

United Nations
Office of the High Commissioner for Human Rights

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8.8.2025

Reference: Concluding observations on the eighth periodic report of Finland, Information from Finland on follow-up to the concluding observations 10.5.2025

CONTRIBUTION FROM THE FINNISH NATIONAL PREVENTIVE MECHANISM

The Parliamentary Ombudsman of Finland would like to comment on the information provided by the State party on the follow-up to the concluding observations.

The comments chiefly focus on police detention facilities, and the people who have been deprived of their liberty and in the custody of the police.

II. Follow-up information on the concluding observations (cat/c/fin/co/8)

Fundamental legal safeguards

Information relating to paragraph 15

The right to inform a family member, or another person of their choice, of their detention within 48 hours.

1. It is the view of the Parliamentary Ombudsman of Finland that the legal safeguards of persons who have been deprived of their liberty and are in the custody of the police are sufficiently secured with regard to giving notifications at the level of the law and in the instructions of the National Police Board. This also applies to foreign nationals who have been deprived of their liberty and are held in the detention facilities of the police. On the other hand, there may be deficiencies in how different police departments and police detention facilities act in practice.

2. The apprehension-documents are also always reviewed during the NPM's inspection visit to police detention facilities. Such information as the notifications made to the family of a detained person should be recorded in documents. It has been observed in this context that there is variation in the entries made. They can be deficient, or they have not been made at all. For example, in the case of a minor who was deprived of their liberty no entry has been made on the notification made to their guardian. However, the National Police Board's instructions on the treatment of a persons in police custody (2020/2013/5490) obligates the entry of information on all notifications to the information system. The apprehension documents do not have a separate section for entries on these notifications or for ,those on the use of an interpretation service.
3. It should be noted that the National Police Board also carries out unannounced legality inspections to police detention facilities. The reports drawn up on these inspections are submitted to the Parliamentary Ombudsman. During these inspections, documents are also reviewed.

The right to request and receive adequate health care, including a medical examination by an independent medical doctor free of charge, or by a doctor of their choice, upon request.

4. Under the Act on the Treatment of Persons in Police Custody (the Police Custody Act), persons who have been deprived of their liberty have the right to access the health and medical care they need in police custody. The Ombudsman states that this is not necessarily realised in all police detention facilities.
5. According to the Police Custody Act, a person deprived of their liberty must also be reserved the opportunity to guidance, support, and other care by a psychologist whenever possible. The Ombudsman is not aware of whether the services of a psychologist have been arranged for detainees in police detention facilities.
6. Health care for detainees in police detention facilities has in most cases been arranged so that the police custodial officers of the detention facility ensure that detainees receive their medication prescribed for them outside the detention facility and that an emergency care unit is called to the facility in acute situations. The Ombudsman has recommended that these police departments at least assess the need for regular visits by a nurse.
7. Under the Police Custody Act, the health care and medical treatment that must be provided to detainees does not include the medical examination upon arrival. In spite of this, the Ombudsman recommended that all police departments should try to ensure that all persons detained for longer than 24 hours get to see a healthcare professional.
8. In 2017, the National Police Board sent a guidance letter to police departments. The letter outlines the practices for observing the

Ombudsman's recommendations given during inspection visits to police detention facilities. The aim has been to integrate these into practice at police detention facilities. The letter also stated that the instructions on the treatment of persons in police custody will only be updated once the reform of the Police Custody Act is adopted. The overall reform of the Police Custody Act has been underway from 2015, and it is not included in the current Government Programme. The validity of the instructions referred to in the letter have been extended to 31 December 2025 without any update.

9. The National Police Board's guidance letter also mentioned the Ombudsman's recommendation on how all detainees who have been in custody more than 24 hours should meet a healthcare professional. The National Police Board has stated that as the law does not obligate this, police departments can continue to act at their own discretion on a case-by-case basis. In practice, this has meant that detainees are not provided a medical examination at the time they arrive at any police detention facilities, not even at those where a healthcare professional visits regularly.
10. However, an amendment was made to the Police Custody Act in 2019, which requires that an examination by a physician or other healthcare professional should be conducted on request for detainees under the age of 18 without undue delay unless it is obviously unnecessary to carry out the examination. It should be noted that the aforementioned instructions by the National Police Board, which are from 2014 and are still valid have no mention of this right.
11. According to the Police Custody Act, a detainee also has the right at their own cost to receive health care in the detention facility with the permission of a physician arranged by the police. The instructions by the National Police Board mentioned above also note that all detainees must be told of this right at the time they arrive at a detention facility. In spite of this, it has been observed during the Parliamentary Ombudsman's / NPM's inspection visits that the people working at police detention facilities are not aware of this right or have neglected to mention it, as it is entered into the documents that a detainee is given upon their arrival. There is also variation in whether the detainee is even given all the information they are entitled to in writing. It is the understanding of the Ombudsman that detainees rarely ask for permission to receive health care at their own cost. It is difficult to determine how much an impact it has that a detained is not aware of this possibility.

The right to have the confidentiality of medical examinations respected.

12. The detainee also has the right to confidentiality with the healthcare personnel who treat them. The Government proposal (HE 90/2005 vp) that led to the Police Custody Act states that the police must make efforts to organise the supervision of examinations of the detainee and conversations between the detainee and healthcare personnel in such a way that this does not violate the protection of the detainee's privacy. However, at the same time, the police have an obligation to ensure the safety of healthcare personnel. Therefore, the police have

the right to supervise detainees also while they receive health care, of there is a justified reason for this. The grounds for the supervision of a health care situation may be the risk that the detainee will escape or a request by a member of healthcare personnel.

13. During inspection visits of police detention facilities, the Ombudsman has also emphasised the right to confidentiality in the relationship between detainees and healthcare professionals. Taking safety aspects into account, the violation of the protection of the patient's privacy must be minimised with all available means.
14. Notwithstanding what is stated above, it seems that confidentiality is not realised in health care provided in police detention facilities, in the manner intended when the Police Custody Act was adopted. Healthcare professionals usually meet with a patient in their own cell. The detention facility's guard either remains in the cramped cell to supervise, or the door of the cell is left open and the guard is within hearing distance. Even in those police detention facilities where a physician or other healthcare professional visits regularly, do not have a separate space for appointments with healthcare personnel.
15. The Ombudsman has commented on the safety of the appointment situation during one inspection visit of a detention facility. The Ombudsman stated that when a healthcare professional can meet a patient in a properly equipped reception room and safety aspects have been taken into account, the safety of personnel and the patient's privacy are substantially better than when the healthcare professional must meet the detainee in their cell. The Ombudsman has given a recommendation that this type of reception rooms be built in police detention facilities that have otherwise undergone renovation.

Adequate and regular training for those involved in detention activities on legal safeguards.

16. The Ombudsman has required that the personnel working in police detention facilities have an understanding of the legislation and administrative guidelines that apply to detainees. It is the understanding of the Ombudsman that the personnel working in police detention facilities is given orientation training when they begin working at a facility, which also covers the rights and obligations of the detainee. In addition to this, police departments organise first aid training, use of force training, and administration of medicines training regularly for personnel working in police detention facilities.
17. In this section of its report, the State of Finland has stated the following: The legality of guarding and detention activities is supervised both by the police and by the Chancellor of Justice. In this context, the Ombudsman would like to clarify that the Chancellor of Justice does not supervise police detention facilities, although they have the competence to do so. The Act on the division of responsibilities between the Chancellor of Justice and the Ombudsman provides that the Ombudsman holds responsibility for all matters related to detainees and thus also supervision of police detention facilities.

Detention of remand prisoners in police detention facilities

Information relating to paragraph 17

Placing remand prisoners in police detention facilities.

18. The aim is to transfer responsibility for the custody of all remand prisoners to the Prison and Probation Service of Finland, so that those suspected of an offence would not be detained in police detention facilities for more than 96 hours. As is stated in the State of Finland's report, the implementation of this objective has been delayed due to the continuous overpopulation of prisons. At the moment, it is not known when the custody of remand prisoners in police detention facilities will come to an end. The number of prisoners has continued to grow, as stated in the new Prison and Probation Service of Finland 2024 year book
<https://www.rikosseuraamus.fi/en/index/topical/pressreleasesandnews/2025/numberofpeopleservingprisonsentencesorcommunitysanctionscontinuedtorise-statisticalyearbook2024published.html>
19. An additional appropriation was granted to the Prison and Probation Service of Finland on 30 April 2025 for the purpose of adding inmate places and to cover the personnel needs related to these. According to a calculation by the Ministry of Justice, the appropriation will allow around 400 new inmate places. The Prison and Probation Service of Finland has estimated that by 2023, more than 1,000 new inmate places and approximately 670 person years will be needed.

Measures necessary to improve the detention conditions of remand prisoners held in police detention facilities.

20. Detainees in custody at police detention facilities must be given the opportunity to spend at least one hour a day outdoors. The Police Custody Act does not contain provisions on what the time spent outdoors must entail and on what the outdoors space should be like. On the other hand, international provisions concerning prisoners, such as the United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules) and the European Prison Rules, require that a prisoner must get at least one hour of suitable exercise in the open air daily.
21. During the NPM inspection visits it has been found that the outdoor facilities at police detention facilities do not comply with being outdoors and it is hardly ever possible to exercise in these areas. During a visit to Finland in 2020, the European Committee for the Prevention of Torture (CPT) found that none of the police detention facilities it visited was suited for long-term housing, in particular because of the lack of activities. In addition, during none of the visits was there a space at the police prison where detainees could genuinely spend time outdoors. Most so-called outdoor spaces were just large cells that were partly open to the outdoors.

22. During the Parliamentary Ombudsman / the NPM inspection visits in recent years it has been found that the outdoor spaces at police detention facilities have become more and more closed. It seems that their purpose is more to allow for smoking than for spending time in the open air. According to information we received, the National Police Board has developed a police station building concept and new open-air spaces have been implemented in this. Detainees do not have any other activities outside their cell at police detention facilities.
23. The Ombudsman has for quite some time reminded police departments that detention facilities should be accessible. The Ombudsman has emphasised that accessibility aspects must be taken into account already at the time new detention facilities are designed and constructed. The Ombudsman has also recommended that police departments carry out an accessibility survey for their detention facilities.
24. In 2024, the Ombudsman issued a decision on a complaint involving the violation of human dignity regarding a person with disabilities in a police prison (151/2023). The Ombudsman proposed that the State of Finland compensate the complainant for any violations committed against them. The Ombudsman also drew the serious attention of the National Police Board and the Ministry of the Interior to the deficiencies of the police prison in question. Based on the reports received in the matter, the Ombudsman took the own initiative to investigate the accessibility of police detention facilities (6945/2024).

III. Information on other follow-up measures

Condition of detention

Information relating to paragraph 22

The Committee is concerned about reports that, in a number of places of deprivation of liberty, health-care services, in particular mental health services, remain inadequate, and that recreational and educational activities to foster the rehabilitation of detainees remain limited, in particular for remand prisoners and prisoners in need of protection (so-called “fearful” inmates), who are reportedly subjected to a very restrictive regime that is akin to solitary confinement.

25. At her own initiative, the Deputy-Ombudsman investigated the availability and accessibility of psychiatric treatment to prisoners (64/2024). In her decision, the Deputy-Ombudsman stated that the need for mental health services among prisoners is significantly higher than what they can be provided with. The Deputy-Ombudsman's decision criticises shortcomings in the availability of and access to psychiatric care for prisoners. The availability of psychiatric care is not at the level required to meet the need for care, and prisoners' right to sufficient health services is not realised in the manner required by law. This is partly due to insufficient resources and lacking or inappropriate facilities. The Health Care Services for Prisoners cannot with its own

actions alone improve the availability of treatment. Instead, the issue is at least in part due to imbalance between the requirements set for authorities and the resources appropriated to authorities. According to the Deputy-Ombudsman, the accountable ministry plays a central role. The Deputy-Ombudsman has requested that all measures will be taken without delay to improve the situation. The decision has been sent to the Ministry of Social Affairs and Health and the Ministry of Justice with the aim of investigating how referring of prisoners to mental health care services and the availability of these services could be improved.

26. The possibility of prisoners to access help and support for mental health problems has further declined. It is the view of the Prison and Probation Service of Finland that it is not responsible for organising health care of prisoners, and this is solely the responsibility of the Health Care Services for Prisoners. For this reason, starting 1 June 2025, the Prison and Probation Service has modified the job description of prison psychologists. In the future, the prison psychologist's job description will not include mental health work. The Health Care Services for Prisoners unit has only four psychologists, who all work in hospitals. The Ombudsman is not aware of whether The Health Care Services for Prisoners has the capacity to replace the psychologists now eliminated and in what time frame this would happen.

Deaths in custody

Information relating to paragraph 25 (a, c)

The State party should ensure that all deaths in custody are promptly, effectively, and impartially investigated by an independent entity, including by means of independent forensic examinations. The State party should also compile detailed information on cases of death in all places of detention and their causes and the outcomes of the investigations into the deaths.

27. Unfortunately, deaths also occur in police detention facilities; 10-20 in general per year in the past few years. The Parliamentary Ombudsman has examined the investigation, monitoring, and prevention of deaths that have occurred in police custody (4103/2016). The Ombudsman has also monitored what measures the Ministry of the Interior and the National Police Board have undertaken after this. In their decision, the Ombudsman states that there are still no reliable data available on the number of deaths in police detention facilities. In addition, the Ombudsman believes that there is a need to invest in the assessment of the cases to develop operations.
28. In December 2024, the National Police Board announced that it was updating its instructions (Instructions on the treatment of a persons in police custody and instructions on the notifications, investigation and

statistics related to the death of a detainee). The instructions will be combined into one administrative standard.

29. In December 2024, the Ministry of the interior announced that the data of the police and prosecutors on the number of deaths in police custody have varied from one another for the most part because the definitions for a death in police custody are different. The new instructions will see the adoption of a harmonised definition for death in police custody. In addition, statistics on deaths in police custody and their analysis will be transferred from the Police University College to the National Police Board.

In this section of its report, the State of Finland has stated the following: All deaths in custody are investigated by an independent police unit under the Ministry of the Interior and the Parliamentary Ombudsman. In this context, the Ombudsman wants to emphasise that the Parliamentary Ombudsman does not investigate all deaths that take place in police custody. The Ombudsman can investigate individual deaths, if a complaint is submitted to the Ombudsman concerning the death or if the Ombudsman finds at their own initiative that there is need for an investigation. The police are always notified of deaths of detainees, who will conduct a medico-legal determination of cause of death. The police must notify the prosecutor of deaths, if these have happened in police detention facilities, or the person has been otherwise in the custody of the police at the time of their death.

30. The Ombudsman has felt it is necessary for at least the data on the number of deaths in police custody to be submitted to the Ombudsman. At the moment, this information is difficult to access as the aforementioned example of a deaths in police detention facilities indicates. On 10 June 2025, the Deputy-Ombudsman conducted an inspection at the Finnish Institute for Health and Welfare concerning health care of prisoners. At the same time, the Ombudsman presented a request that the Finnish Institute for Health and Welfare, which is an expert and research institute investigate how it would be possible for the Ombudsman to access reliable information on the deaths of prisoners. The Ombudsman feels it is important in particular for this information to be available on cases where detainees have committed suicide or attempted to commit suicide. This would help authorities to form a general picture of the situation and to intervene if there is an increase in numbers.

Parliamentary Ombudsman as the National Preventive Mechanism

31. The Parliamentary Ombudsman receives 6,000 - 7,000 complaints a year. About half of these complaints are processed with the accelerated procedure. The complaints wherein the Ombudsman can help the complainant or take other measures will be investigated. The aim is to assist the complainant, where possible, by recommending that an error that has been made be rectified, or that compensation be paid for an infringement of the complainant's rights.
32. Decisions that lead to measures and the NPM's visit reports contain a request for the authority who is the subject of the complaint or inspection visit and sometimes also the ministry in question to notify the Ombudsman by a given deadline of the measures they have undertaken due to the findings of the decision or visit report. All NPM visit reports and a large share of decisions that have led to measures are published on the Ombudsman's website.
33. The Parliamentary Ombudsman publishes an annual report detailing its activities. The number of decisions and the actions by the Parliamentary Ombudsman of Finland as well as summaries by various administrative branches on their main topics during the year under review. The NPM annual report on inspection visits is included in this annual report, and the English Summary of the Annual Report will always also be submitted to the UN Subcommittee on Prevention of Torture.
34. The English language-summary for the Parliamentary Ombudsman's annual report will be completed in the autumn. Please see the link below to the Parliamentary Ombudsman's English website, where the Ombudsman's annual reports for previous years are available:
<https://www.oikeusasiamies.fi/en/toimintakertomukset1>

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This document has been approved in the case management system.