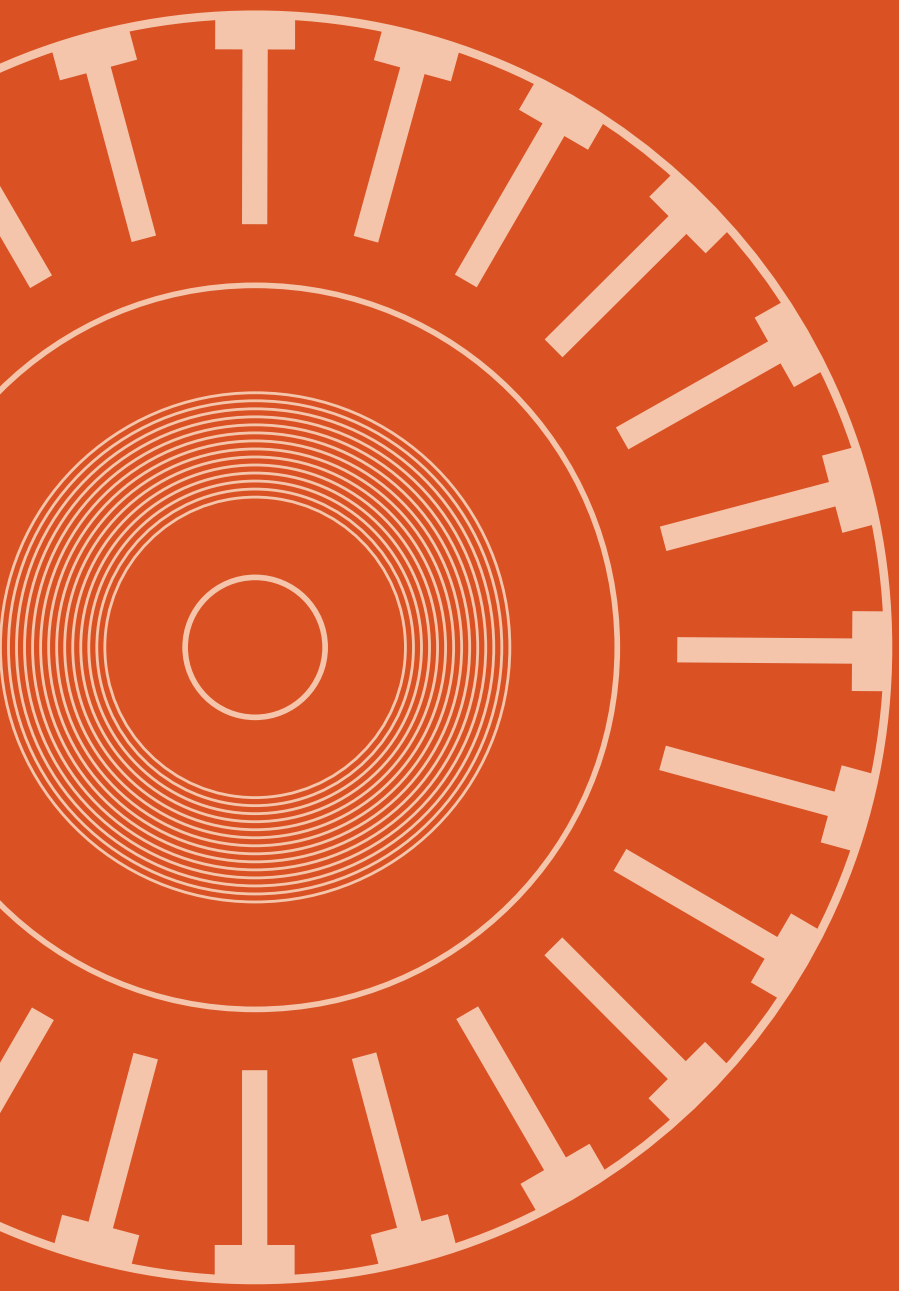
ENGLISH VERSION

National Preventive Mechanism – NPM

REPORT ON THE ACTIVITIES 2022



JO RIKSDAGENS OMBUDSMÄN
The Swedish Parliamentary Ombudsmen

National Preventive Mechanism
NPM

REPORT ON THE ACTIVITIES 2022

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Photos: Sid. 19, police custody facility.
Sid. 29, remand prison in Luleå.
Sid. 38, special residential home for young people Hässleholm.
Sid. 51, psychiatric clinic Linköping.
Sid. 57, Swedish Migration Agency.

All photos were taken by employees of the Parliamentary Ombudsmen.

Production: The Parliamentary Ombudsmen

Cover: Part of a sketch of the Panoptikon, a prison in which all the cells can de monitored from one point. A design introduced by the English philosopher Jeremy Bentham in the late 18th century.

Foreword

The purpose of our role as National Preventive Mechanism (NPM) under OPCAT is to prevent torture and other cruel, inhuman or degrading treatment or punishment of individuals who are deprived of their liberty. An important part in fulfilling this purpose is to identify detainees who for various reasons are at high risk for ill-treatment. During 2022, JO's activities as NPM have had a thematic approach towards children and young persons (under the age of 21) who are deprived of their liberty. Particularly, the focus was on the participation of children and young persons during incarceration.

Detained children and young persons are generally more vulnerable than adults and the environments where detained individuals spend their time are often not adapted for their special needs. This poses great challenges for the institutions that are responsible for detained children and young persons. Questions like safety and security, the use of coercive measures and the treatment by staff are particularly urgent in relation to individuals who are still developing and therefore have a limited ability to uphold their rights.

In this report you will find the main findings and statements from this year's inspections. We carried out elven inspections in total. In addition, we held two dialogue meetings with the civil society. Due to our findings, we can conclude that it is important that JO as NPM monitors the situation for children and young adults who are deprived of their liberty.

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Content

1

The OPCAT activities

The OPCAT activities

Under the 1984 UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the Convention against Torture), the States Parties have undertaken to take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction. Explicit prohibitions on torture are also included in a number of other UN conventions.

The European Convention on Human Rights (ECHR) and the Charter of Fundamental Rights of the European Union (EU Charter) also prohibit torture. The ECHR has applied as Swedish law since 1995. In addition, the Swedish Instrument of Government includes a prohibition on torture. According to the Instrument of Government, every individual is protected against corporal punishment, and no one may be subjected to torture or undue medical influence for the purpose of forcibly extracting or obstructing statements.[1]

1.1 Torture and cruel, inhuman or degrading treatment

The first Article of the UN Convention against Torture contains a relatively comprehensive definition of the term torture. In short, torture means that someone is intentionally subjected to severe psychological or physical pain or suffering for a specific purpose, such as to extract information forcibly or to punish or threaten a person. The Convention lacks definitions of cruel, inhuman or degrading treatment.

The European Court of Human Rights (ECtHR) has stated that inhuman treatment should include, at a minimum, such treatment that intentionally causes someone serious mental or physical suffering and which, in a specific situation, can be considered unjust. Degrading treatment refers to actions that evokes a feeling of fear, anxiety, or inferiority in the victim. A treatment can be degrading even if no one but the victim has witnessed or learned about it.

1.2 The Convention Against Torture and OPCAT

The Convention Against Torture has been in force in Sweden since 1987. States party to the Convention are examined by a special committee, the Committee against Torture (CAT). States Parties must regularly report on their compliance with the Convention. If allowed by a State Party, individuals may also complain to the Committee. Sweden allows individual complaints. The Convention against Torture does not in itself give the CAT a mandate to conduct visits of member states.

1 Chapter 2, Section 5 of the Instrument of Government.

To enable, inter alia, international visits, the Optional Protocol to the Convention against Torture (OPCAT) was adopted in 2002. Sweden ratified the Protocol in 2005 and the Protocol entered into force in June 2006. OPCAT established an international committee, the Subcommittee on Prevention of Torture (SPT).

The CAT periodically reviews Sweden, normally every six years. Sweden is due to submit its ninth periodic report on 3 December 2025.[2]

1.3 Preventive activities

The work performed in accordance with OPCAT shall be conducted with the aim of strengthening the protection of individuals deprived of their liberty against torture and other cruel, inhuman, or degrading treatment or punishment. Preventive work can be carried out in several ways, including through supervision in environments where the risk of abuse and violations is particularly high.

Another important part of the preventive work is to identify and analyse factors that can directly or indirectly increase or reduce the risk of torture and other forms of inhumane treatment, etc. The work must be proactive and dedicated to systematically reducing or eliminating risk factors and strengthening preventive factors and safeguard mechanisms. Furthermore, the work must have a long-term perspective and focus on achieving improvements through constructive dialogue, proposals for safeguard mechanisms and other measures.

1.4 OPCAT activities in Sweden

States party to OPCAT are required to designate one or more bodies charged with the role of National Preventive Mechanism (NPM). Since 1 July 2011, the Ombudsmen have been fulfilling the role of National Preventive Mechanism in accordance with OPCAT.[3] In assigning the Ombudsmen this role, the Committee on the Constitution stated that the tasks and powers that the Parliamentary Ombudsmen have had for many years matches the tasks of a National Preventive Mechanism.

As a National Preventive Mechanism, the Parliamentary Ombudsmen are tasked with:

- regularly inspecting places where individuals may be deprived of their liberty
- making recommendations to the competent authorities with the aim of improving the treatment of and conditions for individuals deprived of

2 Concluding observations on the eighth periodic report of Sweden, website of the United Nations Human Rights Treaty Bodies, CAT/C/SWE/CO/8.

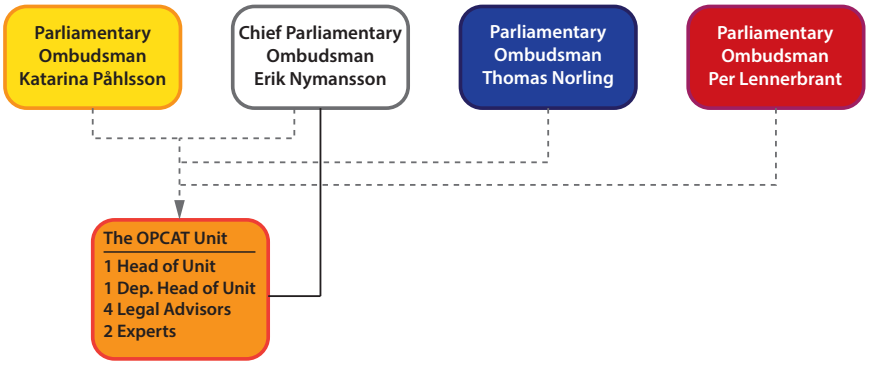
3 Section 18 of the Act with Instructions for the Parliamentary Ombudsmen (SFS 2023:499), previously Section 5 a of the Act with Instructions for the Parliamentary Ombudsmen (SFS 1986:765).

their liberty and preventing torture and other cruel, inhuman, or degrading treatment or punishment

- submitting proposals and comments on existing or proposed legislation relating to the treatment and conditions of individuals deprived of their liberty
- engaging in dialogues with competent authorities and civil society; and
- reporting on the OPCAT activities.

The Parliamentary Ombudsmen have assessed that the places to be inspected within the scope of this assignment are primarily prisons, remand prisons, police detention facilities, facilities for compulsory psychiatric care and forensic psychiatric care, the Swedish Migration Agency's detention centres, and the National Board of Institutional Care's special residential homes for young people and residential homes for the compulsory care of substance abusers.

A special OPCAT unit is tasked with assisting the individual Parliamentary Ombudsmen in their role as a National Preventive Mechanism. Two experts (a medical expert and an expert in psychology) are part of the OPCAT activities.



1.5 Dialogue forum

In January 2020, a forum for dialogue with civil society on the situation and rights of individuals deprived of their liberty was established.[4] The starting point is that the Parliamentary Ombudsmen invite a number of stakeholders from civil society to a meeting two times a year.

In 2022, two dialogue meetings were held. At one meeting, the Ombudsmen presented current issues within their respective areas of responsibility. At the second meeting, various presentations were held. The Swedish Partnership for Mental Health (NSPH) presented its project on patient participation in forensic psychiatric care, the Children's Rights Agency presented its survey of

4 See the Parliamentary Ombudsmen's decision, ref. no. ADM 39-2020.

sexual abuse in State youth care, Civil Rights Defenders presented its annual compulsory care survey and Skyddsvärnet spoke about its work to operate so-called halfway houses.

1.6 The international preventive mechanisms

SPT has 25 independent members who are experts in areas relevant to the prevention of torture. The members are appointed by the States party to the Protocol. An annual schedule determines which countries the SPT will visit.

The European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment entered into force in 1989. The Convention established the European Committee for the Prevention of Torture (CPT), whose main task is to regularly visit institutions in Europe for individuals deprived of their liberty. All 46 Member States of the Council of Europe have ratified the Convention. Swedish authorities are obliged to cooperate with the SPT and CPT.[5]

1.7 The Nordic preventive mechanisms, the NPM Network

The Nordic NPM network was formed in 2015. In 2022, the Network held two meetings, one digital meeting organised by Iceland where one theme was information from institutions that it is not possible to implement a National Preventive Mechanism's recommendations. A meeting was also held in Copenhagen where the theme was the supervision of prisons abroad.[6]

1.8 Purpose of this report

This report contains a summary of the observations made by the Parliamentary Ombudsmen as part of the OPCAT activities in 2022. During the year, the activities had a special focus on children and young individuals up to the age of 21 and their participation during their deprivation of liberty. A more detailed account of the direction for the authorities regarding the focus issue can be found in each respective section of this report.

As a result of the pandemic, this year's inspections did not begin until March, why there were fewer inspections carried out on site than in a normal year.

5 Act (SFS 1988:695) on Certain International Undertakings Against Torture etc.

6 See ref. no. O 5-2022 and O 10-2022.

2

OPCAT inspections

OPCAT inspections

One of the most important elements of the Parliamentary Ombudsmen's OPCAT activities is the inspections of places where individuals may be held deprived of their liberty. In the context of the theme of children and young individuals' participation during deprivation of liberty, the selection of places was made on the basis that the object had not previously been inspected by the Parliamentary Ombudsmen or had not been inspected for a long time. A good geographical spread was also given importance when deciding the inspections.

2.1 Method

As a rule, the Parliamentary Ombudsmen's employees are commissioned by an Ombudsman to carry out an inspection. Sometimes the Ombudsman concerned leads the inspection themselves. An inspection can either be announced or unannounced. Nowadays the majority of inspections are unannounced, which is in line with the interest of institutions constantly being prepared for a visit. Unannounced inspections also increase the credibility of inspection activities. The Parliamentary Ombudsmen's traditional supervisory activities and the Parliamentary Ombudsmen's assignment under OPCAT have many similarities. For this reason, as a rule, employees from the OPCAT Unit participate in inspections conducted by the supervisory departments of places where individuals may be held deprived of their liberty. For the same reason, employees from the supervisory departments regularly participate in inspections assigned to the OPCAT Unit.

The observations made in connection with an inspection are documented in a report and presented to the responsible Ombudsman. If the inspection draws attention to any issue that needs to be specially investigated, the Ombudsman decides to do so in an enquiry (see further in Annex C). However, it is most common for the Ombudsman to comment in the report on the observations made during the inspection.

The Parliamentary Ombudsmen also have dialogue meetings with representatives of various authorities. In 2022, a meeting was held with the Director General of the National Board of Institutional Care (SiS).

2.2 Places where individuals may be deprived of their liberty

In 2022, individuals were deprived of their liberty at, inter alia, the following places:

- 124 police custody facilities with approximately 1,300 beds (Swedish Police Authority)
- 33 remand prisons with approximately 2,300 beds (Swedish Prison and Probation Service)
- 46 prisons with approximately 4,600 beds (Swedish Prison and Probation Service)
- 21 special residential homes for young people with approximately 730 beds (National Board of Institutional Care, SiS)
- 11 residential homes for the compulsory care of substance abusers with approximately 400 beds (National Board of Institutional Care, SiS)
- At least 80 institutions for compulsory psychiatric care and forensic psychiatric care with approximately 4,100 beds (21 regions)
- 6 migration detention centres with approximately 560 beds (Swedish Migration Agency)

The figures presented above are partly based on estimates. The account only includes permanent beds. The high occupancy rate and strained capacity within the Swedish Prison and Probation Service has led to ongoing work within the authority to create different types of temporary beds, including beds for double occupancy. Such beds are not included in the account.

2.3 Inspections carried out

In 2022, 11 inspections were carried out as part of the OPCAT mission.

Inspection item/year	number of
Police custody facilities	1
Remand prisons	2
Prisons	2
Special residential homes for young people	3
Compulsory psychiatric care activities	2
Migration detention centres	1
Total	**11**

For a full account of the inspections carried out, see Annex B.

3

The Police Authority

The Police Authority

The Police Authority has the power to hold people in police custody facilities. Individuals apprehended or arrested are among those placed in police custody facilities. Individuals detained due to intoxication under the Care of Intoxicated Persons Act (LOB) are also regularly placed in police custody facilities.

Police custody facilities are intended for short-term deprivations of liberty. A period of deprivation of liberty can last from a few hours up to a maximum of a couple of days. At the end of 2022, there were 124 police custody facilities with a total of about 1,300 beds. The Police Authority or a security company hired by the authority is responsible for staffing the police custody facilities.

In 2022, one police custody facility was inspected, *the police custody facility in Västerås*.[1] The inspection was carried out on site and was unannounced. The inspection was part of the OPCAT activities' thematic focus in 2022 on children and young individuals deprived of their liberty (individuals under the age of 21). The inspection examined the extent to which, where and under what conditions children are detained in the police custody facility.

The inspection was carried out on behalf of Parliamentary Ombudsman Per Lennerbrant.

3.1 Observations made during this year's inspection

Inspections of police custody facilities focus primarily on how the basic needs of the individuals deprived of their liberty are met. These include their right to food and drink, daily outdoor access, being treated in a dignified manner as well as receiving the necessary information. A key aspect in this context, especially in the case of children, is the design of the physical environment in which the individuals deprived of their liberty reside. Another key issue is the safety and security of individuals deprived of their liberty. It is not uncommon for individuals held in police custody facilities to be in poor physical and mental condition. Therefore, it is important to make a safety and security assessment of the individual held in custody. Based on that assessment, it is then important that individuals deprived of their liberty are regularly monitored and that this monitoring is documented.

During the inspection of the police custody facility in Västerås, the observations described below were made.

1 See the Parliamentary Ombudsmen's report, ref. no. O 14-2022.

Children in police custody facilities

A person under the age of eighteen who has been arrested or detained may, according to Section 6 a of the Young Offenders Act (LUL), be held in police custody only if it is absolutely necessary. The provision entered into force on 1 July 2021. In the preparatory work for the provision it is stated, inter alia, that a police custody facility is not adapted to the special needs of a child and a placement, even temporarily, in a police custody facility should be avoided as it is not a suitable environment for children. Only in exceptional cases may the detention of children in a police custody facility be considered.[2]

The Parliamentary Ombudsmen have previously stated that the provision in Section 6 a of the Young Offenders Act and the clear intentions of the legislation require the Police Authority to plan and have the capacity to ensure that several, sometimes many, children are arrested or detained at the same time.

During the inspection of *the police custody facility in Västerås,* it emerged that there are no rooms specifically set aside for the placement of children. Children who were arrested were therefore placed in an interrogation room adjacent to the police custody facility, on a bench in the police custody facility's intake or in a cell. Children who were arrested were usually placed in a cell until the child was released or detained.

From the entry into force of Section 6 a of the Young Offenders Act and until mid-September 2022, 32 children had been detained in the police custody facility, in several cases for more than twenty-four hours. The inspection revealed that there was limited knowledge among the police personnel of the Police Authority's decision support regarding the placement of children and that attempts are rarely made to find an alternative placement.

After the inspection, the Parliamentary Ombudsman stated that the observations of the conditions at the police custody facility gave the impression that supervisors assume that there will be no conditions for a detained child to be placed anywhere other than in a cell in the police custody facility. Therefore, the supervisors make no effort to find such placement on a case-by-case basis. The Parliamentary Ombudsman emphasised that, according to the legislative history, special efforts must have been made to find a reasonable and suitable

2 See Government Bill 2019/20:129 p. 46 and 60 f.

alternative in order for a child to be detained in a police custody facility.

Furthermore, the Parliamentary Ombudsman expressed his concern that such a large number of children had been detained in the police custody facility in Västerås. The children had been placed in noise-sensitive holding cells in the same corridor as the sobering-up cells and thus in an environment that the legislator had deemed unsuitable for children. It was also considered worrying that supervisors – who have the task of deciding on placement in a cell in the police custody facility – have limited knowledge of the decision support regarding the placement of children. The Parliamentary Ombudsman stated that he could not draw any other conclusion than that what would only be considered in exceptional cases is rather the rule in the police custody facility in Västerås. Whatever the explanation for this, it is, according to the Parliamentary Ombudsman, completely unacceptable.

It is unacceptable for children to be consistently placed in the police custody facility

Shortcomings in the physical environment

The inspection revealed, inter alia, that the custody facilities are old and that, according to the Police Authority, they are not optimal for detention activities. The cells had standard equipment and windows that allowed light to enter, but there was no device to regulate the daylight. Both police employees and custody guards said there are problems with noise-sensitive cells and high noise levels in the police custody facility. The Police Authority has tried to address these problems, for example by installing sound-absorbing tiles in the ceiling in the corridor with the cells.

After the inspection, the Parliamentary Ombudsman concluded that, despite the efforts of the Police Authority, the inmates can continue to communicate with and disturb each other. The Parliamentary Ombudsman stated that he is aware that there are far-reaching plans to build a new police station in Västerås, but pointed out that it will still be a number of years before there is a new police custody facility. In the meantime, the Police Authority needs to seek solutions for the sound environment in the current police custody facility. Issues with soundproofing can, according to the Parliamentary Ombudsman, lead to a number of serious consequences. This can have a negative impact on, inter alia, the physical and mental health of the inmates as well as on the Police Authority's ability to maintain the safety and security of the inmates, restrictions and confidentiality.[3]

The Police Authority needs to review solutions for the sound environment in the current police custody facility

3.2 Concluding remarks by Parliamentary Ombudsman Per Lennerbrant

This year's inspection shows that the Police Authority has extensive work ahead of it when it comes to children deprived of their liberty. Work is to

3 See the Parliamentary Ombudsmen's report, ref. no. O 14-2022, cf. also the Parliamentary Ombudsmen's statements on noise sensitivity in decisions and reports, ref. nos. 8978-2020, 2475-2021 and 1362-2021.

some extent made more difficult by circumstances beyond the Authority's control, such as the strained occupancy situation in the Prison and Probation Service. However, it is completely unacceptable to assume, as in the case of the police custody facility in Västerås, that there is no alternative placement and therefore consistently place children in a custody facility, which also has major shortcomings in the physical environment. The Police Authority therefore needs to take measures to be able to take care of arrested and detained children on its own, e.g. by adapting its premises.

It is very important to monitor the Police Authority's compliance with the requirements of Section 6 a of the Young Offenders Act. I will revisit the issue in the 2023 Annual Report.

4

Prison and Probation Service

The Swedish Prison and Probation Service

At the end of 2022, there were 33 remand prisons and 46 prisons in Sweden with a total of approximately 6,900 permanent beds. In addition, the Swedish Prison and Probation Service has beds for temporary needs, emergency beds in case of double occupancy and temporary beds in other types of rooms than resident rooms that do not meet the standard of cells. In 2022, the use of emergency beds and temporary beds has continued to increase, thus the total number of remand prison and prison beds amounted to approximately 8,000.[1]

The Prison and Probation Service's institutions primarily hold individuals who are deprived of their liberty because they are remand prisoners or serving a prison sentence. Other categories of individuals deprived of their liberty are also placed in the Swedish Prison and Probation Service's remand prisons. For example, individuals who have been taken into care under the Care of Young Persons Act (SFS 1990:52) or the Care of Substance Abusers Act (SFS 1988:870) and who are transported by the Prison and Probation Service's National Transport Unit (NTU). Another group that can be placed in remand prisons and prisons are foreign nationals who are detained under the Aliens Act (SFS 2005:716).

In 2022, four inspections of remand prisons and prisons were carried out.[2] Of these, three inspections were unannounced. The inspections were part of the OPCAT activities' thematic focus in 2022 on children and young persons' participation during deprivation of liberty. All inspections were carried out by or on behalf of Parliamentary Ombudsman Katarina Påhlsson.

4.1 Observations made during the inspections

According to the Prison and Probation Service's definition, inmates are counted as young persons if they have been entered into remand prison before they have reached the age of 21 and have not yet reached the age of 24. A person under the age of 18 is considered a child. The inspections examined what information is given to children and young persons and whether it is done in a way that is adapted to their ability to process the information. Furthermore, it was examined how children and young persons are placed in remand prison and prison and their access to isolation-breaking measures in remand prison.

1 See the Prison and Probation Service's Annual Report 2022.

2 The Sollentuna and Luleå remand prisons and the Täby and Luleå prisons.

Children's right to association with others in remand prison

Since 1 July 2021, an arrested or detained child who is held in remand prison has the right to spend at least four hours with staff or someone else every day, see Chapter 2, Section 5 a of the Act on Detention (SFS 2010:611). The aim is to prevent children from being isolated. The preparatory works state, inter alia, that the right applies without exception and that it is primarily to be fulfilled through association with prison staff. Which contacts count as association with others may be decided on a case-by-case basis. It is crucial that the contact is such that it breaks isolation and that it is a question of meaningful human contact. In addition to contacts with prison officers, this can include contacts with e.g. other inmates, family members, school, social services or volunteers.[3]

During the inspection of *the Sollentuna remand prison*, one child and 41 young persons were inmates in the remand prison. It emerged that it is relatively common for the remand prison to receive children. In the remand prison, there was a special staff group of four people who worked on activities to break isolation during the week. During weekends, an employee had this task. These resources were intended for both children and young persons.

In conversations with the remand prison's management, it emerged that the resources are not sufficient to meet children's right to four-hour association with staff or others if there are more than a couple of children placed in the remand prison. The management noted that Region Stockholm has decided that the remand prisons, as a benchmark, shall have the capacity to receive seven children each. However, the remand prison had not received any extra resources to cope with the task, and when more than a couple of children were placed in the remand prison, they need to be distributed among the other remand prisons.

Young persons do not receive any isolation-breaking measures when there are several children in the remand prison

According to staff, the requirement in Chapter 2, Section 5 a of the Act on Detention has led to the young inmates not receiving interventions to the extent they received before the legislative amendment. As soon as there are two to three children in the remand prison, there is no capacity to offer the young persons isolation-breaking measures. In practice, young inmates basically never get two hours of interpersonal contact, except for those who have limited association with another inmate ('co-sitting'). The fact that young inmates suffer when there are many children in the remand prison was also confirmed by the management.

After the inspection, the Parliamentary Ombudsman stated that the provision in the Act on Detention requires the Prison and Probation Service to plan and have the capacity to have several, sometimes many, children in the remand prison at the same time. Furthermore, she pointed out that the star-

3 See Government Bill 2019/20:129 p. 40-44 and p. 64.

The Prison and Probation Service needs to take the measures necessary to ensure that all children in the remand prison get four hours daily association with staff or others

ting point is that children in remand prison should primarily associate with prison officers who are used to facing children in the stressful situation that deprivation of liberty entails. According to the Parliamentary Ombudsman, the capacity and organisation of the Sollentuna remand prison are clearly inadequate to provide isolation-breaking measures to the number of children, seven of them, that the Stockholm Region Prison and Probation Service has set. In addition, resources are only enough for a few children on weekends. The Parliamentary Ombudsman further stated that this situation is of course completely unacceptable and that she assumes that the Prison and Probation Service takes the necessary measures to ensure that all children in remand prison have their legal right to spend at least four hours a day with staff or others satisfied.

Meaningful contact should be seen from the child's perspective, not the public

The Parliamentary Ombudsman also noted that it appeared from the information obtained during the inspection of the Sollentuna remand prison that police interrogations are reported as association with others and thus as a kind of isolation-breaking measure. In the opinion of the Parliamentary Ombudsmen, the starting point for what constitutes meaningful contact should be seen from the child's perspective, not that of the public. Therefore, the Parliamentary Ombudsman expressed that she is very doubtful that police interrogation can be regarded as such meaningful contact as intended by the preparatory work.

During the inspection of *the Luleå remand prison*, the occupancy was at a record high. None of the inmates were under the age of 18 and only one inmate was considered a young person. It also emerged that it is generally unusual to have children in the remand prison. Furthermore, it was noted that the remand prison has developed procedures aimed at ensuring children's rights in accordance with the provision in Chapter 2, Section 5 a of the Act on Detention.

Although it is generally unusual to have children in the remand prison in Luleå, the Parliamentary Ombudsman chose in her statements to dwell briefly on a couple of issues that specifically concern children. Initially, she stated that it is very positive that the remand prison has developed procedures aimed at ensuring children's rights pursuant to Chapter 2, Section 5 a of the Act on Detention. Subsequently, the Parliamentary Ombudsman stated that as of 1 July 2021, a person who has reached the age of 18 who has been arrested or detained may be held in police custody only if absolutely necessary.[4] In the preparatory work it is stated, inter alia, that a police custody facility is not adapted to the special needs of a child and a placement, even temporarily, in a police custody facility should be avoided as it is not suitable environment for children. An interrogation room or similar, or a room in a remand prison,

4 See Section 6 a of the Young Offenders Act.

is considered to be a clearly more suitable placement for a child than a police custody facility.[5] At the time of the inspection of the Luleå remand prison, there was no room to receive arrested or detained children due to the high occupancy. Thus, according to the Parliamentary Ombudsman, there was a risk that the police would not succeed in arranging an alternative placement of a child deprived of liberty and that, as a result the Prison and Probation Services shortcomings, children may be detained in police custody facilities. In the long term, this may lead to the provision not having the intended effect, which according to the Parliamentary Ombudsman is very worrying.

As a result of the Prison and Probation Service's shortcomings, children may be detained in police custody facilities

Isolation-breaking measures for remand prisoners over the age of 18

The Prison and Probation Service's goal is that remand prisoners with restrictions who are 18 years and older shall have the opportunity for two hours of isolation-breaking measures per day. This can be compared to the European Committee for the Prevention of Torture's (CPT) standard, according to which all inmates in remand prisons and prisons shall be given the opportunity to spend at least eight hours outside the cell on a daily basis.

At the time of the inspection of *the Sollentuna remand prison*, there were just under 30 young inmates with restrictions. In interviews, they brought up that they felt unwell from being locked in a cell. Some days they only had their daily outdoor access and on weekends it was difficult to get isolation-breaking measures. After the inspection, the Parliamentary Ombudsman stated that it is clear that young persons' ability to obtain isolation-breaking measures is affected when children are incarcerated. The investigation clearly shows that many of the young persons have not received isolation-breaking measures for two hours a day. When a child's right to association with others in remand prison is met, there is thus a risk that the young inmates are isolated. According to the Parliamentary Ombudsman, this is unacceptable and she emphasised that even with a strained occupancy situation, the remand prison has a responsibility to ensure association occurs and to break the isolation of inmates. It is not acceptable that the efforts are limited due to a lack of resources, practical conditions or for organisational reasons.

When a child's right to association with others in remand prison is met, there is thus a risk that the young inmates are isolated

Inmates' right to spend time in common areas

An inmate who is neither subject to restrictions nor segregated shall be given the opportunity to spend time during the day with other inmates (association). Well-functioning wards are an important prerequisite for the Prison and Probation Service to be able to satisfy this right. In a ward, the inmates are normally given the opportunity to associate with others for about six hours per day. The Parliamentary Ombudsman has previously stated that

5 See Government Bill 2019/20:129 p 46 f.

association means that an inmate spends time with several other inmates.[6] There is therefore no risk that inmates placed in such wards will become isolated. The Parliamentary Ombudsmen has previously directed very serious criticism against the Prison and Probation Service for the fact that inmates' right to association is not satisfied, including against the Sollentuna remand prison.[7] The review of solitary confinement in remand prisons is presented in a special report.[8]

The inmates do not have their right to association satisfied and risk becoming isolated

During the inspection of *the Sollentuna remand prison*, it emerged that children and young persons were preferably placed in the remand prison's youth department, which is a department for placement of inmates with restrictions. Of the nine young persons entitled to association, five were placed in a ward. The other four, including two young persons who were waiting for a prison bed, did not spend time with others and were not segregated. After the inspection, the Parliamentary Ombudsman concluded that the remand prison is still unable to satisfy the inmates' right to association, which may result in inmates becoming isolated there and that this situation is serious.

During the inspection of the *Luleå remand prison*, there was an inmate who, due to the suspicion of crime, was not allowed to spend time with others, even though he did not have restrictions. In interviews, the inmate stated that he never spends time with other inmates and that he has not been asked if that is something he wants. After the inspection, the Parliamentary Ombudsman referred to previous statements that it is not acceptable that the possibility of association is restricted due to a lack of resources, and that it is deeply unsatisfactory that an inmate is not given the opportunity to spend time with others for organisational or other reasons beyond the inmate's control.[9] The Parliamentary Ombudsman also pointed out that she had previously expressed that the Prison and Probation Service should establish more special wards where inmates who, due to the alleged criminal offence, live under treat at the remand prison can have their right to association with others met.[10] According to the Parliamentary Ombudsman, what emerged from the inspection in Luleå once again highlights this need. It is not acceptable that the Prison and Probation Service's shortcomings entail restrictions on an inmate's right to association and that, in the long run, it risks leading to the inmate becoming isolated.

Shortcomings in the Prison and Probation Service's ability to differentiate inmates can lead to them being isolated

Double occupancy in remand prison

For several years, the Prison and Probation Service has had a strained occupancy situation, which has led to overcrowding in relation to available

6 See, e.g., the Parliamentary Ombudsmen 2020/21 p. 164.

7 See O 5-2020.

8 See thematic report from the OPCAT Unit 2020, Isolation of inmates in remand prisons.

9 See, e.g., Parliamentary Ombudsmen 2006/07 p. 139 and 2018/19 p. 146.

10 See the Parliamentary Ombudsmen's report, ref. no. O 5-2020.

beds. In several decisions, the Parliamentary Ombudsman has drawn attention to the negative consequences that this has for inmates in remand prisons and prisons. In previous decisions, the Parliamentary Ombudsman has stated that the authority has a responsibility not only to ensure that deprivations of liberty are carried out in safe and secure conditions, but also to uphold the rights of the inmates. It is not acceptable that a lack of resources leads to restrictions in these respects. Furthermore, the Parliamentary Ombudsman has commented on the conditions for double occupancy and the requirements that should be imposed on the physical conditions when two inmates share a cell.[11]

11 See Parliamentary Ombudsmen 2021/22 p. 261.

During the inspection of *the Luleå remand prison*, seven cells were double-occupied, and inmates were also placed in the two visiting rooms. In interviews, it emerged that several of the inmates had a negative attitude towards sharing a cell. They did not give a consistent view of whether the staff had asked whether they wanted this or not. Some inmates also said that the staff do not ask how the double occupancy is working. The staff and management, for their part, stated that no one has been forced to share a cell and that the situation is being followed up with the inmates. It also emerged that some inmates who shared a cell regretted requesting limited association ('co-sitting') because it had led to this placement.

Primarily, consenting inmates should share a cell

After the inspection, the Parliamentary Ombudsman referred to previous statements that the time inmates are subject to double occupancy must be limited and that these inmates must be offered a single cell when such a cell becomes available. It is in line with the starting point of the Act on Detention that an inmate has an interest in being placed in their own cell.[12] Furthermore, the Parliamentary Ombudsman pointed out that it is reasonable that it is primarily inmates who consent to sharing cell who do so. It goes without saying that an inmate shall always be asked before they are placed with someone else. The staff must also continuously follow up on how the double occupancy is working. The Parliamentary Ombudsman also emphasised that it is serious if an inmate refrains from limited association ('co-sitting') in order not to risk double occupancy, not least as it can lead to them becoming isolated. It is therefore important that an individual assessment is always made of the suitability of two inmates sharing a cell. According to the Parliamentary Ombudsman, limited association ('co-sitting') should not automatically lead to double occupancy or entail such an expectation of the individual.

According to the Parliamentary Ombudsman, limited association should not automatically lead to double occupancy

Participation during deprivation of liberty in remand prison and prison

During the period in remand prison, an individual detention plan shall be drawn up for each inmate based on the circumstances of the individual case and it shall be established within two weeks of the detention decision. The development of the plan and the implementation of appropriate measures are based on the inmate's participation. It is also a prerequisite for an inmate in an institution to be able to participate in the enforcement that they are aware of both the prison's local procedures and the content of their implementation plan. In order for an inmate to be able to assert their rights, they also need to be informed of what these rights are. The information must be provided in a language that the inmate understands.

When examining children and young persons' detention plans during the inspection of *Sollentuna remand prison*, it appeared that almost all children

12 See Chapter 2, Section 1, first paragraph of the Act on Detention.

and young persons had participated in drawing up the plan. In the interviews held, however, children and young persons stated that they neither knew about the plan nor received a copy of it.

Following the inspection, the Parliamentary Ombudsman emphasised that the starting point must be to continuously adapt the treatment and information to the individual level of maturity of children and young persons during their time in remand prison. Part of this work should be to pedagogically, both in writing and verbally, on several occasions convey information about rights and about the purpose of various measures. When children and young persons have participated in developing a detention plan, the remand prison therefore needs to ensure that they receive a copy of it. There is also reason to follow up that the young person has processed the information conveyed.

Treatment and information for children and young persons need to be adapted to their individual level of maturity

Also during the inspection of *the Täby prison*, it turned out that the young persons were essentially familiar with and active in the work of developing an implementation plan. After the inspection, the Parliamentary Ombudsman referred to the fact that the higher staffing at the prison had provided the conditions for each inmate to have several contact persons involved in the individual implementation. This, together with the prison's work with, inter alia, frequent follow-ups of the implementation planning and staff, provided space for increasing the participation of the young persons. The Parliamentary Ombudsman concluded that the youth activities in the way they were conducted in the prison were very well-functioning.[13]

At the *Luleå prison*, the content of the implementation plan was known to the inmates and the provision of information worked well. Furthermore, the prison had a staffing level that provided the conditions for each inmate to have several contact persons involved in the individual implementation. The Parliamentary Ombudsman expressed that this was positive and that her impression, based on what had emerged from the inspection, was that the prison's activities with contact building, studies and other occupational activities, as well as treatment programmes, were appropriate and that the activities with young inmates worked well.

Visiting opportunities

During the inspection of *the Täby prison*, it turned out that the opportunities for inmates to receive visits to the prison were limited, partly because the visiting premises were also used for other purposes, and partly because the visiting hours were too few and that they were perceived as too short. Even during the inspection of *the Luleå prison*, the visiting opportunities were limited, inter alia because the prison shares a visiting room with the Luleå remand prison. At the time of the *inspection of the Luleå remand prison*, the

13 Since 1 January 2023, the Täby prison no longer has a special youth department.

two visiting rooms were occupied and neither inmates in the prison nor in the remand prison therefore had the possibility of receiving visits. One of the visiting rooms had been occupied on and off throughout the autumn of 2022.

There must be access to visiting rooms

After the inspections, the Parliamentary Ombudsman stated that it is not acceptable that the occupancy situation entails restrictions on the inmates' ability to receive visitors. According to the Parliamentary Ombudsman, it is important that the inmates, especially the young ones, are able to receive visits more regularly than they were, and she assumes that the possibilities of extending the visiting hours will be reviewed. With regard to the remand prison and the prison in *Luleå,* the Parliamentary Ombudsman pointed out that the Prison and Probation Service must ensure that there is access to visiting rooms for inmates both in the remand prison and in the prison. As many relatives also have a long way to travel to the Luleå prison, the Parliamentary Ombudsman considered it particularly important that access to visiting rooms is not dependent on the remand prison, whose occupancy can change from one day to the next.

Luleå Prison's benefit scheme[14]

At the prison, inmates were also involved in the implementation through a benefit scheme that covers all inmates. The Parliamentary Ombudsman's expert in psychology said that there are certain risks associated with such a benefit scheme. Crucial for the scheme to work is that all staff fully understand how it works and thus apply it correctly, e.g. in terms of the importance of direct feedback on behaviour. In addition, it is required that the staff have sufficient knowledge and training to be able to convey to the inmates that the scheme has a standard level and that an inmate can reach the benefit level as a reward for desirable behaviour. Even though the standard level or lack of rewards is not a punishment, there is, in the expert's assessment, a risk that inmates perceive it as such and that the scheme thus risks not contributing to the desired behavioural changes. The Parliamentary Ombudsman argued that it was not possible for her to take a position on the content or effects of the prison's benefit scheme, but that she attaches great importance to the reasoning of the Parliamentary Ombudsman's expert in psychology. Furthermore, the Parliamentary Ombudsman emphasised that if a benefit scheme shall be used within the Prison and Probation Service, it must be predictable and treat the inmates equally and legally secure. To achieve this, staff must have sufficient training and knowledge.

Placement in segregation

During the inspection of *the Täby prison*, a young inmate was segregated and placed in one of the prison's visiting rooms. In connection with other inmates receiving visitors, he had to move to stay in the prison's only solitary confinement cell. The Parliamentary Ombudsman found this situation unworthy and

14 Umeå Prison no longer has a youth department. From May 2023, there are 35 beds in security classification 2.

was critical of the fact that the prison lacks appropriate cells for the placement of segregated inmates. She also expressed that it is worrying that the high occupancy rate in the Prison and Probation Service means that young inmates waiting for relocation are segregated for several weeks**.** One consequence of this is that they risk becoming isolated, which is particularly serious for this category of inmates. The Parliamentary Ombudsmen finds this unacceptable.

Risk of young inmates becoming isolated when segregated for weeks while waiting for relocation

4.2 Concluding remarks by Parliamentary Ombudsman Katarina Påhlsson

The review of the youth activities at the two prisons Täby and Luleå gave a positive impression. The higher staffing in the youth department of the Täby prison and the staff's commitment and presence in the department and during e.g. occupational activities contributed to safe and secure enforcement. The prison's work with frequent follow-ups of the implementation planning and staff also provided space for increasing the participation of the young persons. The young persons were essentially familiar with and active in this context.

Even in my statements after the inspection of the juvenile prison in Luleå, I could state that there was a well-functioning operation there, with a working method adapted to receive young inmates. However, it emerged during this inspection that the youth activities would be phased out in the near future, which is allegedly mainly due to the current occupancy situation within the Prison and Probation Service.

I can note that the development is going in a direction where more and more young persons are being deprived of their liberty and placed with the Prison and Probation Service. It therefore appears important that the authority makes use of the knowledge and experience from the existing work with the young inmates.

The occupancy rate and overcrowding in the Prison and Probation Service affect the situation for the inmates in various ways, such as that they to a greater extent have to share a cell or have more limited opportunities to receive visitors. The authority has still not taken sufficient measures to reduce the risk of isolation of inmates in remand prisons, and this despite the fact that the issue has been topical for several decades. Too many inmates also do not have their fundamental right to association satisfied. I therefore intend to continue to monitor the situation of the inmates in remand prison with a particular focus on these issues.

5

The National Board of Institutional Care

The National Board of Institutional Care

The National Board of Institutional Care is responsible for the residential homes for compulsory care of substance abusers under the Care of Substance Abusers Act (SFS 1988:870). The National Board of Institutional Care is also the principal of the special residential homes for young people receiving care under Section 3 of the Care of Young Persons Act (1990:52) who need to be under particularly close supervision. Young persons who have been sentenced to secure youth care are also placed in special residential homes to serve their sentence in accordance with the Secure Youth Care Act (SFS 1998:603). During 2022, there were 21 special residential homes for young people with 730 beds, of which 68 beds were intended for young persons sentenced to secure youth care. In addition, there were 11 residential homes for the compulsory care of substance abusers with about 400 beds.[1]

In 2022, the Parliamentary Ombudsmen inspected four special residential homes for young people.[2] All inspections were unannounced and were carried out within the framework of the theme of children and young people's participation during deprivation of liberty. The Parliamentary Ombudsman also followed up on issues related to safety and security during the stay in a special residential home for young people.

All inspections were carried out by Parliamentary Ombudsman Thomas Norling.

5.1 Observations during inspections of special residential homes for young people

The placement of boys and girls

The National Board of Institutional Care's annual report states that the activities shall be based on the conditions and needs of girls and boys. The authority shall assess the consequences of measures and consider the best interests of the child before making decisions or other measures that may affect them. The activities shall be based on a user perspective.[3]

During the inspection of the special residential home for young people in Hässleholm, it emerged that the home has very limited opportunities to

1 National Board of Institutional Care Annual Report 2022.

2 The special residential homes for young people Vemyra, Hässleholm and Johannisberg.

3 See Sections 4 and 5 of the Ordinance (SFS 2007:1132) with instructions for the National Board of Institutional Care.

influence which children are placed there. Due to staffing difficulties, inter alia, several departments had also reduced the number of beds, so-called bed reduction. In the home's only girls' ward, three out of seven beds were closed, which meant that girls with different diagnoses and widely differing care needs were cared for together. The home, on the other hand, had more options when it came to the possibility of placing boys based on their individual care needs.

After the inspection, the Parliamentary Ombudsman pointed out that great demands are placed on the staff when a ward receives children with different diagnoses, problems and different care needs, as the staff must then act in different ways based on the children's varying circumstances. The Parliamentary Ombudsman stated that it is unsatisfactory that girls are not given the same opportunities as boys to be cared for in a ward that has special conditions to meet their needs, and that this is a structural problem that the National Board of Institutional Care must do something about.

Staff shortage affects daily operations

During the inspection of the *Johannisberg* special residential home for young people, information emerged that a shortage of staff affected the daily activities. Among other things, the situation risked causing young persons to not receive sufficient treatment efforts or the opportunity to engage in meaningful activities to a sufficient extent. The Parliamentary Ombudsman welcomed the fact that the home had decided to concentrate resources in an institution-wide treatment team to ensure staffing and continuity of programme activities.

Placement at the highest level of security

The National Board of Institutional Care decided on 18 January 2021 that the *Johannisberg* special residential home for young people shall be equipped for the highest level of security, i.e. level 1. The decision states that after implemented measures, the home shall have a good ability to handle young persons who are assessed to have the highest risks in terms of escape, threats and violence. During the inspection of the home in November 2022, it emerged that there was still relatively extensive work to be done before the special residential home for young people can be considered operational as well as having technical and physical security that meets the requirements for the highest level of security. The perimeter protection and camera surveillance were to be expanded, an intake building to be built, etc. Several of the staff stated that they had so far not noticed any real difference in their work due to the higher level of security.

After the inspection, the Parliamentary Ombudsman expressed surprise that the home had not made further progress in its work with safety-enhancing measures. Although the home had previously received young persons with the highest risks in terms of, inter alia, threats and violence, it is worrying, according to the Parliamentary Ombudsman, that the measures that, accor-

It is worrying that children and young people receiving care under the Care of Young Persons (Special Provisions) Act can still be placed with those serving sentences under the Secure Youth Care Act

ding to the National Board of Institutional Care, are needed for the home to have a good ability to handle young persons with such risks were not in place. Furthermore, the National Board of Institutional Care has made a national decision that makes exceptions to the principle that young persons in secure youth care shall be cared for separately from those who are cared for under the Care of Young Persons (Special Provisions) Act. The Parliamentary Ombudsman pointed out that in previous inspections of the National Board of Institutional Care, he had drawn attention to the problems that arise when children and young people who are cared for under the Care of Young Persons (Special Provisions) Act are placed in the same wards as those serving sentences under the Secure Youth Care Act.[4] According to the Parliamentary Ombudsman, it is worrying that the authority has abandoned the principle that such placements should not be made.

About children under 13

During the inspection of the special residential home for young people Hässleholm, three children under the age of 13 were admitted to the home. They were placed in different wards together with children aged 13–16. The inspection revealed that it is not always appropriate for older children to spend

4 See, e.g., the report from the inspection of the Sundbo special residential home for young people on 6 and 7 November 2018, ref. no. 7107-2018.

time with younger children. The head of department was of the opinion that departments should be created within the National Board of Institutional Care that only receive children under the age of 13 where their needs can be specifically met. Based on what emerged from the inspection, the Parliamentary Ombudsman considered that the National Board of Institutional Care should consider whether such special departments should be established.

There may be a need for special wards for children under 13

Physical environment

The *Hässleholm* special residential home for young people is housed in a building that was taken into use a few years ago. The children stay in wards that are bright and spacious and each ward has its own yard. Six of the seven wards can be divided into two sections, each with a large common room, and adjacent to the common room are resident rooms. There are spaces for separate care in each section. Each ward has access to a segregation room and its own classroom. During the inspection of the home, the children and staff expressed that they found the premises functional and pleasant. Following the inspection, the Parliamentary Ombudsman stated that the physical environment was well adapted to the activities carried out there and that the premises were also otherwise appropriate.

Hässleholm has premises that are adapted for the activities

Sexual Assault Prevention

During the Parliamentary Ombudsman's inspection of the special residential home for young people *Vemyra* in 2019, information emerged that a girl had been abused by another girl at night. After the inspection, the Parliamentary Ombudsman stated, inter alia, that the National Board of Institutional Care should immediately review what measures need to be taken to support the home's management in ensuring that the young persons receive safe and secure care. After another inspection of the home in 2021, the Parliamentary Ombudsman concluded that many of the shortcomings highlighted in 2019 still remained.

If the girls are to be safe at night, the staff must feel a clear responsibility to ensure that they are not subjected to abuse

During the inspection of Vemyra in April 2022, the issue of safety and security was followed up. The home informed that one measure that had been taken was that the National Board of Institutional Care's rules of conduct were handed over to the incarcerated girls. The rules stated, inter alia, that everyone staying in a special residential home for young people has the right to feel safe and secure and that violence (physical, psychological or sexual) and threats will not be accepted. It also stated that no one may be forced to have sex. Furthermore, reference was made to the fact that the door alarms to the girls' resident rooms are intended to create security for the girls.

In conversations with the inmates, it was described that they had found ways to circumvent the alarms to the resident rooms and both girls and staff testified that the girls go into each other's rooms at night. Several of the staff also said that they often choose not to act when the girls are not in their rooms.

After the inspection, the Parliamentary Ombudsman noted that he had previously stated that the National Board of Institutional Care should review what measures need to be taken to prevent sexual abuse from occurring in the homes, but that the National Board of Institutional Care has still not taken such measures to ensure safe and secure care for the young persons. Furthermore, the Parliamentary Ombudsman noted that it had emerged that the staff did not work actively to prevent sexual abuse and that the staff did not act when the door alarms were triggered at night. This was something that was noted as early as in 2019. The Parliamentary Ombudsman stated that he is very concerned that the special residential home for young people has not yet managed to deal with this problem. Ultimately, it is about the girls being safe at night and that the staff feel a clear responsibility to ensure that the girls are not subjected to abuse. The management of Vemyra was therefore urged to immediately take the necessary measures for the staff to assume that responsibility.

During the inspection in November 2022 of the *Johannisberg* special residential home for young people, it emerged that the home's ability to act against young persons entering each other's resident rooms at night are dependent upon the appointment of an operational manager and that basic staffing is in place. According to the home's assessment, it would take at least until April 2023. After the inspection, the Parliamentary Ombudsman stated, with reference to the problems that existed in recruiting new employees, that it may take longer than that and that it is worrying. The Parliamentary Ombudsman therefore urged the home to also look for other possible solutions to create a safe and secure environment for the young persons at all hours of the day.

It is not appropriate for children who have been sexually abused to be placed with children undergoing treatment for sexually disruptive behaviour

During the inspection of the special residential home for young people Hässleholm, information emerged that children who have been subjected to sexual abuse are placed together with children undergoing treatment for sexually disruptive behaviour. After the inspection, the Parliamentary Ombudsman pointed out the inappropriateness of placing a child in a ward that is not suitable in relation to the need for care. The starting point for the placement must be that the child's needs, age and development are taken into account. The child's personal circumstances in general should also be taken into account, which may include previous experiences of abuse. According to the Parliamentary Ombudsman, it is of course important to avoid a situation in which children who have previously been subjected to abuse stay in the same environment as children who are being cared for and treated for sexually disruptive behaviour.

Sectioning of wards and the right to associate with several inmates

During the inspection of the special residential home for young people *Hässleholm*, it emerged that sectioning a ward in the home could sometimes

lead to children being left alone in a section or that only two children stayed there together. At the time of the inspection, two girls were staying alone in a section of the girls' ward. In interviews with one of the girls, it emerged that she felt that she had to take responsibility for the other girl that she should not have.

After the inspection, the Parliamentary Ombudsman referred to previous statements that the starting point must be that a young person who is an inmate in a special residential home for young people should be given the opportunity to spend time with other inmates during the day. In order for this to be achieved, a ward, or a sectioned part thereof, must consist of at least three resident rooms. If fewer than three young persons are staying in a ward, the staff must immediately take action to ensure that the situation ends as soon as possible. This is a basic right that must be respected in order to counteract the negative potential consequences of deprivation of liberty.[5] The National Board of Institutional Care is responsible for fully meeting the psychosocial needs of children. Based on the situation at the special residential home for young people Hässleholm, the Parliamentary Ombudsman considered that the National Board of Institutional Care needs to work more actively to get away from a situation where only one or two children are staying in a section. Furthermore, the Parliamentary Ombudsman emphasised that it is the National Board of Institutional Care's responsibility to fully meet children's psychosocial needs. That responsibility cannot be placed on the children.

Young persons shall be given the opportunity to associate with several other inmates

Participation during deprivation of liberty

Interventions for children must be made within Social Services in agreement with the child and their legal guardians in accordance with the provisions of the Social Services Act. The interventions shall be characterised by respect for the young person's human dignity and privacy. When making decisions in accordance with the Care of Young Persons (Special Provisions) Act, the best interest of the young person must be decisive. A child's right to participation consists of different parts, such as the right to information, the right to be heard and listened to, and the right to influence based on age and maturity.[6]

During the inspection of the special residential home for young people *Hässleholm*, it emerged that the staff in the special residential home for young people worked actively in several areas to ensure that the children participated in their care. This concerned, for example, the information provided about rights, follow-up conversations after segregation, the work with youth councils and the handling of complaints. The Parliamentary Ombudsman expressed that this was positive and pointed out that it was also gratifying that

5 See the Parliamentary Ombudsmen's report, ref. no. 6204-2018.

6 See Sections 1 and 36 of the Care of Young Persons (Special Provisions) Act and Articles 3 and 12 of the UN Convention on the Rights of the Child.

the majority of children expressed that they were satisfied with both school and the activities offered at the home.

Inmates shall be informed of their rights in close connection with their admission into a home

During the inspection of the special residential home for young people *Vemyra*, it emerged that a girl who had been admitted to the home had not had her rights or the rules at the home explained to her. This was also the first time that the girl was admitted to one of the National Board of Institutional Care's special residential homes for young people. For this reason, the Parliamentary Ombudsman reminded of the importance of all inmates receiving information about their rights in close connection with their admission to a home. The management of the home was urged to take the necessary measures to ensure this.

Follow-up of the situation at the Vemyra special residential home for young people

The staff's working methods and treatment of the girls

Vemyra has been inspected three times since 2019

As shown, inspections of the *Vemyra* special residential home for young people were carried out in 2019 and 2021.[7] At the follow-up inspection in April 2022, it was revealed, inter alia, that the target home's target group has changed and that the home now accepts school age girls. The staff felt that this group of inmates has a greater need for care than older young persons and that this places higher demands on resources. It was also stated that high staff turnover made it difficult to enforce rules and procedures. The staff also felt that the girls to a large extent had to decide for themselves how to act and handle the conflicts that arose between the girls and between the girls and the staff. The girls testified that the staff do not set clear boundaries and that they are directed to handle their conflicts themselves.

The girls had to deal with conflicts without the support of staff

Measures taken after 2021 have not had an effect on activities in the home

After the inspection, the Parliamentary Ombudsman concluded that the home still has major problems. It was unclear whether this was due to shortcomings in the management and control of the activities, or whether it was a question of a resource or competence problem, for example. The Parliamentary Ombudsman stated that it is part of the staff's duties to ensure that order is maintained in the home. The staff is responsible for intervening to avoid a fight, for example, and the staff must be able to pull an inmate aside if necessary to try to resolve the situation through dialogue. The Parliamentary Ombudsman also considered that the home needs to take further measures to ensure good and safe care. The home needs to deal with the staff's reluctance to set clear boundaries for how the girls should act and behave in the ward, ensure that the staff apply rules and procedures in a uniform way and ensure that the girls receive a functioning schooling. The Parliamentary Ombudsman recommended that the National Board of Institutional Care review what measures the authority needs to take to provide support to the management of the Vemyra special residential home for young people.

The shortcomings in Vemyra's activities affected the home's ability to provide good and safe care

7 See the Parliamentary Ombudsman's Annual Report on 2020-21, section 5.

5.2 Enquiries

Review of how the National Board of Institutional Care uses the special powers of segregation and separate care

In November 2019, an inspection was carried out of the National Board of Institutional Care's residential home for the compulsory care of substance abusers Gudhemsgården and a few weeks later the residential home for the compulsory care of substance abusers Hessleby was also inspected.[8] During the inspection of the residential home for the compulsory care of substance abusers Gudhemsgården, information emerged that indicated that inmates were receiving separate care only because they had requested it. On the basis of this information, the Parliamentary Ombudsman decided to investigate in an intitiative how the provision on such care is applied by the National Board of Institutional Care.[9]

In the subsequent decision, which was announced in November 2022, the Parliamentary Ombudsman made a statement on the question of whether an inmate can consent to separate care. He stated, inter alia, the following. A case of separate care shall be continuously examined and always reviewed within seven days of the last assessment. A decision on such care is thus assumed to apply for a relatively limited period, which sends a clear signal that separate care, as a starting point, shall be a temporary solution. The intervention shall be evaluated on an ongoing basis in order to provide answers to the question of whether the inmate can receive care in less invasive forms and thus return to being cared for with others. The meaning of this is that a coercive measure must be balanced against the inconvenience that the intervention entails for the individual in terms of, inter alia, their right to self-determination and privacy.[10]

The mere fact that an inmate expresses that they wish to receive separate care does not constitute a legal basis for making a decision to that effect

The Parliamentary Ombudsman emphasised that separate care is an intrusive coercive measure that the National Board of Institutional Care may only use if the legal prerequisites for it are met. This means that the National Board of Institutional Care has an obligation to examine in each individual case whether the prerequisites for separate care are met. It is therefore not a question for the individual to decide. Furthermore, according to the Parliamentary Ombudsmen, the assessment should not be made solely because the law imposes a formal requirement for it, but the assessment must be complete and take into account, inter alia, the result of the inmate receiving separate care. In this context, according to the Parliamentary Ombudsman, it is important that the decision-maker carefully documents the reasons on which the measure is based to allow the separate care to continue or, if possible, terminate

8 See Annual Report 2019 p. 49 and matters in the Parliamentary Ombudsmen's ref. nos. O 58-2019 and O 62-2019.

9 See the Parliamentary Ombudsmen's case, ref. no. 2802-2020.

10 See Section 36 a of the Care of Alcoholics and Drug Users Act, Section 20 a of the Care of Young Persons (Special Provisions) Act and Section 18 b of the Secure Youth Care Act as well as Government Bill 2004/05:123 p. 56 and Government Bill 2010/11:107 p. 27 f.

it. Whether there are legal prerequisites to, for example, allow an inmate to stay with other inmates on probation before a decision is made to terminate the separate care, is a question that the Parliamentary Ombudsman intends to revisit, as well as the question of different types of 'transition' in connection with separate care.11 On the basis of, inter alia, the requirement of legal certainty, it is absolutely crucial that the National Board of Institutional Care assumes the responsibility assigned to the authority to examine whether, how and in what situations the special powers may be used. During inspections, the Parliamentary Ombudsman has noted that there were perceptions among staff that the inmates could receive separate care if they wanted to be cared for in such way. Such an approach gives cause for concern, and the Parliamentary Ombudsman underlines his view that the National Board of Institutional Care must continue to place greater emphasis on the work of ensuring a lawful and uniform application of the provisions.

5.3 Concluding remarks by Parliamentary Ombudsman Thomas Norling

I have monitored the situation at the National Board of Institutional Care's special residential home for young people for several years. The inspections carried out in 2022 show that many of the problems that the National Board of Institutional Care has had in recent years remain. Examples include difficulties in recruiting, lack of competence among staff and lack of suitable premises. In addition, the National Board of Institutional Care must accept increasingly younger children and more children and young people with a more extensive and complex need for care. I can state that the activities are not equipped for these changes in the target group, which inter alia leads to inappropriate placements and a deteriorating care content for the inmates.

However, after the 2022 inspections, I believe that the issue of safety and security appears particularly urgent and worrying. As early as in 2019, I stated that the special situation that children and young people deprived of liberty are in means that authorities must always take information about violence and other abuses very seriously. The very serious information that a female inmate at the Vemyra special residential home for young people had been exploited at night by other inmates was also conveyed to the department management. Despite this, during this year's inspection of the special residential home for young people, it emerged that the inmates continue to go into each other's rooms at night, which clearly endangers the girls' safety and security. In this context, the information that the staff do not act when the girls are in each other's rooms at night is particularly worrying. The situation described and the risk of children and young people being exposed to violence and abuse by

11 See statements in Parliamentary Ombudsmen's report, ref. no. O 18-2022 and O 19-2022 and decisions on initiatives, ref. no. 1469-2023.

fellow inmates is also not limited to just one of the National Board of Institutional Care's special residential homes for young people. I therefore consider it still very important in my preventive assignment to examine the issue of safety and security at the National Board of Institutional Care's special residential homes for young people.

6

Compulsory psychiatric care

Compulsory psychiatric care

Care pursuant to the Compulsory Psychiatric Care Act (SFS 1991:1128) and the Forensic Psychiatric Care Act (SFS 1991:1129) is almost exclusively provided by the regions. In 2020, there were an estimated 80 care facilities operating pursuant to the Compulsory Psychiatric Care Act and the Forensic Psychiatric Care Act with approximately 4,100 beds. Patients are also cared for voluntarily at these care facilities in accordance with the Health and Medical Services Act (SFS 2017:30).

In 2022, within the framework of the thematic focus on children and young persons' participation during deprivation of liberty, two inspections were carried out of activities that provide care in accordance with the Compulsory Psychiatric Care Act. Young person refer to individuals under the age of 21. The inspections were unannounced and carried out on behalf of Chief Parliamentary Ombudsman Erik Nymansson.[1]

6.1 Observations made during inspections

Care planning and treatment

Care planning shall begin in connection with an admission decision. The care plan shall form the basis for the treatment of the patient in the acute phase after admission and include the main features of the planning of continued care. The care plan shall be reviewed as soon as there is a basis for establishing such a plan for the continued care. Furthermore, the plan shall, as much as possible, be drawn up in consultation with the patient and, in some cases, the patient's close relatives.[2] The information is needed for the patient to be able to exercise self-determination and decide whether to accept the care offered, but it also makes it easier for the patient to feel increased control over their life by eliminating or reducing uncertainty and enabling planning. If it is not possible to draw up the care plan in consultation with the patient, the reason for this shall be stated in the plan. The care plan shall provide an overall picture of the patient's medical, psychological and social needs. [3]

During the inspections of *Child and Adolescent Psychiatry in Uppsala and Linköping*, various statements were provided about how patients perceived

1 Uppsala University Hospital, Child and Adolescent Psychiatry, ref. no. O 8-2022 and Child and Adolescent Psychiatric Clinic in Linköping, ref. no. O 17-2022.

2 See Section 16, first paragraph of the Compulsory Psychiatric Care Act and Chapter 3, Section 3 of the National Board of Health and Welfare's regulations and general guidelines (SOSFS 2008:28).

3 See Chapter 3, Sections 4 and 5 of the National Board of Health and Welfare's regulations and general guidelines.

the information they received and the communication about the care and treatment. The patients who were unsure expressed that they probably had a care plan, but they were unsure of what it contained. Furthermore, staff expressed that the work of involving patients in care planning can be improved. When reviewing the records, it was not possible in some cases to determine whether the care plans had been drawn up in consultation with the patients in compulsory care and their close relatives. During the inspection of *Child and Adolescent Psychiatry in Linköping*, it appeared that the patients were involved, especially when a so-called treatment plan is drawn up and partly in patient team meetings. However, the review of care plans drawn up according to the Compulsory Psychiatric Care Act revealed that these plans were very brief. The plans also lacked information on, inter alia, consultation with the patient and/or on the reason why it had not been possible to consult them.

Following the inspections, the Chief Parliamentary Ombudsman emphasised that depriving a patient of their liberty and placing them in compulsory care is an intrusive measure and that, in such a situation, it is of great importance that the patient is given the opportunity to participate in the care. It is therefore important to provide information on an ongoing basis and maintain good communication where the patient is given the opportunity to express their attitude, expectations and wishes regarding the content of the care, and that this is taken into account as far as possible. The Chief Parliamentary Ombudsman also emphasised the importance of making it clear from the notes in the medical record whether the care plan was drawn up in consultation with the patient.

Information on procedures and rights

A patient receiving care in accordance with the Compulsory Psychiatric Care Act shall be informed of their right to appeal certain decisions, to engage a representative or counsel and to have a public counsel. The Compulsory Psychiatric Care Act shall be clearly displayed for patients within the care facility.[4] The patient shall also be informed of their right to have a support person through individually adapted information.[5]Furthermore, the European Committee for the Prevention of Torture (CPT) has stated that written information about the care facility's procedures and patient's' rights should be provided to each patient, and their close relatives, in connection with intake. The patient shall also receive help to understand the information.[6]

During the inspection of *Child and Adolescent Psychiatry in Uppsala*, it emerged that children and legal guardians at Child and Adolescent Psychiatry's emergency department received access to the National Board of Health

4 See Section 48, first paragraph of the Compulsory Psychiatric Care Act.

5 See Section 30, first paragraph of the Compulsory Psychiatric Care Act.

6 See CPT/Inf [98] 12, para. 53.

and Welfare's information material from 2015 regarding children's rights in compulsory care. In the material disclosed, there was no written information about the new legislation regarding improvements for children in compulsory psychiatric care, which entered into force in 2020 and which concerns, inter alia, how long belting and segregation may last, as well as the right to outdoor access. The Chief Parliamentary Ombudsman reminded that deprivation of liberty under the Compulsory Psychiatric Care Act is a serious interference with personal freedom. Against this background, it is important that a patient receiving care based on the Compulsory Psychiatric Care Act is informed of their rights, so that they can assert them. The Chief Parliamentary Ombudsman further stated that it is the care provider's responsibility to provide correct information about current regulations and therefore the clinic was urged to take measures to ensure that there is complete and updated information available.

Information on rights needs to be adapted to the child's level of maturity

During the inspection of *Child and Adolescent Psychiatry in Linköping*, a patient did not know whether she had been informed of her rights in the department. Nor was there any note in the patient's medical record that such information had been provided. The care of this patient had begun at another care facility and the patient was then transferred to Linköping. Region Östergötland was therefore urged to ensure that the department's procedures regarding information are followed even when a patient is moved to the department from another care facility. Furthermore, the Chief Parliamentary Ombudsman reminded that it is important to adapt the information to the child's level of maturity and to ensure that the child has understood it.

Coercive measures and medical treatment against a patient's will

Regarding treatment during the length of stay, the patient must be consulted when possible. The treatment measures must be adapted to what is required to achieve the purpose of compulsory care, to enable the patient to voluntarily participate in necessary care and to receive the support the patient needs. If there are special reasons, the patient may, at the discretion of the Chief Medical Doctor, be given different kinds of forced treatment without consent.[7] If there is an immediate danger of a patient seriously injuring themselves or someone else, the patient may be briefly restrained physically with a belt or similar device.[8]

The inspection of *Child and Adolescent Psychiatry in Uppsala* revealed that pinning down had been used in the implementation of treatment without the consent of a child. The Chief Parliamentary Ombudsman referred to the fact that the Parliamentary Ombudsman has previously stated it is not sufficiently

7 See Section 17 of the Compulsory Psychiatric Care Act.

8 See Section 19 of the Compulsory Psychiatric Care Act.

specified what coercion the healthcare professionals are entitled to use to obtain treatment without consent and that the legal basis for the coercion actually used in compulsory care today can be questioned. In the previous decision, the Parliamentary Ombudsman also raised the question of a review of the legislation. [9]

The inspection also revealed that follow-up discussions with patients have not always been had after using a coercive measure, and that both staff and management have identified shortcomings in the structure for how such a discussion should be had. The purpose of a follow-up discussion is, inter alia, to promote the patient's participation in the care. Another important reason for having the discussion is that it can help to ensure that further coercive measures do not need to be taken.[10] The chief Parliamentary Ombudsman stated that Region Uppsala needs to take measures to ensure that patients are offered a follow up-discussion and that this is documented in the medical record in a way that makes it possible to follow up.

During the inspection of *Child and Adolescent Psychiatry in Linköping*, it was found that belting is sometimes used as a means of carrying out treatment in the form of tube feeding without consent. The staff also described that it has happened that a patient complies with a decision to be placed in restraints for tube feeding and that no physical force has been required to carry out the measure.

Following the inspection, the Chief Parliamentary Ombudsman noted that the Parliamentary Ombudsmen had drawn attention to similar circumstances in several previous inspections, i.e. that patients comply to avoid coercion. The Parliamentary Ombudsmen has stated, inter alia, that the expression immediate danger should mean that it is a question of averting a sudden event and that placing in restraints must not be used to prevent something suspected to be brewing.[11] Furthermore, the Parliamentary Ombudsmen has stated that placing in restraints is not intended to regulate forced use in treatment

9 See the Parliamentary Ombudsmen's decision of 21 September 2021, ref. no. 2782-2018.

10 See Government Bill 2016/17:94 p. 30.

11 See the Parliamentary Ombudsmen's report, ref. no. 643-2015.

pursuant to Section 17, third paragraph of the Compulsory Psychiatric Care Act. Here, too, the Chief Parliamentary Ombudsman referred to the fact that it is not sufficiently specified what coercion the healthcare professionals are entitled to use to obtain treatment without consent and that the legal basis for the coercion actually used in compulsory care today can be questioned. The report Good compulsory psychiatric care–safety and legal certainty in compulsory psychiatric care and forensic psychiatric care (SOU 2022:40), proposed appointing an inquiry. The Chief Parliamentary Ombudsman referred to his consultation response to the report, in which he emphasised that for the sake of legal certainty, it is important that such work is initiated promptly.[12]

Outdoor access

A patient under the age of 18 has the right to spend at least one hour outdoors every day, unless medical reasons prevent it.[13]

During the inspection of *Child and Adolescent Psychiatry in Uppsala*, it emerged that children in compulsory care were offered daily outdoor access. The Chief Parliamentary Ombudsman stated that he welcomed that their statutory right was being met in that way. On the other hand, patients aged 18–20 in compulsory care based on the Compulsory Psychiatric Care Act were not given the opportunity for daily outdoor access. The Chief Parliamentary Ombudsman therefore reminded of previous statements that the starting point in compulsory psychiatric care should be that a patient should be given the opportunity to spend at least one hour outdoors daily.[14] He also referred to the CPT's statement that patients shall have access to daily outdoor exercise.[15]

Outdoor access for patients who are cared for voluntarily according to the Health and Medical Services Act

Patients in institutional care have been assessed by doctors to have a need for inpatient care, regardless of whether they are cared for voluntarily or under compulsory care. During the inspections of *Child and Adolescent Psychiatry in Uppsala and Linköping*, it emerged that patients voluntarily receiving care in the two departments were sometimes denied outdoor access or were only allowed to go outside with staff or close relatives. Furthermore, it emerged that in Uppsala, an information sheet is provided to all patients in a department. The information sheet stated that it is the department doctor who decides to what extent patients can be allowed to go outside. At the same time, staff in the same department stated that they are aware that patients must not be locked up. Therefore, discussions are held with the patients about the conditions for leaving the department.

12 See the Parliamentary Ombudsmen's statement of 14 November 2022, ref. no. R 62-2022.

13 Section 31 b of the Compulsory Psychiatric Care Act.

14 See, e.g., the Parliamentary Ombudsmen's reports, ref. no. 3816-2017 and 3887-2018.

15 See The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (CPT/Inf [98] 12, para. 37.

After the inspections, the Chief Parliamentary Ombudsman stated that there is no obstacle to motivating conversations with the patient, but it is important that the information provided is factual and clear and clarifies the conditions for the care. The fact that patients in voluntarily care are limited in terms of outdoor access has been noted during other inspections. The Parliamentary Ombudsmen has repeatedly stated that the Health and Medical Services Act does not offer any legal basis for preventing a patient from leaving a department.[16] The staff's ability to prevent a patient who is being cared for voluntarily from leaving the department is thus limited to what can be considered to follow from the general provisions of the Swedish Criminal Code on necessity and the status of a so-called guarantor of protection that the health professionals may be considered to have, taking into account the patient's maturity and health status.[17] This is an area of difficult balancing, and the Chief Parliamentary Ombudsman emphasised the importance of ensuring that the constitutionally protected freedom of movement is not circumvented by the individual feeling forced not to leave the department, e.g., on the basis of a plan drawn up initially. The clinics were encouraged to take the necessary measures to ensure a legally certain application of the legislation in relation to the patients.

Limitations due to staff resources

During the inspection in Linköping, the staff stated there are times when patients do not have daily outdoor access due to insufficient staff resources, and that this applies to patients receiving care under the Health and Medical Services Act and the Compulsory Psychiatric Care Act. The Compulsory Psychiatric Care Act stipulates that a patient under the age of 18 has the right to spend at least one hour outdoors every day, unless medical reasons prevent it.[18] The Chief Parliamentary Ombudsman stated that a shortage of staff must of course not cause this right to be set aside. As a general rule, patients receiving treatment according to the Health and medical Services Act must not be restricted in their freedom of movement.

Outdoor access shall not be limited due to staff shortages

It is therefore obvious that staff resources must not affect their opportunities to spend time outdoors. The Chief Parliamentary Ombudsman also noted that the clinic management did not share the view that staff shortages can lead to patients not having outdoor access. In light of what emerged during the inspection, the Chief Parliamentary Ombudsman was of the opinion that Region Östergötland should ensure that patients' right to outdoor access does not become dependent on staff resources.

16 See, e.g., the Parliamentary Ombudsmen's reports, ref. no. 3816-2017 and 9-2020.

17 See Section 31 b of the Compulsory Psychiatric Care Act.

18 See Good compulsory psychiatric care–safety, security and legal certainty in compulsory psychiatric care and forensic psychiatric care (SOU 2022:40).

6.2 Concluding remarks by Chief Parliamentary Ombudsman Erik Nymansson

This year's inspections once again show that in the case of compulsory psychiatric care of children and adolescents, the regions make different assessments of what coercive measures can be used to carry out forced treatment without consent. The Parliamentary Ombudsmen have repeatedly pointed out that decisions concerning certain coercive measures shall be subject to appeal to the general administrative court. This is important in order to achieve increased legal certainty for compulsory psychiatric care inmates and forensic psychiatric care inmates. The report Good compulsory psychiatric care proposes such a regulation, which I have welcomed in my consultation response to the report.[19] With regard to the possibilities of appealing decisions on treatment without consent, the Inquiry presented two proposals. One of the proposals means that the current regulation is left unchanged. The second proposal means that a new provision is introduced in the Compulsory Psychiatric Care Act, with reference to the Forensic Psychiatric Care Act, to the effect that the patient may also appeal decisions on treatment without consent to the general administrative court. The Inquiry did not take a position on which alternative should be chosen. There are several weighty arguments both for and against decisions on treatment without consent being subject to appeal to a general administrative court. However, I found that the Inquiry's review of this issue was relatively brief and agreed with the Inquiry's assessment that there is a need to appoint a new inquiry with the task of analysing the legal prerequisites for forced treatment in compulsory psychiatric care and forensic psychiatric care. I would also like to point out once again that such an investigation should result in a review of the legislation that more fully addresses the shortcomings of today's regulation. For the sake of legal certainty, it is important that such work is initiated promptly.

19 See the Parliamentary Ombudsmen's statement of 14 November 2022, ref.no. R62-2022.

7

The Swedish Migration Agency

The Swedish Migration Agency

The Swedish Migration Agency is tasked with, inter alia, operating detention centres where foreign nationals can be placed pending enforcement of a decision on expulsion or deportation from Sweden.[1] Foreigners may also be detained if it is necessary to investigate the identity of the foreign national. A detention decision may be made by the Swedish Migration Agency, the Swedish Police Authority and the migration courts.[2] At the end of 2022, the Swedish Migration Agency had six detention centres with 567 bed, which is an increase of 47 beds compared to the previous year.[3]

In March 2022, Parliamentary Ombudsman Per Lennerbrant carried out an inspection of *the detention centre in Märsta*. The inspection was part of the OPCAT activities' thematic focus on children and young individuals deprived of their liberty, with special focus on issues of participation.[4]

7.1 Observations made during this year's inspection

All observations below were made during the inspection of the detention centre in Märsta.

Arrested children and young persons

The inspection revealed that it is very rare for children under the age of 18 to be placed in the detention centre. No child had been placed in the detention centre during 2021 and up to and including the inspection.

One department of the detention centre was specifically equipped to receive women, families and particularly vulnerable persons. According to staff at the department, all children shall be placed in one of the department's lockable resident rooms, regardless of whether they are detained with or without a legal guardian. In connection with the department, there was a storage room with materials for children, such as high chairs, cribs, toys and children's books in different languages. For the slightly older children, there were age-appropriate video games.

Representatives from the Swedish Migration Agency stated that when a child is taken into custody together with one or both parents, the main rule is that the parents are responsible for the child. If they cannot handle this, staff resources can be allocated to ensure that the child does not get injured, for example. There must also be a preparedness to contact Social Services if there is

1 See Section 3(4) of the Ordinance (SFS 2019:502) with instructions for the Swedish Migration Agency.

2 See Chapter 10, Sections 12–17 of the Aliens Act (SFS 2005:716).

3 Swedish Migration Agency's 2022 Annual Report, p. 84.

4 See the Parliamentary Ombudsmen's report, ref. no. O 2-2022.

concern that the child may be mistreated. The representatives of the Swedish Migration Agency further stated that they shall conduct arrival interviews with children who are twelve years and older. As a rule, the interviews shall be conducted together with legal guardians.

In the case of young persons, i.e. young adults under the age of 21, there were no special procedures for e.g. placement or treatment in the detention centre.

The observations made during the inspection did not result in any specific statements by the Parliamentary Ombudsman in these respects.

Camera surveillance in connection with segregation

A detained foreign national shall be treated humanely and their dignity shall be respected. The foreign national shall be informed of their rights and obligations as a detainee and of the rules that apply in the detention facilities. Activities relating to detention shall be designed so as to minimise intrusion of the foreign national's privacy and rights (Chapter 11, Section 1 of the Aliens Act).

The inspection revealed that there were six segregation rooms in the detention centre. The rooms were relatively spacious and lacked furniture, except for a bunk/bed. Four of the rooms had their own toilet. Two of the rooms had access to a fenced patio of a few square metres ('smoking cage'). All segregation rooms were equipped with surveillance cameras. There were signs outside the rooms that they are under camera surveillance. Staff stated that the cameras are constantly on. A technical solution ensured that the image of the area around the segregation rooms' toilets was pixelated. It also emerged that, following a special decision, it was possible to carry out supervision using camera surveillance.

After the inspection, the Parliamentary Ombudsman concluded that it was possible to observe the image from the camera surveillance on several different screens in the detention centre and that camera surveillance of an inmate in a resident room

or similar area is a very intrusive measure. The Parliamentary Ombudsman further noted that he also drew attention to this issue during the inspection of the Ljungbyhed detention centre in 2019. The Swedish Migration Agency was then urged to immediately take measures to ensure that camera surveillance does not take place in cases other than when deemed necessary.[5] According to the Parliamentary Ombudsman, the camera surveillance in the Märsta detention centre has been carried out in a similar way to that in the detention centre in Ljungbyhed. He also pointed out that camera surveillance, not least long term surveillance, entails other privacy issues. For example, it becomes almost impossible for an inmate to take care of their personal hygiene or change clothes without being observed.

In light of what has emerged from the inspections of the detention centres Ljungbyhed and Märsta, the Parliamentary Ombudsman has carried out a special review regarding the Swedish Migration Agency's camera surveillance of detainees in segregation, see the Parliamentary Ombudsman's decision of 28 March 2023, ref. no. O 11-2022.

7.2 Concluding remarks by Parliamentary Ombudsman Per Lennerbrant

The Swedish Migration Agency's detention operations are complex, and the staff often have to resolve situations quickly. At the same time, it must be taken into account that detainees are in a vulnerable position and often find it difficult to exercise their rights. This means that the Swedish Migration Agency needs to ensure that its staff have the qualifications required, both to provide good treatment and to perform other tasks that are part of the work. The Agency also needs to ensure that the activities are conducted in a legally secure and equitable manner in relation to the detainees. During inspections, I have noted, inter alia, that there are shortcomings in how the coercive measure of segregation is applied. It is important that the basic requirements for the treatment of a detained foreign national are met. The Swedish Migration Agency's compliance with these requirements continues to be an important issue to monitor in the OPCAT activities.

5 See the Parliamentary Ombudsmen's report, ref. no. O 52-2019.

Annexes

A. Participation in meetings

B. Inspections carried out in 2022

C. Own-initiative inquiries based on an OPCAT inspection

ANNEX A

Participation in meetings

In 2022, employees from the Parliamentary Ombudsmen's OPCAT Unit participated in the following meetings:

International meetings

- 1 March 2022, *Nordic NPM meeting*.via audio and video transmission.
- 22–23 March 2022, Copenhagen, Denmark, *Nordic NPM meeting*.
- 5–6 October 2022, *European NPM Conference*, via audio and video transmission

National meetings

- 5 April 2022, *Dialogue Forum with civil society stakeholders on the rights and situation of individuals deprived of their liberty*, Stockholm.
- 30 November 2022, *Dialogue Forum with civil society stakeholders on the rights and situation of individuals deprived of their liberty*, Stockholm.

ANNEX B

Inspections carried out in 2022

Unannounced inspections

Police custody facilities	
Västerås	Ref. no. O 14-2022
Total 1	

Remand prisons	
Luleå	Ref. no. O 20-2022
Total 1	

Prisons	
Täby	Ref. no. O 16-2022
Luleå	Ref. no. O 21-2022
Total 2	

Special residential homes for young people	
Vemyra	Ref. no. O 7-2022
Hässleholm	Ref. no. O 18-2022
Johannisberg	Ref. no. O 19-2022
Total 3	

Compulsory psychiatric care	
Region Uppsala University Hospital	Ref. no. O 8-2022
Region Östergötland, Child and Adolecent Psychiatric Clinic in Linköping	Ref. no. O 17-2022
Total 2	

Total 9 unannounced inspections

Announced inspections

Remand prisons	
Sollentuna	Ref. no. O 3-2022
Total 1	

Migration detention centres	
Märsta	Ref. no. O 2-2022
Total 1	

Total 2 announced inspections

ANNEX C

Own-initiative inquiries based on an OPCAT inspection

Swedish Migration Agency	
Camera surveillance of inmates placed in segregation	Ref. no. O 11-2022
Total 1	

Total 1 case

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