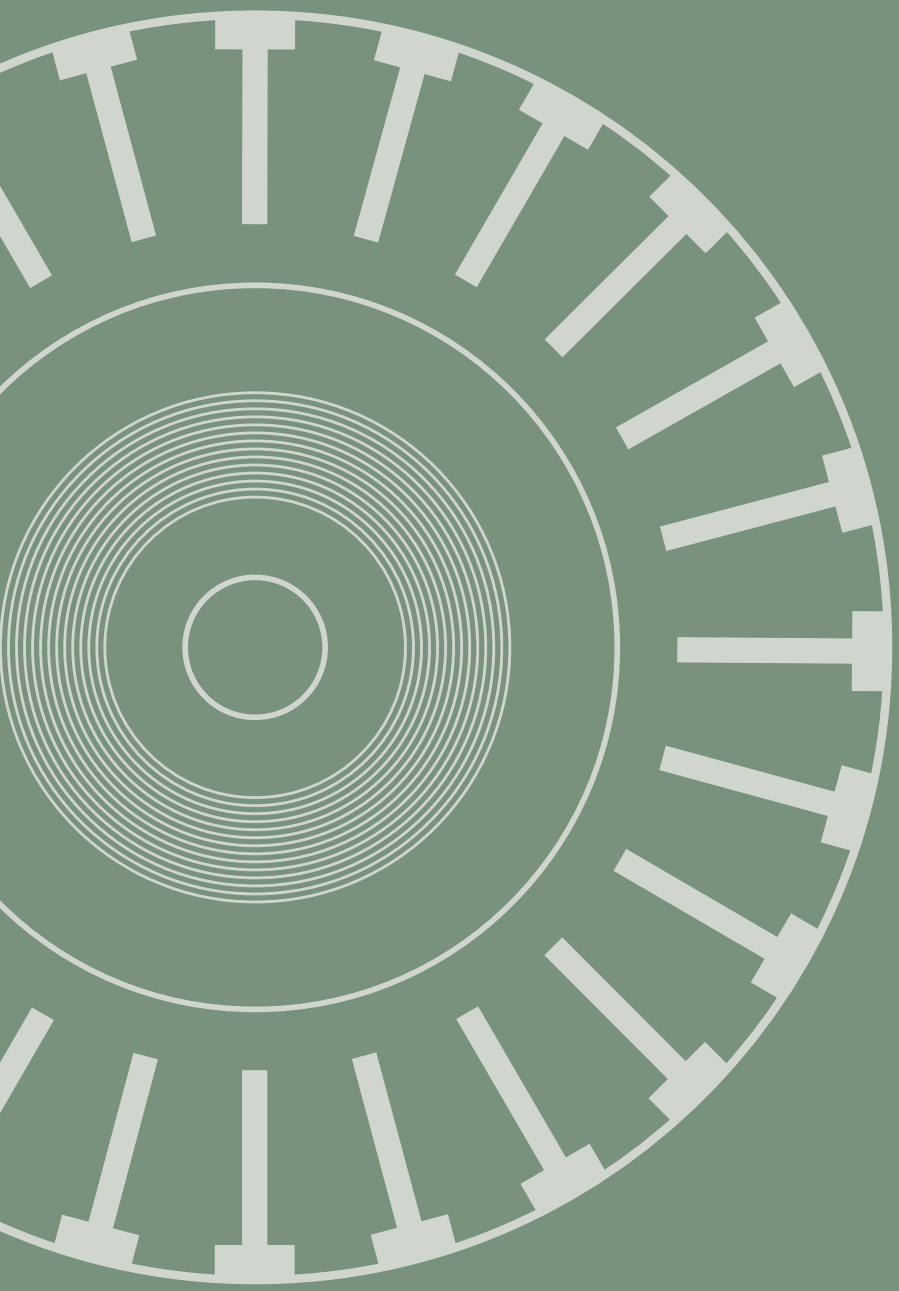
ENGLISH VERSION

National Preventive Mechanism – NPM

REPORT ON THE ACTIVITIES 2023



JO RIKSDAGENS OMBUDSMÄN
The Swedish Parliamentary Ombudsmen

National Preventive Mechanism – NPM

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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 Office of the Parliamentary Ombudsmen (hereinafter "the Parliamentary Ombudsmen") performs the special mandate as a national preventive mechanism (NPM) pursuant to the UN Optional Protocol to the Convention against Torture (OPCAT). The purpose of the mandate is to prevent torture and other cruel, inhuman or degrading treatment or punishment of persons deprived of their liberty. According to the Protocol, the work must be proactive and have a long-term perspective.

This report summarises our main observations and statements arising from this year's inspections. In total, 14 inspections were carried out.

In 2023, the Parliamentary Ombudsmen evaluated its OPCAT activities. One of the aims of the evaluation was to further emphasise the preventive aspect of the mandate. We also reviewed the forms of our dialogue with civil society. In November 2023, a meeting was held with representatives from civil society focusing on the issue of developing that sharing of experience. The results of the Parliamentary Ombudsmen's evaluation work and renewed approach will have an impact in 2024.

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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 (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 contained in a number of other UN conventions.

The European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) and the Charter of Fundamental Rights of the European Union (EU Charter) also prohibit torture. The ECHR has been in force as Swedish law since 1995. In addition, the Instrument of Government, a part of the Swedish Constitution, prohibits torture. According to the Instrument of Government, everyone is protected against corporal punishment, and no one may be subjected to torture or to medical intervention for the purpose of coercing or preventing speech.[1]

1.1 Torture and cruel, inhuman or degrading treatment or punishment

The first Article of the UN Convention Against Torture provides a relatively comprehensive definition of torture. In short, torture is the intentional infliction of severe mental or physical pain or suffering for a specific purpose, for example to extract information or to punish or threaten a person. The Convention does not contain a definition of cruel, inhuman or degrading treatment.

According to the European Court of Human Rights (ECtHR), inhuman treatment must, at a minimum, involve treatment which intentionally causes someone serious mental or physical suffering and which, in the situation in question, can be regarded as unjust. Humiliating treatment refers to behaviour that causes the victim to feel fear, anxiety or inferiority. Treatment can be degrading even if no one but the victim has witnessed or learnt about it.

1.2 The Convention Against Torture and OPCAT

The Convention Against Torture has been in force in Sweden since 1987. The countries that have signed 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 a signatory state has authorised it, individuals can also complain to the Committee. Sweden allows

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

individual complaints. The Convention itself does not authorise the CAT to carry out visits to States Parties.

In 2002, the Optional Protocol to the Convention Against Torture (OPCAT) was adopted to, inter alia, enable international visits. 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 reviews Sweden periodically, normally every six years. Sweden is due to submit its ninth periodic report on 3 December 2025.[2]

1.3 Prevention

The work pursuant to OPCAT is to be carried out with the aim of strengthening the protection of persons 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 by visiting locations 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 inhuman treatment, etc. The work must be proactive and aimed at systematically reducing or eliminating risk factors and strengthening preventive factors and protective mechanisms. Furthermore, the work should have a long-term perspective and focus on achieving improvements through constructive dialogue, proposals for safeguards and other measures.

1.4 OPCAT activities in Sweden

States acceding to OPCAT are obliged to designate one or more bodies with the role of National Preventive Mechanism (NPM). Since 1 July 2011, the Office of the Parliamentary Ombudsmen (hereinafter "the Parliamentary Ombudsmen") has been carrying out the tasks of a National Preventive Mechanism pursuant to OPCAT.[3] When the Parliamentary Ombudsmen was assigned this task, the Committee on Constitutional Affairs noted that the tasks and powers that the Parliamentary Ombudsmen has had for many years corresponded to the tasks of a National Preventive Mechanism.

As a National Preventive Mechanism, the Parliamentary Ombudsmen is to, inter alia

- Regularly inspect places where people may be deprived of their liberty,
- Make recommendations to the competent authorities with a view to improving the treatment and conditions of persons deprived of their liberty

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

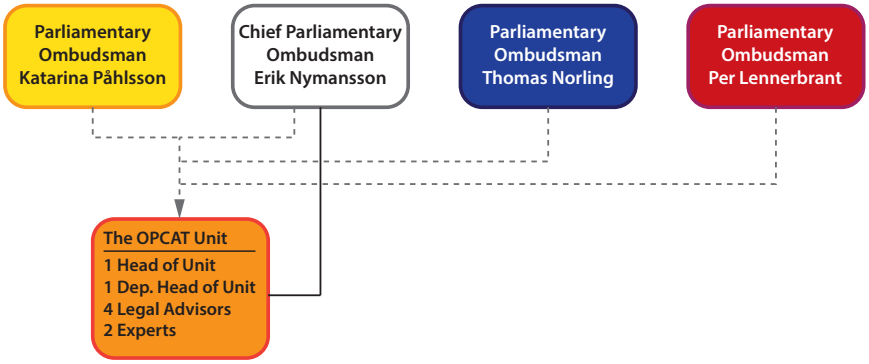
3 Section 18 of the Act (2023:499) with instructions for the Parliamentary Ombudsmen (JO), previously section 5a of the Act (1986:765) with instructions for the Parliamentary Ombudsmen.

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

- Make suggestions and comments on existing or proposed legislation concerning the treatment and conditions of persons deprived of their liberty,
- Participate in dialogues with competent authorities and civil society; and
- Report on OPCAT activities.

The Parliamentary Ombudsmen has determined that the places to be inspected within the framework of this mandate are primarily prisons, remand prisons, police detention facilities, institutions for compulsory psychiatric care and forensic psychiatric care, the Swedish Migration Agency's detention facilities and the National Board of Institutional Care's (SiS) special residential homes for young people and residential homes for the compulsory care of substance abusers.

A dedicated OPCAT unit is tasked with assisting the Parliamentary Ombudsmen in their work as National Preventive Mechanism. Two experts, a medical expert and an expert in psychology, are attached to the OPCAT activities.



1.5 Dialogue Forum

In January 2020, a special forum for dialogue with civil society on the situation and rights of persons deprived of their liberty was established.[4] Initially, the Parliamentary Ombudsmen invites a number of civil society actors to a meeting twice a year.

Two dialogue meetings were held in 2023. At one meeting, the Parliamentary Ombudsmen presented current issues in their respective areas of responsibility. In connection with the establishment of the Forum, the importance of an evaluation of the format of the meeting was emphasised, and the second meeting of the year was devoted to that issue.

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

1.6 The international preventive mechanisms

SPT has 25 independent members who are experts in areas relevant to the prevention of torture. Members are appointed by the signatories 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. It established the Committee for the Prevention of Torture (CPT), whose main task is to regularly visit institutions for persons deprived of their liberty in Europe. All 46 member states of the Council of Europe have ratified the Convention. Swedish authorities are obliged to co-operate with the SPT and CPT.[5]

1.7 The Nordic NPM network

The Nordic NPM Network was established in 2015 and held a meeting in Stockholm in 2023. The theme of the meeting was supervision pursuant to the OPCAT protocol in the 2020s and beyond.[6]

1.8 Purpose of this report

This report summarises the observations made by the Parliamentary Ombudsmen in the context of OPCAT activities in 2023.

5 The Act (1988:695) on certain international commitments against torture etc.

6 See ref. no. O 14-2023.

2

OPCAT inspections

OPCAT inspections

One of the key elements of the Parliamentary Ombudsmen's OPCAT activities is the inspection of places where people deprived of their liberty may be held. In 2023, priority was given to sites that had not previously been inspected by the Parliamentary Ombudsmen or those which had not been inspected for a long time. However, a number of inspections focused on continuing to monitor the situation of children and young people deprived of their liberty. A broad geographical distribution was also an important factor in deciding the inspection sites.

2.1 Method

As a rule, the Parliamentary Ombudsmen's staff members are tasked by an Ombudsman to carry out an inspection. Sometimes the Ombudsman responsible for the inspection leads it him or herself. An inspection can be either announced in advance or unannounced. The majority of inspections are unannounced, which is in line with the interest that institutions are to be constantly prepared to be visited. Unannounced inspections also increase the credibility of inspection activities. The Parliamentary Ombudsmen's traditional supervisory activities and the Parliamentary Ombudsmen's tasks pursuant to OPCAT have many areas in common. For this reason, as a rule, a member of staff from the OPCAT Unit participates in the supervisory divisions' inspections of places where people deprived of their liberty may be held, and the same applies to the inspections that the OPCAT Unit is mandated to carry out.

The observations made during an inspection are documented in a report and submitted to the Ombudsman responsible. If the inspection brings to light any issue that Ombudsman responsible considers in need of a separate investigation, he or she does so as an enquiry case, which is handled by a supervisory division. However, the most common practice is for the Ombudsman to comment in the report on the observations made during the inspection and make recommendations.

2.2 Places where people may be deprived of their liberty

In 2023, people were deprived of their liberty at the following places :

- 121 police detention facilities with a capacity of about 1,300 (Swedish Police Authority)
- 40 remand prisons with a capacity of about 2,900, of which around 2,500 are permanent (Swedish Prison and Probation Service)

- 46 prisons with a capacity of about 5,800, of which around 4,700 are permanent (Swedish Prison and Probation Service)
- 21 special residential homes for young people, with approximately 700 beds (National Board of Institutional Care, SiS)
- 11 residential homes for the compulsory care of substance abusers with approximately 400 beds (SiS)
- At least 80 institutions for compulsory psychiatric and forensic psychiatric care with approximately 4,100 beds (21 regions)
- 6 migration detention centres with approximately 560 beds (Swedish Migration Agency)
- Approximately 30 detention facilities (Swedish Customs)

Some of the figures presented are based on estimates. The high occupancy rate within the Swedish Prison and Probation Service has, for example, led to work being carried out within that agency to develop various types of temporary bed, including double occupancy. The report also includes these reserve and temporary beds.

2.3 Inspections carried out

In 2023, 14 inspections were carried out under the OPCAT mandate.

Facilities inspected	No. of units
Police detention facilities	2
Remand prisons	2
Prisons	2
Special residential homes for young people	4
Compulsory psychiatric and forensic psychiatric institutions	2
Migration detention centres	1
Swedish Customs	1
Total	**14**

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

3

The Swedish Police Authority

The Swedish Police Authority

Persons who have been arrested or formally detained are held in police detention facilities. Persons detained for intoxication under the Act (1976:511) on the Detention of Intoxicated Persons etc. may also be held in detention facilities.

Police detention facilities are intended for detentions that last for a relatively short period of time. A deprivation of liberty can last from a few hours to a few days, at most. At the end of 2023, there were 121 police detention facilities with a total of around 1,300 places. The Swedish Police Authority or a security company contracted by the Authority is responsible for staffing the detention facilities.

Two detention facilities were inspected in 2023, Solna and Umeå.[1] The first inspection was unannounced and the second was announced a few hours before it started. The inspections focused primarily on the situation of children deprived of their liberty and included an examination of the extent to, and the conditions under, which children were held in custody in the detention facilities.

Both inspections were carried out on behalf of Parliamentary Ombudsman Per Lennerbrant.

3.1 Observations made during the inspections

Children in police detention facilities

Section 6 a of the Young Offenders Act (1964:167) (LUL) provides that a person under the age of eighteen who has been arrested or detained may be held in police custody only if absolutely necessary. The provision entered into force on 1 July 2021. In the preparatory work for the provision, it was stated, inter alia, that police custody is not adapted to the special needs of a child and that even temporary custodial placement should be avoided as this is not a suitable environment for children.[2]

The inspection of the Solna detention facility revealed that children are regularly detained in the centre. However, there were no rooms specifically intended for children. Conversations with staff revealed, among other things, that children were made to stay in interrogation rooms or on a bench in

1 See the Parliamentary Ombudsmen's reports in ref. nos. O 8-2023 and O 12-2023.

2 See Government Bill 2019/20:129, pp. 46 and 60 et seq.

the detention facility until a detention decision was made. A child who was arrested could be placed in a cell some distance away from the sobering-up cells and the intake, in other words, in the quieter part of the detention facility. Before a child was placed in a cell, efforts were always made to find an alternative placement, mainly through contact with the remand prisons in the Stockholm area. As long as the child remained in the detention facility, the remand prisons were contacted on an ongoing basis to check whether there were any vacancies.

The Solna detention facility was staffed partly by guards employed by the Swedish Police Authority and partly by guards from a private security company. Guards employed by the Police Authority stated that they were familiar with the agency's national routine document for children in detention. However, several of them felt that the agency at its central level had not taken sufficient measures in preparation for the introduction of Section 6 a of LUL and pointed out that there were insufficient tools to fulfil the provision. The custody officers stated that there were special procedures for children and they also described how they worked to facilitate the situation for children in custody.

Following the inspection, the Parliamentary Ombudsman noted that the Solna detention facility made efforts to find a placement for children other than in a cell at the detention facility. He also noted that the staff employed by the Police Authority were aware of what applies to children and that the custody officers seemed to be doing their best to ensure that the children were as comfortable as possible in the custody centre. While this is beneficial, the Ombudsman was concerned that children were regularly held in custody at Solna police station. He noted that the Police Authority appeared to rely entirely on the Swedish Prison and Probation Service being able to provide places in remand centres in the Stockholm area, while it is common knowledge that the occupancy situation within the Prison and Probation Service has been very strained for some time. Against this background, the Parliamentary Ombudsman stated that he can draw no other conclusion than that the Police Authority has not made sufficient efforts, for example by adapting its premises, to be able to take care of arrested and detained children on its own in accordance with the requirements of the law. In conclusion, the Ombudsman emphasised that the Police Authority needs to take measures to address the fact that children are regularly held in custody at the Solna detention facility and that the issue is urgent.

It is a matter of concern that children are regularly held in detention facilities

The Umeå detention facility had a corridor with eight interrogation rooms, and the room at the end of the corridor had been converted into a children's room. The room was about 6.7 square metres and had no windows. Furthermore, the room was painted in what were said to be harmonious colours and furnished with a sofa bed, a table, a TV, an armchair, a lamp, a bookshelf and

a rug. There was a WC near the children's room and the children were only in the detention corridor if they needed to shower or use an exercise area.

In conversations with staff, it emerged that the few children taken into custody had been placed in the children's room and that no child had been placed in a cell in the past year. Only on one occasion had there been two children in the detention facility at the same time. One child was then in the children's room and the other in one of the interrogation rooms. It also emerged that the detention facility made efforts to find a place in the detention facility for children suspected of crimes as soon as possible. However, the staff expressed concern that in future the detention facility might have to accommodate more children at the same time.

Following the inspection, the Parliamentary Ombudsman reported that it was beneficial that considerable efforts had been made to enable the detention facility to care for arrested and detained children. He got the impression that the location, design and equipment of the children's room were well adapted to the short-term placement of children. However, according to the Ombudsman, the fact that the room was not equipped with windows and thus lacked daylight was unsatisfactory, especially if a child stays in the room for several days. Furthermore, the Ombudsman noted the staff's concern that in the future, the detention facility may need to accommodate more children at the same time. He noted that Umeå detention facility needs to be prepared to deal with such a situation. He also emphasised the importance of the Police Authority regularly following up on whether there is a need for further adaptations of the detention facility.

It is beneficial that considerable efforts have been made to ensure that the detention facility can handle arrested and detained children

Information on rights

During the inspection of both Solna and Umeå detention facilities, differing information emerged about who was responsible for informing children about their rights and the procedures that applied at the facilities. When reviewing a number of cases at Umeå detention facility, the Ombudsman's staff also noted that in some cases it was documented that it was not relevant to inform the child about rights and procedures at the detention facility, as the child had not been placed in a cell but in the children's room. It also emerged from documentation in cases at the Solna detention facility that in some cases it was clearly documented whether information was provided in writing or orally, while in other cases this was not as clear.

Following the inspections, the Parliamentary Ombudsman noted that Appendix 5 to the Police Authority's handbook on custody operations contains a description of the information that a child suspected of an offence should receive and how it can be determined that the child has understood the information. He also noted that he had previously stated that it is of fundamental importance that everyone working in a detention facility adapts both their

Children's room in Umeå detention facility.

approach and the provision of information to the child's level of maturity and that, as a basic principle, information to children should be given in writing and orally on repeated occasions.[3] With regard to the Umeå detention facility, the Ombudsman further emphasised that the inmates' right to information[4] naturally also applies to children who are placed in a special children's room and not in a cell.

During the inspection of the Solna detention facility, the Ombudsman's staff held a conversation with an inmate who had recently turned 18. It emerged that, when he was taken into custody, he had requested that his mother was contacted. He stated that he had not received any feedback on whether his mother had been informed and that he felt troubled about not knowing whether she knew where he was.

After the inspection, the Parliamentary Ombudsman referred to the fact that during its most recent visit to Sweden in 2021, the CPT drew attention to deficiencies in the notification of relatives about the deprivation of liberty. The CPT recommended, among other things, that an inmate who has requested to inform a relative about the deprivation of liberty should receive feedback on whether the relative has been informed or not.[5] The Ombudsman also pointed out that it is important that the suspect is informed of whether his or her

It is of fundamental importance that everyone working in a detention facility adapts both their treatment and the provision of information to the child's level of maturity

3 See the Parliamentary Ombudsmen's report in ref. no. O 14-2022.

4 See Chapter 1, Section 4 PMFS 2015:7, FAP 102-1.

5 See CPT/Inf [2021]20, para. 12.

relatives have been notified of the deprivation of liberty.[6] The Ombudsman stated that he assumes that the Police Authority will ensure that a person held in custody receives this type of feedback.

3.2 Concluding remarks

Five inspections have been carried out as per my instructions, focusing on the impact of the provision in Section 6 a of the LUL. In addition to the detention facilities described above, Malmö, Karlstad and Västerås were inspected.[7] The observations from these inspections are summarised in Opcat's annual reports for 2020-2021 and 2022, as well as in the Parliamentary Ombudsmen's Annual report for 2023.[8]

I note that the impact of this provision has varied from one detention facility to another. In some cases, efforts are regularly made to find a place of detention other than in a holding cell. In other cases, such efforts are almost the exception. The physical conditions also differ considerably. I have previously stated that it is the Police Authority that must ensure that children who are arrested or detained are not held in custody at a detention facility other than when absolutely necessary, and that this obviously applies to all detention facilities in the country. Given the fact that children are a particularly vulnerable group, it is important that the Police Authority actively works to fulfil this responsibility. The issue of children in custody is important and I intend to continue to monitor it.

6 See JO 2013/14, p. 133.

7 See O 27-2021, O 33-2021 and O 14-2022.

8 Note also that JO 2023 p. 328 contains a summary of all five inspections.

4

The Swedish Prison and Probation Service

The Swedish Prison and Probation Service

The Swedish Prison and Probation Service primarily places people who are deprived of their liberty because they are on remand or serving a prison sentence. Sometimes, other categories of persons deprived of their liberty are also placed in the Prison and Probation Service's remand prisons. These categories may be, for example, people who are taken into care pursuant to the Care of Young Persons Act (1990:52) (LVU), or the Care of Substance Abusers Act (1988:870) (LVM), and who are transported by the Prison and Probation Service's National Transport Unit (NTU). Another group that may be placed in remand prisons and institutions are foreign nationals who are detained under the Aliens Act (2005:716) (UtlL).

At the end of 2023, there were 40 remand prisons and 46 prisons in Sweden with a capacity of around 7,200 permanent places. In addition, there were places for temporary needs, both standby places for double occupancy and temporary places in other types of rooms than residential rooms. Temporary places do not fulfil the standard that applies to cells. In 2023, the use of reserve and temporary places increased, bringing the total number of places in remand prisons and prisons to approximately 8 660.[1]

In 2023, four inspections of remand prisons and prisons were carried out.[2] All were unannounced. The inspections were carried out or commissioned by the Parliamentary Ombudsman Katarina Påhlsson.

4.1 Observations from this year's inspections

The physical environment and staffing

Operations at Salberga remand prison were conducted in two buildings, Building 10 and Building 11. Building 10 housed a general detention facility and Building 11 a newly built restriction remand facility. During the inspection, the soundproofing in the two buildings was found to be very poor. Several detainees reported hearing banging, shouting and other noises in the evenings and at night, and being able to communicate with each other. According to the detention centre management, the poor soundproofing affected the inmates' health and also risked rendering the Prosecutor's Office restrictions ineffective. In order to alleviate the problems for the inmates, the remand prison

1 See the Prison and Probation Service's Annual Report 2023.

2 Kronoberg (O 21-2023) and Salberga (O 23-2023) remand prisons and Kumla (O 6-2023) and Borås Prisons (O 9-2023).

firstly offered earplugs free of charge. Secondly, sleep and sedative medication was prescribed.

After the inspection, the Parliamentary Ombudsman stated that she had previously, in connection with a major review of the matter,[3] pointed out that the poor soundproofing between remand cells is serious in several respects, for example for security and the health of the detainees. By extension, it is also a matter of legal certainty. She noted that it is very remarkable that newly built buildings lack soundproofing between cells and sections and emphasised that the Prison and Probation Service, in connection with rebuilding and new construction, must ensure that the premises do not have such deficiencies as were revealed during the inspection.

Poor sound-proofing between remand cells is serious in several respects

At Kronoberg remand prison, there were no toilets in most of the cells. In conversations with inmates, a consistent picture emerged of long waiting times in connection with toilet visits, especially when the remand prison switched to evening staffing. It could take 30-60 minutes after being called before staff arrived and opened the cell for toilet visits. In addition, an inmate could remain in the lavatory for the same length of time before being allowed to return to his or her cell. The long waiting times led to many people using the hand basins and waste bins for their needs. Management stated that they were aware that inmates frequently used the hand basins to relieve themselves. This had led, among other things, to the formation of so-called urine stones in the drains and the need to clean them relatively often.

Following the inspection, the Parliamentary Ombudsman noted that the CPT, as early as May 2015, after visiting Kronoberg remand prison among other places recommended that measures be taken to ensure that inmates who need to use the toilet at any time of day can be released from their cells without unnecessary delay. The Parliamentary Ombudsmen has previously both endorsed and reminded the remand prison of this statement.[4] In the Ombudsman's opinion, it is a question of respect for the inmates' human dignity and the Prison and Probation Service must therefore have an organisation that is capable of meeting the inmates' basic and human needs in this respect. The Ombudsman also considered that the current arrangement raises concerns from a hygiene perspective and that the situation could be resolved with increased staffing.

The Prison and Probation Service must have an organisation that is able to meet the inmates' need to use the toilet, regardless of the time of day

Isolation and isolation-breaking measures

The issue of inmates being isolated in Swedish remand prisons has long been highlighted in international contexts and by the Parliamentary Ombudsmen. According to international rules, an inmate is considered to be isolated if they

3 See JO 2022/23, p. 164, a joint decision in ref. nos. 8978-2020 and 2475-2021, and JO 2022/23, p. 193, ref. no. 1362-2021.

4 See CPT/Inf [2016] 1, p. 34 and the Parliamentary Ombudsmen's decisions of 17 October 2018, ref. No. 8166-2017 and 15 September 2021, ref. no. 6765-2020.

are confined to their cell and deprived of all meaningful human contact for more than 22 hours per day (see the UN's Minimum Standards Rules for the Treatment of Prisoners, Rule 44, the Mandela Rules). In January 2022, the Director General of the Prison and Probation Service decided on an inter-agency definition of the concepts of isolation and isolation-breaking measures, which is close to the so-called Mandela Rules.[5] According to the decision, an inmate is considered to be isolated they are in solitary confinement for 22 hours or more per day, without meaningful human contact. According to the same decision, an isolation-breaking measure is a meaningful stay together with others through physical contact. In order to prevent children from being isolated, anyone under the age of 18 who is remanded in custody or arrested and held in custody has the right to spend at least four hours a day with staff or someone else, see Chapter 2, Section 5 a of the Remand Prisons Act (2010:611).

At both Salberga remand prison and Kronoberg remand prison, staff with the main task of breaking inmates' isolation were present at the time of the inspection, but conversations with inmates and staff gave the unanimous impression that the remand prisons had limited opportunities to offer isolation-breaking measures. They were unable to fulfil the statutory requirement that children have the right to spend at least four hours every day with staff or someone else, despite the priority given to children. Neither juveniles (inmates admitted to custody before the age of 21 and not yet 24) nor adults received isolation-breaking measures to a sufficient extent. The reason for this was said to be both a lack of premises and the increased number of children in custody. During the inspections it was also noted that, among other things, food and medicine distribution and time outside the remand prison, for example in connection with court hearings and meetings with the police, were reported as isolation-breaking measures. At Kronoberg remand prison, it was also found that the administration made a distinction between the concepts of meaningful interpersonal contact and isolation-breaking measures. According to the management, isolation-breaking measures could, for example, consist of an inmate sitting alone in a TV room or going out alone in the exercise yard, since the inmate then comes out of the cell.

It is obvious that inmates are being isolated at Salberga and Kronoberg remand prisons

Following the inspections, the Parliamentary Ombudsman concluded that it is evident that inmates are being isolated at Salberga and Kronoberg remand prisons and that this is very serious. She stressed, once again, that the Prison and Probation Service has a responsibility for the isolation-breaking work even in a pressured occupancy situation, and that it is not acceptable for efforts to be limited due to a lack of resources, practical conditions or for organisational reasons. In the case of Kronoberg remand prison, the Ombudsman emphasised that there was a clear lack of understanding, both within the

5 See the Prison and Probation Service's Decision ref. no. 2020-18386.

Cell in Kronoberg remand prison.

administration team and among the staff, of what the concept of isolation-breaking measures entails and what types of measures can be considered to be interpersonal contact. It is possible that this lack of knowledge could explain the fact that pure environmental changes, where an inmate is completely alone, were considered to be such an intervention. Both the observations at Salberga and at Kronoberg gave the Ombudsman reason to emphasise once

again that the starting point for what constitutes meaningful interpersonal contact should be seen from the perspective of the inmate and not the general public. She therefore questioned why, for example, police interrogation appeared to count as a measure to break isolation for children. Furthermore, the Ombudsman stated that she finds it difficult to consider court hearings as an isolation-breaking measure. She recommended that remand prisons should immediately review their work with isolation-breaking measures and ensure that they are carried out in accordance with both the agency's internal instructions and the so-called Mandela Rules and the Ombudsman's statements.

The inspections revealed that isolation-breaking measures for children were first documented manually and that the information subsequently was digitised by entering it into an Excel file. Copies of the files were sent to the Prison and Probation Service headquarters on a monthly basis. Isolation-breaking measures for adults were similarly documented in their remand plans. During the inspection of the remand prison in Kronoberg, the remand prison management said that they had contacted the head office and requested a digital solution for documentation. However, the head office is said to have rejected this with reference to the manual solution working satisfactorily. After the inspections, the Ombudsman noted that she was surprised to learn that the Prison and Probation Service's head office had stated that there was no need for a digital national planning and follow-up tool for measuring the extent to which inmates are given isolation-breaking measures. In her opinion, it is only when a central digitised system support is in place that it will be possible to obtain reliable data on the degree of isolation in Swedish remand prisons. She assessed that this would also release time at the individual locations for the staff's isolation-breaking measures and thus contribute to improved work to counteract the known risks of isolation. According to the Ombudsman, the Prison and Probation Service should therefore develop such a tool as soon as possible.

Specific to the inspection of Kumla prison

In early February, the Ombudsman received several complaints from inmates in Section S2A at Kumla prison. From these and from decisions on segregation, it emerged that renovation of the shower facilities had been going on for a few days and that all inmates on the section were kept locked in their cells while craftsmen carried out the work. Some complainants stated that this period could amount to 20 hours per day. In view of the seriousness of the information, the Ombudsman carried out an unannounced inspection of the unit less than a week later.

Section S2A was housed in the security unit in the S building, the so-called Fenix building. The inmates in this section actually belonged to the national reception centre, which had been given access to one of the sections in Fenix

Exercise yard in Salberga remand prison.

due to a lack of space in the regular premises. Section S2A had six cells, all of which were subject to double occupancy, and at the time of the inspection there were eleven prisoners there. Conversations with detainees revealed that the physical environment had been significantly affected by the renovation, especially during the first few days. The noise level had been very disturbing, especially when the floor was being demolished. On the worst day, the demolition lasted both morning and afternoon. One inmate described it as being like being in a horror film. Especially during the first few days, it also got dusty in the section's common area. All inmates found it very exhausting to be locked in their cells for as much of the day as they were during the refurbishment, especially with another inmate they had no knowledge of before the double occupancy.

In conversations with staff, it was confirmed that the noise level had been high on some days, but it was also stated that it had not been as bad as feared. However, one staff member described it as being in a resonance box and said it must be like torture for the detainees. Some staff members thought it was undignified to lock two prisoners in a cell during the renovation period and reflected on the fact that the prisoners had no chance of being alone when they were locked up for large parts of the day.

Following the inspection, the Parliamentary Ombudsman initially drew attention to the fact that the Fenix building is associated with enhanced external security and control and is adapted for security detainees. Thus, the detainees placed in S2A, although only enrolled in the national reception centre, were already subject to restrictions that were not necessarily called for. In addition, the cells were double occupied despite being designed for one person and the inmates were unknown to each other prior to their placement. According to the Ombudsman, it was clear that the renovation had caused considerable stress for the inmates. The work had involved high noise levels, which the inmates found difficult to defend themselves against, and the presence of dust and dirt. Furthermore, it seemed obvious under all circumstances that it must be even more stressful to share a cell when the external environment is also heavily influenced by, for example, demolition work.

Added to this was time in solitary confinement. During a day of the renovation, the time in a cell could amount to around 20 hours. The Ombudsman noted that, at the time of the inspection, this had not occurred more than once. If this had instead been the case for several days in a row, and intensive demolition work under the circumstances described had been going on at the same time, the treatment of the persons deprived of their liberty would have appeared almost inhuman. The Ombudsman also stated that it was remarkable that more compensatory measures had not been taken for the detainees. She noted with satisfaction, however, that there were staff members who showed both an insight into the inmates' circumstances and a tangible interest in meaningful prison care.

As a rule, the Parliamentary Ombudsmen refrain from commenting on matters of judgement. This is because the Parliamentary Ombudsmen can neither change nor annul a decision, nor should the Ombudsmen's review replace an ordinary review, for example in court. However, the situation in this case was unique and, given the circumstances, there was much to suggest that no review of the individual seclusion decisions should take place. The Parliamentary Ombudsman therefore departed from this principle and commented on the prison's measure to segregate the inmates pursuant to Chapter 6, Section 5 of the Prison Act (2010:610).

She stated, inter alia, as follows. The provision in question authorises the Prison and Probation Service to temporarily segregate inmates from each other

if this is necessary in order to maintain order or security. The preparatory work emphasises that this is a coercive measure that may never last longer than what is necessary for the Prison and Probation Service to be able to manage a situation, normally no more than a few hours or a day.[6] According to the Parliamentary Ombudsman, there was in itself no reason to question the assessment that there is a security risk when external craftsmen are present with their tools inside the unit. However, the need for remodelling had been known for many years and the work had been planned for several months. Consequently, this was not a sudden event, but something that had been fully predictable and thus controllable by the Prison and Probation Service. The provision in question presupposes that the coercive measure is temporary, while the segregation placements in this case were intended to be recurrent over several weeks. From information obtained during the inspection, the Ombudsman also concluded that the prison had been well aware that the provision was not intended for a situation as the one in Section S2A. Kumla prison had thus not had a legal basis for segregating the inmates in Section S2A in the way that had occurred

Kumla prison has issued decisions on segregation without legal basis

Specific to the inspection of Borås prison

During the inspection of Borås prison, the situation of inmates who were placed in modular buildings within the prison area was examined in particular. Construction of the modular buildings began in autumn 2021 and the buildings were inaugurated in November 2022. The cells that were built were planned to be single cells and all cells were therefore the same size, 9.95 square metres including toilet space. During the construction process, the prison was informed that several cells would be used for double occupancy. The prison then had to purchase doors to the toilets in the cells. Due to the location of the sprinklers in the ceiling, the toilet doors needed to be installed with a gap of at least 70 cm to the ceiling and a gap to the floor. In February 2023, the cells began to be double occupied. In conversations with the Ombudsman's staff, inmates expressed dissatisfaction with the design of the toilet door as it did not allow for privacy and one inmate said that this made it difficult for him tend to his needs. It was also found that detainees were not asked about their attitude towards sharing cells and that decisions on double occupancy were not followed up.

Following the inspection, the Parliamentary Ombudsman stated, inter alia, that the Prison and Probation Service had been under very heavy occupancy pressure for several years and that it should therefore have been clear to the agency already at the planning stage for the construction that there would be a need to use several of the cells for double occupancy for the foreseeable future. As regards the requirements that should be imposed on the physical

6 See Government Bill 2009/10:135, p. 138.

conditions, the Ombudsman pointed in particular to two recommendations of the CPT According to the recommendations, the floor area should be ten square metres excluding sanitary facilities in a cell used for the accommodation of two prisoners and, if the cell is equipped with a toilet, it should be separated from the rest of the accommodation from floor to ceiling. In the modular buildings, there was not a single cell that complied with these recommendations. As a result of the Prison and Probation Service's inadequate planning, a large number of inmates had to share cells that were too small and equipped with toilets that did not offer sufficient privacy. The Ombudsman viewed these conditions with concern and stated that it must be described as undignified for both of the inmates to have to stay in the limited space of a cell when one of them is using a toilet without a proper door. As regards the prison's procedures regarding double occupancy, the Ombudsman again emphasised the importance of an inmate being able to express his or her views and that individual circumstances must be taken into account when considering double occupancy. Furthermore, there must be a structured follow-up of each double occupancy on an ongoing basis

As a result of the Prison and Probation Service's inadequate planning, a large number of inmates had to share cells that were too small and that were equipped with toilets that did not offer sufficient privacy

It was found during the inspection that the process of starting operations in the modular buildings had been too rushed. The prison had wanted three weeks to practise with staff in the new premises before inmates were placed there, but this instead had to be done while inmates were admitted. The premises were not quite ready at that time either, and there were problems with, among other things, a lock function, doors and toilets. The Ombudsman concluded that it is not acceptable to apply such a tight time schedule and jeopardise the safety and security of the inmates.

4.2 Concluding remarks

This year's inspections show that the strained occupancy situation within the Prison and Probation Service is having a major impact on the situation of inmates. Cells are increasingly double occupied and access to isolation-breaking measures is decreasing. The Prison and Probation Service is now in a phase of expansion and, in my statements following the inspection of Borås prison, I emphasised the importance of the agency drawing on its experience of rebuilding and new construction, for example when designing cells. The guidance available in the form of previous statements by the Parliamentary Ombudsmen and recommendations from the CPT must also be taken into account. In this context, I would also like to emphasise that it is particularly important that inmates are allowed to express their views and that individual circumstances are taken into account when double occupancy is being considered. This applies not least from a safety and security perspective.

As regards isolation-breaking measures, following the inspections of Salberga and Kronoberg remand prisons, I can state that inmates are being isolated,

which is very serious. One clear reason for this is the increased number of children in custody. It is not acceptable that efforts to prevent isolation are limited due to a lack of resources, practical conditions or organisational reasons. A lack of understanding on the part of management and staff as to what an isolation-breaking measure entails is of course not acceptable either. The consequences of the critical occupancy situation in the Prison and Probation Service remain a priority. In 2024, I will therefore focus in particular on the consequences and risks of double occupancy for inmates.

5

The National Board of Institutional Care

The National Board of Institutional Care

The National Board of Institutional Care (SiS) is responsible for the homes specifically intended to provide care under the Care of Substance Abusers Act (1988:870) (LVM). SiS is also the authority responsible for the residential homes for young people where children and young people who are cared for under Section 3 of the Care of Young Persons Act (1990:52) (LVU) and who need to be under particularly close supervision can be placed. Young people who have been sentenced to closed youth care, and who are enforcing the sentence under the Secure Youth Care Act (1998:603) (LSU), are also placed in the special residential homes for young people. In 2023, there were 21 special residential homes for young people and 11 LVM homes.[1]

In 2023, the Parliamentary Ombudsmen inspected four special residential homes for young people.[2] All inspections were unannounced and were carried out or commissioned by Parliamentary Ombudsman Thomas Norling.

5.1 Observations from this year's inspections

Physical environment

A key element in enabling SiS to provide good and safe care for children and young people is the availability of suitable and appropriate premises. The CPT has stated that places where children and young people are deprived of their liberty, inter alia, should be properly furnished and decorated in a way that provides appropriate visual stimulation.[3] When the SiS implements decisions on the coercive measures of segregation and solitary care, it presupposes that the authority's institutions have appropriate premises that are designed to be used and to be sufficiently secure.[4]

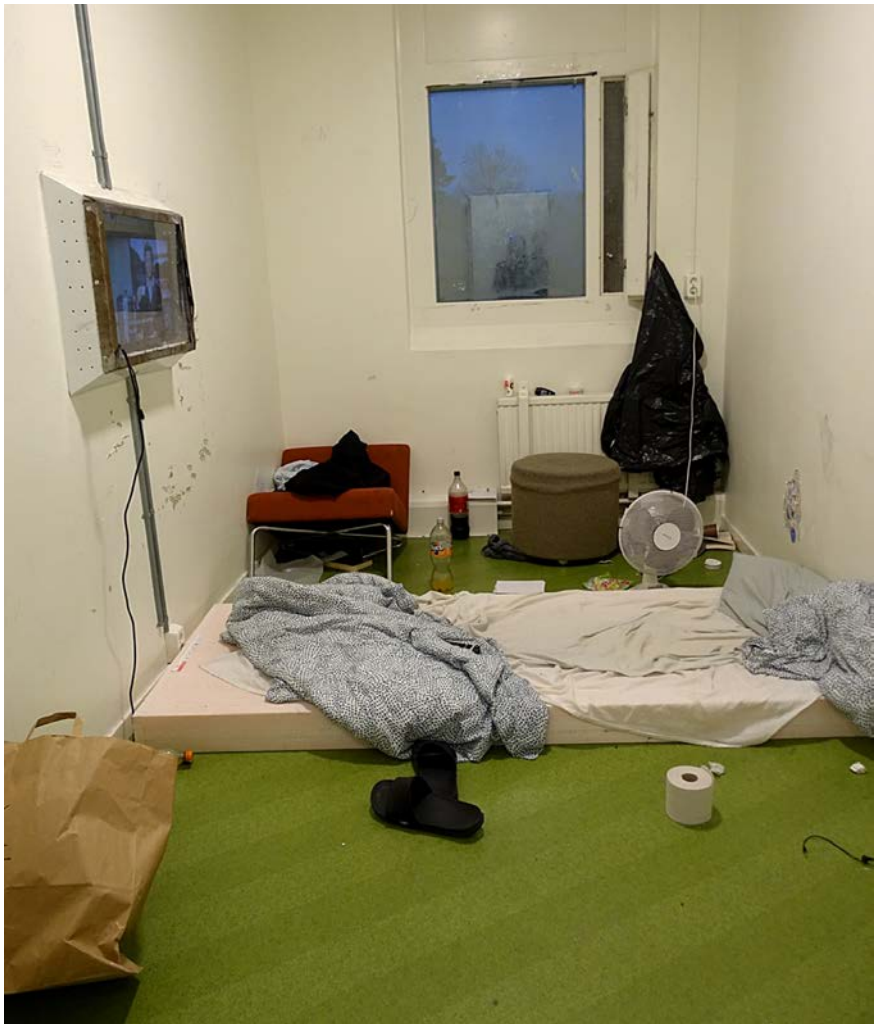
All the inspections revealed that the activities of the residential homes for young people were carried out in premises that were largely inadequate and in serious need of renovation. During the inspections of the Nereby and Tysslinge residential homes for young people it was especially noted that the premises were dark, run-down and dirty. In addition, there were not enough private and seclusion rooms and they did not fulfil the requirements for safety

1 SiS annual report 2023.

2 The special residential homes for young people were Nereby, Brättegården, Rebecka and Tysslinge, see O 5-2023, O 18-2023, O 20-2023 and O 25-2023.

3 See CPT/Inf [99], para. 29, cf. also Chapter 7, Section 1 of the National Board of Health and Welfare's regulations and general advice on residential care homes [HSLF-FS 2016:55]).

4 See decision of 21 November 2022, ref. no. 2802-2020.



Room for care in solitary confinement in Tysslinge youth home.

and security. It was also found that the premises of the Tysslinge residential home were unhygienic and that the room temperature in parts of the premises was far below what could be considered acceptable. The walls in several rooms were also covered with graffiti. The impression was that the premises were not adapted to the children and young people the centre received, who had a high capacity for violence and links to criminal networks. This was also shown by the various ad hoc solutions that the residential home found it necessary to take, for example, dividing sections into smaller units by covering some glass doors with black bin bags to prevent visibility. The Nereby residential home also used temporary solutions, for example, by housing one section in barracks, the windows of which were covered with a frosted plastic film that made it impossible to look out. Furthermore, the Rebecka residential home for young people had such sanitary deficiencies that the environ-

ment was deemed to be potentially pathogenic. During the inspection of the Brättegården residential home for young people, it became clear that it was not possible to divide the sections into smaller units to create a better care environment. This deficiency led to an increased need for coercive measures, especially solitary confinement. In the Tysslinge residential home, the home had been sectionalised even though the premises were not adapted for this. The sectioning resulted in substandard and undignified physical conditions for the residents placed in the smaller units.

Following the inspections, the Parliamentary Ombudsman stated that the premises of the residential homes for young people are predominantly deficient to the extent that they do not constitute an appropriate care and treatment environment for young people. In the case of the Tysslinge residential home and, to some extent, the Nereby residential home, the Ombudsman also considered the premises to be directly unsuitable for the care of children and young people. Following the inspection of the Brättegården residential home, the Ombudsman urged the home to review the possibilities for improving the physical environment and creating a safe and secure care environment pending renovations. At the same time, following the inspections of both Brättegården and Rebecka, the Ombudsman emphasised that SiS, as a central authority, has a responsibility to ensure that compulsory care of children and young people does not take place in inadequate premises for a long period of time.

The premises are in some cases directly unsuitable for the care of children and young people

Staff competence

Another key element in the provision of good and safe care for children and young people by the SiS is the availability of well-trained staff. The CPT has stated that staff should be carefully selected for their personal maturity and ability to deal with the challenges of working with – and safeguarding the welfare of – children and young people. All staff should receive professional training during their induction and ongoing employment.[5] Staff duties include ensuring that order is maintained in the residential home and it is their responsibility to intervene to prevent disorder.[6]

The inspection of the Tysslinge residential home for young people revealed a lack of staff competence and a fear of reprisals by the young people. Staff members were also unable to deal with conflicts with or between young people, with the result that conflicts escalated and led to riot-like situations where young people were left alone in the sections. Furthermore, it was found that many staff members adapted their approach to what the young people wanted and not to their care needs.

Staff members were afraid of reprisals by the young people

5 See CPT/Inf [99], para. 33, cf. also Chapter 5, Section 2 and Chapter 6, Section 1 and the National Board of Health and Welfare's regulations and general guidelines on residential care homes [HSLF-FS 2016:55]).

6 See JO 2008/09 p. 305, ref. no. 1316-2006, see also the CPT's statements following its visit to a residential home for young people in Sweden in 2009, CPT/Inf [2009] 34, para. 119.

Following the inspection, the Parliamentary Ombudsman stated that SiS needs to ensure that the residential home follows up on how management is exercised in the home. The home's management must in turn ensure that the staff have the conditions and knowledge required to fulfil their duties. Furthermore, the Ombudsman pointed out that there are significant risk factors in the organisation that are very complex from a care perspective. In addition to the staff's lack of competence and expressed fear, there are difficult challenges due to the fact that the activities are conducted in premises that are not fit for purpose. These risk factors need to be addressed urgently in order to not continue to cause negative consequences to the young people. According to the Ombudsman, it could be questioned whether the residential home really has the prerequisites required to fulfil its mandate and conduct an operation that offers safe and secure care and treatment.

Security Level 1 operations

In accordance with a mandate from the Government, SiS has decided to introduce a differentiated security classification of its institutions by dividing them into three different security levels. In January 2021, the agency decided that the Tysslinge and Johannisberg residential homes for young people be upgraded to the highest security level, Level 1. The decision means that the homes, after the measures have been implemented, will have a satisfactory ability to handle young people with the highest risks of deviance, threats and violence. According to SiS's feedback regarding the government mandate, the agency estimated that the work on security-enhancing measures at the two residential homes would be completed during the first quarter of 2022.[7]

During the inspection of the Tysslinge residential home for young people, it was found that there was still some work to be done before the residential home fulfils the requirements for being a Security Level 1 institution. After the inspection, the Parliamentary Ombudsman stated that it appears unclear how far the agency has actually come in the work of security classification of its residential homes for young people. According to the Ombudsman, it was both unsatisfactory and worrying that the work had not progressed as far as expected and that Tysslinge therefore seemed to lack the capacity required to be able to receive young people with the highest risks of deviance, threats and violence. The Ombudsman considered that the concern was further reinforced by the fact that neither Tysslinge nor Johannisberg can refrain from accepting this category of young people. When, in reality, there is a shortage of residential homes with the required capacity, the situation risks becoming very serious.

When, in reality, there is a shortage of residential homes for young people with the required capacity, the situation risks becoming very serious

7 See SiS's feedback from March 2021, Reg No 1.1.1-1787-2021.

Care in solitary confinement

The coercive measure of solitary confinement may only be considered if it is necessary in view of the young person's special needs for care or safety or the security of the residential home.[8] A prerequisite for such care is that the child or young person has particular difficulties that prevent him or her from benefiting from treatment in a larger group.[9] Young people in solitary care should be able to have constant contact and interaction with staff to avoid isolation.[10]

The inspection of the Tysslinge residential home for young people revealed that young people were kept in solitary confinement in order, among other things, to protect them from threats and violence from fellow residents and to manage group-related risks. Other recurring reasons were that young people did not follow the rules and routines of the home. It also was found that young people in solitary confinement were almost always left to their own devices without the necessary access to staff and that many of them felt isolated. Following the inspection, the Parliamentary Ombudsman stated that solitary confinement was carried out in a deficient manner. The Ombudsman explained that it appears that young people who are cared for in solitary confinement are virtually segregated and that the measure can lead to isolation. The Ombudsman stated that isolation risks causing serious mental and physical harm and that the requirement for constant access to staff in solitary care must be fully observed in the organisation.

The need for staff to be present with the person being cared for in isolation may differ depending on, among other things, the age of the resident and what problems and needs they may have

The inspection of Nereby residential home for young people also revealed that children and young people felt that they spent a large part of their time alone in solitary confinement. One of these children was nine years old. He was placed in solitary confinement to ensure his safety and to protect him from other older young people. During the inspection, it was noted that he was alone on a couple of occasions. After the inspection, the Parliamentary Ombudsman stated that the need for staff to be present with the person being cared for in solitary confinement may differ depending on, among other things, the age of the resident. According to the Ombudsman, it is clear that a nine-year-old child should not, as a rule, be left alone at all, especially when the child wants staff to be with them. The Ombudsman viewed with great concern the fact that the situation had arisen and stated that he expected the residential home to follow up on this and take the necessary measures to ensure that something similar did not happen in the future.

Specially reinforced sections

SiS has established specially reinforced sections (SFA) for young people with a need for customised care based on extensive psychiatric and neuropsychiatric

8 See Section 15 d LVU and Section 14 a LSU.

9 See Government Bill 2017/18:169, p. 74.

10 See the Parliamentary Ombudsmen's decision of 21 November 2022, ref. no. 2802-2020, and the references made therein.

Exercise yard at ward Kornhall in Nereby youth home.

problems. SFAs have a higher staffing level than other sections. In addition, the approach and choice of methods, as well as the size and design of the premises, are adapted to the needs of the young people.[11]

The Brättegården and Rebecka residential homes for young people each has an SFA.[12] During the inspections of the homes, it was found that placement in the sections in question involved care in a locked unit without SiS having considered whether the care could be provided in an open unit. Furthermore, it was clear that young people placed in the sections risked remaining in a locked unit for a long time and, moreover, after SiS had assessed them as ready for discharge. Placement in the SFA at Brättegården presupposed that there was a need for care in a smaller unit which, in terms of its content, corresponded to the requirements for the coercive measure of solitary confinement. A placement at the SFA at Rebecka meant that the resident would be cared for in solitary confinement regardless of how the individual's care needs changed over time.

Following the inspections, the Parliamentary Ombudsman stated that the observations made lead to the conclusion that a placement at the SFA at Brät-

11 See SiS's programme description for specially reinforced sections, ref. no. 1.1.3-403-2021, and evaluation of the specially reinforced sections, SFA, ref. no. 1.1.4- 6462-2022, and https://www.stat-inst.se/var-verksamhet/sis-tjanster/behandlingsavdelningar/sarskilt-forstarkta-avdelningar-sfa/.

12 The Kullen section at the Brättegården residential home for young people and the Freja section at the Rebecka residential home for young people.

The principle of proportionality is violated by subjecting the individual to coercive measures regardless of their need for care

tegården or Rebecka entails a risk of the principle of proportionality being jeopardised. The individual will be subjected to coercive measures regardless of their circumstances and need for care. According to the Ombudsman, SiS has essentially created a new form of care for a target group that both the social services and SiS have difficulties dealing with. Although there is an understanding that the target group in question needs care in an environment with fewer residents, higher staffing levels and staff with the right skills, the Ombudsman was very sceptical that coercive measures are a necessary prerequisite for SFA activities. SiS was urged to urgently review how the agency conducts care at the specially reinforced sections.

Superficial body searches

Following its visit to residential homes for young people in Sweden in 2021, the CPT recommended that during a superficial body search, a juvenile should not normally be required to remove all of their clothes at the same time, but may instead be allowed to remove the clothes above the waist and put them back on before removing further clothes.[13]

Superficial body searches should in many cases be possible to carry out in a less intrusive way than requiring the young person to stand completely naked in front of staff

During the inspection of the Nereby residential home for young people, it was found that the young person had to take off all their clothes and stand naked for a short time during a superficial body search. Representatives of the home were not aware of the procedure recommended by the CPT. It also was found that staff did not always ask children and young people whether they wanted a particular member of staff to carry out or be present during a strip search. Following the inspection, the Parliamentary Ombudsman stated that in many cases it should be possible to carry out superficial body searches in a less intrusive manner than requiring the young person to stand completely naked in front of the staff. For a child or young person who is already in a vulnerable situation, it can in some cases be very, and even unnecessarily, intrusive to have to do so. The Ombudsman recommended that SiS review the procedures in place for carrying out superficial body searches and, within that framework, consider alternative approaches. The Ombudsman also stated that the residential home must ensure that staff are aware that the young person should be asked if he or she wishes a particular member of staff to carry out or be present during a superficial body search.

5.2 Concluding remarks

In 2023, I have also chosen to follow up on issues relating to young people's safety and security at the special residential homes for young people. The inspections carried out during this year show that many of the problems I have previously highlighted remain. The shortcomings are also so serious that I question whether SiS residential homes for young people really provide the

13 See CPT/Inf [2021] 20, para. 98.

conditions required for the kind of safe and secure care that meets the quality demands that must be placed on the authority. It is particularly problematic that SiS's development work does not seem to be proceeding quickly enough and that the changes made to the organisation do not seem to have had the desired effect either.

In this year's report, I have highlighted some areas where I have found the situation to be particularly worrying. These include, for example, the physical environment in the residential homes, the need for staff to have the necessary skills and the challenges of classifying residential homes at the highest security level. I have also drawn attention to the care provided in specially reinforced sections and SiS's use of the separately regulated coercive measure of solitary confinement.

The government has recently commissioned a special investigator to review the mandate and organisation of state child and youth care. My hope is that the proposals resulting from that review will be realistic, improve quality and bring about a significant improvement in the care provided at SiS residential homes for young people in all respects.

6

Compulsory psychiatric care

Compulsory psychiatric care

Care under the Compulsory Psychiatric Care Act (1991:1128) (LPT) and the Forensic Psychiatric Care Act (1991:1129) (LRV) is provided almost exclusively by the regions. In 2022, just over 12,600 people were treated in inpatient care under the LPT and around 2,000 people were treated in inpatient care under the LRV.[1] At care facilities that provide care under the LPT and LRV, there may also be patients who are treated voluntarily under the Health and Medical Services Act (2017:30), HSL.

In 2023, inspections were carried out in two healthcare facilities. One inspection was carried out at the Psychiatric Clinic in Öjebyn and was previously announced. The second inspection was carried out at the paediatric and adolescent psychiatric emergency department at Södra Älvsborg Hospital and was unannounced.[2] The inspections were carried out at the request of Chief Parliamentary Ombudsman Erik Nymansson.

6.1 Observations from this year's inspections

Care environment

The Psychiatric Clinic in Öjebyn mainly provided care under the LRV. During the inspection, it emerged that the premises were originally built for use as a nursing home and were therefore not entirely fit for purpose. For example, some wards lacked interview rooms and there was only one large common room. The clinic's intake ward, which was located in an extension to the existing building, was described as difficult to work in. According to staff, the layout of the ward made it difficult to meet patients' care-related needs. Furthermore, patients cared for in the intake ward had to share rooms, and patient rooms were both bare and lacked natural light.

After the inspection, the Chief Parliamentary Ombudsman emphasised that the Parliamentary Ombudsmen on several occasions has highlighted that the care environment is of particular importance for patients who are subject to compulsory psychiatric and forensic psychiatric care. The reason for this is that, in essence, these patients in practice have their home at the care institution and the care environment therefore becomes part of the living environment. Furthermore, the Chief Parliamentary Ombudsman noted that the

1 The figures are taken from the National Board of Health and Welfare's statistical database on compulsory psychiatric care and forensic psychiatric care.

2 See O 4-2023 and O 10-2023.

CPT has emphasised that a good care environment and access to both mental and somatic treatment are important prerequisites for reducing the risk of patients being subjected to inhuman treatment.[3] In the light of what had been discovered about the physical environment of the intake ward, the Chief Parliamentary Ombudsman considered that there were grounds for questioning whether it was appropriate to provide forensic psychiatric care there.

The care environment is of particular importance for patients who receive compulsory psychiatric and forensic psychiatric care

Activities and outdoor activities

At the *Psychiatric Clinic in Öjebyn*, the activities rate for patients was very low. Occupational therapy had been closed since spring 2022 and both patients and staff expressed that the care was more akin to detention. At the time of the inspection, the outdoor areas were covered with snow and it was questionable whether the need for daily outdoor exercise could be met under these conditions. It also became clear that the workload of staff was a key factor in determining the frequency with which patients without day release privilege were able to go outside. Following the inspection, the Chief Parliamentary Ombudsman noted that the Parliamentary Ombudsmen had repeatedly referred to the CPT's statement that psychiatric care should be based on an individualised adaptation and treatment plan for each patient. Such a plan should include a wide range of rehabilitative and therapeutic measures and include the possibility of, inter alia, occupational therapy. The CPT has also stated that patients should have the opportunity for daily outdoor exercise.[4] In light of what was found during the inspection, Region Norrbotten was urged to make greater efforts, in consultation with the clinic management, to provide patients with the opportunity for occupational therapy and other activities, as well as daily outdoor exercise.

Outdoor activities for children cared for pursuant to the LPT

Under Section 31 b of the LPT, a patient under the age of 18 is entitled to daily activities in the healthcare facility and to spend at least one hour outdoors every day, unless there are medical reasons not to do so. It is clear from the preparatory work that spending time outdoors means that the patient is given the opportunity to leave the building in which the healthcare facility or ward is housed. It may be a question of staying in an enclosed park or courtyard adjacent to the institution or ward. Medical reasons for denying the right to daily activities and outdoor recreation may include acute life-threatening conditions that could put the patient at serious risk from physical activities or outdoor recreation.[5]

The Paediatric and Adolescent Psychiatric Emergency Department at Södra Älvsborg Hospital cared for patients under both HSL and LPT. The ward was

3 CPT/Inf/E [2002] 1-Rev. 2015, pp. 50-54.

4 CPT/Inf/E [2002] 1-Rev. 2015, p. 51.

5 See Government Bill 2019/20:84, p. 60.

locked and staff assistance was required to get in and out. Staff agreed that patients who were being cared for voluntarily had the right to leave the ward if they so requested. However, there was often a plan in place for patients to go outside the ward, which involved them going out with an adult, in other words, a relative or a member of staff. Staff also stated that patients treated under the LPT could sometimes also be allowed to leave the ward with an adult. There were cases where a strained staff situation led to a patient not being allowed outside when he or she did not have a relative present.

The inspection also revealed that Child and Adolescent Psychiatric Services (BUP) had access to a yard that was significantly smaller than the adult psychiatry yard. Staff stated that the BUP courtyard was rarely used because it was not adjacent to the ward and therefore difficult to access. In addition, it was not fenced off, which made it unsafe for some patients to be in the courtyard. It was also pointed out that the courtyard was not adequately designed for the target group normally cared for on the ward, as it had, for example, a playground adapted to much younger children. The ward had a balcony with a grid to the ceiling and partially glazed walls. For safety reasons, one patient was confined to the balcony for his outdoor time. Discussions with the management revealed that they were of the opinion that spending time on the balcony was sufficient to fulfil a patient's right to spend time outdoors.

Following the inspection, the Chief Parliamentary Ombudsman referred to previous statements by the Parliamentary Ombudsmen concerning restrictions on the ability of voluntarily hospitalised patients to go out.[6] He also recalled the importance of ensuring that the constitutionally protected freedom of movement is not circumvented by patients in voluntary care feeling prevented from leaving the ward, for example on the basis of an initial plan. As regards patients treated under the LPT, the Chief Parliamentary Ombudsman noted that only medical reasons can justify denying a patient the right to daily outdoor activities. The lack of a suitable and escape-proof place to spend time outdoors is thus not an acceptable reason for restricting this right. Furthermore, the Chief Parliamentary Ombudsman noted that patients are not outside of the building when they are on the ward balcony. This is therefore not an outdoor activity as referred to in Section 31 b of the LPT.

Only medical reasons can justify denying a patient the right to daily outdoor activities

Coercive measures

Coercive measures in care under the LRV and LPT may be used only if they are proportionate to the purpose of the measure. If less serious measures are sufficient, these should be used instead. Furthermore, coercion must be exercised as gently as possible and with the greatest possible consideration for the patient (Section 2 a LPT and LRV).

6 See ref. nos. O 8-2022 and O 17-2022.

Balcony used for spending time outdoors in the Paediatric and Adolescent Psychiatric Emergency Department at Södra Älvsborgs Hospital.

The inspection of the *Psychiatric Clinic in Öjebyn* revealed that patients treated in the intake ward were at risk of seeing, or at least hearing, when other patients were subject to restraint and seclusion situations. Following the inspection, the Chief Parliamentary Ombudsman stated that the practice is remarkable and that it raises questions about patient privacy in relation to other patients.

During the inspection, information also indicated that during evenings and weekends, the clinic did not always have access to doctors on site. There was no back-up doctor and instead the back-up doctor from another hospital had

Patients were at risk of seeing or hearing other patients being subjected to coercive measures

to be contacted if necessary. On a few occasions, when it had been assessed that there was a need for a medical examination prior to a possible extension of restraint with a belt, the clinic had been informed by the back-up service that they were unable to come to the clinic in Öjebyn. The restraint had then been cancelled. The Chief Parliamentary Ombudsman noted that the Parliamentary Ombudsmen had stated on several occasions that a medical examination must take place in close connection with the initial decision on restraint. The patient's condition must be continuously monitored and it is the doctor in charge who must make the periodic assessments of the patient. Against this background, the Chief Parliamentary Ombudsman emphasised that it is of the utmost importance that Region Norrbotten has an organisation that provides the conditions for carrying out the medical examinations that are needed.

During the inspection of *the Paediatric and Adolescent Psychiatric Emergency Department at Södra Älvsborg Hospital,* it was found that there was uncertainty among staff as to what constitutes coercion and where the boundaries lie for taking coercive measures. Following the inspection, the Chief Parliamentary Ombudsman noted that the Parliamentary Ombudsmen had previously stated that the basic principles in the treatment of patients under compulsory care must be that measures are taken to reduce the need for coercive measures and to ensure that the use of coercive measures that cannot be avoided is based on the principle of the least intrusive measure.[7] The Chief Parliamentary Ombudsman also noted that he had the impression that staff were indeed working to avoid the use of coercive measures except in exceptional cases and only when absolutely necessary, which is of course positive. At the same time, there were coercive measures on the ward and it is therefore important that all categories of staff are familiar with the regulations and are confident about what applies in such situations. The Västra Götaland region was thus urged to take the necessary measures to provide the necessary expertise in order to give the staff the support and knowledge they need to carry out their work.

Measures falling under what is known as emergency law

During the inspection of the *Paediatric and Adolescent Psychiatric Emergency Department at Södra Älvsborg Hospital*, partly different accounts emerged regarding what happened in a situation where the staff had to act to remove a knife. The written documentation showed that the staff discovered that a patient had access to a knife. As the patient did not voluntarily surrender the knife, a senior doctor decided that the patient should be pinned down to enable staff to dispose of the knife. However, the decision included a reference to the provision dealing with the conditions for placing a minor patient in a restraint bed. During the final review, it was explained that a decision

7 See, for example, the report in ref. no. 4043-2017.

had been taken to place the patient in a restraint bed, but once the knife was removed from the patient, it became a question of pinning the patient down instead.

The Chief Parliamentary Ombudsman stated that although the circumstances are partly unclear, there is much to suggest that this was a situation where measures involving some form of force or coercion can be taken with reference to the so-called emergency law.[8] However, the staff involved was not found to have considered that it might be a case of such an emergency. In the activities carried out on the ward, emergency situations may arise that need to be dealt with quickly in order to avert danger to life or health. It is therefore essential that all staff understand what the emergency law means and when it can be invoked. Otherwise, there is a risk that dangerous situations will not be handled correctly and with sufficient urgency. The Chief Parliamentary Ombudsman therefore concluded that management must ensure that staff have sufficient knowledge in this regard.

It is essential that all staff understand what the emergency law means and when it can be invoked

Specific to a patient had been hospitalised for a long time

During the inspection of the *Psychiatric Clinic in Öjebyn*, the Parliamentary Ombudsmen's staff noted that a patient who was being cared for under the LRV had been hospitalised at the care facility for several decades. Conversations regarding the patient's situation were held with, among others, doctors and the patient himself. The patient's care plan was also reviewed. During the conversation with the patient, it was found that the patient was of the opinion that there was no planning for the future, everyday life was described as boring and the patient's activities consisted mostly of watching TV, playing cards, going out with the staff and meeting their support person one day a week.

The Parliamentary Ombudsmen's expert in psychology participated in the inspection. After the inspection, the expert was consulted. Following a review of, inter alia, the patient's care plan , the expert pointed out the following. The patient's care plan did not contain any actual goals for the care and conveyed a sense of resignation regarding the patient's possibilities for reintegration into society. If the care provider has made the assessment that rehabilitation is not possible, the focus should shift to habilitative measures and the content of the care, in order to create as meaningful a life as possible for the patient. The Parliamentary Ombudsmen's expert also pointed out that it is remarkable that the most recent structured risk assessment was carried out in 2015. Risk assessments of this kind should be recent.[9] In conclusion, the expert noted that what is considered to be the patient's main psychiatric problem area, as far as the care plan shows, was only treated with medication. This was despite the fact that, according to the relevant guidelines from the National Board of

8 See Chapter 24. 4 of the Criminal Code.

9 The risk assessment carried out was HCR-20 version 3.

Health and Welfare, psychological and psychosocial treatment should also be offered.[10]

The Chief Parliamentary Ombudsman agreed with what the expert had said and stated, among other things, that what had been found raised questions about what other alternatives for care and treatment of the patient the clinic management had considered. Based on the information found, it was doubtful whether the clinic had even worked with a long-term goal of being able to care for the patient in a more open manner. Furthermore, the Chief Parliamentary Ombudsman wanted to draw the attention of the clinic to the possibility of bringing in an independent expert for a new medical assessment to ensure that the patient receives good care and treatment.

6.2 Concluding remarks

Patients treated under the LPT or LRV are a particularly vulnerable group. The clinics that have these individuals in their custody bear a great responsibility when it comes to offering meaningful care with an individually adapted and well-balanced content. The purpose of compulsory care is to enable patients to voluntarily participate in necessary treatment, and coercive measures may only be used if they are necessary and proportionate. Unfortunately, this year's inspections revealed several shortcomings in these respects.

At the Psychiatric Clinic in Öjebyn, the possibility of activities was virtually non-existent and the care was described as almost custodial. For the patient who had been hospitalised for decades, there was a sense of resignation regarding the possibility of reintegration into society, which is both regrettable and very worrying. At the Paediatric and Adolescent Psychiatric Emergency Department at Södra Älvsborg Hospital, it was found that there was uncertainty among staff as to what constitutes coercion and where the boundaries lie for taking coercive measures. I can see that such uncertainty entails risks for patients that are unacceptable. It is crucial that Region Norrbotten and the Västra Götaland Region take immediate action to address the shortcomings I have pointed out in the respective inspection reports.

10 See the National Board of Health and Welfare's national guidelines for care and support – for substance abuse and dependence – Support for governance and management, 2019.

7

The Swedish Migration Agency

The Swedish Migration Agency

The Swedish Migration Agency's tasks include operating appropriate detention facilities where foreign nationals can be placed while awaiting enforcement of a decision to deport or expel them from Sweden.[1] A decision to detain someone is made by the Migration Agency, the Police Authority and the migration courts.[2] At the end of 2023, the Migration Agency had six detention facilities with a capacity of about 570.[3]

At the instruction of Parliamentary Ombudsman Per Lennerbrant, an unannounced inspection of the detention facility in Mölndal was carried out in January 2023.[4] The detention facility was then relatively newly opened and all departments were not yet in operation.

7.1 Observations from this year's inspection

Staff behaviour and competence

The inspection revealed serious shortcomings in the treatment of detainees by staff and a lack of competence. There were many newly hired employees at the detention facility who initially received only two weeks of basic training, compared to the normal eight weeks of basic training. There were also staff who did not have a satisfactory command of the Swedish language. In conversations with the Parliamentary Ombudsmen's staff, detainees reported, among other things, that staff talked about isolation in a way that was perceived as threatening. Several testified that staff treat detainees of the same origin or who speak the same language as the staff differently. In conversations with staff, it was also reported that some colleagues "take the chance to mess with" detainees. There were also reports of racist jargon being used.

After the inspection, the Parliamentary Ombudsman stated that he understands that detention activities are complex and that staff often have to resolve situations that arise quickly. At the same time, it must be taken into account that detainees are in a vulnerable position and often find it difficult to safeguard their rights. It is therefore crucial that staff understand the nature of their role as government employees, and that this includes being able to handle even pressurised situations in a professional manner. Furthermore, the Ombudsman emphasised that it is unacceptable for staff to use their superior position, for example through reprimands, special treatment of certain

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

2 See Chapter 10, Section 1 and Sections 12-17 of the Aliens Act (UtlL).

3 Annual report of the Swedish Migration Agency 2023.

4 See the Parliamentary Ombudsmen's report in ref. no. O 3-2023.

detainees or threats of coercive measures. He emphasised that the Migration Agency is responsible for ensuring that its staff have the necessary qualifications, both to provide a good reception and to perform other tasks that are part of their work. The agency needs to ensure that its activities are conducted in a legally secure and equal manner in relation to detainees. An important part of this is that the employees have the right skills and can communicate the rules and procedures that apply in the detention facility.

It is crucial that staff understand what their role as government employees entails

Physical environment

The CPT has stated that persons held in detention should be accommodated in premises designed for that purpose. Care should be taken in the design of the premises to avoid, as far as possible, giving the impression of a prison environment.[5] The inspection revealed that the detention facility's premises were adapted to the standard required by the Swedish Prison and Probation Service in order to conduct remand prison and prison activities. The physical environment was thus characterised by security considerations. The Parliamentary Ombudsman referred to the CPT's statement and noted that the Migration Agency should investigate the possibility of adapting the premises to mitigate the effects of the institution-like environment on the detainees.

Attendance checks and room inspections

The inspection revealed that staff carried out attendance checks and room inspections in the detainees' accommodation rooms. Attendance checks were carried out six times a day, of which two were at night, and room inspections took place three times a day. The local procedures stated that the aim of the attendance checks was to get an idea of how the detainees were feeling, as well as to ensure that they were present in the building. The purpose of the inspections included checking the rooms to detect tampering, unauthorised objects and ongoing escape attempts. In conversations with the Parliamentary Ombudsmen's staff, some staff members criticised the night-time attendance checks for disturbing detainees. They said that the checks led to unnecessary provocations and that this in itself could be a security risk. Several staff members also stated that they did not know the purpose of the attendance checks. They also questioned the need for so many attendance checks and inspections per day, partly in view of the high level of physical security in the detention facility. In one conversation, it was found that staff sometimes searched through the shelves where detainees kept their belongings during room inspections.

After the inspection, the Parliamentary Ombudsman stated that the checks in the detainees' living quarters raised the issue of the constitutional protection against searches and similar intrusions, and that such a measure requi-

5 See CPT/Inf[2017]3, Section 3.

Migrationsverket måste säkerställa att närvarokontroller och rumsrondering-ar är förenliga med regeringsformen

red legal support (see Chapter 2, Sections 6, 20 and 21 of the Instrument of Government). Based on what had been found, the Ombudsman stated that he could not draw any firm conclusion as to whether or not the checks carried out at the detention facility constituted an intrusion with regard to the Instrument of Government. However, it was clear that the Migration Agency's staff had no statutory authority to check a detainee's accommodation.[6] According to the Ombudsman, the Migration Agency must therefore ensure that the control measures are compatible with the Instrument of Government. Furthermore, the Ombudsman stated that the Migration Agency should review whether, in terms of proportionality, there is a need for six attendance checks and three room searches per day. The agency also needed to consider at what times of day these measures should be carried out and ensure that the staff carrying out the control measures are aware of how they are to be carried out and what their purpose is.

Activities, recreation and spending time outdoors

At the time of the inspection, there was no regular organised activity in the detention facility. The detainees described that time passed slowly and that they had too few things to do. They stated that they mainly occupied themselves with the computers, but that they could also play cards and do puzzles. There were no books to borrow in the detention facility, and detainees were only allowed to spend one and a half hour in the yard per day. Following the inspection, the Parliamentary Ombudsman referred to Chapter 11, Section 3 of the Aliens Act, which regulates that an alien held in detention must be given the opportunity for, inter alia, activities and recreation. The Ombudsman noted that it is clear from the preparatory work regarding this provision that the legislature intended to raise the level of ambition with regard to activities and that detainees must be given the opportunity to do more than just watch television, exercise and play board games, etc.[7] They should be given the opportunity to engage in activities of a more qualified nature. The Ombudsman found that the latter types of activities were not provided in an organised manner at the detention facility in Mölndal and that the Migration Agency needs to review this. Furthermore, the Ombudsman emphasised that the CPT has stated that detainees should have access to a library and newspapers, and that detainees, as a rule, should in principle have free access to a place to spend time outdoors, but for at least two hours a day.[8]

The Migration Agency needs to review detainees' access to activities in detention facilities

Decisions on body searches

A foreign national in custody may not, without authorisation, possess alcoholic beverages or other intoxicants or anything else that may cause harm or disturb the peace on the premises. If there are reasonable grounds to suspect that a foreign national in detention is carrying such property, or property that

6 See Chapter 8, Section 2 of the Prison Act and Section 17 b of the LVU.

7 See Government Bill 1996/97:147, p. 24.

8 See CPT/Inf[2017]3, Section 5 and CPT/Inf [2021]20, para. 22.

Corridor with living rooms in Mölndal detention facility.

may not be possessed under the Narcotics Offences Act, the foreign national may be searched to check this. [9]

The inspection revealed that body searches were carried out upon registration and when the detainee received luggage, and that such searches were also regularly carried out after unsupervised visits. Against this background, the Parliamentary Ombudsman concluded that body searches were carried out without an assessment of the legal requirements for the measure in each individual case. He emphasised that everyone has constitutional protec-

9 See Chapter 11. Sections 8 and 9 UtlL.

tion against body searches and that such a measure may only be taken if it is supported by law.[10] The Migration Agency therefore needed to follow up the use of body searches at the detention facility in Mölndal and ensure that they were in accordance with the law.

Medical examination for certain isolation decisions

A foreign national who is held in isolation because of his or her danger to themselves must be examined by a doctor as soon as possible.[11] During the inspection, it was found that it was that the detention facility's nurse who met those held in isolation and that a medical examination was not regularly carried out. When reviewing decisions on isolation, the Parliamentary Ombudsmen's staff noted a case where a detainee had been held in isolation for just over two weeks without being examined by a doctor. In the case, information had been continuously documented that clearly showed that the man was not feeling well. Nevertheless, it took just over two weeks before the Migration Agency acted by taking the man to a psychiatric emergency centre.

The Parliamentary Ombudsman found that the detention facility had neither procedures nor an organisation that complied with the statutory requirement for a medical examination in the case of certain decisions regarding isolation. He stated that this is very serious and that he requires that the Migration Agency take measures to ensure that a doctor examines a person who is held in segregation because they pose a danger to themselves as soon as possible.

The Swedish Migration Agency needs to take measures to ensure that a doctor examines a person who is held in isolation because they are a danger to themselves as soon as possible

7.2 Concluding remarks

During the inspection, consistent information was provided by staff and detainees regarding serious shortcomings in treatment of the detainees by staff members. Information also was found that gives reason to question whether the control measures in accommodation rooms and body searches carried out at the detention facility are in all respects compatible with the Instrument of Government and the requirement of legal support for taking such measures. As I stated after the inspection, the detainees are in a very vulnerable situation and the deficiencies that have been found are of such a nature that they jeopardise the detainees' fundamental rights and freedoms. It is therefore of the utmost importance that the Swedish Migration Agency takes action in the respects I have highlighted in the inspection report. I will carry out a follow-up inspection of the detention facility in Mölndal in 2024.

10 See Chapter 2. Sections 6, 20 and 21 of the Instrument of Government.

11 See Chapter 11. Section 7, third paragraph, UtlL.

8

Swedish Customs

Swedish Customs

In its law enforcement operations, Swedish Customs is authorised to take a person into custody in certain cases. This applies to a suspect who is obliged to remain for questioning if that is necessary for the purpose of the intervention, public order or security, and with regard to a person who is arrested or formally detained. [1]

In 2023, within the framework of the OPCAT assignment, Parliamentary Ombudsman Per Lennerbrant carried out a pre-notified inspection of Swedish Customs' *Lernacken Checkpoint* in Malmö.[2] The inspection focused on the situation of persons taken into custody. In parallel with the OPCAT inspection, a further inspection was carried out of Swedish Customs, which concerned the agency's physical customs inspections and criminal investigations.[3] Swedish Customs has not previously been the subject of an inspection by the Parliamentary Ombudsmen.

8.1 Observations from this year's inspection

All of the observations below were made during the inspection of the Lernacken Checkpoint, Malmö.

The physical environment and regulation of the use of holding rooms

There is no specific regulation concerning Swedish Customs' detention rooms

The premises at the Lernacken Checkpoint contained five detention rooms, three of which could be locked. If the door to a room was locked, the room was regarded as a holding room and Swedish Customs' internal rule on locking up persons deprived of their liberty in holding rooms then became applicable.[4] The internal rule referred to provisions on holding rooms that existed in the Police Authority's now cancelled regulation on police detention facilities.[5] At the time of the inspection, Swedish Customs had therefore produced a draft of a new internal regulation, but this had not yet been finalised or formally adopted

The three detention rooms that could be used as waiting areas were small and had no windows. There was also no signalling system to attract staff attention. The doors to the rooms were alarmed and on the side of the doors facing the

1 See Sections 19, 20 and 21 of the Smuggling Penalties Act (2000:1225) and Chapters 23, Section 9 and Chapter 24, Sections 7 and 22 of the Code of Civil Procedure.

2 See the Parliamentary Ombudsmen's report in ref. no. O 22-2023.

3 See the Parliamentary Ombudsmen's report in ref. no. 7626-2023. Note that some issues raised during the OPCAT inspection are dealt with under a separate heading in those minutes.

4 STY 2017-278.

5 FAP 915-15.

corridor there was a sticker indicating "This door is unlocked". Discussions with staff revealed that the door to a detention room was usually closed but not locked when a person was present. However, the frequency with which staff locked such a door varied. Staff also stated that the two detainees placed in the detention rooms at the time of the inspection had not been locked in, but that the doors to their rooms had been closed. However, in conversations with these two, it was found that they were under the impression that they were locked in the rooms.

Detainees were under the impression that they were locked in when they were not

Following the inspection, the Parliamentary Ombudsman stated that persons who are taken into a detention room in the manner that takes place at the Lernacken Checkpoint, in view of the purposes that underpin the OPCAT protocol, must be regarded as deprived of their liberty and taken into custody, regardless of whether the door is locked or not. Those placed in the rooms are often unaware that the door is unlocked. He also noted that provisions on the enforcement of certain temporary deprivations of liberty are contained in the Remand Prisons Act and the Remand Prisons Ordinance. For remand prisons and police detention facilities, there are supplementary regulations on how detention rooms should be designed and equipped. The intent of these is to prevent detainees from being placed in substandard rooms. Basically, the aim is to ensure, through clear regulations, that detainees are treated with respect for their human dignity and that enforcement is organised in such a way as to counteract the negative consequences of deprivation of liberty. However, there are no corresponding regulations for Swedish Customs' activities, nor has that agency been authorised to issue further regulations on enforcement under the Remand Prisons Act and Remand Prisons Ordinance. According to the Ombudsman, the lack of regulations on the enforcement of detentions at Swedish Customs is unsatisfactory. In light of this, the Ombudsman found reason, pursuant to Section 13 of the Act (2023:499) with instructions for the Parliamentary Ombudsmen, to raise the issue of a statutory regulation of these conditions. He also noted that, pending a legal regulation, Swedish Customs needs to review how persons who are deprived of their liberty and taken into custody by the authority are to be dealt with.

The lack of regulations on the enforcement of detention at Swedish Customs is unsatisfactory

Access to health care and supervision

Each detention facility must have access to a qualified doctor and staff with appropriate medical training.[6] The Swedish Police Authority has issued supplementary regulations on health care for its operations, including regulations stating that a detainee, in connection with his or her registration at a detention facility, must be asked about his or her state of health and whether he or she has been prescribed any medication.[7] Paragraph 7 of Swedish Customs'

6 See Section 15 of the Remand Ordinance (2010:2011).

7 See Chapter 6, Section 1 of PMFS 2015:7, FAP 102-1.

internal rules stated that, before being locked up, a person must be asked about his or her state of health and whether he or she has any prescribed medication. Paragraph 12 stated, among other things, that supervision must take place every fifteen minutes.

Customs did not have access to medical staff, but had to contact the public healthcare system, when the need arises. During conversations with staff and detainees, it was also found that internal procedures did not appear to be followed. Instead, questions about the state of health were only asked in connection with detention interviews. This was not done so that customs staff could obtain information about health conditions, but because the police would request that information when the person was transferred to police custody. In the case of detainees placed in an unlocked detention room, there were no written procedures concerning questions about health status before admission.

Discussions with staff revealed that the internal rule on supervision was applied if the door to the detention room needed to be locked and was thus to be considered as a short-term detention pending possible further action. Staff further stated that supervision was carried out even if the door was closed but unlocked. However, there were no procedures for supervision in these situations. Regardless of whether the door was locked or not, supervision was carried out by staff opening the door or looking through the peephole. One detainee stated that staff members had not opened the door, but that they may have observed him through the peephole. The other person said that on two to three occasions during the time he was placed in the room, staff had opened the door to check on him.

Following the inspection, the Parliamentary Ombudsman stated that a detainee om Swedish Customs' detention facility is in a vulnerable situation and that this can have far-reaching negative consequences if customs staff are not aware of the detainee's state of health. In order to ensure the safety of the detainee, questions about his or her state of health and whether he or she has been prescribed any medication must be asked prior to placement in a detention room. Furthermore, supervision is of fundamental importance for the safety of detainees, inter alia, to recognise whether the detainee's state of health is such that there is reason to call a doctor. It is therefore very important that it is carried out in a way and with a frequency that is adapted to the circumstances of the individual case. The lack of procedures for supervision in cases where a detention room is not locked risks, among other things, exposing detainees to risks of various kinds. In light of this, the Ombudsman stated that Swedish Customs should urgently draw up procedures for health interviews and supervision. The procedures should apply regardless of whether the door to the detention room is locked or unlocked. Furthermore, Swedish Customs needs to ensure that each detention centre has access to a li-

Swedish Customs should urgently draw up procedures for health conversations and supervision

censed doctor and staff with appropriate medical training in accordance with the Remand Ordinance

8.2 Concluding remarks

During the inspection, it was found that there were no regulations on the enforcement of detention. As noted in my statements after the inspection, the purpose of such regulations is, among other things, to ensure that detainees are treated with respect for their human dignity and that the enforcement is designed to counteract the negative consequences of deprivation of liberty. The lack of regulations has consequences for all locations where Swedish Customs can detain persons. It is therefore urgent that a regulation is put in place as soon as possible.

Annexes

A. Participation in meetings

B. Inspections carried out in 2023

ANNEX A

Participation in meetings

In 2023, staff from the Parliamentary Ombudsmen's OPCAT unit participated in the following meetings:

International meetings

- 4–5 September 2023, Stockholm, Sweden, *Nordic NPM meeting*.
- 5–6 October 2023, *European NPM Conference*, via audio och video transmission.
- 9–10 November 2023, Copenhagen, Denmark, *International Conference on Mental Health of Individuals Deprived of Their Liberty*.

National meetings

- 19 April 2023, *Dialogue Forum with civil society actors on the rights and situation of individuals deprived of their liberty*, Stockholm.
- 16 May 2023, *lecture for employees of the Swedish Migration Agency's detention facilities in Märsta and Gävle*, Märsta.
- 29 November 2023, *Dialogue Forum with civil society actors on the rights and situation of individuals deprived of their liberty*, Stockholm.

ANNEX B

Inspections

Unannounced inspections

Police detention facilities	
Solna	Ref. No. O 8-2023
Total 1	

Remand prisons	
Kronoberg	Ref. No. O 21-2023
Salberga	Ref. No. O 23-2023
Total 2	

Prisons	
Kumla	Ref. No. O 6-2023
Borås	Ref. No. O 9-2023
Total 2	

Special residential homes for young people	
Nereby	Ref. No. O 5-2023
Brätteården	Ref. No. O 18-2023
Rebecka	Ref. No. O 20-2022
Tysslinge	Ref. No. O 25-2023
Total 4	

Compulsory Psychiatric care	
Region Norrbotten, Psykiatrin lCounty-wide Psychiatry in Öjebyn	Ref. No. O 4-2023
Region Västra Götaland, Södra Älvsborgs Hospital, Psychiatry Department	Ref. No. O 10-2023
Total 2	

Migration detention centres	
Mölndal	Ref. No. O 3-2023
Total 1	

Total 12 unannounced inspections

Inspections announced in advance

Police custody	
Umeå	Ref. No. O 12-2023
Total 1	

The Swedish Customs	
Lernacken Checkpoint Malmö	Ref. No. O 22-2023
Total 1	

Totalt 2 inspections announced in advance

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