary Ombudsman. Provisions on accessibility as well as the right of persons with disabilities to participate fully in all aspects of life and have access, on an equal basis with others, to, for example, the physical environment are laid down in Article 9 of the CRPD. Article 19 of the CRPD concerns inclusion in society and ensuring that services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs. An accessible environment is an absolute requirement for persons with disabilities to be able to live independently and enjoy equal opportunities with others. The CRPD is based on the notion that the demands of accessibility must be factored into all aspects of society, as accessibility is often a prerequisite for the implementation of other rights.

The following is a summary of individual observations made mostly in connection with inspections.

Child welfare units

- The entrances to the buildings of two reform schools – Pohjolakoti and Vuorela – were not wheelchair-accessible (1353/2018 and 356/2018).

Care and residential units for the elderly

- The interiors of two service units operated by the City of Turku – Elsekoti and Portsakoti – had been designed with accessibility in mind, and the ground in front of the main doors was level. Elsekoti had automatic doors. A physiotherapist in Portsakoti had completed accessibility training, and improvements relating to accessibility had been introduced throughout the building (384/2018 and 383/2018).
- The Deputy-Ombudsman instructed a care home called Taasiakoti to immediately make its bathroom accessible or introduce ergonomic practices that are safe from the perspective of both staff and residents (658/2018).
- Accessibility appeared to have been ensured in Attendo's Linnanharju care home, but a disabled parking space outside was missing proper signage (3367/2018).

Residential units for persons with intellectual and physical disabilities

- The outdoor areas of Validia Housing's assisted living unit in Lintukorpi had been designed to accommodate persons with physical disabilities. For example, there were raised planters to enable wheelchair users to grow herbs and flowers. The building itself was mostly accessible, but it could only be approached along a gravel path, which made it difficult for wheelchair and walker users, for example, to access the building independently. The Parliamentary Ombudsman made some suggestions regarding improvements to accessibility, such as the provision of ramps (1871/2018).

Health care

- Inspectors observed several raised thresholds in psychiatric ward No 12 of Kainuu Central Hospital, which is run by the Kainuu Social Welfare and Health Care Joint Authority. The joint authority promised to take action to improve accessibility (727/2018).

Advance polling stations

- The Ombudsman sent two officials from the Office of the Parliamentary Ombudsman, one of whom was a wheelchair user, to carry out unannounced inspections at seven advance polling stations set up for the 2018 presidential election (in Sipoo, Järvenpää, Mäntsälä, Hyvinkää, Vihti, Lohja and Kauniainen).
- The inspectors discovered that the advance polling stations in Vihti and Lohja did not have an accessible polling booth. At the town hall in Kauniainen, the threshold at the back door was too high for a wheelchair user to be able to enter the building independently. The porch at the entrance to the main library in Vihti was cramped and made it difficult for a wheelchair user to enter the building.
- The Ombudsman communicated the inspectors' general observations on the provision of information about advance polling stations, the visibility of signs and shortcomings relating to accessibility to the inspected local authorities and their central municipal election boards. The visibility of signs was a problem at all the inspected advance polling stations. In many cases, the only sign had been placed right next to the entrance.
- The Ombudsman was pleased to find out that the advance polling stations in Sipoo, Järvenpää, Mäntsälä, Hyvinkää and Kauniainen had accessible polling booths (166/2018*).
- After the inspections, the Ombudsman made a decision to investigate the procedures put in place in Vihti and Lohja to ensure the secrecy of the polls, as their advance polling stations did not have a separate accessible polling booth. The Parliamentary Ombudsman also investigated the procedures that had been put in place in Sipoo on his own initiative, as the local authority had failed to enter information on assistance provided to voters into the list of voters.
- The Ombudsman was pleased to learn from the local authorities that they would take action to correct the non-conformances

Accessible polling booth in the city of Mäntsälä.

In accordance with the view of the Parliamentary Ombudsman, a portable lap desk does not satisfy the key secrecy requirement that voters must be able to cast their vote without others seeing how they mark their ballot paper.

observed by the inspectors by, for example, investing in accessible polling booths, ensuring the accessibility of their facilities and training electoral officials (to enter information on voters' assistants into the list of voters). The Ombudsman drew the local authorities attention to provide a magnifying glass or similar in polling booths to assist visually impaired voters. The Ombudsman took no further action apart from calling attention to the shortcomings relating to accessibility and securing the secrecy of the polls identified in the record of inspections (557, 558 and 559/2018).

The Ombudsman also investigated a complaint according to which there had been issues with the accessibility and the electoral officials' procedures at an advance polling station set up in the town hall of Kouvola. According to the local authority's response, the ability of voters who rely on aids to vote will be improved in the future by ensuring that polling booths in Kouvola satisfy the requirements of accessibility (586/2018).

Voting on the day of the election

- The Ombudsman investigated a complaint according to which persons with physical disabilities had struggled to get to a polling station in Joensuu on the day of the election. One wheelchair user had been told that he or she could vote in their own car. In the Ombudsman's view voting in a car could jeopardise the secrecy of the polls. As a rule, electoral officials should ensure that their polling booths are as accessible as possible. According to the local authority's response, the issues with the accessibility of its polling stations will be rectified by the next elections (578/2018).

Lapland Enforcement Office

- The headquarters in Rovaniemi had been designed with accessibility in mind. There was no induction loop system in the building. Representatives of the Enforcement Office explained that, if necessary, documents are read out to customers who cannot read themselves due to, for example, sensory impairment (977/2018).

Education

- Some of the workspaces of the Kouvola Region Vocational College were not accessible through internal doorways. Some of the facilities could be accessed by exiting and re-entering the building through another door. However, the route was inconvenient due to, for example, weather conditions in the winter.
- Some of the buildings occupied by the Kouvola Region Vocational College (four in total) were not accessible to persons with physical disabilities at the time of the inspection. The inspectors found no information about accessibility and the suitability of the facilities for students with physical disabilities on the college's website.
- The Deputy-Ombudsman urged the college to factor in statutory requirements on accessibility when it next constructs new facilities or renovates the existing infrastructure in order to give disabled students access to education on equal terms with others (324/2019).
- The second floor of the temporary facilities of Kivimaa School could not be accessed by persons who rely on mobility aids (such as a wheelchair), as there was no lift.
- The old school building, which is being demolished, was not accessible.
- There were steps leading up to the main door, and the alternative route through the back door was inconvenient due to an uneven gravel path and a high threshold (4997/2018).

Accessible route to the Jokela Prison facilities.

A disabled shower seat in the communal shower room.

Accessibility of the customer service area of the Insurance Court

- The Parliamentary Ombudsman found that the furniture (a desk bolted to the wall and a nonadjustable chair) in the customer service area of the Insurance Court was likely to restrict or prevent persons with physical disabilities from dealing with the court and accessing documents. The Insurance Court has taken corrective action to promote accessibility (5671/2017).

Jokela Prison

The inspectors identified the following shortcomings and weaknesses mostly related to the rights of inmates and visitors with physical disabilities:

- There was no parking for persons with physical disabilities (designated disabled parking spaces) at the prison.
- There was no built-in induction loop system for hearing-impaired persons anywhere in the prison (e.g. in the visiting areas), and the prison also did not accommodate for portable induction loop systems.
- Neither the prison's website nor the Visitors' Guide provided any information about the accessibility of the visiting areas or how persons who rely on aids (such as a wheelchair) can visit the prison.
- The supervised visiting area in the closed part of the prison was accessible. The visiting area was accessed by a long ramp, which was nevertheless relatively steep at the lower end. There was a disabled toilet adjoining the visiting area.
- The areas used for unsupervised visits were not accessible in either the open or the closed part of the prison.
- The threshold in the doorway of a disabled cell in the open part of the prison was too high.
- The disabled shower seat in the communal shower room of the open part of the prison was inconveniently placed.

- The gym and sauna in the open part of the prison were difficult to access due to high thresholds.
- Inmates with physical disabilities were unable to work in the prison, as the facilities in question were not accessible.

The prison's management and Senate Properties have agreed to take action to improve accessibility (3183/2018).

Pyhäselkä Prison

The Deputy-Ombudsman found that the arrangements made for inmates with physical disabilities violated the Imprisonment Act, as the location of the prison's disabled cell in a special ward meant that, in practice, inmates with physical disabilities always had to be housed in a closed ward even when they would have otherwise been eligible to serve their sentence in a ward with lower security.

The Deputy-Ombudsman proposed the prison's management to consider, among other improvements, investing in a portable induction loop system, positioning door buzzers lower down to allow wheelchair users to reach them, installing an emergency assistance alarm in the disabled toilet, and improving the accessibility of the prison in general (5322/2018).

An inspection conducted in Helsinki Prison on 27 November 2018 led to several findings relating to the prison facilities and accessibility. The inspectors called attention, among other things, to information provided on the prison's website and in brochures, disabled parking, the visitors' entrance, visiting areas, the inmate reception area, disabled cells, telephone booths and induction loop systems (6148/2018).

Neither Laukaa Prison nor Sulkava Prison was accessible or capable of housing inmates with physical disabilities (2337/2018 and 2339/2018).

3.4.5 DECISIONS

Social welfare

Failures to implement the amendments introduced to the Act on Special Care for the persons with intellectual disabilities

The Ombudsman took the initiative to investigate two cases involving inadequate decision-making procedures related to the use of restraints that were discovered in connection with inspections in institutional and residential units for persons with intellectual disabilities. The Ombudsman ended up issuing reprimands in both cases.

The Ombudsman reprimanded the Kainuu Social Welfare and Health Care Joint Authority and the Kuusanmäki Service Centre for unlawful conduct and ordered them to take action to prevent similar occurrences in the future. The Ombudsman found that the Kuusanmäki Service Centre had violated the Act on Special Care for the persons with intellectual disabilities and the Constitution of Finland by failing to follow the proper decision-making procedure relating to the use of restraints, as it had not begun to issue decisions on the use of restraints until the latter half of December of 2016, i.e. more than six months after the new provisions had entered into force, despite having used the kinds of restraints for which a formal decision is required.

The Kainuu Social Welfare and Health Care Joint Authority should have invested considerably more in the implementation of the act and provided training and instruction to its staff even before the entry into force of the act as well as immediately afterwards. On the other hand, the Ombudsman conceded that the authorities had not been given enough time to prepare for the practical implementation of the extensive and complex legislative reform. The Parliament of Finland passed the new laws on 10 May 2016 and they were already in force on 10 June 2016. The Ombudsman emphasised the duty of public authorities to ensure the implementation of fundamental and human rights (872/2017).

The second case that the Ombudsman investigated on his own initiative resulted in the Rinnekoti Foundation being reprimanded for failures to follow the proper decision-making procedure for the use of restraints laid down in the Act on Special Care for the persons with intellectual disabilities and ordered to prevent similar occurrences in the future. What made the failings particularly significant in this case was the fact that the new Act on Special Care for the persons with intellectual disabilities (including the decision-making procedure relating to the use of restraints) had already been in force for more than a year and the fact that restraints had been used to limit the individual autonomy of children with intellectual disabilities who were therefore particularly vulnerable.

The Ombudsman emphasised that the decision-making procedure laid down for the use of restraints in the Act on Special Care for the persons with intellectual disabilities is especially important from the perspective of the legal rights of children with intellectual disabilities. The Ombudsman's decision was accompanied by appeal instructions, according to which the legality of the use of restraints can be referred to a court of law for a final ruling. It is then up to the court to decide whether individual instances of the use of restraints were or were not in compliance with the law. The Ombudsman was pleased to informed that the Rinnekoti Foundation has taken action to correct its failings and to improve its practices (6942/2017).

Criticism of delays in decision-making and the drawing up of service plans

Many of the complaints relating to disability services or the special care of persons with intellectual disabilities focused on delays in decision-making or case management.

The Act on Services and Assistance for the Disabled stipulates that decisions on services and support governed by the act must be taken without undue delay and in any case within three months of a disabled person or their representative filing an application for a service or support. According to the substitute for the Deputy-Ombudsman, the provision lays down a general rule for the maximum period of time within which applications must be processed and it cannot be interpreted as allowing the authorities to postpone making decisions until the end of the three-month period without a valid reason.

The substitute for the Deputy-Ombudsman found that a joint authority for social welfare and health care had violated the Act on Services and Assistance for the Disabled by taking longer than the three months stipulated in the act to process a complainant's application without providing a valid reason as required under the act. The substitute for the Deputy-Ombudsman emphasised that the requirement to process applications without undue delay applies to all stages of case management. This means that, in practice, the authorities must have procedures in place to ensure that there are no delays at any stage of the processing of applications. This is especially important in cases governed by the Act on Services and Assistance for the Disabled, which, in deviation of the general requirement of no undue delay laid down in the Constitution of Finland and the Administrative Procedure Act, are subject to a special maximum time limit (5619/2017).

In another case, the Ombudsman concluded that a joint authority should have issued a written, appealable decision once the complainant expressly asked for their application for support for informal care to be processed. The joint authority had refused to process the complainant's application until a new needs assessment had been carried out. The Ombudsman also found that social services had violated the Social Welfare Act and the Administrative Procedure Act by taking almost seven months to process the complainant's previous application for support for informal care (31/2018).

In yet another case, the Ombudsman found that a local authority's Social Welfare Committee had failed to satisfy the statutory requirement of no undue delay by taking more than 10 months in total to investigate and process a complainant's claim for costs incurred from having a personal

assistant. The Ombudsman emphasised that social services are responsible for ensuring that they can take care of their statutory duties, for example, by having enough staff and social workers available even during the holidays and regardless of staff turnover (4423/2017).

The Ombudsman also concluded a joint authority for primary care had neglected to draw up a service plan for a complainant's son as required by the law. The Ombudsman felt that the joint authority should have produced a more comprehensive service plan for the boy in order to comply with the requirements laid down in the Act on Services and Assistance for the Disabled, the Social Welfare Act and the Act on Social Welfare Customer Documentation for the contents of service plans. The Ombudsman also found that the joint authority's prolonged decision-making process had violated the Act on Services and Assistance for the Disabled (5733/2017).

Rights of persons with severe disabilities at risk due to community transport policies

The substitute for the Deputy-Ombudsman drew the social services of the City of Pori attention to ensure that the subjective right of persons with disabilities to be provided with community transport is implemented in practice. If customers have to pay for community transport themselves and the local authority reimburses them afterwards, the local authority must ensure that all eligible clients are still able to use the service regardless of their circumstances (for example, by giving them vouchers). The substitute for the Deputy-Ombudsman felt that the City of Pori's chosen approach to the provision of community transport services for persons with disabilities was not successful, as it did not take clients' rights into account or promote them. He concluded that the practice had the potential of preventing or at least restricting the implementation of the rights of persons with severe disabilities in some cases (1478/2018).

Procedures in the event of community transport booking cancellations

The Parliamentary Ombudsman could find no justification in the Act on Client Fees for Social Welfare and Health Care or in any other law for the City of Jyväskylä's community transport policy, according to which clients who cancelled their community transport booking too late were still expected to pay for the service. The policy was in breach of the law in this respect. According to a response received from Jyväskylä's social services, the 2018 version of the city's community transport policy no longer contains the unlawful provisions.

In the Ombudsman's opinion clients should be able to demand a refund from social services if they are forced to cancel their booking less than 30 minutes before the appointed time or are unable to use their booking due to reasons beyond their control (such as their health or, within reason, other unexpected events). In the Ombudsman's opinion, this would safeguard customers' rights in the event of cancellations (5661/2017).

Carer card eligibility criteria

A total of 11 local authorities in the Turku region, including Turku and Lieto, had introduced a so-called carer card to improve the opportunities of persons with disabilities and chronic illnesses to participate in cultural and sporting events on an equal basis with others. The card entitled carers to free entry to certain sports and cultural venues specified by the local authorities.

The Ombudsman emphasised that, even though the benefit conferred by the card was not based on law and the eligibility criteria were therefore not expressly laid down in legislation, it was important to make the eligibility criteria for the carer card as fair as possible and to ensure the equal treatment of applicants.

The Ombudsman was informed that the 11 local authorities in the Turku region have now harmonised their carer card eligibility criteria and policies (2/2018).

Communicating client charge increases and what the charges cover

The Ombudsman drew a local authority's Social Welfare Committee attention to communicate changes introduced to its client charges well in advance. The Ombudsman found that the local authority had failed to observe good administrative practice by not communicating changes to client charges well enough in advance of their entry into force. The authorities have a heightened duty to communicate with the public when they introduce changes to their practices that have or will have an impact on the benefits or rights of persons who rely on social welfare. Communicating about changes well in advance also gives clients of social services an opportunity to request an appealable decision on their charges or, if necessary, ask social services to lower or waive their charges pursuant to the Act on Client Fees for Social Welfare and Health Care.

The Ombudsman drew the Social Welfare Committee's attention to the fact that it is an established interpretation in the context of the oversight of legality that client charges must always be based on the actual costs incurred. Clients cannot be made to pay for aids that they do not actually need. Clients must also have the right, if they so wish, to shop around for the services and aids that they need and to pay for them themselves. In the Ombudsman's opinion, it was clear that a service charge imposed on the complainant in this case and the extent to which the complainant was using the aids and services covered by the charge had not been evaluated from the perspective of the complainant's individual needs. It is up to a court of law to deliver a final ruling on the justifiability of the charge (5974/2017).

Personal assistance

The Ombudsman drew the social services of one local authority attention to their obligation to issue a challengeable decision on the model of personal assistance if a person who is entitled to personal assistance requests one. Persons with severe disabilities may be prevented from acting as an employer for their carer due to their circumstances. In such cases, the local authority must find another way to provide personal assistance that takes the client's needs and wishes into account. If a person with a severe disability cannot or does not want to act as an employer for their carer even with the local authority's support and assistance, the local authority must come up with alternatives. The local authority's policy of practically "forcing" persons with severe disabilities to go for the employer model was unlawful (2107/2017).

The Ombudsman urged the welfare services of the City of Oulu to take measures to minimise the possibility of personal assistance not being available, for example, by assigning substitutes for carers or coming up with a model to cater for urgent needs for assistance. Details of the services to be provided and alternative arrangements can also be agreed with each client separately and recorded in the client's service plan on the one hand and in the contract between the local authority and the service provider on the other. The Ombudsman emphasised that it was important for customers who rely on social welfare to be notified immediately if personal assistance is suddenly not available (3270/2017).

A child's right to a special care needs assessment

In the Ombudsman's opinion the disability services of the City of Vantaa acted unlawfully because the city failed to provide advice that could have enabled the identification of a child's special care needs. According to the authorities, the complainants in the case had been told about the city's special care services and explained that disability services' policy was to only draw up a special care programme for persons who have been formally diagnosed with an intellectual disability. The complainants had consequently not submitted a written application and had therefore not received a written decision.

The Ombudsman noted that the policy of the disability services of the City of Vantaa was in breach of the Administrative Procedure Act, the

Constitution of Finland and the Act on the Status and Rights of Social Welfare Clients, as the complainants had not been advised to apply for special care in writing. As a result, the complainants' wish to have a special care programme drawn up for their child was not properly addressed and no special care needs assessment was performed for the child, in addition to which the complainants were unable to exercise their constitutional right of appeal in the case.

The Ombudsman emphasised that clients of social services have the right to receive proper advice and that social services staff must explain to customers their rights and responsibilities. The authorities have a duty to ensure that clients are given clear information about their rights. The authorities' own policies cannot be used to justify departures from this duty, and customers must, regardless of any such policies, still be told clearly about all their rights, including their right to an appealable decision on a special care application. The Ombudsman felt that, in this case, the policy adopted by disability services (whereby a special care programme was only available for persons who had been diagnosed with an intellectual disability) was in violation of legal rules. It is an established interpretation that the Act on Special Care for the persons with intellectual disabilities does not stipulate that only persons who have been diagnosed with an intellectual disability are entitled to special care (7276/2017).

Delays in providing a care assistant for a child with an intellectual disability

The Ombudsman reprimanded the disability services of the City of Espoo for failing to deliver on a promised service to a child with an intellectual disability and for breaking the law by not reacting to enquiries in a timely manner, and ordered them to improve their practices to avoid similar situations in the future.

Short-term care, which had been granted to the child of the complainant in this case on the basis of the Social Welfare Act, had not been provided as agreed. In practice, the child had spent around one year without the promised service, as the city's disability services had been unable to find a new carer or service provider.

The Ombudsman concluded that the City of Espoo's disability services had seriously neglected their duty to provide the child with a care assistant in accordance with the competent authority's decision. The failure in this case was especially serious due to the fact that the person for whom the service was intended was a vulnerable child with an intellectual disability and special needs. It had also taken unreasonably long to begin providing the service and to find a new service provider, despite several attempts. The delay went on even after the complainant had alerted disability services to the fact that the child's behavioural problems and reliance on assistance had increased after school started in the autumn of 2016.

The Ombudsman also noted that the Administrative Procedure Act had been violated, as the complainant's enquiries had not been responded to in a timely manner. The failure to react promptly to the complainant's enquiries contributed to the delays and failures in the provision of a care assistant for the complainant's child (3483/2017).

Provision of residential services for a person with an intellectual disability

The Ombudsman found the Town of Kitee and Siun sote to have broken the law by taking an unreasonably long time to respond to a ruling by the Supreme Administrative Court. The Ombudsman emphasised that clients who rely on social welfare must be able to trust that the authorities are proactive in implementing court rulings. Social services had taken almost 10 months to investigate the case and deliver a decision after the Supreme Administrative Court's ruling. The local authority explained that assessing the customer's need for residential services and consulting interested parties had been time-consuming. Restructuring within the organisation had also delayed the processing of the case.

The Ombudsman found the failings particularly grave due to the fact that the authorities can be expected to take their duty to process cases promptly and implement court rulings in a time-

ly fashion particularly seriously when it comes to the provision of essential services pursuant to the Act on Special Care for the persons with intellectual disabilities. The more important a ruling is from the perspective of the day-to-day life of the individual concerned, the more promptly it should be implemented. In this case, the need for urgency was even greater due to the fact that the process had already been extremely lengthy by the time that the Supreme Administrative Court delivered its ruling. The Ombudsman felt that the aforementioned facts should have been taken into consideration in the decision-making process and the implementation of the Supreme Administrative Court's ruling on the provision of residential services (2944/2017).

Outdoor access, housing and legal rights of children committed to special care involuntarily

The Ombudsman considered it important to ensure that individuals who are committed to special care involuntary also have the right to spend time outdoors if their health permits. The Ombudsman called a joint authority's attention to the fact that even in-patients in hospitals must, as a rule, be allowed to spend time outdoors on a daily basis.

The Ombudsman emphasised that minors should ideally be housed in units where they have company of their own age. The Ombudsman concluded that a child under the age of 18 should not, as a rule, be housed in a unit with adults, unless there are special circumstances that demand it in order to protect the child's interests. The reason given by the joint authority in this case (the physical size of children over the age of 16 and the nature of their behavioural challenges) did not justify housing children with adults, as children should, as a rule, be housed with other children of a similar age.

The Ombudsman concluded that the joint authority's head of services had violated the Act on Special Care for the persons with intellectual disabilities by not informing the complainant about a decision to use restraints (supervision) on the complainant's under-18-year-old child in an appropriate manner. The Ombudsman emphasised that an appeal period only begins once a prospective appellant has been notified of the decision and been provided with appeal instructions. This is why, in order to protect individuals' legal rights, copies of decisions must always be sent to all interested parties even if considerable time has elapsed since the decision was issued. In this case, however, the service of the decision had not been effected in a lawful manner (2036/2017).

Announcement of consultations prior to putting a public contract out to tender

The Ombudsman found that the Kainuu Social Welfare and Health Care Joint Authority should have notified its clients and their families of an information event that it was hosting in relation to a contract for the provision of residential services for persons with intellectual disabilities in order to give them a better opportunity to express their views. The president of Kainuu's intellectual disability support group had arranged a consultation with members of the group and clients' families but had not invited the clients. The Ombudsman emphasised that local-authority decision-makers must, when contracting out services, consult with the prospective users of the service and their families even before the contract is put out to tender. The Ombudsman felt that it was important to inform customers well in advance about the impact that such contracts could have on their status. Sufficient and timely communication and interaction help to prevent uncertainty and disgruntlement among clients when new contracts are awarded. The authorities have a duty to share this kind of information, and the responsibility cannot be delegated.

The Ombudsman emphasised that taking the special needs of clients into account and consulting them is especially important in the context of personalised and long-term services due to the huge importance of the quality and continuity of such services. This is why the status of clients must be taken into account even before a contract is put out to tender and throughout the tendering process (4238/2017).

Interpreting services for persons with disabilities

The Social Insurance Institution of Finland (Kela) took over the responsibility for providing interpreters for hearing-impaired persons, deaf-blind persons and persons with speech impediments from local authorities on 1 September 2010. Kela can organise the service either by producing it or sourcing it from external service producers. Kela established its own servicecentre operation on 1 January 2014. The objective of the interpreter service is to protect the right of persons with disabilities who need an interpreter to be treated equally with persons without disabilities by giving them an opportunity to participate in society and share information and interact with others.

The interpreter service for persons with disabilities is reserved exclusively for individuals who cannot secure the services of a competent and suitable interpreter under other laws. Other laws under which persons with disabilities can request an interpreter include the Basic Education Act and the Act on the Status and Rights of Patients.

Competitive tendering of interpreter services

The Ombudsman emphasised that outsourced services must always satisfy the clients' needs. The Act on Interpreter Services for Persons with Disabilities stipulates that clients' unique needs must be taken into account both when putting contracts out to tender and when choosing an interpreter for a specific customer (Government Bill No 220/2009). The Ombudsman also emphasised that, should Kela learn through consultations that a contract is likely to have a considerable negative impact on the services of individual clients or client groups, it must take this into account and consult with the affected clients or client groups separately.

The Ombudsman considered it important to ensure the continuity of services required by especially vulnerable clients in particular. Persons who rely on interpreters may have certain special needs relating to their rights that Kela cannot ignore by virtue of the provisions of public contracts legislation. The Act on Public Procurement and Concession Contracts also stipulates that contracting entities must, when putting contracts for long-term social welfare or health care services out to tender, specify the duration and other terms and conditions of the contracts so that they do not give rise to unreasonable or inappropriate consequences for service users.

As, according to Kela, it was not possible to take the special needs of different user groups into account in the tendering process in this case, the Ombudsman recommended that, in the future, Kela consider direct award without competitive tendering in individual cases, if this is possible under the provisions of the Act on Public Procurement and Concession Contracts (6638/2017).

Processing times for requests to have an interpreter for international travel

The Ombudsman stressed the fact that one of the objectives of the requirement of timely processing is to protect the fundamental right of clients to appeal if the decision on their application is unfavourable. The Ombudsman concluded that although the delays in the processing of the complainant's application had not been substantial enough to violate the law in this case, Kela should remember in the future that the requirement of timely processing applies to all stages of the decision-making process, which is why any further enquiries required to decide a matter should be made without undue delay.

The Ombudsman asked Kela to report back by 31 December 2018 on whether it has established an estimated processing time for applications concerning interpreting services (7268/2017).

Kela responded saying that it has set a target to process all applications for interpreting services within 21 days.

Health care

Pursuant to Article 25 of the United Nations' Convention on the Rights of Persons with Disabilities, persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties must provide persons with disabilities with the same range, quality and standard of health care as provided to other persons.

DNR orders for persons with intellectual disabilities

The Deputy-Ombudsman reprimanded an attending physician for malpractice and urged the Medical Director of Valkeakoski Hospital to call the medical staff's attention to the importance of making accurate and sufficiently detailed entries in patient records and following the regulations concerning patient record entries in order to improve the hospital's procedures and prevent similar occurrences in the future. In this case, the key issue was the right of patients and their families to receive accurate information, and the Deputy-Ombudsman challenged the attending physician's decision to enter a DNR order in the records of a 61-year-old patient who was suffering from a moderate intellectual disability, cerebral palsy as well as other underlying medical conditions.

The Deputy-Ombudsman agreed with the conclusions of the National Supervisory Authority for Welfare and Health and its permanent expert in intellectual disabilities on non-conformances in the attending physician's practice. According to the National Supervisory Authority for Welfare and Health's expert, the deterioration of the patient's functions was inherently linked to his or her disability and a manifestation of that disability. The patient's underlying medical conditions and health at the time did not justify a DNR order or restricting the patient's right to intensive care. The attending physician's decisions placed the patient in an inferior position on the basis of their disability.

It also appeared that the patient's functions had not been properly assessed before the DNR order was entered in their records. According to the National Supervisory Authority for Welfare and Health, persons with disabilities have the same right to be resuscitated after a cardiac arrest and to receive any necessary intensive care as others, and disability must not be used as a reason to not resuscitate or provide intensive care. According to the National Supervisory Authority for Welfare and Health, the attending physician should have made a note in the patient records of the medical grounds on which the decision was made to not resuscitate and provide intensive care to the patient in the event of acute respiratory failure, namely that the measures would have caused the patient more harm than good. The attending physician should also have monitored the patient's functions on a daily basis in order to differentiate between what was attributable to the patient's underlying conditions and what was due to his or her disability and to determine his or her prognosis (1129/2017).

Undignified treatment of a person with a disability in a psychiatric ward

The Deputy-Ombudsman found that forcing a person whose physical functions were impaired due to cerebral palsy to take their meals sitting on a thin mattress on the floor of a psychiatric ward's isolation room and using unsuitable dishes and utensils constituted humiliating and degrading treatment. The patient's treatment was undignified and violated good health care and nursing practice. The complainant had been in nappies for the duration of the 24 hours that they spent in isolation. The patient records were incomplete, which is why the Deputy-Ombudsman was unable to determine whether the complainant's right to dignity and good health care had been honoured in these respects.

The Deputy-Ombudsman felt that the way in which the patient had been treated in isolation violated their dignity. The Deputy-Ombudsman consequently proposed the joint authority to compensate the complainant for the violations of their fundamental and human rights. The Dep-

uty-Ombudsman reprimanded the Päijät-Häme Joint Authority for Welfare for its illegal practices and negligence in the treatment of a patient with cerebral palsy (3287/2017*).

The joint authority has agreed to pay the complainant EUR 4,500 in compensation pursuant to the Non-discrimination Act.

Adequacy of health care services

The Deputy-Ombudsman found that a complainant's constitutional right to adequate health care had not been respected, as he or she had not been able to get a follow-up appointment for life-time care at Helsinki University Hospital's Spinal Cord Injury Outpatient Clinic as planned in the autumn of 2014 despite several attempts. Instead, the complainant, along with other patients suffering from a spinal cord injury who had been queuing for an appointment, had been sent a letter in early 2017 explaining that their referral had expired and that they would need to get a new referral in order to assess their current health and the urgency of care.

The Deputy-Ombudsman felt that the letter was misleading. The patients who received the letter could have mistakenly interpreted it as meaning that they were not eligible for life-time care at the Spinal Cord Injury Outpatient Clinic. The Deputy-Ombudsman concluded that Helsinki University Hospital had a responsibility to organise itself and its resources so as to be able to take care of its statutory duty to provide interdisciplinary life-time care for patients suffering from a spinal cord injury nationwide (1974/2017).

Guardianship

Cuts to clients' monthly cash payment

The Ombudsman called a public guardian's attention to the fact that they should have consulted more closely with the individuals responsible for the care of their client (a person with an intellectual disability) in order to establish whether essential changes had taken place in respect of their client's needs and circumstances before cutting his or her monthly cash payment. The Ombudsman noted that the starting point based on the assisted decision-making model set out in the United Nations Convention on the Rights of Persons with Disabilities had to be that guardians should, as a rule, consult with their clients before deciding on his or her monthly cash payment. The Ombudsman emphasised 1) the importance of personal interaction between a guardian and their client, 2) the need of guardians to also evaluated their client's cognitive abilities on the basis of their own observations, and 3) the need to consult with the client in all matters that are important to them even when the client's cognitive abilities appear weak on the basis of medical evidence and other information available to the guardian (91/2017).

Protecting the legal rights of patients in psychiatric hospitals

The Ombudsman concluded that a hospital had done the right thing by seeking a court order on the appointment of a guardian but that the guardianship authority had taken too long to make a decision. The Ombudsman was unable to determine on the basis of the evidence whether a patient at the psychiatric hospital had wished to appeal the decision to commit them to institutional care. It was the Ombudsman's impression that the hospital should nevertheless had been more proactive in ensuring the rights of patients to have a say before a guardian was appointed for him or her The hospital could have asked members of the patient's family to help him or her appeal if necessary. It is also an established legal practice to grant appeals submitted by family members on behalf of patients who are unable to pursue his or her own interests (known as *negotiorum gestio*) (3158/2017).

Education

Equal treatment of students at mealtimes

The Ombudsman evaluated a policy adopted by a university of applied sciences for making reasonable accommodations for students with health issues to be able to take their meals. The law does not expressly provide for students' right to meals or the length of meal breaks.

The medical condition of the complainant in this case meant that they needed special arrangements for mealtimes. The Ombudsman felt that the medical condition in question could have been considered a disability within the meaning of the Non-discrimination Act and the United Nations' Convention on the Rights of Persons with Disabilities, making the requirement of reasonable accommodation applicable to the case.

From the perspective of the Non-discrimination Act, adjustments had to be considered "necessary" if the complainant had actually been prevented from taking their meals on an equal basis with other students due to a lack of such adjustments. The key issue in the case therefore was to find a way to accommodate for the complainant's medical condition so as to give them an opportunity to take meals at the university without having to skip classes, which the complainant apparently had had to do. There was nothing in the evidence obtained to show whether the university had evaluated the issue from this perspective in particular and, if it had, what the conclusion of the assessment had been.

The Ombudsman proposed the university to investigate the case and consult with the complainant in order to find a solution for mealtimes that would enable the complainant to attend classes and progress in his or her studies in a manner that factored in his or her unique medical needs (6270/2017).

The university has promised to make reasonable accommodation for the complainant's medical condition once he or she resume his or her studies.

3.5 National Preventive Mechanism against Torture

3.5.1 THE OMBUDSMAN'S TASK AS A NATIONAL PREVENTIVE MECHANISM

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

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

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

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

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

In the case of the Parliamentary Ombudsman's Office, however, it has been deemed more appropriate to integrate its operations as a supervisory body with those of the Office as a whole. Several administrative branches have facilities that fall within the scope of the OPCAT. However, there are differences between the places, the applicable legislation and the groups of people who have been deprived of their liberty. Therefore, the expertise needed on visits to different facilities also varies. As any separate unit within the Office of the Ombudsman would, in any case, be very small, it would be impossible to assemble all the necessary expertise in such a unit. Therefore, the number of visits conducted would remain considerably smaller. Participation in the visits and the other tasks of the Ombudsman, especially the handling of complaints, are mutually supportive activities.

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

The OPCAT requires the States Parties to make available the necessary resources for the functioning of the NPM. The Government proposal concerning the adoption of the OPCAT (HE 182/2012 vp) notes that in the interest of effective performance of obligations under the OPCAT, the personnel resources at the Office of the Parliamentary Ombudsman should be increased. In its recommendations issued on the basis of Finland's seventh periodic report, the UN Committee against Torture (CAT) expressed its concern about the Ombudsman having insufficient financial or human resources to fulfil the mandate of the NPM. The CAT recommended that the State strengthen the NPM by providing it with sufficient resources to fulfil its mandate independently and efficiently. The CAT also recommended that Finland should consider the possibility of establishing the NPM as a separate entity under the Parliamentary Ombudsman.

The Ombudsman submitted his statement on the matter to the Ministry for Foreign Affairs on 13 October 2017. The Ombudsman states that the Office has so far received no additional human resources to fulfil its remit as the NPM, although such increases have been proposed. The Office of the Parliamentary Ombudsman's operating and financial plan for 2019–2022 states that allowances should be made for increasing the human resources in the NPM's area of responsibility in the planning period. In the Office's estimate, two additional posts would be required in addition to the current legal adviser coordinating the duties of the NPM, obtained through internal organisational changes. The required additional officials would be a coordinator and assistant. In the budget proposal for 2018, the Ombudsman did not propose an appropriation for the new posts. This is partly due to the fact that the results of the report on the division of duties between the Parliamentary Ombudsman and Chancellor of Justice have not been yet decided.

3.5.2 OPERATING MODEL

The tasks of the National Preventive Mechanism have been organised without setting up a separate NPM unit in the Office of the Parliamentary Ombudsman. To improve coordination within the NPM, the Ombudsman decided to assign one legal adviser exclusively to the role of coordinator. This was achieved through the reorganisation of duties, as no new personnel resources were gained. At the beginning of 2018, the role of principal legal adviser and full-time coordinator for the NPM was assumed by Senior Legal Adviser *Iisa Suhonen*. She is supported by Principal Legal Adviser *Jari Pirjola* and on-duty lawyer *Pia Wirta*, who coordinate the NPM's activities alongside their other duties, as of 1 January 2018 until further notice.

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

The NPM has provides induction training for external experts regarding the related visits. The NPM currently has nine external health care specialists available from the fields of psychiatry, youth psychiatry, geriatric psychiatry, forensic psychiatry, geriatrics and intellectual disability medicine. Four other external experts represent the Disability Section of the Human Rights Centre, and their expertise will be used on visits to units where the rights of disabled people are being restricted. The NPM also employs five experts by experience. Three of them have experience of closed social welfare institutions for children and adolescents, while the expertise of the other two is used in health care visits.

During its visits the NPM trives to engage more frequently in constructive dialogue with staff regarding good practices and procedures. Feedback on observations as well as guidance and

recommendations may also be given to the supervised entity during the visit. At the same time, it has been possible to engage in amiable discussions of how the facility might, for example, correct the inappropriate practices observed.

3.5.3 INFORMATION ACTIVITIES

A brochure on the NPM activities has been published and is currently available in Finnish, Swedish, English, Estonian and Russian. It will also be translated into other languages, if necessary.

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

3.5.4 EDUCATION AND TRAINING ON FUNDAMENTAL AND HUMAN RIGHTS

In order to promote human rights education and training, The Ombudsman and the Human Rights Centre started a joint project in 2017. The project is particularly targeted at the educational sector. The goal of the project and the inspection visits is to assess and promote education and training on basic and human rights at all levels of school life. Based on the experiences gained during the visits, the project team produced a training package for municipal directors of education and headmasters. In 2018, the NPM initiated a joint project with the Human Rights Centre on the realisation of fundamental and human rights in housing services for the disabled. In preparation for the project, experts employed by the Human Rights Centre have participated in visits of service units for disabled people.

3.5.5 TRAINING

The Office of the Parliamentary Ombudsman provided training related to the duties of the NPM as follows:

- National patient ombudsman days / NPM inspection visits of health care units. Cooperation with patient ombudsmen during visits
- Training on the right to self-determination for special care districts / The Ombudsman's task as a national preventive mechanism
- Forty years of research into intellectual disabilities conference / The Ombudsman's inspection visits of institutions and housing services for the intellectually disabled
- The seminar organised by the Finnish Association on Intellectual and Developmental Disabilities / Human rights and housing – the perspective of the overseer of legality
- Costs and impact of foster care in child welfare services training day / What are the obligations and restrictions imposed by the law?
- Police criminal investigation seminar / Presentation of the Ombudsman's recent decisions concerning the police

The Office of the Parliamentary Ombudsman participated in training related to the duties of the NPM as follows:

- "Abuse and neglect. What has happened to the nurse's ethic?" / Finnish Nursing Congress and Exhibition
- The prisoner's social rights seminar, with topics such as "How are the fundamental rights of prisoners being realised? What is the significance of sentence planning for the implementation of imprisonment?" / The Training Institute for Prison and Probation Services
- Foreigners as perpetrators / The Training Institute for Prison and Probation Services The seminar was opened by Deputy-Ombudsman Pölönen
- Substance addiction as a disease and its treatment – is the Finnish model working? / Parliamentary Committee for the promotion of health and well-being

- The Mental Health Congress seminar, with topics such as "Psychosis patients in prison"
- Seminar on the oversight of legality in the criminal sanctions services. The topics included "How is the principle of legality fulfilled in the criminal sanctions service and especially in the implementation of imprisonment?" The presentations included recent decisions and policy guidelines issued by the overseers of legality, along with experiences from the field. Deputy-Ombudsman Pölönen gave a talk at the seminar

Two Office representatives also participated in an international training event held in Copenhagen on 3 and 4 January ("IOI Workshop for NPMs"). The topic was "Strengthening the follow-up to NPM recommendations" and the event was organised by the Danish Parliamentary Ombudsman, the IOI (International Ombudsman Institute) and the APT (Association for the Prevention of Torture).

The NPM organised an internal workshop whose content was "Restraint measures and involuntary treatment in mental health care settings" in May 2018. The workshop was conducted by Professor Georg Hoyer, Doctor of Philosophy and Emeritus Professor of Social Medicine at the University of Tromsoe. Since 2010, Professor Hoyer is representing Norway at the CPT. He is Chairman of the Norwegian Research Network on the use of coercion in psychiatry. In addition to the Office's representatives, external experts participated in Professor Hoyer's workshop.

3.5.6 NORDIC AND INTERNATIONAL COOPERATION

The Nordic NPMs meet regularly twice a year. The Danish NPM organised a cooperation meeting in Copenhagen in January 2018. The theme of the meeting was solitary confinement in prisons and remand prisons, the various types of isolation and how they are addressed during visits. The "*de facto*" isolation of prisoners, i.e. the fact that, in practice, prisoners and remand prisoners are also isolated in situations that have no basis in law, was the topic of much discussion at the meeting. The meeting also included a visit to a prison in which the majority of inmates were remand prisoners.

In August 2018, the Swedish NPM hosted a cooperation meeting in Lund. The subject of the meeting was the treatment of intoxicated persons and addicts by various authorities. The participants were given a tour of a treatment and rehabilitation unit for people with addictions.

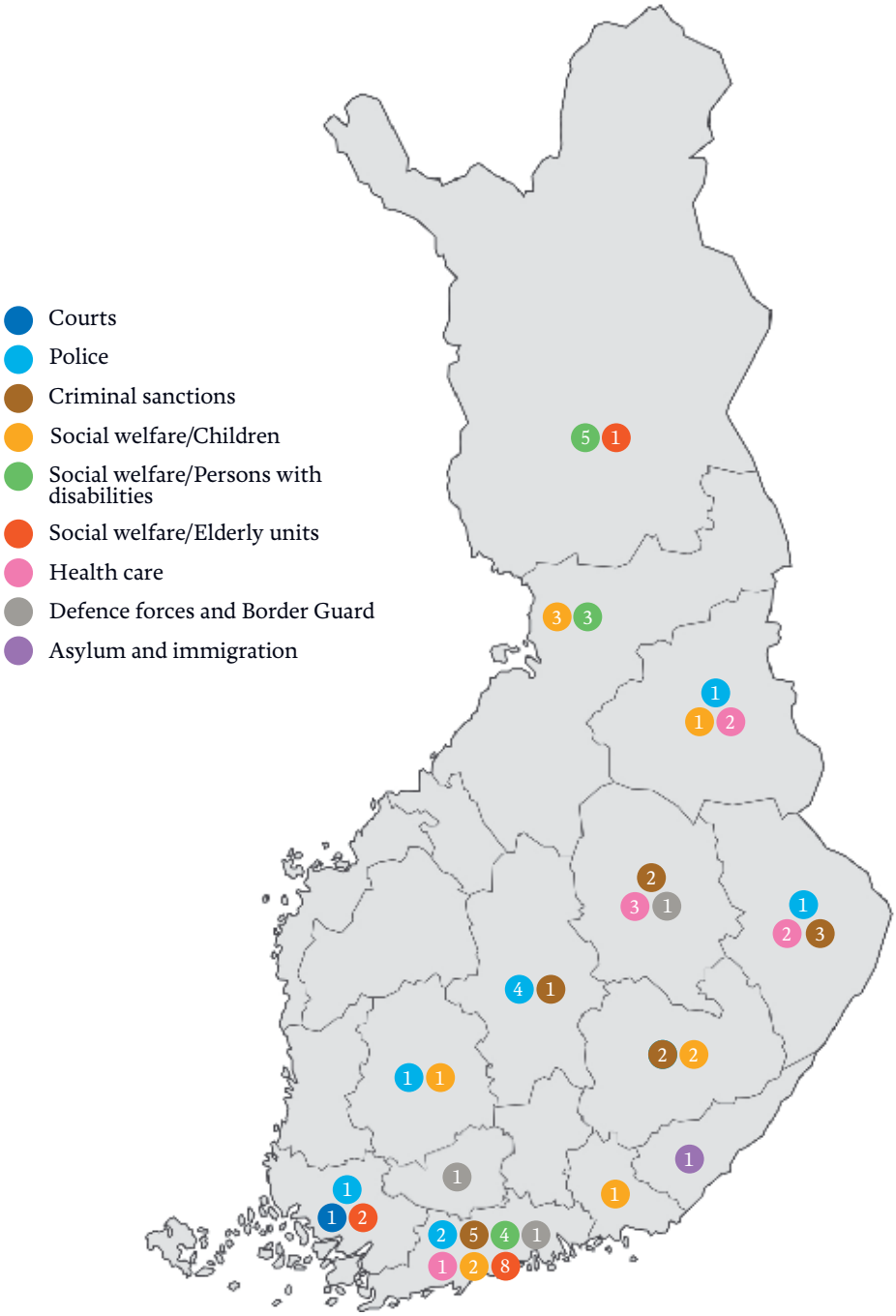
In November 2018, representatives of the Swedish Parliamentary Ombudsman visited the Office of the Parliamentary Ombudsman of Finland with the intent of studying the work methods and special tasks of the Ombudsman. During the visit, the guests were also introduced to the operations of the Finnish NPM.

Representatives of the Parliamentary Ombudsman of Georgia visited the Office of the Parliamentary Ombudsman of Finland in November 2018. They were interested in the operations of the Finnish NPM and, in particular, inspection visits of asylum seeker reception centres and detention centres for foreigners.

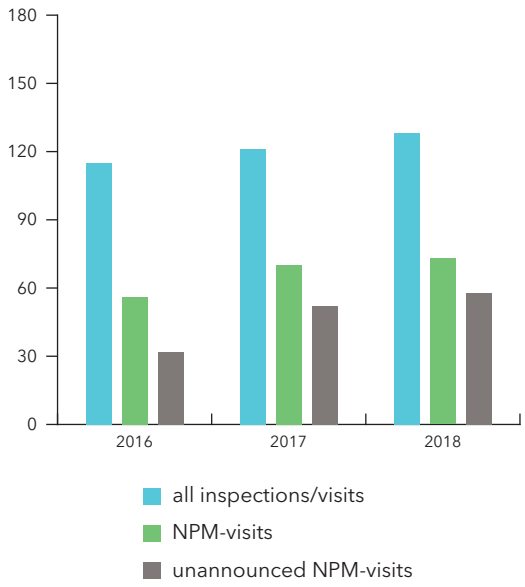
3.5.7 VISITS

Fulfilling the role of an NPM requires regular visits to sites. In some administrative branches, such as the police and criminal sanctions, such visits are also possible in practice. However, in the case of social services and health care, the number of units is so large that sites must be selected for visits on the basis of certain priorities. In 2018, follow-up visits were made in order to determine how the recommendations of the NPM had been implemented in practice. The implementation of recommendations is also monitored through notifications submitted to the Ombudsman by the visited units or other authorities, regarding any changes and improvements made in their operations.

In 2018, the NPM conducted a total of 73 visits (out of 122 conducted by the Office as a whole). Most of the visits were made unannounced. Use of external experts has become an established



NPM visits by region in 2018. A full list of all visits and inspections is provided in Appendix 5.



Visits in 2016–2018.

practice in certain administrative branches. In 2018, external experts where involved in 19 visits. On four visits, the medical expert was supplemented by an expert by experience. The NPM intends to further increase the use of external experts.

Out of the other visits conducted by the Ombudsman, 5 were related to the duties of the NPM, such as visits to the National Police Board and the Central Administration Unit of the Criminal Sanctions Agency.

Since its establishment of the NPM, has increasingly focused on interviewing persons who have been deprived of their liberty. On site, the NPM has sought to interview those in the most vulnerable position, such as foreign nationals. This has meant an increase in the use of interpreter services.

One of the key themes for the Office of the Parliamentary Ombudsman for 2018 was the right to privacy. Further details on the theme of fundamental and human rights are provided in section 3.8. In addition to the key theme, the special duties of the Ombudsman, i.e. the rights of children, the elderly and the disabled, are taken into account on each visit. The visits also involve the "oversight of oversight", i.e. the realisation of the NPM's duty to oversee the activities of other supervisory authorities.

3.5.8 POLICE

It is the duty of the police to arrange for the detention of persons deprived of their liberty not only in connection with police matters, but also as part of the activities of Customs and the Border Guard. The greatest number of people, over 60,000 every year, are apprehended due to intoxication. The second largest group consists of persons suspected of an offence. A small number of people detained under the Aliens Act are also held in police prisons.

From 1 January 2019, the detention of remand prisoners in a police detention facility for longer than seven days has been prohibited without an exceptionally weighty reason considered by a court. The rationale presented in the government proposal (HE 252/2016 vp) also refers to the opinions expressed by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) and the Ombudsman, that police facilities are unfit for the accommodation of remand prisoners. The long-term goal must therefore be to gradually abandon the practice of holding remand prisoners at police facilities.

The Act on the Treatment of Persons in Police Custody (Police Custody Act) is also currently under review. Following the Act's amendment, the National Police Board will update its own guidelines on the treatment of persons in police custody, and determine any general matters possibly provided for in facility-specific rules on custody (a rules template).

The reports on the Ombudsman's visits are always sent to the National Police Board and the visited facility. Internal oversight of legality at police departments is conducted by separate legal

units. It has been emphasised that these units should also inspect the operations of the police prisons in their respective territories. Each year, the National Police Board provides the Parliamentary Ombudsman with a report on the oversight of legality within its area of responsibility.

The police operates 42 police prisons. Nine of the prisons are only intended for short-term custody. Police buildings are quite old, with the majority having been built in the 1960s to 1980s. Many of the buildings are at or near the end of their service lives. A national renovation plan for police prisons has been drawn up, but its implementation has been slow. The old buildings also afford limited potential for modification. In addition, visits have shown that the temporary solutions adopted for the duration of renovations can be quite unsatisfactory. Renovations can also radically increase the transport needs of persons deprived of their liberty.

In 2018, 13 inspection visits were made to police prisons. The visit to Pasila police prison also included a visit of health care at the prison. Visits are also made to the Ministry of the Interior's Police Department and the National Police Board each year. The NPM is in regular contact with the units responsible for the oversight of legality within the police force over matters such as the themes and targets of visits and recent decisions on complaints.

The sites visited were:
- Pasila police prison, 7 March 2018 and 22 March 2018, 94 cells, (849/2018)
- Pasila police prison health care, 7 March 2018 (1488/2018)
- Turku police prison, 17 April 2018, 71 cells, only some of which are in use due to a renovation (1963/2018)
- Kajaani police prison, 28 May 2018, 12 cells (2485/2018)
- Iisalmi police prison, 29 May 2018, 19 cells (2486/2018)
- Kuopio police prison, 29 May 2018, 31 cells (2487/2018)
- Varkaus police prison, 30 May 2018, 16 cells (2489/2018)

A cell at the Pasila Police Prison.

- Joensuu police prison, 30 May 2018, 48 cells (2490/2018)
- Lahti police prison, 3 July 2018, 48 cells (3332/2018)
- Jämsä police prison, 2 September 2018, 12 cells (4390/2018)
- Saarijärvi police prison, 3 September 2018, 8 cells (4391/2018)
- Jyväskylä police prison, 3 September 2018, 8 cells in temporary facilities (4392/2018)
- Mänttä-Vilppula police prison, 4 September 2018, not in use (4393/2018)
- Tampere police prison, 4 September 2018, 62 cells, only some of which are in use due to a renovation (4394/2018)

All visits of police detention facilities were unannounced. One visit (health care in Pasila police prison) was attended by an external expert (specialist in forensic psychiatry). The visit to Jämsä police prison took place on a Sunday, but the others were made on business days.

Inspection visits require up-to-date information on the detention facilities in use

Upon arrival at the site, it became apparent that the police prison had not been in use since 2014 at the latest. The visit had been planned on the basis of a list of police prisons in use, obtained from the National Police Board in November 2017. According to the list, the police prison contained seven cells for persons deprived of their liberty by virtue of an offence. The Ombudsman noted that the availability of reliable and up-to-date information on police detention facilities is crucial to the successful investigation of police activities. As a rule, visits to detention facilities are made unannounced, so checking in advance whether the detention facilities are in operation is not feasible. The list provided to the Ombudsman contained other errors as well. The Ombudsman requested the National Police Board to deliver an up-to-date report on the detention facilities used by the police (4393/2018).

Compliance with the National Police Board's circular in police prisons

In November 2017, the National Police Board issued a circular on matters that should be taken into account in police detention facilities. The circular contained 17 rectification requests, mostly based on observations made by the Ombudsman and the legality oversight unit of the National Police Board.

The visits showed that the implementation of the rectifications required by the circular varied between police prisons. The NPM noted shortcomings in areas such as the storage of medicines, safeguarding the confidentiality of telephone calls with legal representatives as well as knowledge of the provisions concerning appeal in the Police Custody Act. After the visits, the police departments were requested to indicate how they had taken each item of the circular into account.

The outdoor exercise area at the Kajaani Police Prison.

Shortcomings in outdoor exercise areas

Not all police prisons have adequate outdoor exercise yards, and some are lacking them altogether. The acceptability of temporary solutions made during renovations also requires attention. Even temporary solutions are required to comply with the minimum requirements stipulated by law.

A temporary outdoor exercise area had been constructed for a police prison. The area was a small and dim veneer enclosure with direct access from the detention area. This exercise area was not fit for purpose (4394/2018).

The NPM noted a strong smell of tobacco in an outdoor exercise area of a police prison opened in May 2018. The Deputy-Ombudsman noted that the prison should consider how prisoners could be afforded the opportunity to take exercise in fresh air. The cleaning of outdoor exercise areas also requires more attention (3332/2018).

The Häme Police Department reported that there are only two outdoor exercise areas, one of which is mainly reserved for smokers deprived of their liberty. The other exercise area is only available to smokers when the police prison is so full that

equal access to outdoor exercise requires such a measure. However, a clear majority of persons deprived of their liberty are regular smokers. Particular attention has been paid to the daily cleaning of cigarette butts from the exercise area.

The police prison's exercise area was not fit for purpose. The area had next to no ventilation and was poorly cleaned (4391/2018).

Distribution of medicines

The intention was to provide training in the distribution of medicines to all police department guards during 2018. This has not happened, however. The training programme was begun in November 2018, with the objective that all guards should have passed the course and examination by June 2019.

Storage of medication at the Joensuu Police Prison.

Separation of investigation and detention responsibilities

In the context of the oversight of legality, it has frequently been noted that the responsibilities for investigating an offence and holding a suspect should be kept separate, administratively and in practice. If investigation and detention are left "in the same hands", there is a risk of detention conditions and the treatment of remand prisoners becoming dependent on the progress of the investigation and the remand prisoner's attitude towards it. Even though no such cases have been observed, the mere possibility gives cause for criticism. In this regard, practices such as the investigating officer managing the prisoner's meetings with family members are problematic. The police department should conduct a thorough assessment of the separation of investigation and detention responsibilities. This observation and opinion applied to nearly all visited police prisons.

According to the Deputy-Ombudsman, police prisons should have clear and uniform rules for obtaining a television, which should not be left to the decision of the investigating officer. Rather, the decision should be made by police prison staff according to these predefined criteria (849/2018).

According to the Helsinki Police Department, the police prison is equipped with 20 televisions, and access to them is subject to the discretion of the police prison staff. A specific guideline has been drawn up on the remand prisoners' right to obtain a television.

If no restrictions on communication have been imposed on a person, neither can the investigating officer impose such restrictions. In general, the interviews of remand prisoners indicated that the handling of the affairs of persons deprived of their liberty could be much delayed when they were referred to the investigating officer (849/2018).

According to the Helsinki Police Department, the intention was not to create artificial restrictions on communication, and the cases mainly involved the practical arrangements of meetings. The Act on the Treatment of Persons in Police Custody entering into force at the beginning of 2019 will change the visitation practices of all police prisons so that the practical arrangements will fall under the responsibility of police prison staff. Partly due to the increased resource need caused by this, the police department is recruiting new guards. Upon the entry into force of the Act on the Treatment of Persons in Police Custody at the latest, the police department will change its visitation practices so that police prison staff will be responsible for all practical arrangements of visits.

The visit arrangements and handling the affairs of all persons deprived of their liberty must be subject to the same criteria (2485/2018).

According to the Oulu Police Department, investigation and detention responsibilities have been separated in all of its police prisons both administratively and in practice.

Information about rights

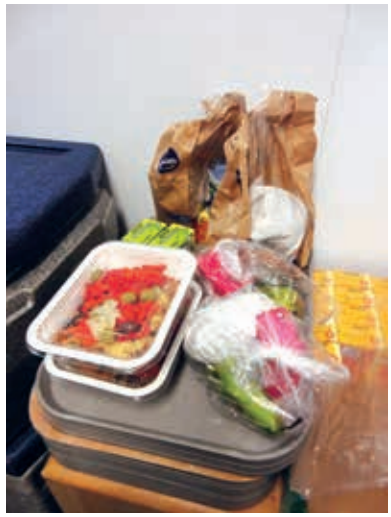
In accordance with the National Police Board guideline, persons deprived of liberty must be informed of their rights as well as of the daily routine in the detention facilities. Fulfilling this obligation must be recorded in the data system. The NPM noted that the police prison had not in all cases been recorded this information. Additionally, the police prison's compliance with another guideline issued by the National Police Board requires further information. According to this guideline, persons deprived of liberty (regardless of the grounds) must immediately upon arrival in the detention facility be provided with a form stating their rights and duties, the police prison's disciplinary regulations as well as the above-mentioned National Police Board guideline (4390/2018).

On visits to police prisons in Lapland in 2017, the Deputy-Ombudsman noted that the document describing the rights and duties of persons deprived of their liberty was available in several languages, some of them quite rare, but not in Sámi. Taking the provisions of the Sámi Language Act into account, the Deputy-Ombudsman considered it justified to have the document translated to all three Sámi languages (6796/2017).

The National Police Board reported having drawn up "Rights and obligations of persons deprived of their liberty" forms in Sámi.

Catering

The Act on the Treatment of Persons in Police Custody specifies that meals must be organised for persons deprived of their liberty, ensuring that they receive healthy, versatile and adequate nutrition. More detailed provisions on catering are provided in a Decree of the Ministry of the Interior specifying that persons deprived of their liberty for a continuous period of more than 12 hours are entitled to two meals per day. At least one of these meals must be hot. Other nourishment appropriate with regard to the time and duration of detention can also be arranged for persons deprived of their liberty.



Catering at the Kuopio Police Prison.

Among other things, the catering at police prisons was investigated during the NPM's visits. The results have shown practices to vary considerably between police prisons and, for example, weekdays and weekends. In some situations, prisoners can be required to go without nourishment for too long. The Deputy-Ombudsman has taken the matter under investigation on his own initiative and requested the Ministry of the Interior to assess whether the prevailing practices and regulations in force secure the provision of the healthy, diverse and sufficient nourishment afforded by

law to persons deprived of their liberty in all situations (4488/2017).

The visits have also raised the question of how catering at police prisons should be assessed from the perspective of food legislation. The Deputy-Ombudsman has decided to investigate the matter. He found a joint investigation by the National Police Board and the Finnish Food Safety Authority Evira (the Finnish Food Authority from 1 January 2019) of the requirements imposed by food legislation on catering in police prisons, both as a whole and taking into account the various local arrangements, to be justified. The Deputy-Ombudsman also noted that the matters described in the report should also be taken into account in future amendments to the Police Custody Act and the decrees and regulations issued by virtue of the Act. The National Police Board was requested to report on the measures it had taken on the matter (59/2018).

As its position, the National Police Board stated that food safety was not completely realised in all police prisons. The Board indicated that it would continue investigating the matter in cooperation with Evira.

The NPM noted that the hot meal was offered quite early in the afternoon. The interval to the morning meal is long, even taking the light evening meal into account. The Deputy-Ombudsman noted that, if changing these meal times is not possible, particular attention should be paid to the diet and meal rhythm of those persons deprived of their liberty whose health requires such considerations, such as persons with diabetes (849/2018).

The National Police Board noted that the canteen delivers extra evening meal bags to the police prison each evening, which can then be distributed to persons who, on account of their health or other equivalent reasons, require more nourishment or meals at shorter intervals.

In his decision on the complaint, the Deputy-Ombudsman recommended the police to compensate the complainants for the harm suffered by them due to the police's serious neglect of its duty to arrange meals in the police prison by virtue of the Police Act. Four persons taken into custody by virtue of the Police Act were deprived of their liberty for 19 hours. They were served no food during this time (5304/2017).

The police reported that it had reached an agreement with the complainants for the compensation of the harm caused to them, and EUR 150 was paid in compensation to each complainant.

Detention of a suspect in the drunk tank

Use of a police prison's detention facilities was banned due to indoor air problems. The temporary detention facilities were primarily reserved for persons detained by virtue of the Police Act, i.e. mostly intoxicated persons. Regardless of this, the documents and accounts of the guards seemed to indicate that persons taken into custody due to suspected offences were held there quite often. The criteria for this measure remained unclear, as there were no cells intended for such detainees in the facilities. A separate investigation of the matter was launched under the Ombudsman's initiative (4392/2018).

Positive observations

The circular sent by the National Police Board to police departments indicates that it is assuming the active role in the supervision of police prisons expected of it.

The Police University College has started again to hold guard courses every autumn and senior guard courses at somewhat longer intervals as of 2019.

3.5.9 THE FINNISH DEFENCE FORCES

In 2018, the NPM conducted three visits to the detention facilities of the Finnish Defence Forces. All of the visits were made unannounced.

The sites visited were:
- The detention facilities for persons deprived of their liberty of the Armoured Brigade's Riihimäki unit, 7 June 2018, two detention rooms (3117/2018)
- The detention facilities for persons deprived of their liberty of Karelian Air Command, 20 November 2018, three detention rooms (6084/2018)
- The detention facilities for persons deprived of their liberty of Guards Jaeger Regiment, 10 December 2018, three detention rooms capable of accommodating 12 persons (6511/2018)

The treatment of person deprived of their liberty in Defence Forces facilities is governed by the Act on the Treatment of Persons in Police Custody. During these visits, the NPM paid attention to the conditions and treatment of those deprived of their liberty, their access to information, and their security.

3.5.10 THE FINNISH BORDER GUARD AND CUSTOMS

The Finnish Border Guard currently uses 15 closed spaces for the detention of persons deprived of their liberty. The facilities are typically shared by the Border Guard and Customs. Customs also has facilities for its exclusive use in three locations. These detention facilities are used for short-term detention before transferring detainees to a police prison, detention unit, or reception centre. The treatment of persons deprived of their liberty at Customs or Border Guard facilities is governed by the Act on the Treatment of Persons in Police Custody. The duration of detention in these facilities varies from one to several hours. The maximum detention time is 12 hours in all cases. The locations, standard and furnishing of the facilities vary. The Border Guard Headquarters have approved the rules for Border Guard's detention facilities and issued regulations for detention facilities. Similarly, Customs has approved of the detention facilities used by it and issued its own rules for its detention facilities. The scope of the Customs rules for detention facilities has been under an own-initiative investigation by the Ombudsman (6194/2017).

No visits to the Border Guard's or Customs' detention facilities were made in the reporting year.

3.5.11 THE CRIMINAL SANCTIONS FIELD

The Criminal Sanctions Agency operates under the Ministry of Justice and is responsible for the enforcement of sentences to imprisonment and community sanctions. The Criminal Sanctions Agency runs 26 prisons. Prisoners serve their sentences either in a closed prison or an open institution. Of Finnish prisons, 15 are closed and 11 open institutions. In addition, certain closed prisons also include open units. Visits mainly focus on closed prisons. The average number of prisoners has remained stable at around 3,000 prisoners for several years now.

There are major construction projects related to prisons currently under way in the criminal sanctions field. The greatest international attention has been focused on the prisons of Helsinki and Hämeenlinna, which have used "bucket cells", i.e. cells without a flash toilet in them. This has no longer been the case in Helsinki Prison after the completion of the renovation in the spring of 2017. The replacement of Hämeenlinna Prison with a new facility has been planned, with the new prison slated for completion in the autumn of 2020. Indoor air problems were discovered in the current facilities, however, and use of the prison building was discontinued immediately in December 2018.

A renovated cell hallway at the Helsinki Prison.

In the reporting year, the Deputy-Ombudsman issued one statement to the Legal Affairs Committee of Parliament on a government proposal related to prisoners (4724/2018). The proposal suggested a new, discretionary basis for imposing supervision on prisoners released to probationary freedom. The proposed basis for supervision was a high risk of repeating a violent or sex offence. In 2018, the NPM also gave two statements to the Department of Criminal Policy at the Ministry of Justice and made 10 proposals, most of which involved legislation or drawing up internal guidelines for the administrative branch.

The Deputy-Ombudsman proposed the payment of compensation in one decision concerning a complaint made by a prisoner. The prison had charged the prisoner's bank account as compensation for a broken item without the prisoner's consent. The Deputy-Ombudsman stated that the prison did not have the right to do this without the prisoners consent and was therefore required to return the funds to the prisoner. If an agreement cannot be reached on the matter, the prison should file an action for damages in the court (3721/2017).

The prison reported that it had returned the money to the prisoner's account

In the field of criminal sanctions, visit reports are sent for information to the Central Administration of the Criminal Sanctions Agency, the management of the criminal sanctions region in question and the Department of Criminal Policy at the Ministry of Justice. In addition, the central and regional administrations are often requested to report measures taken as a result of the observations. The Ombudsman receives reports on the facilities visited, drawn up for the internal oversight of legality in the criminal sanctions field. Furthermore, each month the Criminal Sanctions Agency provides the Ombudsman with its statistics on the number of prisoners and prison leave. Among other things, the prisoner statistics indicate the number of remand prisoners, male and female prisoners, and prisoners under the age of 21. The statistics on prison leave give an indication of the processing practices concerning leave applications in each prison, or in other words, how many prisoners apply for leave and how often, and how much leave is granted.

Visits to the Central Administration Unit of the Criminal Sanctions Agency and Department of Criminal Policy at the Ministry of Justice were also made in the reporting year.

The NPM made a total of 13 inspection visits were made in the field of criminal sanctions. Six of these visits involved the whole facility.

The visited facilities were:
- Kerava Prison, 30 January 2018, 94 places (448/2018)
- Laukaa Prison, 23 May 2018, 59 places (2337/2018)
- Kuopio Prison, 23 May 2018, specific theme (2338/2018)
- Sulkava Prison, 3 May 2018, 48 places (2339/2018)

- Mikkeli Prison, 24 May 2018, specific theme (2340/2018)
- Prisoner transport by train, 29 May 2018 (2648/2018)
- Accessibility in Jokela Prison, 20 June 2018 (3183/2018)
- Juuka Prison, 9 October 2018, 40 places (4652/2018)
- Pyhäselkä Prison, 9–10 October 2018, 87 places (4653/2018)
- Accessibility in Pyhäselkä Prison, 10 October 2018 (5322/2018)
- Helsinki prison, 27 and 29 November 2018, 312 places (5563/2018)
- Visiting ~~area~~ premises of Kuopio Prison, 20 November 2018 (6085/2018)
- Accessibility in Helsinki Prison, 27 November 2018 (6148/2018)

The inspection visits were announced with the exception of the visits of the prisoner transport, Mikkeli Prison, Jokela Prison and the visiting premises of Kuopio Prison. The visit to Mikkeli Prison was mainly a follow-up to the visits conducted in 2016 and 2017.

The observations made during the prison accessibility inspection visits are also reported in Section 3.4 (Rights of persons with disabilities).

The Kerava, Pyhäselkä and Helsinki outpatient clinics of Health Care Services for Prisoners were visited in addition to the above. These visits are described in the health care section.

Conditions in solitary confinement

Provisions on the conditions of observation were added to the Imprisonment Decree in 2015. Among other things, these provisions state that a prisoner's rights may only be restricted if it is necessary in order to fulfil the purpose of observation. The grounds for placing the prisoner under observation must be taken into consideration in restricting the prisoner's rights. In other words, being placed under observation should not automatically mean that, for example, the prisoner would have to eat on the floor.

Seclusion facilities at Juuka Prison.

In his decision issued on 23 February 2018, the Deputy-Ombudsman commented on the furnishings of isolation cells and observation cells. He considered it problematic that all cells in the isolation unit of Riihimäki Prison were unfurnished. The only piece of furniture was a mattress on the floor. Unfurnished isolation cells were also discovered in other prisons. Prisoners are placed in isolation cells on various grounds, for example as a disciplinary punishment or safety measure. For this reason, the type of cell and conditions that each prisoner should be placed in must be considered on a case-by-case basis. According to the Deputy-Ombudsman, it cannot be a general principle that a prisoner can be placed in an unfurnished cell in all situations. He also noted that the prisons should acquire furniture that they could issue to prisoners for their cells. Making prisoners eat on the floor is not acceptable with regard to their human dignity. Different prisons have different practices in the above-mentioned matters. The Deputy-Ombudsman considered it to be justified and important that the Central Administration Unit of the Criminal Sanctions Agency would issue guidelines to prisons on how and in what conditions placement in an isolation unit should be implemented (1276/2017*).

The Criminal Sanctions Agency reported that it will issue guidelines on how and in what conditions solitary confinement should be implemented. The

Central Administration Unit will review the furniture of each unit, taking into account the requirements specified in the Ombudsman's decision.

The only furniture in the isolation cells consisted of a toilet seat and a mattress on the floor (4653/2018).

According to the prison, four table cubes had already been purchased and installed.

The Imprisonment Act requires cells to be equipped with alarm devices that can be used to contact prison staff immediately. Using the alarm button to contact prison staff required the person placed in the cell to go down on their knees and lie down on their stomach to reach the button. This could put the person's life in danger in the event of, for example, a seizure. From the perspective of the persons deprived of their liberty, the location of the button could be seen as extremely humiliating (2338/2018).

The Criminal Sanctions Region of Eastern and Northern Finland reported that the old buttons in Kuopio Prison had been decommissioned, and new buttons were located at door handle height from the floor. Photographs of the new button locations were enclosed with the report.

Deputy-Ombudsman Pölönen is trying out the accessibility of the alarm button.

The NPM recommended the prison to issue drinking water to prisoners in plastic bottles until working water taps could be installed in the cells. The prison took measures to purchase plastic bottles immediately during the visit (2340/2018).

The NPM found that the lights of one of the isolation cells did not work at all. After the visit, the facility reported that the fault in the lights had been repaired and they were once again operational. According to prison management, the isolation cell had been last used in June 2018. The bed in the cell was still unmade (in October). After the visit, the prison reported that the used bed linen had been removed and the cell cleaned (4652/2018).

The isolation cell was equipped with a toilet but no water fixture. There was a pallet in the cell, but no proper bed. The footage from the surveillance camera could be viewed in the control room. It was impossible to tell from the camera in the cell when it was on. The cell's toilet seat was visible in the camera view on the screen. Therefore, when the camera was on, a prisoner placed in the cell could not go to the toilet without being surveilled by a camera. During the visit, the prison was made aware that camera surveillance of a prisoner placed in an isolation cell was only permitted under the Imprisonment Act if the prisoner had been placed in the cell for observation or isolation under observation (4652/2018).

Placement of remand prisoners

The Remand Imprisonment Act requires separate units for remand prisoners and convicted prisoners. Remand prisoners may only be placed in the same unit as convicted prisoners when the specific conditions provided for by law are met.

It was an established practice in the prison to place convicted prisoners and remand prisoners in the same units. This had already been pointed out to the prison during an inspection made by the Ombudsman in 2007. At the time of the visit, the prison was nearly fully occupied and the numbers of remand prisoners varied a great deal. There were also relatively few units in the prison. These factors presented understandable difficulties in

the housing of remand prisoners. However, separating remand prisoners from other prisoners is a principle clearly prescribed by national legislation and international recommendations, which is based on the presumption of innocence. The Deputy-Ombudsman noted that the placement of remand prisoners had not been done according to the law, or even according to the prison's own placement instructions or the unit division specified in the daily schedule. In the case of female remand prisoners, a further error had been committed in placing them in the same cells with convicted prisoners (4653/2018).

Time spent outside the cell

The Ombudsman's decisions and international recommendations have for a long time been based on the premise that prisoners should be permitted to spend a reasonable amount of time, and no less than eight hours per day, outside their cells. During that time, they should be able to engage in meaningful and stimulating activities, such as work, rehabilitation, training and exercise.

After the visit, the NPM asked the prison to provide a report on how many hours of activities the prisoners had attended in a certain week. The situation appeared to be quite good on weekdays, when the majority of prisoners spent more than eight hours per day out of their cells. In the weekends, however, the situation was clearly worse. In addition, the female prisoners' extremely poor ability to function set limits on their placement in activities. The Deputy-Ombudsman noted that open units were difficult to achieve merely by increasing the amount of activities. The Deputy-Ombudsman did not see why cell doors could not be open also when there was no organised or supervised activity going on in the unit (4653/2018).

Depending on the unit, the prisoners had the opportunity to spend from three to five hours out of their cells each day. In addition, the prisoners of two units were not permitted to visit the prison shop, but had to order the products they wanted (5563/2018).

A default prisoner is a person serving a conversion sentence in lieu of an unpaid fine. A conversion sentence is passed for a person sentenced to a fine if efforts to collect the fine have been unsuccessful. The placement of default prisoners is subject to the same provisions as that of convicted prisoners, and they have equal rights to participate in activities. Not a single default prisoner had been placed in an activity, however. The unit was the most closed in the prison, and no activities had apparently been arranged for the prisoners (5563/2018).

Smoking ban

The Imprisonment Act permits smoking to be banned in the accommodation premises of prisoners. If smoking is prohibited in cells, prisoners must be provided with the opportunity to smoke in a designated space or in other ways. The Central Administration Unit of the Criminal Sanctions Agency decides on the prohibition of smoking in prisons. It also issues more detailed regulations on smoking arrangements. On 15 June 2018, the Central Administration Unit issued a regulation stipulating that prisoners were to be allowed to smoke for a minimum of three times a day at regular intervals, such as in the morning, afternoon and evening. Helsinki Prison is the first prison to ban smoking in its residential premises. The smoking ban entered into force on 1 August 2018.

Regarding the smoking ban, the NPM focused on the prison's practical smoking arrangements as well as the prisoners' attitude toward it. The Ombudsman had received several complaints regarding the smoking ban, so the visit did not address the actual prohibition of smoking. The prisoners did not have many complaints about not being able to smoke in the residential quarters anymore. Instead, they criticised the decisions and practices related to the prohibition of smoking. Due to the limited amount of storage space in the units, the purchase of tobacco products had been limited to three packs of cigarettes per week by decision of the prison director. Neither were the prisoners allowed to roll their own cigarettes anymore,

which is cheaper. Giving one's cigarette to another prisoner during outdoor exercise was forbidden. The NPM was told that only prisoners who took their own cigarettes (a maximum of two) with them were allowed to go outside to smoke. Thus, prisoners who did not smoke could potentially spend less time out of their cells than smokers. The NPM also heard that prisoners who were caught smoking elsewhere than in the smoking yard would face a two-week ban on buying cigarettes (5563/2018).

Impact of health care resources on prison activities

During the visits made to Kerava Prison and VTH Kerava outpatient clinic, the NPM observed that a lack of personnel at the clinic limited the number of prisoners undergoing opioid substitution treatment that could be admitted into the prison. The Deputy-Ombudsman found it a cause for concern that a transfer to an open institution could be prevented by a lack of health care resources (448/2018). The same issue was discovered on a visit to Sulkava Prison in May 2018 (2339/2018).

The Deputy-Ombudsman noted that the cooperation between the Criminal Sanctions Agency and Health Care Services for Prisoners (VTH) was not optimal with regard to taking the prisoners' need for health care services and the availability of health care personnel resources into account in the placement of prisoners. As key players in the process, the assessment centres should be aware of the facilities' capacity for meeting the health care needs of prisoners placed in them. VTH's treatment guidelines require multidisciplinary cooperation in the implementation of substitution treatments. The team includes a drug and alcohol counsellor employed by the prison. In accordance with the guidelines, a drug and alcohol counsellor's duty is to take care of the psychosocial rehabilitation of prisoners receiving substitution treatment. The guidelines also specify minimum requirements for the presence of a nurse and physician in the prison before substitution treatment can be implemented in the first place. It seemed that these requirements were not being met in all open institutions. The Deputy-Ombudsman recommended that the prisoner's state of health should always be taken into account in the prisoner's placement when it is known that the prisoner will have a greater than average need for health care services. At the very least, this applies to prisoners with disabilities and prisoners receiving substitution treatment.

Treatment of foreign prisoners

The proportion of foreign prisoners in Finland's prisons has grown. At present, roughly 18 per cent of all prisoners are foreign nationals. The NPM seeks to take these prisoners into account during visits, for example by interviewing them with the help of an interpreter. In these interviews, the NPM seeks to determine whether the prisoners have been informed of their rights and duties, for example.

Prisons still do not employ adequate interpretation services when dealing with foreign prisoners (2339/2018).

The prison reported that it had requested a quotation for interpretation services in order to provide the service in the prison. The working groups will discuss uniform practices for the use of interpretation services.

Even though the guide for new prisoners may have been translated into several languages, the translations are not always actively offered to foreign prisoners arriving at the prison. The availability of books and magazines in other languages also varies between prisons. In particular, foreign prisoners would like to have access to foreign TV and radio channels (5563/2018). The Deputy-Ombudsman has begun an investigation into the opportunities of foreign prisoners to watch television.

In connection with a visit to the Department of Criminal Policy at the Ministry of Justice, the Deputy-Ombudsman expressed the opinion that the Imprisonment Act and Remand Imprison-

ment Act should be translated into English for distribution to prisoners.

According to information received from the Ministry of Justice, the translations have been completed and are available in Finlex. The Criminal Sanctions Agency has been requested to ensure that foreign prisoners are informed of their rights through the translations.

When interviewed, foreign prisoners describe similar issues as other prisoners, i.e. that visiting rights are not fulfilled or that living in a closed unit causes anxiety. On the other hand, fewer foreign prisoners have complaints about the behaviour of prison officers.

In 2018, the Criminal Sanctions Agency announced on its website that it has published multi-lingual orientation materials. In connection with this, a video guide for new prisoners was published in five languages. The objective is for the video to provide prisoners with sufficient basic information on their rights and term of sentence and the operation of a closed institution in their own language. Helsinki Prison was not aware of these materials at the time of the NPM's visit in November, so the NPM did not have the opportunity to investigate the prisoners' experiences of the video guide.

Prisoner transport by train

The prisoner transport route starts in Helsinki and ends in Oulu. The duration of the trip is nearly nine hours. In addition to this, prisoners joining the transport at the station of departure are brought into the train approximately one hour before its departure, so prisoners can spend up to ten hours on the train. The NPM travelled on the train for approximately one hour, from Helsinki to Lahti. Four prisoners were interviewed during the inspection visit. At that time, the total number of prisoners being transported was five.

The information on the potability of the water drawn from cell taps was contradictory. The Deputy-Ombudsman found cause to investigate the potability of the water drawn from cell taps. If nothing else, the quality of the water should be investigated for the reason that the cars have been in use for approximately 35 years. According to the Deputy-Ombudsman, the cells should have notices for the prisoners on the potability of the tap water.

Furthermore, the Deputy-Ombudsman stated that the prisoners must absolutely be informed of the availability of drinking water, whether from the tap or a bottle. In any event, the prisoners' access to drinking water during the trip must be rectified immediately, if necessary by purchasing bottled water. This must be communicated clearly enough and also with due consideration of prisoners who do not speak and/or understand Finnish.

The Criminal Sanctions Agency reported that bottled water had been acquired for the prisoners as a stop-gap measure and a notice on the matter was being drawn up. The notice also states that the tap water should not be drunk as its potability is under investigation. This notice for prisoner car passengers will be drawn up in eight languages.

The Deputy-Ombudsman found the practice that prisoners had to use the toilets in the presence of other prisoners to be degrading of their human dignity. The practice is also a serious violation of the prisoners' right to privacy. In addition to the prisoner using the toilet, the practice is demeaning for the other prisoners in the cell, taking into account the cramped conditions and poor ventilation. The screen envisioned in the Criminal Sanctions Agency's statement does not change these circumstances. The Deputy-Ombudsman found no cause to doubt the guards' account of prisoners being permitted to use the toilet in private upon request. However, a situation in which the prisoners are not aware of this possibility is equivalent to a situation in which the possibility does not exist. The opportunity must be communicated clearly enough and also with due consideration of prisoners who do not speak and/or understand Finnish.

The Criminal Sanctions Agency stated that it had begun drawing up a notice to be posted on the wall of the prisoner car, indicating that prisoners could ask the guards to be permitted to go to the toilet privately. In the future, this information will also be communicated verbally to all prisoners being transported.

A prisoner carriage at the departure train station in Helsinki and photographs from inside the carriage cells.

On the left, a photograph of a toilet in a cell.
Above, a photograph of the tanks for drinking water in a prison carriage.

The Deputy-Ombudsman considered it necessary to inspect the operability of the car's alarm and other technical devices regularly, preferably after every transport. The cleanliness of the cell and, for example, the condition of the mattresses also requires better care. The Deputy-Ombudsman exhorted the Criminal Sanctions Agency to investigate whether anything could be done about the heat in the cells. The need to clean the ventilation ducts should also be determined.

The Criminal Sanctions Agency reported that, in the future, the operability of the toilet and guard call buttons would be checked on a regular basis. The Railway Company (VR) had contacted the company responsible for cleaning the prisoner car in order to improve the level of cleanliness. The walls were cleaned as an immediate measure. VR notified the Ombudsman that it would replace the mattresses in the prisoner cars and have the ventilation ducts cleaned on a regular basis. Other measures for alleviating the heat were also being looked into.

Non-smoking prisoners should not be placed in the same cell with smokers against their will. The prisoners' must be asked about their opinion in this.

One of the targets set in the Criminal Sanctions Agency's strategy is making the Criminal Sanctions Agency smoke-free by 2020. According to the Criminal Sanctions Agency, the conditions of the prisoner car will also be taken into account in this project.

The Deputy-Ombudsman suggested that the Agency should review the quality and quantity of the prisoners' packed lunch for the trip. Particular attention should be paid to the needs of prisoners whose health requires the observance of a special diet (such as diabetics).

The Criminal Sanctions Agency reported that an overall reform of catering was being planned, and the issues noted in the NPM report would be taken into account in it. The contents of the packed lunches will be updated, and the new lunches will be available from the start of 2020.

The Deputy-Ombudsman did not approve of the use of the prisoner transport car to carry prisoners with conditions that require special health monitoring and involve the risk of a seizure. Assessing the health risk of prisoners is not the duty of the guards responsible for the transport, but belongs to health care professionals.

Consideration of prisoners in need of special support

The prison is not always aware of prisoners' disabilities or conditions impairing their ability to function, such as minor intellectual disabilities or autistic disorders such as Asperger's or ADHD, if this information is not provided by the prisoners themselves. However, such information and the ways in which the disabilities or disorders affect the lives of the prisoners are crucial for setting the prisoner's targets in the sentence plan and defining the methods for achieving such targets. The investigators were unable to determine to what extent Health Care Services for Prisoners is involved in drawing up and monitoring the sentence plans of prisoners in need of special support (5322/2018).

The cell for disabled prisoners was located in the unit for new arrivals. There were no common recreational areas in the unit, and the cell doors were kept closed. All prisoners placed in the unit's cells – including the prisoner in the cell for the disabled – had their meals in their cells. The possibility for daily outdoor exercise was provided in the unit. The Deputy-Ombudsman noted that, since the cell for disabled prisoners was located in the arrivals unit, this meant that, in practice, prisoners with impaired mobility had to be placed in a closed unit even if they would otherwise have been eligible for placement in an open unit. This practice for the placement of prisoners with impaired mobility was not in compliance with the Imprisonment Act (5322/2018).

Positive observations and good practices

Everyone had the opportunity to use the prison shop. Even prisoners in solitary confinement were given the opportunity to go shopping once a week. No-one was required to make their purchases by filling in an order coupon (4653/2018).

In connection with a visit to Vantaa Prison in late 2017, the Deputy-Ombudsman was shown a picture book titled "Welcome to Vantaa Prison", drawn up for visitors and especially children. From the book, visitors got a better idea of the conditions in which their family members were imprisoned, which helps to alleviate their concerns about the situations of their loved ones. The Deputy-Ombudsman commended the picture book idea highly and hoped that this initiative would be adopted in all prisons (6206/2017).

Vantaa Prison had also drawn up a cookbook, which instructs the prisoners in cooking with the products available in the prison shop. Several prisoners participated in writing the book, and all recipes were tested by the head cook. Cooking is a life management skill. The Deputy-Ombudsman found the guide to be a highly commendable idea and hoped that other prisons would also introduce the guide or draw up similar guides of their own (6206/2017).

3.5.12 Alien affairs

There were approximately 10,700 asylum seekers in Finland at the end of 2018, the majority of them housed in 43 reception centres. In addition to the reception centres, there were six units for children who had entered the country alone. Some asylum seekers are also housed in private accommodations. Under section 121 of the Aliens Act, an asylum seeker may be held in detention for reasons such as establishing his or her identity or enforcing a decision on removing him or her from the country. There are two detention units for foreign nationals in Finland, one in Joutseno and one in Metsälä, Helsinki. Both currently operate under the Finnish Immigration Service, as the Metsälä detention unit was transferred from the City of Helsinki to the Finnish Immigration Service on 1 January 2018. The Joutseno detention unit has 68 places and the Metsälä unit 40 places.

Some residents in reception centres and detention units may be victims of human trafficking, and recognising such residents is a challenge. A system of assistance for victims of human trafficking operates in connection with Joutseno Reception Centre. According to a release published by the Finnish Immigration Service, 163 new clients were registered in the assistance system in 2018, and 52 of them were thought to be victims of abuse pointing to human trafficking in Finland. In total, the assistance system had 455 clients at the end of 2018.

The Ombudsman does not oversee return flights in its role as the NPM, although this would fall under its jurisdiction. This is because the Non-Discrimination Ombudsman has been assigned the special duty of overseeing the removal of foreign nationals from the country. However, the Ombudsman has received complaints, such as the conduct of the police, regarding issues related to return flights for asylum seekers. The immigration police of Helsinki Police Department was the subject of an inspection in the reporting year (1658/2018).

Until now, inspections to reception centres have been made under the jurisdiction of the Parliamentary Ombudsman. An example would be the unannounced inspection of Lahti Reception Centre, an enhanced support unit maintained by the Finnish Red Cross with 20 places. The unit is intended for adult asylum seekers suffering from mental health or substance abuse problems.

The aim is to make regular visits to both detention units. The NPM visited the Metsälä Detention Unit in December 2017 (6966/2017) and the Joutseno Detention Unit in November 2018 (5145/2018). The following opinions and recommendations concern the Joutseno Detention Unit.

The photos are taken at Joutseno detention unit. On the left, a place for washing feet. On the right, a new indoor football court.

Protection of privacy in the shower facilities of the isolation premises

On the previous inspection visit, the NPM had pointed out that the isolation room's surveillance camera had been installed in a manner that permitted viewing the torso of the person in the shower. The Ombudsman was not convinced that a surveillance camera was necessary in the shower room. According to the Finnish Immigration Service, the surveillance camera was necessary, especially due to the safety of suicidal clients. The prevention of vandalism was cited as another important reason for surveillance. After the Ombudsman gave his opinion, the camera surveillance of the shower facilities was nevertheless changed to exclude the torso of the person using the shower from the picture. In addition, a sign explaining what parts of the body are not visible in the camera was posted on the wall of the shower room. The surveillance camera in the shower premises was non-recording.

The Ombudsman noted that, by virtue of the Detention Act, all premises in the detention unit could be placed under camera surveillance. Recording surveillance cameras are not allowed in certain premises of detention units – such as the accommodation, toilet and shower areas. The only exception to this are facilities in which persons are kept in isolation – such facilities are not considered as accommodation space and the use of recording camera surveillance is allowed in them. The Ombudsman noted that no other administrative branch that has premises for keeping persons deprived of their liberty has a statutory right to use surveillance technology in the scope permitted in alien detention units. This is true for psychiatric hospitals, prisons and police detention facilities alike. Suicidal persons and persons with a risk of causing property damage are also placed in isolation in these facilities.

The Ombudsman was not convinced of the necessity of camera surveillance in the isolation area's shower room. If an individual case requires a person to be under constant supervision due to a risk of self-harm, the Ombudsman considered having someone monitor them in person when they take a shower would be a better alternative. The Ombudsman found the situation to be particularly problematic with regard to the right to privacy of foreign persons placed in the detention unit. The toilets and shower rooms in facilities for keeping persons in isolation are for both male and female detainees placed in isolation. The surveil-

Camera surveillance in the shower facilities of the seclusion premises.

lance personnel also contains members of both sexes. The supervised person is not aware of who is watching them and cannot know whether there is more than one person in the control room. Being aware of being watched while taking a shower may affect a person's willingness to wash themselves at all. Neither was the Ombudsman convinced of the adequacy of the present changes to the shower room's camera surveillance in safeguarding the privacy of its users. It is apparent from the surveillance monitor that the person can be watched right until the moment they are standing under the shower.

Conditions in isolation premises

The isolation premises were renovated and clean, but very ascetic and cell-like. The Ombudsman recommended the detention unit to take measures to ensure the appropriate and dignified treatment of detainees held in the current isolation premises. The room should have at least some type of level surface for eating. The thin mattress used as a bed should be replaced with a thicker, bed-like mattress. The Ombudsman also recommended the purchase of clocks for the isolation premises so that a person would have the opportunity to keep track of time.

The detention unit reported that it had purchased 30 cm high safety beds and cube tables for the isolation rooms. Clocks would also be purchased for the premises.

Identification of suicidal tendencies and suicide prevention

Several cases involving suicidal tendencies and one suicide had occurred in the detention unit during the year. During the visit, the management of the detention unit was provided with information on the Criminal Sanctions Agency's training materials for suicide-prevention and the assessment of the need for urgent care. The NPM had the impression that the detention unit was not aware of the Finnish Immigration Service's instructions concerning these matters.

The Ombudsman recommended that the Finnish Immigration Service should review its guidelines concerning suicides in order to assess whether they contain enough information on

the identification of suicide risks and the actions, responsibilities and communication of employees for the prevention of suicides. The staff's awareness of the guidelines and training in the prevention of suicides should also be increased.

3.5.13 UNITS FOR CHILDREN AND ADOLESCENTS IN THE SOCIAL WELFARE SERVICES

Under the Child Welfare Act, only children placed in an institution or similar place (including emergency placement) may be subjected to the restrictive measures referred to in legislation. Foster care may be provided by units owned by municipalities, or the municipality responsible for the placement may buy foster care services from units maintained by private service providers. There are roughly 770 units providing foster care services in Finland, out of which some 670 are run by private service providers.

Visits by the NPM have been made exclusively to institutions or similar units. As many children as possible, i.e. everyone who will talk to the NPM, are interviewed during child welfare visits. The children interviewed are assured that they can contact the NPM if they are subjected to disciplinary or other similar measures following the visit. The personnel are also reminded that any retaliatory measures against the children are prohibited. This is also mentioned in every visit report.

The visits are, as a rule, unannounced and usually last one or two days. The visits focus on any restrictive measures to which the children may be subjected and the related decision-making process: whether a decision on restrictive measures has been made or not, and has the child been heard regarding the decision. Shortcomings have also been detected in notifying the children of decisions. There is also a lack of awareness of the difference between restrictive measures and acceptable child-drearing methods. Restrictions may be imposed on the children as part of their normal upbringing, but most such restrictions require an administrative decision.

The Deputy-Ombudsman has considered it necessary that the authorities charged with the supervision of foster care react when they notice such issues or deficiencies in foster care that could affect the treatment or care of the child. The authorities should notify the municipality of placement, State Regional Administrative Agency (AVI) and any other municipalities that are known to have placed children in the same place of foster care of such situations without delay. The State Regional Administrative Agency responsible for the regional steering and supervision of social welfare services should also communicate any shortcomings, especially to the municipalities responsible for the placements.

All visit reports are sent to the unit which has been visited and to the local AVI. Some reports are also sent to the National Supervisory Authority for Welfare and Health (Valvira), which is responsible for the national guidance and supervision of social services. A copy is always sent to the local authorities in the municipality responsible for the placement of the child. The Deputy-Ombudsman had also found it necessary to inform the social workers in charge of the placed children of the observations and recommendations made as a result of the visit. The Deputy-Ombudsman has required that social workers discuss the content of the report with the placed child.

Institutions usually take a constructive attitude to the Deputy-Ombudsman's opinions and comply with the recommendations given. In most cases, they react to the observations and recommendations promptly, either while the visit is ongoing or upon receiving a draft copy of the visit report. In the reporting year, however, the Deputy-Ombudsman was exceptionally forced to strictly remind one institution of its obligation to comply with the opinions of the authority charged with the oversight of legality. The Deputy-Ombudsman also drew the institution's attention to the Parliamentary Ombudsman's and NPM's right to receive information. The Deputy-Ombudsman was forced to emphasise that the child welfare institutions have the obligation to cooperate with the Parliamentary Ombudsman or other overseers of legality in order to provide them with all of the information required to perform the inspection

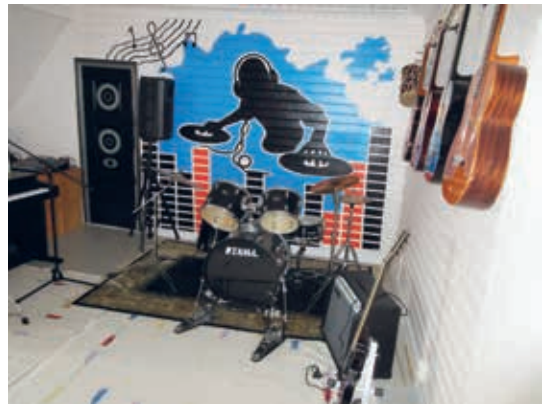
visit and effectively fulfil the children's right to be heard during the visit (1353/2018).

There has also been cause to stress the reasons for and significance of the prohibition against retaliation. The dialogue with the child welfare institution revealed that the unit's employees had not comprehended the contents of the UN Convention against Torture in this regard and experienced the prohibition against retaliatory measures, noted in the visit report, as insulting. The Deputy-Ombudsman noted that it is ultimately the responsibility of the institution's management to ensure that the institution's employees are familiar with the peremptory legislation related to their work and the duties, activities and jurisdictions of the various supervisory authorities, including the right to make unannounced inspection visits to the institution, during which the NPM have the right to interview the persons placed in the institution. The Deputy-Ombudsman has required the institution to arrange training on these matters for its employees (4099/2018).

The NPM made 10 visits to child welfare units in 2018. Two of these were follow-up visits. All visits, with the exception of one follow-up visit, were unannounced. Two of the visits were attended by an expert by experience.

The sites visited were:

- Vuorela Residential School, Nummela, 24 January 2018, 26 placed children, state-run (356/2018)
- Follow-up visit to Vuorela Residential School, 31 January 2018 (846/2018)
- Children's home Sutelakoti, Anttola, 27 March 2018, 5 places, private service provider (1605/2018)
- Children's home Rivakka, 28 March 2018, Hirvensalmi, 12 places, private service provider (1606/2018)
- Pohjola Residential School, Muhos, 17–18 April 2018, 35 placed children, run by a private association (1353/2018)
- Child Welfare Unit Sassikoti, Sastamala, 3 May 2018, 6 places, private service provider (2248/2018)



A music room in the special child welfare unit Loikala kartano.

- Follow-up visit to Children's home Salmila, Kajaani, 19 March 2018, 14 places, run by the municipality (1455/2018)
- Child Welfare Unit Jussin Kodit, Haukipudas, 20–21 November 2018, 16 placed children, private service provider (4099/2018*)
- Special child welfare unit Loikala Kartano, Mankala, 23 October 2018, 14 places, private service provider (5377/2018*)
- Family Home Ojantakanen, Pulkkila, 20–21 November 2018, 16 placed children, private service provider (5916/2018)

The inspection visit to Pohjola Residential School led the Deputy-Ombudsman to order a pre-trial investigation. The observations made during the visit also led to an urgent amendment to the Child Welfare Act (HE 237/2018 vp).

Restrictive measures and setting limits are two different things

Restrictive measures always involve restricting some fundamental right of the individual. They are intended to safeguard the fulfilment of the purpose of placement into care and protect the child or another individual. The use of restrictive measures always requires a case-by-case assessment of the extent to which the child's fundamen-

tal rights must be restricted. Restrictive measures may only be employed in the situations and subject to the conditions provided for in the Child Welfare Act. Restrictive procedures may not be employed systematically as an educational remedy to be applied to all children placed in the institution. Neither may restrictive measures be used as a means of punishment.

The measure that least restricts the child's right to self-determination or other fundamental right must always be chosen from those available. If less drastic means are sufficient, restrictive measures may not be employed at all. The measures must always be implemented as safely as possible and with respect for the child's human dignity.

Setting boundaries is a part of the care and upbringing of a child. Such boundaries must be kept distinct from the restrictive measures referred to in the Child Welfare Act. Restrictions of a disciplinary nature are not used to impinge on a child's fundamental and human rights, but to arrange a child's day-to-day custody and care and to support his or her growth and development. The purpose, duration and intensity of educational methods may not be equivalent to those of the restrictive measures provided for in the Child Welfare Act.

Decision-making on restrictive measures

The use of restrictive measures always requires an individual decision in which the fulfilment of the conditions provided for in the law is evaluated on a case-by-case basis. The place of foster care must ensure that these conditions are met in the case of each restrictive measure employed.

The Deputy-Ombudsman drew the residential school's attention to the fact that restrictive measures may not be used as a means for implementing another restrictive measure. For example, the bodily search of a child cannot be implemented by physically restraining the child. The recording of restrictive measures was also stressed (1353/2018).

The Deputy-Ombudsman considered it important for the place of foster care to draw up a specific plan for supporting the realisation of the child's right to self-determination and promote good treatment. The plan could include an explanation of what the legal restrictions mean for the unit in practice, a description of the practical implementation of the restrictions and methods for decreasing the use of restrictions. In part, the purpose of such plans would be to reduce the need for employing restrictive measures. The plan could also increase the staff's and child's awareness of legal and acceptable practices (4099/2018*).

Isolation

It is not permitted to isolate a child as punishment for his or her behaviour. Isolation may only be used when strictly necessary, and it must be ended immediately when it is not necessary anymore (1353 and 4099/2018).

The forced undressing or dressing of a child is not permitted by the Child Welfare Act. The Deputy-Ombudsman required the residential school to abandon the practice of undressing the children when they were taken to the isolation room. In the future, isolation and any bodily search related to it must be conducted with respect for the child's human dignity and in a manner that permits the child to cover his or her body during the search. A decision to isolate a child must clearly indicate the situation and behaviour that led to the isolation, the implementation method of the isolation, the assessment of the grounds for continuing the isolation, and the grounds for ending the isolation. If the isolation of the child involves holding the child in place or a bodily search or physical examination, the individual records required by law must be drawn up for these. In addition, the names of all employees participating in the isolation must be recorded in the isolation decision. It was the duty of the residential school to ensure that outside persons do not "threaten" the children with illegal measures or restrictive measures that they did not have the jurisdiction to implement in the first place (1353/2018).

The Deputy-Ombudsman required the residential school to abandon all practices reminiscent of isolation. These included shutting the children in their own rooms while doing written assignments given by the instructions, the unjustified severing

of the children's social relations and punishments in the form of segregated dining (1353/2018).

The residential school was required to ensure that the social worker in charge of the child's affairs will always be notified of the child's isolation without delay (1353/2018).

The Deputy-Ombudsman recommended installing a clock in the isolation room of one unit so that the child would have the opportunity to keep track of the time. He also suggested purchasing a thicker, more bed-like mattress for the isolation room (1353/2018).

In the interview of one child, it turned out that the child had been forced to sleep in a bare isolation room resembling a jail cell for three nights after the end of the child's isolation. The Deputy-Ombudsman found the practice to be degrading and strictly reminded the residential school of its duty to arrange safe foster care for the children (356/2018).

The child welfare unit was required to make sure that no outside persons participate in the isolation of children. The Deputy-Ombudsman recommended the unit to take urgent measures to move the isolation room to more suitable premises (4099/2018*).

Seclusion facilities in the Pohjolakoti Residential School.

Restrictions on communication

The Child Welfare Act states that foster care must safeguard the continuous and safe relationships that are important for the child's development. If an agreement on communication cannot be reached, communication between the child and the people close to the child can only be restricted on grounds specifically provided for in the Child Welfare Act. The authority to make such decisions lies with the social worker – not the place of foster care. The restriction of communication always requires a decision subject to appeal.

In her opinions, the Deputy-Ombudsman has stressed that, if a child's freedom of movement has been restricted in a manner that also restricts the child's right to previously agreed-upon contact – such as a scheduled home visit – each such situation requires a specific assessment of whether the legal grounds for making a decision to restrict communications are in place (356 and 1353/2018).

The child's mobile phone cannot be confiscated by the institution as a precautionary or punitive measure. The Child Welfare Act does not give the director of the institution the jurisdiction to make decisions on continuing the restriction of communications (1353/2018).

The children's agreed-upon home visits cannot be cancelled with a simple verbal announcement. A decision to move or cancel a home visit always requires consulting the social worker in charge of the child's affairs (4099/2018*).

Restricting the freedom of movement

A child's freedom of movement is being restricted if, in addition to generally acceptable boundaries related to normal upbringing, the child is prevented from leaving the institution or deprived of the

opportunity to participate in hobbies or other normal activities in or outside the institution. Only permitting the child to move in the company of an employee is also considered a restriction of the child's freedom of movement. Restricting the freedom of movement always requires a written decision subject to appeal.

The children's movement had been limited to either a short period of independent outdoor exercise or leaving the unit only in the company of an adult. Every unit of the residential school restricted the children's freedom of movement without a decision. Children could lose their rights to take walks, or the walks could be shortened as punishment for their behaviour. The arbitrariness of the rules concerning movement was underlined by the fact that several children placed into the institution whose freedom of movement was severely restricted while in the institution were nevertheless permitted to travel independently to home visits in the weekends. The Deputy-Ombudsman stressed that restricting a child's freedom of movement may not be used as a punishment for the child's behaviour. She considered that the residential school's rules restricting the children's freedom of movement had no basis in law (1353/2018).

The movement of the children in their free time had been severely limited without individual decisions on the matter. The children were not permitted to leave the exercise area defined by the institution and their movement outside the institution was supervised. It is possible that the restrictions on the children's movement constituted restrictions on the freedom of movement provided for by law, in which case they would have required individual decisions for each child (356/2018).

In the Deputy-Ombudsman's opinion, the child welfare unit's rules restricting the children's freedom of movement – such as only taking outdoor exercise alone and the related severing of social relationships – had no basis in law. The children's opportunity to go to school must also be specifically secured during any restrictions on the freedom of movement. If this is not possible, the decision must provide specific justifications for such restrictions (4099/2018*).

Physical examinations and bodily searches

The "justified reason to suspect" justifying a physical examination or bodily search must be recorded in the child's documents. Such reasons are always individual and must be evaluated individually for each child. The child's documents must also describe the practical implementation of the bodily search and physical examination.

The Deputy-Ombudsman has required personnel conducting bodily searches and physical examinations to take the child's age, sex, level of development, individual attributes, religion and cultural background into account. Such searches and examinations must be implemented in the manner that causes the least harm to the child (1353 and 4099/2018*).

The residential school must make sure that no unauthorised external persons participate in the bodily searches or physical examinations of children. With regard to the child's legal protection, the Deputy-Ombudsman considered it essential that the samples of children who give a positive screening test result and deny the use of the substance be always sent to a laboratory for examination (1353/2018).

Room and mail searches

The Deputy-Ombudsman has specified that a search of a child's mail or room must always have a legal basis, which must be assessed individually and recorded appropriately in the child's documents. Regular searches of a child's mail without a concrete suspicion of substances or items referred to in the Child Welfare Act are not permitted.

The Deputy-Ombudsman pointed out that the child has the right to know the reason for the search and be present during the search (1353 and 4099/2018*).

Punitive restrictions

The Deputy-Ombudsman considered "*early retirement to your room*" to be punitive when applied as a systematic consequence for minor negligence or other behaviour on the part of the child. On the other hand, the educational objectives of the practice were understandable. Rules and restrictions must nevertheless be proportionate to their objectives. Among other things, this means that disciplinary rules and restrictions imposed on a child must not go further or last longer than is necessary to fulfil the acceptable objectives of such rules or restrictions. Neither may disciplinary rules be arbitrary or excessive. The child's age, level of development and other individual needs and circumstances must always be taken into account in their application (356/2018).

The Deputy-Ombudsman found the residential school's practices for employing and implementing *physical restraint* to be illegal. A child cannot be restrained physically due to disobedience or passive resistance. The use of physical restraint must be necessary in each individual case and may never be used as a punishment. The Deputy-Ombudsman required the residential school to pay particular attention to the operating cultures of its various units (1353/2018).

The Deputy-Ombudsman required the units to immediately abandon their *degrading and humiliating practices* in the use of written assignments. If the children are given written assignments, they must always have an educational objective and purpose and must be genuinely useful for the child. Doing assignments must never cause harm to the child or his or her development (1353/2018).

Consequences for all of the children – "*collective punishments*" – are not acceptable upbringing methods. The Deputy-Ombudsman required the residential school to abandon all collective punishments (1353/2018).

The Deputy-Ombudsman required the residential school to give up *degrading and humiliating rules and punishments* for the children. Placement into care and foster care is not a punishment for the child. The purpose of child welfare services is to protect the child and provide him or her with the most normal childhood and youth possible (1353/2018).

The Deputy-Ombudsman required that, in the future, the *children's possessions would only be confiscated* when the legal requirements were met and after making the decisions required by law. Confiscation must never be used as a punishment (1353 and 4099/2018*).

Disciplinary measures provided for in the Basic Education Act

The Deputy-Ombudsman pointed out to the residential school that it is subject to the Basic Education Act. This means that only the disciplinary measures provided for in the Basic Education Act are permitted during the school day (1353/2018).

The pupils were regularly searched for items falling outside the scope of section 29 of the Basic Education Act. The Deputy-Ombudsman also considered it problematic that the grounds for the searches were not recorded in the pupil's or school's documents in any way. In the absence of such entries, the justification and methods of the searches was impossible to determine in retrospect. The Deputy-Ombudsman considered it necessary for pupils to be informed of the reasons for searches in the manner specifically provided for in the Basic Education Act. The school also searched a child who was not placed in the residential school but came from outside to study. The searches were conducted every morning before the start of the school day. However, the Basic Education Act requires "evident" reasons for conducting a search (356/2018).

Consent for the morning searches had been obtained from the pupil's parents and social worker. The Deputy-Ombudsman considers it problematic that there are views or practices according to which it is possible to infringe on a child's protected rights based on a consent of the child or the child's custodian. This applies also to a social worker. Guaranteeing the genuine voluntariness of consent is always problematic in the case of minors. For example, children can be afraid of being subjected to restrictive measures in the child welfare unit if they do not voluntarily consent to the restriction of their rights. Therefore, a negative stance must be taken to conducting such searches

The school at the Ojantakanen Family Home provides teaching in small groups.

– and extending them to find, e.g. snuff – on the basis of consent alone (356/2018).

In general, the Deputy-Ombudsman drew the State Regional Administrative Agency's (AVI) attention to the fact that, according to section 80 of the Child Welfare Act, it is the special duty of AVIs to monitor the use of restrictive measures in child welfare institutions. The Deputy-Ombudsman also requested the AVIs to take note of the possibility of affording children the opportunity for confidential discussions with AVI representatives as provided for in the Act. On his own initiative, the Deputy-Ombudsman decided to investigate which measures the National Institute for Health and Welfare, in its capacity as the supervisory authority for state-run residential schools, and the National Board of Education with regard to basic education, were going to take on the basis of the observations and opinions presented in the visit report (356/2018).

The Deputy-Ombudsman noted that a practice in which events during school affect the child's free time in foster care has no basis in the Basic Education Act. She decided to request a report on the matter from the residential school (356/2018).

Children's right to express their opinion and influence their everyday lives

The Deputy-Ombudsman required the residential school to provide the placed children with the opportunity to influence and participate in the affairs that concern them. The child's own opinion must be determined and taken genuinely into account in both administrative decisions and the daily implementation of foster care. Children must not suffer consequences from expressing their opinions. The child's place of foster care must be capable of creating a home-like atmosphere in which the child feels safe and is able to discuss to have confidential discussions with the adults participating in the everyday operations of the place of foster care without fear of repercussions (1353 and 4099/2018*).

In the Deputy-Ombudsman's opinion, the children's client documents and accounts paint a particularly concerning picture, in which the children's attempts to influence their everyday lives are considered unwanted behaviour since the unit's adults make all the decisions and define what children are permitted to do and how they are permitted to behave in each situation. Children should have the opportunity to influence their everyday routines and discuss them with their carers. The Deputy-Ombudsman pointed out that children have the right to take part in activities. It is the institution's obligation to support and encourage the children's participation in activities and make practical arrangements permitting the children to participate in them (1353/2018).

The right to meet social workers

A child placed in a child welfare institution has an unconditional right to have confidential discussions with his or her social worker. The Deputy-Ombudsman required the institution to cease limiting the children's right to consult with their social workers and to respect the confidentiality of such discussions in the future. The practice of having the institution and social worker record the date, time and practical arrangements of the meeting between the child and social worker in

the child's documents is a commendable practice that fulfils and promotes the rights of the child. It should also be recorded whether the meeting was private. The Deputy-Ombudsman recommended the residential school to develop practices for ensuring the children's opportunity to express their opinions of the foster care arrangements to their social workers every month (1353/2018).

The Deputy-Ombudsman decided to ask the municipalities that had placed children in the child welfare unit to report on how the social workers in charge of the children's affairs were actually able to perform their statutory duties. In addition, the Deputy-Ombudsman requested every social worker who had placed children in their charge in the unit to meet with the placed children and explain the contents and meaning of the visit report to them. The social worker must give the child an opportunity to discuss the matter in private. The afore-mentioned report must also indicate when and how the visit report was discussed with the child (4099/2018*).

Employee behaviour

Due to the issues reported by the children in their interviews, the residential school was reminded of the appropriate behaviour of employees. The Deputy-Ombudsman noted that employees commissioned by an authority, such as the staff of a private child welfare institution, are also required to behave appropriately and use acceptable language and expressions that demonstrate respect for the child. The educational work of the child welfare institution staff gives the children a model of how adults behave in various situations. For this reason, the persons responsible for the care provided by the institution and those working in the institution must behave in a manner that permits the children placed in the institution to learn appropriate behaviours and good manners (1353/2018).

3.5.14 SOCIAL WELFARE UNITS FOR OLDER PEOPLE

The goal is that older people can live at home with the support of the appropriate home-care services. When this is no longer possible, the elderly person moves into an institution or care and residential unit, where they receive care round the clock, including end-of-life care if necessary. There are some 2,200 care units providing full-time care for older people in Finland. Today, no-one is cared for by any unit solely on the basis of old age. Caring for elderly people with multiple conditions consists of health care and nursing in either a social welfare or health care unit. Visits are primarily made to closed units providing full-time care for people with memory disorders, and to psycho-geriatric units, where restrictive measures are used. The aim is to visit care units run by both private and public service providers within a given municipality. This allows for detecting any differences in the standard of care. In 2018, the focus of visits was on units operated directly by the municipalities.

Social welfare and health care units, including units providing services for older people, are required to draw up a self-monitoring plan. Such a plan includes the key measures taken by the service provider to monitor their operative units, the

Taasiakoti offers intensified assisted living services for the elderly. The home also houses two cats.

performance of their staff and the quality of the services they provide. Staff members have in social welfare a statutory obligation to report any deficiencies in the care provided. Persons voicing concerns may not be subjected to negative consequences of any kind.

Visits to care units for older people pay special attention to the use of restrictive measures. The use of such measures is made problematic for the fact that there is still no legislation on imposing restrictive measures on older people with memory disorders. According to the Constitution, however, such measures would have to be based on law. The Ombudsman has issued several opinions in which he has demanded legislation to be passed on the matter. It is the opinion of the Ombudsman that, even though there is no legislation on restrictive measures yet, their use should be transparent and consistent with human dignity. The provisions of the Mental Health Act on the use of restrictive measures on individuals in involuntary care should be applied as a minimum requirement. On its visits, the NPM paid attention to matters such as the duration and recording of restrictive measures and deciding on them.

All visit reports are published on the website of the Ombudsman. The purpose of the publication is to inform the general public that the operations of a certain unit are being monitored. The reports also provide residents, family members and staff with important information on the observations made during the visit. It may also be requested that the visit report be made available to the public on the noticeboard of the unit for a period of three months. The aim is for residents, family members and other stakeholders to report any shortcomings that have been overlooked to the supervisory authorities.

All visits made to care units for the elderly in 2018 were made under the NPM mandate. Eleven such visits were made in 2018, one of them to a unit operated by a private service provider. All of the visits were made unannounced. One visit was a follow-up visit conducted in the evening.

The sites visited were:

- intensive service unit Portsakoti, Turku, 26 January 2018, 23 places (383/2018)
- group home Elsekoti, Turku, 26 January 2018, 12 places (384/2018)
- intensive service unit Taasiakoti, Loviisa, 8 February 2018, 36 places in total (657/2018)
- intensive service unit Emil-koti, Loviisa, 8 February 2018, 9 places (659/2018)
- Näsmäkieppi serviced housing, Rovaniemi, 21 March 2018, 35 places in total (1212/2018)
- Lohja service centre for the elderly/Alatupa, Lohja, 25 April 2018, 11 places (2114/2018)
- Lohja service centre for the elderly/Kultakoti, Lohja, 25 April 2018, 9 places (2217/2018)
- Lohja service centre for the elderly/Kultakartano, Lohja, 25 April 2018, 18 places (2218/2018)
- Follow-up visit to Lohja service centre for the elderly, 18 June 2018 (3082/2018)
- intensive service unit Riihikoto/Tammikoto, Tuusula, 28 June 2018, 24 places (3290/2018)
- Attendo Linnanharju nursing home, Helsinki, 4 July 2018, 61 places (3367/2018)

Restrictive measures used in units for older people

It is an established practice in the legality oversight of service units for the elderly that the use of any kind of restrictive measures on residents requires the decision of a physician. The physician should also monitor that the restrictive measures are not used to a greater extent or time than necessary. The use of restrictive measures must be stopped immediately when they are no longer necessary. These measures should be discussed with the resident's next of kin or family members before their adoption. The necessity of such a measure must also be explained to them. The decision-making on the use of restrictive measures and their duration may be jeopardised if the physician does not visit the unit often or meet the residents during such visits.

A care plan drawn up in an assisted living unit with intensified support specified that the movement of the resident was restricted. According to the entries, this had been authorised by the resident, who suffered from a memory disorder, and the resident's next of kin. The entries did not

indicate that a physician would have decided on the restriction. The Deputy-Ombudsman did not deem it acceptable to employ restrictive measures on the basis of a permission given by an individual suffering from a memory disorder, who may not have understood the matter. The use of restrictive care measures must always be based on a physician's assessment and decision. In addition, the necessity of such measures must be evaluated on a regular basis (383/2018).

The majority of the residents of a unit offering round-the-clock assisted living with intensified support suffered from memory loss disease. The outer doors of the unit were locked. They could be opened with a numeric code. The gate of the fenced yard was also locked. As a further restrictive measure, the beds were equipped with bedrails to prevent their occupants from falling out of them. The patients' families had agreed on the matter with a physician. The NPM stressed that the use of restrictive measures was only permitted by decision of a physician. Furthermore, the use of restrictive measures must be monitored to ensure that they are only used when and for as long as necessary. For this reason as well, the physician should visit the unit sufficiently often and meet all of the residents. It is also the nurses' duty to discuss the restrictive measures and their grounds with the residents' next of kin or family members (659/2018).

A unit for persons suffering from serious memory loss symptoms sought to organise its operations at the terms of the residents. This meant that the residents were allowed to decide when they woke up or ate. If they did not feel sleepy at night, they were allowed to stay up and walk in the hallways, provided that they did not disturb the other residents. The use of restrictive measures was decided by a physician. These measures included raised bedrails, various belts and back-zip overalls. Back-zip overall, also known as patient overall, is a garment preventing for example persons with dementia from undressing themselves in public. The necessity of continuing the restrictive measures was monitored on a daily basis. The unit was even equipped with restraints. However, the NPM

The furnishings in the service centre for the olderly was modest and worn-out.

were told that the restraints had not been needed for years, since the nurses had learned to work on the terms of the residents and calm them down in other ways. Sedatives had to be given to the residents at times. It was also necessary to lock the rooms of residents every now and then to prevent restless residents from wandering into the rooms of others. In the Deputy-Ombudsman's opinion, locking the doors of residents at night for reasons of client and patient safety was problematic with regard to fire safety and the right to self-determination of the elderly people suffering from memory disorders. The fact that the solution was temporary had no bearing on the matter (2217/2018).

The report given by the city stated that locking the rooms was an extreme measure intended to ensure the safety of the group home's residents.

Nurses at a group home for individuals with severe memory loss symptoms felt that meal times took excessively long. All residents had to be assisted and monitored while they were eating. Some of the residents were so restless that they

had to be restrained to the chair with a belt for the duration of the meal to keep them still. The Deputy-Ombudsman noted that tying a resident down is always a restrictive measure. In addition, such restraints can cause anxiety and aggression. The Deputy-Ombudsman requested the city to report on what basis the resident was tied to the chair for the duration of the meal. The Deputy-Ombudsman also wanted to know why the resident was not allowed to leave the table and later directed back to continue the meal – several times if necessary. Furthermore, the Deputy-Ombudsman asked the city to determine who made the decision to tie the resident to the chair and whether, as part of the decision-making process, the matter had been discussed with the resident's next of kin or family members (2217/2018).

According to the report provided by the city, the decision to restrict the right of self-determination, such as using restraints, is always made by the physician in charge of the patient. The decision on the restrictive measure and its start and end times are recorded in the patient data system. Restrictions are discussed with the residents' next of kin and family members, but their wishes must sometimes be ignored to permit the resident more freedom of movement instead of, e.g., being tied to a wheelchair for the whole day.

In the report, it was stated that people with memory loss disease do not always recognise the feeling of hunger, so they must be provided with relaxed and frequent opportunities to eat. The mobility of the residents must sometimes be restricted during meals to secure their nourishment and safeguard the other residents' right to a peaceful meal. Only those residents who compulsively and repeatedly rise from the table and wander around the dining area and ward hallways are restrained. Such behaviour has a corresponding effect on others who are having their meal, preventing anyone from eating in peace and repeatedly interrupting the meal. The eating and condition of residents tied to their chairs is monitored continuously, and residents who appear anxious are released.

An evening follow-up visit was made to the unit. The NPM noted that at least two residents were wearing back-zip overalls – also at night. Back-zip overalls are a restrictive measure on which there are no regulations. The Deputy-Ombudsman noted that the use of a back-zip overall infringes on the patient's right to self-determination. The use of an overall must always be based on physician's decision and the use must be stopped immediately when it is no longer necessary (3082/2018).

The safety of residents at night

On the basis of observations made during a visit to a unit offering round-the-clock assisted living, the Deputy-Ombudsman noted that conditions in the unit were not safe for the residents at night. The Ombudsman had already drawn attention to the matter on an inspection in 2007. The situation had deteriorated since then, as the number of residents in the unit had grown and the night nurse was also responsible for the residents of the serviced flats. The nurses hoped that two nurses could work the night shift or that the city's mobile night-time service team could take care of the night-time alarms of the serviced housing residents. The nurses did not know the people living in the serviced flats or their illnesses, so the night shifts felt unreasonably stressful to them. The Deputy-Ombudsman requested the city to report on the sufficiency of night-time care and the safety of the residents at night (657/2018).

The city reported that two practical nurses would be hired for the nursing home with fixed-term employment contracts beginning on 1 May 2018. That will enable assigning two nurses to the night shift. In addition, the home care night nurses will answer the night-time alerts made by the residents of the serviced flats around the nursing home from 1 March 2018. The nursing home's nurse will no longer be required to care for the residents of the service flats.

Only one nurse worked the night shift of a nursing home close to the one described above and assisted the night nurse of that care home every night in addition to her own work. For this reason, the doors of the residents had been equipped with alarms so the night nurse would know to return to her post in the nursing home if the residents

left their rooms. This arrangement was not safe for the residents of the nursing home, since the distance between the two buildings was approximately 200 metres. The situation in the other nursing home could have prevented the night nurse from leaving immediately. This matter had also been addressed in connection with the visit made by the Ombudsman in 2007. The Deputy-Ombudsman noted that night-time care must be organised in a manner that does not leave residents without supervision. The Deputy-Ombudsman requested the city to notify him of the measures it had taken (659/2018).

According to the city, the night nurse does not have to leave the unit during the shift anymore, because night care in the other nursing home will be arranged differently from 1 May 2018.

End-of-life care

The NPM discovered no significant shortcomings in the field of end-of-life care in the visited units in 2018. According to the nurses, some units were prepared to hire additional employees for the duration of end-of-life care, and the nursing staff felt sufficiently trained in end-of-life care (657, 659, 1212 and 2218/2018). The organisation of end-of-life care in some units gave the Deputy-Ombudsman cause to issue the following opinions.

One nursing home stated that the number of nursing staff was not increased for the duration of end-of-life care. In addition, the representative of the company providing the nursing home services stated that the nurses could freshen up their end-of-life care skills by watching a video on the company's intranet. In the opinion of the Deputy-Ombudsman, appropriate and competent end-of-life care is the fundamental right of every older person, and every nurse must be familiar with it. Therefore, she suggested considering ways to provide the staff with further training in end-of-life care. The Deputy-Ombudsman did not consider it sufficient that nurses who felt that they required additional instruction on the issue would watch the instructions independently on the intranet. In addition, the city and service provider needed to resolve who was responsible for organising the training (3367/2018).

The report by the city that purchased the care service noted that, according to the outsourced service agreement, the service provider shall have quantitatively and structurally sufficient staff for the service being provided. The unit personnel must have the expertise, competence and motivation required by their duties. This also applies to competence in end-of-life care. The service provider must see to the further training of its personnel. The service provide shall thus arrange training for its personnel, and the city will provide further training if necessary. According to the report, end-of-life care training will be provided to the nursing home's personnel in late 2018. The key themes of end-of-life care will be reviewed through training materials, discussions and the sharing of experiences.

The nursing home strived to provide high-quality end-of-life care. However, the nurses expressed a wish for further training in the area. The Deputy-Ombudsman requested the municipality to report on its measures in the matter (3290/2018).

The municipality reported that its end-of-life care guidelines had been reviewed in the group homes. In addition, the group home nurse who is a member of the municipal end-of-life care team participated in dedicated end-of-life care training. The written feedback on the training was reviewed in the group home. When the unit has a resident in need of end-of-life care, the staff will hold regular and in-depth discussions on the resident's situation, the measures required, how to care for and support the resident, and how to take the resident's next of kin into account and support them.

Outdoor time

The importance of spending time outdoors every day for the quality of care was emphasised in connection with the visits made to the service units for older people. Providing sufficient time outside is a part of caring for the residents' basic needs and, thus, respecting their human dignity. The Deputy-Ombudsman has recommended including outdoor time in the residents' care and service

plan. Taking the residents outdoors should not be left to the next of kin and volunteers. During the visits, it was noted that daily outdoors time is not provided in several units or is impossible to verify due to deficient records.

The staff of the assisted living unit with intensified support told the NPM that they did not have time to take the residents outside. The visit conducted in March did not reveal how the residents' access to the outdoors had been arranged or whether the residents had the opportunity to go outside. According to the report received after the visit, the residents' next of kin saw to taking them outdoors. The report indicated that volunteers visited the nursing unit to take the residents for outings such as rickshaw rides once per week if the weather was good (1212/2018).

The Deputy-Ombudsman considered it important that people suffering from memory loss disease, who are often still quite capable physically, should have the opportunity for regular outings. According to the resident records obtained, this had either not been realised particularly well or the records were incomplete. For example, one outing had been recorded for one resident for a two-week period, while another had no recorded outings. The unit's self-monitoring plan nevertheless required targets related to daily exercise, time spent outdoors and rehabilitation to be recorded in the resident's care and service plan. The realisation of these targets should be followed on a daily basis. On the basis of the care plan records of two residents, this was not the case. The Deputy-Ombudsman pointed out that resident records should correspond to the guidelines provided in the self-monitoring plan (2217/2018).

According to the city's report, efforts are made to provide the residents with as much time outdoors as possible. Volunteers take the residents on outings every week if the weather is good. In the summer, the city hires young people to help with taking the residents outside. In addition, the unit has several individuals in rehabilitative work activities, whose duties also include taking the residents for outings. The city indicated that it would pay attention to recording the time spent outdoors. Advanced memory loss disease can prevent residents from going outside safely, so the situation needs to be considered individually for each resident. The group home has a spacious balcony where the residents can spend time safely.

During a visit to a group home for people with memory disorders, the NPM were told that the residents had the right to sufficient outdoors time. On the basis of the records inspected after the visit, however, it was impossible to verify that the resident had actually spent time outside. The Deputy-Ombudsman noted that the records must indicate the actual events in the resident's day, not just the basics of nursing and care. If a resident takes assisted outdoor exercise or participates in activities, it must be recorded in the documents. Otherwise, it will be impossible to determine whether the service plan is also being realised with regard to outings and recreation. The Deputy-Ombudsman reminded the unit's staff of keeping sufficient records, which indicate the actual quality and diversity of service in addition to basic care (3290/2018).

The municipality reported that, in the future, the group home staff would record outings, participation in stimulating activities, etc. in the patient information system. Particular attention will be paid to recording activities performed with the assistance of other professions and individuals (summer workers, students, assistants, next of kin, etc.). Instructions concerning this were issued in autumn 2018. Furthermore, to secure sufficient access to the outdoors, at least one employee will take residents outside every day.

The time spent outdoors by residents was monitored with lists. In the opinion of the NPM, the realisation of sufficient access to the outdoors should also be monitored in the care and service plans. The Deputy-Ombudsman considered it important that residents should also be provided with the opportunity to leave the balcony and yard if permitted by their condition (3367/2018).

The report of the city that purchased the care service notes that the city requires the client's wishes and willingness to spend time outside to be recorded in the client's care plan, along with targets for the amount of time spent outdoors and the ways of

spending that time. The realisation of the plan should also be evaluated at three-month intervals and when the client's circumstances change. According to the director of the nursing home, residents are also taken outside the yard when their condition permits. They also go on outings outside the unit.

During the inspection visits, some observations were also made on the possibility of round-the-clock assisted living units for ensuring the residents' daily outdoor exercise in a pleasant environment (657, 659 and 2218/2018).

Notary Kaisu Lehtikangas displaying a rickshaw bicycle in the serviced housing Näsmänkieppi. Volunteers take the residents in the serviced housing on rickshaw rides once a week, if weather permits.

THE RIGHT TO SUFFICIENT HEALTH CARE SERVICES

The adequacy of physician's services varied

The Deputy-Ombudsman commended the weekly visits made by physicians (383 and 384/2018).

A municipal geriatrist visited the group home once per week and also met with the residents. The geriatrist could be called when necessary (3290/2018).

Previously, a physician from the health centre had visited the nursing home once per month. The physician mostly dealt with the nurse, but would also visit the residents if necessary. Now, the physician had last visited the unit three months ago. The intent was to return to the monthly schedule. The physician was easy to reach by telephone. However, the frequency of the physician's visits should be based on the needs of the residents. Increasing the interval between visits was problematic as the unit did not employ a full-time nurse. The Deputy-Ombudsman deemed the physician's services available in the unit to be insufficient if a physician or other health care professional is not available when needed. The Deputy-Ombudsman requested the city to report on the measures taken in this nursing home and another home run by the city (659 and 657/2018).

The municipality reported that the provision of physician's services in the nursing homes would continue according to the current plan.

A physician visited the serviced housing unit once per week, focusing on alternate floors on each visit, but also taking care of any acute situations on the other floor. The physician was available by telephone on weekdays, and the geriatric emergency service responded to situations on the weekends. On the rounds during the visit, the physician met with residents according to the needs assessment conducted by the unit's staff (1212/2018).

The representatives of the company providing the nursing services were sorry that the city had put the physician's services out to tender, as they had been satisfied with the long-term, successful cooperation with the physician. Now, a physician only visited the unit once every two months, which the unit felt to be quite a long interval. The physician was easy to reach by telephone, however. The Deputy-Ombudsman requested the city to give a report on the sufficiency of physician's services (3367/2018).

According to the report provided by the city that purchased the nursing services, it invites tenders for outsourced nursing and physician's services at regular intervals, which can lead to changes in service providers. The frequency of physician's visits is

proportionate to the size of the unit, with the maximum interval between physician's rounds being two calendar months. Otherwise, the affairs of patients are taken care of through weekly telephone consultations. In addition to making their regular rounds, the physicians must be available by telephone during business hours on weekdays. The physician is also obligated to visit the unit between rounds if a patient's condition demands it.

Oral health care

A dental hygienist visited the unit once a year to check the patients' teeth. Dentist's appointments were implemented at the health centre, where the resident was accompanied by a nurse (657 and 659/2018).

According to the reports received, patients who still had their own teeth visited a nearby dental clinic annually for check-ups and the required treatment. A dental technician inspected the residents' dentures in case of any problems. Instead of regular visits, the dental hygienist visited the unit when required. The Deputy-Ombudsman commended the regular visits to a dentist (1212/2018).

The nurses tried to see whether the resident's teeth were painful in connection with brushing their teeth every day. The municipal dentist visited the group home to examine and treat the patient's teeth when necessary. A dentist and dental hygienist also visited the unit once per year to examine and care for the residents' teeth (3290/2018).

The staff sought to look after the residents' oral hygiene and health, but problems were caused by the fact that many of the residents refused to open their mouths. According to the nurse, no-one had their teeth brushed by force, however. The nurses tried to see whether any of the residents had oral pains. A dental hygienist from the health centre visited the unit once per year to care for the residents' teeth and assess the treatment needs of residents who the nurses thought to be suffering from tooth aches. Residents were escorted to the health centre's dentist on the basis of these assessments or as otherwise required (3367/2018).

Maintaining the ability to function

The observations made during the visits indicated that some nursing homes had invested in maintaining the residents' ability to function. However, there was room for improvement.

The Deputy-Ombudsman considered it positive that the serviced housing unit had its own physiotherapist who was able to provide individual physiotherapy to the residents (383/2018).

The municipal physiotherapist visited the nursing home once per week. The unit also employed a physiotherapy nurse (657/2018).

The Deputy-Ombudsman considered it insufficient for a service centre for older people to only employ one physiotherapist who worked mostly with home care residents (2218/2018).

The group home for the elderly did not have a dedicated physiotherapist or physiotherapy nurse. Some residents purchased physiotherapy services, and the physician could refer residents to a physiotherapist. The unit had designated employees responsible for ergonomics, but their job description did not include physiotherapy. Therefore, the residents' physical exercise was largely left to the nurses' rehabilitative working methods. The Deputy-Ombudsman considered it to constitute a shortcoming that a unit with 88 places did not have access to physiotherapy services, which are essential to the care of people with memory disorders in maintaining their ability to function. The Deputy-Ombudsman asked the municipality to consider ways of providing such services in the future (3290/2018).

The municipality reported that it had arranged municipal physiotherapy services and instruction in the use of mobility aids for residents who required them and were referred by a physician. Physiotherapy is not part of the concept of assisted living with intensified support. Rather, the residents acquire the services as any other people living at home. The residents have the opportunity to use the gym equipment in the adjacent building free of charge on certain days of the week. The staff support the residents' everyday mobility with rehabilitative work practices and try to spend as much time as possible outdoors with those residents who wish.

The nursing service unit did not have a dedicated physiotherapist or physiotherapy nurse. One practical nurse was responsible for the rehabilitation of the residents, which was not equivalent to the services of a physiotherapist according to the nurse employed by the nursing home. Neither did the elderly residents purchase any physiotherapy services, so their physical exercise was largely dependent on the rehabilitative work practices of the nurses. Taking the unit's large number of residents into account, the Deputy-Ombudsman considers it important to have a professional physiotherapist in charge of maintaining the residents' ability to function (3367/2018).

The report of the city that purchased the nursing services states that the nursing home has rehabilitation-oriented nurses who instruct the other nurses in rehabilitation and actively take part in the rehabilitation of the residents. Residents have the opportunity to purchase additional services at their own expense, including physiotherapy services.

3.5.15 RESIDENTIAL UNITS FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

A goal set in the 2012 Government Resolution on the independent living and services for persons with intellectual disabilities is that no disabled person will be living in an institution after 2020. The Finnish Association on Intellectual and Developmental Disabilities reports that the client volumes of housing with round-the-clock support, or assisted housing services, and supported housing services in particular have been growing. Correspondingly, the number of long-term residents in institutions for the intellectually disabled has decreased. Even though the trend is positive, it appears that giving up institutional housing by the deadline will not be successful. According to information from various sources, there are slightly less than 1,000 intensified support units for people with intellectual and developmental disabilities in Finland, and approximately 400 of these are run by private service providers. There are 26 institutional care units, of which 11 are run by private service providers. The majority of these units employ restrictive measures.

On visits to units providing institutional care and housing services for persons with disabilities, special attention is paid to the use of restrictive measures and the relevant documentation, decision-making, and appeals procedures under the provisions of the Act on Special Care for Persons with Intellectual Disabilities, which entered into force on 10 June 2016. According to the preliminary work on the Act, the restrictions must be highly exceptional and used only as a measure of last resort. If persons in special care repeatedly requires restrictive measures, it should be assessed whether the unit they are currently residing in is suitable and appropriate for their needs. The practices of the unit should always be assessed as a whole. Restrictive measures should only be resorted to when this is necessary in order to protect another basic right that takes precedence over the basic right subject to restriction. It follows from this principle that restrictive measures should never be used for disciplinary or educational purposes. The purpose of the visits is to assess the use of restrictive measures, as well as the living conditions and the accessibility and feasibility of the facilities, while appraising the attainment of the disabled residents' right to self-determination and opportunities for participation, along with the availability of adequate care and treatment.

With the ratification of the UN Convention on the Rights of Persons with Disabilities (10 June 2016), the Parliamentary Ombudsman became part of the mechanism referred to in Article 33(2) of the Convention designated to promote, protect and monitor the implementation of the rights of persons with disabilities. This special duty of the Ombudsman, as well as observations on accessibility, are discussed in more detail in section 3.4.

The number of residential units of intellectually and physically disabled persons visited in 2018 was 12. Two of the units were full-time residential units for disabled persons. One of these was intended for persons with significant functional limitations due to substance addiction and/or mental health disorders, social problems and impaired cognitive abilities. The other was for people under that age of 65 with physical and/or mental

limitations on their ability to function. The other sites visited were units for intellectually disabled people. There were disabled residents under involuntary special care in three of the units visited. Most of the visits (7) were made unannounced. Four of the units were run by private service providers.

The sites visited were:
- Esperi Hoitokoti Narikka, Järvenpää, 19 March 2018, 24 places, private service provider (1376/2018)
- Lintukorven Validia-talo, Espoo, 25 April 2018, 21 places, private service provider (1871/2018)
- Attendo Valkamahovi serviced housing, Helsinki, 4 July 2018, a total of 45 residents in three group homes, private service provider (3351/2018)
- Kolpene service centre joint municipal authority / Palvelukoti Metsärinne, Rovaniemi, 20 September 2018, 17 places, municipal (3375/2018)
- The Rinnekoti Foundation's Pipolakoti housing units, Karjalohja, 6 July 2018, 20 places, private service provider (3524/2018)
- Northern Ostrobothnia Hospital District, Care of the developmentally disabled / Adult rehabilitation unit, Oulu, 11–12 December 2018, 12 places, municipal (4639/2018)
- Kuumaniemi group home, Kemijärvi, 20 September 2018, 12 places, run by the city (4665/2018)
- Kolpene service centre joint municipal authority / Housing services, Rovaniemi, 21 September 2018, 9 group flats and 4 flats, municipal (4701/2018)
- Kolpene service centre joint municipal authority / Mäntyrinne and Mustikkarinne, Rovaniemi, 20–21 September 2018, a total of 26 places, municipal (4880/2018)
- Kolpene service centre joint municipal authority / Kuntoutuskeskus Vuoma, Rovaniemi, 21 September 2018, 15 places, municipal (5028/2018)
- Northern Ostrobothnia Hospital District, Care of the developmentally disabled / Children and youth unit, Oulu, 11–12 December 2018, Oulu, 10 places, municipal (6388/2018)

Sound-insulated chairs at the Kolpene Service Centre joint municipal authority.

– Northern Ostrobothnia Hospital District, Care of the developmentally disabled / Lounastuuli, Oulu, 11–12 December 2018, 8 places, municipal (6389/2018)

A physician specialising in intellectual disabilities participated in six of the visits as an external expert. An expert from VIOK took part in one visit as an external expert. Experts from the Human Rights Centre also participated in some of the visits. Some of the key opinions and recommendations issued on the basis of the visits are presented below. Certain remarks relate to visits made in 2017, but with opinions issued in 2018.

Use of cage beds

In connection with a visit to institutional care and housing units for the intellectually and developmentally disabled, it was noted that cage beds were used in one ward. This was the first time such beds were observed during a visit made by the Parliamentary Ombudsman or NPM.

For one child under the age of 10, the bed was used to prevent the child from falling out of the bed during epileptic seizures. The bed was not a normal cot for small children (0–3 years), but a larger metal cage bed with a roof. The bed had been made by a local workshop. A cage bed was also used for another child in the same ward. The restrictive measure decisions required by the Act on intellectual disabilities had been made for the use of the beds.

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has stated that the use of cage beds can be considered to offend human dignity and must therefore be stopped immediately. In its report (StVM 4/2016 vp), the Social Affairs and Health Committee of Parliament has stated that other means shall always be used in preference to restrictive equipment when possible. Instead of a restrictive measure, it can be possible to use a wide and low bed, or a bed whose height can be electronically adjusted according to the situation.

The Ombudsman urged that the use of cage beds be discontinued and that alternative solutions be found instead. The legality of restrictive measures used in the care of the intellectually disabled can be referred to a court for evaluation. The court will make the final decision on whether the restrictive measure or piece of equipment can be considered legal in each specific case. The Ombudsman also highlighted that restrictive equipment must comply with the requirements of the Act on Health Care Devices and Equipment. Such equipment can include hospital beds with bedrails (visits to the North Karelia social welfare and health care joint authority's (Siun Sote) care units for the intellectually disabled, 6311* and 5920/2017*).

The joint authority reported that it would look for replacement beds compliant with the requirements of the Act on Health Care Devices and Equipment, without endangering the health and safety of the residents.

A metal cage bed with a ceiling.

Sufficiency of human resources

The Deputy-Ombudsman drew the care home's attention to the fact that, among other things, the Act on Intellectual Disabilities requires special care units to be staffed by a sufficient number of social and health-care professionals and other personnel, regarding the nature of the unit's operations and the special needs of the persons in special care. The Ombudsman commended the fact that the city monitored the operations of the private housing units in its area and their fulfilment of the minimum staffing requirements (1376/2018).

The unit's staff turnover was considerable. The situation was perhaps affected by the challenging nature of the work and a shortage of employees. The NPM got the impression that the staff was in need of more supervision. A chronic personnel shortage was also described in the interviews conducted during the visit. The Ombudsman pointed out that care units must be staffed by a sufficient number of personnel with regard to their operations (1871/2018).

The documentation indicated that the unit had also counted students in its staff numbers. On a general level, the Ombudsman pointed out that students are not yet social welfare or health care professionals. The employer is responsible for ensuring that restrictive measures are carried out only by personnel who have the necessary professional qualifications. Whether a student possesses the required professional competence for participating in a restrictive measure requires careful assessment. Students cannot be responsible for the use of restrictive measures, but require guidance and supervision from professionals. The Ombudsman reminded that students temporarily performing the duties of a social welfare or health care professional are subject to the regulations applied to such professionals, and can thus potentially suffer consequences for errors made in the course of their work (visit to the adult rehabilitation unit of Vaalijala joint authority, 7007/2017).

The rehabilitation unit reported that only students hired by the organisation for an apprenticeship were counted in the unit's staffing numbers. The apprenticeship trainees do not participate in the use of restrictive measures.

The realisation of privacy in housing services

The Ombudsman has proposed that every disabled person living in a housing service unit should have a private room equipped with sanitary facilities.

From the perspective of arranging home-like accommodation and guaranteeing the protection of privacy, the NPM found it to be a shortcoming that not all of the residents had their own toilet and shower facilities in their apartment (room) (1376/2018).

The unit had installed camera surveillance in the common areas, isolation area and hallways. The Ombudsman noted that camera surveillance is always an infringement on privacy and may only be used when necessary. The use of camera surveillance cannot be justified by a shortage of staff in the unit, and its necessity must be regularly evaluated against the individual needs of the residents (7007/2017).

Right to self-determination and opportunities for participation

The individual's right to self-determination is one of the guiding principles of the UN Convention on the Rights of Persons with Disabilities. According to the Act on Intellectual Disabilities, the rights of persons in special care to participate in and influence their own affairs must safeguarded.

According to the Ombudsman, children should generally be permitted to use their own telephones according to their age and level of development in the same way as children who are not in rehabilitation in a residential unit. Confiscating a child's technical devices for an individual disciplinary reason, such as for the night, requires a specific reason related to the individual child. Such reasons could include an inability to stop using the telephone or that the telephone disturbs the child's sleep. The Ombudsman stressed that disciplinary rules related to upbringing may not be excessively strict, and the child's age, level of development and other individual needs and cir-

cumstances must be taken into consideration in applying them (Oppilaskoti Jolla, Vaalijala joint authority, 6421/2017).

Disabled persons have the right to be informed of their rights and the rights and obligations of the rehabilitation unit with regard to the arrangement of rehabilitation and care. The Ombudsman considered it important that the rehabilitation unit should increase the clients' awareness of their right to self-determination and other rights (7007/2017).

The rehabilitation unit reported that, after the visit, the unit had started informing its clients of their right to self-determination and their other rights. Clients are free to ask questions and present ideas to the organisation's experts on the right of self-determination.

Use of secure rooms

A secure room can be used to calm a person in special care for the intellectually disabled, if an individual behaving problematically would otherwise be likely to endanger the person's own health or safety, the health or safety of others or cause significant property damage. The use of a secure room requires the conditions specified in the Act on Intellectual Disabilities for short-term isolation of up to two hours to be met. A secure room could also be used in cases in which shutting the person in their own room would cause a negative emotional experience connected to the room, which should be a safe and pleasant place for the person. On the other hand, if isolation in the person's own room is considered to have a soothing effect on the person, it should be preferred to the secure room.

During the visit, it turned out that use of the unit's secure room had decreased significantly from 2016. This was found to be connected to the amendments to the Act on Intellectual Disabilities that entered into force on 10 June 2016. The maximum duration of short-term isolation is two hours, and the preparatory documents for the Act note that isolating the client in his or her own room is to be preferred if it would have a soothing effect on the client. The rehabilitation unit had set the target of being able to handle challenging situations without recourse to the secure room. When isolation has been required, it has usually been ended in 1–2 hours. The achievement of this

On the right a view to a security room which has a separate wc. Below a peephole of a door to a security room.

target has been promoted by making consultation visits to other units and proactively increasing resources for potential crises (7007/2017).

Outdoor time

Taking care of the basic needs of an individual with intellectual disabilities includes ensuring a sufficient amount of exercise and outdoor time.

The interviews of clients and their next of kin indicated that the time spent outside by the clients was not always recorded in the daily logs. The NPM also discovered that outdoor time could be systematically restricted at the beginning of the examination or rehabilitation period. The Ombudsman stressed the significance of spending time outdoors on a daily basis for the high-quality care referred to in the Act on the Status and Rights of Social Welfare Clients. Providing sufficient time outside is a part of caring for the residents' basic needs and, thus, respecting their human dignity. The Ombudsman recommended including the time spent outdoors in the resident's care and service plan and recording its daily realisation in the customer's documentation (7007/2017).

The joint authority reported that, in the future, the time spent outdoors by the clients would be recorded in their personal rehabilitation plans. The clients' outdoor time and possible refusal to go outside will be clearly recorded in the daily logs. Opportunities to spend time outdoors will be offered on a daily basis.

Interviewing clients and their families

The interviews of the clients' families indicated that the families were not always satisfied with how the residential unit staff had consulted them on matters related to the client's care. Furthermore, the discussions revealed a general uncertainty regarding the practices in the residential unit and the practical contents of the child's rehabilitation. In the Ombudsman's assessment, the cooperation between the residential unit and the families of its residents had not been realised in the best manner possible. The Ombudsman recommended that the residential unit should pay more attention to this aspect in the future (6421/2017).

After the visit, a family member of a client sent a letter to the Ombudsman, expressing shortcomings experienced by the family member. The rehabilitation unit was notified of the contents of the letter for the purposes of the evaluation and development of its operations. Development of the client feedback system was an item in the development plan included in the unit's self-monitoring plan. The Ombudsman encouraged the unit to develop its client feedback system further (7007/2017).

After the visit, the unit submitted a report stating that the organisation had developed a uniform feedback system. The unit gathers continuous feedback from clients and their families into a feedback log, which is reviewed at the workplace meeting on a weekly basis and taken into account in operations. Feedback is also collected with a dedicated form. Stakeholders and the people close to the residents are encouraged to give feedback.

Use of security guards

The residential service unit of a private service provider employed a round-the-clock security guard service. According to the staff, the guard could be called if a client behaved in an inappropriate or threatening manner, e.g. due to intoxication, and would not leave the common area when requested. The staff stated that the guard could use physical force to take the client to his or her own flat, for example. If illegal intoxicants, such as drugs, are found on the resident, the police is called. The report provided after the visit specified that the guard service had been acquired for the safety of the staff. The guards could assist in calming clients down by their presence. However, they were not entitled to use physical force to guide clients to their flats. The unit's service manager indicated that the purpose and authorities of the guard service would be reviewed with the staff.

In the Ombudsman's opinion, it is possible to employ security guards for duties permitted by the legislation on private security services in the common areas of serviced housing units. The issue is with the tasks appointed to the security guards or stewards and whether they have the required authority to perform the services ordered by the serviced housing unit. The Ombudsman has stressed that private guards may not take part in measures related to the client's care, which have been appointed to the nursing staff by law. Measures that restrict the client's right to self-determination must be deemed to constitute care-related tasks in which security guards cannot, as a rule, participate. On the other hand, security guards may, within the limits of their authority, secure the nursing staff's physical integrity and the safety of their work (1871/2018).

3.5.16 HEALTH CARE

In the health care sector, an accurate number of health-care units that fall under the NPM's mandate is unavailable. According to information received from the Ministry of Social Affairs and Health, there are approximately 50 psychiatric units that employ coercive measures. In addition, there are health-care units other than those providing specialised psychiatric care where coercive measures may be used (emergency care units of somatic hospitals), or where persons deprived of liberty are treated (health care services for prisoners).

In the health care sector, collaboration partners include the National Supervisory Authority for Welfare and Health (Valvira) and Regional State Administrative Agencies (AVI). Before visits, as a rule the competent regional state administrative agency is contacted in order to gain information on its observations about the facility in question. In recent years, it has also been customary to invite the Regional State Senior Medical Officer of the competent AVI to the visit debriefing. The final visit report is also delivered to the AVI for information. The inspection visit of the psychiatric unit of Kainuu Central Hospital serves as a good example of such cooperation. The Regional State Senior Medical Officer who participated in the debriefing made follow-up visits to the unit in three and five months from the original inspection visit. On the last visit, the Officer reviewed the recommendations made in the NPM's visit report and the measures taken by the hospital together with representatives of the profit centre. The Regional State Senior Medical Officer notified the Ombudsman of his observations.

Background information is requested from the health care unit's patient ombudsman before each visit. The final visit report is also routinely sent to the patient ombudsman for information.

Owing to the large number sites to be visited, certain prioritisations must be made with regard to the allocation of resources. The NPM has therefore mainly elected to visit the units where most coercive measures are taken, and where the patient material is most challenging. These include the state forensic psychiatric hospitals (Niuvanniemi and the Old Vaasa Hospital) and other units providing forensic psychiatric care. The aim is to make regular visits to these units, which in practice means a visit every couple of years. The aim is also to make regular visits to units that conduct research on and treats underage children who are difficult to treat (units in Tampere and Kuopio). Otherwise, the selection of sites will depend on when the place was previously visited and the number of complaints made about the unit.

As a rule, visits to units providing health-care services are almost always attended by an external medical expert. In the reporting year, only the visits to the Health Care Services for Prisoners unit (VTH) was not accompanied by an external expert. Involving a medical expert in the visits has made it possible for the NPM to address the use of restrictive measures from a variety of angles and to explore ways of preventing their use. In 2018, the NPM also trained two experts by experience and employed their expertise in four health care visits.

Visits to psychiatric units are nearly always unannounced. However, the unit is notified by letter that a visit will be made within a certain period

of time. This permits the NPM to request materials from the unit in advance. For example, psychiatric units have been requested to deliver lists of basic patient information, such as the date of admittance, legal status, psychiatric diagnoses and significant somatic diagnoses, for each ward. The list permits the NPM to form an overall picture of the ward's patients in a short time. The information also helps with choosing patients for interviews – e.g. the patient last admitted to the ward, or the patient who has spent the longest time in the ward.

The care staff play a major role in the prevention of mistreatment. For this reason, the inspection visits pay a great deal of attention on procedures, the forms used and the orientation and instruction of employees.

A draft of the visit report, containing the Ombudsman's preliminary opinions and recommendations, is sent to the visited facility, which has the opportunity to comment on the draft. In many cases, the health care unit reports on the measures it has taken on the basis of the Ombudsman's preliminary recommendations already at this stage. The Ombudsman welcomes this development as an indication of constructive dialogue.

The NPM made a total of ten visits to healthcare units. The visits to VTH were announced in advance. The other visits were made with the limited announcement described above or were completely unannounced. Visits to the larger units lasted 2–3 days. The NPM made visits to the following units (the opinions and responses of the units also include the visit to the psychiatric unit of the Päijät-Häme Joint Authority for Health and Wellbeing, 5338/2017):

The sites visited were:
- VTH outpatient clinic in Kerava, 30 January 2018, (450/2018)
- Psychiatric unit of Kainuu Central Hospital, 19–20 March 2018, 50 beds (727/2018)
- Kainuu Central Hospital emergency clinic, 19 March 2018 (729/2018)
- Psychiatric unit of North Karelia Central Hospital, 22–24 May 2018, 97 beds (1600/2018)
- North Karelia Central Hospital emergency clinic, 23 May 2018 (1601/2018)
- Niuvanniemi Hospital, 25–27 September 2018, 297 beds (3712/2018)
- Niuvanniemi Hospital's research and treatment unit for underage children, the NEVA Unit, 25 September 2018, 13 beds (3713/2018)
- KYS joint emergency clinic, 26 September 2018 (4753/2018)
- VTH outpatient clinic in Pyhäselkä, 10 October 2018 (4986/2018)
- VTH outpatient clinic in Helsinki, 29 November 2018 (5323/2018)

Prevention of the mistreatment of patients

Closed institutions always involve the risk of mistreatment of their patients. Such institutions must employ preventive structures and practices for preventing mistreatment. One such practice is a generally known procedure for reporting mistreatment.

In the opinion of the Ombudsman, the unit should have clear instructions for reporting mistreatment and on how such reports will be processed and what will be done to intervene. This also requires that mistreatment is correctly identified and defined, and that a clear position is taken by the management that mistreatment is unacceptable and will always lead to consequences. All hospital employees – not just the nursing staff, but all other professions and substitutes as well – should be instructed in the use of the reporting procedure. Patients and their families should also be notified of the instructions. At the same time, it should be made clear that making a report must never lead to any negative consequences for the person making it (5338/2017, 3712/2018).

The authority reported that its development and patient safety unit will consider the reporting procedure issue mentioned in the feedback at the level of the entire authority and seek to find a technological solution for its implementation. In the meantime, the psychiatric ward units have agreed that matters involving mistreatment shall be reported to the patient ombudsman. The patient ombudsman will attend the head nurse meeting at which the pro-

cess will be discussed. After this the units will be instructed on the temporary process applying only to psychiatric units.

Seclusion premises

Seclusion premises in psychiatric hospitals shall be clean, fresh, ventilated and sufficiently warm rooms in good condition and with windows, equipped with appropriate bed linen, protective clothing and other fixtures (including a clock). Patients must always be able to contact the nursing staff by ringing a bell or in some other way. During visits, the NPM has also paid attention to the furnishings of seclusion rooms; especially the fact that patients should not have to take their meals standing or sitting on the floor. The visit reports frequently cite the National Institute for Health and Welfare's (THL) publication "Decreasing coercion and improving safety in psychiatric care", which also discusses the location and furnishings of seclusion rooms.

According to the Ombudsman, seclusion rooms must be safe and appropriately equipped. The hospital's seclusion premises were more reminiscent of a jail cell than an seclusion room for a psychiatric patient. The Ombudsman considered it to be degrading to force secluded patients to take their meals standing up or sitting on a thin mattress – let alone having to eat on the same floor or mattress on which the patient has urinated or defecated. Such situations expose the patients to degrading and humiliating treatment that is not acceptable under any circumstances. The Ombudsman deemed it possible that staff would not always have the time to take the patient to the toilet or assist the patient in using a bedpan. In such cases, the unit is required to ensure that patients never have to eat or rest on a surface soiled by human excrement. The responsibility for ending such degrading treatment is with the persons in charge of the hospital's operations (5338/2017).

The authority reported that it would take measures to bring the seclusion premises up to an appropriate standard. For example, two-way voice communication equipment has been installed in all seclusion rooms. In 2018, the hospital intended to install armour glass panes on all seclusion room doors, enabling good visibility out of the room and improving interaction with the nurses. The floor surfaces will also be replaced with softer material. In addition, an appropriation for the renovation of the toilet facilities was made in the budget for 2019. High mattresses, cube tables and armchairs will be purchased for all seclusion rooms in 2018.

In Joensuu, the seclusion facilities in the adolescent psychiatric ward feature a scenery wallpaper, a high mattress and a cube table.

The Ombudsman recommended that the hospital should pay more attention to the equipment, furnishings and appearance of the seclusion rooms, without compromising safety. The current situation could be improved by measures such as painting the surfaces and adding soft furniture. At a minimum, some furniture is required for eating, so that the patients do not have to set their meal trays down on the bed or floor. The Ombudsman noted that excrement-resistant soft furniture suitable for such purposes is available. The Ombudsman recommended the unit to remove dangerous details and graffiti from the rooms. It is expected that the condition and equipment of the new hospital's seclusion rooms will be up to the required standard. Since the new premises will not be in use for several years yet and the issue is vital for the fundamental rights of the patients, the Om-

budsman felt that the changes required by him could not wait that long (727/2018).

The authority reported that it had started renovating the seclusion premises. The wall surfaces had been painted and sharp grooves removed. New, soft and excrement-resistant furniture had been ordered. A film had been installed on the glass pane in the door of one seclusion room to protect the occupant's privacy. An alarm bell system had been acquired for the rooms. A dedicated wheeled table had been ordered for serving meals in the seclusion rooms so that the patients are not required to eat on their beds. Every patient in seclusion is permitted to use the toilet next to the seclusion premises in the presence of a nurse/nurses. Efforts will be made to protect the privacy of patients when safe and possible. The staff will actively offer the opportunity to use the toilet. Patients who wish to use the toilet can ask the staff or ring the bell.

Treatment of patients in seclusion

The Ombudsman stated that the dignified treatment of an secluded patient and good health-care standards require that the patient has access to a toilet. Access to the toilet should also be actively offered to patients without waiting for a specific request. For this reason as well, patients in seclusion should always be able to contact the care staff without delay. In his opinions, the Ombudsman has stated that it is inhumane and humiliating if the patient's only means of communicating with nursing staff is to bang on the door or yell. Patients must also be supplied with adequate and humane clothing.

The Ombudsman issued a serious recommendation to the authority to take measures to bring the conditions and treatment of patients in seclusion up to the required standard. The Ombudsman recommended that the guidelines on treatment should more clearly communicate the objective of providing humane treatment for patients in seclusion. At the very least, this means that staff should be instructed to ensure that patient has the opportunity to use the toilet. The implementation of personal surveillance could also be expressed more clearly in the guidelines. Specific examples of how nurses can assist patients during meals and ensure that they do not take their meals sitting or standing on the floor and eating with their hands. Guidelines alone will not suffice, however, and the management must ensure that everyone participating in the treatment of a patient in seclusion are aware of the guidelines and comply with them (5338/2017).

The authority reported that it had updated its seclusion guidelines as recommended by the Ombudsman. By the end of August 2018, the authority intended to draw up a proposal for increasing the staff's level of training and awareness of these and other guidelines and legislation. The proposed methods for this include reading materials and an electronic exam, which everyone working in the wards would be required to pass.

The Ombudsman was satisfied with the measures and plans reported by the authority for bringing the seclusion premises up to an appropriate standard. The Ombudsman commended the fact that more attention will be paid to the staff's and management's knowledge of legislation, guidelines and national recommendations. Clear instructions and dedicated training programmes are methods that can consolidate the staff's capabilities for encountering challenging patients.

The guidelines gave the impression that patients will not necessarily be visited in the room, but supervision can be performed from "behind the door". The Ombudsman did not find such supervision consistent with the supervision required for patients in seclusion. Neither can such supervision, or event two-way voice communications, replace contact between the patient and staff. Patients should have the opportunity to talk with nurses face-to-face (5338/2017).

The Ombudsman did not deem it sufficient that patients can contact staff by waving to the surveillance camera or banging on the door and shouting. A minimum requirement in this regard would be a call button in the seclusion room. A system enabling two-way communication would be an appropriate way of arranging contact (727/2018).

The Deputy-Ombudsman recommended the patient to be compensated for their treatment while in seclusion

The Deputy-Ombudsman felt that the way in which the patient had been treated in seclusion violated patient´s dignity. A person with impaired mobility due to cerebral palsy was forced to take their meals in the psychiatric inpatient ward's seclusion room by sitting on a thin mattress on the floor. The plates, cups and utensils were also unsuitable for the patient. The complainant wore diapers during the seclusion which lasted for more than 24 hours. The Deputy-Ombudsman recommended that the Welfare District compensate the complainant for the violations of fundamental and human rights to which the complainant was subjected (3287/2017*).

The Welfare District reported that it would pay the complainant EUR 4,500 in compensation.

Decreasing the use of coercive measures

Every psychiatric unit that employs coercive meas-ures should have a plan with quantitative and qualitative targets for decreasing their use. It is equally important to inform the entire staff of the plan and monitor its realisation constantly.

The hospital did not have a dedicated programme for decreasing the use of coercive measures. The Ombudsman recommended that the hospital continually monitor the implementation of restrictive measures and draw up a plan or guideline for the reduction of the use of coercive measures. He also suggested familiarising the entire staff with the plan or guideline (5338/2017).

The authority reported that, in addition to the restriction notifications made to the AVI, the psychiatric outpatient wards will start compiling statistics on the use of restrictive measures and a monitoring procedure for restrictive measures will be drawn up. Once the availability of this base data has been secured, a programme and targets for decreasing the use of coercion will be drawn up. The induction of personnel in the targets and measures of the plan will constitute a part of the programme. Guidelines for discussing seclusion with patients will also be drawn up for staff.

During the visit, the NPM did not see convincing evidence of active attempts to decrease the use of coercion. The hospital did not have a dedicated programme for decreasing the use of coercive measures (727/2018).

The authority reported that restrictive measures and their use and documentation had been reviewed with the staff. Restrictive measures will only be employed when other measures will not suffice. The staff was also instructed to document in detail any alternative methods employed to resolve the situation before the use of restriction or seclusion. A training programme for the staff will start soon. There are also dedicated guidelines for decreasing the use of coercion and improving safety in the psychiatric ward, and every staff member has read and signed the guidelines. A specific programme for decreasing coercion and monitoring the use of restrictive measures is being planned. The psychiatric ward uses psychiatric advance directive forms. This voluntary system has been developed to improve the patients' right to self-determination when they are incapable of making decisions for themselves. If an advance directive has been made, it will be respected whenever possible. The new instructions for patients also include written information on the possibility to make an advance directive on psychiatric treatment.

Use of mechanical restraints

The instructions on the use restrictive measures did not state how often physicians should assess the state of restrained patients. The patient documents indicated that, in one case, the physician had only assessed the restrained patient's state once per day. The Ombudsman found this interval to be excessive (727/2018).

All of the inpatient ward's seclusion rooms were equipped with restraint beds as standard fixtures. All new hospital beds ordered for the ward also included the option to install restraints. The Ombudsman felt that this could lower the threshold for using restraints. Some of the patient

Restraint bed in an isolation room at the central hospital in Kajaani.

records inspected gave the impression of a low threshold for the use of restraints in certain cases. As an example, one patient had been permitted to go for a cigarette and go to the sauna in the middle of restraint and seclusion. The Ombudsman stressed that, according to the Mental Health Act, seclusion without mechanical restraints is the primary alternative and restraints can only be employed when other measures are insufficient (727/2018).

During the visit, the NPM noted that patients were transported outside the seclusion rooms with the restraints still attached to their limbs. This could be the case when taking the patient to the toilet or for a cigarette, for example. In the Ombudsman's opinion, moving a patient with the restraints still attached can be considered humiliating for the patient. It can also cause anxiety in other patients. In the Ombudsman's opinion, this practice should be avoided, particularly in the ward's common areas (727/2018).

Involuntary medication

If a patient in involuntary care or under observation refuses to take the medication prescribed for them, the medication may be administered against their will only if the failure to provide medication would seriously endanger the health and safety of the patient or others. In his decision dated 15 March 2018, (1496/2017) the Ombudsman commented on the medication of a patient against their will.

The Ombudsman recommended that, from now on, decisions on involuntary medication should be justified with regard to the requirements of the Mental Health Act. He stressed that psychosis cannot be considered to constitute sufficient grounds for involuntary medication, because all patients under observation and ordered to treatment suffer from psychosis. The patient records should also indicate how the patient was consulted on the medication or why consultation was not possible (5338/2017).

The authority reported that the physician in charge of the psychiatric hospital had started clarifying the guidelines with the objective of assessing the use of restrictive measures in more detail and recording the reasons for employing restrictive measures more systematically. Particular attention will be paid to the use of involuntary medication and recording seclusion situations.

The patient records indicated that involuntary medication was administered in the psychiatric ward. The medication had been justified as "necessary", but the entry in the patient records lacked a detailed assessment of whether the requirements for involuntary medication specified in the Mental Health Act were met (failure to medicate would seriously endanger the safety or health of the patient or others). The Ombudsman recommended that, in the future, involuntary medication should be assessed in the manner required by the Mental Health Act, and that the fulfilment of the conditions be recorded in the patient records (727/2018).

The authority reported that the staff was instructed to accurately document everything related to the administration of involuntary medication.

Quality of care and care culture

The Ombudsman recommended that the rehabilitation ward should be made more comfortable to better support rehabilitation. Excrement-resistant furniture suitable for such purposes is available. The Ombudsman felt the shortcomings in the rehabilitation ward's care environment to be significant and urged the ward to take measures to bring the environment up to the required standard. In the opinion of the Ombudsman, it was not possible to wait for the rectification of the situation with the completion of the new hospital building in 2021 (727/2018).

According to the observations made by the NPM, the treatment times of patients in the rehabilitation ward were long, and many patients appeared to be more in need of nursing and care than rehabilitative treatment. The NPM got the impression that a large portion of the ward's patients were not in a correct or appropriate place of care. The offering of rehabilitative activities was sparse. The Ombudsman issued a serious recommendation to the ward to take measures to bring the conditions and treatment of the patients up to the required standard. The Ombudsman considered it necessary to evaluate the suitability of the place of care individually for each patient (727/2018).

According to the observations made by the NPM, not many nurses could be seen in the rehabilitation ward's common areas or among the patients. If the patients wanted to talk to the nurses, they knocked on the door of the office. The nurses seemed to spend a disproportionate amount of time in the office instead of working with the patients. The nurses' working methods also appeared task-oriented. According to the NPM's observations and patients' accounts, the nurses did not actively initiate contact with the patients. The Ombudsman recommended that the ward should continue assessing its care culture and opportunities to lessen the nursing staff's focus on the office. The Ombudsman urged the ward to consider the implementation of visibility between the office and ward so that the patients could see into the office and the nurses out of it, without compromising confidentiality (727/2018).

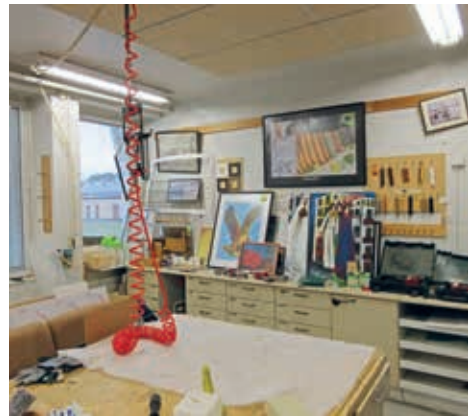
According to the authority, it is part of the ward's care culture that the staff should be as available as possible to the patients. This has been discussed with the staff to an even greater extent. Only the necessary work should be done in the office behind closed doors. Whenever possible, work should be arranged so that one or more staff members are always in the ward and available to the patients. For example, care meetings and other meetings should be arranged in a staggered manner, so that a majority of the staff would not be unavailable at any one time.

Work for decreasing the use of coercion in a state forensic psychiatric hospital

Niuvanniemi Hospital treats patients who have not been convicted due to their mental state (forensic psychiatric patients) and performs psychiatric examinations. The hospital also treats dangerous and/or difficult psychiatric patients. At the end of 2017, the average treatment time of forensic psychiatric patients was 6 years and 8 months (the longest being 35 years and 7 months). The corresponding figures for patients admitted due to difficult conditions was 4 years and 5 months (the longest period being 26 years and 1 month). All of the patients being treated in the hospital had been committed to the hospital against their will. Thus, their right to self-determination can be restricted subject to the conditions provided for in chapter 4a of the Mental Health Act. However, the Act states that a patient's right to self-determination and other fundamental rights may only by restricted to the extent required by the treatment of their condition, the safety of themselves or others, or the safeguarding of other interests provided for in chapter 4a.

In 2011 and 2015, the hospital drew up proposals for plans to decrease the use of coercion, and a steering group for decreasing the use of coercion operates in the hospital. The hospital is committed to decreasing the use of coercive measures on patients. According to the steering group, the hos-

Various activities at the Niuvanniemi Hospital.



pital has succeeded in halving the amount of seclusion and restraint in proportion to treatment days in the 2010s.

Various methods have been developed to decrease the use of restrictive measures. These include the development of special observation (100% observation), facilitating access to occupational therapy, harmonising the practices and record of wards, developing the use of relaxation or sensory deprivation rooms, and replacing traditional violence management training with prevention-oriented training.

The Deputy-Ombudsman commended the hospital's work for decreasing the restrictive measures used on patients. She recommended offering a debriefing opportunity to patients after all restrictions of their right to self-determination, instead of just after seclusion and restraint situations. The Deputy-Ombudsman also commended the hospital's work in reducing the use of seclusion. She nevertheless considered the still occurring long seclusion periods to be problematic. Seclusion is an extremely strong infringement on the patient's personal freedom.

The steering group for decreasing the use of coercion made reducing the use of mobility-restricting garments a focus area for 2018. The use of restrictive clothing is monitored in the hospital. In the last eighteen months, the garment has been used for six patients. At the time of the visit, it was only used for one patient. There are many instances of its use, however, (3,395 in 2017), because the patient is dressed in the garment whenever he moves in the ward's common areas. The hospital has sought to develop alternatives to restrictive clothing (ponchos, muffs). Such clothing permits violent patients to spend time with the other patients. The Deputy-Ombudsman commended the hospital's work for reducing the use of restrictive clothing (3712/2018).

Emergency units

As in previous years, the Ombudsman felt it was important to visit the emergency care units of somatic hospitals, which use so-called secure rooms. Attention is also paid to the privacy of the patient in urgent-care facilities.

Patients can be placed in the secure room because they are, for example, aggressive or confused and cannot be placed with other emergency patients. This situation is problematic because there is currently no legislation on seclusion in somatic health care. However, secluding a patient may sometimes be justified under emergency or self-defence provisions. Such situations tend to involve an emergency, during which it is necessary to restrict the patient's freedom in order to protect either his or her own health or safety, or those of other persons. The Ombudsman has required that the legal provisions and ethical norms governing the actions of doctors and other health care professionals must also be taken into account in these situations, and, as a result, the application of two parallel sets of standards. Furthermore, the procedure may not violate the patient's human dignity.

Having appropriate equipment in the seclusion room is of major importance when assessing whether a patient's seclusion has, as a whole, been implemented in a manner that qualifies as dignified treatment and high-quality health and medical care. The criteria laid down in the Mental Health Act for the seclusion of a psychiatric patient are also applicable as minimum requirements for secure rooms in somatic hospitals. A patient placed in a secure room must be continuously monitored. This means that the patient must be monitored by visiting the seclusion room in person and observing the patient through a video link with image and audio. Appropriate records must be kept of the monitoring at all times.

The NPM visited the emergency care units of three hospitals in 2018. All visits were made unannounced and during the evening. An external expert participated in the visits. The visits paid attention to the fulfilment of the above-mentioned requirements.

Supervision of health care for prisoners

Health Care Services for Prisoners (VTH) operates in connection with the National Institute for Health and Welfare (THL). The VTH is tasked with providing health care services for all prisoners in Finland. As a rule, VTH produces its own primary health care, oral health care and specialised psychiatric health care services. VTH has outpatient clinics in every prison in Finland, with the exception of Suomenlinna Prison, which arranges health care for its prisoners at the Helsinki Prison outpatient clinic. Eleven prisons have dental clinics in connection with the prison clinic. In Vaasa, the dental clinic operates in a municipal health centre. The units of the Psychiatric Prison Hospital in Turku and Vantaa serve as acute clinics for prisoners everywhere in Finland. The Prison Hospital is a national somatic hospital for prisoners, located in Hämeenlinna.

Since the beginning of 2016, the Regional State Administrative Agency of Northern Finland (AVI) has conducted guidance and assessment visits to the outpatient clinics and hospitals of VTH on its own or together with the National Supervisory Authority for Welfare and Health (Valvira). In the reporting year, the AVI conducted five guidance and assessment visits to VTH units. By the end of 2018, the AVI has visited all VTH outpatient clinics and hospitals. A report has been published on the supervision of the national prisoner health care service in 2016–2018: https://www.avi.fi/web/avi/julkaisut-2019). In the report, the supervisory authorities assess VTH's operations as part of the national health care system, along with the treatment recommendations and guidelines issued by VTH.

The Ombudsman receives AVI Northern Finland's supervision plans for VTH and guidance and assessment reports following its visits. As part of this collaboration, the Ombudsman sends its own supervision plans and visit reports to Valvira and AVI. The Ombudsman, Valvira and AVI also hold regular meetings on issues in the field of prisoner health care.

The NPM visited three VTH outpatient clinics in 2018. Such visits are combined with prison visits and are usually announced in advance. Before visiting the outpatient clinic, the NPM interview the prisoners on matters such as the functioning of health care and medical care in the prison.

On these visits, the NPM pays attention to how soon medical screenings are performed on new prisoners and how they are investigated for possible signs of violence. The NPM also determine how the health of prisoners placed in solitary confinement is being monitored. The monitoring is not fully in compliance with the Imprisonment Act, since the majority of outpatient clinics are only open during business hours on weekdays. For example, the mental state of a prisoner placed under observation in the weekend is not examined at the schedule required by the Imprisonment Act, i.e. "as soon as possible" after the start of observation, but only on the next weekday. Prisoners frequently criticise the fact that they do not receive replies to the inquiry forms they send to the outpatient clinic, or that getting a physician's or dentist's appointment is difficult. On these visits, the NPM has frequently drawn the outpatient clinics' attention to the fact that, according to the Patient Act, the time of their appointment must be communicated to patients if it is known. The Act does not distinguish between prisoners and other patients in this regard. However, it is necessary to take certain security considerations in to account, particularly for appointments outside the prison, and these can have an impact on the level of detail disclosed to specific prisoners about the times of their appointments.

3.6 Shortcomings in the implementation of fundamental and human rights

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

Since 2009, upon the suggestion of the Constitutional Law Committee (PeVM 10/2009 vp), the Ombudsman's Annual Report has contained a section outlining observations of certain typical or persistent shortcomings in the implementation of fundamental and human rights. In accordance with a recommendation by the Constitutional Law Committee (PeVM 13/2010 vp), this section is a permanent feature of the Ombudsman's Annual Report.

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

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

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

The list may also exclude obvious fundamental and human rights problems if they have not been brought to the Ombudsman's attention (such as the ECHR's opinion that the requirement for infertility as a precondition for the legal recognition of the gender of transgender people constitutes a violation of a person's right to privacy). Some problems may have been excluded from the list because they concern civil matters or the actions of private individuals, which fall, at least partly, outside the jurisdiction of the Ombudsman (such as violence against women).

For the above reasons, the list cannot provide an exhaustive picture of the various problems involved in the implementation of fundamental and human rights in Finland.

There can be several reasons for possible defects or delays in redressing a legal situation. In general, it is fair to say that the Ombudsman's statements and proposals are complied with very well. When this does not happen, the explanation

is generally lack of resources or defects in legislation. Delays in legislative measures also often appear to be due to insufficient resources for law drafting.

Some of the listed issues, such as shortcomings in the conditions and treatment of elderly people, will probably never be entirely eliminated. This does not mean, however, that we should stop making every possible effort to remedy the situation. Most of the listed problems could be eliminated through sufficient resourcing and legislative development. In fact, significant improvements have been made with regard to some issues. Unfortunately, the problems have also increased in some areas.

3.6.1 TEN KEY PROBLEMS IN FUNDAMENTAL AND HUMAN RIGHTS IN FINLAND

Shortcomings in the conditions and treatment of the elderly

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

Measures limiting the right to self-determination in the care of the elderly should be based on law. However, the required legislative foundation is still entirely lacking. Decision-making concerning restrictive measures is not always appropriate.

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

Despite the increased need for services, the authority does not always make decisions on supplementing the services provided at home or arranging care in an assisted living unit or elderly people's home. When the authority does not make decisions on arranging services, the right to bring a case before the Administrative Court concerning the extent of the municipality's obligation to arrange services is also not realised.

There are insufficient resources for oversight. Regional state administrative agencies have not had any realistic means of overseeing care provision. Self-monitoring and retrospective oversight of the adequacy and quality of services provided to customers at home is not sufficient. New supervision methods are required.

Changing the services of the authorities to electronic format may endanger the availability of services for elderly persons.

Shortcomings in child welfare services

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

The supervision of foster care under child welfare services is insufficient. The child protection authorities at municipal level do not have enough time to visit foster care facilities and are insufficiently familiar with the conditions and treatment of children. The regional state administrative agencies do not have enough resources for inspections.

The supervision of foster care in private families, which is the responsibility of the municipalities, is inadequate; the regional state administrative agencies do not have adequate powers to supervise foster care in private homes.

Repeated changes in foster care placements may compromise the stable conditions and relationships that are particularly important to children placed in care. Child welfare services do not have the correct types of foster care placements available for the children who have the worst standards of well-being and are the most difficult to treat.

Moreover, children's right of access to information is not sufficiently observed. Children who have been placed in care are often unaware of their rights, the rights and obligations of the institu-

tion or the duties and responsibilities of their caseworker.

The right of children placed in institutional care to meet their care worker in person is not observed as provided under the Child Welfare Act. The children are often left without their caseworker's support, which is guaranteed to them by law.

Restrictive measures are imposed in contravention of the Child Welfare Act. Restrictive measures are used in circumstances or ways that the Act does not allow. Decisions on restrictive measures are not made as prescribed by the Child Welfare Act. Units providing foster care and often also the social workers of municipalities that place children in care have considered it possible to restrict children's fundamental rights on educational grounds. The distinction between normal, acceptable boundaries and the restriction of a child's fundamental rights has been obscured.

The customer plans include deficiencies, even though they are a key instrument in the arrangement of social welfare services, decision making and the enforcement of decisions. Customer plans to support parenting are not always drawn up for parents whose children are placed in foster care.

Mental health services for children and young people are insufficient. There are gaps in the reconciliation of child welfare services and paediatric psychiatric care. The service structure lacks suitable placements and services for children with severe behavioural disorders who need services that are not available at children's homes or psychiatric hospitals.

Shortcomings in guaranteeing the rights of persons with disabilities

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

The policies for limiting the right to self-determination vary in institutional care. While the amendment to the Act on Special Care for Persons with Intellectual Disabilities (381/2016) has helped to improve the situation, the practical application of the law is still marred by significant lack of awareness, and shortcomings and failures.

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

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

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

Policies limiting the right to self-determination in institutions

Measures limiting the right to self-determination may lack legal grounds and be solely based on "institutional power", for example. Restrictive measures may be excessive or inconsistent. The supervision of policies limiting self-determination is insufficient, and the controllability of such measures is affected by shortcomings, particularly in cases where there are no procedural guarantees of protection under law.

For example, the required legal framework for care of the elderly and somatic healthcare remains non-existent.

Problems with legal assistance for foreigners and the vulnerability of undocumented immigrants

The unprecedented number of asylum seekers and restrictions in the provision of legal assistance has resulted in a situation where fewer asylum seekers receive legal assistance during the first stage of their process. This may be problematic from the perspective of legal rights and create difficulties in resolving the matter, including at the appeals stage.

Owing to lack of legal advice, detained foreigners are often unaware of their legal rights and their own position.

Shortcomings have been identified in meeting the basic needs, such as adequate social and health services, of undocumented immigrants. A government bill was submitted to Parliament in 2014 (HE 343/2014 vp) that would have improved the right to health services of specific groups among undocumented immigrants (including pregnant women and minors), but the bill lapsed. More decisions to end reception services are likely to be issued, as more negative decisions on asylum applications are issued to asylum seekers whose removal from the country is impossible. Local authorities have adopted different policies on what types of social and health services are still offered to persons whose reception services have ended.

The processing time for residence permit applications based on family ties is often delayed past the statutory nine-month time limit, which can only be exceeded in extraordinary circumstances. In February 2019, the Finnish Immigration Service had a total of 855 applications based on family ties which had been pending for more than nine months.

In addition, the processing of residence permit applications based on employment often takes too long. According to the law, employment-based residence permit applications should be resolved within four months unless there are extraordinary circumstances. However, applications often take longer to process.

Flaws in the conditions and treatment of prisoners and remand prisoners

For many prisoners, lack of activity is a serious problem. The Council of Europe Committee for the Prevention of Torture (CPT) recommends that prisoners be allowed to spend at least eight hours per day outside their cells. In closed units, prisoners get to spend less than eight hours outside their cells in many cases.

Often, when prisoners are placed in units, the legal principle of placing remand prisoners in separate locations from prisoners serving sentences is not observed. None of the inspected prisons have been found to be observing the legal principle that minors should not be housed in adult units.

Remand prisoners are still detained to an excessive extent in police prisons. According to in-ternational prison standards, crime suspects should be kept in remand prisons rather than police detention facilities, where conditions are suitable only for short stays and where remand prisoners are at risk of being put under pressure. The CPT has strongly criticised Finland for this practice for more than 20 years, most recently in 2016, based on an inspection visit made by CPT in Finland in 2014. The situation is expected to improve. The Remand Imprisonment Act was amended by an act (103/2018) that entered into force on 1 January 2019 with the effect that remand prisoners must not be kept in a police detention facility for longer than seven days without an exceptionally weighty reason.

Confining prisoners in cells with no toilet is against the international standards of prison administration and may violate the human dignity of the prisoners. In the review year, cells with no toilets were still in use at Hämeenlinna Prison. Toward the end of 2018, Hämeenlinna Prison was closed due to indoor air problems, so the last remaining cells without toilets were taken out of use.

Problems in the availability of health services and the relevant legislation

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

There are shortcomings in the healthcare of special groups, such as prisoners and undocumented immigrants.

Some emergency care units have secure rooms, in which aggressive and intoxicated patients can be placed. There is no legislation governing the use of secure rooms. The grounds for and the du-

ration of loss of liberty, the person making the decision, the decision-making process and the legal protection of patients should be provided for in legislation in compliance with the criteria for restricting basic rights.

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

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

Medicolegal death investigations are repeatedly delayed by up to a year after the statutory three-month time limit for documentation. The Ombudsman has drawn attention to such delays for more than ten years.

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

The right of schoolchildren to a safe learning environment is not always observed. Bullying remains prevalent in schools. The means available for schools to identify and intervene with bullying are not always sufficient. Indoor-air problems continuously arise in schools, and such problems can present a significant risk not only to health but also to children's equal right to education.

There are shortcomings in the legal expertise, administrative procedures and decision-making of municipal education departments and schools, giving rise to problems of legal protection. For example, administrative decisions that are open to appeal are not always made, are not based on law or do not meet the requirements of the Administrative Procedure Act.

The Office of the Parliamentary Ombudsman and the Human Rights Centre have prepared a joint training project to strengthen the training on fundamental and human rights in education departments, as well as administrative competencies. The training events held and the online material created during the project will reach a large proportion of the managers of municipal education departments and head teachers of educational institutions.

Lengthy handling times of legal processes and shortcomings in the structural independence of courts

Delayed trials have long been a problem in Finland. This has been identified in both the national oversight of legality and in prior ECHR case law. Despite some legislative reforms that have improved the situation, trials can still be unreasonably prolonged. This can be a serious problem, particularly in matters that require urgent handling.

In criminal cases, the total duration of the process depends on the length of the pre-trial investigation, which may be exceptionally long in many complex cases, such as financial crime. The number of exceptionally complex cases has increased. It has become apparent that the current criminal process and appeal system was not designed for such cases. The delays in processing criminal cases are affected by the under-resourcing of the entire criminal process chain – the police, prosecutors and courts.

The cost of a trial and legal fees may be prohibitive from the perspective of legal rights.

With respect to the structural independence of the courts, the fact that the court system has been led by a ministry is problematic. A draft bill for the establishment of a Courts Agency was submitted to Parliament on 20 September 2018. In January 2019, Parliament approved a law under which the majority of the duties required of a central administrative authority for the court institution will be reassigned from the Ministry of Justice to the Courts Agency. Duties related to matters such as service and employment relationships and dismissing judges will be transferred from the Minis-

try of Justice to the new agency. The law will take effect on 1 January 2020. This will contribute to improving structural independence.

However, the large number of temporary judges and the fact that, in practice, local councils select jury members for District Courts on the basis of political quotas, remain problematic issues from the perspective of the independence of courts.

Shortcomings in the prevention of and recompense for fundamental and human rights violations

There are significant gaps in the general awareness of fundamental and human rights, and their implementation and promotion are not always given due attention by the authorities. Training and education in fundamental and human rights is not sufficiently arranged, although progress has been made in this area.

The legislative foundation for the recompense for basic and human rights violations is lacking. Substantive amendment of the Tort Liability Act (the liability of public officials in basic or human rights violations) has not been initiated.

3.6.2 EXAMPLES OF POSITIVE DEVELOPMENT

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

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

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

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

Over the years, the Ombudsman has made numerous recommendations regarding recompense. These proposals have, in most cases, led to a positive outcome. In its reports (PeVM 12/2010 vp and 2/2016 vp), the Constitutional Law Committee has also taken the view that a proposal by the Ombudsman to reach an agreed settlement and effect recompense is in clear cases a justifiable way of enabling citizens to achieve their rights, bring about an amicable settlement and avoid unnecessary legal disputes. The grounds on which the Ombudsman recommends recompense are explained more extensively in summary of the annual reports of 2011 (page 84) and 2012 (page 65).

Under the State Indemnity Act (*laki valtion vahingonkorvaustoiminnasta*, 978/2014), the majority of claims for damages addressed to the State are processed by the State Treasury. The Act applies to the processing of claims for damages addressed to the State if the claim is based on an error or negligence by a State authority.

In the reporting year, the Ministry of Finance requested a statement on a draft bill for amending the State Indemnity Act. The bill calls for the debiting of taxation and tax-like charges payable to the Finnish Transport Safety Agency and the State Department of Åland to be added to the list of functions excluded from the centralised procedure. The proposal would harmonise the way that the authorities process claims for damages concerning taxation. Furthermore, when claims for damages are processed, the proposed regulation applying to the right of the State Treasury to access information would increase clarity within the State Treasury and the authority alleged to have caused the damage. As the proposed amendments were mainly technical in nature and had the effect of increasing clarity, and they did not affect fundamental rights or the Constitution, the Deputy-Ombudsman decided not to issue a statement on the proposals (5490/2018).

According to information obtained from the State Treasury, a total of 647 complaints were submitted in the reporting year. The State Treasury issued 787 decisions and paid a total of EUR 606,000 in compensation. A significant proportion of these decisions (356) and of the compensation paid (EUR 281,000) concerned the administrative branch of the Ministry of Justice, where guardianship matters in particular had again given rise to financial losses. The reasons were the public guardians failure to apply for income support, nursing subsidy and housing allowance, as well as the costs incurred due to the late payment of taxes and fees. In addition, public guardians had not terminated electricity and telephone connections.

The State Treasury issued a decision on 10 July 2018 granting compensation for the suffering endured by a prisoner who had spent approximately two days in observation overalls during an isolated observation procedure at Helsinki Prison in 2011. The decision referenced legal praxis concerning observation overalls. According to a decision issued by the Ombudsman in 2012, the Imprisonment Act (Vankeuslaki, 767/2005) did not provide acceptably precise and clearly delineated authorisation for the use of observation overalls.

The European Court of Human Rights (ECHR) issued a judgment in 2014 applying to Finland, whereby the use of observation overalls violated the right protected by Article 8 of the European

Convention on Human Rights concerning respect for private life because the use of overalls was not stipulated in law in the manner required by Article 8 (2). Helsinki Court of Appeal issued a judgment in 2017 requiring the Finnish State to pay compensation for suffering to the complainants due to the use of observation overalls on the basis of Section 7 of the Constitution, among other legal bases. In the State Treasury's assessment, a reasonable sum of compensation for the violation was EUR 3,000.

The State Treasury issued a decision on 20 August 2018 assessing the violation of the fundamental rights of prisoners at Satakunta Prison due to negligence when parole was discontinued. The Deputy-Ombudsman issued a decision in 2017 reprimanding the prison's governor and deputy governor for their unlawful negligence. On the basis of the Deputy-Ombudsman's decision and the account presented, the State Treasury found that the prison had neglected its duty to ensure that the complainant's urine test was certified and that a lawful decision, open to appeal, was made on the cancellation of parole. According to the State Treasury, cancelling supervised parole constitutes a significant intervention into the prisoner's legal position and, for this reason, the related procedural provisions, such as certifying the results of substance abuse screening, have a key impact on safeguarding fundamental rights. In this case, the prison's procedural errors significantly and irrevocably restricted the complainant's fundamental rights. In the State Treasury's assessment, fair recompense in this case amounted to EUR 2,000.

The Ombudsman issued a decision on 20 December 2017 stating that the Embassy of Finland had acted incorrectly when rejecting the visa applications of the complainant's brother. The Ombudsman recommended that the Ministry for Foreign Affairs find out the whereabouts of the brother and, at its discretion, submit a recommendation for recompense to the State Treasury. In line with the State Treasury's guidance, the person claimed compensation for damages personally.

The State Treasury's decision of 20 September 2018 stated that the complainant's claim for damages was based on the Embassy of Finland in Nairobi having acted improperly when it declined to grant a visa to the complainant although the complainant held a permanent residence permit in Finland. The complainant could not enter Finland, accrued rental debt and lost credit information.

It became apparent from an account provided to the State Treasury by the Finnish Immigration Service that the complainant had been granted a permanent residence permit in Finland on 23 November 2000. The most recent sticker printed to confirm the permanent residence permit was dated 17 April 2007, and it had not been renewed since that date. The sticker confirming the residence permit was valid for five years and, therefore, had expired on 17 April 2012. According to the State Treasury's decision, because the complainant did not have any valid proof of the permanent residence permit in Finland, the Embassy of Finland in Nairobi could have rejected the visa application on the grounds that he could be considered a risk to public order and internal security as he had been convicted and sentenced to imprisonment in 2011. The outcome of the State Treasury's decision was that it had not been proven that the Ministry for Foreign Affairs of the Embassy of Finland in Nairobi had acted in such a manner as to provide grounds for the State to incur liability for damages in this case. As such, the claim for damages was rejected.

Making recompense was recommended by the Ombudsman in eight cases in the reporting year. One recommendation for recompense made to the State Treasury led to the State Treasury paying compensation for delays in court proceedings due to the worry, uncertainty and other comparable harm caused by the circumstances. In addition, during the handling of complaints, communications from the Office to authorities often led to the rectification of errors or insufficient actions and, therefore, contributed to an amicable settlement. In numerous other cases, guidance was provided to complainants and authorities by ex-

plaining the applicable legislation, the practices followed in the administration of justice and oversight of legality, and the means of appeal available.

3.7.1 RECOMMENDATIONS FOR RECOMPENSE

The following gives an overview of the recommendations for recompense made by the Ombudsman during the year under review.

Right to personal liberty and integrity

No access to food during deprivation of liberty

The Åland police arrested four Polish football supporters and took them into custody on the basis of the Police Act (*Poliisilaki*, 872/2011). They were deprived of liberty for 19 hours. The supporters were offered no food during this time. However, they were able to drink water.

According to the Deputy-Ombudsman, nutrition is one of the fundamental human needs. The police investigation of the situation during the period of deprivation of liberty was not an acceptable reason to leave the persons deprived of their liberty without nutrition. The supporters were deprived of liberty for 19 hours and the police should have made sure that they received food. In the worst case, leaving the persons deprived of their liberty without food could have endangered their health. However, this did not arise in this case. According to the Deputy-Ombudsman, the police had severely neglected their obligations under the Police Act. The Deputy-Ombudsman proposed that the police pay recompense for the harm they had caused to the complainants (5304/2017).

According to the statement by the police, the police had reached an understanding with the Polish football supporters concerning compensation for the harm the police had caused. Each of the supporters was paid compensation of EUR 150.

Undignified treatment of a person with a disability in a psychiatric ward

A person whose physical functions were impaired due to cerebral palsy was forced to take her meals using unsuitable dishes and utensils while sitting on a thin mattress on the floor of an isolation room in a psychiatric ward. The complainant wore nappies during the isolation, which lasted for more than 24 hours.

The Deputy-Ombudsman felt that the way in which the patient had been treated in isolation violated their dignity. The Deputy-Ombudsman thus recommended that the Welfare District compensate the complainant for the violations of fundamental and human rights to which the complainant was subjected (3287/2017*).

The Päijät-Häme Federation of Municipalities stated that it had made a commitment to pay EUR 4,500, a sum that it considered reasonable recompense for the violation. In addition, the Welfare Federation made a commitment to comply with the prohibition of discrimination under the Non-discrimination Act (Yhdenvertaisuuslaki, 1325/2014) and to make all necessary and reasonable adjustments for individual patients with disabilities and to otherwise ensure that some patients are not treated less favourably than others due to disabilities. The Welfare Federation made a commitment to train its personnel on non-discrimination and on the obligation to make reasonable adjustments.

Protection of property

Storing the property of a person deprived his/her liberty

The police arrested the complainant on suspicion of a crime. The police left a bicycle used by the complainant at the scene of the arrest. The bicycle was stood up, unlocked, in front of the railway station when the complainant was taken to the police station. The next day, the bicycle was missing.

According to the Police Act, the police must respect fundamental rights and human rights, and, when exercising authority, the police must

take the option that best promotes the implementation of these rights in comparison with the other justifiable alternatives available. In accordance with the principle of minimum intervention as stated in the Act, the police shall not take action that infringes anyone's rights or causes anyone harm or inconvenience more than is necessary to carry out their duty. Persons deprived of their liberty cannot usually take care of their property themselves due to the action of the police. When the police consider the alternative actions, they must take into consideration the protection of property of the person deprived of liberty, as this protection is safeguarded by the Constitution, and the police must take care of the person's property. In this case, this would have meant transporting the bicycle to the police station or at least locking the bicycle.

According to the Ombudsman, there were grounds in this case for making an Ombudsman's proposal on recompense for the complainant due to the loss of the bicycle. However, the police department had already stated that it would begin processing the matter as a claim for damages at its own initiative. As such, there was no need for the Ombudsman to propose recompense (4450/2018).

The police department resolved the case and decided to pay the complainant EUR 200 in damages.

Taking compensation for damages from a prisoner's account

The purchase price of a DVD player broken by the complainant was assessed at EUR 99. The complainant had received a payment of activity allowance amounting to EUR 137.97, and the sum of EUR 99 had been deducted from this for damages. The Deputy-Ombudsman stated that the prison was not entitled to take money from the prisoner's account for damages without the prisoner's consent. It was not relevant to the case whether the matter concerned assets that were already in the prisoner's account or assets that were subsequently remitted to the account, such as, in this case, the earnings paid to the prisoner. If the prisoner does not grant consent, the prison must bring a case for damages to court in order to receive compensation unless an agreement can be reached by other means. According to the Deputy-Ombudsman, the prison should return to the complainant the money taken from their account without their permission (3721/2017).

According to the prison's statement, the money was returned to the complainant's account.

Legal protection and good administration

Processing time in a social security case

A case, which concerned whether the complainant was covered by social security based on residence, was initiated on 31 August 1999 at the Social Insurance Institution of Finland (Kela), which issued a decision on 6 June 2003. After this, the case was handled by the review panel, the Social Security Appeal Board, the Insurance Court and the Supreme Administrative Court. The case took approximately 12 years to be processed at the various instances of appeal. From the date when the case was initiated until 9 June 2015, when the Insurance Court issued decisions to the effect that the complainant ultimately was considered to be covered by Finnish social security, a total of almost 16 years had elapsed.

The Act on Compensation for the Excessive Length of Judicial Proceedings (*Laki oikeudenkäynnin viivästymisen hyvittämisestä*, 362/2009, referred to as the Compensation Act) was amended and the Act became applicable in the Administrative Courts as of 1 June 2013. As the complainant's case was initiated for the final time at the Insurance Court in January 2013, the judgment issued by the Insurance Court on 9 June 2015 included the assessment that the complainant's case was not subject to the Compensation Act on the grounds of the provision of the Act concerning its entry into force. The Supreme Administrative Court later issued a judgment on 17 September 2015 (KHO 2015:139) interpreting the provision of the Act concerning its entry into force differently than the Insurance Court.

According to the Deputy-Ombudsman, the complainant's appeal was not processed within a

reasonable time and without undue delay as called for by section 21, subsection 1 of the Constitution and Article 6 (1) of the European Convention on Human Rights. The Deputy-Ombudsman found that public authority was unable to safeguard the realisation of the complainant's fundamental rights and human rights as required by section 22 of the Constitution. Using the means available to it, the Insurance Court strove to prevent a fair trial from being further jeopardised in the complainant's case. When the it evaluated the evidence presented in the case, the Insurance Court took into consideration the fact that it had apparently become impossible to acquire reliable additional information due to the length of time that had elapsed and that the complainant should not suffer detrimental consequences as a result of this. When it assessed the amount of compensation for the legal expenses incurred by the complainant, the Insurance Court also took into consideration the unreasonably long time taken to process the case for reasons that were not attributable to the complainant.

According to the Deputy-Ombudsman, the need to effectively realise fundamental and human rights requires that, in situations where there has been a failure to realise the right to have a matter processed without delay and where it has been deemed that the Compensation Act does not apply, the party concerned has a right to appropriate recompense for the worry, uncertainty and other comparable harm suffered due to the delay in proceedings. At least, this is how it must be in cases as glaring as the one considered here.

The Deputy-Ombudsman sent the decision to the State Treasury and asked it to contact the complainant in a suitable manner and settle the matter as provided in the State Indemnity Act (*Laki valtion vahingonkorvaustoiminnasta*, 978/2014) (3997/2017).

In its decision dated 19 April 2018, the State Treasury considered that the complainant was entitled to compensation for delays in court proceedings due to the worry, uncertainty and other comparable harm caused by the circumstances. The State Treasury assessed the reasonable sum of recompense as EUR 10,000.

Waiting times for financial and debt counselling in the city of Oulu

The assessment of the customer's financial position – a necessary procedure in order to provide the complainant with actual debt counselling – only took place approximately five months after the case was initiated. The complainant had an appointment with a debt counsellor in May 2017, so the waiting time for new customers, which is used as an indicator of the availability of financial and debt counselling, was more than six months in the complainant's case. According to information received subsequently, the examination of the case had proceeded within a reasonable time, such that a debt restructuring application was submitted to the District Court and, after the schedule of payments was reviewed, the customer relationship ended in August 2017.

According to the Deputy-Ombudsman, the City of Oulu's financial and debt counselling services in the complainant's case or, more generally, at the time referred to in the case did not correspond to the immediacy requirement. The reference level, and the national target for satisfactory service, is 60 days from the beginning of the customer relationship, and the time taken in the Oulu case was approximately three times as long. It is particularly important for action to be taken quickly in the early phases of debt counselling for several reasons, including the fact that clarifying the customer's eligibility for debt restructuring and submitting an application to begin debt restructuring guarantee that debt enforcement through distraint can be suspended more quickly when the District Court has approved a debt restructuring application.

According to the Deputy-Ombudsman, the delay in processing was ultimately due to the resourcing for financial and debt counselling, inadequate steering and measurement methods, and an ambiguous division of responsibilities, which the legal compliance personnel had been reporting to the relevant authorities for many years. According to the Deputy-Ombudsman, when a municipality takes responsibility for arranging financial and debt counselling, it is also responsible for realising the guarantees of good administration ensured by

the Constitution. The Deputy-Ombudsman proposed that the City of Oulu pay the complainant recompense for the harm caused by its actions in contravention of the immediacy requirement of good administration (1210/2017).

The City of Oulu stated that it had sent a letter to the complainant offering its apologies for the unreasonable length of time taken for the complainant's case to be handled by the financial and debt counsellors and for the fact that immediacy had not been realised as ensured by the Constitution.

Traffic warden's decision on a claim for rectification

The complainant had suddenly been forced to stay in hospital for treatment. The attending physician had provided the complainant with a certificate for the traffic control agency to show that the complainant was unable to move his car. Despite the evidence provided, the traffic warden did not consider the complainant's situation to be unforeseeable. According to the traffic warden, the complainant could have paid the parking fee using a mobile phone. According to the Deputy-Ombudsman, the traffic warden exercised discretionary powers in a way that was not intended by the law. Additionally, the traffic warden's assessment did not take into consideration the principle of proportionality; in other words, the traffic warden did not consider whether affirming the parking fine was reasonable in the complainant's situation. The traffic warden did not consider the complainant's legitimate expectations, since the attending physician's certificate stated that the complainant was unable to move their car. The Deputy-Ombudsman asked the city to consider whether it should compensate the complainant for the traffic warden's misjudgment and return the parking fine imposed on the complainant (4825/2017*).

According to the city's statement, it returned the parking fine to the complainant.

The traffic warden's actions when imposing a parking fine

In early 2016, the complainant enquired about the legal guidelines on which the traffic warden's actions were based when the traffic warden issued a new decision overturning the parking fine imposed on 8 December 2015 while the complainant's appeal was pending at the Administrative Court. According to the decision by the traffic control agency dated 1 February 2016, the complainant's demand for rectification on 28 January 2016 had been approved. The complainant requested the demand for rectification that was referred to in the decision. The complainant was not informed of the grounds for the actions, nor was their information request processed and nor was any guidance issued on the case as provided for by the Act on the Openness of Government Activities (*Laki viranomaisten toiminnan julkisuudesta*, 621/1999). The parking fine imposed on the complainant on 8 December 2015 was paid back into the complainant's account on 20 April 2018. According to the complaint, the parking fine imposed on the complainant on 1 November 2016 was not returned. According to the clarification, it was paid into the complainant's account on 30 December 2016.

According to the Deputy-Ombudsman, the city's parking control agency neglected to provide the complainant with the appropriate service and advice for which authorities are responsible under the foundations of good administration. The complainant's parking fine was not returned immediately and conflicting information had been given concerning the return of the second fine. In addition, in the account provided by the city of the complaint, the city did not state which legal guidelines formed the basis for its action to adjust the decision issued due to the demand for rectification, nor did it clarify why the procedures stipulated in the Act on the Openness of Government Activities were neglected when the complainant's request for information was processed. The Deputy-Ombudsman considered this negligence by the city to be unlawful. The Deputy-Ombudsman proposed that the city should consider whether there was good reason to pay recompense to the complainant for the negligence that had occurred and

for the unreasonable delay in returning the parking fine (906/2018).

According to a statement by the city's traffic control agency, an apology was made to the complainant for the inconvenience caused in the case and, according to the traffic control system, both of the fines were returned to the complainant.

3.7.2 CASES RESULTING IN AN AMICABLE SETTLEMENT

In numerous cases, communication from the Ombudsman's Office to the authority during the handling of complaints led to the rectification of the error or insufficient action and, therefore, an amicable settlement. Examples of such cases are presented below.

Preliminary investigation

The complainant's house was burgled in February 2017. The complainant was in prison at the time but his friend reported the incident to the police. The complainant was critical of the fact that the investigation into the case was discontinued without the complainant even being asked what was stolen. The complainant called the police in September 2017 but no progress had been made on the case.

The complainant – the injured party in the crime – had not been heard during the preliminary investigation. The crime was serious in nature and there was significant interest in solving it. When crimes against property are investigated, it is essential to obtain as much detail as possible about the stolen property from the injured party. This information is important in order to evaluate whether the crime constitutes an aggravated offence, including the amount of loss or damage incurred due to the crime, and to contribute to recovering the stolen property. As such, the complainant should have been contacted during the preliminary investigation, at least to identify what was stolen. In this regard, the preliminary investigation was not conducted properly. There were no suspects in the case.

According to the Deputy-Ombudsman, as the relevant information would have been obtained by hearing the injured party, there were no grounds to discontinue the investigation. The case did not require further action by the Deputy-Ombudsman as the police department stated that it had decided to continue the preliminary investigation (6510/2017).

The complainant suspected that a contractor who had renovating the plumbing in the complainant's house had invoiced the complainant for hours that the contractor had not worked. The complainant had monitored the hours that the contractor worked on the site. Supplies were also invoiced at an excessive price and, furthermore, the complainant was invoiced for supplies that they did not even have. The complainant had visited a police station and, according to the complainant, the police officer present said that the case bore the hallmarks of fraud. The complainant was instructed to file a request for investigation with the inspector, after which the complainant would be invited to a hearing.

The detective inspector reviewed the material that the complainant sent to the police and, on this basis, made a decision concerning a preliminary investigation on 12 April 2018. In the decision, the detective inspector judged that the available material did not give cause to suspect a crime and that it was not necessary to hear the complainant.

According to the Ombudsman, it would have been justified for the police to investigate the incident further and, for example, hold a preliminary discussion with the complainant. Only once the police had received detailed information on the complainant's version of events would it have been possible to fairly assess whether there was cause to suspect a crime. The Ombudsman asked the police department to communicate any further action that it would take to resolve the case (2165/2018).

According to the police department's statement, a new notice of investigation had been recorded for the case.

Decision on issuing an identity card

The complainant was not issued an identity card with travelling rights because he was a prisoner. The identity card was valid for several years after the date when the complainant would be released on parole. According to the complainant, the fact that some prisoners had passports or identity cards with travelling rights, which would enable them to leave the country, was discriminatory.

According to the Deputy-Ombudsman, the complainant should have been heard in regard to the need for an identity card with travelling rights and the investigation that formed the basis for issuing an identity card with restrictions. In addition, the Deputy-Ombudsman stated that the decision on the identity card only stated the applicable legal provisions but not which issues and clarification had affected the decision. As such, the grounds for the decision were, in essential regard, inadequate. In addition, the directions for appeal were not attached to the decision.

Therefore, the decision concerning the complainant's identity card was encumbered by two other serious procedural errors in addition to the neglect of the appeal directions. The Deputy-Ombudsman asked the police department to state the measures it had taken as a result of the foregoing (4212/2017).

The police department restarted processing the decision on the complainant's identity card and the complainant was asked for clarification of matters that may be significant in considering whether to issue an identity card with travelling rights during a custodial prison sentence and of the needs and reasons for which the complainant should be granted an identity card with travelling rights.

Archival of emails at the Police Traffic Safety Centre

The complainant did not receive a response from the Police Traffic Safety Centre to an enquiry on how the driving speed, which led to a traffic fine, was measured and whether the measuring equipment was properly calibrated. According to the information obtained, the Police Traffic Safety Centre receives just under 100 emails every day. Responses to emailed feedback are not registered on any system, nor is it possible to retrospectively verify the content or date and time of sending. Therefore, it is also not possible to demonstrate that the complainant's message was replied to.

The Ombudsman found it dissatisfactory that the Police Traffic Safety Centre was unable to show whether it had replied to the complainant and what, if any, message was sent. According to the complainant, no reply was received, and the Ombudsman had no cause to doubt this. The question did not concern the individual case; instead, it was about the operating method selected by the Police Traffic Safety Centre. The Ombudsman agreed with the Helsinki Police Department's view that the Police Traffic Safety Centre should enhance the monitoring of its customer service email account and create a monitoring system that enables retrospective verification, for a period of at least one year, that every message received from the public is responded to. The Ombudsman requested a statement of the measures taken in the case (7076/2017).

According to the police department's statement, the Police Traffic Safety Centre deployed an automatic email archiving system, which automatically transfers the emails in the "Sent" folder to the "Police Administration's projects" folder once a day. The same practice is used by entities such as the Helsinki Police Department's registry. The police department considers the problems of archiving outgoing emails at the Police Traffic Safety Centre to have been resolved by the foregoing measures.

Entitlement to daily unemployment allowance

An unemployment fund had rejected the complainant's application for an earnings-related unemployment allowance on the grounds that it had not received the information necessary to resolve the case. When the Office of the Parliamentary Ombudsman sent a request for clarification in relation to the complaint to the unemployment fund, it noticed that the decision it had issued was incorrect. The unemployment fund stated

that it would rectify the decision and process the application for an earnings-related unemployment allowance again.

In the view of the Deputy-Ombudsman's deputy, the processing of the complainant's unemployment benefit case had been unduly delayed as a result of the unemployment fund neglecting its duty of care when processing the application for an earnings-related unemployment allowance and the unemployment fund had originally rejected the application on grounds that were found to be erroneous. When assessing the blameworthiness of the actions, the Deputy-Ombudsman's deputy took into consideration the fact that the unemployment fund had subsequently altered the decision it had made (1416/2018).

Taxation of a pension received from Estonia

The taxation of the complainant's pension income from Finland and Estonia was inadequately investigated at a tax office in conjunction with the execution of the taxation for 2015. The taxation of the pension received from Estonia was executed without eliminating double taxation. The official who executed the taxation for 2016 attempted to clarify the matter with the international taxation specialists at the tax office. However, these specialists also arrived at an incorrect interpretation on this occasion.

When the tax office received clarification, which was issued by the Tax Administration's Individual Taxation Unit as a result of the complaint, on the taxation of pension income received from Estonia based on social security legislation and the elimination of double taxation, it began taking immediate measures to adjust the taxation for 2015 in favour of the taxpayer and to rectify the taxation for 2016, which had not been completed at that point. The calculation of the withholding tax rate for 2017 was also corrected. According to a statement from the Tax Administration, its training will focus on taking due care when investigating cases and in applying the regulations of tax agreements.

Due to the action taken by the Tax Administration, the Deputy-Ombudsman was content to draw the Tax Administration's attention to its obligation to ensure that cases are investigated properly and sufficiently (4594/2017).

Service in Swedish at a Regional State Administrative Agency

The complainant had sent a message in Swedish to a Regional State Administrative Agency. The complainant had initially received a response from an officer in Finnish stating that the matter did not fall within the area of responsibility of occupational health and safety and that the complainant's message had been transferred to the fire and rescue services' area of responsibility. The complainant subsequently received a response from this area of responsibility in Finnish. Based on the complaints, the agency issued a clarification stating that the agency had begun taking measures to ensure that service was provided in both national languages of Finland. The agency apologised for the incident and stated that a decision was subsequently sent to the complainant in Swedish. For this reason, the complaint did not require further action from the Ombudsman (3205 and 6222/2017).

3.8 Special theme for 2018: Right to privacy

3.8.1 PREAMBLE

For the first time, the special theme for the Office of the Ombudsman for the year under review was 'Right to privacy'. This special theme for 2018 will be prominent in all inspection visits as appropriate for each site. The theme will also be taken into account in other activities, such as when considering unprompted visits. Right to privacy will also continue as the special theme for 2019. The special themes of previous years include 'Right to effective legal remedies' in 2016 and 2017, and 'Guaranteeing the rights of persons with disabilities' in 2014 and 2015.

The starting points for the special theme on privacy were the provisions on the protection of private life set forth in section 10 of the Constitution of Finland and the provisions on the protection of private and family life set forth in Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (also: European Convention for Human Rights, ECHR). Both the Constitution and the ECHR refer to the concept of 'private life', which is commonly equated to 'privacy'. In legal usage, the broader concept of privacy is now used rather than private life.

According to Article 7 of the Charter of Fundamental Rights of the European Union, "everyone has the right to respect for his or her private and family life, home and communications." According to Article 8, Section 1, "everyone has the right to the protection of personal data concerning him or her." Provisions on the right to privacy are also set forth in the United Nations' key conventions on human rights, such as the International Covenant on Civil and Political Rights (ICCPR, Article 17), the Convention on the Rights of the Child (UNCRC, Article 16) and the Convention on the Rights of Persons with Disabilities (CRPD, Article 22). The Universal Declaration of Human Rights also has provisions on the protection of privacy (UDHR, Article 12).

3.8.2 VIEWS ON THE SPECIAL THEME IN LEGALITY CONTROL

Respect for a person and their self-determination requires guaranteeing their right to privacy. Privacy should be analysed in relation to the right to self-determination. In principle, individuals have the right to be let alone in relation to others in society (public power, employer, etc.), as provided by law, or legislation may be used to restrict the right to privacy.

Special attention must be paid to the right to privacy in the treatment of special groups or with persons who are in a vulnerable or subordinate position (e.g. children, elderly persons, persons with disabilities, foreign nationals, health care, social welfare services, loss of liberty). Privacy issues related to the above persons may also cover, for example, their guardian, trustee, assistant (including interpreter) or caregiver.

The following is a summary of individual observations of practices that either promote or hinder the realisation of the right to privacy, mostly made during on-site inspections visits.

PREMISES OF A PUBLIC AUTHORITY OR INSTITUTION

During inspections, attention has been paid to the appropriateness of the public authority's premises, especially from the perspective of guaranteeing the privacy of persons using or placed in the premises. Public authorities must arrange the provision of their customer services in such a manner that the customer's basic right to protection of privacy

will not be jeopardised. The sections of the premises intended for the use of services must be suitable for the processing of confidential information and keeping a confidential conversation private, without the presence of others. If the premises are used to keep or accommodate people, such as persons deprived of their liberty or placed in involuntary treatment, in addition to the above, attention will also be paid to the sufficient number of rooms, how the rooms have been furnished, and supervision. The poor condition of the premises also presents problems to their functionality. For example, the building stock of the Finnish police was mostly built in 1960s to 1980s and many police stations are now nearing the end of the building's useful life.

In an inspection of a care home for persons with disabilities, from the perspective of arranging home-like accommodation and guaranteeing the protection of privacy, the inspectors found it to be a shortcoming that not all of the residents had their own toilet and shower facilities in their apartment. At a general level, the Parliamentary Ombudsman's view was that, based on the principles set forth in the CRPD and the protection of privacy, each disabled person living in a housing service unit should have their own room with their own bathroom (1376/2018).

According to chapter 4, section 20 a of the Act on the Treatment of Detained Foreigners and on Detention Units (the Detention Act), all the spaces of a detention unit may be monitored with surveillance cameras. No other administrative brach that has premises for keeping persons deprived of their liberty has a statutory right to use surveillance technology in as wide a scope as the one specified in the Detention Act. However, recording surveillance cameras are not allowed in certain areas of detention units – such as the accommodation space, toilet and shower room. The only exception to this are facilities in which persons are kept in isolation – such facilities are not considered as accommodation space and the use of recording camera surveillance is allowed in them.

Based on the observations made at the detention unit during the on-site inspection visit, it is questionable whether a shower room in facilities for keeping persons in isolation needs to have camera surveillance. If an individual case requires that the person is constantly supervised, for example, due to a risk of self-harm, having someone monitor them in person when they take a shower would be a better alternative. The Parliamentary Ombudsman found the situation to be particularly problematic for the right to privacy of foreign persons placed in the detention unit.

Furthermore, it was noted that toilets and shower rooms in facilities for keeping persons in isolation are for both male and female detainees placed in isolation. Supervision is carried out by both male and female detention unit employees and, in the Parliamentary Ombudsman's view, the sex of the person carrying out the supervision is not decided on the basis of the sex of the person being supervised, meaning that a male supervisor may be supervising a female detainee. The supervised person is not aware of who is watching them and cannot know whether there are more than one person in the control room. Being aware of being watched while taking a shower may affect a person's willingness to wash themselves at all (5145/2018).

Attention was paid during on-site inspection visits to police prisons on the Personal Data Act's requirement to clearly communicate that camera surveillance is being used. In principle, meetings between a person deprived of their liberty and their legal counsel must be kept confidential. If such a meeting is arranged in a room that has a camera, the camera must be covered or it must be clearly communicated that the camera has been turned off, unless the meeting is a supervised meeting (2485, 2486, 2487, 2489 and 2490/2018).

Attention was paid during on-site inspection visits to prisons to the supervision of the premises in prisoners' use. During one prison inspection, the inspectors saw a surveillance camera in the ceiling of the cells' maintenance room. The inspectors entered the prison ward's control room to have a look at what kind of a view the surveillance camera provided to the cell. The view to the toilet had not been blocked by covering the camera lens or

the monitors. In other words, this was a failure to guarantee the right to privacy of the person deprived of their liberty using the toilet (2338/2018).

During one on-site inspection visit to a prison, it was discovered that camera surveillance is on in the prison's facility for keeping a person in isolation, i.e. the isolation cell, the whole time that a prisoner is kept there. The prison had failed to pay attention to the fact that a prisoner may only be monitored through camera surveillance in a cell if the prisoner has been placed under observation or in isolating observation, and not under any other circumstances (2339/2018).

The Deputy-Ombudsman noted in connection with an on-site inspection visit to a prison that the phone allocated for prisoners use must be placed or covered in such a way that a normal phone conversation cannot be heard by outsiders. Marking an area around the phone with tape is not sufficient to protect the privacy of a phone conversation. The prison had taken measures to convert storage closets into phone booths (4065/2017).

When inspecting a so-called prisoner compartment of a train used to transfer prisoners, the way that the prisoners had to use the toilet with the other prisoners present was considered to be in violation of decent treatment and protection of privacy. It is degrading not only to the prisoner using the toilet but also to the other prisoners present in the compartment. The situation could not be helped by installing a privacy screen. Prisoners must be allowed to use a separate toilet without others present and they must know that they have this opportunity. As such, the inspectors did not have reason to doubt the guards' statement when they told that the prisoners were allowed to use the toilet alone; however, if the prisoners did not know that they had this opportunity, it is almost the same as not having the opportunity at all. The opportunity must be communicated clearly enough and also with due consideration of prisoners who do not speak and/or understand Finnish (2648/2018).

Questions regarding the appropriateness of premises for guaranteeing the right to privacy were also raised during on-site inspection visits of garrisons. As the headquarters were located underground, the military chaplain and conscripts could not have private conversations due to the lack of an appropriate space. This also raises the threshold to make contact at all. Some conversations with the military chaplain had to be carried out in the barracks corridors, which could not be deemed as a satisfactory solution for the protection of privacy. In some cases, the military chaplain had gone jogging with a conscript or invited a conscript to a facility located outside the garrisons in order to ensure that their privacy was protected (5300/2018).

Complaints concerning health care raised the issue of considering persons working at a certain unit, who do not participate in the treatment of a patient or in any related tasks, as outsiders in that patient's treatment. In other words, they should also be taken into account in order to protect the patient's privacy. The disclosure of confidential information to outsiders must be prevented using space solutions or by other means (249/2018).

Complaints lodged by prisoners, in which attention has been paid to the way right to privacy has been guaranteed, often concerned medical procedures or inspection measures targeted at the prisoner lodging the complaint. A common denominator in these cases is that the procedure has been attended – without need or justification – by supervisory staff members deemed as outsiders. As a rule, health care professionals should meet their patients without any outsiders present during treatment – in this case, guards – being able to see or hear what is going on. When security concerns require, the situation should be arranged in collaboration with the care staff so that the patient's privacy is interfered as little as possible (e.g., 5072/2017 and 951/2018).

A complaint lodged with the Parliamentary Ombudsman criticised one branch office of the Employment and Economic Development Services (TE Office) for failure to protect the privacy of

customers. In the TE Office concerned, customers were forced to talk about their case in the lobby area. The Substitute Deputy-Ombudsman noted that customer services must be organised in such a manner that customer data falling within the scope of the protection of privacy will not be disclosed to outsiders. When a customer unprompted starts to provide sensitive information in the TE Office's lobby area, under section 8 of the Administrative Procedure Act, it would be justified to let the customer know that such information does not need to be disclosed and that the customer's privacy cannot be protected in the lobby area, should they unprompted want to continue to provide such sensitive information to the official. Taking such measures would enable the public authority to guarantee the protection of privacy of customers (686/2018).

Procedures of a public authority

The employees of a public authority play a key role in the practical implementation of guaranteeing the right to privacy. Public authority employees are expected to know the basics of using measures to restrict the freedom of individuals subject to the measure, how to implement the measure in practice, and any alternative approaches, in order to minimise the violation of the privacy and immunity of the individual subject to the measure. Public authority employees must be familiar with the non-disclosure and secrecy obligations applicable in their administrative branch, as well as the procedures for handling secret information. Where possible, on-site inspection visits include observing the general attitude, behaviour and professional competence of public authority employees, and the way in which customers are treated.

On-site inspection visits to child welfare institutions have revealed that child welfare institutions do not always take decisions on the use of restrictive measures, as required by law, especially in matters concerning freedom of movement, right to keep in contact and possession of personal effects, nor do they provide children with service of decision as a party concerned in the manner specified in the Administrative Procedure Act. Based on what the children have said, they are unlawfully forced to take their clothes off when they are searched for prohibited substances and objects (1116 and 1353/2018).

Personal data protection and information security are also part of privacy protection. When conducting an on-site inspection visit at a police department, one particularly problematic issue was the staff's concerns about the presence of renovation company workers in the police department's premises. Despite having presumably carried out a security clearance on all persons working inside the police department, the staff were uncomfortable about the constant presence of a changing array of outside workers in the premises. For example, this required paying special attention to locking the doors of personal offices and to the secrecy and non-disclosure obligations in general. It was also found problematic that no security clearance had been carried out on the persons working outside the building (1610/2018).

An inspection targeted at the immigration police included discussing the returning of foreigners to their home country. According to the police, most of the returns are conducted in such a manner that the other passengers on the plane do not notice it. The police officers escorting the returned person enter the plane first, wearing civilian clothes. The returned person is allowed to use the toilet alone. Whilst in a transit country, other than public routes will be used to transfer the returned person to avoid drawing attention. Information is only provided to the receiving authority on a need-to-know basis. Other passengers are not allowed to take pictures of the returned person, only the people they are travelling with (this is based on airline rules and regulations). These are all measures taken by the police to guarantee the returned person's right to privacy (1658/2018).

Institutions must ensure that persons deprived of their liberty do not have to provide the guard of the facilities they are kept in why they want to see a doctor. The guard will put their name on a list that will be delivered to the doctor (1488/2018).

3.9 Statements on basic rights

This section discusses some of the statements on basic rights made during the course of the Ombudsman's oversight of legality. The section focuses exclusively on individual decisions that involve a new aspect of basic rights, or are significant in principle in some other way. Such cases are also referred to in section 3.6, in which the Ombudsman's decisions, including a recommendation for compensation, were discussed.

Setting a maximum age limit for basic education in arts constituted discrimination

Institutes giving basic education in arts had set maximum age limits for their student selections. One justification for the decision was that otherwise the students would not be able to complete their studies before reaching the age of 29 that has been laid down in the Youth Act.

In accordance with the act on basic education in arts, the education is primarily provided for children and young people. The selection criteria should be equal for every applicant. In accordance with the Non-Discrimination Act, no one must be discriminated against on the basis of age. Different treatment does not constitute discrimination if the treatment is based on legislation, otherwise has an acceptable objective and the measures for attaining the objective are proportionate. However, different treatment is justified even if there is no legislation on the justification, if the treatment has an acceptable objective in terms of fundamental and human rights, and if the measures for attaining the objective are proportionate. This provision is not applied to exercising official authority, performing public administration duties or receiving education.

According to the Deputy-Ombudsman, setting maximum age limits is not possible by decisions of the education provider or the institute. If a maximum age limit was to be set for the basic education in arts, it should be laid down in law.

The Deputy-Ombudsman found that the behaviour constituted discrimination under the Non-Discrimination Act, if a person had been denied access to basic education in arts based on his or her age and if such denial was not explicitly supported by law. The Deputy-Ombudsman considered it to be understandable that in a legally ambiguous situation, the institutes tried to implement a practice that would treat students in the same age group equally and in a predictable way. This practice, however, was only seemingly equal, and it was actually discriminating between various students based on their age and without any supporting law (6832/2017).

Reasonable accommodations to student mealtimes

The Ombudsman evaluated, from the basis of non-discrimination, a policy adopted by a university of applied sciences for making reasonable accommodations for students with health issues to be able to take their meals.

The duration of the lunch break was in itself the same for all of the students. From this viewpoint, it seemed that everyone received equal treatment. In reality, however, the duration of the lunch break or its arrangement might have put the student in disadvantageous position, as his or her health required a certain type of mealtime option. Based on this, the Ombudsman concluded that this might have been a case of indirect discrimination.

The Ombudsman felt that the medical condition in question could have been considered a disability within the meaning of Section 15 of the Non-Discrimination Act and Article 24 of the United Nations' Convention on the Rights of Per-

sons with Disabilities, making the requirement of reasonable accommodation applicable to the case. One significant consideration in the evaluation was the nature of the disability and whether it could hinder the person's full and effective participation in society – in this case in education and in student community – on an equal basis to others.

As the denial of reasonable accommodations is determined as prohibited discrimination in the Non-Discrimination Act, the Ombudsman urged the university of applied sciences to investigate the case from the perspective described above and consult with the student in order to find a solution for mealtimes that would enable the student to attend classes in a manner that factored in their unique medical needs (6270/2017).

The language used and equal treatment in home care

Home care is an important part of social welfare and healthcare, and linguistic rights are extremely important for the elderly and people with memory disorders in particular. Only a few customers were satisfied with the services in Swedish. Based on the results of the customer survey, it was deducted that the situation was not in accordance with the regulations regarding the services. The customers have the right to service in whichever official language they choose, Finnish or Swedish.

Social welfare is of poor quality, if the service is unavailable in Swedish for those who wish to have it in that language. Language is a crucial factor in determining the quality of home care. The Ombudsman regarded the situation as problematic also on the basis of equal treatment that is guaranteed as a fundamental right, when the customers requiring home care were treated differently in terms of language. This was not a question of Swedish-speaking people not having the home care service at all, but a question of the language in which the care was provided for them, and thus its quality and differences. The principle of equality includes both the prohibition of discrimination, and the idea of effective equality (724/2017).

Inspecting a prisoner with a mirror violated the prisoner's personal integrity

A prison was performing body searches on prisoners by placing a mirror on the floor. The prisoner had to stand naked on top of the mirror, so that his or her genitals could be inspected. According to the prison, the purpose of this kind of body search was to ensure that no narcotics are taped or hidden in a similar way on the external genital area. The purpose was not to inspect the cavities of the body, as this would have constituted as physical examination.

According to the Deputy-Ombudsman, when a prisoner is required to stand naked over a mirror placed on the floor, it intervenes with personal integrity more than an overall inspection. From a legal point of view, an inspection via a mirror in order to find hidden narcotics is closer to non-intimate body search than intimate body search. Personal integrity is one of the fundamental rights, and it requires that regulations on non-intimate body search and intimate body search are interpreted restrictively rather than expansively.

The conduct had been unlawful. The prison did not pay sufficient attention to the borderlines between non-intimate body search and intimate body search nor to the legitimate conduct of a non-intimate body search (509/2018).

Violating personal integrity and freedom of movement

Ostrobothnia Police Department had drawn an action plan in case of a mass fight between various football fan groups during the match in Vaasa. However, the police did not have any concrete information on such a fight. At Ilmajoki, the police stopped two buses en route from Helsinki to Vaasa. There were people onboard who had been planning to go to see the match in Vaasa. Each passenger's identity and luggage were checked. Also the buses were inspected in order to find out what kinds of items were onboard. After these procedures, the buses and their passengers were turned back to Helsinki.

The Deputy-Ombudsman found that, based on citizens' fundamental right to move freely, it was not necessary nor acceptable to stop the buses in the said situation.

The security check was an infringement on the fundamental right to personal integrity, and there was no concrete evidence to support or justify the suspicion that the persons en route would have dangerous items or goods in their possession. According to the Deputy-Ombudsman, no lawful grounds for the security checks were presented.

Turning the bus back to Helsinki at a location that was quite far from the presumed scene of action involved, according to the Deputy-Ombudsman, a de facto prohibition to arrive at the venue of the match. The preceding was clearly unlawful and violated freedom of movement, one of the fundamental rights guaranteed by the constitution (3230/2017).

Disposing of requested data during a court hearing violated the principle of public access

The Ombudsman considered the Parliament's Security Department to have acted erroneously in disposing of the requested data on visitors before the Supreme Administrative Court was able to arrive at a final judgement on whether such data belonged to the public domain.

The Ombudsman stated that good administration guaranteed in Section 21 of the Finnish Constitution and the foundations of good administration specified in the Administrative Procedure Act include protecting legitimate expectations. This means that the acts of an authority must protect expectations that are legitimate under the legal order. The person requesting information has a justified right to expect that the authority will not render a complaint useless by disposing of related documents during the appeal period. These proceedings would violate the right to appeal guaranteed in Section 21 of the Finnish Constitution and the right to a fair trial under the regulation.

Section 12, Subsection 2 of the Finnish Constitution stipulates that everyone has a right of access to documents in the possession of authorities, if such documents are public. During the appeal period, i.e. when the matter of publicity or confidentiality of the documents are still not settled, the case-specific contents of the publicity principle have not been ultimately determined. If a document is disposed of after the request of information but before the complaint has been legally settled, the outcome effectively violates Section 12, Subsection 2 of the Finnish Constitution, if the court decides to keep the said document public.

In Section 22 of the Finnish Constitution, an obligation has been placed on the public authorities to safeguard fundamental rights, such as the principle of transparency. Disposing of documents in the middle of court hearings on their publicity would impede the application of the principle of transparency, as well as be contrary to the authorities' duty to safeguard fundamental rights.

If the authority had, within its role as a data controller or records creator, determined certain data retention periods and dates for disposal, these periods and dates could not have replaced the constitutional right of access to public documents (4566/2017*) in the said situation.

A No drone zone sign violated the status of national languages

The Ombudsman reviewed the language used in the "No drone zone" signs for restricting the use of remotely controlled camera drones, when the signs were written only in English. The issue was examined from multiple viewpoints relating to fundamental rights.

From the linguistic viewpoint, the signs, as referred to in the Language Act, have to be written in both national languages in bilingual municipalities. Using just a foreign language is possible only in exceptional cases where its usage is based on an international practice. The status of national languages has been guaranteed in the Finnish Constitution, so according to the Ombudsman, their replacement would require a very strong and established international practice, and the existence of such a practice should be then demonstrated.

However, the phenomenon behind the signs is fairly new, and the relating practices are currently taking shape.

The other dimension related to legal protection. The signs defined for the public the no-fly zone, in which the use of a drone contrary to the prohibition might lead to a punishment and seizure of the drone. This emphasized the importance of signs that are understandable for everyone. This legal protection dimension was thus closely connected to communication in national languages.

The third dimension related more generally to the effectiveness of the no-fly restrictions. The purpose of the signs was to increase public awareness of the no-fly zones. Also this emphasized the understandability of the signs.

As the fourth viewpoint, the Ombudsman stated that in all of the dimensions above, linguistic understandability was a key factor in protecting the fundamental right to good administration. According to the Ombudsman, the prohibitory sign in itself was not understandable just based on the illustration, if a person did not already know what the sign was about and if he or she did not understand English.

The Ombudsman found that no sufficiently established international practice was followed, based on which it would have been justified to replace the national languages protected by the Finnish Constitution. Thus, in the prohibitory signs indicating the no-fly zone, either one of the national languages or both of them should be used depending on the linguistic conditions in the said area.

The Ombudsman proposed that the Finnish Transport Safety Agency (Trafi) would take action in the matter and, if necessary, ask for assistance from experts at the Institute for the Languages of Finland (4345/2017 and 2406/2018).

The Population Register Centre neglected the rights of the Sami

The name of a Sami person was not entered with its correct spelling in the Population Information System. For this reason, the name could not be correctly printed out in official documents, such as a passport or in the Kela card. According to the Population Register Centre, it has not been possible to enter all of the letters used in various Sami languages into the Population Information System.

Under Section 17, Subsection 3 of the Finnish Constitution, the Sami, as the indigenous people in Finland, have the right to maintain and develop their language and culture.

According to the Deputy-Ombudsman, it was clear that by virtue of the Finnish Constitution and international conventions that are binding on Finland, the government should have ensured, without undue delay, that the names of the Sami people can be entered in the Population Information System with their correct Sami spelling. This was essential to realising the rights of the Sami people in order to maintain and develop their culture and preserve their identity (3592/2017*).

Kela's (Social Insurance Institution of Finland) policy concerning the healthcare expenses that are accepted for the basic social assistance endangered fundamental rights

In autumn 2017, the Social Insurance Institution of Finland (Kela) changed its policy concerning the granting of basic social assistance for healthcare expenses. Kela's requirement that the expenses must be "essential and necessary" is not based on the wording of the Social Assistance Act, which only requires that the expenses are "necessary". The change reduced the likelihood that basic social assistance customers can obtain medical care and placed them in an inferior position to other people using the same medication and receiving similar treatment. What the Deputy-Ombudsman considered as a major problem, was the fact that

Kela's interpretation could have endangered the continuity of necessary medical treatment for basic social assistance customers and that it could have limited their access to sufficient and necessary health services. Also based on the principle of legitimate expectations, the procedure gave rise to criticism.

In its public statement, Kela referred to addressing the abuse of medication, and from this viewpoint, the proceedings seemed to stigmatize basic social assistance customers. In Kela's guidelines, certain medication was categorically excluded from the basic social assistance, which was discriminating in itself. In terms of good administration, Kela seemed to exceed its authority, as its purpose is not to supervise the actions of healthcare professionals (6468/2017*).

3.10 Complaints to the European Court of Human Rights against Finland in 2018

A total of 174 new applications against Finland were lodged with the European Court of Human Rights (ECHR) in 2018 (181 in the previous year). A response from the Finnish Government was requested in 5 cases. At the end of the year, 20 (14) cases concerning Finland were pending.

Applications must be submitted by using the form drawn up by the ECHR Secretariat, complete with the required information and copies of all supporting documents. The Court will not examine a complaint that does not contain the requisite information or documents.

The decision on the admissibility of an application is made by the ECHR in a single-judge formation, in a Committee formation or in a Chamber formation (7 judges). The Court's decision may also confirm a settlement, and the case is then struck out of the ECHR's list. Final judgments are given either by a Committee, a Chamber or the Grand Chamber (17 judges). In its judgment, the ECHR resolves an alleged case of a human rights violation or confirms a friendly settlement. A very high share of the applications lodged with the ECHR are declared inadmissible.

In 2018, an application was declared inadmissible or struck out of the Court's list in 170 (217) cases that concerned Finland. In 2018, the ECHR did not issue any judgments concerning Finland (2 in 2017 and 1 in 2016).

The total number of judgments issued by the ECHR to Finland by the end of 2018 was 188. The total number of ECHR judgments confirming a violation of rights by Finland since the country's accession is considerably high, at 140 (approximately 75% of all judgments). Of these, 99 were judgments confirming a violation of rights relating to the duration of court proceedings or shortcomings in the implementation of a fair trial. Whereas Sweden, Norway, Denmark and Iceland have been State Parties to the ECHR for considerably longer than Finland, the Court has only ruled against them in a total of 123 cases. However, the differences have levelled out in recent years.

Monitoring of the execution of ECHR judgements in the Committee of Ministers of the Council of Europe

The Committee of Ministers of the Council of Europe monitors the execution of ECHR judgments. The monitoring carried out by the Committee focuses on three different aspects: the payment of compensation, individual measures, and general measures taken as a result of a judgment. The monitoring primarily takes place by diplomatic means.

Where necessary, the Committee of Ministers can refer a question of execution to the ECHR for confirmation. Within six months of the ECHR judgment becoming final, the states shall submit either an action report or an action plan comprising a report on any measures that have been taken and/or that are being planned. The reports are published on the Committee of Ministers' website.

No new monitoring cases were initiated during the year under review. Monitoring of execution remained pending in 29 (42) judgments concerning Finland.

4 Covert intelligence gathering

4
Covert intelligence gathering

The oversight of covert intelligence gathering fell within the remit of Parliamentary Ombudsman *Petri Jääskeläinen*. The principal legal adviser responsible for the area was *Mikko Eteläpää*. Other legal advisers responsible for the area included *Minna Ketola* and *Juha Haapamäki*.

Covert intelligence gathering refers first of all to the covert coercive measures used in criminal investigations and to the corresponding covert methods of gathering intelligence that may be used to prevent or detect offences or avert danger. Such methods include, for example, telecommunications interception and traffic data monitoring, technical listening and surveillance as well as undercover operations and pseudo purchases. The use of these methods is kept secret from their targets and to some extent they may, based on a court decision, remain permanently undisclosed to the targets.

The police have the most extensive powers to use covert intelligence gathering, but the Finnish Customs also have access to a wide range of covert methods of gathering intelligence with respect to customs-related offences. The powers of the Finnish Border Guard and the Defence Forces are clearly more limited.

This chapter also discusses a report on the witness protection programme submitted to the Parliamentary Ombudsman. The witness protection programme act (*laki todistajansuojeluohjelmasta* 88/2015) entered into force on 1 March 2015. According to the act, the Ministry of the Interior must annually report to the Parliamentary Ombudsman on decisions and measures taken under the act.

4.1 SPECIAL NATURE OF COVERT INTELLIGENCE GATHERING

Covert intelligence gathering involves secretly intervening in the core area of several fundamental rights, especially those concerning privacy, domestic peace, confidential communications and the protection of personal data. Its use may also affect the implementation of the right to a fair trial. For intelligence gathering to be effective, the target must remain unaware of the measures, at least in the early stages of an investigation. Thus, the parties at whom these measures are targeted have more limited opportunities to react to the use of these coercive measures than is the case with "ordinary" coercive measures, which in practice become evident immediately or very soon.

Due to the special nature of covert intelligence gathering, questions of legal protection are of accentuated importance from the perspective of those against whom the measures are employed and more generally the legitimacy of the entire legal system. The secrecy that is inevitably associated with covert intelligence gathering exposes the activity to doubts about its legality, whether or not there are grounds for that. Indeed, an effort has been made to ensure legal protection through special arrangements both before and after intelligence gathering. Their key components include the court warrant procedure, the authorities' internal oversight and the Ombudsman's oversight of legality.

4.2 OVERSIGHT OF COVERT INTELLIGENCE GATHERING

Courts

To ensure legal protection, it has been considered important that telecommunications interception and mainly also traffic data monitoring can only be carried out under a warrant issued by a court. These days, undercover operations during a criminal investigation also require authorisation from a court (Helsinki District Court). Depending on the target location, technical surveillance can in some cases also be carried out on the basis of the authority's own decision without court control. The same applies to the majority of other forms of covert intelligence gathering. The decision-making criteria laid down by law are partly rather loose and leave the party making the decision great discretionary power. For example, the "reason to suspect an offence" threshold that is a basic precondition for issuing a warrant for telecommunications interception is fairly low.

Requests concerning coercive measures must be dealt with in the presence of the person who has requested the measure or by using a video conference – written procedures are only allowed under limited circumstances when renewing an authorisation. When considering the prerequisites for using a coercive measure, a court is dependent on the information it receives from the criminal investigation authority, and the "opposing party" is not present at the hearing. The only exception is on-site interception in domestic premises: in these cases, the interests of the target of the coercive measure are overseen (naturally without his or her knowing) by a public attorney, usually an advocate or public legal aid.

According to law, a complaint may be lodged with a Court of Appeal against a District Court's decision concerning covert intelligence gathering, with no time limit. Thus, a suspect may even years later refer the legality of a decision to a Court of Appeal for assessment, and some people have done so. In such cases, courts of higher instances establish case law on covert intelligence gathering. The importance of the courts' role in ensuring a suspect's legal protection and in examining the grounds for the requested coercive measure has been highlighted, for example, in the Supreme Court's decisions KKO:2007:7 and KKO:2009:54.

The courts also play a key role with respect to the parties' right of access to information concerning covert intelligence gathering. As a rule, the target of covert intelligence gathering must be notified of the use of the method no later than one year after the use has ceased. Based on the grounds laid down by law, a court may grant permission to postpone the notification or an exemption from the notification obligation. However, it is important to ensure that the total exemption, in particular, is only granted when it is absolutely necessary. In a state governed by the rule of law, measures that interfere with fundamental rights and are kept completely secret can only be allowed to a very limited extent. The Supreme Court has considered the issue of parties' right to obtain information on undercover operations in its decision KKO:2011:27 concerning the Ulvila homicide case, which was widely covered in the media.

On 28 September 2016, the Supreme Administrative Court issued two decisions on public access to documents on covert intelligence gathering by the police (4077, 62/1/15 and 4078, 2216/1/15). The decisions concerned a request for information about regulations concerning the use of covert human intelligence sources by the police and the SALPA system. In its decisions, the Supreme Administrative Court was of the view that the information contained in the regulations regarding the use of covert human intelligence sources, the related safety and security measures and the organisation of the protection of intelligence gathering must be kept secret because, if these were disclosed in public, there is a risk that the identities of human intelligence sources and the police officers involved in the operations would be revealed.

Authorities' internal oversight

The oversight of the use of covert intelligence gathering primarily involves normal supervision by superior officials. Moreover, provisions separately emphasise the oversight of covert intelligence gathering.

Under law, the use of covert intelligence gathering methods by the police is overseen by the National Police Board (apart from the Finnish Security Intelligence Service, Supo) and the heads of the police units using such methods. Responsibility for overseeing the covert intelligence gathering methods used by Supo was transferred to the Ministry of the Interior at the beginning of 2016. At the Finnish Border Guard, the special oversight duties fall within the responsibility of the Border Guard Headquarters and the administrative units operating under it. At Finnish Customs, covert intelligence gathering is overseen by supervisory personnel of Customs and the units employing the methods in their respective administrative branches. At the Finnish Defence Forces, records drawn up on the use of covert intelligence gathering must be sent to the Ministry of Defence.

In addition to various acts, a government decree has been adopted on criminal investigations, coercive measures and covert intelligence gathering (122/2014). The decree lays down provisions on, for example, drawing up records on the use of different methods and reports on covert intelligence gathering. The authorities have also issued internal orders on covert intelligence gathering.

The Ministry of the Interior, the Headquarters of the Finnish Border Guard (which is a department of the Ministry of the Interior), the Ministry of Finance (which governs Finnish Customs) and the Ministry of Defence report annually by 15th March to the Parliamentary Ombudsman on the use and oversight of covert intelligence gathering in their respective administrative branches.

The authorities reporting to the Parliamentary Ombudsman receive a substantial part of their information on the use of covert intelligence gathering from the SALPA case management system. The only exception is the Finnish Defence Forces, which do not – at least yet – use the SALPA system. SALPA is a reliable source of statistical data. However, it does not cover all methods of covert intelligence gathering, such as undercover operations, pseudo purchases and the use of covert human intelligence sources. The superior agencies also receive information on the activities through their own inspections and contacts with the heads of investigation.

The police have centralised all intelligence gathering from telecommunications operators to be conducted through the SALPA system maintained by the National Bureau of Investigation (NBI). The NBI's telecommunications unit oversees the quality of activities and provides guidance to the heads of investigation when necessary. Centralising the activities under the NBI has improved the quality of the functions.

In the police administration, several officials have been granted supervisory rights in SALPA for the oversight of legality. These officials work mainly in the legal units of police departments. Their task is to oversee activities in accordance with the unit's legality inspection plan and by conducting spot checks.

In addition to internal oversight at police departments, the National Police Board also oversees the units operating under it through the SALPA system and by conducting separate inspections.

In accordance with the previously mentioned decree, the National Police Board has established a working group to monitor the use of covert coercive measures and covert intelligence gathering methods. The members of the group may include representatives from the National Police Board, the National Bureau of Investigation, the Finnish Security Intelligence Service and police departments. Moreover, representatives of the Ministry of the Interior, the Border Guard, the Defence Forces and Customs are also invited to participate as members of the group. The group is tasked with monitoring the authorities' activities, collaboration and training, discussing issues that have been identified in the activities and collaboration or that are important for the oversight of legality and reporting them to the National Police Board, proposing ways to improve activities, and coordinating the preparation of reports submitted to the Parliamentary Ombudsman.

Parliamentary Ombudsman's oversight of legality

Overseeing covert intelligence gathering has been one of the special tasks of the Parliamentary Ombudsman since 1995. At the time, it was provided that the Ministry of the Interior would give the Ombudsman an annual report on telecommunications interception, traffic data monitoring and technical listening by the police as well as on technical surveillance in penal institutions. The National Board of Customs submitted a report on the use of the methods by Finnish Customs. The Ministry of Defence and the Finnish Border Guard prepared similar reports on the methods they had used.

In 2001, the scope of the Ombudsman's special oversight was extended to also include undercover operations and in 2005 to cover pseudo purchases. Both measures were only available to the police.

It was not until the beginning of 2014 that the Ombudsman's special oversight duties were extended to cover all covert gathering of intelligence. In addition to the extended powers, the use of these methods has also significantly increased over the years.

The annual reports obtained from various authorities improve the Ombudsman's opportunities to follow the use of covert intelligence gathering on a general level. Where concrete individual cases are concerned, the Ombudsman's special oversight can, for limited resources alone, be at best of a random check nature. At present and in the future, the Ombudsman's oversight mainly complements the authorities' own internal oversight of legality and can largely be characterised as "oversight of oversight".

Complaints concerning covert intelligence gathering have been few, with no more than approximately ten complaints received a year. This is most likely due, at least in part, to the secret nature of the activities. However, it should be noted that covert intelligence gathering operations remain completely unknown to the target only in very rare and exceptional cases. On inspection visits and in other own-initiative activities, the Ombudsman has striven to identify problematic issues concerning legislation and the practical application of the methods. Cases have been examined, for example, on the basis of the reports received or inspections conducted. However, opportunities for this kind of own-initiative examination are limited.

4.3 LEGAL REFORMS

At the beginning of 2014, the Coercive Measures Act and the Police Act underwent a complete reform, including a significant expansion in the scope of regulation concerning covert intelligence gathering. The provisions on the previously used methods were also complemented and specified in the reform (the Finnish version of the 2013 Annual Report, on pages 157–158).

With respect to the Defence Forces, the act on military discipline and crime prevention in the Defence Forces (*laki sotilaskurinpidosta ja rikostorjunnasta puolustusvoimissa* 255/2014) entered into force on 1 May 2014. Under the act, when the Defence Forces conduct a criminal investigation they may use certain, separately determined methods of covert intelligence gathering as referred to in the Coercive Measures Act, such as extended surveillance and technical observation and listening. In the prevention and detection of crimes, the Defence Forces similarly only have access to certain methods of covert intelligence gathering, although the range is wider than in criminal investigations. However, the Defence Forces cannot use, for example, telecommunications interception, traffic data monitoring, undercover operations or pseudo purchases. If these measures are needed, they are carried out by the police.

The act on the prevention of crime by Finnish Customs (*laki rikostorjunnasta Tullissa* 623/2015) entered into force on 1 June 2015. In the act, the powers of Customs were harmonised with those laid down in the new Criminal Investigation Act, Coercive Measures Act and Police Act. One significant change was that Customs were given powers to conduct undercover operations and pseudo purchases, even though the measures are in practice implemented by the police at Customs' request. Moreover, the use of covert human intelligence

sources in the prevention of customs-related offences was harmonised with the provisions of the Police Act and the Coercive Measures Act.

The act on crime prevention by the Finnish Border Guard entered into force on 1 April 2018. The crime prevention provisions currently included in the Border Guard Act were transferred to the new act. In addition to the previous powers, the right to use a basic form of human intelligence source was added to the powers of the Finnish Border Guard.

The government proposals on powers related to intelligence gathering services significant with regard to covert intelligence gathering were processed in the Parliament during the year under review, and at the end of the parliamentary session in 2019, the Parliament passed the legislative package regarding civilian and military intelligence. The legislation regarding the oversight of intelligence was already passed and entered into force on 1 February 2019.

4.4 REPORTS SUBMITTED TO THE PARLIAMENTARY OMBUDSMAN

The following presents certain information on the use and oversight of covert intelligence gathering obtained from the reports submitted by the Ministry of the Interior, the Headquarters of the Finnish Border Guard, the Ministry of Finance and the Ministry of Defence. The precise figures are partly confidential. For example, the covert intelligence gathering activities of the Finnish Security Intelligence Service are not included in the figures presented below.

Use of covert intelligence gathering in 2018

Coercive telecommunications measures under the Coercive Measures Act

The police were granted 2,867 (2,412 in 2017) telecommunications interception and traffic data monitoring warrants for the purpose of investigating an offence. However, in the statistical evaluation of covert coercive measures the most important indicator is perhaps the number of persons at whom coercive measures were targeted. In 2018, simultaneous telecommunications interception and traffic data monitoring activities carried out by the police under the Coercive Measures Act were targeted at 450 (450) suspects, of whom 37 were unidentified. The use of mere traffic data monitoring was targeted at 1,380 (1,426) suspects.

Simultaneous telecommunications interception and traffic data monitoring activities carried out by Customs were targeted in 2018 at 91 (89) persons, and the number of warrants issued was 421 (218). According to Customs, the increase in the number of warrants is explained by the increase in the number of telecommunication terminal end devices and also to some extent by the fact that it is more usual now for the terminal end devices to have two SIM card slots. This means that a warrant for a single physical device may show in the statistics as two warrants.

Traffic data monitoring is on the increase in Customs, and it was targeted at 200 (171) persons, with 630 (476) warrants being issued.

The most common grounds for simultaneous telecommunications interception and traffic data monitoring by the police were aggravated narcotics offences (75%) and violent offences (9%). Within the administrative branch of Customs, the most common grounds were aggravated narcotics offences (92%) and aggravated tax frauds (8%).

The Finnish Border Guard used telecommunications interception and traffic data monitoring much less frequently than the police and Customs. One simple reason for this is that under the law the Border Guard can only use coercive telecommunications measures in the investigation of a few specific types of offences (mainly aggravated arrangement of illegal immigration and the related offence of human trafficking). Altogether 77 warrants (92) were issued to the Finnish Border Guard for telecommunications interception, traffic data monitoring and for obtaining base station data.

In the Finnish Defence Forces, the use of covert intelligence gathering is even less frequent.

Telecommunications interception and traffic data monitoring under the Police Act

Telecommunications interception and traffic data monitoring in accordance with the Police Act was targeted at four persons. Mere traffic data monitoring was targeted at 104 (74) persons.The method was used most frequently to avert a danger to life or health and to investigate the cause of death.

Traffic data monitoring under the Act on the Prevention of Crime by Finnish Customs

In total, 8 (16) traffic data monitoring warrants were issued to prevent and detect customs offences, most often on the grounds of aggravated tax fraud or an aggravated narcotics offence.

Technical surveillance

In 2018, the police used technical observation under the Coercive Measures Act 28 times with respect to premises covered by domiciliary peace. The method was used in prisons four times during the year. The police also used on-site interception in a prison 18 times, technical observation 157 times, on-site interception 162 times and technical tracking 321 times. On-site interception in domestic premises was used two times. Data for the identification of a network address or a terminal end device were obtained 58 times. The most common reason for using these surveillance methods was an aggravated narcotics offence.

Under the Police Act, technical observation was used 33 times, on-site interception four times and technical tracking 48 times.

Customs used technical tracking under the Coercive Measures Act in 40 (38) instances. On-site interception was used 23 (19) times and technical observation 25 (22) times.

Technical tracking under the Act on the Prevention of Crime by Finnish Customs was used 10 (9) times. No decisions were issued on on-site interception, and technical observation was used 12 (6) times.

In the Finnish Border Guard, a total of 26 (25) decisions were made on technical surveillance and extended surveillance in order to solve an offence, and six decisions were made in order to prevent an offence.

Extended surveillance

Extended surveillance means other than short-term surveillance of a person who is suspected of an offence or who, with reasonable cause, might be assumed to commit an offence. The National Police Board has interpreted this to mean several individual and repeated instances of surveillance (approximately five times) or one continuous instance of surveillance lasting approximately 24 hours.

According to the report submitted to the Parliamentary Ombudsman by the Ministry of the Interior, in 2018 the police made some 250 decisions on the use of extended surveillance. Customs took 59 (39) similar decisions.

Special covert coercive measures

In 2018, a few new decisions were taken to use undercover operations and to continue the validity of previously issued decisions on undercover operations. Undercover operations performed in data networks are more frequent than such operations in real life. Pseudo purchases were mainly used to detect and investigate aggravated narcotics offences.

The prerequisites for controlled delivery are very strict which in practice has restricted the use of this method. The police have only performed a few controlled deliveries during the time the act has been in force. Customs reported having used controlled deliveries 3 (6) times in 2018.

Rejected requests

There was no significant change in the number of rejected requests for the use of coercive telecommunications measures. In 2018, courts rejected 15 requests for coercive telecommunications measures submitted by the police. None of the requests made by Customs were rejected. No requests of the Border Guard were rejected.

Notification of the use of coercive measures

As a rule, the use of a covert intelligence gathering method must be notified to the target no later than one year after the gathering of intelligence has ceased. A court may under certain conditions authorise the notification to be postponed or decide that no notification needs to be given.

During the year under review, the police had around twenty cases in which the notification of the use of a covert intelligence gathering method was delayed. In this respect, the development has been positive. The number of authorisations for postponing a notification or for not giving one at all was very low. It seems that no authorisations for not giving a notification were issued in 2018.

Internal oversight of legality

The unit responsible for the oversight of legality at the National Police Board conducted legality inspections in all police units. During the inspections, attention was paid to the arrangements and scope of the internal oversight of the units. For the purpose of the inspections, the police units were requested to establish their practices with regard to the oversight, procedures, records, compliance with deadlines and legal bases as well as notifications of their covert intelligence gathering methods; an inspection plan, inspection targets and observations and any measures resulting from these.

In addition, the National Police Board monitored the use of covert intelligence gathering methods according to a separate plan by inspecting the intelligence-gathering decisions and requests recorded in the SALPA system.

The National Police Board states that the general level of the decisions and requirements regarding the use of covert intelligence gathering methods is good. As in the previous years, the most common mistake is a delay in preparing the records in accordance with the deadline, but according to the National Police Board, there has not been a significant number of delays. The decree regulating the drawing up of records was amended on 1 October 2016 by extending the absolute time limit for preparing a record to 90 days from the day on which the use of the method was terminated, instead of the previous 30 days. According to the National Police Board, the delay situation has improved but the number of overruns increased during the year under review. In this respect, the Parliamentary Ombudsman said, in his statement on the draft decree that, as provided in the decree, the record must be prepared without undue delay, and that 90 days should not become the main rule.

In particular, it can be said that 2018 was the first entire calendar year when the decisions on undercover operations in data networks and pseudo purchases made on the basis of sales offers only made publicly available were conducted in the SALPA system. In accordance with observations made by the National Police Board, the procedures regarding undercover operations and pseudo purchases and the data content required from the decisions as laid down in the Coercive Measures Act and the Police Act, are taken into consideration well in the document templates of the SALPA system. According to the National Police Board, there was nothing to remark in the relevant decisions.

There are eight regional SALPA officials who have been granted supervisory powers to the daily overseeing of the use of covert intelligence gathering methods in Customs and they compile a report of their observations each year to the Customs official responsible for the national oversight of legality of use of covert intelligence gathering methods. In addition, Customs has performed regular overseeing by inspecting the records made and the documents saved in the SALPA system. This has been completed by a customs

official designated for the task who is not part of the investigation units. According to the oversight of legality performed by Customs, there have not been any severe deficiencies, and there has been improvement in the quality of the covert coercive measures and covert intelligence gathering used.

In the Finnish Border Guard, overseeing is being performed by the Border Guard Headquarters and the authorised administrative units. In accordance with the standing regulation on crime prevention carried out by the Finnish Border Guard, the Border Guard's SALPA overseeing is performed by an official who does not participate in operative crime prevention. In the Border Guard Headquarters, oversight is ensured by the legal department's crime-prevention unit which is also responsible for the general steering of crime prevention.

The Ministry of Defence has not identified any unlawful conduct in the use of covert coercive measures and covert intelligence gathering methods of the Finnish Defence Forces. All decisions and minutes dated in 2018 belong to the sphere of inspection. However, targets of development have been observed in technical issues and in issues open to interpretation.

4.5 PARLIAMENTARY OMBUDSMAN'S OVERSIGHT OF LEGALITY

During the year under review, inspections concerning covert coercive measures conducted at the Police Department of Western Finland focused on requests for coercive telecommunications measures and decisions concerning technical surveillance. For this purpose, a sample of the related request and decision documents was examined.

The inspectors stated that in some coercive telecommunications measures, the justifications were quite concise, and it remained unclear, for example, how a certain connection related to the target of covert intelligence. However, in such cases as well, the court had issued a warrant.

On the basis of information received in the inspection, the Parliamentary Ombudsman found that attention should be paid to the content of the written requests regarding intelligence gathering methods and the scope of the grounds. Even if there is a possibility to orally supplement the request during the district court session, in principle, the request should already contain sufficient grounds with regard to evaluating the issuing of a warrant.

The Parliamentary Ombudsman finds it unsatisfactory that there are at least two varying practices in determining the deadline for the use of a covert coercive measure. This demonstrates that the current legislation is not unequivocal and clear, which was one of the goals of the legislation reform, and which would also be beneficial to facilitating the work of those interpreting the law.

During the inspection carried out by the National Bureau of Investigation, the decisions on undercover operations in data networks (so-called web undercover operations) and pseudo purchases (so-called restricted pseudo purchase) made on the basis of sales offers only made publicly available, were examined.

4.6 EVALUATION

Potential problems with legislation

Notification obligation

As a rule, a written notification of the use of covert intelligence gathering methods must be given to the suspect without delay after the matter has been submitted to the consideration of the prosecutor or the criminal investigation has otherwise been terminated or interrupted, or at the latest within one year of the termination of the use of the method. The manner of giving the notification depends partly on the method used. The provisions on the notification obligation are currently more detailed than before, and the scope of the obligation has been extended.

Under certain conditions, a court may decide at the request of an official with the power of arrest that the notice to the suspect may be postponed at the most by two years at a time. The court may also decide that no notice is given at all,

if this is necessary in order to ensure the security of the state or to protect life or health.

Thus, it is possible that the target will never know of the method used even though under the law giving a notification is the rule and not giving a notification is an exception to the rule. It is important to keep the number of cases that remain completely unknown to the target as few as possible.

When the amendments to the new Coercive Measures Act, Criminal Investigation Act and Police Act were discussed in 2013 and experts were heard during the committee reading, particularly the criminal investigation authorities expressed their concerns about the risk of an undercover officer or a covert human intelligence source being exposed and about their safety (LaVM 17/2013 vp – HE 14/2013 vp).

According to the National Police Board, the feedback received from heads of investigation indicates that the obligation to give a written notification has hampered the use of intelligence gathering methods. The availability of covert human intelligence sources was identified as a problem already in 2014, and the use of on-site interception at prisons significantly decreased in 2015 because the coercive measure is no longer considered as effective as before in preventing serious offences.

According to the National Police Board, the notification obligation has become an obstacle to the use of covert human intelligence sources. As a result, Finnish authorities confine themselves to using "passive covert human intelligence sources", which reduces the effectiveness of the method. In undercover operations, notifying the target of intelligence gathering may, at worst, mean that the police officer in question will in the future no longer be able to work undercover. According to the National Police Board, the notification obligation also significantly reduces international collaboration.

One of the aims of notifying the target of the use of intelligence gathering methods is to ensure a fair trial. The new Criminal Investigation Act was amended in the previous year to emphasise the right of a party to obtain information. Under the Act, when considering the right of a party to obtain information or the restriction of this right, consideration shall be given in the assessment to the party's right to a proper defence or otherwise to appropriately secure his or her right in the court proceedings.

Together with the potential risks associated with notifying the use of covert intelligence gathering methods in investigating an offence, the requirements concerning the right to obtain information and the right to fair trial form a complex issue involving many difficulties in balancing the different aspects.

Undercover operations

The problems identified in undercover operations before the new acts entered into force have been discussed on pages 109–112 of the Finnish version of the 2011 Annual Report. These problems are still relevant.

The point of departure of the law is that police officers performing undercover operations are not allowed to commit or instigate an offence. However, if a police officer commits a traffic violation, public order violation or other similar offence for which the punishment by law is a fixed penalty, he or she will be exempt from criminal liability if the action was necessary for achieving the purpose of the undercover activities or preventing the intelligence gathering from being revealed.

The law also includes provisions on a police officer participating in the activities of an organised criminal group while performing undercover operations. If, when participating in such activities, a police officer obtains premises, or transport or other such objects, transports persons, objects or substances, attends to financial matters or assists the criminal group in other similar ways, he or she is not subject to criminal liability under the conditions laid down by law.

The police officer is exempt from criminal liability in the above-mentioned situations if there are very good grounds to have assumed that the measure would have been performed also without his or her contribution, the action of the police officer does not endanger or harm the life, health or freedom of any person or cause a significant danger or damage to property, and the assistance sig-

nificantly promotes the achievement of the purpose of the covert activity.

These provisions are open to interpretation and leave certain questions unanswered. Based on the provisions, a police officer performing undercover operations has very limited room to operate. Together with the ambiguity of the provisions, this has raised questions among the police, for example, about the legal protection of police officers. It is also unclear how the exemption from criminal liability, as referred to in the law, would be implemented in practice.

Courts play a very limited role in commencing undercover operations, as their powers are limited to deciding whether the formal preconditions for undercover operations are met. Courts cannot take a stand on the plans concerning undercover operations or their practical implementation.

General problems in oversight

Resources must be invested in internal oversight

The Ombudsman's oversight of the legality of covert intelligence gathering focuses on overseeing the internal oversight of authorities. In this context, the inspections of the legal units of police departments are used for emphasising the units' internal oversight of the covert intelligence gathering methods used by the police departments.

The authorities using covert intelligence gathering have in recent years invested resources and efforts in internal oversight. According to the National Police Board, the operation of the legal units of police departments has become established and the scope of activities has become clear, although the constantly expanding task description does take time away from inspection activities.

At the Finnish Customs, Border Guard and Defence Forces, internal oversight has functioned very well according to the authorities' own assessment. In these authorities, oversight is easier because the volume of operations is much smaller than in the police.

The Ombudsman conducts retrospective oversight of a fairly general nature. The Ombudsman is remote from the actual activities and cannot begin directing the authorities' actions or otherwise be a key setter of limits, who would redress the weaknesses in legislation. Annual or other reports submitted to the Ombudsman are important but do not solve the problems related to oversight and legal protection.

The oversight of covert coercive measures is partly founded on trust in the fact that the person conducting the oversight activities receives all the information he or she wants. Due to the nature of the activities, precise documentation is a fundamental prerequisite for successful oversight.

Real-time active recording of events and measures also helps operators to evaluate and develop their own activities, to ensure the legality of their operations and to build trust in their activities. Keeping records is also an absolute precondition for the Ombudsman's retrospective oversight of legality.

At the time of its introduction, the SALPA system was a step forward in the oversight of covert coercive measures in terms of recording the use of covert intelligence gathering methods. The system also guides its users to follow correct and lawful operating models. However, the SALPA system – like other information systems used by the police – is gradually reaching its limits, and the VITJA reform project was intended to solve the problem. Because the project could not be implemented as planned, the SALPA system has required updating. It is important to ensure that the legality and oversight of activities are not compromised due to information system issues.

In the oversight of legality, the Ombudsman has continuously emphasised the importance of providing justifications for requests and decisions. The grounds and justifications should be recorded, for example, to enable the control of decisions. If a court does not require the applicant to provide sufficient justifications or if the court neglects to provide sufficient justifications, there is a risk that warrants will be issued for cases other than those intended by the legislator.

4.7 INTELLIGENCE LEGISLATION

The Parliament passed a legislative package on intelligence with the following included:

- HE 198/2017 vp Government proposal to Parliament for an act to amend section 10 of Finland's Constitution
- HE 202/2017 vp Government proposal to Parliament for legislation concerning civilian intelligence gathering
- HE 203/2017 vp Government proposal to Parliament for an act on military intelligence gathering and certain related acts
- HE 199/2017 vp Government proposal to Parliament for an act on the oversight of intelligence gathering and an act to amend section 7 of the State Civil Servants' Act (oversight of legality of intelligence gathering)
- PNE 1/2018 vp to amend Parliament's Rules of Procedure and section 9 of the Act on Parliamentary Civil Servants (parliamentary scrutiny of intelligence gathering)

Parliamentary Ombudsman Jääskeläinen was heard on the matter on several occasions in the various parliamentary committees.

In the statements regarding intelligence legislation, the Parliamentary Ombudsman found it problematic, among other things, that in their presented form, the covert intelligence gathering methods can be used in intelligence activities under more generous conditions; the current covert intelligence gathering methods can be used for intelligence purposes for a longer period, the scope of use of the current covert intelligence gathering methods has been expanded in content or methods in intelligence activities, and completely new methods are available which covert intelligence gathering does not include.

In the statements regarding the overseeing of intelligence gathering, the Parliamentary Ombudsman stated, among other things, that effective external overseeing is a necessary counterbalance for the new powers granted. Overseeing cannot remain as an internal function. Due to the nature of intelligence gathering, its activities are extremely confidential and its effective overseeing is a necessity. The working methods of the intelligence authorities usually signify interfering in the protection of privacy and confidential communication. The Parliamentary Ombudsman stressed, among other things, the fact that by way of derogation from the proposed, the oversight of the intelligence ombudsman (in accordance with the passed act; an intelligence oversight ombudsman) should include, in addition to intelligence gathering, also the exercise of power by the Finnish Security Intelligence Service under section 5 of the Police Act, as well as the oversight of covert intelligence gathering of the Defence Command and the Intelligence Division of the Finnish Defence Forces. With regard to the Finnish Security Intelligence Service, this was provided accordingly.

Contrary to the proposal, the Parliamentary Ombudsman found that the ombudsman should, in addition to the right to attend, also have speaking rights in the court hearing for warrant issues regarding intelligence gathering methods, and this was later on implemented in the law accordingly.

The Parliamentary Ombudsman expressed a special concern for the resources planned to be allocated to the intelligence oversight ombudsman in the Government Proposal. In accordance with the evaluation of the Government Proposal, there would be two full-time expert officials and one assistant handling the intelligence overseeing functions in addition to the ombudsman. The Parliamentary Ombudsman stated that the oversight of intelligence gathering should be continuous, detailed and operative. According to the Parliamentary Ombudsman, the proposed personnel resources are clearly insufficient in order to perform effective and comprehensive overseeing in all situations.

In accordance with a statement provided to the Constitutional Law Committee by the Parliamentary Ombudsman, the evaluation of resources should consider at least the following factors:

The intelligence oversight ombudsman should be able to effectively oversee all intelligence gathering methods and all dimensions of intelligence gathering, such as compliance with court warrants and other authorisation decisions; the legality of information-gathering methods; the legality of processing, storing and further sharing of data; the erasure of data and the notifications on per-

formed measures to data subjects. The duties of the intelligence oversight ombudsman require extensive expertise. This expertise must be available at all times. The functions of the intelligence oversight ombudsman must have an on-call or standby system. The possibility of the intelligence oversight ombudsman functions to receive external support are very limited, as the issues to be processed are extremely confidential.

According to the Parliamentary Ombudsman, a role of deputy intelligence oversight ombudsman should be established in addition to the intelligence oversight ombudsman. The personnel should also include four legal experts with a high level of knowledge in the legality issues involving the work of authorities and views on fundamental rights and human rights, as well as knowledge in the operative level of intelligence gathering. Two of these experts would focus on the overseeing, methods and tactical etc. issues in civilian intelligence and two especially in the same for military intelligence. In addition to this, two technical experts should also be recruited with technical special expertise enabling the overseeing of information-system and telecommunications intelligence as well as knowledge in technical issues related to other intelligence gathering methods. In addition to the abovementioned, the activities would also require two assistants to work as support persons in administrative and technical issues.

The authorities engaging in intelligence gathering as well as the intelligence oversight ombudsman will be under the oversight of the Parliamentary Ombudsman, whereas the parliamentary intelligence oversight committee as a body consisting of Members of Parliament would fall outside the jurisdiction of the Parliamentary Ombudsman.

With the intelligence legislation, the new powers of the authorities and the reports on intelligence delivered to the Ombudsman shall, in part, increase the share of oversight directed by the Ombudsman at the 'secret methods' during the oversight of legality performed by the Ombudsman. Among other things, the Ministry of the Interior must submit a report to the Ombudsman each year on the use of intelligence gathering methods under the Police Act and on the use of protection of civilian intelligence gathering, as well as on the overseeing of the use thereof, and on the use of telecommunications intelligence. Among other things, the Ministry of Defence must submit a report to the Ombudsman each year on the use and oversight of intelligence gathering methods and the protection of military intelligence gathering. Among other things, the intelligence oversight ombudsman shall submit a report to the Ombudsman each year on its activities.

4.8 WITNESS PROTECTION

The witness protection programme act (*laki todistajansuojeluohjelmasta* 88/2015) entered into force on 1 March 2015. The act constitutes a major reform in terms of fundamental rights and the rights of the individual. It safeguards the right to life, personal liberty and integrity and the right to the sanctity of the home, as enshrined in the Constitution.

A person may be admitted to a witness protection programme in order to receive protection if there is a serious threat against the life or health of the person or someone in their family, because the person is being heard in a criminal matter or for some other reason and the threat cannot be efficiently eliminated through other measures.

Together with the protected person, the police will draw up a personal protection plan in writing that includes the key measures to be implemented as part of the programme. They may include, for example, relocating the protected person to another region, arranging a new home for the person, installing security devices in their home and providing advice on personal safety and security.

If necessary for the implementation of the witness protection programme, the police may make and create false, misleading or disguised register entries and documents to support the protected person's new identity. The police may also monitor the person's home and its surroundings. Protected persons may also receive financial support to ensure their income security and independent living.

The National Bureau of Investigation (NBI) is responsible for the implementation of the witness protection programme together with other authorities. The director of the NBI makes decisions about beginning and terminating witness protection programmes and certain related measures. The Ministry of the Interior submits annual reports to the Parliamentary Ombudsman on decisions and measures taken under the act.

According to the report by the Ministry of the Interior for 2018, witness protection programmes are associated with serious offences, cases of threat against the life or health of a person, and international requests for administrative assistance. In the programmes, the focus is on protecting a person, and the special personal protection team is not actively involved in investigating the relevant offence.

The biggest problem area to be raised is the fact that the police operations and the evaluation process preceding the protection programme have been left outside the sphere of the legislation. During this time, the persons processing the matter cannot use undercover identities or misleading documents, as they can during the protection programme. This may endanger the safety of the processors and those to be included in the programme.

Another problem highlighted by the NBI is that the threshold for terminating the witness protection programme is too high.

The Ministry of the Interior considers it important that the National Police Board has included the witness protection programme as part of the inspection carried out in the NBI by the National Police Board, and that the legality, functionality and update needs of the register of the witness protection programmes is examined and monitored.

5 Issues relating to EU law

5
Issues relating to EU law

Supreme guardians of the law and compliance with the General Data Protection Regulation

The Constitutional Law Committee of the Parliament of Finland addressed the constitutional role of the Parliamentary Ombudsman and the Chancellor of Justice in its opinion on the government proposal for new data protection legislation. The Committee was tasked with examining the powers of the Data Protection Ombudsman from the perspective of, for example, how EU law should be interpreted.

The Constitutional Law Committee concluded that the position and duties of the supreme guardians of the law, as well as the constitutional framework for the supervision of legality, do not allow for the supervision of the supreme guardians of the law by the Data Protection Ombudsman, a lower-level authority. This principle should be expressly stated in the provisions of the Data Protection Act.

The Constitutional Law Committee also pointed out that it is clear that, according to settled case-law of the Court of Justice of the European Union, EU law prevails in relation to national provisions in accordance with the conditions laid down in case-law, and there is no justification for attempting to contradict EU law in national legislation. According to the Committee, it is equally clear that the wording of the GDPR does not appear to allow for providing for such limitation.

As provided in recital 20 of the GDPR, while the Regulation applies, inter alia, to the activities of courts and other judicial authorities, Union or Member State law could specify the processing operations and processing procedures in relation to the processing of personal data by courts and other judicial authorities. However, the restriction of the scope of application does not extend as far in an organisation as the authority to specify the rules, and in accordance with the recital, the competence of the supervisory authorities should not cover the processing of personal data when courts are acting in their judicial capacity, in order to safeguard the independence of the judiciary in the performance of its judicial tasks, including decision-making. It is specifically provided in Article 55 of the Regulation that supervisory authorities shall not be competent to supervise processing operations of courts acting in their judicial capacity.

However, the Constitutional Law Committee noted that the constitutional status of the supreme guardians of the law, as described above, is not, according to the report submitted to the Committee, associable with the supervision of legality in other Member States, and the special features of Finland's national system were not taken into consideration in the drafting of the GDPR.

The Constitutional Law Committee also drew attention to Article 4(2) of the Treaty on European Union, under which it is provided that the Union shall respect the equality of Member States before the Treaties as well as their national identities, inherent in their fundamental structures, political and constitutional, inclusive of regional and local self-government. The Constitutional Law Committee took the view that the provision reflects the principle according to which substantive EU law cannot be seen to call into question the institutional structure in the exercise of public powers as laid down in the constitutions of Member States. The Court of Justice of the European Union has, for example, in its judgment in the *Digibet* case (*Digibet Ltd & Albers v. Westdeutsche Lotterie GmbH & Co. OHG*, C-156/13 p. 34) taken the view that the division of competences between federal states that led to inconsistencies in provisions on games of chance could not be called into question, as it was protected by the provisions of Article 4(2) TEU.

According to the view held by the Constitutional Law Committee, it is, however, clear that a contractual provision concerning the national identities of the Member States inherent in their constitutional structures can only form narrowly applicable proportionate grounds to derogate from the full application of EU law. It is settled case-law that, by virtue of the principle of primacy of EU law, which is an essential feature of the EU legal order, rules of national law, even of a constitutional order, cannot be allowed to undermine the effectiveness of EU law on the territory of that State (see, inter alia, Case 11/70 *Internationale Handelsgesellschaft*, judgment of 17 December 1970, paragraph 3 and Case C-409/06 *Winner Wetten*, judgment of 8 September 2010, paragraph 61, and, in particular, Case C-399/11 *Melloni*, judgment of 26 February 2013, paragraph 59).

According to the Constitutional Law Committee, the key point from the perspective of a proportionality assessment is, in the present situation, that there is no substantive contradiction between the content of the Constitution and EU law. Instead, the issue is that EU law leads to a contradiction with institutional solutions regarding the Constitution of Finland that has not been specifically aimed at in the GDPR. The Committee considered it crucial that the restrictions in the scope of application with regard to the supreme guardians of the law should not jeopardise the objectives of access to justice and effective control as laid down in the preamble to the GDPR and the ultimate objectives of the data protection authorities as provided in the case-law of the Court of the Justice of the European Union.

The Court of Justice of the European Union holds the ultimate competence on the interpretation of Article 4(2) of the Treaty on European Union, the GDPR and their interrelationship. However, the Committee found that while the interpretation is in this respect as yet unestablished, the government proposal does not include sufficient rationale arising from EU law to extend the supervisory authority of the Data Protection Ombudsman over the supreme guardians of the law.

Right to family benefits in cross-border situations

The European Ombudsman enquired after the Finnish Parliamentary Ombudsman's experiences of excessive delays in the payment of family benefits due to lack of cooperation between Member States. The European Ombudsman suspected that there could be a systematic problem with the application of Regulation (EC) No 987/2009 in cross-border situations.

The Deputy-Ombudsman's reply called attention not only to Article 60(3) of the Regulation but also to the principle of sincere cooperation, which can be considered one of the cornerstones of the coordination of social security systems. The principle is laid down in Article 4(3) TEU.

The Deputy-Ombudsman also cited the judgment of the Court of Justice of the European Union in Case C-359/16 *Altun* and opined emphatically that the significance of both effective administrative cooperation and the principle of sincere cooperation will increase in the future. The Deputy-Ombudsman felt that it is therefore important to improve conditions for effective cooperation by means of careful planning. This is the Commission's responsibility. Effective administrative implementation, on the other hand, is on Member States' and national ombudsmen's shoulders.

The Deputy-Ombudsman assumed that some of the delays could be due to certain Member States using a paper form instead of electronic templates. Processing paper forms is a considerable administrative burden. The Social Insurance Institution of Finland has observed excessive delays in the payment of family benefits in some cases. Many of the delays, although low in number as such, have been due to the slowness of Member States' competent authorities in responding to claims.

The Finnish Parliamentary Ombudsman has only had to reprimand the Social Insurance Institution of Finland, which is responsible for processing claims in Finland, for excessive processing times on five occasions in recent years. Even in these cases, the problem has lain with the organi-

sation of the Social Insurance Institution of Finland's work and not with lack of cooperation between Member States.

Notices of requests for preliminary rulings

The Ministry for Foreign Affairs supplied the Office of the Parliamentary Ombudsman with copies of all requests for preliminary rulings sent to the Court of Justice of the European Union that concern fundamental rights. The Office of the Parliamentary Ombudsman uses the requests to draw up opinions, based on the understanding that we have accumulated in the course of overseeing legality in respect of fundamental rights, on the significance of the questions referred to the Court of Justice of the European Union and the Court's potential answers to the same from the perspective of the Finnish and European system of fundamental rights. The Ministry for Foreign Affair's notices required no action from the Deputy-Ombudsman in 2018.

Decisions on complaints

Breach of EU law in the sending of a vehicle tax demand note

The Deputy-Ombudsman criticised the procedure of the Finnish Transport Safety Agency (Trafi) by which it required a person living abroad to officially hand over possession of their vehicle to another person in order for Trafi to be able to send them a vehicle tax demand note. Trafi had not sent a vehicle tax demand note to the complainant's address in Portugal, and the complainant had consequently failed to pay vehicle tax and been prohibited from using their vehicles. Trafi's chosen course of action appeared even more unjustified when the issue could, according to Trafi, have been avoided if the complainant had signed up for e-invoicing, in which case the sending of vehicle tax demand notes is not tied to the taxpayer's registered address.

Trafi argued that its procedure complied with the Government Decree on Vehicle Registration. The Deputy-Ombudsman found the prevailing legal position to be unsatisfactory. The free movement of people is enshrined in Article 21 of the Treaty on the Functioning of the European Union (TFEU). Pursuant to rulings by the Supreme Administrative Court of Finland, the right to free movement of people may be understood to mean that Finnish law cannot place a person residing in Finland in a more favourable position than a person residing in another Member State. In this case, no justification was given for the different treatment of a vehicle owner residing abroad, within the European Union in this instance, and an owner residing in Finland.

The Ministry of Transport and Communications urged Trafi to improve its advisory service in order to actively provide guidance and advice to taxpayers residing abroad.

The Deputy-Ombudsman was satisfied with the corrective action taken by the Ministry of Transport and Communications. She asked the Ministry to report back on the progress of the improvements (1219/2018*).

According to the Ministry of Transport and Communications, the Government Decree on Vehicle Registration has since been amended. Trafi reacted to the decision given on 28 June 2018 by posting instructions for taxpayers who are moving abroad on its website and advising them that tax demand notes will not be sent abroad. As electronic vehicle tax demand notes are always sent to taxpayers via online banking, taxpayers have been advised to begin using e-invoicing for vehicle tax to avoid problems relating to postage.

Deputy-Ombudsman Maija Sakslin spoke at the European Parliament in November. The event focused on bolstering the status of national parliaments and the rights of citizens in the context of the implementation and application of EU law.

Deputy-Ombudsman Sakslin's speech explored the role of complaints filed with the Finnish Parliamentary Ombudsman in detecting and intervening in breaches of EU law. Many complainants approach both the Parliamentary Om-

budsman and the European Commission simultaneously. The Parliamentary Ombudsman does not usually entertain cases that are pending in another tribunal. However, as the Commission's supervisory powers are not purely judicial, the Parliamentary Ombudsman occasionally investigates these kinds of cases. Any complaints that relate to the interpretation of EU law nevertheless fall within the competence of the Court of Justice of the European Union, and such cases are referred to the Court either by way of a national court's request for a preliminary ruling or infringement proceedings brought by the Commission. The Parliamentary Ombudsman is not competent to request preliminary rulings. However, as long as the substance of EU law and its interpretations are unambiguous and well-established, the Parliamentary Ombudsman can, in individual cases, confirm whether or not there is a conflict between national legislation and EU law or whether national administrative procedures are in breach of fundamental rights and the principle of equal treatment and propose that such procedures be revised.

The Parliamentary Ombudsman also notifies the European Ombudsman of any such findings of shortcomings in EU law in order to allow the European Ombudsman to take any necessary further action. This procedure brings the issues to the attention of both the European Parliament and the President of the European Commission. In some cases, the Parliamentary Ombudsman has asked the Finnish Government to take a proactive stance in the Council in order to change EU law and promote fundamental rights. The Parliamentary Ombudsman does not entertain complaints that question whether EU law has been transposed appropriately into Finnish law. This is because the issue usually comes down to whether a law passed by the Parliament of Finland complies with EU law, and the Parliamentary Ombudsman is not competent to judge the legislator's actions.

6 Appendixes

Constitutional Provisions pertaining to Parliamentary Ombudsman of Finland

11 June 1999 (731/1999), entry into force 1 March 2000

Section 27
Eligilibity and qualifications for the office of Representative

Everyone with the right to vote and who is not under guardianship can be a candidate in parliamentary elections.

A person holdin military office cannot, however, be elected as a Representative.

The Chancellor of Justice of the Government, the Parliamentary Ombudsman, a Justice of the Supreme Court or the Supreme Administrative Court, and the Prosecutor-General cannot serve as representatives. If a Representative is elected President of the Republic or appointed or elected to one of the aforesaid offices, he or she shall cease to be a Representative from the date of appointment or election. The office of a Representative shall cease also if the Representative forfeits his or her eligibility.

Section 38
Parliamentary Ombudsman

The Parliament appoints for a term of four years a Parliamentary Ombudsman and two Deputy Ombudsmen, who shall have outstanding knowledge of law. A Deputy Ombudsman may have a substitute as provided in more detail by an Act. The provisions on the Ombudsman apply, in so far as appropriate, to a Deputy Ombudsman and to a Deputy Ombudsman's a substitute. (802/2007, entry into force 1.10.2007)

The Parliament, after having obtained the opinion of the Constitutional Law Committee, may, for extremely weighty reasons, dismiss the Ombudsman before the end of his or her term by a decision supported by at least two thirds of the votes cast.

Section 48
Right of attendance of Ministers, the Ombudsman and the Chancellor of Justice

Minister has the right to attend and to participate in debates in plenary sessions of the Parliament even if the Minister is not a Representative. A Minister may not be a member of a Committee of the Parliament. When performing the duties of the President of the Republic under section 59, a Minister may not participate in parliamentary work.

The Parliamentary Ombudsman and the Chancellor of Justice of the Government may attend and participate in debates in plenary sessions of the Parliament when their reports or other matters taken up on their initiative are being considered.

Section 109
Duties of the Parliamentary Ombudsman

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

The Ombudsman submits an annual report to the Parliament on his or her work, including observations on the state of the administration of justice and on any shortcomings in legislation.

Section 110
The right of the Chancellor of Justice and the Ombudsman to bring charges and the division of responsibilities between them

A decision to bring charges against a judge for unlawful conduct in office is made by the Chancellor of Justice or the Ombudsman. The Chancellor of Justice and the Ombudsman may prosecute or order that charges be brought also in other matters falling within the purview of their supervision of legality.

Provisions on the division of responsibilities between the Chancellor of Justice and the Ombudsman may be laid down by an Act, without, however, restricting the competence of either of them in the supervision of legality.

Section 111
The right of the Chancellor of Justice and Ombudsman to receive information

The Chancellor of Justice and the Ombudsman have the right to receive from public authorities or others performing public duties the information needed for their supervision of legality.

The Chancellor of Justice shall be present at meetings of the Government and when matters are presented to the President of the Republic in a presidential meeting of the Government. The Ombudsman has the right to attend these meetings and presentations.

Section 112
Supervision of the lawfulness of the official acts of the Government and the President of the Republic

If the Chancellor of Justice becomes aware that the lawfulness of a decision or measure taken by the Government, a Minister or the President of the Republic gives rise to a comment, the Chancellor shall present the comment, with reasons, on the aforesaid decision or measure. If the comment is ignored, the Chancellor of Justice shall have the comment entered in the minutes of the Government and, where necessary, undertake other measures. The Ombudsman has the corresponding right to make a comment and to undertake measures.

If a decision made by the President is unlawful, the Government shall, after having obtained a statement from the Chancellor of Justice, notify the President that the decision cannot be implemented, and propose to the President that the decision be amended or revoked.

Section 113
Criminal liability of the President of the Republic

If the Chancellor of Justice, the Ombudsman or the Government deem that the President of the Republic is guilty of treason or high treason, or a crime against humanity, the matter shall be communicated to the Parliament. In this event, if the Parliament, by three fourths of the votes cast, decides that charges are to be brought, the Prosecutor-General shall prosecute the President in the High Court of Impeachment and the President shall abstain from office for the duration of the proceedings. In other cases, no charges shall be brought for the official acts of the President.

Section 114
Prosecution of Ministers

A charge against a Member of the Government for unlawful conduct in office is heard by the High Court of Impeachment, as provided in more detail by an Act.

The decision to bring a charge is made by the Parliament, after having obtained an opinion from the Constitutional Law Committee concerning the unlawfulness of the actions of the Minister. Before the Parliament decides to bring charges or not it shall allow the Minister an opportunity to give an explanation. When considering a matter of this kind the Committee shall have a quorum when all of its members are present.

A Member of the Government is prosecuted by the Prosecutor-General.

Section 115
Initiation of a matter concerning the legal responsibility of a Minister

An inquiry into the lawfulness of the official acts of a Minister may be initiated in the Constitutional Law Committee on the basis of:

1) A notification submitted to the Constitutional Law Committee by the Chancellor of Justice or the Ombudsman;
2) A petition signed by at least ten Representatives; or
3) A request for an inquiry addressed to the Constitutional Law Committee by another Committee of the Parliament.

The Constitutional Law Committee may open an inquiry into the lawfulness of the official acts of a Minister also on its own initiative.

Section 117
Legal responsibility of the Chancellor of Justice and the Ombudsman

The provisions in sections 114 and 115 concerning a member of the Government apply to an inquiry into the lawfulness of the official acts of the Chancellor of Justice and the Ombudsman, the bringing of charges against them for unlawful conduct in office and the procedure for the hearing of such charges.

Parliamentary Ombudsman Act

14 March 2002 (197/2002)

CHAPTER 1
OVERSIGHT OF LEGALITY

SECTION 1
Subjects of the Parliamentary Ombudsman's oversight

(1) For the purposes of this Act, subjects of oversight shall, in accordance with Section 109 (1) of the Constitution of Finland, be defined as courts of law, other authorities, officials, employees of public bodies and also other parties performing public tasks.

(2) In addition, as provided for in Sections 112 and 113 of the Constitution, the Ombudsman shall oversee the legality of the decisions and actions of the Government, the Ministers and the President of the Republic. The provisions set forth below in relation to subjects of oversight apply in so far as appropriate also to the Government, the Ministers and the President of the Republic.

SECTION 2
Complaint

(1) A complaint in a matter within the Ombudsman's remit may be filed by anyone who thinks a subject has acted unlawfully or neglected a duty in the performance of their task.

(2) The complaint shall be filed in writing. It shall contain the name and contact particulars of the complainant, as well as the necessary information on the matter to which the complaint relates.

SECTION 3
Investigation of a complaint (20.5.2011/535)

(1) The Ombudsman shall investigate a complaint if the matter to which it relates falls within his or her remit and if there is reason to suspect that the subject has acted unlawfully or neglected a duty or if the Ombudsman for another reason takes the view that doing so is warranted.

(2) Arising from a complaint made to him or her, the Ombudsman shall take the measures that he or she deems necessary from the perspective of compliance with the law, protection under the law or implementation of fundamental and human rights. Information shall be procured in the matter as deemed necessary by the Ombudsman.

(3) The Ombudsman shall not investigate a complaint relating to a matter more than two years old, unless there is a special reason for doing so.

(4) The Ombudsman must without delay notify the complainant if no measures are to be taken in a matter by virtue of paragraph 3 or because it is not within the Ombudsman's remit, it is pending before a competent authority, it is appealable through regular appeal procedures, or for another reason. The Ombudsman can at the same time inform the complainant of the legal remedies available in the matter and give other necessary guidance.

(5) The Ombudsman can transfer handling of a complaint to a competent authority if the nature of the matter so warrants. The complainant must be notified of the transfer. The authority must inform the Ombudsman of its decision or other measures in the matter within the deadline set by the Ombudsman. Separate provisions shall apply to a transfer of a complaint between the Parliamentary Ombudsman and the Chancellor of Justice of the Government.

Section 4
Own initiative

The Ombudsman may also, on his or her own initiative, take up a matter within his or her remit.

Section 5
Inspections (28.6.2013/495)

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

(2) In the context of an inspection, the Ombudsman and officials in the Office of the Ombudsman assigned to this task by the Ombudsman have the right of access to all premises and information systems of the inspection subjeft, as well as the right to have confidential discussions with the personnel of the office or institution, persons serving there and its inmates.

Section 6
Executive assistance

The Ombudsman has the right to executive assistance free of charge from the authorities as he or she deems necessary, as well as the right to obtain the required copies or printouts of the documents and files of the authorities and other subjects.

Section 7
Right of the Ombudsman to information

The right of the Ombudsman to receive information necessary for his or her oversight of legality is regulated by Section 111 (1) of the Constitution.

Section 8
Ordering a police inquiry or a pre-trial investigation (22.7.2011/811)

The Ombudsman may order that a police inquiry, as referred to in the Police Act (872/2011), or a pre-trial investigation, as referred to in the Pre-trial Investigations Act (805/2011), be carried out in order to clarify a matter under investigation by the Ombudsman.

Section 9
Hearing a subject

If there is reason to believe that the matter may give rise to criticism as to the conduct of the subject, the Ombudsman shall reserve the subject an opportunity to be heard in the matter before it is decided.

Section 10
Reprimand and opinion

(1) If, in a matter within his or her remit, the Ombudsman concludes that a subject has acted unlawfully or neglected a duty, but considers that a criminal charge or disciplinary proceedings are nonetheless unwarranted in this case, the Ombudsman may issue a reprimand to the subject for future guidance.

(2) If necessary, the Ombudsman may express to the subject his or her opinion concerning what constitutes proper observance of the law, or draw the attention of the subject to the requirements of good administration or to considerations of promoting fundamental and human rights.

(3) If a decision made by the Parliamentary Ombudsman referred to in Subsection 1 contains an imputation of criminal guilt, the party having been issued with a reprimand has the right to have the decision concerning criminal guilt heard by a court of law. The demand for a court hearing shall be submitted to the Parliamentary Ombudsman in writing within 30 days of the date on which the party was notified of the reprimand. If notification of the reprimand is served in a letter

sent by post, the party shall be deemed to have been notified of the reprimand on the seventh day following the dispatch of the letter unless otherwise proven. The party having been issued with a reprimand shall be informed without delay of the time and place of the court hearing, and of the fact that a decision may be given in the matter in their absence. Otherwise the provisions on court proceedings in criminal matters shall be complied with in the hearing of the matter where applicable. (22.8.2014/674)

Section 11
Recommendation

(1) In a matter within the Ombudsman's remit, he or she may issue a recommendation to the competent authority that an error be redressed or a shortcoming rectified.

(2) In the performance of his or her duties, the Ombudsman may draw the attention of the Government or another body responsible for legislative drafting to defects in legislation or official regulations, as well as make recommendations concerning the development of these and the elimination of the defects.

CHAPTER 1 a
National Preventive Mechanism (NPM) (28.6.2013/495)

Section 11 a
National Preventive Mechanism (28.6.2013/495)

The Ombudsman shall act as the National Preventive Mechanism referred to in Article 3 of the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (International Treaty Series 93/2014).

Section 11 b
Inspection duty (28.6.2013/495)

(1) When carrying out his or her duties in capacity of the National Preventive Mechanism, the Ombudsman inspects places where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence (place of detention).

(2) In order to carry out such inspections, the Ombudsman and an official in the Office of the Ombudsman assigned to this task by the Ombudsman have the right of access to all premises and information systems of the place of detention, as well as the right to have confidential discussions with persons having been deprived of their liberty, with the personnel of the place of detention and with any other persons who may supply relevant information.

Section 11 c
Access to information (28.6.2013/495)

Notwithstanding the secrecy provisions, when carrying out their duties in capacity of the National Preventive Mechanism the Ombudsman and an official in the Office of the Ombudsman assigned to this task by the Ombudsman have the right to receive from authorities and parties maintaining the places of detention information about the number of persons deprived of their liberty, the number and locations of the facilities, the treatment of persons deprived of their liberty and the conditions in which they are kept, as well as any other information necessary in order to carry out the duties of the National Preventive Mechanism.

Section 11 d
Disclosure of information (28.6.2013/495)

In addition to the provisions contained in the Act on the Openness of Government Activities (621/1999) the Ombudsman may, notwithstanding the secrecy provisions, disclose information

about persons having been deprived of their liberty, their treatment and the conditions in which they are kept to a Subcommittee referred to in Article 2 of the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

Section 11 e
Issuing of recommendations (28.6.2013/495)

When carrying out his or her duties in capacity of the National Preventive Mechanism, the Ombudsman may issue the subjects of supervision recommendations intended to improve the treatment of persons having been deprived of their liberty and the conditions in which they are kept and to prevent torture and other cruel, inhuman or degrading treatment or punishment.

Section 11 f
Other applicable provisions (28.6.2013/495)

In addition, the provisions contained in Sections 6 and 8–11 herein on the Ombudsman's action in the oversight of legality shall apply to the Ombudsman's activities in his or her capacity as the National Preventive Mechanism.

Section 11 g
Independent Experts (28.6.2013/495)

(1) When carrying out his or her duties in capacity of the National Preventive Mechanism, the Ombudsman may rely on expert assistance. The Ombudsman may appoint as an expert a person who has given his or her consent to accepting this task and who has particular expertise relevant to the inspection duties of the National Preventive Mechanism. The expert may take part in conducting inspections referred to in Section 11 b, in which case the provisions in the aforementioned section and Section 11 c shall apply to their competence.

(2) When the expert is carrying out his or her duties referred to in this Chapter, the provisions on criminal liability for acts in office shall apply. Provisions on liability for damages are contained in the Tort Liability Act (412/1974).

Section 11 h
Prohibition of imposing sanctions (28.6.2013/495)

No punishment or other sanctions may be imposed on persons having provided information to the National Preventive Mechanism for having communicated this information.

CHAPTER 2
Report to the Parliament and declaration of interests

Section 12
Report

(1) The Ombudsman shall submit to the Parliament an annual report on his or her activities and the state of administration of justice, public administration and the performance of public tasks, as well as on defects observed in legislation, with special attention to implementation of fundamental and human rights.

(2) The Ombudsman may also submit a special report to the Parliament on a matter he or she deems to be of importance.

(3) In connection with the submission of reports, the Ombudsman may make recommendations to the Parliament concerning the elimination of defects in legislation. If a defect relates to a matter under deliberation in the Parliament, the Ombudsman may also otherwise communicate his or her observations to the relevant body within the Parliament.

Section 13
Declaration of interests (24.8.2007/804)

(1) A person elected to the position of Ombudsman, Deputy-Ombudsman or as a substitute for a Deputy-Ombudsman shall without delay submit to the Parliament a declaration of business activities and assets and duties and other interests which may be of relevance in the evaluation of his or her activity as Ombudsman, Deputy-Ombudsman or substitute for a Deputy-Ombudsman.

(2) During their term in office, the Ombudsman the Deputy-Ombudsmen and the substitute for a Deputy-Ombudsman shall without delay declare any changes to the information referred to in paragraph (1) above.

CHAPTER 3
General provisions on the Ombudsman, the Deputy-Ombudsmen and the Director of the Human Rights Centre (20.5.2011/535)

Section 14
Competence of the Ombudsman and the Deputy-Ombudsmen

(1) The Ombudsman has sole competence to make decisions in all matters falling within his or her remit under the law. Having heard the opinions of the Deputy-Ombudsmen, the Ombudsman shall also decide on the allocation of duties among the Ombudsman and the Deputy-Ombudsmen.

(2) The Deputy-Ombudsmen have the same competence as the Ombudsman to consider and decide on those oversight-of-legality matters that the Ombudsman has allocated to them or that they have taken up on their own initiative.

(3) If a Deputy-Ombudsman deems that in a matter under his or her consideration there is reason to issue a reprimand for a decision or action of the Government, a Minister or the President of the Republic, or to bring a charge against the President or a Justice of the Supreme Court or the Supreme Administrative Court, he or she shall refer the matter to the Ombudsman for a decision.

Section 15
Decision-making by the Ombudsman

The Ombudsman or a Deputy-Ombudsman shall make their decisions on the basis of drafts prepared by referendary officials, unless they specifically decide otherwise in a given case.

Section 16
Substitution (24.8.2007/804)

(1) If the Ombudsman dies in office or resigns, and the Parliament has not elected a successor, his or her duties shall be performed by the senior Deputy-Ombudsman.

(2) The senior Deputy-Ombudsman shall perform the duties of the Ombudsman also when the latter is recused or otherwise prevented from attending to his or her duties, as provided for in greater detail in the Rules of Procedure of the Office of the Parliamentary Ombudsman.

(3) Having received the opinion of the Constitutional Law Committee on the matter, the Parliamentary Ombudsman shall choose a substitute for a Deputy-Ombudsman for a term in office of not more than four years.

(4) When a Deputy-Ombudsman is recused or otherwise prevented from attending to his or her duties, these shall be performed by the Ombudsman or the other Deputy-Ombudsman as provided for in greater detail in the Rules of Procedure of the Office, unless the Ombudsman, as provided for in Section 19 a, paragraph 1, invites a substitute for a Deputy-Ombudsman to perform the Deputy-Ombudsman's tasks. When a substitute is performing the tasks of a Deputy-Ombudsman, the provisions of paragraphs (1) and (2) above concerning a Deputy-Ombudsman shall not apply to him or her.

Section 17
Other duties and leave of absence

(1) During their term of service, the Ombudsman and the Deputy-Ombudsmen shall not hold other public offices. In addition, they shall not have public or private duties that may compromise the credibility of their impartiality as overseers of legality or otherwise hamper the appropriate performance of their duties as Ombudsman or Deputy-Ombudsman.

(2) If the person elected as Ombudsman, Deputy-Ombudsman or Director of the Human Rights Centre holds a state office, he or she shall be granted leave of absence from it for the duration of their term of service as as Ombudsman, Deputy-Ombudsman or Director of the Human Rights Centre (20.5.2011/535).

Section 18
Remuneration

(1) The Ombudsman and the Deputy-Ombudsmen shall be remunerated for their service. The Ombudsman's remuneration shall be determined on the same basis as the salary of the Chancellor of Justice of the Government and that of the Deputy-Ombudsmen on the same basis as the salary of the Deputy Chancellor of Justice.

(2) If a person elected as Ombudsman or Deputy-Ombudsman is in a public or private employment relationship, he or she shall forgo the remuneration from that employment relationship for the duration of their term. For the duration of their term, they shall also forgo any other perquisites of an employment relationship or other office to which they have been elected or appointed and which could compromise the credibility of their impartiality as overseers of legality.

Section 19
Annual vacation

The Ombudsman and the Deputy-Ombudsmen are each entitled to annual vacation time of a month and a half.

Section 19 a
Substitute for a Deputy-Ombudsman (24.8.2007/804)

(1) A substitute for a Deputy-Ombudsman can perform the duties of a Deputy-Ombudsman if the latter is prevented from attending to them or if a Deputy-Ombudsman's post has not been filled. The Ombudsman shall decide on inviting a substitute to perform the tasks of a Deputy-Ombudsman. (20.5.2011/535)

(2) The provisions of this and other Acts concerning a Deputy-Ombudsman shall apply *mutatis mutandis* also to a substitute for a Deputy-Ombudsman while he or she is performing the tasks of a Deputy-Ombudsman, unless separately otherwise regulated.

CHAPTER 3 a
Human Rights Centre (20.5.2011/535)

Section 19 b
Purpose of the Human Rights Centre (20.5.2011/535)

For the promotion of fundamental and human rights there shall be a Human Rights Centre under the auspices of the Office of the Parliamentary Ombudsman.

Section 19 c
The Director of the Human Rights Centre (20.5.2011/535)

(1) The Human Rights Centre shall have a Director, who must have good familiarity with fundamental and human rights. Having received the Constitutional Law Committee's opinion on the matter, the Parliamentary Ombudsman shall appoint the Director for a four-year term.

(2) The Director shall be tasked with heading and representing the Human Rights Centre as well as resolving those matters within the remit of the Human Rights Centre that are not assigned under the provisions of this Act to the Human Rights Delegation.

Section 19 d
Tasks of the Human Rights Centre (20.5.2011/535)

(1) The tasks of the Human Rights Centre are:
1) to promote information, education, training and research concerning fundamental and human rights as well as co-operation relating to them;
2) to draft reports on implementation of fundamental and human rights;
3) to present initiatives and issue statements in order to promote and implement fundamental and human rights;
4) to participate in European and international cooperation associated with promoting and safeguarding fundamental and human rights;
5) to take care of other comparable tasks associated with promoting and implementing fundamental and human rights.

(2) The Human Rights Centre does not handle complaints.

(3) In order to perform its tasks, the Human Rights Centre shall have the right to receive the necessary information and reports free of charge from the authorities.

Section 19 e
Human Rights Delegation (20.5.2011/535)

(1) The Human Rights Centre shall have a Human Rights Delegation, which the Parliamentary Ombudsman, having heard the view of the Director of the Human Rights Centre, shall appoint for a four-year term. The Director of the Human Rights Centre shall chair the Human Rights Delegation. In addition, the Delegation shall have not fewer than 20 and no more than 40 members. The Delegation shall comprise representatives of civil society, research in the field of fundamental and human rights as well as other actors participating in the promotion and safeguarding of fundamental and human rights. The Delegation shall choose a deputy chair from among its own number. If a member of the Delegation resigns or dies mid-term, the Ombudsman shall appoint a replacement for him or her for the remainder of the term.

(2) The Office Commission of the Eduskunta shall confirm the remuneration of the members of the Delegation.

(3) The tasks of the Delegation are:
1) to deal with matters of fundamental and human rights that are far-reaching and important in principle;
2) to approve annually the Human Rights Centre's operational plan and the Centre's annual report;
3) to act as a national cooperative body for actors in the sector of fundamental and human rights.

(4) A quarum of the Delegation shall be present when the chair or the deputy chair as well as at least half of the members are in attendance. The opinion that the majority has supported shall constitute the decision of the Delegation. In the event of a tie, the chair shall have the casting vote.

(5) To organise its activities, the Delegation may have a work committee and sections. The Delegation may adopt rules of procedure.

CHAPTER 3 b
Other tasks (10.4.2015/374)

Section 19 f (10.4.2015/374)
Promotion, protection and monitoring of the implementation of the Convention on the Rights of Persons with Disabilities

The tasks under Article 33(2) of the Convention on the Rights of Persons with Disabilities concluded in New York in 13 December 2006 shall be performed by the Parliamentary Ombudsman, the Human Rights Centre and its Human Rights Delegation.

CHAPTER 4
Office of the Parliamentary Ombudsman and the detailed provisions

Section 20 (20.5.2011/535)
Office of the Parliamentary Ombudsman and detailed provisions

For the preliminary processing of cases for decision by the Ombudsman and the performance of the other duties of the Ombudsman as well as for the discharge of tasks assigned to the Human Rights Centre, there shall be an office headed by the Parliamentary Ombudsman.

Section 21
Staff Regulations of the Parliamentary Ombudsman and the Rules of Procedure of the Office (20.5.2011/535)

(1) The positions in the Office of the Parliamentary Ombudsman and the special qualifications for those positions shall be set forth in the Staff Regulations of the Parliamentary Ombudsman.

(2) The Rules of Procedure of the Office of the Parliamentary Ombudsman shall contain more detailed provisions on the allocation of tasks among the Ombudsman and the Deputy-Ombudsmen. Also determined in the Rules of Procedure shall be substitution arrangements for the Ombudsman, the Deputy-Ombudsmen and the Director of the Human Rights Centre as well as the duties of the office staff and the cooperation procedures to be observed in the Office.

(3) The Ombudsman shall confirm the Rules of Procedure of the Office having heard the views of the Deputy-Ombudsmen and the Director of the Human Rights Centre.

CHAPTER 5
Entry into force and transitional provision

Section 22
Entry into force

This Act enters into force on 1 April 2002.

Section 23
Transitional provision

The persons performing the duties of Ombudsman and Deputy-Ombudsman shall declare their interests, as referred to in Section 13, within one month of the entry into force of this Act.

Entry into force and application of the amending acts:

24.8.2007/804
This Act entered into force on 1 October 2007.

20.5.2011/535
This Act entered into force on 1 January 2012 (Section 3 and Section 19 a, subsection 1 on 1 June 2011).

22.7.2011/811
This Act entered into force on 1 January 2014.

28.6.2013/495
This Act entered into force on 7 November 2014 (Section 5 on 1 July 2013).

22.8.2014/674
This Act entered into force on 1 January 2015.

10.4.2015/374
This Act entered into force on 10 June 2016.

Act on the Division of Duties between the Chancellor of Justice and the Parliamentary Ombudsman

21 December 1990 (1224/1990)

Section 1

The Chancellor of Justice is released from the obligation to monitor compliance with the law in issues within the remit of the Parliamentary Ombudsman concerning:

1) the Ministry of Defence, excluding the oversight of legality of the official activities of the Government and its members, the Defence Forces, the Border Guard, the crisis management personnel referred to in the Act on Military Crisis Management (211/2006), the National Defence Training Association of Finland (MPK) referred to in chapter 3 of the Act on Voluntary National Defence (556/2007) as well as military court proceedings; (11.5.2007/564)

2) the apprehension, arrest, remand and travel ban as well as taking into custody or other deprivation of liberty referred to in the Coercive Measures Act (806/2011);

3) prisons and other institutions, to which persons have been admitted against their will.

(22.7.2011/813)

The Chancellor of Justice is also released from handling an issue within the remit of the Ombudsman initiated by a person, whose liberty has been restricted by remand or arrest or by other means.

Section 2

In cases referred to in section 1, the Chancellor of Justice must refer the matter to the Ombudsman, unless there are special reasons for deeming it appropriate to resolve the matter him-/herself.

Section 3

The Chancellor of Justice and the Ombudsman may also mutually transfer other issues within the remit of both parties, when the transfer can be considered to speed up the processing of the issue or if it is justified for other special reasons. In cases related to complaints, the complainant must be notified about the transfer.

Section 4

This act shall enter into force on 1 January 1991.

This act repeals the Act on the Principles of the Division of Duties between the Chancellor of Justice and the Parliamentary Ombudsman, issued on 10 November 1933 (276/33), as well as the Act on Releasing the Chancellor of Justice from Certain Duties issued on the same day (275/33).

When this act enters into force, it shall apply to the cases pending in the Office of the Chancellor of Justice as well as the Office of the Parliamentary Ombudsman.

Rules of Procedure of the Parliamentary Ombudsman

5 March 2002 (209/2002)

Under section 52(2) of the Constitution of Finland, the Finnish Parliament has approved the following rules of procedure for the Parliamentary Ombudsman:

Section 1
Staff of the Office of the Parliamentary Ombudsman

The potential posts in the Office of the Parliamentary Ombudsman include the post of secretary general, principal legal adviser, senior legal adviser, legal adviser, on-duty lawyer, investigating officer, information officer, notary, departmental secretary, filing clerk, records clerk, assistant filing clerk and office secretary. Other officials may also be appointed to the Office.

Within the limits of the budget, officials may be employed by the Office of the Parliamentary Ombudsman in fixed-term positions.

Section 2
Qualification requirements of the staff

The qualification requirements are:

1) the secretary general, principal legal adviser, senior legal adviser and legal adviser have a Master of Laws degree or a different master's degree as well as the experience in public administration or working as a judge required for the task; and

2) those working in other positions have a master's degree suitable for the purpose or other education and experience required by their duties.

Section 3
Appointing officials

The Ombudsman appoints the officials of his/her office.

Section 4
Leave of absence

The Ombudsman grants a leave of absence to the officials of the Office of the Parliamentary Ombudsman.

Section 5
Entry into force

These rules of procedure shall enter into force on 1 April 2002.

These rules of procedure repeal the rules of procedure of the Parliamentary Ombudsman issued on 22 February 2000 (251/2000).

Division of labour between the Ombudsman and the Deputy-Ombudsmen 1.1.–31.8.2018

Ombudsman Mr Petri Jääskeläinen
decides on matters concerning:

- the highest organs of state
- questions involving important principles
- courts
- health care
- legal guardianship
- language legislation
- asylum and immigration
- the rights of persons with disabilities
- oversight of covert intelligence gathering
- the coordination of the tasks of the National Preventive Mechanism against Torture and reports relating to its work

Deputy-Ombudsman Mr Pasi Pölönen
decides on matters concerning:

- the police
- public prosecutor
- social insurance
- labour administration
- unemployment security
- education, science and culture
- data protecton, data management and telecommunications
- the prison service and execution of sentences

Deputy-Ombudsman Ms Maija Sakslin
decides on matters concerning:

- municipal affairs
- children's rights and early childhood education and care
- social welfare
- Sámi affairs
- agriculture and forestry
- customs
- distraint, bankruptcy and dept arrangements
- taxation
- environmental administration
- Defence Forces, Border Guard and non-military national service
- church affairs
- traffic and communications

Division of labour between the Ombudsman and the Deputy-Ombudsmen 1.9.–31.12.2018

Ombudsman Mr Petri Jääskeläinen
decides on matters concerning:

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

Deputy-Ombudsman Mr Pasi Pölönen
decides on matters concerning:

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

Deputy-Ombudsman Ms Maija Sakslin
decides on matters concerning:

- social welfare
- children's rights
- rights of the elderly
- health care
- municipal affairs
- the autonomy of the Åland Islands
- taxation
- traffic and communications
- environmental administration
- agriculture and forestry
- Sámi affairs
- Customs
- church affairs

Statistical data on the Ombudsman's work in 2018

MATTERS UNDER CONSIDERATION

Oversight-of-legality cases under consideration			**7,252**
Cases initiated in 2018		5,818	
– complaints to the Ombudsman	5,561		
– complaints transferred from the Chancellor of Justice	33		
– taken up on the Ombudsman's own initiative	79		
– submissions and attendances at hearings	145		
Cases held over from previous years		1,434	
Cases resolved			**5,629**
Complaints		5,410	
Taken up on the Ombudsman's own initiative		82	
Submissions and attendances at hearings		137	
Cases held over to the following year			**1,623**
Other matters under consideration			**834**
Inspections		128	
Administrative matters in the Office		659	
International matters		47	

OVERSIGHT OF PUBLIC AUTHORITIES

Complaint cases	5,410
Social welfare	1,008
Police	623
Health	581
Criminal sanctions field	431
Social insurance	419
Administrative branch of the Ministry of Economic Affairs and Employment	273
Administrative branch of the Ministry of Education and Culture	199
Local government	188
Administration of law	175
Highest organs of government	157
Enforcement (distraint)	149
Administrative branch of the Ministry of Transport and Communications	137
Aliens affairs and citizenship	133
Administrative branch of the Ministry of Environment	126
Taxation	106
Guardianship	82
Administrative branch of the Ministry of Agriculture and Forestry	73
Administrative branch of the Ministry of Justice	61
Prosecutors	50
Administrative branch of the Ministry of Finance	41
Administrative branch of the Ministry of Defence	28
Administrative branch of the Ministry of the Interior	17
Customs	14
Administrative branch of the Ministry for Foreign Affairs	12
Other administrative branches	327

OVERSIGHT OF PUBLIC AUTHORITIES

Taken up on the Ombudsman's own initiative		**82**
Social welfare	38	
Health	8	
Administrative branch of the Ministry of the Interior	7	
Administrative branch of the Ministry of Defence	5	
Local government	4	
Police	3	
Criminal sanctions field	3	
Customs	3	
Enforcement (distraint)	3	
Administrative branch of the Ministry of Transport and Communications	2	
Aliens affairs and citizenship	1	
Administrative branch of the Ministry of Education and Culture	1	
Administrative branch of the Ministry of Economic Affairs and Employment	1	
Administration of law	1	
Administrative branch of the Ministry of Justice	1	
Taxation	1	
Total number of decisions		**5,492**

MEASURES TAKEN BY THE OMBUDSMAN

Complaints		**5,410**
Decisions leading to measures on the part of the Ombudsman		**759**
– prosecution		–
– assessment of the need for pre-trial investigation		6
– reprimands		41
– opinions		578
– as a rebuke	368	
– for future guidance	210	
– recommendations		38
– to redress an error or rectify a shortcoming	7	
– to develop legislation or regulations	20	
– to provide compensation for a violation	8	
– to rech an agreed settlement	3	
– matters redressed in the course of investigation		20
– other measure		76
– to rech an agreed settlement	–	
No action taken, because		**2,617**
– no incorrect procedure found		213
– no grounds		2,404
– to suspect illegal or incorrect procedure	1,327	
– for the Ombudsman's measures	1,077	
Complaint not investigated, because		**2,034**
– matter not within Ombudsman's remit		210
– still pending before a competent authority or possibility of appeal still open		723
– unspecified		369
– transferred to Chancellor of Justice		16
– transferred to Prosecutor-General		4
– transferred to Regional State Administrative Agency		58
– transferred to other authority		103
– older than two years		98
– inadmissible on other grounds		21
– no answer		69
– answer without measures		363

MEASURES TAKEN BY THE OMBUDSMAN

Taken up on the Ombudsman's own initiative		**82**
Decisions leading to measures on the part of the Ombudsman		45
– prosecution		–
– assessment of the need for pre-trial investigation		–
– reprimands		5
– opinions		35
– as a rebuke	7	
– for future guidance	28	
– recommendations		2
– to redress an error or rectify a shortcoming	–	
– to develop legislation or regulations	2	
– to provide compensation for a violation	–	
– to rech an agreed settlement	–	
– matters redressed in the course of investigation		–
– other measure		3
No action taken, because		20
– no incorrect procedure found		3
– no grounds		27
– to suspect illegal or incorrect procedure	3	
– for the Ombudsman's measures	24	
Own initiative not investigated, because		7
– still pending		–
– transferred to other authority		–
– inadmissible on other grounds		6
– no answer		1

INCOMING CASES BY AUTHORITY

Social welfare	1,101
Police	634
Health	609
Social insurance	452
Criminal sanctions field	387
Administrative branch of the Ministry of Economic Affairs and Employment	272
Administrative branch of the Ministry of Education and Culture	235
Administration of law	199
Local government	168
Administrative branch of the Ministry of Transport and Communications	162
Highest organs of government	156
Enforcement (distraint)	151
Aliens affairs and citizenship	142
Administrative branch of the Ministry of Environment	117
Taxation	107
Guardianship	79
Administrative branch of the Ministry of Agriculture and Forestry	70
Administrative branch of the Ministry of Justice	66
Prosecutors	47
Administrative branch of the Ministry of Finance	39
Administrative branch of the Ministry of Defence	32
Administrative branch of the Ministry of the Interior	14
Customs	10
Administrative branch of the Ministry for Foreign Affairs	10
Subjects of oversight in the private sector	–
Other administrative branches	335

Proposals for the development of legislation and regulations and for the redressing of errors

To the Region Center of the Criminal Sanctions Region of Eastern and Northern Finland

- Deputy-Ombudsman Pölönen proposed a clarification in the guidelines regarding the processing of prisoners' demands for rectification (5400/2017)

To the Ministry of Transport and Communications

- Deputy-Ombudsman Sakslin made a proposal on the revocation of Section 9(3) of the Government Decree on Vehicle Registration, especially from the perspective of the free movement of persons stipulated in Article 21 of the Treaty on the Functioning of the European Union (TFEU) (1219/2018)
- Deputy-Ombudsman Sakslin made a proposal for the assessment of whether there is a need to clarify the official liability as referred to in Section 21 of the Postal Act or to use other methods to ensure the appropriateness of the handling of the statutory notification of service procedure (2959/2017)

To the Finnish Transport and Communications Agency Traficom

- Deputy-Ombudsman Jääskeläinen proposed that action would be taken to correct the text in signs Helsinki indicating prohibited flying areas ('No drone zone') of remotely controlled (camera) drones, so that the requirements of the Language Act and, thus, language rights are fulfilled (2406/2018* and 4345/2017)

To the Ministry of Justice

- Ombudsman Jääskeläinen made a proposal on considering whether there would be cause to start legislative measures in order to extend the two-year period of limitation regarding labour law violations (6954/2017)
- Deputy-Ombudsman Sakslin made a proposal for consideration of whether the execution code should be changed with regard to the notification of the lowest acceptable offer to the proposed buyers (2095/2017)
- Deputy-Ombudsman Pölönen brought his views to the attention of the Ministry of Justice on the need to clarify the provisions of the Imprisonment Act and the Remand Imprisonment Act on giving a debit card or other prison property to the possession of the prisoner (252/2018)
- Deputy-Ombudsman Pölönen observed flaws in the operation of the computer software used in determining the session rota of the district court's lay members with regard to the implementation of the session arrangement as required by law (443/2018)
- Deputy-Ombudsman Pölönen brought his observations to the attention of the Ministry of Justice on the fact that there are no provisions on the power of decision and on the right to appeal against a decision concerning the work conducted in a prisoner's free time (6042/2017)
- Deputy-Ombudsman Pölönen made a proposal for assessment of whether there is a need to change the regulation on the daily schedule at prisons (6542/2017)

To the Ministry of Education and Culture

- Deputy-Ombudsman Pölönen proposed that the margin of interpretation related to the concept of study attainment as set forth in the Universities of Applied Sciences Act would be taken into consideration in the drafting of the Universities of Applied Sciences legislation (3959/2017)
- Deputy-Ombudsman Pölönen made a proposal for assessment of whether the provisions on the procedures and decision-making related to the right to early education in the Early Childhood Education and Care Act as well as the regulation of appeals should be clarified (6442/2017)
- Deputy-Ombudsman Pölönen proposed measures to be considered in the issue on the upper age limit, unfounded in law, in order to ensure equality of those seeking basic education in art (6832/2017)

To the Päijät-Häme Federation of Municipalities for Wellbeing

- Deputy-Ombudsman Sakslin proposed that the policy of assistive devices in medical rehabilitation be changed in residential service units such that all residents in these units who meet the requirements of Section 1 of the Assistive Device Act are entitled to have assistive devices for medical rehabilitation provided for them in accordance with an individual assessment, regardless of the equipment available in the residential unit (4251/2017)

To the Criminal Sanctions Agency

- Deputy-Ombudsman Pölönen found that the regulation of the Criminal Sanctions Agency on debit cards should be changed (252/2018)
- Deputy-Ombudsman Pölönen found deficiencies in the regulations regarding the placement of prisoners and the determination of the powers of the Assessment Centers (451/2017)
- Deputy-Ombudsman Pölönen proposed that prisons would be issued guidelines on how and in what conditions solitary confinement, observation, isolation under observation, and keeping in isolation during investigation of a breach of prison rules should be enforced (1276/2017)
- Deputy-Ombudsman Pölönen urged to consider whether the marking practices for communication restrictions and the actors responsible for making the markings should be clarified and the institutions issued guidelines on the matter before the commissioning of the Roti ICT-system (3095/2017)
- Deputy-Ombudsman Pölönen found that the practices utilised in prisons regarding the effect of giving a positive urine sample or refusing to provide a urine sample on the placement of prisoners in various activities should be standardised (5037/2017)

To the Ministry of the Interior

- Ombudsman Jääskeläinen proposed that Section 29 of the Act on the Emergency Services College would be changed such that a delay in starting studies would also be possible due to compulsory military service (633/2018)

To the Ministry of Social Affairs and Health

- Ombudsman Jääskeläinen proposed that when developing legislation, provisions regarding a confined patient's use of a phone and seeing to the wellbeing of a confined patient, as well as the equipment in an isolation space, would be considered (2278/2017)
- Ombudsman Jääskeläinen proposed that when renewing the patient injuries legislation, regulations should be made more specific by adding provisions on the prerequisites for recovery and set-off as well as on the related procedures to be followed (3383/2018)

- Deputy-Ombudsman Sakslin expedited the amendment of the Trans Act such that the requirement for infertility as a precondition for gender recognition would be removed. At the same time, the name of the Trans Act should be changed to 'the Act on Gender Recognition'. In addition, the criterion of the age of majority should also be assessed during law drafting and consideration should be given to remove it in the legal validation of gender recognition with consideration of the child's age, level of development and the best interest (2842/2017)
- Deputy-Ombudsman Pölönen proposed that a legislation amendment should be considered, especially with regard to the use of Kela's own medical expertise in income support matters (6468/2017)
- Deputy-Ombudsman Sakslin requested consideration of whether it would be necessary and justified to issue a decree on the implementation of the right of access to information of a guardian or legal representative of a minor patient on the basis of Section 19(5) of the Act on the Electronic Processing of Client Data in Healthcare and Social Welfare (6764 and 1675/2017)

To Sukeva Prison

- Deputy-Ombudsman Pölönen found the time the prisoners living in the closed ward spend outside of their cells to be insufficient (3251/2017)

To the City of Tampere

- Deputy-Ombudsman Sakslin thought it necessary to supplement the criteria for referral to institutional care enforced in the social work with intoxicant abusers by taking the intoxicant abuser's individual needs into consideration when arranging institutional care (4341/2017)

To the Ministry of Economic Affairs and Employment

- Deputy-Ombudsman Pölönen considered the regulation of the interviews of an unemployed person as inconsistent when comparing the Act on Multidisciplinary Services for the Promotion of Employment against the Act on the on Public Employment and Corporate Services (1542/2018)

Inspections

#) = unannounced inspection

Courts

- 17 April District Court of Varsinais-Suomi, covert intelligence gathering, Turku (1920/2018)
- 17 April District Court of Varsinais-Suomi detention facilities for persons deprived of their liberty#), Turku (2064/2018)
- 23 October Ministry of Justice, AIPA project (5507/2018)

Finnish Prosecution Service

- 17-18 April Prosecutor's Office of Western Finland, Turku (1921/2018)
- 13 December Office of the Prosecutor General, Helsinki (6471/2018)

Police administration

- 14 February Helsinki Police Department, virtual operations support (virtual police officers) (847/2018)
- 7 March Pasila Police Station, police prison#), Helsinki (849/2018)
- 7 March Pasila Police Station, police prison health care, (1488/2018)
- 20 March Ministry of the Interior's Police Department, Helsinki (848/2018)
- 17 April Southwestern Finland Police Department, covert intelligence gathering, Turku (1919/2018)
- 17 April Turku Central Police Station, police prison#) (1963/2018)
- 18 April Southwestern Finland Police Department, Turku (1610/2018)
- 28 May Kajaani Police Station, police prison#) (2485/2018)
- 29 May Iisalmi Police Station, police prison#) (2486/2018)
- 29 May Kuopio Police Station, police prison#) (2487/2018)
- 30 May Varkaus Police Station, police prison#) (2489/2018)
- 30 May Joensuu Police Station, police prison#) (2490/2018)
- 3 July Lahti Central Police Station, police prison#) (3222/2018)
- 2 September Jämsä Police Station, police prison#) (4390/2018)
- 3 September Saarijärvi Police Station, police prison#) (4391/2018)
- 3 September Jyväskylä Police Station, police prison#) (4392/2018)
- 4 September Mänttä-Vilppula Police Station, police prison#), not in use (4393/2018)
- 4 September Tampere Central Police Station, police prison#) (4394/2018)
- 26 September National Bureau of Investigation, Legal Unit (4872/2018)
- 26 September National Bureau of Investigation, covert coercive measures and intelligence gathering (4873/2018)
- 9 October National Police Board, Vitja project, Helsinki (5197/2018)
- 9 November National Bureau of Investigation (5804/2018)
- 12 November National Police Board, Firearms Administration, Riihimäki (5805/2018)
- 3 December National Police Board, Helsinki (6287/2018)

Defence Forces and Border Guard

- 28 March Army Command, Mikkeli (1072/2018)
- 7 June The Armoured Brigade, Hämeenlinna (2713/2018)
- 7 June The Armoured Brigade, Riihimäki (2715/2018)

- 7 June The Armoured Brigade, Riihimäki unit's detention facilities for persons deprived of their liberty[#)] (3117/2018)
- 7 June Centre for Military Medicine, Riihimäki (2716/2018)
- 20 November Karelia Air Command, Toivala (5300/2018)
- 20 November Karelia Air Command, detention facilities for persons deprived of their liberty[#)], Toivala (6084/2018)
- 10 December Guard Jaeger Regiment, Helsinki (5301/2018)
- 10 December Guard Jaeger Regiment, detention facilities for persons deprived of their liberty[#)], Helsinki (6511/2018)
- 18 December Naval Academy, Helsinki (5302/2018)

Criminal Sanctions

- 30 January Kerava Prison (448/2018)
- 21 February Criminal Sanctions Agency, Central Administration Unit (957/2018)
- 23 May Laukaa Prison (2337/2018)
- 23 May Kuopio Prison[#)] (2338/2018)
- 24 May Sulkava Prison (2339/2018)
- 24 May Mikkeli Prison[#)] (2340/2018)
- 29 May Prisoner transport by train[#)] (2648/2018)
- 31 May Ministry of Justice, Department for Criminal Policy and Criminal Law (2647/2018)
- 20 June Accessibility in Jokela Prison[#)] (3183/2018)
- 9 October Juuka Prison (4652/2018)
- 9-10 October Pyhäselkä Prison (4653/2018)
- 10 October Accessibility in Pyhäselkä Prison, (5322/2018)
- 10 October Prisoners' health care unit, clinic in Pyhäselkä Prison (4986/2018)
- 20 November Visiting area of Kuopio Prison[#)] (6085/2018)
- 27 and 29 November Helsinki Prison (5563/2018)
- 27 November Accessibility in Helsinki Prison (6148/2018)
- 29 November Prisoners' health care unit, clinic in Helsinki Prison (5323/2018)

Distraint

- 21 March City of Rovaniemi, Finance Services (1195/2018)
- 22 March Lapland Enforcement Office, Rovaniemi (977/2018)

Aliens affairs

- 22 March Helsinki Police Department, Immigration Police (1658/2018)
- 7 June Lahti Reception Centre, intensified support unit (2925/2018)
- 30-31 November Joutseno Reception Centre, Detention Unit[#)] (5145/2018)

Social welfare

- 26 January Sillankorva homeless shelter[#)], Turku (385/2018)
- 21 March Mother and Child Home and Shelter of Lapland[#)], Rovaniemi (1588/2018)
- 28 June Mutterimaja[#)], Tuusula (3291/2018)
- 2 October Kenttätie Service Centre[#)], Oulu (4849/2018)
- 2 October Mother and Child Home and Shelter of Oulu, Shelter[#)], Oulu (5016/2018)

Social welfare/Children

- 24 January Vuorela Residential School[#)], Nummela (356/2018)
- 31 January Vuorela Residential School, Nummela (846/2018)
- 19 March Salmila children's home[#)], Kajaani (1455/2018)
- 27 March Sutela-koti[#)], Mikkeli (1605/2018)
- 28 March Children's home Rivakka[#)], Mikkeli (1606/2018)
- 17-18 April Residential School Pohjolakoti[#)], Muhos (1353/2018)
- 3 May Sassi[#)], Sastamala (2248/2018)
- 21-22 August Childe welfare unit Jussin kodit[#)], Haukipudas (4099/2018)

- 23 October Loikalan kartano[#)], Mankala (5377/2018)
- 20-21 November Ojantakanen substitute care unit, Pulkkila (5916/2018)

Social welfare/Persons with disabilities

- 19 March Esperi care home Narikka[#)], Järvenpää (1376/2018)
- 25 April Lintukorven Validia-talo[#)], Espoo (1871/2018)
- 4 July Attendo, Valkamahovi service home unit[#)], Helsinki (3351/2018)
- 6 July Rinnekoti Foundation, Pipolakoti housing services units[#)], Karjalohja (3524/2018)
- 20 September Kuumaniemi group home[#)], Kemijärvi (4665/2018)
- 20 September Kolpene service centre joint municipal authority / Service home units Metsärinne 1 & 2, Rovaniemi (3375/2018)
- 20-21 September Kolpene service centre joint municipal authority, Service home units Metsärinne and Mustikkarinne, Rovaniemi (4880/2018)
- 21 September Kolpene service centre joint municipal authority, Housing services, Rovaniemi (4701/2018)
- 21 September Kolpene service centre joint municipal authority, rehabilitation centre Kuntoutuskeskus Vuoma, Rovaniemi (5028/2018)
- 11-12 December Northern Ostrobothnia Hospital District, Care of the developmentally disabled, Adult rehabilitation unit, Oulu (4639/2018)
- 11-12 December Northern Ostrobothnia Hospital District, Care of the developmentally disabled, Child and adolescent unit[#)], Oulu (6388/2018)
- 11-12 December Northern Ostrobothnia Hospital District, Care of the developmentally disabled, Adult rehabilitation unit Lounatuuli [#)], Oulu (6389/2018)

Social welfare/Elderly units

- 26 January Portsakodin palvelutalo, services for the elderly[#)], Turku (383/2018)
- 26 January Elsekoti group home[#)], Turku (384/2018)
- 8 February Taasiakoti[#)], Loviisa (657/2018)
- 8 February Emil-koti[#)], Loviisa (659/2018)
- 21 March Palvelutalo Näsmänkieppi, services for the elderly[#)], Rovaniemi (1212/2018)
- 25 April City of Lohja, service centre for the elderly, Pentinkulma group home Alatupa[#)] (2114/2018)
- 25 April City of Lohja, service centre for the elderly, Kultakoti group home Katinkulta[#)] (2217/2018)
- 25 April City of Lohja, service centre for the elderly, Kultakartano group home Kultarinne[#)] (2218/2018)
- 18 June City of Lohja, service centre for the elderly, Kultakoti group homes Katinkulta and Alatupa[#)] (3082/2018)
- 28 June Tuusula service centre Riihikoto, group home Tammikoto[#)] (3290/2018)
- 4 July Attendo, Linnanharju care home[#)], Helsinki (3367/2018)

Health care

- 30 January Prisoners' health care unit, clinic in Kerava Prison (450/2018)
- 19-20 March Kainuu Social Welfare and Health Care Joint Authority, Kainuu Central Hospital, psychiatric wards[#)], Kajaani (727/2018)
- 19 March Kainuu Central Hospital emergency clinic, secure rooms[#)], Kajaani (729/2018)
- 22-24 May Siun sote, North Karelia Central Hospital, psychiatric wards[#)], Joensuu (1600/2018)
- 23 May Siun sote, North Karelia Central Hospital, joint emergency clinic and secure rooms[#)], Joensuu (1601/2018)
- 25 September Niuvanniemi Hospital, ward for examinations and treatment of difficult-to-treat and/or dangerous, under-age patients (NEVA) [#)], Kuopio (3713/2018)

- 25-27 September Niuvanniemi Hospital, Kuopio[#)], Kuopio (3712/2018)
- 26 September Hospital District of Pohjois-Savo, Kuopio University Hospital joint emergency clinic's secure room[#)] (4753/2018)

Social insurance

- 19 April Kela's legal services team, Cooperation meeting with Kela on matters related to Kela (1654/2018)
- 5 June Kela, Joensuu customer service point (2668/2018)
- 5 June Kela, Eastern Insurance District (2670/2018,)
- 5 June Kela, Eastern customer service unit (2706/2018)

Labour and unemployment security

- 5 June North Karelia TE Office, Joensuu (2667/2018)

Education

- 23 May City of Helsinki, Education Division, decision support unit (2516/2018)
- 2 October City of Lahti, Education Division (4998/2018)
- 2 October Kivimaa School, Lahti (4997/2018)
- 12 October Ministry of Education and Culture, Helsinki (5003/2018)
- 24 October Finnish National Board of Education (5004/2018)
- 1 November Kouvola Region Vocational College (324/2019)
- 1 November City of Kouvola, children and young people's services (5005/2018)

Other inspections

- 22 January Advance polling stations for the Finnish presidential election:
  - Söderkulla Library[#)], Sipoo (166/2018)
  - Prismakeskus[#)], Järvenpää (451/2018)
  - Town Hall[#)], Mäntsälä (452/2018)
  - Hyvinkää post office[#)], Hyvinkää (453/2018)
  - Main library[#)], Vihti (454/2018)
  - K-Citymarket[#)], Lohja (455/2018)
  - Town Hall[#)], Kauniainen (456/2018)
- 30 October Finnish Transport and Communications Agency Traficom, Helsinki (4930/2018)
- 3 December Population Register Centre (5803/2018)

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Mr Matti Vartia, LL.M. with court training
Ms Minna Verronen, LL.M. with court training
Ms Pirkko Äijälä-Roudasmaa, LL.M. with court training

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Mr Peter Fagerholm, M.Sc. (Admin)
Mr Reima Laakso

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Ms Heini Lehtinen (till 28 February)
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Ms Tiina Mäkinen

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