



Annual Report 2014

Annual review of the Dutch
National Preventive Mechanism

The Netherlands

2015

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Introduction

This annual report gives an overview of the activities of the members and the associates within the Dutch National Preventive Mechanism (NPM) on the conditions of detention and treatment of persons restricted in their freedom in 2014. The NPM concludes that the rights of persons restricted in their freedom in the Netherlands are generally respected.

In 2014, the network members expressed the need to increase the added value provided by the NPM network with respect to the societal interests of the individual bodies. Each individual organization is already active on detention conditions and treatment of persons restricted in their freedom. Also, the three Inspectorates already cooperate on many subjects. Within the NPM-network initial steps towards enhancing cooperation between all organizations involved were taken in 2014. Therefore, the exchange of information on activities on NPM related issues between the organizations is enhanced. Furthermore, the various NPM-members have drawn attention for detention conditions and the treatment of those who are deprived of their freedom.

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 of the UN (SPT) and all other involved parties in the field.

J.G. Bos
Head of the Inspectorate of Security and Justice



1 Context

In the framework of the UN Convention against Torture and Other Cruel, Inhuman or degrading Treatment or Punishment (OPCAT)¹, several organizations have been appointed as members of the ‘national preventive mechanism’ (NPM) in the Netherlands. In this annual report of 2014 the NPM reports on the conditions of detention and treatment of persons in the Netherlands restricted in their freedom. The NPM annual report is also submitted to the Subcommittee on Prevention of Torture (SPT) of the United Nations. This report starts with describing the context of the NPM and its members. A summary of the supervisory and advisory activities of the NPM in 2014 follows.

1.1 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
- Detention Areas Supervisory Commission of the Royal Netherlands Marechaussee

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

The Dutch NPM is formed by various organizations chosen because they jointly cover the monitoring and advisory area of persons deprived of their liberty. Each participant has its own tasks, responsibilities and mandates, that are established in laws and regulations. In addition, these organizations have a shared responsibility as NPM. Besides its regular supervision and advisory activities, the Dutch NPM has the ambition to combine signals that could indicate inhumane treatment and act when necessary.

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 IVenJ also serves as coordinator of the NPM network.

³ The Sounding Board Group Commissions of oversight for penitentiary institutions represents the CvTs during NPM meetings.

⁴ The National Centre for the commissions of oversight for police custody represents the CvTs during NPM meetings.



In 2014, the National Ombudsman indicated it did not agree with the way the NPM-network operated and has therefore decided to no longer participate. The National Ombudsman particularly asked for attention to those bottlenecks that may impede the proper functioning of the network, specifically, the structure in relation to collaboration, the role of the various Inspectorates, and the lack of an overall vision. In his response to the Ombudsman the State Secretary for Security and Justice stated that the Netherlands possesses a comprehensive and effective system of supervising the conditions of persons deprived of their liberty. This supervision is the responsibility of the three Inspectorates, which are independent bodies as concerns their operation and judgment processes. Furthermore each institution or location where persons are deprived of their liberty features its own commission of oversight. In addition, the Council for the Administration of Criminal Justice and Protection of Juveniles (RSJ) may, when asked or at its own initiative, advise on new policies and future legislation. According to the State Secretary, the existing network meets the obligations arising from OPCAT⁵.

⁵ House of Representatives, 2014-2015, no. 466.



2 Supervisory activities

The Netherlands wants to prevent the degrading or inhuman treatment of persons who involuntarily are cared for or treated, are detained or deprived of their liberty by the government in the Netherlands. The NPM was established to ensure this.

Supervisory activities within the NPM network are carried out by the three Inspectorates and the three different commissions of oversight. The three Inspectorates each supervise their own field of supervision under sectorial legislation. Where the fields of supervision overlap, the Inspectorates collaborate closely. This manifests itself in the joint handling of emergencies, conducting joint research and joint reports.

In their supervision, the Inspectorates use assessment frameworks that are drawn up in advance. The principles of prevention of torture and other cruel, inhuman or degrading treatment or punishment are incorporated in the assessment frameworks of the Inspectorates participating in the NPM network by default.

The Commissions of oversight for penitentiary institutions have been provided with various auxiliaries by the RSJ, allowing for their oversight to come to have a preventive nature. These auxiliaries explicitly refer to, or embed, regulations, both 'hard' and 'soft' law, concerning human rights. These documents include:

- the note 'Framework for civil monitoring of the implementation of sanctions and measures';
- CvT assessment criteria for juvenile and adult detention centres;
- principles of Proper Treatment.

In addition, the Sounding Board Group Commissions of oversight for penitentiary institutions in 2014 drafted the 'Commission of Oversight Quality Development' note to raise awareness of the NPM/OPCAT perspectives within the individual commissions of oversight. This note included observance of the OPCAT obligations as one of the areas requiring supervision.

On the national level, the National Centre for the Commissions of oversight for police custody, in collaboration with the regional commissions, is actively working to safeguard the quality of supervision. In early 2014 this resulted, for instance, in the introduction of a standard CTA inspection visit reporting form, while a standard model for the commissions' annual reports is currently being drafted. All chairmen and secretaries meet twice a year and a conference for all CTA members and police officials, like the Heads of Police Custody, was held in February 2014. The NPM meeting, in which the National Centre represents the ten CTAs, is a fixed item on the agenda.

An overview of the supervisory activities performed in 2014, divided into subareas, is provided below. The NPM has designated the theme of 'transport' to be the theme for 2015.



2.1 Adult litigants

Penitentiary institutions

Because of the imposed budget cuts and the reduced need for cell capacity, the Custodial Institutions Agency has drawn up the Masterplan 2013-2018. Based on this plan various penitentiary institutions were taken out of use in 2013 and 2014. Several locations are adapted for the reception of asylum seekers under the responsibility of the Central Agency for the Reception of Asylum Seekers. In 2014, 29 sites were designated as a penal institution.

Until 2014, the Inspectorate supervised the penitentiary institutions through screening. This is a standardised research method with which a comprehensive judgement is given on the quality of the performance of tasks by an individual organisation. These screenings were carried out in accordance with the Assessment framework for the screening of penitentiary institutions. This assessment framework is based on the current national and international laws and regulations and the daily performance practice. With the screenings in recent years, a positive picture emerged on the quality of the implementation of sanctions and measures in the Dutch system. Supervision reveals no evidence of torture, or other cruel, inhuman or degrading treatment or punishment⁶. The quality of performance, detaining and simultaneously contributing to the return to society meet the requirements and standards of the assessment framework.

Due to the implementation of the Master Plan Custodial Institutions Agency 2013-2018, penitentiary institutions are faced with a number of diverse and far-reaching changes for detainees and staff: austerity of the regimes, more intensive multiple cell occupancy, optimizing staffing, a new daytime program, the closing down of institutions and wards and related large-scale staff turnover and losses in 2014. These changes may pose a risk for the continuity of the institutions and therefore the humane treatment.

For an effective insight in the implications for the quality of detention of these changes the Inspectorate VenJ started the development of risk-based supervision in 2014. Based on a risk analysis, the Inspectorate VenJ focused on three aspects: the detention climate, aggression control and reintegration efforts within the prison system. The report with findings, conclusions and recommendations will be available in 2015.

Furthermore, the Health Care Inspectorate reported on its nationwide visits to the detention centres in 2014. The main conclusion from this research is that there is a responsible medical care in detention centres. The IGZ finds that the collection of data and the initial medical examination at the time of arrival are performed in time and with due care. The agreements on the timely engagement of a doctor and/or psychologist are observed in practice. In addition, the various protocols, working instructions and flows of information have been clarified and become better connected, while investments were made in increasing the expertise of the staff

⁶ In a judgment by the appeal committee of the RSJ, the treatment of a specific detainee is indicated as a violation of article 3 ECHR, see paragraph 3.1.



of the various disciplines. Duties, competences and responsibilities of professionals have been clarified through the introduction of a professional statute.

Forensic psychiatric centres

Prompted by reports by the media that patients (who are convicted of a crime, but aren't held accountable because of a mental disorder) in a forensic psychiatric centre FPC had access to contraband goods like drugs and mobile (smart) phones, the Inspectorate VenJ carried out an investigation. The FPC must achieve two main objectives which are not always easy to unite. On the one hand a patient must be prepared to return to society in a responsible manner for the society. On the other hand there should be provided a safe living and working environment. At the same time the contraband brought by the patient may pose a risk to the internal security of the centre. The investigation looked into the measures employed by the institution to prevent contraband goods being available within its walls. The Inspectorate VenJ found that the institution could have done more to prevent hospital order patients from having access to contraband goods. At the same time, the Inspectorate VenJ found that the institution has implemented important measures to significantly reduce the likelihood of contraband goods entering the institution. Points for improvement do still exist in this connection, though. In his response to the report, the State Secretary for Security and Justice states that measures to improve the situation, including improved access control and staff receiving training on performing room inspections, have in the meantime been taken. The investigation into the situation of this one institution led an investigation of all forensic psychiatric centres about contraband goods. Its report is published in 2015.

Monitoring police custody

The ten Commissions of oversight of police custody (CTA) have monitored police custody in 2014 by performing 972 visits to the approximately 400 locations the police uses for the detention of persons (holding rooms, cells, cell complexes, court buildings) in 2014. 758 detained persons were interviewed during these inspections. The professional, motivated and respectful work method of the police custody officials, in spite of the changes and accompanying unrest caused by the reorganisation of the national police, was found worthy of note by the CTAs in the performance of their regular monitoring activities. Housing generally meets all requirements, all matters concerning the detained person are properly registered, there is sufficient access to medical care. Experience shows that the CTA recommendations are generally followed, though at varying speeds.

One item to be addressed is the situation in the police stations' holding rooms. Barring a few exceptions, these rooms are not meant to be occupied for more than a few hours, nor are they used for longer periods of time. The responsibility for the care of the persons detained in these rooms rests not with policy custody officials, but with the police officials on duty. 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. For instance, a few locations feature camera monitoring in a way or to an extent that might not be provided by the applicable regulations. This subject is currently being investigated, both within the police and by the CTAs.



In addition to the regular monitoring by the CTAs, police custody is the subject of thematic research by the Inspectorate VenJ, IGZ and IJZ. The main research question is: How is custody taken care of by the police and at what places? The preparations for this research were made in 2013, the inspections were performed in 2014 and the report will be published in 2015. The CTAs will include the findings and recommendations of the Inspectorate VenJ in their investigation activities.

Cross-sector

The IGZ in 2014 carried out investigations into incidents. Collaborating with the Inspectorate VenJ, the IGZ conducted investigations into reports on malpractice by professionals, and each case of a person dying while in custody was subjected to an investigation. Such investigations are conducted in accordance with a set procedure and are carried out by an independent multidisciplinary research committee. In addition, the IGZ further developed its own risk-oriented supervision, introducing a dashboard featuring a risk assessment, based on monitoring information from various sources, on the institutional level. Its supervisory activities in 2014 mainly focused on medication safety, suicide assessment and evaluation, documentation, and the transfer of information.

In addition, supervision of aspects of patient safety has led to institutions tightening up their policies. The electronic patient record was introduced in the penitentiary institutions and special facilities sectors so as to improve the exchange of information.

The attention paid to patient safety in the institutions is monitored through announced and unannounced inspection visits. A number of penitentiary institutions received unannounced visits in connection with an incident investigation. This resulted in the IGZ observing high-risk situations as concerns medication safety. In consequence, the IGZ not only requested the institutions concerned to immediately implement measures to improve the situation, but also reported the matter to the penitentiary institutions sector board. The board responded by drawing up an action plan and starting up an audit to assess whether the improvements in the quality of pharmaceutical care in penitentiary institutions are properly implemented. The board will report on the matter to IGZ in 2015.

The various supervisory activities carried out in 2014 have resulted in an improvement of the quality of the health screenings performed in penitentiary institutions. The IGZ, in performing its supervisory activities, found an improvement in the staff of the detention centres acting methodically in cases of mental vulnerability.

In addition, IGZ and Inspectorate VenJ established a joint consultation for the handling of notifications in 2014. During this reports consultation, agreements are made on the carrying out of incident investigations following incidents. The reports submitted in 2014 covered a wide range of issues: malpractice by officials (including sexual harassment and abuse of authority), natural deaths and suicides, medication safety and somatic care. In consequence to a disciplinary complaint issued by the IGZ, the regional disciplinary committee for the healthcare sector has clarified the standards for the actions to be taken by medical staff in case of suicide.



2.2 Care and coercion

The IGZ investigated a sizeable number of individual cases of compulsory treatment in the context of care for the elderly and care for the disabled and also studied the subject of seclusion and the restriction of liberties in these contexts. One of the aspects explicitly included in the supervisory activities by the IGZ in 2014 was the perspective of the citizen. In processing each report, the IGZ considers whether the perspective of the citizen/client was sufficiently heard.

Seclusion

Seclusion is a very drastic measure containing a significant risk of the patient suffering mental or physical harm. Mental healthcare institutions have been trying to reduce the incidence and duration of seclusion measures since 2002. In 2004, the Dutch Mental Healthcare Association announced it would annually reduce the use of seclusion measures by 10 percent. Between 2006 and 2012, the Ministry of Health, Welfare and Sport supported this ambition by providing additional funding. As the supervision of vulnerable patients and the cutting down on coercion and compulsion are important points of attention to the IGZ, it has been closely monitoring the progress made by mental healthcare institutions to further reduce the use of seclusion measures since 2008.

In late 2011, the IGZ, upon completing a long-term investigation, found that the ambitions of the mental healthcare institutions would not be realized. The reduction of the use of seclusion measures was found to stagnate. The IGZ therefore called for all parties in the field to develop standards for effective prevention. However, the multidisciplinary 'Coercion and compulsion' guideline the field parties were to draw up failed to appear, while the field standard for intensive care remained but an intermediary step. In consequence, the IGZ announced that it would alter its supervision of the field. The IGZ supplemented the two existing standards - prevent seclusion as much as possible, and register each instance of seclusion in accordance with the so-called Argus data set - with two new standards all mental healthcare institutions are to meet: seclusion cannot consist of solitary confinement and in cases of a seclusion measure lasting longer than a week, consultation by independent experts at fixed times is mandatory. In consultation with the field, the IGZ in this connection established an assessment framework in 2012.

66 mental healthcare institutions were inspected in 2013, 2014 and the first quarter of 2015 in connection with monitoring the theme of reducing seclusion in regular mental healthcare. Four institutions were visited four times, and two were even inspected five times. The investigation shows that all mental healthcare institutions inspected meet the four standards for reducing seclusion, but that about one third of all mental healthcare institutions required more time, and more pressure by IGZ, to meet the standard. The most difficult standard for the institutions to meet was that of the independent consultation at fixed times. The IGZ required institutions not meeting the standard to immediately implement improvement measures. The IGZ advised the Minister of Health, Welfare and Sport to impose an order subject to a penalty on two institutions, as they failed to register in accordance with the Argus data set. One institution had a department placed under stricter Inspectorate supervision.



In early 2015, all institutions were meeting the Argus data set requirement, while the amount of identification plans available and in use was on the increase. The secluded patient had more contact moments than used to be customary in all institutions.

Restriction of freedom in the care for the elderly and the disabled

It is a well-known fact that restricting the freedom of the elderly and people suffering a mental disability significantly impacts the quality of their life. Reducing the incidence of forced restriction of freedom in the care for the elderly and the disabled is an area of primary concern to the IGZ. In recent years, the IGZ has intensively monitored the reduction of the use of freedom-restricting measures. The IGZ in 2013 and 2014 extensively investigated the process of deciding on and implementing freedom-restricting measures. As part of its investigation into the care for the elderly and the disabled, the IGZ reviewed a large number of individual cases of compulsory treatment⁷ and developed an instrument to assess whether the freedom-restricting measures meet current standards. On the basis of its investigation, the IGZ finds that many care institutions, by implementing targeted policies and with external help, have managed to abolish freedom-restricting measures, even for exceptional situations. This is due to an improved organization with respect to:

- making decisions on and assessing the topic of compulsory treatment in a multidisciplinary context;
- considering alternatives for freedom-restricting measures like restraining or seclusion;
- making use of an identification plan or treatment recommendations in case of behaviour escalation;
- informing the client and/or representative about the reason(s) of the compulsory treatment in considering the measure.

The IGZ has also found a number of items for improvement as concerns the restriction of freedom in long-term care:

- engagement of experts in complex cases;
- not locking up patients in their own room;
- decrease the use of bed restraints;
- unified registration of freedom-restricting measures;
- administer fewer psychoactive drugs;
- opinion of the client and/or their representative on the implementation of the compulsory treatment.

⁷ Psychiatric Hospitals (Compulsory Admissions) Act, Section 38.



2.3 Youth in detention and care

On the youth domain five inspectorates collaborate closely in Collaborative Youth Supervision. These are: Inspectorate of Security and Justice, the Inspectorate for Youth Care, the Inspectorate of Education, the Health Care Inspectorate and the Inspectorate of Social Affairs and Employment. Three of these five inspectorates are also member of the NPM network.

Juvenile detention centres

The IJZ, IGZ and the Inspectorate VenJ co-monitor the judicial youth detention centres as NPM members. The investigations of juvenile detention centres were continued in 2014. These screenings were carried out in accordance with the Assessment framework for juvenile detention centres. This assessment framework is based on the current national and international laws and regulations and the daily performance practice. The framework contains the aspects:

- legal position of juveniles;
- social interaction;
- internal security;
- protection of society;
- social reintegration;
- organizational aspects.

In 2014 two juvenile detention centres were screened, while interim supervision was performed at three centres. The research results were predominantly positive. There are some points for improvement, though, *inter alia* as concerns disciplinary measures and deployment of staff. General tension exists between the need for austerity and performance of the primary process. Due to a decline of juveniles in juvenile detention centres it has been decided to close a number of centres. Particularly noteworthy however is the fact that Inspectorate VenJ believes that even the staff employed at juvenile detention centres that will close down are committed to provide the highest quality in the primary process.

Interim monitoring⁸ has the Inspectorate VenJ, Youth Care Inspectorate and Inspectorate of Social Affairs and Employment conclude that previously reported points of attention have been addressed. The Inspectorates will continue to monitor the further progress made with respect to the points for improvement.

Youthcare Plus

Youthcare Plus is an intensive form of youth and parenting support for juveniles with severe behavioural problems that threaten to evade the necessary treatment. In 2014 the Inspectorate for Youth Care, in cooperation with the Health Care Inspectorate, conducted an investigation into the death of a juvenile detainee in a Youthcare Plus institution. The investigation report is published in May 2015.

⁸ Interim monitoring concerns the compliance with the recommendations listed in previous reports.



In addition, a final report on six years of monitoring Youthcare Plus has been composed. The overall conclusion of this final report on six years of Youthcare Plus is that the Inspectorate for Youth Care, the Health Care Inspectorate and the Inspectorate of Education find that the Youthcare Plus institutions and schools are able to provide adequate care and education to youths requiring a more drastic form of specialized youth care in the future. The youths receive individual treatment and the institutions employ customized solutions when deploying freedom-restricting measures, granting leave and offering elements of the daytime program. The families are involved in the treatment. In most cases, the youths go to school within two working days after their arrival at the institution and only a negligible amount of lessons is cancelled. As part of their personal action plan, the youths are prepared for a next step towards as independent a life as possible, outside of the closed environment.

However, the Inspectorates did identify a number of obstacles and points for improvement that the institutions need to address. The Inspectorate for Youth Care will continue to follow the progress as part of its supervision of the institutions and by way of consultations with the sector association. The final report was submitted to the House of Representatives by the State Secretary for Health, Welfare and Sport and the State Secretary for Education, Culture and Science. In their policy response to the House, they inform the House that they have followed the report's recommendations. The response also describes how the points for improvement will be addressed and what is expected of the field parties. One concrete example is the set of measures implemented to promote and monitor the progression of the youths from the Youthcare Plus institutions to the environment and form of education deemed most suitable.

Furthermore, in 2014, the Inspectorate for Youth Care, together with the Health Care Inspectorate and the Inspectorate of Education examined six cases of (supposedly) physically inappropriate behaviour or disproportionate use of restraints by a group leader with physical damage to the juvenile. For all these cases, the centres themselves announced that they would implement measures to prevent repeat incidents, including more specific agreements on the provision of de-escalation and physical resilience training. The Inspectorate requested that additional improvement measures be implemented in two cases. These points for improvement, too, will be followed by the Inspectorate during its regular supervisory activities.

Also, the Inspectorate for Youth Care and the Health Care Inspectorate conducted research for the death of a juvenile in an institution for Youthcare Plus. This report has been published.

2.4 Detention and repatriation of irregular migrants

In 2014 the Inspectorate VenJ, in cooperation with the IGZ, in the framework of the Second immigration chain monitor conducted an investigation into the compliance with the improvement measures arising from the incident-based investigation into the death of Alexander Dolmatov. These measures relate to, among other things, acting carefully during the stay of a foreigner in police custody and the medical care in detention centres. The second report on the monitoring of the immigration shows that the Inspectorates see results have been achieved and many professionals have a great will to continue to improve. The fact



remains that additional effort is needed on elements. In particular, the transfer of medical and medical-related information remains vulnerable. To ensure the safety of the foreigner, his immediate environment and the employees in the chain, employees must know how to take the medical and psychological condition of a foreigner into account (by formulating an action perspective). The State Secretary for Security and Justice has among others agreed to start a project to draw up a guideline for healthcare professionals involved in the care of foreigners, with attention for the prospects for action.

The Detention Areas Supervisory Commission of the Royal Netherlands Marechaussee supervises the enforcement of the deprivation of liberties in detention centres used by and managed by the Royal Netherlands Marechaussee (KMar). The Commission reports its findings every two year. The next report for 2014-2015 will appear January 2016. If between biannual reports an urgency to report arises, the Commission will report to the Commandant KMar. In 2014-2015 visits have been made to detention centres in Coevorden, Hoek van Holland and Rotterdam. The Commission found no peculiarities.

Repatriation

The Inspectorate VenJ supervises the repatriation of foreign nationals. It took over this duty from the then Supervisory Commission on Repatriation (CITT) on 1 January 2014. The Inspectorate VenJ supervises by methodically inspecting the repatriation process. 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 73 times in 2014. It reported its inspection findings in the 'Accompanied forced repatriation of foreign nationals in 2014' report. The Inspectorate VenJ in 2014 focused its supervisory activities 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. The Inspectorate VenJ assesses the quality of the performance of the implementing organizations involved in the process. The focus is on humaneness and safety, both to the foreign national and to the officials involved and other travellers.

The Inspectorate VenJ finds 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. The Inspectorate VenJ finds that there is still room for improvement with respect to the completeness of the information required for the proper execution of the repatriation process. In addition, the baggage aspect in the preparatory phase preceding the actual departure should be handled with more care, as the KMar only has limited time to perform all required actions. Problems related to the baggage brought along, like having to leave properties behind, may negatively affect the foreign national's state of mind. The Inspectorate VenJ identifies a risk to the quality of the performance by the implementing organizations in those cases when there is (very) little time for the proper performance of the required actions at the location of actual departure.



In response to the report, the State Secretary for Security and Justice announced that he has, *inter alia*, introduced statements of consent and non-consent to the exchange of medical data for the entire chain. In addition, the chain partners involved have concluded agreements, among others on the actual actions to be performed with respect to the foreign national's baggage at the time of transfer.

2.5 Conclusion

Supervisory activities were carried out in the fields of care & coercion, juvenile and also adult detention, and detention and repatriation of irregular migrants. It was found that persons held in custody are, generally, provided with adequate and proper care. Some recommendations to further improve the acting in compliance with human rights in practice were included in a number of reports.



3 Advisory activities

In 2014 the RSJ issued three recommendations relevant for goals of the NPM. In addition, the Council pronounced one judgment in its judicial capacity of a situation characterised as a violation of article 3 ECHR.

3.1 Custodial institutions

Personal contribution to detention

The Council was consulted about the draft legislative proposal 'Prisoners Personal Contribution Towards Their Stay', which makes it possible to charge a personal contribution of € 16 a day to prisoners for their stay in a penitentiary institution or forensic psychiatric centre or to impose a hire charge on electronically-tagged offenders for an electronic ankle bracelet. The Council considers the draft legislative proposal to be contrary to the principle of resocialisation. The proposed personal contribution does not take account of the very limited possibilities for prisoners to generate income. In many cases, they will have accrued a debt after the end of the prison sentence which, when added to the existing debts many of them have, will impede reintegration. In addition, the proposed personal contribution is disproportionate to the limited remuneration for prison jobs. Second, the proposal is contrary to the principle of minimum limitations. The Council considers the personal contribution to be de facto additional punishment and therefore to be contrary to the principle that the prison sentence itself involves the deprivation or limitation of liberty, but does not limit the prisoner in their lifestyle any more than the situation of detention necessitates⁹. In spite of the Council's objections, the Dutch government did not follow its recommendation. The House of Representatives in April 2015 adopted the proposal on the personal contribution.

Persons called to report themselves

In addition, the Council issued a recommendation on individuals having to report themselves. These individuals are sentenced to a punishment involving the deprivation of liberty and are called to report themselves to a prison. The Ministry of Security and Justice intended to shorten the period within which detainees are to report themselves to undergo their prison sentence to three weeks. The Council believes that a possible objection and appeal procedure against the fixed reporting date cannot be completed in this period. The Council finds that this would turn the existing regulations on legal status illusory. In fact, the convicted person would even be partly prevented from exercising the rights they are entitled to by law. The Council is of the opinion that the period must be at least four weeks. On the basis of the recommendation by the Council, the proposed period was lengthened to four weeks.

⁹ Custodial Institutions Act, Section 2, and European Prison Rules, Article 102.2.



Judgment on juvenile detention centres

In addition to giving advice, the Council 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 liberty. The Council received an appeal concerning a complaint on the implementation of the seclusion measure and the use of mechanical constraints with respect to a person detained at a penitentiary psychiatric centre. Due to a number of incidents, he was placed in solitary confinement. The complainant uses medication to regulate his moods, but this was not administered in time. This made the complainant turn aggressive. The RSJ's appeal committee was unable to establish that staff had tried to regulate his behaviour by, for instance, talking with him, consulting a behavioural expert, or discuss administering tranquillizers. The complainant immediately had his hands and feet bound behind his back while a helmet was placed on his head. This treatment not only is painful, but, according to the complainant, also carries risks: almost all movement is prevented and he was afraid he would suffocate if he were to become indisposed. Very important in this connection is that he was unable to alert anyone. This treatment lasted until the following morning.

Staff at a penitentiary psychiatric centre can be expected to be able to deal with situations like these. However, a number of essential legal safeguards provided by the Custodial Institutions Act to ensure proper treatment were disregarded.:

- the use of mechanical restraints lasted longer than the maximum of 4 hours¹⁰;
- upon the end of this maximum term, the direction did not personally assess the situation *in situ* and extend the measure only based on information from third parties;
- night-time observation was disproportionate to the severity of the situation;
- the complaint committee had already established that the essential legal safeguards were not observed as concerned camera monitoring. For instance, no written notice was provided on the use of cameras and the complainant was not provided an opportunity to be heard.

This leads the appeals committee to conclude¹¹ that the principles of proportionality and subsidiarity were insufficiently observed when the means of constraint were applied. The appeals committee considers the situation of a mentally unbalanced person being bound, provided with a helmet, initially deprived of medication and not being provided with adequate supervision to constitute inhumane treatment. The actions were therefore contrary to the prohibition provided in Article 3 of the European Convention on Human Rights (ECHR)¹². As the appeal being declared (partially) well-founded cannot undo the seclusion measure and the use of constraints, the complainant was awarded indemnification amounting to € 250,-.

¹⁰ Custodial Institutions Act, Section 33(2).

¹¹ Judgment on appeal 14/3309/GA, 12 February 2015.

¹² Section 3. Prohibition of torture: No one shall be subjected to torture or to inhuman or degrading treatment or punishment.



3.2 Detention of irregular migrants

The Council was consulted about the bill on repatriation and detention pending the removal of foreign nationals. The bill aims to effect separate legislation for administrative detention of foreign nationals, taking it outside the scope of penitentiary legislation. The proposition therefore does justice to the nature of the administrative detention of foreign nationals as an administrative measure. Declaring European legislation and recommendations including the European Repatriation Directive applicable, underlines the ultimatum remedium nature of detention pending the removal of foreign nationals and offers possibilities for a more humane execution.

These important components of the bill meet the recommendations of the Council from 2008 and of numerous other advisory bodies and organisations. The Council appreciates this and supports the aim of a humane execution of detention pending the removal of foreign nationals. However, the Council also identifies threats and missed opportunities for humane execution in the bill. The Council in view thereof, and in cooperation with the Advisory Committee on Migration Affairs and the Research and Documentation Centre of the Ministry of Security and Justice, recommends the following:

- 1 Recommendation on humane treatment: Do not grant the director of the institution for the administrative detention of foreign nationals competence in the sense of the forced departure of the detainee. The director of the institution has no role in these procedures under the Aliens Act. A neutral attitude with respect to the forced departure is valuable in terms of a humane approach by the institution's staff.
- 2 Recommendation on minimal restrictions: impose *no* limitations on detained foreign nationals, unless required to prevent escape or to protect detainees and staff against aggression or harassment. A maximum internal freedom can be placed against an adequate external security. The total of the ample range of containment measures and competences of the director plus the setting up of a containment regime is disproportionately heavy given the characteristics of the population. The containment regime is characterised by punishment elements which do not belong in detention pending the removal of foreign nationals.
- 3 Recommendation on meaningful detention: offer an ample of activating day activities, which is suitable from a humanising point of view, to counter the atmosphere of lethargy and boredom which is characteristic of the detention pending removal. Forced participation to activities on pain of disciplinary sanctions is rejected as not fitting in with the objective of detention pending removal of foreign nationals.

It is, as yet, unclear whether the recommendations of the Council (and the recommendations of other advisory organizations and interest groups coming to a like conclusion) will be followed, as the bill has not yet been proposed to parliament.



3.3 Conclusion

A number of recommendations made by the Council contain recommendations on the improvement human rights in policy and legislation. In a judgment by the appeal committee of the RSJ, the treatment of a specific detainee is indicated as a violation of article 3 ECHR.



Appendices

Appendix I: Matrix member and associate profiles

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	P ¹⁶				
Police custody ¹⁷	O		O	O		A, O	
Detention centre KMar	O	A ¹⁸	P ¹⁶				A, O ¹⁹
Military detention centre (Stroe)	O	A	P ¹⁶		A, O		
Closed mental health institutions <i>criminal law</i>	O	A ²⁰	O				
Closed mental health institutions <i>civil law</i>		A ²¹	O				
Closed Youth Care (Youthcare Plus) <i>civil law</i>		A	O	O			
Transportation homeland police	O	A	P ¹⁶			A, O	
Transportation homeland (DV&O: Transportation and Subsidy Service)	O	A	P ¹⁶	O	A, O ²²⁻²³		
Transportation to other countries (flight)	O		P ¹⁶				
Closed care retirement homes			O				
Closed disabled institutions			O				
International Criminal Court ²⁴							

Note: for footnotes, see next page.



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

¹⁴ The Council has also legal power.

¹⁵ The Commission has also legal power.

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

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

¹⁸ As far as concerning detention of foreigners.

¹⁹ The Detention Areas Supervisory Commission of the Royal Netherlands Marechaussee has asked the commission of oversight Complex Schiphol to supervise the cells rented by the KMar from the police at Schiphol.

²⁰ As far as concerning juveniles.

²¹ As far as concerning juveniles.

²² There is a special commission of oversight for DV&O. This commission oversee and advice, but not handle complaints. Complaints are handled by the Commission of oversight of the specific detention centre.

²³ The Commission of oversight for DV&O does not investigate Transferium.

²⁴ The Commission of oversight for DV&O does not investigate Transferium.



Appendix II: List of abbreviations

CPT	European Committee for the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CTA	Commission of oversight for police custody (Commissies van Toezicht op de Arrestantenzorg)
CvT	Commission of oversight (Commissie van Toezicht)
DV&O	Transportation and Subsidy Service (Dienst Vervoer en Ondersteuning)
ECHR	European Convention on Human Rights
FPC	Forensic Psychiatric Centre
FTE	Full time equivalent
IGZ	Health Care Inspectorate (Inspectie voor de Gezondheidszorg)
IJZ	Inspectorate for Youth Care (Inspectorate Jeugdzorg)
IND	Immigration and Naturalisation Service (Immigratie- en Naturalisatiedienst)
Inspectorate VenJ	Inspectorate of Security and Justice (Inspectie Veiligheid en Justitie)
IvhO	Inspectorate of Education (Inspectie van het Onderwijs)
KMar	Royal Netherlands Marechaussee (Koninklijke Marechaussee)
LC CTA	National Centre for the commissions of oversight for police custody (Landelijke Centrum voor de Commissies van Toezicht Arrestantenzorg)
NIFP	Netherlands Institute of Forensic Psychiatry and Psychology
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 Strafrechtstoepassing en Jeugbescherming)
SPT	Subcommittee for the Prevention of Torture

