



Annual Report 2015

Annual review of the Dutch National Preventive Mechanism

Table of contents

	Introduction	3
1	Context	4
	The Dutch National Preventive Mechanism	4
	Activities in 2015	5
	Reinforcement of the NPM	6
2	Supervision and Advice Themes	8
	Reorganisation of the Detention Centres	8
	Reducing the use of physical restraints and seclusion in the Healthcare System	9
	Intimate Searches of Youths in Juvenile Detention Centres	9
	Authorisation of the use of (physical) restraints and seclusion in Youth Assistance Services	9
	Appendices	
I	Member and Associate Profiles Matrix	10
II	Supervisory activities	12
III	Advisory Activities	24
IV	Abbreviations	29



Introduction

This annual report details the activities of the members and the additional associates within the Dutch National Preventive Mechanism (NPM) on the conditions of detention and treatment of persons restricted in their freedom in 2015. The NPM concludes that the rights of persons restricted in their freedom in the Netherlands are generally respected.

As in previous years, the NPM in 2015 performed both supervision and advisory activities. In addition, the NPM took the next step in intensifying the collaboration between the organisations involved. The July 2015 advisory visit of the United Nations' Subcommittee on Prevention of Torture (SPT) to the Netherlands and the Dutch NPM contributed greatly to this. The NPM will continue its intensification process in 2016.

Together with the other Dutch NPM members and associates, I expect this annual report to provide a sound overview of the activities of the Dutch NPM network and to provide valuable information to the Subcommittee on Prevention of Torture (SPT) and all other involved parties in the field.

J.G. Bos

Head of the Inspectorate of Security and Justice



1

Context

The Netherlands wants to prevent the degrading or inhuman treatment of persons placed in care or treated outside their own volition, detained in custody or restricted in their freedom by the government in any other way. In the framework of the UN Convention against Torture and Other Cruel, Inhuman or degrading Treatment or Punishment (OPCAT)¹, several organisations have therefore been appointed as members of the "national preventive mechanism" (NPM) in the Netherlands. In this Annual Report over 2015 the NPM reports on the conditions of detention and the treatment of persons restricted in or deprived of their freedom. The NPM Annual Report is also submitted to the Subcommittee on Prevention of Torture (SPT) of the United Nations.

This Annual Report starts with describing the context of the NPM and its members. This is followed by a listing of the activities it performed. Next, the NPM draws attention to four themes relevant to its supervision and advisory functions.

The Dutch National Preventive Mechanism

The NPM of the Netherlands is made up of the following bodies:

- Inspectorate of Security and Justice (Inspectorate VenJ)²
- Health Care Inspectorate (IGZ)
- Inspectorate for Youth Care (IJZ)
- Council for the Administration of Criminal Justice and Protection of Juveniles (RSJ)

The additional associates include:

- Commissions of Oversight for Penitentiary Institutions (CvT)³
- Commissions of Oversight for Police Custody (CTA)⁴

¹ Article 3 of OPCAT obliges each State Party to "set up, designate or maintain [...] one or several visiting bodies for the prevention of torture and other cruel, inhuman or degrading treatment or punishment". Those bodies that hold inspections domestically are referred to as the NPM.

² The Inspectorate VenJ also serves as coordinator of the NPM network.

³ The Sounding Board Group of the Commissions of Oversight for Penitentiary Institutions represents these Commissions during NPM meetings.

⁴ The National Centre for the Commissions of Oversight for Police Custody represents these Commissions during NPM meetings.



- Detention Areas Supervisory Commission of the Royal Netherlands Marechaussee

Appendix I contains a summary of the competences of the individual organisations.

The Dutch NPM is composed of a number of organisations selected to ensure that, jointly, they cover the entirety of the field of the supervision of and advice on persons restricted in their freedom. Each member has its own duties, responsibilities and powers, as laid down by laws and regulations. In addition, these organisations, jointly, have specific responsibilities as the NPM.

The supervisory activities within the NPM network are performed by the three Inspectorates and the commissions of oversight. The organisations collaborate wherever possible whenever their competences overlap. The Inspectorates jointly perform studies, for example. The organisations comprising the NPM act within assessment frameworks laid down in advance when performing their supervisory duties. The principles underlying the prevention of torture and other cruel, inhuman or degrading treatment or punishment are incorporated into these assessment frameworks by default.

Activities in 2015

The Dutch NPM has a supervisory and advisory duty with respect to all types of restriction and deprivation of freedom. In its performance of this duty, the NPM made almost 1,200 visits⁵ in 2015. Not all visits resulted in individual reports⁶. Nor have all reports been made public. The publicly available research and advisory reports are listed in the below. The completed reports (in Dutch) can be accessed directly via the hyperlinks.

Adult prisoners

- [Monitoring police custody in the Netherlands](#)
- [Use of the neck hold](#)
- [Contraband in forensic psychiatric centres](#)
- [Vught Penitentiary Institution following reports in the media](#)
- [Leave practice in forensic psychiatric centres](#)
- [Implementation of DJI 2013-2018 Masterplan, risks to detention centres](#)
- 11 annual reports of the Commissions of Oversight for Police Custody⁷
- [42 annual reports of the Commissions of Oversight](#)⁸
- Annual report of the Detention Areas Supervisory Commission of the Royal Netherlands Marechaussee
- [Advice on the exploration of the privatisation of detention centres](#)
- [Advice on the risks and obstacles related to longstay](#)

⁵ Excluding visits to penitentiary institutions by the Commissions of Oversight.

⁶ For instance, an investigation into individual incidents in the healthcare system.

⁷ One annual report from each of the ten units of the police and one annual report from the National Centre.

⁸ Each year, more Commissions of Oversight draw up an annual report.



Adult patients in the healthcare system⁹

- [Report on the investments by mental healthcare institutions to reduce the use of seclusion measures](#)
- [Fact sheet Supervision of forced restriction of freedom in the care for the elderly and the disabled](#)
- [Advice on the Second Memorandum of Amendment of the Compulsory Mental Healthcare Act](#)

Youths

- [Screening of Het Keerpunt juvenile detention centre](#)
- [Screening of Lelystad juvenile detention centre](#)
- [Interim supervision of Amsterbaken juvenile detention centre](#)
- Screening of De Hunnerberg juvenile detention centre
- [Reviewed Perspective: Advice on the deprivation of freedom in judicial youth detention centres](#)
- [Advice on "Difficult-to-place youths" in institutions for enhanced youth care and youth mental healthcare](#)
- [Step 2 of the Closed Youth Care Quality Framework](#)
- [Closed youth care warning](#)

Irregular migrants

- [Accompanied forced repatriation of foreign nationals in 2014](#)
- [The death of an asylum seeker in the Rotterdam detention centre](#)
- [Second immigration chain monitor](#)
- [Advice on the Repatriation and Immigration Detention Draft Decree](#)

The NPM asks that attention be given to a number of themes identified during the performance of these activities. These themes are elaborated in Chapter 2. Appendix II provides an elaboration of the supervisory activities and Appendix III addresses the advisory activities in more detail.

Reinforcement of the NPM

The first steps towards intensifying the collaboration between the organisations forming the NPM network were taken in 2014. The NPM continued this intensification drive in 2015. The July 2015 advisory visit of the United Nations' Subcommittee on Prevention of Torture (SPT) to the Netherlands and the Dutch NPM contributed to this.

For instance, the NPM drew up a statement in 2015. The various NPM organisations may use this text in the reports drawn up by them on the performance of their NPM-related duties. This allows the NPM organisations to draw attention to their functioning as NPM, which also contributes to preventing inhuman treatment. In addition, the NPM performs a self-assessment to obtain a better view of those fields requiring reinforcement. The collaboration between the various Inspectorates was enhanced as well, evidenced by, *inter alia*, the establishment of a joint Youth Inspection Desk for Municipal Authorities. This desk allows municipal authorities to contact the Inspectorates with their questions in the field of youth care, even within

⁹ In addition to making thematic reports, the IGZ also visits individual healthcare providers that may implement restrictions of freedoms. These can be retrieved from www.igz.nl.



the framework of the Inspectorates' NPM duties. In addition, the Inspectorates have drawn up a youth care institution calamities and violence reporting procedure.

The Dutch government, too, contributed to the State Inspectorates' independent position by once more laying down their independence by legislation. The "Instructions concerning the State Inspectorates" entered into force on 1 January 2016. These Instructions contain the regulations and substantive limitations with respect to a minister's authority to give instructions to their ministry's Inspectorate.



2

Supervision and Advice Themes

The NPM concludes that the rights of persons restricted in their freedom in the Netherlands are generally respected. The NPM has performed its supervision task and rendered advice on the fields of healthcare, detention and repatriation of irregular migrants. It was found that, in general, persons restricted in their freedom are provided with adequate and due care. Some advisory reports did contain recommendations on more strongly embedding human rights in legislation, policy and practice. The following sections address the four primary supervision and advice themes the NPM focuses on.

The NPM designated the subject of "transportation" as a theme for 2015. Wherever possible, this theme was addressed during the regular supervision duties. No specific points of attention were identified. For this reason, the theme of "transportation" is not explicitly discussed in this annual report.

Reorganisation of the Detention Centres

Some 38,000 persons were detained in the Netherlands in 2015.¹⁰ As the number of detainees in the Netherlands is decreasing, the Dutch government is reducing cell capacity. In 2013, this led to the Custodial Institutions Agency being faced with heavy cuts in the budget for the detention centres. These budget cuts resulted in significant changes in the organisation and its policies. The NPM notes that this has also resulted in uncertainty among the staff with respect to the preservation of their jobs and the tasks associated with their positions. Some institutions and wards - in particular the so-called low and very low security (i.e., half-open and open) institutions - have been closed. Facilities, regimes and activities have been economised. Yet the NPM has not identified any signs of this situation having resulted in inhuman or degrading treatment. The NPM does, however, provide the warning that new measures would result in a reduced capability to enforce security and the detention climate and will continue to closely monitor the current reorganisation.

¹⁰ [DJI in figures 2011-2015](#)



Reducing the use of physical restraints and seclusion in the Healthcare System

A small numbers of patients in the care for the disabled, care for the elderly and mental healthcare systems may be restricted in or deprived of their freedoms, being subjected to bed restraints or seclusion. As freedom-restricting measures may have a negative impact on the quality of life, the use of such measures must be prevented wherever possible. The Dutch healthcare institutions do all in their power to prevent the use of such measures as much as possible or to use them in accordance with the principles of subsidiarity, proportionality and efficiency. While a lot of progress has been made in the past few years, the NPM still finds that further improvements are possible. The NPM is of the opinion that too many patients are restricted in their freedom unnecessarily.

Intimate Searches of Youths in Juvenile Detention Centres

A section of the youths in Dutch juvenile detention centres may be systematically subjected to intimate searches¹¹. The NPM is of the opinion that systemic intimate searches constitutes inhuman treatment. Random searches¹² are permitted, as long as they are performed at a frequency of, on average, no more than twice per month. Youths may be searched more often in special circumstances and following a motivated decision thereto by the governor. It is important in this connection that the decision is made after due consideration and for each individual youth concerned. The NPM believes the systemic intimate search of youths to be unjustifiable if no sound motivation exists.

Authorisation of the use of (physical) restraints and seclusion in Youth Assistance Services

The juvenile court judge must issue an authorisation for the use of (physical) restraints and seclusion and the deprivation of freedom of, youths in healthcare institutions. The NPM has noticed an increase in the number of youths placed in wards with a closed regime while no authorisation for such placement was issued. It is, in the end, up to the juvenile court judge to judge whether a youth suffers from such severe problems that deprivation of freedom and the use of freedom-restrictive measures is necessary. This also applies to closed youth assistance within a "voluntary framework". A placement without an authorisation thereto and, thus, without the required legal assessment having been made, is unacceptable to the NPM.

¹¹ This concerns a search of the body. A JJI staff member both examines the outside of the entire body and searches for any banned objects in all body cavities (mouth, ears, anus).

¹² This is the standard for searches following an inspection of the cell.



Appendix

Member and Associate Profiles Matrix

Location ¹³	Inspectorate of Security and Justice	Council for the Administration of Criminal Justice and Protection of Juveniles ¹⁴	Health Care Inspectorate	Inspectorate for Youth Care	Commissions of Oversight for Penitentiary Institutions ¹⁵	Commission of Oversight for Police Custody	Detention Areas Supervisory Commission of the Royal Netherlands Marechaussee
Detention centres	O	A	O		A, O		
Juvenile detention centres	O	A	O	O	A, O		
Forensic care centres <i>criminal law</i>	O	A	O		A, O		
Forensic care centres <i>civil law</i>			O		A, O		
Foreign nationals detention centres	O	A	O		A, O		
Follow-up care centres for former detainees	O	A	O ¹⁶				
Police custody ¹⁷	O		O	O		A, O	
Detention centre KMar	O	A ¹⁸	O ¹⁶				A, O ¹⁹
Military detention centre (Stroe)	O	A	O ¹⁶		A, O		
Closed mental healthcare institutions <i>criminal law</i>	O	A ²⁰	O				
Closed mental healthcare institutions <i>civil law</i>		A ²⁰	O				
Closed youth care (Jeugdzorg-plus) <i>civil law</i>		A	O	O			
Transportation Netherlands police	O	A	O ¹⁶			A, O	
Transportation Netherlands Transportation and Support Service	O	A	O ¹⁶	O	A, O ²¹⁻²²		
Transportation to other countries (by air)	O		O ¹⁶				
Closed care retirement homes			O				
Closed disabled institutions			O				
International Criminal Court ²³							

Note: refer to the next page for the footnotes



¹³ This is not only a location (building), but any place at the moment of the arrest.

¹⁴ The Council also has a judicial task.

¹⁵ The Commission also has a judicial task.

¹⁶ The Inspectorate can supervise when care is given or denied.

¹⁷ Including mobile police custody and police custody by the court police and railway police.

¹⁸ In as far as it concerns the detention of foreigners.

¹⁹ The Commission supervises all detention areas managed and used by the Royal Netherlands Marechaussee. In conformity with the working arrangements, the Commissions of Oversight for Penitentiary Institutions supervise the cells rented by the Royal Netherlands Marechaussee at the Schiphol Penitentiary Complex.

²⁰ In as far as it concerns youths.

²¹ There is a special Commission of Oversight for the Service. This Commission supervises the Service and renders advice, but does not handle complaints. Complaints are handled by the Commission of Oversight of the specific detention centre.

²² The Commission of Oversight for the Transportation and Support Service does not supervise Transferium.

²³ The Red Cross is responsible for monitoring the circumstances of and treatment in detention.



Appendix

Supervisory activities

1. Adult prisoners

Detention centres

Consequences of the Masterplan

Due to the implementation of the DJI 2013-2018 Masterplan, penitentiary institutions are faced with a number of diverse and far-reaching changes: austerity of the regimes, more intensive multiple cell occupancy, changes in staffing, a new daytime program, the closing down of institutions and wards and related large-scale staff turnover and losses. These changes may pose a risk for the continuity of the institutions.

The Inspectorate of Security and Justice by way of its "DJI 2013-2018 Masterplan Implementation" study is investigating whether the quality of the executions of sentences and measures still accords to the set standards. In view of the risk-oriented focus of the study, the Inspectorate has decided not to perform comprehensive screenings but to inspect a limited number of institutions within a limited period, focusing specifically on risks. The Inspectorate's preliminary results over 2015 are that the reorganisation has not resulted in severe negative effects on the quality of the performance of the institutions, like a deterioration of the detention climate or an increase in aggression. The incarceration of detainees and the treatment by the operational staff meet the standards and expectations of the Inspectorate. The staff has been able to find a balance between capacity and burdens. However, significant differences have been observed as concerns the implementation of rehabilitation policy.

The Inspectorate has issued a warning that new measures would result in a reduced capability to enforce security and the detention climate. The current balance found between capacity and burdens is partly the result of the efforts by and loyalty of the staff.

In addition to this thematic study by the Inspectorate VenJ, the Commissions of Oversight, too, have observed the effects of the Masterplan. The threatened closure of institutions due to a decreased demand for cell capacity sharply impacts the staff, as they fear losing their jobs. This, in turn, impacts the treatment of the detainees.



Regular supervision by the Commissions of Oversight

The options available to the Commissions of Oversight to intervene when assessing the government's treatment of detainees are in the main of a preventive nature and are intended to prevent excesses and to effect a compromise between restriction of freedom and preparation for the future in freedom. In 2015, many Commissions were involved with the assessment of the implementation of the new system of promotion and degradation on the basis of the detainee's conduct. In so doing, they contributed to a rightful and predictable course of affairs.

The sounding board group of the Commissions of Oversight for Penitentiary Institutions over the course of 2015 grew from being an observer to being a full participant in the NPM debate and consultations. Formally, the only mandate given to the sounding board group is to reproduce the joint impressions of and questions asked by the individual Commissions of Oversight to the other partners in the domain of penitentiary institutions. However, the sounding board group does play a part in spurring the individual Commissions of Oversight on. The sounding board group in this connection urged the DJI to obtain the annual reports of the Commissions of Oversight more quickly, allowing it to gain a better insight into the issues and complaints the Commissions are confronted with. The performance of a quantitative analysis - for instance, by charting the focuses and trends in supervision on the basis of the data collected - will in time allow the Commissions to be better able to contribute more significantly to improving the practical situation in penitentiary institutions and, thus, to the humane treatment of detainees.

Investigation into signs of alleged abuses

In addition to studying the consequences of the Masterplan, the Inspectorate VenJ also performed an investigation in connection with reports in the Telegraaf newspaper covering the Vught Penitentiary Institution (PI), which suggested that the institution would suffer from a crisis of authority, a cover-up culture and a security leak. The Inspectorate VenJ in August 2015 conducted an investigation among the institution's staff, covering two themes addressed in the newspaper articles. The Inspectorate VenJ also directly investigated a number of security aspects, like the access control at Vught PI and the High Security Ward located within its walls.

The investigation did not lead the Inspectorate VenJ to conclude that a security leak or a problematic authority culture existed. The Inspectorate VenJ found that Vught PI was upset by the media coverage, like the Telegraaf reports. The Inspectorate VenJ found that the management is in control and is transparent in its handling of the signs provided by the staff. The Inspectorate VenJ did, however, find some issues related to the authority culture and security, including staff access control, that required addressing. In the opinion of the Inspectorate VenJ, compliance with its recommendations would result in further optimisation of the institution's security. In his response to the Inspectorate VenJ's report, the State Secretary announced that the institution would follow the recommendations.



Forensic psychiatric centres

Contraband

The Inspectorate VenJ examined the risks related to contraband being smuggled into TBS²⁴ clinics and what the clinics are doing to prevent this. The Inspectorate VenJ concluded that five of the seven clinics investigated had an insufficient understanding of the risks related to the smuggling, by unescorted TBS detainees in psychiatric care, of contraband containing metal. In a number of cases these patients were not checked at the entrance or they were able to pass contraband on before they were checked. The Inspectorate refers to the failure to identify this as "a serious point for attention", but at the same time acknowledges that TBS clinics have since dealt with the situation adequately. The Inspectorate VenJ wants TBS clinics to do more to prevent drugs from being smuggled into the clinics. The State Secretary of Security and Justice concurs with this recommendation and has stated that he will have drawn up an action plan to improve security before 1 January 2016, or so he wrote to the House of Representatives in his response to the "Contraband in Forensic Psychiatric Centres" report of the Inspectorate VenJ.

Leave practice in forensic psychiatric centres case review

It was found in late February 2015 that a forensic psychiatric centre, in implementing an authorisation for patient leave, granted the patient more freedom than was permitted under that authorisation. The authorisation permitted the patient to visit their family for one day. However, the centre also allowed the patient to stay the night with family, while the unescorted leave authorisation did not permit overnight stays. The Inspectorate VenJ investigated the circumstances of this incident. It also investigated whether the incident was an isolated case or an example of a more widespread practice.

Insufficient opposing views were brought in because of changes in the organisation and the choice to keep this case in the portfolio of a director due to its complexity. The opposing views voiced by the administrative department and the legal expert were at some point ignored. The Inspectorate VenJ deems the lack of an opposing view and of objective process monitoring to be contrary to the principle of due care.

The position of the centre became more complex over time. On the one hand, it was implementing a rehabilitation policy based on the agreements with the Ministry of Security and Justice laid down in a 2001 memorandum and the judgments of various courts of justice, but on the other hand, the Ministry of Security and Justice repeatedly refused to grant authorisation for leave applied for under that same rehabilitation policy. This resulted in the course of action deemed best for the patient by the centre in view of the treatment and the July 2001 memorandum being at odds with what was officially authorised by the Ministry, causing a deadlock that influenced the decision made in the present case.

The Inspectorate VenJ therefore concludes its investigation by finding that the forensic psychiatric centre held to too broad and erroneous an interpretation of the unescorted leave authorisation granted. A lack of opposing views brought in in this

²⁴ If someone is placed under a hospital order (TBS) with compulsory treatment, that person is admitted to a so-called TBS clinic.



case and the deadlock between the centre and the Ministry of Security and Justice contributed to the decision resulting in the incident. The Inspectorate VenJ found that, in contrast to the leave incident investigated, no irregularities were observed with respect to the execution of other leave authorisations. The centre follows the proper procedures and exercises all due care in drawing up the leave applications. The execution of the leave authorisations, too, conforms to the preconditions and frameworks set for the authorisations granted to the centre, in contrast to what happened in the case under review.

Monitoring police custody

The government has a special responsibility towards persons deprived of their freedom. The National Police annually detains close to 240,000 arrested persons in police custody. The detainee population is highly diverse.

Regular supervision by the Commissions of Oversight for Policy Custody

The Commissions of Oversight for Police Custody supervise the way the police treats these persons. On 1 July 2015, new regulations²⁵ on the monitoring of policy custody entered into force. The most important changes are:

- Members are no longer appointed by the police commissioner but by the Minister of Security and Justice, after being nominated by the mayor representing the region and the chief public prosecutor.
- The Commissions now also supervise the transportation of persons arrested by the police.

The ten Commissions of Oversight of Police Custody have monitored police custody in 2015 by performing well over 600 inspections at the approximately 400 locations the police uses for the detention of persons (holding rooms, cells, cell complexes, court buildings). Some 550 detained persons were interviewed during these inspections.

In general, the police was found to treat the persons incarcerated under its responsibility properly and responsibly. Such also appears from the thematic study into the care for persons in policy custody in the Netherlands, detailed in the below.

Both the members of the Commissions and the incarcerated persons are positive about the way they are treated by the custody officers. The accommodations in the main meet all requirements. Proper medical care is provided, though there are some concerns about the way medication is handled and stored.

The Commissions provided attention to the way the transportation of incarcerated persons takes place for the first time in 2015. As monitoring of this aspect took place for a short time only, the topic will be further addressed in 2016.

Unfortunately, the situation in the police stations' holding rooms still requires more attention. These rooms are meant for holding persons for no more than a couple of hours. The responsibility for the care of the persons detained in these rooms rests not with the policy custody officials and the Custody Affairs chiefs, but with the

²⁵ The Police Organisation Decree and the Supervisory Regulation governing the Care of Arrestees in Police Custody.



police officials on duty and, thus, with the chiefs of the Basic teams. The care for persons in police custody is not their primary duty, which at times results in these officials being unfamiliar with and failing to meet the requirements set for this care. The police is aware of this problem and is working to improve matters.

Another point of concern for the Commissions is the length of the detainment of persons in court buildings. Detained persons are held for many hours, and often for entire days, in the court building, even though the hearing itself takes a short time only. The provisions in the cells in these buildings are not equipped for long periods of stay. For instance, there are no exercise yards and only limited provisions for food and drink. Except for the Amsterdam unit, the police is responsible for the care of the persons detained in court buildings. However, the long periods of stay are caused by the schedule of, on the one hand, the hearings and, on the other, the transport of the detained persons by the Transport & Support Service. The police has no influence on this schedule. Nor does it have any influence on the provisions available in the buildings.

Thematic study on the care for arrested persons

In addition to the regular monitoring by the Commissions, police custody is the subject of a thematic research conducted by the Inspectorate VenJ, IGZ and IJZ in cooperation with the Commissions. The central research question of the study was: "In what way does the police perform its duty of care for arrested persons and does such performance conform to the applicable legislation and guidelines?" To answer this question, the Inspectorates over 2014 and 2015 inspected all National Police units. On the basis of this research, the Inspectorates have drawn up one national report and more detailed partial reports on each police unit.

The Inspectorates' overall opinion of the performance of the duty of care for arrested persons in the Netherlands is positive. The professionalisation of the police since the introduction of the National Police is slowly starting to bear fruit.

However, there are some issues requiring attention on the national level.

- The Inspectorates deem it important that the new regulations on the searching of persons to be transported become effective soon.
- The Inspectorates ask the police to consider fitting emergency relief vehicles with a partitioning screen to guarantee the safety of the officers as much as possible when buying new vehicles.
- The Inspectorates once again recommend that the police conclude agreements with the various service organisations, like the municipal authorities, the Municipal Health Services, the Mental Healthcare Institutions and the Netherlands Institute of Forensic Psychiatry and Psychology. The agreements should relate to improving medical care, in particular the access to care, medication safety, the exchange of data and, in particular, the reception of and the provision of proper care to disturbed and/or addicted persons.
- The closing down of police stations, in particular in rural regions, has resulted in the transport times of arrested persons increasing. The Inspectorates believe this provides a risk to the deployment of police officers on other tasks, including the visible presence on the streets.

In his response to the report, the Minister of Security and Justice stated to work on, *inter alia*, national Internal Regulations. These regulations aim to guarantee that persons arrested are informed about the reason for their arrest, their rights and the



applicable house rules. The Commissions will include the findings and recommendations presented in the report in their supervisory activities.

Death during detention

The Health Care Inspectorate and the Inspectorate VenJ by default have a role to play in the case of a detainee dying while in a detention centre. All reports of a death are assessed jointly by the Inspectorates. A repeat item that arises and requires attention from the reports in the case of death during detention is the exchange of medical information. The professionals do not always share all required medical information.

2. Adult patients in the healthcare system

Supervision of the restriction of freedom in the healthcare system took place in 2015, as well. The supervisory activities not only focused on compliance with the relevant legislation, but also, and primarily, on preventing and coercion of physical restraints and seclusion. Various supervisory activities were performed. All instances of compulsory treatment were individually assessed, for instance, while institutions' policies on the application and the prevention of having to use physical restraints and seclusion were also reviewed.

Care for the disabled and the elderly

The IGZ in 2015 individually reviewed 48 cases in the care for the disabled and the elderly systems. During its inspections, the IGZ met with the client, their legal representative and the treatment team, and inspected the client file. Half of the cases involved the use of bed restraints and physical holding. In addition, the IGZ reviewed the use of seclusion measures and the application of compulsory medication. The IGZ found that both the decision-making process concerning and the performance of compulsory treatment were in proper order for all institutions visited. Both the decision-making and evaluation processes were performed in multidisciplinary consultations. Almost all institutions actively looked for alternatives to using physical restraints and seclusion. The client and/or their representative were properly informed of the reason for the compulsory treatment. However, the involvement of external experts when administering compulsory treatment, the clear registration of the use of these measures and the involvement of the client and/or their representative remain issues requiring improvement. Fewer psychoactive drugs need to be administered and the incidence of locking patients in their rooms needs to go down.

In addition, the IGZ reviewed the use of physical restraints and seclusion at the level of the institution. In this connection, too, it was found that institutions observed due care when implementing such measures. The responsibility for the use of the measure was properly divided, the measures used were reported in the client file and most institutions conducted a multidisciplinary consultation prior to deciding to use physical restraints or seclusion. However, the IGZ also identified some shortcomings, especially as concerns the analysis of (problem) behaviour. Because



not all behaviour was properly recognised, it is possible that physical restraints or seclusion were implemented unnecessarily. Nor was sufficient consideration given to first applying a psycho-social or behavioural intervention, thereby preventing having to use physical restraints or seclusion. The IGZ was required to perform enforcement activities at a couple of institutions, also because their policy and practice with respect to the restriction of freedom were inadequate.

Similar shortcomings were identified by the IGZ when it investigated problem behaviour by persons suffering from dementia. Institutions varied in their efforts to analyse the problem behaviour of a client suffering from dementia. At half of the institutions, no efforts were made to identify the causes of problem behaviour. All institutions inspected used treatments involving psychoactive drugs. The use of such drugs was not always known to all staff. At most institutions, an insufficiently well-considered and, in particular, too informal an evaluation was performed to assess the effectiveness of a treatment involving psychoactive drugs.

In 2016, too, the IGZ will review the implementation of the Psychiatric Hospitals (Compulsory Admission) Act with respect to the care provided to the disabled and the elderly.

Mental healthcare

On 4 June 2015, the IGZ published its "Report on the investments by mental healthcare institutions to reduce the use of seclusion measures; further action required to meet ambitions". This report showed that mental healthcare institutions had, over the past few years, implemented many improvements to prevent and further reduce the use of seclusion measures. However, there were some differences in the speed by which the mental healthcare institutions implemented improvements. A small group of institutions was constantly working on effecting improvements and using standards featuring an intensive, person-oriented approach that went beyond the standards used by the IGZ for its study. The number and duration of the seclusion measures used had gone down further at these institutions and many seclusion rooms had been put out of service. About one third of the institutions were less rapid with implementing these standards and they needed more time and supervision by the IGZ to improve matters. Six of the institutions required a great deal of time and pressure by the IGZ to implement the desired improvements. In May 2015 and October 2015, the IGZ organised two invitational conferences with all parties in the field, for the purpose of jointly laying down a new assessment framework. This framework allows mental healthcare institutions to reduce the use of both seclusion and segregation measures. All mental healthcare institutions are currently working on implementing this new assessment framework.

The IGZ in the last quarter of 2015 inspected eight mental healthcare institutions where it expected, on the basis of various sources of information²⁶, that the risks of seclusion measures being used on patients overly quickly or for a longer period or of patients being faced with overly restrictive house rules was high. During these eight inspections, the IGZ assessed seven compulsory treatments against the provisions of the Psychiatric Hospitals (Compulsory Admissions) Act and fifteen uses of seclusion measures against the four standards for reducing the use of such measures. Two of the seven compulsory treatments were performed without observing due care, the IGZ found. Both treatments took place within the same



institution. Of the fifteen uses of seclusion measures assessed, one of the uses failed to meet the Argus registration standard, two failed – and three partially failed – the standard to reduce the use of seclusion measures, while five of the uses failed or partially failed to meet the standard of seclusion not being solitary confinement. At two institutions, a seclusion room was put out of service, as it was unsuitable and unsafe. All institutions had to implement improvement measures and the IGZ will monitor the progress.

In 2016, the IGZ will assess performance of the provisions of the Psychiatric Hospitals (Compulsory Admissions) Act in the youth mental healthcare institutions, the psychiatric wards of general hospitals and the specialist addiction services.

3. Youths (care and detention)

Juvenile detention centres

Juvenile detention centres accommodate youths aged 12 through 23 placed there under criminal law for a short or longer stay. These centres execute the custodial sentences and measures imposed on youths. The purpose of the stay is to prepare these youths for a return to society without becoming repeat offenders. The IJZ, IGZ and the Inspectorate VenJ co-monitor the juvenile detention centres as NPM members. The audits of juvenile detention centres were continued in 2015. These audits took place within the context of the Juvenile detention centres audit assessment framework. This assessment framework is based on current national and international legislation and the actual daily practice. The assessment framework includes the following aspects:

- the legal position of the youths;
- the treatment of the youths;
- internal security;
- the protection of society;
- social rehabilitation;
- staff and organisation.

These aspects, when taken together, provide a solid picture of the state and course of affairs in a juvenile detention centre. The Inspectorates find that the institutions, in general, perform their duties properly. However, they have identified a number of items to be addressed:

- involving the information provided by the school in the first perspective plan within the set term;
- deployment of the Internal Support Team within an hour, or substantiate why another response time applies;
- random instead of systemic intimate searches.

The NPM is of the opinion that systemic intimate searches constitutes inhuman treatment.²⁷ The Inspectorates have, therefore, recommended that the policy on the

²⁶ Argus data over 2013 and 2014; reports under the Psychiatric Hospitals (Compulsory Admissions) Act over 2014 and 2015, by number of signals; number of complaints with respect to the Psychiatric Hospitals (Compulsory Admissions) Act upheld.



performance of searches be brought in line with the decisions of the Council for the Administration of Criminal Justice and Protection of Juveniles on this subject.

Closed youth care warning

In both national and international law, the principle is that no-one may be deprived of their freedom without legal basis and without judicial intervention and that no use of (physical) restraints and seclusion may be used without proper cause. The assessment of whether a youth is suffering from growing-up and education problems severe enough to warrant the deprivation of their freedom by the use of (physical) restraints and seclusion within a closed youth care institution is to be made by the juvenile court judge, who can grant an authorisation to have that youth placed in a closed accommodation. This also applies to closed youth assistance within a "voluntary framework". A youth who, together with their parents, voluntarily agrees to or requests closed youth care, may only receive such specialised youth care following the issue of a closed youth care authorisation by the juvenile court judge.

The Inspectorate for Youth Care found that closed youth care institutions increasingly often place youths within a closed regime ward without the juvenile court judge having granted a closed youth care authorisation with respect to that placement. The Inspectorate considers such placements to be unacceptable, as they violate both national and international law. The placement of a youth in closed youth care without judicial assessment severely harms their legal position.

The Inspectorate for Youth Care brought this issue to the attention of the State Secretary of Health, Welfare and Sport in August 2015 by issuing a public warning. The IJZ and IGZ will further investigate this issue in 2016. The findings of their investigation will be published in mid 2016.

Calamities

One of the activities to be performed under the Youth Act is the investigation of calamities. The Inspectorate for Youth Care, the Inspectorate VenJ and the Health Care Inspectorate have, in 2015, set up a joint reporting centre and working procedures in this connection. The supervisory activities performed have as yet been too few to establish the consequences to the youth care system arising from this system change. However, it has become apparent that problems within families are still not tackled comprehensively, also due to the complexity of the collaboration between assistance services. Assistance workers do not draw up a joint plan, too little control is taken over the assistance provided and the exchange of information between assistance workers is limited. This also appears from the Inspectorate VenJ annual report.

²⁷ The RSJ's appeal committee in various specific cases judged that a search following every visit is not contrary to the law. In other cases, the appeal committee has always allowed the use of random searches, provided these occur with a frequency of no more than twice a month. However, the use of systemic searches can, in the view of the appeal committee, be unreasonable and unfair when all interests are balanced.



4. Irregular migrants

Detention

Functioning of the immigration chain

The Inspectorate VenJ, in cooperation with the IGZ, conducted an investigation in 2014 into the compliance with the recommendations arising from the incident-based investigation into the death of Alexander Dolmatov. These recommendations related to, *inter alia*, the use of due care in connection with the stay of a foreign national in a custody complex and the provision of medical care in detention centres. The NPM's annual report over 2014 stated that visible results had already been achieved and that many professionals are very willing to continue to work on improving matters. Some aspects still require additional efforts, however. This applies, in particular, to the staff chain awareness training and the exchange of medical data. The Ministry of Security and Justice in this connection drew up the Guide on the exchange of medical data in the immigration chain in 2016. This Guide details the when, who and how of the exchange of medical data on foreign nationals.

Investigation into the death of an asylum seeker in a detention centre

The Inspectorate VenJ investigated the death of an asylum seeker in a detention centre. In so doing, it investigated whether the procedures, including the immigration-law procedures, have been properly followed from the time of entry of the asylum seeker into the Netherlands till the time of his death. The Inspectorate VenJ found that the immigration chain officials involved properly performed their duties with respect to the quality and the implementation of the procedures followed. The staff had received no signals from the asylum seeker himself, his lawyer or the medical professionals that the asylum seeker suffered from any medical particulars. The asylum seeker concerned was awaiting his removal on the basis of a Dublin claim.

However, some points of attention with respect to the recording and exchange of possibly relevant information were identified during the investigation. The State Secretary of Security and Justice has stated to agree with the essence of the recommendations by the Inspectorate VenJ. In consequence, a provision that the assistant public prosecutor or the designated Repatriation and Departure Service official has to motivate why a measure less severe than immigration detention was not opted for has been included in the procedure.

Supervision of the detention areas of the Royal Netherlands Marechaussee

The Detention Areas Supervisory Commission of the Royal Netherlands Marechaussee supervises the cells actually in use by the Royal Netherlands Marechaussee. The Commission has identified major concerns. These risks and problem areas do not relate to the treatment of the detainees as such, but mainly to the maintenance of the facilities. The state of maintenance of the shower and toilet facilities in the Schiphol holding area needs attention, for instance. The intensity of the use of the location varies. Cells that are intensively used, be it for shorter or longer period, need to be equipped with sufficient provisions, including food, drink and sanitary facilities. The hygiene and the state of maintenance of the showers and toilets at Schiphol remain items to be addressed. The available staff also needs to be properly trained. With respect to the cells at Rotterdam Airport, the Commission is of the opinion that the brigade has to better organise and safeguard the provision of care to detainees, rendering it less dependent on the individual official on duty.



Repatriation

The Inspectorate VenJ supervises the repatriation process by methodically inspecting it. In this connection, the Inspectorate VenJ inspected the actual execution of the process of the accompanied forced repatriation of foreign nationals to a destination country 102 times in 2015. It reported its inspection findings in the "Accompanied forced repatriation of foreign nationals in 2015" report. The Inspectorate VenJ in 2015 focused its supervisory activities with respect to the repatriation process on the process of accompanied forced repatriation by air. It focused on that part of the repatriation process between the moment the foreign national arrived at the location of actual departure to the moment they were transferred to the authorities of the destination country. In the last quarter of 2015, the Inspectorate VenJ started an exploratory inspection of one aspect of the preparation for the departure, specifically, the transportation of the foreign national from their location of stay to the location of departure (usually, the airport) by the Transportation and Support Service. The Inspectorate VenJ assessed the quality of the performance of the implementing organisations involved in the process. The focus was on humaneness and safety, both to the foreign national and to the officials involved and other travellers.

The Inspectorate VenJ found that the implementing officials involved act professionally when accompanying the foreign nationals during the repatriations inspected. The Inspectorate VenJ concludes that the foreign nationals are accompanied with respect for their dignity and that the implementing officials involved at the same time ensured that the repatriation process was as safe and secure as possible. Not all due care is as yet provided during the preparation of the departure. The provision of information prior to the removal once again forms an important cause of concern.

The Inspectorate VenJ identified the following items to be addressed:

- correctness and completeness of the information available to the Royal Netherlands Marechaussee prior to the removal, in particular as concerns the personal belongings and physical characteristics of the foreign national;
- availability and transfer of medical data;
- timely transfer at Schiphol;
- informing the foreign national and the captain of the consequences of resistance. The same applies to discussing the procedure of the application of resources abroad during the briefing;
- conducting a search of minor foreign nationals.

The State Secretary of Security and Justice has stated to agree with the essence of the recommendations by the Inspectorate VenJ. The State Secretary has had a guide for medical care professionals on the transfer or medical data drawn up. This guide is currently being implemented.

5. Cross-sector

Society expects police officials to take action in all situations where such is required. This may force them into having to gain compliance of someone, even if that



someone resists. Police officials need to make use of adequate physical techniques to gain compliance of someone effectively and proportionally. The neck hold is one such technique. The neck hold involves grasping someone by the neck with the arm.

Police officials often use the neck hold to gain compliance of someone in daily practice. It is an efficient technique that involves few risks, provided it is used properly. However, if an official holds someone by the neck with their arm, they may also start to choke that person, compressing either the windpipe or both carotid arteries. This does carry some risk, as the neck is a vulnerable part of the body.

The Inspectorate in 2015 conducted a general investigation into the use of the neck hold and into the training of staff in the use of choking techniques to gain compliance of someone. The investigation showed that neither the Police, nor the Royal Netherlands Marechaussee or the Custodial Institutions Agency include a choke hold in their training curriculum. However, some trainers do teach such a hold in practice. And some officials do use them in daily practice. The Inspectorate VenJ calls upon the organisations investigated to take a clear stance on the use of choke holds. If they believe their use to be unnecessary in practice, such holds may not be taught or used. If they do believe their use to be necessary, such holds must be taught and used properly.

The Inspectorate VenJ is of the view that the neck hold must continue to be allowed as a technique to gain compliance. The Police, the Royal Netherlands Marechaussee and the Custodial Institutions Agency do need to take a stance on using the neck hold as a choke hold and implement this position in their training practice.



Appendix

Advisory Activities

The RSJ issued six advisory opinions and pronounced one appeal judgment relevant to the objectives of the NPM.

Exploration of the privatisation of detention centres

The RSJ conducted an exploratory study into those preconditions for considering the (further) privatisation of detention centres important to safeguarding the proper treatment of detainees. These preconditions are:

- A decision to privatise may be made only after a careful assessment on the basis of a sound decision framework has been made. The decision-making process needs to address, *inter alia*, the form of the privatisation and the objectives the privatisation is to achieve.
- The national government will remain responsible for the execution of the custodial sentence and the content of the regime and the treatment irrespective of the type of privatisation opted for.
- The present objectives of detaining persons remain upheld in full. This means that detention is aimed at promoting the rehabilitation of detainees into society and safeguarding the security of society.
- Existing legislation remains applicable and will continue to be enforced, so the legal position and treatment of detainees will, at the least, be at the same level as in the current situation.
- The execution of the detention is supervised by a government body. The Minister of Security and Justice plays a formal role in this connection, thus ensuring parliamentary oversight.
- Privatisation processes are regularly evaluated (within no more than 5 years from the start date) and, possibly, monitored in the interim. PPP projects, which involve a committal for a period of 25 years, need to be critically assessed in this context.
- The RSJ believes that some existing practices, including the use of private security guards, should have been the subject of such an evaluation for some time now.

Repatriation and Immigration Detention Bill and Draft Decree

The Repatriation and Immigration Detention Draft Decree elaborates the similarly named Bill. The RSJ rendered advice on the Draft Bill in 2014. The RSJ found that the proposed regime in the immigration detention centres would continue to be of a mainly penitentiary nature, despite the intention being to give this measure a purely administrative-law basis. As the Draft Decree forms an adequate elaboration of the Bill, this principled objection also applies to the Decree.



The RSJ finds that penitentiary regulations do not align with immigration detention with respect to the following aspects:

- Powers to maintain order and security in the centre. The RSJ advises against the introduction of the punishment cell in immigration detention in any form, for instance. Not only is this inappropriate in a non-penitentiary setting, the punishment cell is also superfluous because the governor has sufficient alternative measures at his disposal. Furthermore, if a varied day programme is fully substantiated it will rarely be necessary to resort to disciplinary measures.
- Future-oriented focus of the detention. In immigration detention centres, the activities performed in connection with "prospects, rehabilitation and after-care" do not focus on rehabilitation in the context of changing behaviour but on creating opportunities for a fruitful future existence. However, there is no sign of future prospects being offered in the programme of activities: the examples of possible activities provided in the Explanatory Memorandum mostly take the form of passing time.
- Transfer for management reasons. Transferring a foreign national to a penitentiary institution should be based on behaviour in the current situation rather than on documented past behaviour.
- Visits. The RSJ calls for visits to be possible for the entire "operating period" of the institution rather than limiting them, as proposed, to four hours a week.

At the time this annual report was drawn up, the Repatriation and Immigration Detention Bill was still being debated by Parliament, rendering a discussion of the Implementation Decree irrelevant at this time.

Reviewed Perspective: A couple of thoughts about deprivation of freedom in judicial youth detention centres

The Secretary of State for Security and Justice is fundamentally contemplating the future structuring of juvenile detention. This has been triggered by the declining capacity and understaffing of the judicial juvenile detention centres (JJIs) and the resulting closing of these institutions.

From the developments and obstacles in the deprivation of freedom in JJIs, the RSJ concludes that the JJI system itself is problematic. Obstacles include:

- Reduction in the number of institutions consistently makes it more difficult to place youths regionally, in the vicinity of their family or social network.
- JJIs have difficulty in providing adequate, suitable treatment; for most youths the duration of the stay is much too short to start up an intervention.
- Recidivism is very high after a stay in a JJI, which is an indication that treatment and after-care in a JJI has a limited effect.

In the opinion of the RSJ, only a very different application which corresponds to developments in the community and the modern demands, can make an end to the obstacles ascertained. The RSJ is considering a system in which small-scaleness, proximity of family and school and suitable treatment, training and security are of paramount importance. Such a system will still remain part of the justice system and organisations and (local) facilities linked to the department of justice. But in this new set-up the deprivation of freedom still remains geared towards a safe society. In the interests of research it may be necessary that a preventively detained youth stays at a particular place, does not go outside and does not come into contact with other suspects. A number of youths have such serious psycho-social problems and/or problems of a psychiatric nature that a specialised, intensive treatment and a



high level of security in a national institution is required. In such cases, too, a great deal needs to be done to bring about a rapid transition to an urban or regional facility. In following up this advice, the DJI has started up a small-scale youth detention facility pilot.

"Difficult-to-place youths" in institutions for enhanced youth care and youth mental healthcare

Youths who suffer from a mental disorder and also display seriously disruptive behaviour are not, at present, always given the care they need. It concerns about fifty youths. These youths, who reside in a youth care plus or youth mental healthcare institution, are regularly transferred because the institution cannot cope sufficiently with their complex issues. This transfer often aggravates the problems.

The RSJ therefore argues for the provision of appropriate care at the location where the youth is placed, so that a transfer is not necessary. So, the starting point should be to ensure, in the first place, the best possible placement and the provision of care on location. A necessary condition to effect this is for local authorities and the government agency responsible for youth care to be in charge of the placement. Institutions can gain more expertise and find more solutions if there is more intensive collaboration and, if necessary, use is made of (national) expertise such as that of the Consultation and Expertise Centre.

Recommendations in this advisory report are designed to accelerate the previously initiated collaboration between institutions and to allow separate (cooperative) initiatives to develop into general practice. The recommendation is, therefore, not only addressed to the State Secretary of Health, Welfare and Sport, as the party responsible for the system, but also to municipal authorities, as the entities responsible for the youth care, and to those involved in the implementation of the youth care, such as youth care plus facilities and the youth mental healthcare organisation. At the time this annual report was drawn up, the relevant government members had not yet provided their response to the advice.

Second Memorandum of Amendment of the Compulsory Mental Healthcare Act

The Compulsory Mental Healthcare Bill concerns the compulsory treatment - both ambulatory and clinical - of persons suffering from mental health problems. The Second Memorandum of Amendment of the Compulsory Mental Healthcare Act not only intends to amend the Compulsory Mental Healthcare Act, but also to substantially amend the Forensic Care Bill and the Care and Compulsion (Psychogeriatric and Intellectually Disabled Persons) Bill, such with a view of better aligning the three proposed Acts. The RSJ is of the opinion that the better alignment of these proposed Acts by the Memorandum is a positive development and it heartily endorses its purpose of promoting the progression of patients within the mental healthcare system.

In its advice, the RSJ mainly considered the alignment of the Compulsory Mental Healthcare Act and the Forensic Care Act. Its conclusions are as follows:

- the continuity of care between forensic care and regular mental healthcare is as yet insufficiently safeguarded and promoted;
- the legal position of forensic patients treated under the Compulsory Mental Healthcare Act (and the Care and Compulsion (Psychogeriatric and Intellectually Disabled Persons) Act) is as yet insufficiently clear;



- the equivalence of the care provided to detained persons and the care provided to persons in the regular healthcare system (principle of equivalence) cannot as yet be assessed;
- more options will be available for treating forensic patients in mental healthcare institutions and the placement of patients from the mental healthcare system in forensic psychiatric centres are laid down by law. Due to the important role played by the Minister when a judicial ground for placement is lacking, the balance between serving justice and providing care is a point requiring attention.

The RSJ believes the proposed legislation is insufficiently well-conceived, coherent, transparent and unambiguously applicable in practice. Even though the process of passing the proposals into law has been going on for a couple of years, it is necessary that the provision of care is properly laid down by law and that no lack of clarity or unnecessary complexity enters the law due to time pressure. The RSJ attaches great importance to making it sufficiently clear which party is responsible for what action and emphasises that sufficient time and capacity will need to be provided to implement the proposed changes. Haste makes waste in this connection. At the time this annual report was drawn up, the parliamentary debate of the Bill was still ongoing.

Risks and obstacles related to a longstay order

As a result of the DJI Masterplan for the period 2013-2018, there will only be one longstay clinic (divided over two locations) for those under a hospital order ("TBS").

The RSJ identified the following obstacles in this connection:

- A "monopoly position" for the clinic and, thus, a risk of the development of a one-sided view of the treatment and punitive approach to TBS longstay patients. This could impede the outflow from the longstay facility.
- It is not (always) possible to transfer TBS longstay patients, for example, in connection with a deadlock or an incident. This is because the two longstay locations of the institutions, in the current situation, are not comparable with respect to the punitive approach and the level of guidance and counselling.
- The level of awareness of and familiarity with the time-out provision, i.e., the possibility of transferring a TBS longstay patient temporarily (for a period of seven weeks), pursuant to Section 13 of the Hospital Orders (Care) Act, with the purpose of observing the involved person, is insufficient.

Concerns were also voiced during the advisory phase, in connection with the Vught longstay location. A penitentiary environment is not the ideal environment in which to provide TBS longstay patients with the required high-quality climate for their stay and care needs. The small size of the Vught longstay location (a total of 24 spaces) reinforces the existing dependence of Pompestichting on the DJI staff and the facilities at PI Vught. At the Specialised Intensive Care Unit of the Vught longstay location, incidents occur almost daily in the small unit (six spaces), despite the efforts of the staff. The two seclusion cells are used quite regularly and the staff turnover rate is high.

The RSJ in its advice outlines two scenarios with recommendations with which to obviate the risks and obstacles related to a longstay order. An important element in both scenarios is the closure of (at least the majority of) the Vught longstay location. The RSJ recommends that this longstay location be closed in view of the fact that a longstay facility which is embedded in a penitentiary setting, although



explained by historical reasons of shortfall in capacity, is currently no longer needed, nor justified. In addition, the RSJ recommends that it be investigated whether a longstay facility can be set up in a second clinic and to:

- reinforce the practice of temporary transfer ("time-out"), pursuant to Section 13 of the Hospital Orders (Care) Act if it proves to be impossible to arrive at an alternative means to obtain the required second opinion;
- introduce an objection and appeal procedure with respect to the internal transfer of TBS longstay patients.

In his response to this advice, the State Secretary of Security and Justice has stated that the small - and decreasing - number of longstay patients does not justify the establishment of a second location. He will, however, make a start with decreasing the longstay capacity at PI Vught, except for the Specialised Intensive Care Unit. As this clinic will keep its monopoly position, it is requested to implement the recommendations proposed by the RSJ to improve the (legal) position of those under a hospital order. In the short term, a greater focus will be provided to the so-called "time-out placements" at other clinics. The State Secretary's response does not address the recommendation to introduce an objection procedure for internal transfers.

Judgment on appeal

In addition to giving advice, the RSJ is also charged with administering justice. This duty is performed by the appeal committees within the RSJ. These appeal committees, acting as a court of appeal, review judgments on persons being sentenced to a term in prison or a measure involving the deprivation of freedom. The RSJ in 2015 received a notice of appeal relevant to the objective of the OPCAT.²⁸

The appeal concerns a complaint on extending supervision measures during visiting and exercise times. The supervision measures were implemented as the complainant was placed on a list of detainees posing a flight or social risk. Ever since the complainant was transferred to the current penitentiary of stay, the complainant has to have his exercise time alone, due to the structure of the building. The complaints judge had previously considered the complaint to be unfounded.

The appeal committee is of the view that the decision to implement supervision measures with respect to visiting times has been properly substantiated. However, the having to exercise alone is near to being at odds with, *inter alia*, Article 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR). Yet this decision by the governor of the penitentiary institution still meets the requirements of fairness and reasonability. The appeal was, therefore, declared to be unfounded. The appeal committee does expect the governor to expressly consider alternative solutions when extending the supervision measures.

²⁸ Judgment on appeal of the RSJ of 7 December 2015, 15/2880/GA.



IV

Appendix

Abbreviations

Bvt	Hospital Orders (Framework) Act (Beginselenwet verpleging van ter beschikking gestelden)
CTA	Commission of oversight for police custody (Commissies van Toezicht op de Arrestantenzorg)
CvT	Commission of oversight (Commissie van Toezicht)
DJI	Custodial Institutions Agency (Dienst Justitiële Inrichtingen)
DT&V	Repatriation and Departure Service (Dienst Terugkeer en Vertrek)
DV&O	Transportation and Support Service (Dienst Vervoer en Ondersteuning)
ECHR	European Convention for the Protection of Human Rights and Fundamental Freedoms
GGZ	Mental healthcare (Geestelijke gezondheidszorg)
IBT	Internal Support Team (Interne Bijstandsteam)
IGZ	Health Care Inspectorate (Inspectie voor de Gezondheidszorg)
IJZ	Inspectorate for Youth Care (Inspectie Jeugdzorg)
IND	Immigration and Naturalisation Service (Immigratie- en Naturalisatiedienst)
Inspectorate VenJ	Inspectorate of Security and Justice (Inspectie Veiligheid en Justitie)
JJI	Juvenile detention centres (Justitiële jeugdinrichtingen)
KMar	Royal Netherlands Marechaussee (Koninklijke Marechaussee)
NPM	National Preventive Mechanism
OPCAT	Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment



PI	Penitentiary institution
RSJ	Council for the Administration of Criminal Justice and Protection of Juveniles (Raad voor de Strafrechtstoepassing en jeugdbescherming)
SPT	Subcommittee for the Prevention of Torture
TBS	Placement under a hospital order (Terbeschikkingstelling)
Wet Bopz	Psychiatric Hospitals (Compulsory Admissions) Act (Wet bijzondere opnemingen in psychiatrische ziekenhuizen)
Wfz	Forensic Care Act (Wet forensische zorg)
Wvggz	Compulsory Mental Healthcare Act (Wet verplichte ggz)
Wzd	Care and Compulsion Psychogeriatric and Intellectually Disabled Persons Act (Wet zorg en dwang psychogeriatrische en verstandelijk gehandicapte cliënten)



*No rights can be derived from this information.
The reproduction of information from this publication is permitted
provided this publication is listed as the source.*