JO RIKSDAGENS OMBUDSMÄN

Annual Report 2020/21

SUMMARY IN ENGLISH

JO RIKSDAGENS OMBUDSMÄN
THE SWEDISH PARLIAMENTARY OMBUDSMEN

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Photos

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History in short

1809 New constitution and the office of The Parliamentary Ombudsmen is established.

1810 The first Parliamentary Ombudsman is elected, L.A. Mannerheim.

1915 A Military Ombudsman, MO is established.

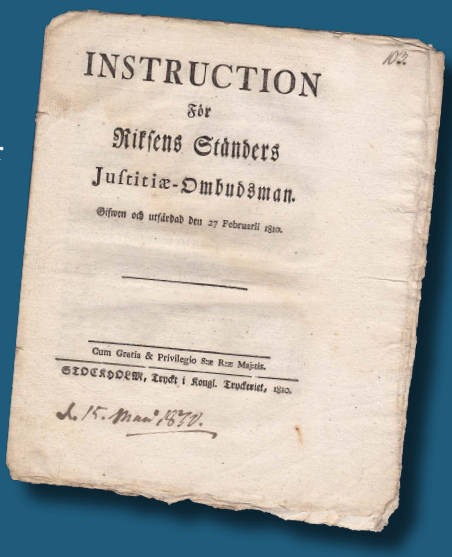
1941 The term of office for the ombudsmen is extended to four years. The rule that only men could be elected as ombudsmen is removed.

1957 Supervison of local/regional authorities.

1967 The office of The Military Ombudsman is abolished and the number of ombudsmen increases to three.

1975 The number of ombudsmen increases to four.

2011 The Parliamentary Ombudsmen is designated National Preventive Mechanism (NPM) under the OPCAT.


INSTRUCTION
För
Rikets Ständers
Justitiæ-Ombudsman.
Gifwen och utfärdad den 27 Februarii 1810.
Cum Gratia & Privilegio Sac. Reg. Majestis.
STOCKHOLM, Tryckt i Kongl. Tryckeriet, 1810.

Anyone can complain to the Parliamentary Ombudsmen if they believe that a public authority has treated them in a deficient manner.

The office of the Parliamentary Ombudsmen was established in Sweden in 1809 as part of the new constitution that was adopted that year. At that time the Swedish parliament, the Riksdag, decided that it needed an institution that could act on its behalf and independently of the King to make sure that public authorities obeyed the laws and other statutes. In 1810 the Riksdag elected its first Parliamentary Ombudsman.

Since then more than two centuries have passed and the work of the Parliamentary Ombudsmen is still based on the same principles, even though some changes have been made through the years, for instance, the number of Parliamentary Ombudsmen has increased from one to four to cope with the authority's rising workload.

One of the ombudsmen has the title of Chief Parliamentary Ombudsman and is responsible for administration, deciding, for instance, which areas of responsibility are to be allocated to the other ombudsmen. However, he or she cannot 'intervene' in another ombudsman's inquiry or decision.

Currently the Parliamentary Ombudsmen receive more than 10,000 complaints per year. Each ombudsman independently conducts investigations and takes decisions within their area of responsibility and is directly accountable to the Riksdag.

The year 2020/21 in brief

During the year, our work was shaped by the ongoing corona pandemic. For example, the Parliamentary Ombudsmen only initiated eleven inspections during the financial year, compared with 51 during the preceding year. The inspections that were carried out were mainly performed remotely or under adapted forms with, inter alia, introductory and concluding dialogues via video link. The Parliamentary Ombudsmen's Opcat activities were affected by the pandemic more than the other activities. Furthermore, the influx of cases continued to be affected by the pandemic to some extent and the Parliamentary Ombudsmen responded to a number of legislative consultations related to the pandemic with short, and in some cases very short, deadlines. The deputy ombudsmen performed their work remotely. The Parliamentary Ombudsmen participated in some international events digitally, and many conferences and visits were cancelled.

During the financial year, almost 10,300 complaint cases were closed, which is about 900 more than in the previous year. Around 700 of these are estimated to have been wholly or partly related to the corona pandemic.

The Parliamentary Ombudsmen's Opcat activities

Significantly fewer inspections were initiated within the Opcat Unit during the past financial year compared with the previous. The ongoing corona pandemic has continued to lead to restrictions on the ability to carry out inspections by means of physical visits.

During the autumn of 2020, the unit's activities focused on completing a project involving the Parliamentary Ombudsmen investigating the situation for people deprived of their liberty during the pandemic, and how their situation was affected by the measures taken by the relevant authorities in connection with the spread of infection. The investigations of four authorities were compiled in a special thematic report submitted to the Committee on the Constitution in December 2020.

International cooperation

The Parliamentary Ombudsmen's international work has continued to be greatly affected by the ongoing corona pandemic. This collaborative work was mainly conducted via e-mail, telephone and streamed audio and video link. Physical visits and physical participation in conferences and meetings were avoided as far as possible.

In various forms adapted for the pandemic, the Parliamentary Ombudsmen took part in 18 international activities. A prominent theme for many of these has been

how ombudsmen institutions around the world have been affected by the ongoing corona pandemic, both in terms of their internal handling of the situation and how the pandemic has affected particularly vulnerable groups in society.

Elisabeth Rynning

Chief Parliamentary Ombudsman

My area of responsibility includes, inter alia, the administrative courts of law, defence, health care, education and research as well as tax and population registration. The area also includes public procurement and various central authorities such as the Financial Supervisory Authority, the Companies Registration Office, the Competition Authority, the Discrimination Ombudsman and the National Board for Consumer Disputes. In terms of the number of reports, the Chief Parliamentary Ombudsman's supervisory area of responsibility had just under 2,000 cases in the last financial year, which is a lower number than that of the other parliamentary ombudsmen.

During the financial year, various issues related to the pandemic recurred in the complaints received as well as in the legislative consultations within my area of responsibility. These issues related to, inter alia, the constitutional preconditions for general infection control measures in society used in order to achieve physical distancing and reduced congestion, the legal basis for the separation of individuals and restricting visitation rights in various activities, and the interpretation of basic health care principles in the prioritisation with regard to the use of vaccinations as a care intervention. It was clear early in the pandemic that neither the authorities nor the regulations were prepared to deal with this extraordinary situation.

Many of the statutory proposals made as a response to the pandemic were associated with difficult balances of interests, often made on sparse grounds. I stated in my response to the Government's proposal for Covid-19 legislation that it is, of course, very important that the state is able to take adequate

Areas of responsibility

- Adminstrative courts
- The Armed Forces and other cases relating to the Ministry of Defence and its subordinate agencies which do not fall within other areas of responsibility
- The National Fortifications Agency.
- Health and medical care as well as dental care, pharmaceuticals; forensic medicine agencies, forensic psychology agencies; protection from infection.
- The school system; higher education (including the Swedish University of Agricultural Sciences); student finance; The Swedish National Board for Youth Affairs; other cases pertaining to the Ministry of Education and agencies subordinate to it which do not fall within other areas of responsibility.
- Income and property tax, value added tax, fiscal control, with the exception, however, of the Taxation Authorities Criminal Investigation Units as laid down in the Act on the Participation on the Taxation Authority's Crime Fighting Activities; tax collection.
- Excise duties and price-regulating fees, road tax; service charges; national registration (including cases concerning names); other cases connected with the Ministry of Finance and its subordinate agencies which do not fall within other areas of responsibility.
- Public procurement, consumer protection, marketing, price and competition within industry and commerce, price regulation, cases concerning limited companies and partnerships, trade names, trade registers, patents, trademarks, registered designs, and other cases pertaining to agencies subordinate to the Ministry of Industry, Employment and Communications which do not fall within other areas of responsibility.
- The Agency for Public Management; the National Financial Management Authority; the Legal, Financial and Administrative Services Agency, the National Appeals Board, the National Claims Adjustment Board; the National Agency for Government Employers, the Arbitration Board on Certain Social Security Issues; the National Property Board; the National Government Employee Pensions Board, the National Pensions and Group Life Insurance Board; the Financial Supervisory Authority, the Accounting Standards Board; the National Institute of Economic Research; Statistics Sweden; the National Disciplinary Offense Board.
- The Equality Ombudsman; the Board against Discrimination.
- Cases that do not fall within the ambit of the Parliamentary Ombudsmen; documents containing unspecified complaints.

and necessary measures to protect people's lives and health by preventing the spread of infection. Additionally, I had a great understanding that such measures might require a degree of intrusion and allow for flexibility at different levels, and in some cases entail restrictions on fundamental rights and freedoms. The proposal presented in the memorandum, however, involved a far-reaching delegation of norm-setting competence from the Parliament to the Government, with, in some cases, delegation additionally passed on to various administrative authorities at national, regional and local levels. This type of legislation must be predictable and compatible with basic constitutional principles and contain satisfactory control mechanisms to ensure, inter alia, legal certainty and proportionality. My view was that the current bill did not meet the high requirements that should be placed on such legislation. Following a referral from the Council on Legislation and certain adjustments, a slightly revised bill was adopted by Parliament. In several of

the following cases concerning the supplementation, adjustment and extension of the law and associated regulations, I had reason to return to these fundamental issues of democracy and restrictions on fundamental rights.

Although new legislation was introduced to provide the Government and relevant authorities with more effective tools for fighting the spread of infection, in several areas of under my supervision I found reason to question whether there was the necessary legal basis for the restrictions that had been decided or could be needed. An examination of, inter alia, the conditions for people who were deprived of their liberty at the Forensic Medicine Agency's forensic psychiatric examination units showed that neither the Communicable Diseases Act nor the laws regulating the authority's activities provide a sufficient basis for satisfactorily proportionate and legally secure infection control.

In the health care area, almost 30 percent of the near 600 complaints registered related to the pandemic. However, many of these were dismissed without further investigation. Most of the supervisory cases, which related to the pandemic and resulted in an investigation being initiated, were not closed at the end of the financial year and are therefore not included in this report. This includes, inter alia, my decision in a case where a general ban on visitors had been issued for all hospitals within a region. In my opinion, there is no legal basis for deciding on a general ban on visiting patients who are voluntarily cared for in the health care system, and this decision could therefore be, inter alia, in conflict with the right of individuals to family life under the European Convention.

A number of investigations were also initiated in several cases regarding vaccinations against Covid-19 with regard to, inter alia, the Public Health Agency's recommendations on the age limit for a certain vaccine and a region's decision to only offer a certain vaccine to people in the age group 65 and older.

Complaints within the Armed Forces case group, which are normally very few, also multiplied during the financial year for reasons related to the pandemic. Nearly half of a total of around 70 cases concerned dissatisfaction with the fact that the then director general of the Civil Contingencies Agency had travelled abroad on holiday during the ongoing pandemic, an issue that I did not consider appropriate for investigation by the Parliamentary Ombudsmen. One complaint that I chose to investigate, however, concerned a decision to have a whole platoon of conscripts isolated for infection control reasons.

During the financial year, the Parliamentary Ombudsmen received many reports regarding various shortcomings in the Agency for Economic and Regional Growth's handling of cases concerning short-term support during the pandemic. The complaints shed light on the importance of how the hand-

ling of decided support measures is made in order to be able to fulfil their intended function, and a number of these complaints are currently being investigated by the Parliamentary Ombudsmen.

The decisions from my area of responsibility that have been included in this year's official report relate almost exclusively to conditions before the pandemic and, as such, partly raise other considerations of interest. However, the vulnerability of people deprived of their liberty in psychiatry, who often find it very difficult to assert their rights themselves, has been a recurring theme in my supervision. This applies, in particular, to the use of coercion and restrictions on liberty, as well as other control measures. In my opinion, the need for clear and predictable legislation, and not least strategic, effective and uniform supervision, is very great in this area. It was, therefore, disappointing to be compelled to state significant shortcomings in the supervision conducted by the Health and Care Inspectorate concerning the provision of care in accordance with the compulsory psychiatric care laws. Two of the six petitions for legislative review I submitted to the Government during the past financial year concerned psychiatry, as were several of the decisions submitted for attention.

Another area of activity that highlights the delicate balance between different rights is schooling, where all students must be offered a safe and good school environment and an education that, inter alia, encompasses fundamental democratic values and principles but simultaneously does not infringe upon students' constitutionally protected freedoms of opinion and expression. Careful consideration is required from both school authorities and their staff in order for schools' activities to be designed in a way that meets these requirements, for example with regard to participation in various activities to promote the equal value of all human beings or the sustainable development of the environment and climate.

The case where the Parliamentary Ombudsmen had previously brought charges of misconduct against two judges due to slow processing times could be closed during the year, after the Supreme Court announced its judgement. The Parliamentary Ombudsmen has repeatedly emphasised that it is an important guarantee of legal certainty that courts of law and other authorities reach their objectives and decide cases within a reasonable time. Unfortunately, there are still many complaints concerning the processing times at, inter alia, certain administrative courts of law. Ultimately, however, the Parliament and the Government are responsible for ensuring that the courts of law perform their tasks and are able to meet the requirements set out in Chapter 2, Section 11 of the Instrument of Government.

Thomas Norling

Parliamentary Ombudsman

The issues that fall within my area of responsibility concern the social services, social insurance and matters concerning the application of the Act on Support and Service for Persons with Certain Functional Impairments Act. Supervision in my area of responsibility also includes labour market issues. The authorities that belong to the area of responsibility include the Public Employment Service, the Social Insurance Agency, the Pensions Agency and the National Board of Institutional Care. A very large number of the complaints received concern the social services and the activities within municipal social administrations.

Frequently, the measures that authorities can decide upon result in a strong intervention for the individual. The principle of legality and its requirements for a legal basis for authorities' actions and legal certainty for individuals are, therefore, decisive in how the legal system works.

The intention is that the administration should be bound by standards and norms, and not be arbitrary. As such, authorities have only the powers vis-à-vis individuals that the statutes provide for. Today, the principle of legality is also expressed in Section 5 of the Administrative Procedure Act (2017: 900), which regulates the grounds for good administration and states that an authority may only take measures that have a legal basis.

In last year's official report, I provided various examples of actions and measures taken by authorities that, in some sense, challenged the requirement for good administration. Likewise, during the past financial year, I can state that there have been shortcomings within my area of responsibility that are typical, recurring and serious.

Areas of responsibility

- Application of the Social Service Act, the Act on Special Regulations on the Care of the Young (LVU) and the Act on the Care of Substance Abusers in Certain Cases (LVM).
- Application of the Act on the Provision of Support and Service for Certain Individuals with Certain Functional Impairments (LSS).
- The Children's Ombudsman.
- National insurance (health insurance, pension insurance, parental insurance and work injuries insurance, housing allowances and other income-related benefits, child allowances, maintenance advances etc.); the Social Insurance Inspectorate; the National Pensions Agency.
- Other cases pertaining to the Ministry of Health and Social Affairs and agencies subordinate to it which do not fall within other areas of responsibility.
- The Public Employment Service, the Work Environment Authority; unemployment insurance; other cases pertaining to the Ministry of Employment and agencies subordinate to it which do not fall within other areas of responsibility.

From my perspective, it is a serious problem if authorities take actions without a legal basis. In the cases that I fully investigated, it emerged that officials at the authority in question considered themselves to have powers that they actually lacked. We can also see that they have not always understood the legal meaning of a particular measure taken in an individual case. Either they consider that the measure can be justified on the basis of the problem at hand and the difficult situation that has arisen, or they assume that the application made in an individual case will be tolerated during a judicial review. The legal certainty issues are obvious in these cases.

The implication of a lack of the required legal basis for a measure does not, of course, mean that an authority has exercised public power without regard to the applicable law. Normally, it can be assumed instead that there is a question of a misinterpretation of applicable – and perhaps sometimes unclear – provisions. In some situations, the line between the incorrect application of legal rules and the lack of a legal basis also becomes unclear. Furthermore, it has emerged that authorities insufficiently investigate whether they have a legal basis or not for the measures they have taken. These problems risk becoming serious when regulations are applied as exceptions and more practical solutions are sought.

In my experience, when problems arise within my area of responsibility they largely concern authorities' difficulties in correctly fulfilling the basic requirements of administrative law. However, there are additionally other problems whereby authorities have actually taken measures with no legal basis. This has emerged in the social services where the shortcomings are both recurring and serious. In this year's official report, I have therefore included several decisions to illustrate this (see, for example, ref. nos. 2232-2019 and 2965-2019).

During the current financial year, I had reason to continue my investigation into the application of the provisions in the Care of Abusers Act and the

Care of Young Persons Act on the so-called special powers of separation and separate care. My concern is whether there exists sufficient knowledge of the rules at the special residential homes for abusers and at the special residential homes for young people. An important question concerns whether application of the rules at these institutions is uniform.

The special powers in the Care of Abusers Act and the Care of Young Persons Act mean that individuals' fundamental freedoms and rights are restricted. The requirements for legal certainty are high here. Separation is a far-reaching encroachment on personal integrity. By its nature, it is not possible to legislate in detail to cover all the different situations that may arise and how, for example, a special residential homes for young people may or may not act. In general, however, it is important that these homes do not apply the rules in such a way that care is provided in a legal "grey zone" where there is uncertainty as to whether measures taken have a legal basis or not.

Together with supervision, party insight and transparency through the principle of public access to official records, the right to appeal a decision by the National Board of Institutional Care to use such powers constitutes an important aspect of legal certainty for the child or young person who is, for example, being forcibly cared for and who is the subject of a decision on separation. At the same time, it can be very difficult for a person detained to assess what claims for judicial review they may have after being held in connection with a decision on separation in a way that cannot be accepted. With regard to a decision by the National Board of Institutional Care to separate a person, it can be questioned whether there is always the real possibility of bringing about a judicial review of an intervention, which has meant that the young person has been detained together with elements of unjustified force, through an appeal to the administrative court.

Based on the inspections I made during the financial year, I can state that staff at the special residential homes for young people have difficulty determining the legal meaning of various measures, which exist to ensure formal compliance with the requirements imposed on the homes' activities. As such, multiple challenges exist. For the staff, it is important to understand what the special powers actually mean and when they may be used. The staff must also be able to distinguish these powers from other types of measures for which they lack legal support. In addition to the legality aspects, it also becomes important concerning how the requirements for predictability are met in the application of these measures. In addition to the sources of error mentioned, there is a risk of a lack of uniformity within the National Board of Institutional Care, which is due to the fact that each special residential home for young people can make its own assessments concerning what has happened.

The ambiguities that exist here concern not only issues of application of rules. In order for the application to be correct and contain legal certainty,

the regulation needs to be clear and the requirement for predictability in the legislation must be met. During my inspections, I have repeatedly highlighted the fact that the regulation of the special powers in, for example, the Care of Young Persons Act does not always give clear information concerning what is applicable, and therefore risks giving rise to situations in the special residential homes for young people that are not legally secure for the young people detained there. The National Board of Institutional Care has also stated that there are problems with the application of rules due to how the regulations are designed, but also because its own guidelines have been too brief in these respects.

My supervision of the National Board of Institutional Care's homes during the financial year

During the spring of 2021, several activities concerning the special powers in the Care of Abusers Act and the Care of Young Persons Act were ongoing and initiated in various places. In January 2021, I commissioned the Parliamentary Ombudsmen's Opcat Unit to conduct inspections of the four special residential homes for young people at Brättegården, Fagared, Sundbo and Vemyra during the spring. The inspections, which ended on 30 June 2021, concerned in particular the issue of the safety and security of the young people detained there and the application of the provisions on the special powers in the Care of Young Persons Act. After the inspections were completed, I was able to state that there are still serious shortcomings in the running of the homes in connection with, inter alia, the young people detained there being forcibly restrained by staff.

Katarina Påhlsson

Parliamentary Ombudsman

My area of responsibility includes the courts of law, the Rent and Tenancy Tribunal, the Prison and Probation Service, the planning and construction sectors, environmental and health protection, and the guardianship system. The area of responsibility includes a number of central authorities, including the Enforcement Agency, the National Courts Administration, the Crime Victim and Compensation Authority, the Board of Agriculture and the Environmental Protection Agency. The focus of the supervision is on issues concerning the general courts of law and the prison and probation regime.

There was a wide variety of complaints concerning the general courts of law, but some questions recur. One such complaint concerns the courts' disclosure of confidential information. Sensitive information often features in court cases and the courts have a high level of knowledge and experience in handling it. It is, however, serious when incorrect handling occurs. For example, if a secret address is disclosed, the consequences can be serious. Unfortunately, there is a lack consistency in the application of the regulations regarding confidentiality, even if it is not a common reason for classified information being disclosed. When such information is disclosed, it instead appears to be due to individual mistakes, which in turn sometimes appears to be the consequence of heavy workloads. With regard to observations made both during inspections and in the handling of complaints, it further cannot be ruled out that the design of the courts' case management system may contribute to such oversights.

Areas of responsibility

- Courts of law, the Labour Court; Ground Rent and Rent Tribunals; the National Courts Administration.
- Prison and Probation Service, the National Prison and Probation Board and probation boards.
- The National Legal Aid Authority and National Legal Aid Board, the Crime Victim Compensation and Support Authority, the Council on Legislation; the Data Inspection Board, petitions for mercy submitted to the Ministry of Justice; other cases concerning the Ministry of Justice and its subordinate agencies that do not fall within other areas of responsibility.
- Cases concerning guardianship (i.a. Chief Guardians and Chief Guardian Committees).
- The Enforcement Authority.
- Planning and building, land survey and cartography agencies.
- Environmental protection and public health; the National Environmental Protection Agency; the Chemicals Agency; other cases connected with the Ministry of the Environment and its subordinate agencies.
- Agriculture and forestry, land acquisition; reindeer breeding, the Sami Parliament; prevention of cruelty to animals; hunting, fishing, veterinary services; food control; other cases agencies subordinate to the Ministry for Rural Affairs and its subordinate agencies which do not fall within other areas of responsibility.

It is not uncommon for a complainant to claim that they have been wrongly convicted. Exactly like in cases concerning dissatisfaction with a substantive decision taken by an authority, I do not usually investigate such complaints. To a large extent, decisions and judgments are based on assessments and they can differ without there necessarily needing to exist any errors. Additionally, normally a judgment can be appealed to a higher court. In this respect I think there may be a misconception concerning the Parliamentary Ombudsmen's role; an ombudsman can review a procedure from a legal perspective but cannot change a judgment. In general, I see it as an important pedagogical task for me as an ombudsman to try to explain what the Parliamentary Ombudsmen's role is in various contexts.

Despite the Covid-19 pandemic's affect on Swedish society since the spring of 2020, the courts have succeeded in hearing many cases. Digitalisation, an increased use of video technology in main hearings and the fact that more cases than before are decided without hearings have been highlighted as explanations for making this possible. However, details have emerged that trials in, mostly, slightly larger or more complex criminal cases with many parties involved, although also in other cases without specific time deadlines, have been cancelled or postponed. This may possibly partly explain the now increased number of complaints received by the Parliamentary Ombudsmen concerning long processing times in the courts of law. It risks affecting legal certainty when individuals have to wait an unreasonably long time to have their cases heard and, as such, a trial must be carried out within a reasonable time. There is reason to assume that the way the courts of law organise their

work and decide on priorities, in line with the relevant legal regulations, will be even more important in the future.

The pandemic has continued to affect significantly the conditions for people deprived of their liberty in the prison and probation regime. Last spring, I carried out a special investigation into the situation for inmates in prisons and remand prisons during the pandemic. The most important observations were reported additionally, together with the results of corresponding investigations conducted by my fellow ombudsmen in their respective areas of responsibility, in a special report published in the autumn of 2020. For my part, I was able to state that inmates in prisons and remand prisons have only a limited possibility to affect their own situations and that they are dependent on the Prison and Probation Service taking appropriate and proportionate measures in a crisis situation whilst maintaining legal certainty. Naturally, this still applies and has motivated, inter alia, an ongoing investigation into the legal basis for decisions on separation of inmates due to feared and established infection of Covid-19.

Complaints having an immediate connection to the pandemic are not as common as last year, but judging by the complaints received, there are restrictions on, for example, the possibility of receiving visits and taking leave, which are, of course, still a significant strain on inmates. In step with the vaccinations of both inmates and society in general, some relief has however been experienced recently. Despite this, there is still a clear concern regarding the spread of infection, such as when a person arriving to serve a prison sentence is placed directly in a unit with others or when inmates are forced to share a cell.

The occupancy situation was strained even before the virus outbreak and it did not improved during the year. Many complaints relate to this: inmates highlight, inter alia, that the double occupancy of cells increases the risk of both the spread of infection and conflicts, that visiting rooms are used for the placement of inmates, which in turn limits their ability to receive visits and that they do not receive their daily outdoor access. Furthermore, it appears that inmates' dissatisfaction with the strained occupancy situation spills over into other issues, as seen by the receipt of the relatively large number of reports during the spring concerning food and diets.

During the year, I completed an investigation into the occupancy situation with particular regard to remand prisons, and many of the issues mentioned above were relevant here. The Prison and Probation Service has a responsibility not only to ensure people deprived of their liberty are held under safe and secure conditions but also for upholding the rights of these inmates. It is particularly serious that the Prison and Probation Service is still unable to satisfy the right to association, i.e. spending time with others during the day. Even with a strained occupancy situation, the authority has a responsibility to ensure association occurs and to break the isolation of inmates. The Pris-

on and Probation Service is now greatly increasing the number of places by, inter alia, building new facilities and it is important that the basic requirements for humane prison care are met.

There have not been many complaints concerning the guardianship system, but those received are characterised by the fact that, behind each report, there is a person in particular need of support and help. The system of guardians and custodians is based to a significant extent on non-profit actors. The assignments can be demanding and place strong requirements regarding suitability, knowledge and personal qualities. In some instances, it is unfortunately difficult for chief guardians to recruit deputies. This means that the processing can be lengthy and I have observed additionally further shortcomings in the case processing of chief guardians. In the recently submitted report Guardians and custodians – an investigation (Government Inquiry 2021: 36), there are proposals that aim to improve the situation. This is one of many responses I provided to legislative consultations.

Per Lennerbrant

Parliamentary Ombudsman

This year, my area of responsibility included, inter alia, public prosecutors, the police and customs, aliens' cases at the Migration Agency, the communications and municipal administrations that are not specially regulated.

The total number of new cases within my area of responsibility was at approximately the same level as last year. The clear majority of new cases received during the year were complaints from individuals. Together with my employees, I have conducted investigations into many interesting and urgent matters. A selection of these is included in the official report.

The effects of the pandemic are a natural starting point for my report. As I mentioned in last year's official report, I, like my fellow ombudsman colleagues, took the initiative to investigate the situation for people deprived of their liberty, which in my case concerned the conditions at two of the Migration Agency's detention centres. The investigation was completed in September 2020 and was reported in a special publication that was submitted to the Committee on the Constitution.

Another investigation related to the pandemic concerned a journalist's request to a number of municipalities and a region for access to compilations of data on Covid-19. I investigated, inter alia, different aspects of the principle of impartiality, in other words the Government's demands for objectivity and impartiality. There were a number of complaints against the police's actions in connection with demonstrations and similar against the pandemic restrictions. None of these complaints led to any statement or opinion on my part.

Areas of responsibility

- Public prosecutors; the National Economic Crime Authority; The Taxation Authority's Criminal Investigation Units as laid down in the Act on the Participation of Taxation Authorities in Criminal Investigations.
- The Police force; The Commission on Security and Integrity Protection.
- Customs authorities.
- Communications (public enterprises, highways, traffic, driving licences, vehicle registration, disabled transport services, roadworthiness testing).
- The Arts Council, The National Heritage Board, National Archives; museums and libraries: The Broadcasting Authority; local music schools, other cases pertaining to the Ministry of Culture and agencies subordinate to it.
- Municipal administration not covered by special regulations.
- Cases involving aliens, not including, however, cases heard by migration courts; citizenship issues and cases relating to the integration of immigrants.
- Rescue services, applications of the regulations relating to public order; lotteries and gambling, licences to serve food or drink, car dismantling.
- Other cases dealt with by the County Administrative Boards that do not fall within other areas of responsibility.
- Housing and accommodation (supply of accommodation, home adaptation grants, accommodation allowances not included in the social insurance scheme); the National Board of Housing, Building and Planning; the National Housing Credit Guarantee Board.
- Cemeteries and burials, government grants to religious denominations.
- Government activities outside Sweden; the International Development Cooperation Agency; the National Board of Trade; the Swedish Institute; other cases pertaining to the Ministry for Foreign Affairs and agencies subordinate to it.
- The Riksdag Board of Administration, the Riksbank, the National Audit Board; general elections.
- Cases pertaining to the Prime Minister's Office and agencies subordinate to it which cannot be allocated to the areas of responsibility to which they pertain from the point of view of their subject matter.
- Other cases which do not fall within areas of responsibility 1–3

The pandemic also entailed a number of legislative measures that were preceded by consultative referrals to the Parliamentary Ombudsmen. In some cases, the measures entailed far-reaching restrictions on constitutional rights and freedoms. In my response in the consultation process regarding the memorandum *Prohibition on holding public gatherings and public events with more than eight participants*, I highlighted a number of shortcomings in the Government's preparation of the proposal, which entailed the risk that certain constitutional aspects were not sufficiently elucidated upon, and further that the preparation did not provide sufficient opportunities for a follow-up review of the Government's actions.

With regard to the general effects of the pandemic within the area of responsibility, it was difficult to see any clear common thread. It is easy to assume that the pandemic has contributed to, for example, longer processing times in some cases and, in addition, possibly a lower degree of availability from the authorities, however I have been unable to draw any substantiated conclusions concerning this.

As for the means of conducting my supervisory role, the pandemic meant that I could not carry out any physical inspections of the authorities. This is, naturally, regrettable but inevitable. I intend to resume physical inspections as soon as the infection allows. One of the issues, that will then be of particular importance to investigate, is the situation for people deprived of their liberty in police custody and physically observe how the Police Authority works to reduce the risk of the spread of infection.

With regard to long processing times, there were many complaints even prior to the pandemic. The complaints concerned several of the authorities I supervise, but most of them concerned the Migration Agency. During the year, I completed an investigation of the processing times of several types of cases at the Migration Agency, including citizenship and asylum cases. Cases such as these are of great importance to the person concerned and long processing times can have a number of negative consequences. The investigation was reported in four separate decisions. The decisions received a great deal of media attention and the number of complaints concerning slow processing at the Migration Agency increased after the decisions were announced. I intend to continue to monitor the processing times at the Migration Agency. In addition, there were a number of complaints concerning slow processing times at the Police Authority, especially in the investigations into suspected financial crime and in applications for permission to possess weapons.

As in previous years, many complaints allege that the police have carried out a body search or property search as a means of crime prevention, without the measure having a legal basis. Following a petition I made, the Government is currently preparing a review of the regulations in the Police Act regarding these coercive measures. Several complaints against the Police Authority concerned publications on Instagram accounts, in some cases concerning an official account for the Police Authority, which described various police activities. The cases were dismissed, however I stated that I will continue to follow how the police act on social media and that I may return to the issue in my future supervision of the Police Authority.

An issue being increasingly raised concerns suspects' right to transparency via disclosure in a criminal investigation. As criminal investigations become ever more extensive and complicated, higher demands are being placed on the heads of investigations when a suspect's right to transparency via disclosure according to the Code of Judicial Procedure is to be met. Another dimension is that criminal investigations are an increasingly collaborative effort between several authorities. This right of access provides suspects with an opportunity to prepare their defence and has an important purpose regarding legal certainty. The official report contains a couple of decisions that deal with questions concerning suspects' right to transparency via disclosure. This is an important issue for me that I will continue to monitor in the future.

In conclusion, I would like to touch upon one aspect of the fact that only a small proportion of the many complaints received by the Parliamentary Ombudsmen are subject to an investigation where the notified authority is invited to respond via a so-called referral. The Parliamentary Ombudsmen is part of the Parliament's supervisory power and has the mandate to promote legal certainty through the supervision of public administration. In order to fulfil this role, it is important not only to find an appropriate balance in terms of which complaints can be decided upon after only a limited investigation, but also that the decisions in the referred cases make an impact. Preparatory work is underway within the Parliamentary Ombudsmen to investigate this issue. The question of the impact of the Parliamentary Ombudsmen's decisions is found additionally within with the 2020 Parliamentary Ombudsmen inquiry, which, to the extent deemed justified, must submit proposals for measures and any constitutional amendments. I see this as a very important issue for the future.

Summaries of individual cases

Summaries of individual cases

The following is a selection of summmaries of cases dealt with by the Ombudsmen during the period 1 July 2020 to 30 June 2021.

Chief guardians

The Parliamentary Ombudsman directs criticism towards the Board of Chief Guardians in Malmö municipality for slow processing of a case on dismissing a custodian

A custodian requested his dismissal from a Board of Chief Guardians regarding two assignment, pursuant to chapter 11, section 19, second paragraph of the Parents Code. In the case of one assignment, six months after the petition to the board, hte custodian requested the court to examine whether he had reasonable grounds for being dismissed as a custodian before a replacement had been appointed, pursuant to chapter 11, section 19 a, first paragraph of the Parents Code. The board took certain measures to find a suitable replacement after the custodian had turned to the court. Despite these measures, it took almost a year before the dismissal was issued. The Parliamentary Ombudsman has taken into consideration that the case is complex, but holds that the board will receive criticism due to the slow processing of the case. During the review of the case the Parliamentary Ombudsman states that processing of a case at a court does not create an obstacle for a board to continue their own processing to find a suitable replacement, to be able to dismiss the substitute pursuant to chapter 11, section 19, second paragraph of the Parents Code. The board's processing of the second case of dismissal was also slow. According to the Parliamentary Ombudsman's understanding, the length of time concerning the second case, was however, in view of the circumstances, not of the nature that the board deserves criticism. The Parliamentary Ombudsman also makes certain statements regarding the management of cases. In the decision, the Parliamentary Ombudsman makes a final statement regarding the requirement to send out a notification to concerned individuals, pursuant to section 11 of the Administrative Procedure Act. (Reg. no. 2586-2019)

The Parliamentary Ombudsman directs criticism towards the County Administrative Board in Västra Götaland county for deciding not to carry out inspections according to the Guardianship Act

With reference to the spread of Covid-19 and the general advice from the Public Health Agency, the County Administrative Board in Västra Götaland decided to stop its review of chief guardian files. The board determined that many municipalities' chief guardian activities would therefore not be inspected according to the Guardianship Act.

The Parliamentary Ombudsman argues that a desire to keep the spread of infection to a minimum cannot be taken so far as an authority allowing itself to deviate from laws and regulations. The board is criticized for deciding not to carry out inspections in accordance with the Guardianship Act without having legal support for it. (Reg. no. 387-2021)

Courts

Public courts

The Parliamentary Ombudsman directs criticism towards Lund District Court for a delay in holding bankruptcy hearings and for giving the state preferential treatment as a creditor when declaring bankruptcy

A creditor's application for bankruptcy that is to be reviewed must, as a rule, be tried in a bankruptcy hearing. The hearing must be held within two weeks from the time when the application was submitted to the court. In connection with an inspection of Lund District Court, the Parliamentary Ombudsman noted that the District Court had waited before scheduling a number of cases for a hearing. The court justified this by saying that as the applicant, the state had been late in paying the application fee and that the cases could not be scheduled before this had been done. Regarding the calculation of the time limit for declaring a bankruptcy, the Parliamentary Ombudsman finds that the regulation in

chapter 2, section 16 of the Bankruptcy Act is very clear, and that due to this there is no room for interpretation other than that the time limit of 2 weeks should start from the time when the application was submitted to the court and not from the time when the application fee was paid and the application is processed. Furthermore, the Parliamentary Ombudsman argues that this regulation is not problematic as long as the application for bankruptcy is complete and the application fee has been paid when the application is received by the court. However, if the application fee is paid one week later, the court has a limited time to schedule a hearing in the case and serve the creditor with the information. In light of this, among other things, the Parliamentary Ombudsman does not find sufficient reason to criticize the court for calculating the time limit based on when the application fee had been paid. However, the district court cannot avoid criticism since it did not hold the hearings within two weeks from when this took place. The Parliamentary Ombudsman also criticizes the court for having a special agreement with the Tax Agency on appointing bankruptcy hearings, which is not compatible with the requirement on objectivity set out in chapter 1, section 9 of the Instrument of Government. (Reg. no. 8454-2019)

The Parliamentary Ombudsman directs criticism towards Varberg District Court for neglecting to hold a renewed arrest hearing, for five months, for a 17-year-old

As a 17-year-old was detained the prosecutor asked, nine times, for an extension to prosecute. The detained 17-year-old went against the first petition but went along with the rest. The district court did not follow through on a single renewed arrest hearing for five months but granted all of the petitions. In the decision the Parliamentary Ombudsman makes certain statements regarding the courts obligation to initiate arrest hearings on a continues basis pursuant to chapter 24, section 18 of the Code of Judicial Procedure. When the court appraise the necessity of such a hearing the detained individual's age is essential, according to the Parliamentary Ombudsman.

The Parliamentary Ombudsman emphasizes that the statement that a prosecutor submits, in connection with a request for an extended period of prosecution, constitutes an essential part of the basis for the court's assessment of whether a question of detention can be dealt with pursuant to existing documents. Even if a suspect's attitude has relevance for the court's examination of whether a renewed arrest hearing is irrelevant, the court's obligation to take a decision to detain an individual cannot be based on a suspect's attitude, especially if a preliminary investigation drags on. The Parliamentary Ombudsman further emphasizes that the suspect does not have to state any specific circumstance in order for a hearing to be held, as the starting point is that such a hearing must be held every fortnight. Moreover, if the detainee puts forward any concrete reason why he or she opposes an extension of the prosecution period, a hearing can almost never be considered to be without significance.

According to the Parliamentary Ombudsman there should be specific demands to process the investigation rapidly and efficiently, when the detained individual is below the age of 18. She further states that detaining an individual below the age of 18 risks the well-being of that individual and that the court should, on a continues basis, supervise how to safeguard the individual while detained, as well as make sure that the detention is absolutely necessary. (Reg. no. 4133-2020)

Administrative courts

Renewed criticism of the Administrative Court in Gothenburg, the Migration Court, for slow and passive processing of cases regarding residence permits pursuant to the Aliens Act

In June 2019, the Parliamentary Ombudsman criticized the Administrative Court in Gothenburg, the Migration Court, for slow processing of a case involving a residence permit pursuant to the Aliens Act. Furthermore, the Parliamentary Ombudsman stated that the court's processing times in cases concerning residence permits for reasons of protection or asylum and visits or residence were significantly longer than was reasonable and acceptable.

In this decision by the Chief Parliamentary Ombudsman, the court is again criticised for the slow processing of three cases involving residence permit. In one of the cases, the duration of the processing time was more than two years and four months, and the court did not take any real action for a period of approximately one year and ten months. According to Chief Parliamentary Ombudsman, the processing time was remarkably long and the passive processing was completely unacceptable.

The Chief Parliamentary Ombudsman notes that processing times have deteriorated further

since the previous Parliamentary Ombudsmen case and are therefore still significantly longer than is reasonable and acceptable. A resource addition and a reorganisation can hopefully lead to shorter processing times in the long term. However, it may take a long time for them to reach a normal level. In this context, the Chief Parliamentary Ombudsman notes that the National Audit Office is currently examining whether migration courts' management of migration cases is efficient.

The decision is submitted to the parliament, the government and the National Courts Administration, for knowledge. (Reg. no. 1030-2020)

Education and research

Statements regarding a school administration's measures towards student organisations, in relation to statute regulated rights

In autumn of 2018, the Municipal Adult Education and Upper-Secondary School Committee in Borås municipality, carried out an inquiry of student organisations at two upper secondary schools. According to the information provided by the committee prior to the inquiry, it would e.g., aim to draw up guidelines that all student organisations must follow. A so-called communication plan stated that the staff had been informed that it was not compatible with their assignment to be a member of the organisations. The committee stated, to the Parliamentary Ombudsmen, that the inquiry's purpose was to inform of, and describe, the activities of a student organisation and other associations, which have a direct connection to the schools. The result of the inquiry would be used as a basis for counteracting offensive actions and possible irregular conduct, and for ensuring that the organisations activities are in line with the school's values and the democratic mission. The Chief Parliamentary Ombudsman states firstly, that the organisations' activities are in line with school activities and are so forth covered by the committee's responsibility under the Education Act, to counteract offensive actions, and secondly that the committee must consider statute-regulated freedoms and rights. According to the Chief Parliamentary Ombudsman's understanding the inquiry does not provide support that any restriction on the freedom of assembly or association has taken place. The committee's actions did not entail any unauthorized restriction of the freedom of speech. However, the Chief Parliamentary Ombudsman finds that the committee's statements, e.g., that the inquiry and the subsequent work would result in guidelines "that all associations must follow", could give the impression that the committee had the opportunity to take a decision regarding the organisation and its activities. The Chief Parliamentary Ombudsman emphasizes that an authority must be very careful with statements that can give rise to erroneous ideas about the authority's powers. This is especially true in the case of constitutionally protected rights. In conclusion, the Chief Parliamentary Ombudsman reminds the committee of the responsibility that an authority holds as an employer, and the responsibility that comes with being a civil servant. (Reg. no. 8070-2018)

The Parliamentary Ombudsman directs criticism towards a principal at a municipal primary school in Umeå municipality for designing an activity as a demonstration

A school had a theme week about the climate and sustainability. The week was closed with students marching and holding signs outside the school area, in which they expressed what they wanted to do to contribute to a sustainable development. The school had called the presentation a manifestation.

According to the Chief Parliamentary Ombudsman, it is obvious that students should be taught about climate and sustainability matters. Schools also have a great deal of liberty when it comes to designing the teaching and in choosing how to present subjects based on what is believed to best suit the students. However, information about the activity in question shows that it must be regarded as a demonstration. Since the activity was included in the mandatory teaching, one could say that the students have been forced to participate in it. According to the Chief Parliamentary Ombudsman, the school has thereby acted contrary to the statute-regulated requirements pursuant to the Instrument of Government in violation of governmental regulations. The school's principal receives criticism for how the activity was designed. (Reg. no. 7013-2019)

Criticism of a principal at a municipal primary school in Växjö municipality for designing an activity in a way that gave students the impression that they were forced to state their opinion

A school had a theme week on the equal value of all human beings. The school finished the week with students waiving rainbow flags in the playground during an activity. Through this activity, the school wanted to point out the equal

value of all human beings as well as hold a pride parade the following day.

The Chief Parliamentary Ombudsman expresses the importance of the school clearly making a statement in support of constitutional values, however it is also important that the school does not act in a way that may give people the impression that they are forced to participate in activities that involve the statement of an opinion. The school's principal cannot avoid criticism for how the activity was organised. (Reg. no. 647-2020)

Environmental and health protection

Severe criticism of the County Administrative Board of Uppsala County for slow processing of cases regarding agricultural support and against the National Board of Agriculture for shortcomings in the IT systems, etc.

In a report, a complaint concerned a County Administrative Board and slow processing of several agricultural support cases. The investigation revealed that in 2020, the County Administrative Board had a large number of cases concerning agricultural support from 2015-2017 that could not be decided on due to shortcomings in the IT systems for which the Board of Agriculture was responsible. The Parliamentary Ombudsman decided to obtain statements from the County Administrative Board and the Board of Agriculture.

In the decision, the Parliamentary Ombudsman makes statements on, among other things, the Administrative Procedure Act's requirements for urgency and notification of delays and on the priorities of authorities in relation to chapter 1, section 9 of the Instrument of Government.

Among other things, the County Administrative Board receives severe criticism for failing to make decisions for several years in cases that have been ready for a decision. The Parliamentary Ombudsman assumes that the County Administrative Board will close the cases as soon as possible and take a decision in the complainant's case as well as other older cases.

Regarding the Board of Agriculture, the Parliamentary Ombudsman concludes that management failed to plan and provide the new IT system in 2015 and beyond and that it has also neglected to consider the administrative requirements that apply to the processing for the Board of Agriculture as well as the County Administrative Boards. The Parliamentary Ombudsman believes that the Board of Agriculture deserves severe criticism for these shortcomings.

According to the Parliamentary Ombudsman, the brief statements submitted by both the County Administrative Board and the Board of Agriculture indicate that the authorities have not taken the issues seriously. The Parliamentary Ombudsman finds this very precarious. (Reg. no. 2876-2020)

Health and medical care

Statements regarding the statutory obligations on objectivity and impartiality due to the National Board of Health and Welfare's national guidelines on care for patients with depression or anxiety

The National Board of Health and Welfare decided, on the 13th of December 2017, on national guidelines for patients that suffer from depression or anxiety. In a complaint against the National Board of Health and Welfare the National Association for Psychotherapy [Riksföreningen Psykoterapicentrum] stated that the authority has not lived up to the statute-regulated requirements on objectivity and impartiality pursuant to the Instrument of Government, nor the Administrative Procedure Act's provisions on conflicts of interest, when completing the guidelines, among other things, five bias experts had been involved in the development of the guidelines.

The Parliamentary Ombudsman has examined the National Board of Health and Welfare's formal processing of the case. The examination has comprised a review of the National Board of Health and Welfare's model to decide on national guidelines and if the guidelines are pursuant to the statutory obligations on objectivity, and if the model in any way violated the demand on objectivity and impartiality. The review put focus on whether the external experts that the authority hired to complete the assignment were bias, and if there were reasons to believe so. The Parliamentary Ombudsman will not go into the actual content of the guidelines and will not make any statements thereof.

The Parliamentary Ombudsman states, in the decision, that there is no reason to pose any questions regarding the National Board of Health and Welfare's model and notes that the model appears as expedient for national guidelines. Moreover, the Parliamentary Ombudsman states that the authority has created the guidelines, and applied the model, in line with the statutory obligation on objectivity.

The Parliamentary Ombudsman also notes that the Administrative Procedure Act's provisions on conflicts of interest are not applicable on the experts who participated in formulating the guidelines, but that the authority has been obligated to abide by the statute-regulated requirements on objectivity and impartiality, pursuant to the Instrument of Government, and ensure that there have not been any circumstances that negatively affect the trust in these experts. The Parliamentary Ombudsman is of the opinion that the National Board of Health and Welfare cannot avoid criticism for employing an external expert which objectivity could be questioned. In other respects, however, the requirement on impartiality has been met. (Reg. no. 4141-2018)

The Parliamentary Ombudsman directs criticism towards a unit manager at Region Stockholm for handing out confidential data to a board of chief guardians

A unit manager at a centre for habilitation filed a complaint to a board of chief guardians concerning his views regarding how a custodian carried out his assignment. In the complaint, the unit manager provided information about the custodian's client's diagnosis and medical arrangements.

The Chief Parliamentary Ombudsman states that the information that the unit manager provided is such that it is covered by chapter 25, section 1 of the Public Access to Information and Secrecy Act. As far as has emerged, the disclosure of information had not been preceded by any probation. It had thus been required either that the individual to whom the information relates had given his consent to the disclosure, or that there was some secrecy-breaking provision that permitted it.

The centre for habilitation has, as a basis for disclosing the information, referred to chapter 10, section 2 of the Public Access to Information and Secrecy Act, regarding the disclosure of information, and to chapter 4, section 3, 2 of the Health Care Ordinance that include abilities for medical staff to report that patients are in need of custodians or other related issues.

The Chief Parliamentary Ombudsman states that the unit manager did not have the individual's consent to disclose the information and that it did not emerge that the disclosure was necessary for the habilitation centre to be able to carry out its activities, or that any other secrecy-breaking provision was applicable. Furthermore, the Chief Parliamentary Ombudsman states that chapter 4 of the Health Care Ordinance only applies to patients who are admitted to a healthcare facility. Against this background, the Chief Parliamentary Ombudsman states that the unit manager cannot escape criticism for the fact that the complaint to the board of chief guardians contained confidential information regarding the client.

Finally, the Chief Parliamentary Ombudsman emphasizes that she understands that the medical staff acted on basis of what is perceived to be the patient's best interests, and that it is problematic that their opportunities to contact the chief guardian are limited to patients under care. The Chief Parliamentary Ombudsman has, on previous occasions, drawn to the government's attention to introduce an obligation for doctors in outpatient care, to be able to file a report regarding the possible need for custodians. Since questions about the current regulations have been brought up yet again in this case, the Chief Parliamentary Ombudsman will hand over the decision to the government, to request a review of the legislation. A copy of the decision is also sent to an ongoing investigation into questions of deputy representation, for knowledge. (Reg. no. 6629-2018)

The Parliamentary Ombudsman directs criticism towards the Health and Social Care Inspectorate due to shortcomings in their supervision of compulsory psychiatric care

The Chief Parliamentary Ombudsman has examined how the Health and Social Care Inspectorate follows up on care pursuant to regulations covering psychiatric compulsory care. In the examination focus has been put on the following questions:

- Follow up of the care provider's coercive measures
- Examinations of complaints filed pursuant to lex Maria
- Follow up of the care provider's mapping of patient safety measures
- Checks conducted on the care environment
- Patients that are secluded during a long duration of time
- The security registry

In the decision, the Chief Parliamentary Ombudsman states that the Health and Social Care Inspectorate has no collective knowledge of the extent to which care providers use coercive measures. She states that it is very severe that the Health and Social Care Inspectorate has not used the means that the authority has been granted, from the legislator, to enable this.

The Chief Parliamentary Ombudsman states

that when a patient is secluded for a long duration of time there should be explicit legal support for the measure and that such intervening measures needs to be supported by comprehensive control measures. Furthermore, the Chief Parliamentary Ombudsman emphasizes that it is important that the Health and Social Care Inspectorate pays attention to the conditions for these patients at an early stage, as the patients' risk being isolated. The authority should also take measures to ensure ongoing supervision of the care of these patients.

The Chief Parliamentary Ombudsman also holds that it is severe that shortcomings in the so-called security registry have remained in place for almost five years when the Health and Social Care Inspectorate stated, in a referral response to the Parliamentary Ombudsman in 2015 that the authority worked actively to develop and improve the quality of the registry. The Parliamentary Ombudsman states that it is completely unacceptable that the registry has not been updated for such a long time and she expects that the Health and Social Care Inspectorate ensures that the information in the registry is continuously kept up to date.

In conclusion, the Chief Parliamentary Ombudsman is very critical of the fact that the Health and Social Care Inspectorate, for more than ten years of carrying out their operations, has not come further in developing methods needed to fulfil the requirement that supervision of care is conducted strategically, efficiently and uniformly pursuant to regulations covering psychiatric compulsory care. The Health and Social Care Inspectorate needs to ensure a centralized management and a systematic follow up of the operations of the regional supervisory unites in order to achieve the purpose of the supervision. In the decision, the Chief Parliamentary Ombudsman also asks the government to review the current legislation on patients that are secluded during a long duration of time. (Reg. no. O 60-2019)

Statements on certain queries regarding Stockholm Region's organization of compulsory psychiatric care

Within Stockholm Region, Stockholm County's Healthcare Area [SLSO] has the task of conducting e.g. psychiatric care. The County's Healthcare Area applies a system where decisions on detention, pursuant to section 6 of the Compulsory Psychiatric Care Act, are taken at the region's only adult psychiatric emergency unit, even though this is rarely where the admission is executed. The decision is considered valid at other care facilities in the region. The decision on detention is also considered the basis for certain coercive measures outside the care facility and for requesting assistance from the Prison and Probation Service. In the decision, the Chief Parliamentary Ombudsman states that the scope of a decision on detention is limited to the care institution where the decision was taken. According to the Chief Parliamentary Ombudsman, a patient who is only covered by such a decision and thus has not yet been admitted for care according to the Compulsory Psychiatric Care Act, cannot be considered detained when the patient leaves the relevant care facility. Therefore, the decision on detention does not give healthcare staff the right to take coercive measures outside the care facility with the support of the Compulsory Psychiatric Care Act, and the provision on legal authority is then not applicable either. The Chief Parliamentary Ombudsman further states that a condition for the Prison and Probation Service to conduct a transfer of a patient is that a decision on admission for care according to Compulsory Psychiatric Care Act has been made.

The Chief Parliamentary Ombudsman states that compulsory psychiatric care in the Stockholm Region is organized in a way that is not compatible with the current provisions in the Compulsory Psychiatric Care Act and that entails a risk of unauthorized restrictions on a patients' basic freedoms and rights. The Chief Parliamentary Ombudsman directs severe criticism towards Stockholm County's Healthcare Area [SLSO] for its handling of these issues and assumes that measures are taken immediately to ensure that all steps in the admissions process are handled in a legally secure and correct manner.

Through the investigation, the Chief Parliamentary Ombudsman has further drawn attention to the fact that certain provisions in the Compulsory Psychiatric Care Act are formulated in an unclear manner which risks complicating a uniform and legally secure administration. The case also illustrates the need to consider how compulsory psychiatric care is organized to ensure a legally secure admission process and abilities to meet a patient's need for safety while in care. In light of the ambiguities in the Compulsory Psychiatric Care Act, the Chief Parliamentary Ombudsman finds reason to, pursuant to section 4 of the Act with Instructions for the Parliamentary Ombudsmen, hand over the decision to the government, to request a review of the legislation. (Reg. no. 1732-2019)

Statements on certain matters regarding the issuing of certificates by healthcare professionals. Also, criticism of the Health and Social Care Inspectorate for inadequate justification of a decision

The issuing of certificates by healthcare professionals is primarily governed by certain provisions of the Patient Safety Act and regulations from the National Board of Health and Welfare. The Health and Social Care Inspectorate has assessed, in a decision, that a particular certificate issued by a doctor outside his or her regular work does not meet the requirements of those provisions, but that the doctor cannot be criticised for it because the provisions were not considered applicable in the present case.

In their decision, the Chief Parliamentary Ombudsman states that there are ambiguities in the area of application for the rules relating to the issuing of certificates by healthcare professionals and that it is not clear whether they apply when a doctor issues a certificate outside of an activity covered by the Health and Medical Services Act. The Chief Parliamentary Ombudsman emphasises that for both legal and patient safety purposes, it is important that certificates issued by licensed healthcare professionals are objective and of a high standard. Deficiencies in this respect can have a decisive impact on public and individual legal relationships and risk undermining the trust that the public and law enforcement agencies have the right to hold in licensed professionals. Furthermore, the Chief Parliamentary Ombudsman notes that healthcare professionals who do not fulfil their obligations under the Patient Safety Act may be subject to sanctions by the state, which is why it is also important for this reason that the legislation is clear and that it is clear to those concerned whether they are covered by the provisions or not. The Chief Parliamentary Ombudsman therefore finds reason to draw the government's attention to the need for a review of the legislation. The Parliamentary Ombudsman's review has not concerned the doctor's conduct or any review of the Health and Social Care Inspectorate's decision in this matter. However, Health and Social Care Inspectorate receives criticism for a deficient justification of the decision in question. (Reg. no. 9-2020)

The Parliamentary Ombudsman directs severe criticism towards a Chief Medical Officer for handing over confidential data to the Police Authority and the Enforcement Authority

During a body search at a clinic for forensic psychiatric care a large amount of money was found. The chief medical officer made a police report of an attempt to escape and also informed the Enforcement Authority of the money and in both cases provided certain information about the patient's personal circumstances.

The Chief Parliamentary Ombudsman states that the information provided to the police and the Enforcement Authority, regarding the patient, was covered by secrecy and that the patient had not given his consent to the information being disclosed. In the decision however, the Chief Parliamentary Ombudsman makes certain statements of when healthcare staff may give out confidential data, under certain conditions, to other authorities, e.g. if the information concerns suspicion of a crime of a certain seriousness or if it is necessary for the issuing authority to be able to carry out its activities. The Chief Parliamentary Ombudsman states that attempts to escape are not a crime of the kind that allows for information to be provided to the police, and that it was not necessary to disclose the relevant information in order for the clinic to be able to carry out its activities. Thus, no breach of confidentiality was applicable when the information was disclosed.

Furthermore, the Chief Parliamentary Ombudsman states that she understands that secrecy legislation can cause problems for healthcare professionals. In this case, the chief medical officer had tried to find out what legal possibilities there were to disclose the relevant information. However, his investigations did not lead to a clear statement on the issue of confidentiality. The Chief Parliamentary Ombudsman emphasizes the importance of the legislation that govern healthcare secrecy, which also is of significance to uphold credibility; and directs severe criticism towards the chief medical officer for deciding that the information should be handed out even though he was aware of the fact that the information he disclosed could violate the confidentiality regulations. (Reg. no. 1936-2019)

The Parliamentary Ombudsman directs criticism towards a clinic for forensic psychiatric care in Växjö municipality for setting up rules that restricted patients' right to property

A forensic psychiatric clinic set up certain routines to manage patients' property that restricted the patients' right to their own property in patient rooms. The Chief Parliamentary Ombudsman states that a patient who is admitted to a forensic psychiatric care facility may not, in addition to drugs and similar substances, possess "other property" that may harm them

or others or be detrimental to the care or order at the facility. What constitutes such property shall be assessed in each individual case and there is no legal support for generally restricting a patient's right to possess certain property. Nor does it appear reasonable that fire protection or hygienic reasons could constitute reasons for the facility's limitations. The clinic deserves criticism, according to the Chief Parliamentary Ombudsman due to setting up rules that lack legal support.

The Chief Parliamentary Ombudsman also states that jewellery, with a high economic value, may be considered such property that could be detrimental to the care or order of the facility. Therefore, after an assessment in the individual case, there may be reasons for refusing a patient to possess jewellery, and apprehend it.

Furthermore, the Chief Parliamentary Ombudsman emphasizes the importance of correct and accurate documentation when storing, caring for and returning patients' property. The Chief Parliamentary Ombudsman holds that property with a high economic value, that is particularly prone to theft, is stored on behalf of a patient, and that documentation as well as a photography of the property, is registered.

In conclusion, the Chief Parliamentary Ombudsman states that there are ambiguities in the implementation of the provisions concerning the management of patients' property at forensic psychiatric care and compulsory psychiatric care facilities. In February of 2020, the Chief Parliamentary Ombudsman handed over a request to the government to review the current legislation, in certain aspects. As this decision concerns the implantation of the same provisions, a copy of this decision is also sent to the government for knowledge. (Reg. no. 4225-2019)

The Parliamentary Ombudsman directs severe criticism towards a doctor for issuing a medical certificate without first performing a medical examination etc.

A doctor issued a medical certificate for compulsory psychiatric inpatient care without first performing an examination of the patient, as it is set out in the Compulsory Psychiatric Care Act. According to the Chief Parliamentary Ombudsman, it is a basic rule of law that such an examination is performed, and there is no room for failing to examine a patient before a medical certificate is issued. The doctor also did not fulfill his/her obligation pursuant to the Compulsory Psychiatric Care Act to ensure that the medical certificate was sent to the care facility where the hospitalization was to be reviewed. The doctor receives severe criticism due to these shortcomings.

In its decision, the Chief Parliamentary Ombudsman determines that current legislation does not answer the question of how a medical certificate should be sent from, for example, a healthcare center to a care facility where a matter of hospitalization will be reviewed. The responsibility to ensure that this takes place falls on the doctor who issued the certificate. According to the Chief Parliamentary Ombudsman, it is important that all involved authorities cooperate to the fullest possible extent. The Chief Parliamentary Ombudsman will not comment on the fact that the Police Authority, in connection with assistance from other authorities, also transports the medical certificate, provided that it can be done safely. However, the care provider is ultimately responsible for ensuring that the medical certificate is sent to the care facility that will review the issue of hospitalization. (Reg. no. 796-2020)

Labour market authorities/ institutions

The Parliamentary Ombudsman directs criticism towards Arbetsförmedlingen for informing a jobseeker, on a number of occasions, that he risked having his benefits withdrawn, without having had support for it

Arbetsförmedlingen (the Public Employment Service) has, during at least two occasions, temporarily withdrawn a jobseeker's benefits and, at one occasion, informed him that he could lose his benefits for not handing in his activity report in due time, in spite of the fact that he handed in his report to Arbetsförmedlingen's office in Norrköping in time. The misleading information was caused by the receiving administrative officer, at Norrköping office, who did not register the reports in the system where the reports belonged but in another system. These deviances hold much resemblance to previously noted shortcomings in decisions by the Parliamentary Ombudsman. As previously concluded, an authority should not notify an individual of a possible sanction until there is actual support for it. Such a procedure is contrary to an authority's obligation to observe objectivity pursuant to chapter 1, section 9 of the Instrument of Government and undermines the authority's credibility. The Parliamentary Ombudsman

directs criticism towards Arbetsförmedlingen in the current case, for once again informing a jobseeker that he risked having his benefits withdrawn, without having had support for it.

It is noted, in the decision, that Arbetsförmedlingen has taken measures to rectify the incorrect notifications of sanctions, e.g. in such a way that benefits are not kept interim and that the system will provide an automatic signal that flags the activity report when it has been registered in the system. The Parliamentary Ombudsman notes that this is positive, but states however, that the measures taken do not fully eliminate the risk of sending out a misleading notification concerning a sanction, if an administrative officer delays in registrating the activity report correctly in the system. (Reg. no. 949-2019)

The Parliamentary Ombudsman directs criticism towards Arbetsförmedlingen for delaying to submit a re-examination

A participator in a labour market policy program had applied for a recess from the activity, due to an upcoming Christmas holiday. The application was rejected in the beginning of December. Two days later the participator requested a re-examination of the decision. It took three months, until March of the following year, until Arbetsförmedlingen processed the request and handed in the re-examination of the decision.

The Parliamentary Ombudsman notes that a request for a re-examination holds many similarities to an appeal and that an appeal, that is not to be rejected due to a regular basis, shall be handed in to a higher court within a week. In line with previous statements by the Parliamentary Ombudsman, there is no valid reason to accept a longer period than that when a case is to be submitted for reconsideration within the same authority. In addition, when the re-examination, as in this case, concern a matter that loses its significance after a certain period of time, the individual should be able to expect that the re-examination is handed in as soon as possible.

The Parliamentary Ombudsman directs criticism towards Arbetsförmedlingen for delaying to submit a re-examination in due time. (Reg. no. 1941-2019)

An examination of the processing of cases on unemployment insurance funds focusing on the issue of processing times and the design of decisions

The Parliamentary Ombudsman has, for a long period of time, received complaints regarding the slow processing of compensation cases by various unemployment insurance funds. In light of this, the Parliamentary Ombudsman decided to launch an investigation into how three unemployment insurance funds processed this type of case. The investigation concerned, in particular, the duration of the process and the reasons for the decisions.

In the decision, the Parliamentary Ombudsman states, among other things, that the processing time for an application for compensation should normally not exceed one month and that the processing time in a reconsideration case should not exceed six weeks. In terms of recovery cases, the starting point for an acceptable processing time should be five weeks and, in the case of sanction cases, three weeks. Not all cases will be closed within these timeframes, but it is the unemployment fund's responsibility to take the case to a decision to push the case forward so that a decision can be made. In order for a longer processing period to be accepted, there must be circumstances which can justify the delay.

The Parliamentary Ombudsman notes that the processing times of the reviewed unemployment insurance funds were generally long, especially regarding claims for compensation and in reconsideration cases. The Parliamentary Ombudsman is critical of the long processing times in these types of cases at both the Alfa Unemployment Insurance Fund and Kommunal's Unemployment Insurance Fund.

The Alfa Unemployment Insurance Fund and Kommunal Unemployment Insurance Fund are also criticized for the design of certain decisions.

In the decision, the Parliamentary Ombudsman is very critical of the fact that the unemployment insurance fund has a case management system where the documentation is done in different systems and in different documents, regardless of the fact that it is a transitional solution, as it has significantly made the Parliamentary Ombudsman's review more difficult.

Furthermore, the Parliamentary Ombudsman states that when the unemployment insurance fund receives supplements in a closed case and assesses that the individual wants a retrial, this examination must be carried out by reassessment unless the individual has expressly made a new application. In some of the cases examined, Alfa and Kommunal's unemployment insurance funds have instead made new basic decisions, which the Parliamentary Ombudsman is critical of. The procedure entails, among other things, a delay for the individual to bring about a judicial review of the decision.

The Parliamentary Ombudsman also makes statements on how the unemployment insurance fund should handle a case when the individual has not submitted a timesheet. (Reg. no. 1214-2020)

The Parliamentary Ombudsman directs criticism towards Arbetsförmedlingen for not allowing an individual to use Finnish when in contact with the authority and for lacking in service duty

In order to be able to ask certain questions in Finnish, AA contacted Arbetsförmedlingen (the Public Employment Service) verbally by telephone, in writing through a chat function and by e-mail. During these contacts, he could not get his questions answered in Finnish. Moreover, he was not offered an opportunity to return at another time when it was possible to speak to a Finnish-speaking administrator. During the telephone conversation, he received information that his activity reports must be submitted in Swedish.

The Parliamentary Ombudsman states that the investigation proves that AA contacted Arbetsförmedlingen to discuss a matter to which he was a party. He therefore had the right to use Finnish and get an answer in a minority language when he contacted the authority in the matter. The Parliamentary Ombudsman directs criticism towards Arbetsförmedlingen for not living up to the individual's right to speak Finnish in his verbal contacts with the authority. Furthermore, Arbetsförmedlingen is criticized for incorrectly informing AA that his activity reports must be submitted in Swedish. As such reports are submitted within the framework of cases at Arbetsförmedlingen, individuals have the right to use a minority language in their written contacts with the authority.

However, when it comes to AA's contacts with Arbetsförmedlingen by e-mail and chat, it does not appear that these occurrences regarded a case at the authority, which implies that there is no right to use a minority language. According to the Parliamentary Ombudsman's understanding, however, Arbetsförmedlingen should, within the framework of its service duty, have asked AA if his contact with the authority concerned a matter in which he was a party or deputy, and in that case refer him to channels that allowed him to address his questions to the authority verbally or written, in Finnish. As Arbetsförmedlingen did not inform AA of this possibility the authority is criticized for lacking in service duty. Arbetsförmedlingen is also criticized for their lack of service duty as the authority took a month to return with a written response, in Finnish, by e-mail. (Reg. no. 4143-2019)

Review of the Work Environment Authority's actions regarding personal protective equipment in the management of patients with possible Covid-19 after a so-called protective stop at a nursing home

On 7 April 2020, the Work Environment Authority decided to ban near-patient work at Serafen's nursing home in Stockholm. In the decision, the Work Environment Authority stated as a condition for the ban to end the staff must wear adequate protective equipment. The explicit meaning of that condition was that visors were to be used in combination with masks. Two days after the decision, the Work Environment Authority participated in a collaboration conference called by the Swedish Association of Local Authorities and Regions (SKR). Other authorities in the so-called pandemic group also participated in the meeting. After the meeting, the Work Environment Authority published its own, and in part a government-wide, information text on its website stating in essence that the decision on Serafen was a decision concerning the workplace in question and that employers and safety representatives should carry out a local risk assessment of the activities regarding personal protective equipment in the care sector.

The Parliamentary Ombudsman notes that what has emerged in the review does not support the claim that the Work Environment Authority acted in violation of the principle of objectivity, pursuant to chapter 1, section 9 of the Instrument of Government. According to the Parliamentary Ombudsman, the investigation into the matter does not show that the Work Environment Authority, after the collaboration conference, has changed its opinion on the question of what requirements should be imposed on personal protective equipment in the event of possible Covid-19. It is also not clear that the Work Environment Authority has taken irrelevant considerations or allowed itself to be affected in any other way during the period under review. (Reg. no.3566-2020)

Migration

Investigation of the Migration Agency's processing times

During several years, the Parliamentary Ombudsmen has received many complaints regard-

ing slow processing at the Migration Agency.

During the first half of 2019, the Parliamentary Ombudsman decided to investigate nine cases that were filed due to a long processing time in cases involving citizenship, family ties and asylum, of which two cases on asylum included the Security Service as referral body. The results of the investigations are documented in four separate cases (see case numbers above).

The Parliamentary Ombudsman has, on several previous occasions, reviewed the processing times at the Migration Agency. In the reviews made after the substantial increase in migration, that began during the second half of 2015, the Parliamentary Ombudsman has so far not directed any criticism towards the Migration Agency due to slow processing. Rather, the Parliamentary Ombudsman has stated that it is a matter for the government and the parliament to ensure that the Migration Agency has the necessary resources to take decisions within a reasonable time span.

The starting point for the review now accounted for is the change in the influx of cases at the Migration Agency as the increase in migration has subsided and that the Migration Agency has had time to adapt its operations to the new conditions. Despite the fact that there may still be lingering effects due to the previous situation, it is no longer possible to overlook the long processing times at the Migration Agency, according to the Parliamentary Ombudsman's understanding.

The Parliamentary Ombudsman directs criticism towards the Migration Agency for slow processing in all examined cases and for passivity in processing most of the cases.

In one decisions, the Parliamentary Ombudsman also makes statements regarding the Security Service's processing times in cases referred from the Migration Agency.

In line with the facts that have been stated by the Migration Agency and the Security Service about e.g. the need for resources, the Parliamentary Ombudsman will hand over the decisions to the Ministry of Justice, for knowledge. (Reg. no. 130-2019)

Cases involving police, prosecutors and custom officers

During a lecture at an Upper-Secondary School, two police officers gave out certain information regarding individuals who had been convicted of a crime, which is in violation of the European Convention

Two police officers gave a lecture about the police's investigative activities at an Upper-Secondary School. During the lecture, the police officers gave out certain information regarding a completed criminal investigation that they themselves had been involved in. The police officers provided information on e.g. names of individuals who appeared in the investigation, and moreover the names of the individuals who had been convicted of a crime. In the audience was a student who was the daughter of one of the persons mentioned by the police.

The names of the individuals who were involved in the criminal investigation had become public when charges were brought against them. The fact that the person's names had become public meant that classified information was not disclosed at the lecture, however, according to the Parliamentary Ombudsman's understanding, to provide information that they had been convicted of a crime goes against the protection of private and family life, pursuant to Article 8 of the European Convention. The Parliamentary Ombudsman directs criticism towards the Police Authority for the occurrence.

In the decision, the Parliamentary Ombudsman makes certain statements regarding what considerations the Police Authority should make before informing about police activities at e.g. lectures and similar contexts. (Reg. no. 3103-2018)

The Police Authority has, at several occasions, without legal support, intervened against an individual that has engaged in passive fundraising (begging) outside a shop

During the first half of 2018, the police intervened on several occasions against a woman who was sitting on the sidewalk outside a shop engaged in passive fundraising (begging). She was removed from her place, at several occasions, in a police car and dropped off between four and five kilometres away. The interventions were made with reference to the provision in section 13 of the Police Act. According to the intervening police officers, her use of the area required a permit pursuant to the Public Order Act and the purpose of the interventions was to avert a criminal act. On some occasions, she was also considered to disturb or pose a danger to public order.

The Parliamentary Ombudsman notes that the woman's use of the area has not hindered accessibility or in any other way been disruptive to public order or safety. The Parliamentary Ombudsman states that the use was not incom-

patible with the purpose for which the area was used for or what is generally accepted, therefore the use of the area was not covered by the Public Order Act's requirement to hold a permit. To intervene due to disorderly conduct was not justified, according to the Parliamentary Ombudsman's understanding. The Police Authority is criticized for conducting interventions without legal support.

In the decision, the Parliamentary Ombudsman also makes certain statements as to whether the interventions constituted removals, or temporary apprehensions, pursuant to the Police Act. (Reg. no. 7139-2018)

The Police Authority neglected to hand over information from an informer to a prosecutor

The police received information about narcotics hidden in a gravel pit. The police informed the prosecutor about this and that the information came from an anonymous woman, who had made a phone call to the police on July 30, 2017. The police began to watch the site and were able to arrest two persons connected to the narcotics at the gravel pit. The two were sentenced at the district court.

Following the sentence at the district court the prosecutor became aware that the police had contacted an informant who had provided information about the hidden narcotics. The new information led to the prosecutor adding a supplement to the preliminary investigation and informing the suspects of what had emerged. The informant and the police officer who had been in contact with him were also heard at the main hearing in the Court of Appeal.

Due to certain statements that the Court of Appeal made in its judgment, the Parliamentary Ombudsman has initiated a case to investigate e.g. the contacts that took place between the police and the informant and moreover, if the information about these contacts were reported to the prosecutor and the suspects. The investigation has concerned both the Police Authority and the Prosecution Authority.

The Parliamentary Ombudsman's investigation proves that the police became aware of the narcotics by an informant several days before 30 July, 2017. According to the Parliamentary Ombudsman's understanding, most indications point to that this information prompted the police to investigate the site. However, the information was not communicated to the prosecutor nor to the suspects.

According to the Parliamentary Ombudsman, the police should have informed the prosecutor of the contacts with the informant already in the beginning of the investigation. By not doing so, the prosecutor was unable to live up to the requirements that are put on an investigator, and moreover it is a severe fault that the suspects' right to a fair trial was jeopardized. The Parliamentary Ombudsman directs criticism towards a police officer in a managing position for not informing the prosecutor that an informant had provided information in the investigation.

The Parliamentary Ombudsman cannot see that there were reasons for the prosecutor, involved in the preliminary investigation, to act in any other way that they have. On the contrary, the Parliamentary Ombudsman holds that the prosecutor who supplemented the preliminary investigation remedied the lack of transparency for the suspects within the preliminary investigation and in the district court. (Reg. no. 7289-2018)

The police handed out confidential data regarding a suspect, to a ticket inspector, without legal support

A security guard performed a so-called citizen's arrest of a woman suspected of travelling on a tram without a valid ticket. The police that arrived at the scene revoked the arrest but decided to perform a body search on the woman to establish her identity. The information regarding the woman's identity was used to search the police's files. The police also informed a ticket inspector of the woman's name and of her social security number so that the inspector could issue a fine.

The Parliamentary Ombudsman notes that the woman's data was established in a context where the Police Authority aimed to investigate or prosecute a crime, and that the data was confidential pursuant to chapter 35, section 1, first paragraph 4 of the Public Access to Information and Secrecy Act. The Parliamentary Ombudsman also notes that there was no legal support for disclosing the data to the ticket inspector. The Police Authority is criticized for disclosing the data.

In the decision, the Parliamentary Ombudsman also directs criticism towards the Police Authority for carrying out a body search, without legal support, and for deficiencies in the documentation. (Reg. no. 3469-2019)

The Police Authority has, without legal support, conducted a house search in a venue used by a motorcycle club

The police surveillanced a venue that was used by a motorcycle club. The motorcycle club was,

according to the police, known for handling narcotics. A man who was known in connection to narcotic dealings, according to the police, was seen leaving the venue a short time after he had entered it and as he was stopped by the police it was clear that the man was under the influence of drugs, moreover he was in possession of three tablets that are classified as narcotics. Against this background, the police decided to conduct a house search of the venue, due to the suspected drug offense.

In the decision, the Parliamentary Ombudsman gives a detailed account of certain parts of the regulations that concern house searches, e.g. in terms of what chapter 28, section 1, second paragraph, and section 3, second paragraph of the Code of Judicial Procedure stipulates regarding the necessity for adequate and specific reasons to conduct a house search. The Parliamentary Ombudsman notes that this particular case did not convey such reasons and so forth there were no legal support for the decision. The Parliamentary Ombudsman directs criticism towards the Police Authority for still taking a decision to conduct a house search and for deficiencies in the documentation. (Reg. no. 3729-2019)

In the search for a missing person who was believed to be suicidal, the police conducted a house search without having had support for it

A person who was believed to be suicidal had disappeared from an adult housing for individual's under care pursuant to the Support and Service for Person with Certain Functional Impairments Act. The Police Authority searched through another person's apartment as part of the general search of the surrounding area.

The Parliamentary Ombudsman states that a house search entailed a search of the premises that must be authorised by law.

Section 21 of the Police Act states that legal support for searching an individual's home rests on the necessity to search for someone who has gone missing, if it is assumed that this person needs help. According to the Parliamentary Ombudsman, there were no indications that the missing person was located in the apartment in question and that the police asked the occupant of the apartment any questions about the missing person before a search was conducted. It appears that one did not consider whether the search was even necessary at all. The Parliamentary Ombudsman finds that according to the investigation there was no basis for the assessment that there was a need for a house search and that the purpose could not have been achieved in a less invasive way. This action was therefore not necessary pursuant to section 21 of the Police Act. Nor was there any other legal basis for the action.

The Parliamentary Ombudsman directs criticism towards the Police Authority for carrying out the search of the home and for shortcomings in the documentation. (reg. no. 5611-2019)

A prosecutor and a police officer have not managed a request to disclose documents, regarding a completed preliminary investigation, in a correct manner

A person requested, from a police investigator and a prosecutor, to obtain certain material in a completed preliminary investigation, where he himself was a suspect. The prosecutor instructed the police investigators to manage the suspect's request. Several weeks later the suspect received some of the material. The investigator had then removed documents from the material that she deemed to be covered by secrecy.

However, the prosecutor had not decided to limit the suspect's access to the documents. The Parliamentary Ombudsman states that the request to access the documents should have been dealt with pursuant to the Code of Judicial Procedure's provisions on party insight. The Parliamentary Ombudsman further notes that the prosecutor, in his capacity as head of the investigation, was responsible for ensuring that the suspect's request was examined promptly and in accordance to relevant provisions. The Parliamentary Ombudsman states that the prosecutor cannot avoid criticism for the deficiencies in the management of the suspect's request to access documents.

The Parliamentary Ombudsman directs criticism towards the Police Authority for not notifying the head of the investigation of the request to disclose documents and for not recording the request until one month after it was received by the authority. (Reg. no. 6743-2019)

The Parliamentary Ombudsman's review of the prosecutor's report at the press conference on the Palme investigation

On 10 June 2020, the Public Prosecution Authority and the Police Authority held a joint press conference. At the press conference, a chief prosecutor, who was head of the investigation, announced the decision to close the preliminary investigation into the murder of Prime Minister Olof Palme. As a reason for the decision, the

prosecutor stated that there was no longer any reason to pursue the preliminary investigation because the suspect had died. During the two-hour press conference, the prosecutor named the suspect (AA) and some witnesses.

In September 2020, the Parliamentary Ombudsman decided to investigate certain matters regarding the rule of law raised in a specific case in connection with the prosecutor's presentation of their assessments and conclusions. The main questions in the review have been whether the prosecution's presentation was consistent with the so-called presumption of innocence, which implies a right to be considered innocent until the issue of guilt has been established by a court and whether AA's interests were adequately protected. The investigation has not considered the prosecutor's assessment that AA is suspected of the crime, the fact that the preliminary investigation was closed or how the preliminary investigation was conducted over the years.

It is the Parliamentary Ombudsman's overall assessment that at the press conference, seen as a whole and in the light of other relevant circumstances, AA was found guilty of the murder. This was done without the issue of guilt being determined by a court. The prosecutor's presentation at the press conference therefore constituted a violation of the fundamental right to be considered innocent as set out in the presumption of innocence.

The Parliamentary Ombudsman notes that nothing has come to light in the investigation that prevented the prosecutor from presenting their decision in a different way. According to the principle of objectivity, the prosecutor had a responsibility to protect the interests of AA, and the Parliamentary Ombudsman believes that more should have been done to achieve that.

It is also the Parliamentary Ombudsman's view that the prosecutor should not have mentioned the witnesses by name and that the written decision to close the investigation was not sufficiently justified.

Finally, the Parliamentary Ombudsman notes that the prosecutor themselves stated that the suspicions against the suspect would not have not been sufficient for a conviction, but that the lasting impression of the press conference is that AA was presented as guilty of the murder of Prime Minister Olof Palme. The Parliamentary Ombudsman is very critical of how the Chief Prosecutor presented their decision to close the preliminary investigation. (Reg. no. 6673-2020)

Prison and probation service

Enquiry regarding conditions for detainees held in security placements within the Prison and Probation Service

For many years, the Parliamentary Ombudsmen has examined the conditions for detainees placed in the Prison and Probation Service. The reviews have led to several critical statements by the Parliamentary Ombudsman and to the government being repeatedly reminded of the need to change the existing regulations. Sweden has also been recommended, by the international community, to stop the placement of detainees, who have been detained with the support of the Aliens Act, within the Prison and Probation Service.

Following upon the Chief Parliamentary Ombudsman inspection of several prions, within the framework of the operations of the Opcat unit during winter of 2017, she decided to conduct an examination of the conditions for detainees, who have been placed in a security placement within the Prions and Probation Service.

In the decision, the Chief Parliamentary Ombudsman states that it is clear that the Prison and Probation Service has not succeeded in creating the practical conditions required for all detainees staying in prisons and institutions, to be able to meet their statutory rights. According to the Chief Parliamentary Ombudsman understanding, the situation for those placed in security placements appears to be particularly worrying. That the Prison and Probation Service has not come further in its work is viewed as a severe deficiency and she directs criticism towards the authority for the fact that the detainees' statutory rights are still not met.

In the opinion of the Chief Parliamentary Ombudsman, the government must review how the regulations for detainees work in practice. It should also be clarified how the detainees' statutory rights can be met. The Chief Parliamentary Ombudsman also states that there is reason to question whether detainees who have not been deported should be placed within the Prison and Probation Service at all. If this is nevertheless considered appropriate, the regulation of their rights need to be clarified, e.g. regarding the right to associate with others and contact with the outside world. Against this background, the Chief Parliamentary Ombudsman finds reason to, pursuant to section 4 of

the Act with Instructions for the Parliamentary Ombudsmen, hand over the decision to the government, to request a review of the legislation. Furthermore, the Chief Parliamentary Ombudsman reminds the Prison and Probation Service of previous decisions made in terms of e.g. the need for a legalised review procedure and for guarantees that detainees are not put in security placements when there are no legal preconditions for it. (Reg. no. 277-2018)

Conditions on so-called bed restraints within the Prison and Probation Service's facilities and remand prisons

The use of bed restraints is one of the most invasive actions that the Prison and Probation Service can take against an inmate on the basis of the Prison Act and the Detention Act. In a comparison between the regulation on the same action within involuntary psychiatric care, it is clear that bed restraints within prison and probation services is not covered by the same rule of law. The Chief Parliamentary Ombudsman refers to the fact that the European Commission against torture, CPT, after its first visit to Sweden in 2015, stated that bed restraints should be used to a minimum, preferably for minutes rather than hours. According to the Chief Parliamentary Ombudsman, such a goal appears to be a highly reasonable basis for all methods of detaining a person in the form of bed restraints, regardless of whether they are done within the framework of involuntary psychiatric care or in another operation. Furthermore, according to the Chief Parliamentary Ombudsman's understanding, it is severe that it is not clearly stated in the Prison Act or Detention Act who is authorised to make decisions on bed restraints or how long a decision on bed restraints can apply at the most before it needs to be re-evaluated. Furthermore, there are ambiguities in the rules on how quickly a medical examination should be performed and ambiguities when it comes to how involuntary care cases are followed up on. Within involuntary psychiatric care, the law dictates that healthcare staff must be present during the time that the patient is restrained. Neither the Prison Act nor the Detention Act has an equivalent regulation. According to the Chief Parliamentary Ombudsman, there are good reasons for involving healthcare staff in the supervision from the very start of the involuntary action, since that would reduce the risk of the bed restraints resulting in the violation of the inmate's rights, or that he or she will suffer psychologically or physically in some other way.

The Chief Parliamentary Ombudsman also finds that the current regulations on bed restraints within the Prison and Probation Service does not meet the recommendations given to the government by CPT after the visit to Sweden in 2015. According to the Chief Parliamentary Ombudsman, there are strong reasons to review the regulations in the Prison Act and the Detention Act when it comes to restraints, including the issue of whether the Prison and Probation Service should even have the right to use bed restraints on inmates. In light of this, the Chief Parliamentary Ombudsman finds that there is cause to, on the basis of section 4 of the Act with Instructions for the Parliamentary Ombudsmen, submit a recommendation to the government to review current legislation.

Awaiting such a review, the Chief Parliamentary Ombudsman states that the Prison and Probation Service must ensure that the use of this far-reaching involuntary action must be kept to a minimum. That means, among other things, that the Prison and Probation Service and its staff must in all situations do their utmost to prevent situations in which inmates become as violent that bed restraints is the only solution. (Reg. no. 279-2018)

Occupancy within the Prison and Probation Service

During spring of 2019 the Parliamentary Ombudsman has investigated how the Prison and Probation Service managed the lack of space in remand prisons and in Kumla prison's national risk assessment unite. In the decision, the Parliamentary Ombudsman notes that the strained occupancy situation has resulted in an even bigger challenge to provide for inmate's right to associate with others. Several remand prisons have employed additional staff but the investigation proves that this measure was due to matters of security in connection to double quarters in cells. The Parliamentary Ombudsman states that security is a central part of the Prison and Probation Service's mission but emphasises that the authority, also when the occupancy is trained, is responsible to provide possibilities for association, to avoid confinement for inmates.

Pursuant to Swedish regulations an inmate in a remand prison is entitled to be placed in a private cell and the Parliamentary Ombudsman states that this should continue to apply. If double quarters are an option only cells with a floor surface of at least ten square meters, not including the rest room, should be considered. The Prison and Probation Service is responsible

to follow up on how inmates manage double quarters. According to the Parliamentary Ombudsman's understanding it is not acceptable that inmates share cells during several weeks and she states that there should be a limitation in exposing inmates to double quarters.

During the investigation of the national risk assessment unite the occupancy rate was above 160 percent. Suitability was not considered before two inmates were forced to share a cell and inmates shared stories of concern and of sleepless nights. According to the Parliamentary Ombudsman it is positive that the Prison and Probation Service now conducts a thorough risk assessments prior to placing inmates in double quarters. However, the Parliamentary Ombudsman questions whether the prison, during spring of 2019, obtained resources and pre-conditions necessary to be able to conduct their operations at the unite, and further on she questions if it is appropriate that the Prison and Probation Service places inmates in double quarters at the unite. The Parliamentary Ombudsman emphasises that the Prison and Probation Service must, on a continues basis, present solutions to adjust the facilities to the occupancy rate. Therefore, it is important that the authority presents methods for remand prison and prison operations to be able to find sustainable measures to plan future needs to create flexibility, which can enable a temporary stop in occupancy without neglecting the purpose of the authority's function. (Reg. no. O 19-2019)

The Parliamentary Ombudsman directs severe criticism towards the Prison and Probation Service due to placing certain inmates in a more intrusive environment than necessary

The Prison and Probation Service has three buildings with a particularly high security classification. These premises are situated in the prisons Hall, Kumla and Saltvik (so-called high security units). The buildings were built to receive inmates covered by decisions pursuant to chapter 2, section 4 of the Prison Act implementing that the inmate is to be placed in a security unit. The Parliamentary Ombudsman has previously criticised the Prison and Probation Service for the fact that the high security unit at Saltvik prison has partly been used for the placement of inmates who should not be placed in security units, but who for various reasons need protection. Within the framework of this enquiry, the Parliamentary Ombudsman will continue to investigate how the Prison and Probation Service use these buildings.

The investigation has shown that the Prison and Probation Service, despite previous criticism, has not taken necessary measures to adjust the situation for inmates in need of protection, who are placed in high security units. These inmates are still subject to more intrusive surveillance and control than is necessary. The Parliamentary Ombudsman finds this remarkable. Moreover, the Parliamentary Ombudsman directs criticism towards the Prison and Probation Service for taking a decision to establish shelters at Hall prison, despite the fact that the prison was not able to adapt their activities for these inmates as at Saltvik prison. It has also emerged that the Prison and Probation Service, during the Parliamentary Ombudsman's ongoing investigation, decided to place groups of inmates, who are not covered by decisions on security placement, in high security units. This is a worrying development, according to the Parliamentary Ombudsman.

The Parliamentary Ombudsman does not question that the Prison and Probation Service has an urgent need to locate more space, due to the problematic occupancy situation. According to the Parliamentary Ombudsman's understanding, however, it is not acceptable to place inmates within premises that hold more intrusive surveillance and control that what is necessary, violating the provisions set out in the Prison Act. The Parliamentary Ombudsman states that the Prison and Probation Service must be able to cater for an inmate's needs for e.g. protection, regardless of the degree of surveillance and control that an inmate otherwise needs. The Parliamentary Ombudsman also holds that the high security units do not offer a flexible space and are limited in terms of adaptations to be able to compensate for the closed environment.

The Parliamentary Ombudsman directs severe criticism towards the Prison and Probation Service due to the deficiencies that have been observed within the framework of this enquiry. A copy of the decision is sent to the government for knowledge. (Reg. no. 1950-2019)

The Parliamentary Ombudsman directs severe criticism towards the Prison and Probation Service, Ystad prison, for conducting bodily searches on inmates in connection to the management of post etc.

Ystad prison conducted body searches on inmates after the inmates had received and read their official post to ensure that they did not take documents from the post that could include sensitive data. The Parliamentary

Ombudsman states that there is no provision in the Prisons Act that provides basis to carry out bodily searches in a general and routine manner, in the current situation. The prison receives severe criticism for routinely using body searches as a control measure in a way that lacks legal support.

As the Prison and Probation Service responded to the Parliamentary Ombudsmen's referral the prison had changed its routine to conducting body searches of the inmates instead of at the arrival of official post. In regard to the change of routines the Parliamentary Ombudsman states the following.

Body search pursuant to chapter 8, section 5 of the Prisons Act, a so-called protective visitation, may not be considered a control measure to ensure that inmates do not carry documents, as the visitation is not intended to be used to search an inmate for weapons or other dangerous objects.

Neither does the provision in chapter 8, section 1 of the Prisons Act provide support to carry out body searches in a general and routine manner after inmates have received official post. In each individual case, the prison must assess whether there is reason to believe that an unauthorized object will be found on the inmate and whether a body search is in reasonable proportion to the purpose of the measure.

The Parliamentary Ombudsman also notes that the handling of official post constitutes case handling. This means that a prison that assess that a certain document with reference to the content may not be managed by an inmate, when the inmate requests it, must take a decision on apprehending property, pursuant to chapter 5, section 2 of the Prisons Act. In the decision, the Parliamentary Ombudsman also addresses other complaints, including a matter of slow processing of an application for a review on an inmate's specific conditions. (Reg. no. 3736-2019)

Enquiry of the Prison and Probation Service, Sahlberga prison, regarding the circumstances surrounding a so-called bed restraint

An inmate at Sahlberga prison was under bed restraint and placed in a so-called restraint bed for approximately 15 hours. When he after roughly 3 hours needed to use the toilet he was offered, due to safety reasons, no other option than to relieve himself in an adult diaper, while restrained to the bed. He declined this offer, however. According to the inmate, he was in this situation treated in a degrading and offensive way. The inmate eventually relieved himself, while restrained to the bed, and was after that left to lie in his own urine.

The Chief Parliamentary Ombudsman states, in her decision, that she has not had an opportunity to do a full evaluation of whether it was necessary to restrain the inmate at the time in question or if the restraints could have been removed when he needed to use the toilet. However, she does find that the information that has emerged in the case in question raises questions regarding the Prison and Probation Service's assessments according to chapter 1, section 6 of the Prison Act. According to that regulation, an inspection or involuntary action can only be used if it is in reasonable proportion to the action. If a less invasive action is sufficient it should be used instead. In her decision, the Chief Parliamentary Ombudsman points to the necessity of the Prison and Probation Service to conduct continuous reviews of the need to use bed restraints, to ensure that the action does not occur longer than what is absolutely necessary.

In her decision, the Chief Parliamentary Ombudsman finds that the documentation of the bed restraints in the inmate's records is highly insufficient, which has made it extremely difficult to evaluate the occurrence after the fact. She is very critical of this.

Regarding the inmate's claims about degrading and offensive treatment, the Chief Parliamentary Ombudsman finds that it is a matter of a word against another and that what has been found in the investigation does not give cause to criticism or any other measure. (Reg. no. 3815-2019)

The Parliamentary Ombudsman directs criticism towards the Prison and Probation Service, Hinseberg prison, for their actions in connection with bodily searches of an inmate etc.

An inmate was placed in isolation to undergo a bodily search because it was suspected that she had swallowed narcotics. The facility used a customs rest room to perform the bodily search. When narcotics was not detected in the excrement, the inmate was asked if she would agree to an additional bodily search at a hospital, in the form of among other things a vaginal and rectal examination. According to the Parliamentary Ombudsman, the documentation indicates that the facility used a perceived consent as the basis for the decision to perform a bodily search. The Parliamentary Ombudsman states that the space for allowing a consent to be enough to execute a forced action which would otherwise

require a legal basis is highly limited and that it is the decision of the Prison and Probation Service that is the deciding factor of whether an inmate should undergo an involuntary action such a bodily search. To the inmate, it must have appeared as though the alternative to a bodily search was continued isolation. The Parliamentary Ombudsman states that the voluntariness in such a situation must be regarded as illusory. The staff responsible receives criticism for how they handled the matter and for certain shortcomings in their documentation. (Reg. no 7070-2019)

The Parliamentary Ombudsman directs severe criticism towards the Prison Service and Probational Service, Kronoberg remand centre, for exposing a female inmate to excessive security arrangements

Questions regarding safety arrangements for hospital stays, including for pregnant inmates, have been raised in several cases with the Parliamentary Ombudsmen in recent years. In this case, a female inmate at Kronoberg remand centre underwent a planned and late abortion at a medical facility. For much of the two-day stay in hospital, she was placed in waist or foot restraints and her monitoring was mainly managed by only male correctional officers, who attended the room even at the most personal and sensitive moments.

The Parliamentary Ombudsman draws attention to several shortcomings in how the remand centre handled the situation, both before and during the inmate's hospitalisation. It appears, among other things, that the risk assessment on which the security arrangements were based was carried out by an official who did not know that the woman was pregnant and was about to have an abortion, and that central officials lacked knowledge of the specific considerations to be taken with regard to pregnant inmates. The Parliamentary Ombudsman says that she views the shortcomings very seriously. As a result, the inmate had to endure, in a situation where she has been particularly vulnerable and particularly exposed, far more intrusive supervision and control than what was justified and proportionate. This is not the first time that the Prison and Probational Service has failed in a similar situation. According to Parliamentary Ombudsman, the remand centre deserves severe criticism.

The case has again raised the issue of the Prison and Probational Service's safety assessments in connection with hospital stays, especially for inmates who are pregnant. The Parliamentary Ombudsman notes that it is clear that work still remains to be done in order for the authority to ensure that pregnant inmates are treated correctly, humanely and proportionately in personal and sensitive situations. The Parliamentary Ombudsman states that she will follow up on these issues. (Reg. no. 4830-2020)

Public access to documents and secrecy as well as freedom of expression

The Parliamentary Ombudsman directs criticism towards the Municipal Adult Education and Upper-Secondary School Committee in Borås municipality for requesting to survey a school newspaper, violating the Freedom of the Press Act's censorship ban

In a complaint to the Parliamentary Ombudsman, it was stated, among other things, that a high school's administration had demanded to survey a school newspaper before publication. The complainant questioned whether the action was compatible with the Freedom of the Press Act. In the decision, the Chief Parliamentary Ombudsman states that the investigation does not clarify whether the school administration had survived the school newspaper before it was published. The Chief Parliamentary Ombudsman holds that the investigation has not revealed if the school administration prevented publication, printing or distribution of the school newspaper. However, the Chief Parliamentary Ombudsman assess that the school administration, already by requesting a preliminary survey of the newspaper, has initiated an action that is not compatible with the censorship ban and the Freedom of the Press Act. (Reg. no. 8013-2018)

The Parliamentary Ombudsman directs criticism towards a Judge at Falu District Court for e.g. the administration of confidential data in a civil case

AA, who's identity was confidential, was a party in a civil case at a district court. In the execution of the decision the custody of the children AA and BB was distributed. The custody of the children should, pursuant to the decision, be initiated in a so-called custody venue in a certain municipality and AA should leave and collect BB at the venue. An appendix to the decision included AA's name, personal identity number and box-address. The decision did not include a confidentiality settlement. The Parliamentary Ombudsman makes certain statements pursuant to chapter 21, section 3 of the Public Access

to Information and Secrecy Act in regards to the applicability to the box-address and of the meaning of including an appendix to a decision. The Parliamentary Ombudsman directs criticism towards the judge as AA's confidential data became public, due to the lack of a confidentiality settlement. The judge also receives criticism as the decision did not include a settlement on custody support pursuant to chapter 6, section 15 c of the Parents Code and for, due to this error, ambiguities in the decision. According to the Parliamentary Ombudsman understanding, it is not possible to rule out that the design of the courts' case management system Vera and how an appendix is drawn up and linked to a decision, may explain errors in matters regarding confidentiality. For that reason, among other things, the Parliamentary Ombudsman will send a copy of the decision to the National Courts Administration for knowledge. (Reg. no. 3562-2019)

The Parliamentary Ombudsman directs criticism towards Norrtälje District Court for handing out data regarding a minor to a parent that was not a guardian

Following upon a prosecutor submitting a petition for an appointment of a counsel to an injured party (a minor), both parents were registered, by the district court, as guardians to the minor, when only the mother was a guardian. The district court took a decision on a counsel and sent a copy of the appointment to the father as well as the mother. Pursuant to chapter 35, section 1 of the Public Access to Information and Secrecy Act, a preliminary investigation, as a general rule, sets forth that data regarding the identity of an injured part is confidential. As a result of the district court's management of the party information in the case, the father was informed, by mistake, that a criminal investigation where his child was the injured party, was in process. Even if what happened appears to be a secluded occurrence, the Parliamentary Ombudsman finds that the district court cannot escape criticism. In the decision, the Parliamentary Ombudsman also makes certain statements about confidentiality when it comes to protecting minors as injured parties. (Reg. no. 3828-2019)

The Parliamentary Ombudsman directs criticism towards Värmland District Court for handing out data regarding a suspected minor to a parent that was not a guardian

As the police submitted a petition to appoint a public defence counsellor for a minor suspected of a crime, the district court registered both parents as guardians to the minor, when only the mother was a guardian. The district court made a preliminary assessment that there was no need for a public defence counsellor and informed the suspect of this. The same notification was sent to both parents for knowledge. Pursuant to chapter 35, section 1 of the Public Access to Information and Secrecy Act, a preliminary investigation, as a general rule, sets forth that data regarding the identity of a suspect is confidential. As a result of the district court's management of the party information in the case, the father was informed, by mistake, that a criminal investigation where his child was a suspect, was in process. Even if what happened appears to be a secluded occurrence, the Parliamentary Ombudsman finds that the district court cannot escape criticism. In the decision, the Parliamentary Ombudsman also makes certain statements regarding notifications, while a case is being processed, to persons other than the guardians when a minor is suspected or charged with a crime. (Reg. no. 6318-2019)

The Parliamentary Ombudsman directs criticism towards Sweden's Consulate General in Jerusalem due to their management of the disclosure of public documents

On three occasions the complainant requested, at the Swedish Consulate General in Jerusalem, to disclose certain public documents. The Parliamentary Ombudsman notes that the Consulate General's handling of the requests did not live up to the to the Freedom of the Press Act's obligation to process such requests promptly and directs criticism towards the Consulate General for the inadequate processing.

The decision also puts focus on the Consulate General's routines when managing a request to disclose public documents, emphasizing that the next request in turn, is processed only when the processing of the previous request has been completed.

Due to what has emerged in the case, the Parliamentary Ombudsman presupposes that the Ministry for Foreign Affairs takes measures to ensure that the Consulate General has the knowledge and ability required to live up to the requirements of the Freedom of the Press Act. The Parliamentary Ombudsman also assumes that the Ministry for Foreign Affairs takes the Parliamentary Ombudsman's statements into account in their ongoing work to improve the handling of public documents throughout the Foreign Service. (Reg. no. 5301-2019)

The Parliamentary Ombudsman directs criticism towards the Culture Committee in Stockholm municipality for destroying official documents in the city's e-archives without legal support

The Parliamentary Ombudsman has reviewed the removal of certain data that Stadsarkivet (the city archive) in Stockholm has performed in 2018 of applications in recruitment matters that were submitted to the city in 2014 and 2015. The documents had been transferred to an e-archive at Stadsarkivet, which is responsible for sorting documents under the committee, due to the fact that the municipality was in the process of discontinuing a case management system for job applications.

Among the documents that were destroyed were applications that had been submitted by people who had been hired and who, according to the city's rules on archives, were to be kept and stored printed on paper in the employee's personnel file at the respective administrative offices. The investigation shows that the city's procedure for keeping such documents had not been used by the administrative offices in all cases, and that some personnel files therefore lacked applications. The Parliamentary Ombudsman finds that this may have caused limitations on the public's access to these files, which is severe.

When the data was destroyed, it was known to Stadsarkivet, that the documentation of these documents had not been used in all cases. Thus, Stadsarkivet had the information that the destruction entailed that some applications would be destroyed, even though they were not stored in any other location within the city.

The Parliamentary Ombudsman states that rules on archives within a municipality must be applied on the basis that the municipality is a unit. As the principle of public access should apply, one cannot, according to the Parliamentary Ombudsman, accept that documents were destroyed with the knowledge that the action in reality means that documents that are meant to be kept are destroyed, even though the responsibility for maintaining them lies with, for example, another municipal committee. (Reg. no. 5698-2019)

The Parliamentary Ombudsman directs criticism towards the manager of human resources in Laholm municipality for the management of a request to disclose public documents

A newspaper reporter sent an e-mail to the manager of human resources in Laholm municipality to ask if there were any personnel cases regarding the municipality's street engineer. The reporter requested to disclose "possible warnings directed towards the street engineer, possible notices or agreements on termination or likewise".

When the request was made the municipality had taken a decision to suspend the street engineer from his position. In spite of this the manager replied, to the reporter, that there were no documents that corresponded to the reporter's request.

The Parliamentary Ombudsman notes that it is not possible to interpret the reporter's request in any other way then that it also included the decision on suspension, and that the manager of human resources could reasonably not have come to any other conclusion. The Parliamentary Ombudsman directs criticism towards the manger for giving misleading information and prolonging the disclosure of a public document. The manager is also criticised due to the fact that she, at a later point in time, asked the reporter why she was interested in the street engineer's file, which violates the prohibition against seeking to obtain certain information pursuant to the Freedom of the Press Act.

The Parliamentary Ombudsman notes that the destruction of these documents, especially in light of the principle of public access, was carried out without any legal support and also criticizes the Cultural Committee in Stockholm municipality for not removing documents that were stored at another location within the city. The Parliamentary Ombudsman also argues that this case shows that a functioning archive formation requires that follow-ups be conducted on a regular basis to ensure that decisions and routines are followed. (Reg. no. 7480-2019)

Review of alleged coordination in the assessment of requests for disclosure of Covid-19 data

This decision presents a review in connection with a complaint against eight municipalities in Södermanland County and Region Sörmland for the management of requests for the disclosure of public documents with information on, among other things, the number of people in elderly care diagnosed with Covid-19. The review also concerns other related issues.

The investigation shows that on 9 April 2020, the municipality of Gnesta, Nyköping, Oxelösund and Trosa received a request for a summary of the stated data from a journalist at Södermanlands Nyheter [newspaper]. The request was forwarded by e-mail to the other municipalities and to the region. According to the

Parliamentary Ombudsman, the investigation gives the impression that people in management positions in several of the municipalities and the region drew up guidelines for how the requests should be handled, which entailed that no information would be disclosed and that information would be given at a certain time.

The Parliamentary Ombudsman cannot establish that the formal decisions of the four municipalities in response to the requests were indeed made on inappropriate grounds. However, according to the Parliamentary Ombudsman, the circumstances surrounding the decision taken in Gnesta municipality are such that there is a reasonable basis for the view that the decision was not taken objectively. According to the Parliamentary Ombudsman, this means that the government's demand for objectivity has not been taken into consideration. The acting municipal manager of Gnesta municipality, who was the one who made the decision, is criticised for it.

The Parliamentary Ombudsman criticises Region Sörmland for removing a public document without legal support and the regional director of Region Sörmland is criticised for deleting three emails after they were requested.

According to the Parliamentary Ombudsman, what has emerged from the investigation shows a lack of understanding and respect among persons in management positions in several municipalities and in the region for the constitutional right to access public documents and for the important role played by the media in the scrutiny of public activities. The discussions that took place were inappropriate and the Parliamentary Ombudsman understands that there have been suspicions that the municipalities and the region has had a desire to limit the transparency of their activities.

According to the Parliamentary Ombudsman, there is a risk of a residual distrust of the municipalities and the region. This is a serious matter and something that municipalities and the region need to address. (Reg. no. 3718-2020)

Social services

Social Services Act

The Parliamentary Ombudsman directs severe criticism towards Farsta District Council in Stockholm municipality for extensive shortcomings in a case involving a child that was placed outside their own home

The child CC was living with his mother BB, who had sole custody of him. In February 2018, social services opened an investigation into CC on the basis of chapter 11, section 1 of the Social Services Act, due to reports about BB relapsing into drug abuse. When the police found BB under the influence of drugs in her home, the council decided in May 2018, in consultation with CC's grandmother AA, that CC would come to live with her for one week. However, CC continued to live with AA for more than seven months.

In its decision, the Parliamentary Ombudsman finds that the council placed CC with his grandmother in May 2018. The council did not formalise its decision in any way, and instead made an informal decision about the placement. The Parliamentary Ombudsman argues that the decision should have been documented. The fact that it was not documented caused confusion among all involved parties in terms of what type of placement it really was. This uncertainty affected CC, AA and BB in a negative way. The Parliamentary Ombudsman also points to the fact that since AA was not CC's legal guardian the council should not have come to an agreement with her about where CC was going to live. In its decision, the Parliamentary Ombudsman criticizes the council on how the placement came about.

Furthermore, the Parliamentary Ombudsman also claims in its decision that the council did not take responsibility for CC during the time when he was placed outside his own home, but instead transferred the responsibility over to AA, despite the fact that she had repeatedly told social services that she needed help in taking care of CC.

The placement of CC with AA continued for more than seven months. It must have been clear to the council that CC was not going to live with AA for only a short period of time. The council should therefore have, when it was evident that the placement was not going to be temporary, conducted a foster home investigation and should after that have decided on where CC would have his permanent placement. The council did not investigate the conditions at AA's home at all. During the autumn of 2018, the council applied to the administrative court to have CC taken under care pursuant to the Care of Young Persons Act. At that time, the council provided the court with incorrect information, which the council is criticized for.

A placement outside the own home is an invasion into a child's life and has consequences for

the child's family. This entails requirements on the correct management of the case by the council. The Parliamentary Ombudsman determines in its decision that in this case the council failed to live up to its requirements and that the management of CC's case has been unacceptable.

In its decision, the Parliamentary Ombudsman directs severe criticism towards the council for the extensive shortcomings that have emerged in this case. (Reg. no. 2232-2019)

Severe criticism of the Social Welfare Board in Mariestad municipality for the placement of a child under care

On 13 February 2019, social services launched an investigation into the child BB after the Social Welfare Board received a report due to concern from the police regarding the conditions at her mother's home, AA. On that same day, BB was placed by the Social Welfare Board with her grandparents, with the support of chapter 4, section 1 of the Social Services Act. The reason for the placement was that BB was to be protected from ending up in an environment where substance abuse occurs. On February 20, 2019, BB's grandmother announced that she had not been granted leave from her work and that she and her husband could not continue to have BB placed with them.

On 22 February 2019, the board submitted an agreement which meant that AA, together with BB, would stay with the grandparents. According to the agreement, they would, among other things, constantly check the whereabouts of AA and BB and they would also have BB with them when they were not working.

In the decision, the Parliamentary Ombudsman notes that the agreement meant that BB remained placed by the board with the grandparents and that it was therefore responsible for ensuring that BB received good care. The Parliamentary Ombudsman is critical of the fact that no decision was taken on the placement and points out that this fact led to uncertainty for everyone involved as to who was responsible for what during the placement. At the time of the agreement, BB's parents had joint custody of her, but the board nevertheless did not collect the father's consent for the placement, for which the board is also criticized.

Furthermore, the Parliamentary Ombudsman points out that the board did not take responsibility for BB during the time when she was placed outside her own home. Instead, the board left the responsibility for her to her grandparents, even though they pointed out that they were unable to take that responsibility. The board was aware of the difficult situation that AA was in, and it is therefore particularly serious that the board did not then take responsibility for BB. In the Parliamentary Ombudsman's opinion, one cannot help to view the agreement as an attempt by the board to waive its statutory liability for BB. The Parliamentary Ombudsman states that such a thing cannot occur and that a social welfare board can never relinquish responsibility for a placed child.

In the decision, the Parliamentary Ombudsman directs severe criticism of the Social Welfare Board for the extensive shortcomings that have emerged in the case. (Reg. no. 2965-2019)

The Parliamentary Ombudsman directs criticism towards the Social Care Board in Avesta municipality for using a digital communication service when contacting an individual without considering the legal prerequisites

A 14 year old girl was taken into care pursuant to the Care of Young Persons Act, in April 2019 she escaped from the residential home where she was placed. She was found three weeks later. During the time she was away, the administration communicated with her via the digital communication service Snapchat.

The Parliamentary Ombudsman states that it is the responsibility of the Social Services to ensure, in each individual case, that a digital communication service is used in such a way that it is not in conflict with the regulations governing the handling of data. As the administration, in this case, had not investigated the legal conditions for using the digital communication service Snapchat, the Parliamentary Ombudsman states that the administration should have refrained from using the service. Despite this, the service was used on several occasions to, for example, give the girl information covered by chapter 26, section 1 of the Public Access to Information and Secrecy Act. The Parliamentary Ombudsman views this as unacceptable and directs criticism towards the Social Care Board. (Reg. no. 3224-2019)

The Parliamentary Ombudsman directs severe criticism towards the Social Welfare and Labour Board in Sundbyberg municipality for shortcomings in the investigation of two cases

The Social Welfare and Labour Board in Sundbyberg municipality initiated a so-called child investigation pursuant to chapter 11, section 1 of the Social Services Act. When the investigation had been going on for six months, the board closed the investigation without action.

The investigation included many shortcomings according to the board's response to the Parliamentary Ombudsman. It was initiated on unclear grounds and did not clarify whether the child's care needs were met. The investigation was not documented and is thus missing in written form.

On the same day as the investigation was finalised, the board initiated a new investigation based on a continuing concern for the child. The new investigation was completed almost six months after it began, with a decision to grant the child assistance, pursuant to chapter 4, section 1 of the Social Services Act, to a certain extent.

Pursuant to chapter 11, section 2 of the Social Services Act a child investigation shall be conducted promptly and completed no later than within four months. If there are special reasons, the board may extend the investigation for a certain period. The board has a responsibility to make sure that an investigation is carried forward, and to see that active measures are taken, on an ongoing basis. When an investigation is completed, the intention is that the authority is able to form an opinion of the circumstances in the individual case, and of whether there is a need for action.

The Parliamentary Ombudsman notes that the first investigation contained a number of shortcomings and that it also exceeded the statutory deadline. If the investigation had been handled with sufficient care, the board should have been able to assess the need for assistance already in the first investigation. The board has now conducted two investigations when the investigation time, in both investigations, has exceeded the statutory deadline. The total investigation time, which in this case amounted to one year, is completely unacceptable. The board circumvented but also completely disregarded the provision in chapter 11, section 2 of the Social Services Act. The Parliamentary Ombudsman directs severe criticism towards the board for the shortcomings stated above. (Reg. no. 3372-2019)

The Social Welfare Board in Ovanåker municipality is criticised for having carried out a home visit to a house where the applicant and a woman lived, without having obtained the woman's consent to the measure

As part of an investigation into a man's right to financial support, the board carried out a home visit to a house where both he and a woman lived. The purpose of the home visit was to investigate whether the man and woman were cohabiting. They had both provided information in the course of the investigation in question that the man was a resident of the woman and that she alone was in possession of certain spaces in the house.

Before the home visit was made, an administrator contacted the man who consented to a home visit. The board did not contact the woman regarding the matter. During the home visit, the administrators went around inside the house and also into the rooms identified as the woman's own rooms.

Each person is, pursuant to chapter 2, section 6 of the Instrument of Government protected against intrusion into their residence by officials. In order for social services to have the right to enter an individual's home, they must have obtain consent for it. The Parliamentary Ombudsman has stated, in several previous decisions, that in some cases the board may have a legitimate interest in being able to make a home visit to an individual's home in order to form an idea of the need for assistance and to what extent the individual is entitled to assistance.

In the decision, the Parliamentary Ombudsman emphasises that the board must consider whether an investigative measure may affect third parties in any respect and may even violate their constitutionally protected rights and freedoms. The board must ensure that it does not infringe on the right of the applicant or any third party to protection against intrusion into their home when carrying out a home visit as part of an investigation.

According to the Parliamentary Ombudsman, since nothing else had been clarified at the time of the home visit, the administrators should have assumed that the woman alone had possession of certain rooms in the house. If that was the case, her consent was required for the administrators to have the right to enter there.

The board is criticized for not obtaining consent from the woman before entering the rooms identified as hers. (Reg. no. 6367-2019)

The Parliamentary Ombudsman directs criticism towards the Municipal Adult Education and Employment Committee in Örebro municipality for denying an application on financial support that was signed by a custodian

A woman was eligible for financial support from the Municipal Adult Education and Employment Committee. The woman had a custodian assigned to safeguard her rights. The committee demanded that the woman should sign an

application for financial support herself or with her custodian.

In the decision, the Parliamentary Ombudsman states that there are no formal requirements on the design of an application for financial support and that the committee therefore cannot require that the individual in question signs the application.

A custodian with the task of safeguarding the rights of an individual helps him or her to exercise his or her legal capacity, this implies that a custodian takes various legal actions on behalf of an individual. To apply for financial support can be part of the assignments of a custodian. A prerequisite for a custodian, in a case where an individual´s consent should be obtained, is to be able to apply for financial support, if the individual gives his or her consent. The custodian should make sure that the individual agrees to the measure.

According to what has emerged, the woman was able to express her opinions whether an application for financial support should be made or not. The committee has not claimed that that the matter concerned that the woman did not give her consent to the application. According to the Parliamentary Ombudsman, the committee should have accepted that the custodian applied for financial support on behalf of the woman.

The committee can therefore not escape criticism. (Reg. no. 8665-2019)

Care of Young Persons (Special Provision) Act [LVU]

The Parliamentary Ombudsman directs criticism towards the National Board of Institutional Care, Vemyra residential home for young people, for how an employee acted towards a resident at the home

A girl was under care pursuant to the Care of Young Persons Act at the National Board of Institutional Care's residential home for young people Vemyra. The girl handed in a complaint to the Parliamentary Ombudsmen and stated that an employee at the home had, among other things, kissed her.

Support given, by the social services, within the area of children and young people shall be characterized by respect for the young person's right to privacy and personal integrity, pursuant to chapter 1, section 1 of the Care of Young Persons Act. Employees of the National Board of Institutional Care shall contribute to make sure that support and operations are carried out adequately, pursuant to chapter 14, section 2 of the Social Services Act. An employee must immediately report to the administration of the National Board of Institutional Care if he or she notices, or becomes aware of, a misconduct or a significant risk of a misconduct concerning a young person at a home, in accordance to chapter 14, sections 3 and 4 of the Social Service Act. A misconduct or a significant risk of a misconduct shall be documented, investigated and remedied or eliminated without delay, pursuant to chapter 14, section 6 of the Social Service Act.

In the decision the Parliamentary Ombudsman states that the employee's actions towards the girl are completely unacceptable and that there is reason to look at the incident as something very severe. The home has failed in proving adequate care. What happened also constituted an infringement of the girl's right to privacy. The residential home is criticized due to the occurrence.

The Parliamentary Ombudsman also notes that the residential home's investigation of the incident has failed and that the documentation of what measures were taken is deficient, which means that it is not possible to understand how the home handled the incident. The residential home is also criticized for these shortcomings.

According to the Parliamentary Ombudsman's understanding two employees at the home became aware of the incident. The Parliamentary Ombudsman states that they should have reported the matter to the authority's administration. The Parliamentary Ombudsman is critical of the fact that no report was submitted.

In conclusion, the Parliamentary Ombudsman makes certain statements about the National Board of Institutional Care's obligation to receive and investigate complaints and views from the young people detained. (Reg. no. 5013-2019)

The Parliamentary Ombudsman directs criticism towards the National Board of Institutional Care, Vemyra residential home for young people, as an employee at the home hit a resident under care

A girl was under care pursuant to the Care of Young Persons Act at the National Board of Institutional Care's residential home for young people Vemyra. The girl handed in a complaint to the Parliamentary Ombudsmen and stated that an employee at the home had hit her while she was being secluded to her room.

The residential home may, under certain conditions, keep a young person in solitary confinement pursuant to section 15 c of the Care of Young Persons Act. The Parliamentary Ombudsman states that it is not acceptable that

the National Board of Institutional Care has not been able to clarify whether the girl was secluded in her room or not. Of course, there must be no ambiguity as to whether the home has acted on the basis of legal authority. The Parliamentary Ombudsman directs criticism towards the home for this occurrence and also for inadequate documentation regarding the incident.

Support given, by the social services, within the area of children and young people shall be characterized by respect for the young person's right to privacy and personal integrity, pursuant to chapter 1, section 1 of the Care of Young Persons Act. Employees of the National Board of Institutional Care shall contribute to make sure that support and operations are carried out adequately, pursuant to chapter 14, section 2 of the Social Services Act. An employee must immediately report to the administration of the National Board of Institutional Care if he or she notices, or becomes aware of, a misconduct or a significant risk of a misconduct concerning a young person at a home, in accordance to chapter 14, sections 3 and 4 of the Social Service Act. A misconduct or a significant risk of a misconduct shall be documented, investigated and remedied or eliminated without delay, pursuant to chapter 14, section 6 of the Social Service Act.

The investigation proves that the employee hit the girl. The Parliamentary Ombudsman states that such actions, by an employee, should not occur. The home has failed in proving adequate care. What happened also constituted an infringement of the girl's right to privacy. The residential home is criticized due to the occurrence.

The Parliamentary Ombudsman also notes that the residential home's investigation of the incident has failed and that the documentation of what measures were taken is deficient, which means that it is not possible to understand how the home handled the incident. The residential home is also criticized for these shortcomings.

Several employees at the home became aware of the fact that a college had hit a girl. The Parliamentary Ombudsman states that they should have reported the matter to the authority's administration. The Parliamentary Ombudsman is critical of the fact that no report was submitted.

In conclusion, the Parliamentary Ombudsman makes certain statements about the National Board of Institutional Care's obligation to receive and investigate complaints and views from the young people detained. (Reg. no. 5022-2019)

The Parliamentary Ombudsman directs criticism towards the Employment and Social Welfare Committee in Malmö municipality due to their processing of an immediate order for care pursuant to section 6 of the Care of Young Persons Act

In the decision, the Parliamentary Ombudsman makes certain statement regarding if the Act on Calculating the Statutory Time should be applied when the time limit in section 7 of the Care of Young Persons Act, is pursued. In this case, it meant that the deadline of one week, due to the intervening Easter weekend, became eleven days and therefore expired on April 23, 2019. The administration neglected to observe this. The administration believed that the deadline had already expired on 19 April, 2019. This resulted in a youth under care being released, on false grounds, from the youth home where he was placed. The Parliamentary Ombudsman states that the case management has failed and that the board will receive criticism due to this fact.

In the decision, the Parliamentary Ombudsman also puts attention to the board's referral response concerning the authority's experiences with young persons deviating and evading enforcement in certain cases after they have been informed that the board has taken a decision on an order for immediate care pursuant to section 6 of the Care of Young Persons Act. Therefore, the board, in certain cases, waits to submit the decision to the Administrative Court until it has been enforced. In these cases, the decision is always subject to the court within one week.

Due to the board's statements the Parliamentary Ombudsman holds that a decision on an order for immediate care is a very intrusive measure that is taken in an emergency situation and due to legal certainty, it is important that such decisions is subject to judicial review as soon as possible. According to the Parliamentary Ombudsman, there is no scope for the board to wait to submit the decision until it has been enforced.

The Parliamentary Ombudsman states that in view of the need for care in this particular case, it is of importance that a decision on an order for immediate care is enforced. It is possible, that the issues that the board addressed in the referral response, also exist in other municipalities. A copy of the decision has been sent to the Ministry of Health and Social Affairs and the National Board of Health and Welfare for knowledge. (Reg. no. 5117-2019)

The Social Welfare and Employment Board in Lidköping municipality is criticised for, among other things, the design of two decisions pursuant to section 11 and 14 of the Care of Young Persons Act

During May 2019, AA, born in 2017, was taken under care pursuant to the Care of Young Persons Act. AA was placed in a so-called emergency counsellor's home.

In the decision, the Parliamentary Ombudsman directs criticism towards the board for how the decision to place AA in the counsellor's home was formulated. The Parliamentary Ombudsman states that it is not clear, in the decision, in which counsellor's home AA is to be placed and that the design of the decision gives the impression that the board has handed over, to a counsellor, to decide on a home. The Parliamentary Ombudsman states that this is not compatible with section 11, first paragraph of the Care of Young Persons Act, which stipulates that a board should take a decision on where a young person stays while under care.

In the decision, the Parliamentary Ombudsman also directs criticism towards the board for not following up on AA's care in accordance to section 13 a of the Care of Young Persons Act. The Parliamentary Ombudsman states that even if a child is placed in a so-called emergency counsellor's home, the board's responsibility, to follow up on the care in accordance with section 13 a of the Care of Young Persons Act, still remains. It is necessary, according to the Parliamentary Ombudsman, when placing a small child, as in this particular case, that the board initiates regular visits to the home where the child is placed. The Parliamentary Ombudsman is therefore critical of the fact that it took three months before someone from the administration visited the home. The Parliamentary Ombudsman is also critical of the fact that the board seems to have been satisfied with the information provided by the counsellor and that the administration did not have any contact with the providers of the home where AA was placed, for a period of more than three months.

In conclusion, the Parliamentary Ombudsman directs criticism towards the board for the formulation of a decision on restrictions on custody in accordance with section 14, second paragraph 1 of the Care of Young Persons Act. The decision does not state in what way the relations between AA and his parents is restricted nor does it specify the period for which the decision applies. The Parliamentary Ombudsman states that, based on the decision, it is impossible for AA's parents to know how and why the custody is limited, which is unacceptable when it comes to a decision on coercive measures. (Reg. no. 5731-2019)

Taxation

The Parliamentary Ombudsman directs criticism towards the Tax Agency due to the management of notifications regarding incorrect population registration

The Tax Agency has, when managing notifications from individuals, concerning incorrect registry of other individuals in their residence, prolonged the case up to fifteen months before taking a decision to adjust the population registry. According to the Tax Agency a case of an administrative character is set up when a notification on incorrect registration arrives to the authority. If the Tax Agency, upon this, initiates a case to investigate an individual's residence, the authority commences a legal administrative case. The Chief Parliamentary Ombudsman notes that also a case of an administrative character is a case that falls under the ambit of the Administrative Procedure Act which implies that a notification should be efficiently processed, i.e. already prior to when the authority decides to initiate an investigation regarding incorrect data.

An individual may be affected negatively on the basis that other persons are incorrectly registered in their home. The one that has handed in a notification will not become a party in the case. The Chief Parliamentary Ombudsman states that the individual that has handed in the notification and is affected of the incorrect registry should be notified of the fact that the Tax Agency has decided to initiate a case on the matter and when the authority has closed the case, if they request it. Therefore, the Tax Agency needs to inform concerned individuals that they are able to request a notification regarding such decisions. The information could be submitted via the authority's web-page or directly to the one that has handed in the notification regarding the incorrect population registration.

The Chief Parliamentary Ombudsman is critical towards the long processing times and notes that it does not adhere to the statute-regulated requirements on efficient processing pursuant to the Administrative Procedure Act. The Chief Parliamentary Ombudsman also states that the long processing times indicates that the Tax Agency is not able to live up to the assignment that is regulated in the authority's instruction.

The Chief Parliamentary Ombudsman looks positive upon the change management that the Tax Agency has initiated but puts forward the importance of the authority to follow up and evaluate planned and implemented measures. The Chief Parliamentary Ombudsman notes that a specific commissioner has received the assignment of investigating and suggesting measures that can, among other things, improve pre-conditions to determine an individual's residence, and therefore she finds reason to send a copy of this decision to the commissioner as well as to the Ministry of Finance. (Reg. no. 466-2019)

Other areas

The Parliamentary Ombudsman directs criticism towards the Electoral Committee in Örnsköldsvik's municipality for several deficiencies in connection to the general election 2018

A party official handed in a complaint against the Electoral Committee in Örnsköldsvik municipality, and certain related persons, regarding their actions during the general elections in autumn 2018. At the end of June 2018, the complainant asked questions to the electoral committee secretary, also the head of the municipality's election office, about the rules for ballot paper handling. He reminded the committee and its secretary on several occasions regarding the question posed. However, the questions were not answered until the end of September, after the election had taken place.

The Parliamentary Ombudsman notes that the questions should have been answered immediately and that the delay is incompatible with the Administrative Procedure Act's requirement on authorities to reply to questions from the general public without unnecessary delay. The Parliamentary Ombudsman considers it remarkable that the questions were answered after the elections were held and considers this a severe deficiency. The Parliamentary Ombudsman directs criticism towards the electoral committee and its secretary for their delay in answering the questions.

The Electoral Committee instructed, in a decision, the committee secretary to organize and lead the work at the electoral committee office in connection to the elections. According to the Parliamentary Ombudsman's understanding, this did not mean that any formal decision-making power was delegated to the committee secretary, and from what emerged from the investigation, it was not the committee's intentions. Despite the fact that the committee secretary, in the opinion of the Parliamentary Ombudsman, lacked authority for the decisions he made, his handling of ballot papers was in accordance with what the electoral committee referred to in its decision. This was not an acceptable arrangement and the Parliamentary Ombudsman views also this as severe. The Electoral Committee is criticized for its actions.

In conclusion, the Parliamentary Ombudsman states that a member of the electoral committee participated in a decision to appoint his wife and children as so-called voter recipients, despite the fact that he was bias. The Parliamentary Ombudsman directs criticism towards the electoral committee due to this occurrence. (Reg. no. 7703-2018)

The Parliamentary Ombudsman directs criticism towards the Financial Supervisory Authority for deficient documentation and poorly formulated guidelines

In an enquiry the Chief Parliamentary Ombudsman has investigated six cases at the Financial Supervisory Authority. The authority is criticised in several respects for not complying with their internal guidelines. Shortcomings have been noted in the investigated cases when it comes to documentation of decisions to initiate and close cases and of decisions to continue processing. It is also noted that a so-called memorandum to conduct an examination have not been filed in any of the investigated cases, despite of the fact that such memorandums should be documented in line with the authority's guidelines. According to the Chief Parliamentary Ombudsman's understanding it is startling that the Financial Supervisory Authority has not been able to provide a satisfactory explanation as to why deviations have been made from the internal guidelines in the examined cases.

The identified shortcomings in the documentation, as well as certain deviancies in the formulations of the internal guidelines, have led to ambiguities as to when the authority considers that a case has been closed. The Chief Parliamentary Ombudsman emphasizes that these shortcomings may affect how a request to disclose documents is assessed and that, in her opinion, they have entailed a risk to limit public access to documents and public transparency.

Finally, the Chief Parliamentary Ombudsman makes certain statements regarding the authority's use of so-called final letters. (Reg. no. 8490-2018)

The Parliamentary Ombudsman directs criticism towards Örgryte-Härlanda City District Board in Göteborg municipality as the board did not adhere to the statute-regulated requirements on objectivity pursuant to the Instrument of Government

The Reclaim Pride festival was held in August 2018 in venues provided by Örgryte-Härlanda City District Board within the framework of a youth initiative organised by Göteborg municipality. On the festival program was a screening of the film Burka Songs 2.0 and a subsequent panel discussion. Representatives of the board demanded, prior to the realisation of the event, that a woman who particiapted in the film should not be allowed to take part in the panel discussion, as planned by the organizers. The board justified this by stating that the board does not cooperate with activities or people that do not stand up for democracy and human rights. According to the board, the woman had connections to questionable movements.

The Parliamentary Ombudsman states that it is not compatible with the statute-regulated requirements on objectivity pursuant to chapter 1, section 9 of the Instrument of Government, that an authority justifies a decision solely on the opinions of an individual, or of opinions that an individual is expected to express.

The Parliamentary Ombudsman states that the investigation proves that the decisive reason for cancelling the women's participation in the panel discussion was the opinions she perhaps would express. No objective reasons for the board's actions have been discovered. The City District Board has therefore, in regard to the protection of the freedom of speech pursuant to chapter 2, section 1 of the Instrument of Government acted in violation to the statute-regulated requirement on objectivity pursuant to chapter 1, section 9 of the Instrument of Government. Örgryte-Härlanda City District Board in Göteborg municipality is criticised due to their actions. (Reg. no. 1414-2019)

Matter concerning the National Board for Consumer Dispute's jurisdiction to try a case concerning the practice of law

An estate had applied for an administrator and an associate at a law firm had been assigned to the assignment. After complaining about the estate administrator's work to the law firm, the estate was referred to the Bar Association's Consumer Disputes Board. However, that board did not address complaints from legal entities, such as estates.

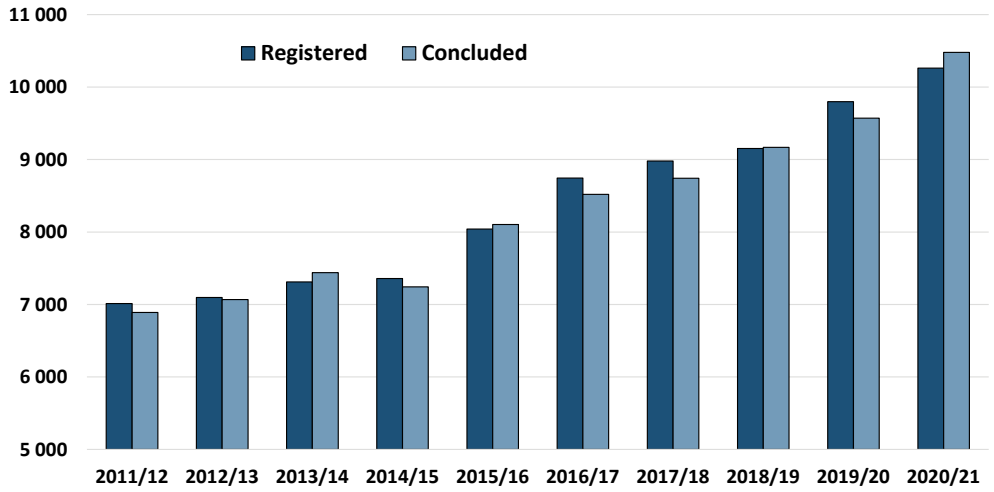
The estate submitted a report to the National Board for Consumer Disputes, but the authority rejected the application based on the fact that the board was not authorised to try the dispute. The National Board for Consumer Disputes referred to the fact that disputes over fees and other demands that a consumer has against a lawyer or a law firm is tried by the Bar Association's Consumer Disputes Board. However, under the regulatory framework governing the activities of the Consumer Disputes Board, estates are not covered by the definition of a consumer. In the decision, the Chief Parliamentary Ombudsman states that there is no rule that expressly exempts disputes over legal practice from the National Board for Consumer Dispute's field of activity. However, such provisions have existed in previous regulations that have regulated in the authority's activities.

According to the Chief Parliamentary Ombudsman, it is clear that the legislator's intention was to exclude disputes relating to legal practice from the National Board for Consumer Dispute's jurisdiction and that the situation arising in the case appears to be due to circumstances which the legislator did not foresee. The Chief Parliamentary Ombudsman states, in the decision, that she, in the light of the circumstances, does not find sufficient reason to direct criticism towards the National Board for Consumer Disputes for failing to examine the estate's report. In view of the ambiguity that according to the Chief Parliamentary Ombudsman is in the legislation in question, a copy of the decision is submitted to the government, for information. (Reg. no. 9136-2019)

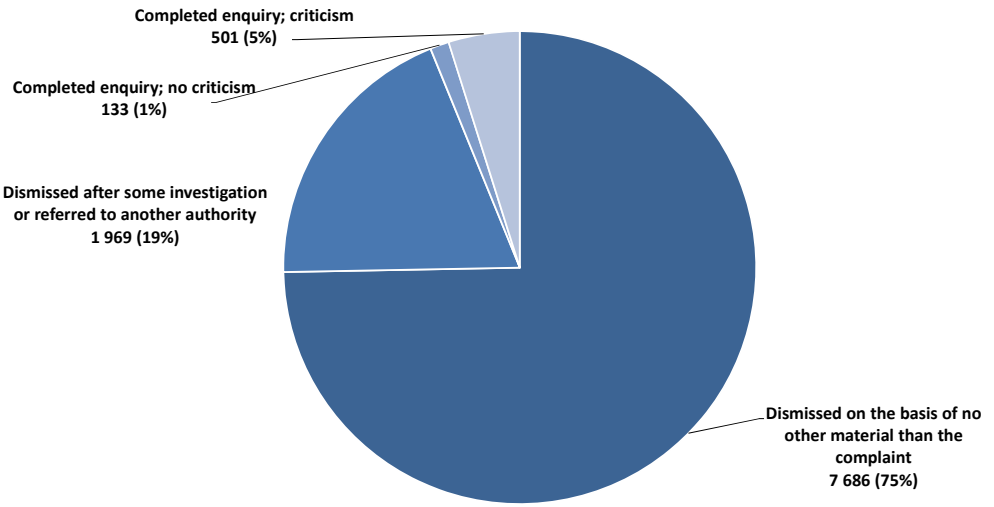
Statistics

Statistics

Development of complaints received and initiatives in the last 10 years



Decisions in complaints and initiatives 2020/21, total 10,289



Registered complaints in the last 5 years

Area	2016/17	2017/18	2018/19	2019/20	2020/21
Adm. of parliament and government office	76	33	48	33	32
Administrative courts	117	121	167	168	166
Armed forces	23	27	21	17	71
Chief guaridans	92	86	83	92	89
Communications	241	217	184	231	228
Complaints outside jurisdiction	169	202	285	233	252
Courts	351	369	377	406	426
Culture	25	28	15	24	57
Customs	14	17	16	16	27
Education	303	380	347	480	481
Employment of civil servants	88	121	116	— [1]	— [2]
Enforcement	265	222	179	220	233
Environment and health protection	191	284	208	277	288
Housing	8	13	6	10	7
Labour market	218	258	276	254	396
Medical care	334	361	314	587	592
Migration	920	636	709	608	741
Other municipal matters	148	120	130	199	183
Other public administration	112	96	147	134	205
Other regional matters	29	14	28	29	22
Planning and building	249	219	239	251	253
Police	907	1,032	1,010	1,107	1,082
Prison and probation	913	934	1,071	1,378	1,474
Prosecuters	160	164	180	209	219
Public access to documents, freedom of expression	525	521	548	— [3]	— [4]
Social insurance	615	735	753	860	644
Social services incl. LSS	1,203	1,374	1,451	1,418	1,709
Taxation	179	137	165	183	206
Sum	**8,604**	**8,826**	**9,058**	**9,675**	**10,083**

1 Cases concerning employment of civil servants are from this year included in the area of public administration to which they belong. This year 145 such cases have been registred.
2 Cases concerning employment of civil servants are from this year included in the area of public administration to which they belong. This year 154 such cases have been registred.
3 Cases concerning public access to documents are from this year included in the area of public administration to which they belong. This year 624 such cases have been registred.
4 Cases concerning public access to documents are from this year included in the area of public administration to which they belong. This year 615 such cases have been registred.

Concluded complaints and most criticized

Most complaints 2020/21

Area of supervision	Concluded complaints
Social services	1,726
Prison and probation	1,578
Police	1,075
Migration	750
Social insurance	663
Access to public documents	661
Health and medical care	583
Education	519
Courts	410

Most criticised 2020/21

Area of supervision	Criticism	Percent of complaints
Social services	106	6 %
Prison and probation	79	5 %
Social insurance	39	6 %
Health and mediacal care	32	5 %
Police	28	3 %
Education	26	5 %
Migration	22	3 %
Other municipal matters	19	9 %
Adminstrative courts	18	10 %

Inspections 2020/21

Regular inspections

Institution	Amount
Chief guardians	1
The Public Employment Service	2
Unemployment insurance	3
Inspections sum	**6**

Opcat inspections

Institution	Amount
Institutional care (SiS)	4
Psychiatric wards	5
Opcat inspections sum	**9**

THE SWEDISH PARLIAMENTARY OMBUDSMEN – JO
Box 16327
Västra Trädgårdsgatan 4 A
se-103 26 Stockholm
SWEDEN

Telephone +46 8 786 51 00
Telefax +46 8 21 65 58
E-mail jo@jo.se
Website www.jo.se

Opening hours Monday–Friday 09.00–11.30 and 13.00–15.00