JO RIKSDAGENS OMBUDSMÄN

Chief Parliamentary Ombudsman
Elisabeth Rynning

OFFICIAL LETTER

Submission to the UN Committee against Torture for the review of Sweden's eighth report on its compliance with the UN Convention against Torture

1 Background

1. In a letter received on 10 December 2019 from the UN Committee against Torture (CAT), the Parliamentary Ombudsmen was given the opportunity, in its capacity as National Preventive Mechanism (NPM), to provide a submission prior to the review of Sweden's eighth report on its compliance with the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UN Convention against Torture). I appreciate the opportunity to provide this submission before the forthcoming review.

2. The Swedish office of the Parliamentary Ombudsmen was established in 1809. The Parliamentary Ombudsmen is assigned by the Swedish Parliament to ensure that public agencies and courts comply with the provisions of the Swedish constitution on impartiality and objectivity, and that public activities do not infringe upon citizens' fundamental rights and freedoms. In addition, the Parliamentary Ombudsmen supervises the application of laws and other regulations in public activities. The Chief Parliamentary Ombudsman and three Parliamentary Ombudsmen are elected by the Swedish Parliament and are completely independent in their decisions. The institution has around 80 employees, the majority of whom are lawyers. The Ombudsmen have their respective areas of responsibility and, since January 2020, the allocation is as follows:

- Chief Parliamentary Ombudsman Elisabeth Rynning has supervision of, inter alia, the general administrative courts as well as health care, including compulsory psychiatric care and forensic psychiatric care. (Until 31 December 2019, the Chief Parliamentary Ombudsman had supervision of the Swedish Prison and Probation Service.)

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- Parliamentary Ombudsman Thomas Norling has supervision of, inter alia, the Swedish National Board of Institutional Care and its residential homes for young people and homes for the care of substance abusers.
- Parliamentary Ombudsman Katarina Påhlsson has supervision of, inter alia, the general courts and the Swedish Prison and Probation Service.
- Parliamentary Ombudsman Per Lennerbrant has supervision of, inter alia, public prosecutors and the Swedish Police Authority as well as the Swedish Migration Agency.

3. The Parliamentary Ombudsmen's supervision can be prompted by complaints received from the public and through own initiatives. The Parliamentary Ombudsmen also regularly inspects courts and agencies, including such areas where individuals may be deprived of their liberty. In their decisions, the Parliamentary Ombudsmen have the right to make statements that act as guidance, and contribute to the uniform and appropriate application of the law. In addition, the Parliamentary Ombudsmen can make representations to the Swedish Parliament or Government on legislative amendments. The Parliamentary Ombudsmen also makes statements regarding legislative proposals.

2 The Parliamentary Ombudsmen's preventive work in their capacity as National Preventive Mechanism

4. Since 2011, the Parliamentary Ombudsmen have carried out their assignment as a National Preventive Mechanism (NPM) in accordance with the Optional Protocol to the UN Convention against Torture (Opcat). All four Parliamentary Ombudsmen are responsible for the mandate and a special Opcat Unit supports them in their work. Six lawyers work at the unit. In addition, a medical expert (psychiatrist) and an expert in psychology are used if necessary. In my capacity as Chief Parliamentary Ombudsman, I have an administrative responsibility for the Opcat Unit.

5. Since CAT's last periodic review of Sweden in 2015, the Parliamentary Ombudsmen have carried out an average of 25 inspections per year of places where people are held deprived of their liberty. The results of the Parliamentary Ombudsmen's Opcat work are reported in particular in the official report that the Ombudsmen submit each year to the Committee on the Constitution of the Swedish Parliament.

6. Inspections form the core of the Parliamentary Ombudsmen's work in preventing violations of the rights of individuals deprived of their liberty. In its preventive work, the Parliamentary Ombudsmen also uses other methods such as dialogue meetings with representatives of the agencies that we examine. In my opinion, these meetings are an effective tool for following up the implementation of the preventive recommendations that the Parliamentary Ombudsmen makes in connection with its inspections and decisions.

7. I would like to emphasise that the Parliamentary Ombudsmen's regular supervisory activities, the Parliamentary Ombudsmen's representations on legislative amendments and the Parliamentary Ombudsmen's opinions on legislative proposals also have an important preventive effect. Through the complaints made by the public, the Office of the Parliamentary Ombudsmen receives a lot of information concerning, inter alia, the situation for people deprived of their liberty, and the Office of the Parliamentary Ombudsmen has a very long experience within the framework of its regular supervisory activities of inspecting operations at facilities where people may be held deprived of their liberty.

8. In early 2020, I decided to establish a special dialogue forum with representatives from civil society on issues relating to the rights and situations of individuals deprived of their liberty. The purpose of this forum is for the Parliamentary Ombudsmen to be able to have a regular exchange of information and experiences with civil society actors who have a mission or interest in preventing violations of the rights of individuals deprived of their liberty. The first meeting took place in March and a second meeting was held in September. The intention is to hold two meetings per year.

3 The content of the submission

9. Based on the Parliamentary Ombudsmen's work, I would like to present a number of factors that are important for Sweden's compliance with the UN Convention against Torture. This presentation mainly follows the questions posed by CAT. Where applicable, the numbering of the paragraph in CAT's list of issues is indicated in the heading in parentheses. Finally, I address a number of other aspects that are important. There are also a number of other observations and statements made by the Ombudsmen within the framework of the assignment as NPM. For a more complete account of our work, I would like to refer you to the reports attached to this opinion. The topics I wish to address here are:

a) Access to health care in police custody (paragraphs 10–16)
b) Isolation of inmates held on remand (paragraphs 17–30)
c) The risk of isolation in other institutional activities
    Inmates in residential homes for the care substance abusers and residential homes for young people (paragraphs 32–34)
    Patients receiving compulsory psychiatric care or forensic psychiatric care (paragraphs 35–38)
d) Self-harming incidents in police custody facilities (paragraphs 40–43)
e) Conditions for foreigners in migration detention (paragraphs 44–50)
f) Other questions
    Safety and security for inmates at residential homes for young people (paragraphs 52–58)
    Transportation of inmates deprived of their liberty (paragraphs 59–66)
    Deprivation of liberty with no legal basis (paragraphs 67–68)

Situation for inmates in connection with Covid-19 (paragraphs 69–71)

With the exception of the last section, each section ends with a number of conclusions drawn by the Ombudsmen based on the observations and statements made.

4 Access to health care in police custody facilities (paragraph 3 b)

10. CAT has asked the Swedish Government which measures have been taken to ensure that all individuals deprived of their liberty are guaranteed access to health care.[1] In its response, the Swedish Government has only reported on the conditions in the Swedish remand prison system.[2] In this context, I note that in its final comments in the sixth and seventh reports examining Sweden's compliance, CAT expressed concern that details had emerged showing it remained the case still that individual police officers decided whether individuals held in police custody should have access to health and medical care.[3] For this reason, I find reason to submit an account of the information that has emerged regarding this issue from the Parliamentary Ombudsmen's work.

4.1 In general, police custody facilities do not have constant access to healthcare personnel

11. In addition to individuals apprehended or arrested on suspicion of a crime, the Swedish Police Authority's custody facilities also receive individuals taken into custody due to intoxication in accordance with the Act on Care of Intoxicated Persons (1976:511). This concerns short-term care (usually no more than eight hours). It is not uncommon for the persons taken into custody due to intoxication to have a history of alcohol and/or substance abuse, and to therefore be in poor physical and mental condition.

12. With a few exceptions, police custody facilities do not have constant access to healthcare personnel. In order for an individual held to have contact with a nurse or doctor, the Swedish Police Authority must either contact the public health service, which then sends health or medical staff to the custody facility, or take the individual to a healthcare establishment. In several cases, the Parliamentary Ombudsmen have drawn attention to situations when the Swedish Police Authority has been in breach of its responsibility to satisfy individuals' right to health care.

13. I would like to highlight three cases concerning the situation of individuals taken into care in accordance with the Act on Care of Intoxicated Persons (1976:511) who were placed in police custody. In the first case, a woman died

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[1] See CAT/C/SWE/QPR /8 paragraph 3 b.
[2] See CAT/C/SWE/8 paragraph 9.
[3] See CAT/C/SWE/CO/6-7 paragraph 7.

after she fell and hit her head in a cell whilst in police custody in Borlänge.[4] The staff at the police custody facility did not call medical personnel and it took several hours after she fell before she was taken to hospital. In the second case, it emerged that the Swedish Police Authority had not called a doctor to the police custody facility in Luleå after an individual taken into care in accordance with the Act on Care of Intoxicated Persons (1976:511) tried to take her own life.[5] The then Parliamentary Ombudsman Cecilia Renfors stated that it must never be case that a perfunctory assessment of an individual's health condition is made simply because he or she is heavily intoxicated or acting out. It must also not be the case that the health service is not contacted solely on the basis of a general perception that it does not want to receive an intoxicated person. In the third case, the station commander at the police custody facility in Östersund made the assessment that it was not appropriate for an individual taken into care to take the medication he was prescribed.[6] The then Parliamentary Ombudsman Cecilia Renfors stated that, since the premise is that an individual who has a prescription for certain medicine should have access to it, the station commander should have consulted a doctor regarding the appropriateness for the individual taken into care to take the medicine in the condition he was in.

14. When the Act on Care of Intoxicated Persons (1976:511) was introduced in the mid-1970s, the intention was to create conditions for a more humane level of care for intoxicated individuals. In the view of the then Parliamentary Ombudsman Cecilia Renfors, this intention has not been achieved and, as such, individuals who are taken into care due to intoxication should, as a general rule, be placed under medical supervision and not taken into police custody.[7] For this reason, on 22 September 2017, she made a representation to the Government to review the legislation. No such review has taken place yet.

15. The Swedish Police Authority is currently running a project on the handling of intoxicated individuals and in May 2020 a report was published.[8] It shows, inter alia, that 11 of the 21 regions in Sweden completely lack places for individuals to sober up in a healthcare facility. The compilation shows that, for example, there are no places for sobering up in Sweden's second largest city - Gothenburg with just under 600,000 inhabitants – and that in Sweden's third largest city – Malmö with just over 300,000 inhabitants – there are only two places for sobering up in healthcare facilities. Approximately 60,000 people are

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[4] See the Parliamentary Ombudsmen's report 2018/19 p. 352 (2468-2016). The matter is also mentioned in Annex 4 to the Swedish Government's report to CAT.
[5] See the Parliamentary Ombudsmen report 2018/19 p. 361 (5864-2016).
[6] See the Parliamentary Ombudsmen report 2019/20 p. 327 (3622-2017).
[7] See the Parliamentary Ombudsmen report 2018/19 p. 352 (2468-2016).
[8] The Swedish Police Authority, Health care interventions for individuals taken into custody in accordance with the Act on Care of Intoxicated Persons or are in custody for other reasons, 26 May 2020.

taken into care annually in accordance with the Act on Care of Intoxicated Persons (1976:511) and, in 2015, 88 per cent were placed in police custody.

4.2 Conclusions

16. On a number of occasions, the Parliamentary Ombudsmen have drawn attention to the risks involved in placing intoxicated individuals in police custody and has made a representation to the Swedish Government concerning the need for a review of the legislation. The review requested by the Parliamentary Ombudsmen should be conducted.

5 Isolation of inmates in the remand prison system (paragraphs 18 and 19)

17. For a number of years, the Parliamentary Ombudsmen have worked in various ways with the issue of the isolation of inmates in the Swedish Prison and Probation Service's remand prison regime. Part of the work has been to follow up on the criticism that, inter alia, CAT and the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) directed at Sweden. Between 2015 and 2019, the Parliamentary Ombudsmen carried out 31 inspections of the Swedish Prison and Probation Service's remand prison regime. As mentioned above, until 31 of December 2019 the Swedish Prison and Probation Service was under my supervision. On several occasions, I have highlighted the deeply unsatisfactory fact that the agency does not have a reliable system for the uniform measurement of, and follow-up on, the use of isolation-breaking measures.[9] This lack of reliable statistics makes it difficult to follow the isolation-breaking work that takes place at the local level over time and to compare different years. In December 2018, I decided to follow up on, inter alia, the issue of isolation in an own-initiative inquiry. In a decision on 5 February 2020, I directed very serious criticism at the Swedish Prison and Probation Service for the isolation of inmates within the agency's remand prison regime.[10] The decision is also at the core of the special report on the isolation of inmates attached to this submission.

5.1 The Swedish Prison and Probation Service has difficulty satisfying inmates' rights of association with others

18. In my decision of February this year, I stated that inmates who have not had limitations in their contacts with the outside world, so-called restrictions, imposed by a prosecutor, or are segregated by the Swedish Prison and Probation Service, have a statutory right to associate with other inmates during the day. Despite this, measurements by the Swedish Prison and Probation Service in 2018 showed that 33 per cent of these inmates had received less than two hours

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[9] See, for example, the Parliamentary Ombudsmen's inspection report, 416-2017, and the Parliamentary Ombudsmen report 2018/19 p. 146 (5969-2015).
[10] See the Parliamentary Ombudsmen's decision on 5 February 2020, O 7-2018.

of interpersonal contact per day. This meant that a not insignificant proportion of inmates who had the right to associate with others were instead isolated in conditions amounting to solitary confinement and, as a result, risked suffering negative consequences.

19. The inquiry revealed that one of the decisive reasons for the Swedish Prison and Probation Service's difficulties in satisfying inmates' rights to associate with others is that the number of remand prison places with access to adequate communal space does not correspond to the needs. Another reason why not all inmates can be offered association time with others, and that there are shortcomings in the work with isolation-breaking measures, is that the agency does not have sufficient staffing levels to perform these tasks. During the inspections, details emerged that members of staff assigned to work with isolation-breaking measures are used for other tasks. An exacerbating problem in this regard is the current overcrowding in the Swedish Prison and Probation Service's remand prison regime (see further under paragraph 26).

5.2 A majority of inmates held with restrictions are isolated

20. With regard to isolation-breaking measures, the Swedish Prison and Probation Service's own measurements show that the majority of inmates who have restrictions, or are segregated with a basis in law, are isolated. As such, they are not given the opportunity of at least two hours of interpersonal contact per day. The measurements from 2018 show that only 17 per cent of inmates with restrictions received isolation-breaking measures to the extent that they were not isolated. I stated that this is not a new situation and that Sweden has received international criticism for the isolation of inmates held on remand for several decades. In my opinion, there is a fear that the measures that the Swedish Prison and Probation Service can and must take will not be sufficient in solving the problem of the high degree of isolation that currently prevails in the agency's remand prison regime. At a dialogue meeting in March 2019, representatives of the Swedish Prison and Probation Service stated that they unfortunately believe that the amount of time inmates receive isolation-breaking measures will not increase more than marginally, despite the fact that Sweden has a relatively high staff density when compared internationally.

5.3 Even in modern remand prisons, inmates are isolated

21. In its opinion to CAT, the Swedish Government argued that the Swedish Prison and Probation Service has difficulty breaking the isolation of inmates due to the fact that the agency's older remand prisons lack adequate communal spaces.[11] In January 2020, Parliamentary Ombudsman Katarina Påhlsson inspected one of the Swedish Prison and Probation Service's more modern

[11] See CAT/C/SWE/8 paragraph 112.

remand prisons.[12] The inspection revealed that Sollentuna Remand Prison, which opened in 2011, could not satisfy its inmates' rights of association with others. The statistics collected during the inspection showed that many inmates in the remand prison spent time alone without meaningful human contact for more than 22 hours per day and were, thus, isolated in conditions amounting to solitary confinement. This also applied to young inmates. It could be stated that there were significant shortcomings in the remand prison's measurements of the use of isolation-breaking measures. For example, not all departments had measured the use of isolation-breaking measures and some departments had not reported their measurements. Furthermore, there was some uncertainty amongst both staff and management concerning what was considered as an isolation-breaking measure. As a result, Parliamentary Ombudsman Katarina Påhlsson questioned how the remand prison's management was able to work systematically with isolation-breaking measures.

22. During the inspection, it was also noted that a number of inmates who were suspected of sexual or relationship offences were segregated due to security reasons. The remand prison made the assessment that their safety would be jeopardised if they were placed in one of the remand prison's association departments. After the inspection, Parliamentary Ombudsman Katarina Påhlsson stated that she understood the Swedish Prison and Probation Service must take measures to protect inmates who are held on remand due to a suspicion of, for example, sexual offences. However, in her opinion, it is doubtful whether such an application of the provisions of the Remand Prisons Act (2010:611) on segregation is compatible with the legislator's intention and emphasised that it should be the individual or individuals who pose a threat to a fellow inmate, are violent or otherwise pose a security risk who should be placed in segregation.

23. According to the Parliamentary Ombudsman Katarina Påhlsson, the current problem means that there is reason for the Swedish Prison and Probation Service to establish more special departments where inmates, who are under threat whilst on remand due to the suspicions against them, can have their right to associate with other inmates met. She was critical of the fact that the Swedish Prison and Probation Service's own shortcomings – the lack of association places – in this way led to further restrictions of remand prisoners' freedoms during their remand period.

5.4 Inmates who are segregated with no legal basis

24. During the inspection of Sollentuna Remand Prison, there were also 21 inmates on the remand prison's segregation list who were described as

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[12] See the Parliamentary Ombudsmen's inspection report, O 5-2020.

"segregated at their own request". These were inmates who were not subject to restrictions, but who, for various reasons, did not want or dare to associate with other inmates. Parliamentary Ombudsman Katarina Påhlsson stated that the Remand Prisons Act (2010:611), unlike the Prisons Act (2010:610), does not provide a legal basis for segregating an inmate at their own request. In the view of the Parliamentary Ombudsman, the fact that the remand prison reported the inmates as segregated at their own request gave the impression that the Swedish Prison and Probation Service had a legal basis for the measure. Furthermore, this categorisation creates the risk that the staff did not work actively to try to change the situation for the individual inmates. In the view of Parliamentary Ombudsman Katarina Påhlsson, the remand prison has a great responsibility to ensure that inmates do not withdraw from associating with others and that staff make daily efforts to try to improve the conditions for these inmates. It is not sufficient that – as described during the inspection – staff ask the inmate every ten days if he wants to associate with other inmates.

25. I would also like to highlight that, in a decision on 19 December 2017, I drew attention to the fact that inmates were segregated with no legal basis at the Swedish Prison and Probation Service's high-security prison departments.[13] Such situations arose when the agency did not find another inmate who was deemed suitable to be placed with the inmate in question. I stated that, in these cases, the inmates would also find it difficult to have their segregation placement reviewed. In the light of the ambiguities that I considered to exist regarding the legal preconditions for placing inmates in such circumstances, I made a representation to the Swedish Government to review the legislation. Within the framework of an own-initiative inquiry, an investigation is underway into the preconditions for placing other groups of convicted inmates, other than those with a decision on a high-security placement, in the Swedish Prison and Probation Service's special high-security prison units.[14] On 14 June 2018, I made another representation in which I drew the Government's attention to the need for, inter alia, introducing provisions in the Remand Prisons Act (2010:611) that which would require the Swedish Prison and Probation Service to review decisions on segregation at specific time intervals.[15]

5.5 The Swedish Prison and Probation Service has operated the remand prison system in deficient premises

26. It should also be highlighted that, on several occasions over a number of years, the Parliamentary Ombudsmen have made statements regarding the Swedish Prison and Probation Service conducting remand activities in the Swedish Police Authority's custody facilities in Halmstad and Östersund. In

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[13] See the Parliamentary Ombudsmen report 2018/19 p. 218 (7488-2016).
[14] See the Parliamentary Ombudsmen's ref. no. 1950-2019.
[15] See the Parliamentary Ombudsmen report 2018/19 p. 146 (5969-2015).

these premises, it has been difficult to satisfy the right to associate with others and the need for isolation-breaking measures.[16] There is currently a strained occupancy situation in the Swedish prison and remand prison regimes. This has led to the Swedish Prison and Probation Service starting to regularly double-occupy cells in both remand prisons and prisons. Due to this strained occupancy situation, the Swedish Prison and Probation Service has established, or intends to establish, new remand prison branches in a number of police custody facilities.[17] The issue of overcrowding in the prison and remand prison regimes was in focus during a number of inspections in 2019 and the issue is currently being investigated by the Parliamentary Ombudsman Katarina Påhlsson.[18]

5.6 Conclusions

27. In my decision in February 2020, I made a representation to the Government for changes to both the Prisons Act (2010:610) and Remand Prisons Act (2010:611). In my opinion the following measures must be taken:

- The meaning of association with other inmates must be defined in both the Prisons Act (2010:610) and Remand Prisons Act (2010:611). It is necessary that this right is not given an arbitrary meaning. A reasonable starting point is that association means that an inmate spends time together with several other inmates.
- The Prisons Act (2010:610) and Remand Prisons Act (2010:611) must state the extent to which inmates have the right to associate with other inmates on a daily basis. It is not sufficient that it is stated only in the Swedish Prison and Probation Service's own regulations for prisons (KVFS 2011:1), and it is not acceptable that such provisions are completely absent for remand prisons.
- A provision needs to be introduced which guarantees that all inmates who are segregated from associating with other inmates receive isolation-breaking measures per day for a certain period of time. In my opinion, the minimum time should be set higher than the two hours proposed by the Remand Prison and Restrictions Government Inquiry.[19]

In the decision, I also emphasised that the Swedish Prison and Probation Service needs to take a uniform approach to ensure there is sufficient staff and adequate premises in all prisons and remand prisons so that inmates can be guaranteed the opportunity to associate with others or receive isolation-breaking

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[16] See the Parliamentary Ombudsmen's decision on 30 August 2018, 1387-2017.
[17] See https://www.kriminalvarden.se/om-kriminalvarden/nyheter/2020/juni/drygt-60-nya-platser-oppnas/ (read on 19 August 2020).
[18] See the Parliamentary Ombudsmen's ref.no. O 19-2019.
[19] See the Swedish Government Official Report (2016:52) Fewer people in remand and reduced isolation.

measures. I further emphasised that it is very important that the Swedish Prison and Probation Service receives a support system that makes it possible to follow the work with isolation-breaking measures over time.

28. The representations for a review of the legislation that I made in this area have been dealt with only to a limited extent to date. The Swedish Government has submitted proposals for certain changes to, inter alia, the Remand Prisons Act (2010:611). Unfortunately, the Government has chosen not to proceed with the important proposal submitted in an investigation that adults held on remand with restrictions should always have the right to associate with another person every day for at least two hours.[20] This is very problematic in light of the high proportion of inmates who are isolated in the Swedish Prison and Probation Service's remand prisons. This is a problem that not only exists in the Swedish Prison and Probation Service's older remand prisons as there are difficulties in these respects in the modern remand prisons too.

29. In many countries, for example Denmark, Germany and the Netherlands, there are limits as to how long a period of remand may last. There is no such time limit in Sweden today. Instead, any limit is seen to follow from the so-called the principle of proportionality that a period of remand may not last for an excessive amount of time. Sweden has received criticism from, inter alia, the CPT and CAT because there is no limit as to how long a period of remand may last. In 2016, a Swedish Government inquiry submitted proposals for remand periods to be limited.[21] In March 2020, the Government submitted a proposal to the Parliament that, as a general rule, a period of remand should not last more than six months. During the ongoing consideration of the Government's bill, the Parliament's Committee on Justice has proposed that the time limit should instead be nine months.[22] In an opinion regarding the Committee's proposal, Parliamentary Ombudsman Per Lennerbrant stated that time limits often induce action, which in turn creates an effective incentive for shorter lead times.[23] In the view of the Ombudsman, this relationship as well as Sweden's international commitments, inter alia, argued in favour of the proposed time limit of six months.

30. The difficulties that the Swedish Prison and Probation Service has had to date in breaking the isolation of inmates and satisfying the right of association with others, in conjunction with the strained occupancy situation, make it very likely that the problems of isolation will persist for several years to come.

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[20] See CAT/C/SWE/8 paragraph 114. The proposals that concern the Government were submitted in the Swedish Government Official Report (2016:52).
[21] See previously mentioned Swedish Government Official Report (2016:52).
[22] See the Parliament Committee on Justice's memorandum Extension of proposed time limits for remand, Committee's ref. 2019/20-2113.
[23] See the Parliamentary Ombudsmen's opinion on 28 August 2020 (R 72-2020).

6 The risk of isolation in other areas

31. Individuals deprived of their liberty at agencies other than the Swedish Prison and Probation Service may also be at risk of being isolated. This applies, for example, to inmates in the Swedish National Board of Institutional Care's residential homes for young people as well as patients who receive compulsory psychiatric care or forensic psychiatric care.

6.1 Inmates in residential homes for young people

32. In certain situations, the Swedish National Board of Institutional Care is able to prevent inmates from associating with other inmates. This can be done partly through a decision on separate care, and partly through a decision on segregation. On several occasions, the application of the provisions on separate care has attracted the attention of the Parliamentary Ombudsmen. An inspection of the residential home for young people in Sundbo revealed that the home received many young persons who had been relocated from other residential homes for young people.[24] According to the staff, it was not possible to place these young persons directly into a department. Therefore, they initially received separate care with the intention that the staff could "get to know" them. The young persons had access to the staff between 7.30 and 21.00, and for the rest of the time they were locked in their rooms. According to the management of the youth home, it was only possible to access the young persons if the night staff was reinforced by a so-called duty supervisor.

33. In a case concerning a 13-year-old in a residential home for young people who received separate care for a long time and finally took her own life, Parliamentary Ombudsman Thomas Norling stated that, if an inmate receiving separate care explains that he or she wants to be alone, then there is often good reason for the home to respect such a wish.[25] At the same time, there is a risk that separate care can result in the young person isolating him or herself. This kind of isolating effect from the type of care provided must be counteracted. With regard to children and young people receiving separate care, it is more or less natural that the home must actively counteract any tendency for separate care to become isolating. This places great demands on the staff to spend time with the child or young person, ensure that he or she is activated, see that he or she is given as much opportunity as is possible and appropriate to spend time with others who are cared for at the home and, for example, participate in any organised, joint activities. In the decision, the Ombudsman also stated that the Swedish National Board of Institutional Care had left the responsibility to the individual homes to ensure internal routines were developed regarding, for example, individuals' access to staff and how supervision is to be exercised. In

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[24] See the Parliamentary Ombudsmen's inspection report, 7107-2018.
[25] See the Parliamentary Ombudsmen report 2019/20 p. 502 (5302-2017).

the opinion of the Ombudsman, there was reason for the Swedish National Board of Institutional Care to consider whether the agency should draw up central guidelines that more clearly state in detail how care is to be carried out and how supervision is to be exercised.

34. During an Opcat inspection in 2019 of the residential home for young people in Långanäs, observations were made regarding the application of the provisions concerning separate care.[26] The home had a special department of four places for young people with neuropsychiatric disabilities, mental health problems and difficulties with social interaction who were acting out. A prerequisite for placement in the department was that a young individual admitted there received separate care. A mapping exercise carried out by the Swedish National Board of Institutional Care in 2017 showed that the average length of time for separate care in the department was 16 months. Following the inspection, Parliamentary Ombudsman Thomas Norling stated that the issue concerned the length of care periods, and that even after the Swedish National Board of Institutional Care's survey, young persons were given separate care for lengthy periods. The Ombudsman stated that there may be reason to reinvestigate the conditions at the department.

6.2 Patients receiving compulsory psychiatric care or forensic psychiatric care

35. A patient who receives compulsory psychiatric care or forensic psychiatric care has the right to associate with other patients. A patient may be segregated from other patients only if necessary on grounds that the patient, through aggressive or disruptive behaviour, seriously impedes the care provided to other patients. A decision on segregation is valid for a maximum of eight hours. The length of segregation may be extended by a maximum of eight hours by means of a new decision. If there are exceptional reasons, a decision on segregation pursuant to the first paragraph may allow a fixed period exceeding eight hours. The Chief Medical Officer decides on questions of segregation. If a patient is segregated for more than eight hours, the regular supervisory authority, the Swedish Health and Social Care Inspectorate, is to be notified without delay. During segregation, the patient must be under the constant supervision of healthcare professionals.

36. It can occur that patients are segregated from other patients for very long periods of time. In 2015, the Parliamentary Ombudsmen began to follow the issue of long-term segregation of patients. The issue was raised during inspections of Umeå Psychiatric Clinic in March 2015, Karsudden Regional Hospital for forensic psychiatric care in November 2015, Säter Forensic

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[26] See the Parliamentary Ombudsmen's inspection report, O 57-2019.

Psychiatric Regional Clinic in October 2016 and Stockholm Forensic Psychiatry Care, Section South, Helix in January 2019.[27]

37. In March 2019, I inspected Växjö Regional Forensic Psychiatric Clinic.[28] At the time of my inspection, there were four patients at the clinic in long-term segregation. The patient who had been segregated the longest had been there since October 2017. The patients were allowed to inter alia, periodically spend time with other patients on the ward, spend time by themselves on the hospital grounds or go shopping or for a coffee. They were then returned to segregation, without any new decision being made. During the conversations I had with the clinic's management, it was stated that the doctors discussed daily what could be done to lift the segregations. Furthermore, the management admitted that it needed to learn more from the 24 cases where the clinic had managed to conclude long-term segregations for patients. The clinic's management stated that the issue of long-term segregation of patients had been discussed in a network of chief medical officers in forensic psychiatry, but that they had not reached a consensus on how to work with these patients.

38. I would also like to highlight that, within the supervisory framework (inspections and complaint handling), I follow the issue of the use of other coercive measures, for example patients being held fastened with a belt.[29] In 2019, I chose to start a dialogue with the Swedish Health and Social Care Inspectorate, and raised, inter alia, the question of how the inspectorate, in its supervisory role, handles issues concerning the use of coercive measures in psychiatric and forensic psychiatric compulsory care.[30] At a dialogue meeting with the management of the Swedish Health and Social Care Inspectorate in September 2019, I emphasised that, from a legal perspective, it is completely unacceptable that patients are segregated with no basis in law. I asked the management of the Swedish Health and Social Care Inspectorate how the inspectorate deals with this in its supervision. In my opinion, the prevailing conditions sent a signal that it is possible to circumvent the rules and regulations if necessary, and this in turn risks leading to other rules being hollowed out. I have not yet made a decision on the matter.

6.3 Conclusions

39. The above shows that there is a risk that individuals deprived of their liberty will be segregated with no legal basis and risk being isolated, even in

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[27] See the Parliamentary Ombudsmen's inspection reports 1350-2015, 6308-2015, 5556-2016 and O 3-2019.
[28] See the Parliamentary Ombudsmen's inspection report, O 18-2019.
[29] The Ombudsman is currently investigating the use of restraint in the prison and remand prison system, see the Parliamentary Ombudsmen's ref. no. 279-2018.
[30] See the Parliamentary Ombudsmen's ref. no. O 60-2019.

facilities other than the prison and remand prison regimes. The Parliamentary Ombudsmen have highlighted the risks that this entails and, additionally, have ongoing cases concerning these issues. With regard to the long-term segregation of patients in compulsory psychiatric care, it should be noted that this issue was previously dealt with in a memorandum from the Swedish Government Offices.[31] It stated that patients are segregated "without it being possible to clearly state from the legislation that this may happen". In order to ensure the treatment of these patients follows the rule of law, the memorandum proposed that a new provision be added to the legislation which makes it possible to keep patients in long-term segregation. The proposal is yet to be implemented, which means that patients will continue to be kept in long-term segregation with no legal basis. This is, of course, very serious. There will be reasons for me to return to the issue of patients who are kept in long-term segregation in my decision following the review of the Swedish Health and Social Care Inspectorate.

7 Self-harming incidents in police custody (paragraph 20)

7.1 There are shortcomings in the layout of police custody cells

40. During inspections of police custody facilities, the Parliamentary Ombudsmen examine, inter alia, the occurrence of deaths and reports of inmates' attempts at self-harm. In January 2019, the Parliamentary Ombudsmen conducted an Opcat inspection of the police custody facility in Luleå during which it was noted that a large number of self-harming incidents had occurred there over a period of just over ten years.[32] The self-harming incidents all had in common the fact that inmates had attached a noose to various interior fixtures in the cells. Between 2007 and 2017, at least 14 incidents occurred where inmates used the toilet door in the cell to self-harm or attempt suicide.

41. Only in 2018 did the Swedish Police Authority decide that the custody cells should be rebuilt and the toilet doors removed. Before the renovation could begin, two more suicide attempts occurred, one of which was fatal. During the renovation, the Swedish Police Authority removed the toilet doors. However, the wall-mounted stools in the cells – used in at least three suicide attempts – had not been changed. Similar stools have been observed during the inspections

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[31] See Participation and legal certainty in psychiatric compulsory care (Ds 2014:28), p. 71 and 72. The memorandum proposes adding a section to the law on psychiatric compulsory care which would make it possible to keep a patient in long-term segregation for a maximum of four weeks if it is unavoidable as the patient poses a serious danger to others through prolonged, extremely aggressive and/or disruptive behaviour. The time for long-term segregation may be extended by a maximum of four weeks by a new decision.

[32] See the Parliamentary Ombudsmen's inspection report, O 2-2019.

of, inter alia, the police custody facilities in Arvika, Karlskoga and Kristinehamn.

42. Following the inspection of the police custody facility in Luleå, the then Parliamentary Ombudsman Cecilia Renfors stated that it was very serious that it had taken more than ten years before the necessary changes had been implemented and that this length of time had very serious consequences. In a letter to the Parliamentary Ombudsmen in December 2019, the Swedish Police Authority announced that on 17 December 2019 it had decided to rebuild all wall-mounted stools.[33] The space under the stool will be covered and all cells with this type of stool are expected to be rebuilt by 31 December 2020.

7.2 Conclusions

43. The review that the Swedish Police Authority has carried out of the physical environment in its custody cells will probably improve the safety of inmates. However, the physical environment is only one of several interacting factors required for an individual deprived of their liberty to be safe and secure whilst in police custody. Other important factors are that correct safety assessments are made, that the individuals deprived of their liberty are taken care of with a frequency of supervision which is based on a decision, and that individuals deprived of their liberty are taken to a healthcare establishment if necessary. For a number of years, shortcomings on these issues have been raised and police custody staff have even been convicted of misconduct after failing to carry out such decision-based supervision.[34] The examination of the Swedish Police Authority's work in preventing self-harming incidents in police custody will continue to be important in the Parliamentary Ombudsmen's inspections of police custody facilities.

8 Conditions for foreigners in migration detention (paragraph 22)

44. In its statement to CAT, the Swedish Government emphasised that, since detention under the Aliens Act (2005:716) is not a punishment, the Swedish Migration Agency's detention centres have been designed to offer, as far as is possible, an environment similar to that in the agency's asylum accommodation.[35] This means, inter alia, that detainees can move freely in the buildings and are given the opportunity to exercise outdoors at certain times during the day.

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[33] See document no. 6 in the Parliamentary Ombudsmen's request for reporting back, O 23-2019.
[34] See Värmland District Court's judgment on 30 October 2019, case no. B 151-19.
[35] See CAT/C/SWE/8 paragraph 134.

8.1 Layout of a detention centre

45. In September 2019, the Parliamentary Ombudsmen inspected a newly-opened migration detention centre with 44 places in Ljungbyhed.[36] During the inspection, it was found that the detention's residential units lacked any communal spaces, apart from a relatively small dining room. In the dining room, at the time of the inspection, there were not enough seats for the detainees to sit down at the same time. On the third floor of the detention centre, there was a large communal space, but since it was not adjacent to the residential units, the detainees only had access to it for one hour a day. Furthermore, the detainees were usually only given the opportunity for one hour of outdoor exercise per day. The detainees therefore resorted to either spending time in the residential unit's corridor and dining room or in their own rooms for large parts of the day.

46. Following the inspection, Parliamentary Ombudsman Per Lennerbrant stated that it was clear that the layout of the detention centre had been greatly limited by the premises in which it was located. This, in turn, led to far-reaching limitations on the ability to associate amongst the detainees. In the opinion of the Ombudsman, it was clear that the detention centre was not designed for as many as 44 detainees. On 4 May 2020, the Swedish Migration Agency decided to revise the number of places in the detention centre. Following this, the detention centre had 32 places.

8.2 Conditions for security placements in the prison and remand prison system

47. The Aliens Act (2005:716) allows for the Swedish Migration Agency to decide, in certain situations, that a detainee should be placed in a prison, remand prison or police custody facility (security placement). During several Opcat inspections, the Parliamentary Ombudsmen have noted that security placements can occur for a long time and that detainees in the Swedish Prison and Probation Service's remand prisons are not given the opportunity to associate with other detainees or inmates.

48. During several inspections of the remand prison system in 2017, it emerged that detainees often lived under conditions similar to those that apply to inmates held with restrictions.[37] This meant that a detainee could be locked in his cell for 23 hours a day. Furthermore, it was noted that it was unusual for the detainees to be returned to the Swedish Migration Agency from the Swedish Prison and Probation Service's remand prison system. Following the inspections, I stated that this issue had previously been brought to the attention of both the CPT and the Parliamentary Ombudsmen. In my opinion, it was

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[36] See the Parliamentary Ombudsmen's inspection report, O 52-2019.
[37] See the Parliamentary Ombudsmen's inspection report 416-2017 et al.

unacceptable that detainees were still deprived of their liberty in conditions which did not fulfil the requirements of the law.

49. The Parliamentary Ombudsmen have stated on several occasions that the reasons for a high-security placement must be the subject of continuous review. Furthermore, the Parliamentary Ombudsmen have expressed the view that the obligation to review a security placement decision should be regulated by law. Following an inspection of a detention centre in March 2018, the then Parliamentary Ombudsman Cecilia Renfors stated that no proposals had been made for any such rules in the draft bill on modern and legally certain rules for holding foreigners in detention that had recently been decided by the Government and sent to the Council on Legislation for scrutiny.[38] The draft bill to the Council on Legislation resulted in the bill that the Government refers to in its opinion to CAT.[39] On 28 November 2018, the Swedish Parliament voted down the Government's proposal.[40] There are still no such rules regarding the need to review security placements as requested by the Parliamentary Ombudsmen.

8.3 Conclusions

50. For several years, the Parliamentary Ombudsmen have highlighted the problems associated with the security placement of detainees in the Swedish Prison and Probation Service's remand prison regime. The detainees run a significant risk of being isolated. Following an inspection of the Swedish Migration Agency on 13 November 2018, the then Parliamentary Ombudsman Cecilia Renfors made a representation to the Government, in which she pointed out the need for provisions to be introduced regarding the obligation to review decisions on security placements.[41] This representation has not led to any changes. It is eagerly awaited that this issue, as highlighted by the Parliamentary Ombudsmen, becomes the subject of the legislator's considerations. Further questions concerning the conditions for detainees in security placements within the prison and remand prison regime are currently being investigated by the Parliamentary Ombudsmen.[42]

9 Other issues

51. Under this heading, I would like to point out a few more issues that are not covered by CAT's list of questions, but which are nevertheless important for the Committee's examination. These are the safety and security of individuals in the Swedish National Board of Institutional Care's institutions, the transportation of

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[38] See the Parliamentary Ombudsmen's inspection report, 939-2018.
[39] See CAT/C/SWE/8 paragraph 137.
[40] See the Parliament Committee on Social Insurance's report 2018/19:SfU10.
[41] See the Parliamentary Ombudsmen's inspection report, 6665-2018.
[42] See the Parliamentary Ombudsmen ref. no. 277-2018.

individuals deprived of their liberty and the situation for inmates in connection with the ongoing Covid-19 pandemic.

9.1 Safety and security of individuals at residential homes for young people

9.1.1 Serious deficiencies have been found at two residential homes for young people

52. In November 2018, an inspection was carried out of the residential home for young people in Sundbo.[43] In the discussions that the Parliamentary Ombudsmen's employees had with young persons in the home, it emerged, inter alia, that staff subjected them to unjustified violence. The situation at one department (Aspen) was described as particularly problematic. Similar information had emerged during an inspection carried out by the Swedish Health and Social Care Inspectorate the previous year. Over a period of almost two years, the Swedish National Board of Institutional Care had also made five reports of serious misconduct at the youth home to the Swedish Health and Social Care Inspectorate. The management of the home had taken certain measures to try to remedy the situation.

53. The Parliamentary Ombudsman Thomas Norling asked the Swedish National Board of Institutional Care to respond with details concerning which measures have been taken, or that the agency planned to take, to ensure the young persons would receive safe and secure care. In the Swedish National Board of Institutional Care's response, it emerged that the authority had, inter alia, temporarily closed down Aspen, removed three employees from service, appointed a deputy head of department as a resource directly subordinate to the director of operations and begun an evaluation of the home.

54. That young people felt unsafe was also noted during an inspection of the residential home for young people in Vemyra in June 2019.[44] During the inspection, it emerged that, inter alia, there had been fires at the home on several occasions and one of the departments was closed due to fire damage. Members of staff described themselves as "overrun" and said that the substitute personnel who were brought in were inexperienced. The young persons also stated that staff members were "stressed out" and did not have control over the departments. According to the young persons interviewed, the staff did not always act even when they witnessed incidents, for example when an inmate harms herself.

55. It has also been noted that the Swedish National Board of Institutional Care's staff restrain young persons by placing them in a lying position. In a

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[43] See the Parliamentary Ombudsmen's inspection report, 7107-2018.
[44] See the Parliamentary Ombudsmen's inspection report, O 55-2019.

decision, Parliamentary Ombudsman Thomas Norling stated that staff must not be allowed to develop a perception that, in addition to the special powers provided in the Care of Young Persons Act (1990:52), there are other unwritten powers, which in reality mean that the staff act in violation of Chapter 2 Section 6 of the Instrument of Government in taking coercive measures against the young persons.[45] In an incident at the residential home for young people in Tysslinge, members of staff restrained a youth instead of taking him to a segregation room. The youth was restrained until, in the staff's opinion, he had calmed down. In the opinion of the Ombudsman, there was no legal basis for the staff's action, and this action took place in violation of the constitutional protection against forced physical intervention.

9.1.2 Conclusions

56. The details which emerged during the inspection of the residential home for young people in Sundbo show the risks that individuals are exposed to if the responsible agency does not take sufficient measures to handle a situation. Following the inspection, Parliamentary Ombudsman Thomas Norling stated that it is imperative that the Swedish National Board of Institutional Care ensures that all young people placed in the home received safe and secure care. In this work, the Swedish National Board of Institutional Care should focus on, inter alia:

- effective measures to prevent young people from being subjected to unjustified violence,
- staff's treatment of young people, and
- the composition and competence of its staff.

57. In a decision following the Swedish National Board of Institutional Care's response, Parliamentary Ombudsman Thomas Norling stated that it was clear that the shortcomings in the residential home for young people had been known by the agency's central management for a long time.[46] However, it appeared that it was mainly for the institution and the director of operations to try to remedy such problems. In the Ombudsman's view, there must be a central control within the agency that can deal with this type of problem. The measures that the Swedish National Board of Institutional Care's head office took following the inspection should, in the view of the Ombudsman, have been implemented much earlier. The details which emerged during the inspection are very serious, and there will be reasons for the Parliamentary Ombudsman to continue to raise the issue with the Swedish National Board of Institutional Care of how the agency works in a systematic way to improve the safety and security of the inmates in its care.

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[45] See the Parliamentary Ombudsmen's decision on 29 November 2019, 6774-2017.
[46] See the Parliamentary Ombudsmen's decision of 30 April 2019, O 9-2019.

58. In addition to issues regarding staff's treatment and competence, the fact that the Swedish National Board of Institutional Care mixes inmates of different categories in its residential homes for young people is also of great importance for the individuals' sense of safety and security. This means that young people convicted of crimes, and subsequently sentenced to secure youth care, spend time together with other young peoples deprived of their liberty for care reasons.[47] Following the inspection of the residential home for young people in Sundbo, Parliamentary Ombudsman Thomas Norling stated that there is reason to follow up on this issue.

9.2 Transportation of individuals deprived of their liberty

59. From 1 April 2017, new regulations apply to the transportation of individuals deprived of their liberty. In short, the provisions mean that the Swedish Prison and Probation Service must, in certain situations, transport individuals deprived of their liberty at the request of other agencies, for example children, young persons and alcohol and/or substance abusers who are taken into care to receive treatment and patients who receive psychiatric compulsory care. In 2018 and 2019, the Parliamentary Ombudsmen's Opcat Unit examined the Swedish Prison and Probation Service's transport operations.

9.2.1 Shortcomings were found in the Swedish Prison and Probation Service's transportation capacity

60. In connection with the examination, it could be established that the Swedish Prison and Probation Service's transport operations lacked sufficient resources and that the agency could not perform transportations to the extent requested by other agencies. In a decision in May 2020, I was able to state that the Swedish Prison and Probation Service did not expect to have the capacity required to be able to fulfil the extended assignment until 2021, i.e. four years after the regulations entered into force.[48] For this reason, the Swedish Prison and Probation Service decided to give a lower priority to transportations requested by the Swedish Police Authority.

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[47] During an inspection of the residential home for young people in Johannisberg, the management of the institution stated that, in many cases, it was a pure coincidence if a young person was taken into care for treatment or sentenced to secure youth care, and that the courts in the large cities are more likely to decide on secure youth care with support of the Secure Youth Care Act (1998:603) (see the Parliamentary Ombudsmen's inspection report, 6204-2018). During the inspection of the residential home for young people in Sundbo, deprived of their liberty for care reasons expressed that they felt afraid of being placed together with convicted criminals. The management of the home stated that they did not know about this problem, but understood this fear because the young persons who have been sentenced to secure youth care and placed in the home may have committed very serious violent crimes.

[48] See the Parliamentary Ombudsmen's decision on 12 May 2020, 8337-2018.

61. Within the framework of the examination, I took note of a number of deviation reports made by the Swedish Police Authority when the Swedish Prison and Probation Service's transportations were delayed. Of a total of some 500 deviation reports in 2018, 35 concerned young people taken into care in accordance with the Care of Young Persons Act (1990:52) and who were placed in police custody pending transportation. The Prison and Probation Service's deprioritisation of these transportations meant that the young persons were in a police custody facility for one or more days. Similar information emerged during an inspection of the police custody facility in Borlänge in March 2019.[49]

62. In my decision, I stated that the Swedish Prison and Probation Service's attempt to deal with this problematic situation by making a decision to downgrade the prioritisation of transportations requested by the Swedish Police Authority was in direct conflict with the ordinance with instructions for the agency issued by the Swedish Government.[50] The Government's intention in steering its authorities through, inter alia, ordinances is to create clarity and predictability. The Prison and Probation Service's decision, in my opinion, went against this intention and, as such, one of the foundations of a state governed by the rule of law. It also led to serious consequences for the individuals deprived of their liberty and, for these reasons, I gave the Swedish Prison and Probation Service serious criticism.

63. The connection between individuals taken into care for treatment, who are then placed in the remand prison system, and these transportation issues was brought to the attention of Parliamentary Ombudsman Thomas Norling during an inspection of the residential for home for the care of substance abusers in Gudhemsgården in November 2019.[51] Following the inspection, Parliamentary Ombudsman Thomas Norling stated that, although the Swedish Prison and Probation Service has the responsibility to plan and carry out transportations, the Swedish National Board of Institutional Care should have a responsibility to participate so as to ensure the assisted transportation does not become more intrusive than is necessary. In the view of the Parliamentary Ombudsman, this means that the Swedish National Board of Institutional Care should ensure that

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[49] During the inspection, it was noted that several young persons had been placed in police custody – in some cases for more than three days – before the Swedish Prison and Probation Service could carry out the transportation. After the inspection, the then Parliamentary Ombudsman Cecilia Renfors stated that a police custody facility is usually unsuitable for the placement of young persons who, in many cases, lack previous experience of such environments. If a young person is to be placed in police custody at all, a transportation must be started as soon as possible, but no later than the day after he or she has been taken into police custody (see the Parliamentary Ombudsmen's inspection report, O 13-2019).

[50] See the Ordinance with Instruction to the Prison and Probation Service (2007:1172).

[51] See the Parliamentary Ombudsmen's inspection report, O 58-2019.

there are overnight accommodation options within the agency's institutions. As such, the Swedish National Board of Institutional Care can, for example, contribute to ensuring a remand prison is only used for overnight stopovers in exceptional cases.

64. The investigation into the Swedish Prison and Probation Service's handling of assisted transportations has also shown that the agency carried out some transportations in a manner which was not in accordance with statements from the Parliamentary Ombudsmen. There was a regular occurrence of individuals taken into care for treatment being taken into remand prisons for transport stopovers. Furthermore, they were transported together with, for example, the Swedish Prison and Probation Service's clients. This led to the individuals in care for treatment perceiving transportations as stigmatising and they felt that they were made to feel like criminals.

9.2.2 Conclusions

65. According to statements from the Parliamentary Ombudsmen, the relevant agencies must take measures to ensure that the transportation operations meet, inter alia, the following requirements:

- There must be a capacity within the Swedish Prison and Probation Service to perform assisted transportations within, inter alia, the timeframes that are in accordance with the Parliamentary Ombudsmen's statements.
- The planning and execution of assisted transportations must be based on the premise that, inter alia, people who are taken into care for treatment should not be placed in the police custody and remand prison systems nor transported together with the Swedish Prison and Probation Service's clients.
- Transportation stopovers at police custody facilities need to be organised in such a way that the police custody staff has sufficient time to carry out all the necessary checks and measures upon admission.
- The transportations must be designed in such a way that people taken into care for treatment are not made to feel like criminals.

66. The implemented transportation reform has had, at least initially, negative consequences for individuals deprived of their liberty. Coordination between the relevant agencies has improved and, today, there are not the delays to the transportation previously seen. The fact that the Swedish Prison and Probation Service – which mainly transports the agency's own clients – has the main responsibility for assisted transportations, risks, however, continuing to lead individuals deprived of their liberty who have not committed crimes to being made to feel like criminals. It is not just a question of individuals being taken into care for treatment being transported by staff who wear the Swedish Prison and Probation Service's uniform, but that they are also handcuffed. A further important factor is how the transportation is carried out. Despite statements made by the Parliamentary Ombudsmen, it is, for example, not uncommon for individuals taken into care for treatment to be temporarily taken into remand

during transportation. Furthermore, individuals taken into care for treatment are, on occasion, transported together with clients from the prison and remand prison regime. This is problematic and it is an issue which gives reason for the Parliamentary Ombudsmen to continue to follow in the coming years.

9.3 Deprivation of liberty with no legal basis.

67. It should be highlighted that the Parliamentary Ombudsmen are also aware of situations where individuals are living under conditions that mean they are, in fact, deprived of their liberty, and with no legal basis for such a violation. In early 2020, information emerged in the Swedish media that a person (beneficiary), who received support under the Support and Service for Person with Certain Functional Impairments Act (1993:387), was living under conditions that could be equated with a deprivation of liberty. Based on this information, Parliamentary Ombudsman Thomas Norling decided to inspect the Skogsbo home for persons with certain functional impairments in Gnosjö municipality where the beneficiary lived.

68. During the inspection, it emerged that the beneficiary could not leave the home whenever he wanted and that his freedom of movement had therefore been limited.[52] He was only given the opportunity to leave the home in the company of members of staff for, inter alia, short walks and car excursions. Following the inspection, Parliamentary Ombudsman Thomas Norling stated that, in his opinion, it was clear that the beneficiary had, in fact, been deprived of his liberty. He further stated that the Support and Service for Person with Certain Functional Impairments Act (1993:387) does not provide any scope for such a measure. The municipality received serious criticism for the fact that the beneficiary had lived under these conditions for several years. In the opinion of the Ombudsman, the details which emerged in the case showed how important it is for those responsible for running such a home to have a good knowledge of the relevant legal preconditions.

9.4 The situation for inmates with regard to Covid-19

69. The ongoing Covid-19 pandemic has had a major impact on the work of the Parliamentary Ombudsmen's Opcat Unit. In March 2020, I and my colleagues at the Parliamentary Ombudsmen decided not to carry out regular inspections until further notice – including, inter alia, visits to places where people are held deprived of their liberty as well as conversations with individuals and staff – and therefore avoid the risk of spreading the virus. At the same time, we considered there was a need to examine how the agencies treated individuals with regard to the pandemic. A number of agencies introduced restrictions on individuals' rights and freedoms in order to reduce the spread of

[52] See the Parliamentary Ombudsmen's inspection report, O 10-2020.

the virus, and there is always a risk that when such measures are introduced at such short notice, they become too far-reaching and violate individuals' rights.

70. For these and other reasons, the Parliamentary Ombudsmen have examined the impact of Covid-19 on individuals deprived of their liberty. Parliamentary Ombudsman Katarina Påhlsson examined the Swedish Prison and Probation Service's handling of the impact, and announced a decision in June 2020. Parliamentary Ombudsman Thomas Norling investigated the treatment of individuals in institutions run by the Swedish National Board of Institutional Care. He announced his decision in September 2020. Parliamentary Ombudsman Per Lennerbrant examined the Swedish Migration Agency's detention operations. Finally, I carried out an examination of the situation for individuals at the National Board of Forensic Medicine's forensic psychiatric examination units. Both decisions will be announced in October 2020.

71. In order to describe the situation for these individuals, the Ombudsmen have partly used new methods. Individuals under the care of the Swedish Prison and Probation Service and the National Board of Forensic Medicine were given the opportunity to answer questionnaires. Conversations with individuals detained by the Swedish Migration Agency's took place via video link. In the case of individuals under the care of the Swedish National Board of Institutional Care, interviews were conducted outdoors. All these measures were taken to reduce the risk of spreading the virus. The Ombudsmen's observations and statements from the own-initiative inquiries will be compiled in a special report in autumn 2020.

10 Concluding remarks

72. The observations and statements reported above show that, in most of the areas concerned, there are significant risks that the fundamental rights of people deprived of their liberty are violated, and even, in some cases, that individuals are subject to cruel or inhuman treatment. As previously stated, the Parliamentary Ombudsmen have repeatedly made representations to the Swedish Government to review the legislation in various respects in order to improve the rule of law and guarantee the rights of individuals deprived of their liberty. It is remarkable that so few of these representations have led to any action by the Government.

When preparing this submission, I have consulted with Parliamentary Ombudsmen Thomas Norling, Katarina Påhlsson and Per Lennerbrant.

Elisabeth Rynning