Annual Report 2022

(Excerpts)

THE ALTHINGI OMBUDSMAN

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Introduction by the Ombudsman[1]

1.1

The ombudsman's mandate vis-à-vis the Althingi

Apart from possibly pointing out flaws in existing legislation, the ombudsman's mandate does not cover the activities of the Althingi (the legislature) itself or those of its institutions and bodies. These are explicitly exempted from the scope of the mandate, the ombudsman being elected and entrusted to monitor the executive sector "on behalf of the Althingi" as is further prescribed in the Ombudsman Act. The role of the ombudsman must therefore be understood in context of the powers of the Althingi to monitor the executive sector or to assign certain monitoring functions to parliamentary bodies or agencies, in particular the office of the auditor-general, standing parliamentary committees or investigative commissions. Given this, it is, as a rule, to be expected that the ombudsman will hold back if, for instance, the standing constitutional and supervisory committee of the Althingi has taken a matter up, or might do so in the foreseeable future.

On the other hand, in carrying out his duties, the ombudsman is independent of instructions from others, including the Althingi. Thus, the Althingi has itself determined by law that it is not to instruct the ombudsman either to open or to close cases, or how to proceed with them. It follows that it is for the ombudsman alone to assess whether a matter is outside the scope of his mandate, temporarily or permanently, this including matters which touch upon the activities of the Althingi. In this connection it must nevertheless be emphasised that it is clearly the prerogative of the Althingi (including its committees) to decide whether and how the legislature will take up a matter. In these circumstances it is naturally not for the ombudsman to point out to the Althingi (or other bodies working under its auspices) that if such a decision is taken, he might be precluded from examining it at the same time. Although relations between the Althingi and the ombudsman are, as a rule, unproblematic, I nevertheless believe there is some room for improvement with regard to the information that members of the Althingi, and in particular members of its constitutional and supervisory committee, have regarding how their activities may bear upon on the mandate of the ombudsman when dealing with certain issues.

In this connection I should like to recall two cases from last year which gave rise to questions of this sort. The former was opened after the publication of a press release on the government website where it was announced that

[1] This is a translation of the authentic Icelandic version which, in case of possible discrepancies, takes precedence.

the minister of culture and commerce had decided to appoint the (then) serving auditor-general as the permanent secretary of her ministry. From what could be inferred from the press release it seemed that the appointment had been made without a public advertisement and was based on the general powers of government authorities to transfer public servants pursuant to the Public Servants Act. However, since the auditor-general was directly elected by the Althingi (and not appointed by an agent of the executive), I decided to open an inquiry. When issuing a letter to this effect I nevertheless explicitly noted that it was outside the scope of the ombudsman's mandate to examine the decision made by the speaker of the Althingi to accept the resignation of the auditor-general and consent to his transfer. However, after my enquiry to the minister in question had been made public, a memorandum discussing the legal basis of the transfer was published on the Althingi's website. In this document it was argued that the auditor-general fell within the scope of the relevant provision of the Public Servants Act, allowing for the transfer of public servants. It was also made clear that this was viewed as the legal basis for the decision made by the speaker of the Althingi, i.e. to consent to the transfer in question.

Given the position taken by the speaker with regard to the legal basis of this disposition, I considered further involvement as being outside the scope of my mandate. Although there was no doubt that the appointment by the minister was, as such, covered by the mandate, the legality of that decision could not be examined without at the same time assessing the position that the speaker of the Althingi had substantiated with regard to its legal basis. Therefore, continuing the case would foreseeably have been tantamount to indirectly examining the legality of a decision made by the speaker – a scenario that, in my view, could be reconciled neither with the letter of the Ombudsman Act nor with its spirit.

The latter case I consider worth mentioning involved questions relating to the impartiality of the minister of finance and economic affairs when approving the sale of shares in a state-owned bank, Íslandsbanki, after a tendering procedure concluded on 22 March 2022, in which a company owned by his father had participated. Several issues concerning the sale immediately became the subject of debate in the Althingi, but without it being clear whether or how the matter would be pursued there. On 8 April the auditor-general decided, at the request of the minister in question, to open an inquiry as to whether the sale had gone ahead in compliance with the law and the standards of good administration. On 2 May, after receiving several complaints and informal dispatches from the public, I published a press release declaring that I did not, at that time, consider conditions being satisfied for opening an investigation into matters relating to the sale. The auditor-general submitted his report to the Althingi in November 2022, and the constitutional and supervisory committee issued its findings, drawing on the report, in February 2023.

I decided to open my own inquiry with a letter addressed to the minister of finance and economic affairs on 2 March 2023. In this I noted that the auditor-general had not, in his report on the sale, specifically tackled legal questions relating to the minister's impartiality. It followed that I could not regard the treatment by the Althingi's constitutional and supervisory committee as being the last word on the matter. Under these changed circumstances, I therefore regarded this aspect of the sale as lying within my mandate. It may be noted that the majority of the committee had indeed expressed a certain view on the matter, though without substantiation.

In this respect it is important to distinguish between the role of the Althingi as the forum of political debate and its monitoring function vis-à-vis the executive. It goes without saying that the ombudsman is not to meddle in the political workings and policy-making of the legislature. Hence, questions regarding the ombudsman's mandate vis-à-vis the Althingi arise first and foremost with regard to the Althingi's monitoring role, which is chiefly aimed at ensuring that administrative bodies function in accordance with the law and the requirements of good administration. However, the demarcation line here is not always clean-cut. Legal matters can be of political significance and political ones may be intertwined with legal elements. Even when something has been examined by the parliamentary body chiefly responsible for monitoring the executive, i.e. the Althingi's constitutional and supervisory committee, this may still be the case. It may be inferred from the discussion above that in these circumstances the ombudsman, when deciding whether a matter is within or outside his mandate, will not only have in mind whether the Althingi or one of its bodies has addressed a matter (or will presumably do so), but also how and on what basis this was done.

Finally, I must recall that in this country we have a long-standing tradition of majority governments. Hence, when the actions of ministers are called into question it may be expected that they will enjoy the support of the majority of the Althingi and, as the case may be, that this will also be reflected in the actions and opinions delivered by parliamentary committees. Given the legal function of the ombudsman, including monitoring the actions of the highest agents of the executive (i.e., ministers), I believe, also for this reason, that one must be careful in concluding that a general debate in the Althingi or proceedings in parliamentary committees will automatically result in a matter being considered as lying outside the scope of the ombudsman's mandate.

1.2 The ombudsman is not part of the executive

Various forms of internal monitoring by the executive, including responding to complaints or administrative appeals from the citizens, are a characteristic of any modern state aspiring to respect the rule of law. From this viewpoint it is not sufficient that the judiciary be competent to review the legality of

administrative acts and exercise restraint over the executive. It is also necessary that the legislature be able to verify how the executive is being governed, including as regards its internal monitoring and handling of complaints and administrative appeals. Under Icelandic constitutional law, these are matters for which the ministers are responsible to the Althingi.

The role of the ombudsman constitutes, in a sense, part of the surveillance that the Althingi exercises over the executive. It follows that the ombudsman is, as such, not part of the executive, but nor would it be justified to see the office as something that could or should replace internal monitoring by the executive itself (by ministerial supervision, response to administrative appeals, the activities of specialised surveillance bodies, etc.). Hence, the ombudsman's inquiries are in fact generally directed towards the higher levels of the executive, at the request of individuals and legal persons who have exhausted available administrative remedies. It is not impossible that intervention by the ombudsman will be the first surveillance action, especially in the case of own-initiative inquiries. Statistically, however, this is contrary to the trend.

This is mentioned here since this position of the ombudsman does not always seem to be clear to those who have dealings with the office. It may be understandable that representatives of international bodies only have a limited idea about the role of the office under Icelandic law and its position as a monitoring body operating independently of the executive. The same may also be said about the citizens who submit complaints to the ombudsman without having, perhaps, fully explored the avenues open to them to have decisions reviewed within the executive structure, for instance by submitting administrative appeals. However, misunderstanding to this effect can also be found amongst public servants and even members of the Althingi.

One manifestation of this problem takes the form of an expectation that the ombudsman will become involved in work in the ministries on drafting bills for acts of law or regulations. The opinions and reports issued by the ombudsman may well contain legal analysis and observations that give rise to a revision of existing laws and regulations. However, it would be incompatible with the role of the ombudsman to engage actively in a drafting project undertaken by a ministry – something that, strictly speaking, constitutes part of the executive functions that the ombudsman is expected to monitor on behalf of the Althingi. In spite of this, it seems to me that the ombudsman is increasingly included on consultation lists by ministries at various stages of preparatory work, even with the expectation that the office will participate in an exchange of views for these purposes. For good order, I should like to note that we consider ourselves as having certain duties with regard to keeping members of the executive informed about developments of administrative law and good administration. Any requests for an informal exchange of views with

the office, on behalf of the executive, are therefore considered with an open mind. Nevertheless, the authorities cannot expect the ombudsman to engage actively in the preparation of draft legislation, regulations or the revision of administrative procedures.

In my view, another manifestation of the same lack of understanding are proposals whereby the ombudsman would undertake monitoring in specific fields, replacing or supplementing internal monitoring expected by the executive. Here it should be recalled that by an amendment in 2018, the ombudsman was given the function to act as the national preventive mechanism under the Optional Protocol of the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). As is discussed in greater detail in another part of this report, this function covers not only prisons, detention facilities, etc., but any type of arrangement where persons may be deprived of their liberty, formally or *de facto*. I am aware of my predecessor having, at the time, been concerned that this special and direct monitoring function could give the impression that the ombudsman was in some way part of regular administrative monitoring, regardless of the responsibilities of ministries and their institutions for the matters in question.

In view of ideas that have come forward later about assigning certain further tasks to the ombudsman, e.g. in relation to the monitoring of the transport of persons under deportation orders, I believe the concerns expressed by my predecessor were not entirely unwarranted. It must also be observed that it may be tempting to exploit the public confidence enjoyed by the office of the ombudsman by assigning it new tasks that involve direct monitoring in a certain field. However, if we go too far down that road, there is the risk of bringing about a fundamental change in the ombudsman's role and, at the same time, lowering the standard for the authorities' *prima facie* responsibility to ensure, themselves, that administration takes place according to law and standards of good administration.

1.3 Administrative appeal committees – the problem of responsibility and accountability

The trend over the past decades towards transferring monitoring functions from the ministries and assigning them to more or less independent committees or quasi-judicial bodies has been discussed in several earlier ombudsman's reports. It has been noted that when legislating and executing such arrangements whereby a certain monitoring function is dissociated from general supervisory powers (e.g., when the power of decision on complaints or administrative appeals is taken from a ministry and assigned to an independent committee), certain challenges must be addressed. In particular, the ombudsman has recalled that notwithstanding such changes, the relevant ministry continues to be responsible for the matter in question in various other

ways, such as regarding the facilities and the general working conditions of the committee entrusted to handle complaints or appeals. It is therefore the responsibility of the relevant ministry to observe the workings of committees operating under their auspices, *inter alia* to ensure that they have the facilities needed to carry out their function.

This is brought up here against a backdrop of cases that are regularly brought to the attention of the ombudsman, where there are indications that committees or monitoring bodies are struggling to carry out their legal functions, sometimes without the supervising ministry being fully aware of the problem or having taken any action to address it. An example of this is a case from last year concerning a committee established by Act No. 69/1995, on the Payment of Compensation to Victims of Offences. The ombudsman received a complaint from a person who, 12 months after submitting a request to the committee, had received neither a formal response nor any indication of when a decision might be expected. A letter from the ombudsman enquiring about the case was sent to the committee on 11 August. As no word was received from the committee, a letter was sent again on 14 September, and again on 28 September and 12 October. The first reaction from the committee appeared in an e-mail received on 14 October stating that a reply to the ombudsman's enquiry would be sent no later than 17 October. No reply was forthcoming, however. After some further unfruitful attempts made by my staff, I decided to contact the chairman of the committee personally. I eventually received a letter from the committee on 30 November, informing me that a decision had just been taken on the complainant's request by the committee, and that the person had been notified and the case was closed. At that point, some 16 months had elapsed since the complainant's application had been submitted to the committee.

In the light of these events, and considering the length of time taken by the committee in its procedures and the difficulties it appeared to have in interacting with the ombudsman, I wrote a letter to the minister of justice on 15 December. In this, I expressed the view that the answers given by the committee, as well as certain other factors, indicated the existence of systemic problems in its procedures and *modus operandi* as well as more general defects in its structure and working environment. In this connection I also referred to the information given by the committee itself to the effect that it had no proper registry of cases, apparently due to lack of resources, while there also seemed to be mismanagement with regard to filing. Given this, the ministry was asked whether it was aware of the problems facing the committee and how supervision of its activities had been carried out with regard to the efficiency of the procedures and the adequacy of funding and facilities.

This part of the case remains open. Given the number of comparable committees established by law in the past few decades, the question nevertheless remains whether a more general inquiry into the facilities and circumstances

of these bodies is needed. In this respect it should be kept in mind that in many cases these committees have neither full-time members nor any full-time staff. I should also like to note that the problems mentioned here are not restricted to the case or the committee discussed in the case described above.

I should also like to make it clear that these problems are not limited to appeal committees. For instance, I wrote letter to the minister of health on 23 December about long-standing problems at the directorate of health in the processing of complaints from patients – problems that the directorate itself had, in fact, repeatedly attempted to bring to the attention of the ministry over the past years. As with relations between a ministry and an appeal committee, in such circumstances the ministry is not to interfere in the procedure dealing with individual complaints by its subordinate institution. On the other hand, faced with a situation at a lower administrative level that does not conform with the law, the minister is under an obligation, legally and constitutionally, to take adequate reform measures.

1.4 Continuing challenges with regard to digital administration

In line with practice over recent years, the ombudsman has closely observed the evolution of digital administration, which is currently being implemented by the government under the Act on a Digital Mailbox in the Government Central Service Portal ('the Postbox Act'). This provides for digital and centralised communication between the executive and both individuals and legal persons, which is intended to become the norm no later than by the end of next year, 2024.

In earlier reports, the ombudsman has carefully noted the various advantages of digital administration. However, it has also fallen to me to point out possible negative aspects of developments in this area and, simultaneously, to draw attention to the challenges involved, particularly as regards those who, for some reason, do not have a full opportunity to use this technology or are, perhaps, not willing to do so – children, persons with disabilities, the elderly, etc. The importance of adequately preparing digital administration projects from the outset has also been emphasised. This is also due to the fact that mistakes in this area, e.g. errors in automated calculations, may be costly for the state for several reasons.

In my communications with the ministry of finance in 2021, I was informed that the forthcoming implementation plan, to be issued under the Postbox Act, would also cover vulnerable groups with the aim of ensuring "access for all" to digitised communication with the authorities. However, when that plan was published in January 2022, it included no mention of any such intention. Furthermore, even though Article 9 of the act provided for the issue of a ministerial regulation implementing certain provisions of the act, no such regulation had been published by the end of 2021. Once again, therefore,

I requested an explanation from the ministry in November 2022. I should note here that I have recently been informed by the ministry that the regulation in question is currently in the final stages of preparation. However, from what I have seen it does not contain any explicit provisions ensuring access for all. It may therefore presumably be expected that these are only to appear in instructions and general information published by the authorities, in particular on governmental websites.

A major step was nevertheless made on these matters in November 2022 when the ministry of social affairs and labour and the ministry of finance and economic affairs issued a joint declaration on Island.is (the governmental web portal), stating that henceforth, persons with disabilities would be able to access the portal through their personal representatives. In the ministry's answer to my questions I was also informed that changes had already been made, or preparations begun, to make it more generally possible to use the portal through an agent. Even with these positive developments, however, the fact is that existing laws and regulations contain no explicit provisions on these issues. In my opinion, time must be the judge on whether this state of affairs is fully satisfactory.

In my last annual report, I recalled the amendment made in 2003 to the Administrative Procedure Act intended to create a general legal framework for digital administration. I noted that the amendment had been based on concerns for equality inasmuch as it explicitly stated that digital administration was to be an option for the citizen, not an obligation. In addition, the amendment postulated specific requirements with regard to the duty to provide information on the digital means being used and contained certain principles that were to ensure technological equality, so to speak.

Unfortunately, the complaints received during the year, as well the ombudsman's own-initiative cases, indicate that there is still some way to go with regard to achieving full understanding within the executive of the aforementioned principles. For instance, the case of "Loftbrú" (Airbridge) concerned an on-line system run by the road and coastal administration for the subsidising of domestic air fares for the benefit of persons living in certain regions of the country. Not only could applications solely be made online, but it was also impossible to submit an application through an agent. This meant that a person without an electronic ID (who was therefore unable to sign into the system) was unable to benefit from the subsidy. The case was concluded in November when I noted that the administration had stated its intention of amending the system and making available methods of non-digital communication. After media coverage in February this year, from which it appeared that parents or guardians of children had been unable to access the subsidy on their behalf, I nevertheless felt compelled to raise the matter once more.

In these cases the authorities often react positively to the ombudsman's observations or directions, for instance where it is pointed out that citizens should, notwithstanding the establishment of a digital interface, have the option of communicating with the administration by other means. Typically, they will also express an understanding as to why the public should be adequately informed about such alternatives, even though they would like the majority of people to embrace the digital option. On the other hand, the cases testify to digital systems often being prepared and implemented without due regard to those who are less adept with digital technology or who may choose not to use it. The reaction by the authorities therefore often consists in fixing things *ex post facto,* typically by stating that this or that improvement to the system is on its way. This mentality has to change so that systems for digital administration are, from the very outset, designed and implemented in conformity with the law and standards of good administration.

1.5 Collaboration and consultation between ministries – issues relating to involuntarily committed patients

The lack of adequate collaboration and consultation between ministries on the handling of multi-faceted issues is one of the recurring themes in the ombudsman's annual reports. It should be noted that this problem may emerge at various administrative levels. For instance, at the primary level, we may have the police or a prison attempting unsuccessfully to obtain the necessary medical services for a person in their custody; at the highest level, we may have a scenario where a minister does not adequately engage in sufficient political consultation with his or her fellow ministers within the cabinet. In between these examples lie countless interfaces between ministries, their subordinate institutions and their employees where questions of collaboration and consultation arise.

One manifestation of this problem are issues pertaining to persons committed involuntarily to psychiatric wards which were, once again, in the lime-light last year, partly because of repeated recommendations and directions from the ombudsman going back as far as 2019. As can be seen from the ombudsman's reports, opinions and letters, most of these issues come under the auspices of the ministries of health and justice respectively, though some cases involving the underlying causes of involuntary (and sometimes repeated) commitments fall within the scope of the ministry of social affairs. In recent years the ministry of health has been working on an amendment to the Patients' Rights Act with the aim of reinforcing the rights of those who are committed to medical facilities against their will, and the minister of health has submitted a bill to this effect to the Althingi. I am also aware of work taking place in the ministry of justice, and also in a parliamentary committee, regarding the revision of the Legal Competence Act.

It is not for the ombudsman to comment on policy or the content of legislative bills submitted by ministers. I have nevertheless taken the liberty of pointing out that the legislation allowing for the deprivation of liberty and involuntary commitment to medical facilities (under the Legal Competence Act), on the one hand, and rules pertaining to the medical field concerning the use of force, on the other, must be mutually consistent. For this reason I decided to meet with the ministers of health and justice in May 2022, where I underscored the importance of their ministries working on these matters in collaboration so that any future legal reforms would be based on a sufficiently holistic and cohesive approach. I would, for instance, expect that any bill amending the Patients' Rights Act would be accompanied by a reasoned view on how the amendment would affect the relevant provisions of the Legal Competence Act. The same would naturally apply, *vice versa,* to a bill amending the Legal Competence Act.

At present, the ministerial work in question has not been concluded. Given the nature of the issues at stake here and the time that has elapsed, I nevertheless use this opportunity to highlight the need for inter-ministerial collaboration in this area, as well as the importance of conformity with respect to any future amendments.

1.6 Farewell to covid?

The ombudsman's last intervention into governmental actions taken in response to the covid pandemic was in February 2022, when I enquired as to the minister of health's assessment of the situation when, acting on a memorandum from the director of health, he restricted the size of gatherings by regulation to a maximum of 50 persons. More precisely, I asked the minister on what basis he had found these restrictions necessary as a matter of 'urgent necessity' and, at the same time, in the light of constitutionally-protected rights, whether other less drastic measures would not have been adequate. At the end of February, however, all restrictions relating to covid were lifted, which in the public mind probably constituted the end of the pandemic and a return to normal life. According to the media and official information, the virus nevertheless continued to spread among the population throughout the rest of the year, with occasional reports of people falling ill or even dying from it. In spite of this, the authorities have not seen it necessary, so far, to take any action comparable to the steps that were still considered justified in the situation in which we found ourselves in early February 2022.

I find it necessary to recall this here since in my report for 2021, I noted there was the apparent risk that, after a long-lasting situation such as that which arose during the pandemic, the authorities might increasingly tend to view the restriction of fundamental rights as something of little consequence, or even to be taken for granted – with potential long-term negative implications

for the legal protection of the public. I also noted that as the nature and real threat posed by a disease becomes better known, the authorities must live up to a higher standard with regard to preparing and assessing whether "urgent necessity" justifies the restriction of fundamental rights in the interests of public health. I also emphasised that as time goes by, it was to be expected that the authorities could take other measures with smaller impact on constitutional rights, such as vaccination programmes, the bolstering of the relevant medical facilities and actions aimed at the protection of vulnerable groups. In this connection it may be mentioned that in February 2022, i.e., when I made my inquiry described above, almost two years had passed since the virus was first reported in the country, with the bulk of the population having been fully vaccinated during the preceding year.

After covid-related restrictions were lifted at the end of February, I decided not to pursue the inquiry any further. In my closing letter I nevertheless noted that a proposal submitted to the minister by the director of health (assisted by the state epidemiologist) for certain restrictions did not alter the obligation on the minister to assess, independently and thoroughly, whether the legal conditions for taking such measures were met. This was to emphasise the fact that a ministerial decision prescribing measures to deal with a pandemic involved, under the relevant legislation and principles, not only medical questions but also other factors. It follows that the minister's obligations were in no way ended by simply receiving a proposal from the director of health (the state epidemiologist). Finally, I noted that the minister was directly responsible and accountable for the matter vis-à-vis the Althingi, whereas the director of health and the state epidemiologist were not.

In October 2022, the government issued an extensive report prepared by a committee of experts, entitled 'The Government's Crisis Management during Covid-19'. Although this was prepared at the request of, and under the auspices of, the very authorities who were responsible for the measures taken during this period, it is, in my view, a constructive input into the legal analysis of the covid saga. I nevertheless draw attention to the fact that in the report there is an explicit reservation to the effect that that the question of the legal basis of various governmental measures, and whether they conformed with the principles of proportionality, equality, etc., had not been addressed. Nevertheless, the report stated that further analysis of such questions might be appropriate.

I fully understand that many may want to forget all about covid and our predicament during the two years or so that it lasted. However, as the ombudsman, entrusted by law to safeguard citizens' rights vis-à-vis the authorities, it impossible for me to turn a blind eye to the fact that during this period, few, if any, fundamental citizens' rights were not affected. Although the covid response was made by the authorities on a statutory basis, the secondary

regulatory framework that emerged was characterised by instability, a lack of transparency and limited involvement by the Althingi. Without implying that by taking this or that action the authorities overstepped their limit, I nevertheless continue to consider it important that lessons be drawn from this period by adequate analysis and research.

1.7 Internal organisation and priorities of the office

No demographic analysis is available to characterise the individuals who submit complaints to the ombudsman or how this may have evolved over the years. On taking office in 2021, I was nevertheless somewhat surprised to see that relatively few seemed to come from certain sectors of the population, even though other sources indicated that their predicament was by no means free of problems. In this context I refer, for instance, to the affairs of persons involuntarily committed to medical facilities and the observations and recommendations the ombudsman has made in previous years on the basis of monitoring under OPCAT. After one monitoring visit to the forensic psychiatric unit at the Kleppur Psychiatric Hospital, I decided to open an inquiry into the position of patients in the security ward of the facility. My decision was also influenced by information I had received indicating that one patient had been placed there for a considerable time, a total period of 572 days (including 542 days with certain relaxations of restrictions), as turned out to be the case.

This is mentioned here to explain why the office of the ombudsman is unable to perform its general function by acting solely on complaints submitted and, thus, why it must not only have legal but also factual premises on which to take up cases on its own initiative. Indeed, I would submit that without the realistic possibility of making own-initiative inquiries, there is a risk that vulnerable groups will enjoy a lower level of legal protection as compared with those who are in a better position to submit formal complaints; the impediments may include language barriers, lack of computer skills or insufficient access to legal counsel. Hence, own-initiative cases and monitoring under OPCAT, together with responses to complaints, should be looked at as a whole in terms of the main function of the ombudsman, i.e. to ensure that the rights of the citizen are safeguarded vis-à-vis the authorities.

It is also important that the ombudsman has the power of launching own-initiative investigations since certain issues are of such nature that there may be no one who is capable of submitting a complaint, or that such complaints, if submitted, may for some reason be inadmissible for substantive review. This was, for instance, the case in several interventions by the ombudsman into governmental actions taken to tackle the covid pandemic. A further example of this is a case dating from this year concerning the lack of consultation between ministers within the cabinet and several issues relating to digital administration.

With this in view, attempts have been made to organise the office in such a way as to create room, as far as possible, for own initiative-investigations. Given the modest staff complement available, it is impossible to run a large department dealing only with these cases, which arise unpredictably and are of widely differing proportions. Therefore, this problem has been met by deploying legal staff who usually deal with complaints also on own-initiative cases. This optimizes the utilisation of available in-house knowledge and experience and also underscores the connection between the complaints and own-initiative cases noted above.

In my view the outcome of 2022 testifies that these arrangements have yielded positive results. Thus, in spite of an increase in own-initiative inquiries, we have managed to maintain due speed of procedure in dealing with complaints and even increased it slightly. In line with the intention of the Althingi in the annual budget for 2022, the OPCAT unit of the office was strengthened by the engagement of one additional staff member, making it possible to take on some new issues in that area. None of this would have been possible, however, if the ombudsman was not able to rely on staff who not only have an outstanding knowledge of the issues involved but are also truly dedicated to securing the effective functioning of the office. Although it is I who sign this report and submit it to the Althingi, I would therefore like to take this opportunity to point out the perhaps obvious fact that the work of the office is not done by one person but is at all times the outcome of a collective effort, and I take this opportunity of thanking my colleagues for good relations and a job well done.

The year in figures

2.1 Complaints

Five hundred and twenty-eight complaints were registered in 2022, 18 own-initiative inquiries were opened and six visits were made as part of OPCAT monitoring. The number of complaints submitted was slightly lower than the record of 570 received in 2021; this was balanced by a greater number of own-initiative inquiries and more OPCAT monitoring. Over the past five years the average number of complaints received each year has been 470. More complaints (528) were processed than were received during the year. Fifty-nine opinions were delivered, including 20 without recommendations to the authorities.

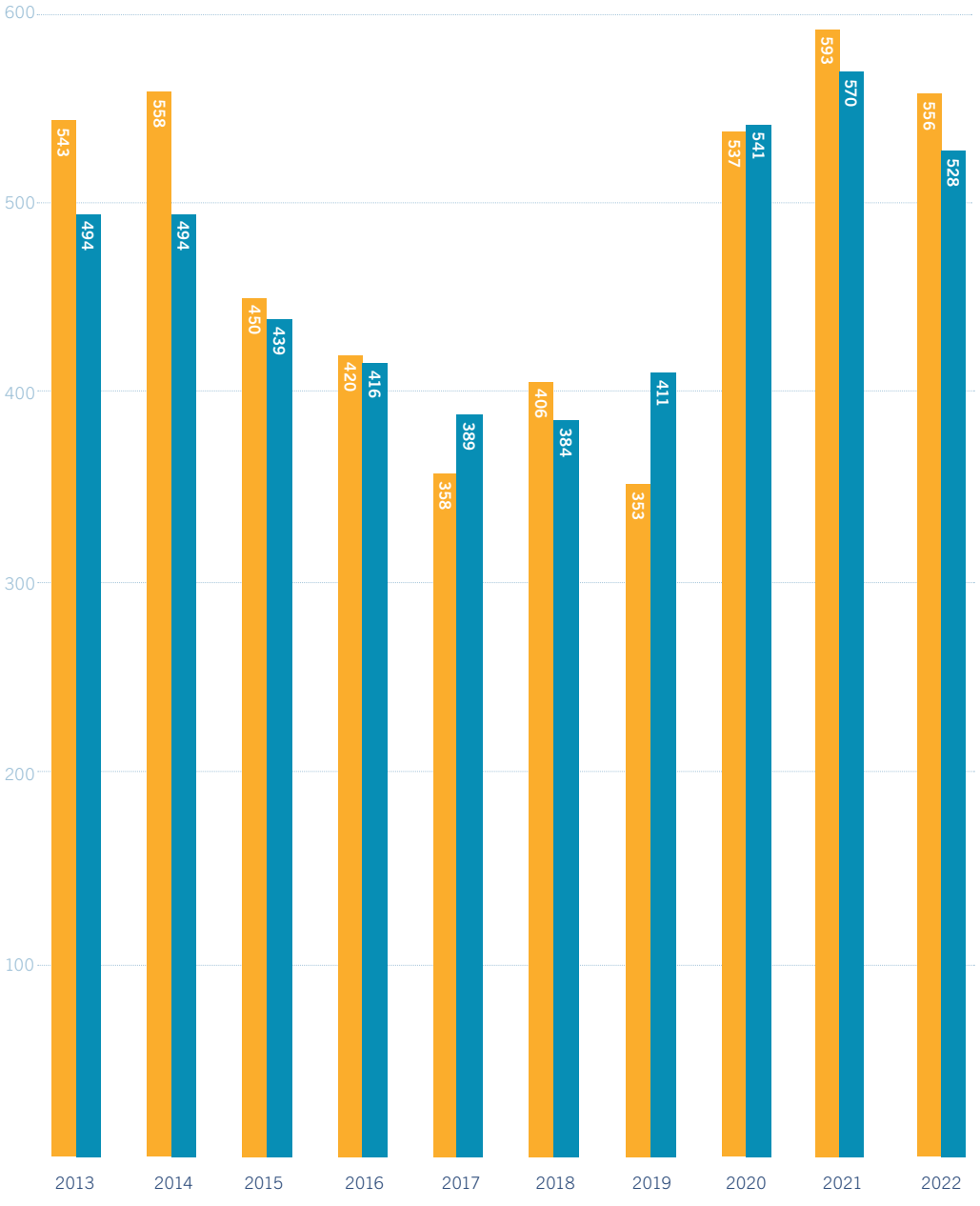
These figures cover registered cases only. In addition, a large number of informal tip-offs were received on various matters; these have been recorded by the division of the office dealing with own-initiative cases. Furthermore, many enquiries were received asking for information or guidance in connection with communications between the public and the authorities, including whether there were grounds for making formal complaints. It also happens that the authorities ask for guidance or information, without these requests being recorded in the case register.

Number of complaints registered and processed in past 10 years

Registered complaints

Processed complaints

Number of cases



Complaints monthly distribution

Case processing

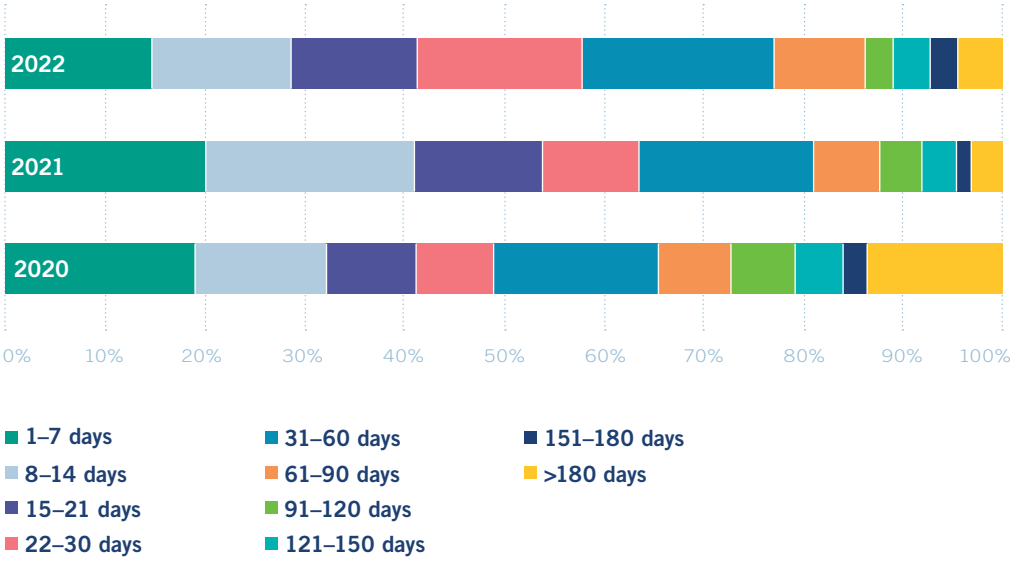
An average of 44 complaints were submitted to the office each month in 2022, by far the greatest number (more than 60 per month) during the first quarter, with the smallest number, 105, during the third quarter. There was a sharp rise in the number in December, to 49, with the lowest number, 31, received in July.

Of the 78 cases pending at the end of the year, 46 were under examination by the ombudsman, 6 were awaiting comment by the complainants and in 26 cases replies were pending from the authorities. During the year, 60% of complaints were processed within a month of submission, just under 80% within two months and almost 90% within three months.

The number of opinions delivered, 59, was the same as in the previous year.

2022	Received	Processed	Pending at EOM
Jan	62	39	129
Feb	56	72	113
Mar	59	44	128
Apr	33	55	106
May	37	51	92
Jun	54	62	84
Jul	31	4	111
Aug	35	37	109
Sep	39	50	98
Oct	37	50	85
Nov	36	51	70
Dec	49	41	78
Total	**528**	**556**	

Case processing time 2020–2022



Opinions were delivered in 61 cases, three being covered by a joint opinion. Though a third of these opinions included no recommendations to the authorities, they nevertheless contained conclusions that were of general significance or guidance value, as did other opinions delivered.

Government authorities regularly review their decisions or re-open cases following enquiries from the ombudsman. This happened in 9% of cases in 2022: reviews were made in 41 cases and nine cases were re-opened following the submission of requests for clarification in the light of complaints. This number, and proportion, was similar to what it had been the previous year.

Case outcomes

Outcomes	2022		2021	
Opinion *(incl. 20 without recommendations)*	**59**	(10,6%)	**59/27**	(10,0%)
Recommendation to take dispute to court	**15**	(2,7%)	**15**	(2,5%)
Dropped following review or explanation from authority *(incl. 41 following review and 9 following reopening)*	**72**	(13%)	**104**	(17,5%)
Outside purview of the ombudsman				
a. Functions of the Althingi, its committees or institutions	**16**	(2,9%)	**21**	(3,5%)
b. Actions by the judiciary	**8**	(1,4%)	**3**	(0,5%)
c. Private law actions	**26**	(4,7%)	**17**	(2,9%)
d. Other matters	**4**	(0,7%)	**5**	(0,8%)
Case party intends to appeal to higher authority	**113**	(20,3%)	**100**	(16,9%)
One-year deadline past (see par. 2 of Art. 6 of Act 85/1997)	**10**	(1,8%)	**10**	(1,7%)
Complaint withdrawn or found not to warrant further action	**233**	(41,9%)	**259**	(43,7%)
Total	**556**		**593**	

2.2 Own-initiative cases and OPCAT

Eighteen own-initiative investigations were launched during the year, ten of which were concluded, three of these resulting in the delivery of opinions. Four older cases were also concluded. Six cases were closed after the authorities stated that they intended to take action of various types. In cases of this type, the ombudsman continues to monitor developments and intervenes if there is a need to do so. In five cases, following explanations given by the authorities, no further action was considered necessary.

Six visits were made as part of the office's monitoring under OPCAT. Two of these were to the main prison at Litla-Hraun. Four reports were issued. Other visits were made to the prison at Kvíabryggja, the police detention facilities in the Northeastern Region in Akureyri and Siglufjörður, the psychiatric ward of the Akureyri Hospital and the security detention facilities in Akureyri. Own-initiative cases and OPCAT monitoring often involve the same matters. Examples of this have been the examination of particular aspects of how deportation orders on foreign nationals are carried out. After a request for information from the ombudsman, who had received a tip-off, the national hospital Landspítali initiated an investigation of working procedures regarding time spent out of doors by patients who are committed without their consent for psychiatric treatment in Ward 33A of the hospital.

OPCAT

Monitoring of facilities where persons deprived of their liberty reside

The Ombudsman conducted six visits in 2022 to facilities where persons are deprived of their liberty. Three visits took place in prisons: two in the prison of Litla-Hraun and one in the prison of Kvíabryggja. The Ombudsman also visited the Northeast Police Commissioner detention facilities located in Akureyri and Siglufjörður. In Akureyri the psychiatric ward of the Healthcare Institution of North Iceland and a security housing facility run by the Municipality were inspected as well.

The Ombudsman published four monitoring reports in 2022 including one following a visit from the previous year to the Acute Psychiatric Ward 32C of the National University Hospital. The other three reports were issued upon visits to Kvíabryggja, the police detention center in Akureyri and Siglufjörður and the psychiatric ward in Akureyri. With the publication of a report on the security housing in Akureyri May 2023, reports of all visits conducted in 2022 have been completed with the exception of a report on the prison of Litla-Hraun which is expected before the end of 2023. Additionally, the Ombudsman's first thematic report was published in July 2023 on the facilities and conditions of women serving sentence in Icelandic prisons.

The National University Hospital of Iceland

Acute Psychiatric Ward 32C
29–30 September 2021

The Althingi Ombudsman visited the psychiatric ward of the National University Hospital (NUH) on Hringbraut on 29 and 30 September 2021. In this instance, the Ombudsman's examination was directed at the Acute Psychiatric Ward 32C, a psychiatric intensive care unit for acutely ill patients. The examination concerned in particular the legal framework for involuntary commitment and the legal status of patients, as well as the facilities in the ward.

The Acute Psychiatric Ward 32C handles the reception, diagnosis and treatment of individuals with serious mental illnesses who because of their illness are considered dangerous to themselves, their environment or others. This is a closed ward where patients can be detained against their will, either on the basis of involuntary commitment or deprivation of legal competence under the Act on Legal Competence. Some patients also stay there at their own request, although this group of patients is in the minority. The ward has ten beds; four for women and four for men, as well as two beds for patients in recovery. During the period from the end of August 2020 to the end of August 2021, there were 322 admissions to the ward.

As a general rule, medical treatment may not be administered without the patient's consent. The commitment and treatment of patients in an acute psychiatric ward against their will is therefore a deviation from the principle of the patient's right to self-determination. No person may be deprived of his/her liberty except as authorised by law. In this connection, the Ombudsman makes, among other things, a recommendation to NUH to ensure that it is clear to staff and patients on what legal basis patients are admitted and that procedures and information provision to patients who are admitted voluntarily to the ward take into account their legal status. Furthermore, that restrictions on fundamental rights are relevant and do not exceed what is necessary. Recommendations and suggestions are also addressed to the Minister of Justice, concerning the clarity of the legal authority for treatment of persons deprived of legal competence in mental health institutions and the possibility for persons deprived of their liberty to have a decision on their commitment in a psychiatric ward reviewed.

The report also recommends that the Minister of Justice examine the substantive requirements of the Act on Legal Competence for involuntary commitment and assess whether there is a need to have the Act state more clearly that involuntary commitment on the grounds of mental health problems is unauthorised unless a mental illness calls for such deprivation of liberty and other less severe remedies are out of the question, such as when persons present a danger to themselves or when their lives or health would otherwise be endangered. Recommendations are also made to NUH to ensure that involuntary commitment cases follow appropriate legal channels. Suggestions and recommendations are also made to the Minister of Justice in connection with the involvement of a consultant physician in the District Commissioners' decisions on involuntary commitment, including the setting of rules in this regard.

The Act on Legal Competence states that the Minister of Health may set further rules on providing information on the legal status of a person in involuntary commitment; however, such rules have not been set. Given disclosures on certain flaws in information provision to patients in this respect,

the Ombudsman directs the suggestion to the Minister of Health to consider whether there is cause to set further rules on providing information on the legal status of persons in involuntary commitment, in accordance with the legal authorisation to this effect.

Under the Act on Legal Competence, a person in involuntary commitment has the right to enjoy the advice and support of a special counsellor in connection with the hospital stay and treatment there. With reference to previous suggestions in this regard, as well as information that emerged during the examination that in some cases knowledge of the counsellor's role was lacking, the Ombudsman recommends that the Minister of Justice set rules on counsellors of those committed involuntarily. The ombudsman also directs recommendations and suggestions to the hospital on procedures and information disclosure in connection with the counsellors' role. A suggestion is also made to the Minister of Justice concerning the poorer legal status of persons deprived of their legal competence in this respect. The recommendation is made that the Minister of Health issue a regulation on advice and support following involuntary commitment, to accord with the statutory obligation to this effect.

The report suggests the Minister of Justice consider whether there is cause to re-examine rules on appeals to the courts concerning 72-hour and 21-day involuntary commitment, with the aim of giving a person committed involuntarily a more realistic possibility of obtaining a substantive review of the decision. A suggestion is also made to NUH regarding the provision of information to staff on the role of lawyers and their access to their clients.

A legal decision on deprivation of liberty does not automatically result in restricting other fundamental rights, such as the right to respect for private life. Any restriction on the right to private life must be based, among other things, on statutory authority and the requirement of necessity. As previously stated in the Ombudsman's report regarding the visit to three closed psychiatric wards at Kleppur psychiatric department, there is no clear legal authority under Icelandic law to apply various types of interventions, coercion and the use of force on patients in mental health institutions. In this connection, the Ombudsman reiterates previous recommendations and suggestions to the Minister of Health and Minister of Justice to ensure that such measures are defined and an appropriate statutory framework provided, if it is the will of the government and the parliament to have such measures that require special legal authority used on patients in closed psychiatric wards.

As a state institution, the National University Hospital is a government authority in the legal sense. With regard thereto, previous recommendations to the hospital are reiterated regarding the need to analyse which of its decisions comprise administrative decisions. Certain perspectives also need to be considered when deciding when measures used on patients are, on the one

hand, treatment measures and, on the other hand, safety measures or other measures. Furthermore, the hospital must obtain patients' consent for interventions as treatment; if consent is not available, a formal decision must be made on compulsory treatment, taking care to ensure that both the relevant documenting and procedure comply with law. When a measure involves a decision on a patient's right or obligation, in the meaning of the Administrative Procedures Act, the rules of administrative law on procedure and legal certainty must be observed and care taken to ensure that the case file demonstrates this.

The report recommends that NUH apply a procedure for follow-up on patients after the use of force, insofar as possible, and review ward rules and the implementation of interventions towards patients, with regard to assessment of their necessity in each individual's case. Various recommendations and suggestions are also directed to the hospital in connection with other interventions, such as restrictions on outdoor activities, phone access, hospital clothing and the involvement of police in transport and overpowering of patients.

The premises of the acute psychiatric ward were renovated in 2013 and the facilities there are generally good and neat. The report does, however, set out various recommendations and suggestions in this regard, including in connection with windows, outdoor facilities, ventilation, tableware, activity and visiting rooms and certain safety issues in the environment of patients and staff. The hospital is also advised to assess whether the activities and leisure available to patients give adequate consideration to their needs and seek ways to improve these, especially with regard to persons who remain in the ward for longer periods.

There was no indication otherwise than that the work atmosphere on the acute psychiatric ward was generally good. The visit did reveal, however, a shortage of professionally trained staff and some staff turnover among general employees. In this connection, it is pointed out that high staff turnover and associated inexperience among staff, as well as understaffing, can affect patient care and increase the likelihood of coercion being applied.

International supervisory bodies have emphasised the importance of having effective procedures for complaints and appeals in preventing degrading treatment in mental health institutions. In this connection, it is recommended that NUH review its current rules and procedures on the ward so that patients, and as the case may be their families, receive information about routes for complaints and appeals within and outside the hospital in an easy-to-understand format. Provision of information to staff about patients' routes for complaints and appeals and the procedures concerning them also needs to be improved.

The Patients' Rights Act provides, among other things, for patients to be informed of significant rules and practices that apply at the institution. In this

context, it is recommended that NUH see to it that ward rules are generally made known to patients in the acute psychiatric ward, in a language they understand, both in writing and orally. The hospital is therefore asked to follow up on plans to prepare a booklet to hand out to patients explaining, among other things, the ward's activities, the rights of persons admitted there and ways to have decisions reviewed.

Satisfactory record-keeping in connection with deprivation of liberty is a basic aspect of protection against ill treatment and a premise for persons deprived of liberty to seek to enforce their rights. In this connection, a recommendation is made to NUH to have follow-up procedures involving staff and patients after the use of force properly recorded. The hospital is also advised to take into consideration other perspectives on record-keeping that appear in the report in the review of the ward's documentation system currently underway.

It was pointed out during the Ombudsman's visit that a lack of appropriate accommodation could lead to patients remaining on the acute ward for longer than necessary. There are lengthy waiting lists for long-term places in psychiatric wards and a lack of accommodation for patients after hospitalisation. In this connection, the suggestion is made that NUH and the Minister of Health seek ways to shorten waiting lists of long-term psychiatric wards so that the deprivation of liberty of patients is not more onerous than necessary at any given time. The report also reiterates previous recommendations and suggestions to the Minister of Social Affairs, made in the Ombudsman's report on the visit to three closed wards at Kleppur, to consult with municipalities on how to make patients' deprivation of liberty no more lengthy and burdensome than treatment providers consider necessary.

The Ombudsman will continue to monitor the development of these issues, and requests that the National University Hospital and other authorities to whom these recommendations or suggestions are directed provide an account of actions taken in response to the report by 15 September 2022.

Contents of the report
The National University Hospital of Iceland

The Northeast Iceland Commissioner of Police

Police Cells
23 and 25 May 2022

The Althingi Ombudsman visited the police cells of the Northeast Iceland Commissioner of Police in the towns of Akureyri and Siglufjörður on 23 and 25 May 2022. The Ombudsman's examination focused on the detention of individuals in police cells, the facilities there and the general procedures and practices of the police in connection with the detention. In this instance, the Ombudsman did not announce the exact arrival time in advance.

The main station of the Northeast Iceland Commissioner of Police is on Þórunnarstræti in Akureyri, with four additional police stations located outside of Akureyri, i.e. in Húsavík, Siglufjörður, Dalvík and Þórshöfn. Persons arrested in the Police Commissioner's district are usually held at the police station in Akureyri, and there are also examples of remand prisoners being held there while they await transfer to Hólmsheiði Prison. During the 12-month period preceding the visit, 480 persons were arrested in the district, 299 of whom were held in police cells.

The Ombudsman has emphasised that an individual assessment must be made of the necessity of individual decisions that comprise an interference with the right to respect for private life. The report refers, among other things, to the use of video surveillance in the police cells of the police station in Akureyri, which is general practice and always takes place upon the detention of arrested persons. In this regard, the recommendation is addressed to the Northeast Iceland Commissioner of Police that the implementation of video surveillance be reviewed, so that an assessment is made in each case as to whether there is a reason to subject an arrested person or remand prisoner to continuous video surveillance. At the same time, its use raises questions about whether the procedure for using video surveillance needs to be clarified, and the suggestion that this be considered is directed to the National Commissioner of Police. The recommendation is also addressed to the Northeast Iceland Commissioner of Police that inmates in police cells be adequately informed about video surveillance, for example, with notices inside the cells.

The facilities in the Commissioner's police cells are generally adequate for detentions that do not last more than 24 hours. In this regard, however, various recommendations and suggestions are made to the Northeast Iceland Commissioner of Police, among other things, concerning access to a clock, lighting in cells, the location of a bell and sanitary facilities. The report also describes the conditions in the police cells in Siglufjörður, where detainees are kept only in exceptional cases and then only for a brief period.

The criteria of the European Committee for the Prevention of Torture (CPT) point out that holding children as well as young people in traditional police cells should be avoided. In Akureyri, six young people under the age of 18 were held in police cells during the 12-month period in question. In this regard, it should be noted that no child protection facility, such as Stuðlar emergency detention, is operated in the Police Commissioner's district. The Ombudsman's visit revealed that efforts were being made to keep young people in special cells, which do not have the same highsecurity appearance as other cells; however, records showed that in three of the six cases, young people were kept in traditional police cells. The report recommends to the Commissioner of Police that the procedure for detaining children take into account the special considerations that apply to them, including which cells should be used for their detention.

The suggestion is also addressed to the Northeast Iceland Commissioner of Police and the Minister of Justice that they consider whether facilities at the police station are considered adequate with regard to the special considerations that apply to the detention of children. The recommendation is also made that the Police Commissioner have a special information sheet prepared for children who are detained in police cells, as appropriate with the assistance of the National Commissioner of Police and the Ministry of Justice.

Remand prisoners are generally held in Hólmsheiði Prison, but may be detained for a short time in police cells, if circumstances permit. Since the closure of the prison in Akureyri there is no remand detention facility in the district of the Northeast Iceland Commissioner of Police. Prisoners who have been placed in remand custody must therefore be transferred to Hólmsheiði Prison. The Ombudsman's visit found examples of remand prisoners being kept in police cells in Akureyri when there were delays in their transport to the prison.

Following the visit, more information was requested from the Commissioner of Police, including on the length and number of remand detentions in police cells since the prison was closed. The police replies revealed that remand prisoners were generally not kept in police cells and in such cases only for a few hours at a time, and that more detailed information on the number and duration of remand detentions could be obtained from the Prison and Probation Administration. According to the information requested from the Prison and Probation Administration, there were examples of remand prisoners being held at the police station in Akureyri for up to three days. In the comments on the final draft of the report, more detailed information was received from the Commissioner of Police on remand detentions in police cells, which also included examples of detention of remand prisoners of up to 72 hours in police cells. Information from the Prison and Probation Administration and the police does not completely match in this respect, but according to the police's explanations, this may be due to the fact that the reference periods differ, as well as the fact that the institutions interpret the data in different ways. In light of this, the Ombudsman points out in the report that the available information and data, as well as the lack of this, indicate that records on detention of remand prisoners at the police station are inadequate.

Due to the fact that detailed information was not received from the police in the first instance about the detention of remand prisoners in police cells, the report refers to the role of the Ombudsman when it comes to OPCAT inspections and draws attention to the importance of receiving adequate information. In this regard, it is pointed out that satisfactory provision of information by the authorities is a prerequisite for the Ombudsman to be able to carry out the supervisory role provided for by law, based on the Optional Protocol to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

Satisfactory record keeping in connection with the deprivation of liberty of persons is an important aspect in clarifying their conditions and whether they have enjoyed the basic rights that should be guaranteed to them. Such records are also a prerequisite for persons deprived of their liberty to be able exercise their rights, including the right to complain and appeal. The visit revealed that recording by the police of information on detentions was made using a word processing program and not the police records system (LÖKE) and thus was not in accordance with the operating procedures of the Commissioner of Police. From the responses of the police and the Prison and Probation Administration, the only conclusion was that uncertainty prevailed as to who was responsible for recording information on detainees held in police cells while awaiting transfer. The recommendation was therefore made that the Minister of Justice clarify responsibility for the detention of remand prisoners and the related registration.

It can be concluded from the available data and information from the police and the Prison and Probation Administration that the procedure is unclear regarding the actions and collaboration of institutions when an arrested person is remanded and transferred to prison. This could result in a remand prisoner being detained for longer in a police station than is necessary and the recommendation is therefore addressed to the Commissioner of Police and the Prison and Probation Administration, as appropriate with the involvement of the Minister of Justice, that they clarify the responsibilities and procedures for detention and transport of remand prisoners.

The CPT has objected to remand prisoners being held in police cells, in part because the facilities there are generally not designed to hold persons deprived of their liberty for more than 24 hours. In the police cells in Akureyri, detainees have no outdoor access, for instance, and are isolated for the most part during their detention. Statutory provisions authorising the short-term detention of remand prisoners in police cells appear to be conditional upon the detainee having access to minimal facilities. With this in mind, the Ombudsman directs the Prison and Probation Administration and the Northeast Iceland Commissioner of Police to improve the procedure for the detention of remand prisoners to ensure they are transported without delay to an appropriate prison facility. It is also pointed out to these same parties, together with the National Commissioner of Police and the Minister of Justice, that facilities in police cells in general do not meet the requirements for the detention of remand prisoners.

The report focuses on the training and education of police officers, given that a good number of substitute police officers perform general law enforcement in the district. In this regard, the recommendation is made to the Northeast Iceland Commissioner of Police, as appropriate, in cooperation with the National Commissioner of Police and the Minister of Justice, that it is necessary to review and, as appropriate, increase training and education of

substitutes. This will ensure that they have knowledge of human rights standards and legislation, as well as methods for the use of force and first aid, not least in light of the obligations incumbent upon the police when detaining arrested persons.

The right to healthcare has been considered a fundamental element of the protection of people in police custody. In that regard, the recommendation is made to the Commissioner of Police that information about the right to have a doctor called in is communicated adequately and that an individual assessment is made of the presence of police in medical consultations.

In parallel with the visit to the police cells of the Northeast Iceland Commissioner of Police, the Ombudsman also visited the Psychiatric Ward of Akureyri Hospital. In both visits, it was noted that there was a certain lack of remedies concerning the detention of persons who end up in the hands of the police due to a mental condition, in some cases due to the effects of substance abuse. For this reason, the report refers to discussion in the Ombudsman's annual report of the need for increased co-operation between the criminal justice, prison and healthcare systems so that individuals in this situation receive the healthcare services they are entitled to by law. In light of this, recommendations are made to the police to strengthen co-operation with the Psychiatric Ward of Akureyri Hospital and also to follow up on plans for adopting procedures in relation to statutory tasks in the field of law enforcement and healthcare services involving both institutions. The suggestion was also made that the Commissioner of Police take advantage of the updated registration options in LÖKE for incidents such as self-harming behaviour in police cells, and ensure that recording of such is adequate.

The authorities may be obliged to take the initiative in providing information to citizens, including information on avenues for complaints in the public administration system. In this regard, the recommendation is made that the Commissioner of Police ensure that information on complaint and appeal routes is presented systematically to arrested persons in police cells and that staff are informed of how these rights should be ensured. The registration in detention reports was generally good, with the exception of the records which were lacking concerning the detention of remand prisoners; however, there were a few instances where longer periods elapsed between recorded monitoring than is prescribed by the operating procedures. Therefore, the recommendation was addressed to the Northeast Iceland Commissioner of Police to ensure the accuracy of records on when an arrested person is attended to.

The Ombudsman will continue to monitor the development of these issues, but requests that the Northeast Iceland Commissioner of Police and other authorities to whom recommendations or suggestions are directed, report on their responses to the report by 1 July 2023.

Contents of the report
The Northeast Iceland Commissioner of Police

Psychiatric Ward of Akureyri Hospital

Inpatient Unit
May 2022

The Althingi Ombudsman visited the Psychiatric Ward of Akureyri Hospital for the purpose of OPCAT monitoring on 24 May 2022. The Ombudsman's inspection focused on the Inpatient Unit of the Psychiatric Ward, where some patients may be held against their will. In this instance, the Ombudsman did not announce the exact arrival time in advance.

The Psychiatric Ward of Akureyri Hospital is the only specialised psychiatric ward outside the capital area. The Inpatient Unit of the hospital's Psychiatric Ward provides both 24-hour and outpatient services. The main function of the unit is to ensure the safety of people in acute mental distress and to provide appropriate care and nursing. However, various types of therapeutic work are also carried out there. In 2021, 197 persons were admitted to the Inpatient Unit in a total of 273 instances, most of them staying in the unit for 2-5 days. The vast majority of patients are admitted on their own volition, but those who dwell there against their will are either kept there on the basis of involuntary commitment or deprivation of legal competence under the Act on Legal Competence. In 2021, only one patient, or about 0.6% of those hospitalised, was involuntarily committed. During the 26-year period 1996-2021, there were 164 involuntary commitments to the ward, representing 0.6% to 5.6% of those admitted per year.

For OPCAT inspections, it may be necessary to examine the legal basis on which individuals have been deprived of their liberty and which specific legal framework applies to their detention. The operations of the Psychiatric Ward of Akureyri Hospital are part of public health and hospital services, and are subject to various laws and regulations providing for these services. The Act on Legal Competence accords a person committed involuntarily the right to receive advice and support from a counsellor of persons involuntarily committed. The doctor or nurse on duty must notify the counsellor of the involuntary commitment as soon as possible. In this regard, the Ombudsman recommends that the Hospital ensure that the notification to the counsellor is always made as soon as possible, and that staff are provided with adequate education about the role of the counsellor. The Hospital is directed to provide patients committed involuntarily with adequate information about their right to advice and support in a clear and accessible manner and in a language that the person understands. Furthermore, it must ensure that the implementation of involuntary commitment accords with the provisions and purpose of the Act on Legal Competence, to ensure that such cases are put through the correct legal channels. In this regard, attention is drawn to the fact that the Act on Legal Competence provides for certain steps in connection with involuntary commitment, with the procedure becoming more extensive with each step to ensure the legal security of the person committed involuntarily.

In a previous report on a visit to three closed psychiatric wards at the hospital Kleppur, part of the National University Hospital, the Ombudsman made recommendations and suggestions to the authorities concerning the lack of a clear legal framework for the use of force, coercion and other interventions impinging on the rights of patients in psychiatric wards. These recommendations and suggestions were reiterated in the report on the visit to the Acute Psychiatric Ward on Hringbraut. In light of the fact that the issues

are being acted on through certain channels in the Ministry of Health, these recommendations are not repeated specifically in this report. Despite the fact that, as indicated above, a clear legal basis may be lacking for the specific criteria followed by the Inpatient Unit of Akureyri Hospital concerning interventions, coercion and the use of force in the Unit, nothing was found during the visit to indicate that patients are subjected to inhuman or degrading treatment in the Unit. On the contrary, it could generally be concluded from the visit that the administrators and staff of the Unit respect patients and seek their consent and co-operation. The report does emphasise, however, that this does not alter the Ombudsman's previous conclusion that the uncertainty concerning the legal authorisations of staff in this respect is unacceptable.

The report addresses the recommendation to Akureyri Hospital, as appropriate in consultation with the National University Hospital, the Directorate of Health and the Ministry of Health, that it analyse which decisions within the Hospital comprise administrative decisions that are subject to the rules of the Administrative Procedures Act. In this regard, special consideration must be given to decisions involving more than the specifics of the treatment of the patient in question and any kind of interference in privacy, coercion or the use of force. The Hospital is also directed, as appropriate in consultation with the same parties, to analyse what measures comprise treatment measures, on the one hand, and security measures or other measures, on the other.

The Psychiatric Ward of Akureyri Hospital has no special security team, specially trained to respond to and take defensive action against violence, as in the psychiatric wards of the National University Hospital. If difficult incidents occur or when it is evident that a patient needs coercion, such as during medication administration or transportation, assistance is requested from the police or a security company responsible for specific security-related tasks under a contract with the Hospital. In this context, and in accordance with comments from other supervisory bodies, the recommendation is addressed to Akureyri Hospital to stop the practice of involving security guards, who have not received the required training, in the subduing of patients, and to review its procedures with intention of limiting as much as possible the involvement of the police in subduing patients and transferring them between institutions.

A doctor may prescribe that patients considered a danger to themselves and/or others be placed in a secure area of the Inpatient Unit. In this regard, the recommendation is made that Akureyri Hospital establish a proper channel for decisions on detention in a secure area, in accordance with the Administrative Procedures Act, so that it is formal and registered and the patient informed about complaint and appeal channels. The recommendation is also made that Akureyri Hospital seek ways to ensure access to outdoor

exercise for all patients on a daily basis, to the extent possible, and to ensure that debrief of patients following the use of force is recorded. The suggestion is also made that the Hospital consider whether there is reason to review its record keeping, as appropriate in consultation with the National University Hospital, to ensure that statistics on the use of force and other serious incidents in the Inpatient Unit can be easily retrieved. Finally, the recommendation is made that Akureyri Hospital ensure that patients deprived of their liberty are informed that they can request a physical examination, for example following the use of force or violent incidents, including with regard to alleged injuries or accusations thereof, and that records indicate this has been taken care of.

The Inpatient Unit of the Psychiatric Ward of Akureyri Hospital was formally opened in March 1986 in its current premises, which were intended to be temporary. The facilities and environment of the Unit are generally neat and clean. An assessment by the Directorate of Health discussed in the report states that the Unit is still in temporary facilities, which reflect their age and do not meet today's requirements. The report therefore presents various recommendations and suggestions in this regard. Among other things, it recommends that the Minister of Health examine and assess whether the building that currently houses the Inpatient Unit satisfies the requirements made for its activities and scope. The recommendation is directed to Akureyri Hospital that it examine whether an outdoor activity area could be provided for the Unit, in particular in consideration of patients who are not trusted to leave the Unit. Suggestions are also directed to the Hospital concerning securities issues in sanitary facilities in the secure area and the lack of a visiting space or other space where patients can deal with personal affairs in privacy, in particular in the case of patients sharing rooms.

Patient participation in daily activities is part of their rehabilitation. It was revealed during the Ombudsman's visit that occupational therapy for inpatients takes place in the Outpatient Unit. This means that patients committed involuntarily, who are not trusted to leave the Unit, do not have access to occupational therapy. Furthermore, the patients placed in the secure area naturally have no access to group work in the Inpatient Unit or occupational therapy in the Outpatient Unit. In that regard, the recommendation is addressed to Akureyri Hospital to seek ways to ensure that patients who are not allowed to leave the Unit have appropriate activity and rehabilitation, as far as possible given their condition, including patients staying in the secure area.

During the Ombudsman's visit, it was noted especially that the vast majority of the staff in the Inpatient Unit are healthcare professionals. It also attracted the special attention of the Ombudsman and staff that the administrators and staff of the Inpatient Unit appear to be making every effort to limit any kind of intervention and coercion towards patients in the Unit. In this regard, however, recommendations are directed to Akureyri Hospital

in connection with self-defence courses attended by staff, in light of the special considerations that apply to physical subduing of patients with mental disabilities.

Patient access to effective complaint and appeal channels is a significant factor in preventing inhuman or degrading treatment in mental health institutions. In this regard, the recommendation is made that Akureyri Hospital review its current procedure in the Inpatient Unit for providing information to patients and their relatives to ensure that they are informed about complaint and appeal procedures, both inside and outside the hospital, in an easy-tounderstand format and in a language they understand. Information provision to staff of the Unit also needs to be improved, and education provided on patients' complaint and appeal routes inside and outside the hospital, including what procedures apply when such complaints and appeals are made and in which channels they should be placed. Furthermore, on their role in guiding patients and, as the case may be, their relatives in this regard.

Finally, the report draws attention to a specific problem on the borderline between law enforcement and the healthcare system, of which the Ombudsman has become aware, in the case of individuals whom the police need to deal with but who are struggling with mental health problems, sometimes related to drug abuse. These cases do not always concern persons suspected of a criminal act, as they may either be in some situation where the police feel they need to intervene or where the persons themselves contact the police. It can be concluded from information obtained by the Ombudsman on a visit to the Northeast Iceland Commissioner of Police, that the police do not feel that these persons belong in police cells and in fact their placement there may threaten their health and well-being. Furthermore, that in Akureyri there is a lack of social remedies for individuals struggling with drug addiction. Suggestions of the administrators of the Psychiatric Ward of Akureyri Hospital on these matters point out that even though it is not considered appropriate to keep these persons in police cells, they do not necessarily belong in healthcare institutions. Thus, special measures may need to be established, such as through the co-operation of different services. The report emphasises that it is not up to the Ombudsman to decide how to solve the above-mentioned problem, but that it is unacceptable that persons in police custody who are visibly in need of healthcare or other services are staying in police cells and do not receive appropriate treatment. In this regard, there is a need for consultation and co-operation between institutions and ministries responsible for law enforcement and healthcare and possibly, as the case may be, social affairs.

The Ombudsman will continue to monitor the development of these issues, but requests that Akureyri Hospital and other authorities to whom recommendations or suggestions are directed, report on their responses to the report by 1 July 2023.

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Security Housing in Akureyri

25 May 2022

The Althingi Ombudsman visited a security housing in Akureyri on 25 May 2022. This was the first visit by the Ombudsman to security housing, although in 2018 the Ombudsman visited the forensic psychiatric ward of the National University Hospital at Kleppur, where individuals can also be placed on the basis of a sentence. In the security housing in Akureyri, there are [...] persons who have been sentenced to security detention based on Article 62 of the General Penal Code. Because of their situation, the legislation on disabled persons also applies to them.

The security housing is operated on the basis of a service contract between the Ministry of Social Affairs and Labour and the Municipality of Akureyri. The contract is concluded retroactively for one year at a time. For that reason, the Minister of Social Affairs and Labour and the Welfare Department of the Municipality of Akureyri are instructed to make sure that there is a valid service contract in force for the operations at all times.

In Iceland, no comprehensive legislation has been enacted on the implementation of security detention. The report points out that the lack of a legal framework has led to various problems that are reflected, among other things, in the fact that it is not fully clear how responsibility is divided between the enforcement authorities and the authorities of health and social affairs when it comes to various decisions on the implementation of sentences for security detention. Furthermore, it varies what legislation applies to persons who have been sentenced to security detention. As a result, different rules may apply to those in detention depending on whether the facility operates on the basis of a contract with local authorities or whether the person in question is held within the health care system, e.g. in a forensic psychiatric department. Some individuals are also covered by legislation on disabled persons while others are not, and this difference may affect the implementation of placement and details of the legal protection of the person in question. As a result, it is not clear either what authority is ultimately responsible for administration and supervision in each instance.

The Minister of Social Affairs and Labour has presented a draft bill for an Act on the implementation of security measures and secure placement. According to the revised parliamentary agenda, the Minister plans to present the bill in the current legislative session. The report urges the Minister to follow through on these plans, including clarifying which authority is responsible for the enforcement of judgments under Article 62 of the General Penal Code and for deciding on the detailed arrangements for detention.

The Act on the Protection of the Rights of Disabled Persons provides for a general prohibition of telemonitoring and the use of compulsion in dealing with disabled persons. The Act allows a service provider to apply for an exemption from the ban to an exemptions committee. In certain emergency cases, compulsion may be authorised without the committee's decision; however, the service provider must then send a description of the incident to a specialist team within a week of the compulsion being applied. The exemptions committee has not accepted applications from the facility for processing; however, during the visit it was revealed that new conditions have given rise to a new application. It was also revealed that no incident descriptions had been sent to the specialist team which operates under the Act. Therefore, the Ombudsman recommends to the Welfare Department of the Municipality of Akureyri that it follow through on its plans to send an application to the exemptions committee and also to send incident descriptions to the team.

There do not appear to be any authorisations for the use of force or intervention in the personal privacy of the sentenced persons except based on an exemption or rules on emergency defence measures and emergency actions. Therefore, the Ombudsman directs the Minister of Social Affairs and Labour to follow through on the plans to present a bill that meets the requirements for a legal grounding under the Constitution and human rights conventions regarding the compulsion that is considered necessary to authorise for security detention.

During the ombudsman's visit, it was revealed that the sentenced persons could be given sedatives, as the case may be, with forced administration of medication. However, such cases were very rare, and nothing during the visit gave reason to believe that the practice of such medication would be cause for censure. The Ombudsman did note, however, that the procedure did not provide for the involvement of a healthcare professional in the administration of the medicine in each individual case, nor for monitoring following it. In consideration of this, the recommendation is addressed to the Welfare Department that it review the procedure for forced administration of medication.

There is constant video surveillance in the common areas of the sentence persons' apartments, and their apartments are subject to audio surveillance for part of the day. In view of personal privacy considerations, the recommendation is addressed to the Welfare Department of the Municipality of Akureyri that it examine the implementation of video surveillance in the security housing on an individual basis. The Welfare Department is also instructed to keep a record of the telemonitoring in accordance with the provisions of the Act on the Protection of the Rights of Disabled Persons.

The sentenced persons' opportunities to communicate with the outside world are in some cases limited, for example, by their restricted access to their mobile phones. During the visit, it was learned that there were examples of this being done at the request of relatives [...]. The Ombudsman points out that during visits to psychiatric departments, such practices have raised questions regarding the requirement of necessity and proportionality. It should be kept in mind here that relatives themselves have the option of limiting calls, for example, through the settings on their phones. Therefore, the recommendation is addressed to the Welfare Department of the Municipality of Akureyri that it review the practice of restricting the sentenced persons' access to their phones in this way.

The Ombudsman noted that [...] of the [...] sentenced persons moved from their home district at the beginning of their placement in the security housing. The report points out that this raises questions about a person's right to live in contact with family and, as the case may be, friends. The suggestion is therefore made to the Minister of Social Affairs and Labour to consider whether the right of the sentenced persons to enjoy living in contact with family and friends, in cases where they are detained far from their home district, is adequately guaranteed.

Residents can generally get outdoor exercise accompanied by staff. [...] The suggestion was addressed to the Welfare Department to seek ways to provide all the sentenced persons with access to suitable outdoor exercise on a daily basis. According to recent information from the Department, the person is now given the opportunity for outdoor activity outside the town limits every day.

The ombudsman raises objections to the arrangement whereby the employees or managers of the facility are in charge of the personal finances of the sentenced persons. Although there was no indication during the visit

that any contentious issues related to this had arisen, such an arrangement can easily lead to conflicts of interest and endanger the independence and neutrality of the employee in question. For that reason, the Welfare Department is instructed to consider whether another arrangement for the management of funds is more desirable, e.g. based on the provisions of the Act on Legal Competence concerning so-called administrators.

The recommendation is made to the Welfare Department that it review procedures for the use of force with the aim of ensuring adequate information is provided about appeal and complaint channels and that issues related to the examining of incidents are adequately recorded, such as whether debriefing has taken place and whether the person concerned has been instructed on complaint channels.

Organised and continuous activities are not offered in the facility. Consideration must be given to the fact that residents live in a closed facility and have limited opportunities to choose a suitable pursuit. For that reason, the suggestion is made to the Welfare Department of the Municipality of Akureyri that it continue looking for ways to ensure that access to daily activities, such as work, school and leisure, is adequate for all sentenced persons staying in the facility.

All the sentenced persons have a service plan that sets out short-term and long-term objectives. According to specifications, the service plan is to be drafted in consultation with the user. Two service plans were not signed by the users, so it is difficult to see whether the person had been involved or accepted them. Therefore, the suggestion is made that the Welfare Department ensure that it is evident from the service plans that the sentenced persons were involved in making them and that they sign them.

The recommendation is addressed to the Welfare Department of the Municipality of Akureyri that it continue seeking ways to ensure that staff training in response and defence measures against violence is appropriate and takes sufficient account of the situation of the sentenced persons of the facility. There were conflicting reports as to whether summer replacement staff always had the opportunity to attend courses before they began work. Therefore, the suggestion is addressed to the Welfare Department that it ensure that the training of replacement staff is carried out in accordance with specifications, so that they always receive adequate training before starting work.

The report emphasises the importance of clear and efficient channels for complaints and appeals, not least in view of the vulnerable position of the sentenced persons. It points out that it can be difficult for them to find out where to go within the administration to present complaints or appeal individual decisions concerning the implementation of their detention. Although complaint and appeal channels exist, it is questionable whether they are a viable option for the persons in question when their framework is as complex as that discussed in the report. Since a draft of comprehensive legislation on

security measures and secure placement exists, which will be considered by the Althingi in the coming months, it is considered sufficient to direct the suggestion to the Minister of Social Affairs and Labour to keep these points of view in mind in the further processing of the bill.

The Ombudsman also directs the Welfare Department of the Municipality of Akureyri to analyse which decisions are considered administrative decisions and what complaint and appeal channels are available to the sentenced persons. A clear procedure for recording and handling comments and complaints must be established in order to ensure that they are processed in the manner that their presentation calls for and that appropriate instructions are provided.

At the meeting at the beginning of the detention, complaint and appeal channels are not explained specifically. Therefore, the Ombudsman directs the recommendation to the Welfare Department that it ensure that the sentenced persons and their relatives receive adequate information about complaint and appeal channels at the beginning of detention and regularly during detention, if deemed necessary. To that end, it is essential that staff are aware of the sentenced persons' rights in this respect and can thus provide instructions on them.

Security detention is indefinite and ends only by order of a judge. The supervisor appointed for the sentenced person is to monitor that their stay will not be longer than necessary; furthermore, the Minister can seek a ruling from a District Court in this regard if certain conditions are met.

A re-evaluation of the indefinite detention of a sentenced person in the security housing is generally carried out every five years; however, there are examples where a longer period has elapsed. During the visit, it was revealed that the need for re-evaluation depended on the individual and the sentenced persons could meet the conditions for relaxation of or release from security detention before re-evaluation. From the sentenced persons' supervisors it was learned, among other things, that their work lacked a framework, they had difficulty understanding their role and duties and believed that it was likely that understanding of the role varied among supervisors. The Ombudsman's report on a visit to the forensic psychiatric ward at Kleppur made various recommendations regarding the reassessment and the work of supervisors. With reference to the plans of the Minister of Social Affairs and Labour to present a bill in the coming months, which includes mention of the appointment, role and supervision of the work of supervisors, the Ombudsman does not see reason to direct recommendations to the Minister in this instance. On the other hand, it should be noted that the office will continue to follow these developments.

The Ombudsman will continue to monitor the development of these issues, but requests that the Minister of Social Affairs and Labour and the Municipality of Akureyri give an account of their responses to the report by 1 December 2023. The report is also sent to the Ministry of Justice for information purposes.

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Organisational chart