2021 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], various organisations in the Netherlands together form the National Preventive Mechanism (NPM).

The Dutch NPM consists of all organisations with a supervisory or advisory role in the area of people whose freedom has been restricted. Each participant has their own tasks, responsibilities and powers, each laid down in laws and regulations. Together, the participants of the NPM have all the powers that NPMs should possess based on the OPCAT. Appendix I contains an overview of the powers of each separate organisation.

This annual report deals with the activities of the following organisations:

- Inspectorate of Justice and Security (which also serves as coordinator of the NPM network)
- Health and Youth Care Inspectorate
- Supervisory Commission for Penitentiary Institutions[2]
- Supervisory Commission for Police Custody[3]
- Detention Areas Supervisory Commission of the Royal Netherlands Marechaussee

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.

[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.
[2] The National Supervisory Committee for Penitentiary Institutions represents the Supervisory Commission during the NPM meetings.
[3] The National Centre for the Supervisory Commission for Police Custody represents the Supervisory Commission during the NPM meetings.

Exploratory study into the implementation of the NPM

Since 2019, the NPM annual reports referenced an ongoing exploratory study into the question whether the current implementation of the NPM is still the right one. The NPM participants have contributed input, but, at the time of publication of this annual report, this has not yet led to a change by the Minister for Legal Protection in the composition of the NPM.

Overview of 2021

In this annual report for 2021, the NPM reports on the treatment of persons whose freedom is restricted or deprived and the conditions under which they are cared for. This annual report makes clear that the rights of persons in the Netherlands whose freedom is restricted are generally respected. The supervision shows that persons whose freedom is restricted almost always receive adequate and carefully provided care and are treated humanely. To further improve, recommendations were made in 2021 aimed at strengthening human rights in legislation, policy and practical implementation.

The following sections include the most important findings from the supervision in 2021 of the various aspects.

1. Supervision on non-consensual care and medical care by the Health and Youth Care Inspectorate

As part of the NPM, the Health and Youth Care Inspectorate monitors the quality of medical care in general and non-consensual treatment in particular of persons in mental health care, nursing home care, care for the disabled and youth care, as well as medical care in asylum seekers' centres and medical care for detainees. Adequate and humane care should be provided in each case.

Care for detainees

Care provided to detainees must — within the possibilities of the specific setting — be of the same quality as care received by free members of society. However, those held in a penitentiary institution (such as a prison or forensic hospital) are not free to choose their doctor or practitioner. This makes it even more important to monitor the care received by detainees.

All sectors under supervision of the Health and Youth Care Inspectorate must operate on the principle that non-consensual care 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 expects care providers to provide non-consensual care carefully and sparingly, and that they document it in a verifiable way. The Health and Youth Care Inspectorate is aware that non-consensual care, due to the risks to the patient and his/her surroundings, can be unavoidable.

The Health and Youth Care Inspectorate assessed these topics, such as good prevention policy, at a large number of care providers in 2021. Its assumption is that, if the applicable standards in these areas are met, there will be less need for restrictions on freedom and non-consensual treatment, which will benefit clients' or patients' quality of life. The Health and Youth Care Inspectorate has published its inspection reports of the visited care providers on its website. It also published a number of reports (fact sheets) on its monitoring of non-consensual care.

In addition to monitoring non-consensual care, it also examined the quality of care in penitentiary institutions in 2021. Over 2021, the joint inspections[4] concluded that the quality of care in the different penitentiary institutions is being increasingly pressured. Reasons that play an important role are the increased labour market shortage, the complication of problems of youths and pressured staff capacity. In addition, the Health and Youth Care Inspectorate sees that the ageing population issue is present in different sectors in different degrees. In this context, the Health and Youth Care Inspectorate investigated palliative care in penitentiary institutions in 2021/2022.

Overview of non-consensual care 2021

The Health and Youth Care Inspectorate monitors compliance with the Mandatory Mental Healthcare Act (*Wet verplichte geestelijke gezondheidszorg*) and the Care and Compulsion (Psychogeriatric and Intellectually Disabled Patients) Act (*Wet zorg en dwang*). As of 1 January 2020, both acts are in force and the Inspectorate receives information on its implementation from players such as care providers. The information consists of analyses of non-consensual care and information at patient/client level. Although few conclusions could be reached, the Inspectorate published fact sheets on the received information: 'Gedwongen zorg in 2021 in beeld' (Overview of non-consensual care in 2021), Analyseren om te sturen: Wat ziet de inspectie in de aangeleverde analyses over de toepassing van verplichte zorg? (Analysing to guide: What does the Inspectorate see in the provided analyses on the implementation of non-consensual care? and 'Analyseren om te leren: Wat ziet de inspectie in de aangeleverde analyses over de toepassing van verplichte zorg? (Analysing to learn: What does the Inspectorate see in the provided analyses on the implementation of non-consensual care?) Through its supervision and by publishing its findings, the Health and Youth Care Inspectorate aims to contribute to realising the objectives of both acts: improving the legal position of clients, reducing non-consensual care and stimulating the quality of (non-consensual) care.

Compulsion in care: from act to mindset

The Mandatory Mental Healthcare Act and the Care and Compulsion (Psychogeriatric and Intellectually Disabled Patients) Act protect the legal position of persons provided compulsory or non-consensual care and describe how care providers should act when it comes to compulsion. In the publication 'Dwang in de zorg: van wet naar mindset' (Compulsion in care: from act to mindset), the Health and Youth Care Inspectorate shares the results of its monitoring visits in 2021 around the topic of 'non-consensual care'. For this publication, the Inspectorate visited 12 institutions

[4] Inspectorate of Justice and Security, Health and Youth Care Inspectorate, Education Inspectorate, Netherlands Labour Authority.

providing (youth) care based on the Mandatory Mental Healthcare Act and 45 visits to institutions providing (youth) care based on the Care and Compulsion (Psychogeriatric and Intellectually Disabled Patients) Act. What goes well is that awareness of non-consensual care has grown further, that the client confidential adviser is present and that those responsible for care are present. What should be improved is the (practical) knowledge in the workplace and methodical working. In addition, crisis relief is still problematic and the external expert is called in on too few occasions.

Monitoring observed risks in mental health care in forensic care

Although forensic care has a great focus on quality improvement, the Health and Youth Care Inspectorate observed risks to the quality and safety of the forensic mental health care during (incident) investigations over the last years. This is based on findings and conclusions from incident reports and investigation reports into the quality of forensic care provision in recent years. These inspections took place after reports and signals from the care sector. In particular, the risks relate to the areas of information transfer and chain collaboration, risk management, treatment offer and leave policy. The situation requires monitoring and, if necessary, enforcement by the Health and Youth Care Inspectorate. That is why a focused monitoring procedure was established in 2021.

Capacity and staff shortage

The Inspectorate observes that multiple sectors are dealing with labour market issues and a pressured capacity. These issues are detailed later in this chapter. These issues pose a risk to the quality of care and causes turnover issues within and between sectors. This is at play at the Young Offenders Institutions, further discussed in section 6, as well as in forensic care. At the end of 2021, 107 patients under a hospital order are living in prisons, waiting to be moved to a forensic psychiatric centre. The result is that care deemed necessary is delayed. In its 2020 report 'Geen kant meer op kunnen' (Having nowhere to go), the Inspectorate already noted that the capacity shortage results in increased patients under a hospital order on the waiting list and the increased duration of the waiting list.

2. Police Custody

Police

The Netherlands has ten Supervisory Commission for Police Custody, one for each regional unit of the national police. They 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. The latter occurs in the so-called holding rooms available to local police units and holding rooms at court buildings, where detainees stay before they appear in court.

The assessment framework used by the Commissions is based on 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 in particular during their monitoring activities in particular. In 2021, these topics were 1) compliance with Covid-19 measures, 2) the procedure for the release or transfer of a detainee and 3) the care for minors and moderately mentally disabled.

On the whole, the police custody which facilities provided has been unreservedly assessed as good. The accommodation is up to standard, as are the practical care in providing for food and outdoor exercise/leisure activities and personal care. Medical care is adequately provided by doctors and custody officers. The custody officers treat detainees with care and respect.

The three areas above were in order during the inspections in basically every instance. A single relevant comment was that it was not always clear if you are dealing with a moderately mentally disabled person. However, no faults were observed in the care for this group.

Unfortunately, an area that is repeatedly not in order is the company emergency response, especially for holding areas/rooms. The Covid-19 pandemic and the related restrictive measures can partially explain why fewer evacuation drills were held. However, this was and is also a matter of concern before and after the pandemic. In any case, it is important to ensure that evacuation drills are actually performed and that company emergency response plans are kept up to date.

The Supervisory Commission 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 Supervisory Commission for Police Custody with the national portfolio holder for police custody at the police.

Each Commission publishes an annual report. These can be found on the website of the Supervisory Commission for Police Custody.

Royal Netherlands Marechaussee

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 detention areas, such as holding rooms and cells, are located at about 30 locations in the Netherlands and the Caribbean region, where the Marechaussee also performs police and border tasks. The tasks and methods of the Marechaussee and the police are similar, so in order to enable uniform supervision, the Detention Areas Supervisory Commission of the Royal Netherlands Marechaussee supervises in a manner similar to that of the Supervisory Commission for Police Custody.

Its 2021 annual report shows that the Detention Areas Supervisory Commission of the Royal Netherlands Marechaussee visited 12 locations in 2021, the same number as in 2020.

Generally speaking, the treatment and care of those held in the detention facilities of the Royal Netherlands Marechaussee were found to be adequate. The 2021 inspections did not reveal any shocking facts. The recommendations made were diverse in nature, such as improved registration of the inspection of first-aid boxes, fire extinguishers and eyewashes, and the regular calamities training with such bodies as the fire department. The majority of these recommendations have been or are being actioned by the relevant brigade commanders. Previously made recommendations will receive attention during re-inspections.

3. Monitoring by Supervisory Commission in penitentiary institutions

A Supervisory Commission monitors the day-to-day affairs in a penitentiary institution. The National Supervisory Committee for Penitentiary Institutions mostly functions as a point of contact for the Supervisory Commissions. Topics discussed in the National Supervisory Committee come from places such as consultations with the chairs of the Supervisory Commissions. These topics were also brought up during the conversations with external partners that the National Supervisory Committee regularly consults. These are the Minister for Legal Protection, the Council for the Administration of Criminal Justice and Protection of Juveniles, the Inspectorate Justice and Safety, the Health and Youth Care Inspectorate, the National Ombudsman and the Custodial Institutions Agency.

The Supervisory Commissions observed that the Covid-19 pandemic demanded a lot of the detainees. No visitors, isolation, unable to shower, no recreation and no possibilities for labour. Covid contamination among the staff also limited the execution of the day programme, forcing detainees to stay in their cells more often.

In addition, various themes influence the work of the Commissions. These are detailed in the next paragraphs.

In multiple consultations, there was attention for and discussion about confinement of detainees in the isolation cell for a maximum term of 14 days. The advice 'Disciplinair straffen en afzonderen in detentie' (Disciplinary punishment and isolation in detention) of the Council for the Administration of Criminal Justice and Protection of Juveniles questions the humanity of confining people in isolation and states that this isolation can lead to traumas and hinder proper rehabilitation.

Rehabilitation is a topic that is increasingly defined and important in penitentiary institutions. How can detainees return to society improved and how do we increase their odds of making a fresh start?

The National Supervisory Committee for Penitentiary Institutions keeps a watch on the developments regarding long-term prisoners. The National Supervisory

Committee states that hopeless lifelong detention is a topic that asks for reflection. The work of the Advisory Body Long-term Prisoners, which extensively investigates and advises on individual possibilities of long-term prisoners to be set free after 25 years, has led to a single release.

4. Penitentiary Psychiatric Centres

In 2021, the Inspectorate of Justice and Security started an investigation into the functioning of the four Penitentiary Psychiatric Centres in the prison system. In this investigation, the Inspectorate of Justice and Security looks at how the rights of detained patients are ensured, at how they are treated and at the status of internal safety for staff and patients. It also takes into account personnel aspects, such as whether there is enough properly trained staff.

The Inspectorate of Justice and Security has created a system of standards for the inspection of these centres. The report will be published mid-2023.

5. Forensic care

In 2021, the Inspectorate of Justice and Security looked at the effect of improvement measures applied by a forensic clinic after two forensic patients successfully fled the clinic in 2020. The Forensic Psychiatric Centre in question took steps to improve the internal security of the clinic. It has tightened its access policy and the method for bringing in goods, among other things.

However, the Inspectorate of Justice and Security still observes major points for improvement. For example, there is insufficient attention to team development in the department for extremely difficult to manage and highly likely to escape forensic patients, in part due to staff shortage, and employees do not work in a uniform manner. There is also no modified policy for dealing with hostage situations. The Inspectorate is keeping watch on these points for improvement as part of their regular monitoring since this inspection.

6. 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.

For five years, the inspectorates have been expressing their worries about the quality of performance of duties in the Young Offenders Institutions and related schools. The inspectorates are very worried about the pressing capacity and staff

shortage and its consequences for the upbringing, care and treatment, for education/practical training and for safeguarding the internal security for young offenders and the staff in the short and medium terms. Since summer 2021, they are keeping intensive watch on these institutions and their schools. As part of the intensive monitoring, the inspectorates publish a status report twice a year.

In October 2021, in response to the progress report of the inspectorates, the Minister for Legal Protection provided a hefty aid package to solve the capacity and staff shortage in the Young Offenders Institutions. The progress statement of the inspectorates stated that extra capacity was realised and the external waiting list was reduced, but a shortage of personnel and suitable places still remained. One consequence is that internal waiting lists are not solved. Youths cannot always move on to a place that is suited for them, because departments are full. The legal requirements for day programmes were also not met for the majority of the institutions in the summer of 2021. As a result, youths spent more time in their rooms than what is legal. The security for staff and youths is not in order, because employees have insufficient time to get to know the juveniles and gauge their mood. Several violent incidents took place. Collaboration with the schools is also under pressure.

In 2022, the inspectorates indicated that a critical threshold has been reached. The inspectorates state that the Young Offenders Institutions and the responsible Custodial Institutions Agency have an impracticable task. No matter the effort of their employees. As a result, court judgments and the legal requirements of juvenile criminal law cannot be adequately enforced for all youths. The four inspectorates therefore state that from now on, placement in a Young Offenders Institutions can only be ordered if a suitable treatment and a responsible stay are guaranteed. In their view, placement is only possible if there are at least a full-fledged day programme, a minimum of two qualified group leaders for each group, as well as no internal waiting list. This is in the interest of the youths and the security of the staff, which works under great pressure. They have called on the responsible Minister for Legal Security to act immediately and to ensure a responsible stay in accordance with the law.

Involuntary medical treatments in penitentiary institutions provided properly

The Health and Youth Care Inspectorate monitors the involuntary medical treatments and activities that are administered in penitentiary institutions. Administering an involuntary medical treatment or activity is a drastic event. For the health and safety of both the patients and their surroundings, it is important that this happens in a careful manner. In 2021, the Health and Youth Care Inspectorate investigated by consulting all institutions where this care is administered. This investigation concluded that most penitentiary institutions work carefully, that procedures are followed and that this treatment is administered carefully in practice. The results of the investigation are presented in a fact sheet: Penitentiary institutions are careful with compulsory treatments.

In 2021, the Inspectorate monitored the care and guidance of youths staying in institutions for secured youth care. It did so through frequent visits to multiple institutions, a reassessment of the enforcement of measures restricting freedom and a calamity inspection within an institution for secured youth care.

Temporary Young Offenders Institution

At the temporary Young Offenders Institution Horsterveen, youths above 18 years of age who are accused of a crime or have been convicted stay for a maximum of three months. This temporary location serves as their shelter until the new building of the private penitentiary youth institution Teylingereind is finished in 2023.

The Inspectorate for Justice and Security, the Health and Youth Care Inspectorate, the Inspectorate of Education and the Netherlands Labour Authority visited the temporary Young Offenders Institution and its school in October 2021 and in May 2022. They inspected whether the security, treatment, medical care and education met the basic requirements.

Situation October 2021

After their first visit, the inspectorates expressed their positive opinion on the phased occupation of this location. However, they also saw that due to the quick start of this location, various matters were insufficiently arranged. There were pressing needs for improving healthcare and education.

Situation May 2022

Although outside the scope of this annual report, the inspectorates saw major improvements in healthcare and education during their second visit in May 2022. Medical care is organised adequately. The day programme to be followed by the youths meets the basic requirements. There is sufficient and motivated staff at the Young Offenders Institution and its school to offer care and education to the three groups, each with eight youths. During the inspection visits, the youths indicated that they felt taken seriously by the group leaders and teachers.

Recruitment

The recruitment of qualified group leaders is tricky, however. According to the inspectorates, this location can only expand into a fully operational institution if sufficient qualified personnel is available. This is difficult in the current labour market shortage. Four groups have opened since the start. The inspectorates will visit the temporary location again once the intended five residential groups are 'up and running'.

7. Foreign nationals in the criminal justice chain

In 2021, the Inspectorate for Justice and Security investigated foreign nationals in the criminal justice chain. It concluded that not all agreements laid down in the

Chain Process Description[5] correspond to the actual situation. In addition, information is not always shared in the agreed method. This means that information transfer is not safeguarded and is often dependent on persons and individual agreements.

The causes are a lack of central management of the process as well as incomplete and unclear agreements. In addition, employees of some organisations are insufficiently aware of how to act.

To improve the transfer of information, the Inspectorate for Justice and Security makes a number of recommendations to ensure that everyone keeps to the work agreements and shares information on time. For example, institutions should examine how to manage the further development of the Chain Process Description for foreign nationals in the criminal justice chain and its implementation. The Inspectorate recommends a periodic evaluation of the Chain Process Description to see if it should be amended. In addition, it makes specific recommendations to involved organisations to better perform their tasks.

8. Monitoring the repatriation of foreign nationals

The Inspectorate Justice and Security monitors the accompanied repatriation of foreign nationals. The report Jaarbrief Terugkeer vreemdelingen 2020 (2020 Annual Statement on the return of foreign nationals), published in 2021, of the Inspectorate shows that the accompanied repatriation of foreign nationals typically proceeds in a safe, careful and humane manner. However, health information should become more usable. The registration of personal possessions can also be improved. The monitoring in 2021 confirms this image. The information exchange prior to deportation remains a point of attention, as well as the timing with which foreign nationals are picked up from the detention centre by employees of the Transport and Support Service. These have room for improvement. In regard to the use of aids, the Inspectorate notes - based on the mentioned reports - that there is a significant difference in the use of aids by the employees of the Transport and Support Service and the Royal Netherlands Marechaussee.

Investigation into the interests of foreign nationals

Although outside the scope of this annual report, the Inspectorate also investigated in 2022 if the interest of the foreign national is sufficiently safeguarded in the departure process, within the fact that they must leave the Netherlands.

During the departure process, it is important that coordinators of the Repatriation and Departure Service, the organisation tasked with the repatriation of foreign nationals, constantly consider if special circumstances should delay or cancel a departure. The inspection of 200 files shows that in practice the employees check too rarely and do not properly document if any special circumstances exist. As a

[5] This Description contains the agreements on information exchange between organisations, for example on the release of a detainee.

result, potentially important information that could be in the interest of the foreign national may be lost.

The special circumstances should be assessed in three so-called departure consultations, which must be held with the foreign national. In addition to assessing and documenting these special circumstances, the coordinator should use these conversations to provide information on the departure and to take into account realistic departure wishes, such as establishing a business in the country of origin. Assistance in these matters can facilitate the departure.

Part of the employees hold all three conversations and would like to hold more, have an active attitude and try to build a bond of trust with the foreign national. Other employees do not hold all three conversations and make few individual arrangements. Their process orientation puts the human dimension at risk.

In addition, coordinators have little time and resources to take the wishes into account and realise the departure. Some employees call on aid agencies for support or have the Service contribute money to the departure. They believe that substantive consultation will lead to more applications to aid agencies, which can voluntarily organise the departure. However, this is not always the case, as some employees do not hold all conversations and are unaware of all the options.

The Inspectorate for Justice and Security has recommended the Repatriation and Departure Service to stimulate its employees to work actively in the departure process and to take (follow-up) training to keep their knowledge up to date. Also, information from foreign nationals should be documented in the departure plan in a uniform manner. The Inspectorate further recommends the Service to let employees reflect among themselves on the number and contents of the departure conversations.

Appendix NPM consultation member profile matrix

Location[7]	Inspectorate Justice and Safety	Health and Youth Care Inspectorate	Supervisory Commission for Penitentiary Institutions[8]	Supervisory Commission 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[9]	V		
Police custody[10]	V	V		V	
Detention areas of the Royal Netherlands Marechaussee	V	V[9]			v[11]
Military detention areas (Stroe)	V	V[9]	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[9]		V	
Transportation within the Netherlands Transport and Support Service	V	V[9]	V[12-13]		
Transportation to other countries (by air)	V	V[9]			
Secure care retirement homes		V			
Secure disabled care facilities		V			
The Hague International Criminal Court[14]					

Note: see the next page for footnotes.

[7] 'Detention areas'/'locations where people are deprived of liberty' are not limited to physical locations/buildings, but include all locations from the time of arrest onwards.
[8] The Supervisory Commission also has a judicial function.
[9] The Health and Youth Care Inspectorate monitors locations where care is provided or withheld.
[10] Includes court police and railway police holding locations and mobile police detention complexes.
[11] 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.
[12] A special Supervisory Commission 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 Supervisory Commission.
[13] The Supervisory Commission for the Transport and Support Service does not monitor the Transferium.
[14] The Red Cross is responsible for monitoring the conditions and treatment of those who have been incarcerated.

II

Appendix Activities 2021

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 the main themes mentioned above can be found in the separate annual reports of the various organisations.

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

Inspectorate Justice and Safety	2021 Annual Statement
Health and Youth Care Inspectorate	2021 Annual Report
Supervisory Commission for Penitentiary Institutions	• National Supervisory Committee board group annual report • Annual Reports of the individual commissions for 2021
Supervisory Commission for Police Custody	Annual Reports of the individual commissions and National Centre for 2021
Detention Areas Supervisory Commission of the Royal Netherlands Marechaussee	2021 Annual Report

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