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Response

of the Government of the Netherlands to the report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on its visit to the Netherlands

from 2 to 13 May 2016

The Government of the Netherlands has requested the publication of this response. The CPT's report on the May 2016 visit to the Netherlands is set out in document CPT/Inf (2017) 1.

Strasbourg, 21 September 2017

RESPONSE OF THE DUTCH AUTHORITIES TO THE REPORT OF THE EUROPEAN COMMITTEE FOR THE PREVENTION OF TORTURE

I. Introduction

The CPT trusts that the Dutch authorities will take the necessary steps to ensure that, in the future, management in all prison establishments are fully informed of the mandate and competencies of the CPT and that they are tasked to facilitate the work of the visiting delegations, in line with the principle of cooperation set out in Article 3 of the Convention.

The government wishes to thank the CPT for its comment on the generally excellent level of cooperation its delegation received throughout the visit, on the part of both the national authorities and staff at the establishments it visited.

The government regrets – as already stated by the State Secretary for Security and Justice at the final meeting held in The Hague on 13 May 2016 – that the delegation experienced difficulties during the visit to the Penitentiary Psychiatric Centre (PPC) of Scheveningen Prison.

This incident was evaluated with the Custodial Institutions Agency and the director of the PPC in Scheveningen after the CPT visit, partly in light of the fact that the PPC had been sent detailed guidelines describing the CPT's powers before the visit, and that even the intervention of the liaison officer after the delegation had reported the incident failed to prevent a situation arising in which the delegation found itself compelled to abandon its visit to the PPC.

The evaluation concluded that it should never have been allowed to happen that a private interview being conducted with a seriously disturbed patient was interrupted by staff (see p. 10 of the report). The incident resulted from the fact that the guards concerned had finished their shift and were insufficiently aware that they needed to find a way of solving the problem that did not involve interrupting an interview being conducted by an international monitoring body.

As for the institution's difficulty in generating the information requested by the delegation, the government would note the following. Prior to a CPT visit, all institutions are sent guidelines informing them of the delegation's powers and drawing their attention to certain issues that

frequently arise. Following the CPT's visit in 2007, the guidelines preceding the 2011 visit included some practical information on access to registers:

> Should any questions arise in this connection within the institution as to how these overviews can be generated from the database concerned, staff can contact the relevant user coordinator for system administration at the Information Systems Service (IVD).

Unfortunately, this information was not reiterated in the guidelines sent out before the 2016 visit. The government will ensure that it is included in the next ones.

The CPT trusts that the Dutch authorities will take the necessary steps to ensure that, in the future, visiting delegations enjoy unconditional access in all establishments to all the medical records necessary in order for it to carry out its task and that the Convention's provisions are thus fully implemented.

As the CPT is aware, the government has already drafted legislation defining the Committee's powers with respect to access to institutions and the inspection of patient files with or without a patient's permission. The three bills concerned – the Care and Compulsion (Psychogeriatric and Intellectually Disabled Patients) Bill, the Forensic Care Bill, and the Compulsory Mental Healthcare Bill – are currently before Parliament. The current status of these bills is as follows. The House of Representatives has adopted the Care and Compulsion Bill (19 September 2013), the Forensic Care Bill (18 December 2012) and the Compulsory Mental Healthcare Bill (14 February 2017). The Senate has decided it wishes to examine the three bills jointly, which means that they have not yet entered into force.

The CPT encourages the Dutch authorities to ensure the independence and effective functioning of the NPM which should be competent to monitor all places of deprivation of liberty throughout the Kingdom of the Netherlands – including in its Caribbean part. (paragraph 9)

The Optional Protocol to the United Nations Convention Against Torture (OPCAT) imposes certain criteria as regards the independence and powers of a National Preventive Mechanism (NPM), but leaves States Parties free to decide how to fulfil them. The Dutch NPM is independent.

In his response of 26 September 2016 to a report issued by the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), the State Secretary for Security and Justice explained why the Netherlands had opted for the current institutional format of the NPM. Since the Netherlands already has a comprehensive and effective system for monitoring the treatment of persons who are in custody or who are subject to other restrictions on their liberty, it decided to rely on a number of existing advisory bodies to exercise supervision in the framework of the OPCAT. Each of these bodies exercises supervision and intervenes where necessary on the basis of its own statutory responsibility and powers. It does so independently, but in collaboration with the other bodies.

In response to the SPT's report, the Netherlands carefully reviewed the operational parameters of the NPM, in line with the OPCAT, to ensure that the mechanism is as effective and future-proof as possible. It was decided that the bodies with a statutory duty to implement NPM tasks and powers (including access to institutions) should all continue to perform these tasks separately from one another. The NPM is an umbrella mechanism within which these organisations cooperate and share information where necessary, in order to draw attention to specific matters.

As regards the implementation of the OPCAT in the Caribbean Netherlands, talks are currently taking place between the NPM and the Law Enforcement Council. The Law Enforcement Council is responsible for the general inspection of the organisations that make up the justice system – with the exception of the Joint Court of Justice – in Curaçao, St Maarten, Bonaire, St Eustatius and Saba. In these inspections the Council looks at an organisation's performance in terms of effectiveness, quality and management. The Council is also responsible for conducting general inspections of the quality and effectiveness of cooperation between the countries' justice systems. In the current talks, the NPM and the Council are exploring the potential for a framework for cooperation between the Law Enforcement Council and the other organisations that are responsible for performing NPM tasks.

II. Law enforcement establishments

The delegation was informed that the authorities intended to 'modernise' the CCP and notably to increase, from six to nine hours, the time during which the police may hold a person for identification. The CPT would like to be kept informed of any changes in this regard. (paragraph 11)

The extension from six to nine hours of the time during which the police may hold a person for investigation at a police station entered into effect as from 1 March 2017 (see articles 56a and 56b of the Code of Criminal Procedure). The new article 56a of the Code of Criminal Procedure introduces a differentiation in this regard: the nine-hour maximum applies in the case of a person suspected of a serious criminal offence *for which pre-trial detention is permitted*, whereas in the case of other criminal offences the maximum is six hours, with the possibility of extension of another six hours (see article 56b of the Code of Criminal Procedure). The existing provision that this period does not include the time between midnight and 9 a.m. remains in place. Since the time during which the police may hold a person suspected of a serious criminal offence for which pre-trial detention is permitted for investigation has been extended by three hours, it makes sense to similarly increase by three hours the time limit before which the suspect must be brought before an examining magistrate. This period has therefore been extended to three days and eighteen hours. In the government's view, this is still compatible with the obligations imposed by article 5, paragraph 3 of the ECHR and the relevant case law.

It was a clear practical problem under the old provisions that the six-hour period for holding a person for investigation was too short, given the time required for preparing for questioning (in particular for arranging for legal counsel and an interpreter). The time involved in arranging these matters was deducted from the time intended for the actual interview. This could have adverse consequences for the suspect – if a suspect's questioning could not be completed within the time limit, they would sometimes subsequently be remanded in police custody.

The CPT recommends that measures be taken, including at legislative level, to abolish remand detention in police cells. (paragraph 12)

The government has set itself the goal of confining reliance on section 15a of the Custodial Institutions Act to a minimum. The government was pleased to note the CPT's comment that this provision allowing for remand in police custody has been invoked only occasionally in

the past few years. Nonetheless, the Netherlands does not wish to revoke the provision. In exceptional circumstances (when there is a shortage of prison cells), the Netherlands wishes to retain the possibility of remanding a detainee in police custody for the first 10 days of their deprivation of liberty. It should be added that the authorities do their utmost to avoid such a situation. In view of the current conditions regarding cell capacity in the Netherlands, the expectation is that the Dutch authorities can act in accordance with the CPT's recommendation *de facto* if not *de jure*.

The above also applies *mutatis mutandis* to the application of section 15 of the Young Offender Institutions Framework Act.

The CPT recommends that police officers be reminded that where it is deemed necessary to handcuff a person at the time of apprehension or during the period of custody, the handcuffs should under no circumstances be excessively tight and should be applied only for as long as is strictly necessary. (paragraph 13)

The government welcomes the CPT's observation that 'hardly any person interviewed by the visiting delegation who was or who had in the recent past been in police custody complained about ill-treatment by the police. On the contrary, many persons with whom the delegation spoke stated explicitly that they had been treated correctly and respectfully by the police and appreciated their politeness and professionalism.' This observation is in line with the findings of the Supervisory Committees and the Security and Justice Inspectorate in 2015.

The recommendation concerning the use of handcuffs was passed on to the National Police, who replied that greater attention will be paid in future to monitoring compliance with the rules governing the use of handcuffs.

The CPT recommends that the Dutch authorities take the necessary steps, including by reminding police officers of the relevant legislation and procedures, to ensure that all persons detained by the police who are not subject to the restrictions of Section 62 (2) of the Code of Criminal Procedure are effectively granted the right to notify a third person of their choice of the fact of their detention as from the outset of their deprivation of liberty. (paragraph 15)

The provision concerned (National Regulations for the Treatment of Detainees, p. 8) states that if the person detained has reached the age of majority, a third party will be informed of the detention only at the person's request. In the case of a minor, the police will always notify

the minor's legal representative (p. 16). Notification may be postponed if called for in the interests of the investigation. However, this is a matter for the Public Prosecution Service to decide.

In response to the CPT's findings, the National Police was informed that compliance with the above regulations in practice must be improved.

The CPT must once again reiterate its long-standing recommendation that the Dutch authorities circumscribe more precisely the possibility to delay the exercise of the right of notification of deprivation of liberty. Section 62 (2) of the CCP could be amended in the context of the current on-going modernisation of the CCP (see paragraph 11) or specified in subsidiary regulations. To this end, the Committee recommends that the possibility of refusing the request to notify a relative be limited to a maximum period of 48 hours; this would strike a fair balance between the needs of the investigation and the interests of the person in police custody. (paragraph 16).

One of the changes made to implement Directive 2013/48/EU of the European Parliament and the Council of 22 October 2013 [on the right of access to a lawyer in criminal proceedings and in European arrest warrant proceedings and on the right to have a third party informed upon deprivation of liberty and to communicate with third persons and with consular authorities while deprived of liberty (OJ EU L294)] was to amend the Code of Criminal Procedure with effect from 1 March 2017 to include the right of a suspect to immediately notify at least one person of his own choosing of his deprivation of liberty (article 27, paragraph 1, Code of Criminal Procedure).

What has changed in comparison with the previous legislation is that the suspect himself designates the person he wishes to be notified of his deprivation of liberty. The existing legislation provided for a relative or a member of the suspect's household to be notified by the police as soon as possible that he had been taken into custody. Article 27, paragraph 3 provides that such notification may be deferred insofar as, and for as long as, such deferral is justified by the urgent need to:
a. avert serious adverse consequences for a person's life, liberty or physical integrity or
b. prevent substantial jeopardy to the investigation.

Now that the suspect may himself designate the person who is to be notified of his deprivation of liberty, virtually all the cases at issue involve circumstances in which it is essential to prevent fellow suspects from learning of the suspect's arrest.

The condition laid down in the Directive, that any such derogation must be temporary and strictly limited in time, is expressed by providing that deferral is possible 'insofar as, and for as long as' there is an urgent need for it on the basis of the grounds defined in paragraph 3. In relation to paragraph 3 it is important to note that recital 35 of the Preamble to the Directive states that when the competent authorities envisage deferring the notification of a specific third person, they should first consider whether another third person, nominated by the suspect or accused person, could be informed of the deprivation of liberty. Complying with paragraph 1 in accordance with the principles of subsidiarity and proportionality would implicitly entail proceeding in this way.

Under paragraph 4, the assistant public prosecutor is obliged to record the decision to defer notification in the official report. This ensures that the decision is made known to the public prosecutor, who can assess its compatibility with legislation. Eventually the judge hearing the case can decide whether the deferral of notification was justified.

For juvenile suspects who have been arrested, the Directive was implemented by the addition of a new provision, article 488b, paragraph 1, to the Code of Criminal Procedure, which provides that if an assistant public prosecutor orders the remand in police custody of a minor who has been brought before him, he must notify the parents or legal guardian of the minor's deprivation of liberty as soon as possible. The scope for deferring this notification on the basis of the proposed article 27e, paragraph 3, of the Code of Criminal Procedure also applies in the case of juveniles. It goes without saying that this possibility is considered only in highly exceptional circumstances. Under article 5, paragraph 4 of the Directive, in the event that the notification of the minor's parents or legal guardian is deferred for compelling reasons, an authority responsible for the protection or welfare of children must be informed of the minor's deprivation of liberty immediately. Paragraph 2 of article 488b therefore provides that in this event, the Child Protection Board shall be notified of the minor's deprivation of liberty.

The CPT would like to be informed of the number of cases in which the right of notification of custody to a family member or a third person was postponed by virtue of Section 62 (2) of CCP, for each of the years 2012 to 2016, and the nature of the offence. (paragraph 16)

Neither the National Police nor the Public Prosecution Service is in the possession of any figures in this connection.

[I]t was unclear at the time of the visit whether lawyers were entitled to intervene in the course of the questioning. Moreover, the issue of remuneration of ex officio lawyers participating in a questioning was still open. The CPT would like to be informed by the Dutch authorities whether these issues have now been resolved. (paragraph 17)

The right of access to a lawyer when being questioned by the police was introduced in the Netherlands with effect from 1 March 2016. The rules governing the lawyer's conduct during police questioning are clearly defined in the relevant administrative rule of the Public Prosecution Service, which was issued on 1 March 2016. With the entry into force of the legislative amendments on 1 March 2017, the Order governing the Organisation and Conduct of Police Questioning (BIOP), which defines in detail the rules governing the lawyer's conduct during questioning, also entered into force. These rules are regarded as minimum standards. In broad outline, they state that the lawyer should sit beside the suspect and may address the officer conducting the interview if there is any violation of the ban on coercive questioning, and may point out that the suspect has not understood the question, or that his physical or mental state renders him incapable of carrying on. The lawyer is given an opportunity to comment on the official report of the interview after it concludes. The lawyer and the officer conducting the interview may agree that the lawyer can play a more active role than that defined in the BIOP, but the officer retains full control and if the lawyer disrupts proceedings, the officer may revert to the rules laid down in the BIOP.

As regards the remuneration of lawyers for being present during questioning, it may be noted that a flat rate fee will be allocated to lawyers as of 1 March 2016 for being present at one or more interviews in the 'duty lawyer' stage (the period from arrest up to and including detention in police custody, where appropriate) in the event that the person is suspected of a criminal offence for which pre-trial detention is permitted. In other words, legal assistance is free of charge for the suspect in such cases.

The CPT reiterates its recommendation that the restriction on access to free legal aid for persons suspected of 'C category offences' be removed. (paragraph 18)

The government takes the view that the right of access to legal counsel does not mean that the costs involved should necessarily be borne by the government. This depends on factors such as the seriousness of the allegation and – in conjunction with this – the coercive measures that the government may adopt. Thus, suspects who have been arrested on suspicion of criminal offences for which pre-trial detention is permitted are entitled to the assistance of legal counsel both before and during questioning free of charge. In 'category C

cases' – i.e. minor offences (*overtredingen*) and offences on the lower end of the scale in the serious offences (*misdrijven*) category – the suspect can be detained for investigation for a maximum of six hours. In cases of this kind, there is no question of prolonged deprivation of liberty (or an extension of such) being imposed after the questioning.

Nonetheless, an important change should be noted. As of 1 March 2017, vulnerable suspects who have been arrested on suspicion of a 'category C offence' are also provided with legal assistance free of charge prior to police questioning. This provision follows from an amendment to the Code of Criminal Procedure that entered into effect on 1 March 2017 and which provides that vulnerable persons who have been arrested can no longer independently waive their right to consult legal counsel prior to police questioning, regardless of the seriousness of the criminal offence of which they are suspected. 'Vulnerable' suspects within the meaning of the law are minors as well as adults who have intellectual disabilities or a psychiatric disorder. Minors are no longer permitted in any circumstances to waive their right to be assisted by legal counsel. A lawyer will therefore always be called upon to provide assistance where a minor is involved. Vulnerable adult suspects can only waive their right to consult legal counsel if a lawyer has drawn their attention to the consequences of doing so. They too, therefore, will always receive advice from a lawyer before being questioned by the police. For this reason, the government believes that it is reasonable that it should also bear the costs of this advice. Other adults suspected of category C offences will continue to be liable for payment of the limited costs of consulting a lawyer and receiving a lawyer's assistance during questioning in the initial stage after arrest.

The CPT recommends that the Dutch authorities ensure that juveniles are never subjected to police questioning or requested to make any statement or to sign any document concerning the offence(s) they are suspected of having committed without the presence of a lawyer and, in principle, a trusted adult person. (paragraph 20)

As of March 2017 juvenile suspects (including those aged 16 or 17) will no longer be permitted to waive their right to assistance by legal counsel. This means that arrangements will always be made to put them in touch with a lawyer before first being questioned by police. Minors are not obliged to make a statement or to sign any document prior to police questioning. This is included in the National Regulations on the Treatment of Persons in Custody and the police will specifically ensure compliance with this provision.

The CPT recommends that the Dutch authorities ensure that these precepts [with regard to requests to see a doctor] are effectively implemented in practice at Deventer Police Station and, where applicable, also in other police establishments in the Netherlands. (paragraph 22)
The CPT reiterates its recommendation that police officers be reminded of the right of persons in police custody to be examined by a doctor of their own choice. (paragraph 24)

If a person in police custody asks to see a doctor,[1] the police will contact the contracted healthcare provider.[2] Persons who are being held in police custody have the right to ask to see their own doctor, in which case the police officer will inform the doctor concerned of this request (article 32 of the Police Official Instructions).

The doctor will decide in consultation with the police, with a view to the efficient use of resources and the effective deployment of medical capacity, how the medical consultation should be arranged (whether by telephone or on site). That is not for the police to decide. In the example cited in the CPT report, the factors underlying the doctor's decision are unclear.

The police naturally have an obligation to ensure that medicines have not exceeded their expiration date. The doctor bears responsibility for prescribing the correct medication, including the correct expiration date. Police officers ensure that the correct medicine is handed to the correct person at the correct time.

The CPT considers [..] that all medical examinations should be conducted out of the hearing and [..] out of the sight of police staff. The presence of police staff during medical examinations of detained persons could discourage a detained person who has been ill-treated from saying so and, more generally, is detrimental to the establishment of a proper doctor-patient relationship. The CPT recommends that these precepts be effectively implemented in practice at Houten Police Detention Facility. (paragraph 23)

In the case of medical examinations in Houten, the doctors' consulting room is used if necessary. Minor examinations take place in the cell. The choice of room is always up to the doctor. Efforts are made to safeguard the privacy of the person in custody as far as is possible, while at the same time ensuring the safety of all staff (both the doctor and custody officers).

[1] It is not only at the request of the person in custody that a doctor is called. Police officers may themselves decide to call a doctor if the behaviour of the person in custody gives them reason to do so.
[2] The police works with specific organisations of medical practitioners that are under contract to provide their services.

The CPT considers that lights in a cell should be switched on at night only if there is a clear need to do so. (paragraph 26)

In many cell complexes the cells have switches and the lights can be turned off at night. If there is no such switch, a low-voltage bulb is used to enable the person in custody to rest. The key requirement, however, is that it must be possible to monitor a cell and the person in it. Custody officers therefore have to balance the interests of the person's privacy against safety concerns. They do so to the best of their ability.

The CPT considers it essential that when it is deemed necessary to place a detained person under video-surveillance, his/her privacy should be preserved when he/she is using a toilet, for example by pixelating the image of the toilet area. (paragraph 28)

Placement in an observation cell (with video surveillance) is often done to protect the person concerned. In this situation it is particularly important to weigh the person's privacy against his/her safety. It is therefore important to be able to monitor the entire cell, including the toilet area. Care is taken to ensure that no one stays in an observation cell longer than necessary. Images are only viewed by custody officers of the same sex.

At Houten Police Detention Facility [...] the vehicles did not possess seat belts in the compartments for detained persons, which represents a safety hazard. The CPT recommends that this shortcoming be remedied. (paragraph 29)

On the basis of the Traffic Rules and Signs Regulations (RVV) – the Dutch highway code – the requirement to wear seat belts does not apply in relation to police vans. Installing seat belts in the compartment used to transport persons who have been arrested presents other risks, such as that of strangulation during the journey.

Complaints were received about the amount of food provided to detained persons coming from police stations, which staff confirmed was an issue. The CPT invites the Dutch authorities to review this matter. (paragraph 30)

Detained persons are given a standard packed lunch if they are transported to court to be brought before the public prosecutor. Where incidental complaints arise regarding the quantity of food that is provided, each case is dealt with separately to find a practical solution. There are no plans to increase the size of the standard packed lunch, given the desire to avoid excess waste.

III. Prison establishments

The Committee recommends that the metal container be taken out of service and all outdoor exercise facilities be sufficiently large to allow prisoners to exert themselves physically (as opposed to pacing around an enclosed space), less oppressive in design (e.g. allowing a horizontal view of the outside) and equipped with means of rest and shelter against inclement weather. (paragraph 38)

The primary concern here is that the detainees in question – who are subject to restrictive measures by order of the investigating judge – may have no contact whatsoever with fellow detainees. Depending on the number of detainees to whom this applies, this limits the opportunities to allow these detainees access to a regular exercise yard. However, the container will be removed and other ways of ensuring that the detainees can exercise, for instance in the exercise yards of the segregation wing, will be explored.

The Committee invites the Dutch authorities to ensure an equitable remuneration of the work of prisoners. (paragraph 41)

The government considers that the wages paid to detainees are fair, even though they are considerably lower than those paid in the outside world, which may lead detainees to consider them too low.[3] Detainees work in conditions that differ essentially from those in the outside world: since the prison provides *inter alia* food, accommodation, free medical care and free education, detainees have no living expenses and are able to spend their wages on cigarettes, food supplements and phone credit. In addition, labour productivity levels in detention are not comparable to those in businesses in the outside world. Furthermore, the new skills that detainees acquire through work may increase their chances of finding work after release from the institution and provide them with opportunities for working together with others in a controlled environment so as to develop team skills.

The CPT recommends that the authorities further improve the educational programmes and vocational training in the establishments visited. (paragraph 42)

[3] See also the judgment of the European Court of Human Rights (ECtHR), which ruled that States Parties have a considerable margin of appreciation in such matters (ECtHR 9 February 2016, *Meier v. Switzerland,* appl. no. 10109/14).

Education has improved in many ways over the past year, and new initiatives involving e-learning are currently underway.[4] In future, almost the entire curriculum will be accessible online. Licences have been purchased for the subjects Dutch, English, arithmetic, computer skills, and literacy. The advantage of these online licences is that the detainee can continue to use them after a transfer and for a further twelve months following release.

In institutions for detainees serving long sentences, the goal is to ensure that they complete a course of vocational training. Where the period of detention is too short to complete an entire course, which is often the case, shorter modules are provided that can quickly lead to a certificate in a sector with sufficient opportunities for paid employment. These include modules leading to qualifications for the hospitality sector, fork-lift truck certificates, and qualifications relating to workplace safety and accident prevention. The skills acquired by working in prison workshops also help detainees learn employment skills.

All institutions have received new study computers. Every education department has both internet computers and computers with a Microsoft Office package. The internet computers have access to only a limited list of approved links. In the future, detainees will have access to all purchased digital teaching materials on the Self-Service Portal for Detainees. This will enable them to study 24/7 at their own convenience rather than just one or two hours a week.

The programme adapts to the user, fostering development, since the exercises identify and target the core competences that the user has not yet mastered. The programmes are also attuned to those used by Regional Training Centres (ROCs). Agreements have been made with teachers to ensure that the educational programmes are also attuned to those at other institutions, which is key to guaranteeing continuity and sustaining motivation.

In addition, since 2016 far more use has been made of national tests that can identify functional illiteracy and establish a person's ability level at an early stage. This makes it possible to offer the detainee the most suitable course straight away and to devise a personal curriculum.

One immediate consequence of [..] [the budget] reduction was the decrease in the number of hours of open door regime in the evening. [Moreover], the CPT invites the authorities to

[4] Online teaching materials are also purchased for the Contractors Safety Checklist (VCA).

reconsider the decrease in the number of hours of the open door regime and to keep the prison libraries open. (paragraph 43)

The number of hours that detainees can spend in a 'plus programme' outside their cells is the same as it was before the budget cuts. The plus programme is part of the system of gaining or losing privileges that was introduced to encourage detainees to behave well in prison and to work on preparing for a successful reintegration into society. Good behaviour can lead to promotion to the plus programme. Detainees who show that they are motivated to work on a safe return to society are therefore not disadvantaged by the cuts. At present, an estimated 80% of the total prison population is taking part in a plus programme. The government therefore sees no grounds for reviewing this policy.

It should also be noted that detainees will be given access to a digital library with newspapers, magazines and literature. The idea behind the digitisation of the library is that it helps detainees to deal better with the demands of modern society. The physical libraries will not be closed until the Self-Service Portal for Detainees (ZBJ) is in place. The switch to a digital library service will not be made until the new system is judged to be a totally satisfactory replacement.

From that time on, the reintegration centres (RIC) in prisons will take over the library's function as a social meeting place. The RIC is the new place where detainees prepare for the period following release, by working on looking for employment, getting out of debt and finding a place to live once they return to society.

The Committee recommends, once again, the introduction of a comprehensive risk assessment process as the basis for placement in a 'terrorist' unit and a regular review of the placement in which the person concerned is involved (notification, right to be heard). Further, the applicable regime should be improved by offering more out-of-cell time and activities. (paragraph 50)

With a view to limiting the danger of radicalisation and recruitment in prisons, the government decided, in response to the recommendations of the National Coordinator for Security and Counterterrorism and based on information received from the General Intelligence and Security Service, to pursue a general policy to concentrate the detention of persons with links to terrorism in a limited number of prisons.

Concentrating detainees with links to terrorism in a few prisons and housing them in separate wings helps to prevent them from influencing fellow detainees and recruiting them for terrorist purposes. In this sense, the policy helps to achieve the desired objective. It also helps to prevent the dissemination of messages that foster radicalisation, possibly through a fellow detainee who has not yet been linked to terrorism, or who has not been convicted (or is not suspected) of a terrorist offence. The existence of a special terrorist wing (TA) also makes it possible to develop a regime tailored to these detainees and to deploy specially trained and instructed staff.

The basic principle is that those who have been convicted, or are suspected, of acts of terrorism are concentrated together in specially adapted wings and kept apart from others. The current selection criteria for placement in a terrorist wing are being retained. However, each detainee is subjected to a risk assessment upon admission to the institution. This spring, the Custodial Institutions Agency started carrying out assessments of inmates of terrorist wings, using the VERA 2R method. In the case of new admissions, the assessments are carried out by the probation service. In order to prevent persons being held in a terrorist wing from influencing each other, those classified as ‘confirmed extremists’ will be separated from those who are reassessing their views. The Netherlands is thus responding to calls for the development of a placement policy that separates ‘confirmed extremists’ from those who are rethinking and are susceptible to influence.

The government agrees with the CPT’s recommendation that those detained in terrorist wings should be offered more activities aimed at reintegration, including activities outside their cells.

With a view to the above points, the government intends to introduce a differentiated placement policy in terrorist wings.

Both confirmed extremists and those who are rethinking and are susceptible to influence will follow a regime with an approach that fosters motivation and a schedule including meaningful activities that are appropriate to the person’s risk profile. This will enable detainees to spend more time outside their cells. Where possible, programmes will also be offered that foster disengagement and deradicalisation, as well as preventive programmes tailored to the individual, and/or regular resocialisation activities.

[T]he above recommendations as regards the regime and the placement procedure apply equally to prisoners placed in the BPG unit. (paragraph 51)

To ensure proper supervision, each detainee's behaviour is assessed at least once every six weeks in the BPG unit – the unit for detainees posing management problems (*Beheersproblematische Gedetineerden*). The detainee is discussed in multidisciplinary consultations (MDO). In response to the recommendations arising from the MDO and the advice of the Privileges Committee, the prison governor may propose to the assignment officer that the person concerned be transferred out of the BPG unit. Detainees are involved in this process through mentoring meetings: their views are listened to and they are kept informed of the results of the process.

The CPT recommends that measures be taken to equip health-care units with an ECG and increase the number of rooms available for medical consultations at Krimpen aan den IJssel and Zuyder Bos Prisons. (paragraph 52)

A healthcare service in a prison is not wholly comparable to the practice of a regular general practitioner. Doctors are not present around the clock to determine whether there is a need for an ECG. If an inmate has severe cardiac problems and requires hospital treatment, an ambulance is called. One does not need to travel far in the Netherlands to reach a hospital. As a rule, an ambulance will be on the scene within fifteen minutes, and each one has ECG equipment on board.

As regards the need to expand the number of medical consulting rooms at Krimpen aan den IJssel Prison, the government would note the prison is currently seeking to achieve this. The number of consulting rooms at Zuyder Bos Prison has already been increased.

[T]he isolation rooms for disciplinary sanctions were also used for seclusion for medical reason. In the CPT's view, this practice should be immediately discontinued as these two types of isolation are fundamentally different and should not be confused in the minds of prisoners – or staff [..] Other arrangements should be found for prisoners requiring medical or psychiatric care and such persons should be placed in rooms equipped for this purpose. The CPT recommends that a health-care unit be provided with adequate premises in light of the above remarks, in the three establishments visited and in other prisons in the country if appropriate. (paragraph 53)

First and foremost, it should be noted that the Netherlands intends to reduce placements in isolation cells. In this connection a new policy framework has been developed, entitled

‘Isolation in detention’. In line with the CPT’s recommendation, this new policy framework distinguishes disciplinary isolation from seclusion for medical reasons. When the person’s mental health is the underlying reason for seclusion, soft furniture will be placed in the isolation cell and the person concerned will also be offered a different kind of programme.

The Committee recommends that the presence of general practitioners in the establishments visited be doubled and that the presence of a psychiatrist be increased notably at Krimpen aan den IJssel Prison. (paragraph 54)

As the government set forth in its response to the CPT’s previous report, equivalence is the guiding principle in Dutch policy. The quality of medical care for detainees must be equivalent to that enjoyed by people in the outside world. The government is convinced that this is the case.

In all prisons, a general practitioner is on call for emergencies 24 hours a day, seven days a week. In addition, prisoners can generally see a doctor about non-acute medical issues within 24 hours on weekdays. Besides general practitioners, every prison also has a medical service that employs specialist prison nurses.

The deployment of psychiatrists at this site has changed since the CPT’s visit. At the time of the inspection, 0.4 FTE psychiatrist was available, while the current availability is 1.6 FTE. This meets the CPT’s recommendation to achieve a notable increase in the presence of psychiatrists at Krimpen aan den IJssel prison.

A fundamental review of health-care services in Dutch prisons in general and the role of health-care staff in particular should be undertaken. (paragraph 55)

The government does not see any reason to undertake a fundamental review of the role of healthcare services in prisons. The medical staff are obliged to act in accordance with the professional guidelines and standards and must be qualified and competent to perform certain interventions. These requirements follow from the healthcare legislation. As the CPT is aware, the Health Care Inspectorate (IGZ) exercises strict supervision over the care provided in prisons. This supervision is carried out by the IGZ’s forensic team. The IGZ is part of the organisational structure of the Ministry of Health, Welfare and Sport. As part of its regular inspections, the IGZ visited several locations over the past few years. These visits did not bring to light any structural shortcomings that would call for a fundamental review

such as that suggested. Developments continue to be monitored through regular inspections.

The Committee recommends that steps be taken to ensure that a person competent to provide first aid is always present in every prison establishment, including at night and on weekends; preferably, this person should be a qualified nurse. (paragraph 56)

Qualified and trained in-house emergency personnel (BHV) must be present in every prison seven days a week, 24 hours a day. These employees are also trained to provide first aid and are certified annually. The government therefore believes that existing practice in the Netherlands already complies with this recommendation, albeit that those concerned are not qualified nurses.

[N]urses wore prison administration uniforms which did not allow inmates to properly distinguish them from custodial staff. The CPT recommends that this practice be changed. (paragraph 57)

While regular prison officers wear a shade of blue that radiates authority, medical staff wear different uniforms: light-coloured polo shirts and khaki trousers. These colours were chosen to project a certain image and for considerations of hygiene, since they show up any stains – and hence the need for cleaning – straight away. The same applies to the medical coats that must, on the basis of occupational health and safety guidelines, be worn by all who perform medical interventions.

The CPT recommends that a systematic examination of all prisoners be carried out within 24 hours of their arrival in detention, including voluntary testing for infectious diseases (HIV, hepatitis C, etc.). (paragraph 58)

In accordance with standard procedure, all detainees must go through a medical intake assessment, to be performed by a nurse, within 24 hours of their arrival (including in the weekend). On this point, standard procedure therefore already complies with the recommendation.

As far as voluntary testing for certain infectious diseases is concerned, the government would note as follows. The Custodial Institutions Agency follows special guidelines in relation to screening for TB, hepatitis C, and MRSA (for other diseases, it follows the same guidelines as those that apply in the rest of society). The staff member conducting the

medical intake assessment will also determine whether there is any particular reason to offer the detainee a test for hepatitis B/C or for HIV. The Custodial Institutions Agency does not offer such tests to all detainees, since detainees do not as such constitute a high-risk group for these diseases in the Netherlands.[5]

The Committee recommends that necessary measures be taken to ensure that the record drawn up after the medical screening contains:
i) an account of statements made by the person which are relevant to the medical examination (including his/her description of his/her state of health and any allegations of ill-treatment),
ii) a full account of objective medical findings based on a thorough examination, and
iii) the health-care professional's observations in the light of i) and ii), indicating the consistency between any allegations made and the objective medical findings.

The record should also contain the results of additional examinations carried out, detailed conclusions of specialised consultations and a description of treatment given for injuries and of any further procedures performed.

Findings from medical examinations in cases of traumatic injuries should be recorded on a special form provided for this purpose, with body charts for marking traumatic injuries that are kept in the medical file of the prisoner. Further, it would be desirable for photographs to be taken of the injuries, and the photographs should also be placed in the medical file. In addition, a special trauma register should be kept in which all types of injury observed should be recorded.

The record should also contain the results of additional examinations performed, detailed conclusions of any specialised consultations and an account of treatment given for injuries and of any further procedures conducted. A certificate containing the abovementioned information should be made available to the prisoner and to the prisoner's lawyer.

The same approach should be followed whenever a prisoner is medically examined following a violent episode in prison. In addition, if the prisoner so requests, the doctor should provide him/her with a certificate describing the injuries.

[5] This in contrast to countries where intravenous drug use is also a problem in prisons.

Procedures should be in place to ensure that whenever injuries are recorded which are consistent with allegations of ill-treatment made by the prisoner concerned (or which, even in the absence of an allegation, are clearly indicative of ill-treatment), the record is systematically brought to the attention of the competent prosecuting authorities, regardless of the wishes of the person concerned. The results of the examination should also be made available to the prisoner concerned and his or her lawyer. Health-care professionals (and the inmates concerned) should not be exposed to any form of undue pressure or reprisals from management staff when they fulfil that duty. (paragraph 59)

All detainees undergo a medical intake assessment upon arrival, the aim of which is to get a clear picture of the detainee's medical problems and to estimate the health risks for the detainee. This initial assessment does not include a full medical examination with a view to discovering and describing any injuries. If a detainee states that he has suffered such injuries this will be recorded in the case file, but it is not within the remit of the medical service to actively investigate the existence of injuries. The government believes that in essence this procedure complies with the CPT's recommendation: a 'thorough examination' takes place (which is not the same thing as a complete physical examination, in the government's view), and the detainee's own comments are recorded.

Any detainee placed in an isolation or observation cell must be visited by a doctor, who notes down any injuries in the person's medical file.

Finally, the CPT recommends that medical records of traumatic injury be systematically brought to the attention of the prosecuting authorities. In the Netherlands, there is a strict separation between these two areas (one involving a person's medical file, which is kept up-to-date by the attending physician, the other involving criminal investigations and prosecution). The government believes that there are good grounds for this separation, such as respect for a detainee's autonomy: a medical practitioner cannot disclose medical facts to the authorities without the detainee's consent. That said, the government believes that the substance of the CPT's recommendation is safeguarded. The doctor records his or her findings in the medical file, including any findings of injury. If an injury has been caused by a third party (whether a fellow detainee or a staff member), there is nothing whatsoever to stop the person concerned from reporting the matter to the police. In some cases the medical service will – strongly – advise the detainee to do so. The police can then ask a forensic physician to describe the injuries and to request the relevant information from the attending physician, with the consent of the person concerned. This system may be different from the one proposed by the CPT but achieves *de facto* the same result.

In the CPT's view, medication should preferably be distributed by health-care staff. In any event, a list of medication to be distributed only by health-care staff (such as anti-psychotics, methadone and antiretroviral drugs) should be established. (paragraph 60)

In the Netherlands, whereas prescribing medication and setting dosage levels are reserved by law to care professionals / medical personnel, this does not apply to the distribution of medication. While the government endorses the importance of medication safety, which is at the heart of the CPT's recommendation, it pursues this objective along different lines than those proposed by the CPT.

Medication is supplied by external pharmacies every day, thus minimising the number of times it needs to be handled in the prison. The pharmacy wraps each detainee's medication separately and according to the time it is to be taken, arranging it in the order in which it is to be distributed in the prison. Pharmacies are required to perform an additional check before delivering the medication to the prison. In the Netherlands, all packaging must by law be clearly labelled with the name and dose of the medication it contains. Delivering unlabelled medication is prohibited.

As far as prison staff is concerned, efforts are currently underway to better safeguard certain preconditions, such as structural training for personnel and setting a specific time of day within the institution's schedule for distributing medication.

The Committee recommends that the Dutch authorities review their drug policy as regards care, prevention and harm-reduction in light of the above principles. (paragraph 61)

The government agrees with the CPT that admission to prison provides an opportunity to address a person's drug-related problems. Drug control policy is therefore an integral part of detention. On the one hand, this involves suppressive policy as described in section 61 of the report: periodic drug testing, and disciplinary procedures in the event of a positive result. But the policy is also aimed at providing drug users with support if they are motivated to quit drugs. At both national and regional level there is a partnership with organisations that are active in addiction care, in order to raise awareness and enhance expertise relating to substances and addiction within the institution. It is also possible to transfer a detainee to a drug rehabilitation clinic to receive the necessary treatment. Since 2015 prisons have been offered the opportunity to sign up for supplementary information for prison staff about drug abuse, signs of abuse, and attached risks. This is to be continued in 2017.

The CPT recommends that the Dutch authorities take the necessary steps, including at normative level, to ensure that medical transfers (transport, escort and supervision) of prisoners are geared to the above considerations and recommendations [use of restraint and the presence of escorting staff during medical examinations]. (paragraph 62)

Detainees are provided with necessary medical care. This may include transfer to a civilian hospital. The general principle of doctor-patient confidentiality continues to apply in such circumstances. However, when a detainee is moved to a place outside the prison, other interests also necessarily come into play, such as the risk of the person evading supervision and the safety of third parties (hospital staff). In this context, it may be justified to take measures to deprive the person of his liberty and – after carefully balancing the doctor's duty to respect doctor-patient confidentiality against the safety of all persons concerned and the supervisory duties of the officers who are escorting the detainee – to violate doctor-patient confidentiality. After all, the fact that a court has imposed a custodial sentence or a measure depriving someone of their liberty will necessarily lead to certain inherent restrictions in that regard. In such a case, there will be consultations between the transport escort and the physician concerned. This may lead to the examination taking place in the presence of the transport escort. Alternatively, this officer could take up a position close to the door (provided he considers this to be responsible, with regard to guaranteeing safety).

The CPT invites the Dutch authorities to consider the possibility of bringing prison health-care services under the responsibility of the Ministry of Health. (paragraph 63)

The government believes that the health service and the justice system together share responsibility for caring for mentally disturbed detainees. This shared responsibility applies not only to ministries involved in forensic psychiatry but also to the justice system as a whole and the health services sector (see also the letter to the House of Representatives of 5 November 1997 from the Minister of Health, Welfare and Sport and the Minister of Justice, Parliamentary Papers 1997-1998, 25 715, no. 1). However, the government does not see any grounds for reopening debate as to whether this responsibility should be transferred in its entirety to the Minister of Health, Welfare and Sport.

In the Netherlands, the Minister of Security and Justice is responsible for the implementation of sanctions. This remit includes responsibility for access to – and the provision of – forensic care within the criminal justice system. This care is provided or purchased by the Custodial Institutions Agency (DJI). The Dutch Healthcare Authority (NZA) advises on tendering and

purchasing procedures, ensuring that the quantity, quality and nature of care are attuned to the criminal justice setting. The focus is on ensuring that detainees receive the care they need. This modus operandi enables the Minister of Security and Justice to fulfil his ministerial responsibility to parliament for the implementation of sanctions.

The government does not consider the structure of the Dutch system of government or the division of tasks among different ministries to come within the CPT's mandate.

The Committee recommends that the necessary legislative and administrative measures be taken rapidly to provide persons sentenced to life imprisonment with a clear avenue for consideration of release, based upon objective criteria, after a defined time period. (paragraph 65)

On 26 April 2016 the Grand Chamber of the European Court of Human Rights ruled in the case of *Murray v. the Netherlands* (appl. no. 10511/10). Following this ruling, the State Secretary for Security and Justice announced in his letter of 2 June 2016 to the House of Representatives – to which the CPT itself refers in its report – that he plans to introduce periodic reviews of the cases of people serving life sentences and to set up an advisory body for this purpose. After someone has served 25 years of a custodial sentence, this advisory body will decide whether the continued enforcement of the life sentence still serves a legitimate punitive purpose. The advisory body will also examine whether a person serving a life sentence could be considered for reintegration activities – activities that give detainees (additional) opportunities to prepare for actual re-entry into society.

In this review, the central question is whether the person has changed to such an extent, and achieved such progress in his or her rehabilitation, that the continued enforcement of the life sentence no longer serves any legitimate punitive purpose. The review will incorporate the recommendations of the Public Prosecution Service and the judiciary, as is currently the practice in the pardon procedure.

The criteria used for examining pardon applications submitted by persons serving life sentences are the risk of reoffending, the criminal threat posed by the person in question, the impact on the victims and the bereaved, the detainee's conduct and progress made while serving the life sentence, the seriousness of the offences that led to the life sentence, and the detainee's character. Age as well as mental and physical health also play a role, as does the question of whether the detainee has grasped the consequences of his crime for those directly involved. The criterion 'impact on the victims and the bereaved' is based on

the results of an assessment of the expected impact on the victims and the bereaved of reducing or terminating the sentence. Such an assessment could be taken into account when considering any reduction or remission of the sentence. The seriousness of the crimes for which the life sentence was imposed is taken into consideration when answering the question of whether retribution is still a relevant factor or how this should continue to be assessed. In other words, not all the criteria enumerated here are accorded equal importance. Of key importance, however, is the assessment of the criminal threat posed by the person serving a life sentence and whether they are likely to reoffend.

The Advisory Body on Persons Serving a Life Sentence (Establishment) Order was published in the Government Gazette at the end of last year. Talks with the Council for the Judiciary and senior management of Arnhem-Leeuwarden court of appeal resulted in a decision to set up this independent advisory body under the auspices of this court's Parole Appeals Division. In consequence, preparations are being made at this location to put in place the necessary logistics, infrastructure and administration. The advisory body is expected to start work in June 2017.

In addition, a document is currently being prepared that details all the steps to be taken by the various organisations that make up the criminal justice system. In addition to describing the activities to take place at each stage of the process, this document identifies for each stage the client and the service provider, as well as the time limits for each stage, from the moment someone is remanded in police custody up to and including the reassessment of the case in the form of a pardon procedure carried out *ex proprio motu*.

Finally, the government wishes to draw attention to a judgment of 5 July 2016 of the Supreme Court of the Netherlands regarding the imposition and enforcement of life sentences in relation to the requirements of article 3 of the ECHR. The Supreme Court held first and foremost that a life sentence is not in itself incompatible with the provisions of article 3 of the ECHR, even when enforced in full. However, it follows from the relevant legal framework that a life sentence cannot be imposed if it is not already clear at the time of imposition that there is a real possibility of the life sentence being reassessed at some point, potentially leading, where applicable, to the sentence being reduced or to release on parole.

The regime offered to [life sentenced prisoners] [..] was relatively ordinary, with no open door regime. The CPT invites the authorities to improve the situation in light of the above remarks. (paragraph 66)

In Norgerhaven Prison, part of Veenhuizen custodial institution, K Wing was created as a special wing for detainees serving life sentences, to prevent them from coming into contact with those who were serving short sentences. In 2015 Norgerhaven Prison was made available to Norway for the detention of persons who had been convicted in Norway. Some detainees, including a number of those assigned to K Wing, sought an interim injunction to prevent the State from transferring this prison to the Norwegian authorities, or in any case to prevent them having to serve the rest of their sentence elsewhere, away from Norgerhaven. The court rejected their injunction application. During these proceedings, the State undertook to ensure that a wing similar to the one at Norgerhaven would be created for these detainees at Zuyder Bos Prison, part of Heerhugowaard custodial institution. In the court rulings arising from these interim injunction proceedings (judgment of 6 March 2015 by The Hague district court and judgment of 14 July 2015 by The Hague court of appeal), the court considered that not every divergence from the facilities of K Wing could be deemed unlawful. For instance, detainees could not derive any rights from the view they had enjoyed in K Wing at Norgerhaven. These detainees would have to be offered an adequate alternative.

The detainees' applications for judicial review of their transfer from K Wing at Norgerhaven to Zuyder Bos Prison were subsequently rejected by the highest court with jurisdiction over detention-related cases.

Following their transfer to Zuyder Bos Prison, a number of detainees instituted multiple legal proceedings regarding the question of whether the facilities at Zuyder Bos were equivalent to those at Norgerhaven. On a small number of points the highest court with jurisdiction over detention-related cases found in favour of the detainees. Adjustments were subsequently made in respect of these points – too few television channels, no uninterrupted access to telephone and Skype calls. The other complaints were dismissed by the court for a variety of reasons.

In view of the above, there are no grounds for changing the situation in wing E0 of Zuyder Bos Prison of Heerhugowaard custodial institution.

[T]he recent decrease in the prison administration budget led to a reduction of available staff, an issue of concern for custodial staff but also certain inmates, notably the most vulnerable ones. [..] The CPT would like to receive the comments of the Dutch authorities on these issues. (paragraph 67)

The staff shortages within the Custodial Institutions Agency (DJI) arising from a higher than expected outflow of personnel were discussed with parliament in the review of the budget of the Ministry of Security and Justice earlier this year.[6] In order to prevent operational problems and to guarantee the safety of staff and detainees, capacity and staff will be concentrated as much as possible. At the same time, a national recruitment drive is currently underway for 140 FTE prison officers. The selective freeze on recruitment that was introduced as part of the DJI Master Plan for 2013–2018 has been relaxed for this category.

There is no question of any prisons, including young offender institutions, being closed down. For completeness' sake, it should be noted that there has been a small rise in the prison population. Such a rise is in itself customary at the end and at the beginning of the year, but the current numbers are higher than expected on the basis of the previous estimates of the need for institutional capacity in the Justice System Forecasting Model (PMJ). The extent to which this reflects a more structural trend will need to be assessed on the basis of the new PMJ estimates that will be published in due course.[7]

The delegation received, in the three establishments visited, a large number of complaints regarding the lack of effectiveness of care officers. […] The CPT would like to receive the comments of the authorities on this matter. (paragraph 68)

Every custodial institution makes a staffing allocation for case managers (which the report refers to as 'case officers' or 'care officers'). On average there is one case manager for every 30 detainees. In addition, senior case managers are attached to Persistent Offenders Institutions and Prison Programmes (PP), with an average caseload of 12 detainees each. Case managers and senior case managers have a back office providing administrative support, with one administrative assistant for every two case managers. The case manager sees the detainee within 10 working days and supports him or her in making arrangements and with activities geared towards re-entry into society following detention.

The complaints to which the CPT refers may be attributable to a variety of causes. In practice a case manager's caseload may be higher than expected as a consequence of staff turnover, sickness absenteeism, pregnancy and parental leave, the part-time working scheme for older staff (PAS) and/or obligations relating to participation in the in-house emergency response team or works council without any provision for replacement. It should

[6] See Proceedings of the House of Representatives 2016/17, no. 30, items 7 and 12.
[7] Letter of 6 February 2017 from the State Secretary for Security and Justice to the House of Representatives (House of Representatives, 24 587, no. 672).

also be noted that the case manager relies in part on cooperation with others. Finally, detainees' experiences may relate to the procedures surrounding release on parole. Eligibility for certain measures, including release on parole, is based on meticulous legal assessment, which detainees view as too time-consuming.

It should be added that the deferment or rejection of release on parole requires an application to this effect by the Public Prosecutor based on one or more of the grounds that are listed exhaustively in legislation. These grounds do not include alleged inaction on the part of a case manager.

In light of the above considerations, the government does not view the picture presented by various detainees as an accurate reflection of the situation.

The CPT recommends that the Dutch authorities increase the number of telephones accessible to inmates at Krimpen aan den IJssel Prison and ensure that detained persons have access to telephone communication at a cost comparable to that in the community. (paragraph 70)

There are incidental peaks in demand for the telephones in the exercise yard at Krimpen aan den IJssel Prison. The number of telephones in the prison as a whole is sufficient.

More generally, the Custodial Institutions Agency is currently reviewing the policy on detainees' access to telephones. The Self-Service Portal for Detainees (ZBJ) is geared towards ensuring that detainees will be able to make calls from their own cells using a device and headset provided by the institution. This is expected to virtually eliminate the pressure on the central telephone points. In view of these plans, the government is not investing at present in creating additional telephone points.

As far as the high costs of calls are concerned, the Netherlands is dependent on the tenders it receives from service providers in accordance with compulsory European tendering procedures. In this connection it is reasonable that the provision of access to telephones be cost-effective.

The CPT recommends that the necessary measures, including at legislative level, be taken in order that the disciplinary procedures comply with the above-mentioned due process requirements. (paragraph 71)

The government is constantly working to ensure that prison inmates have access to adequate complaints and judicial review procedures. Draft legislation aimed at improving the procedure for judicial review and thereby enhancing the quality of the administration of justice by the Council for the Administration of Criminal Justice and Protection of Juveniles (RSJ) will be submitted to parliament later this year.

An approach designed to motivate detainees was introduced to prisons in recent years as the standard way of interacting with detainees. Motivating detainees and continuing to engage them in dialogue can resolve many of their complaints at an early stage. In addition, efforts are being stepped up to use mediation to address detainees' grievances. A bill currently before parliament (the Bill amending the Custodial Institutions Act, the Hospital Orders Framework Act, the Young Offender Institutions Framework Act and other legislation in connection with transport, the medical right of complaint and several other subjects, Parliamentary Papers 33 844) proposes including a detailed mediation procedure in the legislation.

As far as complaints against disciplinary sanctions are concerned, the government takes the view that the existing procedures and legislation comply with the relevant requirements of due process. The complaints procedure, it should be added, differs in nature from criminal prosecution.

The government will discuss the CPT's recommendations in this connection within the prison system and with the complaints committees and take any measures that are deemed to be necessary.

For other offences, less severe sanctions were used, notably confinement to their own cell without access to a television. At Zuyder Bos Prison, the delegation observed that there had been a high resort to disciplinary procedures in the recent past leading to the placement in disciplinary confinement of 58 inmates in just four months. The CPT would like to receive the comments of the Dutch authorities on this issue. (paragraph 72)

The number quoted of 58 disciplinary sanctions in the first four months of 2016 translates to an average of four reports a week. This is an acceptable number and does not differ significantly from the situation at other prisons. The sanctions policy at Zuyder Bos does not differ from that pursued in other prisons. All 58 of the cases cited above refer to 'confinement to their own cell' or placement in a punishment cell.

The Committee recommends that steps be taken, including at legislative level, to ensure that the role of health-care staff vis-à-vis persons held in solitary confinement is reviewed, in the light of the above remarks. In so doing, regard should be had to the European Prison Rules, in particular, Rule 43.2, and the comments made by the Committee in its 21st General Report. (paragraph 73)

The role of medical staff in situations involving solitary confinement will be reviewed and regulations modified where necessary.

The CPT recommends that cells used for disciplinary solitary confinement, in the three establishments visited and in other prisons of the country if appropriate, be equipped with a table and chair, if necessary fixed to the floor, in addition to a proper bed. (paragraph 74)

The possibility of installing soft furniture, consisting of a bed, a table, an armchair, and a small bookcase, is currently receiving consideration.

In all the establishments visited, the facilities used for outdoor exercise for inmates undergoing disciplinary solitary confinement were too small (some being around 12 m²) for genuine exercise and did not have means of rest. The recommendation formulated in paragraph 38 applies equally in this context. (paragraph 75)

First and foremost, the government would note that the Custodial Institutions Agency seeks to reduce the number of placements in solitary confinement, which also has implications for the use of the related exercise yards. For the rest, the government will look into the scope for following this recommendation and enlarging the exercise yards concerned. The reason why the government is not giving unconditional assurances that it will follow the recommendation has to do with limitations related to buildings (e.g. objects next to the exercise yard that cannot be removed).

The Committee recommends that the regulations and the practice applicable to strip searches be changed accordingly. (paragraph 76)

As regards the recommendation that a strip search must only be carried out in front of custodial staff of the same sex, the government would note that as a rule this is already the case. Very rarely, however, the urgency of a situation may make it impossible to postpone the search. The government wishes to retain the freedom to depart from standard procedure in these exceptional cases.

The CPT also urges that a detainee not be required to remove all his or her clothing at the same time. The government considers that this recommendation may be problematic, both from a practical point of view and for considerations of hygiene. What is more, this would make it more difficult to check clothing thoroughly for the presence of contraband. The government agrees to review current practices relating to the removal of clothing and to see whether they can be modified.

The CPT encourages the Dutch authorities to abandon the resort to fixation beds in prisons. (paragraph 77)

In practice, fixation beds are almost never used. Medication administered to restrain the detainee generally suffices to bring a situation under control. However, it is impossible to rule out the possibility that in highly exceptional cases the use of a fixation bed may be the sole remaining way of bringing a situation under control.

At De Schie Prison, the delegation gained the impression that the IBT was being overused. [...] The Committee would like to receive the comments of the authorities on this issue. (paragraph 78)

Given the nature of the population, an approach designed to de-escalate situations is necessary, fosters good relations with the detainee, and benefits the living environment. However, one of the key responsibilities of the Custodial Institutions Agency is to guarantee that the living environment in detention is also *safe*. In order to restore peace and order, staff must be able to intervene when de-escalation is not sufficiently effective. Protective clothing and the use of handcuffs are essential in order to protect staff (in accordance with health and safety legislation, the employer also has an obligation to accord great importance to employees' safety) as well as the patient. Employees of the Custodial Institutions Agency are aware that operating in protective gear may sometimes be counterproductive. Before any deployment of a special intervention team (IBT) the prison governor will always carry out a risk assessment, in which this possibility is taken into consideration. An emergency transfer to hospital likewise involves a variety of risks that the governor takes into account. It may be relevant here that De Schie is a high-security prison in which the nature of the population – unlike a PPC and yet similar in the sense of it being in a separate category in terms of security – may make the deployment of an IBT necessary in the situations concerned. Since the CPT does not cite any specific examples, it is impossible to confirm the picture it presents.

IV. Penitentiary psychiatric centres

At the beginning of the visit, the Dutch authorities informed the CPT's delegation that an independent review of placement in PPCs was scheduled to start in May 2016. The CPT would like to be informed of the outcome of the review. (paragraph 81)

In October 2014 the thematic evaluation of the legislation on compulsory care was presented to the House of Representatives. The evaluation was launched to examine differences in legal status that exist among those who are receiving care, as defined in this legislation. These differences arise from the statutory provisions on the basis of which people receive compulsory care. The evaluation examined the provisions regulating the legal status of juveniles and adults on whom compulsory care has been imposed, in both current and prospective legislation, what differences exist, and whether these differences can be justified. It also examined how the current regulations for juveniles and adults work in practice and identified loopholes and problems. In addition, it looked at whether the current and prospective regulations constitute a consistent and efficient statutory framework and what can be done to improve it. The scope of the evaluation included the Custodial Institutions Act and other framework acts in this field. It makes recommendations on matters including ensuring people receive the most appropriate care, transitions between different healthcare domains and the relevant laws, legal protection procedures, and monitoring compliance with the law.

A policy response that was sent to the House of Representatives on 7 July 2016 describes the next steps that the Government plans to take. One important next step is to prepare umbrella legislation governing legal status, geared towards creating an educational therapeutic climate for juveniles in young offender institutions and juveniles in secure youth care.

[T]he CPT invites the Dutch authorities to consider how the role of the Ministry of Health in the management and supervision of the PPCs could be increased, with a view to ensuring the provision of optimum care to the patients and the principle of equivalence of care in prison with that in the wider community. Reference is made in this context to the remarks set out in paragraph 63. (para. 82)

PPCs have been responsible for providing psychiatric care to detainees since 2009. An individual's eligibility for referral to a PPC is assessed by a prison psychologist. Just as in the regular mental healthcare sector, PPCs are staffed by nurses, doctors, psychiatrists,

healthcare psychologists and occupational therapists. Three PPCs were awarded ISO 9001 quality management certification in 2015, meaning that they comply with international quality management requirements. The fourth PPC opened in mid-2016 and embarked on the certification procedure at the beginning of this year.

The Health Care Inspectorate (IGZ) supervises the examinations conducted by PPCs to establish each patient's physical and mental health upon admission. It also checks that files are kept properly updated and that transfers of information take place as they should. When an incident such as a suicide occurs in spite of the professionals' efforts, the IGZ instructs the institution to launch an independent investigation to determine whether any mistakes were made and to see where there is room for improvement. The IGZ then assesses the quality of the investigation and the proposed measures for improvement.

In other words, the IGZ already monitors the care provided within custodial institutions, and hence at PPCs. In doing so, it has not identified any structural shortcomings that would necessitate a greater focus on management and supervision. The developments in PPCs are followed through the regular supervisory mechanisms. The government therefore sees no grounds for transferring healthcare provision to the Ministry of Health, Welfare and Sport and/or expanding the IGZ's supervisory procedures.

The CPT recommends that all members of special intervention teams in the Netherlands be reminded that no more force than is strictly necessary and proportionate should be used to bring an agitated and/or violent patient or prisoner under control. (paragraph 85)

The government endorses the CPT's point of departure that no more force than is strictly necessary and proportionate should be used. This is enshrined in legislation and regulations applicable to all staff, including those operating as part of a special intervention team (IBT). This principle is explicitly incorporated into IBT training and regular follow-up training. The basic principle is to seek to de-escalate situations and thus to avoid any need for the deployment of an IBT and the possible attendant use of force.

At Zwolle, the delegation was informed that a female patient had lodged a formal complaint with the police and the prison supervisory committee about excessive use of force by IBT members. [...] The CPT would like to be informed of the outcome of the police investigation into this case. (paragraph 86)

In response to this patient's lodging a complaint with the police, the Department of Safety, Integrity and Complaints (VIK) of the Public Prosecution Service launched an enquiry and compiled a case file to establish the causes of her injury. Six witness statements were taken in the course of the enquiry. In view of the consistency of the witness statements, it was not established that the IBT team had violated the applicable rules. The Public Prosecution Service therefore did not find any grounds for prosecuting one or more members of the IBT team.

The CPT recommends that the Dutch authorities review the regime and lock-up times at Scheveningen and Zwolle PPC, as well as, where applicable, in other PPCs in the country, with a view to re-establishing the previous regime in which patients could spend up to 12 hours a day out of their rooms, engaged in purposeful activities and interaction with staff and/or other patients, and that the PPCs thus provide a truly therapeutic regime to the patients. (paragraph 90)

The government does not endorse the CPT's recommendation in this regard. PPCs provide a daily programme of activities spanning 73.5 hours per week, which is well over the national standard as laid down in the Custodial Institutions Act. This is in line with the therapeutic nature of PPCs. At the same time, the current programme also does justice to the element of detention: the patients have been given custodial sentences by a court of law. Furthermore, there is a need to incorporate opportunities for patients to rest, which is particularly important for the PPCs' target group. The government believes that the current programme strikes the right balance between these different dimensions.

The CPT recommends that the Dutch authorities:

- *take urgent steps to strengthen the leadership and to stabilise the psychiatric team, as well as to increase the number of psychiatrists working in the establishment;*
- *thoroughly review the number of ward-based staff and therapists;*
- *ensure that a wider range of therapeutic options is introduced;*
  ensure that an individual treatment plan is drawn up for every patient, including pharmacotherapy and a broad range of therapeutic, rehabilitative and recreational activities and indicating the diagnoses, the treatment goals, the therapeutic means used and the staff member responsible; the treatment plan should also contain the outcome of a regular review of the patient's mental health condition and a review of the patient's medication. Patients should be involved in the drafting of their individual treatment plans and be informed of their progress. (paragraph 96)

The government broadly endorses this recommendation. At present, recruitment procedures are underway for a new Director of Care and Treatment as well as for treatment coordinators to strengthen substantive leadership. The number of psychiatrists to be appointed has recently been increased and all vacancies are now filled. The existence of treatment plans as referred to by the CPT is already formal standard policy. The management of the PPC will take active steps to ensure that these treatment plans are properly filled in for all patients. An evaluation will be conducted, together with the new Director of Care and Treatment, to see whether there is any need for changes to staffing levels as far as the staff responsible for treatment are concerned.

The CPT recommends that the Dutch authorities review the staffing levels at Zwolle PPC, with a view to increasing the number of psychiatrists and therapists providing nonverbal therapies. The number of ward-based staff should also be reviewed. (paragraph 98)

Following on from the above observations, the staffing levels of psychiatrists and other professionals will also be evaluated at Zwolle PPC by line management and the Director of Care and Treatment, and supplementary measures will be taken where necessary. The care portfolio holder of the Custodial Institutions Agency will also evaluate the staffing levels of those involved in providing care in custodial institutions.[8]

In the CPT's opinion, the necessity for polypharmacy used for some patients at Zwolle PPC should be reviewed. (paragraph 99)

The current guidelines for the assessment of medication in the Netherlands define the target group for such assessments as follows: older patients (over 65 years of age) who use five or

[8] Every year each of the four PPCs submits a quotation for the coming year to the Forensic Care Department of the Custodial Institutions Agency in the framework of funding for DBBC (Diagnosis, Treatment and Security). The quotation submitted by Zwolle PPC links different intensities of care to the 120 available places. A fixed, higher level of staffing is set where there is a need for a higher intensity of care. This guarantees that sufficient numbers of staff are always present to cope with the intensity of care required by patients. Fewer staff members are needed to attend to patients in categories requiring low-intensity care, while almost two members of staff are available for every patient in the highest category. The basis for treatment in the PPC is our supportive therapeutic environment in the living units. This is maintained throughout the daily programme by care and treatment facility (ZBIW) workers: mid-level, senior and nursing staff (111 FTE in total). Besides the ZBIW workers, each PPC wing also has a healthcare psychologist appointed as treatment coordinator, psychologists who are called on to provide treatment, and four socio-psychiatric nurses. In addition, four psychiatrists work in the PPC, and the Director of Care and Treatment is also a psychiatrist. This means that staffing levels in terms of psychiatrists are relatively high. When a patient is admitted to a PPC, a multidisciplinary treatment plan is drawn up. This individual treatment plan is approved by the treatment coordinator in consultation with the patient, after which it is evaluated at least once every six weeks and adjusted where necessary. The treatment coordinator makes suggestions for training and/or therapy in response to discussions of the treatment plan. Occupational therapy is one of the options that may be offered within the institution. The PPC has three occupational therapists: a music therapist, a psychomotor therapist and an art therapist. To date, there is no waiting list for non-verbal therapy for which a need has been indicated.

more medicines on a chronic basis. The guidelines also include risk factors. Developments are currently taking place in the Netherlands in this field. Doctors and external pharmacists together determine whether, in the case of someone with polypharmacy who is a subject of the justice system, there is any indication of the need for an assessment of medication. This can take place in the regular pharmacotherapy consultations held in every institution at least twice a year.

The CPT's considerations concerning the role of health-care services in the prevention of illtreatment have been already set out in detail in paragraph 59. The Committee recommends that these precepts and recommendations be effectively implemented at Scheveningen and Zwolle and, where applicable, also in other PPCs in the Netherlands. (paragraph 103)

In this regard the government would refer the CPT to its reply to the recommendation in paragraph 59.

The CPT considers it essential that when it is deemed necessary to place a detained person under video-surveillance, his/her privacy should be preserved when he/she is using the toilet, for example by pixelating the image of the toilet area. (paragraph 107)

The patient's privacy in the event of video surveillance is already safeguarded in PPCs, but the government considers it undesirable for security reasons to install a partition or to blur the image. Such measures would limit supervision and make it harder to intervene immediately if necessary. Cells used to have partitions, and patients took advantage of them to try to break their necks or extremities or to crack their skulls open on the toilet out of direct sight of staff. This is why the partitions were removed and the government considers it undesirable to put them back.

The CPT recommends that the Dutch authorities thoroughly review the use of the IBT teams in PPCs, duly taking into account the aforementioned principles and considerations, notably with a view to reducing their deployment in full protective gear and the application of handcuffs. (paragraph 111)

Given the nature of the prison population, seeking to de-escalate situations is necessary, fosters good relations with the detainee, and benefits the living environment. However, one of the key responsibilities of the Custodial Institutions Agency is to guarantee that the living environment in detention is also *safe*. In order to restore peace and order, staff must be able

to intervene when de-escalation proves insufficiently effective. Protective clothing and the use of handcuffs are essential in order to protect staff (in accordance with health and safety legislation, the employer also has an obligation to accord great importance to employees' safety) as well as the patient. Employees of the Custodial Institutions Agency are aware that operating in protective gear may sometimes be counterproductive. Before any deployment of a special intervention team (IBT) the prison governor will always carry out a risk assessment, in which this possibility is taken into consideration.

Only in exceptional situations [..] may the administration by nursing staff of rapid tranquillisers under a 'conditional' PRN prescription be justified, meaning that a medical doctor must be contacted (e.g. by phone) and must confirm the prescription prior to its use. [..] Moreover, the use of a PRN prescription for rapid tranquillisers must be accompanied by specific safeguards [..] Indeed, other more general safeguards accompanying any use of means of restraint in psychiatric settings should also apply when rapid tranquillisers are administered on the basis of a PRN prescription. The CPT recommends that these precepts be effectively implemented in practice at Zwolle PPC and, where applicable, in other PPCs in the Netherlands. (paragraph 112)

The working methods in PPCs with regard to medication to be taken *pro re nata* (as required) are in line with the existing/regular practice in the Netherlands. Medication is prescribed where necessary by the attending physician/psychiatrist, who will take into account the relevant considerations in relation to care assessments, safety, and safeguards. This physician also bears responsibility for this policy, and specifies dosages, time intervals, and the maximum number of times each medicine may be administered.

When *pro re nata* medication is administered by nurses, it generally happens on a voluntary basis. Where the medicine must be injected, there will be consultations with the attending physician/psychiatrist, or the duty doctor outside office hours.

If medication has to be injected without the patient's consent, the duty physician will attend the patient to make an assessment and to confirm the nurse's judgment. Only in extreme situations (involving danger) can the nurse administer *pro re nata* medication by force after consulting the psychiatrist by telephone. In any case, several safety measures and checks are carried out for 24 hours after medication is administered, such as checking consciousness and blood pressure. The nurse is responsible for organising these checks.

This established policy is in accordance with the CPT's recommendations but the government will remind all PCCs of the need to monitor compliance with this policy in practice.

The Committee encourages the Dutch authorities to abolish disciplinary sanctions vis-à-vis patients in PPCs. (paragraph 113)

The Government endorses the substance of the CPT's recommendation. The behaviour of patients in PPCs is generally related to their confused mental state and the approach should therefore be therapeutic rather than punitive. However, in exceptional cases – when culpability is at issue – a more punitive sanction will be appropriate. For this reason, this form of sanctioning will be maintained as a formal possibility.

The CPT recommends that clear distinction be made between the 'good order measure' of seclusion and disciplinary solitary confinement. The latter should not be implemented in the seclusion units; if disciplinary solitary confinement needs to be executed outside the patients' own rooms, care should be taken to use dedicated and adequately equipped cells. (paragraph 114)

First and foremost, it should be noted that the Netherlands is planning to reduce placements in isolation cells. In this connection a new policy framework has been developed, entitled 'Isolation in detention'. In line with the CPT's recommendation, this new policy framework distinguishes disciplinary isolation from seclusion applied as a good order measure. In the latter case, policy is geared towards installing soft furniture in the isolation cell: that is, a bed, a table, a chair and a bookcase.

The CPT recommends that an information brochure be drawn up and provided to every patient who is admitted to a PPC. (paragraph 116)

Every PPC has its own information leaflet. These leaflets are broadly similar. In addition, work is currently underway to produce leaflets designed for all PPCs, describing the different care pathways that exist and the kinds of treatment that are offered for each disorder.

The leaflets also provide patients with other types of information such as house rules, information relating to specific somatic conditions, and matters relating to reintegration following detention, insofar as this is possible and corresponds to the patient's needs, state of health, and capacity. It may be noted that many patients are very disturbed when they are

admitted to a PPC and over half have an IQ of less than 80. This makes it particularly important to provide a measured flow of information, tailored to the individual.

Given that the PPCs are a relatively new and developing concept, more attention from the IGZ may well be appropriate. (paragraph 117)

The IGZ is responsible for supervising the care provided in custodial institutions, which includes the PPCs attached to four of these institutions. This supervision is conducted by the IGZ's Forensic Team. The IGZ comes under the organisational structure of the Ministry of Health, Welfare & Sport. It supervises the examinations conducted by PPCs to establish each patient's physical and mental health upon admission. It also checks that files are kept properly updated and that transfers of information take place as they should. When an incident such as a suicide occurs in spite of the professionals' efforts, the IGZ instructs the institution to launch an independent investigation to determine whether any mistakes were made and to see where there is room for improvement. The IGZ then assesses the quality of the investigation and the proposed measures for improvement.

The PPCs receive visits at set intervals as part of the IGZ's regular supervision. The Security and Justice Inspectorate also supervises custodial institutions, including PPCs, for instance monitoring access to care.

V. Civil psychiatric institutions

[A]t Kastanjehof, long-term patients in particular should be encouraged by staff to personalise and decorate their rooms. (paragraph 122)

The government agrees with the CPT that patients could perhaps be given more encouragement to make their rooms more attractive. However, an absence of decoration may also arise from a lack of time/energy or desire for it. In the government's view, the role of staff is therefore chiefly to facilitate such efforts.

The CPT recommends that the number of psychiatrists at Kastanjehof be increased. (paragraph 127)

The 2017 budget provides for an increase in staff numbers at Kastanjehof. Efforts are underway to increase the number of psychiatrists. In addition to expanding the number of hours allocated to psychiatrists (from 2 FTE in 2016 to 2.5 FTE in 2017), the number of hours allocated to registrars is also being increased (from 3.62 FTE in 2016 to 3.84 FTE in 2017) and a vacancy has been announced for a nursing specialist (from 0.89 FTE in 2016 to 1.78 FTE in 2017).

The CPT recommends that patients held under a closed ward regime at Kastanjehof be offered a range of therapeutic activities. (paragraph 129)

Kastanjehof is devoting close attention to its programme of daily activities and ways of expanding it. The 2017 budget will include extra resources for this purpose. In addition, a vacancy has been created for an activities supervisor.

The CPT recommends that patients at Kastanjehof be involved in the drafting of their individual treatment plans and their subsequent modifications, and that they be informed of their therapeutic progress. (paragraph 130)

Under the terms of the Healthcare Quality, Complaints, and Disputes Act, the Mental Health Care Centre (GGZ Centraal) is responsible for good care provision. It will ensure that patients at Kastanjehof are involved more actively in their treatment plans and any changes to them. In addition, more attention will be paid to checking that patients provide their signed agreement to these treatment plans. The IGZ can question institutions on whether they are complying with their commitments in this regard as part of its supervisory task.

The CPT considers that a register giving [the frequency and/or duration of the actual use of seclusion and forced medication] should be maintained to record all instances of recourse to means of restraint [...], in addition to the information contained within the patient's personal medical file. [...] [T]he CPT recommends that the register maintained at Kastanjehof and, where applicable, in other psychiatric establishments in the Netherlands, be modified in line with the abovementioned considerations. (paragraph 132)

Any compulsory treatment, most notably in cases of isolation and compulsory medication, is registered in the central national dataset Argus. During the CPT visit these registration figures and the related management information at departmental level were not provided. The government therefore encloses the figures and percentages regarding seclusion and compulsory medication in Eemland, Kastanjehof from the 4th quarter of 2015 onwards.

Since 1 January 2012 the registration of measures depriving persons of their liberty has been compulsory for all care providers working with patients who have been involuntarily committed to a mental healthcare facility. The following are measures registered: seclusion, isolation, restraint, enforced confinement to an individual room, compulsory enforced medication in spite of the patient's physical resistance, and liquids and food administered to the patient in spite of the patient's physical resistance. The times at which the intervention starts and ends are also registered.

The government considers that the above complies with the CPT's recommendation.

The CPT considers it essential that when it is deemed necessary to place a patient under video-surveillance, his/her privacy should be preserved when he/she is using a toilet, for example by pixelating the image of the toilet area. (paragraph 134)

Great importance is attached to respecting the privacy of patients while they are using the toilet.

The High Intensive Care units (HIC) in use today do not have camera surveillance of the toilet. In the apartments that are created in the course of renovations, the toilet is in the shower room. If it is necessary to maintain surveillance of a patient, the cameras will be directed at the person's feet.

Both institutions express reservations concerning the pixelation of video images (to the extent that it is technically feasible), arguing that it appears to do little if anything to strengthen the sense of privacy, since the patient still thinks he is under surveillance. Furthermore, continuous supervision is important if a patient is liable to self-harm.

[T]he outdoor exercise yard of the seclusion unit at Kastanjehof did not have a shelter against inclement weather. This deficiency should be remedied. (paragraph 135)

The Health Care Centre plans to create a shelter in the exercise yard of the seclusion unit; this is currently under development.

[T]here were plans to refurbish the seclusion units to allow for more direct contact between staff and patients. [...] The CPT welcomes this approach and would be interested to receive an update on future developments. (paragraph 136)

Care providers are responsible for further reducing coercive measures and making improvements in this regard. The IGZ monitors these efforts.

The Health Care Centre paid a working visit to Inforsa, which already works with de-escalation teams. The combination of de-escalation approaches with 'comfort rooms' is currently at the design stage. The acute psychiatric response team has recently had a policy meeting to elaborate the policy.

The CPT's considerations concerning the use of PRN prescriptions to administer rapid tranquillisers in psychiatric settings have been already set out in detail in paragraph 112. The CPT recommends that these precepts be effectively implemented in practice at Zon en Schild hospital and, where applicable, also in other psychiatric establishments in the Netherlands. (paragraph 137)

Further to the above response to the recommendation in paragraph 112 of the CPT's report, the Health Care Centre wishes to add that benzodiazepines are only prescribed in consultation with the doctor. The patient's vital functions are monitored. In accordance with the '*pro re nata 2*' policy, a benzodiazepine cannot be administered without the doctor's consent. It goes without saying that this already applied to the dispensation of antipsychotic tranquillisers.

The CPT recommends that the Dutch authorities put an end to the practice of involving police officers or private security guards in managing agitated patients in psychiatric establishments. Further, all nursing staff in psychiatric establishments should be trained in the appropriate ways of managing agitated patients and refresher courses should be organised at regular intervals. (paragraph 138)

As a rule, nursing staff are highly adept at dealing with tensions that arise in the ward, but the government nonetheless considers this recommendation impossible to implement in practice. There are simply not always sufficient personnel available to deal with violent – at times extremely violent – situations, as a result of which the incidental involvement of police remains necessary.

The Kastanjehof recently reintroduced sessions on Aggression Regulation Training (ART) for nurses, which teach skills in dealing with aggressive patients. As a result of financial cuts and reorganisations, many trained nurses left to take jobs elsewhere. This improvement has been incorporated as a verifiable objective of Kastanjehof/High Care and will be discussed in the quarterly meetings between management and the directors.

The CPT recommends that the Dutch authorities ensure that the precepts set out in paragraph 59 are effectively implemented in practice in all psychiatric establishments in the Netherlands. Further, the Committee would like to receive information about the manner in which violent instances, including those that have involved a police intervention, are recorded in civil psychiatric institutions in the Netherlands. (paragraph 139)

Setting up an investigation after every intervention involving the use of force is seen as unnecessary, but patients are examined if any reason presents itself or if the patient complains of physical symptoms.

Following any police intervention, it is standard procedure for patients to be examined by a doctor to check for, or exclude, the presence of any injuries.

[I]n the Committee's view, requiring a second psychiatric opinion from a doctor who is independent of the establishment in which the patient is placed [...] would offer an additional, important safeguard in the context of involuntary placement or its review. The Committee would like to receive the comments of the Dutch authorities on this subject, in particular how this issue will be dealt with in the new legislation which will replace BOPZ (see paragraph 119). (paragraph 143)

As before, the new legislation for compulsory care makes it mandatory to obtain a statement from a second, independent psychiatrist. Without this second opinion it is not possible to submit an application for compulsory care. The psychiatrist must meet certain criteria: he must not have provided the person concerned with any care for at least a year, and he must be independent in relation to the care provider.

[T]he transfer of a patient could potentially be carried out against his/her will and was subject to no written decision or possibility of appeal. [..] The CPT would like to receive the comments of the Dutch authorities on this issue. In addition, the Committee would like to be informed, for the years 2015 and 2016, of the number of civil involuntary patients transferred to forensic settings from all psychiatric establishments in the Netherlands. (paragraph 145)

If the forensic clinic to which a patient is transferred is classified as a psychiatric hospital, it is not possible, under the terms of the Psychiatric Hospitals (Committals) Act, for the patient to apply for judicial review of the transfer decision. Under the terms of the new legislation, a patient who objects to a transfer can first submit a complaint to the complaints committee, after which it is possible to apply for judicial review.

Transfer to a maximum-security clinic, a Forensic Psychiatric Centre (FPC), is only possible if it is included in the compulsory care order. The court therefore examines the lawfulness of the committal to an FPC in advance. There is no right of complaint, as such, against the implementation of that part of the compulsory care order (nor against the initial placement with a care provider).

No figures are known on transfers of patients from the regular mental healthcare system to a forensic setting. Such transfers can be effected if the care provided in a forensic setting is more appropriate than that provided in a regular care facility. In other words, the primary emphasis is on meeting the patient's care needs. In the case of a transfer, the person concerned retains the same legal status as before, as defined in the Psychiatric Hospitals (Committals) Act.

[T]he delegation was informed that the IGZ did not deal with individual complaints lodged by patients. The CPT would like to receive the clarification of this issue from the Dutch authorities. (paragraph 148)

Central government is responsible for dealing with complaints both in the voluntary care sector and in custodial institutions, where care is contracted out to care providers. Individual

complaints are dealt with by the care providers themselves, under their own responsibility. Each provider is obliged to set up a complaints procedure to ensure that complaints are dealt with expertly and objectively. Patients also have access to a confidential adviser who plays an important role within the institution, informing individual patients of their rights and obligations and helping them to submit complaints. This means that patients are never left to fend for themselves; there is always someone looking out for the individual patient's interests.

The IGZ monitors this system to check that it is functioning properly in the case of non-custodial institutions. In the case of custodial institutions, the Supervisory Committee and the Council for the Administration of Criminal Justice and Protection of Juveniles are responsible for supervision. The different responsibilities are elaborated in the relevant acts of parliament.[9]

[At Kastanjehof] a patient was de facto deprived of his liberty without benefiting from the relevant legal safeguards. [..] The CPT would like to receive an update on the legal situation of the patient concerned. More generally, the Committee considers that any patient in such a situation should be regarded as involuntary and thereby benefit from the relevant legal safeguards. (paragraph 149)

The patient concerned has been a patient at Zon & Schild for many years. He goes through periods in which his mental state deteriorates, during which times he is temporarily transferred from an open setting to a secure ward. At present he is subject to an extended court order, which expires in April. He is currently in the secure ward of his own volition, and is content with this situation. No measures restricting his liberty, in the narrow sense of the term, have been imposed. He is able to go out, accompanied by a nurse, whenever he wants. The patient's anxiety and psychosis are far too severe for him to want to leave, nor does he ask to. His mentor (in the legal sense), a role taken over by his sister-in-law after his brother's death last year, agrees. She has stated clearly that her client is remaining in the secure ward in complete accordance with her and his own wishes. There is therefore no need for a court order at this point in time.

The CPT has certain misgivings about applying such restrictions on voluntary patients who are de facto deprived of their liberty without benefiting from the legal safeguards surrounding the involuntary placement procedures. The CPT would like to receive the comments of the

[9] The Healthcare Quality, Complaints, and Disputes Act (Wkkgz), the Hospital Orders Framework Act (BvT), the Custodial Institutions Act and the Police Act 2012.

Dutch authorities on this subject. Moreover, the Committee would like to be informed how this issue will be regulated in the new legislation. (paragraph 150)

Voluntary patients are subject to the terms of the Medical Treatment Contracts Act (WGBO). Within the statutory regime established by the WGBO, the basic principle is that the methods and objectives of treatment should be determined with the patient's informed consent and then recorded in the case file.

Where the Mental Health Care Centre places voluntary patients in a secure ward, it is because it has been decided upon their admission that they require a more highly structured environment and closer supervision than is possible in an open setting. The secure wing is familiar to the patients; privileges are agreed in consultation with them and incorporated into the treatment plan. If patients object to this, whereas staff consider that they do need more supervision because they pose a threat to themselves or to others, an independent psychiatrist will assess the need for involuntary committal.

The CPT also asks how this issue will be regulated in the new legislation. In the new legislation and regulations, the patient can request advice and assistance from the patients' confidential adviser at a very early stage, as soon as preparations for a court order are set in motion. At this point this confidential adviser will inform the patient of his rights. Under the new legislation, no measures restricting a patient's liberty can be imposed without prior judicial examination of their compatibility with legislation. Under the Psychiatric Hospitals (Committals) Act, the court examines only cases of involuntary committal. A restriction of liberty that is imposed later, within the clinical setting, is not subject to prior judicial examination, but the court may examine it at a later stage, in response to a complaint submitted by the patient.