# 2020 Annual Report

Annual review of the Dutch National Preventive Mechanism

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# 1 Monitoring

No one should be treated in a degrading or humiliating manner. This aim also applies in the Netherlands to those detained, cared for or treated under non-consensual conditions, or whose freedom has been restricted by the government in any other way. Under the United Nations Optional Protocol to the Convention against Torture (OPCAT)[1], organisations with a supervisory or advisory role in the area of people whose freedom has been restricted in the Netherlands together form the National Preventive Mechanism (NPM). In this annual report for 2020, the NPM reports on the conditions and the treatment of detainees or people whose freedom has been restricted. This annual report was published after the usual date on account of the exploratory study into the implementation of the NPM.

According to the annual report, the rights of those whose freedom has been restricted in the Netherlands are respected. Based on the outcomes of these monitoring efforts, the NPM concludes that people whose freedom has been restricted are cared for in an adequate and conscientious manner. There are, however, recommendations to further strengthen human rights at the legislative, policy and implementation level.

The following sections contain the main findings of the NPM's monitoring activities in 2020.

## Medical care

As part of the NPM, the Health and Youth Care Inspectorate monitors the non-consensual treatment of clients and patients in mental health care, nursing home care, care for the disabled and youth care, as well as monitoring medical care in asylum seekers' centres and medical care for detainees.

Care provided to detainees must be of the same quality as care received by free members of society. However, those held in prisons or forensic hospitals are not

[1] According to Article 3 of the OPCAT, member states are obliged 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'. These bodies, responsible for conducting site visits within the member state, are referred to as the NPM.

free to choose their doctor or practitioner. This makes it even more important to monitor the care received in custodial institutions.

All sectors under supervision must operate on the principle that coercion is only to be applied if no other option remains ('no, unless'). Ways to achieve this include good preventive policy, individually tailored care, high-quality skilled healthcare practitioners and management focus on quality. The Health and Youth Care Inspectorate assessed these topics at a large number of care providers. Its assumption is that, if the applicable standards in these areas are met, there will be less need for restrictions on freedom and coercion, which will benefit clients' or patients' quality of life. The Health and Youth Care Inspectorate has published all inspection reports on www.igj.nl. Its main findings have been outlined in the report entitled: '*2020 in vogelvlucht*' (2020 in brief). The next sections highlight a number of findings from 2020, in particular those that relate to prevention and reducing the use of coercion in care.

*Care greatly impacted by COVID-19*

COVID-19 had a profound impact on care in 2020. The Health and Youth Care Inspectorate devoted a great deal of effort to monitoring coronavirus testing and vaccines, among other things. It also gathered data on the first wave of the coronavirus and published information on this in a number of sector reports. In addition, the Inspectorate monitored good treatment for the coronavirus in penitentiary institutions and detention centres, for young people in young offenders institutions and for patients under a hospital order in forensic psychiatric centres. The measures that were put in place led to significant changes in the living environment within institutions. Among staff and those held in the justice system, there was both opposition to and support for the measures that were introduced. The Custodial Institutions Agency and the custodial institutions themselves took swift and adequate action in response to the first wave of COVID-19, with institutions pursuing a clear approach. The Inspectorate published the following report on this: '*COVID-19 in penitentiaire inrichtingen, detentiecentra, justitiële jeugdinrichtingen en forensisch psychiatrische centra*' (COVID-19 in penitentiary institutions, detention centres, young offenders institutions and forensic psychiatric centres).

*Focus and ambition reduce freedom-restricting measures in youth mental healthcare and special education centres*

The Health and Youth Care Inspectorate visited a total of 12 locations for 7 special education centres and 4 institutions for youth mental healthcare. The Inspectorate reviewed the approach taken by institutions in order to reduce freedom-restricting measures, highlighting positive developments such as things that had gone well and any good examples, as well as areas for improvement and obstacles. All the institutions visited are working to reduce freedom-restricting measures. However, freedom restrictions are still a regular occurrence, including unintentionally at times. This is undesirable, especially where these young and vulnerable individuals are concerned. Use of freedom-restricting measures, such as being sent to their own rooms or being placed in a segregation unit, is only permitted if no alternatives are available.

The Inspectorate observed that, in reducing freedom-restricting measures, the majority of institutions attach great importance to a transparent treatment culture.

If there is a good relationship between young people and professionals that includes a custom approach, treatments are often successful without any freedom-restricting measures being necessary. In contrast, unstable teams with turnover among professionals are a hindrance to the reduction of freedom-restricting measures. This is because no relationship is developed with the young people in the group. The complexity of problems is also increasingly a limiting factor. This is the case in both special education centres and youth mental healthcare. In addition, it is often challenging to find suitable follow-up care facilities for young people who have completed treatment.

Some young people with a minor mental impairment run into difficulty, at home, at school or within society. They may be admitted to a special education centre. Youth mental healthcare services provide treatment for young people and young adults suffering from a mental condition that severely restricts their ability to function or increases the risk of disruption to their development. This review is a continuation of monitoring activities carried out in secure youth care institutions during the first six months of 2019. The review was reported on in this fact sheet published in 2019. The Inspectorate will continue to monitor this topic over the years to come.

See also the report entitled *'Aandacht en ambities leiden tot minder vrijheidsbeperkende maatregelen in jeugd-geestelijke gezondheidszorg en behandelcentra'* (Focus and ambition reduce freedom-restricting measures in youth mental healthcare and special education centres).

*Monitoring new legislation*

The Mandatory Mental Healthcare Act (*Wet verplichte geestelijke gezondheidszorg*) and the Care and Compulsion (Psychogeriatric and Intellectually Disabled Patients) Act (*Wet zorg en dwang*) came into force on 1 January 2020. A key objective of this legislation is to strengthen the legal position of clients and their families and next-of-kin. The aim of the Mandatory Mental Healthcare Act is to prevent involuntary treatment, restrict involuntary treatment to the shortest possible duration and increase the quality of care, whether involuntary or otherwise. In this area, the Health and Youth Care Inspectorate chose to focus its monitoring activities on identifying and raising issues and promoting improvement. There is scope here to align care with the new statutory requirements. Monitoring activities were guided by the question whether the quality and safety of care was at stake or whether the use of coercion was unlawful.

Partly because of the COVID-19 pandemic, there is only a limited view of the first three months of the Mandatory Mental Healthcare Act and the Care and Compulsion Act in 2020. The Inspectorate did, however, present an initial impression of its inspection findings.

A follow-up to this was given in the publication covering the April-September 2020 period. During these months, the Inspectorate visited 19 care providers, focusing specifically on the aspect of coercion in care. In this period, the Inspectorate received 50 reports and signs and approximately 300 rulings by complaints committees. The Inspectorate's focus is on the implementation of the two Acts and issues in the practical application of the Acts. Almost one year on from their introduction, a number of bottlenecks remain, despite all the extra efforts by the care sector. Examples include the administrative burden experienced by healthcare practitioners with regard to the implementation of these Acts, the recording of

mandatory care and professional development for healthcare practitioners. Healthcare practitioners endeavour to reduce coercion as much as possible, but proper arrangements in relation to key matters are taking too long to put in place. At times, this is complicated further still by the coronavirus measures in the care sector. At regional level in particular, care offices, health insurers and providers in mental healthcare, care for the disabled and care for the elderly must make arrangements regarding the available crisis shelter facilities and beds.

## Terrorist detention units

In the year under review, the Commissions of Oversight for Penitentiary Institutions observed that a number of measures were put in place with regard to individuals suspected or convicted of terrorist offences. One of these is an increase from 7 to 14 available spaces in the terrorist detention unit at the De Schie location of the Rotterdam Penal Institution. Contrary to the individual regime in place and previous policies, a number of activities, including work and sports, are undertaken jointly. Friday prayers for Islamic detainees are held with the imam positioned behind glass.

The Zwolle Penal Institution is also creating additional spaces, in particular for women returnees from Syria who are required to appear before a Dutch court for suspected terrorist crimes.

And finally, the Vught terrorist detention unit has increased its capacity to more than 36 spaces. Vught also hosts the central reception department, which analyses the personal profiles used during selection and placement.

## Police custody

*Police*

The Commissions of Oversight for Police Custody – of which there are ten, spread throughout the country – monitor the accommodation, safety, care, treatment and transport of detainees, as provided by the police forces. This relates to both cell blocks that provide 24-hour care, including an overnight stay, and locations offering only a day room area. Custody facilities include holding rooms available to local police teams and holding rooms in court buildings, where detainees stay before they appear in court.

The assessment framework used by the Commissions naturally covers national and international legislation and regulations, as well as supplementary rules or instructions imposed internally within the police forces, such as the *Landelijk Reglement Arrestantenzorg* (National Police Custody Regulations). Each year, the Commissions consult to choose the topics they will highlight during their monitoring activities in particular. In 2020, these topics were emergency response, medical care and care for minors.

On the whole, the police custody facilities provided have been unreservedly assessed as good. The accommodation is up to standard, as are the medical care, the practical care in providing for food and outdoor exercise/leisure activities and personal care. The custody officers treat arrestees with care and respect.

Elements of the emergency response – the currency of and familiarity with evacuation plans and the organisation and evaluation of evacuation exercises – are a recurring area of concern, as a result of which emergency response was selected as a topic for 2020. Unfortunately, it was concluded that arrangements are still inadequate, particularly in the holding rooms of local police teams. The number of exercises held is often insufficient, and familiarity with evacuation plans is lacking. For this reason, the Commissions, when presenting their 2020 annual reports, requested that chief officers dedicate specific attention to this.

The Commissions of Oversight for Police Custody maintain good relations with the police, at both the local and the national level. Locally, findings are promptly reported to senior police custody officers. Issues requiring attention at several locations and in several police units are discussed at national level by the National Centre for the Commissions of Oversight for Police Custody with the national portfolio holder.

*Royal Netherlands Marechaussee (KMar)*

The Detention Areas Supervisory Commission of the Royal Netherlands Marechaussee forms part of the NPM. The Commission monitors the detention facilities managed and used by the Royal Netherlands Marechaussee and the care provided by the latter to those who have been detained or taken into custody in these facilities. The annual report prepared by the Commission shows it visited 12 sites in 2020, meaning all detention sites received a visit over the 2018-2020 period.

Generally speaking, the treatment and care of those held in the detention facilities of the Royal Netherlands Marechaussee were found to be adequate. The 2020 inspections did not reveal any shocking facts. The recommendations made (for example organising regular disaster response exercises) have been or are being actioned by the relevant brigade commanders.

## Life sentence prisoners

The Commissions of Oversight for Penitentiary Institutions noted increased dynamics with regard to life sentence prisoners.

When taking administrative decisions, the executive may increase the value attributed to expert opinions by the special advisory bodies serving the government (the Minister for Legal Protection). This follows from case law established by the European Court of Human Rights in Strasbourg and further elucidation of rulings by the Dutch Supreme Court.

In these, the European Court of Human Rights and the Supreme Court have created the possibility that some convicted individuals still retain a prospect of release after many years, even in the event that the Minister refuses this.

## Forensic care

In 2020, the Inspectorate of Justice and Security carried out a review of forensic psychiatric centres. These are secure hospitals for the mandatory admission of individuals sentenced to detention under a hospital order with compulsory treatment. In its review, the Inspectorate of Justice and Security concluded that additional investment is required to prevent a deadlock in the forensic care system. This is because supervision of forensic patients' resocialisation by the forensic psychiatric centres has come under excessive pressure due to a number of factors.

When enforcing a hospital order, a delicate balance must be struck each time between the social mandate to keep society safe and the incremental increase in leave for forensic patients for the purpose of their phased return to society. The Inspectorate of Justice and Security feels that the ability to safeguard that balance is under threat. Although the choices by forensic psychiatric centres in the course of a resocialisation process should be guided by this balance, the Inspectorate found that this is not always the case. This is in part due to staff shortages and a lack of treatment places in hospitals, as well as a lack of follow-up care facilities (transitional care spaces) in treatment units subject to a lighter regime. Forensic psychiatric centres must be able to provide more custom treatment, free from constraints such as a lack of time, space or funds.

In addition to this overarching review, the Inspectorate of Justice and Security also reviewed the resocialisation process in a specific case. This case related to a forensic patient on trial leave who became suspected of involvement in the death of a former forensic patient. The review showed that the forensic psychiatric centre did not adequately supervise the resocialisation process of a forensic patient on trial leave. The forensic psychiatric centre also lacked insight into the patient's personal contacts.

## The Custodial Institutions Agency in times of COVID-19

There is more to supervision than merely carrying out reviews. It is important for the Inspectorate of Justice and Security to understand the state of affairs at implementing bodies. Insight into this is gained via interviews, site visits and linking up with data flows (in the form of incident or other reports, for instance). This enables the Inspectorate of Justice and Security to build a better picture of operations within the organisations and institutions being supervised and strengthen stakeholder relations.

During the coronavirus pandemic, the Inspectorate of Justice and Security was not able to carry out as many physical visits to the individual locations/departments of

the Custodial Institutions Agency. Visits and contacts took place by digital means wherever possible. This included virtual visits to a number of units in the Transport and Support Department, whose responsibilities include the transport of arrestees, detainees and foreign nationals. In order to monitor events at the various sites/departments, the Inspectorate of Justice and Security accessed data flows within the Custodial Institutions Agency. In addition to this, it organised telephone or virtual interviews with all penitentiary institutions and detention centres in relation to the impact of the coronavirus and the measures put in place to prevent onward transmission at their sites. This topic was also actively raised and addressed in all conversations with the head office and national services of the Custodial Institutions Agency for instance.

## Young offenders institutions

Integrated monitoring of young offenders institutions is carried out as a collaboration between four Inspectorates: the Inspectorate of Justice and Security, the Health and Youth Care Inspectorate, the Netherlands Labour Authority and the Inspectorate of Education. With the coronavirus creating a physical distance between the Inspectorates during inspections, regular monitoring of the young offenders institutions changed in 2020. The Inspectorates further strengthen internal access to data by tapping into existing data flows wherever possible and by receiving operational information from the institutions and the Custodial Institutions Agency on a regular basis. In parallel with this, the Inspectorates intensified their contacts with institutions, associated schools and alliance partners, by organising frequent rounds of online or offline interviews with administrators, works councils and supervisory boards, for instance. This enabled the parties to identify and share bottlenecks and good practices. The Inspectorates visited institutions in person as necessary.

During this period, monitoring of young offenders institutions also focused more specifically on issues in the system, including concerns in relation to preconditions such as capacity and staff shortages. The Inspectorates raised these issues with commissioning and contracting parties. The Inspectorates issued several reports on progress made in 2021.

## Migration

*Forced repatriation*

The Inspectorate of Justice and Security report entitled *Toezicht op terugkeer in 2019* (Monitoring of repatriation in 2019) – published in 2020 – shows that the accompanied repatriation of foreign nationals typically proceeds in a safe, careful and humane manner. The exchange of information between the parties involved remains an area for concern, even though it has improved somewhat in recent years. The monitoring activities reported in 2020 (*Jaarbrief Terugkeer vreemdelingen 2020* (2020 Annual Statement on the return of foreign nationals)) confirm this finding.

# 2 About the National Preventive Mechanism

The Dutch NPM is made up of all organisations with a supervisory or advisory role in the area of people whose freedom has been restricted. The members of the NPM jointly hold all authorisations required of NPMs under the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).[2] All members have their own duties, responsibilities and competences in accordance with the law. Some organisations do not take part in the NPM's periodic consultations.

The following organisations take part in the NPM consultations:

- the Inspectorate of Justice and Security (which also serves as coordinator of the NPM network);
- the Health and Youth Care Inspectorate;
- the Commissions of Oversight for Penitentiary Institutions;[3]
- the Commissions of Oversight for Police Custody;[4]
- the Detention Areas Supervisory Commission of the Royal Netherlands Marechaussee.[5]

The overview in Appendix I describes the competences of the various individual organisations.

The organisations work together in areas where their supervisory competences overlap. The NPM organisations carry out their monitoring activities on the basis of existing assessment frameworks. The principles on the prevention of torture or other cruel, inhuman or degrading treatment or punishment are a standard component of these assessment frameworks.

*Exploratory study into the implementation of the NPM*

The 2019 Annual Report referenced an ongoing exploratory study into the question whether the current implementation of the NPM is still the right one. The NPM is contributing to this exploratory study by sharing the experiences gained in its

[2] Parliamentary Papers TK 33826, No. 18
[3] The sounding board group of the Commissions of Oversight for Penitentiary Institutions represents the Commissions of Oversight during NPM meetings.
[4] The National Centre for the Commissions of Oversight for Police Custody represents the Commissions of Oversight during NPM meetings.
[5] The Commission was reinstated at the end of 2017 with three new members. A fourth member joined in early 2019.

blended composition, as well as by sharing thoughts on alternative set-ups for the NPM that would reflect the OPCAT even better. Whilst the Ministry of Justice and Security has discussed an alternative implementation with stakeholders, the Minister for Legal Protection has not yet made any changes to the design of the NPM. The organisations forming part of the NPM will continue their monitoring activities and advisory tasks in the meantime.

## Activities in 2020

Activities relating to the restriction and deprivation of freedom are partly carried out within the context of the members' NPM duties. Further information on their activities outside of the above themes can be found in the separate annual reports of the various organisations.

**Tabel a.** *Activities in relation to restrictions of freedom and deprivation of liberty*

| | |
|---|---|
| Inspectorate of Justice and Security | 2020 Annual Report |
| Health and Youth Care Inspectorate | 2020 Annual Report |
| Commissions of Oversight for Penitentiary Institutions | • Sounding board group annual report<br>• Annual reports of the individual commissions for 2020 |
| Commissions of Oversight for Police Custody | Annual reports of the individual commissions and National Centre for 2020 |
| Detention Areas Supervisory Commission of the Royal Netherlands Marechaussee | 2020 Annual Report |

# Appendix
# NPM consultation member profile matrix

| Location[12] | Inspectorate of Justice and Security | Health and Youth Care Inspectorate | Commission of Oversight for Penitentiary Institutions[13] | Commission of Oversight for Police Custody | Detention Areas Supervisory Commission of the Royal Netherlands Marechaussee |
|---|---|---|---|---|---|
| Prison system | V | V | V | | |
| Young offenders institutions | V | V | V | | |
| Forensic care institutions *criminal law* | V | V | V | | |
| Forensic care institutions *civil law* | | V | V | | |
| Detention centres for foreign nationals | V | V | V | | |
| Aftercare institutions for former detainees | V | V[14] | V | | |
| Police custody[15] | V | V | | V | |
| Detention areas of the Royal Netherlands Marechaussee | V | V[14] | | | V[16] |
| Military detention areas (Stroe) | V | V[14] | V | | |
| Secure mental health care institutions *criminal law* | V | V | | | |
| Secure mental health care institutions *civil law* | | V | | | |
| Secure youth care institutions (Youth Care Plus) *civil law* | | V | | | |
| Police transportation within the Netherlands | V | V[14] | | V | |
| Transportation within the Netherlands Transportation and Support Service | V | V[14] | V[17–18] | | |
| Transportation to other countries (by air) | V | V[14] | | | |
| Secure care retirement homes | | V | | | |
| Secure disabled care facilities | | V | | | |
| The Hague International Criminal Court [19] | | | | | |

*Note: see the next page for footnotes.*

[12] 'Detention areas'/'centres' are not limited to physical locations/buildings, but include all locations from the time of arrest onwards.
[13] The Commission of Oversight also has a judicial function.
[14] The Health and Youth Care Inspectorate monitors locations where care is provided or withheld.
[15] Includes court police and railway police holding locations and mobile police detention complexes.
[16] The Detention Areas Supervisory Commission of the Royal Netherlands Marechaussee monitors all detention areas managed and used by the Royal Netherlands Marechaussee. In accordance with new working agreements from October 2018, this Commission monitors cells leased by the Royal Netherlands Marechaussee at the Schiphol Criminal Justice Complex and the waiting rooms in the court section of this complex where the Royal Netherlands Marechaussee acts in the capacity of court police. The Detention Areas Supervisory Commission does not handle complaints. Complaints relating to actions by Royal Dutch Marechaussee employees are handled by the Defence Complaints Commission.
[17] A special Commission of Oversight has also been established for the Transport and Support Service. This Commission carries out monitoring activities and makes recommendations, but does not handle complaints. Complaints are handled by the relevant penitentiary institution's Commission of Oversight.
[18] The Commission of Oversight for the Transport and Support Service does not monitor the Transferium.
[19] The Red Cross is responsible for monitoring the conditions and treatment of those who have been incarcerated.