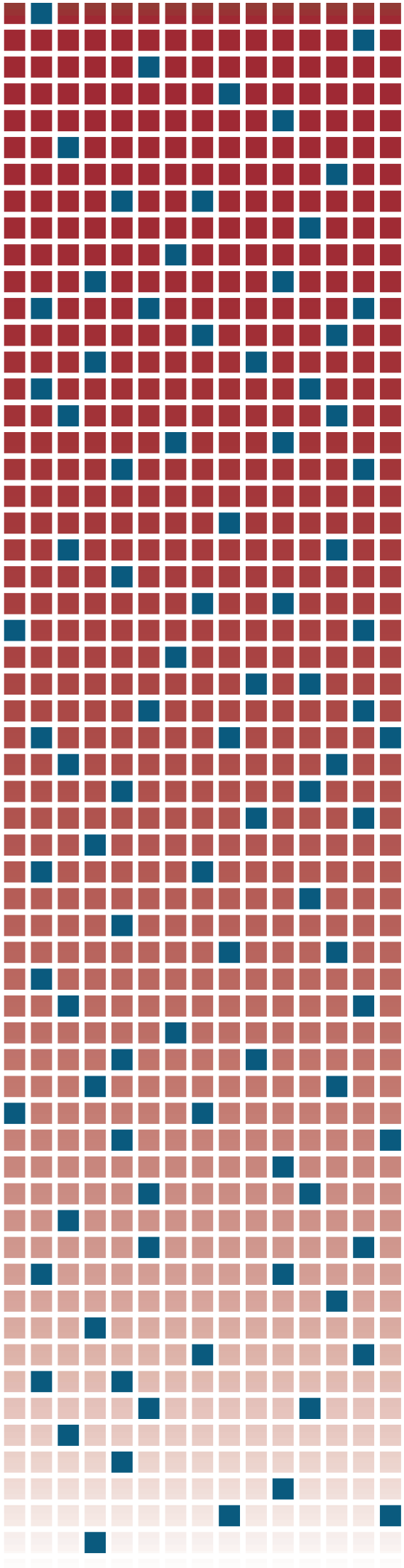

Annual report 2017/18

SUMMARY IN ENGLISH

JO RIKSDAGENS OMBUDSMÄN

THE SWEDISH PARLIAMENTARY OMBUDSMEN

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Elisabeth Rynning

Chief Parliamentary Ombudsman

The supervision within my area of responsibility comprises, inter alia, the correctional care system, the Armed Forces, health and medical care services and, as of 1 February 2018, taxation and population registration. The Area of responsibility also comprises a number of other government agencies including the Swedish Financial Supervisory Authority, the Swedish Competition Authority, the Equality Ombudsman and the National Board for Consumer Disputes. In organisational terms, the OPCAT unit belongs to my area of responsibility in an organisational respect, but the unit's inspections are carried out uoon the instructions of the Ombudsman that supervise the authority to be inspected. A more detailed account of the OPCAT unit's activities is found in a separate section.

During the fiscal year, the division received 1,765 new complaint cases, which is around the same number as the preceding year. However, approximately 200 of these complaints were such that, upon receipt at the Parliamentary Ombudsmen's secretariat, they were deemed to fall outside the competence area of the Parliamentary Ombudsmen – e.g. complaints against private businesses – and were thus dismissed following decisions delegated to Heads of Division.

During the fiscal year, a total of 1,626 cases were settled at the division, of which 17 per cent were settled by delegated Heads of Division. As with previous years, the majority of the division's work related to cases concerning the correctional care system. Around 16 per cent of the settled cases that were assessed as falling within the competence area of the Parliamentary Ombudsmen had been subject to a full enquiry, and a little over 9 per cent led to criticism. Within the large group of cases dismissed, either following some investigation or solely based on the information provided by the complainant, there are some forty cases where I nevertheless found reason to remind the authority of the provisions that apply to the organisation, and around twenty five cases which were dismissed with reference to another case where the same issue had been the subject of enquiry or had already resulted in criticism.

Areas of responsibility

- 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.
- Prisons and probation service, the National Prison and Probation Board and probation boards.
- Health and medical care as well as dental care, pharmaceuticals; forensic medicine agencies, forensic psychology agencies; protection from infection.
- 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 of Taxation Authorities in Criminal Investigations [1997:1024]); 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.
- The Opcat unit

During the fiscal year, a total of 14 inspections were carried out within my areas of responsibility. Together with co-workers from the supervisory division, I have inspected the correctional facilities Saltvik and Hall, Uppsala Probation Authority and the psychiatric clinic in Västerås. Inspections of Sollentuna Probation Authority and the National Board for Consumer Disputes have been carried out by Heads of Division. A further eight inspections have been conducted within the framework for the Parliamentary Ombudsmen's assignment as a national preventive mechanism according to the protocol OPCAT that supplements the UN Convention Against Torture (see section 4). One visit to an authority has been carried out at the Health and Social Care Inspectorate (IVO).

In addition to the inspections, five enquiries have been concluded during the fiscal year and six new have been initiated. The issues that are being addressed in the new cases include the following: the conditions for tube-feeding against the patient's will within compulsory psychiatric care, the conditions for detainees under the Aliens Act who are placed in a remand prison, and the regulations for the late termination of pregnancy.

There have been no prosecutions during the fiscal year. I have initiated and closed a preliminary investigation concerning the obligation of secrecy, and I have closed another previously initiated preliminary investigation with the same crime classification.

In six cases I have, pursuant to Section 4 of the Act with Instructions for the Parliamentary Ombudsmen, made requests to the Government regarding a review of the legislation. Among other things, these requests concerned the conditions for the placement of inmates in isolation in correctional facilities and remand prisons, visitation constraints in voluntary healthcare, and the conditions for time-limitation and re-examination of decisions on interventions under the Act concerning Support and Service for Persons with Certain Functional Impairments (LSS).

I will now highlight some of the decisions that have been included in the annual report within the areas of correctional care and health and medical care, the areas that together account for more than 80 per cent of the complaint cases processed at the division.

The Swedish Prison and Probation Service

The Swedish Prison and Probation Service is therefore the organisation that gives rise to most supervisory cases within my area of responsibility. The stream of cases has remained relatively stable in recent years, and during the fiscal year, 927 new complaint cases were received within this area. A comparatively high proportion of the complaint cases settled during the year have been the subject of a full enquiry (around 20 per cent) and just under 10 per cent resulted in criticism.

The majority of the Prison and Probation Service's activities relate to individuals who are detainees, in a remand prison or in a prison, which entails high requirements regarding, for example, statutory support, application of the law, proportionality assessments and satisfactory guarantees of legal certainty. That fact that the Prison and Probation Service's assignment also imposes high demands on security and strong public protection can of course give rise to the delicate balancing of interests, which must be carried out with the utmost transparency. It is also important that the authority has clear and uniform guidelines for its documentation, to enable internal monitoring and evaluation as well as external control of operations.

I would like to start by mentioning a couple of decisions that address the requirement of satisfactory legal support for restrictions on individuals' fundamental rights and freedoms. In the annual report for the preceding fiscal year, I stressed that placement in isolation from other people is a very intrusive coercive measure that can ultimately be viewed as an issue of violation of fundamental human rights, and that it is therefore important that the exceptions from the Act on Imprisonment's general rule on association with other inmates are clearly regulated and combined with satisfactory guarantees of legal certainty that are also applied in practice. My predecessor Elisabet Fura has in several previous decisions criticized the Prison and Probation Service for shortcomings in these respects. It is therefore regrettable that during the past fiscal year I have also been compelled to conclude that the problems persist. One of the decisions included in the annual report relates to inmates spending time alone at the Prison and Probation Service's security units, without any decision having being issued regarding placement in isolation (ref. no. 7488-2016). In its statement

to the Parliamentary Ombudsmen, the Prison and Probation Service states, inter alia, that in view of the need to avoid inappropriate client constellations, a situation may occur where an inmate, for a limited period of time, stays alone at a security unit and that such a situation of separate housing does not constitute isolation in the sense indicated in the Act on Imprisonment. For my part, I find that, regardless of the difficulties encountered in finding suitable client constellations, it is extremely unsatisfactory that inmates are still housed at a security unit under conditions which entail that they are periodically living alone, despite the statutory conditions for placement in isolation not being met. In the absence of a formal decision, the inmates in these cases will also find it difficult to have the issue re-examined. In light of this, I decided to raise the issue of a legislative review through a request to the Government (Ministry of Justice) pursuant to Section 4 of the Act with Instructions for the Parliamentary Ombudsmen.

A further decision concerns, inter alia, issues concerning placement in isolation, in this case of detainees in remand prison (ref. no. 5969-2015). It relates to an enquiry initiated by Elisabet Fura regarding the placement in isolation of detainees etc. Even in this case, I note that there are no legal grounds for keeping an inmate isolated due to actual circumstances or practical conditions, with the result that the inmate is living under a corresponding degree of isolation as inmates who have received a formal isolation decision or have restrictions determined by a prosecutor. The decision additionally highlights other shortcomings in regard to placing detainees in isolation. This decision has also been handed over to the Government with a proposal for a review of the legislation.

In the annual report, there are three decisions that address different problems concerning the Swedish Prison and Probation Service's telephone system INTIK (ref. no. 2689-2015, 3682-2016 and 7618-2016). In recent years, the Parliamentary Ombudsmen have received a number of complaints regarding the INTIK system, and during the 2017/18 fiscal year, twenty-one cases were dismissed with reference to one or more of the cases that have been the subject of investigation. The investigated cases concerned, inter alia, the lack of information to the inmates regarding various control functions in the system, but also the lack of reliability and legal certainty as well as unclear points regarding the Prison and Probation Service's proportionality assessments. The Prison and Probation Service has a responsibility to maintain order and security in the country's prisons and to prevent recidivism. At the same time, the enforcement of inmates' sentence must be structured so that their adjustment in society is facilitated and the negative consequences of detention are counteracted. The enforcement of sentence must not entail any restrictions on the freedom of the inmate other than those stipulated in the Act on Imprisonment or those necessary to ensure order and security. Regarding the work with inmates' telephony, all aspects of the Prison and Probation Service's assignment are in evidence. I realise that it is not a simple matter for the Prison and Probation Service to satisfy the need for control over inmates' telephony while at the same time achieving legal certainty in its handling. Nevertheless, I request that the Prison and Probation Service finds acceptable solutions to these issues. For those being detained in a prison or remand prison, it is undoubtedly of great importance for them to be able to keep in touch with, among others, their loved ones. It is important both to counteract

the negative consequences of detention and to facilitate reintegration in society.

Finally, I would like to mention a couple of decisions where I had reason to emphasise the Prison and Probation Service's obligation to offer all inmates equivalent and acceptable content in the enforcement of their sentence in order to facilitate their adjustment in society. It concerns two enquiries initiated by my predecessor Elisabet Fura, occasioned by observations in connection with a series of OPCAT inspections of the prison facilities that receive women. Firstly, during the inspections, a number of areas were observed where differences in the Prison and Probation Service's management of female and male inmates appeared to generally disadvantage female inmates, and, secondly, it was observed that the Prison and Probation Service did not clearly and uniformly focus attention on the situation for female inmates with accompanying children or for pregnant inmates when it came to planning, placement and the enforcement of sentences. The structure of the Prison and Probation Service's operations is markedly characterised by the fact that 94 per cent of the inmates are men.

In the first decision (ref. no. 1087-2016), I conclude that the Prison and Probation Service does not manage to offer equal correctional care for men and women, but rather that female inmates are in several respects disadvantaged by the existing regulations and restrictions in the physical environment of the prisons and the content of the enforcement. Although I understand that the low number of female inmates constitutes a challenge for the authority, it is not acceptable for women inmates to experience an inferior enforcement compared to men. Female inmates are investigated to a greater extent than men at the Prison and Probation Service's reception centre (Riksmottagningen), which in itself may be beneficial in improving the possibilities for individually adapted enforcement. However, inadequate resources at the women's reception centre often lead to delayed placement at a facility and consequently to a deterioration in the content of the enforcement. It is of course unacceptable that a group of inmates that the Prison and Probation Service considers to have particularly complex needs that require investigating in order to be accommodated experiences, rather contrarily, inferior content in the enforcement due to lack of investigative resources. There is also an obvious need for increased possibilities with respect to differentiating female inmates. My opinion is that the Prison and Probation Service should review the security classification for women's prisons and prioritise efforts to create increased differentiation possibilities, and also develop customised prison spaces and treatment initiatives based on the special needs of female inmates.

In the second enquiry (ref. no. 1089-2016), I criticise the Prison and Probation Service for not taking into account whether a woman has an infant or is pregnant at the time of deciding on a suitable prison placement. Furthermore, I encourage the Prison and Probation Service to consider setting up adapted spaces for inmates with accompanying children at special facilities, where the needs of both the inmate and child can be better accommodated, and also to review its work methods and develop partnerships with external actors to offer these inmates acceptable content in the enforcement, in addition to parental leave. When it comes to pregnant inmates, it is important that the prisons – well

in advance of the estimated due date – prepare an internal plan in consultation with the relevant obstetrics clinic and provide the pregnant woman with as much information as possible about the planning.

In conclusion, I find that there is a need for changes in the Prison and Probation Service's activities in order for the authority to be able to offer equal correctional care for women and men and succeed in accommodating women's individual needs and facilitating their adjustment in society, as its assignment dictates. The Prison and Probation Service has now implemented several initiatives to review these issues, which I welcome. I intend to follow developments in this respect.

Health and medical care

Activities within the area of health and medical care gave rise to 356 new complaint cases at the Parliamentary Ombudsmen during the 2017/18 fiscal year. This is slightly more than the previous year and, from a five-year perspective, represents an increase of almost 26 per cent. This case group, which was transferred to my area of responsibility on 1 April 2017, encompasses both voluntary healthcare and compulsory psychiatric care and forensic psychiatric care, as well as a number of central authorities such as the National Board of Forensic Medicine, the Swedish Medical Products Agency, the Swedish Institute for Infectious Disease Control and parts of IVO's activities.

Less than 5 per cent of the settled complaint cases relating to health and medical care were subject to a complete investigation by the Parliamentary Ombudsmen, but virtually all of these resulted in criticism. Since the extraordinary supervision of Ombudsmen is focused on legal scrutiny, the Parliamentary Ombuds-

men have generally not investigated issues concerning medical assessments or treatments. The Parliamentary Ombudsmen lack internal expertise in such matters and have in many cases been able to refer complainants to the regular supervisory authority (now the Health and Social Care Inspectorate – IVO) and, prior to 2011, also to the Medical Responsibility Board to have the issue of disciplinary responsibility for members of healthcare staff examined. Another point of departure for the ombudsmen's supervision is that the Parliamentary Ombudsmen do not usually investigate complaints relating to dissatisfaction with an authority's decision in a case as, among other things, the Parliamentary Ombudsmen's supervision is not to replace or anticipate possible judicial proceedings in the matter. Furthermore, the Parliamentary Ombudsmen does not usually comment on the assessments made by an ordinary supervisory authority in the matter itself. However, in the area of health and medical care, many types of decisions have not been considered to be appealable, and the individual's ability to bring about an independent assessment within the context of a disciplinary case or supervisory case has gradually decreased. The most recent step in this development was taken through the amendments in Chapter 7 of the Patient Safety Act, entailing that IVO's duty of enquiry in complaint cases is even more limited as of 1 January 2018. Patients that are not subject to compulsory care now only have the right to have their complaints investigated by IVO if they concern a serious healthcare injury or an incident that has seriously and negatively affected or threatened the patient's self-determination, integrity or legal status. It is also required that the healthcare provider first be given the opportunity to respond to the complaint. Naturally, the developments accounted for here have also affected the Parliamentary Ombudsmen's ability to refer complainants to the regular supervisory authority for an independent review of their complaints. In my activities as Parliamentary Ombudsman, I often see examples of patients perceiving themselves to be without rights, but also healthcare professionals who have been criticised in a decision by IVO. In my opinion, this is very worrying, but not a problem that Parliamentary Ombudsmen – as an extraordinary supervisory authority with a focus on legal scrutiny – has the opportunity to resolve. The increasing proportion of health and medical care services being provided by private actors also falls outside the area of competence of the Parliamentary Ombudsmen. However, I do intend to follow developments in this respect.

The decisions concerning health and medical care that I want to mention here illustrate the legal nature of the Parliamentary Ombudsmen's oversight and the requirement of legal support for restrictions on individuals' fundamental rights and freedoms.

The first decision concerns the conditions for deciding on visiting restrictions within voluntary healthcare (ref. no. 3999-2016). An operational manager at a university hospital decided that a close relative of a patient being cared for under the Health and Medical Services Act was only allowed to visit the patient at specified times, which entailed a limitation in relation to how the relative had previously visited the patient and to the regular visiting times at the ward. The operational manager considered it to be a question of measures of a purely executive nature that he was authorised to take on the basis of the hospital's rules of

procedure. In my decision, I firstly note – in line with a previous Parliamentary Ombudsmen statement – that the operational manager's decision on visiting restrictions for a close relative has been intrusive for the individual and required significant scope for independent assessments, which is why they cannot be regarded as measures purely executive in nature that the operational manager had been authorised to decide on. The operational manager was criticised for having exceeded their authority. However, the case gave rise to questions regarding the need for explicit legal support with regard to visiting restrictions for close relatives, in light of, inter alia, the European Convention's provisions concerning protection of family life. While visiting restrictions during certain compulsory care have been subject to regulation by law, there is no corresponding legal support when it comes to voluntary healthcare as the Government, in the legislative case in question, has expressed that visiting restrictions strictly speaking should not feature whatsoever within voluntary healthcare (see Govt. Bill 1995/96:196 p. 10 f. and 13). However, according to what has emerged in, inter alia, cases at the Parliamentary Ombudsmen, health and medical care staff find that there can also be a need within voluntary healthcare to manage visiting times to some extent so as to guarantee good and safe care. Given that such restrictions are intrusive for both visitors and care recipients, my opinion is that these should be regulated by law with the possibility for appeal. I therefore decided, pursuant to Section 4 of the Act with Instructions for the Parliamentary Ombudsmen, to raise the issue of a review of the legislation, whereby I submitted my decision to the Government (Ministry of Health and Social Affairs).

The other decisions I want to mention here also relate to the requirement of legal support for restrictions to the individual's basic freedoms and rights (ref. no. 4746-2015). A patient who was being cared for pursuant to Compulsory Mental Care Act complained that his electronic equipment – a tablet and an mp3 player, among other devices – had been seized for inspection by technicians. The investigation showed that the clinic in question applied a routine document stipulating that the senior consultant could decide on the inspection of a patient's personal technical equipment – i.e. the electronically stored information – upon suspicion that the equipment was being used for activities such as buying drugs, downloading unauthorised pornography or for threats and harassment. In my decision, I conclude that inspections of the information stored in a patient's electronic equipment relate to several of the fundamental rights and freedoms mentioned in the Instrument of Government and the European Convention, and that there is no legal support for the violation of personal privacy entailed by the inspection. Nor is there, in my opinion, any scope for a provider of compulsory psychiatric care to use a patient's consent to inspect stored information on the patient's computer or similar device. The clinic's actions were thereby criticised. However, it cannot be ruled out that in some cases an inspection of the patient's electronic equipment may appear as a less intrusive measure compared to other possible options, namely that the right to use the equipment is restricted and the equipment is seized. For reasons of legal certainty, however, it is important that coercive measures that can be taken within compulsory psychiatric care are clearly specified. I therefore decided to direct the Government's attention to the problems and also recommended a legislative review in this case.

Lars Lindström

Parliamentary Ombudsman

My area of responsibility comprises the Swedish courts, the Swedish Enforcement Authority, the planning and construction area, the land survey authorities, environment and health protection, the Swedish Tax Agency (until 31 January 2018), the Chief Guardians, the education system (starting 1 February 2018) and the communications area. During the fiscal year, 1,971 complaint cases were received, which is an increase of 185 cases compared to the previous year. During the year, 1,904 complaint cases were settled, of which 393 were settled by delegated Heads of Division.

During the fiscal year I have inspected Eskilstuna District Court. Head of Division Carina Sjögren has on my behalf inspected the Enforcement Authority's debt reconstruction operations in Sundbyberg and Täby. Senior Legal Advisor Cecilia Melander has on my behalf inspected the Local Building Committees in Tyresö, Nynäshamn, Gävle and Östersund.

In the following account, I will highlight some of the decisions that are described in this year's annual report, and account for certain other measures that I have taken during the fiscal year.

Courts and conflict of interest

A foundation of the constitution is, pursuant to Chapter 1, Section 9 of the Instrument of Government, that the courts and administrative authorities are to take into account the equality of all people under the law as well as observe objectivity and impartiality (principle of objectivity). The procedural regulations for the courts and administrative authorities contain rules regarding conflict of interest. These regulations contribute to the constitutional principle of objectivity being effectively applied.

Areas of responsibility

- Courts of law, the Labour Court; Ground Rent and Rent Tribunals; the National Courts Administration.
- Administrative courts.
- 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.
- Communications (public enterprises, highways, traffic, driving licences, vehicle registration, roadworthiness testing).
- The school system; higher education (including the Swedish University of Agricultural Sciences); student finance; the 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.
- 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.

The handling of matters concerning conflict of interest has been developed in the past few decades. In the courts, there is an increasing number of situations that are deemed to constitute a conflict of interest. The fact that the administration of justice is subject to public confidence is of outmost importance. Another change that has occurred in recent decades is that many people seem to use the term "conflict of interest" more to generally express dissatisfaction with the processing than to directly claim that the processing is biased in some way.

But the term itself has a well-defined meaning in Swedish legislation. The decision-maker who receives an objection claiming conflict of interest should, in my opinion, assume that the objecting party means the same thing as the legislator. If the party appealing a decision notifies the superior court in writing that a conflict of interest has applied to the decision-maker, my opinion is that the superior court should assume that the appellant means what he or she says. It is therefore not acceptable to simply casually dismiss claims of conflict of interest for the reason that many such claims are unfounded. A party that submits an objection claiming conflict of interest expects that the objection will be taken seriously and examined.

In this year's annual report, there is an enquiry regarding administrative courts that concerns five judges' handling of allegations regarding biased processing or prejudiced decision-makers at the authorities that have made decisions in the first instance (ref. no. 8001-2017). In all five cases, a party had notified the Administrative Court in writing that there had been a conflict of interest during the processing in the first instance. However, the courts did not take a stance on the allegations of conflict of interest. In two of the cases, the court responds to

the Parliamentary Ombudsmen indicating that the court has made a mistake and that it should have taken a stance on the alleged conflict of interest. However, it is troubling that two of the courts in their response to the Parliamentary Ombudsmen state that the judges did not perceive there to be any objections claiming conflict of interest submitted in the cases, despite the appellants explicitly writing that it was a question of conflict of interest. I personally find it very hard to see how an explicit objection claiming conflict of interest can be interpreted as anything other than precisely that. A court that interprets a party's objection in some other way should, in my opinion, explain its interpretation in the grounds for a decision. In my decision, I criticise the five judges because they have not taken a stance on the allegations concerning conflict of interest.

I address an even more serious conflict of interest issue in another decision (ref. no. 331-2018). When processing a case concerning an assessment of legality, an Administrative Court is to comprise a legally competent member and two special members. Both these members are to have adequate knowledge of municipal operations. As is the case with the legally competent member, they are judges, and the provisions concerning conflict of interest also apply to them. An administrative court assessed the validity of a municipal decision according to the rules concerning an assessment of legality. One of the special members had been a legal consultant for the municipality that was a party in the case. He had assisted the municipality in the case; for example, he had drafted statements to the Administrative Court and Administrative Court of appeal. From my viewpoint, it was clear that the member could be assumed to have a conflict of

interests and that he should have reported this in the court. He was seriously criticised for not doing so.

Another issue concerning conflict of interest is dealt with in a decision on 20 October 2017 (ref. no. 363-2017). One party in a civil case objected to a judge who handled the preparation in the case, claiming that there was a conflict of interest. Despite the objection, the judge continued to process different matters in the case, and it was not until more than two months after the objection that the District Court's Chief Judge took a position on the matter. The matter concerning conflict of interest was thus not handled correctly. The Chief Judge and the judge received criticism.

These seven cases involving the incorrect handling of conflict of interest issues call for reflection. Has the increased use of the term "conflict of interest" resulted in the judges being less attentive to the term's actual meaning and the importance of taking such an objection seriously and really taking a position on the matter? If so, this is a troubling development.

Another noteworthy case during the year that concerns a conflict of interest in a court related to a high court judge who was reported for having processed a case despite there being a conflict of interest (ref. no. 8268-2017). I initiated a preliminary investigation into suspected official misconduct. On 19 June 2018, I closed the preliminary investigation as I did not feel that I could prove that the judge had, intentionally or through negligence, made a ruling in the case in contravention of the provisions concerning conflict of interest.

Other court decisions

One interesting court decision concerns a so-called lay judge ruling that was heavily criticised in the public debate due to the formulation of the grounds for the decision (ref. no. 2243-2018). The grounds for the decision were formulated in a notable manner. Among other things, information emerged in the debate indicating that the member of the bench had written a judgment that differed from that determined by the lay judges. In my decision, I state that a member of the bench who believes that the lay judges may come to an incorrect judgment should make an effort to make sure that this does not occur. My investigation does not indicate that the member of the bench wrote a judgment containing grounds that deviated from what the lay judges concluded during the court's deliberation. However, it does state that the member of the bench did not review the grounds for the decision with the lay judges before the judgment was delivered. My opinion is that a person reading the grounds for the decision cannot reasonably come to any other conclusion than that she should have done so. She is therefore criticised.

Slow processing is a problem both in administrative authorities and in courts. A party in a court matter or case can criticise a delay in a court and thereby obtain a declaration that the processing of the case or matter will be given priority in the court (Act [2009:1058] on Declaration of Precedence in court). It is also possible to report the delay to the Parliamentary Ombudsmen. In a case dealt with by the Parliamentary Ombudsmen, an anonymous complaint stated that a judge had taken too long to pronounce a judgment in three cases (ref. no. 2436-

2017). Although the Parliamentary Ombudsmen does not normally address anonymous complaints, I found that the information in the complaint was quite remarkable and therefore I decided to investigate it as a separate matter. In connection with this, a complaint was received – which was not anonymous – concerning the same judge alleging that he had taken a long time to pronounce a judgment in an additional case (ref. no. 3061-2017). After requesting a statement from the District Court, I concluded that the judge had neglected the obligations of his position in such a way that it constituted neglect of duty, and the matter of disciplinary responsibility for the judge was turned over to the National Disciplinary Offence Board. The National Disciplinary Offence Board issued the judge a warning. The Board found it unacceptable that the judge had repeatedly pushed back the date for pronouncing judgment in the manner done in three of the cases. According to the Board, the judge had therefore intentionally neglected the obligations of his position in such a way as to constitute a neglect of duty deemed to be of a not inconsiderable nature.

The Swedish Enforcement Authority

As presented in last year's annual report, I have in recent years received many complaints regarding the management of funds by the Swedish Enforcement Authority. The authority's problems with funds management has led to delays in received payments being registered, and it has happened that payments received have been registered to the wrong debtor – debts have remained logged in the collection and enforcement database despite having already been paid by the debtor. This has entailed risks of negative consequences for the Enforcement Authority's clients that has potentially led to incorrect records of non-payment, seizure of property owned by a party that has already paid its debts, and delayed disbursements.

In a decision dated 15 November 2017 (ref. no. 7750-2016 et al.), I state that the Enforcement Authority has failed in fulfilling the requirements in its instructions that the tasks are to be managed in a legally certain, cost-effective and simple manner. The cause of this failure is the serious deficiencies in the authority's management of funds. It has been the responsibility of the Enforcement Authority's key management to ensure that this important part of the operation works, and the authority is seriously criticised in this respect.

The Enforcement Authority's annual report for 2017 indicates that the authority has implemented numerous measures to address the problems, and further measures are planned.

In last year's annual report I indicated that the Enforcement Authority had experienced difficulties keeping up with the debt reconstruction cases and that this was connected to a significant increase in the applications in recent years. The number of application for debt reconstruction was 11,000 in 2015, 12,000 in 2016 and 19,000 in 2017. I have followed up my observations through inspections of debt reconstruction operations in Sundbyberg and in Täby and was thus able to conclude that the difficulties remain.

The planning and construction area

In recent years I have received many complaints indicating that it has taken an excessively long time for the municipalities to process so-called supervisory cases in accordance with the planning and construction legislation. In several of these cases I have criticised the responsible committees for slow processing. In light of this, I decided in the spring of 2018 to conduct a follow-up of the processing of supervisory cases at four of the Local Building Committees that had previously been inspected – the municipalities of Tyresö, Nynäshamn, Gävle and Östersund. The follow-up has been done through new inspections where primarily case's processing times have been examined.

The overall impression I got from the observations made during the inspections is that at these committees, there are still an excessive number of supervisory cases that have not be processed with the speediness prescribed in the the Administrative Procedure Act (1986:223). At all four committees, it was noted that there are many cases that are several years old where the processing has been characterised by passivity. In certain cases, no measures at all have been taken, and in other cases there have been long interruptions in the processing. Several cases concerning potentially illegal builds also risk being subject to the rules on statutory limitation, which entails, for example, that the possibilities for neighbours to obtain rectification are lost.

In the case (ref. no. 4290-2018), I make statements regarding, inter alia, the resource problems of the committees and regarding the possibility of awaiting a decision on a building permit after the fact. It pleases me to note that an initiative implemented by Gävle Municipality's Community Planning Committee concerning its supervisory cases has yielded results while the situation in the other three committees has not changed since the previous inspections. In these committees, the processing of the supervisory cases has been neglected and has only been pursued as time allowed. My opinion is that this approach is unsustainable and that these committees must now take the necessary measures to make progress with the processing of the cases.

The education system

As one of its primary tasks, the Parliamentary Ombudsmen monitors compliance with the constitutional requirements on impartiality and objectivity persuent to Chapter 1, Section 9 of the Instrument of Government.itors One case that concerns the education system involved this. A principal of a school wrote a message to parents concerning asylum-seeking pupils. In the message, the principal expressed their personal views on the asylum process and the decisions made therein. I considered there to be no objective reason for the principal to do so and found the principal's action to therefore contravene the stipulations on impartiality and objectivity persuant to the Instrument of Government. The principal receives criticism (ref. no. 7627-2016).

Persuant to Chapter 2, Section 6 of the Instrument of Government, every citizen shall be protected – in their relations with the public institutions – against

searches of premises. In many schools, the pupils each have access to a locker, and a question regularly addressed at the Parliamentary Ombudsmen is whether the school management is prevented from searching the lockers under this provision. In one case (ref. no. 7914-2016), the students had their own locks for the lockers. The lockers were school's property and were on loan to pupils for the storage of school-related material. Written information on the lockers indicated that the school had the right to open the lockers upon suspicion that unauthorised items were being kept there. On one occasion, the school's principal searched a number of lockers, and the measure was reported to the Parliamentary Ombudsmen. My opinion is that the lockers, given their purpose and the terms under which the pupils may borrow them from the school, cannot be seen as closed storage spaces in relation to the school. The action of searching the lockers can therefore not be viewed as a search of premises in the sense indicated in the Instrument of Government, and there is no grounds for criticism (ref. no. 7914-2016).

Legislative referrals

During the fiscal year, I have been given the opportunity to respond to a large number of legislative referrals of proposed bills. I have focused on responding to referrals that are more closely connected to the central parts of my supervisory area. The following are among the referrals that I have commented on: the memorandum *En snabbare lagföring – försöksprojekt med ett snabbförfarande i brottmål (Ds 2017:36) [Speedier legal proceedings – pilot project involving rapid processing in criminal cases]*, the memorandum *Frekventa och omfattande* ärenden *om utlämnande av allmän handling (Ds 2017:37) [Frequent and comprehensive cases on the disclosure of a public document]*, the report *Rekrytering av framtidens domare (SOU 2017:85) [Recruitment of judges of the future]*, the memorandum *Ett särskilt straffansvar för deltagande i en terroristorganisation (Ds 2017:62) [Special criminal liability for participation in a terrorist organisation]*, the report *Stärkt straffrättsligt skydd för blåljusverksamhet och andra samhällsnyttiga funktioner (SOU 2018:2) [Strengthened legal protection for emergency services and other vital societal functions]* and the memorandum *Snabbare lagföring (Ds 2018:9) [Speedier legal proceedings]*.

Cecilia Renfors

Parliamentary Ombudsman

My area of responsibility includes police, prosecution and customs matters, Aliens Act cases and certain issues involving the Government Offices and municipal operations. The outmost focus lies on supervising the police and public prosecutors as well as cases involving aliens.

As previously, complaints dominate the supervisory work. Over the year, 2,250 complaints were submitted in my supervisory area. The number of cases is no longer increasing, it has instead decreased by around 360 cases. The likely explanation for this is the reduced number of complaints against the Migration Agency regarding long processing times, and a redistribution within my supervisory area, as labour market cases were moved to a different Parliamentary Ombudsman in 2017.

In my supervisory area, the largest number of complaints is usually against the police. Last year, the complaints amounted to 1,021, which is more than previously. As I just mentioned, the number of complaints against the Migration Agency dropped in relation to the previous year, as it was 633 compared with 915 in the preceding year. The number of initiatives during the year was four.

During the year, I received nearly 40 legislative referrals. Among the responses I have issued, a couple are worth mentioning, regarding means of coercion in an electronic environment: Hemlig dataavläsning – ett viktigt verktyg i kampen mot allvarlig brottslighet (SOU 2017:89) [Secret data reading – an important tool in the fight against serious crime] and Beslag och husrannsakan – ett regelverk för dagens behov (SOU 2017:100) [Seizure and search – a regulatory framework for current needs]. Both opinions present proposals that, if implemented, will facilitate measures that interfere with individuals, with far-reaching integrity violations. My assessment, however, was that the proposals in both cases were adequately well balanced. I had some objections in relation to the

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 Swedish Commission on Security and Integrity Protection.
- Customs authorities.
- The Swedish Arts Council, The Swedish National Heritage Board, Swedish National Archives; museums and libraries: The Swedish 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

proposals in the last opinion regarding the more traditional means of coercion and their application in an electronic environment. For example, the proposals gave too much discretion for law enforcement to adjust the balance between privacy and the need to use means of coercion that allows access to considerable information regarding the private sphere of individuals.

Jointly with my colleagues, I have conducted inspections of a local police area in Malmö and the Migration Agency's detention facility in Kållered, Gothenburg. I also met with the Migration Agency's Director General and his colleagues as part of a review of my previous decisions regarding the Migration Agency's processing times and availability.

At my request, the Opcat unit conducted inspections at six police detention facilities. One of these concerned the temporary detention centre that the Swedish Police Authority opened in connection with the NMR-demonstration on 30 September 2017 in Gothenburg and the EU-summit in the same location on 17 November 2017. The inspection was conducted when the summit took place, to observe, on site, how the police worked with temporary detention and the conditions thereof. There were fewer cases of deprivation of liberty than the police had expected, and the temporary detention centre was not used during the summit. We did, however, gain valuable experience and make observations that will be useful in similar inspections in the future.

The Police

In last year's report, I raised the issue of how the supervision of individuals in police detention facilities is carried out and how these individuals are treated. I have had reason to consider these issues during the past year as well. In other respects, as previously, the supervision has focused in particular on the use of means of coercion. Based on the ongoing review and the inspection of the Police Authority that I have conducted, I conclude that major problems with the authority's processing times remain.

Care and treatment of intoxicated persons

Over the year, I have had several cases involving events where a detainee has died in police custody. In my view, they indicate that there is an urgent need for reform. At the same time, I wish to underline that no direct connection was found between the shortcomings and the death of the persons taken into custody in any of the cases.

In two cases, where the detainees died while in custody, I have criticised the Police Authority for deficiencies in supervision, for example failure to enter the cell and check the detainee's condition (ref. no. 2468-2016 and 7054-2016). In one case, I also considered that the person taken into custody should have been taken to a doctor sooner than actually took place. These cases illustrate the deficiencies that exist today in relation to taking care of heavily inebriated persons and the difficulties in ensuring the necessary medical supervision in the police detention facilities. Individuals protected because of being drunk should not, in my view, be placed in police custody, but under medical supervision. Against this background, I delivered two decisions to the Government Offices pursuant to article 4 of the Act with Instructions for the Parliamentary Ombudsmen.

Another decision concerns a death in connection with police custody (ref. no. 332-2017). A man with prescribed drug abuse was to return to residential care with the help of the police. The transport was time-consuming and carried out by so-called relaying of different police patrols. The items the man took with him during the transport included certain medication, and during a break at a police station he was allowed to take two pills which he had with him. During a break later in the transport, the man was so tired and affected by the drugs that it was not advisable to continue. He was placed in a cell with extra supervision. After 30–45 minutes, it was noted that he was not breathing. He was taken to hospital, where he died. The case shows that there are deficiencies in the procedures relating to protective visitation and transfer of information that should apply when the police are responsible for transports of this type. The Police Authority was criticised for failure to control the man's access to medication during the transport.

Another decision in this year's report relates to the treatment of a person taken into custody and illustrates the lack of understanding of the difficulties associated with deprivation of liberty, which I have raised previously (ref. no. 5864-2016). A woman is protected because of intoxication at a party. She was 'acting out' in the custody cell and on one occasion tried to hang herself. For nearly three hours, she was in the cell wearing only underpants and was told to urinate in the floor drain when she asked, several times, to go to the toilet. The Police

Authority was criticised for the treatment of the woman and for failing to have the woman examined by a doctor when she showed signs of wanting to commit suicide.

Coercive means

The conditions for interventions under the Police Act are often hard to assess, and decisions are often made under difficult conditions. However, it is always important that the conditions are carefully considered and that an individual assessment is made in each individual case. A decision regarding protection and removal, pursuant to article 13 of the Police Act, of a 13-year old boy from a youth festival, illustrates deficiencies in these respects (ref. no. 4915-2016). The boy fought with some security guards and was apprehended. The police decided to remove him from the site and left him one hour later, at around 1 am, at a bus stop nearly four kilometres from the location of the festival. In my opinion, the police should have considered that this involved a child and whether such an intervention was proportionate. They should also have considered the legal basis of their actions as it took time to implement the removal. The circumstances were that the intervention against the boy turned into an apprehension, and there are express provisions regarding special measures where the person apprehended is below the age of 18.

Another decision concerned an intervention against a person on unclear grounds (ref. no. 7330-2016). One of the intervening police officers stated that

the intervention was based on article 19 of the Police Act to search for weapons. The other police officers stated that the man was under surveillance as a measure to prevent serious violent crime and that a body search was carried out. Nearly all other measures against the man were doubtful and gave the impression that coercive measures were used for purposes other than the intended ones. A body search and a search in the man's residence, due to observations on narcotic effects, were conducted, these measures were specified only in connection to the Parliamentary Ombudsman's investigation, and the man's mobile phone was confiscated without grounds. The man was also incorrectly taken to an interrogation. These errors are serious and affect the trust in the police. It is a serious matter that the information submitted by one of the intervening police officers, to the Parliamentary Ombudsmen, raises questions, as it differs, in some respects, from what other police officers stated. Against this background, I have underlined the duty of truthfulness and the need for the Police Authority to emphasise, to their employees, the importance of accuracy and truthfulness of information provided to Parliamentary Ombudsmen.

Coercive means may only be used if there are supporting legal grounds. One decision relates to a situation where such grounds are lacking, but where there are reasons to consider whether there should be such legal grounds (ref. no. 2015-2016). The police were summoned to a passenger ferry, about to dock, in connection with suspected gross rape. It was decided that all male passengers – around 500 – would be taken into custody for a body search. The female passengers were allowed to leave the boat while the male passengers had to pass by a windowpane with toned glass in the so-called customs filter so that the plaintiff could try to identify the suspected offenders. This procedure took one and a half hour. It is doubtful whether this was a body search, and in any case there was no basis for a body search since all men could not be suspected of the rape. The decision includes a thorough review of other potential grounds for the action taken. However, I noted that there were no such grounds. It is unacceptable that the police takes action restricting the freedom of movement of such a large number of persons without any legal basis. In view of the potential need for legislation, I submitted the decision to the Ministry of Justice.

Miscellaneous

Another issue, which is beyond day-to-day police work and which was raised in a decision in connection with this year's general election, is about the scope for an individual police officer to participate in political contexts (ref. no. 2439-2017 and 2456-2017). The starting point is obviously that freedom of speech applies to police officers and that they are entitled to express their views in their leisure time. However, it must be clear to the audience whether a police officer is making a statement as a private individual or making a statement on behalf of the authority.

In this case, a police officer had participated in a political campaign film, where he makes statements, for example, about the work situation for police officers, and there are images of him in a police uniform driving a painted police car. Therefore, it was not clear that he was participating in the film as a private individual, and he was criticised for this.

Immigration Law

The number of complaints filed against the Migration Agency for long processing times and availability problems has dropped, but the number remains high, and these issues have featured in the supervisory work in relation to immigration law this year as well. I met with the Director General of the Migration Agency and some of his colleagues in November 2017 and discussed, for example, the Migration Agency's efforts to shorten processing times. I have also reviewed the processing times in a few individual cases in a couple of decisions. The situation in relation to processing times remains unsatisfactory, and I continue to track the development. I will also continue to monitor the Migration Agency's management of age assessments of young asylum applicants.

Good administration

For persons who come to Sweden from other countries and receive a residence permit, it is important, for several reasons, that the personal data provided by Swedish authorities are correct. Since a few years, it is possible for a person to have a personal identity number with a date of birth that is different from the person's actual date of birth. This situation is a result of running out of personal identity numbers with certain dates of birth. In these cases, there is a risk that the wrong date of birth is used when a document is issued. This applies to a case in this year's annual report (ref. no. 2998-2016). The Migration Agency issued a residence permit card to a woman with the date of birth indicated by the personal identity number, which was incorrect. When the woman pointed out to the Migration Agency, that this was incorrect, she was referred to the population registry maintained by the Swedish Tax Agency. In the investigation by the Parliamentary Ombudsmen, it emerged that it was impossible, from a purely technical point of view, to have a different date of birth on the card than the one in the personal identity number. Even though this system of allocating personal identity numbers has existed for nearly ten years, it was impossible to use the correct date on the residence permit card. The same problem arose for the applicant when she became a Swedish citizen and received a Swedish passport issued by the Police Authority (ref. no. 5340-2017). Both authorities have stated that they will now correct the problems identified by the cases.

Enforcement

Immigration law is complex in many respects, including in relation to enforcement. The Migration Agency has the main responsibility for enforcing decision regarding rejection and expulsion, and the same applies if a person is to be transferred to another country pursuant to the Dublin Regulation. However, in some cases the Migration Agency may transfer an enforcement matter to the police. It is important that the provisions on who is responsible for enforcement are complied with and that the Police Authority only acts when authorised to do so. This was not the case in a decision included in the report (ref. no. 1210-2016). The police decided to take a person who was to be transferred to another country in custody and took over the enforcement, without being authorised to do so. The decision on custody was also incorrect in several other respects. The information provided by the Police Authority on the course of events is scarce and difficult to reconcile with the information provided by the Migration

Agency. The police probably had information that the relevant person could be a security risk, but this is not clear, neither is the custody decision nor the investigation conducted by the Parliamentary Ombudsmen. Even though the police custody decision was incorrect, the Migration Agency decided, at the police's request, to place the person taken into custody in detention. Both authorities were criticised. The case is remarkable for several reasons, partly because such serious errors are involved on the part of the police, and partly because the authorities have been unable to clarify what actually happened. I also want to point out that, if there are security risks, it is particularly important that everything is formally correct from a security perspective as well.

Custody

I have included an inspection report in this year's report, which is unusual. The report concerns an inspection of the Migration Agency's detention facility in Kållered, Gothenburg, which was conducted in connection with information given in several complaints and in the media regarding deficiencies in the handling by the detention centre of segregation and placement in custody of detainees for security reasons (ref. no. 939-2018). I could see that the detention centre is working under rather difficult conditions and that there are, for example, difficulties in dealing with the presence of narcotics in the detention centre. I noted, among other things, that segregation was used as a form of punishment for handling narcotics, which goes beyond the parameters of legislation. The inspection also showed that there was a need for improvement in relation to the wording of decisions, to clarify the basis of the decision to segregate and to place in custody. Furthermore, I could see that the decisions on security placements referred to the Migration Agency's lack of resources and that persons taken into custody with mental disorders were placed in custody mainly because the detention centre had no competence to take care of them. There were also shortcomings in the handling of the review of decisions on security placements. This is unacceptable, and I have decided to review several of the shortcomings I identified. However, already when the report was completed, I found it appropriate to notify the Ministry of Justice of the result of this review.

Freedom of speech

Freedom of speech and opinion also applies to employees in the public sector and is one of the prerequisites for a free debate on the actions of public authorities. To protect the freedom of speech it is – with some exceptions –forbidden for a public authority to intervene against a person who exercised his freedom of speech and, for example, criticised his employer. It is important that this so-called ban on reprisals is observed, which in turn requires that the authorities' representatives are aware of it. In one case that I dealt with this year, this was disregarded (ref. no. 4213-2016). The case concerned two hourly firemen who publicly criticised their employer's – a fire brigade – position in relation to recruitment and employment. They were not offered continued employment because they did not share the fire brigade's values and orientation. The fire brigade failed to specify what considerations had been made or identify the relevant values. Based on the investigation in the case, I could only draw the conclusion that the decision not to offer the two firemen continued employment was based on

the critical opinions they expressed regarding the fire brigade and its management. The fire brigade and its manager were severely criticised for their actions.

Official documents

Cases regarding the handling by public authorities of official documents are frequent, and unfortunately, a lack of knowledge of the applicable rules and the significance of our constitutional public access principle for government and municipal administration to function well is frequent. In particular, this can be observed in municipalities and small authorities. However, there are also deficiencies in knowledge-rich authorities, such as the Government Offices. I have previously examined the management of applications to access official documents by the Ministry for Foreign Affairs and criticised the lack of compliance with the applicable urgency requirement. In a decision in this year's annual report, I dealt with similar issues in connection with a complaint regarding the handling of documents relating to Sweden's candidature to the UN Security Council and again criticised the Ministry for Foreign Affairs treatment of official documents (ref. no. 6579-2016). The Ministry has also been criticised repeatedly by the Committee on the Constitution at the Riksdag and also by the Chancellor of Justice. Against this background, it appears imperative that comprehensive measures be taken to address these problems. At the beginning of 2018, the Ministry for Foreign Affairs presented a number of proposed measures to improve the treatment of official documents. This is obviously positive, and I look forward to the results of these measures in the day-to-day management.

Thomas Norling

Parliamentary Ombudsman

The issues encompassed within my area of responsibility concern social services, social insurance and cases regarding the application of the Act concerning Support and Service for Persons with Certain Functional Impairments (LSS). The supervision within the area of responsibility also includes labour market cases. Up until 31 January 2018, cases related to the education system were included in this area of responsibility, but this is no longer the case. The authorities belonging to the area of responsibility include Försäkringskassan (the Swedish Social Insurance Agency), the Swedish Pensions Agency and Arbetsförmedlingen (the Swedish Public Employment Service). A significant proportion of the complaints management concerns the area of social services and the activities of the municipal social services departments, which is why a relatively high number of decisions are directed at social welfare boards.

I assumed my duties on 1 April 2018. My predecessor, Stefan Holgersson, left his position as Parliamentary Ombudsman on 18 September 2017. During the relatively long interim period, Deputy Parliamentary Ombudsman Cecilia Nordenfelt and Deputy Parliamentary Lilian Wiklund took turns serving at the division.

During the fiscal year 2,772 complaint cases were received in my area of responsibility, which is an increase of 436 cases (18.7 per cent) compared to the previous year. In this context, however, it has to be taken into account that during the year there was a redistribution of case groups between the various areas of responsibility, which may explain some of the increase. During the year, 2,756 complaint cases were settled, and this is also an increase compared to the previous year (around 25 per cent). Of the settled cases, 382 (14 per cent) of these were settled through delegated Heads of Division. The majority of the division's work (about 52 per cent) concerned cases relating to the social services. Because

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.

the division was left without a regular Parliamentary Ombudsman for most of the fiscal year, the focus was on complaints handling, which is why the inspections have taken a back seat. During the year, 13 initiatives (including inspections) were taken within this area of responsibility. In addition, within my area, the OPCAT unit has carried out three inspections that have related to the conditions at different SiS (Swedish National Board of Institutional Care) homes. On one occasion during the fiscal year, Deputy Parliamentary Ombudsman Lilian Wiklund decided to initiate a preliminary investigation due to a suspicion that a crime had been committed by one official within my supervisory area. There is currently an ongoing preliminary investigation into the matter. The number of answered referral is on the same level as the year before (28).

As indicated, I was responsible for my area of responsibility for a limited time during the fiscal year. I will therefore also address my predecessor's decisions involving criticism as well as decisions taken by the Deputy Parliamentary Ombudsmen during the year. In order to select some decisions involving criticism for the purposes of the annual report – and at the same time formulate my own focus in the ongoing supervisory work – I have reviewed the most important decisions during the fiscal year, and moreover gone over my predecessor's observations and conclusions in recent years' annual reports. In this year's report, I have included decisions that provide several examples of case management that lead to concern that the basic requirements of administrative law are not always followed. In some of the decisions referred to, the child perspective has been the central focus. As an almost thematic thread, I have also chosen decisions that illustrate the authorities' difficulties in ensuring that data of a personal and sensitive nature is not handled carelessly. My impression so far is that the authorities have in far too many complaint cases explained that slow processing and shortcomings in the investigation quality are due to insufficient competence, work accumulation or a lack of resources. These may be contributory factors to the authorities failing to meet the requirements of administrative law but they cannot, from a perspective of legal certainty, serve as mitigating circumstances in the judicial review that the Parliamentary Ombudsmen has to perform. It remains to be seen how the stricter requirements of the Administrative Procedure

Act (2017:900), which came into force on 1 July 2018, will be handled by the authorities and strengthen the confidence that public administration tasks are being managed responsibly and properly. These are issues that I intend to return to in my continued supervisory work.

Labour market

An overall theme observed in the previous annual reports I have read is that there is a great need in the labour market area for education and development in administrative law issues. During the inspections previously carried out by Parliamentary Ombudsman Cecilia Renfors at Arbetsförmedlingen (the Swedish Public Employment Service), attention has been focused on the deficiencies relating to documentation, communication of documents and data, and the reasoning behind decisions. In all cases, the deficiencies have related to the processing stage, which is central to ensuring that cases are handled in a legally certain manner. Although I have only included one decision involving criticism against Arbetsförmedlingen in this annual report, it is clear to me that there remains much to be done to strengthen the authority's capacity to correctly fulfil the basic requirements of administrative law.

The decision in this year's annual report concerning Arbetsförmedlingen relates to the difficulties in ensuring that confidential data is not handled carelessly and to the detriment of the individual (ref. no. 1029-2017). The case is presented below in the next section (Public access and secrecy) and illustrates the need for employees to have appropriate and adequate competence. The case also shows the general responsibility that an authority's senior management has to ensure, through legal guidance and support, that working practices and procedures are introduced that contribute to legal certainty in the processing, but also ensure that data of a personal and sensitive nature is protected.

Public access and secrecy

Complaints regarding the handling of public documents and other matters relating to public access and secrecy are common within my areas of responsibility. As I look back at the conclusions that my predecessors have drawn in previous annual reports, I can observe that developments in recent years have not been entirely positive. The regulations on disclosure of public documents are still cause for concern in many respects, and it is apparent from the complaints that are now being received by the Parliamentary Ombudsmen that individuals often find that it takes a long time before a confidentiality review of the documents and information requested is carried out. Another problem seems to be a lack of knowledge among various authority representatives regarding the substantive meaning of the regulations and, more surprisingly, regarding the content of their own procedures.

Of the 155 complaints concerning public access and secrecy that were received during the fiscal year within my supervisory areas, I have chosen to refer to two decisions relating to issues concerning the protection of data of a personal and sensitive nature, and concerning an individual's request for access to public documents.

The first decision (ref. no. 1029-2017) concerns the actions of an employment officer in connection with the placement of a jobseeker in an internship. Prior to a meeting with the staff manager for the internship, the individual was urged by the employment officer to talk about his background during the meeting and say that he had been in prison. However, the individual did not do so. Despite the fact that this type of information is typically classified, the employment officer contacted the staff manager and informed him of the individual's background. I found that disclosure of this information was not preceded by careful considerations by the employment officer pursuant to the Public Access to Information and Secrecy Act. Since Arbetsförmedlingen's referral response revealed that the authority subsequently performed a confidentiality review, I also commented on the scope for disclosing confidential information to an internship site without the consent of the individual.

In the second decision (ref. no. 1039-2017) I criticised a social welfare board for its processing of a request to access an e-mail log. The case is a good illustration of the difficulties that may arise when neither managers nor administrators have a clear understanding of the procedures that apply to the disclosure of public documents or the legal significance of the substantive provisions. The decision concerned a woman who requested that a social welfare board allowed her access to an e-mail log. During the processing of the case, the board sought the woman's identity by asking the individuals who were included in the e-mail log if they knew who she was. It appeared that the woman did not use her real name but instead used a fictitious name when requesting the e-mail log. It was only after two weeks that the woman received a decision where the board rejected her request. The social welfare board not only receive criticism for its slow processing of the case. I also found it unacceptable that the officials and managers appointed to handle disclosure issues lack the adequate knowledge to be able to properly address these issues. In conclusion, I considered that the social welfare board should be criticised for its incorrect actions in seeking the woman's identity.

I have also included three decisions by Deputy Parliamentary Ombudsman Cecilia Nordenfelt in the annual report that in different ways relate to the issue of how personal and sensitive data is to be protected. In one decision (ref. no. 5606-2017 et al.), Försäkringskassan (the Swedish Social Insurance Agency) was criticised for repeated cases of careless processing (incorrect dissemination) of confidential information. In two other decisions, she commented firstly on the risk of confidential information being disseminated through the signing of a certificate (ref. no. 3283-2016) and, secondly, on the privacy risks of authorities using text messages when communicating with individuals (ref. no. 494-2016).

Social insurance

The number of complaints that relate to social insurance increased for the third year in a row. During the fiscal year, 733 new cases were registered. During the preceding fiscal year the corresponding number was 613, and 346 for the year before that. The increase is therefore less dramatic this year, even though it amounts to about 19 per cent.

The content of the complaints varies greatly, making it difficult to get a definite idea of what is causing the increase. There have also been many complaints relating to long processing times this year, while complaints relating to the more typical administrative issues have slightly dropped in number. This may indicate that the knowledge base has improved at the authorities and that their own guidelines are being followed, while at the same time there is a perceived lack of resources.

The number of complaints regarding long processing times in cases concerning insurance affiliation and EU family benefits has increased again. In the past years, the cause of the lengthy processing times in foreign cases has often been the difficulties in obtaining investigative material from other countries. This year, long processing times have often been the result of Försäkringskassan's own passivity. In the annual report I have included a decision (ref. no. 803-2017) by Deputy Parliamentary Ombudsman Cecilia Nordenfelt, where she criticises Försäkringskassan for the unacceptably long processing time caused by the authority's passivity in a case concerning insurance affiliation and EU family benefits in the form of child benefit. For my part, I have made decisions in a number of cases where I criticised Försäkringskassan's slow processing of applications concerning compensation for costs arising from care in another EEA country (see ref. no. 4421-2017 and 5343-2017, which are not included in the annual report). Despite the fact that Försäkringskassan has taken a number of steps to shorten processing times, I concluded in my decisions that the authority's efforts to live up to the requirement of issuing a decision within 90 days of the authority receiving a complete application have thus far been insufficient, and that the problems with long processing times remain. In this context, I would like to refer to a decision on 13 June 2018 where the Chancellor of Justice had expressed criticism of Försäkringskassan in a claims adjustment case (ref. no. 5734-17-4.3) concerning a decision on care in another country not being made within the stipulated time limit. I intend to return to these issues in future supervisory cases.

Regarding the issue of the careless handling of personal and sensitive data, I have mentioned above the problem with Försäkringskassan having repeatedly sent documents with confidential information to a person other than the data subject. In a comparison with previous years, I can note that the number of complaints relating to this issue has increased once more, while at the same time it is difficult to pinpoint the cause of the problems. What is clear is that I have not yet seen any positive signs that the measures taken by Försäkringskassan, which are primarily technical in nature, have actually led to an improvement. Due to the fact that, even after the turn of the year, complaints have continued to come in regarding Försäkringskassan's deficient management, I will return to this issue in the form of a decision in autumn 2018 at the earliest. I have chosen to include a decision by *Deputy Parliamentary Ombudsman Cecilia Nordenfelt* (ref. no. 5606-2017 et al.) to illustrate the problem that there is a risk of personal and sensitive data being incorrectly disseminated in a manner that is detrimental to the individual.

Social Services

During this fiscal year, social services has been the Parliamentary Ombudsmen's single largest supervisory area. During the year, a total of 1,319 social services cases were registered. Of these, 849 cases concerned children, for example, issues regarding the application of the Care of Young Persons Act (LVU), 422 cases concerned various forms of assistance, and 48 cases related to the Care of Abusers (Special Provisions) Act (LVM).

Complaints in the area of social services are often extensive and concern multiple and diverse issues, which my selection of referenced decisions indicates. The focus of the first group of decisions are the children's investigations conducted by social welfare boards in certain cases. In another group, the child perspective is in focus, which means that the Parliamentary Ombudsmen has had to assess whether the board in question has adequately considered the best interests of the child in a particular situation. I have also included decisions that provide different examples of inadequate processing and of situations where the privacy of the individual has not been respected.

The Social Services Act

Of the decisions I wish to highlight here, the first decision concerns the conditions required for a social welfare board to request extracts from the suspect register and criminal records (ref. no. 2446-2016) during a children's investigation. These registers contain personal and sensitive information on the individual. According to Deputy Parliamentary Ombudsman Lilian Wiklund, there should therefore be no doubt as to when the conditions are met for the social welfare board to access data from the registers. She considered it important that the rules be clarified on this point. In another decision, Parliamentary Ombudsman Stefan Holgersson criticised a social welfare board for having acted in such a way as to circumvent the provision stipulating that a children's investigation should be completed within four months (ref. no. 2565-2016).

In one case that specifically raised the issue of how best to consider the best interests of the child, Deputy Parliamentary Ombudsman Lilian Wiklund decided to criticise a social welfare board for placing a girl in a foster home even though it had been reported that the 13-year-old girl was married to an adult son of the foster home parents (ref. no. 1556-2017). Deputy Parliamentary Ombudsman Lilian Wiklund's criticism also related to the failure of the board to follow up on the care of the girl. In another case where the child perspective was in focus, the social welfare board had, in a case concerning housing assistance, set a condition for the entitlement to assistance stating that the individual would do all she could to find her own accommodation through a national-wide search. The recipient of the assistance had custody of two children who alternated living with her and the children's father (ref. no. 1126-2017). I found that the investigation on which the board's decision on assistance was based did not contain any considerations as to whether the decision could affect the children's situation, and if so, in what way.

In conclusion, I would like to address two decisions with similar circumstances. In one case, the board in question has searched a training apartment without

the consent of the tenant to check if there were any drugs in the apartment (ref. no. 7179-2016). I concluded that an authority cannot readily enter a dwelling, and that the board's search of the dwelling constituted an intrusion of the kind that every citizen is protected against under Chapter 2, Section 6 of the Instrument of Government. The statutory protection, however, applies only to forced intervention, and since the tenant did not consent to the accommodation being searched, the board was criticised for its actions. In a similar case, the social welfare board granted a man assistance in the form of housing in a so-called transitional apartment. The municipality and the man signed a lease agreement containing clauses that gave the social services department the right to conduct inspection visits in the apartment once a month. Such inspections were also carried out (ref. no. 7595-2016). In the decision I discussed, for example, the question of when an individual can be considered to have given real consent to an intervention of this kind. I also concluded that because the municipality has signed a lease agreement with the man, a state of tenancy existed between the parties. The problem in this context, however, was that the inspection visits described in the lease contract were significantly more far-reaching than what is stipulated in the Land Code's provisions on rent. I therefore came to the conclusion that, when formulating the terms, the board failed to adequately take into account the existence of a tenancy between the parties. Furthermore, in this case the board's processing was deficient to the extent that the individual's personal privacy was not respected.

Care of Young Persons Act, LVU

In recent annual reports, my predecessor has focused on the quality of the investigations and the criticisms expressed in complaints to the Parliamentary Ombudsmen regarding the lack of thoroughness and objectivity. This year's annual report refers to seven decisions concerning care under LVU. What is striking is that the issues in these cases vary widely, while at the same time they concern key issues of legal certainty. As an example, I would like to highlight four decisions.

In the first decision (ref. no. 305-2016), which was made by Deputy Parliamentary Ombudsman Cecilia Nordenfelt, the question was whether it had taken too long for the social welfare board to take a stance as to whether a 16-year-old boy detained in a criminal case was to be taken into care pursuant to Section 6 of the Care of Young Persons Act (LVU). In the decision, Deputy Parliamentary Ombudsman Cecilia Nordenfelt found that the authority's perceived inaction caused the boy to be detained for an unnecessarily long period of time. In one decision, Deputy Parliamentary Ombudsman Lilian Wiklund raised issues relating to the ability of the social welfare board to delegate the right to make decisions – pursuant to Section 14 of LVU – not to reveal the young person's place of residence and regarding access restriction (ref. no. 7984-2016). In another decision, the issue concerned care at a lockable unit at a particular residential home for young people (ref. no. 263-2017). In the first of these decisions, Deputy Parliamentary Ombudsman Lilian Wiklund raised the question of reviewing the provisions on delegation in the Social Services Act and the Swedish Local Government Act. In the latter decision, she stated that the two-month deadline pursuant to

Section 15b of LVU is not affected by the fact that the young person is transferred from one residential home to another during the period of care. In the fourth decision (ref. no. 2533-2017) I had to examine whether the social welfare board in question should be criticised for shortcomings in the formulation of a decision regarding so-called access restriction. Of the complaints received by the Parliamentary Ombudsmen, it appears that this is a problem area. In the decision, the board had restricted the access between a father and a son. I stated that a decision on so-called access restriction pursuant to Section 14, second paragraph, point 1 of LVU must be clear. The decision shall indicate the manner in which the access is being restricted and whether the decision is valid until further notice or if it is time-limited. Furthermore, the reasons must be stated in the decision. The board's decision contained shortcomings in all of these aspects, which is why it was criticised.

Care of Abusers (Special Provisions) Act, LVM

I have chosen to include two decisions (ref. no. 3577-2016 and 5747-2016) in the annual report, both of which raise the issue of whether the social welfare board should have initiated an investigation pursuant to Section 7, the Care of Abusers (Special Provisions) Act [LVM] to clarify whether an abuser needed compulsory care.

In the latter case (ref. no. 5747-2016), a number of questions arose concerning basic requirements concerning the social welfare board's processing and the board's special responsibility for investigating and assisting individuals with serious substance abuse problems. The main question in the case was, simply put, whether the board had done what it should do with regard to people who have serious substance abuse problems. In the decision, I commented on whether the social welfare board had waited too long in initiating an investigation into the individual's need for compulsory care. I also addressed the issue of whether the board should have discontinued its investigation, considering it had already started, because the individual stated that he was positively inclined towards receiving help. An investigation could have revealed whether the individual was engaged in the ongoing abuse of, among other things, drugs, if he was in need of care, and if that care really could be given on a voluntary basis. It is a matter of carefully assessing the reliability of the individual's consent and whether necessary care could be guaranteed. The investigation showed that on 31 August 2016, the board made a decision to initiate an investigation pursuant to Section 7 of LVM. However, the individual had already died on 27 August.

Municipal activities according to LSS

Although the number of complaints to the Parliamentary Ombudsmen each year is not so large, it is clear that the problems with the application of the Act concerning Support and Service for Persons with Certain Functional Impairments (LSS) that have been highlighted over the years remain, while at the same time new ones have emerged. When I read the annual reports of previous years, it is primarily deficiencies in the application of the basic rules of administrative law that are highlighted. This has applied to, inter alia, requirements for communication, documentation, the reasoning behind decisions and the right to party insight.

In 2016 and 2017, the Parliamentary Ombudsmen received several complaints indicating that it is taking too long for municipalities to process applications for interventions under LSS. Several of these complaints showed that the processing time for an LSS case was more than one year. In view of the complaints regarding slow processing and what had been revealed in individual cases, Deputy Parliamentary Ombudsman Lilian Wiklund found there was cause to initiate a more comprehensive investigation into the municipalities' processing of cases pursuant to LSS, with focus on processing times (ref. no. 7477-2017). A decision in this enquiry will be made in autumn 2018 and published in the annual report of the next fiscal year.

As the Parliamentary Ombudsmen's supervision mainly concerns the formal processing of the authorities, in this year's annual report I have chosen to include a decision that concerned the conditions under which a social welfare board may re-examine and amend an earlier decision regarding an intervention under LSS to the disadvantage of the individual (ref. no. 921-2017). The background was that the social welfare board, in a decision from September 2009, had granted the individual an extended intervention in the form of personal assistance of 27 hours per week. The decision was not time-limited but applied until further notice. The question was whether such a beneficial decision could be amended to the individual's disadvantage. I stated, inter alia, that amending a decision that applies until further notice so that it instead applies for a specified time period is an amendment that can be considered to be to the disadvantage of the individual. The opinion of the board that the decision could be amended was not supported by any statute or case law. Therefore, my only conclusion could be that the board had amended the decision to the disadvantage of the individual, and with no legal grounds to do so.

Opcat activities

During the year, a previously initiated supervision of the Opcat activities was completed. In connection with the supervision, changes were made to the procedures of the Parliamentary Ombudsmen and the guidelines for the Opcat activities. The Parliamentary Ombudsmen were granted additional funding in the budget year 2018 to meet the need for a reinforced Opcat unit. A deputy head of unit and an additional rapporteur have been hired, and as of 1 June 2018 the unit consists of six employees. With these increased resources, the Opcat activities are better equipped to assist the Ombudsmen in their role as National Preventive Mechanism (NPM) under the Optional Protocol, Opcat, to the United Nations Convention against Torture.

Over the year, the Opcat unit has continued its regular exchange on issues regarding substance and method with the Ombudsman institutions in Denmark, Norway and Finland, who, like the Parliamentary Ombudsmen, fulfil their assignment as NPM. Iceland's Ombudsman institution also participates in these meetings since they will be formally appointed NPM. Furthermore, over the year the unit has participated in several European meetings and communicated with a number of volunteer organisations at a national level.

Opcat inspections during the year

During the past year, 17 inspections were conducted. The theme for 2018 is transports of detainees. During the year, a survey of this area will be made, and issues will be addressed in further inspections on the same theme in 2019. The theme in 2017 was supervision of detainees. In addition to inspections in the past year, this report also includes a few inspections conducted in previous years, where the reports regarding the inspections were adopted in this year.

Both the number of inspections and the number of inspection days has decreased compared with the previous year. This is mainly because the Opcat unit has not, for various reasons, been fully staffed. Overall, 25 inspection days were used in the year. The composition of the inspection teams has varied and was adapted mainly to, for example, the size, target group and security class, if applicable, of the visited institution. For example, two visits were made to the Police Authority in the context of an inspection of the authority's temporary detention facilities and the detention centre in Gothenburg in connection with the EU summit on 17 November 2017. As of 1 January 2018, as a main rule, one rapporteur from a supervisory department must always participate in inspections conducted by the Opcat unit. During the year, nine unannounced inspections were conducted, which included all the inspections of residential homes for young people run by the Swedish National Board of Institutional Care (SiS).

During the year, the Opcat unit conducted several follow-up inspections, including inspections of some of the Police Authority's detention facilities and SiS's LVU-home Rebecka.

Opcat inspections of the Swedish Prison and Probation Service

On the instructions of *Chief Parliamentary Ombudsman Elisabeth Rynning,* during the year, the Opcat unit inspected four of the Swedish Prison and Probation Service's detention facilities and two institutions. Several were follow-up inspections where the Parliamentary Ombudsmen had previously expressed an opinion and issued recommendations for measures, for example, the institutions Visby and Hinseberg. The main focus of the inspections was transport.

After the inspections of the detention facilities in the first six months of 2017, it was noted that a large proportion of detainees who were not subject to restrictions were placed in restricted places and therefore not given any possibility during daytime *to be in communal areas* (ref. no. 416-2017, 417-2017, 418-2017, 419-2017 and 581-2017). The Swedish Prison and Probation Service was asked by *Chief Parliamentary Ombudsman Elisabeth Rynning* to review their procedures regarding reporting and documentation of detainees' access to communal areas, and measures to reduce isolation in relation to detainees who are not granted such access. In June 2018, the Swedish Prison and Probation Service reported to the Parliamentary Ombudsmen on this work. The report indicates that the placement situation in the country's detention facilities is strained, which means that, according to the Swedish Prison and Probation Service, it is still difficult to cater to the need for group placement of detainees. The authority states that over 160 new group places have been created since the inspections. In relation to measures reducing isolation, the Swedish Prison and Probation Service has started work on developing a uniform and effective planning and review tool, which clearly supports local measures to reduce isolation and provides a correct basis on a national level.

One of the most important issues for the Swedish Prison and Probation Service in the years ahead is the work on *measures to reduce isolation* and to try, through such measures, to counteract the negative consequences that may result from deprivation of liberty. It is positive that work has been initiated to create more flexible detention operations and that several additional places have been created in the past year that facilitate detention in groups. The high occupancy rate in detention operations and the increased need for institutional places is worrying, since it may lead, going forward, to a lack of places in the Swedish Prison and Probation Service and consequential difficulties in catering to the need, for example, for group places in detention facilities. As of April 2017, the Swedish Prison and Probation Service has an obligation to assist other authorities with transports of detainees. As a rule, during transport, detainees are placed in the Swedish Prison and Probation Service's detention facilities, and it is questionable whether and how this extended transport assignment affects the availability of places. Accordingly, it is a crucial issue for the Parliamentary Ombudsmen to observe how the Swedish Prison and Probation Service works in this field. The focus of the Parliamentary Ombudsmen's work is the situation of detainees, and this includes how the Swedish Prison and Probation Service works to create a flexible organisation enabling the authority to cater to the right of detainees who are not subject to restrictions to stay in a group with other detainees during

daytime. The report indicates that considerable work remains to be done in relation to this issue. There are also grounds for the Parliamentary Ombudsmen to review how measures reducing isolation taken in relation to individual detainees are documented.

The inspections during the year also showed that detainees of the Swedish Prison and Probation Service remain subject to considerably worse conditions

than individuals in the Migration Agency's detention facilities. Detainees of the Swedish Prison and Probation Service do not have the same possibility of exercising their statutory rights. Of the Swedish Prison and Probation Service's detention centres, Storboda complies, to the greatest extent, the requirements of the legislation. On the other side of the scale are, for example, Huddinge and Sollentuna detention centres, where detainees often stay under conditions that apply to detainees subject to restrictions. This means that a detainee can be locked up in their room 23 hours a day. It is problematic that detainees of the Swedish Prison and Probation Service are still in environments where their statutory rights cannot be met. *Chief Parliamentary Ombudsman Elisabeth Rynning* stated that action must be taken to change the situation for detainees of the Swedish Prison and Probation Service, and she therefore decided to follow up the issue in an enquiry. In the report following the inspection of the Storboda detention facility, *Chief Parliamentary Ombudsman Elisabeth Rynning* refers to a previous decision where the Parliamentary Ombudsmen stated that it would be optimal for the Migration Agency to assume all responsibility for detainees who will not be expelled after having served a prison sentence and that the Swedish Prison and Probation Service should be released from this assignment (ref. no. 581-2017). The *Chief Parliamentary Ombudsman* will return to this issue in the context of the same enquiry. Detainees of the Swedish Prison and Probation Service constitute an issue that will continue to be central in the Parliamentary Ombudsmen's Opcat activities.

In a decision in an enquiry dated 14 June 2018, *Chief Parliamentary Ombudsman Elisabeth Rynning* stated her view on the placement of detainees in solitary confinement (ref. no. 5969-2015 see p. 146). This initiative was taken in connection with an Opcat-inspection of the Helsingborg detention facility and comprised, among others, segregated placement without formal decisions. The decision stated that the Swedish Prison and Probation Service, by relocating detainees and changing the proportion of the number of group placements, controls the placement situation and can therefore prevent most situations where the detainees cannot be placed in group placements. It was also noted that the Swedish Prison and Probation Service did not fully consider the Parliamentary Ombudsmen's previous views that a lack of resources or lack of a possibility to differentiate between detainees are not acceptable grounds for keeping a detainee segregated from other detainees. According to *Chief Parliamentary Ombudsman Elisabeth Rynning* it is deeply unsatisfactory that a detainee is not granted, for organisational reasons or other reasons that the detainee cannot influence, a possibility of staying in a group. This issue is also a part of the Parliamentary Ombudsmen's continued work on following work to reduce isolation of detainees.

Time spent outdoors daily fills an important function to counteract the potential negative consequences of detention. In order for time spent outdoors to fulfil this function, the outdoor environments (exercise areas) for detainees must be designed so that detainees can observe their environment. However, this aspect has had a secondary role in the design of exercise areas in for example detention facilities, where security considerations have prevailed. There are grounds for

monitoring the Swedish Prison and Probation Service's actions to address the potential problems caused by deficient outdoor environments.

Opcat inspections of compulsory psychiatric care and legal psychiatric care

In Sweden, compulsory psychiatric care is operated by county councils. In 2017, there were at least around 80 compulsory psychiatric care institutions with a total of around 4,000 places. Persons who are subject to compulsory psychiatric care according to the Compulsory Psychiatric Care Act (1991:1128), CPCA, and persons who have been sentenced to forensic psychiatric care and are cared for under the Forensic Psychiatric Care Act (1991: 1129), FPCA, are placed in these institutions. The Health and Social Care Inspectorate (IVO) is responsible for keeping an automated register of healthcare institutions and units where care may be administered according to the CPCA or the FPCA and of other forensic psychiatric examination units (Chapter 2, article 4 second paragraph and Chapter 7, article 7 of the Patient Safety Act [2010:659]).

In 2014 the Opcat unit noted that the information in the IVO's register was partly incomplete; among others, in several cases, the information on the head of operations was incorrect. Therefore, the Parliamentary Ombudsmen decided to investigate the matter in the context of a special case (ref. no. 733-2015). IVO stated in its statement that the authority was considering suitable measures both in the short and the long term, having regard to the findings. In a decision dated 9 May 2016, the then *Parliamentary Ombudsman Stefan Holgersson* expressed some criticism that IVO had failed to update the register. In the past year, it has emerged that it remains difficult to get an overview of the number of places available for compulsory psychiatric care. This is troublesome from several points of view. This issue was also described in the report: För barnets bästa? (SOU 2017:111) [In the interests of the child?]. The report highlights, among others, that it is very important in relation to the investigation's proposals that there is total control over which clinics operate compulsory care of children (p. 279). However, the investigation did not include proposals in this part. There are grounds for the Parliamentary Ombudsmen to return to this issue.

During the year, two psychiatric clinics were visited following the instructions of *Chief Parliamentary Ombudsman Elisabeth Rynning*, Danderyd hospital ward 130/PIVA and the compulsory psychiatric care in Region Gotland.

Chief Parliamentary Ombudsman Elisabeth Rynning stated in the report after an inspection in the early summer of 2017 of Stockholm County Council's Children's and adolescent psychiatric clinic's full-time care (BUP), that it is important to be able to follow the development of compulsory measures taken systematically over time. Furthermore, she stated that minor patients in compulsory care must generally be deemed to be vulnerable. It is therefore particularly important that they are examined by a doctor in connection with a decision to restrain or segregate. It was noted during the inspection that supervision of patients in residential premises was conducted in a variety of ways by staff, that supervision was documented only in exceptional cases, and that observations made were communicated verbally and documented in writing "only if some-

thing special happened". Furthermore, there was no written procedure regarding what must be documented and by whom. *Chief Parliamentary Ombudsman Elisabeth Rynning* stated that the clinic must take action to ensure that there are sufficient staff resources to conduct necessary supervision, and that the staff always has the information about the patients that they need to conduct the supervision in a manner that is safe for patients (ref. no. 3816-2017).

Opcat inspections of the Swedish National Board of Institutional Care's residential homes for young people and LVM-homes

During the year, three special youth homes were inspected. During the inspection of one such home, it was noted that the staff had, in two cases, delayed documentation regarding review decisions on care in solitary confinement by several days. *Acting Parliamentary Ombudsman Lilian Wiklund* stated that it is important for documentation to be drafted promptly. It must also be possible, based on the documentation, to determine whether the detainee was notified of the contents in the decision and whether the individual received information on how he or she can appeal the decision (ref. no. 5903-2017). The inspection also gave *acting Parliamentary Ombudsman Lilian Wiklund* grounds for investigating an event when staff at the home restrained a detained youth for nearly one hour (ref. no. 6774-2017).

In autumn 2017, reports were adopted following inspections conducted in spring the same year. Among others, at the inspection of the LVM-home Renforsen, it emerged that staff had different understandings of how frequently they should check on segregated detainees (ref. no 2514-2017). The then *Parliamentary Ombudsman Stefan Holgersson* stated that the home must clarify how the supervision must be conducted. In connection with the inspection of the LVM-home Lunden, it was noted that supervision approved in connection with a risk of suicide could continue for several weeks without any continuous assessment of the need for such supervision (ref. no. 2515-2017). *Parliamentary Ombudsman Stefan Holgersson* stated that the home must review how care in solitary confinement and segregation is conducted and take action to ensure that approved supervision is conducted and documented. In one of the inspected LVM-homes, staff stated that the premises used for care in segregation was not effective. Since such care can continue for a relatively long time, *Parliamentary Ombudsman Stefan Holgersson* invited the home to contact the head office of SiS to discuss how these deficiencies would be addressed (ref. no. 1762-2017).

Opcat inspections of Police detention facilities

During the year, six detention facilities were inspected, of which three were follow-up inspections. One inspection related to the temporary detention facility in Gothenburg and the detention centre Gothenburg in connection with the EU summit on 17 November 2017 (ref. no. 7081-2017). The Opcat unit made two visits, one before the summit and the second during the summit. The temporary detention facility was built at the end of September 2017 and consisted of 40 detention cells placed in the garage of the police building. The detention facility was operational 16–18 November 2017 and allowed for the police to detain a large number of persons (around 100 detainees and 200 protected). No detain-

ees were placed in the temporary detention facility, but 85 individuals were placed in the ordinary police detention facility during the relevant period.

The report indicates that the police had intended, at the summit, to fill a few cells at a time by placing several persons in the same cell rather than starting by placing detainees in individual cells and then, if needed, filling up the cells with more detainees. *Parliamentary Ombudsman Cecilia Renfors* stated that placement of two or more detainees in the same cell should still be viewed as an exception and not a general rule. Obviously, this applies not only in case of placement of persons taken into custody under the Police Act (1984:387) but also in case of placement of several persons who are suspected offenders. *Parliamentary Ombudsman Cecilia Renfors* also noted the intention of the Police Authority to determine the political affiliation of detainees, if required, in order to determine person(s) they could share a cell with. She stated that there may be reason for her to consider this issue in more detail in the future. Finally, she concluded that there was a lack of constitutional grounds for the use of new temporary detention facilities if the storage rooms do not meet the requirements set out in Section 2 of the Regulation (2014: 1108) on the design of detention facilities and police detention facilities.

In relation to other detention operations, during inspections, it was noted that there is still a lack of procedures to ensure compliance with the Police Authority's new regulations (PMFS 2015:7, FAP 102-1) on e.g. submission of information on the detainee's rights. *Parliamentary Ombudsman Cecilia Renfors* underlined that this is unacceptable and that measures must be taken immediately (ref. no. 6464-2017 and others).

A certain improvement has taken place in relation to procedures for supervision of detainees in police detention facilities. Experience from the past inspection period shows, however, that shortcomings remain and that there is still a need for the authority, in relation to its employees, to underline the importance of complying with the procedures. There are also grounds for the Parliamentary Ombudsmen to follow up on this issue.

Every detention facility must have access to a qualified medical practitioner and staff with adequate medical training. A detainee who needs healthcare must be examined by a doctor, and a doctor must be called at the request of a detainee where it is not obvious that such an examination is not required. Where needed, public healthcare must be hired. In around 70 Opcat inspections conducted in the Police Authority's detention facilities since 2011, various deficiencies have emerged in relation to management of detainee medication etc. Access to healthcare based on the needs of the detainees is important, and accordingly this issue will remain an important part in the preventive Opcat review of detention facilities.

International cooperation

One of the overall objectives of the Parliamentary Ombudsmen's activities is to promote the international dissemination of the idea of judicial control through independent Ombudsman institutions.

To achieve this objective, the Parliamentary Ombudsmen must, as far as possible, receive individuals and delegations wishing to visit the Parliamentary Ombudsmen to receive information on their activities and also participate in international contexts and provide information on their activities, and exchange knowledge and experience with, and support, foreign Ombudsman institutions.

In relation to this objective, the Parliamentary Ombudsmen have conducted the following activities, among others, during the year.

The Parliamentary Ombudsmen have received 19 visits. One of the visits was from the Baltic and Nordic Ombudsman institutions, when the Parliamentary Ombudsmen hosted the Baltic Nordic Ombudsmen annual meeting in October 2017. At the meeting, which lasted for two days, topics of common interest were discussed, such as best practices for inspection activities, human rights in daily work and the role of the Ombudsman in the legislative process.

Another, longer visit, which lasted one week in April 2018, was from the Ombudsman institution in the Ukraine (The Ukrainian Parliament Commissioner for Human Rights). An employee of the institution was a Parliamentary Ombudsmen intern in the framework of the Swedish Institute's Peer Shadowing for individuals who participate in the Institute's education programmes. During the visit, which had a special focus on supervision of asylum cases and how the Parliamentary Ombudsmen work in practice, the employee followed the work of a rapporteur on migration and police matters. One day was also dedicated to the Opcat unit's work. Visits were also made to the Migration Agency's detention facility in Märsta. The visitor also gained some insight into the work of the administrative unit, and the Parliamentary Ombudsmen's employees received information on the work methods of the Ukrainian Ombudsman.

The parliamentary ombudsmen and officials of the Parliamentary Ombudsmen also participated actively in foreign conferences and seminars. Among others, *Chief Parliamentary Ombudsman Elisabeth Rynning*, *Parliamentary Ombudsman Cecilia Renfors* and *Head of Division Charlotte Håkansson* participated in November 2017 in the workshop of the International Ombudsman Institute (IOI) and the Dutch Ombudsman in The Hague on cases initiated at the Ombudsman's initiative.

Finally, *Chief Parliamentary Ombudsman Elisabeth Rynning* and *International Co-ordination Director Charlotte De Geer Fällman* participated in a workshop in Tallinn on the theme of Human Rights in the Digital Age, arranged by IOI and the Attorney General in Estonia. They also participated in the European Ombudsman Conference in Brussels for Ombudsmen in the framework of the European Network of Ombudsmen. The conference concerned, among others, the issue of the Ombudsmen's presence in social media.

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

Courts

Public courts

The Parliamentary Ombudsmen directs criticism towards a Chief Judge and a judge at Gävle District Court for the handling of a case regarding a conflict of interest

In the decision, the Chief Judge and a judge at Gävle District Court are criticised for how a conflict of interest in a dispute was handled.

Subsequent to an objection by one of the parties, against the judge, regarding a conflict of interest, the judge took certain actions in the case that the judge was not authorised to perform, in accordance with Chapter 4, Section 15 of the Swedish Code of Judicial Procedure and the Chief Judge did not take a decision on the matter until two months later. The Parliamentary Ombudsmen states that the conflict of interest was not handled correctly and directs criticism towards the judge and the Chief Judge. (363-2017)

Disciplinary action for a judge who failed to communicate judgments within the prescribed time limits, in three cases

A judge at Västmanland's District Court failed to provide a notification of judgements within the prescribed time limits, in four cases. During the spring of 2017, he postponed the notification of judgements on 18 separate occasions which resulted in the judgements being notified between two and a half weeks to almost two months after the main hearing. The judgements included a custody case and two criminal cases with detained persons.

In a decision on 26 September 2017, the Parliamentary Ombudsman assessed that the judge had breached his obligations in a manner that constituted misconduct and handed the question of disciplinary action over to the Government Disciplinary Board for Higher Officials.

In a decision on 5 December 2017, the Disciplinary Board issued a warning to the judge. The Disciplinary Board assessed that it was not acceptable to repeatedly move the day of a judgement notification in the manner that the judge had done for three of the cases. The judge had therefore deliberately been in breach of his obligations in such a manner that misconduct existed.

The Disciplinary Board's decision is final, and the Parliamentary Ombudsman thereby closed the case (2436-2017, 3061-2017)

The Parliamentary Ombudsmen directs criticism towards a judge at Solna District Court for failure to go through a draft of the grounds for the decision with the two lay judges who decided the outcome of a criminal case before the sentence was expedited

After a main hearing in a criminal case in which lay judges are participating, the court shall debate and decide upon the judgment. It is the judge who then writes the judgment, and there is no requirement in the law for the lay judges to inspect the written judgment, or sign it.

Solna District Court announced a judgment on 19 February 2018, wherein a person was acquitted from prosecution for abuse. The judgment was decided by two lay judges while the judge (i.e. the presiding judge) and a lay judge wanted to approve the prosecution. The formulation of the grounds for the decision received attention in the general debate and, among other things, it emerged that the judge had written a different verdict than that which the two lay judges had concluded.

The Parliamentary Ombudsmen writes in her decision that a judge who is of the opinion that the lay judges are on their way to make an incorrect decision must do their best to avoid this from becoming reality. In many cases this is facilitated, according to the Parliamentary Ombudsmen, if the judge writes a draft judgment with the grounds for the decision considered by the lay judges and then goes through this draft with the lay judges. By doing this the judge can more easily explain to the lay judges the problems there may be with the judgment

and the grounds for the decision. In this way, it is possible to avoid mistakes and to prevent the lay judges from telling the media, after the judgment has already been announced, that the written judgment is not consistent with what they decided during the deliberation.

The Parliamentary Ombudsmen's investigation does not reveal that the judge wrote a judgment with grounds for the decision that deviates from what the two lay judges concluded during the court's deliberation. However, it is stated that the judge did not review the written grounds for the decision with the lay judges prior to the judgment being expedited. The Parliamentary Ombudsmen is of the opinion that a person reading the grounds for the decision cannot reasonably come to conclusion other than that she should have done so. Therefore, the judge cannot avoid criticism. (2243-2018)

Administrative courts

The Administrative Court of Appeal in Sundsvall decided upon a judgement during a deliberation to end a patient's psychiatric compulsory treatment. The judgement was not announced until the following day. In the decision, the Parliamentary Ombudsmen direc

The Administrative Court of Appeal in Sundsvall decided upon a judgement during a deliberation to end a patient's psychiatric compulsory treatment. The judgement was not announced until the following day. In the decision, the Parliamentary Ombudsmen directs criticism towards the judges responsible for the delay. (2807-2017)

Decision to close a preliminary investigation against three lay judges at the Administrative Court in Stockholm and to close the Parliamentary Ombudsmen's case; an assessment of point 4 in the transitional provisions of the Swedish Limitations Act

On June 14, 2017, the Parliamentary Ombudsmen decided to open a case specifically to investigate the Migration Court at the Administrative Court in Stockholm's processing and assessment of the residence permit and deportation case as pronounced in a judgement in May 2017. The Parliamentary Ombudsmen decided to initiate a preliminary investigation on the same day regarding suspicion of misconduct under Chapter 20, Section 1 of the Swedish Penal Code.

In the decision, the Parliamentary Ombudsmen closes the preliminary investigation and concludes its handling of the case. As per the formulation of point 4 of the transitional provisions of act (2016:752) on temporary limitations of the opportunity to be granted residence permit in Sweden, (the so-called "Swedish Limitations Act"), a copy of the decision is be handed to the Ministry of Justice. (4068-2017)

The Administrative Court in Stockholm recieves criticism for a lack of diligence in verifying the court's jurisdiction and at a judge at the Administrative Court for deciding to transfer a case to another administrative court without statutory support

The Swedish Social Insurance Agency filed an appeal in a case concerning sickness compensation with the Administrative Court in Stockholm. The Administrative Court initiated proceedings via an exchange of letters. Approximately five months later, the Administrative Court decided to send the case documents to the Administrative Court in Malmö. In its reasoning, the Administrative Court in Stockholm stated that it did not have jurisdiction for the appeal, but the Administrative Court in Malmö did have jurisdiction.

The Parliamentary Ombudsman directs criticism towards the Administrative Court for having failed in the verification of the court's jurisdiction, which must be performed when a case is received by the court.

The Parliamentary Ombudsman further states that since the Administrative Court in Stockholm had initiated proceedings in the case, there was no legal basis for handing the case documents over to the Administrative Court in Malmö. Instead, the Administrative Court in Stockholm should have dismissed the appeal. The Swedish Social Insurance Agency's obligation to submit an appeal to the administrative court with jurisdiction would thereby have been re-established. The Parliamentary Ombudsmen directs criticism towards the judge who issued the faulty appeal. (7923-2017)

The Parliamentary Ombudsmen directs criticism towards five judges at four Administrative Courts due to failing to take a position with regard to allegations of biased processing or prejudiced decision-makers at the decision-making authority

In the decision, five judges are criticised at four Administrative Courts for, in their pronounced judgments, not taking a position with regard to allegations of biased processing or prejudiced decision-makers at the decision-making authority.

The Parliamentary Ombudsmen states in the decision that the regulations concerning conflict of interest are one of the cornerstones of justice and administration and that they are

an expression of the constitutional objectiveness principle, which means that courts and administrative authorities must observe objectively and impartiality, as well as take into account everyone's equality before the law (Chapter 1, Section 9 of the Instrument of Government). An Administrative Court that handles an allegation that the processing of the decision-making authority has been biased, or that a decision-maker there has been prejudiced, must always observe this principle. A party that asserts such a claim is entitled to request that the Administrative Court explicitly takes a position on this allegation. A legitimate claim can indeed constitute an impediment to the examination of a case at the Administrative Court and entail that the processing of the decision-making authority must be redone.

The Parliamentary Ombudsmen also states in the decision that the assessment of a poorly substantiated claim that the processing of the decision-making authority has been biased or that a decision-maker has been prejudiced may be presented fairly briefly, while a well-substantiated claim requires a more thorough account of the assessment. It is important for the court in question to take a position on the allegation. (8001-2017)

The Parliamentary Ombudsmen directs severe criticism towards a particular member of the Administrative Court in Karlstad who was involved in settling a case concerning judicial review without notifying a circumstance that could be a conflict of interest

A particular member of the Administrative Court in Karlstad was involved in settling a case concerning judicial review of a municipal decision. The member had previously dealt with the subject of the decision as a legal consultant for the municipality; he had assisted the municipality as a counterparty in the case by, among other things, drafting proposals for statements to the Administrative Court and the Chamber of Commerce in Gothenburg. The member did not, as the law prescribes, voluntarily report that this could be assumed to imply a conflict of interest before taking part in the Administrative Court's new examination of the case. The Parliamentary Ombudsmen states in the decision, that it was obvious that the member's previous position on the case could be assumed to imply a conflict and that he was obliged to make this known. The member receives severe criticism from the Parliamentary Ombudsmen for not doing so. (331-2018)

Education and research

The Parliamentary Ombudsmen directs criticism towards a Senior Lecturer at Stockholm University regarding her actions in connection to an application on research grants etc.

In a complaint to the Parliamentary Ombudsmen, several complaints were raised regarding a Senior Lecturer's actions in connection to an application on research grants and an application on doctoral studentship.

The Parliamentary Ombudsmen's investigation has shown that: the complainant got in contact with the Senior Lecturer as she wished to conduct her doctorate with the Senior Lecturer as her supervisor. To finance the research they applied for research grants from the Competition Authority. Along with the application, they attached a project description; the complainant was in principle the author of the description. Upon this, the complainant applied for a doctoral studentship at the university. Before the Competition Authority took a decision on research grants the Senior Lecturer received information that the student's application on doctoral studentship at the university was rejected. At that point, a formal decision on the matter had not been taken by the university. The Senior Lecturer informed the Competition Authority that the complainant was not going to be accepted as a doctoral student, and shortly after the Senior Lecturer handed in a revised application on research grants to the Competition Authority. According to the new application, the project was going to be the Senior Lecturer's project only. The new application's project description on research grants was essentially identical with the project description in the previous application. The Senior Lecturer did not inform the complainant about her contact with the Competition Authority until the Competition Authority had taken a decision on research grants, and subsequent to the university's decision to reject the application on doctoral studentship. When the decisions had been taken the Senior Lecturer initiated new contacts with the complainant and the Competition Authority. During the Parliamentary Ombudsmen's investigation it has been discovered that the Senior Lecturer, at several occasions, handed over information, that was inaccurate to the Competition Authority and to the complainant.

Pursuant to chapter 1, section 9 of the Instrument of Government, courts of law, administrative authorities and others performing public

administration functions shall pay regard in their work to the equality of all before the law and shall observe objectivity and impartiality. According to the Parliamentary Ombudsmen's understanding, the Senior Lecturer actions are in several regards contrary to the statute-regulated requirements on objectivity.

In addition to this, the Senior Lecturer has handed in inaccurate information regarding her actions to the Parliamentary Ombudsmen, which goes against the obligation to tell the truth pursuant to chapter 13, section 6, second paragraph, of the Instrument of Government.

The Parliamentary Ombudsmen directs severe criticism towards the Senior Lecturer. (4183-2016)

The Parliamentary Ombudsmen directs criticism towards a school nurse at Karolinerskolan in Mellerud municipality for, among other things, conducting a health check of a pupil without informing the pupil's custodian

A school nurse conducted a health check of a nine-year-old pupil without informing the pupil's custodian. During the health check, the nurse spoke to the pupil about her weight and handed over certain documents to the pupil, including, among other things, a weight curve and a sheet of paper including information regarding the pupil's weight gain.

Pursuant to chapter 6, section 11 of the Children and Parents Code a custodian holds the right and obligation to decide on matters regarding a child's personal circumstances. Regarding small children, a custodian takes every decision. This means that a small child under care obligates healthcare staff to consult with the child's custodian regarding the child's care, how it shall be organized and carried out.

The Parliamentary Ombudsmen directs criticism towards the school nurse for not informing the pupil's custodian before conducting the health check. The school nurse also receives criticism for speaking to the pupil about the pupil's weight without first having discussed the matter with the custodian and for handing over certain documents directly to the pupil. The Parliamentary Ombudsmen states that the school nurse could have sent the material to the custodian or disclosed the documents in another manner. (7313-2016)

The Parliamentary Ombudsmen directs criticism towards the headmaster of Nordhemsskolan in Gothenburg municipality

A headmaster sent information to the students' guardians. The information in question concerned students that are seeking asylum in Sweden and contained the headmaster's personal views regarding the asylum procedure and the decisions made in that process. The headmaster received criticism by the Parliamentary Ombudsmen as these issues are not in compliance with the requirement for impartiality. (7627-2016)

Complaint in connection with a search of student lockers at Stenungskolan in Stenungsunds Municipality

Pursuant to Chapter 2, Section 6 of the Instrument of Government, every citizen is publicly protected from premises searches.

Students at a school had access to their own lockers to which they had their own locks. The municipality's procedures for drug-free schools as well as information on student lockers indicated that the lockers were the property of the school and were lent to pupils for the storage of school-related materials. Furthermore, it indicated that the school was entitled to open the lockers if there was reason to believe that some unauthorised item was stored there. On 9 December 2016, the school's principal searched a number of the students' lockers. Parents of one of the students reported the principal to the Parliamentary Ombudsmen and argued that the principal's behaviour violated the regulations in the Instrument of Government and the school's guidelines. The Parliamentary Ombudsmen establishes that the student lockers, with regard to the purpose of them and the conditions in which the students borrow them from the school, may not be considered closed storage spaces in relation to the school. Action from the school management's side to search the lockers was therefore not considered to be a premises search in the sense indicated in the Instrument of Government. The Parliamentary Ombudsmen comes to the conclusion that there is no reason to criticise the search of the students' lockers. (7914-2016)

The Enforcement Authority

The Parliamentary Ombudsmen directs severe criticism towards the Enforcement Authority for failures in the authority's asset management

From December 2016 to July 2017, the Parliamentary Ombudsmen received a large amount of complaints against the Enforcement Authority. A reoccurring complaint was due to the authority's lack of keeping records of completed payments, which had resulted in consequences for the complainants, inter alia; it led to in-

complete investigations and distrains as well as delays in the authority's repayments.

In the authority's referral response to the Parliamentary Ombudsmen, the Enforcement Authority admits to the failures that the complainants have observed. The authority regrets the mistakes that have occurred and the inconvenience that the deficient processing has led to. The Enforcement Authority accounts for their failures in the asset management and for several measures taken to correct these failures.

In the decision, the Parliamentary Ombudsmen states that the authority's management of restraints has not been in compliance to the instructions of how to administer the procedures according to the rule of law, as well as being cost efficient and done simply. The reason why these mistakes have occurred is, according to the Parliamentary Ombudsmen's understanding, mistakes and failures in the authority's asset management. To administer these duties according to the authority's functions is the obligation of the senior management; the Parliamentary Ombudsmen directs severe criticism towards the Enforcement Authority.

The Parliamentary Ombudsmen will hand over a copy of this decision to the Ministry of Finance for knowledge. (7750-2016)

Health and medical care

The Parliamentary Ombudsmen directs criticism towards Region Norrbotten, Countywide Psychiatry, for examining the stored information in a patient's electronic equipment without legal support

A patient who was cared for pursuant to the Compulsory Mental Care Act complained that the clinic had taken his electronic equipment in order to examine it.

The investigation reveals that the clinic in question applies a routine document entitled "Search of electronic communication aids". According to the document, the chief medical officer may decide on the examination of a patient's personal technical equipment if, for example, there are suspicions that the equipment is being used to buy drugs or to download unauthorised pornography, or for threats and harassment. Technical equipment that is taken for review is handed over to technicians who investigate the contents of the equipment, i.e. the electronically stored information.

The Parliamentary Ombudsmen notes that examinations of the stored information in a patient's electronic equipment brings into focus several of the fundamental rights and freedoms mentioned in the Instrument of Government and the European Convention. According to the Parliamentary Ombudsmen, examinations of this kind entail, inter alia, violation of personal privacy which the provision in Chapter 2, Section 6 of the Instrument of Government is intended to protect citizens against, and legal support is therefore required to take such action. According to the Parliamentary Ombudsmen, there is no such legal support, nor is there any scope for a care provider within psychiatric compulsive care to, with the patient's consent, carry out investigations concerning the stored information in the patient's computer or the like. The Parliamentary Ombudsmen directs criticism against the clinic.

However, from the patient's perspective, an examination of his or her electronic equipment may in some cases appear to be a more minor invasive measure than perhaps the applicable alternative, namely a restriction of the right to use the equipment or its removal. For reasons of legal certainty, it is important however to clearly state what coercive measures may be taken within psychiatric compulsive care. The Parliamentary Ombudsmen draws attention to this and raises the issue of a legislation review. (4746-2015)

Criticism against a Head of Operations at Skåne University Hospital for the management of an issue concerning visiting restrictions for a relative of a patient under care pursuant to the Swedish Health Care Act

A Head of Operations at Skåne University Hospital decided that a relative of a patient under care pursuant to the Health Care Act would only be allowed to visit the patient at certain specified times. These visitation hours meant a limitation in relation to how the relative had previously been able to visit the patient and to the regular visitation times within the care unit. The Head of Operations believed that this was a measure of purely executive nature that he was authorised to decide upon on the basis of the hospital's general policies concerning procedures and proper conduct at the hospital.

The Parliamentary Ombudsmen has previously stated that a decision to suspend until further notice the possibility of a relative from visiting a patient who is being cared for in accordance with the Health Care Act cannot be regarded as a purely executive measure. In the present case, the Parliamentary Ombudsmen states that decision-making concerning the limi-

tation of visitation of a relative of a patient being cared for in the non-compulsory healthcare cannot be regarded as a purely executive measure that an executive officer is authorised to make. The Head of Operations is therefore criticised for his deficient handling of the matter.

During the course of the processing of the case, the Parliamentary Ombudsmen has highlighted ambiguities regarding the legal prerequisites for issuing visitation restrictions in the non-compulsory health care.

Restricting the right to visit a close relative is a very intrusive measure for an individual, both for the visitors and the recipient of the care, and constitutes an infringement of their family life under Article 8 of the European Convention of Human Rights. Thus, according to the Parliamentary Ombudsmen it is therefore important that such restrictions be based on preconditions defined by law and that decisions in a specific case may be appealed to a court. When it comes to non-compulsory care, such special regulation is missing. The Parliamentary Ombudsmen wishes to draw the Government's attention to this particular matter and raises the issue of a review of the legislation. (3999-2016)

Criticism against the Swedish Health and Social Care Inspectorate for how they handled a case

In a complaint filed with the Parliamentary Ombudsmen a doctor complained about how a case, relating to him, had been processed by the Health and Social Care Inspectorate (IVO). The doctor stated, inter alia, that he had not been provided with an opportunity to comment on the matter previous to when the Health and Social Care Inspectorate came to a decision on the case. In the decision, the Health and Social Care Inspectorate directed criticism towards the doctor.

In the Parliamentary Ombudsmen's investigation it was found that despite that the case was commenced via a complaint, the Health and Social Care Inspectorate had dealt with this within the framework of an initiative case pursuant to Chapter 7, Section 19 of the Swedish Patients' Safety Act and not as a complaint case under Chapter 7, Section 18. According to the latter provision, inter alia, the complainant and the party to whom the complaint relates, is provided an opportunity to comment on a recommended decision prior to the decision being by the Health and Social Care Inspectorate. The Parliamentary Ombudsmen criticises the Health and Social Care Inspectorate for not handling the matter pursuant to the complaints provisions and not communicating a proposal for a decision to the party whom the complaint related to.

Chapter 7, Section 19 (2) of the Patient Safety Act states that Chapter 7, Section 18, as applicable parts, shall also apply to matters where initiatives are taken. However, the Health and Social Care Inspectorate has made a statement to the Parliamentary Ombudsmen that the obligation to communicate a proposal for a decision cannot be regarded as applicable in the case of an initiative. According to the Parliamentary Ombudsmen, there are uncertainties in the legislation in this regard, and therefore there is a need for a review. A copy of the decision is forwarded to the Ministry of Health and Social Affairs. (4450-2016)

Migration

The Parliamentary Ombudsmen directs criticism towards the Police Authority and a police officer for detaining an individual and executing a decision on removal in spite of the fact that the Police Authority was not authorized to do so

The Migration Agency decided to transfer an individual to Germany pursuant to the Dublin Regulation. The Migration Agency had not handed over the execution of the decision, and the Police Authority was not authorized to take a decision regarding detention and execution. In spite of this, a police officer took a decision on detention and execution. The police officer's decision regarding the detention was based on a regulation that was not applicable. The next day, following upon a contact with the Migration Agency, the decision was adjusted which led to, among other things, a new legal assessment. The Parliamentary Ombudsmen notes that the information in the decision regarding the grounds for the detention was very brief and the Police Authority was not able, not even in hindsight, to recognize the grounds on which the decision was based upon. According to the Parliamentary Ombudsmen's understanding the processing of this case gives the impression that the legal prerequisites for detaining an individual was not applied by the Police Authority and that the authority decided to detain the individual as well as execute the transfer with force, in spite of the factual circumstances. The Parliamentary Ombudsmen directs severe criticism towards the police officer and the Police Authority for this occurrence.

Following upon a request by the Police Authority, the Migration Agency decided to detain the individual, in spite of the fact that the Police Authority was not authorised to take such a decision. The Parliamentary Ombudsmen states that the case demonstrates that the Migration Agency need to take part in a detention decision, and, in the present case, the decision on removal, which form the basis for a motion on detention measures. Such strategy will allow the Migration Agency to discover if a decision is incomplete. If such faults exist, there may be reasons to conduct further check-ups of the legality of the decision. According to the Parliamentary Ombudsmen, there are reasons to believe that the Migration Agency, when conducting such examinations, are able to discover if a detention decision lack legal basis. The Migration Agency is criticised for taking a decision prior to taking part in the Police Authority's adjustment of the detention decision and for neglecting to conduct an adequate control of the legality of the detention decision. (1210-2016)

The Parliamentary Ombudsmen directs criticism towards the Migration Agency for stating the wrong date of birth on a certificate for residence permit

The complainant was provided a date of birth, other than her correct date of birth, by the Swedish Tax Agency. On the certificate that the Migration Agency issues for persons that have received a residence permit, a person's date of birth, among other things, is included. The complainant received four certificates from the Migration Agency including the birth date the complainant received from the Swedish Tax Agency, and not her correct date of birth. The Migration Agency held that the mistakes occurred due to technical limitations in their IT system.

The Parliamentary Ombudsmen directs criticism towards the Migration Agency for failing in their processing of the complainant's certificate. The Migration Agency has taken a decision on measures to avoid similar problems, the Parliamentary Ombudsmen looks positive upon this decision. (2998-2016)

Cases involving police, prosecutors and custom officers

The Parliamentary Ombudsmen directs criticism towards the Police Authority for keeping 500 male passengers on a ferry without having had support for it

On the 30th of March 2016, several police units were ordered to Värta marina (Värtahamnen) in Stockholm because of a suspected aggravated rape on board of a ferry. When the ferry had arrived to the marina, a police inspector took a decision to conduct body searches pursuant to chapter 28, section 12 of the Code of Judicial Procedure. All female passengers were allowed to leave the ferry while all male passenger, around 500 men, were forced to stay. One by one, they were placed in front of a tinted glass wall, at the custom office, so that the injured party, on the other side of the wall, could identify the suspected offender. The injured party did not identify anyone of the men that passed the glass wall. Three offenders were instead arrested on board of the ferry.

One man, which was on the ferry, handed in a complaint to the Parliamentary Ombudsmen and questioned the fact that the police had forced the man to stay on the ferry. He stated, among other things, that he was forced to stay on the ferry for an hour and a half and that he, because of this, missed his flight.

According to the Parliamentary Ombudsmen understanding, it was clear that all male passengers could not have been suspects of the crime. So forth there was no prerequisite to conduct a body search of all the men. The Parliamentary Ombudsmen further states that the measure, consisting of the injured party observing the possible offenders through a glass wall, could not constitute a body search pursuant to the Code of Judicial Procedure.

In the decision, the Parliamentary Ombudsmen considers if the legal prerequisites were met when keeping the men pursuant to the Code of Judicial Procedure, and concludes that the measure lacked legal support.

The Parliamentary Ombudsmen express that it is unacceptable that a police measure lacks legal basis and results in a large number of people having their liberty restricted. The Parliamentary Ombudsmen directs criticism towards the Police Authority for keeping the male passengers in the manner that occurred. The Police Authority is also criticised for not registering the decision that the measures were based upon.

The Parliamentary Ombudsmen state that there might be a need to further the legislation within this scope as there may occur situations when the police need to keep persons on a specific place in order to conduct a criminal investigation. The decision is therefore forwarded to the Ministry of Justice. (2015-2016)

The Parliamentary Ombudsmen directs criticism towards the Police Authority for failing in their supervision of a woman apprehended due to intoxication, and for not taking her to see a doctor

M.K. was apprehended due to intoxication at the hospital where she earlier that night had sought care. She was taken to the arrest in Borlänge. Around five o'clock in the morning M.K. fell out of her bed and injured her head. The guard at the arrest made the assessment that M.K. was not in need of a doctor. Instead, he decided to give M.K. additional supervision.

However, the personnel at the arrest was not informed of this measure, but still additional supervision was provided to M.K. until the change of personnel at six o'clock in the morning. Around half past eight, the personnel discovered that M.K's breathing was incoherent and that she wheezed. M.K. was brought to the hospital where she later passed away due to severe brain damage.

The Parliamentary Ombudsmen holds that the requirement that a detained person who may have suffered injuries to their head should receive a medical examination, should not be interpreted in a way that a medical examination is always necessary. On the other hand, it is not possible to grasp the need for a medical examination only through visible injuries. The detained person's general condition, the effect of the intoxication and the person's disease profile should also be taken into account. For a nonprofessional it is particularly difficult to assess an injury to the head, much more so if the detained person is severely intoxicated. The scope for refraining from a medical examination if the detained person has incurred injuries in the face or head, while in the arrest, is thus very limited.

The Parliamentary Ombudsmen states that M.K. should have been brought to a doctor, as soon as the personnel discovered that she was unable to stand up after falling to the floor. The Police Authority is criticised for this failure. The Parliamentary Ombudsmen emphasise the importance of registering decisions on provided supervision to secure that the personnel is informed about how to execute the supervision. The Parliamentary Ombudsmen notes that M.K. was supervised every fifteenth minute during the morning, and as far as known, no one entered M.K.'s cell to check on her condition, in spite of the facts clearly stating that this was necessary. The Police Authority is criticised for the lack of supervision.

In conclusion, the Parliamentary Ombudsmen holds that persons apprehended due to intoxication should, as a main rule, be under medical supervision and not kept in a police arrest. According to the Parliamentary Ombudsmen's understanding, the Government should once again review the necessity of legislative measures within this area. This decision is handed over to the Government Offices, pursuant to section 4 of the Act with Instructions for the Parliamentary Ombudsmen. (2468-2016)

The Parliamentary Ombudsmen directs criticism towards the Police Authority for the treatment of a woman apprehended for intoxication

AA was apprehended for intoxication and brought to a police arrest. In the arrest, she acted out and, at one occasion, tried to hang herself. In spite of her mental state, she was not taken to a doctor. During the apprehension AA asked repeatedly to use the washroom but was told to urinate on the floor. During the course of three hours, she was inside the cell without access to a blanket or a mattress, wearing only her underpants. During this period, only male staff members came to check on her.

In the decision, the Parliamentary Ombudsmen states that a perfunctory assessment of an inmate's health may not occur on the basis that the inmate is intoxicated or acting out. Mental illness caused by intoxication may need a doctor's assessment; also thoughtless attempts to commit suicide should be taken seriously. If there are signs that an inmate has been through previous circumstances that can cause difficulties for the inmate during an apprehension it is particularly important to consider medical care. Against the background of the safety assessment that was made of AA, and her behaviour when she was placed in the arrest, the Parliamentary Ombudsmen directs criticism towards the Police Authority for not making sure that a doctor examined her when she showed signs of trying to commit suicide.

The Parliamentary Ombudsmen states that only extra ordinary security reasons can justify why an intern is held in an arrest without a blanket or mattress wearing only their underpants, for nearly three hours. During such circumstances the staff at the arrest need to, on a continues basis, observe the intern's conditions to make sure that the intern does not spend time without clothing for a longer time than necessary. The Parliamentary Ombudsmen directs criticism towards the Police Authority for not providing AA with a blanket when she was placed in the arrest and for forcing her to spend approximately three hours in her underpants

without sufficient reasons.

The Parliamentary Ombudsmen also holds that only in exceptional cases should an intern be told to urinate in a floor drain and that these circumstances need to be justified in every separate case. AA was told to urinate on the floor outside the door to the wash room, for nearly eight hours. The Police Authority is criticised for their treatment of AA.

The Parliamentary Ombudsmen also directs criticism toward the Police Authority for the lack of documentation in several respects. (5864-2016)

The Parliamentary Ombudsmen directs criticism towards the Police Authority for their supervision of a woman apprehended for intoxication and for the lack of documentation

AA was apprehended for intoxication and brought to the arrest in Lund. Around nine o'clock in the morning the staff members at the arrest noticed that AA snored and put her in recovery position to free her airways. The staff members at the arrest continued to check on AA through a window in the cell door. The investigation proves that it took approximately 35 minutes until the staff at the arrest entered the cell again. Proceeding to this AA's breathing stopped and the staff members began life saving measures. AA was brought by ambulance to the hospital where she was declared dead. No records were kept of the supervision that was performed of AA in connection to her arrest.

According to the Parliamentary Ombudsmen's understanding AA's circumstances proved that her condition needed to be checked upon inside the cell. Especially in regards to the fact that AA was left in recovery position. AA should also have been woken up when she was snoring. The Parliamentary Ombudsmen states that the supervision of AA did not lived up to the requirements on accuracy and care in regards to persons kept during coercive measures. The Police Authority is criticised for their lack of supervision of AA.

The Parliamentary Ombudsmen also directs criticism towards the Police Authority for the lack of documentation and emphasises the importance of registering observations and other essential facts during the supervision of an apprehended person.

The Parliamentary Ombudsmen has recently stated that a person apprehended for intoxication should, as a main rule, be kept under medical examination and not be kept in a police arrest, moreover there may be reasons for the Government to review the necessity of legislative measures within this area. That decision is handed over to the Government Offices. In addition, this decision demonstrates the shortcomings in the current legislation. A copy of this decision will be handed over to the Government Offices for knowledge. (7054-2016)

Criticism of the Swedish Police Authority for, among other things, releasing photographs from a preliminary investigation of an individual who was a suspect, for public release and publication, when no precondition supported it

In June 2016, photographs from a surveillance camera were published in a programme broadcast over the Internet by a media company and in the media company's printed newspaper. The photographs showed two people suspected of fraud and attempted fraud, which had been forwarded to the media company by the police to appear in a programme in order to obtain assistance from the general public in identifying one of the suspects. In a complaint filed to the Parliamentary Ombudsmen the complainant stated that the police already knew her identity, when the photographs were released.

A photograph of a suspect in an ongoing investigation is usually encompassed with secrecy. The Parliamentary Ombudsmen has previously considered the preconditions if a publication of an electronic surveillance camera's image of a suspected person on the police's website may be within the confines of the law (decision: JO 2011/12 p. 118). In the present case, the Parliamentary Ombudsmen states that the purpose of releasing the pictures has been identical with that in the decision previously announced, i.e. to obtain the public's assistance in order to identify a suspect, and that corresponding considerations regarding the privacy of the suspect should be made as when the police publish a photograph. According to the Parliamentary Ombudsmen, the assessment of whether the photographs could be released to the media company for publication, should be on the basis of the preconditions stated in JO 2011/12 p. 118, which are essentially consistent with the Swedish Police Authority's guidelines regarding publication on the police's website. However, when the police release a picture from a preliminary investigation to another party for publication for identification purposes, one loses control over how the image is used. Particular consideration should therefore be taken of whether or not the image should be released.

According to the Parliamentary Ombudsmen the measure to disclose the photograph in this case was not in accordance with the precon-

ditions as established by the Parliamentary Ombudsmen and the Swedish Police Authority's guidelines. It has thus not been compatible with the provisions of Chapter 10, Section 2 and Chapter 35, Section 1 of the Swedish Public Access to Information and Secrecy Act, nor with the principle of assessing certain necessary interests as outlined in Chapter 23, Section 4 of the Swedish Procedural Code. The Parliamentary Ombudsmen directs criticism towards the Police Authority for this occurrence and for the lack of documentation in the case. (3572-2016)

Criticism of the Police Authority for forcing a person apprehended due to intoxication to provide their identification, without having had support for it

T.E. was apprehended due to intoxication. T.E. refused to provide his identification and was accordingly recorded as 'unknown' when arriving at the arrest. At several occasions, a guard at the arrest asked T.E. to provide his personal identity number, for his own good. When T.E. asked what would happen if he did not provide his identification he was informed that it might lead to an extension of the apprehension. The guard also told T.E. that an apprehension due to intoxication usually lasts for 6 to 8 hours, but that he could possibly release T.E. earlier than that if T.E. provided his personal identification number. T.E. became frightened and gave up his name, address and personal identification number. A person that is apprehended due to intoxication is not obligated to provide their identification, and the police cannot use coercive measures to establish a person's identity. The Parliamentary Ombudsmen states that the information T.E. received regarding the possibility of extending T.E.'s apprehension if he did not provide the guard with his personal identification number lacked legal support. According to the Parliamentary Ombudsmen, what has occurred is unacceptable. Moreover, the Parliamentary Ombudsmen holds that the Police Authority is responsible to see to it that employees at a police's arrest are adequately educated to be able to conduct their job in a competent manner.

The Parliamentary Ombudsmen directs criticism towards the Police Authority for the occurrence. (4222-2016)

Criticism against the Police Authority for the manner in which the police handled the removal of a 13-year-old and for inadequate documentation concerning the intervention

A 13-year-old boy, AA, was taken just before midnight by a guard at a youth festival for disturbing the peace. The police decided to remove AA pursuant to Section 13 of the Police Act, and approximately one hour later, the police left him alone at a bus stop 3.8 kilometres from the festival area. AA was not familiar with the location where he had been dropped off.

Contrary to what applies in the case of detention under the Police Act, the manner in which the police should go about removing a minor has not been specifically regulated. According to the Parliamentary Ombudsmen, a reasonable premise must be that the special considerations the legislation expresses in the handling of minors must also be taken into account in the application of the provisions concerning removal. The Parliamentary Ombudsmen states that there are limited legal possibilities to remove a child in their early teens under the conditions that apply in this case. The Parliamentary Ombudsmen also states that what is proportionate and acceptable in the case of intervention against an adult is rarely the same as what is acceptable against a child.

According to the Parliamentary Ombudsmen, it was not absolutely necessary for the police to decide to remove AA from the site, as other alternatives could have been considered. However, the Parliamentary Ombudsmen does not find sufficient reason to criticise the police in this regard. According to the Parliamentary Ombudsmen, it is however clear that the manner in which the police performed the removal of AA was not proportionate and the Police Authority is criticised for this. The Parliamentary Ombudsmen also establishes that the overall circumstances - the intervention's duration, the distance AA was driven and the action of performing a forced physical intervention by handcuffing AA - was such that the decision on removal, from a legal standpoint, turned into the child being taken into custody. When the police makes a decision regarding removal, it is important that they consider the possibility of executing the decision in accordance with the legal conditions that apply. If the execution of the decision takes an extended amount of time, consideration should be given to whether or not it is possible and sufficient to cancel the decision and instead ask the person to voluntarily leave the scene, or alternatively handle the intervention as temporarily taking the person into custody when the conditions for this are found to exist.

The Police Authority is also criticised for insufficient documentation in several aspects. (4915-2016)

The Parliamentary Ombudsmen directs criticism towards the Police Authority for deficient documentation of an apprehension pursuant to section 13 of the Police Act

A man was apprehended pursuant to section 13 of the Police Act for disturbing the public order. The Parliamentary Ombudsmen notes that the police's record of the apprehension was deficient on several accounts. The police failed to register the grounds for the apprehension in an adequate manner and neglected to register a questioning with the apprehended man. In addition, the review of the prerequisite for the release was not registered. There is also a lack of documentation of, among other things, having informed the apprehended man of the reasons for the apprehension and his right to contact relatives. The Parliamentary Ombudsmen directs criticism towards the Police Authority for these failures.

On several occasions in the past year, the Police Authority has received criticism for deficient documentation in connection to conducting apprehensions. The Parliamentary Ombudsmen states that the lack of documentation can damage the police's credibility; it may so forth be questioned if a police measure is in accordance to applicable rules and regulations. It is not acceptable, according to the Parliamentary Ombudsmen, that the procedures of an authority cannot be monitored at a later point in time due to the reason that the measures were not registered. Incomplete documentation appears as quite severe as the relevant measures are carried out on a regular basis. According to the Parliamentary Ombudsmen's understanding, there may be grounds to emphasize, to police personnel, the importance of registering complete documentation of the police's measures.

In the decision, the Parliamentary Ombudsmen also holds that it is the responsibility of the police to make sure that they are understood in the foremost extent, to be able to execute their duties and that it is essential that the police collects and understands the wishes of the person that is subject to the apprehension. If necessary, the police should employ an interpreter. If the one that is apprehended requests an interpreter and the police makes the assessment that an interpreter is not necessary, the request and the assessment should be registered. (5014-2016)

The Parliamentary Ombudsmen directs criticism towards the Police Authority for, among other things, detaining and questioning a person without having had support for it

The police stopped a man as he exited a restaurant in Göteborg. The man was under the suspicion for using narcotics and therefore brought to a questioning. The police also took a decision to conduct a body search of the man. When the body search was completed, the man was kept for almost three hours, until the questioning began. During this period the police conducted a house search in the man's home, to, among other things, search for narcotics. During the house search, the police came across objects that resulted in the man becoming a suspect for further crimes. The police did not find any narcotics in the man's home.

The Parliamentary Ombudsmen's investigation reveals that there have been significant failures during the intervention of the man. The Police Authority is criticised for acting in force and in a way that is not defensible when considering the purpose of the intervention, for conducting a body search of the man without prerequisites to conduct a body search and for taking the man's mobile phone into possession. The police authority is also criticised for taking a decision to question the man and for keeping him for three hours until the questioning took place. The investigation also proves that the Police Authority's processing has failed when it comes to registering measures taken. The Police Authority has, in several cases, neglected to register the prerequisites that a decision has been based upon, until the Parliamentary Ombudsmen has initiated an investigation. The Parliamentary Ombudsmen finds this unacceptable.

According to the Parliamentary Ombudsmen, the investigation proves that the police planned to conduct a house search in the man's home to search for inadmissible objects and took measures to make sure that the man would not be present at the house search. The Parliamentary Ombudsmen holds that these actions can damage the police's credibility in a negative way.

The police official that took a decision on coercive measures has, in connection to the statement that the Parliamentary Ombudsmen received, handed in inaccurate information and information that, in several respects, deviates from what other police officials present have declared. The Parliamentary Ombudsmen does not find that there are enough material to maintain that the police official knowingly has handed in inaccurate information to the Parliamentary Ombudsmen, but emphasise that an official that hands in information to the Parliamentary

Ombudsmen is under an obligation to tell the truth. (7330-2016)

A man died in connection to a police transport to a home for residential care. The Parliamentary Ombudsmen directs criticism towards the Police Authority for insufficient control of the man's access to medicines

AA had a leave of absence from a home for residential care in Småland and was located at the community in Värmland when the home's manager decided that AA should return due to relapse, and so requested assistance from the Police Authority. When AA, whom had a drug abuse problem, was met by the police, he was taken to hospital to the emergency care unit for observation. Later that same day, the transport to the home for residential care was arranged using a system called "relay driving". During the first part of the journey AA started feeling unwell, the transport therefore turned to the psychiatric ward in Karlstad. During both these visits, certain medicines were prescribed for AA. Before the transport continued from Karlstad, AA was driven to the police station. There, he took two tablets of unknown variety to help with his headache. The tablets were packed in a bag of belongings that AA had with him. They had not been prescribed by the emergency care unit or the psychiatric ward. AA arrived at two o'clock in the night to stay in custody in Jönköping. The station's commander made the assessment that AA was tired and affected by the medicine to such a degree that it was not advisable to continue the transport. AA was placed in a cell with extra supervision. After 30-45 minutes, staff at the police station noticed that AA was not breathing. He was driven to the hospital, where he later died.

The Parliamentary Ombudsmen states that it is a basic requirement that the transportation of detainees is done in such a manner that it is not possible for the detainees to overdose on drugs. According to the Parliamentary Ombudsmen, the fact that AA, while in transport, had the possibility to take more medicine than what was prescribed for the journey, constitutes a serious deficiency in the implementation of the assistance, therefore the Police Authority is criticised for not having control of AA's access to medicines during transportation. The authority is also criticised for insufficient documentation concerning AA's custody in Jönköping.

The incident indicates that the Police Authority must revise their procedures with regard to assistance, including ensuring that the transportation of persons suffering from drug abuse takes place in a safe manner. According to the Parliamentary Ombudsmen, the police should always carry out a provisional protective search of a protected person before assistance commences, unless it is clear that this is unnecessary. Such a search should also include objects carried by the protected person concerned. Dangerous items or medicines that the protected person could use to harm themselves, should of course be kept in a place where he or she cannot access them. If several police patrols are involved in an assistance, it must be ensured that all information for the implementation of the assistance is relayed safely. The Parliamentary Ombudsmen also states that procedures for documentation must be so well incorporated that complete documentation is required even when there is a very high workload. (332-2017)

The Parliamentary Ombudsmen directs criticism towards the Police Authority for entering an incorrect date of birth in a passport

The complainant had been assigned a national registration number with a date of birth that deviates from her correct date of birth. When the Police Authority issued a passport for the complainant, a date of birth corresponding to the numbers in the assigned national registration number was stated, instead of the correct date of birth. The Police Authority is criticised for their insufficient handling in connection with the issuing of the passport. The Police Authority has begun an adaption of their IT system and handed out information to all passport officers in order to avoid similar problems, which the Parliamentary Ombudsmen views as positive. (5340-2017)

Prison and probation service

Criticism of the Prison and Probation Service, Södertörn Probation Authority, for the processing of a personal case study

By request of the Court of Appeal, a personal case study was initiated on a person sentenced to prison by the District Court. During the District Court's processing of the case the Probation Authority had handed in two statements. The purpose of the Court of Appeal's decision to collect a third statement from the Probation Authority was to examine the preconditions for a court-imposed care order. In spite of this, the Probation Authority decided to terminate the investigation into a court-imposed care order

without leaving a suggestion on a specific treatment. The Parliamentary Ombudsmen is critical towards the fact that the Probation Authority terminated the investigation with reference to the penal value established by the District Court. According to the Parliamentary Ombudsmen's understanding, it is evident that the Court of Appeal asked for an additional investigation regarding a court-imposed care order not to rule out the possibility of such an order.

As the investigation of the court-imposed care order was terminated, the case officer that conducted the personal case study concluded that it was not necessary to account for the involvement with the social services in the statement's review. As a result of this the notes on the social service's involvement were disposed of. As the statement's material was disposed of, according to the Prison and Probation Service's guidelines on personal case studies and probation, the Parliamentary Ombudsmen finds no reason to direct criticism against the Probation Authority for the lack of documentation. However, the Parliamentary Ombudsmen emphasise that there are requirements on establishing complete records even when the Probation Authority terminates an investigation into a court-imposed care order without a suggested treatment. Because of this, the Parliamentary Ombudsmen intends to follow up on the Prison and Probation Service's planned measures to modify the regulations on documentation. (2017-2015)

Enquiry concerning electronic communication for inmates within the Prison and Probation Service

The Parliamentary Ombudsmen has in recent years received many complaints concerning the Prison and Probation Service's INTIK system. Through inmates' accounts in complaints and during inspections, it has become apparent that inmates are unhappy with both the INTIK system's technical limitations and with the cost to make calls through the system. The Prison and Probation Service has, in their preparation of a statement to the Parliamentary Ombudsmen, established that general practice with regard to the situations in which inmates are granted permission to call people who have IP subscriptions or mobile subscriptions seems to vary to a certain extent. In her decision, the Parliamentary Ombudsmen states that it is not acceptable from a legal certainty perspective that general practice differs in cases where the circumstances are the same. The Parliamentary Ombudsmen is therefore positively inclined towards the Prison and Probation Service's intention to map the differences to be able to achieve a more uniform practice. The Parliamentary Ombudsmen further states that she welcomes the fact that, in the course of the enquiry, the Prison and Probation Service has introduced a new call tariff for calls within the INTIK system, meaning that calls within Sweden cost the same, regardless of whether the call is a landline call or a mobile phone call. The Parliamentary Ombudsmen shall follow the progress regarding this matter and the Prison and Probation Service's continued work in regards to queries concerning this. (2689-2015)

Enquiry concerning placement of inmates in detention in isolation, etc.

The Parliamentary Ombudsmen emphasises in the decision that a detainee, according to the general rule in the Act on Detention, shall be given the possibility to stay together with other inmates. Operations in a detention centre may not entail restrictions of the inmate's right to stay together with other inmates, other than those set forth in the Act on Detention.

The Parliamentary Ombudsmen states that there is no legal support for holding an inmate in isolation due to actual circumstances and practical conditions. Actual solitary confinement means that the inmate is housed with an equivalent degree of isolation as those who have restrictions. However, the inmate has no possibility of having the actual solitary confinement examined by a court.

A detainee that has had restrictions imposed on them by the prosecutor may be refused housing with other inmates on this basis. The Parliamentary Ombudsmen's starting point is that the Prison and Probation Service, which is responsible for safety in the detention centre, shall assess if the restrictions that the prosecutor has communicated are sufficient. A decision from the Prison and Probation Service that does not lead to any actual difference in relation to the restrictions on the detainee decided by the prosecutor should be avoided. However, the Parliamentary Ombudsmen considers that the Prison and Probation Service for safety reasons should be able to make a decision that entails further restrictions in addition to the restrictions the prosecutor communicated.

According to the Parliamentary Ombudsmen's opinion, a statutory regulation is required with deadlines for the examination of whether the conditions for placing a detainee in isolation for safety reasons still exist. The Parliamentary

Ombudsmen also considers that the legislation needs to be clarified with regard to the conditions for the Prison and Probation Service's decisions regarding placement in isolation, in relation to the restrictions imposed by the prosecutor concerning incursion on the right to stay with other inmates. The Parliamentary Ombudsmen raises the question of review of the legislation in these respects. A copy of the decision has therefore been submitted to the government. (5969-2015)

Enquiry initiated by the Parliamentary Ombudsmen regarding the Swedish Prison and Probation Service's options on differentiating the treatment of female inmates in its facilities, etc.
In response to a series of Opcat inspections of the Swedish Prison and Probation Service's women's prison facilities that revealed a number of areas where the treatment of female and male inmates appears to place female inmates at a disadvantage. An enquiry was initiated to further investigate, inter alia, the risk assessment team's (Riksmottagningen) activities and the potential outcomes of currently available opportunities for differentiating the treatment of women within the Swedish Prison and Probation Service's facilities.

In the decision, the Parliamentary Ombudsman states that the Swedish Prison and Probation Service has failed to offer equal correctional opportunities for men and women, and finds that women, in many respects, are being disadvantaged by the existing regulations as well as by the restrictions in the facility's physical environment and enforcement conditions. The Parliamentary Ombudsman maintains that even though she understands that the low number of female inmates constitutes a challenge for authorities, it is not acceptable for female inmates to be subject to enforcement that is inferior to that for male inmates.

Female inmates undergo a closer examination than male inmates during the risk assessment. The Parliamentary Ombudsman states that, in and of itself, this is a positive for improving the chances that an individual will have access to personalised enforcement, but instead, a lack of resources leads to delay and deterioration in enforcement conditions for many inmates. The Parliamentary Ombudsman states that it is not acceptable for a group of inmates, for which the Swedish Prison and Probation Service has identified as having particularly complex needs meriting further investigation, is instead subject to poor enforcement conditions due to a lack of investigative resources. The Parliamentary Ombudsman therefore calls into question if, under the current conditions, the special provisions for female inmates are justified.

Further, the Parliamentary Ombudsman states that there is a clear need for increased options to differentiate the treatment of female inmates in the correctional system. The Parliamentary Ombudsman therefore calls on the authority that oversees security classification for female facilities to prioritise efforts to create increased opportunity to differentiate the treatment of female inmates. The Swedish Prison and Probation Service also needs to prioritise the development of customised facilities and treatment efforts based on female inmates' unique needs.

The Parliamentary Ombudsman states that changes need to be made in the Swedish Prison and Probation Service's operations so that the authority will be able to offer equal correctional opportunities for women and men and so that it succeeds in its task of meeting women's individual needs and facilitates their reintegration into society. The Parliamentary Ombudsman welcomes the authority's efforts in starting several initiatives and reviews concerning issues that are relevant to the case. The Parliamentary Ombudsman intends to monitor and follow up on these issues. (1087-2016)

Enquiry initiated by the Parliamentary Ombudsmen regarding inmates with accompanied children, as well as pregnant inmates in prison
In connection to a sequence of Opcat inspections of prisons that receive only women the Parliamentary Ombudsmen observed that the situation for female inmates with accompanied children, as well as pregnant women, was not recognized in a clear and consistent way by the Prison and Probation Service in regards to planning, placement and execution of penalties. An enquiry was initiated to further investigate cases regarding the two categories of inmates.

In the decision, the Parliamentary Ombudsmen directs criticism towards the Prison and Probation Service for not considering the fact that a female inmate cares for an infant or is pregnant, when assessing a suitable placement. The Parliamentary Ombudsmen encourage the Prison and Probation Service to consider adapting placements for inmates with accompanying children, at certain prisons, where the inmates as well as the children's needs can be met in a satisfactory manner. The Parliamentary Ombudsmen also holds that female inmates with

accompanied children should not be referred to only parental leave during their execution. The Prison and Probation Service should look over their routines and develop a cooperation with external actors to be able to offer inmates with accompanied children an acceptable content for the execution in addition to the parental leave. The Parliamentary Ombudsmen states, in regards to pregnant inmates, that prisons, in good time prior to child birth, conduct an assessment in consultation with the relevant obstetric clinic and so forth informs the pregnant woman of all necessary information regarding the planned measures.

The Parliamentary Ombudsmen notes that the Prison and Probation Service has initiated an important assignment to correct failures observed when looking into the authority's efforts regarding inmates with accompanying children as well as pregnant inmates in prison. The Parliamentary Ombudsmen will conduct a follow up on these questions. (1089-2016)

The Parliamentary Ombudsmen directs criticism towards the Swedish Prison and Probation Service facility in Ystad for failing to notify an inmate of the use of video surveillance and for a lack of documentation

The facility decided to utilise camera surveillance for a seclusion room where the complainant was located. The investigation revealed that the complainant was not informed of the decision. The Parliamentary Ombudsman's decision included criticism of the facility for failing to inform her that she was being monitored by video surveillance. The fact that there was a sign indicating that video surveillance may occur in the seclusion wing was, according to the Parliamentary Ombudsman, insufficient. The Parliamentary Ombudsman also directed criticism towards the facility for falling not to complete necessary camera surveillance documentation. The facility documented at what time video surveillance and recordings were decided upon. However, there is no documentation regarding the termination of these actions. (1365-2016)

The Parliamentary Ombudsmen received a complaint against the Swedish Prison and Probation Service, Hällby facility, regarding video surveillance of inmates

At Hällby facility, which is a facility for male inmates, there is a camera in the room where the inmates change clothes, are frisked and undergo a superficial body inspection before visitation. The report stated that the inmates felt violated standing fully unclothed in front of a camera, not knowing who is viewing the screen in the facility's central security room. In the decision, Chief Parliamentary Ombudsman states that she finds that what the Swedish Prison and Probation Service reports concerning video surveillance constitutes a legitimate purpose as referenced in § 23 of the Video Surveillance Act, and that these purposes weigh heavier than the individual's interest in not being monitored. However, the Chief Parliamentary Ombudsman considers that, as far as possible, only male staff should be able to view surveillance of inmates via a monitor. (1692-2016)

Enquiry initiated by the Parliamentary Ombudsmen regarding a serious incident of violence at the Swedish Prison and Probation Service's facility in Salberga

An inmate was subjected to violence at the hands of a fellow inmate at one of Salberga facility's cellblocks. At the time of the violent incident, preparations were being made for out-of-cell time for inmates in another block. For security reasons, the facility had prioritised staffing in that division. For the same reason, releases for out-of-cell time were also prioritised in terms of camera surveillance resources. During a few minutes, there were no staff dedicated to the entire floor of the building, rather, the only staff assigned to the block were performing rounds between the floors. In the decision, the Parliamentary Ombudsman states that the Swedish Prison and Probation Service's duties include protecting inmates from threats and violence perpetrated by other inmates. The investigation does not, however, show that the circumstances were such that the facility should have realized that there was a real and immediate risk that a fellow inmate would be subjected to violence if the block was left unattended during the very limited time when the time-out-of-cell release was carried out. Taking all factors into account, the Parliamentary Ombudsman finds no reason to criticise the facility or to make further statements on the matter. (2214-2016)

Statements in connection with the Prison and Probation Service's network detection of inmate conversations within the telephone system INTIK

Since autumn 2015, the Parliamentary Ombudsmen has, during inspections of institutions, received many complaints that apply to the Prison and Probation Service revoking the inmate's telephone privileges, with reference to alleged manipulation attempts that were identified through so-called network detection within

the telephone system INTIK. However, the investigation indicates that there can be other reasons for a telephone number ending up on the detection list, other than that an attempt was actually made to speak with someone other than the person specified in connection with the telephone privilege. Instead, it may be that someone has called an entry phone, or that there is a security alarm, fax, voice mail, or similar connected to the extension. In her decision, the Parliamentary Ombudsmen states that she finds it very unsatisfactory that the system that the Prison and Probation Service uses cannot differentiate between cases where it could actually be an issue regarding impermissible actions. The Parliamentary Ombudsmen further states that she is critical that the Prison and Probation Service has not ascertained whether inmates have been informed in advance that these telephone services should be disconnected if the person wishes to avoid the telephone privileges being revoked. The Parliamentary Ombudsmen states that it is not a simple task for the Prison and Probation Service to fulfil the requirement of control over the inmate telephony and simultaneously achieve a legally certain process. Despite this, the Parliamentary Ombudsmen expects the Prison and Probation Service to find acceptable solutions for these issues. (3682-2016)

Statements regarding interns' stay in isolation at the Prison and Probation Service's security units

In a decision dated May 24, 2016 former Chief Parliamentary Ombudsman Elisabeth Fura directed criticism towards the Prison and Probation Service for placing an intern in isolation at his unit (security unit) when the prerequisite for placing the intern in isolation were not met. In the decision, the Chief Parliamentary Ombudsman express some understanding regarding the difficulties that the Prison and Probation Service, according to the authority, face, when it comes to placing interns in a suitable context, but the Chief Parliamentary Ombudsman states that the Prison and Probation Service does not hold the right to disregard the provisions regarding an intern's stay pursuant to the Prison Act.

Due to complaints received during December 2016, from the same intern, regarding the fact that he and other interns were placed in isolation at security units without a decision on isolation, an investigation was initiated. The Prison and Probation Service held, in a statement to the Parliamentary Ombudsmen that as a consequence of the need to avoid inappropriate "client-constellations" there may be a situation where an intern is placed on their own in a security unit, during a limited time, and that such a secluded stay is not an isolated stay pursuant to the Prison Act.

The Chief Parliamentary Ombudsman express, in the present case, that, according to her opinion, regardless of the difficulties that exists when it comes to locating suitable "client-constellations" it is unsatisfactory to discover that interns are placed at security units under conditions that result in an isolated stay in spite of the fact that the prerequisites for a placement in isolation are not met. According to the Chief Parliamentary Ombudsman, the interns will also have problems getting their matter reviewed, as a formal decision on placement in isolation does not exist.

In view of the legal uncertainties that the Chief Parliamentary Ombudsman considers are at hand when placing interns under such conditions were the interns in practice are placed in isolation without a formal decision and the lack of procedural guarantees in such situations, the Chief Parliamentary Ombudsman now raise the question of a review of the legislation within this area. A copy of the decision is sent to the Government offices. (7488-2016)

Statements in connection with a new function in the Prison and Probation Service's telephone system, the INTIK system

On 6 December 2016, the Prison and Probation Service implemented a new function called a "voice prompt" in the INTIK telephone system. The new function entails that the person who takes a phone call from an inmate is met by a voice message during every call which reads: "This is a call from an inmate within the Prison and Probation Service, to accept press hash (#)." The Prison and Probation Service has received several complaints from inmates, which mainly concerns the lack of information given to inmates regarding the voice prompt and the fact that it causes their confidentiality to be violated as the information that the inmates is in prison is disclosed. Several complainants have also pointed out that relatives who are old or very young, may be afraid or confused by the voice message and that there is a risk that relatives who have not mastered or English do not understand the voice message. In the decision, the Parliamentary Ombudsmen criticises the Prison and Probation Service for some institutions failing to inform inmates, or that they informed the inmates only one day before the function was

implemented.

It is not the Parliamentary Ombudsmen's task to decide whether the inconveniences for inmates inherent in the voice prompt are offset by the security benefits. The Parliamentary Ombudsmen states, however, that she got the impression that the Prison and Probation Service failed to sufficiently predict and weigh in the negative consequences that the voice prompts could entail for the inmates. According to the Parliamentary Ombudsmen, the system's suitability may also be questioned, because it implies that the inmates in practice are forced to accept that confidentiality could be violated. The Parliamentary Ombudsmen further finds it concerning that the Prison and Probation Service has implemented a system that complicates inmate's contact with relatives. (7618-2016)

The Parliamentary Ombudsmen directs criticism towards the Prison and Probation Service, Malmö detention centre, for the treatment of a minor

An individual below the age of 18 was placed in a detention centre with restrictions. The Parliamentary Ombudsmen emphasise that individuals below the age of 18 deprived of their liberty should belong to a "protected group" and that the Prison and Probation Service holds a particular responsibility during these circumstances to make sure that the minor is not isolated. It is not acceptable, according to the Parliamentary Ombudsmen, to allow a minor to make their own decisions on when to participate in activities with other detainees, and if a minor keeps avoiding the activities it is significant that this is registered and followed up upon. In the present case, it appears as if a minor has had access to common activities less than two hours per day, which is minimum, according to the Prison and Probation Service's guidelines regarding minors held in detention. The Parliamentary Ombudsmen states, regarding this separate case, that it is difficult to direct criticism towards the detention centre's management of the joint activities, but concludes that the lack to register these circumstances complicates the Prison and Probation Service's follow up of internal goal as well as external check-ups of the operations.

In the decision, the Parliamentary Ombudsmen also emphasise the importance of the staff members' involvement and dedication to encourage the minors to take part in joint activities. Measures regarding joint activities have also become relevant in other complaints, therefore the Parliamentary Ombudsmen will return to this question.

In the decision, the Parliamentary Ombudsmen directs criticism towards the detention centre as the staff members at the detention centre put a condition on a minor to restore damaged property before the minor could move to another unit. The detention centre is also criticised for their management of a minor's schooling and for their slow processing in two matters of possession. (1704-2017)

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

The Parliamentary Ombudsmen directs criticism towards the Child and Education Administration in Luleå municipality for sending an e-mail that include information of a sensitive and personal nature without taking certain security measures

The Child and Education Administration sent an e-mail with a student's medical certificate through a web based e-mail server to the student's custodian and other officials. Certain security measures should have been taken to make sure that only the right person could access the information and that the information was transferred in a secure way (for example through encryption). Neglecting to carry out these security measures created a risk that others, i.e. unauthorized receivers, could take part in the information. The administration is criticised for their management of the correspondence. Moreover, the administration is criticised for delaying almost seven months to answer questions from the student's father regarding, among other things, the administration of the medical certificate. (6466-2015)

Criticism of the Upper-Secondary School Committee in Huddinge municipality for infringing an employee's right to the freedom of speech

During autumn of 2015 a counselor, employed at a municipal school within Huddinge municipality, liked a photograph using his private Facebook account. The Facebook status was later republished and commented on by the organisation Anti Fascist Forum Stockholm. The status included photographs of two persons deceased during the Trollhättan school attack and a request to hold named right-wing politicians and journalists responsible.

Due to the occurrence the Chairman of the Upper-Secondary School Committee in Huddinge municipality, Christina Eklund (also councillor of the Municipal Council) got in contact with the principal of the school where the counselor was employed. On the 24th of

October, 2015, Christina Eklund met with the principal.

In November of 2015 politician S.P. directed a question to the Municipal Council in Huddinge municipality and asked if the counselor's actions, to publicly approve the Anti Fascist Forum Stockholm opinion that certain politicians and journalists were murderers, were in line with the school and municipality's values. He wanted to look into the possibility of releasing the counselor from his employment. In an official letter, on December 4th, 2015, Christina Eklund replied to S.P.'s question and stated that the counselor's Facebook post was "clearly unsuitable".

According to the Parliamentary Ombudsmen's understanding, Christina Eklund's meeting with the principal did not constitute any victimisation. However, the Parliamentary Ombudsmen holds that Christina Eklund's statement, in the official letter dated December 4th, where she stated that the counselor's post was "clearly unsuitable" infringed the counselor's freedom of speech, pursuant to Chapter 2, section 1 § 1 of the Instrument of Government. The Parliamentary Ombudsmen directs criticism towards the formation of the official letter. (172-2016)

The Parliamentary Ombudsmen directs severe criticism towards Södertörn Fire Prevention Association and its chief for deciding that two firefighters who criticised the association would no longer receive further employment

AA and BB had for one and half years held different time-limited positions at Södertörn Fire Prevention Association when, in autumn 2014 in an open letter and a polemical article, criticism was directed against the employment conditions for those who were not permanently employed and against the association's principles of recruitment. When they applied for temporary jobs in the summer of 2015, they received notification that they were not candidates for future positions at the association due to a lack of consensus on the association's values and direction. The decision was made by the association's fire chief.

According to the Parliamentary Ombudsmen, it is not possible to draw any conclusions from the investigation other than that the decision that AA and BB no longer had continuing employment was due to the fact that they had criticised the association and its management in the letter and article. Taking into account the contents of the letter and the article, no acceptable reason to take any action against AA and BB was found. The fire chief and the association has thus broken the constitutional prohibition against reprisals. The intervention is strikingly similar to a termination, and the Parliamentary Ombudsmen deems this to be a very severe violation of AA's and BB's freedom of speech.

According to the Parliamentary Ombudsmen, the fact that a government employee, outside of work, publicly debates workplace issues of the kind in question, is a good example of what freedom of speech aims to achieve. In addition to the direct consequences for AA and BB, the behaviour of the fire chief and the association may cause other employees to refrain from expressing their views on how the association fulfils its mission, which is a serious matter. (4213-2016)

The Parliamentary Ombudsmen directs criticism towards the Government Offices, the Ministry for Foreign Affairs, for, on a re-occurring basis, neglecting to take a decision on registering documents, and for the processing of a request to access e-mail logs

In a complaint to the Parliamentary Ombudsmen questions were raised regarding the Ministry for Foreign Affairs administration of documents on Sweden's candidature to the UN Security Council for 2017-2018 (the Security Council campaign). According to the complainants, the Ministry had neglected to register certain documents related to the campaign, for instance, e-mails including classified data sent to and from the Dag Hammarskjöld Foundation, and in addition, the Ministry had neglected to promptly process a request to access campaign official's e-mail logs.

Concerning the e-mails, the Ministry for Foreign Affairs stated, that the e-mails included classified data, but of little importance to the Ministry's operations and therefore not registered or filed. The Parliamentary Ombudsmen does not question the Ministry's assessment of the importance of the documents and states that documents including classified data do not exclude the fact that the documents are of little importance. The Ministry for Foreign Affairs cannot avoid criticism for neglecting to take a decision, on a re-occurring basis, on registering the e-mails.

The Parliamentary Ombudsmen is also critical towards the Ministry's processing of a request to access official's e-mail logs. The manner in which the Ministry processed the request went against the Freedom of the Press Act's

condition on promptness. The Parliamentary Ombudsmen is also hesitant to the fact that the Ministry let officials handle the request when the request in fact required a number of consultations and an extensive procedure to lay down suitable principles. The Parliamentary Ombudsmen also notes that a considerable amount of data included in the logs were under foreign classification, in spite of the fact that such data should not be handled in the e-mail system, according to the Government's guidelines.

In recent years the Parliamentary Ombudsmen, as well as the Committee on the Constitution and the Office of the Chancellor of Justice have directed criticism towards the Ministry for Foreign Affairs for the processing of requests to access public documents. The Parliamentary Ombudsmen assumes that the Ministry for Foreign Affairs now takes action due to the criticism. (6579-2016)

The Parliamentary Ombudsmen directs severe criticism towards the Public Employment Service for having disclosed information about an individual's personal circumstances without first having examined whether the data was covered by secrecy

Prior to a meeting with the staff manager for an internship, the individual was asked by the employment officer to provide information concerning their background during the meeting. However, the individual did not follow the request. After the meeting the employment officer made contact with the staff manager and notified him of the individual's background. The data was such that is typically covered by confidentially in Chapter 28, Section 11 of the Public Access to Information and Secrecy Act (OSL). The Parliamentary Ombudsmen establishes that, prior to disclosure, the employment officer did not consider whether the data was covered by secrecy and, if so, if the data could still be disclosed to the internship employer. For this, the Public Employment Service receives severe criticism.

In the decision, the Parliamentary Ombudsmen also comments on the confidentiality examination that followed, concerning, inter alia, the conditions for disclosing classified data pursuant to Chapter 10, Section 2 of the Public Access to Information and Secrecy Act. (1029-2017)

The Parliamentary Ombudsmen directs criticism towards the Social Welfare Board in Halmstad Municipality for the processing of a request to gain access to a public document

A woman requested to access an e-mail log from the Social Welfare Board. During the case's handling, the Board sought the woman's identity by asking the individuals included in the e-mail log if they knew who she was. It was only after two weeks that the woman received a decision in which the Board rejected the request to access the e-mail log.

The Social Welfare Board receives criticism for the slow processing of the request. The Social Welfare Board is also criticised for enquiring about the woman's identity in an incorrect manner. The Parliamentary Ombudsmen also considers that based on the anonymity protection in Chapter 2, Section 14 of the Freedom of the Press Act, it is inappropriate that the authority, on its own initiative, gives out information concerning who requested access to various documents. Furthermore, the Parliamentary Ombudsmen's investigation indicates a lack of knowledge among the Social Welfare Board's managers and other staff members with regard to how cases and official documents should be handled. The Social Welfare Board is responsible for how managers and other staff members with knowledge of these cases manage their cases, therefore the Board receives criticism. (1039-2017)

The Parliamentary Ombudsmen directs criticism towards the Committee on Planning and Community Development in Värnamo municipality for having informed a company that a newspaper had requested documents about the company's business operations

A Committee on Planning and Community Development was in charge of supervising a company. A committee official informed the company that a newspaper had requested documents about the company. The official also inquired whether the company would like to receive the documents that the newspaper had requested and subsequently sent the documents to the company. According to the Parliamentary Ombudsman, the official's actions can not be perceived in any other way than as a warning to the company that a review of its business activities had been initiated. Therefore, the Parliamentary Ombudsman finds that the official's actions were inappropriate in accordance of the interests supporting the Swedish Principle of Public Access. According to the Parliamentary Ombudsman, these actions can also be subject to scrutiny in compliance to the statutory requirement on impartiality.

The Committee on Planning and Community

Development is responsible for ensuring that its staff members are aware of the regulations governing their actions. The Parliamentary Ombudsmen directs criticism towards the committee for the incident. (1200-2017)

Some notes on the importance of anonymity protection when a request for document disclosure is to be forwarded to the individual's immediate superior for assessment

AA, who is employed at the Migration Agency, requested to receive some documents and personal details concerning a colleague. As AA did not want his unit manager to know about the request, he turned to the Migration Agency's HR department. After six days, his request was forwarded to the unit manager for review regarding the matter of disclosure. The unit manager contacted AA and proposed a meeting so that AA could explain his reasons for requesting the information. More than three months passed before AA was able to retrieve the documents he had requested.

One prerequisite for an authority to comply with the promptness requirement of the Freedom of the Press Act is that there are procedures ensuring that a request for access to public documents is promptly forwarded to an official who is competent to assess the matter of disclosure. The Parliamentary Ombudsmen establishes that the processing time is not consistent with the promptness requirement. Since the information requested by the unit manager was not required to determine whether the documents could be disclosed, the investigation ban was also disregarded. The Migration Agency is criticised for these shortcomings.

The Parliamentary Ombudsmen also states that AA's name was specified in the request and that the request did not contain any wish to remain anonymous in the event of any forwarding within the authority, and that the reason for the unit manager's receipt of the request was that she was to be the person to assess whether the documents could be disclosed. The Parliamentary Ombudsmen therefore directs no criticism towards the Migration Agency for enlightening AA's name to the unit manager, but points out that in situations such as the matter at hand - where it is apparent that the person who will assess the request is the applicant's immediate superior - there may be reason to observe some caution. The applicant may have had a particular reason for not turning directly to their manager with their request. It may for example be appropriate, in light of this, to inform the applicant that the request is being reviewed elsewhere within the authority and that it will be forwarded there. (1851-2017)

Social insurance

The Parliamentary Ombudsmen directs criticism towards Försäkringskassan for failures in the formation and grounds of a decision on modification and re-examination pursuant to chapter 113, section 3 and chapter 113, section 7 of the Social Insurance Code

Försäkringskassan took a decision to establish Y.Y.'s sickness benefit to a certain amount. Following upon Y.Y.'s request for a re-examination of the decision Försäkringskassan took a decision to, in connection to the request for re-examination, lower the sickness benefit pursuant to chapter 113, section 3 of the Social Insurance Code. The Parliamentary Ombudsmen holds that the decision on re-examination was not adequately formulated as it did not include information regarding the modification on which Försäkringskassan took an initiative, or to which extent the re-examination was based on Y.Y.'s request for a re-examination. In the decision, the Parliamentary Ombudsmen emphasize that an authority's decision need to include adequate and well formulated grounds and moreover, the regulations that the decision is based upon. (2606-2016)

The Parliamentary Ombudsmen directs criticism towards Försäkringskassan for not informing an individual, that a decision that the individual could take part of through Försäkringskassan's personalised webpage [Mina sidor], was an interim decision and only

By Försäkringskassan's personalised webpage [Mina sidor] it appeared as if the authority had taken a decision on sickness benefit up to a specific date and that a renewed doctor's certificate was required if the insured individual wished to apply for further sickness benefits. However, there was no explanation of the fact that the decision was an interim decision regarding benefits throughout the course of the investigation. In the decision, the Parliamentary Ombudsmen emphasize that information released on Försäkringskassan's personalised webpage need to be adequately and clearly formulated. (7314-2016)

The Swedish Social Insurance Agency received criticism for, inter alia, not informing the insured parties that they had the option to conduct written communication in Finnish and for fail-

ing to hire qualified interpreters to the degree necessary

AA and BB applied for assistance compensation and care allowance for their son. In the application, they indicated that they had a need for a Finnish interpreter. Despite their request, almost all communication in the case was conducted in Swedish. The Parliamentary Ombudsman states in the decision that the Swedish Social Insurance Agency needed to inform AA and BB that they had the right to communicate with the authority in Finnish. The Swedish Social Insurance Agency should have also utilised interpreters to a larger extent than occurred. The Parliamentary Ombudsman also made a statement as to whether an email would be deemed as a request for respite. (7993-2016)

Severe criticism of Försäkringskassan for slow processing in cases on insurance affiliation and child benefits

R.S. applied for child benefits on the 4th of February 2016. On the 18th of March 2016, he also handed in information regarding the investigation of his wife M.S.'s case on insurance affiliation. Försäkringskassan did not initiate the case on insurance affiliation until four and a half month had passed. M.S. received insurance affiliation in Sweden on the 18th of August 2016 but it was not until the 6th of February 2017 that Försäkringskassan took a decision on R.S.'s case. The Parliamentary Ombudsmen notes that Försäkringskassan's slow processing was not due to difficulties in obtaining documents from a foreign country, which the Parliamentary Ombudsmen has recognized in previous cases, but due to Försäkringskassan's own lack of initiative. (803-2017)

The Parliamentary Ombudsmen directs critic towards the Swedish Social Insurance Agency for, in several cases, sending documents with information subject to confidentiality to a person other than the person to whom the information referred

Three insured parties independently reported to the Parliamentary Ombudsman that the Swedish Social Insurance Agency had sent documents with information subject to confidentiality to a person other than the person to whom the information referred. The Parliamentary Ombudsman directed severe criticism towards the Swedish Social Insurance Agency for the lack of diligence the authority had demonstrated in the handling of confidential information. The Parliamentary Ombudsman has repeatedly emphasised the importance of handling information subject to confidentiality with the utmost care. An official that handles confidential information in his or her work duties has a personal responsibility to see that confidentiality is maintained. (5606-2017, 5820-2017, 6105-2017)

Social services

Social Services Act

Criticism of the Social Welfare Board in Linköping Municipality for obtaining extracts from a certain registery in a child welfare investigation, which did not relate to the case pursuant to the Care of Young Persons Act

he Social Welfare Board commenced a child welfare investigation after it had been revealed that a child and some schoolmates had shown abnormal behaviour while playing. During the investigation, the Social Welfare Board obtained data from the Police's Registry of Criminal Convictions and Registry of Suspected Offenders concerning the child's parents. The issue is whether the measures taken by the Social Welfare Board had statutory support.

A Social Welfare Board may collect data from the Registry of Suspected Offenders (Misstankeregistret) and the Registry of Criminal Convictions (Belastningsregistret) if a case concerns measures pursuant to the Care of Young Persons Act, and if the Board finds it necessary, upon an assessment of proportionality, that the information is useful in order to be able to take a position concerning the child's need for protection or support. There are no provisions that clarify when a child welfare investigation pursuant to the Social Services Act becomes a case pursuant to the Care of Young Persons Act. According to the Parliamentary Ombudsmen's understanding, a case concerns measures pursuant to the Care of Young Persons Act when a certain matter is discovered within an ongoing investigation, i.e. when the Board is considering an intervention pursuant to the Care of Young Persons Act. The Parliamentary Ombudsmen finds that in this case, when the investigation commenced, there was hardly any circumstances that suggested that the child was in need of care pursuant the Care of Young Persons Act. Nor was it apparent, in the investigation conducted by the Board, that the Board was at any time in the vicinity of considering such an intervention. Thus, the measure of retrieving data from the registries did not have statutory support. The Board receives criticism for the fact that the data was collected.

Data contained in the Registry of Criminal Convictions and Registry of Suspected Of-

fenders is of a sensitive and personal nature. Therefore, according to the Parliamentary Ombudsmen, there should be no doubt as to when the preconditions are fulfilled for the Social Welfare Board to obtain information from the registries. Rules concerning the Social Welfare Board's abilities to obtain such data need to be clarified. Pursuant to Section 4 of the Act with Instructions for the Parliamentary Ombudsman (1986:765), the decision is handed over to the Swedish Government Offices (Ministry of Justice and the Ministry of Health and Social Affairs). (2446-2016)

The Parliamentary Ombudsmen directs criticism towards Mönsterås municipality for the placement of an unaccompanied married girl and for failures in the follow up of the care of the girl

An unaccompanied girl arrived to Sweden accompanied by her aunt and the aunt's family members. The Migration Agency assigned the girl to Mönsterås municipality. When the girl arrived to Sweden, she stated that she was 13 years old and married to her cousin, an adult son in the aunt's family.

The Social Welfare Board began an investigation of the girl's situation in January 2016. The Social Welfare Board made efforts to find housing for the girl in agreement with the girl and her husband, but the girl did not agree on placement in another housing. The Social Welfare Board decided that coercive measures pursuant to the Care of Young Persons Act was not justified and found no other possibility than to grant the girl aid pursuant to the Social Services Act, and so forth place the girl in the home of her aunt and aunt's husband. The Social Welfare Board informed the girl and the family members regarding what is applicable for 13-year-olds in Sweden and placed certain demands on the family. The Social Welfare Board also assigned a social welfare worker to correspond with the girl and the family.

The Parliamentary Ombudsmen holds that a child below the age of 15 need to have unconditional protection against sexual acts. A child below the age of 15 that has sexual relation with an adult is subject to a crime. It holds no bearing if the child consents to the sexual act.

An indication that a child, below the age of 15, is married or is living in a relationship similar to a marriage with, for example, a son in the considered family home, is, according to the Parliamentary Ombudsmen, an indication of such a character that it appears as inappropriate to place the child in the home, pursuant to the Social Services Act. The possible protective factors, which may exist in such a case, do not live up to the possible risks that a placement in the family home implies.

The Parliamentary Ombudsmen holds that the Social Welfare Board's assignment, to carefully follow up on the care, and make sure that a child placed in a family home is well taken care of, is one of the Social Welfare Board's most fundamental assignments. In line with the facts that have become known of the girl the Parliamentary Ombudsmen states that it was particularly important to monitor the girl's situation and that the social services kept a close and continues correspondence with the girl and the family home.

According to the Parliamentary Ombudsmen, it was wrong to hand over the responsibility of monitoring the girl's situation and the family home to a social welfare worker.

In the decision, the Parliamentary Ombudsmen directs criticism towards the Social Welfare Board for placing the girl in the family home in spite of the fact that it had become known that the girl was below the age of 15 and married to a grown son in the family. The board also receives criticism for failures in the follow up of the care of the girl. Consequently, the Parliamentary Ombudsmen notes that the failures in the processing of this case are severe. (1556-2017)

The Parliamentary Ombudsmen directs severe criticism towards Farsta City District Board in Stockholm Municipality for having searched a training apartment without consent

A City District Board granted a man assistance in the form of housing in a so-called training apartment. The Board and the man entered into a tenancy agreement concerning the apartment. Due to difficulties with keeping this form of accommodation drug-free, the set-up was changed in such a way that the staff would carry out supervised visits in the rented apartments if there were indications that drugs were present.

The Board then searched the man's residence to check if there were any drugs in his apartment. An authority must not outright enter a residence. The Board's search of the accommodation constituted an intrusion of the type that every citizen is protected against, pursuant to Chapter 2, Section 6 of the Instrument of Government (RF). Restrictions on the protection may be made by law. However, there is no legal support for the search that the Board carried out.

The basic protection only applies to forced

intervention. The individual may thus consent to a measure from the authority's side, e.g. a search of the residence, that otherwise would have constituted a violation of the provisions in the Instrument of Government. In the current case, however, such consent is missing.
The Board receives severe criticism for, in violation of the Instrument of Government's provisions, searching a training apartment. (7179-2016)

The Parliamentary Ombudsmen directs criticism towards the Labour Market and Social Welfare Board in Malmö Municipality for including a condition on regular supervised visits in a tenancy agreement

The Labour Market and Social Welfare Board granted a man assistance in the form of housing in a so-called transitional apartment. The municipality and the man entered into a tenancy agreement that contained clauses, which gave the social services department the right to carry out supervised visits in the apartment once per month. The Board carried out supervised visits in the man's residence.

An authority must not outright enter a residence. The supervised visits in question constituted intrusion of the type that every citizen is protected against, pursuant to Chapter 2, Section 6 of the Instrument of Government (RF). Restrictions on the protection may be made by law. However, there is no legal support for the supervised visits that the Board carried out.
The basic protection only applies to forced intervention. Thus, the individual may consent to a measure from the authority's side, e.g. a supervised visit, that would otherwise have been a violation of the provision pursuant to the Instrument of Government. The Parliamentary Ombudsmen has in several previous decisions stated that this must be a question of genuine consent from the individual. He or she may thus not be "forced" to provide consent.

In the decision, the Parliamentary Ombudsmen expressed that it cannot be ruled out that the man actually consented to supervised visits upon signing the tenancy agreement. The Parliamentary Ombudsmen emphasise the importance of the individual receiving clear information regarding what other alternatives there are in regards to housing.

Because the municipality entered into a tenancy agreement with the man, a lease was created between the parties. The rules regarding tenancy in Chapter 12, of the Land Code (JB) were thereby applicable.

A landlord is entitled, without delay, to gain access to a residence in certain urgent situations (Chapter 12, Section 26 of the Land Code). However, contract terms and conditions which give the landlord more advanced entitlement are not valid. The supervised visits which are outlined in the tenancy agreement are significantly more advanced than what is indicated in the provisions of the Land Code. The Labour Market and Social Welfare Board are criticised for the condition regarding supervised visits being entered into the tenancy agreement. The Parliamentary Ombudsmen states that the Board, through the formulation of the conditions, did not sufficiently take into account the existence of a lease relationship between the parties. The Parliamentary Ombudsmen expects the Board to review the conditions and adapt them to the applicable provisions. (7595-2016)

Complaint against the Social Services Department in Kiruna Municipality

An official at the Social Services Department in Kiruna Municipality contacted the delivery ward in Gällivare and prompted the midwife to submit a notification of concern regarding a newborn baby at the ward and who could be her grandchild. The midwife submitted a notification of concern to the department. In a so-called preliminary assessment, it was recorded, among other things, that the official from the telephone conversation with the delivery ward, according to the midwife's details, had presented themselves as a unit manager at the department in question.

As part of the referral response, the official stated that she did not present herself as a unit manager, although her name may be recognised by various authorities because of her professional role, and for that reason the midwife may have perceived that she was calling in her official capacity.

In the decision, the Parliamentary Ombudsmen states that it cannot be considered established that the official, in the conversation with the delivery ward, stated that she was calling in the official capacity of unit manager. In view of what the official herself said, claiming that she may be known to the staff, she should have, according to the Parliamentary Ombudsmen, highlighted the fact that she called as a relative to the child and not as an executive from the social services, because there was a risk that the delivery ward would assume it was an official call. Since the documentation in the case does not provide any definite conclusions as to what was said during the telephone conversation in question, the official therefore receives no criti-

cism. However, the Parliamentary Ombudsmen emphasises the importance of an official within the social services presenting themselves in such a manner that there is never any doubt as to whether he or she is acting in an official capacity or as an individual. It is of course not permitted, for an official in a private context, to use their title in such a manner that it could be understood as a coercive element.

In the decision, the Parliamentary Ombudsmen also addresses if it was a case of conflict of interest in the processing of the preliminary assessment. (7803-2016)

Criticism of the Social Welfare Board in Säter's municipality for not administrating an investigation on child welfare within the period of four months, pursuant to Chapter 11, section 2 of the Social Services Act

An investigation by the Social Welfare Board regarding the need to intervene to protect or care for a child should be carried out promptly and executed within four months. If there are special circumstances the Social Welfare Board may extend the time period of the investigation pursuant to chapter 11, section 2 of the Social Services Act [2001:453] (SoL).

The regulation is a general provision when processing a case on child welfare. In the present case, the Social Welfare Board in Säter municipality carried out three child welfare cases subsequently, during a total time period of more than one year. The two latter investigations were initiated upon the conclusion of the proceeding investigation. The Parliamentary Ombudsmen holds that the Social Welfare Board did not endorse the purpose of the provision when the board conducted several investigations of one family on a reoccurring basis, where the investigation essentially concerned the same circumstance. The Parliamentary Ombudsmen also notes that the Social Welfare Board should not conclude an investigation and immediately initiate a new investigation to be able to extend the time period for the investigation. The respite of four months thereby becomes ineffectual. The Parliamentary Ombudsmen directs severe criticism towards the Social Welfare Board for not administrating cases on child welfare pursuant to the general provision's regulation of four months. (2565-2016)

Criticism against the Municipal Executive Board in Bengtsfors Municipality for inadequate management of a child welfare investigation

An investigation pursuant to Chapter 11, Section 2 of the Social Services Act (2001:453) (SoL), has the purpose and intention to clarify whether or not there is a need for the Social Welfare Board to intervene in the protection or support of a child. If it is shown during a child welfare investigation that the child is in need of an intervention or resources from the Social Services Department, the Board has the obligation to investigate whether the interventions and efforts can be provided on a non-compulsory basis pursuant to the provisions of the Social Services Act and, if this is not possible, consider whether there is a need for measures pursuant to the Care of Young Persons (Special Provisions) Act (1990:52) (LVU). The investigation shall be conducted expeditiously and completed no later than within four months. The issues concerning the child's need for assistance and how this should be adequately satisfied should be considered in the same investigation.

In the present case, the Municipal Executive Board of Bengtsfors Municipality has conducted two child welfare investigations immediately consecutive to each other over a period of ten months. In the first investigation, the Social Services Department made the assessment that the child would be placed in a home with a family that takes care of other children. When the parents did not consent to such an intervention and assistance, the Social Services Department concluded the investigation without action and commenced a new investigation on the same day in order to investigate whether the child should be provided care with the scope of LVU.

In the decision, the Parliamentary Ombudsmen states that if the Municipal Executive Board carried out the first investigation correctly, the Social Services Department could have been able, on the basis of that investigation, to determine whether or not the child was in need of care within the scope of LVU. How the Social Services Department managed the matter resulted in that the time for investigation was dragged out far too long. The Parliamentary Ombudsmen criticises the Municipal Executive Board for inadequate and deficient management of the matter. (2411-2017)

The Parliamentary Ombudsmen directs criticism towards the Social Welfare Board in Gagnef Municipality due to the Board making a decision concerning a follow-up pursuant to Chapter 11, Section 4 of the Social Services Act without legal support

A so-called child investigation pursuant to Chapter 11, Section 1 of the Social Services Act, which the Social Welfare Board carried out con-

cerning two children, was concluded without the Board proposing any measures, but with a decision that a follow-up pursuant to Chapter 11, Section 4 of the Social Services Act would be carried out within three months, or as soon as an ongoing custody process between the parents was settled. The question in the case is whether the conditions existed for the Social Welfare Board to decide on a follow-up according to the afore-mentioned provision. The Social Welfare Board may decide on a follow-up of a child's situation when an investigation concerning the child's need for support or protection concludes without a decision concerning intervention. Such a follow-up may be made if the Board considers that the child, without the presence of such conditions as justify compulsory care, has a special need for support or protection from the Social Welfare Board but consent to such a measure is lacking. In this case, the Parliamentary Ombudsmen stated that the guardians were not offered any measures that they refused. The conditions therefore did not exist for deciding on a follow-up according to the provision in Chapter 11, Section 4 of the Social Services Act. In the decision, the Parliamentary Ombudsmen directs criticism against the Social Welfare Board due to the Board making such a decision without the conditions for it existing. (167-2018)

The Parliamentary Ombudsmen directs criticism towards the Health and Social Care Committee in Sala Municipality for failure to allow a parent with visitation rights to comment on a child investigation that concerned the visitation

The District Court decided that a girl would be entitled to visitation with her father. Some months after the District Court's judgment, the social services received notifications of concern regarding the girl. The committee in question initiated an investigation and recommended the mother to cancel the visitation. In the decision, the Parliamentary Ombudsmen makes some comments about how a social welfare board should refer to a court decision regarding the visitation if there is concern that the child is at risk during visitation. The Parliamentary Ombudsmen also addresses the question of whether the father should have been considered as a party in the investigation, which was initiated despite the fact he was not the girl's guardian. In the latter issue, the Parliamentary Ombudsmen concludes that the father should have been considered as a party in that part of the investigation that concerned the visitation, and that he should have had an opportunity to comment on the information provided in that respect. (2355-2016)

The Parliamentary Ombudsmen directs criticism towards the Social Welfare Board in Ekerö municipality for reading a report due to concern to a child in its entirety

When the social services take action related to a child, the child shall receive relevant information on the measure. The information that the child receives should be given with consideration to the child's age and maturity, in every separate case. In the relevant complaint case, the Parliamentary Ombudsmen directs criticism towards the Social Welfare Board for reading an entire report due to concern to a child, in spite of the fact that the report included information that was unsuitable to share with the child. (2623-2017)

The Parliamentary Ombudsmen directs criticism towards the Committee for the Labour Market and Adult Learning in Karlstad Municipality for not indicating who made decisions on matters of assistance

A Committee for the Labour Market and Adult Learning has on a number of occasions named the chair of the committee as decision-maker in decisions on assistance, despite the fact that the chair has not made the decisions in question, all in order to protect the staff. It is a basic requirement in cases where the decision is made by an authority that the responsible decision-maker not remain anonymous. A party in a case has a legitimate interest in knowing who has decided on his or her case. The fact that a decision-maker may not remain anonymous also means that another person cannot be named in place of the real decision-maker. In the decision, the Parliamentary Ombudsmen expresses criticism against the committee for their handling of the decision-maker's identity. (8000-2016)

The Parliamentary Ombudsmen directs criticism towards the Social Welfare Board in Österåkers Municipality for failure to observe the child perspective in a case concerning housing assistance

In a decision concerning housing assistance, the Social Welfare Board set conditions for assistance entitlement that the individual would do everything they could to find their own accommodation throughout the country. The assistance recipient had custody of two children who lived alternately with herself and the father of the children.

When measures concern children, the Social Welfare Board should observe what is best for the child, the so-called "child perspective"

(pursuant to Chapter 1, Section 2 of the Social Services Act).

In an investigation relating to assistance for an adult who is also a parent, the Social Welfare Board should investigate the consequences of a decision from the child's perspective. The considerations of the Social Welfare Board shall be presented in the supporting material for the decision.

It is apparent that the children in this case would be affected by the individual needing to move to a property that is far away from the father. The Parliamentary Ombudsmen confirms that the investigation that formed the basis for the Board's decision on assistance did not contain any considerations concerning whether and in what manner the decision could affect the children's situation. The Social Welfare Board is subject to criticism for neglecting to observe the child's perspective. (1126-2017)

Care of Young Persons (Special Provisions) Act (LVU)

The Parliamentary Ombudsmen received a complaint regarding the possibility to delegate decisions pursuant to section 14 of the Care of Young Persons Act, about not disclosing a youth's domicile and limited custody

The Parliamentary Ombudsmen received a complaint against the Employment and Welfare Board in Kristianstad municipality regarding the processing of two cases pursuant to the Care of Young Persons Act (LVU); on matters concerning the possibility to delegate decisions pursuant to section 14 of the Care of Young Persons Act, about not disclosing a youth's domicile and limited custody

According to the board's delegation order decisions pursuant to the Care of Young Persons Act, about not disclosing the youth's domicile and limited custody, was delegated to the board's committee. A team leader at the administration decided, during the deliberation of the committee's decision, that a child's domicile should not be disclosed for the parents and to limit the father's custody with the child. According to the Parliamentary Ombudsmen's understanding, there was not enough reason to criticise the board for the processing of the case. The case did, however, raise a question regarding the board's possibility to delegate the capacity to take a decision on the matter, in cases such as these.

The Supreme Administrative Court has, in their ruling HFD 2016 ref. 74, decided that a decision pursuant to section 17 of the Care of Young Persons Act, not to disclose a child's domicile is a decision based on the exercise of a public authority and is a specific statement of principle. Such a decision is therefore taken by the "delegation alliance" pursuant to chapter 6, section 34, third paragraph, of the Local Government Act. The right to take such a decision can so forth not be delegated, with the exception of very urgent cases, and during these circumstances only by the chairman or other commissioner that the board has proposed.

The Parliamentary Ombudsmen notes that the Supreme Administrative Court's ruling leads to decisions pursuant to the Care of Young Persons Act, about not disclosing a youth's domicile, cannot be delegated, during any circumstances, to a committee or other official. According to the Parliamentary Ombudsmen's understanding the Supreme Administrative Court's ruling makes it possible to delegate the decision-making in certain cases. The question is, when it comes to the possibility to delegate, if it is possible to separate decisions about not disclosing a youth's domicile and decisions on limiting custody.

There are municipalities were the municipality board is responsible for cases within the social services' scope. Individual cases are usually not administrated by the municipality board. Instead, a committee administrates the cases. The purpose for this way of order is to safeguard the information included in the cases, since the information is of a sensitive nature, and should therefore be handled by a small circle.

That a committee is not able to take a decision on coercive measures in an individual case is, according to the Parliamentary Ombudsmen, not pursuant to how the legislation should be interpreted. The Parliamentary Ombudsmen states that there are reasons to review the regulations on delegation within the scope of the Social Services Act and the Local Government Act.

Pursuant to section 4, of the Act with Instructions for the Parliamentary Ombudsmen, this decision is forwarded to the Government offices (Ministry of Health and Social Affairs and the Ministry of Finance). (7984-2016)

The Parliamentary Ombudsmen directs severe criticism towards the Social Welfare Board in Huddinge Municipality for insufficient communication in a case regarding the re-examination of care pursuant to the Care of Young Persons (Special Persons) Act

The Social Welfare Board re-examined the care of a child pursuant to Section 13 of LVU and determined that care would continue according

to Section 3 of LVU. The child was over 15 years old and had a custodian appointed in accordance with the rules of the Act on Custodianship for Unaccompanied Children (2005: 429). Prior to the re-examination decision, the Social Welfare Board had conducted an investigation in which data was collected from other sources than the child. However, the investigation did not communicate with the child and only with the child's custodian.

According to Section 36 of LVU, a child who is 15 years old is entitled to voice their opinion in a case or matter pursuant to LVU. The child then adopts a position as party in the case or matter. Thereby, the custodian no longer represents the unaccompanied child. Therefore, the Social Welfare Board should also have informed the child of the investigation prior to the re-examination decision being made.

During the investigation of the case it was discovered that the reason for the lack of communication by the Social Welfare Board was that the Board had internal procedures that were contrary to the provision in Section 36 of LVU.

In the decision, the Parliamentary Ombudsmen directs severe criticism against the Social Welfare Board for the insufficient communication with the child and for taking procedures that are in violation of the law. (1366-2017)

The Parliamentary Ombudsmen directs criticism towards the Social Welfare Board in Lekeberg Municipality for shortcomings in the formulation of a decision on so-called restrictions on visitation

The Social Welfare Board made a decision to restrict the visitation between a father and his son. In the decision, the Parliamentary Ombudsmen declares that a decision concerning so-called restrictions on visitation pursuant to Section 14, Paragraph 2, point 1 of LVU must be clear. The decision shall state the manner in which the visitation is limited and whether the decision shall be valid until further notice or if it is time-limited. Furthermore, the reasons for the decision must be stated. The Social Welfare Board's decision regarding restrictions on visitation was lacking in all of these respects. The Board receives criticism for the formulation of the decision. (2533-2017)

The Parliamentary Ombudsmen directs criticism towards the Social Welfare Board in Huddinge municipality for the processing of a case concerning a child deprived of their liberty in a criminal case

A 16-year-old boy, N.N., was apprehended on January 6, 2016 suspected of a serious crime. Two days later the Social Services Department of Huddinge municipality was informed that N.N. should be apprehended if it was not possible to place him in a so-called "locked institution" pursuant to the Care of Young Persons Act (LVU). The District Court of Uppsala municipality apprehended N.N. on January 9, 2016. On January 13, 2016 the Social Services Department met N.N. for the first time since he was deprived of his liberty. The following day N.N. was placed under care pursuant to section 6 of the Care of Young Persons Act (LVU). The prosecutor revoked the apprehension and placed N.N. in a home for young people.

Only in exceptional cases are children suspected of a crime apprehended. The Parliamentary Ombudsmen has previously held that when a person below the age of 18 is apprehended there is a strong assumption that the youth shall immediately be placed under an order for care pursuant to section 6 of the Care of Young Persons Act (LVU).

In the decision, the Parliamentary Ombudsmen states that when considering N.N.'s age and the crimes he has been a suspect of, the question regarding placing him under an order for care, pursuant to section 6 of the Care of Young Persons Act (LVU), should have become relevant upon the police's correspondence with the administration on January 8, 2016. The Parliamentary Ombudsmen notes that it was not until January 14, 2016 that a decision was taken on immediate care. According to the Parliamentary Ombudsmen's understanding the authority's slow case handling led to N.N. being apprehended for an unnecessarily long duration of time. The Social Welfare Board receives criticism for the processing of the case.

In the decision, the Parliamentary Ombudsmen makes certain statements regarding the Social Services presence during a child examination. (305-2016)

The Parliamentary Ombudsmen directs criticism towards the National Board of Institutional Care, Bärby residential home for young people, for the processing of a case pursuant to section 15 b of the Care of Young Persons Act (LVU)

A youth was under care at a residential home for young people in a secure unit pursuant to 15 b of the Care of Young Persons Act (LVU). When the youth was moved to Bärby residential home for young people a decision was taken to terminate the care at the secure unit. Bärby residential home decided, that same day, to place

the youth under care at the secure unit at Bärby. In total, during the time the youth spent at the two residential homes, the youth was kept under care at a secure unit for a considerably longer consecutive period than the two-months period specified in section 15 b, second paragraph, of the Care of Young Persons Act (LVU).

In the decision, the Parliamentary Ombudsmen holds that the respite of two-months pursuant to section 15 b, second paragraph of the Care of Young Persons Act (LVU) was not adjusted as the youth was moved from one residential home to another. The Parliamentary Ombudsmen directs criticism towards Bärby residential home for young people for not verifying if the youth had been under care at a secure unit before the youth was moved. Neglecting to do so resulted in the respite of two months, pursuant to section 15 b, second paragraph of the of the Care of Young Persons Act (LVU) was exceeded. (263-2017)

Criticism of the Social Welfare Board in Karlstad municipality for neglecting to structure the care of a child pursuant to the Care of Young Persons Act (LVU) regulations that aims to benefit a child's relationship to a parent

The Parliamentary Ombudsmen directs criticism towards the Employment and Social Welfare Board in Karlstad municipality for, in the present case, not administrating the care of a boy cared for in a manner that supported his relationship to his mother, pursuant to the Care of Young Persons Act (LVU). (6178-2015)

The Humanities Committee in Örnsköldsvik Municipality receives criticism for delays in considering whether a removal ban was still necessary

When a guardian requested that a child who was placed in a foster home pursuant to the provisions of the Social Services Act should move home again, the Committee decided on a temporarily removal ban for the child. Following an application from the Committee, the Administrative Court decided in a judgment made on 1 July 2016 that the child should not be moved from the foster home until further notice. The judgment came into force with immediate effect.

Section 26 of LVU outlines that the Committee should reconsider whether a decision for a removal ban is still required every three months. In the case, the question arises regarding how to calculate the time until the first consideration. According to the Parliamentary Ombudsmen, the period shall count from the date on which the Administrative Court decided on a removal ban.

The Parliamentary Ombudsmen establishes that the committee should have considered whether the removal ban was still required, by the end of September/October 2016. The consideration was not made until 16 November 2016. The Committee is criticised for the delay in considering the removal ban. (646-2017)

Care of Abusers (Special Provisions) Act (LVM)

The Parliamentary Ombudsmen directs criticism towards the Social Welfare Board in Kumla municipality for the processing of a case concerning a man with a substance abuse problem

A unit for adult care in Stockholm municipality sent a report due to concern to the Social Welfare Board in Kumla municipality regarding a man with a substance abuse problem. The report included detailed information regarding the man's situation. As soon as the board received the report the board started an investigation pursuant to chapter 11, section 1 of the Social Services Act (SoL). The Social Welfare Board sent an appointment to the man's registered address in Kumla municipality and made a phone call to a social welfare worker in Stockholm municipality. The information that was collected from the social welfare worker was not registered. The case was later closed without any measure.

According to the Parliamentary Ombudsmen's understanding, given the information in the report due to concern, there were adequate reasons to start an investigation pursuant to section 7 of the Care of Abusers Special Provisions Act (LVM). If an investigation had been pursued accordingly, the Social Welfare Board would have been able to rapidly collect information concerning the man from other authorities without any restraints. The board had also managed to set up a doctor's appointment for the man.

When information from a person that is operative within the field of substance abuse reach the Social Welfare Board the assumption is that the board shall use the information to make sure that the need for possible measures is investigated in such a manner that the investigation may form the basis for an accurate decision. According to the Parliamentary Ombudsmen a more significant investigation should have been pursued of the man's situation. The Social Welfare Board's investigation did not live up to the condition that should be met. The measures taken were not adequate or sufficient. In

addition, the collected information, that was substantial for the case, were not registered.

The Parliamentary Ombudsmen directs criticism towards the Social Welfare Board in Kumla municipality for neglecting to investigate the case pursuant to section 7 of the Care of Abusers Special Provisions Act (LVM) and for their lack in investigating the case pursuant to chapter 11, section 1 of the Social Services Act (SoL).

The Parliamentary Ombudsmen will send a copy of this decision to the Health and Social Care Inspectorate for knowledge. (3577-2016)

The Parliamentary Ombudsmen directs severe criticism towards the Social Welfare Board in Södertälje Municipality for neglecting to investigate whether an addict needed care pursuant to the Care of Alcoholics and Drug Users Act

AA had been misusing drugs for a long time. He died in late August 2016. AA's sister made a complaint to the Parliamentary Ombudsmen, informing that the social services had not acted fast enough with measures to help her brother. In the present case, there are currently a number of issues that apply to the basic requirements for the Social Welfare Board's handling and the Board's special responsibility to investigate and assist serious addictions. In the decision, the Parliamentary Ombudsmen emphasises that there are relatively high demands on the Board to conduct active and adequate investigation work. The Parliamentary Ombudsmen is especially critical of the Board's non-performance of an investigation pursuant to Section 7 of LVM. The Parliamentary Ombudsmen does not consider that the Social Welfare Board, despite repeated irregularities and clear indications regarding AA's state of health and life situation, has done what it takes to assess the severity of AA's abuse and need for LVM care. The shortcomings that characterise the Board's handling of the case are such that the Parliamentary Ombudsmen considers there are reasons to direct severe criticism towards the Board. (5747-2016)

Case handling

The Parliamentary Ombudsmen directs criticism towards the Individual and Family Care Division in Ånge municipality for making contact with a parent via a text message before an information inquiry was provided to the court

In the context of a dispute regarding visiting rights, the court requested that the Social Welfare Board submit a so-called rapid information inquiry to the court. Before the Social Welfare Board provides such information they shall, when appropriate, consult with the parents of the child. The Social Services attempted to contact the mother by phone in response to the court's request. The mother did not answer, and the social secretary therefore sent her a text message. The Parliamentary Ombudsman states that there are particular risks, e.g. risks to confidentiality, in using text messages for individual communication, and directs criticism towards the case officer that decided to contact the mother in this manner. (494-2016)

The Parliamentary Ombudsmen directs criticism towards Skärholmen City District Board in Stockholm municipality for handing out a certificate to a parent that the parent was going to refer to, in a passport case

An administrator at the Social Services handed out a certificate to a parent that intended to apply for a passport for the child, without the other parent's consent. The certificate included information regarding the other parent that was of a sensitive and personal nature.

In the decision, the Parliamentary Ombudsmen makes statements regarding the Social Services' policies on issuing certificates.

The Parliamentary Ombudsmen directs criticism towards the City District Board for, among other things, issuing a certificate that may lead to their objectiveness being questioned, and for releasing information that was of a sensitive and personal nature. (3283-2016)

Support and service for persons with certain functional impairments (LSS)

The Parliamentary Ombudsmen directs severe criticism towards the Health and Social Care Committee in Töreboda municipality for, inter alia, the formation of a decision pursuant to the Support and Service for Person with Certain Functional Impairments Act

The Health and Social Care Committee in Töreboda municipality granted a girl personal assistance [personlig assistans] pursuant to the Support and Service for Person with Certain Functional Impairments Act (LSS). The decision was in effect for five months, and joined with several restrictions regarding re-examination.

In previous decisions, the Parliamentary Ombudsmen has made statements on prerequisites when imposing a time limit on decisions pursuant to the Support and Service for Person with Certain Functional Impairments Act (LSS) and questioned the regularity when imposing such time limits. An authority should, in every separate case, consider the necessity of imposing

a time limit. It is, according to the Parliamentary Ombudsmen's understanding, less justified, to impose a time limit when the need for assistance will not be altered within the near future.

The Parliamentary Ombudsmen also emphasise that a limited measure can only be altered with a new decision, and that it is essential to take a new decision in good time prior to when the previous period has ended. A new decision should also be proceeded by a follow-up of the measures granted. As measures pursuant to the Support and Service for Person with Certain Functional Impairments Act (LSS) are only provided when the individual requests it, the individual must apply for a new measure to be able to receive a new decision. In addition, the Parliamentary Ombudsmen now adds that an authority that considers to join a decision pursuant to the Support and Service for Person with Certain Functional Impairments Act (LSS) with a requirement that the decision can be subject to a re-examination, need to conduct an equivalent assessment of the individual's needs. The authority need to be clear on the purpose of such reservation and be certain to the extent that it is pursuant to the requirements on predictability and in compliance with the requirement on legality, objectivity and proportionality.

The outset for measures granted pursuant to the Support and Service for Person with Certain Functional Impairments Act (LSS) is that the measure is permanent. Regarding personal assistance, necessary measures may vary over time. Decisions concerning personal assistance should therefore be joined with a time limit or a requirement that the decision can be subject to a re-examination.

When there is a choice between different alternatives there are, according to the Parliamentary Ombudsmen's understanding, reasons to join a decision regarding personal assistance with a requirement that the decision can be subject to a re-examination after a certain period, or an altered situation, instead of limiting the validity of the decision. The municipality is responsible to initiate a new investigation. The decision that is to be re-examined is in effect until a new decision is taken. As the municipality conduct a re-examination it is possible that the municipality comes to a new assessment of the need for personal assistance, this should not lead to any further uncertainty for the individual.

In the decision, the Parliamentary Ombudsmen directs severe criticism towards the municipality for, inter alia, not responding to the individual's claim in regards to the decision being applicable until further notice, and for neglecting to give an account of the requirement that the decision can be subject to a re-examination. The Parliamentary Ombudsmen's decision also include statements on the need to look into the prerequisites for re-examination and the adjustment of favourable decisions pursuant to the Support and Service for Person with Certain Functional Impairments Act (LSS). The Parliamentary Ombudsmen requests that the Government conduct a review of the legislation. (589-2016)

The Parliamentary Ombudsmen directs criticism towards the Social Welfare Board in Vaggeryd Municipality for, inter alia, re-examining and amending a previous decision without any valid reason

The Social Welfare Board in Vaggeryd Municipality decided on 18 September 2009 to grant AA a continuing intervention in the form of personal assistance with 27 hours per week, according to Section 9, Paragraph 2 of the Act concerning Support and Service for Persons with Certain Functional Impairments (1993:387). The Board made a new decision regarding personal assistance for AA on 24 May 2016. According to the new decision, AA was granted assistance to the same extent as before. However, this new decision was time-limited, upon correction, until 31 December 2017.

The decision that the Social Welfare Board made on 18 September 2009, giving AA the right to personal assistance pursuant to Section 9 of LSS, was not time-limited and was ongoing until further notice. Such a beneficial decision cannot be changed outright by the Board to the disadvantage of the individual.

The Board considered there to be no impediment to a new decision imposing a time limit on the previously decided intervention. This approach seemed to originate from the opinion that the re-examination had been in line with a new working method entailing that existing cases are followed up upon.

The Parliamentary Ombudsmen stated that an amendment to a decision that applies until further notice, rather than for a limited period, is such a change which may be considered to be detrimental to the individual. There is no support in any statute or law for the Board's stance.

The Parliamentary Ombudsmen could not reach a conclusion other than that the Board had amended the decision to AA's disadvan-

tage without the support of the law. The Board receives criticism for failures in the handling process. (921-2017)

Other areas

Criticism of the Competition Authority for a number of failures when processing a case on the suspected abuse of a dominant position

In a complaint case against the Competition Authority, the complainant declared that the Competition Authority had committed several errors during an investigation of suspected abuse of a dominant position.

According to the Parliamentary Ombudsmen's understanding, the Competition Authority's investigation took longer time than what was needed. The Parliamentary Ombudsmen also directs criticism against the Competition Authority for, in several cases, delaying to establish official notes during investigations.

The Parliamentary Ombudsmen further states that the Competition Authority, in connection to a confidentiality assessment against a party in the case, on a number of occasions, failed in conducting an accurate assessment when handing out information, already at the time when the complainant made their original request.

The matters raised by the complainant regarding the investigation being too extensive and onerous, and that interrogators were not allowed to look over transcripts of their enquiry, will not lead to any criticism. (1145-2016)

The Parliamentary Ombudsmen directs criticism against the Health Care and Social Services Committee in Mölndal Municipality for applying a procedure for drug testing of employees which contravene Chapter 2, Section 6 of the Swedish Form of Government Act

A suspicion arose that an employed 'after-school activities teacher' within the Health Care and Social Services Committee was under the influence of narcotics. The employer therefore asked the employee to submit to a drug test. The test results were negative. In the present case the Parliamentary Ombudsmen takes a position on whether the drug test was conducted in violation of Chapter 2, Section 6 of the Form of Government Act.

Every citizen is protected against forced physical interventions (Chapter 2, Section 6, Form of Government Act). Under certain circumstances, the protection may be limited by law. An intervention is i.e. forced if it is conducted after a threat of any sanction/penalty or other forms of pressure.

The Parliamentary Ombudsmen notes initially that Chapter 2, Section 6 of the Form of Government Act was applicable in the relationship between the Committee and the employee. Legal support to require an employee to carry out a drug test, is, in this case missing. This means that the employee must provide their consent to submit a drug test in order for it to be carried out. The Committee stated that the test had been conducted on a non-compulsory, voluntary basis, the Parliamentary Ombudsmen states that what has been shown in the matter does not provide sufficient evidence or foundation to criticise the Committee for conducing the drug test.

However, on the Municipality's Intranet, employees are informed i.e. a refusal to take a drug test is equated with a positive test. An employee who receives that information should not perceive the possibility to refrain from submitting a drug test as a real alternative. The Committee's guidelines and procedures for drug testing in that section constitute a form of pressure that is contrary to Chapter 2, Section 6 of the Form of Government Act. The Parliamentary Ombudsmen criticises the Board for the formulation of the procedures in this area. (2089-2016)

The Parliamentary Ombudsmen directs criticism towards the Social Welfare Board in Örkelljunga municipality for not giving out certain information to a legal representative

A lawyer informed the municipality that an employee of the municipality had hired the lawyer as his legal representative in regards to the matter, among other things, that the municipality had suspended the employee from his job. According to the Social Welfare Board, the employed had no right to hire a legal representative in this particular context. Because of this, the municipality decided to correspond only with the employed.

The Parliamentary Ombudsmen states that matters of employment such as the relevant matter may include many questions of a varying character and, if the employer is an authority, the circumstances should be processed pursuant to the Administrative Procedure Act. The legal matter now in question, were the rule of law holds particular ground, should, according to the Parliamentary Ombudsmen's understanding, be considered a case in compliance to the Administrative Procedure Act. Pursuant to section 9 of the Administrative Procedure Act the regulation on the right to hire a legal representative was so forth applicable. The Parliamentary

Ombudsmen holds that if a legal representative exists, it is, primarily, the legal representative that the municipality shall contact. The correspondence in the case should therefore go through the legal representative. The Parliamentary Ombudsmen directs criticism towards the Social Welfare Board for not corresponding with the legal representative. (3522-2016)

The Parliamentary Ombudsmen directs criticism towards the Medical Products Agency for deficient advertising of vacancies

In two cases the Medical Products Agency has advertised vacancies on the authority's internal web page and notice board, while the advertisement of a third vacancy was advertised on the authority's external web page. None of the three vacancies were reported to Arbetsförmedlingen.

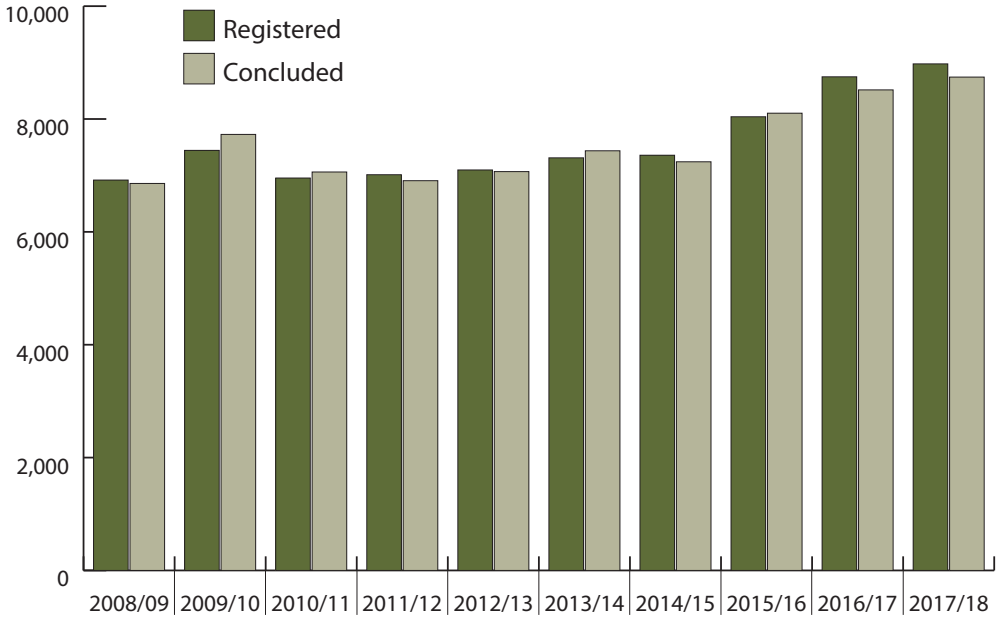
An authority that intends to employ is obligated, according to the Employment Regulation, to advertise their vacancies adequately so that those interested in the employment are able to apply. In the decision, the Parliamentary Ombudsmen notes that individuals interested in a vacancy may exist both within and outside of the authority. Therefore, to be able to reach all interested parties, an advertisement on the authority's internal webpage and notice board is not enough. An advert on the authority's external web page, and/or in the daily and periodical press, are, according to the Parliamentary Ombudsmen's understanding, suitable ways to spread information concerning a vacancy to individuals that are interested in an employment.

The Parliamentary Ombudsmen directs criticism towards the Medical Products Agency for not advertising the two vacancies in such a manner that interested parties outside of the authority could access information regarding the vacancies. The authority is also criticised for not reporting the three vacancies to Arbetsförmedlingen pursuant to the Public Employment Regulation, and for, during a certain time period, applying an employment instruction within the authority, that was not in accordance to applicable legislation. (7470-2016)

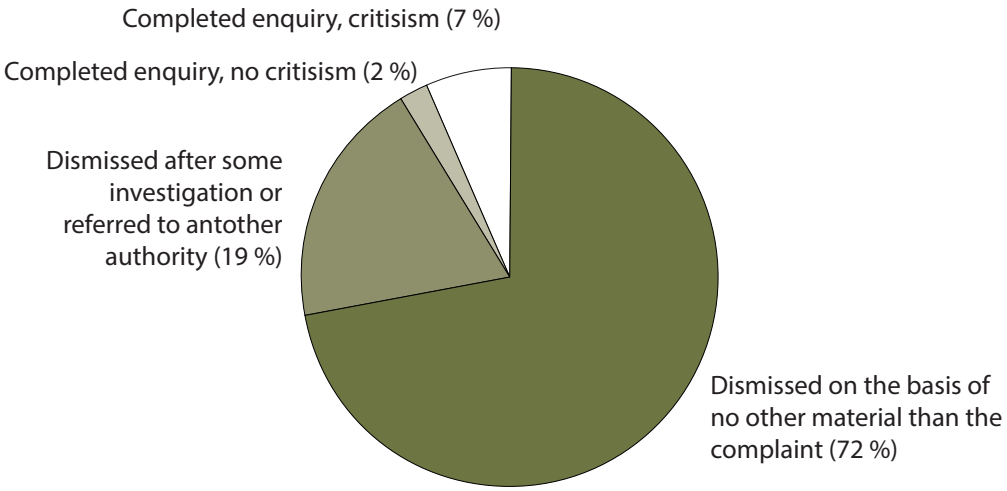
Statistics

Statistics

Evolution of the number of complaints and initiatives in the last 10 years



Decisions in complaints and initiatives 2017/18, total 8,564



Registered complaints the last 5 years

Area	2013/14	2014/15	2015/16	2016/17	2017/18
Adm. of parliament and forreign affairs	19	34	18	76	33
Administrative Courts	90	98	110	117	121
Armed forces	22	14	16	23	27
Chief guaridans	72	77	91	92	86
Communications	266	224	300	241	217
Complaints outside jurisdiction	150	158	221	169	202
Courts	439	401	338	351	369
Culture	20	14	31	25	28
Customs	13	6	7	14	17
Education	275	307	269	303	380
Employment of civil servants	79	59	84	88	121
Enforcement	155	166	165	265	222
Environment and heath protection	196	187	186	191	284
Housing	4	5	8	8	13
Labour market	220	201	215	218	258
Medical care	282	311	330	334	361
Migration	252	283	577	920	636
Other municipal matters	97	101	146	148	120
Other public administration	102	76	104	112	96
Other regional matters	29	31	30	29	14
Planning and building	172	194	251	249	219
Police	1,147	972	1,010	907	1,032
Prison and probation	829	904	993	913	934
Public access to documents, freedom of expression	353	415	492	525	521
Social insurance	396	341	350	615	735
Social services incl. LSS	1,189	1,294	1,203	1,374	1,451
Taxation	131	160	179	137	165
Sum	**7,190**	**7,221**	**7,885**	**8,604**	**8,826**

Most common complaints and most criticized

Most complaints 2017/18

Area of supervision	Complaints
Social services	1,425
Police	1,000
Prison and probation	829
Social insurance	739
Migration	620
Access to public documents	502
Education	344
Courts	343
Health and medical care	327

Most criticized 2017/18

Area of supervision	Criticism	Percent of complaints
Access to public documents	92	18 %
Social services	90	6 %
Prison and probation	78	9 %
Social insurance	53	7 %
Enforcement	48	19 %
Planning and building	33	15 %
Police	19	2 %
Education	17	7 %
Health and medical care	14	4 %

Inspections 2017/18

Regular inspections

Institution	Amount
Courts	1
The Enforcment Authority	2
Migration	1
Municipalities, environment/planning	4
Municipalities , social welfare boards	4
The Nat. Board for Consumer Disputes	1
Police	1
Prison and probation	4
Psychiatric care	1
Social insurance	1
Swedish Public Employment Service	1
Inspections sum	21

Opcat inspections

Institution	Amount
Institutional care (SiS)	3
Police cells	6
Prisons	2
Psychiatric wards	2
Remand prisons	4
Opcat inspections sum	17

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