



# Monitoring places of detention

Second annual report

National Preventive Mechanisms

The Netherlands

2012

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# Introduction

2012 was the second year the Inspectorate of Security and Justice (IVenJ), the Health Care Inspectorate (IGZ), the Inspectorate for Youth Care (IJZ), the Supervisory Commission on Repatriation (CITT) and the Council for the Administration of Criminal Justice and Protection of Juveniles (RSJ) operated as the Dutch national preventive mechanism. This second annual report mainly focuses on the activities of the Dutch NPM on the different places where people are deprived of their liberty. Furthermore, it provides information about the monitoring bodies that are appointed as NPM and about the associate organisations.

Collaboration between the members continues to develop. In autumn 2013, the Dutch NPM will organise a meeting during which the issue of how the various members can more effectively carry out collective tasks in the future will be discussed.

Overall, the picture that is outlined in this annual report is relatively positive. The rights of persons that have been deprived of their freedom in the Netherlands are generally adequately respected. This does not detract from the fact that improvements are desirable and, on occasion, vital. The investigation into the death of a Russian asylum seeker in a Dutch detention centre at the beginning of 2013, highlighted this in relation to the detention of foreign nationals. This will be dealt with at some depth in the next annual report, focusing on the activities of the Dutch NPM in 2013.

On behalf of the other Dutch NPM's and associates, I hope this second annual report will be valuable to the SPT and to those concerned about those deprived of their liberty.



Gertjan Bos  
*Head of the Inspectorate of Security and Justice*



# 1 Context

The Netherlands signed the OPCAT in May 2005 but did not ratify it until September 2010. In December 2011 the Netherlands designated its NPMs. This is the second annual report of the Dutch NPM.

## 1.1 NPMs of the Netherlands

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

- Inspectorate of Security and Justice (IVenJ).
- Health Care Inspectorate (IGZ).
- Inspectorate for Youth Care (IJZ).
- Supervisory Commission on Repatriation (CITT).
- Council for the Administration of Criminal Justice and Protection of Juveniles (RSJ).

The additional associates ('toehoorders') include:

- Commissions of oversight for penitentiary institutions.
- Commissions of oversight for the police cells.
- Commission of oversight for military detention.
- National Ombudsman.

## 1.2 Coordination

Before the completion of the official designation process, the government selected the IST to carry out the coordinating and communication functions of the NPM. In January 2012 the Inspectorate for the Implementation of Sanctions merged with the Public Order and Safety Inspectorate into the Inspectorate of Security and Justice (IVenJ). The purpose of coordination is to promote cohesion among the NPM members, to facilitate a collective understanding of OPCAT and its requirements, and to encourage collaboration between a wide-ranging group of organisations and sharing experiences among them. At the same time, however, the independence of individual members is respected, as is their ability to set their own priorities for monitoring detention. Through working with all of the NPM members, the coordinator is able to gain an overview of all the monitoring activities and possible gaps in regulatory oversight.

Additionally the IVenJ communicates with other (inter)national bodies. This is done by acquiring information about monitoring activities from all the NPMs and associates. Secondly, by combining that information and publishing the annual report of the National Preventive Mechanisms of the Netherlands on the basis of acquired information.





## 2 Being in a place of detention

The members of the Dutch NPM conclude that the rights of persons that have been deprived of their freedom in the Netherlands are generally adequately respected. Several shortcomings that were observed in earlier years, have now been improved. However, improvements are still desirable and, on occasion, vital. High-quality staff and a good daily programme are crucial factors, that are now sometimes vulnerable because of sometimes high absenteeism of employees. Special attention is necessary for the at moments unneeded physical interventions in Jeugdzorgplus institutions and immigration detention centres, and the manner in which restrictive measures are applied in residential care for the elderly or persons with a physical or mental disability.

To be more clear about what kind of situations are being dealt with, the NPM presents the following examples. Although these – partial fictional – cases can depict a rather exceptional situation, they are not unlikely to occur.

### 2.1 Anup

Anup was detained for a violent offence after excessive alcohol consumption. At the police station, aside from his drunken condition, no physical and/or mental problems were noted. He was then transferred to a penitentiary institution (PI). During his time at the PI, Anup came across as morose and withdrew into his own room. He had little contact with other detainees and people outside the PI. He often left his meals untouched. The PI staff were concerned and engaged the medical services. A nurse from the medical service assessed Anup and established that he had psychological as well as physical problems. This could well have been a case of clinical depression. Anup was extremely concerned about his wife and children and, in particular, about his future with or without them. He began to question the value of life if he 'had to stay in prison'.

The nurse from the medical service introduced Anup's case during the Psycho-Medical Discussion (PMO). The GP linked to the PI and the psychologist set up a plan and visited Anup. As a result of the visits, both physical and psychological assistance was commenced. During the subsequent PMO, a psychiatrist from the Dutch Institute for Forensic Psychiatry and Psychology (NIFP) was engaged. Together, the various options and scenarios were discussed: could medication be used? Was it wise to continue the detention in the particular department? Was there a risk of suicide? Should a transfer to the Penitentiary Psychiatric Centre (PPC) be

considered? Anup himself wanted to move to the GGZ (Association of Mental Health and Addiction Care) in the PPC region. This, however, was not possible due to the fact that he was being detained on a preventive basis and his risk profile was too high.

One week later, Anup displayed impulsive and uncontrolled behaviour. He entered into a confrontation with another detainee and slapped and kicked him. The fact that the PI staff intervened quickly meant that Anup was prevented from causing serious injury. Anup spoke of suicide on numerous occasions after the fight. The psychologist from the PI then suggested that Anup was transferred to a PPC. The psychiatrist agreed with this suggestion and Anup was then transferred several days later.

By then, the judge had ruled in the criminal case against Anup: he was to be freed one month after his move to the PPC. As a result, the people at the PPC were only able to diagnose Anup and put a treatment plan in place. The treatment plan was never really substantiated. The PPC endeavoured to share the treatment plan and other relevant information with a local GGZ (Association of Mental Health and Addiction Care) but encountered various problems. The PPC was located too far from Anup's home and he refused to give permission for a change to the local psychiatric clinic. The fact that the judiciary no longer had any power over Anup meant that the transfer never went ahead. Ultimately, upon his release, Anup was given medication for a few days and was advised to report to his own GP for a referral to a local GGZ centre. Anup then disappeared out of the system.

## 2.2 Klaas

Klaas is 21 and is staying in a judicial youth centre. When he was 17, he had a PIJ measure<sup>1</sup> imposed as a result of a violent attack. As a result of the length of the PIJ measure, Klaas has reached adulthood but finds himself within a youth centre. In general, Klaas has no complaints about his detention there. The groups are furnished in a more appealing manner than is the case in the (adult) prison system; the group leaders treat him well and do their best to ensure that he can take his place in society after six months effectively.

Klaas does, however, have a problem with how he has to spend his days. The fact that he is in a youth centre means that he has to go to school every day and he is completely opposed to this. With an IQ of 80, Klaas is not a gifted individual and finds it very hard to follow lessons. Outside the centre, he will not go to school and he would, therefore, prefer to learn a trade. Something with cars or metallurgy, for example. This option is not available; the education is not really adjusted to youngsters aged 21, but to a much younger age group. So Klaas has to go to school, even though he is not obliged by law to attend school, because the centre has no other daily programme for him or others of the same age. He is not learning any useful skills

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<sup>1</sup> PIJ stands for Plaatsing In Jeugdstrafrecht (Placement in a judicial youth detention centre) The measure is intended to be used to treat and (re)educate criminal youngsters with developmental issues or psychological complaints. The PIJ measure lasts at least two years from the moment of the irrevocable decision. The measure may be extended by up to two years if the case concerns violence or an act of indecency. If there is a case of a developmental deficiency or a mental disturbance, the measure can be extended by another two years. The PIJ measure can therefore last for a maximum of six years.

and this hinders him in terms of an effective return to society.

Another difficult point is the fact that, when numerous group leaders are off sick, Klaas ends up being faced with different people than usual on the group. Group leaders from other groups come to fill in but are not always familiar with Klaas' exact problems.

Jelmer, Klaas' 15 year old brother, is currently staying in a Youthcare<sup>plus</sup> establishment. Here, the outflow of personnel and the many staff off sick can lead to a temporary worker leading the group of youngsters instead of a group leader. The people in the group are then not familiar with one another and do not know how to get on together. Jelmer uses this to his advantage. The fact that the temporary workers are less familiar with the rules means he knows exactly how to play them off against one another. This lack of familiarity with Jelmer's problems also means, however, that the group leaders can suddenly take hold of him if he does not obey their orders. Jelmer's treatment plan states that he cannot cope with being touched. This causes him to be very aggressive. As a response to this, he once went into a rage which resulted in injuries to him and the group leader. On this occasion, Jelmer was detained in an exclusion room.

## 2.3 Chris

Chris, having been convicted for a serious criminal offence, has been detained for many years (since 1998). At the time of the trial he was a non-documented alien. For this reason, according to his legal advisor, he was convicted to a prison sentence where a hospital order should have been the appropriate sanction, regarding his psychiatric problems. As his country of origin was unknown at the time, he could not be expelled.

Chris may, because of his mental state of mind, show extremely aggressive, reactive behaviour. Forensic experts recommended that he would be placed in the very intensive care unit of a forensic psychiatric hospital. Several prison directors have acknowledged, both in complaint as in appeal procedures, that a prison regime is not suitable for the complainant. However, complainants behaviour stands in the way of a transfer to a treatment clinic, which has therefore never been established during detention.

During his detention Chris has often been placed in extra secure establishments where individual regimes apply. In none of these he could be appropriately 'helped'. Because of his aggressive behaviour he has been frequently (no less than twelve times) transferred and subjected to disciplinary punishments, order measures, and restraints. The penalties and measures were often executed in a facility specially designated for this purpose and were often extended, causing his stay there to last for longer than fourteen days. Complainant went in appeal against at least thirty-two of the director's decisions. In six of these cases the Council deemed his appeal grounded.

During the period from 24 May 2011 until 16 July 2012 Chris spent 119 days in seclusion on his own cell and 273 days in a solitary cell. After the expiration of his prison sentence Chris was taken into alien detention. On February 26 2013 complainant was deported to Ghana.



# 3 Summary of activities

## 3.1 Penitentiary institutions

In 2012 the Inspectorate of Security and Justice (IVenJ) visited three penitentiary institutions (PI's). Two other PI's were visited for a follow-up research. In the last years, almost all PI's have been visited by the IVenJ. The IVenJ concluded in 2012 that the detainees were treated well in all PI's. In all but one of the PI's the other aspects the IVenJ monitors also sufficed. The one PI which didn't suffice, will be visited again in 2013.

A few aspects of the implementation of sanctions need improvement. An often seen threat to the stability in PI's is the high absenteeism. Due to the absence of employees activities for detainees are being cancelled or employees aren't able to participate in obligatory trainings, like physical defensibility.

The several ways in which detainees are prepared for their reintegration in society sometimes don't seem compatible with each other. There generally are two working methods, both based upon their own line of thought. Some of the reintegration activities are indicated with a thorough diagnostic instrument, while others are indicated with only a quite basal screening. The two methods often aren't aligned with each other and the choice between those methods isn't discussed.

### *Advice RSJ*

In 2012 the RSJ has researched the detention planning. The RSJ advised that detainees are granted privileges necessary for social reintegration or care, unless the detainee does not appear to be able to handle these privileges. Gradually allowing increased responsibilities and privileges should be part of the organisation of detention, in which the encouragement and stimulation of detainees should be the norm. To earn privileges is not the right approach in the context of care and interventions, as it suggests that receiving care and participating in behavioural interventions will make the detainee's stay 'more pleasant', which he or she first has to earn by good behaviour. Care and behavioural interventions should be provided because the detainees need them and not because (or if) this makes him or her feel happy and satisfied.

### *National Ombudsman*

The National Ombudsman concluded in 2012 in its report 'Deaths in detention' that shortcomings in the way the authorities investigate deaths in custodial institutions in the Netherlands exist. The Ministry of Security and Justice has given the IVenJ the task to improve the investigation of deaths in detention.

## 3.2 Juvenile detention centres

There are different types of residential facilities for juveniles in the Netherlands. Two of these, the Jeugdzorg<sup>plus</sup> institutions and the justitiële jeugdinrichting (judicial youth detention centres), are secure facilities.

### *Juvenile care based on a civil justice detention order: Jeugdzorg<sup>plus</sup>*

Jeugdzorg<sup>plus</sup> institutions have been providing accommodation, counselling and treatment since 2008 for a very difficult group of juveniles who would previously have been sent to youth detention centres. The Inspectorate for Youth Care co-monitors Jeugdzorg<sup>plus</sup> with the Healthcare Inspectorate and the Education Inspectorate.

The young people in these institutions have been placed there on the basis of a civil justice detention order imposed by the juvenile court. The treatment programme may entail freedom restrictions if the juvenile in question constitutes a danger to himself or others and/or has evaded treatment in the past.

As Jeugdzorg<sup>plus</sup> is still a work in progress, it is being monitored in steps. The first step (2009-2010) focused on the safety and legal position of the juvenile, primarily because of the secure nature of Jeugdzorg<sup>plus</sup> institutions. Particular attention was paid to measures for restricting freedom, to the complaint and leave regulations and to opportunities for accessing confidential counsellors.

The Inspectorate for Youth Care stated in its Interim Report on the first step (2010) that the majority of the Jeugdzorg<sup>plus</sup> institutions met the criteria for a good legal position. Seven of the seventeen institutions were deemed *inadequate*. Now, all the institutions meet the criteria, partly because the Inspectorate has overseen the implementation of improvements in recent years and has encouraged the institutions to share best practices.

The focus in the second step (2010-2011) was on social environment and cooperation with the school. The results were published at the end of 2011 in the Second Interim Report on the Jeugdzorg<sup>plus</sup> monitoring programme. The audit was conducted in association with the Inspectorate of Education. Amongst other things, it revealed that high-quality staff and a good day programme are crucial factors in the maintenance of a good social environment. Differences emerged in the quality of the social environment, which was deemed adequate or good in a small majority of the institutions. The Inspectorate found cooperation between the Jeugdzorg<sup>plus</sup> institutions and the internal school *inadequate* in half the institutions. Most of the follow-up audits in 2012 concerned both parts of step 2. The results show that almost all the institutions received adequate scores. Both Inspectorates will closely follow the improvements and carry out further audits in the institutions deemed inadequate.

Looking back over the past four years, the Inspectorate for Youth Care is satisfied with the way the quality of Jeugdzorg<sup>plus</sup> is developing in terms of the legal position of the juveniles (step 1), and social environment and cooperation with the school (step 2). In the follow-up audits the institutions that had initially emerged as inadequate showed sufficient improvement in these areas. This required the necessary effort from the Inspectorate, which was charged with the task of assessing the improvement plans, supervising the implementation and performing the

follow-up audits.

The monitoring of Jeugd zorg<sup>plus</sup> and the judicial youth detention centres is also part of the Annual Working Programme of the Inspectorate for Youth Care for 2013. This year will see the third and final step in the phase-based monitoring programme of Jeugd zorg<sup>plus</sup> institutions, which will focus primarily on the content of the treatment.

In the past year, the Council for the Administration of Criminal Justice and Protection of juveniles during its advisory work identified two structural bottlenecks which, in the opinion of the Council, may hinder the functioning of the Jeugd zorg<sup>plus</sup> and touched on its duties as NPM.

The first point is that juvenile courts increasingly authorize the court custody for a limited duration only, aiming to ensure that the institution makes a quick start with the treatment of the juvenile and enabling the judge to follow its progress adequately. The institution understands this procedure well enough, the parents and young people concerned however take the short-term authorization to indicate that the judge looks upon the problems as being slight and the child will be coming back home soon. This leads to the juvenile failing to cooperate with the (start of the) treatment. This way, the court practice giving short-term authorization for the benefit of good and timely care turns out counterproductive.

The second point is that more and more juveniles with a criminal background, or even as a consequence of an offense (e.g. by suspending remand custody), are being placed in Jeugd zorg<sup>plus</sup>. The Council fears that these young people in Jeugd zorg<sup>plus</sup> receive less specialized care, tailored on their behaviour and background, in comparison to what the youth detention centres designed for this purpose may offer.

### *Judicial youth detention centres*

Justitiële jeugdinstellingen (Judicial youth detention centres) are for juveniles who have been sentenced to detention by a criminal court. The Inspectorate for Youth Care, the Inspectorate of Education, the Health Care Inspectorate, the Inspectorate of Security and Justice, and the Inspectorate Social Affairs and Employment work together when monitoring the judicial youth detention centres. From 2012 onwards this takes place under the heading of Samenwerkend Toezicht Jeugd (STJ)/Collaborative Youth Supervision).

In 2012 the five government inspectorates that oversee judicial youth detention centres continued to implement their collective monitoring programme in this sector. In this year the inspectorates carried out audits in two judicial youth detention centres. These audits focused on the legal position of juveniles, the relationships with the juveniles, internal security, protection of society and social reintegration, and some associated organizational aspects. In March 2012 an audit was performed at De Hartelborgt youth detention centre. The collaborating inspectorates concluded that the implementation of sanctions was largely in order, but there was scope for improvement in legal position and internal security. The report issued in mid-2012 for 'Den Hey-Acker' youth detention centre was much less positive. The inspectorates were either critical or very critical of the relationships with the juveniles, internal security and protection of society. A further audit will therefore be performed in 2013 to assess the progress and results of the improvement programme.



At the end of 2012 an interim audit also took place at Teylingereind Forensic Centre. These audits are carried out to monitor the progress of improvements one year after a report has been issued. As the institution had vigorously implemented most of the recommended improvements a further audit was deemed unnecessary.

### *Judgements RSJ*

The Council for the Administration of Criminal Justice and Protection of Juveniles (RSJ) in its judiciary task has passed a number of judgements that have a bearing on his task as NPM. This concerns institutions for Jeugdzorg<sup>plus</sup> as well as juvenile detention. In one case, the Council noted that a camera had needlessly been running during a body cavity search in an institution for Jeugdzorg<sup>plus</sup>. In another case, it appeared that after transfer from one Jeugdzorg institution to another a juvenile had unnecessarily been subjected to a body cavity search. Finally, it appeared that in 2012 within an institution for Jeugdzorg<sup>plus</sup> and within a judicial youth detention centre physical interventions were carried out without necessity. This presses all the more concern as the Council already had commented on several occasions of unneeded physical intervention in Jeugdzorg<sup>plus</sup> institutions in 2011.

## 3.3 Forensic care institutions

In 2012, the focus of the Dutch Health Care Inspectorate was on ensuring an adequate response to incidents and emergencies, from which lessons must always be learned. An improved reporting procedure was implemented alongside a structured system of investigation by the relevant forensic institutes. As part of the new system, a number of Calamity Investigation Commissions have been established. These interdisciplinary commissions will work independently.

In 2012, several major incidents were subject to investigation by the Inspectorate itself in addition to the efforts of the Calamity Investigation Commissions. In the autumn of 2012, an incoming report prompted the Inspectorate to launch a programme of visits to all detention centres in the Netherlands to assess the quality of both medical and psychological care. The programme will conclude in 2013.

In 2011 en 2012 the IVenJ has carried out audits in four forensic care clinics. Over-all the IVenJ was positive, but there also was some need for improvement. In choosing a balance between safety requirements and the individual treatment of patients, the clinics make different choices. Sometimes with too much focus on security and sometimes on the treatment. The IVenJ has a strong preference for an integral approach, so all interests concerned (both the safety of the patient, his co-patients and society) are sufficiently guaranteed.

### *The Inspectorate and mental health institutions: reduced use of restrictive measures*

Through its regulatory activities addressing over two hundred psychiatric units between 2008 and 2011, the Inspectorate has been successful in reducing the use of restrictive measures, notably seclusion, for the purposes of controlling patients. Shortly after the Inspectorate drew attention to the matter, the number of seclusion incidents decreased by approx. ten percent

per year. After some further progress, the downwards trend levelled out. The Inspectorate therefore intensified its supervision policy in 2012. The objective is a situation in which no patient is ever subject to seclusion measures unless the care provider can establish beyond question that there is no alternative. Even so, every effort must be made to ensure that the period of seclusion is as humane as possible ('solitary confinement' is not acceptable) and as brief as possible. A field norm which effectively prohibits any form of solitary confinement has been developed. Points for attention include frequent contact with the patient concerned, and the opportunities enjoyed by that patient for (self) management of the situation and setting.

To bring about a further reduction in the use of seclusion measures, the Inspectorate has introduced a system of mandatory consultation whenever a patient has been secluded for more than a week. The intensity of these consultations is in direct proportion to the duration of seclusion.

With effect from 2012, all psychiatric units are obliged by law to register all use of seclusion measures (and other interventions which restrict patient freedom) using the Argus system.

#### *The Inspectorate and residential care*

During the first half of 2012, the Inspectorate assessed the use of restrictive measures in residential care for the elderly or persons with a physical or mental disability. Over one hundred institutions were visited and 220 patient files were analyzed. The patients concerned had been subject to restrictive measures such as the use of sedation, seclusion or physical restraint. In a number of cases, the institution concerned had been successful in reducing or discontinuing the use of restrictive measures.

The Inspectorate concluded that the decision to apply any form of restrictive measure must be taken with greater caution and forethought. The manner in which measures are currently applied is unsatisfactory. This is largely due to a failure to observe the quality requirements in place, such as consultation with external experts, a focus on the reduction or discontinuation of the measure at the earliest opportunity, and adequate reporting.

The investigation also concluded that a substantial reduction in the use of restrictive measures is possible. In over 75% of the cases examined, the measure was indeed withdrawn in a conscientious manner. In no fewer than 88% of cases, the patient or the patient's representative found the alternative to be preferable to the restrictive measure it replaced.

Further progress calls for ongoing efforts on the part of all concerned. Care organizations must adopt a clearer vision. Staff must critically assess the use and rationale of restrictive measures on an individual, case-by-case basis. If they see no opportunity to responsibly decrease or discontinue the use of the measure, they must be able to call upon the assistance of external experts.

The Inspectorate will continue to monitor the use of restrictive measures, encouraging a further reduction in the years ahead.

### 3.4 Detention centres for aliens

#### *National Ombudsman*

In 2012 the National Ombudsman expressed his concerns regarding the detention of aliens. In his report ‘Immigration Detention: penal regime or step towards deportation?’ the National Ombudsman concludes that foreign nationals are being detained under an inappropriate regime that is seriously in danger of infringing their fundamental rights. The Ombudsman states that the government wrongly assumes that foreign nationals spend only relatively short periods of time in detention. Furthermore the current regime fails to reflect the administrative rather than penal nature of immigration detention. Foreign nationals are detained under a regime that is, in several respects, more austere than that in penal institutions, even though the purpose of their detention is to prevent them from avoiding deportation. Foreign nationals are subject to security measures (frisking, strip searches and restraints during transportation) and to disciplinary punishments and measures (such as segregation and solitary confinement). These measures infringe their basic human rights. The National Ombudsman strongly advised that immigration detention may be used only as a last resort and that Dutch government needs to develop less drastic alternatives to immigration detention.

#### *Inspectorate of Security and Justice*

In 2012 the Inspectorate of Security and Justice (IVenJ) published a report regarding several detention centres. The IVenJ found various needs for improvement. Although the Inspectorate found the programs of activities for detained aliens have improved (mostly in the more modern centres), the variety of activities remains an issue. This is especially the case when compared to penal institutions. The Inspectorate is further concerned that the earlier made recommendation to act on a less strict safety protocol in escorting detained aliens to the hospital is not yet implemented. Detained aliens were in 2010 still transferred to hospitals while handcuffed or subjected to other forms of limb restraint. Another example of a recommendation that was not yet correctly implemented, is the recommendation to no longer – by standard – conduct a body cavity search when detained aliens are transferred while being observed.

During the visits of the Inspectorate, several detention supervisors asked for special attention for the restraint in sharing information by the medical staff. The interpretation of medical confidentiality could play a role here. As a result, the detention supervisors sometimes don’t know how to react sufficiently to the behaviour of detained aliens. The IVenJ recommends to think about the possibilities of proactively sharing relevant information about the behaviour of detained aliens and prescribed medicines, without harming the medical confidentiality.

However, the IVenJ also noted that improvements were made. Many of the recommendations the Inspectorate made in 2010 in regard to the detention of aliens were implemented. For example, women and men are no longer placed in the same unit and the Inspectorate notes a decrease in the use of seclusion (in amount and in length). The recent renovation of (parts of) the detention centres, as well as the construction of new buildings, also has a notable positive effect.

## **CITT**

In 2012 the Supervisory Commission on Repatriation, in Dutch the Commissie Integraal Toezicht Terugkeer (CITT), paid special attention to the forced return of aliens with a medical history and mentally ill criminal aliens. The CITT spoke with the firm Medicare, who accompanies aliens with a medical problem. Medicare indicated that they sometimes miss essential information regarding the medical history of the alien. Privacy laws prevent that medical information is disclosed to third parties without consent of the person involved. The CITT recommends nonetheless that basic medical information (such as medicine use) accompanies the alien during transport to the airport and is available to the personnel responsible for the alien through the whole return process to ensure the safety of the alien and the personnel involved.

Regarding the transport of aliens from the detention centre to the airport, the CITT found that sometimes the transfer of the aliens to the Royal Constabulary took too long, and the aliens had to wait outside the airport area. The CITT recommends that the aliens are brought to the detention centre just outside the airport area until they can be transferred to the Royal Constabulary.

The CITT visited a detention location/clinic especially for mentally ill criminal aliens. One of the issues is the moment of return: do you treat the illness before returning the alien to his/her country of origin or is it better to organize treatment in the country of origin?

The CITT also paid special attention to the way travel documents issued by the authorities of countries of origin were obtained by monitoring the presentation of aliens at their embassies. The CITT spoke in this regard with the International Organization for Migration (IOM) and the ministry of Foreign Affairs.

In 2012 the CITT observed 13 flights, by supervising the flight to the country of origin, and observed the ground process before boarding 18 times. The CITT also monitored 6 Joint Return Operations, organized by one of the participating countries and financed by the European border agency FRONTEX. The CITT also visited FRONTEX and spoke with the newly appointed Fundamental Rights Officer. The CITT also discussed a draft code of conduct for monitoring Joint Return Operations.

In the experience of the commission the expulsion process on the whole is executed carefully and humanely. In 2012 the CITT has not come across major incidents regarding maltreatment of aliens during the return process.

## **RSJ**

In 2012, the RSJ was asked to react on an amendment to the Regulations on Selection, Placement and Transfer of Detainees. The amendment implies that foreign nationals in pre-trial detention will be transferred soon after their arrest to a so-called VRIS facility rather than after being convicted in the first instance. The aim is that preparations for their departure may start sooner, increasing the number of successful returns. In principle, the Council deems it wise to commence preparing for their return in good time, once it is clear that the foreign national in question can and must be deported.

However, the Council does not welcome the introduction of the envisaged amendment because

1. the anticipated effect will be limited. Making the return a success depends on several factors, such as the circumstances in the country of origin and whether or not the foreign national can be deported. The policy programme in a VRIS facility has little influence on those factors;
2. there are good reasons for the existing rule that people in pre-trial detention are placed in a remand centre within the district in which they are tried until their conviction in the first instance. These reasons have to do with the preparation of the trial and the presumption of innocence. The Council cannot see sufficient arguments to make an exception to this rule for foreign nationals;
3. early placement in a VRIS facility is possible under the existing regulations, provided that it increases a realistic possibility of returning home.

### 3.5 Military detention

The Commission of oversight for military detention focusses on the locations where the Royal Netherlands Marechaussee<sup>2</sup> has detention places and persons are detained for a minimum of six hours. The next annual report of the Commission of oversight for military detention will cover the years 2012 and 2013. In this report, the commission will report its findings and recommendations over these years.

In 2012 the Commission of oversight for military detention visited the locations Schiphol and Coevorden. Overall the Commission was positive about these locations; no new focus points emerged in comparison with the years 2010 and 2011.

### 3.6 Transport of detainees and their property

The information regarding this topic has been derived from the recommendation with the same title by the Council for the Administration of Criminal Justice and Protection of Juveniles (RSJ) dating June 25th 2012. Additional information was obtained from the NPM-associate Sounding Board Group Commissions of oversight for penitentiaries, three members of which have been installed in 2010 as a commission of oversight for the Transport & Support Service of the Custodial Institutions Agency (DJI).

In most cases the transport takes place without any problems. However, this is not always the case. Noticeably:

- sometimes journeys take very long, due to complicated transport schemes. This may be burdensome for the detainees concerned;
- it is often unclear who is responsible and who is authorised to make decisions about security measures. The lack of uniform legislation and regulations causes problems for parties involved in the transport;

<sup>2</sup> The Royal Netherlands Marechaussee is a police organisation with military status.

- supervision of transport and the right of complaint for the transported detainee exist but are limited. Further legislation regarding the right of complaint is expected.

Unlike the transport of persons, the transport of detainee property is for the most part clearly arranged; yet this too can yield practical problems, such as lost or damaged property.

According to the Council, responsibilities and powers should be held by the parties that play an essential role in transport: the director of the institution where the detainee resides and the person who performs the transport. The State Secretary for Security and Justice has been recommended to:

- limit transport as much as possible and organise it as a ‘customised process’, taking into account the specific characteristics of for example juveniles, foreign nationals and ill detainees;
- lay powers and responsibilities down in legislation and regulations and make these clear to all parties involved;
- provide an independent complaints procedure for all detainees who are transported;
- provide independent and effective supervision of all forms of detainee transport;
- provide ‘customised transport’ that satisfies predetermined conditions and is in line with the characteristics of the detainees to be transported;
- work on the implementation of this recommendation in a comprehensive way, so that coherent and consistent legislation and regulation for the entire field of transport is created.



## 4 Joint activities of the NPM's and associates

In 2012 the IVenJ organised several meetings. During these meeting, the NPM's exchanged information about the activities they've carried, discussed working methods and prepared the annual report.

In order to create awareness about OPCAT, Subcommittee for the Prevention of Torture (SPT) and NPM's among Dutch NPM's, the Inspectorate of Security and Justice organised an international conference in June 2012 on the synergy between the SPT, European Committee for the Prevention of Torture (CPT) and NPM's.

### *International conference SPT-CPT-NPM*

Over time various mechanisms have been developed to safeguard the basic human dignity of those deprived of their liberty. Noteworthy are the CPT within the Council of Europe and the SPT within the framework of the United Nations. States that ratify OPCAT are furthermore requested to designate, within one year after ratification, a NPM. The main aim of the conference was to look at the practical cooperation and synergy between all of these various players on a domestic, regional and global level.

Today an impressive structure has been put in place which begs the question how inspectorates should be organised in this multi-layered society of domestic, regional and global mechanisms. How do they interact? Also, in view of the fact that one of the essential pillars of OPCAT is cooperation between the SPT and NPMs; how do they cooperate? To what extent will international bodies 'influence' the working methods of the national inspection, the standards applied by the domestic inspectorates, et cetera? How can you combine the principle of cooperation between various players as well as the principle of confidentiality?

A full report of the conference can be found on the website of the Inspectorate of Security and Justice (<http://www.ivenj.nl>).





# 5 National Preventive Mechanism member profiles

## 5.1 Inspectorate of Security and Justice (IVenJ)

### *Introduction*

In January 2012 the inspectorate for the implementation of Sanctions merged with the Public Order and Safety Inspectorate (IOOV) into the Inspectorate of Security and Justice (IVenJ). One of the tasks of the IVenJ is supervising the implementation of sanctions with a view to a visible improvement of the effectiveness and quality of the implementation of sanctions. The IVenJ advises the Ministry of Security and Justice with respect to ensuring the appropriate implementation of sanctions. In this, the IVenJ is independent in its assessments, transparent in its methods and professional in its knowledge, skills and conduct. When carrying out an investigation, the IVenJ receives no instructions concerning the method to be used, the judgment it forms and its reporting thereof.

The IVenJ is interlocutor of the CPT.

### *Staff*

In December 2012 a total of 59 fte (full time equivalent) worked at the IVenJ, of which around 10 inspectors are involved with NPM-related functions on a regular basis.

### *Work method*

The IVenJ performs its tasks through inspection surveys and has four different forms of research. First, a screening of an institution, in which the institution or centre is examined. Secondly a subject-specific inspection, which is an inspection of specific aspects of detention, for example 'solitary confinement' or 'food'. Third an incident-based investigation; either at its own initiative or upon the request of the minister. Finally a follow-up research; after a given period of time, to find out if the institution is performing better.

One year after the publication of a report the IVenJ checks via a short visit to what extent the recommendations have been implemented satisfactory.

Each inspection is conducted by at least two inspectors. Screenings require a couple of weeks, i.e. one week's preparation, one week for the actual visit and a few weeks for reporting. The time required for subject-specific visits depends on the nature of the subject and the number of institutions involved in the inspection. During visits meetings are normally held with:

- the board or the unit or location director;
- members of (specialised) staff and/or employees;

- detainees/probation service clients;
- and for the Custodial Institutions Agency: the monitoring board.

### **Reporting**

Following a visit, the IVenJ drafts a report of its visit/minutes of meetings. The institution which has been visited is given two weeks to respond to factual inaccuracies in the report/minutes. Within two weeks the draft report is amended and adopted by the Chief Inspector. The IVenJ submits the adopted report to the Minister/State Secretary. The minister, who is not allowed to intervene in the text, sends the report to Parliament. In general the Minister adds his own viewpoint in writing about which recommendations will be implemented and which not and for what reasons. Six weeks after the report has been sent to the Minister/State Secretary, the report is posted on the IVenJ website ([www.ivenj.nl](http://www.ivenj.nl)).

## **5.2 Healthcare Inspectorate (IGZ)**

### **Introduction**

The Dutch Health Care Inspectorate (IGZ) promotes public health through effective enforcement of the quality of health services, prevention measures and medical products. It advises the responsible ministers and applies various measures, including advice, encouragement and coercion, to ensure that health care providers offer only 'responsible' care. The IGZ investigates and assesses in a conscientious, expert and impartial manner, independent of party politics, and unaffected by the current care system.

### **Staff**

The Health Care Inspectorate consists of 537 employees (including 140 Inspectors and 60 Inspectorate Officers). Of these, 30 are regularly involved in NPM-related functions.

### **Field of activities**

The field in which the Health Care Inspectorate performs its work comprises some 40,000 individual care providers and organizations. Some 1.3 million people work in the Netherlands' health care system, of whom 800,000 are qualified medical practitioners. The Inspectorate's work covers four main areas: public and mental health, curative care, nursing and long-term care, and pharmaceuticals and medical technology.

### **Working method**

Reports of incidents, unsatisfactory situations and ongoing shortcomings play an important role in the Inspectorate's supervisory and enforcement activities. Some reports may prompt the Inspectorate to take immediate enforcement action. All reports form an important source of information regarding the quality of care.

If the Inspectorate receives a report which suggests serious shortcomings in the quality of care, or less serious shortcomings which are nevertheless of a structural, ongoing nature, the Inspectorate will take enforcement action. The measures available range from advice and encouragement to correction and coercion.

The Inspectorate analyses all incoming reports, using the results to underpin its opinions regarding the quality of care in the various sectors of the health care system. The Inspectorate may also investigate the reports further during its inspection visits.

In the interest of efficiency and effectiveness, the Inspectorate does not investigate all incoming reports itself. It may request the health care provider concerned to conduct an internal investigation and to submit a report. However, the Inspectorate does impose certain conditions with regard to the quality and thoroughness of the internal investigation. In certain circumstances, the Inspectorate will instigate its own investigation further to an incoming report. It will do so:

- In the case of an extremely serious situation with exceptionally high risk.
- If the Inspectorate believes that its own investigation will improve quality within a particular health care sector in one fell swoop.
- If the health care provider concerned is not considered capable of conducting a satisfactory internal investigation.
- If the analysis offered by the health care provider does not meet the required standards.

### Reporting

Virtually all reports produced by the Inspectorate are made public under the national Freedom of Information Act. The reports can therefore be accessed by anyone who wishes to consult them. In the case of reports concerning specific health care institutions, there is no statutory obligation to publish, but the Inspectorate will generally do so in accordance with its policy of 'proactive publication'. This simply means that the Inspectorate does not wait until it is asked for information about a health care institution, but makes the inspection reports available on its website as soon as they have been finalized. This policy has been in place since 1 July 2008 and applies to the inspection reports on health care institutions in most sectors. Each report remains on the Inspectorate's website for a period of three years.

Inspection reports relating to individual health care providers, or those which concern events which are subject to criminal or disciplinary proceedings, are not 'proactively' published.

## 5.3 Inspectorate for Youth Care (IJZ)

### Introduction

The Inspectorate for Youth Care, in Dutch *Inspectie Jeugdzorg (IJZ)*, monitors the quality of youth care and compliance with legislation. IJZ was established by law in 1988. Organizationally it falls under the Ministry of Healthy Welfare and Sports and in substantive terms it operates independently.

Through its supervisory activities the Inspectorate for Youth Care stimulates facilities to provide proper and safe care, education and treatment of children in the youth care sector and also promotes support for the parents and care-providers of these children. Furthermore, through its supervisory activities the Inspectorate helps to ensure that society can be confident that

children and parents receive timely and appropriate assistance and care from the institutions and professionals in the youth care sector. The Inspectorate provides an independent verdict on the quality of youth care services that is relevant to the professionals, the institutions, government and citizens and that helps to improve youth care services. The motto of the Inspectorate for Youth Care is: 'Towards visible quality in youth care!'

### *Staff*

A total of 45 fte work at the Inspectorate for Youth Care, 28 of which are inspectors. All of them are involved with NPM-related functions. Nine of them on a regular basis.

### *Field of activities*

On the basis of five different statutes the Inspectorate for Youth Care supervises the following organizations:

- child welfare offices (including assessment, case management, voluntary youth services, family guardianship, custody and probation);
- child welfare service providers (including open residential facilities and Jeugd zorg<sup>plus</sup>);
- juvenile detention centres;
- licensees for intercountry adoption;
- reception facilities for unaccompanied foreign minors;
- the Child Care and Protection Board;
- schippersinternaten (residence for children whose parents regularly travel for work reasons, like children of bargemen and children of showmen).

The supervision on the organisations for Jeugd zorg<sup>plus</sup> and the juvenile detention centres is NPM-related.

### *Work method*

The Inspectorate conducts thematic supervision which systematically investigates a specific aspect within a specific a type of care (such as residential care or foster care).

In addition, the Inspectorate also supervises the response to emergencies. Institutions are required to report emergency cases to the Inspectorate. Emergencies are serious incidents such as death, sexually transgressive behaviour and physically unacceptable behaviour. Once the Inspectorate receives notification of an emergency, it takes control of the investigation and determines which parties are to be involved in the investigation. Sometimes an incident can be dealt with and concluded directly, but in most cases the Inspectorate will take further action such as requesting a factual account, asking detailed questions, requesting an internal inquiry or conducting an independent investigation. In the event of an emergency resulting in death, the Inspectorate will generally commission an independent investigation.

The inspectors also monitor the youth care institutions in the region by means of Inspectorate visits. These visits may address issues such as weak points in the risk profile, complaints and indications of shortcomings, reports of emergencies as well as the implementation of improvement measures.

The Inspectorate supervises the locations where, according to its own estimate, the risks for children and young people are the greatest. This estimate is made on the basis of a risk

assessment model which has been developing since 2009. A risk assessment profile is drawn up for each youth care institution, with data obtained from the following sources: the impression that the involved inspector has gained on the basis of his visits, interviews and investigations, whether or not the institution is certified according to the standards of the 'Stichting Harmonisatie Kwaliteitsbeoordeling in de Zorgsector' (HKZ/the Dutch foundation for harmonization of quality assessment in the care sector), an analysis of the annual reports of the institution on (in this order) quality, complaints and finances, an analysis of reports, indications and complaints about the institution received by the Inspectorate and finally the answers to the risk assessment profile questionnaire which is presented to the institutions every two years. The risk assessment profiles are then used to determine how supervision will be conducted in the year in question.

Each supervisory activity is carried out by at least two inspectors. The duration of thematic supervision or supervision of emergency cases depends on the nature, gravity and content of the issue and varies from several weeks to several months. The thematic supervision and emergency supervision normally consists of the following phases: the preparation (this involves drawing up a plan of action, the central questions and a testing framework), a study of the policies of the institution, and visits to the institution(s) in question. During visits to the institutions the inspectors talk to children and young people, group leaders, behavioural experts, team leaders and the management.

### Reporting

The thematic supervision always leads to preparation of reports, incorporating the findings of the Inspectorate, its conclusions and any recommendations at institutional level. If the investigation provides a suitable opportunity, the Inspectorate (also) issues a comprehensive report at the national level with recommendations that are addressed to the responsible managers and the responsible members of the Provincial Executive or the responsible minister. Furthermore, the independent supervision of emergency cases always leads to reports being issued at the institutional level. If several similar emergencies have taken place, the Inspectorate may (also) issue a report at the national level.

If no independent supervision is conducted by the Inspectorate during the supervision of the emergency case, it will always conclude its supervision with a substantiated letter to the institution and the responsible manager. On the basis of Inspectorate visits and working visits, the Inspectorate always issues a letter in which it provides brief feedback on the visit, possibly including points of attention or recommendations.

All reports by the Inspectorate are actively publicized by offering them to the relevant members of parliament and simultaneous placement on the website of the Inspectorate for Youth Care. In addition, each year the Inspectorate issues an Annual Report in which it reports on its monitoring activities in the past year and provides a brief report on the developments in youth care.

## 5.4 Supervisory Commission on Repatriation (CITT)

### *Introduction*

The Supervisory Commission on Repatriation, in Dutch the Commissie Integraal Toezicht Terugkeer (CITT), is an independent commission that was founded in 2007 after some incidents occurred during the expulsion of former asylum seekers to the Republic of Congo and Syria. Parliament wanted closer supervision on the whole return process, which eventually resulted in the CITT.

The CITT supervises the return process of aliens who don't have a legal basis for staying in the Netherlands and are returned to their country of origin or a third country, voluntary or by force. The supervision is to ensure that the return process is correctly executed and to give advice to improve the quality of the integral return process. The commission is independent in its judgment, transparent in its methods, and professional regarding knowledge, skills and attitude. Special attention is given to the safe and humane return of aliens, but also to the effectiveness and efficiency of the integral return process.

### *Staff*

The commission has three members, who each chair a chamber dedicated to a special area within the return process. Each chamber has a maximum of five chamber members. The commission is supported by a small administrative staff, which falls under the Ministry of Security and Justice.

### *Field of activities*

The chamber return facilities deals with the international cooperation regarding return, which includes the travel documents issued by the authorities of countries of origin, and the cooperation within FRONTEX, the border control service of the EU. The chamber return chain focuses on the cooperation between the departments and services dealing with return on the locations where aliens are held in detention or custody. The chamber expulsion supervises during forced return flights to the countries of origin. This can be individual flights, or charter flights organized by the Netherlands, or with several EU countries together via FRONTEX.

### *Work method*

The CITT supervises the return process and how the return policies are executed by the services involved. The CITT speaks with the responsible State Secretary, directors of services, but also with the men and women working in the locations where aliens are held in detention. The CITT also receives data from the responsible services and observes repatriations. For the latter, observers are selected for their knowledge of the return process or their medical or psychological expertise.

The CITT selects the repatriation flights of aliens on the basis of different criteria, for example whether the returnee is expected to resist deportation, whether there are special circumstances like the return of families with young children or returnees with health problems. Also flights with high (political) risk are monitored. The return flights combined with other European countries are all observed.

When the CITT observes repatriations, it works according to an inspection form to ensure that all relevant aspects of the repatriation are observed. These aspects are the briefing, boarding, use of force, transfer of the returnee to the authorities of the country of origin and so forth. This also is discussed with the Royal Constabulary in workshops where direct feed back can be given on points of improvement. The inspection form can be found on the website of the CITT, so a maximum of transparency is achieved. The use of this form also makes it possible to compare different flights that are observed by different observers.

### **Reporting**

The CITT delivers an annual report to the responsible State Secretary and Ministers. In the annual report are suggestions to improve the return process. The report will be sent to Parliament by the State Secretary for Security and Justice with the comments of the State Secretary. The annual report is discussed in Parliament by the select committee for Immigration affairs.

The annual report and the reaction of the State Secretary for Security and Justice are published on the website of the CITT. As mentioned, the inspection form is also published on the website.

## **5.5 Council for the Administration of Criminal Justice and Protection of Juveniles (RSJ)**

### **Introduction**

The Council is an independent body carrying out two law-assigned tasks: administering justice and giving advice on youth protection and the enforcement of sentences and non-punitive orders. The Council has been established in 2001, combining its two predecessors (CRS, 1953 and CAJK, 1955).

### **Mission**

By administering justice and producing advisory reports, the Council sees to it that the government, in developing as well as enforcing measures concerning criminal justice and juvenile protection, acts in a legally correct way and according to principles of proper treatment. Proper treatment is a leading concept in this mission statement. The Council has elaborated on the concept of proper treatment in the publication 'Proper treatment, principles for dealing with detainees' (updated 2012).

### **Staff**

The Council consists of sixty members, amongst whom are experts on penitentiary law and science, juvenile and family law and behavioural sciences, as well as members of the judiciary, public administration, advocacy and medical doctors. The Council being an independent body, members have no ties with any ministry or service dealing with matters concerning the Council's competence.



### **Field of activities**

#### **Advice**

The Council advises the Minister of Security and Justice and other ministers, solicited as well as unsolicited, on policy implementation and the application of rules in the following areas:

- The enforcement of sentences and non-punitive orders.
- Youth protection.

Many advisory reports concern the improvement of implementation practice but the Council also deals with matters of principle or issues in process of policy-making. About fifteen advices appear every year. Major advisory reports are:

- Alternatives for remand custody (2011).
- Juvenile criminal proceedings: future proof! (2011).
- The increasing duration of tbs (hospital orders) (2011).
- Transport of Detainees and their Property (2012).
- Forensic Care during Detention (2012).

The Council combines data from scientific sources with information obtained by visits to custodial institutions (to which end the Council has a right of access to these institutions), interviews and expert meetings. As a follow-up to, or inspiration for its advices the Council organises a conference for policymakers and academics about every year. The latest conference (March 29, 2012) concerned meaningful activities in penal institutions.

#### **Administration of Justice**

The Council on appeal reviews decisions made regarding persons serving a custodial sentence or detention order: prisoners, hospital order patients and juveniles held in correctional or custodial care institutions.

The Council also reviews decisions made by an institution's governor, medical treatment provided by an institution's doctor or decisions made by an assignment officer or the Minister of Safety and Justice. Matters on which the Council may be asked to rule are for instance:

- Placement and transfer.
- Disciplinary punishments and measures.
- Medical care by the institution's doctor.
- Refusal to grant leave.

The Council gives judgement according to law (particularly the Custodial institutions act, the Hospital orders (framework) act and the Youth custodial institutions (framework) act) and principles of reasonableness and fairness. No further appeal existing, the Council's decisions are binding.

### **Cooperation**

The Council has good working relations with several other NPM's, in particular with the Inspectorate of Security and Justice, the Inspectorate for Youth Care and the Commissions of oversight for Penitentiaries. Another relationship worth mentioning is the one with the European Committee against Torture and inhuman or degrading treatment or punishment

(CPT). The CPT receives a copy of each of the Council's advices and the Council meets with the CPT's committees at the occasion of their regular visits to the Netherlands.

### **Work method**

#### **Advice**

The Council collects information necessary for advice by study of literature and data from scientific sources, interviews, visits to relevant institutions, inspection reports and other sources. Visits to penitentiary institutions are aimed at a general inquiry into the application of sanctions and detention circumstances, not in order to review the local situation but to be able to make recommendations towards national government policy makers. The Council focuses on improving policy and practices rather than on reporting bad practice.

Advisory reports are being drafted by subcommittees consisting of members and one or two staff employees (advisors) and determined by either one of the Council's three sections or by the Council's Board.

About one half of the advisory reports are issued on demand of the government; the other half is chosen by the Council itself. The yearly program is drafted after consultation of stakeholders as well as the relevant ministries.

#### **Administration of Justice**

This task is dealt with by committees of appeal, consisting of three members and a staff employee (secretary). The committee's chairman is an active member of the judiciary.

### **Reporting**

The Council issues an annual report concerning its accomplishments but, not being a supervisory body, does not report about individual visits to institutions.

#### **Advice**

Advisory reports are published in the official Government Paper (Staatscourant) and at [www.rsj.nl](http://www.rsj.nl); summaries are available in English.

#### **Administration of Justice**

- Data base: A data base containing all decisions relevant for jurisprudence is available on the Council's website.
- Periodical bulletin: About eight times a year a bulletin of the most important new decisions is issued to a mailing list as well as on the Council's website.



# 6 Associates

## 6.1 Commissions of oversight for penitentiaries

### Introduction

In the Netherlands there are 69 Commissions of oversight for the penitentiary institutions (prisons, juvenile detention centres, forensic care institutions and detention centres for aliens; in Dutch 'Commissies van toezicht'). These commissions supervise the manner in which persons serving a custodial sentence or detention order are treated.

### Staff

Commissions of oversight vary in size from six to fifteen members, the average number of members is 10. They are appointed for a maximum term of five years with the possibility of re-appointment for two terms of 5 years. By law it is required that various groups of professionals are represented in the commissions of oversight (e.g. physicians, judges, lawyers).

### Field of activities

#### Supervision

Members of the commissions of oversight have access to the institution at all times. Relevant information concerning detainees should be provided to the commission members at any time. All documents that concern the way in which custodial sentences and enforcement measures are imposed may be viewed and generally supervisory councils should be actively informed of the important facts and circumstances within the institutions by the Board of directors of the penitentiary institute.

Practically all commissions of oversight have a monthly commissioner who frequently visits the institution and with whom detainees have contact. He/she collects complaints from inmates and first tries to solve them by mediation.

#### Complaints

Detainees can submit complaints to the Commissions of oversight in the following two ways:

- Oral or written ('sprekersbriefje') complaints directly to the monthly commissioner.
- Or using special documents ('klachtformulier') for making complaints in relation to article 60 C.I. Act about decisions (or the absence of a requested decision) by the Direction.

#### Advisory role

Commissions of oversight can make recommendations towards (A) it's own "Board of directors" and/or (B) towards the Minister of Security and Justice directly. They actively perform their advisory role to the Board of directors of the penitentiary institution.

## **Sounding Board**

The Sounding Board Group Commissions of oversight for penitentiaries ('Klankbordgroep Commissies van Toezicht') is a delegation of members from commissions of oversight for penitentiaries. The Sounding Board Group was founded in 2009 and has periodically (monthly) personal communication with the Ministry of Security and Justice throughout the year. The aim of the Sounding Board Group is collecting and making an inventory of national 'main problems' and trying to solve them, and safeguarding the independent position and working from the separate commissions of oversight for penitentiaries.

The Sounding Board works together with a so-called 'Knowledge Centre ('Kenniscentrum CvT') and judicial authorities like the RSJ and IVenJ. Every month the Knowledge Centre publishes a newsletter.

In 2012 the Sounding Board introduced house rules and a protocol concerning her responsibilities, role and work method. In November 2012 the Sounding Board organized a National meeting about interpersonal conduct within penitentiary institutions. This meeting was attended by more than 200 members of Commissions of oversight for penitentiaries.

## **Reporting**

The annual reports 2012 of the Commissions of oversight for penitentiaries will be published on the website of the "Dienst Justitiële inrichtingen" of the Ministry of Security and Justice.

## **6.2 Commissions of oversight for the police cells**

### **Introduction**

Until December 31st 2012 the police of the Netherlands consisted of 25 independent regional police forces and the Netherlands Police Agency (KLPD). Police forces varied greatly in size and character. In each of the Netherlands' 25 police regions as well as for the KLPD there was a Commission of Oversight for the Police Cells (hereinafter to be referred to as: the commission). The commission supervised the treatment, the accommodation conditions and the stay of persons taken into custody who are under the supervision of the police, and the observation of the related regulations. The commission functioned as an independent body of the Commissioner (at that time Head of Police and mayor of the largest town in the region at the same time) and did not receive any instructions from others (such as the police) with regard to its work method, its views, and reports. The commission was established on the basis of the principle that citizens and persons taken into custody may have more confidence in the police when the care for detainees is supervised independently, which increases the legitimacy of the police actions.

In 2013 the police organisation will change significantly. For the commissions these changes mean that their number will be reduced to ten commissions. However, their objective as well as their independent position will not change.

### **Mission**

The objective of the commission is to contribute to a sound, professional care for persons who are taken into custody by the police through the tasks it performs. The tasks of the commission

include in any case:

- supervising the housing, safety, care and treatment of persons taken into custody in police cell complexes;
- offering an annual report to the Commissioner about its work;
- offering advice to the Commissioner, whether requested or non-requested, and providing information about matters concerning police cell complexes.

### *Staff*

In each of the Netherlands' 25 police regions as well as for the KLPD is a Commission of Oversight for the Police Cells. Each commission has three to seven members. These members do not work for the police in the region or at any other bodies that are involved in the regional police. The commission is supported by a secretariat.

### *Field of activities*

Supervising the treatment, the accommodation conditions and the stay refers to persons who are held in premises used by the police, irrespective of the grounds and irrespective of the place in these premises where this deprivation of liberty is taking place.

Once or several times a year the various Commissions of Oversight for the Police Cells organise a joint meeting to exchange experiences or views.

### *Work method*

In order to carry out its tasks, the members of the commission inspect the holding rooms that are used at the regional police, and the other rooms in the police buildings where persons taken into custody (can) stay (such as the lawyers' room, recreation yard etcetera).

The commission members visit the cell complexes and police stations in the police region without any prior announcement, on different days and at different hours. They speak with persons taken into custody and police staff and have free access to the detainee registers. During a visit the rooms where persons taken into custody stay regularly are inspected. When persons who have been taken into custody are present during the visit, the member of the commission will speak with a few of them in order to hear about the treatment and the care. Things that are unclear or shortcomings which can be solved on site are usually discussed immediately with the manager. A written report of each visit is drawn up, which is discussed at the periodical meeting of the commission.

At least one time a year the chairman, a member of the commission and the secretary have consultations with the caseholder of care for detainees of the executive of the police force in the police region. During these meetings remarkable findings, possible points for improvement and any current matters and changes in the operability of cell complexes and police stations are discussed. The police force management team offers requested and non-requested information to the commission.

Moreover, the commission can offer requested and non-requested advice to the Commissioner and provide information regarding the police cells in question and the care for detainees in the region.

### *Reporting*

Every year the independent commission reports its findings – without interference of third parties – to the Commissioner and the regional executive (this is the board) of the police region. The commission makes recommendations through this annual report. The Commissioner then gives his reaction to the annual report and the recommendations. The local councils in question are informed about the annual report by the mayors (who are members of the board) of the police region.

The annual report will be published through the press and by offering the annual report to various persons/bodies, including the Minister of Security and Justice.

## **6.3 Commission of oversight for military detention**

### *Introduction*

On 23 November 2007, the Regulation on the Detention Areas Supervisory Commission of the Royal Netherlands Marechaussee (RNLN, in Dutch Koninklijke Marechaussee) became effective. The Regulation provides for a Supervisory Commission exercising supervision over the detention areas used and managed by the Royal Netherlands Marechaussee. Following the appointment of its members by the Minister of Defence, the Supervisory Commission began its activities on 1 January 2008.

### *Staff*

The Commission comprises four members, including the chairman, and is supported by a secretary from the Royal Netherlands Marechaussee.

### *Field of activities*

The Commission carries out periodic inspections and meets twice yearly to discuss its findings. The number of locations where the Supervisory Commission carries out its work has been reduced to two, namely the Schiphol detention centre and Coevorden.

### *Work method*

The Commission inspects whether the detention spaces are used in accordance with the guidelines and assesses whether the relevant regulations are observed. The Commission also inspects the structural state of repair of the spaces, checks whether the technical facilities are functioning, whether logs are being kept, whether the work instructions are being observed, the state of maintenance and cleanliness, and whether there are regulations in place with regard to medical and other forms of care. In addition, the Commission establishes whether a contingency plan is in place (e.g. in the event of fire) and whether this plan is practised regularly.

The Supervisory Commission focuses primarily on the cells in which arrested persons and aliens are detained for periods longer than six hours and where they also spend the night. This requires the RNLN to provide specific facilities and care because the people detained fall directly under the duty of care of the RNLN. The Supervisory Commission checks whether the

RNLM looks after its detainees in a responsible manner. In addition, the Royal Netherlands Marechaussee uses so-called holding areas and holding rooms. These rooms are used exclusively for the detention of persons for periods of no more than six hours. If, for the purposes of investigation, these persons have to be held for a longer period, they are transferred to other locations (police station or another RNLM post) where they can be detained for the night. Given their use (short stays of less than 6 hours and not during the night), the detention areas and holding rooms are not part of the scope of supervision of the Commission. In performing its supervisory tasks, the Commission is, however, indirectly informed of the use of holding areas and holding rooms. If deemed desirable or necessary by the Commission, it will include its findings regarding these areas in its report. The Commission performs its inspections on the basis of a checklist, in order to ensure that the inspections are performed according to the same standard, irrespective of the individual tasked with carrying out the inspections. This working method enhances the objectivity and continuity of the supervision.

### *Reporting*

The Commission presents its findings to the Commander of the Royal Netherlands Marechaussee in an annual report.

## **6.4 National Ombudsman**

### *Introduction*

The National Ombudsman of the Netherlands is an independent institution which exists to give individuals the opportunity to lodge complaints about the practices of government with an independent, expert body. The institution and its role are enshrined in the Dutch Constitution. The Ombudsman oversees complaints procedures, initiates investigations on his own initiative, and has the power to take a wide range of measures that can help guarantee effective access to human rights.

As a High Council of State, the institution is independent of the executive and judicial powers of government. However, the National Ombudsman is appointed by parliament for a period of six years and receives his budget from parliament. The National Ombudsman works alongside existing provisions, such as parliament, the courts and internal complaints procedures.

The National Ombudsman institution was established in order to give individuals the opportunity to submit complaints about the practices of government to an independent, expert body. It was established by the National Ombudsman Act of 1981 and enshrined in the Constitution in 1999. Its powers of investigation and procedures are governed by the General Administrative Law Act, Chapter 9, title 9.2.

### *Staff*

The National Ombudsman is supported by an office employing around 170 staff members (150 FTE) at the time of writing.



### *Field of activities*

The National Ombudsman acts as a backstop protection for the legal rights of detainees. He is normally competent to investigate complaints about situations outside the jurisdiction of inspectorates and other institutions. These include, for instance, situations where the complaint is not about a decision, but about actual behaviour or treatment or where the complainant is a third party. In addition, the National Ombudsman can have a preventive role, for example, by issuing recommendations on the basis of complaints or by conducting investigations on his own initiative.

### *Working methods*

The Constitution lays down that ‘the National Ombudsman shall investigate, on request or of his own accord, actions taken by central government administrative authorities and other administrative authorities designated by or pursuant to Act of Parliament’. In the course of his investigations, he has the power to:

- Conduct on-site visits.
- Order administrative authorities to appear.
- Order complainants, witnesses and experts to appear.
- Hold hearings under oath.
- Require the provision of verbal information.
- Demand access to all relevant documents.
- Demand access to confidential documents.
- Conduct formal hearings.

### *Reporting*

The National Ombudsman sends an annual report of his activities to parliament. In reports on individual cases or on investigations conducted on his own initiative, he can make recommendations. If the relevant administrative authority refuses to follow such recommendations, the National Ombudsman may inform parliament of its failure to take action and so obtain a political opinion on the matter.





# 7 Appendix 1: list of abbreviations

CITT	Supervisory Commission on Repatriation (Commissie Integraal Toezicht Terugkeer)
CPT	Committee for the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
DJI	Custodial Institutions Agency (Dienst Justitiële Inrichtingen)
Fte	Full time equivalent
GGZ	Association of Mental Health and Addiction Care
IGZ	Health Care Inspectorate (Inspectie voor de Gezondheidszorg)
IJZ	Inspectorate for Youth Care (Inspectie Jeugdzorg)
IOM	International Organization for Migration
IVenJ	Inspectorate of Security and Justice
KLPD	National Police Services Agency
NPM	National Preventive Mechanism
OPCAT	Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
PI	Penitentiary institution
PIJ	Placement in a judicial youth detention centre (Plaatsing In Jeugdinrichting)
PMO	Psycho-Medical Discussion
PPC	Penitentiary Psychiatric Centre
RSJ	Council for the Administration of Criminal Justice and Protection of Juveniles (Raad voor de Strafrechtstoepassing en jeugbescherming)
SPT	Subcommittee for the Prevention of Torture
STJ	Collaborative Youth Supervision (Samenwerkend Toezicht Jeugd)
VRIS	Aliens in Criminal Law (Vreemdeling in de Strafrechtketen)



