PARLIAMENTARY OMBUDSMAN OF FINLAND

SUMMARY OF THE ANNUAL REPORT 2019

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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 2019. 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 88 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 400 pages long. This brief summary in English has been prepared for the benefit of foreign readers. The longest section of the original report, a review of oversight of legality and decisions by the Ombudsman by sector of administration, has been omitted from it. However, the chapter dealing with the oversight of covert intelligence gathering 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 2019.

Petri Jääskeläinen
Parliamentary Ombudsman of Finland

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Photos

The photographs on the front pages of the sections feature shots of the steel statue deplating giant strawberries called "Oma maa mansikka" (2007) by sculptor Jukka Lehtinen, located at the front of the Finnish Parliament Annex. Photos: Office of the Parliamentary Ombudsman photo archive (p. 10, 26, 44, 184, 201, 206).

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1 General comments

Parliamentary Ombudsman
Mr Petri Jääskeläinen

100 years of the Parliamentary Ombudsman

The institution of the Parliamentary Ombudsman was established by the Constitution of 1919, and the first Parliamentary Ombudsman took office at the start of 1920 – 100 years ago. The institution is, therefore, almost as old as the independent nation of Finland, and it is the second-oldest parliamentary ombudsman institution in the world.

The Parliamentary Ombudsman received his first complaint on 11 February 1920. For this reason, the institution has traditionally celebrated its anniversary on the eleventh day of February, and the institution's centenary celebration was held on 11 February 2020 in the Finnish Parliament Annex.[1)]

How has the Ombudsman institution developed from its original role as the formal judicial overseer of legality to extend its focus into fundamental rights and guiding the activities of the authorities? What expectations have the Parliament and Members of Parliament placed on the Ombudsman's work? How has the Parliamentary Ombudsman appeared in the media over the last 100 years?

In a book published to celebrate the institution's centenary, Markus V. Kari, LL.D., Jukka Lindstedt, LL.D., and legal affairs journalist Susanna Reinboth answer these questions and discuss the activities of the Parliamentary Ombudsman in the societal, political and journalistic contexts of each period.

In my opinion, the book is impressive, both visually and in terms of its content. Assessing some of the same events from different standpoints using different material provides deeper insight into the Parliamentary Ombudsman's activities and how they have developed over the course of a century. I would like to thank the authors of the jubilee book and everyone involved in editing it!

1) This text is based on the undersigned's opening speech at the celebration.

Features of the institution's development

It almost happened that the Institution of the Finnish Ombudsman never came into being. In 1918, a government proposal for a *monarchical* Constitution included regulations concerning the Ombudsman. However, no such regulations were included in the proposal for a *republican* Constitution submitted to the Parliament in 1919. Nevertheless, the Constitutional Law Committee added the regulations with regard to the Ombudsman into that proposal, which the Parliament approved.

The Parliamentary Ombudsman's early years were fraught with difficulty. In her contribution to the jubilee book, Susanna Reinboth characterised the first Ombudsman's term in office in the following title, which could also be extended to cover the early years of the institution more generally: "The Parliamentary Ombudsman seeks out work and a purpose and finds neither."

In the early years, there were numerous calls for the institution of the Parliamentary Ombudsman to be abolished. These came from the first Ombudsman himself, several Members of Parliament, several newspapers, the Chancellor of Justice, and it was ultimately proposed in a draft Government bill in 1932. Fortunately for us, the Constitutional Law Committee did not approve the proposal, and the Parliament rejected the Government's bill.

What was the reason behind these difficulties? The root cause was that when the institution of the Parliamentary Ombudsman was established, Finland already had a supreme overseer of legality – the Chancellor of Justice – whose position was already well established. For this reason, there were simply not enough complaints or work for the Parliamentary Ombudsman in the early years.

The Parliamentary Ombudsman's remit and responsibility for overseeing legality are laid down in the Constitution of Finland, and they have remained largely the same ever since the institution was established. However, other provisions in the Constitution concerning the Ombudsman have undergone some changes. In 1933, the Parliamentary Ombudsman's term of office was extended from one to three years, and in 1957, it was extended to four years. Since 1957, it has been possible to elect a "person" to serve as the Parliamentary Ombudsman, whereas the original provision called for the election of a "man". However, it would be 30 years before the first female overseer of legality was elected: Pirkko K. Koskinen was elected Deputy-Ombudsman in 1988. The first and – so far – only female Ombudsman was Riitta-Leena Paunio, who served two terms beginning in 2002.

Since 1928, it has not been possible for the Ombudsman to be a Member of Parliament. Before this, in the most extraordinary cases, the Parliamentary Ombudsman could have served as a Member of Parliament and Chair of the Constitutional Law Committee!

Initially, the election of the Parliamentary Ombudsman was highly political, and for a long time, it was typical for the post of Parliamentary Ombudsman and that of Vice-Ombudsman – and later Deputy-Ombudsman – to be held by people of different political orientations. Political leanings are discernible in the activities of the early Ombudsmen, but the articles in the jubilee book lend weight to the idea that Finland's Parliamentary Ombudsmen have, in general, been relatively successful in avoiding political bias in their work. Since the mid-1990s, the elections of Parliamentary Ombudsmen have no longer been political – at least not on the basis of the voting behaviour of Members of Parliament.

The post of Deputy-Ombudsman was created in 1971, and the second Deputy-Ombudsman's post was established in 1997. These changes reflect the number of cases and the increase in the volume of activities. It should be noted that there have been years, already in the post-war era, when the Parliamentary Ombudsman has received more complaints – and nowadays a three folded number - than the Chancellor of Justice. The creation of the two Deputy-Ombudsman posts has had the natural effect of attenuating the once highly personalised nature of the institution.

Since 1995, the duties assigned by the Constitution to the Parliamentary Ombudsman have included the oversight of fundamental and human rights in addition to the oversight of legality. In-

deed, the Ombudsman has been a leading figure in promoting fundamental and human rights and pioneered the instilment of the topic in Finland. By contrast, the Ombudsman's activities in the early years of the Office were highly legalistic and focused on formal judicial oversight. In the 1960s, the Parliamentary Ombudsman issued his first individual statements containing argumentation on fundamental rights. By the 1970s and 1980s, this practice had become more established, and the Ombudsman also invoked international human rights treaties. The actual breakthrough that led to the Parliamentary Ombudsman's focus shifting to the realisation of individual rights in the field of fundamental and human rights took place in conjunction with the internationalisation of the 1990s and the accession to the European Convention on Human Rights.

I will not go into any more detail here on the development of the Ombudsman's activities in different periods – the articles in the book cover the topic thoroughly. I would like to highlight just one aspect.

Ever since the early years, the complaints and other cases processed by the Parliamentary Ombudsman have overwhelmingly concerned prisoners and courts. In the 1970s, the majority of cases still focused on prisoners or courts. Cases concerning prisoners were significant and politically sensitive in the early years of the Ombudsman's activities because Finland was a country with political prisoners, firstly following the Civil War and then during the World Wars. Cases concerning prisoners became an even more pronounced figure of the Parliamentary Ombudsman's work when the Act on the Division of Duties between the Chancellor of Justice and the Parliamentary Ombudsman entered into force in 1933, delegating such cases primarily to the Parliamentary Ombudsman for review. The Ombudsman at that time was opposed to the Act as, in his opinion, prisoners' complaints were "often of rather minor importance".

In retrospect, however, it would seem that this focus onto prisoners' rights laid the foundations for the future development of the institution of the Parliamentary Ombudsman. Prisoners are not only offenders but also persons in closed institutions who find themselves in a vulnerable position. It is not by chance that the Parliamentary Ombudsman has since begun focusing on the oversight of the human rights and treatment of all institutionalised people and those in vulnerable positions.

This development has culminated in the special responsibilities based on UN Conventions. Since 2014, the Parliamentary Ombudsman has had the special duty, based on the UN Convention, of monitoring all places of detention and the treatment of persons deprived of their liberty. In addition to prisoners, such persons may include for example children, elderly persons, persons with disabilities and psychiatric patients. Since 2016, another duty of the Ombudsman derived from the UN Convention is monitoring and promoting all of the rights of persons with disabilities in collaboration with the Human Rights Centre. This development is also demonstrated by the fact that the Human Rights Centre was established in connection with the Office of the Parliamentary Ombudsman.

Present and future

The institution of the Parliamentary Ombudsman has found the work and the purpose that it was lacking in the early years. This is apparent from the number of cases it handles. Whereas in 1920, the Parliamentary Ombudsman received 39 complaints, the year 2019 saw a record number – 6,267. The institution's development could be described thus: the ugly duckling of the early years has gradually grown feathers, and, perhaps in the 1970s, it became a swan, which took flight in the 1980s and 1990s.

It is hard to predict the future, but I think the swan will reach new heights. The most important reform on the horizon is the development of the division of duties between the Parliamentary Ombudsman and the Chancellor of Justice. If this reform is enacted, it will further strengthen the Parliamentary Ombudsman's role as an overseer and promoter of the rights and treatment of people

in vulnerable positions. The reform will also strengthen the role of the Chancellor of Justice in his current special duties and give him certain new responsibilities.

In the future, the institution of the Parliamentary Ombudsman may come under threat. For example, responsibilities closely related to the legal positions of individuals could be left outside the Ombudsman's remit, or reforms may be enacted or actions taken that would jeopardise the Ombudsman's independence. Such threats may arise from the European Union or national actors. Some examples of such threats already exist, both in Finland and elsewhere. As the caseload continues to increase, efforts must be made to ensure the sufficiency of the Ombudsman's resources.

Events in the centenary year

The Parliamentary Ombudsman is there to serve everybody. In this spirit, the Office of the Parliamentary Ombudsman decided not to hold the institution's centenary celebration at Finlandia Hall, but instead to hold a smaller event in the Finnish Parliament Annex, and moreover, we reach out to the people. During the jubilee year, we will arrange several public events to coincide with the inspections the Ombudsman performs in various parts of Finland. At these events, we will cover selected themes relevant to the sites under inspection, present the activities of the Parliamentary Ombudsman and talk to people who the Ombudsman may be able to help. We will also organize several public events at the Finnish Parliament Annex, each covering one of the areas of the Ombudsman's activities. In addition to these events, everybody will be able to read the jubilee book, one copy of which will be sent to each of the 600 libraries in Finland.

Internationally, the Parliamentary Ombudsman's centenary will be celebrated at the International Ombudsman Institute's World Conference in Dublin.

Conclusion

The transformation of the ugly duckling into a handsome swan is the result of many factors. The Parliamentary Ombudsman performs his duty by virtue of the trust vested in him by the highest organ of government, the Parliament. The institution's establishment, survival and development have required the support, trust and foresight of the Parliament and its Constitutional Law Committee. An institution largely based on investigating complaints also requires the trust of citizens – otherwise, no complaints will be made. As the Parliamentary Ombudsman's statements are not legally binding, the effectiveness of decisions ultimately requires the authorities to show trust in the Ombudsman's activities.

The Parliamentary Ombudsman's activities enjoy the institutional support deriving from the authority of the nation's highest organ of government. Ultimately, the Parliamentary Ombudsman must himself or herself earn the trust of various parties – trust that is vital for the Ombudsman's activities. In conclusion, I would like to thank all of the former Parliamentary Ombudsmen and Deputy-Ombudsmen and the current and former personnel in the Office for the work they have done over the course of a century to build up the trust that the institution can lean on today.

Deputy-Ombudsman
Ms Maija Sakslin

Guarantees of the Parliamentary Ombudsman's effectiveness and independence

The Parliamentary Ombudsman in a state governed by the rule of law

The history of the Parliamentary Ombudsman describes how the Ombudsman, as an overseer of legality, has upheld trust in the exercise of public power and in the respect for the Constitution and laws of Finland. Over the last hundred years, the Parliamentary Ombudsman has become a strong institution that builds on our understanding of legality and lays the foundations for a functional democracy and the strong rule of law, thereby promoting the realisation of fundamental and human rights.

However, in order to fulfil its role, the Parliamentary Ombudsman institution relies on the strong rule of law for support.

Rule of law is not only dependent on the existence of legal and institutional structures; it also requires institutional practices. Bodies such as the Venice Commission have drawn attention to the importance of sincere collaboration between institutions and highlighted that the basis for the rule of law is that state actors share a respect for each others' duties. The oversight of legality can be effective only as long as it enjoys sufficient authority within the parliament, judiciary, administration and society in general.

However, trust in the Parliamentary Ombudsman's activities and the respect on which the oversight of legality depends could easily crumble. For this reason, it is important for the Parliamentary Ombudsman to be able to take action to promote and maintain this trust.

At present, there are more than 140 ombudsman institutions in the world. In recent years, many of them have come under threat or been attacked in ways that have jeopardised their independence or finances or restricted their authority. In many countries, the dwindling support for the national constitutional tradition and its political and judicial culture has increased the international monitoring of the activities of national ombudsmen. Several international mechanisms of protection and control have arisen to supplement and safeguard national institutions.

One of the distinctive characteristics of Finland's constitutional system is the strong position of the Parliamentary Ombudsman, underpinned by the culture of constitutional law. Indeed, we

can be proud of the success we have had in fostering the institution of the Parliamentary Ombudsman as an integral part of the Finnish constitutional legal tradition.

The Parliamentary Ombudsman in the Constitution of Finland

Section 109 of the Constitution of Finland assigns the Parliamentary Ombudsman the duty of overseeing compliance with the law and the realisation of fundamental and human rights. This duty of the oversight of legality is anchored in several provisions of the Constitution. The constitutional basis for every exercise of public power and public action is set out in the first section of the Constitution of Finland, which states that our constitution guarantees the inviolability of human dignity and the freedom and rights of the individual and promotes justice in society. Paragraph 3 of section 2 of the Constitution confirms the principle of the rule of law, which is based on the principle that the administration conforms with and commits to the law and the obligation to safeguard the realisation of fundamental and human rights in accordance with section 22 of the Constitution.

The duties and authority passed down to the Parliamentary Ombudsman in the Constitution are strongly linked to the aforementioned constitutional principles. They also guarantee that the Parliamentary Ombudsman has a strong constitutional position.

The position of the Parliamentary Ombudsman in relation to the government as the holder of executive power and the courts as the holder of judicial power is based fundamentally on the provision of paragraph 1 of section 2 of the Constitution, which states that the powers of the State in Finland are vested in the people, who are represented by the Parliament. The Parliamentary Ombudsman and Deputy-Ombudsmen are elected by the Parliament, and the realisation of their legal responsibilities is also an essential matter for the Parliament. The new Constitution included the option of relieving a Parliamentary Ombudsman or Deputy-Ombudsman from their position for weighty reasons, a provision that was lacking in the previous Constitution Act. The possibility was considered a necessary option for use in the event that a Parliamentary Ombudsman or Deputy-Ombudsman no longer had the capabilities to discharge their duties. According to the justifications for the amendment to the Constitution, the Ombudsman or Deputy-Ombudsman cannot be relieved of their position if an individual decision is severely criticised.

The Parliament and its members have traditionally respected the integrity and independence of the Parliamentary Ombudsman institution. If Members of Parliament contact the Ombudsman, it is usually to convey a message they have received amounting to a complaint. When a report from the Parliamentary Ombudsman is debated in Parliament, the discussion is both positive and negative, but the Constitutional Law Committee has very seldom criticised individual decisions or statements by the Parliamentary Ombudsman.

The 2019 reporting year was the first occasion that the Parliamentary Ombudsman's report for 2018 was sent to other select committees in addition to the Constitutional Law Committee for commenting. This procedure provides the opportunity to expand the interaction and direct dialogue between the Parliament and the Parliamentary Ombudsman. As such, it promotes the involvement of the Parliament in the evaluation of the fundamental and human rights situation in Finland. This is a positive development in terms of the realisation of fundamental and human rights, as well as for the institutional support that the Parliament shows to the Ombudsman.

The Constitutional Law Committee has stated that the Parliamentary Ombudsman is a parliamentary body with the constitutional duty of overseeing all public administration on behalf of the Parliament. According to the Committee, the fact that the Constitution requires the Parliament and the Constitutional Law Committee to investigate of the legality of the official activities of the supreme overseers of legality highlights the importance of the independence of the supreme overseers of legality, especially in relation to the authorities under supervision.

International principles and recommendations

In the last 30 years, international organisations have paid increasing attention to national bodies tasked with promoting and safeguarding human rights.

The first international recommendations of significance to the Parliamentary Ombudsman were the Paris Principles relating to the status of national institutions that promote and protect human rights, approved by the General Assembly of the United Nations in 1993. According to the Paris Principles, governments should establish permanent bodies with the special duty of promoting and safeguarding human rights at a national level. These bodies should be afforded independence, financial autonomy and pluralism.

Since approving the Paris Principles, the General Assembly of the United Nations has approved several resolutions acknowledging the roles of ombudsmen and other human rights bodies in promoting and protecting human rights and highlighting the importance of the autonomy and independence of ombudsmen. The resolutions take into consideration the role of the ombudsman institution in ensuring good governance and strengthening the availability of public services, as well as in effectively realising the rule of law. States are called upon to strengthen the independence and autonomy of the ombudsman and to raise public awareness of the ombudsman institution. States should also reinforce the legitimacy of ombudsmen by taking constitutional, legislative and financial measures. Ombudsmen are encouraged to operate in accordance with the Paris Principles.

In 2019, the Council of Europe's Venice Commission approved the 25 principles guiding the establishment and operations of ombudsman institutions. The principles were approved against a background of numerous threats to ombudsman institutions.

The Venice Commission emphasises the importance of effective and independent institutions in line with the Paris Principles in promoting and protecting human rights, and it encourages Member States to establish and reinforce them by means such as guaranteeing their financial and administrative independence and stability, as well as their independent right to conduct investigations. According to the Venice Commission, the role of ombudsmen in publicly highlighting problems serves to raise people's awareness of their rights and strengthens a culture of human rights in society. As the ombudsman institution has an important duty to promote and protect the rule of law, good administration and human rights in democracies, states should support and protect the ombudsman institution and refrain from taking any action that endangers its independence and impartiality.

Ombudsmen should be entitled to demand that civil servants and authorities take action on the basis of their recommendations. They should also be entitled to issue recommendations to parliaments and governments, including proposals to amend legislation or enact new legislation. Ombudsmen are tasked with warning the legislature if legislation conflicts with human rights, and they should be entitled to question the constitutionality of laws, decrees and administrative measures. Ombudsmen should be guaranteed sufficient financial resources. The funding should be adequate to guarantee the full, independent and efficient realisation of duties.

In October 2019, the Committee of Ministers of the Council of Europe approved an updated recommendation expressing grave concern about the challenging working conditions, threats, pressures and attacks which ombudsman institutions are at times exposed to in Member States. For this reason, the Committee of Ministers recommends that Member States adopt the principles of the Venice Commission and strengthen their ombudsman institutions, avoid weakening them, and regularly evaluate the effectiveness of the measures taken. According to the recommendation, Member States should ensure that ombudsman institutions operate in a conducive environment which allows them to carry out their mandate independently of any provider of public services over which they hold jurisdiction. States should take all necessary measures to protect ombudsmen from threats and harassment. Ombudsmen should be assured sufficient and sustainable finan-

cial and human resources. Ombudsmen should also have a confirmed mandate to oversee human rights treaties. The ombudsman's oversight of legality should be effective, impartial, transparent and just. According to the recommendation, the ombudsman should provide right-holder-friendly, nonjudicial means in order to protect people against maladministration, violation of rights, unfairness, abuse, corruption and injustice.

The Parliamentary Assembly of the Council of Europe also discussed the ombudsman institution and the need for common European standards in October 2019. It stated that the duty of ombudsman institutions to protect individuals plays a crucial role in democracy, the rule of law and human rights. It welcomed the Venice Commission's principles, which describe the minimum standards for protecting ombudsman institutions and increasing their effectiveness. The Parliamentary Assembly called upon Member States to refrain from taking any action or launching attacks that could prevent the office of the ombudsman and its staff from operating and to protect them from any such actions. States should also promote an atmosphere conducive to the activities of ombudsmen, in particular by guaranteeing that ombudsmen are easy to contact, by granting sufficient financial resources.

Various monitoring mechanisms are also connected with some of these international principles and recommendations. Monitoring focuses not just on the realisation of human rights, but, in particular, the independent and impartial position of the national ombudsman institution and its effectiveness in promoting and protecting human rights.

The enforcement of the Paris Principles was adopted as the most significant and advanced structure for monitoring. At regular intervals, the UN's international network of national human rights institutions evaluates whether the actions and operating conditions of national human rights institutions meet the requirements of the Paris Principles. Institutions are granted 'A' status if they fulfil the Paris Principles.

In addition, the UN's General Assembly has asked the Secretary-General to report to the Assembly on the implementation of his resolution and any impediments and best practices in implementing the resolution.

The recommendation of the Committee of Ministers of the Council of Europe provides for a review of the implementation of the recommendations in five years' time. In addition, the Council of Europe's Commissioner for Human Rights monitors the impartiality of ombudsmen and the adequacy of their financial resources.

Conclusion

It is a matter of grave concern that the impartiality and effectiveness of ombudsman institutions have come under threat in some states in recent years. The threats have typically taken the form of legislative amendments that erode the institution, unjustified delays in appointing ombudsmen in parliaments, or parliaments refusing to debate their ombudsman's reports. These have also included unfounded budget cuts, unjustified financial audits or difficulties in obtaining the documents or information required for the oversight of legality. In some states, ombudsmen have also been the targets of verbal attacks from politicians or even ministers.

Although the Parliamentary Ombudsman in Finland holds a robust constitutional position, threats of this kind are not entirely unheard of in Finland either. However, a strong constitutional culture and the rule of law have effectively prevented the erosion of the Parliamentary Ombudsman institution so far.

On the other hand, the content and conditions of the Parliamentary Ombudsman's operations have already been subjected to regular international evaluations. In particular, attention is paid to the effectiveness and impartiality of the national oversight of the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities, and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The Parliamentary Ombudsman has been evaluated as a national human rights body on the basis of the Paris Principles.

Traditionally, effective means of legal protection for citizens' rights and political rights have primarily referred to appeal bodies other than the courts. Conversely, other bodies are required to support these rights in a welfare state. One of the distinctive characteristics of the Parliamentary Ombudsman's activities is that social, financial and cultural rights constitute a significant proportion of the cases related to the oversight of legality. In part, this may explain the increasing international interest in safeguarding the effective and independent activities of national parliamentary ombudsmen. It is clear that the institute of the Parliamentary Ombudsman, which was created by Finland's previous Constitution Act as a very national institution, will increasingly become the focus of international evaluations in the future. These evaluations will examine the Parliamentary Ombudsman's institutional operating conditions and the content of the Ombudsman's oversight of human rights. It is already apparent that closer international interaction has altered the Ombudsman's activities as well as the nature of the Parliamentary Ombudsman as an institution. In the future, it will not be enough for the Parliamentary Ombudsman to concentrate on preventing violations of fundamental and human rights. The Parliamentary Ombudsman's duty is to effectively use and reform the full diversity of means at its disposal for the oversight of legality to influence the kind of future we can expect and ensure that the Finnish state is ruled by law, remains strong, and safeguards fundamental rights for everyone.

Deputy-Ombudsman
Mr Pasi Pölönen

Good governance secures basic and human rights in basic education

Of all functions in society, education is the most comprehensive one measured by the number of people participating in it. At the beginning of the year under review, there were approximately 1.84 million people in Finland studying at 3,200 educational institutions. There are 715 education providers in Finland, mainly local authorities and joint authorities. There were 2,234 comprehensive schools (with 560,000 pupils) and 336 general upper secondary schools (with 103,000 students). Nearly one-fifth of comprehensive school pupils received intensified or special support [1].

Education also represents a major sector in the oversight of legality carried out by the Parliamentary Ombudsman. As the overseer of all public administration, the Parliamentary Ombudsman's remit extends to all levels of education from early childhood education through pre-primary and comprehensive school education to secondary, tertiary and liberal education. Deputy-Ombudsman Jussi Pajuoja has discussed questions relating to education in two annual reports (Parliamentary Ombudsman Annual Report 2013 pp. 18–22 and 2015 pp. 17–21). Owing to the significance of the area, I again wish to raise this topic; this time I will be concentrating on comprehensive schools.

The rights of a child in basic education

The Finnish comprehensive school is widely deemed a success story and the leaning outcomes are among the top in international comparison. As an overseer of legality, the Parliamentary Ombudsman does not intervene in matters related to pedagogical methods or outcomes. The Parliamentary Ombudsman focuses on good governance and the rights of pupils. The provision of education is largely an administrative service function. While one role of comprehensive schools is to provide education and support upbringing, they also have the role of an administrative authority. Those working at comprehensive school must have a good command of administrative princi-

[1] Statistics Finland, Official Statistics of Finland – education publications, www.tilastokeskus.fi/til/kou.html; referred 22 January 2020.

ples and be able to meet the requirements following from the Administrative Procedures Act and the Basic Education Act and Decree as well as the Student Welfare Act, Child Welfare Act and the UN Convention on the Rights of Persons with Disabilities. The oversight of legality comes into play when deciding on the application of law.

All activities in the field of education rest on basic and human rights and, more specifically, the rights of a child. Basic and human rights belong to everyone, including children. Children must be treated as individuals. Children are not "extensions of their parents", and the rights of a child are not always identical to the interests of their parents. Engaging the children and hearing their voice should always be ensured as appropriate when decisions concerning them are being made, including and especially regarding the context of schooling. Pursuant to the UN Convention on the Rights of the Child the best interests of the child shall be a primary consideration. The diverse nature of actions taken and the legal norms that govern them makes this a challenging regulatory field to negotiate. The priority is to find a balance between respecting the autonomy of the child and safeguarding their needs.

An aspect worth noting is that the Basic Education Act was not drafted under the guidance of the Constitutional Law Committee, nor was the process informed by the UN Convention on the Rights of the Child in any systematic manner. From the perspective of legal oversight, all legal guidelines governing a child's legal situation must be observed when making decisions.

Complaints as an instrument of legal oversight in education

Regardless of the extensive scope of the activities taking place in the field of education, administrative decisions are taken at schools only with regard to a limited group of subjects. Similarly, cases taken to administrative court in the field of education are rare, and even in these rare cases, the administrative courts have no jurisdiction to evaluate and oversee the actual content of tuition. In fact, comprehensive schools are not subject to any external oversight on a regular basis. Unlike in Sweden and many other countries, Finland does not have a system of school inspections. External control is exercised by the Regional State Administrative Agencies and by the supreme overseers of legality through handling of complaints. This gives the decisions passed by overseers of legality added and exceptional weight.

In 2019, the Parliamentary Ombudsman received 256 complaints in the field of education. The number of complaints has increased slowly but steadily in the past few years. In addition, the Chancellor of Justice processes annually approximately 50 cases concerning the field of education. A significant number of such complaints is also handled by the Regional State Administrative Agencies. Monitoring the decisions passed, or even obtaining quantitative statistics on complaints, is challenging, and few decisions are published online. This is a regrettable situation, bearing in mind how important the role of the Regional State Administrative Agencies is in the information steering and training within this sector. The number of complaints filed with Regional State Administrative Agencies in the education and cultural sector has increased noticeably: while in 2015 the number of complaints filed was slightly over 250, last year it had already reached 416.

During the year under review, the Parliamentary Ombudsman passed 243 decisions on complaints in the field of education. A quarter of these warranted full investigation with all parties heard. The number of cases taken under investigation is slightly higher than the average of all administrative branches in general. Some 20% of the cases led to measures, a percentage which is also above the average (approximately 15%). The legal oversight afforded to this sector is, in other words, somewhat more intensive than usual.

Most of the measures taken within the education sector concerned basic education. However, the number of cases requiring measures in the secondary and tertiary education is also perhaps surprisingly high. The cases were typically to do with the observation of students' and pupils' rights. Shortcomings were also identified in the HR administration within the sector, usually in connection with recruitment.

Implementing the strategy of the Finnish Human Rights Institution

Protecting basic and human rights and securing good governance are among the constitutional obligations of public organisations and form the foundation of their decision-making processes and operations. Formed by the Office of the Parliamentary Ombudsman, the Human Rights Centre and its Human Rights Delegation, the Finnish National Human Rights Institution's operative strategy aims at increasing public awareness, understanding and competencies in the field of basic and human rights. Another aim is to support human rights education and training as prescribed in the UN Declaration on Human Rights Education and Training and training of basic rights (for more details, see https://www.humanrightscentre.fi/hreducation/). The aim is also to exercise well-organised and efficient internal administrative oversight.

The above goals are general in nature and ones that govern all activities of the Finnish National Human Rights Institution. The goals concerning basic and human rights and good governance are, however, particularly relevant for the education sector. Cooperation between the Human Rights Centre and the Parliamentary Ombudsman has been highly effective in achieving tangible results in this sector. Thanks to the active role played by the Human Rights Centre, the Office of the Parliamentary Ombudsman has been involved in the project Basic and Human Rights in Education (2018–2019). In this project, the decisions adopted by the Parliamentary Ombudsman in its legal oversight task have been utilised as training materials for senior leaders in the education sector.

Another project worthy of mention is the Democracy and Human Rights in Teacher Training project (2018–2019), a collaboration between the Human Rights Centre, Ministry of Justice and the University of Helsinki, which included a 5-credit study module focusing on democracy and human rights education with the Parliamentary Ombudsman's decisions used as the learning materials. As a continuation to the above projects, the Office of the Parliamentary Ombudsman signed a collaboration agreement in 2019 with the University of Helsinki Faculty of Educational Sciences on co-production of e-learning materials including case studies that presented challenges from the basic and human rights perspective, reflective assignments, Parliamentary Ombudsman's statements and clarifying instructions for teachers.

These projects are excellent examples of the initiatives the Finnish National Human Rights Institution has launched to promote human rights and human rights education. Actions such as this help communicate the legal message of individual complaint resolutions – that good governance protects basic and human rights – to a wider audience within the education sector than isolated cases concerning specific municipalities or schools.

Securing and improving good governance and legal rights

The Parliamentary Ombudsman's opinions for the education sector typically concern failures in administrative procedures and decision-making. The general legislative point of reference for the education is the Administrative Procedure Act. However, sometimes education providers or even local education authorities may have gaps in the basic knowledge of good governance.

The themes brought to the Parliamentary Ombudsman for opinion include equal access to education (e.g. the provision of education for children with disabilities or illnesses), failures in administration or decision-making, decisions on awarding special support, religious elements in schools and the safety of the learning environment (e.g. the mould problems in school buildings and the prevention of and intervention in bullying).

Pupil disciplinary measures and decision making process may also prove difficult on occasion. The disciplinary measures and securing peaceful conditions are always subject to measures prescribed in the law. However, children also have the right to expect assistance and intervention in

problems they may be facing.[2)] In one case I handled in the year under review, a student had been suspended for two weeks with immediate effect as a disciplinary measure. The decision conflicted with the provisions of the Basic Education Act under which a decision concerning the enforcement of a pending decision on suspension and the date on which its enforcement is instigated shall be made simultaneously with the decision on suspension.

The Parliamentary Ombudsman is approached relatively often in matters related to the indoor air quality at schools: of all decisions passed last year, 17 concerned indoor air quality at schools and the measures taken by the local authorities to address the problem. This figure includes three municipal and school inspections focusing on this aspect. When addressing problems in indoor air quality at schools, the question is about students' right to a safe learning environment. Equally, the matter is relevant to the occupational health and safety of all staff groups working at the property. For the purpose of legality oversight, the actions taken by local authorities are reviewed specifically from the perspective of the oversight of supervision: have the actions taken by the local authority been sufficient and appropriate to identify and remove or limit adverse health effects? The Parliamentary Ombudsman's competence does not extend to commenting on technical building or medical questions. Instead, the Parliamentary Ombudsman must focus on evaluating the procedure the local authority has followed. Indoor air quality issues must be addressed using multi-professional expertise to ensure that the problem is identified, investigated and documented, that the necessary risk assessments and the contracting and execution of the repair work are carried out as appropriate and with due transparency. The outcomes of the process must also be monitored and evaluated.

In the following, I am discussing two examples of the Parliamentary Ombudsman's oversight of children's rights in the education sector. The first example highlights a child's right to free education. Certain municipalities had adopted practices that proved to be in violation of the principle of free basic education. One case concerned a school's physical education day for which the activities were selected according to whether families had opted for a free-of-charge or paid alternative. In other cases, families had been asked for money to cover the costs of optional physical education or a school field trip. In my decisions, I pointed out that the requirement of free basic education is plain and unequivocal: it is the responsibility of the education provider to allocate enough resources for activities it organises, including those taking place outside school. Organising field trips and physical education days in such a way that free-of-charge and paid alternatives are offered has the result of dividing the pupils into two groups: those who are able to pay to participate and those who are not. As the parties responsible for organising education, municipalities have an obligation to refrain from establishing practices that may de facto lead to an increase in inequality between children. It is naturally perfectly acceptable that parents contribute voluntarily to raising funds for an activity, but on the condition that the funds are divided equally between students.

The second example concerns religious practices in basic education, a theme that accounts for a fair number of complaints. As with the principle of free basic education, this question is also closely linked with equality. The basic tenet behind the legal practice adopted by the Constitutional Law Committee and the European Court of Human Rights (ECHR), as well as the guidelines of the Finnish National Agency for Education based on it, and the statements issued by the supreme overseers of legality, is that the government must remain impartial and neutral in relation to religions and beliefs, while allowing for national margin of manoeuvre based on local tradition. The expressions of traditions, including religious ones, that are integral to Finnish cultural history are a well-established part of school life. However, there may be situations where established

2) See Hakalehto-Wainio, Suvianna: Oppilaan oikeudet opetustoimessa [Pupils' rights in education], 2012, p. 194.

traditions cannot be easily be reconciled with the above-mentioned legal principles and boundaries.

The presence of religious elements at school is also a matter of legal consideration in relation to which children and their parents must have access to effective legal remedies. The demand for rectification and a lawsuit are instruments only available in the case of religious and ethics education, and even then, the administrative court has no jurisdiction over the content of education (see Supreme Administrative Court 23 February 2017, Record number 763). In matters related to a child's right to education and freedom of religion, the European Court of Human Rights may take a very close look at the core curriculum to establish whether students are in fact obliged to participate in the practicing of a religion as part of school activities. This applies to religious education as a separate school subject and also other religious elements in the general activities at school (see ECHR judgment on *Hasan and Eylem Zengin v. Turkey* (9 October 2007), sections 47–55, and *Lautsi and others v. Italy* (18 March 2011, GC), sections 63–65). The only legal remedy practically available in Finland in matters other than those related to choosing of religious education as opposed to ethics as a school subject is to file a complaint with the Regional State Administrative Agency or to either of the two supreme overseers of legality. Whether or not a structure such as this can be considered sufficient as a legal remedy as provided in Article 13 of the European Convention on Human Rights has not been tested, as far as is known. As Finland is the only Nordic country where education in one's own religion is part of the national core curriculum, at the same time when legal remedies through courts of law appear to be highly limited, effective access to legal remedy cannot be considered undisputable.

The decisions of the Parliamentary Ombudsman are legal decisions arrived at through normal methods of legal interpretation. On example is the decision I passed towards the end of the year under review on the end of autumn term celebrations, that is, the school Christmas celebrations. In this case, the school had organised the end-of-term celebrations as an event with religious content and, therefore, was in breach of the national core curriculum and the policy adopted by the Constitutional Law Committee. In my decision, I also touched on the choice of venue, and found it in principle legally problematic to organise the celebrations in the church hall of an Evangelical Lutheran church. The decision was met with wide public debate, and to some extent, the arguments presented by different parties concerned areas that completely fell outside the scope of my decision. The end-of-term celebration is an educational activity participated in by all students together, so its content must remain neutral in terms of religion and beliefs. That the chosen venue was a church building presents certain problems from the perspective of the school's educational remit. Unlike the singing of certain hymns and including other similar items of cultural traditions involving religious elements in school events, which has been discussed and found acceptable by the Constitutional Law Committee, the above question had never been previously specifically examined. For the sake of clarity, this decision does not govern voluntary church services that may be arranged as part of end-of-year celebrations and for which an alternative non-religious format of celebration is available.

Student welfare services are facing challenges

As I mentioned at the beginning of this brief article, the scope of the remit of local education authorities is wide and varied. The services they provide will leave a lasting imprint on an individual and the community. To conclude this overview, I wish to emphasise the importance of student support services, which schools are by law obliged to offer.

Support for learning and school attendance and student welfare services form one thematic entity. The Basic Education Act specifies a three-tier support model. Only in the case of the third, "highest" tier, known as 'special support', as well as interpretation and teaching assistant services, an administrative decision that is open to appeal must be provided. While student welfare services are a child's subjective right, their provision de-

pends largely on the discretion of the education provider. Therefore, there is substantial variation between the ways different providers organise student welfare services, and there are no binding regulations on the required number of staff in student welfare services. This means that children in Finland may not have equal access to student welfare services. On average, a school psychologist is responsible for 985 pupils. Only approximately 20% of school psychologists' time is spent on collective student welfare which, according to law, should be the primary format of service provision.[3)] The supervision of student welfare services is not supported by comprehensive effective legal protections to ensure that pupils' subjective rights are adequately met.

It is therefore not surprising that, based on the observations of the Parliamentary Ombudsman, the organisation and resourcing of student welfare services are consistently found to be lacking. The recruitment of school psychologists is known to be a nationwide, ongoing problem. Inspections have also revealed that the workload of school counsellors is found to be excessive in the light of the actual demand. Collective student welfare services, in particular, seem to suffer in this equation.

Collective services are targeted at preventive work and timely identification of needs and early interventions. This is a matter of children's rights, the best interest of the child. Deficiencies in support services may result in far-reaching consequences for the individual and the community – our school years shape us, and some carry their experiences with them for the rest of their lives. The period between year one and year nine can be decisive for a young person at risk of social marginalisation. It is my intention to put emphasis into questions related to student welfare services in my future oversight work.

3) See Finnish Education Evaluation Centre: Oppilas- ja opiskelijahuoltolain toimeenpanon arviointi esi- ja perusopetuksessa sekä lukiokoulutuksessa [Provision of student welfare services in pre-primary, basic and general upper secondary education] (https://karvi.fi/app/uploads/2018/03/KARVI_0418.pdf) and THL – Tutkimuksesta tiiviisti, [THL Research summary] February 2019 (http://www.julkari.fi/handle/10024/137541)

2 The Finnish Ombudsman institution in 2019

2.1 Review of the institution

The year 2019 was the Finnish Ombudsman institution's 100th 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 the Parliamentary Ombudsman are regulated by the Constitution of Finland and the Finnish Parliamentary Ombudsman Act. These provisions can be found in Appendix 1.

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

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 the police, the Emergency Response Centre Administration and rescue services, guardianship, language, the rights of foreigners and persons with disabilities, as well as covert intelligence gathering. His responsibilities also included the prosecution service; however, not including the Office of the Prosecutor General. 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 health care, social welfare, children's rights and rights of the elderly, regional and local government, the Church, debt enforcement and the Customs. In addition, she assumed re-

sponsibility for matters relating to taxation, the environment, agriculture and forestry, traffic and communications as well as Sámi affairs.

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

A detailed division of labour is provided in Appendix 2.

If a Deputy-Ombudsman is prevented from performing their tasks, the Ombudsman can invite a Substitute for the Deputy-Ombudsman to stand in. The substitute for the Deputy-Ombudsman in 2019 was Principal Legal Adviser Mikko Sarja, who served as a substitute during the year under review for a total of 88 working days.

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

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

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

The two supreme overseers of legality, the Ombudsman and the Chancellor of Justice, have virtually identical powers. The only exception is the oversight of advocates, which falls exclusively within the scope of the Chancellor of Justice. 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 primarily responsible for monitoring matters concerning the Defence Forces, the Finnish Border Guard, crisis management personnel, the National Defence Training Association of Finland, and courts martial. The act on the division of tasks between the Parliamentary Ombudsman and the Chancellor of Justice can be found in Appendix 1.

In 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 (e.g. PeVM 2/2019 vp, PeVM 3/2018 vp, PeVM 2/2017 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 Chief Director, succeeded by Committee Counsel Sami Manninen. Professor Tuomas Ojanen was appointed permanent expert and special expert Anu Mutanen as secretary, succeeded by Senior Ministerial Adviser Marietta Keravuori-Rusanen. The working group submitted its report in May 2019.

The working group proposed that the division of responsibilities should be based on leveraging and concentrating expertise as required by each task. The group recommends that in addition to what is currently provided for in the law on the division of responsibilities, the Parliamentary Ombudsman should also include in its remit matters pertaining to the rights of children, the elderly and persons with disabilities, to social welfare, health care and social insurance, police and customs officials, secret information and intelligence gathering and most aspects of pre-trial investigations. The Chancellor of Justice would, in turn, focus on matters pertaining to the Government, government ministers and the President of the Republic, courts and most aspects of the prosecution service and certain other areas.

Nearly all commentators on the report concurred with the changes proposed to the division of responsibilities of the overseers of legality. However, the suggestion that oversight of courts should be concentrated under the Chancellor of Justice faced some sharp criticism.

The government proposal on the division of responsibilities will be submitted to the Parliament in 2020.

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

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

Today, the Ombudsman's tasks also include overseeing and actively promoting the implementation of fundamental and human rights. This has 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.

A summary of the values and objectives of the Ombudsman's Office is on next page.

2.1.4 OPERATIONS AND PRIORITIES

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

In the year under review, a new regulatory framework for intelligence gathering was adopted. The Act on the Oversight of Intelligence Gathering (121/2019) entered into force on 1 February 2019. The amendment to the Police Act, Chapter 5a (civilian intelligence, 581/2019), Act on Telecommunications Intelligence in Civilian Intelligence (582/2019) and Act on Military Intelligence (590/2019) entered into force on 1 June 2019. The legislation includes the obligation of the authorities to submit an annual report to the Ombudsman on their operations. The oversight of 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 in-

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

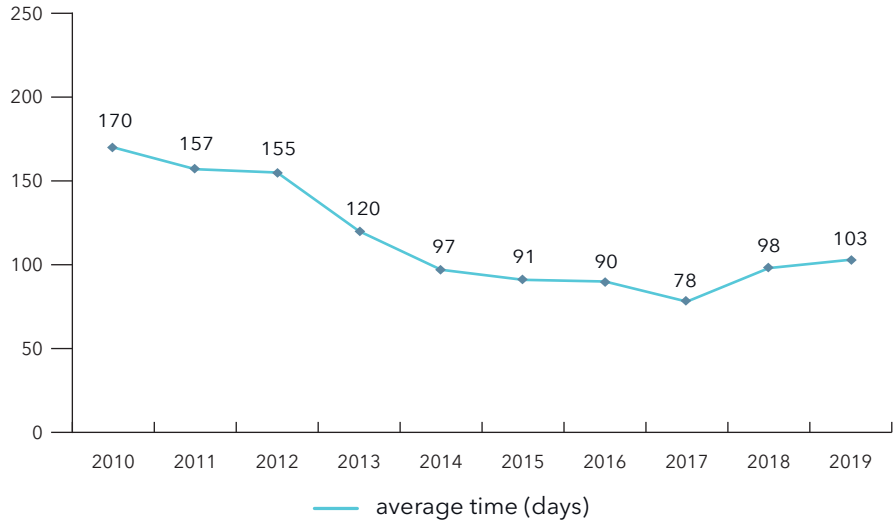
The aim in all activities is to ensure high quality, impartiality, openness, flexibility, expeditiousness and good services for clients.

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.



Average time taken to deal with complaints in 2010–2019

dividual cases as such. In 2019, 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.

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

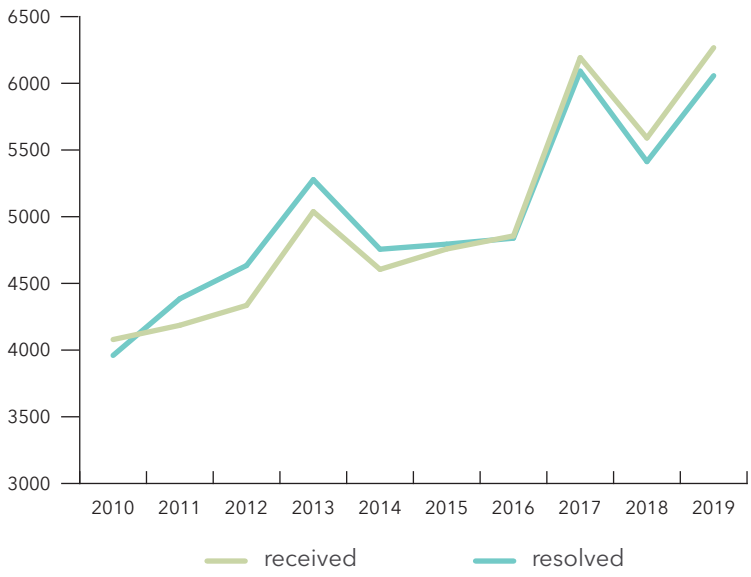
Complaints are processed within one year

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

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

With the more effective processing of complaints, the Ombudsman achieved the target time – of maximum one year for handling complaints – for the first time in 2013. The target has subsequently been met each subsequent year, including 2019, when there were no complaints older than one year pending a decision.

The average time taken to deal with complaints was 103 days at the end of the year, compared to 98 days at the end of 2018.



Complaints received and resolved in 2010–2019

Complaints and other oversight of legality matters

A record number of complaints were received in 2019, in total 6,267. This is around 670 (12%) more than in 2018 (5,594). The number of cases increased across every branch of administration. The largest numbers of complaints concerned social services (1,112), the police (752) and health care (698). In 2019, 6,057 complaints were resolved. The figure for 2018 was 5,410.

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 2019, the majority of complaints, 76%, were submitted electronically.

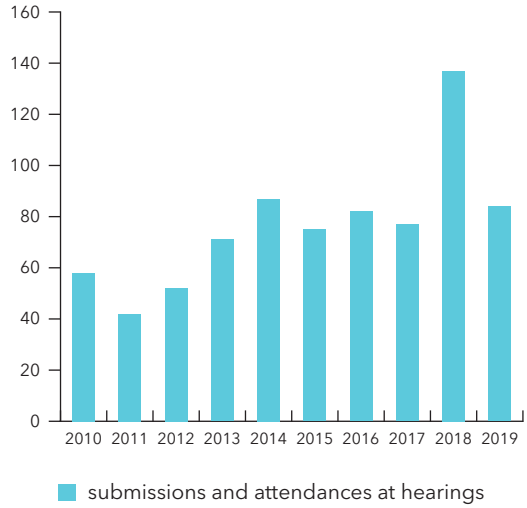
Before the introduction of the electronic case management system, complaints received by the Ombudsman were recorded under their own subject category (category 4) in the register of the Office of the Parliamentary Ombudsman. Other communications were recorded under category 6 ("Other communications");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

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

Once a complaint has been filed with the Office, a confirmation of receipt is sent to the complainant if the complaint leads to an investigation. The complainant also receives an immediate notification of the receipt of the email.

■ received ■ resolved	2018	2019
Complaints	5,561 5,410	6,223 6,057
Transferred from the Chancellor of Justice	33	44
Taken up on own initiative	79 82	95 63
Requests for submissions and attendances at hearings	145 137	82 84
Total	5,818 5,629	6,444 6,204

Oversight-of-legality matters received and resolved in 2018–2019



Resolved requests for submissions and attendances at hearings between 2010 and 2019

Some complaints are handled through an accelerated procedure. In 2019 around one half of all complaints 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 Office. 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 2019 a total of 7,471 written communications submitted for information were received.

In addition, submissions and attendances at hearings in various committees of Parliament are counted belonging to oversight of legality. The number of statements and hearings decreased to approximately the previous level.

In 2019, 74% of all the complaints that arrived were related to the ten largest categories. Statistics on the Ombudsman's activities are provided in Appendix 6.

In 2019, a total of 63 matters investigated on the Ombudsman's own initiative were resolved. Of these, 47(75%) led to action on the part of the Ombudsman.

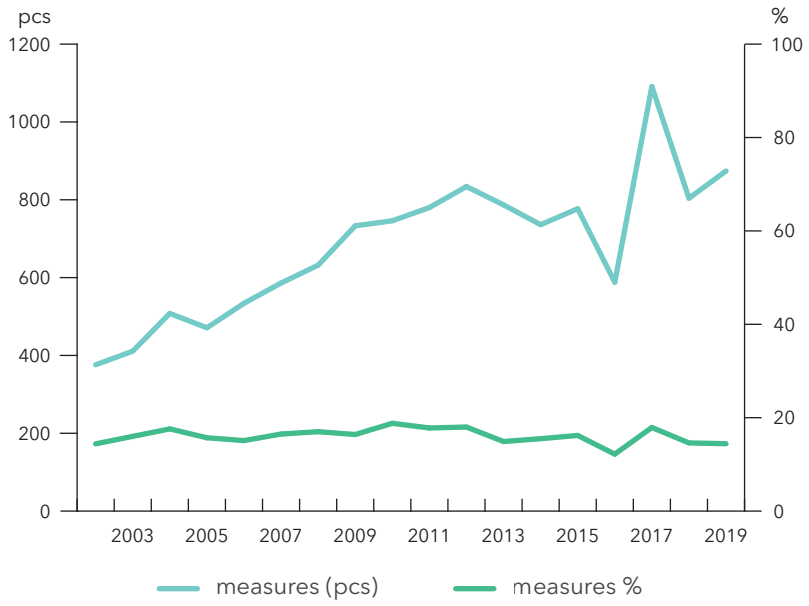
Measures

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 fulfil 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 3.

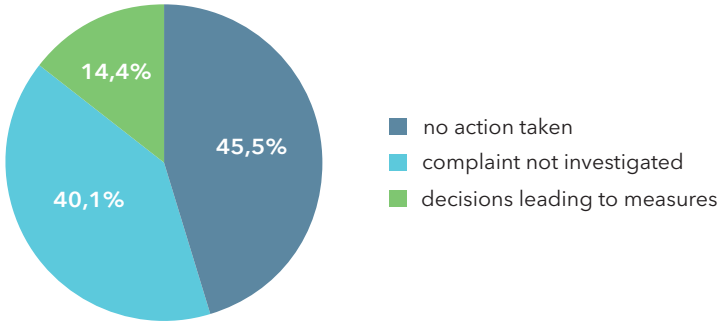
Decisions on complaints and investigations at the Ombudsman's own initiative that led to measures totalled 921 in 2019, which represented nearly



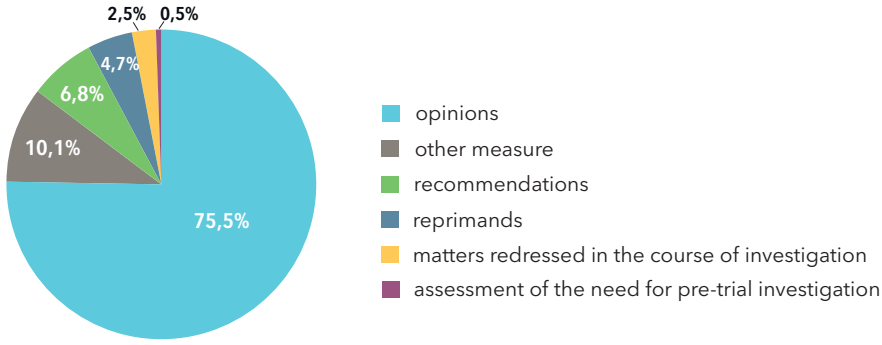
In 2002–2019, the number of measures taken as a result of complaints increased from 320 up to over 1,000. The number of resolved complaints within the same period increased from approximately 2,500 up to over 6,000. Despite the increase in the number of complaints, the relative proportion of complaints leading to measures (measure %) has remained unchanged.

MEASURES TAKEN BY PUBLIC AUTHORITIES	Prosecution	Assessment of the need for pre-trial investigation	Reprimand	Opinion	Recommendation	Rectification	Other measure	TOTAL	Total number of decisions	Percentages*
Social welfare	–	–	25	162	5	7	19	218	1102	19,8
Criminal Sanctions field	–	1	2	109	15	2	7	136	462	29,4
Health	–	–	5	58	13	2	21	99	643	15,4
Police	–	3	–	67	5	2	12	89	720	12,4
Administrative branch of the Ministry of Economic Affairs and Employment	–	–	–	83	2	–	3	88	331	26,6
Soial insurance	–	–	3	67	–	2	4	76	455	16,7
Administrative branch of the Ministry of Education and Culture	–	–	1	34	3	1	10	49	248	19,8
Local government	–	–	6	15	–	–	7	28	196	14,3
Aliens affairs and citizenship	–	–	12	7	–	1	4	24	159	15,1
Administrative branch of the Ministry of Transport and Communications	–	–	–	15	–	–	5	20	169	11,8
Enforcement (distraint)	–	–	1	9	4	1	1	16	200	8,0
Taxation	–	–	2	9	1	–	1	13	118	11,0
Administrative branch of the Ministry of Defence	–	–	–	10	–	–	1	11	50	22,0
Administrative branch of the Ministry of the Environment	–	–	1	9	–	–	–	10	129	7,7
Administrative branch of the Ministry of Finance	–	–	–	5	1	2	1	9	35	25,7
Administration of law	–	–	1	6	–	–	–	7	230	3,0
Guardianship	–	–	–	5	–	1	1	7	73	9,6
Administrative branch of the Ministry of Justice	–	–	–	5	–	1	–	6	78	7,7
Administrative branch of the Ministry of Agriculture and Forestry	–	–	1	2	–	1	1	5	77	6,5
Customs	–	–	1	4	–	–	–	5	13	38,5
Administrative branch of the Ministry for Foreign Affairs	–	–	–	2	1	–	–	3	11	27,3
Prosecutors	–	–	–	2	–	–	–	2	64	3,1
Total	–	4	61	685	50	23	98	921	6 120	15,0

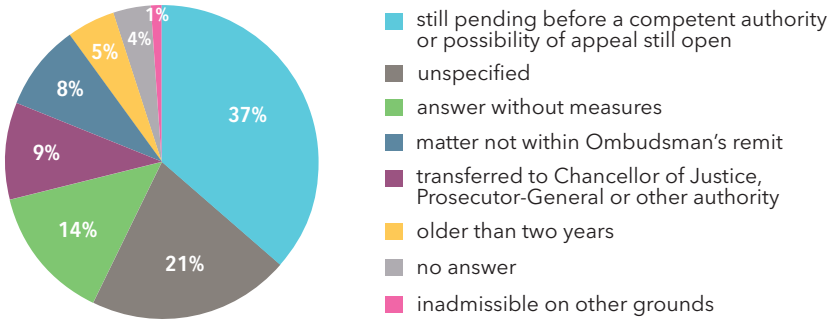
* Percentage share of measures in decisions on complaints and own initiatives in a category of cases



All cases resolved in 2019



Decisions involving measures in 2019



Complaints not investigated in 2019

15% of all decisions. Nearly one quarter 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 42% of the cases (2,560), there were no grounds to suspect erroneous or unlawful action, or there was no reason for the Ombudsman to take action. A total of 194 cases (approximately 3%) were found not to involve erroneous action. No investigation was conducted in 40% of the cases (2,429).

In most cases, the complaint was not investigated because the matter was already pending with a competent authority. An overseer of legality usually refrains from intervening in a case that is being dealt with at the appeal stage or by another authority. Matters pending with other authorities, and therefore not investigated, accounted for 15% (909) of all complaints dealt with. Other matters not investigated include those that fall outside the Ombudsman's remit and, as a rule, cases that are more than two years old.

The proportion of all investigated complaints that led to measures, when cases not investigated are excluded, was 24%.

None of the matters handled in the year under review were brought to prosecution for breach of official duty. There were four matters that merited pre-trial investigation by the police. A total of 61 reprimands were given, and 686 opinions were expressed. Rectifications were made in 22 cases while under investigation. Decisions classed as recommendations numbered 50, although opinions regarding the development of governance that count as recommendations were also included in other types of decisions. Other measures were recorded in 97 cases. In reality, the number of other measures that the decisions lead to is greater than the figure shown above, because only one measure is recorded under each case, even though several measures may have been taken.

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

Inspections

A total of 104 inspections were carried out during 2019. A full list of all inspections is provided in Appendix 4. The inspections are described in more detail in connection with the respective topic.

Approximately half of the inspections were conducted under the leadership of the Ombudsman or the Deputy-Ombudsmen and the remainder by legal advisers. A total of 60 visits were made to places and facilities where individuals are or may be kept while deprived of their liberty; 45 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 2010 and 2019

Deputy-Ombudsman Maija Sakslin and Parliamentary Ombudsman Petri Jääskeläinen handed the Ombudsman's Annual Report for 2018 to Matti Vanhanen, Speaker of the Parliament, on 11 June 2019.

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

2.1.5 COOPERATION IN FINLAND AND INTERNATIONALLY

Events in Finland

Ombudsman Jääskeläinen and Deputy-Ombudsman Sakslin submitted the Parliamentary Ombudsman's annual report 2018 to Speaker of the Parliament Matti Vanhanen on 11 June 2019. The Ombudsman attended a preliminary debate and a parliamentary debate on the report in plenary sessions of the Parliament on 13 June 2019 and on 13 November 2019 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.

Parliament's Legal Affairs Committee paid a visit to the Office on 24 October and the Constitutional Committee on 29 November. The Office received visits from representatives of the Supreme Administrative Court on 24 November and 28 November and the Border Guard on 25 November. Ombudsman for Children Elina Pekkarinen visited the Office on 14 June and the Non-Discrimination Ombudsman Kirsi Pimiä on 15 October.

The Office also hosted discussion events on the over-indebtedness of the elderly, children and persons with disabilities as a result of the social and health care fees. The event was attended by Deputy-Ombudsman Pasi Pölönen and his officials as well as representatives of several NGOs and the church.

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 gave a presentation on intelligence gathering legislation at a training

event for judges on 16 May and introduced the new MPs to the activities of his office on 9 October. He also participated in the panel discussion held on 13 September marking the 100th anniversary of the Finnish Constitution and gave the opening address at the Kalle Könkkölä Symposium on 22 October.

Deputy-Ombudsman Sakslin gave interviews to the media on the oversight and promotion of the rights of the elderly. She also gave a lecture on the topic in the above centennial seminar. Deputy-Ombudsman Pölönen gave a talk on 20 September at the seminar for the senior command of the Finnish Defence Forces and on 25 October at the training event for Chief Legal Advisors of the Defence Forces. The topic of the latter event was "Parliamentary Ombudsman as the overseers of courts – the history and regulatory framework for legality oversight"

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, IOI Europe held working meetings in Riga, Latvia on 16–17 October on the theme "General Data Protection Regulation and its challenges from human right's aspect". The event was attended by Deputy-Ombudsman Pölönen.

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. Ombudsman Jääskeläinen and Principal Legal Adviser Länsisyrjä participated in the conference of the network in Brussels on 8–9 April. Ombudsman Jääskeläinen gave a presentation and chaired a working group on the theme "Developing soft powers: Relations with stakeholders, strategic initiatives, building support among the public".

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, no meeting was held.

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 26–27 September in Vilnius, Lithuania. The meeting was attended by Parliamentary Ombudsman Jääskeläinen and Deputy-Ombudsman Sakslin. Ombudsman Jääskeläinen gave a presentation at the meeting on "Securing economic and social rights of persons with disabilities: Ombudsman's role and activities in Finland".

Furthermore, the Nordic countries have established a Nordic network for NPMs, with meetings held on 23–24 January at the Office of the Parliamentary Ombudsman in Helsinki and on 29–30 August in Reykjavik.

On 22-23 February and on 22-23 May, Deputy-Ombudsman Sakslin attended the meetings of the Nafplion group, which was established at the initiative of the Greek Parliamentary Ombudsman in Athens. The purpose of the group is to monitor and assess the implementation of fundamental rights in the activities of Frontex (the European border and coast guard agency) when it implements return flights and monitors the return flights that it implements. Member States' Parliamentary Ombudsmen, National Preventive Mechanisms (NPM), the European Union Agency for Fundamental Rights and the European Committee for the Prevention of Torture (CPT) have been involved in discussions on the effectiveness of monitoring. The theme of the first meetings was "Strengthening the independence and increasing the accountability of the FRONTEX pool of monitors" and of the second meeting "NPM institutions to remedy the absence of an external, independent governance of the pool of forced-return

monitors". Deputy-Ombudsman Sakslin attended the meetings.

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

Deputy-Ombudsman Pölönen and Senior Legal Adviser Kristian Holman participated in a conference held in Sarajevo, Bosnia-Herzegovina on 28–29 October themed "The 11th International Conference of Ombuds Institutions for the Armed Forces – Building resilient and sustainable ombuds institutions".

One of the main events during Finland's Presidency of the Council of the European Union was the high-level conference held in Helsinki on 26–27 February on the impact of artificial intelligence on human rights, democracy and the development of the rule of law. The conference was attended by Deputy-Ombudsman Sakslin.

Parliamentary Ombudsman Jääskeläinen and Deputy-Ombudsman Sakslin attended and participated in the international conference held in Finlandia Hall, Helsinki on 10–11 September as part of Finland's Presidency of the Council of the European Union; the topic of the conference was "How to Ensure the Resilience of Our Societies in a Changing European Landscape – The interaction between democracy, the rule of law and fundamental rights".

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

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.

The European Ombudsman, Emily O´Reilly, visited the Office on 3 June. Ombudsman Jääskeläinen participated in the open panel discussion organised as part of the visit on 6 June.

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

- 20 February: Delegation from Kosovo (Kosovo Probation Services)
- 2 May: Delegation from the national police supervision and inspection body of the Republic of Korea
- 28 May: A group of Iranian women MPs
- 19 June: A Palestinian delegation representing AGO Judicial Inspection Department

2.1.6 SERVICE FUNCTIONS

Client service

The objective of the Office of the Ombudsman is to make it as easy as possible to turn to the Ombudsman. Information on the Ombudsman's tasks and 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 Par-

liamentary Ombudsman. The Registry received around 2,200 (2,400) calls during the year. There were approximately 70 (120) visits from clients and 800 (550) requests for documents/information.

Communications

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

In 2019, the Office published 29 (32) press releases on the Ombudsman's decisions, inspections and statements, if they were of particular legal or general interest. In addition, information was actively provided on the special tasks of the Office. The press releases are given in Finnish and Swedish and are also posted online in English. The Office has increasingly transferred to utilising Twitter when providing information 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 2019 in the context of 2,499 news items and articles. Use of Twitter and visibility on social media were increased significantly. In 2019, there was a total of 10,303 media hits, i.e. 3,545 more than in 2018 (6,758). There were 25% more Tweets generated from the Ombudsman's Twitter account in 2019 than in 2018.

A total of 335 (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 2019, there were 61 permanent positions in the Office, including the Ombudsman and two Deputy-Ombudsmen. At the end of the year under review, the share of women on the staff was 68%, including the personnel at the Human Rights Centre.

At the end of 2019, 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, three specialists and an assistant of the Human Rights Centre. The Office also had an information officer, an information management specialist, two investigating officers, five notaries, an administrative secretary, a filing clerk, an assistant filing clerk, two departmental secretaries, a records management secretary, an assistant for international affairs and six office secretaries.

The share of personnel at least 45 years in age was 85.3%. The personnel's education level index was 6.6. The share of personnel possessing a university-level degree was above 83.8%. Of this, the share of personnel with a Master's level university degree was 75% and the share of those who have completed research training was almost 10.3%.

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

The Finnish Parliament Annex.

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 Team convened 11 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

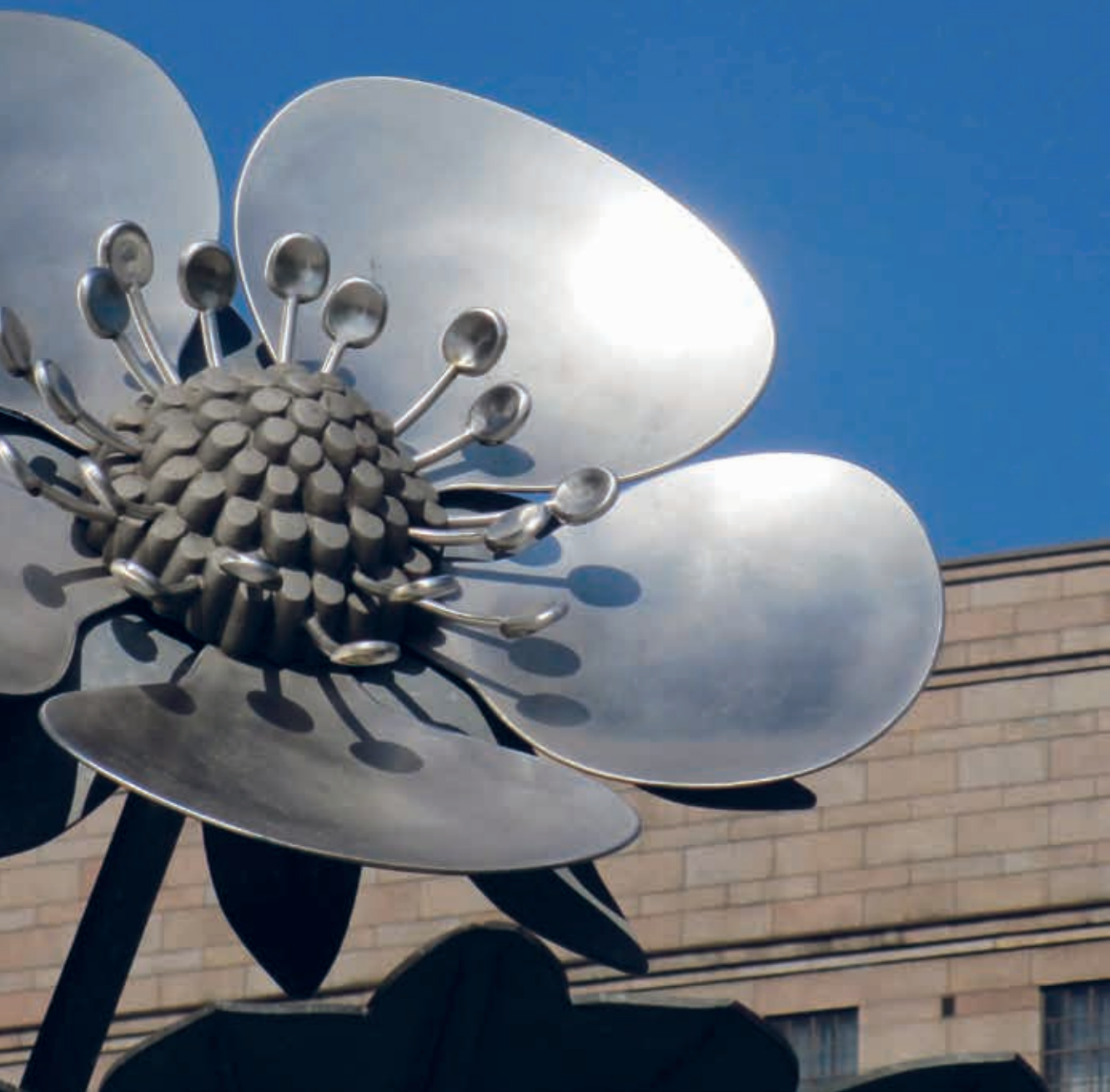
The activities of the Office are financed through a budget appropriation each year. Rents, security services and some of the information management costs are paid by Parliament, and these expenditure items are therefore not included in the Ombudsman's annual budget.

The Office was given an appropriation of EUR 5,950,000 for 2019. Of this, EUR 6,000,841 was used. The appropriation was exceeded by EUR 50,841, mainly due to information management costs, which exceeded the estimate.

At the end of the year 2018, the Office of the Parliamentary Ombudsman received a supplementary appropriation of 250,000 euros. In the beginning of 2019, it received in total 350,000 euros from the first supplementary budget for the supervision and promotion of the rights of the elderly. A part of the appropriation was used to create three fixed-term Senior Legal Adviser posts at the Office of the Ombudsman to supervise that the rights of the elderly are implemented. A part of the appropriation was used to employ fixed-term experts at the Human Rights Centre.

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 emphasis 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

3.2.1 COMPOSITION, DUTIES AND POSITION OF THE HUMAN RIGHTS INSTITUTION

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

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

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

The 'A status' is considered highly significant in the UN and, in more general terms, in international cooperation. 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. The Finnish Human Rights Institution has also joined the European Network of National Human Rights Institutions (ENNHRI). The Finnish institution was a member of the ENNHRI and GANHRI Bureaus until March in the year under review.

3.2.2 ACCREDITATION LEADS TO A STATUS ONCE AGAIN

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

In December of the year under review, the National Human Rights Institution of Finland was awarded an A status for the second time, covering the period from 2020 to 2025. The granting of an A status may be accompanied by recommendations on how to improve the institution. The recommendations given to Finland stressed, among other things, the need to safeguard the resources necessary to ensure that the tasks of the Finnish National Human Rights Institution are effectively discharged and that it is able to make its own decisions concerning the focal points of its activities. In addition, GANHRI emphasised the importance of submitting the Human Rights Centre's annual report to the Parliament in addition to the Parliamentary Ombudsman's report.

3.2.3 THE HUMAN RIGHTS INSTITUTION'S OPERATIVE STRATEGY

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

The strategy outlined the following main objectives for the Institution:

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

3.3 The Human Rights Centre and the Human Rights Delegation

3.3.1 THE HUMAN RIGHTS CENTRE'S MANDATE

The Human Rights Centre began operating in 2012. It works autonomously and independently, although it is administratively connected to the Office of the Parliamentary Ombudsman. The Human Rights Centre's duties are laid down in the Parliamentary Ombudsman Act. The Human Rights Centre's statutory duties are:

- Promoting information, education, training and research associated with fundamental and human rights
- Drafting reports on the implementation of fundamental and human rights
- Presenting initiatives and issuing statements in order to promote and implement fundamental and human rights
- Participating in European and international cooperation related to the promotion and implementation of fundamental and human rights
- Performing other similar tasks associated with the promotion and implementation of fundamental and human rights
- Promoting, protecting and monitoring the implementation of the UN Convention on the Rights of Persons with Disabilities

The Human Rights Centre does not handle complaints or other individual cases.

In 2019, the Human Rights Centre's budget was EUR 855,000. The Human Rights Centre had five permanent posts in 2019: the Director, three experts and an administrative assistant (as of May 2019). In the first half of the year, two experts were recruited on fixed-term contracts to promote the rights of older people.

3.3.2 OPERATION OF THE HUMAN RIGHTS CENTRE IN 2019

The Human Rights Centre's Plan of Action for 2019 was approved in January 2019. In the Human Rights Centre's assessment, it has reached its objectives. In addition to the duties included in the Plan of Action, the Human Rights Centre received additional resources granted by Parliament in March, enabling it to begin working to promote the rights of older people.

PROMOTING FUNDAMENTAL AND HUMAN RIGHTS

The areas involved in the promotion of fundamental and human rights are education, research, communication and public promotion. The Human Rights Centre's fundamental and human rights education projects progressed well, and training packages on new themes were prepared for the Human Rights Centre's website.

The Human Rights Centre worked with the Ministry of Justice and the European Union Agency for Fundamental Rights to organise training on the Charter of Fundamental Rights of the European Union for civil servants working at ministries. The training aimed to strengthen civil servants' competences in the Charter of Fundamental Rights and provide tools for applying the Charter to their own work, particularly during Finland's presidency of the European Union.

The project to strengthen competence in fundamental and human rights in the education sector was carried out jointly with the Parliamentary Ombudsman and involved the Regional State Administrative Agencies, the Finnish National Agency for Education, the Trade Union of Educa-

tion in Finland (OAJ), the Finnish Association of Principals (SURE) and the Finnish Association of Educational Directors and Experts (OPSIA).

A project to strengthen competences in fundamental and human rights continued at the University of Helsinki's Faculty of Education as part of teacher training. The project involved producing a pilot course in democracy and human rights education, analysing educational materials for teachers on the subject of democracy and human rights, and arranging a networking meeting in order to support democracy and human rights education at universities and universities of applied sciences. The project is ongoing in 2020.

In the field of research into fundamental and human rights, the Human Rights Centre is a member of several working groups, advisory boards and management groups. The research focuses in 2019 included the rights of people with disabilities and the rights of older people, as well as research related to human rights education.

The Human Rights Centre actively communicated and disseminated information on themes of relevance to fundamental and human rights in its various communication channels. A campaign aiming to promote the rights of older Sámi people attracted particular attention and positive feedback in 2019.

Monitoring the implementation of fundamental and human rights

The Human Rights Centre contributes to periodic reporting on human rights treaties by issuing statements and attending consultation events, communicating the recommendations issued by treaty monitoring bodies and monitoring the implementation of such recommendations. The Human Rights Centre also encourages NGOs to contribute to the reporting by issuing statements of their own.

In 2019, the Human Rights Centre provided comprehensive information on the periodic reporting process as well as on individual and collective complaints. As a member of the legal working group of the European Network of National Human Rights Institutions (ENNHRI), the Human Rights Centre also contributed to the process of reforming the European Court of Human Rights and the *amicus curiae* practice in relation to complaint processes.

Finland received recommendations concerning the implementation of the Council of Europe's Framework Convention for the Protection of National Minorities and the convention on preventing and combating violence against women and domestic violence (the Istanbul Convention). The European Commission against Racism and Intolerance (ECRI) also issued recommendations to Finland.

The treaty monitoring bodies submitted preliminary questions to the Government for the periodic reporting on the treaties on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, and the Committee Against Torture. The deadlines for these reports are in 2020. The Human Rights Centre had a substantial influence on the types of preliminary questions that Finland received for reporting by issuing statements during the List of Issues Prior to Reporting (LOIPR) phase.

The Human Rights Centre's website contains consolidated information on periodic reporting, individual complaints, collective complaints and the annual reports of various actors in the fields of fundamental and human rights.

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

In 2018 and 2019, the Human Rights Centre conducted an online survey on the rights of disabled persons in collaboration with the Finnish Disability Forum. The survey analysed all of the themes covered by the UN Convention on the Rights of Persons with Disabilities (CRPD). The work to compile and interpret the results of the survey began in late 2018, and the results were published in 2019. The Finnish Disability Forum held a seminar in September to review the survey material in depth.

In 2019, the Human Rights Centre continued working on its national fundamental rights survey project in cooperation with the Ministry of Justice. The project involved conducting a national survey in conjunction with the Fundamental Rights Survey conducted by the European Union Agency for Fundamental Rights. The national segment was targeted at persons with disabilities and physical impairments, as well as selected linguistic minorities (Swedish, Russian and Arabic). The survey studied the views, experiences, and awareness among the aforementioned population groups of fundamental and human rights and their implementation in Finland. The Fundamental Rights Agency's Fundamental Rights Survey targets the entire population in every EU Member State. The national fundamental rights survey sample of persons with disabilities and persons with physical impairments was collected by sending more than 10,000 participation requests to a group of recipients selected by random sampling from the register of disability benefit recipients maintained by the Social Insurance Institution of Finland. The results of the Fundamental Rights Agency's survey and the national fundamental rights survey will be published in 2020.

The Human Rights Centre participated in the ENNHRI CRPD working group meeting in Brussels on 13 May 2019. Especially the obligation under the UN Convention on the Rights of Persons with Disabilities (CRPD) to ensure inclusive education and its purpose in practice were discussed at the meeting.

The Human Rights Centre participated in the Conference of States Parties to the CRPD in New York on 11–13 June 2019. The meeting addressed such issues as the challenges posed by digitalisation to the inclusion of persons with disabilities in society, and the rights of disabled persons to inclusion in cultural life and leisure time activities. During the conference, the representatives of national human rights institutions established the CRPD working group of the Global Alliance of National Human Rights Institutions (GANHRI) and held the working group's first meeting.

The special duty related to the rights of people with disabilities is also discussed in section 3.4.

Promoting and monitoring the rights of older people

In spring, the Human Rights Centre started systematic work on a new priority theme: promotion of the rights of older people. The aim of these activities is to introduce a stronger legal perspective to the activities, decision-making and attitudes more broadly in relation to older people.

In 2019, the aims of the work to promote the rights of older people were:

- Strengthening the rights-based perspective in services for older people
- Influencing values and attitudes
- Influencing knowledge and awareness of the rights of older people
- Influencing the quality of the legislative drafting process and the contents of laws/recommendations related to the rights of older people

The work to promote the rights of older people began by creating networks with actors working with older people and topics related to their rights, at the same time as charting the implementation of their rights. The Human Rights Centre met with organisations representing older people, Regional State Administrative Agencies and representatives, researchers and other experts at Valvira. In addition, the Human Rights Centre worked in close cooperation with the experts from the Office of the Parliamentary Ombudsman.

The Human Rights Centre held a seminar entitled The Rights of Older People at the Finnish Parliament Annex on 10 October 2019, covering the status of older people in Finland, particularly from the legal standpoint. The Human Rights Centre arranged a training event in collaboration with the Finnish Institute for Health and Welfare (THL), the Ministry of Social Affairs and Health, and the Association of Finnish Municipalities. The event was held on 19 November 2019 and focused on the provision and procurement of services for older people.

October saw the publication of The Rights of Older People – Key International Treaties and National Legislation, which provides a concise review of human rights treaties and other instruments

from the perspective of the rights of older people. The publication also discusses the Constitution of Finland and other national legislation from the point of view of older people. The Human Rights Centre commissioned a Finnish translation of an English publication from the European Union Agency for Fundamental Rights entitled "Shifting perceptions: towards a rights-based approach to ageing". This publication examines the impacts of age discrimination on an individual level as well as on social groups and society as a whole.

A section on the rights of older people was added to the Human Rights Centre's website. The section includes concise information on the rights of older people, the Human Rights Centre's publications, and the latest news on the Human Rights Centre's activities related to the rights of older people. During the Sámi language week, articles on the status of older Sámi people and the linguistic rights of Sámi people were published in the Inari Sámi, Northern Sámi and Skolt Sámi languages.

As part of the promotion of older people's rights, the Human Rights Centre began examining issues related to corporate responsibility in the social welfare and health care services sector. In June, the Human Rights Centre met with representatives of the FIBS ry corporate responsibility network and the Finnish Association of Private Care Providers, an advocacy organisation. The meeting laid the basis for the Human Rights Centre's potential follow-up measures on the topic of corporate responsibility.

International cooperation

The Human Rights Centre engaged in international and European cooperation, and it was a member of the boards of GANHRI and ENNHRI until March 2019. In addition, an expert from the Human Rights Centre chaired ENNHRI's Legal Working Group. The term of the Human Rights Centre's Director as chair of the Management Board of the European Union Agency for Fundamental Rights continued. The centre has been able to influence the operational development of its international networks by means such as participation in thematic working groups.

In 2019, the Human Rights Centre worked actively in its networks to reinforce the principle of states being governed by the rule of law – a principle that has increasingly faced challenges in certain European states. In this area, cooperation with the European Union Agency for Fundamental Rights became stronger throughout the year. The Human Rights Centre participated as an expert in a project developing the EU Fundamental Rights Information System. During Finland's presidency of the EU in the latter half of 2019, questions surrounding the rule of law were high on the agenda. The presidency offered national human rights institutions the opportunity to contribute to promoting the theme of the rule of law and several other issues of fundamental and human rights.

The Human Rights Centre participated in the Business and Human Rights Forum, a UN event held in Geneva from 25 to 27 November 2019, as well as a corporate responsibility event during Finland's presidency of the EU entitled Business and Human Rights: Towards a Common Agenda for Action. The latter event was held in Brussels on 2 December 2019.

3.3.3 ACTIVITIES OF THE HUMAN RIGHTS DELEGATION IN 2019

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

The second term of office of the Human Rights Delegation ran from 1 April 2016 to 31 March 2020. The Delegation had 39 members, including specialised ombudsmen and representatives of the supreme overseers of legality and the

Sámi Parliament. The Director of the Human Rights Centre chairs the Delegation and its working committee. The Deputy-Chair of the second Human Rights Delegation was Kalle Könkkölä until his death, after which Markku Jokinen took up the post. The Delegation convened five times in 2019.

At its meetings in 2019, the Human Rights Delegation discussed several relevant issues in the area of fundamental and human rights. Based on introductory speeches given by a range of specialists, the Delegation discussed themes such as:

- The principle of the rule of law, and the status of the rule of law in Finland and other countries
- The issues of fundamental and human rights that were at the forefront during Finland's presidency of the EU, as well as the results achieved during the presidency in these areas
- The freedom of religion in school activities
- Legal protection for asylum-seekers.

A Permanent Working Committee and a Sub-Committee on the Rights of Persons with Disabilities operate under the Human Rights Delegation. The working committee helps the Delegation to prepare for meetings. The Sub-Committee on the Rights of Persons with Disabilities is a mechanism for engaging people with disabilities and disability associations in the work of the national human rights institution in general, as well as in the procedure for monitoring and promoting the UN Convention on the Rights of Persons with Disabilities in accordance with a draft government bill (HE 284/2014 vp).

The Human Rights Centre publishes its own annual report, which is submitted to the Human Rights Delegation for approval.

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 gave the Parliamentary Ombudsman a new special task, which is laid down in the Parliamentary Ombudsman Act. The duties set out in Article 33.2 of the CRPD are attended to by the Parliamentary Ombudsman, the Human Rights Centre and its Human Rights Delegation, which together form Finland's National Human Rights Institution.

The purpose of the CRPD is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. The leading principles of the CRPD are 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.

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

In 2019, decisions in this category were taken by Parliamentary Ombudsman *Petri Jääskeläinen*, with Senior Legal Adviser *Minna Verronen* acting as the principal referendary and Senior Legal Adviser *Juha-Pekka Konttinen* acting as referendary.

3.4.2 TASKS AND ACTIVITIES OF THE NATIONAL MECHANISM

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

Promotion refers to forward-looking proactive measures, such as the provision of guidance, advice, training and information. The objective 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 prescribed in the CRPD.

Parliamentary Ombudsman

The Parliamentary Ombudsman protects, promotes and monitors the implementation of the CRPD within the remit of his or her mandate. The Ombudsman is responsible for overseeing legality in the exercise of public authority and supervising 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 receives assistance from experts who are disabled themselves.

After these individuals complete the necessary training, the Ombudsman can invite them to participate in OPCAT inspections as experts. During the year under review, two members of the Disability Rights Committee, which operates as a permanent division under the Human Rights Delegation, participated in NPM's inspections as external 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 Parliamentary 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 operators.

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 Human Rights Centre is collaborating with the Ministry of Justice to implement a national fundamental rights survey. This survey is part of the implementation of the National Action Plan on Fundamental and Human Rights. The population groups selected for the survey include three language groups (Swedish, Russian, and Arabic speakers), as well as persons with disabilities and persons with physical impairments. The fundamental rights survey studies the views, experiences, and awareness of the afore-mentioned population groups of fundamental and human rights and their implementation in Finland.

The collection of material for the survey was carried out for all population groups in 2019. The sample concerning persons with disabilities and persons with physical impairments was collected by sending more than 10,000 participation requests to a group of recipients selected by random sampling from the register of disability benefit recipients maintained by the Social Insurance Institution of Finland. Among the general population, the party responsible for collecting the data was the European Union Agency for Fundamental Rights (FRA). The drafting of the survey report began towards the end of 2019. The report does not only analyse the views and experiences of individual minority groups concerning the implementation of fundamental and human rights, but it also compares them in relation to the responses of the general population.

During the year under review, the Disability Rights Committee convened a total of eight times. In spring, the committee began preparing the programme for the Kalle Könkkölä symposium and the content of the event. At the beginning of 2019, the committee actively discussed the government proposals for a new Act on Services and Assis-

tance for the Disabled (HE 159/2018 vp) and an Act on Client Charges in Health Care and Social Welfare (HE 310/2018 vp), which were in committee reading at the time. In addition, the committee prepared the observations and recommendations concerning the rights of persons with disabilities for the Human Rights Delegation's publication *Perus- ja ihmisoikeustilanne Suomessa – ihmisoikeusvaltuuskunnan suositukset hallituskaudelle 2019–2023* [Fundamental and human rights situation in Finland – Recommendations of the Human Rights Delegation for the Government term 2019–2023].

In autumn, the committee prepared a memorandum regarding the monitoring of the disability policy measures included in the government programme during the ongoing government term. The committee will focus on monitoring a few specific themes related to the government programme entries with a direct connection to improving the socio-economic status, educational level, and labour market inclusion of persons with disabilities, enhancing accessibility and the opportunity to participate, and promoting the inclusion of people with disabilities.

At the request of the Human Rights Centre, the committee drafted an expert opinion in response to the Deputy Chancellor of Justice's consultation related to the implementation of subtitling of YLE news. A complaint lodged with the Deputy Chancellor of Justice enquired whether visually impaired TV viewers were being treated equally to others, because the subtitles of YLE news were not displayed on a darkened background. Based on the statement given on the matter by Yleisradio Oy, the committee concluded that Yleisradio Oy should provide more comprehensive information about the services intended for the visually impaired than they currently do. Furthermore, the committee considered it important to investigate whether the service available via Teletext is easy to use. In his decision, the Deputy Chancellor of Justice agreed with the views presented by the committee.

At the proposal of the Disability Rights Committee, the Human Rights Centre will collaborate with the Ombudsman to arrange a Kalle Könkkölä symposium at regular intervals. The event is held in memory of Kalle Könkkölä's life work as a defender of the rights of persons with disabilities. The purpose of the event is to offer an arena for discussion and exchange of information relating to the current state of the implementation of the rights of persons with disabilities.

The first Kalle Könkkölä symposium was held in the Parliament Annex on 22 October 2019. The keynote speaker at the symposium was Kirsi Varhila, Permanent Secretary of the Ministry of Social Affairs and Health, whose speech addressed the focus areas of disability policy and practices used for its implementation. In a panel discussion, the representatives of disability associations expressed their own views about what kind of a picture of the daily lives of persons with disabilities has been conveyed to the organisational field. The other panel at the event discussed the status of Finnish disability research.

On 21 November 2019, the Human Rights Centre, together with the University of Helsinki, Faculty of Social Sciences, and the Finnish Society for Disability Research, as well as the European Union Agency for Fundamental Rights (FRA), organised a seminar on the independent living of people with disabilities. At the seminar, a representative of the Agency for Fundamental Rights (FRA) presented the results of the third report related to the independent living of persons with disabilities and recommendations related to the theme. The results of the research project's field work conducted in Finland were also heard at the event. In addition, there was a panel discussion on the present government's plans for reducing institutional living, and people shared their personal experiences of what it had been like to move from an institution into their own home. The participants also discussed, in a wider context, the right of persons with disabilities to live independently in a community on an equal basis with others.

To honour the International Day of Disabled Persons on 3 December and the International Human Rights Day on 10 December, the Human Rights Centre ordered table talkers to be placed at the tables of the restaurants in the Parliament buildings to increase awareness of the rights of persons with disabilities and the elderly. Regarding the right of persons with disabilities, our table

talker bulletin highlighted that, when processing bills related to the rights of persons with disabilities, it is important to keep the obligations of the UN Convention on the Rights of Persons with Disabilities in mind and to pay attention to one's personal attitudes as well.

Disability Team

The Disability Team at the Office of the Parliamentary Ombudsman consisted of three experts representing the Parliamentary Ombudsman and one expert from the Human Rights Centre. The Disability Team worked in close cooperation with the Disability Rights Committee throughout 2019. It became natural to share the 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 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 related 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 legal oversight. 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.

In 2019, the Human Rights Centre continued working together with the Ombudsman on the project on the Implementation of Fundamental and Human Rights in Housing Services for the Disabled. The purpose of the project is to develop a tool that steers the operations of residential units to strengthen the individual autonomy of the residents. On 3 June 2019, the project partners convened at a joint workshop to comment on and discuss the first model of the tool, 'the assessment framework', and its suitability for steering the operations of residential units. Towards the end of the year, the work focused on producing and complementing the contents of assessment frameworks to render them as easy to use as possible, while enabling the operations of residential units to be steered in a direction that strengthens the individual autonomy of the residents.

In connection with the project, an expert from the Human Rights Centre participated in an inspection visit made by the Office of the Parliamentary Ombudsman to the Support and Expert Centre for Persons with Intellectual Disability, KTO, on 5 November 2019. The programme of the inspection visit included a small-group meeting with the staff members responsible for strengthening the clients' individual autonomy. Furthermore, private meetings with staff members and residents had been arranged in the programme. The inspection visit further reinforced the view that residential units need a tool for steering the operations of residential services towards strengthening the individual autonomy of the clients.

The Disability Team's public-sector partners include the National Supervisory Authority for Welfare and Health (Valvira), 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 operators to be inspected.

Members of the Disability Team attended events hosted by the Parliament of Finland's Committee for Disabled Affairs related 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 related to disability services and the progress of the reform of the Act on Services and Assistance for the Disabled. A member of the Disability Team was also appointed as an expert member of the Advisory Board for the Rights of Persons with Disabilities. The Advisory Board is tasked with promoting the national implementation of the

UN Convention on the Rights of Persons with Disabilities and taking into account the rights of disabled persons in the operations of all administrative sectors. Furthermore, a member of the Disability Team participated in the work of the monitoring group on the Act on the Provision of Digital Services. The group is tasked with monitoring the implementation of accessibility regulations and the practical realisation of accessibility requirements in the digital services falling within the scope of the act, assessing the means and efficiency of the promotion of accessibility, and supporting the Regional State Administrative Agency for Southern Finland in the relevant implementation tasks.

At the initiative of the Disability Team, two training sessions related to the disability theme were arranged at the Office of the Parliamentary Ombudsman, to which the members of the Disability Rights Committee were also invited. The theme of the first training session was ascertaining the views of children with disabilities (12 June 2019). The theme of the autumn training session was the role of the UN Convention on the Rights of Persons with Disabilities in national and supranational jurisdiction (30 October 2019).

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

- The Keys of Citizenship seminar in Seinäjoki on 16 January 2019
- The meeting of Nordic National Preventive Mechanisms in Helsinki on 23–24 January 2019
- The International Day of Sign Languages seminar in Helsinki on 12 February 2019
- The Round Table on Human Rights workshop in Helsinki on 9 April 2019
- Evaluation of the action plan of the Advisory Board for the Rights of Persons with Disabilities for 2018–2019 in Helsinki on 24 May 2019
- The Baltic-Nordic Ombudsman Conference in Vilnius on 26–27 September 2019
- An event of the National Supervisory Authority for Welfare and Health (Valvira) and the Regional State Administrative Agency for Southwestern Finland in Pori on 23 October 2019
- A seminar for municipal councils on Disability in Vantaa on 27 October 2019
- An Independence Day Celebration for persons with disabilities in Salo on 8 December 2019

During 2019, a member of the Disability Team participated in an evaluation interview of the EU Disability Strategy 2010–2020 on 3 September 2019. In addition, a member of the Disability Team participated in an evaluation interview for the evaluation study of the Non-discrimination Act, with the funding provided by the Government's analysis, assessment, and research activities.

International cooperation

The Human Rights Centre participated in the ENNHRI CRPD working group meeting in Brussels on 13 May 2019. As its special theme, the meeting addressed the practical implications of the obligation of inclusive teaching imposed by the UN Convention on the Rights of Persons with Disabilities (CRPD). In addition, the meeting went through themes in accordance with the working group's action plan. The Human Rights Centre has been in charge of coordinating and planning operations related to influencing at the EU level. In this respect, it was agreed that the working group would target its limited resources at the evaluation of the EU Disability Strategy 2010–2020 and participate actively in the drafting of the new strategy. To this end, a representative of the Human Rights Centre participated later in the year in the evaluation interview of the EU Disability Strategy 2010–2020. In its meeting, the ENNHRI CRPD working group also laid down a policy that the working group should schedule regular meetings with independent EU structures, and the European Union Agency for Fundamental Rights (FRA) in particular.

A representative of the Human Rights Centre participated in the Conference of States Parties to the CRPD in New York on 11–13 June 2019. The meeting addressed such issues as the challenges posed by digitalisation to the inclusion of persons with disabilities in society, and the rights of disabled persons to inclusion in cultural life and lei-

sure time activities. During the conference, the representatives of national human rights institutions present established the CRPD working group of the Global Alliance of National Human Rights Institutions (GANHRI) and held the working group's first meeting.

On 18 October 2019, the members of the Disability Team attended a study trip to the European Union Agency for Fundamental Rights (FRA) in Vienna, organised jointly by the Ombudsman and the Human Rights Centre, where the FRA presented its operations and topics related to the EU Charter of Fundamental Rights. During the trip, the parties also examined the future cooperation between the FRA, the Human Rights Centre, and the Ombudsman.

3.4.3 OPERATING ENVIRONMENT AND CURRENT LEGISLATIVE PROJECTS

The new Administrative Judicial Procedure Act (808/2019) entered into force on 1 January 2020, changing the appeal process to the Supreme Administrative Court in such a manner that decisions on disability services of the Administrative Court may be challenged by appeal to the Supreme Administrative Court only if the Supreme Administrative Court grants leave to appeal the case. In appeals related to disability services, the leave to appeal will be required in matters concerning services and support measures, such as personal assistance, assisted living services, day-care activities, and transport services, that the municipalities have a statutory obligation to provide.

A goal set in the 2012 Government Resolution on independent living and services for persons with intellectual disabilities was 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 through the 21st century.

According to a statistical report compiled by the National Institute for Health and Welfare (THL), at the end of 2018, a total of 631 individuals (920 in 2016) were living in institutions for the intellectually disabled, which is 15 per cent less than the year before. Of those living in institutions, 521 (795 in 2016, and 962 in 2015) were long-term residents. Long-term residents are those clients for whom a decision has been made on long-term care or who have been in care for more than 90 days. At the end of 2018, 8 of the long-term residents were under the age of 18 (131 in 2016), of whom 13 were between the ages of 0 and 7.

On 13 December 2019, the Ministry of Social Affairs and Health set up a working group on inclusion tasked with evaluating and preparing regulatory proposals for disability services legislation. The goal is to ensure and further increase the participation of persons with disabilities in decision-making that concerns them and the arrangement of services, and to clarify the legal remedies concerning the choice of the way in which services are provided.

3.4.4 OVERSIGHT OF LEGALITY

The Ombudsman oversees the realisation of the rights of persons with disabilities concerning all authorities and private bodies performing public tasks, regardless of the administrative sector of the authority or other party. In statistics, complaints are primarily filed under 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 action plans 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 related to the rights of persons with disabilities.

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

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

Complaints and investigations on the initiative of the Ombudsman

The Ombudsman delivered decisions on a total of 281 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 (257) and the year 2017 (242). The Ombudsman investigated five cases on his own initiative. Three of these involved deficiencies in accessibility and securing the confidentiality of polls at certain advance polling stations. The number of cases warranting further action was higher than in previous years, i.e. 82 cases (29%). Similarly to previous years, the percentage of cases warranting further action was higher than the average at the Office of the Parliamentary Ombudsman (14.5%). In three of the cases, the Ombudsman issued a reprimand, and in four of them a proposal. The Ombudsman also communicated his opinion on what would be the legal course of action in 65 (42) cases and took other action in 4 (12) cases. Due to the high number of cases that warranted further action, it is not possible to give an account or even mention in this report anywhere near all of the decisions taken in 2019 that related to the rights of persons with disabilities.

Most of the decisions (179) concerning the rights of persons with disabilities related to social services, which is similar to previous years (150 each year in 2018 and 2017). This is due to the fact that the category of social services, such as special care for persons with intellectual disabilities and services and support based on disability, is the responsibility of municipal authorities. A total of 26 cases (38 in 2018, and 40 in 2017) related to personal assistance within the meaning of the Act on Services and Assistance for the Disabled, 30 (19 in 2018, and 34 in 2017) to transport services , and 25 (28 in 2018, and 22 in 2017) to the rights of persons with intellectual disabilities. Cases in which the Social Insurance Institution of Finland has the role of a provider of interpreters for persons with disabilities were also included in the category of social welfare services. In this category, the Ombudsman addressed 28 cases in 2019 (11 cases in 2018).

Cases related to social insurance numbered 46 in 2019 (28 in 2018, and 34 in 2017), while cases related to health care amounted to 57 (55 in 2018), and cases related to education to five (seven in 2018, and 12 in 2017). Cases concerning the monitoring and promotion of the rights of persons with memory disorders are discussed in section 3.5.15.

Cases related 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 client charges, advice and guidance related to services, the treatment of individuals in the context of client 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 were 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 psychiatric hospitals and residential and institutional units for persons with disabilities combine the two special mandates that the Ombudsman has under international conventions (CRPD and OPCAT). These kinds of inspections numbered 28 (25) in 2019. A total of 8 of the inspections were conducted in residential and institutional units for persons with intellectual disabilities and/or severe disabilities, and 18 in residential and institutional units for the elderly (persons with memory disorders). The providers of psychiatric hospital care inspected in 2019 included Harjavalta Hospital in Satakunta Hospital District and the geriatric psychiatric ward of Pitkäniemi Hospital in Pirkanmaa Hospital District.

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, and inspect documents, the communal areas of the units, and the surrounding area, as well as clients' private rooms with their permission.

Inspection visits in residential units for persons with intellectual and/or severe disabilities were conducted in the units run by joint authorities (Eteva Joint Authority and the Joint Authority of Southwest Finland's special care district) in Nurmijärvi and Paimio. Inspections were also made in service units run by private service providers (such as Omakoti Oiva and temporary care home Alma in Vantaa) to whom local authorities had outsourced services.

Key issues addressed in connection with inspections of residential and institutional units for persons with intellectual disabilities included the new provisions of the Act on Special Care for the Persons with Intellectual Disabilities that entered into force on 10 June 2016, 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. Promoting accessibility and inclusion requires continuous work.

Shortcomings in the accessibility of premises and services and in the implementation of adaptation measures have been detected on the Ombudsman's inspection visits. The following is a summary of individual observations made mostly in connection with inspections.

Care and residential units for the elderly

- In Pakilakoti of Helsingin Seniorisäätiö, the toilet facilities of residential rooms were discovered to be cramped, especially if the residents were using mobility aids. The communal areas were also quite cramped in places. The building had a lot of corridors, and, for example, workstations and lifting devices had been placed along some of the corridors (3763/2019).
- The ramp leading to the entrance of Lizeliuskoti in Mynämäki was relatively steep, which may, for example, make it difficult for persons using a wheelchair independently to use the ramp safely (2009/2019).
- The main entrance to Pihlajakoti (Padasjoki) was located at the bottom of a steep hill, which made it difficult for persons using a walker or other mobility aids to enter the building through the front door (1842/2019).

Residential units for persons with intellectual and physical disabilities

- From the perspective of mobility, the old premises of the residential units of Tahkokangas service centre were not accessible in all respects (4639/2018, 6388/2019, and 6389/2018).
- The door buzzer at the front door of the temporary care home Alma in Vantaa was so high up that it was difficult to reach for those using a wheelchair or other mobility aids (1684/2019).

Education

- At Otsola school, it was discovered that not all floors could be reached by lift, and the toilet facilities had not been designed with accessibility in mind. There was no designated disabled parking space in the parking area of the school (4775/2019).

Accessible entrance to Vuoma rehabilitation centre.

- On the inspection of Haaga-Helia University of Applied Sciences, the Deputy-Ombudsman emphasised on a general level the requirements of the UN Convention on the Rights of Persons with Disabilities and the Non-discrimination Act regarding the promotion and safeguarding of the rights of persons with disabilities and students in need of special support. Reasonable accommodations may be necessary to enable access to education and to ensure that a student can cope with their studies and make progress in them. In practice, the adjustments may include individual steps related to the accessibility of the place of study, or the arrangement of special support for the studies (2550/2019).

Health care

- There were no lifts in the buildings of Niuvanniemi Hospital. Therefore, patients with impaired mobility were placed in the wards on the first floors, which had been equipped with ramps (3712/2018).
- The Deputy-Ombudsman recommended that Espoo Hospital should estimate whether they could improve the interior decoration of the wards or post signs to make it easier for patients with memory disorders in particular to obtain an overall picture of the hospital and its wards and to move around in them. Furthermore, when planning and implementing communications, it should be taken into account that elderly patients have limited opportunities and skills to use electronic devices (1706/2019).
- In his decision on a complaint (5467/2018), the Ombudsman informed the joint municipal authority and the deputy chief physician of the Hospital District of Southwest Finland of his opinion concerning the inaccessibility of the entrance to Tykslab sampling point on Käsityöläiskatu. Based on a letter of complaint and the information provided, it seemed that the inaccessibility of the entrance (electronic push-button door opener and a ramp at the entrance) may put restrictions on or prevent the entry of persons with physical disabilities to the sampling point. According to the Ombudsman, this may effectively place persons with physical disabilities in an inferior position compared to those with no mobility impairments. The Ombudsman emphasised that the patient is entitled to choose which Tykslab sampling point they want to use. The Ombudsman requested the hospital district to report by 28 February 2020 on the measures it has taken in response to his opinion.

  According to the hospital district's report (13 February 2020), the property owner had moved the door opener downwards and lengthened the time the front door remains open. According to the report, the wheelchair ramp will be elevated to reduce the difference between the level of the ramp and the entrance, caused by the sinking of the street.
- In another decision (1811/2018), the substitute for the Deputy-Ombudsman stated that the entrance of a laboratory was not accessible within the meaning of article 9 of the CRPD. Since, in this case, it had been agreed later that the door between the draught lobby and the entrance hall would be kept open during the opening hours of the lab, also allowing the entry of persons using a wheelchair by pushing the front-door button, the case did not warrant any further action by the substitute for the Deputy-Ombudsman.
- In the Deputy-Ombudsman's opinion, during advance polling, psychiatric hospitals should separately consider whether each isolated patient could visit a polling station and vote under supervision, and, if deemed possible, then actively offer this opportunity to the patient. The Deputy-Ombudsman felt that, by taking such an approach, the hospital would promote the opportunity of patients to participate in societal activities, as intended under the Constitution of Finland (892/2018).

Inspections of polling stations in parliamentary elections and European elections and investigations on the initiative of the Ombudsman

On 8 April 2019, two public servants from the Office of the Parliamentary Ombudsman made unannounced inspections of seven randomly selected polling stations for the parliamentary elections (Porvoo, Pornainen, Askola, Pukkila, Myrskylä, Lapinjärvi, and Loviisa) following the orders of the Ombudsman. Two public servants made similar inspections on 26 May 2019 at eight polling stations for the European elections (Vantaa, Riihimäki, Loppi, Tammela, Somero, Forssa, Salo, and Jokioinen). The purpose of the inspections was to determine the accessibility of polling stations, the general order of the premises, and the smooth running of the voting situation from the perspective of the implementation of the rights of persons with disabilities.

- A general observation made during the inspections was that the arrangements made at the polling stations regarding provision of information about the polling station and voting, and guidance to the location were rather modest. There was also room for improvement in the training and orientation of electoral officials in matters regarding accessibility and the voting of persons with disabilities.
- Many of the advance polling stations for the parliamentary elections and the polling stations for the European elections did not have accessible polling booths. In one of the polling stations, persons using mobility aids were offered a plywood writing pad they could place on their lap in the polling booth. In some places, persons using a wheelchair were offered an opportunity to vote at a table without a separate privacy screen. In one of the places, the space for voting was so cramped that, for example, persons using a broad electric wheelchair did not fit into the polling booth or the booth was too narrow for them. Some polling stations did not have a magnifying glass or other similar aid available for visually impaired voters.

Staircase leading to a polling station.

- There were deficiencies in the accessibility of the advance polling stations for parliamentary elections. At one of the polling stations, the ramp leading to the entrance was quite steep for persons using a wheelchair. In addition, a heavy door made independent access to the premises difficult. At another polling station, the front door was heavy, and the thresholds at the entrance were so high that persons using a wheelchair could not reach the premises independently without someone assisting them. All polling stations for the European elections except one had deficiencies in the accessibility of the polling facilities or the route leading to them. Two of the polling stations were totally inaccessible due to staircases.

Due to the deficiencies observed during the inspections, the Ombudsman investigated on his own initiative the election arrangements of four local authorities for parliamentary elections and, similarly, the actions of four local authorities regarding the European elections. In his decisions, the Ombudsman considered it positive that local authorities and cities announced that they would take corrective action based on the observations made. For example, in the next elections, the organisers will reserve another accessible location as the voting district's polling station, or they will provide accessible polling booths at all advance polling stations and the polling stations used on

Polling station with privacy screens at a municipal government office.

Polling station for people with reduced mobility at an education centre.

Polling station intended for persons with physical disabilities.

the actual election day, and provide aids for the visually impaired.

Due to the corrective action announced by local authorities and cities, within the Ombudsman's oversight of legality, the Ombudsman's own initiatives did not lead to any other action than the Ombudsman drawing the attention of central municipal election boards and municipal and city governments to the problems related to accessibility and the realisation of the confidentiality of the polls caused by the issues identified in the inspection report.

Inspection reports 1670/2019 (parliamentary elections) and 2657/2019 (European elections) have been published online at www.oikeusasiamies.fi in Finnish.

The Ombudsman's decisions on cases taken on his own initiative are also available online in Finnish: 2347/2019, 2348/2019, 2349/2019, 2350/2019, 3332/2019, 3333/2019, 3334/2019, and 3335/2019.

Reception centre and detention unit

– In Tampere Reception Centre, there had been and still were residents with disabilities at the time of inspection. The inspectors were informed about problems related to, for example, getting sign language interpreters. They were also told that it was difficult for asylum seekers to be granted special services. However, they had succeeded in acquiring assistive devices for the residents, and, for example, one

minor had been fitted with a hearing aid by Tampere University Hospital (3440/2019).
- Helsinki (formerly Metsälä) detention unit reported to inspectors about a foreign detainee on whom they did not have any background information at the time of their arrival. The detainee had to be isolated from others due to violent behaviour. It was not until later that it transpired that the detainee suffered from an autism spectrum disorder. Some of their behaviour derived from the fact that their special needs were not understood from the beginning. After the incident, a representative of the Autism Foundation Finland was invited to the unit to talk about how to act with persons in need of special support and how to prevent the escalation of similar situations (6841/2019).

Disabled parking spaces

- In decision 4418/2018, the substitute for the Deputy-Ombudsman drew the City of Tampere attention to the need to arrange parking areas (designated disabled parking spaces) for disabled persons (persons with physical disabilities) particularly during construction work and renovation projects, because the information received did not indicate whether replacing (designated disabled) parking spaces had been arranged for the duration of renovation work taking place in the street area in front of the main police station or whether other alternative parking arrangements had been made.
- The substitute for the Deputy-Ombudsman considered it very positive that Tampere had conducted a survey on the arrangement of parking for persons with physical disabilities, based on which it had proposed measures for developing disabled parking and improving the situation. By regularly monitoring the implementation of such measures, the city may continue the development of the disabled parking system and the promotion of the rights of persons with disabilities.

Prisons

In inspection reports concerning prisons, the inspectors identified the following shortcomings and development needs mostly related to the rights of inmates and visitors with physical disabilities:

The *Vilppula Prison* facilities were not accessible or capable of housing inmates with physical disabilities (1592/2019).

The *Vanaja Prison* (Ojoinen unit) facilities were not accessible or capable of housing inmates with physical disabilities. According to the staff, the prison was planning to build an accessible visiting area that would also allow visits by persons using a wheelchair (3420/2019).

Sukeva Prison

- The visiting area was problematic from the viewpoint of accessibility, because the premises could not be accessed by lift.
- On the road with signs indicating the way to the prison, there is a barrier with a call button placed in such a way and so high up that it is impossible to press it without stepping out of the car, and it is impossible to reach from a wheelchair.
- There was no parking for persons with physical disabilities (designated disabled parking space) in the prison area. The Deputy-Ombudsman recommended having such a space arranged near the entrance to the prison.

The Deputy-Ombudsman pointed out the inspection observations to Sukeva Prison, the Regional Centre of the Criminal Sanctions Region of Eastern and Northern Finland, and the Central Administration Unit of the Criminal Sanctions Agency, and requested them to report by 1 June 2020 on what action the observations had warranted (5291/2019).

Turku Prison

- The Deputy-Ombudsman stated that living in a disabled cell as required by a disability or illness must not be used as grounds for not placing prisoners in various activities or placing them in more closed circumstances than order and security would warrant. Therefore, prisoners with disabilities should be placed in activities suitable for them despite the fact that they live in a ward where other prisoners are still waiting for a placement in activities. It is also problematic if the prisoners are kept in otherwise very closed circumstances even though such an environment would not be necessary with a view to institutional security in the case of the prisoner concerned. The Deputy-Ombudsman also referred to the Ombudsman's decision (EOAK/2871/2016, 30 August 2017).
- In the cell, the call button to alert the guard/emergency alarm was placed so high up on the wall that it could not be reached from the bed or, for example, the floor. According to the Deputy-Ombudsman, the opportunity to sound an alarm must be secured in situations where the prisoner's ability to move is weak and the possibility of problems arising from that is high. In this respect as well, the Deputy-Ombudsman referred to the Ombudsman's decision, as a result of which a prison solved the issue by giving a portable alarm device to a prisoner with disabilities.

The Deputy-Ombudsman requested the prison to report by 1 June 2020 at the latest on what actions the observations and views described above have warranted (2449/2019).

3.3.5 DECISIONS

Social welfare

Reprimands

In 2019, the Ombudsman gave two reprimands. The first case, 2520/2018, was about arranging child care. The Ombudsman issued a reprimand to the City of Helsinki Social Services and Health Care Division, and the Hospital District of Helsinki and Uusimaa (HUS) for future reference, because the cooperation issues between these authorities and the administrative decisions taken in relation to the obligation to organise care led to a situation in which continued provision of home care to a child could not be initially guaranteed and, on the other hand, the child's return from hospital to home care was delayed. All in all, the Ombudsman considered the way the City of Helsinki and HUS acted in the case highly reprehensible. When assessing the blameworthiness of the actions, the Ombudsman took account of the fact that the case was about organising the care and nurture of a very young child. In this case, the authorities failed to ensure the child's best interests in the organisation of their care and nurture in accordance with the UN Convention on the Rights of Persons with Disabilities and the Social Welfare Act.

The Ombudsman agreed with the view presented in the statement by the National Supervisory Authority for Welfare and Health (Valvira) that the city and HUS should have jointly undertaken immediate action to investigate how to organise the services responding to the needs of the complainant's child in a place other than a hospital ward, and that they should have taken a more active approach to seeking alternatives for organising the child's care at home or in a homelike environment.

The Ombudsman emphasised that the administrative decision-making concerning care and nurture and the boundaries between different authorities must not constitute obstacles to arranging and implementing services responding to the

needs of clients or patients and safeguarding their continued provision. The basic premise of both the Social Welfare Act and the Health Care Act is that social welfare and health-care authorities must collaborate to ensure seamless service chains for clients and patients.

In the same decision, the Ombudsman stated that the city had unlawfully neglected its duty to draft a comprehensive client plan for the child, drawn up in multidisciplinary cooperation. Considering the difficult overall situation of the child, the Ombudsman was of the opinion that a comprehensive social welfare client plan (or other similar care and service plan), including a plan on disability services, should have been drawn up for them well in advance. In connection with making plans for the child, the officials could also have assessed and planned means and services to support the parents in coping, if necessary. The Ombudsman emphasised that a multidisciplinary and multiprofessional client plan enables taking account of the client's individual needs and promotes the implementation of cooperation between the authorities from various administrative sectors.

In another case, 6372/2018, the Ombudsman issued a reprimand to the disability services of the City of Jyväskylä for unlawfully delaying the implementation of a decision issued by the Administrative Court. In the Ombudsman's opinion, the city had not processed the special care programme of the complainant's child without undue delay, as required by the Administrative Procedure Act and ordered by the decision of the Administrative Court of Vaasa. In its ruling, the Administrative Court expressly ordered that the matter concerning the special care programme of the child should be processed without undue delay and bearing the child's best interests in mind, even if the city were to appeal the Administrative Court's decision. The disability services failed to comply with this decision.

The Ombudsman stated that it is possible to conclude from the Administrative Court ruling that this was not a case in which implementation could render an appeal useless, because the statement stipulated that the only matter that could prevent the implementation of the decision would be the Highest Administrative Court prohibiting the implementation of the decision. The Ombudsman stated that the disability services of the City of Jyväskylä had unlawfully and without appropriate grounds delayed taking action in the implementation of a decision issued by the Administrative Court. The Parliamentary Ombudsman emphasised that clients who rely on social welfare must be able to trust that the authorities are proactive in implementing court rulings as ordered by the court and provided for in law.

Delays in decision-making and neglecting the authority's duty to make decisions

The most common shortcomings found in the oversight of legality by the Ombudsman involve delays in processing applications for benefits or services granted to persons with disabilities and neglecting the authority's duty to make decisions. The specified procedural errors jeopardise the implementation of legal protection.

The Ombudsman found a city's negligence concerning decision-making to be unlawful in case 6153/2018*, in which the authority had failed to make a decision even though the client's round-the-clock rooming-in care had ended. The Ombudsman emphasised that the authorities are under an obligation to issue a competent authority's challengeable decision on the organisation of assisted living and the way it is organised, as referred to in the Act on Services and Assistance for the Disabled. A municipal official had failed to issue a challengeable decision on their own initiative on the termination of rooming-in care related to the organisation of assisted living, but the rooming-in care had ended based on the client's service plan. The Ombudsman stated that the care and service plan serves as a basis for functional decision-making, but drawing up the plan is no substitute for an administrative decision.

The Act on Services and Assistance for the Disabled provides 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.

In case 1283/2018, the Ombudsman concluded that the prolonged processing of an application concerning disability services had violated the Act on Services and Assistance for the Disabled. The Ombudsman underlined that the relevant provision of the Act on Services and Assistance for the Disabled 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 requirement to process applications without undue delay means that authorities must start processing the matter immediately after the application has been filed. An authority cannot postpone its duty to investigate and make decisions for such reasons as changes in staff or holiday arrangements or due to a backlog in the local authority's processing of applications.

In case 266/2019, the Ombudsman emphasised that a decision concerning disability services must be made without undue delay once the requested statements have been received. In this case, the investigation of the need for special needs footwear had required a prolonged processing period.

Case 2343/2018 was also about prolonged decision-making in disability services. The Ombudsman pointed out to a city that the transport services and car assistance referred to in the Act on the Services for the Disabled are not mutually exclusive forms of service and assistance. Using a car for mobility and community transport services may complement each other.

In case 1030/2018, the substitute for the Deputy-Ombudsman underlined that a new decision must be made well enough in advance before the end of the period of validity of the previous decision to prevent unjustified interruption in the provision of assistance to a social welfare client. The substitute for the Deputy-Ombudsman found that the implementation of a decision concerning informal care had been unlawfully prolonged and drew the attention of the City of Oulu Well-Being Services to the fact that the decision should have been implemented within three months from the date when the application was filed at the latest. In case 6708/2018, the substitute for the Deputy-Ombudsman concluded that the processing of the complainant's transport service case had failed in many ways. In violation of the Administrative Procedure Act, a senior social worker had neglected to take the complainant's demand for rectification to the local authority's social welfare committee for investigation. This negligence, on the other hand, had prolonged the overall processing time of the complainant's transport service case, since the complainant had to file a new demand for rectification to the committee concerning a later decision made by a municipal official. The complainant's individual need for transport service had not been investigated before the demand for rectification was pending. The substitute for the Deputy-Ombudsman was of the opinion that an appropriate and timely assessment of the need for service would also have accelerated the processing of the case.

In some of his decisions, the Ombudsman also assessed how local authorities or service providers responded to enquiries and complaints. The Ombudsman underlined that authorities are obliged to respond to complaints within a reasonable time from the date of a complaint being filed. When assessing how long it has taken for the authorities to respond to a complaint, the Ombudsman takes account of what kind of a matter the complaint concerns and how the shortcoming referred to in the complaint affects the welfare client's position and the organisation of services intended for them. The Ombudsman stressed that good governance requires that appropriate letters and enquiries addressed to authorities are responded to in an appropriate manner and without undue delay (1283/2018).

In decision 4679/2018, the Ombudsman found that the City of Oulu Well-Being Services had not responded to a complainant within a reasonable time from a complaint being filed. In decision 3993/2018, the Ombudsman concluded that the period of three months it had taken for a service home to respond to a complaint was too long.

Legal protection issues related to service plans

In case 5152/2018, the Ombudsman drew the attention of a city's disabled services and social welfare services to the need to draw up individual service plans without undue delay. According to the Ombudsman, an individual service plan is also of special importance when a person with disabilities and an authority disagree on the way in which disability services or other services under the Social Welfare Act should be organised or implemented. Therefore, the service plan must indicate potential differing views between the authority and client about the organisation of services. In a conflict situation, the client's own view may be of significance when the client is appealing a decision issued by an authority. It may be a question of the amount of services, or the way in which the services are implemented, or what kinds of services can or should be organised in a particular case.

In case 5826/2018, a city had neglected to make a multidisciplinary social welfare client plan for a child. The substitute for the Deputy-Ombudsman emphasised that a multidisciplinary client plan enables taking account of the client's individual needs and promotes the implementation of cooperation between the authorities from various administrative sectors and also between the various sectors within the same field of administration. In the case concerned, it would have been reasonable to draw up such a plan from the perspectives of the child's best interests and service planning.

In one case, it had taken 18 months to draw up a service plan for a child, which the Ombudsman considered unlawful. What made the failings particularly significant in this case was the fact that the complainant had requested a service plan to be drawn up on several occasions, but in spite of this, no plan had been drawn up (912/2019).

In connection with complaint case 6327/2018, the Ombudsman assessed the role of a guardian appointed to manage financial affairs in the service planning of a client with an intellectual disability. In the Ombudsman's opinion, a solution that is in the client's best interests can be reached if the municipal social welfare services, the social welfare client, and the legal representative (the guardian and family members or other persons close to the client) mutually agree on the matters and their interaction regarding their participation in the service plan meetings, as well as on the role each one of them will play in the assessment of the service needs, drafting of the service plan, and decision-making concerning the services and potential appeals processes. In this connection, it is possible to assess whether the participation of "support persons" could promote the realisation of, for example, the disabled person's own goals and preferences and genuinely support them in making their own personal decisions.

Other decisions concerning disability services

In connection with complaint case 5658/2018, the Ombudsman pointed out to a local authority that there is an employment contract between a person with a severe disability (employer) and a personal assistant (employee). If the local authority deals directly with the personal assistant in matters related to the organisation of personal assistance, such an arrangement should be agreed with the employer.

The Ombudsman recommended to a service home that when they draw up their self-monitoring plans, they should take account of the fact that some of the clients in the service home may be there based on the Act on Services and Assistance for the Disabled, and, therefore, restrictive measure in accordance with the Act on Intellectual Disabilities may not be used on them. The Ombudsman pointed out generally to a service home that restrictive measures within the meaning of the Act on Intellectual Disabilities may only be used if assisted living services are organised as special care in intensified assisted living services and only when the client's around-the-clock assisted living has been organised as special care (1504/2018 and 1826/2018).

With a view to realisation of the rights of persons with severe disabilities, the Ombudsman considered it a good and recommended practice

that the local authority pay the costs incurred from the organisation of occupational health care for a personal assistant as they emerge, if it is difficult for the person with disabilities to apply for compensation for them in arrears. In such a situation, the person with severe disabilities may, for example, give a power of attorney to the local authority, which files the application for compensation with the Social Insurance Institution of Finland on behalf of the employer with severe disabilities. The Ombudsman also pointed out to the municipal social welfare services that it should also be written down in the client plan and decision how the compensation of costs is implemented in practice (1289/2018).

The Deputy-Ombudsman concluded that a service home had neglected its duty to ensure appropriate care and good treatment of clients, as a client had been left sitting in a wheelchair overnight. After the erroneous action, the matter was investigated by the service home and the city that had outsourced the assisted living service, and guidance was provided to the staff on the correct care procedures. Since the local authorities had taken remedial action in the matter, the case gave rise to no further action by the Deputy-Ombudsman (93/2019).

Oversight of private care homes

The Ombudsman drew the general attention of the Rovaniemi Municipal Authority for Health Care and Social Services to the importance of cooperation between authorities in the oversight of intensified assisted living units. The local authority in charge of the placement of clients is also responsible for monitoring that the client they have placed in a service unit receives the kind of service agreed upon. The City of Rovaniemi had not been able to supervise the implementation of the services for clients placed by other local authorities, because it did not have information – nor should it have had – about the contents of the service agreements of the residents placed by other local authorities or about the service agreement between the care home and other local authorities in charge of placing clients. On the other hand, the City of Rovaniemi could have informed the other local authorities in charge of placing clients about the shortcomings observed by them so that they could have taken the matter into account in their own oversight activities.

The Ombudsman agreed with the opinion of the National Supervisory Authority for Welfare and Health (Valvira) that the care home run by Esperi Care Oy had had limited personnel resources and a large number of changing employees (substitutes) over a specific period. The changing employees may also have been a major contributory factor to generating restlessness and feelings of insecurity in the daily lives of the clients. In addition, the changing personnel also burden the regular staff, because they need to provide orientation to substitutes after each absence, at least in some respects.

The Ombudsman pointed out at a general level that the opportunities of the residents to lead a normal life and receive necessary care must be secured at all hours. When deciding on the allocation of staff for night-time supervision duties, account must be taken of the clients who need to be assisted by two people. The service unit must have enough staff in terms of quantity and professional skills to meet the unit's operational needs and the special needs of the persons living in the service facility. This is one of the essential factors for securing high-quality treatment and care that respects the human dignity of the residents. The changes in the care needs of the residents must also be appropriately observed in staff allocation (1504/2018 and 1826/2018).

Application forms for disability services

In case 2059/2018*, the Ombudsman took a stand on the contents and drafting of application forms for disability services. The Ombudsman considered it possible for a city to have, in addition to a general application form for disability services, a separate form for applying for transport services. The application forms may be made available both in the electronic service system and as printable

versions on the relevant website. The application forms should be consistent in terms of subject matter and questions, no matter in which system or version they are presented.

The Ombudsman emphasised that the standard forms used by authorities must be clear and comprehensible. The forms must not lead to loss of benefits or the narrowing of procedural legal protection due to the fact that their interpretation may cause misunderstandings or uncertainty among clients. Therefore, authorities need to pay special attention to the comprehensibility, clarity, and accessibility of the information provided by them, particularly when, among their clients, there may be people with a limited ability to receive and process information (persons with disabilities and the elderly).

In the Ombudsman's opinion, it is important that when authorities ask among their clients to give their consent for the acquisition of information, they identify with sufficient precision what kind of information they are referring to. If the form describes the consent requested from social welfare clients in too general terms, the client will not be able to assess from which bodies or from whom such data will be requested and what the scope of the request for data will be. Therefore, in the Ombudsman's view, the form should mention at least the authorities or other bodies from whom information may be requested. It is also one of the principles of good governance that authorities clearly state that social welfare clients have the right to withdraw their consent at any point in the processing of the case.

In another case, Tampere Social Welfare Office for the Disabled had stopped providing online application forms in its special care services for persons with intellectual disabilities. The Ombudsman considered the removal of the application forms problematic from the viewpoint of fundamental rights of the disabled but did not find it unlawful. Application forms may be one way of getting an application filed. Providing the clients with various options for applying for services is in keeping with the service principles laid down in the Administrative Procedure Act, for which reason the Ombudsman did not consider the change made by the Social Welfare Office for the Disabled, or the removal of the application form, a very good decision.

The Ombudsman considered it possible that the different application procedures for intellectual disability services and disability services may make it difficult for clients to establish an overall picture of the service packages available, and may prevent and narrow the realisation of the rights of persons with disabilities in other respects as well. The Ombudsman requested Tampere Social Welfare Office for the Disabled to report by 31 December 2019 on what actions it had possibly taken due to the Ombudsman's decision (2769/2018).

On 19 December 2019, Tampere Social Welfare Office for the Disabled reported that they now offer a separate updated application form for the purpose of applying for a special care programme, which is available both from social workers and online on the Social Welfare Office for the Disabled website.

Deductible in transport services provided under the Act on Services and Assistance for the Disabled

The Ombudsman drew the attention of the City of Hyvinkää to the determination of the client fee (deductible) in the community transport services provided under the Act on Services and Assistance for the Disabled, considering it problematic that the minimum deductible charged for the transport services was higher than the fee collected in the Hyvinkää local transport system. The Ombudsman emphasised that the duty of public authorities to guarantee sufficient social welfare and health care services for everyone includes the duty to determine the fees charged for these services in such a manner that they do not prevent or jeopardise a person's opportunities to use the statutory services that they may need (1739/2018).

EU Disability Card

The Ombudsman was of the opinion that, at the time of assessment, the actions taken by the Dis-ability Card Office and the Finnish Disability Forum in granting and defining the criteria for granting the EU Disability Card did not constitute the performance of a public duty within the meaning of the rules of jurisdiction applied to the Ombudsman. Therefore, the Ombudsman did not have the competence to investigate the procedure for defining the criteria and principles for granting the marking A for the EU Disability Card.

The EU Disability Card system is based neither on the national legislation of Finland nor on supranational EU regulation, but on the criteria and principles decided by disability organisations. However, the potential development and expansion of the Disability Card system may have an impact on the assessment of issues that fall within the Ombudsman's jurisdiction. Within the remit of his mandate, the Ombudsman may investigate the Social Insurance Institution of Finland's practices in its role as an authority that manages various phases of the Disability Card application and ordering procedure (3142/2018).

Interpreting services for persons with disabilities

The Social Insurance Institution of Finland 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. The Social Insurance Institution of Finland can either use in-house interpreters or outsource interpreting to other service providers. The Social Insurance Institution of Finland established its own interpreter service centre 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.

Defining the need for an interpreter for international travel

The Ombudsman considered it problematic that the need for an interpreter is defined in advance, particularly with regard to longer international travel or other travel where it may be difficult to anticipate the actual need for an interpreter on justifiable grounds. Announcing the need for an interpreter and making a decision on it in advance may result in a situation in which the client is granted less or potentially even more interpreter services than they actually need in practice. As such, the Ombudsman considered it good client service that the client is allowed to specify their need for an interpreter up to one week before a trip. However, the views of the client and the Social Insurance Institution (Kela) may differ as to whether the need for an interpreter has been itemised to a sufficient extent. The Ombudsman pointed out to Kela that, if the client so requires, Kela should issue a written, appealable decision on the matter in a situation in which Kela is of the opinion that the applicant has not itemised their need for an interpreter to a sufficient extent and the applicant disagrees with this (206/2018).

The duty of authorities to examine the content of an order for an interpreter

The Ombudsman drew the attention of Kela's Centre for Interpreting Services for Clients with Disabilities to the need for care in client communications related to ordering interpreters, to ensure that all the information needed for relaying an order, such as the time of termination of the order, is communicated appropriately and to a

sufficient extent. In the Ombudsman's opinion, this case was not only about client communications, but basically it was a question of the duty of authorities to ensure that the contents of an order for an interpreter are based on sufficient information. Since Kela announced that it has taken action to improve its client communications, the matter did not give rise to further action by the Ombudsman (2538/2018).

Protection under the law after the competitive tendering of interpreters

Usually, the users of interpreter services do not have the legal remedies provided by the Act on Public Procurement at their disposal, because they are not a concerned party in the procurement matter. In the year under review, the Ombudsman assessed, in many of his decisions, the realisation of the legal protection of the users of interpreters for the persons with disabilities in a situation in which it was claimed that the procurement decision on the provision of interpreters for the disabled taken by Kela jeopardised the observation of the individual special needs of the service user in the implementation of interpreter services.

According to the Ombudsman's view, Kela should have processed a complainant's demand for rectification of a procurement decision, as provided in the Act on Interpreter Services for Persons with Disabilities. The complainant's demand had been based on the requirement to take account of their special needs even though it had been titled 'demand for rectification on a procurement matter' and the complainant was not a concerned party in the procurement matter. The Ombudsman found the title understandable, because the state of affairs on which the demand was based had come about due to a procurement decision. An interpreter may play a key role in whether the right of the person concerned to an interpreter service is realised. To ensure the realisation of this right, the service user should have a right of appeal in a situation where they are of the opinion that their special needs require the organisation of interpreter service in an individual manner, and the service providers selected through the procurement process are not suitable with regard to their special needs.

According to the Ombudsman, in such a situation, the service user should have the right to ultimately have their case heard before a court of law. Therefore, Kela should attach the decision it is issuing with the appeal instructions required under the Act on Interpreter Services for Persons with Disabilities, as far as the matter does not fall within the Market Court's jurisdiction. However, the Ombudsman came to the conclusion that the questions of which procedure to follow and whether the client is entitled to appeal the decision are open to interpretation, and the questions will ultimately be solved by a court of law. The interpretation presented above would guarantee the service user's access to a court of law in a situation in which the individual special needs of the party concerned have not been taken into account in a public procurement of social welfare or health care services. The same outcome (i.e. access to a court of law) could also be achieved if the service user files a separate direct procurement request based on their individual special needs, and the authority gives an appealable decision on this request (760/2018).

In three of his decisions, 1108/2018, 4875/2018, and 5156/2018, the Ombudsman was of the opinion that Kela should have issued an appealable decision on a complainant's direct procurement request. The complainants had required that their interpreter services be organised as a direct procurement by the interpreters of a specific service provider, because the interpreters they had been using earlier had been left outside the scope of the procurement. The Ombudsman found it problematic that Kela's view was that the processing of the direct procurement request filed by the user of interpreter services was actually an administrative matter and, therefore, there was no need to issue an appealable decision on the matter to the complainant. According to the Ombudsman's view, when deciding on the right of the user of interpreter services to a direct procurement, Kela as-

sesses and investigates whether the user meets the requirements for awarding a direct procurement, as required by the Act on Public Procurement and Concession Contracts.

Therefore, the Ombudsman was of the opinion that, in this case, the service user's rights were involved in such a manner that it must be possible to have the case dealt with by an independent body for the administration of justice, as required by section 21 of the Constitution of Finland. To ensure realisation of these rights, the service user should have a right of appeal in a situation in which they are of the opinion that their special needs require the organisation of interpreting services in an individual manner, and the service providers selected through the procurement process are not suitable with regard to their special needs. In the Ombudsman's opinion, the request of the interpreter services client to have the service organised through a direct procurement is a matter pertaining to the practice by which the service is organised. For the sake of clarity, the Ombudsman also stated that the question of the right of appeal is a different matter than the appeal actually being approved.

In its decisions 5156/2018 and 1108/2018, the Ombudsman considered the processing times for direct procurement requests to be too long. It has been an established practice, in the Ombudsman's oversight of legality, that a lack of personnel cannot be a special reason that can be used as justification for prolonged processing of applications.

Another decision also related to the competitive tendering of interpreter services was taken by the substitute for the Deputy-Ombudsman. He agreed with the view of the Ministry of Social Affairs and Health about how important it is that, drawing on the interpreter resources from other areas, Kela tries to organise interpreter services in areas where they have previously failed to acquire the desired interpreter resources. From the viewpoint of the flexibility of the system, the substitute for the Deputy-Ombudsman found it good that Kela had emphasised in its statement that, according to their guidelines, in certain situations, the search for an interpreter can be extended to the procurement area neighbouring the municipality where the interpreting is to take place. The organisation of interpreter services and the client's right to an interpreter service in an individual case should be implemented in such a manner that it promotes the opportunities of persons with disabilities to act as equal members of society in every manner possible (1342/2018).

Delays in the organisation of an interpreter for studies after the procurement of interpreter service

The Ombudsman pointed out to Kela that it must take account of the special needs of service users and factors related to the continuity and comprehensiveness of services when acquiring interpreter services. In addition, the contracting entity must 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. Kela had failed to organise a sign-language interpreter for studies for a complainant at the beginning of a new procurement period at the beginning of 2018. The Ombudsman was of the opinion that Kela should have, better and earlier, ensured that the provision of the services of a sign-language interpreter for studies to the complainant would continue. The Ombudsman finds that, as such, competitive tendering and its outcome are not valid grounds for not organising interpreter services for a client who needs them (1268/2018).

Early childhood education and teaching

Organisation of therapy in early childhood education

Case 4536/2018* was about a time limitation set for the provision of individual therapy arranged in early childhood education. As a rule, the Deputy-Ombudsman found the time limitation set in the early childhood education plan of the City of

Raisio (no therapy during the activity period from 9 to 11) problematic, because a categorical time limitation actually steers the operating units of early childhood education to ignore the observation of each child's individual circumstances and needs.

According to the Deputy-Ombudsman's opinion, an organiser of early childhood education must assess each child's situation individually, in good collaboration with the child's parents or other guardians. If necessary, day-care centres should offer opportunities for individual flexibility in therapy and rehabilitation matters if the child's best interest so requires, and if the therapy cannot be otherwise arranged. The various operating units of the organiser of early childhood education must also be informed about these opportunities for flexibility.

Implementation of special adjustments at university

The Ombudsman assessed the implementation of special adjustments (peaceful examination room) at a university. According to the Ombudsman, actions related to reasonable accommodation to help a person with disabilities, as referred to in the Non-Discrimination Act, are needed if, for example, it is actually impossible for the student to take exams in a similar manner as other students without such adjustments being made. The key issue in the case was to find a way to accommodate the student's circumstances so as to give them an opportunity to take the exams in such a manner that they can make progress in their studies and complete their education.

Denying reasonable accommodation to help a person with disabilities also constitutes discrimination within the meaning of the Non-Discrimination Act. In this case, the adjustments had not been denied, but it was a question of how they were implemented in practice. The adjustments should be tested in advance, because, should they fail, the whole exam may fail. If the adjustments do not work in practice, from the student's point of view, the outcome is the same as if they had been denied.

According to the Ombudsman, the university seemed to apply the same practice in the provision of a peaceful examination room to everyone needing this kind of special accommodation. The Ombudsman emphasised that reasonable accommodation should always be made on a case-by-case basis and that they should respond to the needs of the person with disabilities in each particular situation. Therefore, the arrangements are not necessarily the same for everyone, nor can they be. Reasonable accommodation to help a person with disabilities must be differentiated from general accessibility measures of a permanent nature. The university pointed out that the shortcomings could have been remedied had the complainant informed the supervisor of the exam about them. However, according to the complainant's account, in the acute exam situation, it was impossible for them to call the arrangements into question. The university had tried to investigate the matter afterwards, but the complainant had not taken the opportunity to do so.

The Ombudsman did not have sufficient grounds to conclude that the university had acted unlawfully or neglected its duty. He drew the university's attention to the viewpoints he presented and to the steps that the complainant had considered to be a sufficient solution to the situation. The Ombudsman proposed that the university consider contacting the complainant to have the matter solved and requested the university to report its potential action in the matter (2719/2018).

The university reported that it had paid attention to the arrangements of the faculty's general exams in such a manner that the study secretary is present in the hall at the beginning of each exam to ensure, together with the supervisors of the exam, that, for instance, the exam begins smoothly and that potential special arrangements have been taken into consideration. The faculty has also acquired new computers for exams that can be easily moved around. In addition, a special examination room has been introduced at the university level, which is intended for students with a recommendation to use a separate room in exam situations.

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.

Case 2680/2018 was about the City of Tampere's criteria for providing a wig as an assistive device for medical rehabilitation. According to the substitute for the Deputy-Ombudsman, the criteria should be complemented with factors based on individual need, such as medical reasons. The substitute for the Deputy-Ombudsman informed the city about his opinion. Furthermore, he proposed that the city contact the complainant in a manner they consider suitable to potentially reassess their need for an assistive device 2680/2018.

The City of Tampere announced that it had taken the substitute for the Deputy-Ombudsman's decision into account and taken action in response to the decision. The complainant had been granted a voucher for a custom-made wig. In the future, the criteria for granting a custom-made wig will also take account of, in addition to an exceptional head size, potential skin symptoms or other medical reasons.

The Deputy-Ombudsman reprimanded the HUS Assistive Device Centre for unlawful conduct, because the provision of care at the HUS Assistive Device Centre was not at a level required by law. The Deputy-Ombudsman considered it problematic that paediatric patients were treated very differently depending on where they had been referred to the Assistive Device Centre. There also seemed to be delays in the provision of assistive devices for adults; for example, the centre had been unable to process the queue of non-acute patients in a timely manner (5646/2018). The following decisions concerning unlawful conduct of the HUS Assistive Device Centre have also been published on the website of the Parliamentary Ombudsman: 5093, 5617, and 6202/2018.

The Substitute for a Deputy-Ombudsman emphasised that individual and functional assistive device solutions and well-functioning services are of major importance for the functional ability of persons with disabilities and their equal participation in society. If a patient's situation changes, and previous assistive devices are no longer suitable for them, their need for assistive devices must be reassessed. If necessary, the patient should also be guided to use other social welfare and health-care services 1607/2018.

Case 6173/2018 was about a delay in the access of a patient with intellectual disabilities to dental treatment under general anaesthesia. Due to the patient's restricted ability to open their mouth and their insufficient ability to cooperate, the patient's need for dental treatment could not be assessed during a clinical appointment. The Deputy-Ombudsman found that the dentists at the Oral and Maxillofacial Surgery Outpatient Clinic of Tampere University Hospital should have considered bringing forward the patient's appointment for dental treatment under general anaesthesia at the latest when the patient's mother contacted the outpatient clinic because of the patient's toothache. The patient had displayed signs of toothache such as pained facial expressions and moaning; painkillers had also been used to alleviate their toothache. The dentists should have taken this change in the course of the patient's illness into account.

Even though the patient received treatment within the treatment time guarantee applied for specialised medical care, the Deputy-Ombudsman noted that the patient should have been provided with dental treatment under general anaesthesia earlier than it actually happened, considering the overall situation of the patient's oral health and the delayed assessment of the need for treatment, and the pain and suffering they were subjected to while waiting for treatment. In the Deputy-Ombudsman's opinion, the patient did not receive treatment within a reasonable time. The Deputy-Ombudsman brought her view of the erroneous conduct to the attention of the dentist in

charge of oral and maxillofacial surgery and the dentist in training in the unit.

In case 5160/2018, the Deputy-Ombudsman recommended that a psychiatric hospital start monitoring more carefully the realisation of the opportunities of patients and those undergoing examinations to have outdoor exercise. The Deputy-Ombudsman found the time of 12 to 30 minutes reserved for outdoor exercise to be much too short. The Deputy-Ombudsman stressed how important it is to arrange outdoor exercise and stated that only in exceptional cases can the lack of personnel or the treatment of other patients in the ward be used as a reason to limit the amount of outdoor exercise.

The Deputy-Ombudsman found it a deficiency that there are no legal provisions for providing patients ordered to involuntary treatment with opportunities to purchase foodstuffs and other items for personal use, as there are in the field of criminal sanctions (3952/2018).

3.5
National Preventive Mechanism against Torture

3.5.1
THE OMBUDSMAN'S TASK AS A NATIONAL PREVENTIVE MECHANISM

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

The NPM is responsible for conducting 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 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, and 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. In giving his opinion, the Ombudsman stated that the Office had received no additional human resources to fulfil its remit as the NPM, although such increases had 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 during the planning period. In the budget proposals for 2018 or 2019, however, the Parliamentary Ombudsman did not propose an appropriation for the new posts. This was largely due to the savings targets set by the Office Commission.

In 2019, several cases of negligence were identified in service units for the elderly. The Parliament granted additional funding for the Office of the Parliamentary Ombudsman for 2019 to step up the supervision of the rights of the elderly. In 2019, new instances of neglect were identified, and closures of service units were carried out. The Office of the Parliamentary Ombudsman was granted additional funding for 2020 to establish new posts. Three of the new posts concentrate on the supervision of the rights of the elderly, which also contributes to the resourcing the NPM, as most of the inspection visits to elderly care units are carried out under the NPM mandate.

3.5.2 OPERATING MODEL

The tasks of the National Preventive Mechanism have been organised without setting up a separate NPM unit in the Office of the Parliamentary Ombudsman. To improve coordination within the NPM, the Ombudsman 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 Principal 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 and until further notice.

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

The NPM has provided induction training for external experts regarding the related visits. The NPM currently has 12 external health-care specialists available from the fields of psychiatry, youth psychiatry, geriatric psychiatry, forensic psychiatry, geriatrics, and intellectual disability medicine. A further three external experts represent the

Sub-Committee on the Rights of Persons with Disabilities operating under the Human Rights Delegation at the Human Rights Centre. Their joint expertise will benefit inspection visits carried out at units where the rights of persons with disabilities may be restricted. In addition, the NPM has trained five experts by experience to support this work. Three of them have experience of closed social welfare institutions for children and adolescents, while the expertise of the other two is used in health-care inspection visits.

3.5.3 INFORMATION ACTIVITIES

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

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

3.5.4 EDUCATION AND TRAINING ON FUNDAMENTAL AND HUMAN RIGHTS

The Parliamentary Ombudsman and the Human Rights Centre launched a joint initiative in 2018 to promote fundamental and human rights within residential service units for persons with disabilities. In preparation for the project, experts employed by the Human Rights Centre participated in inspection visits of service units for disabled people. The aim is to develop an assessment framework as part of the self-monitoring plan to guide the residential unit staff to assess how well the human rights of the residents with disabilities are respected. The initiative is introduced in section 3.4.

3.5.5 TRAINING

In 2019, members of the Office of the Parliamentary Ombudsman participated in the following events and courses as part of their duties under the NPM:

- Memory Disorders Expertise seminar, 17 May 2019. The programme included a presentation on the elements in a living environment for persons with memory disorders by Laura Arpiainen, architect and professor at Aalto University. Organised by the Finnish Society for Memory Disorders Expertise.
- Seminar on elderly care, 10 June 2019. The programme included presentations on the conditions in elderly care (Professor Teppo Kröger, University of Jyväskylä) and increasing life expectancy, leading to changes in demand and access to care (Professor Marja Jylhä, University of Tampere). Organised by the Parliamentary Ombudsman.
- Internal training for the Office of the Parliamentary Ombudsman on obtaining the opinion of a child with a disability, 12 June 2019. The training included expert guidance on methods and tools suitable for establishing the views of adults with memory disorders and learning disabilities.
- Internal training on conducting interviews during visits made in the capacity of the NPM, 13 September 2019.
- Violence and domestic violence against women, 25 September 2019. The theme was the recommendations for Finland based on the first evaluation procedure under the Istanbul Convention. The event was joined by Iris Luarasi, Member of the Group of Experts on Action against Violence against Women and Domestic Violence (GREVIO). The event was organised by the Human Rights Centre.
- Use of coercion in social and health-care services – where to draw the line? seminar, 2 October 2019. Themes included: 1) restrictive measures in social and health-care services, 2) restrictive measures in institutions, and 3) improving quality through increasing monitoring. The discussion on restrictive measures

involved representatives from different fields of practice: child welfare and foster care, services for persons with learning disabilities, elderly care, and mental health care. The event was organised by FCG Finnish Consulting Group Oy.
- Rights of the elderly seminar, 10 October 2019. The themes included services for the elderly and inclusion and self-determination in elderly care. The event was organised by the Human Rights Centre.
- Kalle Könkkölä Symposium, 22 October 2019. The theme was the rights of persons with disabilities – a snapshot. The event was organised by the Parliamentary Ombudsman and the Human Rights Centre.
- Internal training on the legislative implementation of the Convention on the Rights of Persons with Disabilities, 30 October 2019. The speaker was Professor Tuomas Ojanen, University of Helsinki.
- Internal training on identification and prevention of radicalisation in Finnish prisons, 3 December 2019. The presentation was delivered Annika Finnberg, who has served as a temporary deputy investigating officer at the Office of the Parliamentary Ombudsman.
- Internal training on oral health care for the elderly, 17 December 2019. The training was delivered by specialist dentist Pauli Varpavaara.

3.5.6 NORDIC AND INTERNATIONAL COOPERATION

The Nordic NPMs meet regularly, twice a year. The Finnish NPM organised a cooperation meeting in Helsinki in January 2019. The main theme of the meeting was inspection visits at elderly care units. The opening address was given by Jari Pirjola, Principal Legal Adviser and Member of the Committee for the Prevention of Torture, on the topic "Are elderly people in social care homes deprived of their liberty?". Furthermore, the Finnish NPM gave a presentation of the visits it had made to residential units for persons with disabilities, while the Swedish NPM shared its observations on the special theme of transport of persons deprived of their liberty.

Iceland ratified the Optional Protocol to the Convention against Torture (OPCAT) on 20 February 2019, and the Icelandic NPM hosted its first cooperation meeting in August 2019 in Reykjavik. The topic was "Ethical issues regarding therapeutic treatment, a person´s rights to privacy and security measures in secure settings – where do we draw the line?. Principal Legal Adviser Håkan Stoor gave a talk on "Ethical issues in NPM visits in Finland". Principal Legal Adviser Jari Pirjola discussed the same topic from the perspective of the CPT. The meeting included a site visit to a psychiatric hospital (Kleppur).

The implementation of the UN Convention against Torture is overseen by the Committee against Torture (CAT). Parties to the convention have the obligation to report at regular intervals on the implementation of the Convention. According to the reporting procedure, to which Finland has agreed, CAT presents a document known as the List of Issues Prior to Reporting (LOIPR), with responses submitted to the list serving as the report. For the purpose of compiling the 8th periodic report, in June 2019, the Parliamentary Ombudsman and the NPM submitted a list to the UN Committee Against Torture (CAT) of the issues they wished to bring to the attention of the committee and to be raised in the list of questions submitted by the committee to the Finnish Government. A total of eight topics were covered. These covered themes such as preventing the mistreatment of the elderly, securing and improving the right to self-determination of persons with disabilities, honouring the rights of children placed in child welfare institutions, and the detention of intoxicated persons in police custody. A general theme relevant to everyone who has been deprived of the liberty is the need for training in fundamental and human rights for those who, in their professional capacity, must intervene with a person's right to self-determination and integrity (3513/2019).

3.5.7 VISITS

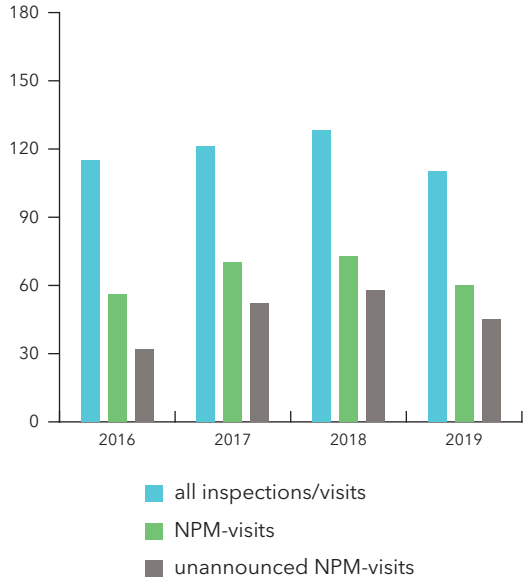
Fulfilling the role of an NPM requires regular visits to sites. In some administrative branches, such as the police and criminal sanctions, such visits are also possible in practice. However, in the case of social services and health care, the number of units is so large that sites must be selected for visits on the basis of certain priorities. In 2019, some follow-up visits were also made in order to determine how the recommendations of the NPM had been implemented in practice. Compliance with the recommendations is monitored by requesting the facility visited and sometimes also the officials responsible for its supervision to report any changes and improvements in the practices.

During 2019, the NPM carried out 60 visits (compared to 73 in 2019). The total number of site visits carried out by the Office of the Parliamentary Ombudsman was 110 (120). The majority (45) of the NPM visits were carried out unannounced.

Of these, 25 visits included participation by one or several external experts (compared to 19 in the previous year). On five visits to housing service units for persons with disabilities, a medical expert was also accompanied by two representatives from the Sub-Committee on the Rights of Persons with Disabilities. Two visits to health-care units included participation by an expert by experience. Involving external experts in visits has become an established practice in certain administrative branches. During 2019, a total of ten external experts (of 15 experts available) were invited to join inspection visits.

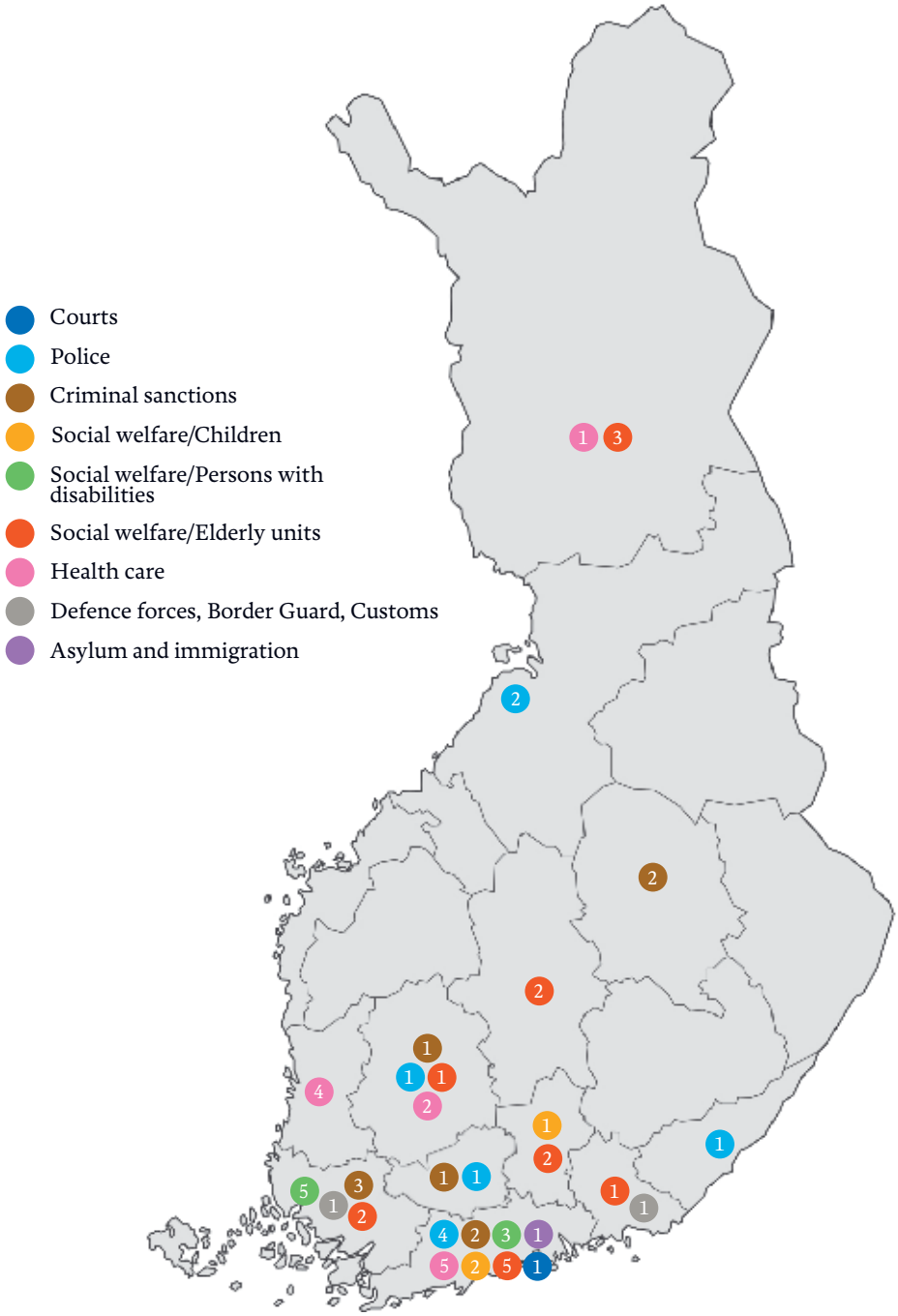
Of the other visits conducted by the Parliamentary Ombudsman, five were related to the duties of the NPM, including visits made to the National Police Board of Finland, the Border Guard Headquarters, and the Defence Command of the Finnish Defence Forces.

Since the establishment of the NPM, the inspectors have increasingly focused on interviewing persons who have been deprived of their liberty. The aim is to give a voice to those in the most vulnerable positions, such as minors and foreign nationals. This has meant an increase in the use of interpreter services, among other things. The confidential discussions held with children in foster care during visits made to child welfare institutions have been crucial in producing effective outcomes in the exercise of NPM's visiting mandate.



Visits in 2016–2019.

One of the key themes for the Office of the Parliamentary Ombudsman for 2019 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 Parliamentary Ombudsman, namely, the rights of children, the elderly, and the disabled, are considered on each visit. The visits also involve the "oversight of oversight", meaning the realisation of the NPM's duty to oversee the activities of other supervisory authorities. A good example of this is the measures put forward on the visit reports, which the supervisory authorities of child welfare institutions and elderly care units are expected to observe.



NPM visits by region in 2019. Most of the population and the sites visited are located in Southern and Western Finland. A full list of all visits and inspections is provided in Appendix 5.

3.5.8 THE IMPACT OF NPM'S PREVENTIVE MANDATE

Regardless of the number or frequency of visits, their impact will be inconsequential if recommendations made based on the visits do not lead to improved treatment and conditions of persons deprived of their liberty at the respective institutions. If tangible results cannot be documented, the visits will lose their corrective impact. Overall, the opinions and recommendations of the Ombudsman lead to positive actions. Often, the dialogue during the actual visit alone helps establish mutual understanding on how operations could be improved and issues addressed. Following the visit, a draft visit report is sent to the visited facility, which has the opportunity to comment on the provisional opinions and recommendations made by the Ombudsman. In many cases, the visited unit reports on the measures it has taken on the basis of the preliminary recommendations already at this stage.

An official request for information is sometimes enough incentive to take the necessary actions. A good example of this is the plan launched by the police administration that led to an investigation into the suitability of detention facilities and the introduction of an approval system. Sometimes putting recommendations into practice takes time, as was the case in organising training on the distribution of medicines for guards working at police detention facilities.

On occasion, the operations of the NPM have led as far as the amendment of legislation; for example, the Child Welfare Act was amended as a matter of urgency based on the findings of the NPM. Other administrative branches have also benefitted from the identification and addressing of legislative gaps, leading to improved legislation.

3.5.9 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 are apprehended because they are intoxicated: more than 50,000 every year. The second largest group is formed by persons suspected of an offence, numbering approximately 22,000. A small number of people detained under the Aliens Act are also held in police prisons.

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

According to information provided by the National Police Board, its plan is to focus more attention in 2020 on developing detention and guarding practices. The prioritisation stems from observations made by the police themselves and the Parliamentary Ombudsman. The development work is also informed by observations made by the Ombudsman in connection with deaths in custody. The rights of persons deprived of their liberty is also a focus area in the internal oversight within the police in 2020.

The police currently have 45 police prisons in use. The NPM visits are usually carried out at police detention facilities unannounced. This is why it is important that the Ombudsman has reliable and up-to-date information on whether, for example, a detention facility in use. The information obtained from the National Police Board was partly outdated. For this reason, the Ombudsman requested an updated list of police detention facilities from the National Police Board in March 2019 and the immediate notification of the Ombudsman of any changes to the list. Another finding to surface in 2019 was that the Ombudsman has not received fully updated information on the actual use of detention facilities (6000/2019 Imatra).

In 2019, 9 inspection visits were made to police prisons (compared to 13 visits made in the previous year). The visit to the Espoo police prisons also included an inspection visit at the adjacent City of Espoo sobering-up station. All of the visits were made unannounced. The sites visited were:

date of inspection	target	number of inmates	case number	other / previous visit
27 February 2019	Espoo police prison#	30 cells	1201/2019	Ombudsman included, previous visit 2017 (1382/2017)
27 February 2019	City of Espoo sobering-up station#	15 places	1202/2019	Ombudsman included, previous visit 2017 (1606/2017)
10 April 2019	Raahe police prison#	15 cells	1950/2019	previous visit 2016 (1940/2016)
10 April 2019	Haukipudas police prison#	18 cells	1954/2019	previous visit 2005
27 May 2019	Tampere Central Police Station, police prison#	64 cells	2982/2019	previous visit 2018 (4394/2018)
1 July 2019	Hämeenlinna police prison#	59 cells	3621/2019	previous visit 2011
1 July 2019	Hyvinkää police prison#	18 cells	3622/2019)	previous visit 2016 (212/3/16)
1 July 2019	Järvenpää police prison#	14 cells	3623/2019	previous visit 2016 (211/3/16)
6 November 2019	Lappeenranta police prison#	24 cells	5999/2019	previous visit 2009
6 November 2019	Imatra police prison#	1 cell	6000/2019	previous visit 2015 (4620/3/15)

#= unannounced inspection

During 2019, one visit was also made to the Police University College, where the themes raised included guard training and deaths in custody. During the visit to the National Police Board, the issues raised included police prisons and their renovation work, and the NPM visits to police prisons. During the visit to the Oulu Police Department, the previous day's visits to Raahe and Haukipudas police prisons and the observations during the visits were discussed (1951/2019).

The following issues were repeatedly identified during the visits to the police detention facilities:

- guards are working alone
- guards are assigned additional duties such as recording personal descriptions, which could interfere with their guarding duties
- police officers are used as guards without sufficient training
- guards are aware of the rectification procedure but are unable to identify which actions require a written decision
- persons deprived of their liberty are not notified of their rights
- the outdoor spaces are not suitable for outdoor exercise
- the detention facilities are not suitable for long-term stays
- cells used for intoxicated persons lack privacy when using the toilet
- persons deprived of their liberty have no facilities to wash daily
- the level of cleanliness of the facilities is unsatisfactory

The impact of inspection visits

The opinions and recommendations of the NPM are sent to the respective police departments for comment before finalising the visit report. The police departments have taken a constructive view of the opinions and recommendations. For example, more than half of the police departments visited during 2019 reported at the commentary stage the actions they were taking to improve their practices and the conditions of persons deprived of their liberty. However, as is evident from the list above, some issues remain, although they have been repeatedly raised, sometimes repeatedly with certain police prisons.

To maximise the impact of visits, it is important that visits to police detention facilities are made regularly, including as part of the independent legality oversight of the police. In November 2017, the National Police Board issued a circular (guidelines) on matters that should be considered in police detention facilities. The circular required, for example, that persons deprived of their liberty should be informed of the conditions of the detention facilities as soon as possible on arrival. This could be arranged by handing persons deprived of their liberty a form specifying their rights and obligations and a list of house rules (as required by the National Police Board guidelines). Records should be made indicating that the information has been duly provided. Regardless of this, more room for development in communications was identified in the visits to police detention facilities in 2019 (1201/2019 Espoo, 3621/2019 Hämeenlinna, 3622/2019 Hyvinkää, 1950/2019 Raahe, 1954/2019 Haukipudas, 5999/2019 Lappeenranta). The National Police Board finds it reasonable to expect that every police detention facility make available a written list of oversight authorities, which can be given to persons deprived of their liberty for information. Although such as list was appended to the National Police circular, it had not been made available at sites visits in 2019 (1950/2019 Raahe, 3621/2019 Hämeenlinna, 3622/2019 Hyvinkää).

Police departments have reported the following with regard to deficiencies in information dissemination and self-monitoring:

- Line managers at detention facilities have been reminded of the importance of handing out written information materials to all persons deprived of their liberty and also communicating the same information verbally. Managers and the Legal Unit review detention forms on a regular basis and notify the staff of any deficiencies in the information (1950/2019 Raahe, 1954/2019 Haukipudas).
- The police department will issue guidance to all detention facility guards to give all detained persons, on arrival, the necessary information about the facilities and procedures while in detention, such as the use of the cell alarm, mealtimes, outdoor exercise, shower facilities, and phone calls. The detained persons, including those detained under the Police Act (intoxicated persons), will also be informed about supervisory authorities and their contact details. Written instructions will also be made available in Swedish at the reception desk on arrival at the detention facility (3621/2019 Hämeenlinna).
- The police department reported that the notifications and records of persons deprived of their liberty, as well as information provided to them on the conditions at the facility, have been given attention both in self-monitoring and legal oversight. Checklists have been distributed amongst staff to support this measure. Following the visit of the NPM, the records have been monitored in real time. New guidelines are also under preparation, including instruction on verbally informing new arrivals of the conditions at the facility and the regulations governing police detention facilities (5999/2019 Lappeenranta).

It would seem that changes in practices require ongoing training for detention facility staff. This, in turn, requires that managers at the facilities are motivated to actively influence and develop the practices at their facilities. The training received

by guards, and senior guards as their line managers, has a key role when further aligning the treatment of persons deprived of liberty and the condition of detention facilities with fundamental and human rights.

There are, however, examples of how practices can be overhauled at a rapid pace. In 2017, the NPM intervened in the use of a restraining bed discovered at Espoo police prison. It was noted during a visit at the same facilities in 2019 that the restraining bed had been removed and the space was used as an ordinary cell. According to the staff, any problem situations have been dealt with by other methods, such as placing the detained person under observation (1201/2019 Espoo).

Approval of police detention facilities

Under the Act on the Treatment of Persons in Police Custody, police detention facilities must be approved by the National Police Board. However, specific approval decisions have not been issued.

The Ombudsman placed an inquiry with the Ministry of the Interior regarding the approval process for detention facilities. The National Police Board issued a plan in February 2019, according to which an audit of the current condition and suitability of detention facilities for detaining persons deprived of their liberty began the same year. The aim was to issue an approval decision on the fitness for use of all detention facilities by the end of 2020.

In November 2019, the National Police Board also issued guidelines on the approval of detention facilities for persons in police custody, which entered into force on 1 January 2020. The guidelines refer to the statements issued by the Ombudsman and the CPT on the treatment of detained persons, which must be observed when approving detention facilities. The condition for approval is that the space meets the criteria laid down in the legislation on detention facilities for persons deprived of their liberty and that the facilities allow for due compliance with the legislation governing the detention of persons deprived of their liberty. The space must be safe and must honour the detained person's right to privacy. The space must be equipped so that a person deprived of their liberty has access to all the rights that they have not been deprived of on the basis of the law, such as the right to meetings or the right to follow public media. The space must provide conditions that comply with the principle of normality. The facilities must be organised so that different persons of different genders, age groups, and grounds for detention can be kept apart.

Police departments have since initiated inspections of police station detention facilities based on the National Police Board guidelines. During these inspections, observations have been made of any issues and deficiencies regarding the right to privacy and lighting in cells, and access to verbal communication channels for persons deprived of their liberty. Evacuation safety has also been given attention. Following these measures, a representative of the National Police Board has carried out an audit at the facility. In conjunction with this, a need has also arisen to update the house rules at police stations. The National Police Board has started its process of approval for detention facilities. The precondition for approval is that the required measures have been carried out within the agreed time scale. At the time of writing this annual report, the matter was still pending with the Ombudsman. The Ombudsman has already received some completed approval decisions.

The role of Senate Properties as the lessor of detention facilities

Senate Properties serves as the lessor of all government agency facilities, including police detention facilities. It is regularly brought to the attention of the Ombudsman and the NPM during site visits that addressing any deficiencies at the leased premises is not possible without a contribution from Senate Properties. The Deputy-Ombudsman has launched an investigation at his own initiative into the role of Senate Properties as the sole lessor of government agency facilities. Issues requiring further inquiry include the division of liability for maintaining the condition and healthiness of detention facilities for persons deprived of their liberty.

The pictures show outdoor recreation facilities in different police prisons.

Serious deficiencies at Haukipudas detention facilities

The detention facilities used at the Oulu Police Department's Haukipudas Police Station were previously used as police cells (already decommissioned in 2009) and were modules built from shipping containers in the police station courtyard. The facilities were originally designed for temporary use for only a few months but have since remained in permanent use. It was not yet known at the time of the visit when the facilities would be finally decommissioned. However, the Ombudsman finds it obvious that even temporary facilities must meet all the requirements laid down in the law on the treatment of persons deprived of their liberty.

The Ombudsman found it problematic from the perspective of legal requirements for the facilities that sections of the modular space needed regularly to be closed off for reasons of fire safety, indoor temperature, and drainage. The following other issues that were integrally linked with the humane treatment and safe detention of persons deprived of their liberty:

- The right of persons deprived of their liberty to immediately contact staff was compromised because cell calls were received at the control room, which was not always manned.
- Furthermore, the lack of an audio connection to the old police station cells presented a clear safety risk for the detained persons. An audio connection to the modular cells could be made only if the detained person had first pressed the call button.
- Persons deprived of their liberty were received and examined in a narrow corridor that was not fit for the purpose and could also present an occupational health and safety risk.
- The rules regarding the storage of personal property were unclear, as there was no designated space for the purpose.

- The outdoor exercise premises did not meet the needs for exercise as intended in the law. The outdoor exercise premises must offer plenty of fresh air and a view to the outside.
- The outdoor exercise area had been out of use at times, so that persons deprived of their liberty had no access to outdoor exercise.
- Due to a lack of meeting rooms, visits by a legal counsel or family members took place in the changing room next to the shower rooms, under camera surveillance. A changing room is not a suitable meeting room. Visits by a legal counsel, in particular, should take place without camera surveillance.
- Camera surveillance should not be used in washing facilities or changing rooms, where persons deprived of their liberty may be naked.
- Up to six persons could be detained in one cell, where they were forced to use the toilet in full view of the others and under camera surveillance. This practice is against the right to privacy of persons deprived of their liberty.

The Ombudsman found it highly problematic that the detention of persons deprived of their liberty at Haukipudas police prison had been organised using a temporary arrangement that is, in many respects, unsatisfactory or even illegal. This situation has remained unchanged for years. The Ombudsman considered it paramount that these practical issues at the detention facilities be remedied as a matter of urgency, if the facilities are to continue to be used for detaining persons deprived of their liberty.

Besides the police department in question, the Ombudsman also requested that the Ministry of the Interior and the National Police Board submit a report on measures carried out. The National Police Board reported that the facilities have been or will be upgraded to a satisfactory standard during spring 2020. According to the report of the Ministry of the Interior, the Haukipudas police prison will remain in use until the new police station building is completed. At the time of writing this annual report, the National Police Board was pending its decision on the approval of the Haukipudas detention facilities.

The separation of police detention and investigation operations

It was noted on nearly each visit to police detention facilities that criminal investigators participated in many ways in duties that fall under the remit of the detaining authorities. Investigating officers could decide on various aspects of civilian life and purchases, and sometimes even on meetings and phone calls allowed for persons deprived of their liberty (3622/2019 Hyvinkää, 3623/2019 Järvenpää). The head of the investigation could also decide on access to private property, such as having a TV in the cell. In some units, the house rules specifically assigned certain detention duties to the investigating officer.

On a general level, it is acceptable according to legality oversight that police officers with appropriate training may participate in the supervision of persons deprived of their liberty, and it is obvious that the head of investigation can decide on the restriction of communication as provided in the law. However, the Deputy-Ombudsman finds it problematic that the police officer investigating the matter concerning a person deprived of their liberty participated in the detention duties and decisions concerning the latter at the police prison. The Ombudsman has requested that the investigation of a criminal case and the detention of a person deprived of their liberty be kept strictly separate.

Following the opinions expressed by the Ombudsman, police departments have taken the following measures, among others:

- The house rules have been updated with guidelines prohibiting criminal investigators or the head of investigation from participating in decisions regarding the basic care, meetings, phone calls, civilian matters, or purchases of persons deprived of their liberty. The head of the crime prevention sector has guided all heads of investigation to make sure that criminal investigation and detention duties are kept separate in all eventualities (1950/2019 Raahe, 1954/2019 Haukipudas).
- The police station has reported that it will adjust and clarify the conduct by guards at the detention facilities and by the investigating police officer when making decisions on the detention of a person and the conditions of the detained person (3621/2019 Hämeenlinna).
- The police department commented that, based on its own observations, investigators do not make decisions on the affairs of persons deprived of their liberty as described in the visit report. However, the updated rules for the detention facilities will issue guidance on keeping the police prison operations and criminal investigations as separate entities. The police department will also take note of the Ombudsman's observations in their future operations and guidance (3622/2019 Hyvinkää).
- The new rules for the police detention facilities will include guidance on the appropriate conduct for the police prison and criminal investigation (3623/2019 Järvenpää).
- The aim is to keep these two domains as strictly separate as possible. The staff serving in guarding duties at a police prison work under different management from those investigating crime. Only police prison staff have access to the cells of persons detained at the police prison (1201/2019 Espoo).

According to information based on a visit made by the National Police Board, the separation of criminal investigation and detention is one of the reasons for amending the Act on the Treatment of Persons in Police Custody.

Catering in police detention facilities

Catering in police prisons was discussed in the 2018 annual report in section 3.4.8. During 2019, the Ombudsman has brought to completion matters under investigation at his own initiative. The Ombudsman has noted, for example, that catering for persons deprived of their liberty should be more tightly regulated in the reformed Act on the Treatment of Persons in Police Custody. The intervals between meals should not be too long, and food safety must be secured.

Prevention of deaths in custody

The Ombudsman has carried out investigations on his own initiative into deaths in custody (4103/2016). The Ombudsman recommended in his decision of July 2019 that the National Police Board step up its actions to prevent and monitor deaths in custody. The report revealed that the National Police Board had no detailed statistics on the number of deaths in custody. According to the data obtained, the annual number of deaths in custody in the 2000s varied between 6 and 27. In addition to statistical data, it is essential to analyse the information gathered for investigations and possible criminal procedures following the deaths. This would provide valuable knowledge that could help prevent deaths in custody and could be used in the training of police officers and police prison guards.

Since the beginning of 2014, it has been the law to report all deaths in custody to prosecution services. According to the Ombudsman, the role of the prosecutor in the process is unclear. The Ombudsman also drew attention to the lack of separate sobering-up stations even in some of the largest cities, although it is widely agreed that it is not an appropriate use of resources for the po-

lice to care for intoxicated persons. According to the Ombudsman, the act on treating intoxicated persons, which dates back to the 1970s, needs to be reviewed. The Ombudsman has also identified needs for amendment in the acts on the treatment of persons in police custody, criminal investigation, and the investigation of the cause of death. The Ombudsman presented his findings and views regarding these acts to the ministries responsible for the respective legislation.

The Ombudsman also urged the National Police Board to pay closer attention to deaths in custody that take place during transport and to the prevention of suicide by persons deprived of their liberty. As the Ombudsman discussed the training of police officers and police prison guards in his decision, this was also submitted for the attention of the Police University College. The Ombudsman asked the National Police Board, the Ministry of the Interior, the Ministry of Justice, the Ministry of Social Affairs and Health, and the Office of the Prosecutor General to report on the measures they have taken to remedy the matter.

The reports submitted by public authorities concur with the Ombudsman's views. The National Police Board reported, for example, that it is updating its guidance on deaths in custody to secure the availability of accurate data. It also announced it is exploring technologies that could be used to improve safety in custody. Above all, the organisation intends to focus on improving its operations in relation to custody in 2020. The Prosecutor General has also reviewed her guidance on the prosecutor's role in investigating deaths in police custody. According to the Ministry of Justice, projects to reform the Criminal Investigation Act and the Coercive Measures Act will begin in 2020. The process will also involve assessing the prosecutor's role in investigating deaths in police custody, including in cases where a person dies or is severely injured as a consequence of the use of force by the police. Reforms of the Act on the Treatment of Persons in Police Custody and the Act on Determining the Cause of Death are currently underway, and the Ombudsman's positions will also be taken into consideration as part of these reforms.

Positive observations

Health care at detention facilities

Based on visits to police detention facilities, increased attention has been paid to access to health care. As a rule, all facilities visited had appropriate arrangements in place for the storage of medicines, as well as the documentation of their distribution. All guards at police detention facilities have completed medicine distribution training.

The Ombudsman has recommended that any person deprived of their liberty for more tha 24 hours in police detention facilities should receive a health check on arrival. This recommendation has not been observed even in places where health-care professionals deliver care on a regular basis. Furthermore, the National Police Board has not provided guidance in its circular to organise health checks. However, the Western Uusimaa Police Department has notified the Ombudsman that negotiations with the manager of the Espoo sobering-up station have been initiated to enable those kept at the Espoo police prison for longer tha 24 hours to be seen by a health-care professional (1201/2019* Espoo).

Training

One of the topics raised during the visit to the Police University College was the training of police prison guards and senior guards. The guard training with a reformed curriculum provided by the police administration started in autumn 2018 and the reformed senior guard training in spring 2019. The guard training provides the competence to serve independently as a guard at police detention facilities and to apply the relevant legislation while honouring fundamental and human rights. The senior guard training provides qualifications to work independently as a line manager of guards.

Detention of remand prisoners

Since 1 January 2019, the detention of remand prisoners in a police detention facilities for longer than seven days has been prohibited without an exceptionally weighty reason considered by a court. Based on observations made during visits, the amendment has shortened the time that persons deprived of their liberty spend at the police prison (1201/2019 Espoo, 1950/2019 Raahe, 3621/2019 Hämeenlinna, 3622/2019 Hyvinkää, 3623/2019 Järvenpää, 5999/2019 Lappeenranta).

The Ombudsman has repeatedly criticised the practice of detaining remand prisoners in police facilities, which are not suited for long-term detention. According to the Ministry of Justice, legislation governing the placement of remand prisoners in prisons is awaiting review. The aim is to place all remand prisoners in prisons following the detention hearing, rather than in police detention facilities, from 2025 onwards. The period of detention would be shortened to four days.

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

According to the legislative plan of the Government, the reformed Act on the Treatment of Persons in Police Custody will be enacted in January 2021.

3.5.10 DEFENCE FORCES AND BORDER GUARD AND CUSTOMS

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, attention is paid to the conditions and treatment of those deprived of their liberty, their access to information, and their security. A preannounced visit to the detention facilities at Utti Jaeger Regiment was carried out on 17 April 2019 (2420/2019). The detention facilities had last been used in 2013. Regardless of this, the NPM received all the necessary information from the person introducing the facilities regarding the staff, rules, supervision arrangements, arrival health assessment, and delivery of health care. In addition, a handout explaining the rights and obligations of persons deprived of their liberty was made available, together with a folder containing information about the rules of the facility. The facilities were in clean and tidy condition. The room had a call button and a fire alarm. The area for outdoor exercise was not protected from outsiders, but it was located within a closely guarded and fenced-off military property. The visit gave rise to no measures.

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. These detention facilities are used for short-term detention before transferring detained persons to a police prison, detention unit for foreigners 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 has approved the Border Guard's detention facilities and issued the house rules for detention facilities No visits to the Border Guard's detention facilities were made in 2019. Customs has approved the detention facilities that is uses and has issued its own rules for its detention facilities.

The crime prevention unit of Customs Enforcement Department has a detention room at Turku Customs, where an unannounced visit was made on 17 December 2019 (7048/2019). The new space had not yet been used. A need for a detention facility for persons deprived of their liberty had arisen following the closure of Turku police prison. The purpose was not to hold anyone at the detention facility for longer than a few hours and never, for example, overnight. The Deputy-Ombudsman made some suggestions on what the rules of the facility should contain and how the monitoring should be organised.

3.5.11 DISTRICT COURT DETENTION FACILITIES

An unannounced visit to the detention facilities for persons deprived of their liberty at Helsinki District Court was carried out on 11 September 2019 (5072/2019). This was a follow-up visit based on the 2017 visit (5560/2017). During this visit, special attention was paid to issues on which recommendations had been made during the previous visit.

During the previous visit, the Deputy-Ombudsman had commented on the size of the single reserve cells on different floors and, in particular, on their size, lighting, and lack of alarm equipment. These cells were no longer in use in 2019. The Deputy-Ombudsman had also recommended that at least one cell should be reserved for non-smokers. During the 2019 visit, it was noted that the non-smoking cells were tidy and fresh, and the walls were clean and white.

However, the cleanliness of the other cells, as well as the meeting rooms for persons in custody and their legal counsels, still had room for improvement. For example, there were inscriptions on the walls, which in the Deputy-Ombudsman's view undermine the purpose of the restriction on communication. The Deputy-Ombudsman suggested that the walls and the doors should be checked on a regular basis, and inscriptions such as those discovered should be removed immediately. The Deputy-Ombudsman repeatedly drew the District Court's attention to the requirement that all persons in custody and their legal counsels should have access to a space where confidentiality can be ensured. Furthermore, the Deputy-Ombudsman found it problematic that there was only one room for the meetings.

The District Court noted that the graffiti and inscriptions on the walls would be given more attention in the future. The walls will be repainted at shorter intervals, more than once a year. If there is a clear indication that the walls are used for communication between persons in detention, or for naming or shaming other individuals or similar conduct, the inscriptions will be removed before the cell is used for the next person.

Furthermore, the District Court reported that it has negotiated with the owner of the property to carry out alterations in the meeting space and to build a new meeting space, as intended in the report. The design and alteration work in these premises will commence in the near future. The alterations will be carried out in compliance with the provisions of Chapter 14, section 4 of the Remand Imprisonment Act.

3.5.12 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. THE NPM visits mainly focus on closed prisons. The average number of prisoners has remained stable at around 3,000 prisoners for several years now.

During 2019, the Deputy-Ombudsman issued one statement to the Legal Affairs Committee of Parliament on a government proposal related to prisoners. In addition, eleven proposals were made, mostly related to legislation or internal guidance within an administrative branch. The biggest point of public debate was the smoking ban for prisoners. The Deputy-Ombudsman found the regulations governing the smoking ban unclear and proposed their speedy amendment. The Deputy-Ombudsman also proposed that the prison should compensate the cost of nicotine replacement products for the duration of the time that the prisoner is suffering from withdrawal symptoms (5349/2019).

The Deputy-Ombudsman proposed that compensation be paid to a prisoner in a matter that involved the inappropriate treatment and violation of human dignity of the prisoner while placed under observation (5960/2018). This issue is discussed further in section 3.7.

During 2019, a decision was issued on the monitoring of the health of a prisoner living in segregation at their own request (247/2016). The decision is discussed in section 3.5.17 on health care.

A delegation from the national the national support organisation for prisoners and prisoners' families (VAO) visited the Office of the Parliamentary Ombudsman during 2019.

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

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. The NPM visits also draw attention to the processing of prison leave applications, emphasising the importance of taking the related decisions individually, based on the law and reasonable grounds.

Indoor smoking area.

In previous years, the NPM visits have been made to prisons with the focus exclusively on accessibility. In 2019, accessibility was covered during regular visits as one of the points of interest. Observations of accessibility in prisons are discussed in section 3.4 on the rights of persons with disabilities.

Prisons and prisoner transport facilities were visited 6 times during 2019 (compared to 13 in 2018). The visits were preannounced except for the visit to the prisoner transport facilities, which was a follow-up visit based on the visit in 2018. The visited facilities were:

date of inspection	target	number of inmates	case number	other / previous visit
8 April 2019	Vilppula Prison	capacity 73	1592/2019	previous visit 2006
7-8 May 2019	Jokela Prison	capacity 65	1936/2019	Deputy-Ombudsman included, previous visit 2016
28-29 May 2019	Turku Prison	capacity 255	2449/2019	Deputy-Ombudsman and external expert included, previous visit 2016
25 June 2019	Vanaja Prison, Ojoinen Unit	capacity 50	3420/2019	previous visit 2012
20 August 2019	Prisoner transport by train#		4575/2019	previous visit 2018
5.-7.11.2019	Sukeva Prison	capacity 181	5291/2019	Deputy-Ombudsman included, previous visit 2015

#= unannounced inspection

In addition, three visits were made to prisoner health-care units (also three in 2018). These visits are discussed in section 3.5.17 on health care. Opinions and recommendations based on prison visits were issued on the following topics:

- updating the sentence plan
- communication to prisoners on prison conditions/prisoner induction

Inside view of Turku Prison transport vehicle.

- access to regulations and other information
- conditions in isolation cells
- placement of remand prisoners
- position of Roma prisoners
- meeting arrangements, particularly for child and Skype visitors
- outdoor exercise facilities
- library services
- duration of detention in so-called "travelling cells" for temporary accommodation

The special theme on all the Ombudsman's prison visits was "Right to privacy". Observations and opinions on privacy are further introduced in section 3.8. In prisons, privacy issues are related to the use of the toilet, the arrangements for testing as part of illegal substance control, and the privacy of telephone conversations.

Prisoners need more constructive activities and time outside their cells

International recommendations and the Parliamentary Ombudsman's decisions have for a long time been based on the premise that prisoners and remand prisoners should be permitted to spend a reasonable amount of time outside their cells:

Prisoners have access to a variety of activities.

at least eight hours each day. During that time, they should be able to engage in rewarding and stimulating activities, such as work, training, and exercise. This is considered essential for prisoners' mental and physical wellbeing. It has been noted during prison visits that most closed prisons still have problems in this respect (2449/2019 Turku, 5291/2019 Sukeva).

Time spent outside the cell is important not only to avoid extended solitary incarceration. It is particularly important in order to allow prisoners to fill their time with activities that will be beneficial to the prisoner and their eventual adjustment back to society. Access to constructive activities outside the cell is also necessary for remand prisoners.

For this reason, the Deputy-Ombudsman found it necessary that prisoners' use of time is researched in more detail. However, collection of such data has proved a challenging and labour-intensive task, particularly with prisoners who are not placed in work activity wards. Prisoners' use of time could not be established based on daily programmes or prisoner information statistics. Judging by the daily programmes, activities mostly involved sports and exercise, making the choice of activities extremely limited. As a result, the Deputy-Ombudsman has requested the Regional Centre in conjunction with prison to provide data on the activities in which prisoners participate and the time engaged in these activities (2449/2019 Turku).

Pictures of Sukeva Prison.

Coercive behaviours among prisoners

A prisoner has the right to serve their sentence free of any pressure or threat placed on them by other prisoners. The way prisoners are placed in different wards is essential for maintaining order in prisons and for the safety of prisoners and prison staff. Legislation gives tools for intervening in coercion among prisoners. Authorities have wide discretion concerning the prison or ward in which a prisoner is placed and to which activities they are given access. However, a successful prisoner placement requires that the authorities who decide on the placement have all the necessary information available. Such information includes possible membership of criminal organisations.

Two closed prisons were visited during 2019, both housing a high number of prisoners with connections to organised crime. However, the two prisons were very different in that the structure of one prison allowed for a high level of security through compartmentation into fairly small wards (2449/2019 Turku). According to the prison management at the other prison, compartmentation was not possible in the building, which, together with the increased time outside the cells, created ample opportunities for coercion and violence among inmates (5291/2019 Sukeva). There had been several violent altercations between prisoners at the prison, some extremely serious.

In both prisons, prisoners who exercised coercion and made threats against other prisoners were placed in the more open wards. This led to a situation in which other prisoners, who otherwise would have been suitable for an open setting, refused to move to these wards. It also appeared that organised crime prisoners had the power to decide which courses other prisoners were able to attend. In Sukeva Prison, the guarding staff found it problematic that organised crime prisoners ran the narcotics trade inside the prison and were in control of the lives of the other inmates.

It was noted during the visit to Sukeva Prison that the entire operating culture in the prison was quite open. Prisoners from different wards were in contact with each other in workspaces, during outdoor exercise and mealtimes, and at the gym. Organised crime prisoners made up approximately 18% of all the prisoners at Sukeva, and none of them were placed in wards for prisoners whose behaviour puts the order and safety of the prison at risk. A high proportion of the prisoners (20%) had requested to live in segregation. The same phenomenon was discovered in Turku Prison,

where a number of prisoners have requested to serve their sentence in the closed ward for fear of threats and pressure. Prisoners' families had been intimidated, and opportunities for unsupervised meetings and leave were declined to avoid pressure from other prisoners.

The challenge in intervening in coercive behaviours at Turku Prison seemed to be the reluctance of the staff to use information about the problems between prisoners in their decision-making. The staff felt that prisoners spoke to them about their issues in confidence, and acting based on this could place them at serious risk. The Deputy-Ombudsman understands that this is a very real risk. However, methods must be found to intervene in coercion among prisoners. According to legislation, a party involved in such a situation does not have the right to all the information about themselves. For the prison authorities to place prisoners in appropriate wards, they must have all possible information about prisoners who form a threat to other prisoners. This should make it possible to remedy a situation in which some prisoners can compromise the safety of other prisoners because of their placement in the same ward.

The situation in Sukeva Prison was, in the Deputy-Ombudsman's view, extremely grave. The prison was unable to organise its operations so that prisoners could serve their sentences without experiencing coercion or threats from other prisoners. The Deputy-Ombudsman recommended that the prison and the Regional Centre of the Criminal Sanctions Agency investigate what remedial measures could and should be taken. The Deputy-Ombudsman also found it necessary for the Regional Centre, the prison, and the assessment centre to cooperate to optimise prisoner placement. The Deputy-Ombudsman considered it justified to request that the prison thoroughly examines the grounds for the placement of each prisoner. The prison should make sure that those deciding on prisoner placement have all the necessary information available.

Sukeva Prison has since reported having initiated the requested measures to improve safety at the prison and to intervene more effectively in coercive behaviours among prisoners. The measures were also aimed at improving staff health and safety. According to the prison's subsequent report, the criminal sanctions managers deciding on prisoner placement are now informed about a prisoner's involvement in organised crime.

Position and treatment of foreign prisoners

The proportion of foreign nationals in the prison population has varied between 15–20% over the years, which is near the European average. It is typical in Finland that an exceptionally large proportion of foreign prisoners are remand prisoners. In international matters, the most common problems experienced by foreign prisoners include the language barrier and gaps in knowledge about their rights, inadequate training of prison staff, and difficulties in maintaining contact with families and people close to them (for further discussion, see Jussi Pajuoja: *Rikosseuraamuslaitoksen toiminta- ja asiakasprosessien tulevaisuus,* (in Finnish only) Publications of the Ministry of Justice 2019:15).

The aforementioned problem areas are also repeatedly identified by the NPM during inspection visits. It would appear that while some arrangements have been made at a prison through the provision of written material and interpretation services to better communicate with foreign prisoners, these options are not fully utilised. It has been established during visits that foreign prisoners appear to have no or only sporadic access to essential information. The Deputy-Ombudsman has, therefore, recommended that prisons review their practices regarding foreign prisoners. It must be clearly established whose role it is to manage foreign prisoners' induction and how the induction is to be carried out. Moreover, it should be clear to everyone how to communicate with foreign prisoners in the course of daily routines (2449/2019 Turku).

There are many prisoners with whom the prison staff are unable to communicate because of the language barrier. However, according to the law, all prisoners must be informed about the conditions at the prison and their rights and obligations, without delay on arrival. This information must be made available in the most commonly spoken languages, as necessary. Interpretation services must be utilised as much as possible. Prisons nowadays have access to a tablet-based mobile interpretation service, through which an interpreter can be contacted remotely. The purpose of the visits has been to establish how widely the interpretation services are used by requesting the prison to report their annual interpretation costs and by interviewing the staff and foreign prisoners regarding the use of interpretation services.

Prisoners' induction guides and prison rules are increasingly available in foreign languages other than English, which is a positive development. However, during visits, the NPM still come across foreign prisoners who report having no or insufficient access to the necessary information about prison procedures or the rights and obligations of the inmates. Prisoners may have had insufficient information about their opportunities to contact their families through video calls, or how to gain access to their personal belongings. There has also been uncertainty as to what is prohibited and what is allowed in prison, what the sanctions are for breaking these rules, and how health-care services can be contacted. The NPM heard on occasion that the guarding staff never once made use of interpretation services. Documents have shown that interpretation services have not been used even in situations where a breach of the rules has been investigated (2449/2019 Turku).

The Ministry of Justice published unofficial English translations of the Imprisonment Act and the Remand Imprisonment Act in spring 2019, which have subsequently been distributed to the Central Administration Unit of the Criminal Sanctions Agency. Information about the publication of the translations was also shared with prisons through the Central Administration Unit's intranet, from where they can be printed out. Some prisons have unfortunately overlooked the opportunity to print out the translations for prisoner use, as was discovered during some visits (1936/2019 Jokela, 5291/2019 Sukeva).

Video meetings (Skype calls) may be the only way for a foreign prisoner to see their family and people close to them. However, this option is not always actively offered, or the instructions for organising a Skype meeting are available in Finnish only. This may give the staff the wrong impression on how much demand there is for Skype meetings. Once this need was recognised, the prison in question had the Skype meeting guidelines translated into English. The Deputy-Ombudsman finds it important that the possibility of video meetings is sufficiently communicated among both Finnish speakers and non-Finnish speakers (1592/2019 Vilppula).

Access to media in a prisoner's preferred language varies between prisons. The selection of TV channels in prison is not necessarily extensive enough to serve all major languages spoken by foreign prisoners. Even in prisons where over 30% of the population are foreign nationals, only Finnish channels can be accessed. The Deputy-Ombudsman requested the Central Administration Unit of the Criminal Sanctions Agency to investigate how easily foreign prisoners can access interna-

tional TV programmes in different prisons. He also asked the Central Administration Unit to find suitable ways for prisons to subscribe to foreign TV channels as soon as possible. As a result of this request, it was discovered that some prisons already had a wide selection of international TV channels available for foreign-language speaking prisoners. It was also discovered that several foreign channels were available free of charge through satellite TV packages, which can be installed at a very reasonable cost. The Central Administration Unit urged prisons to investigate the actual situation of their foreign inmates and take measures to offer them reasonable opportunities to follow television programmes in languages spoken by them. The Deputy-Ombudsman asked the Central Administration Unit to provide a report on the measures taken in prisons to address this matter. The Deputy-Ombudsman also noted that he will pay attention on future visits to the access of foreign prisoners to foreign-language TV programmes (757/2019).

The number of titles in foreign languages in prison libraries varies. As a positive observation, the action plan of the prison included a plan to allow foreign prisoners to borrow literature as interlibrary loans from the Multilingual Library (5291/2019 Sukeva).

The prison library had the Ombudsman's annual reports available for the use of prisoners.

Prisoner transport by train

The NPM visit of prisoner train transport was made in May 2018, when serious deficiencies were identified in the conditions for prisoners during transport. The Deputy-Ombudsman gave recommendations on 1) access to drinking water, 2) the use of a toilet without the presence of others, 3) testing the alarm equipment, 4) the temperature of the prisoner carriage, 5) meals, 6) the level of hygiene, and 6) the comfort of non-smoking prisoners In addition, the Deputy-Ombudsman made some observations regarding health care. The Central Administration Unit of the Criminal Sanctions Agency reported in October 2018 to the Deputy-Ombudsman on the measures it had taken.

The NPM carried out a follow-up visit of prisoner train transport in August 2019 The Deputy-Ombudsman was mostly satisfied with the measures taken by the Criminal Sanc-tions Agency and The Railway Company (VR) since the previous visit The NPM noted that prisoners were now given

View of a prisoner train carriage.

bottled water to drink. The prisoners were also informed of the possibility to use the toilet and a non-smoking space. Prisoners interviewed during the visit confirmed they were aware of these facilities. However, the prisoners were not aware of the call buttons that can be used to contact a guard and to flush the toilet. The level of cleanliness of the cells had not improved. Communication with the private cleaning service provider was also found to be a problem. As a positive improvement, the mattresses in the cells had been replaced by new ones. In addition, the windows of prisoner carriages had been fitted with heat and light-reflecting films. According to the staff, these helped lower the temperature in the prisoner carriage. Significant changes had been made in food provision. Prisoners were given a hot meal for dinner if they had missed a meal because of the transport.

The Central Administration Unit of the Criminal Sanctions Agency reported that VR will attach a pictogram (a drawing) to inform all users that tap water in the toilets is not suitable for drinking. The guard call button and the toilet flush button will be marked with pictograms indicating their purpose. The Central Administration Unit considers it particularly important that the standard of cleaning be improved and any deficiencies in the quality of the service be addressed without delay. VR has reported that it will step up the quality control of the prisoner carriage cleaning and give prisoner carriage guards contact details for the cleaning service provider to give any immediate feedback on the standard of cleanliness.

Positive observations and good practices

Prisoners' access to the Internet and video meetings (Skype) has been organised in Sukeva Prison by appointing a supervisor exclusively for electronic communications at the prison. Because of the remote location of the prison, which makes the journey to meet prisoners exceptionally long, it is important that the prisoners are given easy access to contacts through video technology. The Deputy-Ombudsman noted that the prison had organised Skype meetings and Internet access

An official from the inspection team trying out a terminal available for prisoners to file a complaint electronically with the Ombudsman.

exceptionally well and with great flexibility. He found the arrangements at Sukeva Prison a good example for other prisons who wish to improve prisoners' access to electronic communications in the same way.

Sukeva Prison has reported that the prison has appointed a new supervisor as of 1 February 2020 to deputise for the regular Internet and Skype meeting supervisor.

3.5.13 ALIEN AFFAIRS

Finland had 38 reception centres for adults and families at the end of 2019. 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 accommodation. Under section 121 of the Aliens Act, an asylum seeker may be held in detention for reasons such as establishing their identity or enforcing a decision on removing them from the country. Finland has two detention units for foreigners in operation, one in Metsälä, Helsinki (40 places), and one in Konnunsuo, adjacent to the Joutseno reception centre (68 places). Both units operate under the Finnish Immigration Service.

Some residents in reception centres and detention units may be victims of human trafficking, and recognising such residents is a challenge. The assistance system for victims of human trafficking operates in connection with the Joutseno reception centre. According to the media release of the Finnish Immigration Service, a record-high number of new customers, 229, were accepted into the assistance system in 2019. Of these, 70 were estimated to have become victims of exploitation indicative of human trafficking in Finland. It was estimated that most of the victims of exploited in Finland were subject to forced labour. There were a total 676 people within the scope of the assistance system's services at the end of 2019 (compared to 455 in 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.

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

The aim is to make regular visits to both detention units. The detention unit at the Joutseno reception centre was last visited in November 2018 (5145/2018) and the Helsinki detention unit in December 2019 (6841/2019).

At the Joutseno detention unit, the NPM was informed about a male asylum seeker who had been brought to the unit from Helsinki Police Department's Pasila police prison. Prior to this, the asylum seeker had been hospitalised for periods at a psychiatric hospital, where he had been placed under an order of treatment and isolation. On arrival at the detention unit, the asylum seeker, who had been deprived of his liberty, had to be placed directly in isolation. On the same day, he was transferred to Lappeenranta police prison, from where he was taken to the emergency care unit on several occasions and the psychiatric ward of the South Karelia Social and Health Care District for assessment. Owing to his aggressive behaviour, he was not admitted to the hospital for observation, and instead he remained in police detention facilities. At the hospital, he was prescribed antipsychotic medication, which became the responsibility of the police prison staff to administer. Eventually, he was admitted to Niuvanniemi Hospital. The Ombudsman decided to launch an investigation into the case on his own initiative (5675/2018). Based on the initial findings, it would appear that the conduct of the police or the detention unit gave no rise to suspect of any wrongdoing that would merit an intervention by the Ombudsman. However, it remains questionable whether the detainee received appropriate treatment. On request by the Ombudsman, the National Supervisory Authority for Welfare and Health (Valvira) initiated an inquiry into the care aspects of the case. At the time of writing this annual report, the matter is in process at Valvira.

The following opinions and recommendations following the visit conducted by the NPM concern the Helsinki detention unit only. The visit was made unannounced. The detention unit had 29 detainees at the time of the visit. The detainees reported to the NPM that they had been treated well at the unit.

Information on rights and obligations

Following the previous visit in December 2017, the Ombudsman drew attention to, for example, the duty to inform persons placed under detention of their rights and obligations immediately upon their arrival. The NPM was now told that the residents are given information about their rights and obligations as soon as they arrive. The detainees confirm receipt of the information with their signature.

Health-care resources and health assessment on arrival

Following the previous visit, the Ombudsman reiterated the recommendation that all detainees should receive a health assessment within 24 hours of arrival. Fulfilling this recommendation naturally requires adequate health-care personnel resources. At the time of the visit, there was one nurse on site responsible for the delivery of health care at the unit. It was discovered during the December 2019 visit that there were two nurses on duty at the unit, with one of them on a temporary contract. According to the director of the unit, they would be allowed to keep the one temporary contract nurse in addition to the permanent nurse in 2020. This was considered highly necessary. The nurse is on duty from Monday to Saturday.

The NPM was told that the aim was the health assessment of each arriving resident within 24 hours from their arrival, and that this goal was achieved with 83% of the residents. The aim is to carry out a health assessment on all arriving residents. An exception to this rule is made with detainees who are detained for less tha 24 hours, who arrive during the weekend, or who decline the health check. The arrival health assessment covers the individual's mental and physical well-being, medications, oral health, vision, and hearing. The person is also asked questions about possible infectious diseases and injuries, and their experience of the transport to the detention unit. Detainees transferred from another detention unit also undergo the health assessment. A more extensive arrival interview form will be introduced with the new electronic patient information system.

On arrival and in the case of unsuccessful repatriation or deportation, health-care providers will pay special attention to possible signs of violence on a detainee. Any findings are recorded in the medical history of the individual, and the patient is referred to a physician if necessary.

Consent to release medical records

The Ombudsman considered it good practice to use a separate consent form in the detention unit, with which the detained person can give their consent to the sharing of their medical records between other health-care organisations. The Ombudsman was also pleased to note that the form is available in several languages. However, the Ombudsman also noted that only the medical records for which the consent has been given may be shared. The person giving their consent must be made aware of which specific records are released and for what purpose. Ultimately, the party releasing the medical records must ensure that the person giving the consent was given the appropriate information before the release.

Premises

The outdoor exercise space at the detention unit had no rain shelter. According to the director of the unit, residents could borrow raincoats to spend time outdoors.

The premises cannot be compartmented, which could help reduce the need for segregation.

Moreover, the health-care staff had no separate space for medicine distribution. Medicines were given at the surgery, so when the room was occupied for a medical examination, the nurse had no access to the medicine cabinet.

Medication times, or, the times a nurse dispenses medications.

Reporting on mistreatment

The detention unit had no system or guidelines in place indicating how and to whom the detainees or staff could report any mistreatment observed. The feedback box was used only little, as far as is known, and it was not clear to the NPM whether the detainees were aware of the feedback box or its purpose.

The Ombudsman noted that the detention unit should operate an effective complaint system that both the detainee and the staff would be aware of, and that would enable the filing of complaints to both an external remedial body (such as the Parliamentary Ombudsman) or internally (such as to the director of the unit). Under international recommendations, the complaints procedure must be accessible, transparent, and sufficiently advertised. In addition to this, all complaints and actions arising from them must be documented.

Positive observations

All supervisors at the detention unit had received medicine distribution training in 2018.

Health-care professionals monitor the detainees' health is segregation at least once a day, and more frequently if necessary.

The NPM was told about a detainee whose background information was not available and who had to be placed in isolation because of their aggressive behaviour. It transpired only later that the detained person had an autism spectrum disorder. Some of their behaviour derived from the fact that their special needs were not understood from the beginning. After the incident, a representative of the Autism Foundation Finland was invited to the unit to talk about how to act with persons in need of special support, and how to prevent the escalation of similar situations.

3.5.14 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 currently some 1,000 units in Finland offering substitute care. There are seven residential schools; five are managed by the state, and two are privately run. The state residential schools operate under the guidance and supervision of the National Institute for Health and Welfare and the Finnish National Agency for Education as non-profit child welfare institutions.

Visits by the NPM have been made exclusively to institutions or similar units. As many children as possible, that is, everyone who is willing to share their issues with the NPM, are interviewed during child welfare visits. When speaking with children, they are informed of the possibility to contact the NPM if they are subjected to disciplinary measures or similar conduct as a result of the visit. The personnel are also reminded that any retaliatory measures against the children are prohibited. This is also mentioned in every NPM visit report.

It has not been entirely unproblematic to communicate the rationale and importance of the prohibition on retaliatory measures. The dialogue with the child welfare institution revealed that the unit's employees had not always comprehended the contents of the UN Convention against Torture in this regard, and had experienced the prohibition against retaliatory measures, noted in the NPM visit report, as insulting. Ultimately, it is the duty of the institution management to ensure that their staff are aware of the legal provisions governing their work. It is also vital for them to be knowledgeable about the duties and powers of different supervisory authorities. The Deputy-Ombudsman has required the institution to arrange training on these matters for its employees (4099/2018 Child Welfare Unit Jussinkodit).

As will become apparent from the opinions and recommendations presented later in this report, the management and staff at child welfare institutions have an obvious need for further training on fundamental rights and the content of the Child Welfare Act and the principles presented in the rationale of the Act. The comments submitted by the child welfare institutions on the reports suggest that the child welfare service providers do not always understand what concepts such as the good treatment of a child, an acceptable method of upbringing, restriction on the freedom of movement, isolation, or requesting a person to remove their clothes entail from a legal perspective. It has repeatedly proved necessary during visits to draw the institution staff's attention to the importance of always documenting a specific and reasoned decision when restrictive measures are applied.

Inspection visits to child welfare institutions are carried out unannounced and last for 1–3 days. The NPM pays attention to the treatment of the children and to any restrictive measures to which they may be subjected, and to the related decision-making process. The visits have revealed a lack of awareness of the difference between restrictive measures and acceptable child-rearing 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, without delay, the municipality of placement, the State Regional Administrative Agency (AVI), and any other municipalities that are known to have placed children in the same place of foster care of any issues identified. 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.

The NPM visit reports are sent to the visited unit and the local AVI. According to the Child Welfare Act, the local AVI is responsible for the supervision and monitoring of restrictive measures, in particular. In addition, the report is submitted to the local authorities of the municipality that has placed children in the institution in question. The Deputy-Ombudsman has required that social workers discuss the content of the report with the placed child and explain what it means. The Deputy-Ombudsman may also have required that the social worker ensures that the child is aware of their rights and of what actions they may take if they face inappropriate treatment in the future. In such situations, the Deputy-Ombudsman has requested information on how the child was met with for the purpose of providing this information (5377/2018 Special Child Welfare Unit Loikalan kartano). Reports are often sent for information to the National Supervisory Authority for Welfare and Health (Valvira), which is responsible for the national guidance and supervision of social services.

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. However, it has become apparent in recent years that the institutions have taken a more critical

view of the inspection operations of the Parliamentary Ombudsman and NPM. Some institutions have publicly criticised the inspections and the observations made during them. It has even been claimed that the Parliamentary Ombudsman's and NPM's actions could create obstacles to finding suitable institutions for children placed in care outside the home. The Deputy-Ombudsman has been forced to strictly remind an institution of its obligation to comply with the opinions of the authority charged with the oversight of legality. The Deputy-Ombudsman was also forced to emphasise that child welfare institutions have the obligation to cooperate with the Parliamentary Ombudsman, the NPM, or other overseers of legality in order to provide them with all of the information required to perform the inspection and effectively fulfil the children's right to be heard during the visit (1353/2018 Residential School Pohjolakoti).

The visits made to child welfare facilities over the past few years have been proven to have a far-reaching impact. The observations made during the visits have also led to an urgent amendment to the Child Welfare Act. For example, systematic measures will be required in the future to help reduce the use of restrictions to a minimum. Each child welfare institution will be required to present a plan for the good treatment of children as part of their self-monitoring plan. It is also required to involve and engage the children placed in the institution in the creation of the plan. If restrictive measures are used, they must be discussed with the child in a mandatory debriefing. A child's care and education plan drawn up by the institution must include measures agreed on by the social worker and the child on how the use of restrictive measures could be avoided. The amendments entered into force on 1 January 2020.

Observations made by the NPM have led to several other legislative projects focusing on the legal position of children placed in care and their right to necessary services during the placement. There will also be a review of what amendments to legislation governing restrictive measures would be required.

Following visits by the NPM, many child welfare institutions have reviewed their practices and rules as recommended in the visit reports. Observations made during these visits have gained wide publicity. At the same time, the awareness of children placed in institutions of their rights has improved. This shows in the substantial increase in the number of complaints filed by the children.

More attention has also been paid to the effectiveness of the work carried out by respective supervisory authorities responsible for the monitoring of child welfare institutions. There are cases where the monitoring efforts fall far short of satisfactory. The Deputy-Ombudsman has reprimanded Valvira for negligence in the supervision of substitute care provision and, in particular, the use of restrictive measures in this setting (4168/2018). Following visits conducted by the NPM, amended legislation entered into force on 1 January 2020, requiring that children residing at a unit visited by a Regional State Administrative Agency must be given an opportunity to be heard in person.

The visit reports may also have requested the local AVI, as the authorising public official, to ascertain that the institution complies with the licence under which it operates. For example, does the institution genuinely employ personnel as specified in its licence, or does the children's extensive demand for various services call for a re-evaluation of the licensing decision or the licensing criteria (5377/2018 Loikala). In some cases, it is may be left for the local AVI to verify that the recommendations made on the visit report have been implemented by the institution, in which situation a separate report on the measures from the institution is not necessary. This is the case when, for example, a Regional State Administrative Agency has conducted their own guidance and assessment visit at the institution concurrently with the Ombudsman's visit and reported that it will continue to monitor the standard of foster care provided by the institution and the nature of restrictive measures applied (5916/2018 Family Home Ojantakanen).

During 2018, the NPM carried out 10 visits to child welfare institutions. The reports on the visits are extensive and detailed. In 2019, it was necessary to give priority to finalising past visits instead of carrying out new ones, so the number of visits made during the year was only one. The institution was Jaloverso youth home in Hollola, and the visit took place on 28–29 October 2019 (5930/2019). The visit was carried out unannounced and concurrently with the inspection of AVI Southern Finland. The visit focused, among other things, on measures taken at the institution following the decisions made by the Ombudsman in summer 2019. These decisions were made as a response to complaints filed by five children placed at the institution. These covered the isolation of a child and the inappropriate conduct by institution staff (4566/2018) and withholding of an incentive payment (3662/2019). At the time of writing this annual report, the final report on the visit to Jaloverso was not yet available.

Picture of Loikala Manor.

Some of the key opinions and recommendations issued on the basis of the visits are presented below. They concern visits made in 2018, with the respective opinions issued in 2019. The institutions visited were Children's Home Sutelakoti (1605/2018), Children's Home Rivakka (1606/2018), Special Child Welfare Unit Loikalan kartano (5377/2018), and Family Home Ojantakanen (5916/2018).

The Deputy-Ombudsman has ordered pretrial investigations to be carried out on instances of suspected unlawful conduct at two child welfare institutions. The pretrial investigations are currently in process.

House rules and educational culture at the unit

A child welfare institution must continually evaluate how to best sustain the growth and development of a child, and how the institute can support the child's independence and life skills after the placement in substitute care ends. The rules and practices at an institution must support the achievement of these goals. The rules of the institution cannot override the provisions of the Child Welfare Act, and they may not restrict a child's right to self-determination any more than is necessary. Situations must be evaluated on a case-by-case basis with each individual. Collective punishment aimed indiscriminately at all the children is not an acceptable method of upbringing.

Based on observations, the institution had adopted a culture of upbringing heavily based on restrictions. The rules placed unlawful restrictions on the children's freedom of movement, social life, and self-determination. The policy was deliberate, and the staff members endorsed this approach. The fact that restricting the rights of a child must be based on the law was simply ignored in daily life at the institution. According to the Deputy-Ombudsman, neither the rules and practices of the institutions nor their application supported and promoted such high-quality care, education, and rehabilitation that would serve to prepare the placed children for the kind of daily life that

can be considered normal in today's society. The Deputy-Ombudsman required that the rules of the institution and their implementation must be brought into line with the provisions of the Child Welfare Act (5377/2018 Loikala).

The Deputy-Ombudsman has made the recommendation to a number of institutions that they work together with the resident children to draw up rules that are understandable and fair, so that the children will find it possible to commit to them. Changes to the rules should also be agreed on in cooperation (1606/2018 Rivakka, 5377/2018 Loikala, 5916/2018 Ojantakanen).

The institution reported that the unit had adopted rules that were in line with the recommendations, that were drawn up in cooperation with the resident children, and that were available for the children to read at all times (5377/2018 Loikala).

It was noted during the visit that children were expected to knock on their door if they wished to leave their room. Permission to leave the room was not necessarily given immediately. The practice was a rule adopted by the institution which restricted the child's right to freely leave their room. The rule was enforced at all times. The practice was against the law, according to which a child has the right to free movement within the indoor areas of an institution that serves as the child's home. In reality, the practice constituted confinement in one's room. The Deputy-Ombudsman found that the practice had no basis in the Child Welfare Act, and there were no acceptable educational grounds to justify it. The practice was demeaning for the children (5377/2018, Loikala).

The institution has since reported that it has abandoned the practice.

Decision-making on restrictive measures

It has been repeatedly necessary to remind institutions of the provisions of the Child Welfare Act when making decisions on restrictive measures. The Deputy-Ombudsman has drawn the serious attention of the institutions to, for example, the fact that a restrictive measure must always be based on a separate decision, for which the provisions of the law are reflected on a case-by-case basis. The institution must ensure that these conditions are met in the case of each restrictive measure employed. The requirement is especially relevant now that the aim of avoiding the use of restrictive measures is enshrined in law.

The institution has since reported that its staff has received training in the assessment of restrictive measures in individual circumstances. Moreover, the customer data system Nappula has added consistency in the use of restrictive measures (1605/2018 Sutelakoti).

The institution reported that it will pay further attention to the individual grounds for decisions on restriction in the future. The staff will receive training in the use of restrictive measures (5377/2018, Loikala).

Restrictive measures are not to be applied routinely on all children in certain situations. It is prohibited to search through each child's belongings on arrival as a routine practice. Conducting "mass raids" in children's rooms is unacceptable, and children's freedom of movement may not be restricted as a matter of regular practice (5916/2018 Ojantakanen).

Restrictive measures and disciplinary methods must be documented as required by the law (5377/2018 Loikala, 5916/2018 Ojantakanen).

The institution reported that attention had been paid to the documentation of restrictive measures and customer records in the Nappula data system. Authorised access to customer records has also been limited (5377/2018, Loikala).

A child should also receive the original decision, or a copy of it, on the use of restrictive measures concerning them. The delivery of the decision should be indicated in the child's records. If the child does not wish to keep the decision themselves, the child should be informed that the original or the copy of the decision will be archived in a place where they can access it on request. The decision should be kept within easy access at least during the appeals period, should the child wish to see the decision (1606/2018 Rivakka).

The child should always be appropriately notified of restrictive measures. The child should always be given sufficient and understandable information about the content of the decision. The child should also be informed about their rights and the obligations of the institution. The way the information has been delivered must be described in the child's records (5377/2018 Loikala).

Restrictions on contact

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. This must be assessed on a case-by-case basis. The authority to make such decisions lies with the social worker responsible for the child's affairs, not the place of foster care. The restriction of communication always requires a decision open to appeal. In no case should restrictions on communication be based on the rules of the institution alone. The Deputy-Ombudsman required that the institution inform the child's social worker in advance about their plan to restrict the child's communications (e.g. when a child's leave is being cancelled). The institution cannot exercise powers that by law belong to the social worker (5377/2018 Loikala).

The institution reported that the restriction of communication is mainly aimed at restricting the use of the phone. The restriction does not apply to maintaining contacts with the child's parents, as the child has access to a phone for that purpose. When a decision to restrict a child's communication needs to be made during the weekend or evening, it has not always been possible to consult the social worker.

In situations when it is necessary to cancel the child's leave, the matter is always first discussed with the social worker. There have been situations when the child's leave has been cancelled because of the parents' situation. If the leave has been cancelled because of an event or a camp organised by the institution, the child's leave has been rescheduled rather than cancelled. It is possible that the child's records are not appropriately updated on these details, and the institution will take steps to remedy this in the future. According to the institution, it has not used, and has never intended to use, powers that belong to the social worker. Any restrictions on communication have not been imposed based solely on the rules of the institution.

The starting point for a child's access to their own phone is that each child can use their phone as is appropriate for their age and level of development, as any child outside an institutional setting would. If using their phone causes no harm to the child, there are no educational grounds to intervene in the child's use of their phone by confiscating it "just to be safe", let alone as a punishment. The Deputy-Ombudsman has proposed that the institution draw up a plan on procedures that would help reduce or completely avoid the use of certain restrictive measures (5916/2018 Ojantakanen).

Encouraging social relationships

Every child has the right to build and maintain social relationships within and outside the institution. A child must have opportunities to interact with other people. Methods by which a child is prevented from speaking with another person for long periods of time are inhumane and reprehensible. It transpired during a visit that the institution restricted and even completely prevented the children's social interaction by limiting or prohibiting conversations between children in certain situations. For example, the institution had adopted quiet mealtimes as a permanent practice. All social contacts between children during mealtimes were prohibited. Under the rules, the mealtime continued until everyone had emptied their plates. The children had been compelled to agree to this practice for fear of repercussions. The Deputy-Ombudsman found that the institution was exercising institutional powers that were not based on law. The Deputy-Ombudsman requested that the institution immediately discontinue the

Dining room at a child welfare institution.

unlawful and demeaning practice of restricting the children's social relationships (5377/2018 Loikala).

The institution reported that it has reviewed its practices and the children are allowed to freely communicate with each other. Maintaining social relationships is supported by allowing children the use of their phone at all times of the day. Exceptions include restriction measures by which a child's phone has been confiscated. Social relationships are no longer restricted or supervised in daily life without appropriate restriction decisions. Normal conversation is allowed during mealtimes and children can freely choose where they sit at the table. Children are encouraged to taste different foods. However, they are not expected to eat anything against their will.

The children's movements within and outside the property will no longer be restricted without an appropriate restriction decision. Children's conversations are no longer intervened in except in cases of verbal abuse witnessed by an adult. The children are allowed to spend time in each other's rooms for an agreed period of time. The children will be given the opportunity to visit the shopping centre in the nearby town for independent shopping once a week.

Violations of a child's right to self-determination and privacy

The children placed in substitute care also reported to the NPM that they were forbidden from using make-up in the institution, dyeing their hair, having piercings, and wearing tops or other clothing that the institution deemed inappropriate. The children could not understand the purpose or reason for these rules. The institution confirmed that the rules described by the children were in force at the institution. The Deputy-Ombudsman found that piercings, clothing, and matters such as dyeing one's hair are an essential element of a person's self-expression. The rules of the institution regarding the physical appearance of the children violate children's fundamental right to self-determination and privacy, in other words, their rights over their own bodies and appearance. The rules may not restrict a child's right to self-determination any more than is necessary. Each case must be considered within its own context (5377/2018, Loikala).

The institution reported that the children's choice of clothing, piercings, personal appearance, and self-determination will no longer be intervened in. Previously, these aspects were intervened in if they supported or maintained symptomatic behaviours. In the future, the use of hair dyes and piercings will not be restricted.

The children reported to the NPM that they were not allowed to dye their hair. Some children reported restrictions on their choice of clothing. The baseline in the protection of personal integrity is that everyone has the right to live their own lives without arbitrary or unjustified intervention by authorities or anyone else in their private life. The Deputy-Ombudsman noted that the place of substitute care may offer the child support and guidance through discussion, and may help the child choose their outfits taking into consideration the event they may be attending, the weather conditions, and their health. Such situations are an opportunity to guide a child to understand traditions and customs related to clothing in different cultures. The Deputy-Ombudsman empha-

sised that a child has the right to decide on their appearance and clothing (5916/2018 Ojantakanen).

A review of documentation during the visit revealed that under the institution's rules, girls were allowed to use tampons only when participating in sports or swimming and in the sauna. According to the documents, girls were not allowed to decide for themselves on the type of period protection to use while residing at the institution. They were not allowed to purchase the type of menstrual pads they preferred from the shop, as the institution prohibited shopping. The Deputy-Ombudsman considered that this rule was an example of the extent to which the institution exercised control over the children's personal lives. The institution's practices on menstrual protection severely restricted the rights of a girl to make decisions concerning her own body and to decide on matters intimately related to her own person and privacy. The practice was demeaning and did not respect the girls' right to dignified treatment. The practice violated the central element of personal privacy protected by section 10 of the Constitution: everyone's right to make decisions concerning their private life (5377/2018, Loikala).

The institution reported that it no longer interferes with the residents' personal privacy and does not dictate which type of period protection the girls are allowed to use. To the contrary, the staff give encouragement, advice, and guidance on personal hygiene.

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 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. Restrictions are always subject to a written decision open to appeal.

Restricting a child's freedom of movement may not be used as a punishment for the child's behaviour. If the child's personal contacts are restricted while restrictions of the child's freedom of movement are in place, a separate decision must be made on the restriction on personal contacts.

The institution reported that, in the future, an individually reasoned restriction decision will be made on the possible restriction of a child's freedom of movement, if the conditions for such as decision exist (1605/2018 Sutelakoti).

The de facto restrictions on the children's freedom of movement imposed by the institution affected every child at the institution and were in force at all times. Restrictions on the children's freedom of movement were based solely on the institution's own rules and without an individual assessment of the child's situation based on the law. It was not a matter of restricting the free movement as provided in the Child Welfare Act, but a much farther-reaching practice concerning all the children. The Deputy-Ombudsman requested that the free movement of children be restricted only if the conditions determined by law are met. Restrictions on the freedom of movement must be based on decisions in due process, open to appeal. Restricting a child's freedom of movement may not be used as a punishment for the child's behaviour. The Deputy-Ombudsman required that during a restriction on the freedom of movement, the child's right to social relationships must be ensured. The child's right to education and hobbies must also be safeguarded during a period of restriction (5377/2018 Loikala).

The institution reported the practices have been changed so that if a decision on the restriction of freedom of movement has not been made in accordance with the Child Welfare Act, child will be allowed to move freely within and outside the institution. Curfew times are agreed on together with the child. Decisions on restrictions of freedom of movement and the grounds for the restrictions are made according to due process, and they will not prevent the child from attending school or hobbies or participating in activities organised by the institution.

The Deputy-Ombudsman drew the institution's attention to their decision-making obligation under the Child Welfare Act. If it is necessary to restrict the child's freedom of movement by prohibiting their access to areas outside the institution's grounds or otherwise, the institution must make a decision on the matter. The decision on a restriction on the freedom of movement does not allow for the actual isolation of the child or the prohibition of social contacts (5916/2018 Ojantakanen).

Confiscation of substances and objects

The Deputy-Ombudsman has drawn the attention of institutions to the legal provision under the Child Welfare Act that a child's property can only be confiscated under certain, specified circumstances. If a child's property is confiscated by the institution, a decision required by law must be duly made and entered into the records. Confiscation may never be used as a punishment (1605/2018 Sutelakoti, 5377/2018 Loikala, 5916/2018 Ojantakanen).

Adolescents' possessions in safekeeping at the institution.

The child's mobile phone cannot be confiscated by the institution as a precautionary or punitive measure (1605/2018 Sutelakoti).

A child has the right to keep their belongings in their own room. A child's property cannot be taken for storage without the child's own request (5377/2018 Loikala).

Bodily search and physical examination

The bodily search of a child must be based on due statutory decisions with the required documentation in place. The child's records must provide the reason for a bodily search or physical examination. According to the law, only when there is a justified reason to suspect that the child has in their clothing or otherwise on them prohibited substances or objects, a bodily search or physical examination may be carried out on them for the purpose of investigate the matter. Such reasons are always individual and must be evaluated individually for each child. The child's documents must also describe the practical implementation of any bodily search or physical examination.

The institution has since reported that it has made a focused review of the practices regarding this issue. In the future, bodily searches and physical examinations will be performed only on a case-by-case basis. In addition, the decision describes how the restrictive measure was implemented in practice (1605/2018 Sutelakoti).

According to the institution, attention has been paid to the grounds for the decisions and the accuracy of the related records. The number of bodily searches performed has been significantly reduced, which has led to an increase in the influx of drugs, fire-making tools, and blunt instruments into the residents' rooms. Staff observations are not considered to form a sufficient basis for performing bodily searches (5377/2018 Loikala).

Bodily searches may not be performed routinely every time a child goes on leave or returns to the institution (5916/2018 Ojantakanen).

Several of the children reported to the NPM that on occasions they had been required to undress during a bodily search. This meant having to

remove all their clothes and turn around in front of the supervisors. According to the children, the undressing practice had taken place at least after each unauthorised absence (5916/2018 Ojantakanen).

Upon arrival at the institution, the child is subjected to a bodily search. The children reported to the NPM that they had been asked to remove all their clothes for the bodily search and that their bodies had been contemplated by supervisors. Most of the children said they had been subjected to the practice more than once, some up to 5–6 times. According to the children, all their clothes are removed until they are completely naked, and they must place their clothes in a basket. Once naked, the children are required to wear the institution's clothes, including the underwear. During the visit debriefing with the institution, the institution admitted to the practice of requiring children to undress until they are naked (5377/2018 Loikala).

The Deputy-Ombudsman seriously emphasised the importance of taking the child's age, sex, level of development, individual attributes, religion, and cultural background into account when conducting bodily searches and physical examinations on a minor. Such searches and examinations must be carried out in a manner that causes the least harm to the child. The Deputy-Ombudsman required that the practice be discontinued immediately, as the Child Welfare Act does not allow for the undressing of a child in connection with a bodily search. A child's personal consent to the method is not sufficient justification for a bodily search (5377/2018 Loikala, 5916/2018 Ojantakanen).

The institution reported that, in the future, the children will be given a bathrobe to protect themselves when changing their clothes. The bodily search is always carried out in a camera-free room (the surveillance camera is covered) by two staff members of the same sex as the child (5377/2018 Loikala).

Isolation

The Deputy-Ombudsman requested the institution to immediately discontinue the ongoing practice of de facto isolation. Isolation may only be used as a measure when specific conditions laid down by law are met. In the future, a decision to isolate a child must clearly indicate: 1) the situation and behaviour that led to the isolation, 2) the implementation method of the isolation, 3) the assessment of the grounds for continuing the isolation, and 4) the grounds for ending the isolation. The Deputy-Ombudsman emphatically drew the institution's attention to the fact that the time limits for isolation laid down in the law are absolute and may never be exceeded (5377/2018, Loikala).

The institution has reported that it will pay further attention and be more careful in documenting the use of restrictive measures, observing time limits, and assessing the necessity of each measure taken. According to the institution, the use of the safety room on a resident's arrival is justified to establish the resident's initial situation, wellbeing, and physical condition, and to protect their privacy. The present practice is to carry out an assessment of a new arrival based on their current wellbeing and behaviour, to decide whether they can be placed directly in their own room and whether they are immediately able to participate in shared activities at the unit. For example, if the resident is intoxicated, they cannot participate in any activities.

However, the institution disagreed with the finding in the report according to which the institution imposed isolation on the children lasting for days or weeks. In the view of the institution, enhanced adult supervision and monitoring of the residents' wellbeing on arrival or in times of crisis does not constitute isolation. The child may have been taken to their room for a reasoned didactic purpose for the duration of the staff handover report, which takes place on weekdays.They were not obliged or forced to stay in the room for several hours, as described in the visit report. At the moment, the residents are free to move in and out of their rooms and around and outside the institution grounds.

Security room used for isolation.

A child may be isolated only if the specifically assessed conditions laid down in the Child Welfare Act are met. Isolation may not continue any longer than is necessary and must be discontinued as soon as the conditions for isolation have ceased to exist. The Deputy-Ombudsman required the institution to discontinue all practices resembling isolation (5916/2018, Ojantakanen).

Transport services in child welfare service provision

During 2019, the Substitute Deputy-Ombudsman issued a decision in an investigation on his own initiative concerning the use of private companies providing transport services in child welfare service provision (4771/2017). It was noted during NPM visits to child welfare institutions that institutions with children with extensive needs for services relied heavily on private transport services. The users of private transport services include state residential schools, private child welfare institutions, and local authorities. The Substitute Deputy-Ombudsman requested Valvira to investigate the use of private transport services and the oversight of the services by the relevant authorities.

In their decision, the Substitute Deputy-Ombudsman found it a serious failure from the perspective of a child's legal rights and right to self-determination that the authorities responsible for the child, state residential schools, and other places of substitute care have, in practice, not supervised the operations of the businesses providing search and transport services. Moreover, there is no documentation on the transport and searching of a child as required by law. It remained unclear to what extent local authorities and child welfare institutions had disclosed confidential information about the children or other persons (such as their relatives) to private companies. It also remained unclear how that information had been recorded and possibly stored in companies' databases. The Substitute Deputy-Ombudsman considered it a grave malpractice that, according to the information obtained during the visits, children would have been subjected to coercive or restrictive measures during transport. However, under no circumstances do the employees of a private company have the right to use coercive or restrictive measures on a child without the express authorisation provided by law.

There has been uncertainty within the child welfare services sector whether or not the use of private companies has been lawful. This uncertainty is partly due to the lack of explicit provision in the law on the transport and search of a child. The uncertainty has been compounded by the fact that at least one Regional State Administrative Agency has entered two service providers within its jurisdiction in its register of private social service providers. In the registration information, both companies had stated that they provided transport services as well as other open-care child welfare services. It was not clear from the decisions of the local AVI that transport and search activities would have been excluded from the scope of the registration, or in other words, that their registration for these services would have been specifically rejected.

The use of private companies for transport in child welfare services was brought to the attention of the Ministry of Social Affairs and Health as a result of the Ombudsman's findings, as well as through other channels. As a result, a provision

(Section 69a) was added to the Child Welfare Act on the acceptable methods of returning a child to an institution from unauthorised leave and how the transport should be safely organised. The provision entered into force on 1 January 2020. It explicitly stipulates that a child welfare institution or a social worker may not use a private company to search for and transport a child back to the place of substitute care. The transport may only be carried out by a professionally qualified member of the institution's care and educational staff, the child's own social worker, or another public authority. The amendment also provides for the safe transport of a child, the related decision-making process, and documentation obligations.

The Substitute Deputy-Ombudsman considered it necessary for the Regional State Administrative Agencies to issue guidance to the local authorities and service providers in their area on the changes in the Child Welfare Act, including provisions on the safe transport of a child in accordance with the new legislation.

3.5.15 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 institutional care and residential unit, where they receive care round the clock, including end-of-life care if necessary. 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. There are some 2,000 social welfare units providing full-time care for older people in Finland. Visits made by the Parliamentary Ombudsman and the NPM 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 the detection of any differences in the standard of care.

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

NPM visits to care units for older people pay special attention to the use of restrictive measures. The use of such measures is made problematic by the fact that there is still no legislation on imposing restrictive measures on older people with memory disorders. According to the Constitution, restrictive measures must be based on law. The Parliamentary Ombudsman has issued several opinions in which he has demanded legislation to be passed on the matter. It is the opinion of the Parliamentary Ombudsman that, even though there is no legislation on restrictive measures yet, their use should be transparent and respectful of human dignity. As a minimum, the provisions on restrictive measures under other relevant legislation, such as the Mental Health Act and the Act on Special Care for Persons with Intellectual Disabilities, should be observed. On its visits, the NPM paid attention to matters such as the grounds, duration, and recording of restrictive measures and deciding on them.

All NPM visit reports are published on the website of the Ombudsman. The purpose of the publication is to inform the general public that the operations are being monitored. The reports also provide residents, family members, and staff with important information on the observations made during the visit. The visit report may also stipulate that the 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.

Restraint clothing.

The Parliament granted additional funding for the Office of the Parliamentary Ombudsman for 2019 to step up the supervision of the rights of the elderly. In 2019, new instances of neglect were identified, and closures of service units were carried out. Since the promotion of the rights of the elderly required additional resources, the Office of the Parliamentary Ombudsman was granted supplementary funding for 2020 to establish new posts.

Most visits to social welfare units for the elderly in 2019 were made under the NPM mandate. A total of 16 visits were made in 2019 (compared to 11 in 2018). Four of these were made to private service providers' facilities. All of the visits were made unannounced. In addition, nine visits were carried out at general health-care units, with the focus on the health care of the elderly. The findings and recommendations based on these visits are presented in section 3.5.17 on health care.

During visits to care units for the elderly, special attention was paid to the use of restrictive measures and the safety of the residents during the night. In addition, attention was paid to the protection of privacy, oral health care, and the availability of outdoor activities. Several of the visited units provide end-of-life care, which is why the visits also touched upon the principles of end-of-life care and how the humane and dignified treatment of elderly patients and their right to self-determination can be provided in practice.

There are also cats living at the Lizelius Home.

The following is a summary of the NPM visits to social welfare units for the elderly and the observations and recommendations made in connection with visits:

date of inspection	target	number of inmates	case number	other
19 March 2019	Mariahemmet, City of Raasepori	29 places	1764/2019	institutional care, Deputy-Ombudsman included
19 March 2019	Villa Rosa, Folkhälsan, Karjaa	21 places	1765/2019	24-hour residential service, Deputy-Ombudsman included
28 March 2019	Pihlajakoti, Päijät-Häme Joint Authority for Health and Well-being, Padasjoki	20-30 places	1842/2019	24-hour residential service
10 April 2019	Lizeliuskoti, Akseli Joint Authority for Social Services, Mynämäki	15+33 places	2009/2019	24-hour residential service 15 places and institutional care 33 places
10 April 2019	Moisiokoti, Akseli Joint Authority for Social Services, Nousiainen	50 places in total	2010/2019	24-hour residential service and institutional care
11 June 2019	City-koti, Joint Authority for Health Care and Social Services in Kymenlaakso, Kotka	60 places	3015/2019	24-hour residential service, external expert included
13 June 2019	Mäntylä residential service unit, Päijät-Häme Joint Authority for Health and Wellbeing, Heinola	73 places	3016/2019	24-hour residential service, external expert included
4 July 2019	Pakilakoti, Helsingin Seniorisäätiö, Helsinki	210 places	3763/2019	short-term and long-term institutional care
27 August 2019	Vaahterakoti, Keski-Uusimaa Joint Authority for Health Care and Social Services, Järvenpää	27+60 places	4743/2019	short-term care 27 places and 24-hour residential service 60 places
2 September 2019	Esperi Hoivakoti Niva, Rovaniemi	31 places	4921/2019	short-term and long-term 24-hour residential service
3 September 2019	Palvelukoti Onnela, Municipality of Pelkosenniemi	24 places	5023/2019	24-hour residential service, Deputy-Ombudsman included
3 September 2019	Saukoti, Municipality of Savukoski	25 places	4922/2019	24-hour residential service, Deputy-Ombudsman included
17 October 2019	Himminkoto, Municipality of Lempäälä	76 places	5595/2019	24-hour residential service
29 October 2019	Villa Mäntykoto, Hoiva Mehiläinen, Hyvinkää	38 places	5880/2019	24-hour residential service, 2 external experts included
5 November 2019	Palvelukeskus Lehtiniemi, Keuruu	41 places	6033/2019	24-hour residential service
5 November 2019	Kotikylä Sammonkoti, Humana, Jyväskylä	67 places	6032/2019	24-hour residential service, external expert included

#= unannounced inspection

The Saukoti Sheltered Home features a large fenced outdoor area.

Service Center Lehtiniemi lobby area.

Oversight of oversight

In 2017, the National Supervisory Authority for Welfare and Health (Valvira) took under its supervision a group of private companies that delivered residential care services for the elderly. Valvira passed a decision in April 2019 that each company was required to take measures specified by Valvira to remedy any malpractices and failures and to submit a report of these measures to Valvira by the end of July 2019. The decision extended to all residential service units in elderly care managed by the provider.

At the order of the Deputy-Ombudsman, one of the units of the above-mentioned group was visited in September 2019 (4921/2019 Niva). Both the local AVI and the municipal authorities had made several inspections at the unit. Most of them were pre-announced. The local AVI had carried out its first inspection at the facility in December 2017, based on several notification of shortcomings made by the staff. The municipal authorities had placed the unit under special supervision and steering for 2018. The most recent inspections prior to the NPM visit were an unannounced inspection by the local authorities in March 2019 and one by the local AVI in May 2019. Following the earlier NPM visit and based on a new notification, an additional unannounced visit was conducted by the local AVI in 2019 and attended by representatives from Valvira as experts.

The Deputy-Ombudsman drew attention to the fact that the institution had been under special supervision since 2017. In spite of that supervisory authorities received continually notifications of shortcomings on the institution. It was obvious that the supervision and special measures were not sufficient to remedy the issues in the standard of care and treatment and to prevent the emergence of new shortcomings. The short duration of the inspections carried out by the authorities, and their implementation mostly as pre-announced visits, may have led to a delay in the identification of shortcomings. The Deputy-Ombudsman found it extremely concerning that the authorities had not required improvements immediately.

The effectiveness of supervision may have been affected by the extensive workload of the supervisory bodies, insufficient resourcing, and in-

adequate time reserved for reflecting on practices. However, the Deputy-Ombudsman welcomed the fact that Valvira and the AVIs had identified the shortcomings and were working on further developing their operations. However, the Deputy-Ombudsman stressed that the public service unit itself, as well as the local authority providing the service, has the primary responsibility for ensuring services are delivered to a high standard and in compliance with the law.

The Deputy-Ombudsman required that the unit immediately take the measures mentioned in the NPM report, as well as any measures requested by Valvira and the local AVI in other documents. In addition, the Deputy-Ombudsman required the local authorities to ensure that the shortcomings does not recur. The local authorities were also to take measures to ensure that the service provided to a resident met their service needs and that the unit delivering the service had sufficient staff, as required by the service decisions. If a resident was not in reality able to live at the unit with no staff on site at night, or if they would not be able to independently seek help when needed, a decision on 24-hour residential service for them should be made. Service decisions were to meet the needs of the residents and the delivery of services were to meet the conditions for a licence.

Right to privacy

Sharing a room or bathroom with another resident

The protection of privacy is a fundamental right, and care for the elderly is no exception. The aim is that every elderly person in long-term care should have their own room, including sanitary facilities. When residents unknown to one another are placed in the same room in long-term care, this should be based on the persons' own fee will. The Deputy-Ombudsman stated that in an institutional setting, attention should be paid to maintaining the privacy of residents living in double-occupancy rooms in, for example, the delivery of personal care (1764/2019 Mariahemmet).

In a 24-hour residential service unit, some residents did not have a private room and thereby no private toilets and bathrooms. Furthermore, it was not always possible to determine whether clients were willing to be placed in a double-occupancy room with a stranger, due to the clients' diminished cognitive capacity. However, these clients had given their consent to be accommodated in a double-occupancy room. The Deputy-Ombudsman emphasised the importance of privacy protection, which is a fundamental right, and of listening to the will of the clients (1842/2019 Pihlajakoti).

The long-term care ward had a total of 37 residents and 8 double-occupancy rooms. Some residents could not have a private room despite having requested one. The toilet between some rooms was shared by the residents of the two rooms and could not be locked from the inside. Adjacent rooms could accommodate people of different sexes, who then had to share the toilet. In the short-term care ward, some residents also used the toilet independently, so it was possible that residents would need to use the toilet at the same time (3763/2019 Pakilakoti).

Protection and use of confidential information

In the short-term care ward, patient records were updated in a room that also served as a staff break room and kitchen. The space could be separated from the residents' quarters by a sliding door. However, the sliding doors were kept open to allow for the monitoring of the residents. Therefore, the residents in the dining area could overhear discussions between staff members (3763/2019 Pakilakoti).

It was discovered during a visit that a unit no longer had the practice of inquiring about residents' biographical information. The policy had changed after one relative prohibited questions about a resident's biographical information, finding it to be unlawful. A note had been posted in the staff office informing that biographical information could no longer be inquired about for reasons of security. The Deputy-Ombudsman noted that clarifying the biographical information of a

person with memory disorders was important in order to respect their preferences and, for example, religious beliefs. It is, therefore, the view of the Deputy-Ombudsman that residents' biographical information can and should be inquired about in elderly care units. However, data protection and data security must be observed in the care unit in accordance with legislation. This does not conflict with the need to inquire about biographical information from clients or their relatives for the purpose of delivering high-standard care. Since the Deputy-Ombudsman found that data protection law had, in this respect, been generally misinterpreted, it was important that relevant care units were informed about the correct interpretation of the law. The unit in question has since changed its practice following the Deputy-Ombudsman's decision (4922/2019 Saukoti).

Protection of privacy

Some of the rooms at a care facility had doors with a narrow glass window allowing a view into the room. The members of staff reported that the windows were difficult to cover. They also found it convenient that they could monitor the wellbeing of the residents without waking them up by opening the door. The Deputy-Ombudsman drew attention to the lack of privacy and required that doors like this be altered to protect the residents' privacy. The Deputy-Ombudsman requested the unit to provide clarification on the remedial measures (3763/2019 Pakilakoti).

The Deputy-Ombudsman stated that a high standard of care includes respectful treatment. The Deputy-Ombudsman considered it inappropriate to keep a resident's catheter bag in full view. It was hung on the back of a resident's wheelchair, including when spending time in the common areas. The Deputy-Ombudsman found that respecting the dignity and privacy of a resident cannot solely depend on whether their relatives have provided sufficient supplies for them (4922/2019 Saukoti).

Self-monitoring plan

A unit delivering institutional care for the elderly was to ensure that its self-monitoring plan was reviewed and updated. The plan was also to be made available to the staff and relatives without a separate request. It was also recommended that the self-monitoring plan be made publicly available on the website of the unit of the local authority (1764/2019 Mariahemmet).

The original self-monitoring plan had been drawn up in 2015. The entire staff had been involved in authoring the plan. The plan had been updated in 2017 and 2019, but no revision dates were indicated on the plan, and the updated plan had not been signed off. At the time of the visit, the self-monitoring plan was not publicly available, and the staff were not aware of where it was kept. The Deputy-Ombudsman emphasised that sufficient and appropriate self-monitoring can only be achieved if staff are aware of the content and objectives of the plan. The Deputy-Ombudsman recommended updating the plan together with the staff. The plan was also to be made publicly available (4922/2019 Saukoti).

The self-monitoring plan should be added, with procedural guidance on the implementation of the notification obligation, and it should be ensured that all staff members are familiar with the guidance. It is essential for the purpose of honouring a person's legal rights while ensuring effective self-monitoring that the person in charge of self-monitoring at the unit is knowledgeable about applicable laws, regulations, and recommendations, and takes them into consideration when planning and exercising self-monitoring (5595/2019 Himminkoto).

The use of restrictive measures

Restrictions on the fundamental rights of care recipients in elderly care are not provided for in the law. However, the established view of legality oversight authorities is that restrictive measures applied to elderly residents must be subject to a physician's permission. The use of restrictions should be monitored by the staff and the physi-

cian. Restrictions may not be used to any greater extent or for longer than is necessary, and the methods used must not be excessive for the purpose.

The Deputy-Ombudsman drew attention to the fact that a unit did not have written guidelines on restrictive measures. Moreover, restrictive measures were not addressed in any detail in the self-monitoring plan. The Deputy-Ombudsman required that care policies and practices be clearly recorded in the self-monitoring plan. The main goal must be to avoid the use of restrictive measures and to make a plan for alternative methods. The unit had several restrictive measures in place. The grounds for the measures and the name of the person who had authorised them had not been recorded in the care and service plans. The Deputy-Ombudsman required that the unit make sure, for each resident individually, that the restrictive measures applied are based on a physician's decision and that this decision is duly recorded. In addition, it was important to ensure that the necessity of restrictive measures be continuously assessed (4922/2019* Saukoti).

The Deputy-Ombudsman drew attention to the documentation of decisions on restrictive measures. The self-monitoring plan included a mention that restriction decisions could be made for a maximum period of one month. Among the restriction decisions submitted to the Deputy-Ombudsman, there was a decision issued by a physician according to which the restrictions were to be reassessed in one year's time at the latest, when the decision would expire. The Deputy-Ombudsman found that a restriction on a resident's freedom of movement is permissible only on the basis of a physician's decision. The physician should ensure that restrictive measures are not used to any greater extent or for a longer period of time than necessary. A restrictive measure may be introduced only if there is no other alternative, less restrictive method available. Residents' records must include information on the use of restrictive measures, and the use of restrictive measures must be stopped immediately as soon as they become unnecessary. Restrictive measures should be discussed with the resident themselves, or their relatives or next of kin, before their use. Restrictions cannot be based solely on the consent of a relative or next of kin (1765/2019 Villa Rosa).

According to the unit's self-monitoring plan, restrictive measures were used only in extreme cases. The restrictions applied included a wheelchair seat belt and raised bed rails at night. According to the plan, involuntary treatment and its criteria are regulated separately in, for example, the Mental Health Act and the Act on Social Work with Substance Abusers. At the time of the NPM visit, one resident was wearing back-zip overalls. No other restrictive measures were observed during the visit. It was noted that the supporting and/or restriction of a resident's right to self-determination was described in the self-monitoring plan mainly from the perspective of the health-care assistants and medical care. Some of the restrictive measures in use had not been specified in the principles for restrictive measures, and the principles for their application had also not been described. The Deputy-Ombudsman drew attention to the fact that the elderly care unit in question did not, as such, deliver involuntary treatment. None of the units referred to were authorised to deliver involuntary treatment measures without a specific legal basis. In order to avoid misunderstandings, the Deputy-Ombudsman recommended that concepts related to self-determination and involuntary care be further clarified in the self-monitoring plan (2009/2019 Lizeliuskoti).

A unit was applying restrictive measures subject to a physician's assessment and decision, according to the guidelines. According to the Deputy-Ombudsman, the physician should visit the unit frequently and meet all the residents at regular intervals. Where meetings with residents are rare, there is a risk that the use of restrictions will continue, even if they are no longer necessary (3763/2019 Pakilakoti).

Definitions of restrictive measures

In a 24-hour residential service unit for persons with memory disorders, a chair would be placed in front of the door of a single-occupant room at night to alert the staff if the resident attempted to leave their room. According to the staff, the resident in question was in the habit of wandering around the unit at night and going into the rooms of other residents. The Deputy-Ombudsman considered the approach adopted by the unit inappropriate because the restriction on movement constituted a restriction on the resident's right to self-determination and freedom. The chair also posed a potential safety risk. The Deputy-Ombudsman recommended that the unit consider other ways to resolve the situation (2009/2019 Lizeliuskoti).

It was discovered during a visit that the staff were not always able to recognise a restrictive measure. The Deputy-Ombudsman emphasised the importance of understanding the concept of restriction, so that the staff would be able to make the right decisions. For example, a resident has the right to prevent another resident from entering their room. Closing a door and placing an obstacle in front of the door does not violate another person's freedom of movement. However, if the door of the resident's own room is closed because of another resident's behaviour while they themselves wish to keep the door open, or they are unable to make their preference known, this constitutes a restriction. According to established legal practice, a person cannot give consent on behalf of another person to use restrictive measures. A relative or next of kin cannot give definitive permission on behalf of a resident to close a door. The Deputy-Ombudsman noted that security is not in itself sufficient reason to restrict a person's fundamental rights, as each restriction of a fundamental right must meet all criteria for restrictions, such as the requirements of necessity and proportionality. When weighing various options, the goal is to ensure that a person receives appropriate care and is not subject to abandonment. If a situation arises in which a person is in immediate danger, it is possible to intervene in the situation based on self-defence or compelling circumstances. However, self-defence and compelling circumstances are relevant only in acute situations. They cannot be referred to as a justification for locking doors.

It should be possible to deliver appropriate care and treatment without compromising the rights and safety of other residents. With insufficient staffing, locking the door of a resident's room may be dangerous, even if the resident has asked for their door to be locked. It must be possible in the case of fire for residents to leave the building or to be evacuated. The Rescue Act has special provisions on evacuation safety in residential units. Locking a person in their room, especially if the unit does not have staff on site at all times who can rapidly evacuate the residents, poses a serious fire safety risk. However, if the door mechanism and the resident's functional capacity allow them to open the door by themselves both from the inside and outside, the resident will not be restricted, and their safety will not be at risk. However, in assessing the situation, it must be taken into consideration that it may not be possible for a person to unlock their door if they are alone and in distress (5595/2019 Himminkoto).

Palliative treatment and end-of-life care

The dignity, humane treatment, and self-determination of a resident at a care unit must be safeguarded at all times, including during palliative treatment and end-of-life care. For this reason, principles governing palliative treatment and end-of-life care must be documented in the unit's self-monitoring plan. In addition, it should be ensured that the staff are trained and instructed in the delivery of appropriate palliative treatment and end-of-life care (1842/2019 Pihlajakoti).

The delivery of palliative treatment and end-of-life care should be based on a predictive care plan and end-of-life care decision that has been drawn up well in advance (2009/2019 Lizeliuskoti).

In the short-term care ward of a care unit, the physician in charge made the decision on end-of-life care in acute situations, and the care was delivered as part of home nursing. In these situations, it was possible to have extra staff on duty and the patient would be placed in a private room. Family members were able to stay the night on the ward. In the long-term care ward, the aim was to give residents a private room for the duration of end-of-life care, but this was not always possible. A family member was able to stay the night with the patient, who would be given a private room. Palliative medication was available on the ward, and administration of intravenous medication was taken care of by the home nursing team. The Deputy-Ombudsman welcomed the fact that a number of staff members at the unit had received training in end-of-life care, and they were available for other staff members for consultation. The Deputy-Ombudsman suggested increasing training in end-of-life care so that each member of the nursing staff could participate in it. When reviewing the end-of-life care guidelines, the national guidelines for palliative treatment and end-of-life care should be referenced (3763/2019 Pakilakoti).

The Pakilakoti nursing home features a pleasant outdoor area.

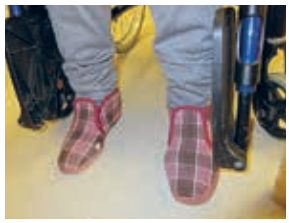
Outdoor exercise and stimulating activities

Providing sufficient time outdoors is part of caring for the residents' basic needs and respecting their human dignity. It is important that residents with memory disorders but a high level of physical function should have the opportunity for regular outings. Special attention should be paid to those residents who are unable to move independently and cannot clearly express their views. The time planning for the entire staff should allow adequate time for outdoor exercise and stimulating activities in accordance with the needs of the residents (4921/2019 Niva, 5023/2019 Onnela).

The Deputy-Ombudsman found the 24-hour residential service for persons with memory disorders somewhat understaffed. The Deputy-Ombudsman drew attention to the fact that long-term treatment and care should also include access to personalised stimulating activities, outdoor exercise, and the maintenance of social relationships (2009/2019 Lizeliuskoti).

The unit aimed to offer various outdoor activities as much as was possible. In short-term care, daily coffee breaks were held outdoors. It was emphasised at the long-term care ward that sitting on a balcony could not replace outdoor activities. However, there were no systematic records of the residents' access to outdoor activities. The ward has volunteers visit once a week to take the residents outdoors. In addition, the time use of holiday cover staff is directed towards outdoor activities. When other acute duties took longer than anticipated, the time for outdoor activities was reduced. For residents who actively expressed their wish to spend time outside, more opportunities for outdoor activities were arranged. The Deputy-Ombudsman emphasised the importance of giving residents daily access to outdoor activities. With no systematic records in place, there is the danger that individual residents end up inadvertently spending long periods of time indoors. The Deputy-Ombudsman recommended that outdoor time be included in the residents' care and service plan and that the execution of each plan is monitored (3763/2019 Pakilakoti).



The Deputy-Ombudsman welcomed the contribution of volunteers who took the residents at the 24-hour residential service unit outdoors. However, the access of the residents to the outdoors cannot rely on volunteers alone. Sufficient and regular outdoor activities should be arranged based on the residents' needs. Outdoor activities should be included in the resident's care and service plan with a daily monitoring practice in place, involving either customer-specific records or a unit-specific list, to ensure the completion of the plan (5595/2019 Himminkoto).

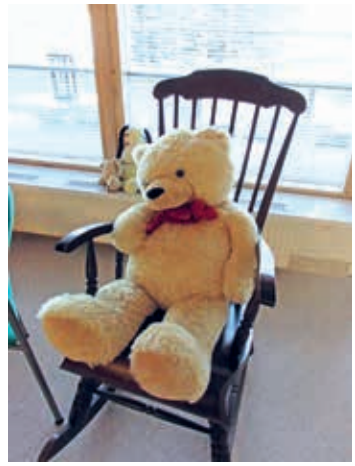
Physician's services

The Deputy-Ombudsman welcomed the fact that the nursing staff on the ward had the opportunity to consult a doctor through various channels, including times when the doctor was not at the unit. However, it was considered a disadvantage that the actual appointments with patients were very few and that they were carried out by a specialist in general medicine. The residents were severely memory-impaired elderly care recipients considered to need institutional care. The Deputy-Ombudsman found that the ward should also employ a consultant in geriatrics (3763/2019 Pakilakoti).

Oral health care

The care plans at a care unit included no information on the oral and dental care of the residents or even whether the resident had their own teeth or dentures. The daily notes could include sporadic mentions of brushing a resident's teeth. The Deputy-Ombudsman noted that oral and dental health is of great importance in the well-being and general health of an elderly person. Therefore, more attention should be paid to daily oral and dental hygiene (1764/2019 Mariahemmet).

The unit was visited by a dental hygienist if the resident themselves had booked an appointment. There was nobody with specialised knowledge of oral health on the staff. Efforts were made to take notes about dental care. The goal was to deliver dental care twice a day, but this was not always possible due to the workload of the nursing staff. If necessary, relatives would book a dental appointment for a resident. The nursing staff also had the opportunity to be in contact with dental care if a resident had an acute need for dental care. The Deputy-Ombudsman noted that regular tooth brushing prevents many oral conditions and is beneficial for overall health and well-being. For patients with memory disorders, oral pain can cause anxiety and restlessness, and can make it difficult to eat. Regular tooth brushing is an integral part of good treatment and care of every elderly person. The unit should make sure that regular tooth brushing was not neglected. If the brushing had to be skipped during the shift, this needed to be recorded in the notes so that the matter could be rectified later. The services of a dental hygienist should be available to all residents. The



Pictures of units for the elderly.

unit should also provide a dental care plan by a dentist without delay and ensure that the staff adhere to the plan (4921/2019 Niva).

No separate guidance for the oral health care of the residents with memory disorders at the unit were available, and the services of a dental hygienist were not available. The Deputy-Ombudsman pointed out that oral hygiene should be part of daily care. If dental care is not monitored and recorded, the residents may go without dental care for extended periods of time, and problems arising from poor oral hygiene may go unnoticed (3763/2019 Pakilakoti).

The checklist for the nursing staff in a group home showed that special attention was paid to the oral health and dental care of the residents. The dental hygienist from the local health centre visited the unit once a year to check the oral health of each resident. If necessary, the hygienist referred a patient to the dentist. If a resident needed acute dental health, they were taken to the dentist. The Deputy-Ombudsman commended the correct approach of an annual dental check to maintain good oral health among the residents. The Deputy-Ombudsman finds it important to ensure on arrival that a new resident has a recent dental care plan in place and that the staff are aware of what steps to take to follow that plan. Maintaining oral health also requires that the nursing staff have a general understanding of how oral health is maintained and how various oral diseases can be prevented. The Deputy-Ombudsman recommended that the care facility organise staff training in oral health (3015/2019 City-koti).

3.5.16 RESIDENTIAL UNITS FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

A goal set in the 2012 Government Resolution on independent living and services for persons with intellectual disabilities was that no disabled person will be living in an institution after 2020. The Finnish Association on Intellectual and Developmental Disabilities reports that the customer volumes in 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 fewer than 1,000 intensified assisted living units for people with learning disabilities in Finland, and approximately 400 of these are run by private service providers. There are 22 institutional care units, of which only one is run by private service providers. The majority of these units employ restrictive measures.

On visits to units providing institutional care and residential 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 the 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 a person 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 NPM 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 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 and the promotion of inclusion, are discussed in more detail in section 3.4.

The Parliamentary Ombudsman and the Human Rights Centre have jointly prepared a project with the aim of promoting the fundamental and human rights of assisted living services for persons with learning disabilities. The project is also introduced in section 3.4.

The number of residential units for persons with learning and physical disabilities visited in 2019 was 8 (compared to 11 in 2018). Three of the visits were made unannounced. One unit was run by private service providers. One of these was offering intensified round-the-clock assisted living services for adults with severe disabilities It was also suitable for adults with neurological conditions (such as ALS). At the time of the visit, the unit also had one resident who was in hospice care. Another unit run by the private service provider offered temporary individual and rehabilitative round-the-clock care to children and adolescents with learning disabilities, severe disabilities, and autism spectrum disorders. The other sites visited were mainly units for persons with intellectual disabilities. In one of the units visited, there were disabled residents under involuntary special care.

The sites visited were:

date of inspection	target	number of inmates	case number	other
21 March 2019	Omakoti Oiva, Mehiläinen Oy, Vantaa	10 places	1683/2019	
21 March 2019	Tilapäishoitokoti Alma, Mehiläinen Oy, Vantaa	7 places	1684/2019	
4 April 2019	Eteva Joint Authority's residential service units, Nurmijärvi	33 places	2008/2019	
5 November 2019	KTO Medical care, research and rehabilitation unit, Paimio	11 places	5491/2019	3 external experts included
5 November 2019	KTO Neuropsychiatric research and rehabilitation unit NEPSY1, Paimio	13 places	6769/2019	3 external experts included
5 November 2019	KTO Neuropsychiatric research and rehabilitation unit NEPSY2, Paimio	16 places	6770/2019	3 external experts included
5 November 2019	KTO Neuropsychiatric research and rehabilitation unit for children and adolescents, Paimio	10 places	6771/2019	3 external experts included
5 November 2019	KTO Neuropsychiatric crisis and research unit, Paimio	20 places	6772/2019	3 external experts included

#= unannounced inspection

The NPM visits conducted in the KTO units included participation by several external experts. One of them was a medical expert specialized in intellectual disability medicine. Two other external experts were representatives of the Sub-Committee on the Rights of Persons with Disabilities, which operates under the Human Rights Delegation of the Human Rights Centre. An expert 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 2018, but with opinions issued in 2019.

Human resources

The Ombudsman has emphatically drawn the attention of both private and public service providers to the issue of understaffing. With regard to the private sector operator, the Ombudsman noted that the number of staff must be at least equal to that required in the licence and the Act on Private Social Services. Challenges in recruitment do not justify deviation from the minimum staffing as based on the unit's operating licence. The Ombudsman was also concerned about the long shifts of some nursing staff members, which may have a detrimental impact on their

capacity and the delivery of care to the residents (1683/2019 Omakoti Oiva).

The service provider reported that the problem of understaffing had been resolved during the spring.

Regardless of the notification, the Ombudsman requested that the licensing and supervisory authorities monitor the adequacy of staffing by the service provider and the staff allocation, within their respective spheres of jurisdiction.

With regard to the public service providers, the Ombudsman emphasised that care should be taken at a unit providing intensified assisted living services for persons with learning disabilities that the residents are guaranteed round-the-clock care, treatment, and monitoring, as required by their individual needs (2008/2019 Eteva).

Temporary nursing home Alma encourages residents to exercise their right of self-determination.

Promotion of self-determination

The Ombudsman has emphasised that in the social care units, situations should be resolved through methods other than restrictive measures. These methods include individual service planning, preventive procedures and development work, and reasonable adjustments made in individual cases. The primary goal should always be to support an individual's right to self-determination.

Where restrictions are placed on the personal freedom or self-determination of a person with a disability, it must always be ensured that no other, less restrictive methods are available. Restrictions should never be applied to a greater extent or for a longer period of time than is necessary. The Ombudsman finds it important that the use of restrictive measures is supervised. The legality of restrictive measures should ultimately be evaluated in court. If the use of restrictive measures is not based on law, the right to self-determination is not honoured in practice.

Identifying restrictive measures

Residential unit staff are not always aware of what constitutes a restriction. It was discovered during a visit that the freedom of movement outside the unit was restricted for all residents for reasons of safety. The door leading from the unit to the stairwell was always kept locked. The unit could be exited only with a key, which the children were not given. According to the staff, all the children and adolescents placed in the home needed adult support and/or supervision when moving outside. According to the self-monitoring plan, the restrictions on a child's freedom of movement were agreed on in cooperation with the social services and families. The restrictions were based on a medical evaluation, and they were always motivated by a child's own safety. None of the children had been issued decisions under the Act on Special Care for the Persons with Intellectual Disabilities on supervised movement, even in cases in which the child's freedom of movement had been restricted.

According to the staff, the supervised movement of children had been discussed with the local authorities responsible for the cost of the chil-

dren's accommodation, but the authorities had not required any decisions to be made. The local authorities had not paid attention to the issue during their own inspections. The freedom of movement of children who could not be subjected to restrictions under the Act of Special Care for Persons with Intellectual Disabilities was nonetheless restricted. The Ombudsman decided to take the issue of the procedure and decision-making process concerning the restrictive measures applied by the service provider and the residential unit under investigation on his own initiative (1684/2019 Tilapäishoitokoti Alma).

The door of the group home was kept locked on the inside and outside, but a staff member was not always present. The movements of the residents were also monitored with technical equipment. The Ombudsman noted that the practice seemed to meet the criteria for restrictive measures under the Act on Special Care for the Persons with Intellectual Disabilities. Supervised movement should always be based on a written decision open to appeal. The Ombudsman also noted that when a person is placed under supervised movement, it is important to ensure that the freedom of movement of other persons is not restricted at the same time (2008/2019 Eteva).

The NPM was informed that no "actual" restrictive measures were used in the unit, but raised bedrails were sometimes used for reasons of safety. In many cases, the resident's consent could be obtained for the purpose. It was noticed during a visit that the doors downstairs leading from the group homes to the lobby were locked. This meant that the fundamental right to personal liberty of residents, who could not get out of the unit upon request or with their own key, was effectively restricted (3351/2018 Valkamahovi).

Decisions on restrictions

It was noted during the NPM visit that the grounds cited for the restriction decisions were very uninformative. The decisions did not include instructions on how to appeal, and the person authorising the decision also remained unclear. The Ombudsman drew the service centre's attention to these shortcomings. Each decision must clearly indicate the name of the public official issuing the decision. The decisions must include a description of how the criteria for a restrictive measure are met for the subject of the decision. The Ombudsman also pointed out that the decision on the repeated use of restrictive instruments or clothing in dangerous situations must clearly indicate the maximum period of time for which restrictive instruments or clothing can be applied at one time, and the reasons why other available methods are not appropriate and sufficient in the given situation. The Ombudsman emphasised that when making a decision, expert assessments must be requested and taken into consideration (3375/2018 Kolpene joint authority, service homes Metsärinne, Mäntyrinne, and Mustikkarinne).

The director of the joint authority recounted during the debriefing of the NPM visit that the issue of the appeal instructions would be remedied immediately.

The joint authority has since reported that the service managers at the service centre had been verbally instructed on the correct procedure for making decisions on restrictive measures. The guidance on the right of self-determination is currently being updated, and more detailed instructions on making decisions on restrictive measures will be added.

Restrictive measures

Safety belt and wrist cuffs

It was discovered during a visit that a safety belt and wrist cuffs were used to control a resident's compulsive movements and to prevent them from disturbing the PEG feeding tube button (Section 42 k of the Act on Special Care for the Persons with Intellectual Disabilities). It had been taken into consideration in the decision passed by the office holder that the restrictive equipment would not restrict the voluntary movement of limbs and body parts to more than a minor degree, and they would be used for as a short a period of time as possible (3375/2018 Kolpene). The Ombudsman decided to take the issue of safety belts and wrist cuffs and the related documentation practices under investigation on his own initiative.

Wrapping a resident in a rug

A resident at a care unit was prevented from harming themselves and others by being wrapped in a soft rug, leaving their head free. The wrapping method was said to help calm the resident down and to minimise the consequences of the episode. Usually the resident would calm down in less than an hour, after which the rug would be removed. If the rug is not used, it takes several hours for the individual to calm down. The NPM had constructive dialogue with the care unit staff about the wrapping method and the possibility of other methods (such as a weighted blanket) replacing the use of a rug The staff reported that the resident themselves felt that the rug was a good method for calming down. On occasion, the resident wanted to be wrapped in a rug at their own request.

The Ombudsman found the method of wrapping a resident in a rug to be problematic. It prevented the individual from moving and was similar to restraining. According to the Act on Special Care for the Persons with Intellectual Disabilities, restrictive equipment or clothing may be used in highly dangerous situations only. A person can be restrained only if no other method proves sufficient. The Ministry of Social Affairs and Health only recognises medical restraining equipment as a legal form of restraint. The legality of restrictive measures used in the care of persons with learning disabilities 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 noted that restrictive equipment must comply with the requirements of the Act on health care devices and equipment (3375/2018 Kolpene).

Mat used as a restrictive measure.

The joint authority commented on the draft report that the use of the restraining method in question had been discontinued following the NPM visit.

Debriefing of restrictive measures

The Act on Special Care for the Persons with Intellectual Disabilities requires that restrictive measures must be followed by a debriefing, which must be documented. However, observations made during the NPM visits suggest that debriefings and their documentation are not always carried out as required by law. The Ombudsman drew the service centre's attention to the fact that the person subject to the restrictive measure must be invited to a debriefing to discuss the reasons for and impact of the measure. The law regulates

in great detail what information must be recorded (3375/2018 Kolpene).

The joint authority reported that the staff have received guidance on the evaluation of the use of restrictive measures and their documentation in the client records.

Privacy of residents

The Ombudsman has referred to the Convention on the Rights of Persons with Disabilities (CRPD) and noted that the goal should be for each person with a disability living in a residential unit to have access to a private room, including a bathroom.

The unit had four apartments, with two apartments sharing a toilet and shower facilities. The bathrooms were located between two apartments with direct access from the apartments to the space. According to the staff, sharing the facilities had not presented problems because the residents used them at different times. This was because the residents required assistance in personal hygiene. 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 apartments. The need for a private toilet and shower room is emphasised in long-term accommodation (1683/2019 Omakoti Oiva). This principle should also be observed in temporary care and accommodation services (1684/2019 Tilapäishoitokoti Alma).

In the view of the Ombudsman, the use of a technical listening device at a resident's apartment could prove problematic from the perspective of privacy and private life (2008/2019 Eteva).

Positive observations and good practices

The resident had a bed which was lowered for the night. A soft bedside rug was used to soften any possible fall from the bed (3375/2018 Kolpene).

Two residents had been provided with activity passes. These included personal information

Power outlets in the rooms of the Tempo housing unit residents can be either on view or behind a locked door, according to an individual assessment.

on guidance and communication for the resident, meaningful activities, and the anticipation and handling of challenging situations (3375/2018 Kolpene).

The NPM found it commendable that spatial design had been used to support the resident's self-determination and wellbeing. This was made possible by the spacious architecture of the service home. The unit offered its resident a sensory room, an echo room (empty room), and a workshop for a resident who was unable to go outside the unit for daytime activities. The needs of two residents with challenging behaviours had been met by placing them in sub-units with several rooms. The solution effectively supported their rehabilitation. A resident with impaired hearing has a doorbell outside their room that activates a flashing light inside the room. The staff push the doorbell before entering the room, so the resident's room cannot be accessed by surprise and without the knowledge of the resident (3375/2018 Kolpene).

3.5.17 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 and geriatric care units), or where persons deprived of liberty are treated (VTH).

The Ombudsman and the NPM collaborate in the health-care sector with the National Supervisory Authority for Welfare and Health (Valvira) and Regional State Administrative Agencies (AVI). Before NPM visits, as a rule, the competent Regional State Administrative Agency is contacted in order to gain information on its observations and possible measures concerning 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. During 2019, this practice was followed during the visit to Harjavalta Hospital. The final NPM visit report is also delivered to the AVI for information.

Background information is requested from the health-care unit's patient ombudsman before each visit. According to the Act on the Status and Rights of Patients, a patient ombudsman shall be appointed for each health care unit. A patient ombudsman's task is amongst other things to inform patient of their rights. The final NPM visit report is also sent to the patient ombudsman for information.

Owing to the large number of health-care facilities 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 the most coercive measures are taken, and where the patients are most challenging. These include the state forensic psychiatry clinics (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 studies 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 always attended by an external medical expert. Involving a medical expert in the visits has made it possible to address the use of restrictive measures from a variety of angles and to explore ways of preventing their use.

Visits to psychiatric units are nearly always unannounced. However, the unit may be notified in advance by letter that a visit will be made within a certain period of time. This lets the NPM 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 discussions with the NPM: for example, the patient last admitted to the ward, or the patient who has spent the longest time on the ward.

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

A draft of the NPM 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 preliminary recommendations already at this stage. The Ombudsman welcomes this development as an indication of constructive dialogue.

A total of 15 visits were made to health-care units in 2019 (compared to 10 in 2018). The focus of the visits to health-care units was on somatic care for elderly patients. The following visits were made:

date of inspection	target	number of inmates	case number	other / previous inspection visit
26 March and 3 April 2019	Espoo Hospital	247 beds	1706/2019	external expert included
26 March 2019	HUS Jorvi, joint emergency clinic		1707/2019	external expert included
8-9 May 2019	Katriina Hospital, Vantaa	163 beds	2458/2019	2 external experts included
9 May 2019	HUS, geriatric psychiatric research and care	7 beds	2759/2019	2 external experts included
15 May 2019	Vantaa Hospital, acute geriatric unit	48 beds	2456/2019	external expert included
28 May 2019	Psychiatric Prison Hospital, Turku Unit	40 beds	2570/2019	Deputy-Ombudsman and external expert included, previous visit 2009
29 May 2019	VTH, Turku outpatient clinic		2571/2019	external expert included, previous visit 2016
11-12 June 2019	Satakunta Hospital District psychiatric wards/ Harjavalta Hospital	102 beds	2301/2019	3 external experts included, previous visit 2008
11 June 2019	Satakunta Hospital District Satasairaala joint emergency unit		3009/2019	2 external experts included
11 June 2019	Keski-Satakunta joint authority for health care, Harjavalta Health Centre Hospital	30 beds	3264/2019	external expert included
13 June 2019	Pori City Hospital	148 beds	3007/2019	2 external experts included
3 September 2019	Pelkosenniemi-Savukoski joint authority for public health, inpatient ward	12 beds	5022/2019	Deputy-Ombudsman included
16 October 2019	TAYS Pitkäniemi Hospital, geriatric psychiatry	17 beds	5592/2019	external expert included
16 October 2019	Hatanpään puistosairaala, geriatric psychiatric wards	28 beds	5593/2019	external expert included
6 November 2019	VTH, Sukeva outpatient clinic		5468/2019	previous visit 2015

#= unannounced inspection

The visits to VTH units were announced in advance. The rest of the visits were made either completely unannounced (emergency clinics) or the sites were informed that an inspection visit would be carried out within a certain time period.

Visits to elderly care units

Adequate staffing

A "hybrid ward" had only one night nurse, which the Deputy-Ombudsman found a matter of concern. The ward had a number of separate corridors. Covering two wards seemed a challenging task, especially if a patient required two nurses for handling or was restless (2458/2019 Katriina Hospital).

The Deputy-Ombudsman drew attention to the long shifts of the nursing staff. These could pose a risk to patient safety. The Deputy-Ombudsman urged the managers to actively monitor the workload of the nurses. The Deputy-Ombudsman also recommended that effective measures be identified to recruit more nurses (3264/2019 Harjavalta Health Centre, inpatient ward).

The joint authority reported that the Deputy-Ombudsman's opinion had been forwarded for the attention of the management group of the joint authority and line managers at the health centre hospital. The authority had succeeded in recruiting an adequate number of experienced nurses to cover for planned leave by the nursing staff.

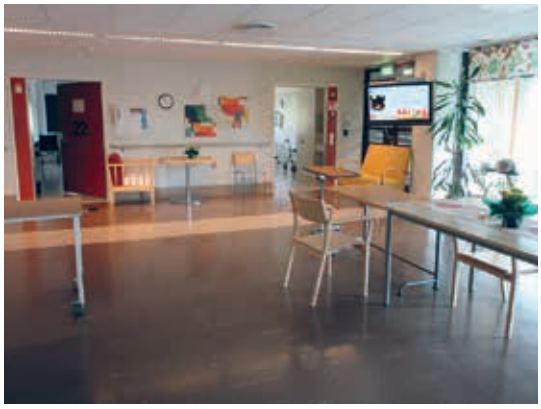
Acknowledging the needs of patients with memory disorders in spatial design

The spaces in hospitals should be well designed and easy to negotiate by their intended users. When caring for the elderly and patients with memory disorders, it is particularly important to support the orientation and functional capacity of the patients through spatial and interior design. The orientation skills of patients with memory disorders can be improved by paying more attention to the distinctive features of patients' rooms and other facilities, such as wall colours and pictures. Finding one's own care unit or room can be made easier by the use of signs and personal items.

Innovation developed in the Pori City Hospital's memory disorder ward, the bus stop.

It was discovered during the visit that a very monotonous colour scheme had been used in the design of the wards. All wards looked remarkably similar. Colour or other visual features had not been used to help distinguish between wards or rooms. The lack of colour and the "clinical" appearance were particularly noticeable on the hospice ward, where comfort and personable details would be of particular importance owing to the nature of the treatment. The Deputy-Ombudsman recommended that the hospital should estimate whether they could improve the interior decoration of the wards or post signs to make it easier for patients with memory disorders in particular to obtain an overall picture of the hospital and its wards and to move around in them (1706/2019 Espoo Hospital).

The patient rooms had no radio or television. The television sets were placed in the common premises. It remained unclear to the NPM whether the seclusion rooms had television sets. The arrangements were intended to motivate the patients to move around. However, the practice was prob-



The ward only had a television in the shared spaces.

lematic, especially if a patient was bedridden or in seclusion. The Deputy-Ombudsman urged the hospital to consider whether the individual needs of the patients could be more flexibly considered in the furnishing of the rooms, without compromising the rehabilitative goals of the care. At least the seclusion rooms should have a television (2458/2019 Katriina Hospital).

The hospital reported that its goal was to support the activeness and independence of its patients to improve their functional capacities and rehabilitation. Following the NPM visit, the common premises have been improved to better meet patients' needs. The aim is to increase the number of activities for the patients during the day. As a result, the patients are encouraged to participate in daytime activities and move as much as possible within the limits of their health and functional capacity. For this reason, television and other stimulating activities are kept mainly in the common premises. In addition, the hospital wants to consider the individual needs of patients more flexibly, including in situations where a patient may be unable to spend time and participate in activities in the common premises. Seclusion rooms can be furnished with a television, as the hospital has movable televisions.

Important decisions concerning treatment

The Deputy-Ombudsman recommended that the hospital provide guidelines to help determine when a decision concerning a patient with diminished capacity is important enough to warrant the involvement of the family or people close to them (2458/2019 Katriina Hospital).

The local authorities reported that, in order to clarify its guidance, the hospital has launched a guidelines project for predictive care planning. With the guidelines, the role of families will be better taken into consideration in situations in which the patient is no longer able to decide on their own treatment. If the patient is unable to make decisions concerning their treatment, the patient's family members will be consulted. The purpose of consulting the family is to establish what the patient's wishes most likely would be and what would be in their best personal interest. In connection with the guidelines, specific procedures will also be developed to support the staff in implementing the guidelines and ensure that the staff are aware of the guidelines. The guidelines will be updated annually in the future. The guidelines are drawn up as a multiprofessional collaboration and they were scheduled for release in February 2020.

Discharging an elderly patient

Discharging a patient is a crucial and also a risky stage from the perspective of patient safety. The discharge process should be seamless so that good communication between service providers is ascertained and services are delivered on time without disruptions. The City of Espoo and Espoo Hospital have acknowledged a number of problems related to patient discharge and have taken measures to improve their processes. The Deputy-Ombudsman considered this issue to be of major importance and considered it necessary that development measures be continued and the situation closely monitored in the future (1706/2019* Espoo Hospital).

With elderly patients, it is often necessary to involve a representative from social services in the planning and implementation of the discharge process. The Deputy-Ombudsman reiterated that a patient who is unable to manage independently at home should not be discharged before making sure that there is someone to meet the patient at home and that all services required by the patient are arranged (3264/2019 Harjavalta Health Centre, inpatient ward).

According to the joint authority, cooperation between municipal residential units and care homes, as well as home nursing, has been successful. Patients are never discharged without a realistic chance of coping. The discharge process has been allocated plenty of resources: there is a full-time nurse on the ward concentrating exclusively on patient discharge.

Patients waiting for a place in a care facility

A hospital ward had patients waiting for a transfer to a care facility who no longer required hospital care. At the time of the NPM visit, there were five and eight patients on two wards, respectively, waiting for a place in a care facility. The waiting time for a care home place could be months. According to the information provided by the local authority, it was able to organise care places within the maximum time of three months, as determined by law. Waiting for a care place did not, according to the hospital, mean that the patient's rehabilitation was suspended. However, the NPM finds that the above factors were impairing the progress of the care chain. Patients kept on hospital wards "for no real reason" took up beds that could have been used for patients who required hospital treatment. Those waiting for a place in a care facility did not have access to appropriate activities, outdoor exercise, and a home-like environment, in accordance with the care plan. While at hospital, the patients were also unnecessarily exposed to infections and were at risk of becoming institutionalised (2458/2019 Katriina Hospital).

According to information received from the local authority, the goal of the hospital was to facilitate a speedy return to the patient's own home or a home-like residential environment. The planning of discharge begins as soon as the patient arrives at the hospital. The hospital has initiated the development of proactive and supported discharge together with the providers of independent living services.

The Deputy-Ombudsman decided to take the problems in allocating care facility places under a separate investigation.

The Deputy-Ombudsman drew attention to the fact that, for some patients, the inpatient ward had become a much longer-term solution than their health situation required. Owing to the lack of exercise in a hospital setting, the functional capacity of the elderly may rapidly deteriorate. In these situations, active efforts should be made to seek other solutions for the care and treatment of the patient (5022/2019 Pelkosenniemi).

Methods to avoid the use of restrictions

The NPM was informed that various measures were taken in the course of the delivery of care to prevent the occurrence of patients' behavioural symptoms and the associated risk of mistreatment. The non-pharmaceutical methods included music, physical exercise, and stimulating and creative activities. The aim was for the patients to leave their beds; this means that all patients were assisted as needed. The unit also paid attention to the manner in which patients were approached. The guidance was that care is delivered taking an individual patient's natural daily rhythm into account.

The importance of recognising different behaviours was emphasised at the unit, and different situations were regularly discussed. For example, the acoustics of the spaces and the high level of noise, and restless behaviour in the evening were among topics raised. The unit considered outdoor exercise to be of vital importance, and all those who wished to go outdoors could do so. Outdoor time was worked into the daily programme and shifts so that those arriving for their evening shift first took patients outside before changing into their work clothes. The care principles emphasised the importance of engaging with the patients, as

this was believed to create a sense of security and calm on the ward. The nurses' breaks were phased so that there was always at least one nurse in the view of the patients. The nurses did not spend their time in the office but rather in the company of the patients. The fruits of this approach were clearly visible during the NPM visit. The choice and the personality of the nurse assigned to a patient was also carefully considered.

All employees had attended the MAPA (Management of Actual or Potential Aggression) training as well as the Dementia MAPA training, which aims to prevent aggressive behaviour. The nursing staff participate in supervision sessions once a month. The ward had adopted a rehabilitative approach, and the staffing level supported the implementation of the approach. The multiprofessional teamwork was evident in the delivery of care. The ward had its own physiotherapist. There were also three wellbeing assistants, whose role was to offer stimulating activities and to engage with the patients (5593/2017 Hatanpää).

In special observation (100% observation), the nurse remains close to the patient at all times. There are three levels of special observation: 1) intensive observation, 2) within eyesight, 3) within arm's length. On one ward, one nurse was involved in special observation, and on another ward sometimes even two. The most common reason for special observation was the risk of a fall. If special observation was required, this was based on a physician's decision that was documented in the patient records. According to information obtained from the hospital, the physician determined the required number of nursing staff based on a medical assessment (risk of self-harm, aggressiveness, restlessness, patient safety, risk of falling).

The Deputy-Ombudsman welcomed the method of using special observation for the prevention of falls in the care of the elderly with memory disorders. The special observation approach reduced the need for restrictive equipment and supported the patient's rights to freedom of movement and self-determination. Special observation is also a suitable method in other situations where there is no imminent risk of violence. The staff all gave consistent descriptions to the NPM of the practices adopted in special observation. However, the written guidance referred to special observation only as part of seclusion. The Deputy-Ombudsman recommended updating the guidance to correspond to the actual practice on the ward (5592/2019 Pitkäniemi).

Restrictive measures

The Deputy-Ombudsman welcomed the wide adoption of the special observation method on the wards, as this eliminates the need for some of the more restrictive measures. The NPM was told that sometimes a patient must be restrained to their bed for the time a nurse needs to step out of the section. Following the visit, the hospital reported that the nursing staff leaves the section or room of a patient under special observation only in exceptional circumstances. The Deputy-Ombudsman found it problematic that the practice was for a patient to be restrained "to be safe" for the period the nurse had to leave the patient. Moreover, understaffing is never an acceptable justification for restraining a patient (1706/2019 Espoo Hospital).

The restrictive measures adopted at the hospital were: 1) restraint belt (waist strap with possible wrist and/or ankle straps), 2) pelvic strap (while the patient is seated), 3) back-zip overalls, 4) raised bedrails, and 5) sedative medication. Furthermore, the doors of one ward were locked, and at least some patients were prevented from leaving the ward. Based on the records, the use of restrictions seemed justified in most cases. Decisions on restrictive measures were made by a physician. However, it appeared that raised bedrails and back-zip overalls were not considered methods of restriction. The duration of restrictive measures was also not defined. Permission to use restrictions could be granted beforehand, particularly before weekend shifts (2458/2019 Katriina Hospital).

The anti-strip jumpsuit has a zipper on the back that cannot be opened by the user. In the picture, a member of the inspection team is trying on the jumpsuit.

The NPM was told that if a patient refused to take medication, attempts would be made to reason with the patient. Patients are not forced to take their medication. The unit used, albeit very rarely, the back-zip overall as restrictive clothing. Its use was not always based on a physician's decision (3264/2019 Harjavalta Health Centre, inpatient ward).

Guidance on restrictive measures and their documentation

In the absence of applicable law, it is vital that care facilities provide sufficiently detailed guidance on the application of restrictive measures. The guidance should include a complete list of all restrictive measures in order to achieve a common understanding among the staff on the concept of restricting a patient's fundamental rights. The guidance should also specify how long a restrictive measure may be applied and how often a physician should re-evaluate the need for the continuation of a restrictive measure.

The documentation should comply with the provisions of the Ministry of Social Welfare and Health decree on patient records. Under the decree, the patient records should indicate the cause, nature, and duration of a measure, as well as the assessment of the impact of the measures on the patient's treatment, and the names of the physician authorising the measure and those delivering the measure. It should also be clearly indicated if the measure is based on patient consent.

The Deputy-Ombudsman noted that the hospital's guidance on protective and restrictive measures failed to give a full list of the restrictive measures in use. These included involuntary administration of medication and technical surveillance, such as camera surveillance. There was also no mention in the instructions of how the patient's relatives are consulted or informed about the use of the restrictions unless the patient is able to decide on their own treatment (1706/2019 Espoo Hospital).

The hospital reported that, in the absence of applicable law, it will utilise the recommendations made by the Deputy-Ombudsman in the development of its guidance on the use of protective and restrictive measures. The guidance was due for an update to align with the Deputy-Ombudsman's recommendation during autumn 2019.

The Deputy-Ombudsman commended the hospital for providing guidance on the use of restrictive measures. The hospital guidance differentiated between protective and restrictive measures, but the grounds on which these definitions were based were not clear from the guidance. Nor did the guidance refer to any applicable regulatory framework or provide a full list of all restrictive measures used. The guidance should also specify

how long a restrictive measure may be applied and how often a physician should re-evaluate the need for the continuation of a restrictive measure. The guidance mentioned the necessity of consulting a "legal representative" of a patient incapable of self-determination, but no definition of a "legal representative" was given. According to the Act on the Status and Rights of Patients, a legal representative refers to a guardian or a person authorised by the patient. If the patient has no such representative, the Deputy-Ombudsman recommended that a close relative or a person closely connected with the patient who is incapable of self-determination be consulted, as provided for in section 6 of the Act on the Status and Rights of Patients. The nursing staff appeared to be well aware of the hospital guidance on restrictive measures. However, the physicians and the ward physiotherapists were not all familiar with the guidance. The Deputy-Ombudsman requested the hospital to ensure that the entire staff was duly informed about the existence of the guidance (2458/2019 Katriina Hospital).

The local authorities reported that the Service Area for the elderly and persons with disabilities would receive updated guidance in accordance with the instructions of the Deputy-Ombudsman. Studying the guidance would be part of the hospital staff's onboarding training. Furthermore, the ward staff and multiprofessional teams would also be expected to study the guidance.

There should be written guidelines on restrictive measures, specifying the restrictive measures to be used at the unit, as well as the grounds and decision-making process for their application and how these measures are monitored and when they must be discontinued. The unit had no such guidelines in place (3264/2019 Harjavalta Health Centre, inpatient ward).

The chief physician in charge of home nursing and institutional care has drawn up written guidelines on restrictive measures, dated 10 February 2020, which are in line with the Deputy-Ombudsman's recommendations.

Monitoring of restrictions

Each unit where restrictive measures are adopted should also monitor their implementation. Without qualitative and quantitative data on the measures adopted, systematic monitoring of the practice is impossible. Monitoring also serves to reduce the systematic use of restrictive measures.

A hospital's quality assurance and patient safety plan and the information on the notice boards on wards showed that a wide range of care-related data was collected at the hospital. No separate statistics on the types of restrictions were maintained, however, and no quantitative data was available. The Deputy-Ombudsman recommended that the hospital start keeping systematic records on the use of restrictive measures (1706/2019 Espoo Hospital).

The hospital reported that it would start systematic monitoring of the most restrictive measures.

No separate statistics on the types of restrictions were compiled at a hospital and no summary of quantitative data was available. The Deputy-Ombudsman recommended that the hospital continually monitor the implementation of restrictive measures and draw up a plan or guidelines to reduce the use of coercive measures (2458/2019 Katriina Hospital).

The local authorities reported that the hospital has adopted guidelines on the use of restrictive measures on patients. As part of developing the guidelines, the systematic and ongoing documenting of the use of restrictive measures will be emphasised. The new patient information system, Apotti, will facilitate better monitoring and record-keeping on the use of restrictive measures. In addition, guidance to reduce the use of coercive measures will be developed in collaboration with Elderly Services and Services for the Disabled.

Restraining as a restrictive measure

Restraining imposes a heavy restriction on a patient's right to self-determination and integrity. Restraining involves serious, even life-threatening risks. A restrained patient must remain under special medical observation for the duration of the application of the measure. The need for observation must be assessed individually for each patient and situation. Therefore, the Deputy-Ombudsman has recommended that patients at a somatic care unit who have been immobilised should be monitored according to the principles provided in the Mental Health Act, at least in situations where the immobilisation has been deemed necessary because of the patient's acutely agitated and confused state. This would mean, among other things, that the status of the restrained patient is constantly monitored so that the nursing staff can see or hear the patient at all times (1706/2019 Espoo Hospital, 2458/2019 Katriina Hospital).

Restricting the freedom of movement

If a patient is prohibited or prevented from moving outside a designated space or area, the practice constitutes a restriction on the freedom of movement. The national legislation of Finland does not offer legal remedies in the event of a loss of the freedom of movement in a somatic care setting, as referred to in the Human Rights Convention. Furthermore, admission to a ward does not require an administrative decision open to appeal. The Human Rights Convention forms a legal provision directly applicable in Finland. According to legal practice, complaints from clients in institutional care have been investigated in the light of the Human Rights Convention, although there is no national legislation governing the matter (e.g. KHO 2013:142).

The ward provided care for patients with various degrees of confusion. The patients were mostly elderly people, but there were also younger patients who had sustained injuries as a result substance abuse. The doors leading outside from the ward were kept locked, and certain patients were not allowed to leave the ward without permission. The Deputy-Ombudsman recommended that the patient or their representative be referred to legal aid if they requested clarification of the legal basis for the patient's deprivation of liberty (2458/2019 Katriina Hospital).

The local authorities reported that the ward had been profiled as a unit for treating and rehabilitating patients with impaired orientation to time, place, and/or person. The patients' moods could be highly volatile, and they could present aggressive behaviours and delusions. Owing to the patients' acute symptoms and to ensure patient safety, the doors of the ward were kept locked. The practice at the ward was that the doors were opened for patients on request if they were capable of independent outdoor activities.

The NPM was told that the doors to the ward were locked so that patients with memory disorders would not wander outside. Patients are allowed out on request unless the staff deem this to pose a risk to their safety. The doors of patients' rooms were not kept locked. If a patient wished to leave the hospital, the patient's capacity to make reasonable decisions and to understand the consequences of their decisions would be assessed. If the patient is considered to be incapable of taking responsibility for such a decision, the patient is not allowed to leave the hospital (3264/2019 Harjavalta Health Centre, inpatient ward).

Outdoor activities

The right of patients in voluntary psychiatric care to spend time outdoors should be at least as equally honoured as it is in involuntary treatment. The aim should be that those whose situation allows, are arranged a possibility to spend time outdoors on a daily basis. This goal should be adhered to systematically, including by increasing the number of staff, if necessary.

For patients who could not go outside alone or with the assistance of relatives, it was not possible to arrange outdoor activities except during the summer, when summer workers oversee the outdoor activities. The Deputy-Ombudsman welcomed the hospital's aim of increasing the patients' access to the outdoors during the summer. However, the situation was problematic, particularly on a ward where the freedom of movement of some patients was restricted. While the average length of stay on the ward was 30 days, some patients stayed on the ward up to one year. In the view of the Deputy-Ombudsman, the principle of daily outings should also apply to patients whose freedom of movement had been restricted (2458/2019 Katriina Hospital).

The local authorities reported patients with memory disorders were taken outdoors by their relatives, and during the summer, they could also go outside with staff assistance. The ward also employed an activity supervisor, whose task was to support and engage patients to participate in stimulating activities. They would accompany the patients outdoors to some extent.

The Deputy-Ombudsman further stressed that the patients' access to the outdoors should be guaranteed outside the summer period, as well. Furthermore, a patient's access to the outdoors should not rely solely on the assistance of relatives.

Patient information

It is essential for the purpose of securing patients' rights that patients and their next of kin are aware of patients' rights and the legal remedies available to them, including objection, complaint, and notice of patient injury. Patients on all wards, and their families, should be provided on arrival with clear and simple information on the rights and obligations of the patients, both verbally and in writing. Public information provided by the government and local authorities in a bilingual municipality must be issued in Finnish and Swedish.

A hospital's wards did not provide a brochure on the important information about the ward, such as contact details or visiting hours. Each ward had a notice board, where general information about the ward was posted, but information about patients' rights or the Patient or Social Welfare Ombudsman was not made available. The material on the notice board was provided almost entirely in Finnish. The wards also had electronic information screens. The Deputy-Ombudsman found that, particularly with elderly patients, the electronic communication channels could not fully replace information provided in paper format. The Deputy-Ombudsman recommended that information about the Patient Ombudsman and the Social Welfare Ombudsman be posted on the notice boards. He noted that any information shared on the notice board, verbally, or in writing should also be provided in other languages than Finnish (1706/2019 Espoo Hospital, 2458/2019 Katriina Hospital, 3264/2019 Harjavalta Health Centre, inpatient ward).

The local authorities reported that the hospital will update its brochure on its services and different wards, which is handed out to patients and their relatives on admission. The brochure will introduce the operations of the ward, as well as the services and practices adopted at the hospital. In conjunction with this, patients and relatives will be informed of the contact details of special workers, such as social welfare supervisors and the hospital chaplain. In addition, the hospital had ordered posters in Finnish, Swedish, and English to be posted on the notice boards on the wards explaining the role of the Patient Ombudsman and Social Welfare Ombudsman and providing their contact details. The posters are posted on the notice boards of each ward (2458/2019).

The joint authority reported that the matter had already been acknowledged on the ward during the NPM visit and that the information was posted on the notice boards of each treatment group immediately after the visit (3264/2019).

Protection of privacy

Camera surveillance

The hospital had the technical capability for camera surveillance in patient rooms. CCTV could be used for either observing the patient or alerting of potential falls. No recording CCTV cameras were used. The camera image could be viewed in real time on the ward, at an office next to the service desk. The NPM was told that camera surveillance was seldom used at the hospital for observation, and mainly on the acute ward. The hospital also operated a fall detection system. This was based on patient room cameras and produced data on the movements of a person, which made it possible to detect a fall. This triggered an alert through the nurse intercom. The camera did not transmit any actual image. The Deputy-Ombudsman noted that placing a camera in a patient's room always constituted an intervention into the patient's privacy. There are currently no legal provisions regulating the use of camera surveillance in patients' rooms. The Deputy-Ombudsman found that camera surveillance should not be used for the observation of patients unless absolutely necessary. Understaffing is not an adequate basis for camera surveillance. The patient and their relatives should be informed about camera surveillance and the possibility of observation (1706/2019 Espoo Hospital).

Two patient rooms on a ward had camera surveillance. The camera image could be viewed in the nurse break room and the office. The Deputy-Ombudsman considered it important that patients whose rooms are monitored by the camera are made aware of the monitoring and that the camera is turned off if there is no special need for monitoring (2458/2019 Katriina Hospital).

The local authorities reported that there was camera surveillance equipment in two patient rooms on a ward. The camera surveillance was in use only under special circumstances, such as when the condition of a patient in a room required close observation but the presence of a nurse in the room would disturb the patient (a restless, anxious patient, etc.). Camera surveillance was relied on only in extreme cases to ensure the safe treatment of a patient, and the patient and their relatives would always be informed about its use. Camera surveillance is discontinued as soon as it stops being in the patient's best interest.

Protecting confidential data

A hospital operated workstations along corridors and mobile workstations that were moved around the ward. It was possible for unauthorised persons to view text on the computer screen at a workstation in the corridors, or at the mobile computer station. The Deputy-Ombudsman recommended that the visibility of the screens of workstations and mobile computers to outsiders should be prevented by, for example, installing separate privacy filters on the screens (1706/2019 Espoo Hospital).

Mobile workstation.

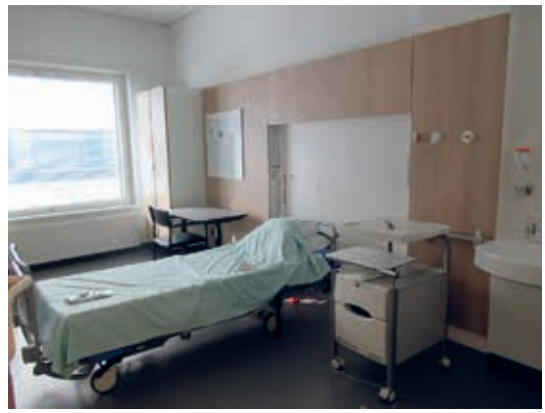
Protection of patient privacy

Some patient rooms in a hospital had three beds, which made the room overcrowded. While curtains and screens could be placed between the beds, securing the privacy of patients was difficult owing to the small size of the room. The doors of the patient room were heavy. They were kept open to the corridor so that patients relying on support equipment could access the common spaces on the ward. From the perspective of privacy, however, this practice presented some problems. The NPM noted during its visit to one ward that the door was kept open even when the patient was being washed. In the debriefing of the visit, the hospital representative admitted this error and said that the staff had been reminded of the importance of honouring the privacy of the patients. The Deputy-Ombudsman requested the hospital to ensure that patients' privacy is protected, especially during treatment, and that the locks on the lockers in all patient rooms are intact. The Deputy-Ombudsman also urged the hospital to consider a way of reducing the number of patients from three in one room (2458/2019 Katriina Hospital).

The local authorities reported that the matter has been raised as a key issue with the staff of the department in autumn 2019, with guidance on the delivery of care while respecting a person's right to privacy. In addition, owing to the multiple-occupancy patient rooms, a separate quiet space has been designated for patients and their family members, where they can discuss treatment and rehabilitation and carry out the personal rehabilitation programme. A plan has been drawn up together with property maintenance on checking the locks on patient lockers, the management of keys, and carrying out necessary repairs. Any issues will be corrected by the property maintenance personnel during January and February.

The Deputy-Ombudsman found the large patient rooms hosting five patients problematic. The Deputy-Ombudsman found that a large room such as this was not conducive to optimal patient recovery. The Deputy-Ombudsman recommended that patients be placed in rooms with fewer beds, if possible, to allow them more peace and privacy (3264/2019 Harjavalta Health Centre, inpatient ward).

The joint authority reported that the aim of the ward was to keep the number of patients in each room fewer than the maximum of 5 patients in the largest patient rooms whenever possible. The aim was to reduce the number of beds from the current 30 to 20 by the end of 2020. The reduction in the number of beds will mean that fewer patients need to be placed in one room.



Left-side image shows a three-person shared room. Right-side image shows a spacious one-person room with a private bathroom.

The Deputy-Ombudsman recommended that patients are always offered the opportunity to discuss their situation with a physician in private, if they share a room with other patients. Attention must be paid to honouring a patient's right to privacy not only during the doctor's rounds but also in connection with treatment procedures (3264/2019 Harjavalta Health Centre ward).

According to the joint authority, physicians have two fully accessible offices on the ward that can be used. The patients are offered the opportunity to see the physician in private.

Prevention of inappropriate treatment

Identifying inappropriate treatment or mistreatment is difficult, as is defining what constitutes inappropriate treatment. The management of each caregiving unit is responsible for providing a definition of mistreatment. Mistreatment may involve overmedication, verbal threats, physical abuse, shouting, poor positioning in a bed or geriatric chair, or leaving a resident in a soiled or wet bed or clothing. It should be emphasised to staff that mistreatment is never acceptable, and it will always carry consequences.

The hospital had no specific whistle-blowing policy in place should any mistreatment of patients be detected or suspected. The staff were expected to report any observations of mistreatment to their superiors. The Deputy-Ombudsman noted that the hospital would benefit from clear staff guidance on the concept of mistreatment and on the process by which reports are handled. Patients and their families should also be provided with instructions on the matter. At the same time, it should be made clear that reporting on mistreatment or deficiencies must never lead to any negative consequences for the person filing the report (1706/2019 Espoo Hospital).

The hospital reported that it would bring the Deputy-Ombudsman's opinion on the reporting practice for mistreatment to the attention of the City of Espoo Social and Health Services for information and action.

According to the Deputy-Ombudsman, the hospital should provide the staff with clear guidance on how to report mistreatment. It should also clearly indicate that reporting mistreatment or deficiencies will never lead to any negative consequences for the person filing the report. The Deputy-Ombudsman also emphasised that informing patients about patients' rights and the legal remedies available could not be based solely on online information (2458/2019 Katriina Hospital).

The local authorities reported that the hospital's management system was overhauled during the autumn of 2019, including a review of the hospital's operating methods, culture, and policies. The hospital also launched a two-year development scheme in November 2019 with the aim of improving customer service and quality of care by focusing on patient safety, pharmaceutical therapies, the smooth care process, the quality of care chain, and the leadership of multiprofessional teams. The new leadership and management goals include supporting staff members' professional development and making leadership and management work more transparent and accessible through proactive interaction, Gemba walks, and timely communications. In conjunction with this, guidelines on identifying, reporting, and processing cases of mistreatment will be published.

Inspection visits of emergency units

As in previous years, the Ombudsman felt it was important to visit the emergency care units of somatic hospitals, which use 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 a problem 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 in

Emergency clinic entrance.

his legal practice 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.

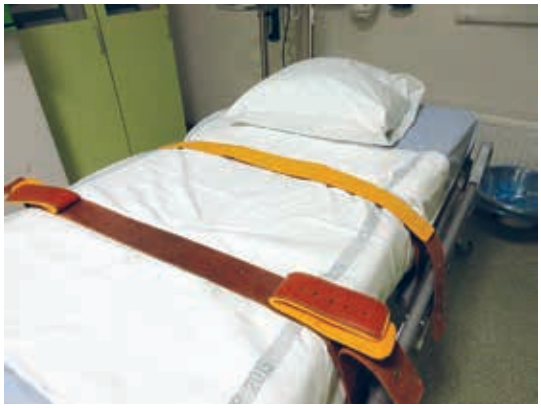
Having appropriate equipment in the seclusion room is of major importance when assessing whether a patient's seclusion has, as a whole, been implemented in a manner that qualifies as dignified treatment and high-quality health and medical care. The criteria laid down in the Mental Health Act for the 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 urgent care units of two hospitals in 2019. Both visits were made unannounced and during the evening. An external expert participated in both visits. In both emergency units, the monitoring of aggressive or disruptive patients had been carried out in a different manner to that described above.

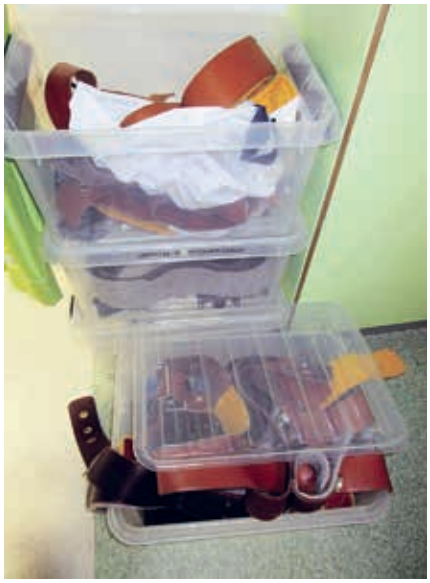
The NPM visits were conducted at HUS Jorvi to both the adult and paediatric joint emergency units, which have separate entrances and facilities. As provisional observations, the NPM noted that neither unit had a separate space for isolating a patient showing aggressive behaviour or presenting a danger to themselves or others. The established practice is that, as a last resort, a patient may be restrained on a bed. In the adult emergency unit, the bed equipped with restraints was located in the acute observation ward, with a total of nine beds. The beds were in one room, where curtains could be drawn between the beds for privacy. Aggressive patients under the age of 16 would be treated in the paediatric observation ward and for them, too, the treatment of last resort would be restraint. In all cases, the use of restraint was decided on by a physician. It remained unclear to the NPM why the practice of restraining a patient had been adopted instead of introducing a safety room, as in most other emergency care units. At the time of writing this annual report, the Deputy-Ombudsman's final opinions and recommendations based on the observations made during the visit were still pending (1707/2019).

An aggressive or disruptive patient who has sought treatment or has been brought into the emergency unit at Satasairaala hospital will be referred to acute care, the sobering-up unit Selma, or an examination room, based on a case-by-case assessment. The unit also had a designated room where a patient could be placed in seclusion from other patients. However, the use of this room has been discontinued, and the space was used as storage at the time of the visit. It remained unclear why this space was no longer in patient use. A bed equipped with restraints was provided near the separate ambulance entrance. Based on a prealert from the first response personnel, the physician could make a preliminary decision on the use of restraints prior to the patient's arrival. Mental health patients with no aggressive symptoms were usually placed in an examination room from which unnecessary medical equipment is removed. One such room was in use.

The NPM was told that the room was used weekly. If there is no medical reason for the pres-



Emergency clinic limb restraint bed.



Spare leather limb restraint belts in a box.

ence of a nurse, the observation of the patient is trusted to a security guard. The guard may remain in the same space as the patient or may monitor the patient through a window in the door. The room also has camera surveillance, with the image visible on the screen in the nurses' office and security guard room. If necessary, restraints could be applied in the room. The sobering-up unit Selma is located adjacent to the emergency department as a separate facility operating under the emergency department. Usually the patients placed in Selma arrived at the joint emergency unit escorted by first responders or the police. The beds in Selma are also equipped with restraints in case they are needed. The Deputy-Ombudsman's final opinions based on the visit are still pending (3009/2019).

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 outpatient clinics in connection with the prison outpatient clinic. In Vaasa, the dental outpatient clinic operates in a municipal health centre. The units of the Psychiatric Prison Hospital in Turku and Vantaa serve as acute psychiatric outpatient clinics for prisoners everywhere in Finland. The Prison Hospital is a national somatic hospital for prisoners, located in Hämeenlinna.

Since the beginning of 2016, AVI Northern Finland has conducted guidance and assessment visits to the outpatient outpatient clinics and hospitals of VTH on its own or together with Valvira. By the end of 2018, the AVI had visited all VTH outpatient clinics and health-care units. 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 larger health-care system,

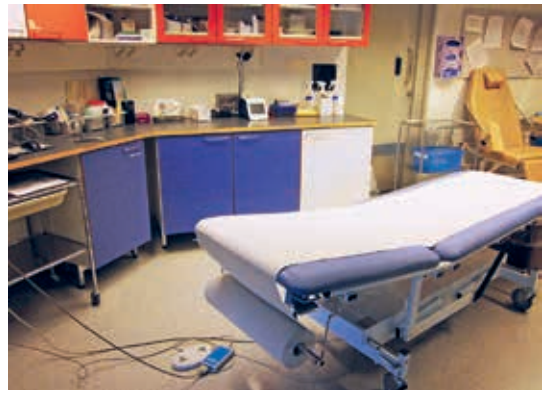
along with the treatment recommendations and guidelines issued by VTH. In 2019, the local AVI conducted three guidance and assessment visits to prisoner health-care units. The units were chosen based on a risk and needs assessment.

The Ombudsman receives AVI Northern Finland's annual 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 reports, for information, to Valvira and the AVI Northern Finland. The Ombudsman, Valvira, and AVI Northern Finland also hold regular meetings on issues in the field of prisoner health care.

During 2019, the Office of the Parliamentary Ombudsman visited two units of the VTH. These inspection visits were combined with prison visits and were announced in advance. Before visiting the outpatient clinic, the practice is for the NPM to interview the prisoners on matters such as the functioning of health care and medical care in the institution. In addition, a visit was conducted to the Psychiatric Prison Hospital in Turku. The visits to the Turku Outpatient clinic and the Psychiatric Prison Hospital were attended by an external expert in psychiatry.

On outpatient clinic visits, the Ombudsman pays attention to how soon arrival examinations 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 isolation 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 at the weekend is not always examined on the schedule required by the Imprisonment Act, which is "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 forms they send to the outpatient clinic, or that getting a physician's or dentist's appointment is difficult. On these inspections, the Ombudsman has frequently drawn the outpatient clinics' attention to the fact that,



Examination room.

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 into 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.

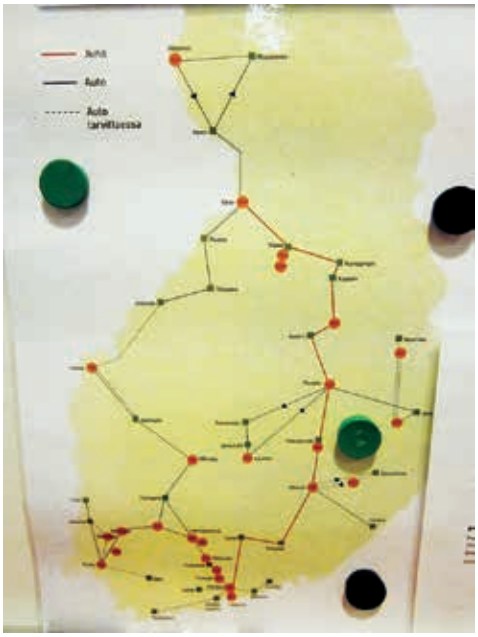
The visit to the *Psychiatric Prison Hospital Turku* (2570/2019) was the first visit made by the Ombudsman and the NPM to the unit since VTH was moved from the remit of the Criminal Sanctions Agency on 1 January 2016. Separating the delivery of health care and guarding duties supports the autonomy of health-care providers. However, the change has not been without its problems at a unit such as the Psychiatric Prison Hospital, where patients are treated both with their own consent and against their will. What makes the situation challenging is that a prisoner receiving treatment as a patient at the unit is governed by the provisions of the Imprisonment Act and the Remand Imprisonment Act, as well as health-care legislation. Prisoner health care is still regulated by the Imprisonment Act and the Remand Imprisonment Act, although the responsibility for implementing health care for prisoners has been transferred to the Ministry of Social Affairs and

Health. It is stated in the Government proposal to Parliament for new legislation that although the VTH is administratively a separate entity and falls under a different administrative branch, as a service provided within prisons, it constitutes a part of the prison service.

It was not possible to focus adequately on all aspects within the confines of one visit to allow for the Deputy-Ombudsman to issue an opinion. For this reason, a follow-up visit to the unit was scheduled for March 2020. Owing to the coronavirus epidemic (COVID-19), the visit was postponed until further notice. The key opinions and recommendations based on the first visit are presented in the following:

The prison guards of Turku Prison serving at the Psychiatric Prison Hospital conduct an initial examination on each patient arriving at the unit. In this situation, the prisoner must remove all their clothes. While they are changing their clothes, the guard also inspects the soles of the patient's feet, their underarms, and their hair. According to the Central Administration Unit of the Criminal Sanctions Agency, the initial examination is not the arrival check, as referred to in the Imprisonment Act, but rather a security check. The Deputy-Ombudsman agreed with this statement and notes that in a security check, a prisoner may be obliged to change their clothes in the presence of the staff. However, the prisoner may not be made to undress until naked, and the body may not be searched in detail, as was now done. This constitutes a bodily search, which requires a separate assessment and decision. The Deputy-Ombudsman also stressed that the changing of clothes should always be carried out with tact and respect for the prisoner's privacy.

Prisoners arrive at the Psychiatric Prison Hospital sometimes following an exceptionally long journey. It may have been necessary during the journey to use force or coercive methods, such as handcuffing. The Deputy-Ombudsman recommended that with each arriving prisoner, possible signs of the use of force are examined, and the prisoners are actively asked about any use of force. The Deputy-Ombudsman also considered it important that the health-care providers also enter into the records on arrival how the prisoner was transported and what possible means of restraint were used, if known. It remained unclear to the NPM why the arrival check does not involve a somatic medical examination of the patient. It also remained unclear how patients suffering from delirium would be treated and where.



Prisoner transport routes marked on a map of Finland.

The seclusion rooms at the hospital were almost identical to isolation cells in prisons. They were very austere and the only "furnishing" was a thin plastic-covered mattress on the floor. One isolation room had a thick mattress. The Deputy-Ombudsman recommended that the hospital should pay more attention to the equipment and furnishings of the seclusion rooms, without compromising safety.

The seclusion room at the hospital was used for purposes other than secluding a patient under involuntary treatment. A patient arriving under an observation (M1) referral is taken directly to the

seclusion room, which serves as a holding cell (so-called "travelling cells") until the duty physician has examined the patient. The seclusion room is also used as a holding cell when the patient is discharged from the hospital and has to wait for transportation to prison. In this situation, the prisoner is placed in the holding cell to await transportation. The Deputy-Ombudsman noted that, in its present condition, the seclusion room is not suitable for use as a holding cell. Even when used for the seclusion of a patient, its condition merits attention so that the patient need not, for example, eat while seated on the floor without a table.

The Turku unit reported that when the "isolation cell" is used as a temporary holding cell, the patient is always given a thick mattress, an isolation chair/table, normal patient clothes, and the same personal items as in the normal unit.

The Deputy-Ombudsman found it problematic that the hospital seclusion room was used as a prison holding cell. This could jeopardise the international legal principle in criminal sanctions, according to which the prisoner's health-care staff should not be involved in any kind of guarding or policing tasks. It did not become clear during the NPM visit on whose authorisation and based on which section of the law a prisoner was placed in the seclusion room. It also remained unclear whose duty it was to look after a prisoner's basic needs during the placement, when the placement took place under the Imprisonment Act or the Remand Imprisonment Act.

The Ombudsman's established policy has been to take a negative view of a patient being taken directly into seclusion on arrival at a psychiatric unit under an M1 referral. Health-care providers have often defended this practice by the fact that the care staff are not familiar with the patient at this stage. However, the legal criteria for seclusion must always be met before a patient may be placed in seclusion under the Mental Health Act, and the assessment of these criteria must always be conducted on a case-by-case basis. The fact that the patient is unknown to the care staff is not, by itself, sufficient reason for seclusion. The Deputy-Ombudsman considered whether it would be possible to place the patient directly in a hospital cell from which objects that could be used for self-harm had been removed as necessary. The unit's opinion was not available for this report.

According to the Deputy-Ombudsman, an alternative during patient discharge could be to place the prisoner temporarily in the holding cell of Turku Prison. In its response, the prison did not oppose the use of the holding cell in the prison when a discharged prisoner has to wait for transportation to their designated prison. The Deputy-Ombudsman decided to issue an opinion on the use of the seclusion room after a follow-up visit.

The Deputy-Ombudsman found it a deficiency that there was no guard at the unit during the night. The guard working at the unit locked the patient rooms for the night in the early evening. The NPM was informed that if the door needs to be unlocked after this time, the nursing staff is not authorised to lock the door, and a guard from Turku Prison must be called specifically for the purpose. The prison reported that the level of supervision at the hospital could not be extended due to a cost-saving scheme. The Deputy-Ombudsman noted that the issue of prisoners' opportunity to spend time outside their room and the

absence of a guard after 6/7 p.m. were matters dependent on resourcing. The Ombudsman cannot ignore the question of resources if the statutory duties imposed on the authority have become more difficult or impossible due to a lack of resources. It would appear that the potential of the Psychiatric Prison Hospital or Turku Prison to take any remedial measures independently is extremely limited. The Deputy-Ombudsman noted this, and before being able to take any measures, they would need to form a more detailed picture of how the under-resourcing affects various official duties and operations, as well as prisoners' conditions and treatment.

Health-care legislation does not allow for routinely locking the doors of patient rooms, even for patients in involuntary care. It is the view of the Central Administration Unit that the Turku unit should have a daily programme, as provided for in the Imprisonment Act, indicating the time period when, for example, the rooms of prisoners are kept locked. The Deputy-Ombudsman recommended confirming the daily programme, and noted that this was the duty of the director of the prison.

It was noted during the visit that the intervals between meals for the prisoners was exceptionally long. The interval between meals on weekdays was 17 hours and at weekends up to 18 hours. The weekly programme included no mention of an evening snack. It seemed that the hospital catering provisions had been arranged in line with the catering services at Turku Prison, even to the extent that only one hot meal was offered to patients at weekends. The Deputy-Ombudsman questioned the rationale of organising the catering around the mealtimes observed in the prison. The Ombudsman has not noticed during visits to any other psychiatric hospitals that the provision of main meals would be reduced at weekends. It is stated in the Criminal Sanctions Agency order that food is provided more infrequently on non-working days, which is a principle ill-suited for the prisoner psychiatric hospital.

According to the report by the Turku Unit, the Criminal Sanctions Agency and Leijona Catering Oy have a partnership agreement on the organisation of catering services, which the Psychiatric Hospital has joined. The Criminal Sanctions Agency has negotiated the content of the catering services agreement. The VTH did not participate in the negotiations. Therefore, the unit was not able to explain the grounds for the reduced meals and prolonged meal intervals at weekends.

The Deputy-Ombudsman recommended that the hospital ensure that patients under imprisonment receive appropriate, clear, and sufficient information about their situation, rights, and obligations, as well as the treatment and examinations provided to them. Information for patients should be available in at least Finnish and Swedish.

Under the Mental Health Act, a hospital that provides psychiatric care should have written and adequately detailed instructions on how restrictions of the patient's right to self-determination are implemented. The Turku Unit had guidance in place at the time of the NPM visit that only covered the seclusion and restraint of a prisoner but did not discuss any other restrictive measures. The lack of appropriate guidance was already commented on once, during the 2016 visit made by Valvira and AVI Northern Finland. The Deputy-Ombudsman considered it inappropriate that, even after recommendations provided by a supervisory authority, the hospital had failed to produce guidance on the use of measures restricting a person's right to self-determination. The Deputy-Ombudsman urged the hospital to immediately

produce guidance that covered all restrictions referred to in Chapter 4a of the Mental Health Act. The Deputy-Ombudsman also requested the unit to ensure that the staff are familiar with the guidance and implement it in practice.

The Psychiatric Prison Hospital's instruction dated 12 February 2020 on restricting a patient's right to self-determination during involuntary psychiatric treatment was submitted by the Turku unit.

The Deputy-Ombudsman welcomed the hospital's guidance on the reduction of the use of coercive measures. The Deputy-Ombudsman recommended that the hospital monitor the use of all restrictive measures, not only seclusion and restraint. The Deputy-Ombudsman also recommended the assessment of whether a separate coercion reduction programme or a more detailed code of conduct for staff, in addition to the existing guidance, was needed.

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. According to the Deputy-Ombudsman, the hospital should provide the staff with clear guidance on how to report mistreatment.

Monitoring the health of a prisoner placed in segregation

The Ombudsman gave a decision on 18 November 2019 in an investigation on his own initiative concerning the monitoring of the health and health care of a prisoner placed in segregation at their own request. It had been brought to the attention of the Ombudsman during a visit to a prison that a prisoner had remained in segregation for more than two years. The placement was based on the prisoner's own request to be accommodated separately from other prisoners. The prisoner declined to discuss his situation with the NPM.

An investigation revealed that the prisoner health-care services had almost completely neglected to monitor the impact of long-term segregation on the prisoner. A nurse had met with the prisoner on the day when he had been placed under observation in a cell with camera surveillance. The prisoner had made it known that he did not require health-care services. The health-care service providers did not see the prisoner at the point when he was moved from isolation (under observation for safety purposes) to segregation. The health-care providers left the prisoner "in peace", and the prisoner met with the nursing staff approximately once a year. The most recent of these meetings took place on the initiative of the health-care services. The physician met the prisoner only once over a three-year period and not until the prisoner had been in the prison in question for 1 year 7 months, of which 1 year 3 months was in segregation.

The Ombudsman understood the views presented in the report that the privacy of a person deprived of their liberty must also be respected. This must not, however, lead to a situation in which the regular monitoring of a prisoner's health and assessment of the impact of segregation on the prisoner is neglected. While there was a need to use discretion in the allocation of the limited resources, the Ombudsman saw no acceptable justification for seeing a prisoner in segregation for a health check only once a year. The Ombudsman considered it necessary for the health-care services for prisoners to prepare guidelines for medical and nursing staff on how to arrange monitoring of the health of prisoners in segregation.

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. Shortcomings are often due to insufficient personnel numbers or flawed management.

Measures limiting the right to self-determination in the treatment and care of the elderly should be based on law. However, the required legislative foundation is still entirely lacking. Restrictive measures are also used even when situations can be resolved by other means.

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.

Municipalities do not adequately monitor the quality of services, and problems may persist in private care homes for a long period before there is any intervention. The guidelines issued by Regional State Administrative Agencies are not always followed, and issues sometimes take an unreasonably long time to rectify. Municipalities often have no means of arranging substitute services, even when severe problems arise.

The Parliamentary Ombudsman and the Regional State Administrative Agencies have received additional grants for overseeing and promoting the rights of elderly people, and this can be expected to improve the implementation of elderly rights over the long term.

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 administra-

tive 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 institution 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.

Inspections ordered by the Parliamentary Ombudsman at polling stations used for advance voting and voting on the election day revealed that almost all polling stations had some deficiencies in terms of the accessibility of the voting premises themselves or the routes for accessing the premises. The inspections also revealed that the lack of accessible polling booths or facilities could jeopardise the election secrecy.

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 restriction of legal aid for asylum-seekers has led to a situation in which many asylum-seekers do not receive legal aid in the first instance. This may have led to problems from the perspective of legal rights and created 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 Finnish Immigration Service is not able to meet the deadlines for processing asylum applications, residence permit applications based on family ties and residence permit applications based on employment as laid down in the Aliens Act. Certain new deadlines have further extended the processing times of old applications that were not subject to the new deadlines. The Parliamentary Ombudsman has issued numerous reprimands to the Finnish Immigration Service in relation to the unlawful delays in processing cases, but processing times have remained poor.

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. The principle of the law is that minors should not be housed in adult units. According to the available information, no units have yet been arranged for minors.

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

A further positive development is the elimination of cells with no toilets in the year under review.

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 duration of loss of liberty, the person making the decision, the decision-making process and the legal protection of patients should be provided for in legislation in compliance with the criteria for restricting 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. The means available for schools to identify and intervene with bullying are not always sufficient.

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. The legislation on the National Courts Administration of Finland, which took effect on 1 January 2020, has improved the structural independence of the courts.

However, the large number of temporary judges and the fact that, in practice, local councils select jury members for District Courts on the basis 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 occasional gaps in the general awareness of fundamental and human rights, and the implementation and promotion of rights 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 recompense and matters that have led to an amicable solution

The Parliamentary Ombudsman Act empowers the Ombudsman to recommend to authorities that they correct an error that has occurred 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 recommendations have, in most cases, led to a positive outcome. In its reports (PeVM 12/2010, 2/2016 and 2/2019 vp), the Constitutional Law Committee has also taken the view that a proposal by the Ombudsman to reach an agreed settlement and effect recompense is in clear cases a justifiable way of enabling citizens to achieve their rights, bring about an amicable settlement and avoid unnecessary legal disputes. In the latter two reports, the Committee considered it a positive development that the Parliamentary Ombudsman's activities have undergone a clear shift in focus from monitoring the actions of the authorities to promoting human rights. The grounds on which the Ombudsman recommends recompense are explained more extensively in the summary of the annual reports for 2011 (page 84) and 2012 (page 65).

The Ombudsman proposed recompense in 16 cases in the reporting year. Two proposals for recompense were made to the State Treasury, which paid out compensation for violations of fundamental rights. In addition, during the handling of complaints, communications from the Office to the authorities often led to the rectification of errors or insufficient actions and, therefore, contributed to an amicable settlement. For example, in the year under review, the police force decided to begin a preliminary investigation in relation to nine cases concerning police decisions, either due to the investigation of the complaint or on the basis of a subsequent decision. In numerous other cases, guidance was provided to complainants and authorities by explaining the applicable legislation, the practices followed in the administration of justice and oversight of legality, and the means of appeal available.

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.

3.7.1 STATE TREASURY COMPENSATION DECISIONS 2019

As agreed, the State Treasury notifies the Parliamentary Ombudsman annually of all the compensation decisions it issues on the basis of the State Indemnity Act. As per the State Treasury's notification, a total of 865 claims for damages were submitted to the State Treasury in 2019. Most of these cases were initiated as claims for damages filed with the State Treasury or the relevant authority. Two cases were initiated as a result of a proposal for recompense made by the Parliamentary Ombudsman. Legal action was initiated against the State in 53 cases within the scope of the State Indemnity Act. In 2019, the State Treasury issued a total of 815 decisions and paid out a total of EUR 655,940 in compensation on the basis of the State Indemnity Act. A significant proportion of these decisions (484) and of the compensation paid (EUR 282,400) concerned the administrative branch of the Ministry of Justice.

In particular, a substantial collection of compensation decisions concerned the State's legal aid and guardianship offices (general guardianship), and the sums varied from a few euros in invoices and charges for overdue taxes to several thousand euros. The grounds for compensation in the latter cases included a legal action that was not brought, an undisputed receivable that was not transferred to debt collection, shares that had not been entered into the book-entry securities register and various benefits for which no applications were submitted (such as child care allowance, income support, housing allowance, labour market subsidy, disability benefits and child maintenance allowance, as well as guarantee pensions, Kela compensation, renovation grants and payment relief for client fees). Guardians had also failed to terminate unnecessary insurance policies, tenancy, electricity and waste management agreements, telephone and internet connections, emergency telephone services and credit card agreements on behalf of their clients. The failure to take out insurance had also caused clients to incur loss or damage. Shortcomings in the oversight of clients' affairs gave rise to excessive indebtedness and damages subject to compensation, as well as the payment of the wrong person's invoices, payments to the wrong entities, payment of expired invoices and repeat payments of the same invoice. Compensation was also paid for the costs of cancelling lost share certificates, a loss incurred due to the disposal of property and losses due to the failure to increase rents and charge rents. Excessive guardianship fees had also been charged, and income had not been reported on a tax declaration or the tax declaration had been submitted late in a manner that left the State liable for damages.

The State Treasury issued a decision on 18 July 2019 to grant compensation to a prisoner on the grounds that the prison had acted unlawfully in conjunction with two meetings after which the prisoner had been unduly subjected to strip searches and documentary material covered by legal client confidentiality in the prisoner's possession was inspected. The Deputy-Ombudsman issued a decision in 2018, finding that the prison had acted unlawfully. The State Treasury paid out EUR 2,000 in compensation for human rights violations.

The State Treasury issued a decision on 2 December 2019 to pay the prisoner EUR 500 in compensation for intangible damage. During a strip search at the prison, the prisoner was forced to stand over a mirror placed on the floor so that the prison wardens could verify that no forbidden substances were hidden in the prison's groin. The Deputy-Ombudsman assessed the case in a decision issued in 2018 and found that thorough visual inspections of the groin, external genital areas, buttocks and anus expressly constitute physical examinations and are more substantial interventions than simply obliging the prisoner to undress. The scope of strip searches must not be expanded into physical examinations unless the criteria stipulated in the law are met. The Deputy-Ombudsman found that the prison had acted unlawfully. The State Treasury had no cause to evaluate the case differently.

The State Treasury issued a decision on 4 April 2019 to pay compensation for items including foodstuffs, which a prisoner claimed had remained in one prison when the prisoner was transferred to a different prison. The prison contested the liability for damages on the grounds that prisoners are responsible for the property in their possession. The State Treasury referred to the Parliamentary Ombudsman's praxis whereby foods purchased from a shop in the institution must be given to the prisoner in the new prison, irrespective of whether they were packed in sealed prison bags or in the prisoner's hand luggage. In light of the praxis, the State Treasury deemed that prisoners must also have the opportunity to bring foods with them when they are transferred to new prisons. In the circumstances, the State Treasury considered it credible that the prisoner was not able to take their food items with them to the new prison and, for this reason, compensation was deemed payable for the food items.

3.7.2 RECOMMENDATIONS FOR RECOMPENSE

The following gives an overview of the recommendations for recompense made by the Ombudsman during the year under review. Some of the recommendations have not yet received a response from the authority to declare which action has been taken in the case.

Rights of the child

Safeguarding a child's language rights in foster care

The mother tongue (Spanish) and culture of the complainant's child was not maintained during foster care. The city placed the child in a foster family in November 2015. The foster family did not speak Spanish, and the child's school did not arrange Spanish lessons. The child welfare service began investigating the arrangement of Spanish lessons in 2017, and teaching began at the start of 2018. In the first two years of foster care, during which the child received no teaching in the mother tongue, the child's language skills deteriorated, and the child lost the language shared with the mother.

The Deputy-Ombudsman stated that the child placed in the foster family had been deprived of teaching in the mother tongue for more than two years. In this time, the child's only means of maintaining the mother tongue was during meetings with the complainant, which occurred an average of once per month. The right of a child to their own mother tongue is strongly connected to the child's right to remain in contact with their parents and other relatives. It is particularly important for a child to learn or retain their own mother tongue in order to form and develop their own identity. It may be harmful to the child if the child becomes alienated from their own culture. The realisation of a child's language rights cannot be consigned solely to the contact between the child and their relatives. Instead, the child welfare service has an obligation to actively support the child's linguistic and cultural background.

According to the Deputy-Ombudsman, the department of social welfare and health care had neglected this obligation as stated in the Child Welfare Act by failing to arrange lessons in the child's mother tongue for two years after the child was placed in care outside the home. The Deputy-Ombudsman did not consider it acceptable that the arrangement of lessons in the mother tongue of a child placed in care outside the family could take so long, as Spanish is a major world language, and lessons are widely held in Finland. The Deputy-Ombudsman considered the negligence unlawful. The child's right to maintain their mother tongue was not respected, and this may have affected the child's identity and cultivation and development of their cultural background. It may also have jeopardised the child's right to stay in contact with their biological parents and other relatives. The Deputy-Ombudsman recommended that the city responsible for realising the child's fundamental rights recompense the complainant's child for violating their fundamental rights in the manner it deems appropriate (125/2018).

The city paid EUR 5,000 in compensation for the intangible damage caused by its child welfare service. The city's child welfare service issued an apology for the damage caused by its actions.

Right to personal liberty and integrity

Humiliating and oppressive treatment in foster care

In this case, the complainants were siblings who were critical of the treatment they received in foster care. The city's welfare services considered the treatment of the children unlawful when the complainants' freedom of movement was restricted by the decision of a foster parent by way of punishment for the children's behaviour or for failing to follow the rules laid down by the foster parent. In addition, the complainants' contact with others was restricted when their phones were confiscated and their internet connections were disconnected. The information provided by the welfare services office revealed that the complainants did not receive allowances for their own

use in the amount to which they were entitled under the Child Welfare Act. The welfare services did not contest the complainants' view that they had received inappropriate treatment in their foster home and, therefore, that the treatment breached the Child Welfare Act.

According to the substitute for a Deputy Ombudsman, the rights enshrined in the Constitution were not respected in full in the complainants' case. He stressed that the inappropriate and oppressive treatment of a child severely jeopardises the interests and rights of a child in foster care, particularly in the case of children in vulnerable positions who are entitled to special protection. The substitute recommended that the city welfare committee responsible for respecting fundamental rights compensate the complainants for the violations of their fundamental rights (1669 and 1829/2019).

According to the city's welfare services, a reasonable level of compensation in light of the severity and consequences of the violations of fundamental rights, as well as the duration of the violations, is EUR 4,000 per child. Compensation was also paid for the allowances that were not received as reported by the complainants themselves.

Placing a prisoner under observation, and conditions during observation

An isolation cell used for observation is a place within a prison where a prisoner is in a strictly controlled environment, and their functional capacities are substantially limited. The complainant was placed in the observation cell, which is separated off from the rest of the prison by bars. When in the isolation cell, the prisoner should not, in practice, pose any hazard or threat to the personnel.

The complainant had been forced to remain naked with their hands bound behind their back while in observation. The rather long duration of this practice and the presence of camera surveillance exacerbated the offensiveness and reprehensibility of the action. A person of the other gender was involved when the complainant was undressing for a strip search. The complainant was also unduly refused permission to have clothing and bedclothes in the observation cell. The complainant's conditions during observation were in breach of the rules, and the conditions violated the complainant's human dignity.

In the Deputy-Ombudsman's understanding, the complainant had been subjected to treatment in violation of sections 7 and 10 of the Constitution of Finland as well as Article 8 of the European Convention on Human Rights (ECHR) while under observation. In addition, the Deputy-Ombudsman did not rule out a violation of the rights enshrined in Article 3 of the ECHR, at least with regard to the degrading treatment referred to in the Article. The Deputy-Ombudsman proposed that the State pay compensation to the complainant for inappropriate treatment that violated their human dignity (5960/2018).

The State Treasury paid the complainant EUR 1,500 in compensation for the human rights violation.

Care and treatment of a patient

A medical doctor working as the on-call physician at Jorvi Hospital was probably acting out of necessity as referred to in the Criminal Code of Finland in authorising the medical staff to use limb restraints to limit the freedom of movement of the complainant, who was acting aggressively in the accident and emergency ward. The Deputy-Ombudsman stated that she was not convinced that the stated grounds for placing the patient in limb restraints – i.e., that the situation necessitated it – were still valid when the complainant arrived in acute monitoring. In addition to the limb restraints, a sheet restraint was placed over the complainant and affixed to the bed using cable ties.

It had apparently been generally accepted practice to use such a sheet as a restrictive measure at Jorvi Hospital. The Deputy-Ombudsman considered this inappropriate. The use of the sheet as a restraint did not fulfil the safety requirements of the authority, nor were any instructions provided within the Hospital District of Helsinki and Uusimaa (HUS) concerning the use of the sheet. The sheet should not have been used to restrain

the complainant. The use of the sheet represented a major intervention in the complainant's bodily integrity. The Deputy-Ombudsman considered it justified and essential to prohibit Jorvi Hospital from using sheets as restraints under all circumstances.

The Deputy-Ombudsman stated that restrictive measures are only permissible for as long as they are necessary, and the use of such measures must stop as soon as they are no longer essential. It was not justifiable to keep the complainant restrained, at least on the basis that the complainant would need to wait to be examined by a physician. The Deputy-Ombudsman considered the actions of Jorvi Hospital to be unlawful in the care and treatment provided to the complainant. In the Deputy-Ombudsman's opinion, the treatment of the complainant was a violation of human dignity and personal liberty in breach of the Constitution and the European Convention on Human Rights. The Deputy-Ombudsman recommended that HUS compensate the complainant for the violations of fundamental and human rights to which the complainant was subjected. She asked HUS to state the action it had taken by 31 March 2020 (5485/2018).

Employee vaccination cover at a city's psychiatry centre

The complainant was given a written warning for not taking vaccination cover. The grounds for the warning were that the complainant did not have vaccination cover in accordance with the Communicable Diseases Act despite the employer's request and that the complainant had no health-related reasons for not being vaccinated. The warning also stated that if the complainant engages in similar behaviour in the future, the employment relationship will be terminated.

In the wording of the Act on Local Government Officials, warnings can only be issued for breaches of the obligations deriving from an employment relationship or as a consequence of neglecting such obligations. Refusing a vaccination does not constitute negligence of the obligations deriving from an employment relationship, nor the breach of such obligations. In itself, the state of being unvaccinated cannot be grounds for issuing a warning, nor can it be used as grounds for a warning in a legally sustainable way. As no other grounds were provided, the complainant's fundamental rights to personal liberty and protection of privacy were violated.

A written warning issued for the exercise of a fundamental right is a severe sanction to impose on an employee, as it carries the threat of dismissal. Its severity is also underlined by the fact that a holder of office cannot appeal the warning in court. From this perspective, the person receiving the warning has no effective legal recourse. The Deputy-Ombudsman recommended that the hospital district assess how the violation of the complainant's fundamental rights caused by the warning could be rectified or remedied, and how the complainant could be compensated for the violation (1678/2018).

The hospital district stated that it would withdraw the written warnings issued to the complainant and all other employees for neglecting to take influenza vaccinations. The hospital district did not consider there to be grounds for paying compensation. The violation of fundamental rights will be remedied by withdrawing the warnings. The employer had previously altered its vaccination practices, and the influenza vaccination is voluntary for employees.

Freedom of speech and openness

Written warning issued to a civil servant

In the view of the education manager, an official letter sent by the complainant to the board of education and some members of the city council contained accusations against the complainant's supervisors – the education manager and the head of an upper secondary school – of dishonest activity, and cast the headteacher of another school in an unfavourable light on the basis of hearsay. The education manager issued a written warning to the complainant on the grounds of the official letter

sent to elected officials, actions in contravention of the employer's instructions and inappropriate behaviour at an information event.

According to the substitute for a Deputy Ombudsman, the complainant felt that the board of education did not have access to all of the information related to a merger of upper secondary schools, and the complainant wanted to make the board of education aware of their own views and the views of their upper secondary school concerning the school merger. Such an action in such a context can, of itself, be considered a natural feature of the role of a headteacher. However, the loyalty obligation expressly states that, in principle, any perceived shortcomings must be reported first to the employer. In this context, the board of education can be considered to represent the employer. From this perspective, the complainant's actions can be considered consistent with the loyalty obligation.

According to the substitute, the appeal to the members of the board of education, the headteacher's behaviour at the information event and the headteacher's official letter to elected officials could not be used as grounds for a written warning in a legally sustainable manner due to the exercise of freedom of speech. As no other grounds were provided, the complainant's freedom of speech had been violated. The Deputy-Ombudsman's deputy recommended that the city assess how the violation of the freedom of speech caused by issuing a warning to the headteacher of upper secondary school A could be rectified or remedied, and how the complainant could be compensated for the violation (3343/2019).

The local government stated that it takes human rights seriously and strives to comply with the Constitution of Finland and the European Convention on Human Rights in all of its activities. As a result of the decision by the substitute for a Deputy Ombudsman, the city was and is reviewing its management processes, including the process for issuing warnings, to ensure that these measures do not violate anybody's human rights. However, the local government did not state that it would rectify or remedy the violation of free speech caused by issuing a written warning.

Processing of a document request

The complainant had submitted a detailed information request to the Southwestern Finland Police Department by email in relation to a criminal case concerning the complainant. The case concerned a request for access to an official document as referred to in the Act on the Openness of Government Activities. However, the police department treated it as a request for a certification of police action. It appeared that the police department had not recognised the fact that the complainant had made a document request, and the reply to such a request should comply with the procedural provisions of the Act on the Openness of Government Activities. The police department provided the complainant with some of the information in the form of a certificate by email. The complainant had paid EUR 26 for the certificate that the police department sent by email.

The request for access to an official document was not processed in compliance with the procedural provisions of the Act on the Openness of Government Activities. Based on the available material, it was unclear whether the police department had yet processed the complainant's document request as required by the Act on the Openness of Government Activities. According to the Ombudsman, the police department should ensure that the document request is processed in accordance with the provisions of the Act on the Openness of Government Activities in such a way that the public documents are delivered to the complainant and, if necessary, an appealable decision is issued if any of the documents cannot be delivered to the complainant. The police department should also ensure that the complainant is refunded the fee that was charged in error (2049/2018).

The police department refunded the complainant for the fee that was incorrectly charged. According to the police department, it was clear that the practice was incorrect. The police department will act as specified in the Ombudsman's decision.

Right to social security

Social welfare assistance for a victim of human trafficking

The Office of the Non-Discrimination Ombudsman, as the National Rapporteur on Trafficking in Human Beings, requested an investigation into whether a city's social welfare office had complied with the Act on the Reception of Persons Applying for International Protection and on the Identification of and Assistance to Victims of Trafficking in Human Beings and fulfilled its obligation to arrange assistance for a Finnish person who had fallen victim to aggravated human trafficking. The case related to the request was submitted to the National Rapporteur on Trafficking in Human Beings as a request for advice in relation to a process under criminal law.

In her assessment, the Deputy-Ombudsman stated that victims of human trafficking are in a vulnerable position and in special need of help and protection. The special position of a person identified as a victim of human trafficking is based on international regulations binding on Finland and national legislation. In Finland, the fundamental right to social security is safeguarded by the Constitution, including the right to indispensable subsistence and care. In this case, the client was officially recognised as a victim of human trafficking and included within the scope of the system for assisting victims of human trafficking. As such, there was no ambiguity as to whether the client was entitled to assistance under the aforementioned Act as a victim of human trafficking.

According to the Deputy-Ombudsman, the city's social welfare office materially neglected its obligation to arrange the necessary services and support for the client as referred to in the Social Welfare Act. As services were neither provided nor even planned in a timely manner, the client had no opportunity to participate in the planning and implementation of the services as provided in the Act on the Status and Rights of Social Welfare Clients. The matter was not evaluated comprehensively in the client's interests, nor was any attention paid as required by the Act on the Status and Rights of Social Welfare Clients to which of the various methods of action and solutions could have best safeguarded the provision of timely, appropriate and sufficient support in light of the client's needs related to reinforcing wellbeing, independent capacity and self-direction. The social welfare office did not identify the client as a person requiring special support in accordance with the Social Welfare Act and, therefore, no decisions were made to offer the client special support as provided for in the Social Welfare Act.

According to the Deputy-Ombudsman, the practice was thus unlawful. There were serious shortcomings in the arrangement of the assistance that the client needed and that is intended for victims of human trafficking and in the client's social care. The rights enshrined in the Constitution were not realised in the client's case. For this reason, the Deputy-Ombudsman recommended that the city's committee for basic security and health, which is responsible for respecting fundamental rights, compensate the client for the violations of their fundamental rights (3489/2017).

The committee for basic security and health decided to pay the client a total of EUR 3,900.00 in compensation for the violation of their fundamental rights. In addition, the city's social welfare office issued an apology to the victim of human trafficking for its incorrect application of the law.

Neglecting to accrue funds for promoting independence

According to the Deputy-Ombudsman, the social welfare and health care department in city A had neglected to appropriately accumulate funds for promoting independence for the complainant after the Child Support Act entered into force. Steps had been taken to confirm child support in September 2014, when the complainant's guardians at the time had been asked for consent to apply for a trustee to act instead of the guardians in the child support case. The case progressed after this, but, following the confirmation of child support and an application for a child support allowance, the funds intended for promoting independence only

began to accrue in November 2016, more than two years after the first actions were taken in the case. In 2014, a decision was made to recover student financial aid for the purpose of funds for promoting independence. However, the case included no explanation of why funds were not accrued from student financial aid into the complainant's funds for promoting independence.

When the Deputy-Ombudsman assessed the case, she took into consideration the information that a negative approach had been taken to the principle of supplementing the complainant's funds for promoting independence on a discretionary basis according to the complainant's needs. The case was not considered in the light of the individual needs and circumstances of the young complainant. It also appears that there was no decision made concerning the funds for promoting independence which the complainant could appeal. The case gave the impression that an unlawful maximum amount had been applied. Compensation for the costs of aftercare was also not assessed appropriately, nor was the complainant issued with an appealable decision concerning these costs.

In the Deputy-Ombudsman's view, city A's social welfare and health care department acted unlawfully. The complainant had likely incurred financial losses of a magnitude that is impossible to assess retrospectively. The complainant was still young during the aftercare process, and they had no assets or income of their own. The Deputy-Ombudsman recommended that the federation of municipalities consider how it could compensate the complainant for the violation of their rights (695/2018).

The federation of municipalities stated that it had decided to pay an additional EUR 6,240 to the complainant in funds for promoting independence and issue an apology to the complainant for actions that were not in the child's interests.

Legal protection and good administration

Advice on entries in a person's credit record due to a prolonged enforcement process

When the complainant contacted the district enforcement officer following an entry in the credit record, the enforcement officer failed to explain the requirement for having the entry withdrawn, which is that the enforcement process is terminated at the debtor's request. According to the district bailiff, this was because the district enforcement officer was unaware of the content of the legislation. The requirement for the debtor to request the removal of an entry means that the enforcement officer's advisory obligations play an important role. It can be difficult for debtors to understand their obligations in cases concerning a decision by the public authorities to terminate distraint. In this case, the debtor had specifically discussed the entry in the credit record with the district enforcement officer. According to the advisory obligation stipulated in the Enforcement Code, the district enforcement officer should have explained that the requirement for withdrawal is to submit a request when distraint is terminated. The complainant was notified of the withdrawal approximately eight months after distraint ended.

According to the Deputy-Ombudsman, if a debtor subject to enforcement proceedings has not received sufficient advice regarding the realisation of their rights based on the law in an important case, the relevant party should be able to receive compensation for the harm caused by the negligence, as well as for the worry and uncertainty. This right to compensation was underlined in this case because the government agency's negligence resulted in the credit record containing an entry for a period unduly prolonged by at least several months. Credit record entries cause substantial harm to the relevant party. For this reason, the Deputy-Ombudsman asked the District Bailiff to contact the complainant in a suitable manner and resolve the matter with regard to a potential compensation claim. He asked the Dis-

trict Bailiff to confirm by 31 March 2020 how the case had been resolved with regard to compensation (218/2019).

Verifying the log data on the patient register

The complainant requested log data on 30 August 2016, 15 May 2017 and 1 June 2017. According to the information provided, the decision to provide the data was made at the end of September 2017, but the reports were not sent to the complainant until 31 May 2018. The provision of the data was substantially delayed. If the intention was to decline to provide the data, the procedural requirements of the Act on the Openness of Government Activities should have been followed. If the information request was sent to the wrong entity or if it was incomplete, the complainant should have been advised in accordance with the Administrative Procedure Act on how to handle the matter. The city's basic security centre had acted unlawfully. The practice had violated the complainant's right to have their case dealt with appropriately and without undue delay, a right that is safeguarded by the Constitution. The Deputy-Ombudsman asked the basic security centre to consider whether it could compensate the complainant for the violation (1770/2018).

A city's health and hospital services manager sent the complainant a letter sincerely apologising for the delay in providing the log data. There were clear shortcomings in the process for handling log data requests, and this, combined with disruptions to the flow of information within the organisation, had led to the failure to fulfil the complainant's request.

Fee charged for an unused appointment

The complainant was sent an invitation by post to attend an 18-year-olds' check-up. The invitation was not based on the complainant having made an appointment or that an appointment was agreed with the client in joint understanding. When the client did not attend the appointment, a charge was imposed as referred to in the Decree on Client Fees in Social Welfare and Health Care. According to the Decree, only appointments made by the client can be invoiced, unless the appointment is cancelled or there is an acceptable reason for the client's absence. The imposition of a charge contravened the Decree on Client Fees in Social Welfare and Health Care because the appointment was not based on an expression of the client's will; instead, information about the appointment was sent to the client by post. The EUR 51.40 invoiced for the appointment was incorrectly levied. The Deputy-Ombudsman recommended that the city compensate the complainant for the ungrounded charge, including any associated debt collection and enforcement costs (6217/2018).

The city stated that the most recent uncancelled and unlawful charge had been withdrawn from debt collection and that any costs incurred will be met by the city.

Processing of a request concerning the allocation of vehicle tax

On 9 August 2018, the complainant had paid a vehicle tax bill with a due date of 13 September 2018 using an incorrect or incomplete reference number. The Finnish Transport and Communications Agency's information system only allocates payments to the correct bill if the correct reference number is given. The Agency sent the complainant a payment reminder dated 27 September 2018, stating that the vehicle tax due on 13 September 2019 had not been paid and that use of the vehicle was prohibited. The complainant sent a letter to the Agency on 4 October 2018 stating that they had paid the tax on 9 August 2018. The complainant stated their expectation of receiving a written response from the Agency by 16 October 2018.

The prohibition on the use of a vehicle due to the payment of vehicle tax or an overdue part thereof, as provided for in the Act on Vehicle Tax, is a severe sanction to be imposed on a taxpayer. The legislative history of the Act did not include an assessment of the reasonableness of a prohibition on use or its impact on mobility. According to the Deputy-Ombudsman, such a severe sanction imposed on an administrative customer on the

basis of the law places the tax authority under a special obligation to provide appropriate service and advice. Therefore, the Agency has a greater duty to process and respond to requests and enquiries from customers immediately or as quickly as possible, whether they are made electronically, by telephone or in writing.

The Agency only began investigating the complainant's enquiry and request of 4 October 2018 two months later, and even then, it was only because of a request for information sent by the Deputy-Ombudsman due to the complaint. It was not until 5 December 2018 that the complainant's tax payment was allocated to the tax bill and the prohibition on use was lifted. No special measures were required to process the matter and respond to the complainant, so the Agency should have begun processing the request immediately. The complainant was, therefore, unduly prohibited from using the vehicle for approximately two months due to the Agency's negligence in processing the request.

According to the Deputy-Ombudsman, if a government agency has neglected to process a matter appropriately and has failed to discharge its obligation to provide service and advice, the relevant party should be entitled to compensation for the harm caused by the negligence, as well as for the worry and uncertainty. The right to compensation is underlined in this case because the government agency's negligence resulted in an unduly prolonged prohibition on the use of a vehicle. The use of the vehicle was particularly necessary for the complainant, as the complainant had been granted a disabled parking permit. The Deputy-Ombudsman asked the State Treasury to settle the matter as provided in the State Indemnity Act (5559/2018).

The State Treasury stated that it had decided to pay the complainant EUR 350 in compensation for the violation of fundamental rights.

Collection of a fee from a customer following a non-disclosure request

The South Karelia Social and Health Care District (Eksote) had outsourced invoicing to a private company, which, in turn, had made an agreement with a debt recovery company on collecting overdue invoices. The Deputy-Ombudsman stated that outsourcing the public administrative duty of invoicing or debt collection does not release the public entity from its duty to ensure that invoicing and debt collection comply with the law and good debt collection practice.

In February 2017, the complainant received a notification from the enforcement authority concerning a customer fee. At that time, the complainant had a non-disclosure request in force covering their address. After the non-disclosure request expired in July 2018, the complainant received a debt enforcement notification in September 2018 and a payment reminder concerning a new customer fee. According to the complainant, the complainant did not receive an invoice for the customer fee. According to the information received from Eksote, it sent the complainant five invoices in the period from 2016 to 2018. The information does not reveal whether 'unique invoices' refers to the invoices that were ultimately sent for enforcement and that are the subject of the complaint. Lawful debt collection activities, such as sending payment demands, should not be entered into before a payment reminder has been sent insofar as the case concerns an entity that handles debt collection activities professionally.

According to the Deputy-Ombudsman, Eksote should clarify the matter and compensate the complainant for the costs incurred due to the enforcement collection of invoices sent for enforcement without an original invoice or payment reminder being sent, and consult the enforcement authority to clarify the possibility of removing the entries from the enforcement register (4780/2018).

Eksote stated that it had asked the enforcement authority to remove the ungrounded register entries and issued a decision to compensate the complainant for the costs incurred due to debt enforcement in the amount of EUR 31.52.

Correcting an incorrect entry in the Population Information System

Information on a decision issued by the rural district court in Vantaa on 17 April 1975, wherein the complainant was confirmed to have been born to parents who were not married, and the related entry in the population information managed by the Evangelical Lutheran Church, was not transferred to the Local Register Office. Information on the change in family relations was only sent from the central register of the Vantaa parishes on 19 September 2018 in a request to correct the entries concerning the complainant's father. The correction of the information on the Population Information System was requested urgently because the person listed as the father had died, and the incorrect information would have caused confusion in the estate inventory procedure.

The Local Register Office was of the understanding that the parish's central register had already consulted the complainant on the matter. The complainant had become aware of the apparent error in the Population Information System when the police contacted them due to the death of the person listed as the father. The official at the Local Register Office had considered it necessary to correct the information on the Population Information System as quickly as possible due to the urgent request from the parish's central register and the need to rectify a clear error.

According to the Deputy-Ombudsman, allowing the relevant parties to be heard is an important fundamental right for a fair trial and good governance as enshrined in the Constitution. As the Local Register Office stated in the information it provided, the parties in this case should have ensured that the hearing had occurred appropriately by allowing the relevant party a reasonable time to issue a statement on the matter. The Deputy-Ombudsman made the Local Register Office aware of his interpretation that the practice was incorrect. Due to the harm caused to the complainant in this case, the Deputy-Ombudsman stated that the Local Register Office should apologise to the complainant for its actions (37/2019).

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. The Parliamentary Ombudsman may also propose an amicable settlement to an authority. Examples of such cases are presented below.

Payment of benefits into the wrong account

The complainant had applied for travel compensation from Kela for her children's travel. The compensation was paid into an account held by the children's father. Kela was asked to provide a preliminary report on the matter. According to Kela, it had made a mistake when paying the travel compensation. Kela had contacted the complainant, and the compensation case was adjusted in her favour (EUR 70 and EUR 20). Kela apologised for the errors that had occurred when the compensation claim was processed, as well as for the hassle and inconvenience that was caused. As Kela rectified the errors, the case did not lead to any further measures by the Deputy-Ombudsman (6481/2019).

Recovery of social loans from a student

In a decision issued in December 2013, the Deputy-Ombudsman had found that the City of Helsinki had acted unlawfully when granting means-tested income support by counting the social loans for studies, covered by the legislation on social credit, as income in the same way as a student loan in accordance with the Student Financial Aid Act (65/1994). The Act on Social Credit was enacted after the Act on Means-Tested Income Support. The statements issued by parliamentary committees in conjunction with the

enactment of the law clearly indicate the legislature's intention that social credit must not affect the entitlement to means-tested income support or the amount of support.

In the means-tested income support decisions issued to the complainant from December 2013 to May 2014, the amount of a social loan had been counted as disposable income, in contravention of the Act on Social Credit, thereby resulting in a deduction from the amount of means-tested income support. As such, the majority of these deductions from the means-tested income support had occurred during a period when the City was aware of the Deputy-Ombudsman's viewpoint. He proposed that the City takes this matter into consideration when recovering the social loan for studies (5704/2018).

The City stated that it had sent the client a decision whereby the City would abandon the recovery of a social loan with EUR 1,824.06 in outstanding principal.

Disclosure of a client relationship for means-tested income support in a Kela letter

The Deputy-Ombudsman's deputy recommended that Kela assess the design of a client letter sent to a landlord about a rent deposit from the perspective of whether it is essential to explicitly mention a social welfare client relationship when taking into account perspectives such as the appropriate processing of the matter, the complainant's privacy and, potentially, the interests and rights of the landlord, or for any other legally justified reason (4582/2018).

Kela stated that it grants rent deposits as a part of basic income support. Kela had altered the design of the cash deposit letter as a consequence of the decision by the Deputy-Ombudsman's deputy, removing the mentions of basic income support.

A wig as a medical rehabilitation aid

According to the decree of the Ministry of Social Affairs and Health on the provision of medical rehabilitation aids (the medical aid decree), the need for medical aids should be assessed in a timely, individual and user-oriented way. Medical aids should be selected in agreement with the patient, and before selecting an aid, the patient must be informed of the alternatives in a way that is easy to understand.

In the City of Tampere's criteria applying to wigs, the sole criterion affecting whether a payment commitment is granted for a custom-made wig is whether the client's head is an unusual size and shape, but the criteria do not make it clear how the client's other individual needs, such as medical needs (e.g., rashes), are taken into consideration. In the understanding of the Deputy-Ombudsman's deputy, timely, individual and user-oriented needs should have been taken into consideration in the complainant's case in such a way that an exception could have been made on the purchase costs of the wig in accordance with the client's individual needs. Factors other than the unusual size and shape of the client's head should have been taken into consideration as individual needs in the City's criteria for medical rehabilitation wigs. The Deputy-Ombudsman's deputy recommended that the City contact the complainant in the manner that it deemed appropriate in order to reassess the need for a medical aid, and that it inform the Deputy-Ombudsman which measures are taken as a result of his interpretation and recommendation (2680/2018).

The City of Tampere stated that the complainant had been granted a voucher for a custom-made wig. In the future, the criteria for granting a custom-made wig will also take account of potential skin symptoms or other medical factors in addition to unusual head sizes.

Denial of a medical rehabilitation aid

The complainant asked the medical aid centre to move the power-assisted wheels from a Compact wheelchair onto an Etac Cross wheelchair, which was mainly used outdoors. The medical aid centre refused to install the power-assisted wheels because the complainant's own aids cannot be attached to the health care service's equipment for liability reasons. In addition, the centre took the view that the criteria for providing medical aids had not been met because the complainant's vision was very poor due to multiple sclerosis. The chief physician made the decision.

The substitute for a Deputy Ombudsman stated that the complainant's need for medical aids should have been investigated more comprehensively in order to enable the complainant to spend time and exercise outdoors and to prevent the complainant's functional capacity from deteriorating. If necessary, the health care service should work in cooperation with the municipality's disability service to identify changes in the need for services. The substitute emphasised that individual and functional medical aid solutions and other effective services are highly significant for the functional capacity of persons with disabilities and their equal participation in society. If a patient's situation changes, and previous medical aids are no longer suitable for them, their need for medical aids must be reassessed. If necessary, the patient should also be guided to use other social welfare and health care services. The substitute recommended that the hospital district contact the complainant in the manner that it deemed appropriate in order to reassess the complainant's need for medical aids and to put the complainant into contact with the disability services provided by the City of Rauma (1607/2018).

According to the hospital district's statement, the complainant will be offered the opportunity to attend a rehabilitation examination at the out-patient clinic for demanding rehabilitation, part of the hospital's rehabilitation centre. This will involve the preparation of an individual rehabilitation plan, which will include an assessment of the need for a functional, individual medical aid solution. In the complainant's case, one challenge is that motorised medical aids cannot be granted to severely visually impaired people because there is a clear risk of injury to the patient or the patient's environment. The new assessment will take into consideration the complainant's individual requirements when evaluating the need for medical aids, and it will also involve cooperation with the city's disability services.

Arrangement of basic education

The complainant criticised the music-weighted teaching in a secondary school attended by their son in year eight. The pupils in music classes were obligated to participate in practices held at weekends and concerts arranged outside of school hours. Furthermore, the complainant stated' the child's freedom of religion was violated when the child was obligated to perform religious material (the song, 'Silent Night') in a church. In addition, the complainant criticised the school's decision to discontinue the teaching of French lessons, which had begun in year six as an elective language (A2), in the autumn of year 7.

The complaint led to a legal advisor contacting the city's basic education manager by telephone, with the outcome that the party responsible for arranging education will contact the complainant in the near future to address the questions sent to the Parliamentary Ombudsman. As such, the matter did not require the Deputy-Ombudsman to take any further measures than to ask the city's department for education to declare the action it had taken in the case (6523/2018).

The city's notification stated that, according to a lawyer at the Finnish National Agency for Education, pupils cannot be obligated to engage in school activities at weekends, except on school days. At all other times, participation is voluntary. The city stated that it would endeavour to select the concert programme in such that does not offend anyone's beliefs, or the pupil will be offered the opportunity of refraining from participating in concerts that are incompatible with their beliefs. Teaching of an A2 language syllabus may also be arranged in cooperation with another school if the schools are located

close enough for the pupils to travel between them during break times. In this case, the pupil had not been directed to attend a joint A2 French course at another school due to human error.

Misleading information on the website of the Population Register Centre

The 'Notification of change of address' section of the Local Register Office's website states that a notification of a change of address causes the information to be updated simultaneously on the national Population Information System maintained by the Local Register Offices and on Posti's system. The Population Information System automatically sends the new address to the authorities. In addition, many pension institutions, banks, insurance companies, organisations, publishers and companies receive new addresses directly from the Population Information System. The page referred to on the Local Register Office's website includes a link to the Population Register Centre's website, which lists the entities that update their address details using the Population Information System. This list includes unemployment funds. A preliminary report requested from the Population Register Centre stated that it maintains this information and that the information concerning unemployment funds is misleading, so the information will be urgently updated. The case did not require the Deputy-Ombudsman to take any further measures (4083/2019).

Shortcomings in the occupational health and safety of prisoners in work functions

The complaint highlighted occupational health and safety shortcomings in prisoners' work functions (welding and painting). The legal advisor addressing the complaint contacted the prison's assistant director, and the Deputy-Ombudsman sent the complaint and his response to the prison director to enable the shortcomings to be investigated. The Deputy-Ombudsman asked the prison director to state which measures were taken in this case (821/2019).

According to the information provided by the prison, the occupational health and safety shortcomings were rectified.

3.8 Special theme for 2019: Right to privacy

3.8.1 GENERAL

As in the previous year, the special theme for the Office of the Ombudsman for the year under review was the 'Right to privacy'. The annual theme is a prominent aspect of all inspection visits as appropriate for each site. The theme is also taken into account in other activities, such as when considering unprompted visits. The special themes of previous years include the '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'.

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.

Findings made during inspections on the premises of authorities and institutions

During inspections, the Parliamentary Ombudsman has paid attention 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. The premises must be suitable for processing 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 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. On the whole, the inspection findings related to the special theme are largely the same as in the preceding year.

In the area of institutional care for elderly people, every client requiring long-term care must have their own room and sanitary facilities. In principle, people who do not know each other should only be placed in the same room of their own volition. The double-occupancy rooms had room dividers to ensure privacy, but the dividers were not used (2009/2019). It was not always possible to determine whether clients were willing to be allocated to a double-occupancy room with a stranger due to the clients' diminished cognitive capacity, nor were they capable of understanding the implications (1842/2019). Similar questions concerning accommodation arose during inspections of assisted-living units for people with intellectual disabilities (1683 and 1684/2019).

Particularly in forensic psychiatry hospitals, where long treatment periods are the norm, allocating psychiatric patients to single-occupancy rooms reduced the occurrence of altercations and the use of restrictive measures, and accelerated the recovery of patients. Allocating severely ill patients to the same room for several years is highly problematic in terms of the good care and respect for privacy mandated by the Act on the Status and Rights of Patients. The goal should be to have single-occupancy rooms with their own hygiene facilities. The Parliamentary Ombudsman has recommended increasing the number of single-occupancy rooms available in psychiatric hospital care.

The inspections of police prisons focused on the number of people accommodated in each cell and the possibility of realising their right to privacy. In some police prisons, persons deprived of their liberty only had access to a toilet that was within view of other people. Conversely, several police prisons promoted privacy by taking technical measures to prevent camera viewing around the toilets in detention rooms (1954, 3622 and 3623/2019).

In terms of privacy, it is problematic if there is a direct line of sight from an adjacent residential building onto the entrance used when intoxicated persons and other persons detained on the basis of the Police Act are taken into the police prison (2982/2019). Persons deprived of their liberty should not come to the attention of external parties, for example, when they are going outside (1954/2019). Camera surveillance should not be used in the washing facilities or changing rooms of police prisons where persons deprived of their liberty are naked (1954/2019).

The inspections performed in prisons also found particular shortcomings in privacy protection in relation to the procedures for toilet visits. Even in situations where the camera surveillance of a prisoner is legal, it is not acceptable if a prisoner could be subjected to camera surveillance while using the toilet. It is only acceptable when the prisoner is placed in isolation and, even in this case, efforts must be made to enable some degree of privacy when the prisoner uses the toilet. Several persons deprived of their liberty may only be held in the same cell if the toilet in the area is separated from the remainder of the area or if prisoners have the opportunity to use a separate toilet area where no other people are present (1592, 1936 and 4575/2019).

Various types of sample-taking related to substance abuse checks are problematic in terms of privacy because the prisoner must be under constant observation, but the prisoner's privacy must be upheld as well as possible in the circumstances. One good practice for promoting privacy when a prisoner is required to undress is to provide the prisoner with a bathrobe and use a mirror-glass window for surveillance, enabling the prisoner to be alone in the sampling room when providing a sample (2449/2019).

Phones allocated for the use of prisoners must be placed or protected in such a way that a phone conversation at normal volume cannot be overheard by outsiders. For example, an open room divider installed around a phone does not adequately safeguard the privacy of phone calls (2449/2019). One of the best solutions for securing privacy during phone calls is to provide phone boxes (1936/2019).

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 practices of public authorities and the general attitude, behaviour and professional competence of public authority employees, and the way in which customers are treated.

Girls placed in child welfare institutions have not been allowed to make their own choices concerning the hygiene products the use during menstruation. In principle, tampons were forbidden. The girls were dependent on the products chosen and procured by the institution. The institution's practices severely restricted the rights of a young girl to make decisions concerning her own body and to decide on matters intricately related to her own person and privacy. Children were also forbidden from using make-up in the institution, dyeing their hair, having piercings and wearing tops or other clothing that the institution deemed inappropriate. Piercings, clothing and matters such as dyeing one's hair have an essential connection to the way a person expresses their identity (5377/2018).

When a child arrived at a child welfare institution, they were not usually permitted to talk to the other children in the initial phase and were required to spend most of their time alone. The child was only allowed to engage in activities outdoors or outside their room with an instructor and, even then, they were not permitted to talk to the other children. In practice, it was only possible to talk to the other children when the children were taking exercise outdoors under surveillance or in common areas. Even then, the conversations were monitored, and certain topics were forbidden. This practice encroached on a core aspect of the freedom of speech, restricting the child's right under Convention on the Rights of the Child to freely express their opinions and impeding the protection of privacy and the child's right to self-determination as safeguarded by the Constitution (5377/2018).

Asylum-seekers belonging to sexual and gender minority groups in reception centres have generally been accommodated in separate, shared rooms. The inspector was told that when other residents are selected for inclusion in the area, efforts are made to ensure that they have an unprejudiced attitude towards diversity. The inspectors suspected that allocating a person to a different area could cause them to become labelled and jeopardise their privacy protection if they do not want others to gain knowledge of their sexual or gender orientation.

In addition, it became apparent that the reception centre reviews the welfare and circumstances of residents with a multi-professional approach in different professional groups. In conjunction with this, a resident's privacy protection could be endangered if their confidential health details are reviewed without their consent. When medications are distributed, it is also possible that residents' privacy is violated if the medications are distributed by a person who does not have an entitlement to access medical information on the basis of the law or the person's consent (3440/2019).

A prison inspection found that cell doors bore the surnames of prisoners in addition to their prisoner numbers. This procedure was problematic in terms of the protection of the privacy and safety of the prisoner. In the Deputy-Ombudsman's view, the prison should discontinue the practice of displaying prisoners' surnames (1936/2019).

Complaints lodged by prisoners, in which attention has been paid to the way the right to privacy has been guaranteed, often concerned inspection measures targeted at the prisoner lodging the complaint. According to the Imprisonment Act, prisoners and persons coming to visit prisoners can be subjected to security checks to ensure that they are not carrying any prohibited substances or objects. Dogs may be used to assist in performing security checks. Placing the subject of the inspection on a perforated seat or mesh stool in such a way that a dog is commanded or otherwise guided to sniff the person's genitals from beneath the seat could be criticised in terms of its indiscretion and impact on privacy protection (5948/2018 and 1328/2019).

Personal data protection and information security are also part of privacy protection. The information held in patient records is confidential, and the fact that a person is a health care client is, in itself, confidential information. According to information obtained from documentation, a hospital district sent out letters addressed to patients featuring symbols indicating the place where the patient was being treated. One of the letters sent to the complainant was labelled "Surgical Hospital" alongside the name of the hospital, while another letter bore the information "Hospital T9" alongside the name of the hospital and the municipality of the institution. This specific information on the place of treatment could connect the complainant to treatment relationships in these units. Therefore, the information could have jeopardised the protection of the complainant's privacy if it had been revealed to external parties.

It may be justified and necessary for documents such as invitations to surgery to be able to be returned to the sender so as to manage the waiting list for surgical procedures. However, the sender's details must not include text that reveals the name of the place of treatment to external parties. The intended goal can be reached by different means; for example, codes could be used to direct returned post to the correct location without delay (4362/2018).

During inspections of police prisons, it came to light that detention facilities kept various records of the everyday activities of persons deprived of their liberty, such as outdoor exercise and washing. The means of record-keeping varied from paper-based forms to the police information systems. The varying range of practices for keeping and processing records can be considered problematic in terms of the protection of privacy (4489/2017).

The police forbade people from taking photos and videos while they handled an emergency rescue of a person on the roof of a block of flats. In this case, no legal grounds were provided for forbidding people from taking photos and videos of the incident from beyond the exclusion area, as it was not subject to the protection provided for homes and designated public places. If a person is taking photos or videos, the police may make the person aware of the potential sanctions for publishing material that could violate the protection of privacy afforded to the person depicted (2521/2019).

The police had provided notification of a traffic accident involving a car and a motorcycle. The notification should have paid special attention to the fact that the suspected motorcyclist was a minor, and it should have refrained from including information that could contribute to the identification of the person, particularly the fact that the person was suspected of using amphetamines. Blood tests subsequently proved this suspicion to be unfounded. A local newspaper published the police notification, and the motorcyclist was named on social media and labelled as a drug-user. Providing notification of this crash, which was not extraordinary by any means, was not particularly necessary under the provisions of the Criminal Investigation

Act concerning notification. For more ordinary and less severe crimes, there is usually less need to communicate information that could identify the parties or precisely list the crimes involved (4217/2018).

During a control inspection, a civil servant at the Finnish Transport and Communications Agency used their own personal accounts to monitor the complainant's Instagram and Facebook accounts. The Deputy-Ombudsman stated that if a civil servant monitors private accounts, whether they are in a business name or personal name, may be problematic in some cases, particularly if the monitoring violates fundamental and human rights – in this case, the protection of privacy. In terms of the protection of privacy, even public social media accounts may give rise to problematic situations regarding the protection of third parties' privacy. Although the action was not illegal, the problematic nature of the case from the perspective of legal rights means that the Finnish Transport and Communications Agency should draw up instructions that set unambiguous boundaries for the use of personal social media profiles in official duties (4552/2018).

3.9 Statements on basic rights

This section discusses some of the statements on fundamental 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 fundamental rights or are of importance in principle. They are also included in section 3.7, which describes the Ombudsman's decisions leading to a recommendation for compensation.

3.9.1 DECISIONS

Restriction of library services on the basis of age (Constitution, section 6)

Due to disorderly conduct, a library had prevented customers under the age of 20 from using its self-service features.

It is possible to intervene in disorderly conduct in a library on a case-by-case basis. However, everyone under the age of 20 was prevented from using the self-service features of the library because the disorderly users were impossible to identify. As such, people under the age of 20 were placed in a less favourable position than other users of the service as referred to in the Non-Discrimination Act, based solely on their age.

Public libraries should be available and accessible to everyone as stipulated in the Public Libraries Act, and the prohibition of age-related discrimination protects library customers of all ages. The rules of use or other actions taken by officials at libraries must not impose restrictions which are not based on the law on the use of libraries. As such, from the perspective of the Non-Discrimination Act, it was not necessary to enter into a deeper analysis of whether the goal of the discriminatory treatment applied by the library was otherwise acceptable and whether the means of reaching the goal were proportionate.

According to the Deputy-Ombudsman, a blanket restriction on the use of libraries by everyone under the age of 20 amounted to direct discrimination, even though the restriction was applied to a service considered incidental to the main purpose of a library, and was based on disorderly conduct of a type in which there is a case-by-case right to intervene as provided specifically in law (328/2018).

Court hearing on the isolation of an alien (Constitution, sections 7 and 21)

A District Court judge declined to investigate a case relating to the isolation of a detained alien.

The Ombudsman stated that there was no discretion of the court regarding the arrangement of a hearing or refusal to arrange a hearing. According to the law, a court hearing should have been arranged, and the civil servant at the detention unit who decided to detain the person in isolation should have been called to the hearing. In addition, the regulation was not open to interpretation: it was clear and unambiguous. The basis of the regulation is that an action that further deprives a detained foreign national of liberty must be submitted to a court of law for evaluation. This case concerns an intervention in the right to personal liberty enshrined in section 7 of the Constitution, a precautionary measure that further deprives a person of their liberty, and the court's supervision of the lawfulness thereof – a matter of essential importance to the legal protection of the person subjected to the action (1015/2017).

Religious celebrations at schools (Constitution sections 6 and 11)

Sections 6 and 11 of the Constitution require that school pupils are not obliged to participate in religious activities against their will, irrespective of whether the pupil belongs to a religious community. According to the Basic Education Decree, school Christmas parties are a part of education that should be unconnected to religion or beliefs as referred to in the curriculum. The traditional celebrations held at Finnish schools are a part of the education and school activities in which pupils must participate. By arranging a school Christmas party as a religious event, the school could have violated the freedom of religion and conscience of its pupils and their parents or guardians, as well as the pupils' right to equal participation in the school's Christmas party.

Arranging an end-of-year celebration with content of a confessional nature cannot be justified by the provision of an alternative event. The ceremony at the end of a school's academic year cannot be considered a religious event. The matter concerns a joint celebration for all pupils as part of their education, and it must be arranged in such a way that all pupils can attend it, irrespective of their beliefs (2186/2018).

Freedom of speech of a teacher serving as a municipal politician (Constitution, section 12)

A municipality issued a verbal warning to a teacher due to a blog article. The warning was based on a single sentence in the article. According to the warning, the article defamed the employer.

The part of the article on which the warning was based did not refer to an individual representative of the employer by name or in any other identifiable manner. Instead, it referred to civil servants in very general terms. Above all, the post was a value judgement concerning the financial calculations made by civil servants, and it was not, in principle, necessary to present factual bases to support the value judgement. The section could also be construed as a form of self-criticism by municipal decision-makers – who numbered the complainant among them – in which the complainant called for decision-makers to take a critical approach to the information and civil servants' preparatory work underlying the decision. Freedom of speech was of special importance to the complainant, who was also a politician, and the threshold for intervention in opinions presented during political activity was very high. The appropriateness of the complainant's personal motives was not called into question, nor was it even claimed that the complainant's article had caused the municipality as the employer to incur any loss or damage.

According to the Ombudsman, the civil servant's freedom of speech was not adequately assessed when the warning was issued. In addition, the special characteristics of the complainant's dual role as a teacher and a municipal politician and the opinions expressed in political activity were not given sufficient consideration. As the complainant's freedom of speech was impacted by the verbal warning due to the blog article, and there were no acceptable grounds for issuing such a warning, the complainant's freedom of speech, which is safeguarded by section 12 of the Constitution of Finland and Article 10 of the European Convention on Human Rights, had been violated (1307/2018).

Right of appeal against decisions made on the basis of the Assembly Act (Constitution, sections 13 and 21)

Decisions to stop and move demonstrations on the basis of the Assembly Act are decisions concerning rights and obligations as referred to in section 21 of the Constitution. Such decisions represent interventions into the fundamental rights, enshrined in section 13 of the Constitution, to arrange and participate in demonstrations, and they cannot be considered exclusively *de facto* administrative measures with no right of appeal. The decisions must be accompanied by appeal instructions. Ultimately, a court of law rules whether a decision can be appealed (5998/2017).

Arranging voting in a psychiatric hospital (Constitution, section 14)

A patient in isolation in a psychiatric hospital was isolated on an advance voting day and, due to their state of health, was not able to vote. For the same reason, they were also not able to leave the hospital to vote on the actual polling day.

While the person was in isolation, they had not expressed the wish to be able to vote in advance. In a decision concerning voting in institutions, the Ombudsman has stated the view that the personnel should ensure that residents are aware of their opportunity to participate in public advance voting. If the patient was unaware of this possibility, it is understandable that they did not make a request related to it.

In the Deputy Ombudsman's opinion, during advance polling, institutions should separately consider whether each isolated patient could visit a polling station and vote under supervision, and, if deemed possible, then actively offer this opportunity to the patient. By taking such an approach, the hospital would promote the opportunity of patients to participate in societal activities, as intended under the Constitution of Finland (892/2018).

Activities subject to fees in basic education (Constitution, sections 6 and 16)

From the perspective of free basic education and equality among school pupils, it is problematic if, at the school's initiative, excursions and events are planned on the presumption that families will cover some or all of the costs and are implemented as part of the school's activities during school hours.

For example, organising excursions and physical education days in such a way that a free-of-charge alternative is also offered has the result of effectively dividing the pupils into two groups: those who are able to pay to participate and those who are not.

As the parties responsible for arranging education, municipalities do not have the discretionary power to decide whether basic education is free of charge. The subjective right for everyone to receive basic education free of charge in accordance with section 16 of the Constitution means that it must be possible for pupils to receive education without incurring any costs. In addition to teaching, essential teaching tools, such as textbooks, must also be free of charge. This requirement also covers all necessary school-related transportation and adequate nourishment.

In this context, 'equality' in accordance with section 6 of the Constitution means that every child has an equal right to free basic education, irrespective of their financial position. Every pupil should have the opportunity to participate equally in the activities planned in accordance with the school's curriculum and the Basic Education Decree without any additional fees. As the parties responsible for organising education, municipalities have an obligation to refrain from establishing practices that effectively increase inequality. The Non-Discrimination Act requires that the party organising education and the educational institutions managed by such parties must assess whether their activities have been non-discriminatory and must take the necessary measures to promote non-discrimination (1120, 2882 and 5984/2018).

Enforcement of a decision concerning social assistance (Constitution, section 19)

It is a principle of the Administrative Judical Procedure Act that a decision qualifying for appeal shall not be enforced before it has become final.

However, the decision may be enforced before it has become final if there is a provision to this effect in an Act or a Decree, if the decision is of such a nature that it requires immediate enforcement, or if its enforcement cannot be delayed for reasons of public interest.

If leave to appeal is required in the matter, an appeal shall not preclude enforcement. However, enforcement may not begin if the appeal would become futile due to the enforcement, or if the Supreme Administrative Court denies enforcement.

The Social Insurance Institution of Finland (Kela) had sought leave to appeal a certain case and had not enforced a binding decision of the Administrative Court.

In the Deputy-Ombudsman's view, if an authority postpones the enforcement of a decision that has not become legally valid, for example on the grounds that leave to appeal and the appeal itself seek to obtain a preliminary ruling or policy ruling, this alone is insufficient justification for postponing the enforcement of a decision if there is a danger that the postponement could result in the realisation of fundamental rights, such as an individual's subjective right to social assistance, being delayed or compromised.

With regard to an interpretation of the law that affirms fundamental rights, there were strong grounds in this case in favour of Kela enforcing a ruling of the Administrative Court before it had obtained legal validity, in spite of the application for leave to appeal. In doing so, Kela would have provided the basic subsistence to ensure the purchase of the medical care that the Administrative Court deemed necessary for the complainant, while also ensuring the continuity of the complainant's medical care while the case concerning leave to appeal was pending at the Supreme Administrative Court. From the complainant's perspective, the question was one of the subjective right to basic subsistence and the fundamental right to social security and the security of a life of dignity (6123/2018).

Openness of legal proceedings on imprisonment (Constitution, section 21)

The Deputy-Ombudsman stated that a session of a District Court can be held in a location other than the actual place of the District Court for extraordinary reasons in accordance with the Courts Act. It is not rare for court sessions concerning coercive measures to be held on police premises. However, the perspective of openness must also be taken into consideration when selecting a place for the court session. The place of session or courtroom should not have been selected on the basis of where it was easiest to restrict the presence or number of members of the public. When a court session was held on premises other than the District Court's courtroom, the court should have ensured that the trial was open. Holding a trial in a place that the public could not access freely may have represented a material impediment to openness. In such cases, the court was obliged to take special measures to ensure that the public and the media were notified of the place where the trial was held and guaranteed effective access to the place.

In the Deputy-Ombudsman's view of the imprisonment case, the question of whether to conduct a hearing without the presence of the public should have been resolved and justified for each court session individually. The Deputy-Ombudsman did not find any grounds for the interpretation that the validity of decisions concerning the conduct of a case without the presence of the public as passed down in prior imprisonment sessions could continue and be extended to future imprisonment hearings without taking separate measures. According to the Deputy-Ombudsman, public trials were the general rule and principle on which the situation should always be reassessed. The investigational reasons that supported the restriction of the openness of oral hearings in imprisonment trials did not necessarily carry the same weight in subsequent imprisonment hearings. The subsequent imprisonment hearings did not even necessarily cover the general requirements for imprisonment. Instead, they focused on matters such as the alleged unfairness of keeping a person imprisoned.

In a criminal case that attracted widespread interest among the public and suspicions of the impartiality of the authorities, it would have been especially important to give an exhaustive justification for the decision to deny the public access to the case (2268/2018).

3.10 Complaints to the European Court of Human Rights against Finland in 2019

A total of 131 new applications against Finland were lodged with the European Court of Human Rights (ECHR) in 2019 (174 in the previous year). A response from the Finnish Government was requested in four (5) cases. At the end of the year, 19 (20) cases concerning Finland were pending.

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

A very large proportion of the applications lodged with the ECHR are declared inadmissible. In 2019, the application was declared inadmissible or struck out of the Court's list in 131 (170) cases that concerned Finland. In 2019, the ECHR passed two judgments concerning Finland (none in 2018, two in 2017), one of which found violations of Article 2 (Right to life) and Article 3 (Prohibition of torture) of the European Convention on Human Rights.

3.10.1 JUDGMENTS AND DECISIONS

The Court found against Finland on 14 November 2019 (*N.A. v Finland*, 25244/18) in a case concerning an asylum-seeker who were returned to Iraq. The ECHR stated that Articles 2 and 3 of the European Convention on Human Rights were violated when the asylum application of the complainant's father was processed. The complainant's father was killed in Iraq. In the view of the ECHR, the Finnish authorities' assessment of the merits of the case and the risks that the complainant's father would face upon being returned to Iraq did not meet the requirements of Articles 2 and 3 of the European Convention on Human Rights in terms of quality. In the view of the ECHR, the authorities were or should have been aware of the facts indicating that the complainant's father was likely to be in mortal danger or at risk of mistreatment if he were deported to Iraq. The ECHR took the view that the complainant's application on their own account was clearly without merit, and it did not admit the matter for consideration in this regard. The ECHR ordered the Finnish State to pay the complainant EUR 20,000 in compensation for intangible loss or damage and EUR 4,500 in legal expenses.

The other judgment against Finland (14 February 2019) concerned a process that culminated in a ruling by the Supreme Administrative Court of Finland in a case about an asphalt cartel (*SA-Capital Oy v Finland*, 5556/10). The judgment of the ECHR concluded that the principle of the right to a fair trial enshrined in the European Convention on Human Rights had not been violated in this case. According to the ECHR, an adequate amount of evidence had been exhibited in the case

to demonstrate SA-Capital Oy's involvement in a cartel, and circumstantial evidence and hearsay did not have a decisive impact on the outcome of the case. Overall, the case was handled fairly.

The total number of judgments issued by the ECHR to Finland by the end of 2019 was 190. The total number of ECHR judgments confirming a violation of rights by Finland since the country's accession is strikingly large, at 141 (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 135 cases, although 12 of these judgments were issued in 2019.

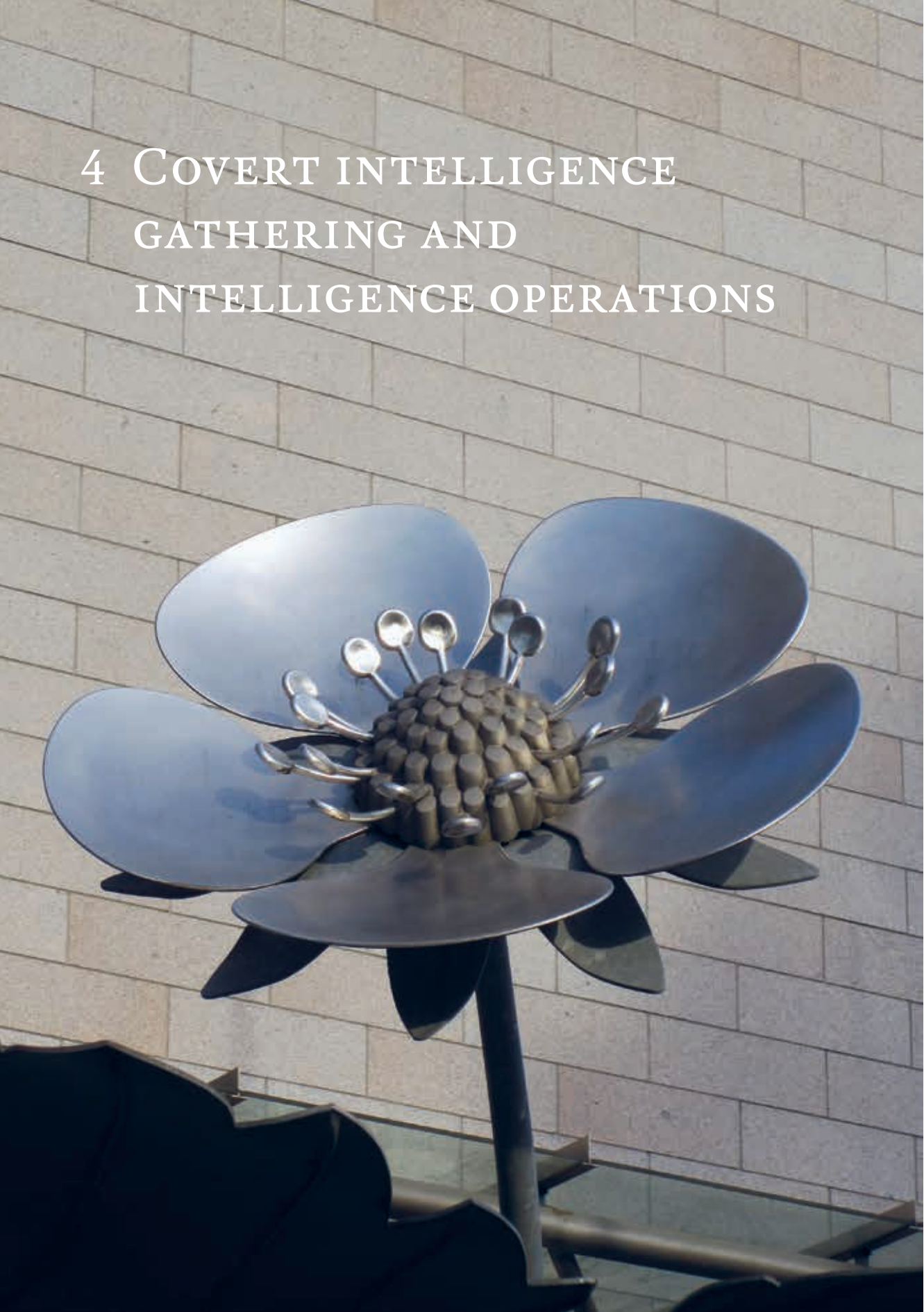
3.10.2 MONITORING OF THE EXECUTION OF JUDGMENTS IN THE COMMITTEE OF MINISTERS OF THE COUNCIL OF EUROPE

The Committee of Ministers of the Council of Europe 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. As in the previous year, monitoring of execution remained pending in 29 judgments concerning Finland.

4 Covert intelligence gathering and intelligence operations



4 Covert intelligence gathering and intelligence operations

The oversight of secret information gathering and intelligence operations fell within the remit of Parliamentary Ombudsman *Petri Jääskeläinen*. The principal legal adviser responsible for the area was *Mikko Eteläpää*. Themes included in this area are also presented by Legal Adviser *Minna Ketola* and Principal Legal Adviser *Juha Haapamäki*.

Covert intelligence gathering refers first of all to the covert coercive measures used in criminal investigations and to the corresponding covert methods of gathering intelligence that may be used to prevent or detect offences or avert danger. Such methods include, for example, telecommunications interception and traffic data monitoring, technical listening and surveillance as well as undercover operations and pseudo purchases. The use of these methods is kept secret from their targets and to some extent they may, based on a court decision, remain permanently undisclosed to the targets.

The police have the most extensive powers to use covert intelligence gathering, but the Finnish Customs also have access to a wide range of covert methods of gathering intelligence with respect to customs-related offences. The powers of the Finnish Border Guard and the Defence Forces are clearly more limited.

This chapter also discusses a report on the witness protection programme submitted to the Parliamentary Ombudsman. The witness protection programme act (*laki todistajansuojeluohjelmasta* 88/2015) entered into force on 1 March 2015. According to the act, the Ministry of the Interior must annually report to the Parliamentary Ombudsman on decisions and measures taken under the act.

In the year under review, a new regulatory framework for intelligence gathering was adopted. The Act on the Oversight of Intelligence Gathering (121/2019) entered into force on 1 February 2019. The amendment to the Police Act, Chapter 5a (civilian intelligence, 581/2019), Act on the Use of Network Traffic Intelligence in Civilian Intelligence (582/2019) and Act on Military Intelligence (590/2019) entered into force on 1 June 2019. The legislation includes the obligation of the authorities to submit an annual report to the Ombudsman on their operations.

In addition, the Parliament passed the proposal of the Speaker's Council to amend the Parliament's Rules of Procedure and Section 9 of the Act on Parliamentary Civil Servants (parliamentary scrutiny of intelligence gathering). They entered into force on 1 February 2019.

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 asso-

ciated 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 LEGISLATION

At the beginning of 2014, the Coercive Measures Act and the Police Act underwent a complete reform, including a significant expansion in the scope of regulation concerning covert intelligence gathering. The provisions on the previously used methods were also complemented and specified in the reform.

With respect to the Defence Forces, the act on military discipline and crime prevention in the Defence Forces (*laki sotilaskurinpidosta ja rikostorjunnasta puolustusvoimissa* 255/2014) entered into force on 1 May 2014. Under the act, when the Defence Forces conduct a criminal investigation they may use certain, separately determined methods of covert intelligence gathering as referred to in the Coercive Measures Act, such as extended surveillance and technical observation and listening. In the prevention and detection of crimes, the Defence Forces similarly only have access to certain methods of covert intelligence gathering, although the range is wider than in criminal investigations. However, the Defence Forces cannot use, for example, telecommunications interception, traffic data monitoring, undercover operations or pseudo purchases. If these measures are needed, they are carried out by the police.

The act on the prevention of crime by Finnish Customs (*laki rikostorjunnasta Tullissa* 623/2015) entered into force on 1 June 2015. In the act, the powers of Customs were harmonised with those

laid down in the new Criminal Investigation Act, Coercive Measures Act and Police Act. One significant change was that Customs were given powers to conduct undercover operations and pseudo purchases, even though the measures are in practice implemented by the police at Customs' request. Moreover, the use of covert human intelligence sources in the prevention of customs-related offences was harmonised with the provisions of the Police Act and the Coercive Measures Act.

The act on crime prevention by the Finnish Border Guard entered into force on 1 April 2018. The crime prevention provisions currently included in the Border Guard Act were transferred to the new act. In addition to the previous powers, the right to use a basic form of human intelligence source was added to the powers of the Finnish Border Guard.

4.4 REPORTS ON SECRET INFORMATION GATHERING SUBMITTED TO THE PARLIAMENTARY OMBUDSMAN

The following presents certain information on the use and oversight of covert intelligence gathering obtained from the reports submitted by the Ministry of the Interior, the Headquarters of the Finnish Border Guard, the Ministry of Finance and the Ministry of Defence. The precise figures are partly confidential. For example, the covert intelligence gathering activities of the Finnish Security Intelligence Service are not included in the figures presented below.

Use of covert intelligence gathering in 2019

Coercive telecommunications measures under the Coercive Measures Act

The police were granted 2,738 (2,867 in 2018) 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 2019, simultaneous telecommunications interception and traffic data monitoring activities carried out by the police under the Coercive Measures Act were targeted at 410 (450) suspects, of whom 33 were unidentified. The use of traffic data monitoring was targeted at 1,537 (1,380) suspects.

Simultaneous telecommunications interception and traffic data monitoring activities carried out by Customs were targeted in 2019 at 146 (91) persons, and the number of warrants issued was 518 (421). This shows a substantial increase. According to Customs, the increase in the number of warrants is explained by the increase in the number of extensions to warrants applied for and in the 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.

Like last year, traffic data monitoring is on the increase in Customs. it was targeted at 230 (200) persons, with 701 (630) warrants being issued.

The most common grounds for simultaneous telecommunications interception and traffic data monitoring by the police were aggravated narcotics offences (69%) and violent offences (11%). Within the administrative branch of Customs, the most common grounds were aggravated narcotics offences (80%) and aggravated tax frauds (17%).

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 88 warrants (77) 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

Telecommunication interception and traffic data monitoring under the Police Act was targeted at five (four) persons. Mere traffic data monitoring was targeted at 129 (104) 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

A significantly lower number of permits was issued to Customs for the use of traffic data monitoring procedures to prevent or detect customs offences: 32 (eight), most often on the grounds of aggravated tax fraud or an aggravated narcotics offence.

Technical surveillance

In 2019, the police used technical surveillance under the Coercive Measures Act 33 times with respect to premises covered by domiciliary peace, technical surveillance 131 times, on-site interception 121 times and technical tracking 318 times. On-site interception in domestic premises was used eight times. Data for the identification of a network address or a terminal end device were obtained 55 times. The most common reason for using these surveillance methods was an aggravated narcotics offence.

Under the Police Act, technical surveillance was used 10 times, on-site interception five times and technical tracking 52 times.

Customs used technical tracking under the Coercive Measures Act in 57 (40) instances. On-site interception was used 38 (23) times and technical surveillance 20 (25) times.

Technical tracking under the Act on the Prevention of Crime by Finnish Customs was used nine (10) times. Two decisions (0) decisions were issued on on-site interception, and technical surveillance was used 11(12) times.

In the Finnish Border Guard, a total of 21 (26) decisions were made on technical surveillance and extended surveillance in order to solve an offence, and 11 (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 2019 the police made some 198 decisions on the use of extended surveillance. Customs took 85 (59) similar decisions.

Special covert coercive measures

In 2019, a few new decisions were taken to use undercover operations and to continue the validity of previously issued decisions on undercover operations. Undercover operations performed in data networks are more frequent than such operations in real life. Pseudo purchases were also mainly used to detect and investigate aggravated narcotics offences, although property offences also featured as grounds for the use of this investigation method.

The prerequisites for controlled delivery are very strict which in practice has restricted the use of this method. The police have only performed a few controlled deliveries during the time the act has been in force; however, during the year under review, no controlled deliveries were carried out. Customs reported having used controlled deliveries 18 (three) times in 2019.

Rejected requests

There was no significant change in the number of rejected requests for the use of coercive telecommunications measures. In 2019, courts rejected 14 requests for coercive telecommunications measures submitted by the police. Usually, the cause of a rejection has been insufficient general or special preconditions for the request or a misinterpretation of the law. 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.

In the year under review, the police reported five (approx. 20) cases where the notice of secret information gathering had been filed late; *i.e.* there were fewer cases of negligence than previously. The number of authorisations for postponing a notification or for not giving one at all was very low. In Customs, the filing periods of notices were postponed on court order in seven cases. In the Border Guard, notices were duly filed for all cases.

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 inspections, police departments were requested to report on how the methods of pseudo purchases made on items offered exclusively for public consumption and undercover operations performed in data networks have been supervised; how a unit's other regular SALPA surveillance has been conducted during the year under review; and possible surveillance findings and measures taken as a result of these findings.

The National Police Board states that the general level of the decisions and requirements regarding the use of covert intelligence gathering methods is good. There were only isolated cases of qualitative noncompliance, and no recurring errors or a pattern of qualitative noncompliance were detected with any intelligence gathering method. Most of the instances of qualitative noncompliance related to decisions or requests detected in the remote inspections carried out by the National Police Board were connected to consent-based traffic data monitoring. The detected cases involved the use of the wrong decision-making or consent-giving bodies.

In a few requests related to coercive telecommunications methods on obtaining location data to catch a suspect of an offence, an incorrect selection of methods had been applied. The necessity of location data had been justified, in addition to catching the offender, with the need to obtain information required for the solving of the offence. If obtaining location data through methods of traffic data monitoring is necessary to solve a criminal offence, the correct path is to use traffic data monitoring powers under the Coercive Measures Act.

Overall, the deficiencies detected in inspections carried out by the National Police Board were minor and the National Police Board found the supervisory notes recorded in the SALPA system to provide sufficient guidance to address any issues requiring attention. Only in a small number of cases, the National Police Board was required to request police operative units to take necessary measures to remedy the use of information gathering methods.

The oversight of the Finnish Security Intelligence Services falls under the remit of the Ministry of the Interior, not the National Police Board. The Ministry of the Interior conducted an inspection at the Finnish Security Intelligence Service on 6 March 2020 with the focus on the secret information gathering methods used in 2019. Based on this inspection, the Finnish Security Intelligence Service were issued two recommendations: one regarding the development of legality over-

sight practices and another on an isolated matter involving methods of information gathering.

More resources have been allocated to the internal legality oversight of the Finnish Security Intelligence Service and its independence has been strengthened by separating the oversight activities into a separate function. The Ministry of the Interior found the measures taken by the Finnish Security Intelligence Service to be appropriate and of a high standard, as they support in real time and proactively the lawfulness of the organisation's activities, promote the honouring of fundamental rights, support the Finnish Security Intelligence Service leadership and the guidance and oversight exercised by the Ministry of the Interior within its administrative branch. The Ministry of the Interior finds that with the entry into force of new intelligence surveillance legislation, the emphasis of the legal oversight exercised by the Ministry on the Finnish Security Intelligence Services with regard to secret information gathering has also been affected by the legality oversight performed by the Intelligence Ombudsman under the Act on the Oversight of Intelligence Gathering and the mandate of the Parliamentary Intelligence Oversight Committee. In the new situation, the duties of the Ministry of the Interior concentrate on the strategic guidance of the Finnish Security Intelligence Service and civilian intelligence gathering as well as administrative oversight, which is a natural direction in the development of the legality oversight performed by the ministry.

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.

The Customs Enforcement Department inspected a total of 534 secret information gathering records for 2019 (approx. 85% of all secret information gathering records) involving coercive telecommunication measures and surveillance-type information gathering methods as well as documents on certain other aspects of secret information gathering. The legality oversight of Customs brought forward no serious shortcomings. The records that were not reviewed as part of the institutional inspection were reviewed by the unit managers as part of the management review, and they were reported on to the authority in charge of the oversight of secret information gathering, in compliance with the applicable regulations.

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 drawn up in 2019 at the Defence Command belong to the sphere of inspection. In addition, the Ministry of Defence has found the internal legality oversight in the Defence Forces effective, comprehensive and appropriately organised.

4.5 PARLIAMENTARY OMBUDSMAN'S OVERSIGHT OF LEGALITY

In the year under review, the Oulu Police Department was visited. Inspections concerning covert coercive measures focused on requests for coercive telecommunications measures as well as decisions concerning technical surveillance and controlled undercover purchase. For this purpose, a sample of the related request and decision documents was examined.

During the visit, the grounds for a number of requests were found to be cursory and partly unclear. However, the District Court had awarded permissions as requested in these cases.

Based on the inspection, the Ombudsman undertook, under their own-initiative, an investigation and fast-tracked a decision on traffic data monitoring under Chapter 10, Section 7 of the Coercive Measures Act. According to the grounds for the decision, consent from the owner of the network address for traffic data monitoring had not been obtained, although the case was one where consent is required under subsection 2 of the legal provision.

The visit to the Border Guard Headquarters included the review of the decisions made in 2018 on technical surveillance and extended surveillance under the Coercive Measures Act as well as decisions made for the purpose of crime prevention and the two most recent telecommunications interception or traffic data monitoring requests for 2018 from each lead investigator and the respective court decisions.

Based on the visit, the Ombudsman undertook, under their own-initiative, investigations into two extended surveillance decisions and one decision on technical surveillance to establish whether the measures met with the legal criteria.

4.6 EVALUATION

General problems in oversight

Resources must be invested in internal oversight

The Ombudsman's oversight of the legality of covert intelligence gathering focuses on overseeing the internal oversight of authorities. The inspections of the legal units of police departments are used for emphasising the units' internal oversight of the covert intelligence gathering methods used by the police departments.

The authorities using covert intelligence gathering have in recent years invested resources and efforts in internal oversight. According to the National Police Board, the operation of the legal units of police departments has become established and the scope of activities has become clear, although the constantly expanding task description does take time away from inspection activities.

The National Police Board has mentioned as one problem area the fact that the analysis of on-site interception material is currently not stored on "any centralised platform". According to the National Police Board, there is a need for such a platform owing to the increasing utilisation of on-site interception and the resulting increase in the volume of material. The existence of such a platform would ensure that lead investigators would be able to order and supervise the legal steps required for the analysis of such material. According to the National Police Board, progress has been made in this matter during the year under review; however, the instability detected in the system has created challenges for its overall functionality.

At the Finnish Customs, Border Guard and Defence Forces, internal oversight has functioned very well according to the authorities' own assessment. In these authorities, oversight is easier because the volume of operations is much smaller than in the police.

The Ombudsman conducts retrospective oversight of a fairly general nature. The Ombudsman is remote from the actual activities and cannot begin directing the authorities' actions or otherwise be a key setter of limits, who would redress the weaknesses in legislation. Annual or other reports submitted to the Ombudsman are important but do not solve the problems related to oversight and legal protection.

The oversight of covert coercive measures is partly founded on trust in the fact that the person conducting the oversight activities receives all the information he or she wants. Due to the nature of the activities, precise documentation is a fundamental prerequisite for successful oversight.

Real-time active recording of events and measures also helps operators to evaluate and develop their own activities, to ensure the legality of their operations and to build trust in their activities. Keeping records is also an absolute precondition for the Ombudsman's retrospective oversight of legality.

In the oversight of legality, the Ombudsman has continuously emphasised the importance of providing justifications for requests and decisions. The grounds and justifications should be recorded, for example, to enable the control of decisions. If a court does not require the applicant to provide sufficient justifications or if the court neglects to provide sufficient justifications, there is a risk that warrants will be issued for cases other than those intended by the legislator.

4.7 INTELLIGENCE

Intelligence gathering methods

Intelligence operations may be used to gather information on military operations or other operations that form a clear threat to national security.

Chapter 5a (civilian intelligence) of the Police Act provides for information gathering conducted by the Finnish Security Intelligence Services and the utilisation of information to protect national security, support government decision-making and the statutory national security duties of other authorities and state agencies.

According to the Act on Military Intelligence, the purpose of military intelligence is to gather and analyse information about military operations targeted against Finland or significant to Finland's security environment or the activities of a foreign state or other such activities that place a significant risk on the military defence of Finland or threaten the essential functions of society. The purpose of information gathering is to support government decision-making and the execution of the specific statutory duties of the Defence Forces.

Network traffic intelligence refers to technical gathering of information that crosses the national boundaries of Finland on the information network, based on automated analytical tools, and the processing of the information gathered.

Differences between intelligence gathering and secret information gathering methods

There are certain decisive distinctions to be made between intelligence gathering and secret information gathering.

The same secret information gathering methods may be used in intelligence gathering under less restrictive criteria, because intelligence gathering is not offence-based and its targeting can be less accurate.

The targets of intelligence gathering may be quite vague compared to the targets of secret information gathering. According to Chapter 5 of the Police Act, secret information gathering may be utilised only on a named person when there are reasonable grounds to believe that he or she would commit an offence. However, in intelligence gathering, it can remain unclear under which authorisation, which circumstances and within which limits an intelligence gathering method may be targeted at other than an individual who is personally engaging in or associated with military operations or operations forming a substantial threat to national security.

For example, traffic data monitoring, when conducted as part of secret information gathering, can only be targeted at a person when there are reasonable grounds to believe that he or she would commit an offence referred to. In the military intelligence context, the use of these methods need not be limited to a person; it is sufficient that traffic data monitoring can be shown to have a significant role in gathering information necessary for an intelligence operation. In civilian intelligence gathering, the legal provisions on traffic data monitoring, personalised targeting is not mentioned.

With many intelligence gathering methods, the permission can be issued for up to six times as long (1 months/6 months) than is possible in secret information gathering. These methods include telecommunications interception, traffic data monitoring, technical surveillance, technical surveillance of devices and pseudo purchases.

The scope of secret information gathering methods in intelligence operations has been expanded both in terms of content and methods. In secret information gathering, the target of telecommunications interception must be a named network address or terminal device, while in intelligence gathering, the target may be a person (in which case the connection between a network address or terminal device and the target of information gathering remains outside the control of the courts). In intelligence gathering, many of the methods can be targeted at groups of individuals while in secret information gathering, the same methods must be targeted at a named individual. In secret information gathering, the technology enabling the obtaining of the identifying data of a network address or terminal device must not be suited for telecommunications interception, whereas in intelligence gathering no such limitations exist. In intelligence gathering, telecommunications interception may be carried out using the intelligence agency's own equipment whereas in secret information gathering, an external operator is used as a rule. The methods of secret information gathering can be used on a court order or other official authorisation within Finnish territory only, whereas in intelligence operations, the same methods can also be used abroad, subject to the decision of the Finnish Security Intelligence Service or the Chief of Intelligence for the Defence Command and without the legal remedies available in Finland.

In addition to the methods available for secret information gathering, intelligence gathering methods also include methods that cannot be adopted in secret information gathering. These include intelligence gathering on specific locations, reproduction, intercepting a shipment for the purpose of reproduction, gathering of information from a private organisation and network traffic intelligence.

Oversight of intelligence

The domain of the oversight of intelligence includes the following elements: the parliamentary oversight, the oversight of legality, court proceedings on intelligence powers, internal supervision of authorities and supreme oversight of legality.

The parliamentary oversight of intelligence is conducted by the Parliamentary Intelligence Oversight Committee. The duties of the Committee are provided for in Section 31 b of the Parliament's Rules of Procedure.

According to Section 2(3) of the Act on the Oversight of Intelligence Gathering, the legality oversight of intelligence gathering is the responsibility of the Intelligence Ombudsman. The Intelligence Ombudsman also supervises the non-intelligence operations of the Finnish Security Intelligence Service. This supervision is provided for in Chapter 3 of the Act on the Oversight of Intelligence Gathering where applicable. Hence, the Intelligence Ombudsman has all the powers referred to in the act for the purpose of overseeing all other operations of the Finnish Security Intelligence Service excepted for intelligence operations, with the exception of powers specifically concerning intelligence gathering methods. Thereby, the jurisdiction of the Intelligence Ombudsman, for example, also covers the activities of the Finnish Security Intelligence Service including the non-intelligence activities.

An independent court of law is a central instrument in the control of intelligence gathering methods. That the use of certain intelligence powers requires the authorisation by a court is of vital importance when ensuring that their application remains within the law and for the purpose of honouring fundamental and human rights.

The responsibility for internal legality oversight of authorities in civilian intelligence gathering is divided between the Finnish Security Intelligence Service and the Ministry of the Interior, where the legality oversight of the police is carried out by the Police Department. Military intelligence is overseen by the Chief of Defence Command. The Chief Legal Advisor of the Defence Forces is responsible for the internal legality oversight of military intelligence gathering. Military

intelligence gathering is also supervised by the Ministry of Defence (the Legal Unit and the Permanent Secretary).

The Parliamentary Ombudsman and the Chancellor of Justice have, by virtue of their powers, an equal authority to oversee civilian and military intelligence authorities as well as courts of law and the Intelligence Ombudsman.

In practice, however, the supreme legality oversight must be exercised in line with the established practice according to which the oversight of secret information gathering and secret coercive measures is a special duty of the Parliamentary Ombudsman. This division of duties is based on the obligation by which the ministries responsible for the operations of the authorities exercising these methods must submit an annual report on the use of these methods as well as their protection and oversight to the Parliamentary Ombudsman. According to the regulations in force, the reports must be submitted every year by 15 March.

The same practice has been adopted with intelligence legislation. Therefore, the legality oversight has concentrated on the Parliamentary Ombudsman. Moreover, attention should be paid to Section 1 (1)(1) of the Act on the Division of Responsibilities between the Chancellor of Justice of the Government and the Parliamentary Ombudsman, under which the Chancellor of Justice is released from the obligation of legal oversight in such matters as those within the jurisdiction of the Parliamentary Ombudsman related to the Ministry of Defence and the Finnish Defence Forces. This, in turn, has practical implications on the supreme legality oversight on military intelligence.

With the intelligence legislation, the expansion of the scope of supervision under the remit of the Ombudsman, including the reports on intelligence submitted to the Ombudsman shall, in part, increase the share of oversight directed by the Ombudsman at the 'secret methods' during the oversight of legality exercised by the Ombudsman.

The operations of the Parliamentary Intelligence Oversight Committee do not fall under the jurisdiction of the Parliamentary Ombudsman.

Parliamentary Ombudsman's oversight of legality

The purpose of supreme oversight of legality in intelligence is the same as in that of secret information gathering. In the oversight of secret information gathering and secret coercive measures, the Ombudsman's attention has, in practice, focused on the "oversight of supervision", that is, that the internal legal oversight exercised by authorities adopting these methods would be as effective as possible. However, the Ombudsman's "direct" oversight is of particular importance with methods that the authorities can use without a court order.

Within the scope of the Ombudsman's jurisdiction, the legality oversight of intelligence gathering is important with respect to methods that fall outside the jurisdiction of the Intelligence Ombudsman. One such aspect is the secret information gathering conducted by the Defence Forces, which is provided for in Chapter 9 of the Act on Military Discipline and Combating Crime in the Defence Forces. This oversight is important because of, for example, the boundary between secret information gathering and intelligence.

The Intelligence Ombudsman falls partly under the oversight of the Ombudsman. However, the oversight of the Intelligence Ombudsman takes mainly the form of collaboration rather than inspection in the traditional sense, although the latter is not ruled out. Complaints filed on the Intelligence Ombudsman are processed following the normal procedure.

In the year under review, a visit was made to the Intelligence Ombudsman's area of operations.

During the visit, the topics discussed included the establishment and launch of the operations; the recruitment of office staff; number of cases; the relationship between the roles of the Intelligence Ombudsman and the Data Protection Ombudsman; and any gaps in the regulatory framework.

The oversight of courts of law is by virtue of their independence always mainly based on dialogue. However, the oversight of courts carried out by the Ombudsman is important in that the

jurisdiction of the Intelligence Ombudsman does not extend to the courts of law.

Parliamentary Ombudsman Jääskeläinen was consulted by and gave his statement to the Parliamentary Intelligence Oversight Committee on topical matters in the legality oversight in intelligence (O 40/2019 vp, EOAK/5611/2019). The Ombudsman's statement included a chart illustrating the roles within intelligence oversight (see table on next page)

Problem areas in intelligence oversight

According to the Act on the Oversight of Intelligence Gathering, the Parliamentary Intelligence Oversight Committee has the right to request reports from "those carrying out an public task" (Section 4), whereas the Intelligence Ombudsman has the right to request necessary reports from "those carrying out a public administration duty" (Section 9).

The Ombudsman drew attention to this difference in connection with the reading of the bill in, for example, the format of a statement submitted to the Constitutional Committee (EOAK/5231/2018). In his statement, the Ombudsman presented the view according to which the right of access to information of the Intelligence Ombudsman, as well as the latter's right to obtain information (Section 9) and right to inspect (Section 10) should be extended to cover all public tasks. The current situation is that the Intelligence Ombudsman may not carry out an inspection required by the Parliamentary Intelligence Oversight Committee or submit information or a report if the object is a private body carrying out a public task (which is not a public administrative task).

If the operators are considered to be carrying out exclusively a public task, but not a public administrative task, this distinction has a decisive significance from the perspective of access to information and the performance of oversight.

Reports submitted to the Parliamentary Ombudsman

As mentioned in the report of the Intelligence Ombudsman, he made 50 official inspection visits in addition to various courtesy and introductory visits; during inspections, the Intelligence Ombudsman carried out a detailed review of the decisions issued by intelligence authorities on the use of intelligence methods and the protection thereof. In addition, the Intelligence Ombudsman participated in all hearings, except one, concerning intelligence methods at the Helsinki District Court. During the year under review, no grounds were identified for lodging a complaint against a court decision, issuing a suspension or termination of a surveillance method, bringing the conduct of an intelligence authority to pre-trial investigation, or issuing a reprimand to a surveillance authority or another legal sanction imposed on an intelligence authority.

The Ministry of the Interior has as one of its duties to evaluate the legality and relevance of civilian intelligence operations based on the report submitted by the Finnish Security Intelligence Service. According to the Ministry of the Interior, the internal monitoring at the Finnish Security Intelligence Service has been as timely as possible with respect to methods of civilian intelligence gathering and any findings have been addressed as necessary. The new powers have been exercised as provided for in the law and the report submitted by the Finnish Security Intelligence Service is, in the view of the Ministry of the Interior, appropriate and sufficiently informative.

The Ministry of Defence notes in its report that it has reviewed all decisions made in 2019 by the military intelligence authority. In addition, the legality oversight within the Ministry of Defence has inspected and reported on its findings on other documents that have legal implications for military intelligence. The Ministry of Defence finds that the Intelligence Ombudsman has delivered an observation to the ministry regarding technical surveillance of a device. According to the observation, there may be confusion between on-site interception and technical surveillance of a device

OVERSEEING SYSTEM

SUBJECTS OF OVERSIGHT	OVERSEERS			
	Parliamentary Ombudsman	Chancellor of Justice of the Government	Intelligence Oversight Committee	Intelligence Ombudsman
Finnish Security and Intelligence Service Chapter 5a of the Police Act and the Act on Telecommunication Intelligence in Civilian Intelligencea	O + A + R	O + A	O + A + R	O + A + R
Finnish Security and Intelligence Service Chapter 5a of the Police Act	O + A + R	O + A	O + A	O + A
Finnish Security and Intelligence Service other activities	O + A	O + A	O + A	O + A
The Finnish Defence Forces Act on Military Intelligence	O + A + R	O* + A	O + A + R	O + A + R
The Finnish Defence Forces Chapter 9 of the Act on Military Discipline and Combating Crime in the Defence Forces	O + A + R	O* + A	–	–
The Finnish Defence Forces other activities	O + A	O* + A	–	–
Intelligence Ombudsman	O + A + R	O + A	A +R**	
Court	O + A	O + A	A	A + P
Public administrative task	O + A	O + A	A	A
Public task	O + A	O + A	A	–

O = oversight
A = access to information
R = report
P = procedural powers

* see Section 1 of the Act on the Division of Duties between the Chancellor of Justice of the Government and the Parliamentary Ombudsman
** Report to the Parliament; Section 19 of the Act on the Oversight of Intelligence Gathering

as the detailed rationale for regulations refer to keystroke logging. The Ministry of Defence has issued guidance to the Defence Command on the matter, stating that keystroke logging must be based on technical surveillance of a device.

The Ministry of Defence has not identified any specific development areas or unlawful conduct in its legality oversight of military intelligence in 2019.

The Parliamentary Ombudsman has received no complaints related to intelligence operations in the year under review.

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. The programme focuses on the protection of the individual, not the criminal investigation.

If necessary for the implementation of the witness protection programme, the police may make and create false, misleading or disguised register entries and documents to support the protected person's new identity. The police may also monitor the person's home and its surroundings. Protected persons may also receive financial support to ensure their income security and independent living.

The National Bureau of Investigation (NBI) is responsible for the implementation of the witness protection programme together with other authorities. The director of the NBI makes decisions about beginning and terminating witness protection programmes and certain related measures. The Ministry of the Interior submits annual reports to the Parliamentary Ombudsman on decisions and measures taken under the act.

It is stated in the 2019 report of the Ministry of the Interior that all witness protection programmes are linked with criminal cases and the parties threatening witnesses are either Finnish or international crime organisations. In addition to domestic executive assistance, the National Bureau of Investigation has been contacted by a few international witness protection units. The National Bureau of Investigation has collaborated with Valvira on the system of maintaining health records and personal identification of persons in witness protection programmes. Based on this collaboration, a memorandum was drawn up.

As in previous years, the National Bureau of Investigation has proposed amendments and clarifications to the legislation. These relate to powers before an actual witness protection programme begins, the connection of persons awarded witness protection to the criminal proceedings and priority of the process, the high threshold for terminating the witness protection programme and the right of appeal in the event that a protected person spontaneously terminates the programme, the right to keep the temporary identity after the termination of the programme and, in accordance with a resolution approved by the Parliament, the utilisation of material obtained with the aid of a technical surveillance device or a method more widely in criminal proceedings.

The Ministry of the Interior notes that the National Police Board evaluated the report of the National Bureau of Investigation in its own report and finds that the latter report gives a comprehensive and informative snapshot of the witness pro-

tection programme. Following its legality oversight inspection of 2018, the National Police Board had requested the National Bureau of Investigation to submit the privacy policy of the witness protection programme under Section 13 by 31 March 2019. The National Bureau of Investigation has submitted the decision on the establishment of a personal data register and the privacy policy on 29 March 2019.

It is the view of the National Police Board based on the visit to the National Bureau of Investigation and the information available in the annual report that the witness protection programme does not involve any deficiencies or give rise to any other measures by the National Police Board.

The Ministry of the Interior considers it important that the matter of the personal data register to be provided under Section 13 of the Act on Witness Protection Programmes brought up in conjunction of the National Police Board's visit has been concluded, albeit an update of the register as described in the National Bureau of Investigation's report remains topical. The National Police Board should continue the monitoring of this matter in the future.

In the view of the Ministry of the Interior, questions regarding powers are ones that require careful evaluation and oversight. The National Police Board shall pay particular attention to the practical application of Section 5(2) of the Act on Witness Protection Programmes. As in previous years, the Ministry of the Interior finds it vital that data and experiences on the overall effectiveness of the witness protection legislation and its impact continues to be gathered.

The Ombudsman received no complaints regarding witness protection.

5 Issues relating to EU law

5
Issues relating to EU law

5.1
FUNDAMENTAL RIGHTS IN THE EU

Finland held the presidency of the EU in the second half of 2019. During its presidency, Finland promoted matters related to the rule of law in member states, democracy and fundamental rights in the EU.

One of the most significant achievements during Finland's presidency was that the Council of the European Union confirmed its intention for the EU to accede to the European Convention on Human Rights. This would further improve the protection of fundamental rights in Europe. The EU's accession to the European Convention on Human Rights is a legal obligation based on the Treaty on the European Union. The nation states that have acceded to the Convention have consented to the European Court of Human Rights supervising their compliance with the Convention. The European Union will become the 48th Contracting Party. The accession will make it possible for individuals and companies to apply to the European Court of Human Rights for a review of the actions of EU institutions.

THE CHARTER OF FUNDAMENTAL RIGHTS

The Council of the European Union also called upon Member States to guarantee a favourable environment for the operation of independent, national human rights institutions and other human rights mechanisms. The Council encouraged Member States and EU institutions to enhance their cooperation on national mechanisms for the promotion of human rights and to support them in their mission to implement and promote the Charter of Fundamental Rights of the European Union.

Under Finland's presidency, the decision was taken to enhance the significance and utilisation of the European Union Agency for Fundamental Rights as an expert institution. The Council confirmed its willingness to make use of the expertise and knowledge of the European Union Agency for Fundamental Rights – for example, by requesting advisory opinion when it prepares initiatives that could affect fundamental rights. The Council also requests that Member States utilise the Agency's information when they prepare legislative and political initiatives related to fundamental rights.

During its presidency of the EU, Finland hosted a conference entitled "How to ensure the resilience of our societies in a changing European landscape – the interaction between democracy, the rule of law and fundamental rights", which concluded that fundamental rights could only be realised in democratic societies based on the rule of law. The statement that these norms and values are mutually reinforcing is a significant one, as the topics of the rule of law and fundamental rights had previously been separated from one another in EU discourse.

Finland also worked with the European Commission and the European Union Agency for Fundamental Rights to arrange a conference in Brussels entitled "Making the EU Charter of Fundamental Rights a reality for all: 10th anniversary of the Charter becoming legally binding". Deputy-Ombudsman Sakslin gave a speech on the importance of the Charter of Fundamental Rights in terms of the Parliamentary Ombudsman's oversight of legality, and Sirpa Rautio, the Director of the Human Rights Centre, gave a speech on the work of national human rights institutions in promoting the Charter of Fundamental Rights.

Return flights

Deputy-Ombudsman Sakslin attended the meetings of the Nafplion group, which was established at the initiative of the Greek Parliamentary Ombudsman. The purpose of the group is to monitor and assess the implementation of fundamental rights in the activities of the European border and coast guard agency Frontex when it implements return flights and monitors the return flights that it implements. The European Union Agency for Fundamental Rights has frequently highlighted a shortcoming in the monitoring of fundamental rights in relation to the EU's return flights: the return operations are conducted and monitored by the same authority. It is open to question whether this can be considered effective monitoring as intended by the Return Directive. Member States' Parliamentary Ombudsmen, National Preventive Mechanisms (NPM), the European Union Agency for Fundamental Rights and the European Committee for the Prevention of Torture (CPT) have been involved in discussions on the effectiveness of monitoring. The European Council has supported the work of the group. The group has also been involved in discussions with Frontex and the European Commission. Frontex employs a fundamental rights delegate and civil servants specialising in the monitoring of fundamental rights.

5.2 THE GENERAL DATA PROTECTION REGULATION

The Ministry of Justice has carried out an inquiry into the user experiences and the feasibility of the General Data Protection Regulation (GDPR). The Parliamentary Ombudsman was invited, among other sources, to provide a statement on their experiences on the application of the GDPR and their views on its feasibility and the exercise of the national regulatory margin of manoeuvre.

Deputy-Ombudsman Pölönen stated the following:

- In the practice of legal oversight, the body responsible for the duties of the controller is difficult to identify and the difficulty to draw a distinction between a controller and a processor of personal data has caused problems in attributing official accountability. The absence of accountability has also impeded investigations into alleged failings by a controller.
- The GDPR has resulted in the allocation of additional resources for the Office of the Parliamentary Ombudsman. This is a positive outcome, although the resources are still probably inadequate for the purpose. The duties of the Data Ombudsman and Deputy-Ombudsmen emphatically fall within the domain of fundamental rights. Section 22 of the Constitution of Finland gives public authorities the duty and the obligation to guarantee the effective observance of fundamental rights and liberties and human rights, including by way of adequate resourcing of such authorities. It is vital that the level of resources of the Office of the Data Ombudsman is actively monitored and the allocation of resources is reviewed as necessary.
- When comparing the content of the GDPR with Article 16(2) of the Treaty on the Functioning of the European Union (TFEU), the conclusion is that the applicability and sphere of the applying parties of the GDPR are substantially larger than TFEU Article 16(2) seems to allow.
- With regard to joint controllers, the GDPR and the Law Enforcement Directive allow Member States a margin of manoeuvre to determine whether their legislation will provide for the areas of responsibility of joint controller and what the content of that law should be. I find it important that the national margin of manoeuvre would be duly utilised and the division of responsibilities provided for in the law in as much detail as possible, including matters related to joint controllership.

- Practices adopted by different public authorities in confirming the identity of a person requesting the review of personal data vary, which creates an unsatisfactory situation. In my view, Article 15 of the GDPR is open to many interpretations as to what "right of access by the data subject" actually means.
- The Deputy-Ombudsman found that the fundamental error in the GDPR was made when parties such as the Parliamentary Ombudsman (and the Chancellor of Justice) were not exempted from the monitoring of compliance with the regulation in the same manner as courts are when acting in their judicial capacity. Owing to this, the GDPR will now be in conflict with institutional decisions under the Constitution of Finland (see chapter 'Issues relating to EU Law' in 2018 Annual Report).
- The scope of discretionary powers relating to the choice of instruments and their application offered by the GDPR must be seen as a positive, as this allows for the observance of the principle of proportionality in practical situations that may arise within the wide scope of application of the GDPR. However, the wide scope of powers also presents a challenge for the consistency and predictability of the sanctions system. The need for precedents, and possibly even sanction guidelines, has been evident during the first few years of applying the new regulation. The "one-stop-shop" mechanism emphasises the requirement of harmonised practices throughout the EU.
- According to Article 17 of the GDPR, the processing of personal data may continue under certain conditions irrespective of a data subject's request to be forgotten. As a rule, the rights of a data subject, as specified in Articles 7 and 8 of the EU Charter of Fundamental Rights, override the interest of the general public to access the personal data of a data subject by searching for them by their name. However, there needs to be a balance between the rights of the data subject and the interest of the general public, which may be relative to the nature of the information in question and their sensitivity regarding the data subject's right to privacy as opposed to the interest of the general public to access such information. The latter may vary depending on, for example, the status of the data subject as a public figure.

5.3 CUSTOMS PROCEDURES

Deputy-Ombudsman Sakslin issued a statement on the correctness of an administrative procedure in connection with a decision to seize property during a customs check in a case where the interested party had not been provided with all the evidence that the decision was based on during his hearing. The Deputy-Ombudsman based the decision on the EU Charter of Fundamental Rights, among other things, and found that the right to be heard is a legal principle integral to good administration and one of the key procedural requirements in EU law. It is defined as one of the principles of good administration under Article 41 of the EU Charter of Fundamental Rights and, therefore, it must be a consideration in all administrative procedures with relevance to EU law, such as customs clearance (2385/2018).

In another decision regarding a customs inspection, the Deputy-Ombudsman gave their opinion on the content of the customs border cooperation agreement with Sweden in light of the Act of Accession, as questions had been raised whether customs procedures had been carried out on Swedish territory. The Deputy-Ombudsman concluded that the wording of the agreement "in such terms that are in compliance with the legislation of both states" leaves room for interpretation. This is particularly the case when interpreting the legal significance of the exemption on the ban of selling snus tobacco, which Sweden was granted in the Act of Accession, in the context of customs control under the customs border cooperation agreement. According to Article 8 of Directive 2001/37/EC, Member States shall prohibit the placing on the market of tobacco for oral use, without prejudice to Article 151 of the Act of Accession of Austria, Finland and Sweden. Article

151 of the Act of Accession grants Sweden a permanent exemption on the ban on the market of tobacco for oral use. This means that Sweden has an exemption on the sales of snus tobacco. In customs control as well as in all customs operations, regulations must be observed with strict compliance, and if the purpose of control is extended to the Swedish territory at the Tornio border crossing, any control operations under the agreement and the decree on its implementation must be carried out according to a plan and in compliance with regulations on separate agreements and definitions on the forms of border cooperation (233/2018).

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

Ombudsman Mr Petri Jääskeläinen
decides on matters concerning:

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

Deputy-Ombudsman 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

Proposals for the development of legislation and regulations and for the redressing of errors

To the City of Helsinki's Social Services and Health Care Division

- In the view of Sarja, the Substitute for a Deputy-Ombudsman, the City's permanent instructions on care supplies for patients with diabetes do not take into account the needs of individuals and, therefore, they are in conflict with the Act on the Status and Rights of Patients as well as the Health Care Act. He proposed that the City take action to modify the instructions (268/2018).

To the Ministry of Justice

- Ombudsman Jääskeläinen proposed that the Ministry consider adding information to the notice of voting entitlement to state that the voter should always check the Ministry of Justice's election website for the latest information on advance polling stations abroad (2319/2019).
- Deputy-Ombudsman Sakslin considered legislation on photography in health care units to be necessary (3016/2018)
- Deputy-Ombudsman Sakslin agreed with the proposals included in the Constitutional Law Committee's statements (PeVL 62/2018 vp and 7/2019 vp) concerning the necessity and urgency of appropriate regulations on automated decision-making. She stated that the need to regulate automated decision-making should be assessed without delay (3379/2018)
- Deputy-Ombudsman Pölönen proposed that the regulations prohibiting smoking in prisons be amended for greater clarity (5349/2019)
- In a matter pertaining to the placement of a prisoner in a unit, Deputy-Ombudsman Pölönen found that the obligations on registration and decision-making have been legislated in a haphazard and unsystematic manner (6065/2016)
- Deputy-Ombudsman Pölönen stated that the Imprisonment Act includes no provisions on the right to issue rules of a lower order than an act of parliament concerning the taking of urine samples and that the guidelines concerning monitoring of the provision of urine samples should be amended for greater clarity (6034/2016)
- Deputy-Ombudsman Pölönen considered the registration and decision-making obligation in the case of inmates' ward placements to be fragmented and unsystematic (6065/2016)
- Deputy-Ombudsman Pölönen stated that the Imprisonment Act includes no provisions on when a prisoner can be placed in an open institution for a fixed period and when a placement decision is made for an indefinite period (1512/2018)
- Deputy-Ombudsman Pölönen stated that the Imprisonment Act does not expressly stipulate who should decide on the immediate transfer of a prisoner from an open institution to a closed prison, decision-making powers outside normal working hours, and decisions on immediate transfers are not mentioned in the provisions of the Imprisonment Act concerning the right to appeal (6554/2018)
- In the view of Deputy-Ombudsman Pölönen, the rules on whether prisoners are given possession of a smartphone and allowed to use the internet when they are outside the institution on the basis of study or civilian work release or permission to be absent vary from one prison to another. He called for the regulations to be amended for greater clarity (1786/2017 and 3293/2019)
- Deputy-Ombudsman Pölönen stated that there are grounds for amending the provisions of the Imprisonment Act on the withholding

of letters or postal items and the handover of possession of property (1941/2018)
- Deputy-Ombudsman Pölönen stated that the Imprisonment Act does not specify which matters should be considered significant when making decisions, as the Act permits prisoners to supply money and other means of payment via the prison to a party outside the prison or another prisoner for justified reasons (5366/2018)

To the Ministry of Education and Culture

- Deputy-Ombudsman Pölönen proposed that the Ministry assess whether the Universities Act should be amended with regard to the election of a chairperson to the academic board of a foundation university (1327/2018)

To the National Police Board of Finland

- In the view of Ombudsman Jääskeläinen, the Act on Treating Intoxicated Persons should be reassessed (4103/2016)
- Ombudsman Jääskeläinen considers it necessary to harmonise the processing of the personal data and guidance of persons deprived of their liberty (4489/2017)

To the Criminal Sanctions Agency

- Deputy-Ombudsman Pölönen stated the view that when the public authorities prevent smoking in a way that may lead to prisoners suffering from withdrawal symptoms, it is justified for nicotine substitutes to be made available to prisoners at the prison's expense for as long as the symptoms persist (5349/2019)
- In the view of Deputy-Ombudsman Pölönen, prisons' guidelines on overseeing the provision of urine samples should be amended to state that the prisoner's provision of the sample should not be monitored to a greater degree than is essential and that the monitoring should be conducted as discreetly as possible (6034/2016)
- Deputy-Ombudsman Pölönen stated that the regulations concerning the storage of a prisoner's property had not been amended despite the promise of an amendment in 2017 (6554/2018)
- Deputy-Ombudsman Pölönen proposed that consideration be given to whether amendments are required to the guidelines that call for a prisoner to be given possession of the products purchased by the prisoner from the shop in the institution when the prisoner is transferred from one closed prison to another unless the prison can provide justification for preventing the prisoner from having the product (1653/2018)

To the Ministry of the Interior

- According to Ombudsman Jääskeläinen, the provision of food to persons deprived of their liberty and the processing of personal data in police prisons should be subject to more detailed regulations when the Act on the Treatment of Persons in Police Custody is reformed (59/2018 and 4488/2017)
- In Ombudsman Jääskeläinen's opinion, there are grounds for assessing the need to amend the registration provision for greater clarity when the Act on the Treatment of Persons in Police Custody is reformed (4489/2017)

To the Ministry of Social Affairs and Health

- In Deputy-Ombudsman Sakslin's view, the lack of legislation for providing patients ordered to involuntary treatment with opportunities to purchase foodstuffs and other items for personal use during their treatment periods is a shortcoming (3952/2018)
- Deputy-Ombudsman Sakslin proposed that the Communicable Diseases Act be amended so that it also applies to care provided at home (2273/2018)

To the City of Turku's Welfare Division

- Deputy-Ombudsman Sakslin called upon the health care service organisations in the welfare division to investigate appropriate procedures and review its guidance on medical rehabilitation aids so that it corresponds to the national guidelines on the grounds for providing aids and ensures that individual needs assessments are taken into consideration (487/2018)

To the Ministry of Economic Affairs and Employment

- Deputy-Ombudsman Pölönen stated that the instructions on independent study supported by unemployment benefits should more clearly state that the general criteria, as set out in the rules concerning the granting of benefits, are related to an assessment of the applicant's need for services and that the instructions should highlight the matters that should be considered when assessing the need for services (2244/2018 and 1133 and 1872/2019)
- According to Deputy-Ombudsman Pölönen, the Ministry should consider taking measures to clarify the public administrative tasks carried out by Business Finland Oy in order to ensure that the company's duties are based on authorisation in accordance with section 124 of the Constitution of Finland (883/2018)

To the Ministry of Finance

- Ombudsman Jääskeläinen made the Ministry aware of the practical problems inherent in applying the State Indemnity Act which should be taken into consideration in the guidance for state indemnity operations and in the drafting of regulations (447/2018)

To the National Supervisory Authority for Welfare and Health (Valvira)

- Deputy-Ombudsman Sakslin proposed that Valvira use the means available to it to instruct hospital districts to intervene more effectively in the event of medication errors and ensure that home-care clients receive the correct medications at the correct times (3230/2018)
- Deputy-Ombudsman Sakslin stated that the terminology used for the delimitation of patient care is ambiguous (722/2018)

Inspections

#) = unannounced inspection

Courts

- 11 September Helsinki District Court, detention facilities for persons deprived of their liberty#) (5072/2019)

Finnish Prosecution Service

- 11 April Oulu Prosecution Authority, main office in Oulu (1952/2019)

Police administration

- 27 February Espoo Central Police Station, detention facilities for persons deprived of their liberty#) (1201/2019)
- 12 March Helsinki Police Station, preliminary proceedings unit (1457/2019)
- 10 April Raahe Police Station, detention facilities for persons deprived of their liberty#) (1950/2019)
- 10 April Haukipudas Police Station, detention facilities for persons deprived of their liberty#) (1954/2019)
- 11 April Oulu Police Department (1951/2019)
- 27 May Tampere Central Police Station, detention facilities for persons deprived of their liberty#) (2982/2019)
- 28 May The Police University College, in Tampere (2924/2019)
- 1 July Hämeenlinna Police Station, police prison#) (3621/2019)
- 1 July Hyvinkää Police Station, police prison#) (3622/2019)
- 1 July Järvenpää Police Station, police prison#) (3623/2019)
- 6 November Lappeenranta police station, detention facilities for persons deprived of their liberty#) (5999/2019)
- 6 November Imatra police station, detention facilities for persons deprived of their liberty#) (6000/2019)
- 11 December National Police Board, in Helsinki (7050/2019)

Defence Forces and Border Guard

- 26 February The Defence Command Finland (476/2019)
- 17 April Utti Jaeger Regiment (1964/2019)
- 17 April Utti Jaeger Regiment, detention facilities for persons deprived of their liberty (2420/2019)
- 13 June The Border and Coast Guard Academy, in Imatra (3141/2019)
- 15-19 September Finnish crisis management force in Lebanon (1380/2019)
- 16 December Border Guard Headquarters, in Helsinki (2421/2019)
- 16 December Border Guard Headquarters, covert coercive measures and intelligence gathering, in Helsinki (7062/2019)

Criminal Sanctions

- 8 April Vilppula Prison (1592/2019)
- 7-8 May Jokela Prison (1936/2019)
- 28-29 May Turku Prison (2449/2019)
- 28 May Psychiatric Prison Hospital, Turku Unit (2570/2019)
- 29 May the Health Care Services for Prisoners: Turku Prison Outpatient Clinic (2571/2019)
- 25 June Vanaja Prison, Ojoinen Unit, in Hämeenlinna (3420/2019)
- 20 August Prisoner transport by train#) (4575/2019)

- 5-7 November Sukeva Prison (5291/2019)
- 6 November Health Care Services for Prisoners: Sukeva Prison Outpatient Clinic

Indebtedness and distraint

- 24 September National Administrative Office for Enforcement, in Turku (3596/2019)
- 24 September Legal Aid Office of Southwest Finland, financial and debt advice, in Turku (6732/2019)

Aliens affairs

- 25 June Tampere Reception Centre (3440/2019)
- 12 December Detention Unit in Helsinki#) (6841/2019)

Social welfare/Children

- 28-29 October youth home Jaloverso, special child protection unit for young substance abusers, in Hollola#) (5930/2019)

Social welfare/Persons with disabilities

- 21 March Mehiläinen: Omakoti Oiva, housing services for adults with severe disabilities#), in Vantaa (1683/2019)
- 21 March Mehiläinen: temporary care home Alma#), in Vantaa (1684/2019)
- 4 April Eteva: Nurmijärvi housing services and Ohjastie housing units#) (2008/2019)
- 5 November KTO Support and competence centre for persons with learning disabilities, Medical care, research and rehabilitation LAKU, in Paimio (5491/2019)
- 5 November KTO Support and competence centre for persons with learning disabilities, Neuropsychiatric research and rehabilitation unit NEPSY1, in Paimio (6769/2019)
- 5 November KTO Support and competence centre for persons with learning disabilities, Neuropsychiatric research and rehabilitation unit NEPSY2, in Paimio (6770/2019)
- 5 November KTO Support and competence centre for persons with learning disabilities, Neuropsychiatric research and rehabilitation unit for children and adolescents LANEKU, in Paimio (6771/2019)
- 5 November KTO Support and competence centre for persons with learning disabilities, Neuropsychiatric crisis and research unit KEPSY, in Paimio (6772/2019)

Social welfare/Elderly units

- 19 March City of Raasepori: Mariakoti#), in Pohja (1764/2019)
- 19 March Folkhälsan: Villa Rosa, 24-hour residential service#), in Meltola (1765/2019)
- 28 March Pihlajakoti, 24-hour residential service#), in Padasjoki (1842/2019)
- 10 April Akseli: Moisiokoti, 24-hour residential service, in Nousiainen#) (2010/2019)
- 10 April Service centre Lizeliuskoti, 24-hour residential service, in Mynämäki#) (2009/2019)
- 11 June Kymsote: City-koti, 24-hour residential service, in Kotka#) (3015/2019)
- 13 June City of Heinola: housing service unit Mäntylä, 24-hour residential service#) (3016/2019)
- 4 July Helsinki Seniorisäätiö: Pakilakoti, old people's home#) (3763/2019)
- 27 August and 1 October Keusote: Vaahtera-koti, 24-hour residential service, in Järvenpää#) (4743/2019)
- 2 September Esperi Care: Esperi Care Home Niva, 24-hour residential service, in Rovaniemi#) (4921/2019)
- 3 September Pelkosenniemi municipal home care (4738/2019)
- 3 September Pelkosenniemi municipality: Service home Onnela#) (5023/2019)
- 3 September Savukoski municipality: Saukoti, service housing unit with 24-hour assistance#) (4922/2019)

- 4 September Salla municipal home care (4739/2019)
- 17 October Lempäälä municipality: Himminkoto, 24-hour residential service#) (5595/2019)
- 17 October Lempäälä municipal home care (5596/2019)
- 29 October Villa Mäntykoto, 24-hour residential service, in Hyvinkää#) (5880/2019)
- 5 November Humana: Kotikylä Sammonkoti, 24-hour residential service, in Jyväskylä#) (6032/2019)
- 5 November Service centre Lehtiniemi: Saarelmakoti and Suvanto-koti#), in Keuruu (6033/2019)
- 6 November City of Jyväskylä home care (5789/2019)

Health care

- 27 February City of Espoo, sobering-up station#) (1202/2019)
- 26 March City of Espoo, Espoo Hospital (1706/2019)
- 26 March HUS: Jorvi Hospital, joint emergency clinic (1707/2019)
- 8-9 May City of Vantaa, Katriina Hospital (2458/2019)
- 9 May HUS: geriatric psychiatric research and care in Katriina Hospital#) (2759/2019)
- 15 May Vantaa Hospital, acute geriatric unit in Peijas Hospital#) (2456/2019)
- 11 June Satakunta Hospital District: Satakunta Hospital, joint emergency clinic#) in Pori (3009/2019)
- 11 June Keski-Satakunta joint authority for health care: Harjavalta Health Centre Hospital, in-patient ward#) (3264/2019)
- 11-12 June Satakunta Hospital District, Harjavalta Hospital#) (2301/2019)
- 13 June Pori City Hospital#) (3007/2019)
- 3 September Pelkosenniemi-Savukoski joint authority for public health: in-patient ward at Pelkosenniemi health centre#) (5022/2019)
- 14 October TAYS, Pitkäniemi Hospital, geriatric psychiatry#) (5592/2019)
- 16 October City of Tampere, Hatanpään puistosairaala, geriatric psychiatric wards#) (5593/2019)

Social insurance

- 21 March Kela, Cooperation meeting
- 25 April Appeals Board for Social Security Affairs (SAMU) (2006/2019)

Labour and unemployment security

- 21 May Uusimaa TE Office, Helsinki centre office (2900/2019)
- 21 November Central Finland Employment and Economic Development Office (5860/2019)
- 21 November City of Jyväskylä, employment services (5861/2019)
- 21 November Multidisciplinary joint service for promoting employment in southern Central Finland, in Jyväskylä (5862/2019)

Education and early childhood education

- 17 May International School of Vantaa (2638/2019)
- 22 May Haaga-Helia University of Applied Sciences, in Pasila (2550/2019)
- 5 June City of Helsinki, nursery school Lehtisaari#) (3136/2019)
- 5 June City of Espoo, Roosaliina nursery school#) (3137/2019)
- 27 August City of Kotka Department of Education (4029/2019)
- 27 August City of Kotka, Otsola school (4775/2019)

Other inspections

- 8 April Polling stations for advance voting in general elections:
  - S-Market Näsi[#)], in Porvoo (1670/2019* includes all inspected polling stations)
  - Council chamber of the municipal administration[#)], in Pornainen (2128/2019)
  - Monninkylä library[#)], in Askola (2129/2019)
  - Service point at the Onni well-being centre[#)], in Pukkila (2130/2019)
  - Municipal administration[#)], in Myrskylä (2132/2019)
  - Municipal hall[#)], in Lapinjärvi (2134/2019)
  - Liljendali rural department[#)], in Loviisa (2135/2019))
- 22 May The Office of the Data Protection Ombudsman (2292/2019)
- 26 May Polling stations for European parliament elections:
  - Kaivoksela school[#)], in Vantaa (2657/2019* includes all inspected polling stations)
  - Adult education centre[#)], in Riihimäki (3107/2019)
  - West Loppi school[#)], in Loppi (3111/2019)
  - Teuro school[#)], in Tammela (3112/2019)
  - Theatre building[#)], in Forssa (3113/2019)
  - Municipal administration[#)], in Jokioinen (3114/2019)
  - Kirkkomäki school[#)], in Somero (3115/2019)
  - Suomusjärvi library[#)], in Salo (3116/2019)
- 10-11 September Tuomas and Sakari systems at Helsinki District Court and Helsinki Prosecution Authority (1406/2019)
- 24 September Legal Aid Office of Southwest Finland, in Turku (4709/2019)
- 22 November Project office for the project to develop an enterprise resource planning and document management system for the Administrative Courts and specialist courts (HAIPA), in Helsinki (5487/2019)
- 4 December Office of the Intelligence Ombudsman (6829/2019)
- 17 December Customs: Customs office in Turku, detention facilities for persons deprived of their liberty[#)] (7048/2019)

Staff of the Office of the Parliamentary Ombudsman

Parliamentary Ombudsman
Mr Petri Jääskeläinen, LL.D., LL.M. with court training

Deputy-Ombudsmen
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Mr Pasi Pölönen, LLD., LL.M. with court training

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Mr Juha Niemelä, LL.M. with court training
Mr Jari Pirjola, LL.D., M.A.
Mr Pasi Pölönen, LL.D., LL.M. with court training (on leave)
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Mr Tapio Räty, LL.M.
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Ms Elina Castrén, LL.M. with court training
Mr Kristian Holman, LL.M., M.Sc. (Admin.)
Ms Lotta Hämeen-Anttila, M.Soc.Sc. (on fixed term since 24 June)
Ms Riikka Jackson, LL.M.
Ms Marja-Liisa Judström, LL.M. with court training
Ms Minna Ketola, LL.M. with court training (on leave 15 January–31 July)
Mr Juha-Pekka Konttinen, LL.M.
Ms Heidi Laurila, LL.M. with court training
Ms Kaisu Lehtikangas, M.Soc.Sc. (on fixed term since 15 August).
Mr Juho Martikainen, M.Sc.(Admin.), LL.M. with court training
Ms Päivi Pihlajisto, LL.M. with court training
Ms Piatta Skottman-Kivelä, LL.M. with court training
Ms Iisa Suhonen, LL.M. with court training
Ms Mirja Tamminen, LL.M. with court training
Mr Jouni Toivola, LL.M.
Ms Päivi Vainio (on fixed term, 4 March–30 June)
Mr Matti Vartia, LL.M. with court training
Ms Minna Verronen, LL.M. with court training
Ms Susanna Wähä, M.Sc. (Admin.) (on fixed term since 1 November)
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Ms Jaana Romakkaniemi, LL.M. with court training
Ms Pia Wirta, LL.M. with court training

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Ms Citha Dahl, M.A.

Information Management Specialist
Mr Janne Madetoja, M.Sc. (Admin.)

Investigating Officers
Mr Peter Fagerholm, M.Sc. (Admin.)
Ms Annika Finnberg, M.Sc. (Admin.) (on fixed term since 1 October)
Mr Reima Laakso (on leave since 1 October)

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Ms Sanna-Kaisa Frantti
Ms Johanna Koli, M.Soc.Sc. (on fixed term since 26 August)
Ms Taru Koskiniemi, LL.B.

Ms Kaisu Lehtikangas, M.Soc.Sc. (on leave since 15 August)
Ms Eeva-Maria Tuominen, M.Sc.(Admin.), LL.B.
Ms Riina Tuominen, M.Sc. (Admin.) (since 1 July)

Administrative secretary
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Filing Clerk
Ms Helena Kataja

Assistant Filing Clerk
Ms Anu Forsell

Departmental Secretaries
Ms Päivi Ahola
Ms Mervi Stern

Case Management Secretary
Ms Nina Moisio, M.Soc.Sc., M.A. (on leave since 15 August)
Ms Anna-Liisa Tapio (on fixed term since 15 August)

Assistant for International Affairs
Ms Tiina Mäkinen

Office Secretaries
Ms Minna Haapaniemi (on fixed term since 1 April)
Ms Johanna Hellgren
Ms Sari Holappa
Mr Mikko Kaukolinna
Ms Krissu Keinänen
Ms Virpi Salminen
Ms Anna-Liisa Tapio (on leave since 15 August)

Staff of the Human Rights Centre

Director
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Mr Mikko Joronen, M.Pol.Sc.
Ms Kristiina Kouros, LL.M. (on leave till 31 January)
Ms Leena Leikas, LL.M. with court training

Coordinator for International Affairs
Ms Elina Hakala, M.Soc.Sc. (till 31 October, on leave 21 February–31 October)

Assistant
Ms Katariina Huhta (since 24 April)

Statistical data on the Ombudsman's work in 2019

MATTERS UNDER CONSIDERATION

Oversight-of-legality cases under consideration			**8,071**
Cases initiated in 2019		6,444	
– complaints to the Ombudsman	6,223		
– complaints transferred from the Chancellor of Justice	44		
– taken up on the Ombudsman's own initiative	95		
– submissions and attendances at hearings	82		
Cases held over from previous years		1,627	
Cases resolved			**6,204**
Complaints		6,057	
Taken up on the Ombudsman's own initiative		63	
Submissions and attendances at hearings		84	
Cases held over to the following year			**1,867**
Other matters under consideration			**1,118**
Inspections		110	
Administrative matters in the Office		953	
International matters		55	

OVERSIGHT OF PUBLIC AUTHORITIES

Complaint cases	6,057
Social welfare	1,088
Police	712
Health	631
Criminal sanctions field	456
Social insurance	455
Administrative branch of the Ministry of Economic Affairs and Employment	329
Administrative branch of the Ministry of Education and Culture	243
Administration of law	229
Enforcement (distraint)	200
Local government	192
Highest organs of government	178
Administrative branch of the Ministry of Transport and Communications	168
Aliens affairs and citizenship	158
Administrative branch of the Ministry of Environment	129
Taxation	117
Administrative branch of the Ministry of Justice	78
Administrative branch of the Ministry of Agriculture and Forestry	77
Guardianship	73
Prosecutors	63
Administrative branch of the Ministry of Defence	47
Administrative branch of the Ministry of Finance	35
Administrative branch of the Ministry of the Interior	24
Customs	10
Administrative branch of the Ministry for Foreign Affairs	10
Other administrative branches	355

OVERSIGHT OF PUBLIC AUTHORITIES

Taken up on the Ombudsman's own initiative		**63**
Social welfare	14	
Health	12	
Police	8	
Criminal sanctions field	6	
Administrative branch of the Ministry of Education and Culture	5	
Local government	4	
Administrative branch of the Ministry of Defence	3	
Customs	3	
Administrative branch of the Ministry of Economic Affairs and Employment	2	
Administration of law	1	
Administrative branch of the Ministry of Transport and Communications	1	
Prosecutors	1	
Aliens affairs and citizenship	1	
Administrative branch of the Ministry for Foreign Affairs	1	
Taxation	1	
Total number of decisions		**6,120**

MEASURES TAKEN BY THE OMBUDSMAN

Complaints		**6,057**
Decisions leading to measures on the part of the Ombudsman		**874**
– prosecution		–
– assessment of the need for pre-trial investigation		4
– reprimands		59
– opinions		660
– as a rebuke	438	
– for future guidance	222	
– recommendations		41
– to redress an error or rectify a shortcoming	3	
– to develop legislation or regulations	18	
– to provide compensation for a violation	14	
– to rech an agreed settlement	6	
– matters redressed in the course of investigation		22
– other measure		88
– to rech an agreed settlement	–	
No action taken, because		**2,754**
– no incorrect procedure found		194
– no grounds		2,560
– to suspect illegal or incorrect procedure	1,430	
– for the Ombudsman's measures	1,130	
Complaint not investigated, because		**2,429**
– matter not within Ombudsman's remit		202
– still pending before a competent authority or possibility of appeal still open		909
– unspecified		504
– transferred to Chancellor of Justice		27
– transferred to Prosecutor-General		10
– transferred to Regional State Administrative Agency		66
– transferred to other authority		120
– older than two years		126
– inadmissible on other grounds		35
– no answer		96
– answer without measures		334

MEASURES TAKEN BY THE OMBUDSMAN

Taken up on the Ombudsman's own initiative		**63**
Decisions leading to measures on the part of the Ombudsman		47
– prosecution		–
– assessment of the need for pre-trial investigation		–
– reprimands		2
– opinions		26
– as a rebuke	8	
– for future guidance	18	
– recommendations		9
– to redress an error or rectify a shortcoming	–	
– to develop legislation or regulations	8	
– to provide compensation for a violation	1	
– to rech an agreed settlement	–	
– matters redressed in the course of investigation		1
– other measure		9
No action taken, because		5
– no incorrect procedure found		–
– no grounds		5
– to suspect illegal or incorrect procedure	2	
– for the Ombudsman's measures	3	
Own initiative not investigated, because		11
– still pending		–
– transferred to other authority		–
– inadmissible on other grounds		6
– no answer		5

INCOMING CASES BY AUTHORITY

Social welfare	1,112
Police	752
Health	698
Social insurance	469
Criminal sanctions field	385
Administrative branch of the Ministry of Economic Affairs and Employment	322
Administrative branch of the Ministry of Education and Culture	256
Administration of law	223
Local government	213
Highest organs of government	205
Enforcement (distraint)	200
Administrative branch of the Ministry of Transport and Communications	168
Aliens affairs and citizenship	161
Taxation	140
Administrative branch of the Ministry of Environment	137
Guardianship	92
Administrative branch of the Ministry of Agriculture and Forestry	81
Administrative branch of the Ministry of Justice	81
Prosecutors	65
Administrative branch of the Ministry of Defence	49
Administrative branch of the Ministry of Finance	28
Administrative branch of the Ministry of the Interior	28
Customs	12
Administrative branch of the Ministry for Foreign Affairs	11
Subjects of oversight in the private sector	–
Other administrative branches	379

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