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Strasbourg, 5 April 2012

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REPORT TO THE GOVERNMENT OF THE KINGDOM OF THE NETHERLANDS ON THE VISIT TO THE NETHERLANDS CARRIED OUT BY THE EUROPEAN COMMITTEE FOR THE PREVENTION OF TORTURE AND INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT (CPT)

FROM 10 TO 21 OCTOBER 2011

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Adopted on 9 March 2012

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Copy of the letter transmitting the CPT's report

Prof. Dr M. Martin Kuijer
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Directorate of Legislation
P.O. Box 20301
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Strasbourg, 5 April 2012

Dear Professor Kuijer,

In pursuance of Article 10, paragraph 1, of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, I enclose herewith the report to the Government of the Kingdom of the Netherlands drawn up by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) following its visit to the Netherlands from 10 to 21 October 2011. The report was adopted by the CPT at its 77th meeting, held from 5 to 9 March 2012.

The various recommendations, comments and requests for information formulated by the CPT are listed in Appendix I of the report. As regards more particularly the CPT's recommendations, having regard to Article 10 of the Convention, the Committee requests the Dutch authorities to provide within **six months** a response giving a full account of action taken to implement them. The CPT trusts that it will also be possible for the Dutch authorities to provide, in the above-mentioned response, reactions and replies to the comments and requests for information.

I am at your entire disposal if you have any questions concerning either the CPT's report or the future procedure.

Yours sincerely,

Lətif Hüseynov
President of the European Committee for the
Prevention of Torture and Inhuman
or Degrading Treatment or Punishment

I. INTRODUCTION

A. Dates of the visit and composition of the delegation

1. In pursuance of Article 7 of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereinafter referred to as "the Convention"), a delegation of the CPT carried out a periodic visit to the Kingdom of the Netherlands from 10 to 21 October 2011. It was the Committee's fifth periodic visit to that country.[1]

2. The visit was carried out by the following members of the CPT:

- Timothy DALTON (Head of delegation)
- Yakin ERTÜRK
- Isolde KIEBER
- Stefan KRAKOWSKI
- Dajena KUMBARO
- Vladimir ORTAKOV.

They were supported by Fabrice KELLENS, Deputy Executive Secretary of the CPT, Julien ATTUIL-KAYSER and Petr HNÁTÍK of the CPT's Secretariat and assisted by:

- Timothy HARDING, psychiatrist and former Director of the University Institute of Forensic Medicine, Geneva, Switzerland (expert)
- Hildo BOS (interpreter)
- Stanley BRAFHEID (interpreter)
- Lee MITZMANN (interpreter)
- Josephus VINCK (interpreter)
- Wilhelmina VISSER (interpreter).

[1] The CPT's previous periodic visits to the Kingdom of the Netherlands took place in August/September 1992, November 1997, February 2002 and June 2007. The reports on these visits and the responses of the Netherlands authorities are available on the CPT's website: http://www.cpt.coe.int/en/states/nld.htm.

B. Establishments visited

3. The delegation visited the following places of deprivation of liberty:

Law enforcement establishments

- Apeldoorn Police Headquarters
- Arnhem Police Station (Head Office)
- Nijmegen Police Station
- Sprang-Capelle Police Station
- Tiel Police Station
- Tilburg-West Police Headquarters
- Uden Police Station

- Royal Military Police (KMAR) facilities, Schiphol Airport

- Court House Detention Facility, The Hague

Prisons and detention centres for foreign nationals

- Arnhem-Zuid Prison
- Veenhuizen Prison, Esserheem

- Detention Centre for foreign nationals, Rotterdam Airport
- Detention and Expulsion Centre for foreign nationals, Schiphol-Oost

Establishments under the Ministry of Health, Welfare and Sports

- Forensic Psychiatric Centre Dr van Mesdag, Groningen
- Forensic Psychiatric Department, Oostrum
- "Long stay" wards for TBS patients of the Pompe Institute, Zeeland.

In the course of the visit, the CPT's delegation also carried out a visit to Tilburg Prison, an establishment accommodating prisoners sentenced by Belgian courts by virtue of the Interstate Convention signed between the Kingdom of the Netherlands and the Kingdom of Belgium on 31 October 2009. A separate report will be drawn up on this visit and submitted to both governments concerned.

C. Consultations held by the delegation and co-operation encountered

4. In the course of the visit, the CPT's delegation held consultations with Ivo Willem OPSTELTEN, Minister of Security and Justice, and Fredrik TEEVEN, State Secretary of Security and Justice. It also met senior immigration and asylum officials, as well as senior officials from the Ministry of Security and Justice, the Ministry of the Interior and Kingdom Relations, the Ministry of Defence, and the Ministry of Health, Welfare and Sport. Further, it had talks with representatives of the National Agency for Correctional Institutions (DJI), the Inspectorate for Implementation of Sanctions (IST), the Health Care Inspectorate (IGZ), the Committee for the Integral Supervision of Return (CITT) and the Council for the Administration of Criminal Justice and Protection of Juveniles (RSJ).

The delegation also held discussions with Alex BRENNINKMEIJER, National Ombudsman. In addition, meetings were arranged with representatives of non-governmental organisations active in areas of concern to the CPT.

A list of the national authorities, non-governmental organisations and other persons met by the delegation is set out in Appendix II to this report.

5. The delegation received very good cooperation from the Dutch authorities. Apart from the two exceptions mentioned in paragraphs 6 and 7 below, one of which included misleading information (see paragraph 23), it was granted ready access to all places it wished to visit and to all documentation it wished to consult. It was also able to interview in private persons deprived of their liberty with whom it wished to speak. All staff met by the delegation at the establishments visited made a genuine effort to be helpful and cooperative.

The CPT also wishes to express its appreciation for the assistance provided before and during the visit by the liaison officer, Martin KUIJER, his deputy, Joyce DREESSEN, and their team.

6. The first exception mentioned above concerns Arnhem and Sprang-Capelle Police Stations, where access to the establishments was delayed for about half an hour. The police officers in charge had apparently received no information concerning either the possibility of a CPT visit, or the CPT's mandate, and consulted their superiors before granting access to the facility. It should also be noted that Sprang-Capelle Police Station was not included in the list provided to the CPT before the visit of police stations where persons may be deprived of their liberty. In this respect, the CPT wishes to recall that States Parties to the Convention are under an obligation to provide full information on all places of deprivation of liberty; such information should include all establishments where persons may be held against their will by a public authority, regardless of the reasons, the length of time or the type of establishment.

The CPT trusts that the Dutch authorities will take appropriate steps to ensure that, in future, visiting delegations enjoy access without delay to all places of deprivation of liberty, and that visiting delegations are provided with full information on all such places.

7. Secondly, serious difficulties arose in respect of access to medical files of persons deprived of their liberty in the Detention Centre for foreign nationals, Rotterdam Airport. Prior to the CPT's visit to the country, the Dutch authorities had sent a circular informing places where persons could be deprived of their liberty of the powers of the Committee, including the right to consult all information (including medical) which the CPT may consider relevant. Despite this, at the above-mentioned detention centre, access to medical files was made subject to the explicit consent of every detainee concerned. In some cases, such consent could not be obtained for practical reasons and the delegation was refused access to the relevant medical files.

The importance of CPT delegations having unrestricted access to medical records has been explained on several occasions in the past by the Committee and the Dutch authorities have accepted the arguments put forward by the Committee.[2] On its previous visit to the Netherlands in 2007, no difficulties were encountered in this connection. The same was true of the 2011 visit, with the single exception of the Detention Centre for foreign nationals, Rotterdam Airport, the management of which chose not to act in compliance with the above-mentioned circular.

The CPT notes that in their response to the report on the 2007 visit, the Dutch authorities had indicated that it was their intention to lay down by law CPT's right of access to personal medical data; however, at the time of the 2011 visit, no such draft law had been presented before Parliament.

The CPT trusts that the Dutch authorities will take appropriate steps to ensure that, in future, visiting delegations enjoy unconditional access 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.

D. Immediate observations under Article 8, paragraph 5, of the Convention

8. At the end of the visit, the CPT's delegation met senior Government officials in order to acquaint them with the main findings of the visit. On that occasion, the delegation made an immediate observation, in pursuance of Article 8, paragraph 5, of the Convention, in respect of six "cubicles" (each measuring 2m²) found in Sprang-Capelle Police Station. The delegation requested that the Dutch authorities strictly limit the use of any such cubicles to brief waiting periods, either prior to questioning or before transfer to a suitable detention facility.

The above-mentioned immediate observation was subsequently confirmed in a letter of 17 November 2011 from the Executive Secretary of the CPT. The Dutch authorities were also requested to confirm, within one month, that the immediate observation had been acted upon.

In a letter of 1 February 2012, the Dutch authorities provided information in response to the CPT's observations. The CPT will consider this information later in the report (see paragraph 23).

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[2] The CPT stressed in this context that unconditional right of access to medical data should not be difficult to grant to the CPT, as it has already been afforded to an inspection body working at national level, the Health Inspectorate.

E. National Preventive Mechanism

9. The Netherlands ratified the Optional Protocol to the United Nations Convention against Torture (OPCAT) on 28 September 2010. During the 2011 visit, the CPT's delegation was informed that several existing national inspection bodies, such as the Inspectorate for Public Order and Safety (IOOV), the Health-Care Inspectorate (IGZ), the Council for the Administration of Criminal Justice and Protection of Juveniles (RSJ), the Committee for the Integral Supervision of Return (CITT) and the Inspectorate for Implementation of Sanctions (IST) would be designated as parts of the National Preventive Mechanism (NPM), with the IST having a coordinating role. However, this new function of the inspectorates would not be accompanied by any increase in budgetary or human resources.

The general *modus operandi* of several of the above-mentioned inspection bodies is described in more detail later in this report, but the CPT wishes to make some remarks in respect of the coordinating role of the IST in the NPM.

The CPT notes that the Regulation issued by the Minister of Justice on 22 August 2005, governing the activities of the Inspectorate for Implementation of Sanctions (the IST Regulation), stipulates that when carrying out an investigation, the IST receives no instructions concerning the method to be used, the judgment it forms and its reporting thereof, and that its reports are adopted by its Chief Inspector. However, the CPT also notes that the IST is an organisational division of the Ministry of Justice whose members are appointed by the Ministry's Secretary General and that the Minister of Security and Justice adopts the IST's annual inspection plan and may instruct it at any time to carry out a specific investigation.

The CPT considers that care should be taken to ensure that all elements of the NPM's structure and all the personnel concerned comply with the requirements laid down by the OPCAT and the Guidelines established by the United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT).

II. FACTS FOUND DURING THE VISIT AND ACTION PROPOSED

A. Law enforcement agencies

1. Preliminary remarks

10. It should be stated at the outset that during the visit, the CPT's delegation heard no allegations of ill-treatment of persons detained by the police. On the contrary, most of the detainees interviewed stated that they had been treated properly by police officers, both at the time of their apprehension and during their subsequent custody (see, however, paragraph 23).

11. At the time of the visit, the Dutch police forces were awaiting a fundamental reorganisation[3]. The existing 25 regional police forces and the Dutch Police Services Agency will be replaced by a national police force consisting of 10 regional units and one or more national units, such as the National Criminal Intelligence Unit and the Police Service Centre responsible for operational management. The national police force will be headed by the National Police Commissioner and the general responsibility, including for staffing, logistics and general administration, will be transferred from the Minister of the Interior to the Minister of Security and Justice. However, local mayors[4] will remain responsible for the maintenance of public order and will continue to decide local policing priorities, together with the local public prosecutor. **The CPT would like to receive updated information concerning the above-mentioned reorganisation of the Dutch police forces and, in particular, on any changes that might affect deprivation of liberty by the police (legal framework, police holding facilities and detention units, monitoring bodies entrusted with visiting detention facilities, etc.).**

12. In its previous visit reports, the CPT described the legal provisions regulating police custody in the Netherlands. To sum up, police custody *(in verzekeringstelling)* of criminal suspects can last up to three days and may, exceptionally, be extended by a further three days. Police custody may be preceded by a period of up to six hours during which a person can be held in a police station for the purpose of examination (*ophouden voor onderzoek*). Consequently, following a maximum period of six days and 15 hours[5] in police detention, a criminal suspect detained by the police should be either remanded in custody and sent to a remand prison, or released. However, Article 15a of the Penitentiary Principles Act - which entered into force in March 2002 - authorises the detention of a remand prisoner in a police cell for a further ten days. Article 16a of the Juvenile Detention Principles Act similarly allows for juveniles between 16 and 18 years of age to be remanded in police stations for up to ten days. As regards the detention of a foreigner ("vreemdeling bewaring") in a police or KMAR establishment, the period of detention can last up to five days.

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3 Initially, it was expected that the new national police force would be operational as from 1 January 2012. Subsequently, the reorganisation was postponed to a later date in the course of 2012.

4 Mayors are appointed by the Minister of the Interior and report to the respective municipal councils.

5 In principle, police questioning should not continue into the night, therefore the hours between midnight and 9 a.m. are not taken into account when calculating the length of the initial police examination. Including the nine hours between midnight and 9 a.m., a detainee may spend in total up to 15 hours in a police station during the initial examination phase. For identification purposes, this initial period can be extended by an additional six hours in those cases where the apprehended person is suspected of an offence for which custody may not be imposed.

The decision to keep a person on remand in a police cell after expiration of police custody is made by the selection officer (*selectie functionaris*) of the prison service. The reason for these 2002 amendments to the Penitentiary Principles Act and the Juvenile Detention Principles Act was to provide a legal basis for the practice, already observed by the CPT in 1992 and in 2002, of using police cells for holding persons on remand.

13. During the 2011 visit, the delegation was pleased to note that the capacity problems encountered in the remand prisons and the juvenile detention system had been overcome and that police cells were no longer being used as "surplus detention capacity". In practice, the persons detained in police facilities (including juveniles) at the time of the visit were held for no more than six days, and often for significantly shorter periods of time not exceeding several hours or a few days. However, some police officers admitted that, occasionally, remand prisoners could still be detained in police facilities under the 2002 amendments. **The CPT trusts that the positive trend observed as regards the length of stay of persons in police detention facilities will be maintained.** In addition, **it invites the Dutch authorities to consider revoking Articles 15a and 16a of the above-mentioned legislation.**

2. Safeguards against ill-treatment

a. notification of custody

14. The information gathered during the 2011 visit indicates that, in compliance with Article 27 (1) of the Police Service Guidelines, the relatives of adults deprived of their liberty by the police were, at the detained person's request, informed promptly about the detention. In the case of the detention of a minor, the notification was carried out by the police irrespective of a request from the detained person. The situation in this regard had therefore improved as compared with the findings made during the 2007 visit.

15. Nevertheless, the CPT remains of the view that the wording of Article 62 (2) b of the Code of Criminal Procedure (CCP), according to which an "all restrictions system" can be imposed, is not satisfactory. In particular, the exception to the right of notification of custody should be more closely defined; the current criterion of "the interest of the investigation" is too vague. Further, the application of such an exception should be made subject to an explicit time-limit by the relevant legislation. **The CPT recommends that the Dutch authorities amend Article 62 of the CCP in order to circumscribe more precisely the possibility to delay the exercise of a detained person's right to notify his/her deprivation of liberty to a third party and to set a time-limit on the application of such a measure.**

Further, **the CPT would like to be informed, for the years 2010-2011, of the number of cases in which Article 62 (2) b was invoked vis-à-vis criminal suspects**.

b. access to a lawyer

16. In its previous visit reports, the CPT criticised the fact that access to a lawyer was denied during the initial period of six hours of police custody (*ophouden voor onderzoek*). It recommended that the right of access to a lawyer be guaranteed to any person detained by the police as from the very outset of his/her deprivation of liberty. In this regard, some positive developments were noted during the CPT's visit in 2011.

Following the judgment of the European Court of Human Rights in the case of *Salduz v. Turkey* and the Dutch Supreme Court's interpretation of its impact on the Dutch legal system, the modalities of the right of access to a lawyer for persons detained by the police in the Netherlands underwent important changes. Any criminal suspect is now entitled to consult his/her own lawyer prior to the first interrogation on the substance of the case and, in the case of a minor, the lawyer can be present during interrogations (but cannot actively intervene during the questioning).

Further, the delegation was informed that a pilot project launched on 1 May 2008 in the regions of The Hague, Amsterdam and Rotterdam, provided that a defence lawyer was allowed to attend police interrogation in the case of suspicion of an offence against life within the meaning of Title XIX of the Dutch Criminal Code.

The delegation was also informed that a draft law prepared by the Ministry of Security and Justice, providing access to a lawyer from the very outset of the deprivation of liberty for persons suspected of having committed an offence punishable with six or more years of imprisonment, was to be submitted to a government advisory body before the end of 2011.

17. To sum up, the issue of access to a lawyer was the subject of intensive debates at national level at the time of the visit and was evolving rapidly. **The CPT trusts that further steps will be taken to ensure the full recognition of the right of access to a lawyer for all detained persons as from the outset of their deprivation of liberty. In addition to the right to talk to the lawyer in private, the person concerned should also, in principle, be entitled to have a lawyer present during any interrogation conducted by the police. Naturally, this should not prevent the police from beginning to question a detained person in those exceptional cases where urgent questioning is necessary, even in the absence of a lawyer (who may not be immediately available), nor rule out the replacement of a lawyer who impedes the proper conduct of an interrogation.**

18. For the right of access to a lawyer to be fully effective in practice, appropriate provision should be made for persons who are not in a position to pay for a lawyer. In this context, the CPT noted that persons suspected of "C category offences" (the minor offences under the Criminal Code) were not entitled to legal assistance paid by the Legal Aid Board. **The CPT recommends that this restriction be removed.**

c. access to a doctor

19. As was the case during the previous CPT visit, access to a doctor for persons in police custody was generally satisfactory. Upon a detainee's request - or if considered necessary by the police officer in charge - the duty doctor of the municipal or forensic medical service was summoned. The medical examination usually took place in designated area that guaranteed inter alia respect of medical confidentiality.

20. As regards access to a doctor of one's own choice, Article 32 (2) of the Police Guidelines provided that "if the detainee requests medical assistance from his own physician, the officer will inform the physician thereof"[6] and the official explanation of the article makes clear that the physician in question should be allowed to visit, examine and treat the detained person. However, police officers in several of police establishments visited seemed to be unaware of the fact that persons detained by the police did enjoy the aforementioned right. In the CPT's view, allowing such persons to consult a doctor of their own choice is important regarding continuity of care and can provide an additional safeguard against ill-treatment. **The CPT recommends that all police officers be reminded of the purpose and content of Article 32 (2) of the Police Guidelines.**

4. Conditions of detention

a. police establishments

21. Material conditions of detention in all the police detention units visited were, on the whole, satisfactory and several of them were located in recently constructed purpose-built premises (e.g. in Apeldoorn, Nijmegen, Tiel and Sprang-Capelle). The cells offered sufficient space (some 6 m²) for individual accommodation not exceeding a few days and were equipped, as a minimum, with a bed and a toilet (most of them also had a chair and a table). All cells benefited from good ventilation and artificial light (sufficient to read by), and were in a satisfactory state of repair and clean. It should also be noted that persons in police custody were provided with food on a regular basis and given the opportunity to use the showers daily and to benefit from one hour of outdoor exercise every day.

22. Most of the cells in the police detention units visited had some access to natural light, generally through windows fitted with glass bricks. However, the CPT's delegation was surprised to find that natural light was virtually non existent in all 40 cells at Apeldoorn Police Station, notwithstanding the fact that this establishment was one of those most recently built. The CPT considers that police cells should enjoy access to natural light and it notes that Article 6 (1) of the Regulation on police cell complexes (*Regeling Politiecellencomplex*) provides that "a [police] cell needs to be provided with light openings created in the inner or outer walls in such a way that the detainee can observe the day and night cycle." This provision had not been followed at Apeldoorn Police Station. **The CPT recommends that steps be taken to ensure that cells at Apeldoorn Police Station respect Article 6 (1) of the Regulation on police cell complexes. The CPT also invites the Dutch authorities to establish whether all police cells in the Netherlands comply with the above-mentioned provision and, if necessary, to remedy any shortcomings.** Further, **this provision should be taken into account when refurbishment or construction of police stations is carried out in the future.**

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[6] See doc. CPT/Inf (2009) 7, page 8.

23. At Sprang-Capelle Police Station, the detention facility consisted of six confined and windowless cubicles, immediately adjacent to two interrogation rooms. Each of the cubicles was fitted with solid doors, measured 1.40m x 1.40m (i.e. just less than 2 m²), with a seat (a concrete block) measuring 50 x 50 cm as sole equipment. The police officer in charge informed the delegation that these cubicles could be used "for no more than six hours". However, the delegation met two minors who alleged that they stayed for some 10 hours in the above-mentioned cubicles, with only a brief interruption of some 20/30 minutes. This allegation was later confirmed by the delegation's examination of the files concerning the detention of the two minors.[7]

One of the minors in question was examined shortly after his arrival at Tilburg Police Station, where he had been transferred from Sprang-Capelle, by a medical member of the delegation and he showed clear signs of acute distress. The CPT considers that placing a minor (or even an adult) in such a cubicle for long periods of time could in many cases trigger serious stress. Moreover, it seems that such cubicles exist in other police stations in the Netherlands, since another detainee met by the delegation described having been kept "in a tiny cupboard" for about one hour at Kaatsheuvel Police Station.

As already mentioned (see paragraph 8 above), at the end of the visit, the delegation made an immediate observation pursuant to Article 8, paragraph 5, of the Convention and requested the Dutch authorities to strictly limit the use of any such cubicles to brief waiting periods, either prior to questioning or before transfer to a suitable detention facility.

In their letter of 1 February 2012, the Dutch authorities indicated that the facilities visited by the delegation were not police cells but "holding rooms" which are used if a suspect is detained for further inquiries on the order of the public prosecutor or assistant public prosecutor pursuant to Article 61, paragraph 1 of the Code of Criminal Procedure (CCP). A person may be detained in this way for no longer than six hours; however, the time between midnight and 9 a.m. does not count towards the six-hour period.

The CPT recommends that the use of any such cubicles be strictly limited to very brief waiting periods, either immediately prior to the questioning of the suspect or immediately before his transfer to a suitable detention facility. The total time actually spent in these facilities should never exceed 6 hours. Furthermore, **the cubicles in question should never be used as overnight accommodation.**

Moreover, **the CPT recommends that any such facilities be fitted with secured translucent doors to avoid as much as possible their oppressive effect and enable direct monitoring of the detained persons.**

[7] Both minors were arrested at their homes at shortly after 6 a.m. and arrived at Sprang-Capelle Police Station shortly before 6.30 a.m. They were immediately placed in the detention cubicles. They left the cubicles briefly to see a lawyer, shortly before being questioned (for approximately 20 to 30 minutes each) by a police officer, respectively at 9.30 and 10 a.m. The extension of the detention order was obtained at 2.55 p.m. The boys were however kept in the cubicles for a further 1 ½ hours before being transferred to Tilburg Police Station, where they were subsequently interviewed by the delegation.

b. The Hague Central Court detention facility

24. The Hague Central Court detention facility consisted of 52 holding cells for individual accommodation, most of them measuring some 5m². Two bigger cells measuring respectively 13m² and 21m² were available for holding juveniles. All cells were equipped with a bench, a call bell and an intercom, had adequate artificial lighting (the two cells for juveniles had also access to natural light) and were sufficiently ventilated. They were not equipped with toilets or running water; however, detainees could, on request, use the sanitary facilities situated at the end of the corridor. Six additional cells immediately adjacent to three of the main court rooms were used during short adjournments. Detainees were provided with food (sandwiches, coffee, tea and one hot meal a day). The CPT considers that these arrangements do not call for any particular comments.

25. In the course of the visit to the detention facility of The Hague Court House, the delegation was informed that a suspected suicide had occurred at the detention facility the day before its visit. Indeed, a man, aged 41, was found hanged in one of the court cells at 1.30 p.m. **The CPT would like to receive information on the progress of the official investigation that was launched concerning this case.**

B. Prison establishments

1. Preliminary remarks

26. In recent years, there has been a significant decrease in the prison population in the Netherlands. By way of example, in 2004, the prison system accommodated some 20,000 inmates, in 2007, some 18,000, and, in 2010, some 15,000 prisoners (a level comparable to that observed in 2001). The CPT welcomes this trend, which is rather unusual in Europe at the present time. However, over the last ten years, the number of female prisoners has almost doubled and currently represents 8.7 % of the prison population in the country, the highest in Europe. **The CPT would like to receive the Dutch authorities' comments concerning the implications of the increase in the female prison population for the prison system (capacity of the female detention units, female staff resources, etc.).**

27. The delegation was informed that the concept of "Measured Detention and Treatment" *(Detentie en Behandeling op Maat)*, which had been under preparation during the CPT's 2007 visit, had been abandoned and replaced by the "Prison system modernisation project" *(Project Modernisering Gevangeniswezen (MGW))*. One of the objectives of the MGW was to focus on an individualised approach to be put in place for every prisoner throughout his/her whole "life-cycle", enhancing interaction between prisoners and staff, re-integration and re-socialisation activities and on enhanced cooperation among "chain partners"[8]. These are highly commendable objectives. They aimed at the improvement of quality of life and work in prisons, at giving prisoners more responsibility during their detention and for their rehabilitation, and at facilitating a smooth transition from the prison environment back to society, with a subsequent reduction in recidivism. **The CPT would like to receive updated information on the evolution and implementation of the MGW.**

28. Further, the delegation was informed of the existence of a pilot project, planned to start in 2012, which aimed at placing lifers and other long-term prisoners[9] in special units in the prison system. These plans were based on preferences expressed by some lifers and other long-term prisoners who had been interviewed and who had found it distressing to be accommodated together with those serving shorter sentences. **The CPT would like to receive updated information on this pilot project. It would also like to stress that lifers and other long-term prisoners should not be systematically segregated from other prisoners.**

29. In the course of the visit, the delegation visited Veenhuizen - Esserheem Prison and Arnhem-Zuid Prison. It also visited Tilburg Prison which accommodated prisoners sentenced by Belgian courts; this establishment is the subject of a separate visit report.

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[8] "Chain partners" include various entities such as the Public Prosecutor's Office, the police, the Central Fine Collection Agency, the Central Probation and After-Care Office, the local municipalities, the healthcare institutions, the cooperative housing associations and the Unemployment Benefits Agency.

[9] At the time of the visit, there were some 30 life-sentenced prisoners in the Netherlands.

Veenhuizen–Esserheem Prison forms part of Veenhuizen penitentiary establishment.[10] It is located in a building more than one hundred years old, rectangular in shape and with a large inner courtyard. The building was expanded in the 1960s and underwent major refurbishment some 25 years ago. In 2008, Veenhuizen-Esserheem Prison was transformed into an institution accommodating solely convicted male adult inmates under the "VRIS" *(Vreemdelingen in de Strafrechtketen)*[11] concept. This concept, implemented in 2007, concerned convicted foreigners who would be deported from the Netherlands after having served their sentence. With an official capacity of 253 places, the prison was accommodating 245 inmates at the time of the visit.

Arnhem-Zuid Prison forms part of Arnhem penitentiary establishment.[12] It is located in a cross-shaped building in the southern part of the city of Arnhem and has been in use since 1989. With an official capacity of 241 places, the prison was accommodating some 210 convicted prisoners and 23 remand prisoners at the time of the visit. A special care ward (24 single-occupancy cells) was accommodating inmates who could not function in a larger group, such as sex offenders or inmates with mild mental disorders. All prisoners were adult males.

2. Ill-treatment

30. The CPT's delegation heard no allegations of physical ill-treatment of prisoners by staff in either of the establishments visited. On the contrary, the relations between prisoners and staff appeared to be generally very good, and staff displayed professionalism and engagement in their interaction with prisoners.

31. The CPT still has some concerns about the reporting and examination of allegations of ill-treatment. In the report on its 2007 visit to the Netherlands (see CPT / Inf (2008) 2, paragraphs 31-38), the CPT recommended that the authorities draft a comprehensive procedure on how to deal with allegations of ill-treatment within the establishments under the responsibility of the National Agency for Correctional Institutions (DJI).

In their response, the authorities referred to a ministerial circular of 9 January 2003 (ref. 5195514/02/DJI) that had established such a procedure. However, in the course of the 2011 visit, it became rapidly clear that the staff working in the establishments visited were aware neither of the above-mentioned circular nor of the specific procedure it had established. **The CPT recommends that the attention of management and staff working in all establishments under the responsibility of the National Agency for Correctional Institutions be drawn to the above-mentioned circular.**

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10 The latter consists of three different prisons, namely Esserheem, Groot Bankenbosch and Norgerhaven. They are physically separate, but have formally been merged into one institution.

11 *Vreemdelingen in de Strafrechtketen* = Aliens in the criminal law chain.

12 The latter consists of three formerly separate prisons, Arnhem-Zuid, De Berg and Extramural Detention. They were integrated into one institution in October 2009.

32. Numerous complaints were received throughout the visit, from various sources, concerning the frequency of strip searches carried out in prison establishments in the Netherlands and the manner in which they were performed. A strip search is a very invasive - and potentially degrading - measure. Therefore, resort to strip searches should be based on an individual risk assessment and subject to rigorous criteria and supervision. Every reasonable effort should be made to minimise embarrassment; detained persons who are searched should not normally be required to remove all their clothes at the same time, e.g. a person should be allowed to remove clothing above the waist and to get dressed before removing further clothing. In addition, more than one officer should, as a rule, be present during any strip search as a protection to detained persons and staff alike. Further, inmates should not be required to undress in the presence of custodial staff of the opposite sex. **The CPT recommends that steps be taken to ensure that the above-mentioned principles are applied throughout the prison system in the Netherlands.**

3. Conditions of detention

a. material conditions

33. The material conditions of detention in both the establishments visited were of a high standard. The vast majority of prisoners were accommodated in single-occupancy cells, measuring some 9.5 m². All cells were well-equipped (including bed, table and chairs, shelves, TV and refrigerators to store pre-packed "hot meals"), had sufficient access to natural light and good artificial lighting and ventilation. As for the in-cell sanitary annexes, they were fully partitioned from the rest of the cell. Further, the accommodation was in a very good state of repair and clean.

At both establishments, a small number of the cells[13] measuring the same size were being used for double occupancy. Although living space in these cells was rather restricted, the situation could still be regarded as acceptable given that the prisoners concerned spent some nine hours a day out of their cells (see paragraph 35).

34. However, the delegation was inundated with complaints concerning the food provided to prisoners. They received three meals a day, including a main meal. However, the latter was systematically delivered in a frozen box, and needed to be heated in the micro-wave before consumption. The delegation observed for itself that a large quantity of the frozen meals remained untouched and were ultimately wasted. **The CPT would like to be informed of any measures taken to address the above-mentioned issue.**

On a more positive note, the meals provided to the inmates took account of religious and other convictions (halal, kosher and vegetarian) and dietary needs. Moreover, fully equipped kitchens were at the disposal of inmates in the accommodation wards and inmates were allowed to cook their own meals from the food products bought in the prison shop.

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[13] Respectively, 15 cells at Veenhuizen–Esserheem Prison and 12 cells at Arnhem-Zuid Prison.

b. regime

35. Prisoners in both the establishments visited spent a large part of the day (from 7.30 am to 4.45 pm) out of their cells. They were expected to work four hours per day during the week, the remaining part of the day being used for outdoor exercise (a minimum of one hour per day), sport or recreation. That said, there was a clear distinction between the situation of the general prison population and that of foreign prisoners with "VRIS" status, to the disadvantage of the latter. This is all the more of concern given that some of the foreign prisoners awaiting deportation were serving sentences of more than 15 years.

36. Prisoners at *Veenhuizen Esserheem Prison* did not benefit from creative, vocational training or re-socialization activities. Further, education courses foreseen for them were extremely limited (theory courses on the European driving licence, basic forklift training, English classes and computer lessons) and only available for one hour a week. "VRIS" prisoners also did not benefit from any form of prison leave, even if their family was still resident in the Netherlands.

By way of comparison, in *Arnhem Zuid Prison*, prisoners could participate in a range of handcraft activities, in an industrial cleaning course with the possibility of obtaining a diploma, in a metal work course and a Dutch language course. In total, 59 and 43 hours of organized activities were available per week respectively to convicted and remand prisoners at Arnhem. Moreover, the social services helped the prisoners concerned to take care of pending private matters (such as rent payments, etc.), as well as preparing for their re-integration.

This difference in treatment was confirmed by different sources, including monitoring bodies, NGO's, the prison staff and the prisoners themselves. **The CPT recommends that the Dutch authorities review the programme of activities available to foreign prisoners with "VRIS" status, in particular in respect of education, vocational training, and re-socialization activities, with a view to ensuring that they are not disadvantaged in comparison with the general prison population in the Netherlands.**

4. Health care services

37. The medical team at *Veenhuizen penitentiary establishment*[14] consisted of one post of medical doctor (covered by two general practitioners (GPs) working on rotation at the time of the visit, for a total of 44 hours). The medical team was supported by 13 nurses, three of them being present on an average week day in each of the three prisons, together with one administrative health care assistant. As regards psychiatric care, a psychiatrist was available every fortnight and could come by appointment if needed; there were also three psychologists (covering 2.6 posts) and a psychiatric nurse. The prison had also engaged a dentist. In case of need, an emergency service was available 24 hours a day, including on weekends.

The CPT considers that the staffing level as regards medical staff is not sufficient for a prison population of some 600 prisoners and, indeed, the visiting delegation received a number of complaints from the prisoners concerning delayed access to medical care. Such an establishment requires two full time equivalent (FTE) posts of medical doctor. **The Committee recommends that the medical staffing level at the establishment be increased accordingly.**

[14] PI Veenhuizen accommodates around 600 prisoners.

38. At *Arnhem Zuid Prison*, the medical team consisted of one FTE post of medical doctor which was covered by two GPs working on rotation. They were present two days a week each and were on call the rest of the time. They were supported by a team of five nurses, of whom two would be on duty in the establishment during the day. A psychiatrist also was available once a week and a dentist for five hours a week. The health care staffing level could be regarded as sufficient at this establishment.

39. The delegation noted that medication was distributed to the prisoners in "pre-packed" sealed transparent plastic bags (the so-called "Baxter" system) by the custodial staff, who also oversaw the intake of medication by prisoners. Consequently, the name of the medication and its dosage were clearly visible to the custodial staff. Such a practice could compromise medical confidentiality and does not contribute to the proper establishment of a doctor-patient relationship. In the CPT's view, **medication should preferably be distributed by health-care staff.** Further, **the Dutch authorities are invited to draw up a list of medication that should in every case be distributed by health-care staff (such as anti-psychotic and anti-retroviral drugs and methadone).**

5. Other issues

a. prison staff

40. In both establishments visited, staff levels and the number of prison officers on duty at any given time appeared adequate[15].

However, in *Veenhuizen- Esserheem Prison*, the delegation was informed that a recent staff satisfaction survey carried out in the institution showed that particularly high scores were reached in the area of "emotional work stress". The management indicated that this state of affairs was most probably connected to a lack of staff motivation, the latter being linked to the fact that staff dealt exclusively with "VRIS" prisoners. The absence of professional challenge in terms of preparing prisoners for re-integration into the Dutch society and the related absence of prospect of helping the prisoners in a meaningful way was in particular highlighted. This situation was further aggravated by the existence of language barriers.

The CPT considers that job alienation resulting from passive security duties and social distance between staff and foreign prisoners may in the long run lead to indifference on the part of the staff, which could in turn well lead to negative impact on the treatment of prisoners.

The CPT would like to be informed of the measures taken or envisaged to address the issue of "emotional work stress" of staff at *Veenhuizen – Esserheem Prison* (reference should also be made in this context to the recommendation made in paragraph 36).

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[15] *Veenhuizen penitentiary establishment* employed some 500 staff members (out of which 170 were custodial officers and the same number were security personnel). *Arnhem penitentiary establishment* employed some 380 staff (the number of custodial officers and security personnel being of some 115 each). In *Veenhuizen – Esserheem prison*, 22 prison officers were on duty during day time and 7 at night, while in *Arnhem Zuid Prison*, the respective figures were 35 and 7.

b. discipline

41. Article 51 of the Penitentiary Principles Act provides for the following disciplinary sanctions: solitary confinement in a punishment cell or other cell for a maximum period of two weeks; cancellation of visits for up to four weeks if the offence took place in connection with the visit; exclusion from participation in one or more specific activities for a maximum period of two weeks; refusal, cancellation or restriction of the next leave; and a fine up to a maximum amount of twice the weekly wages current in the institution or wing. The sanctions are imposed by the prison governor; prisoners have the right to be heard and to receive a copy of the disciplinary decision.

The prisoner concerned can challenge the sanction imposed before the Complaints Committee, the decision of which can be appealed before the RSJ.

42. In both establishments visited, the delegation heard no complaints of excessive resort to disciplinary sanctions and an examination of available disciplinary records confirmed this position. This being said, the delegation was informed that in some prison establishments in the Netherlands, there was a tendency to delegate the disciplinary power to lower level management (as opposed to the governor or his deputy themselves), including for the imposition of the most severe disciplinary sanctions, such as solitary confinement in a punishment cell.[16] **The CPT would like to receive the comments of the Dutch authorities on this issue.**

43. Material conditions in disciplinary cells in both the establishments visited were generally adequate as far as size, access to light and ventilation are concerned. However, in both establishments, the windows were fitted with frosted glass which prevented inmates from seeing outside the cells, thereby generating a potentially oppressive effect. **The CPT invites the Dutch authorities to remedy this shortcoming.**

Moreover, in *Arnhem-Zuid Prison*, the disciplinary cells were not properly equipped. The cells had no bed (instead, a mattress was placed on the floor), table or chair. **The CPT recommends that the disciplinary cells at Arnhem-Zuid Prison be equipped with a table, adequate seating for the daytime (i.e. a chair or bench), and a proper bed and bedding at night.**

In addition, the "outdoor exercise" area for prisoners placed in the disciplinary unit consisted of a cell of some 14m² with a large window in one of the walls and another opening covered with a metal grill in the ceiling. The CPT considers that such a cell has none of the features that would enable it to be described as an open-air exercise area worthy of the name. **The CPT recommends that proper "outdoor exercise" facilities be provided for prisoners placed in the disciplinary unit.**

[16] According to the relevant legislation, this power is given to the governor of the establishment or his deputy.

c. contact with the outside world

44. In both establishments, prisoners are entitled to receive visitors for at least one hour per week (Article 38 of the Penitentiary Principles Act). Moreover, the prisoners serving a sentence of at least three months of imprisonment could be granted an unsupervised (partner) visit of two hours, once every four weeks (and this minimum entitlement was in practice often extended to two and a half to three hours). Further, at *Veenhuizen – Esserheem Prison*, those prisoners who rarely received visitors could accumulate the unused visit time and benefit from an unsupervised visit between 9 a.m. and 3.30 p.m. In addition, external volunteers from NGOs and religious institutions were allowed to visit prisoners who would otherwise receive no visits.

45. The visiting rooms for supervised visits in both establishments could accommodate some 50 persons. They were in a very good state of repair and clean. However, at *Veenhuizen – Esserheem Prison*, prisoners and visitors were separated by an approximately one meter high partition. The delegation was informed by the management of the *Arnhem Zuid prison* of their intention to arrange partitioned visits also. **The CPT considers that visits around a table (with no partition) should be the rule and visits with partitions the exception, based on an individual risk assessment.**

46. At *Veenhuizen – Esserheem Prison*, the visiting room for unsupervised visits was also in good state of repair, clean and very well-equipped, including a double-bed with clean bed-linen, radio, coffee-machine, refrigerator and some children's toys. Adequate sanitary facilities were located in an adjacent room. The visiting room for unsupervised visits in *Arnhem-Zuid Prison* was equipped with a bed, shower, washbasin and toilet. The management informed the delegation that they intended to enlarge and better equip the room, a project which also applied to a nearby room that was meant for family visits with children.

47. Under Article 39 of the PPA, prisoners are entitled to one or more telephone conversations with persons outside the institution for ten minutes at least once a week. In practice, at *Veenhuizen – Esserheem Prison*, prisoners' access to the telephones in the living units was not limited. Moreover, two computers with internet access and communication equipment, including web cameras, were available for 40 minutes a week per person, a system which allowed them to make free internet calls. However, numerous complaints were made about the impossibility of making cheaper international calls by using pre-paid phone cards. It transpired that this was due to the contract with the telephone service provider. **The CPT would like to receive comments of the Dutch authorities on this issue.**

48. As regards correspondence, the delegation was informed that letters sent to or received from persons or bodies enumerated in Article 37 of the Penitentiary Principles Act are exempted from checks by the prison administration. The delegation was informed that, in practice, letters from and to the CPT would be treated confidentially; however, the CPT is not explicitly mentioned in the list of institutions/bodies with which any prisoner might communicate on a confidential basis. **The CPT invites the authorities to amend Article 37 of the PPA accordingly.**

d. complaints and inspection procedures

49. The CPT welcomes the existence in the Netherlands of several avenues of complaints for prisoners, as well as the existence of specific monitoring bodies. The Supervisory Board and the Complaints Committee for each prison, as well as the Council for the Administration of Criminal Justice and Protection of Juveniles (RSJ) and the National Ombudsman play a very important role in the protection of prisoners. Furthermore, these bodies and institutions regularly issue reports and opinions on matters relating to deprivation of liberty. The role of the RSJ, established in 2001, in particular as an appeal mechanism in individual cases (for example, in placement and transfer issues, disciplinary punishments, prescription or non-prescription of medicine by the institution's doctor, or refusal to grant leave) is considerable.

50. The Inspectorate for Implementation of Sanctions (IST), established in 2005, has a nation-wide mandate. It carries out full inspections to assess an establishment as a whole, including treatment of detainees, activities available to them, as well as internal safety and security arrangements. It also carries out thematic investigations as well as investigations into individual incidents. In doing so, the IST is entitled to inspect all information which is of interest in fulfilling its tasks, has access at all times to all locations where sanctions are enforced and can speak in private with individuals deprived of their liberty. In the light of the information gathered during the visit, **the CPT requests clarification as to whether the IST's mandate covers the investigation of allegations of ill-treatment and issues related to prison disturbances.**

C. Foreign nationals held under aliens legislation

1. Preliminary remarks

51. The CPT's delegation visited the Detention Centre for foreign nationals at Rotterdam Airport. In the context of its examination of the procedures for the deportation of foreign nationals by air, it also went to the Detention and Expulsion Centre for foreign nationals at Schiphol-Oost, and the Royal Military Police (KMAR) facilities at Schiphol Airport. At the outset, the CPT would like to raise some issues of a general nature.

52. The relevant legislative framework provides two legal grounds for detaining irregular aliens in the Netherlands: (i) border detention[17], which is provided for in Article 6 of the Aliens Act 2000 (*Vreemdelingenwet 2000*) and applies to aliens to whom access to the territory is denied; such aliens can be obliged to stay in an appointed space or location which can be secured to prevent unauthorised leave; (ii) territorial detention[18], which is provided for in Article 59 of the Aliens Act 2000 and concerns aliens who do not - or who no longer - have legal residency in the Netherlands (including asylum seekers whose application for asylum has been dismissed and who are no longer allowed to remain on the territory). In the latter case, detention is carried out in the interest of public order or national security and with a view to expulsion.

53. At the time of the visit, the Dutch government was preparing a draft law according to which illegal stay in the Netherlands would be regarded as a misdemeanour and could be punished accordingly. More specifically, the misdemeanour would belong to a category of offences for which a fine of up to 3000 – 4000 EUR could theoretically be imposed (though it was expected that, in practice, a fine of some 300 – 400 EUR would be imposed). In case of default on the payment, the person concerned could be imprisoned. In the authorities' opinion, this measure should put pressure on aliens illegally resident in the Netherlands to return voluntarily. This measure could potentially affect many people who have been resident in the Netherlands for many years and even have their families there. **The CPT would like to receive further information about the implementation of this legislation and its foreseeable impact as regard the country's prison population.**

54. In the report on its 2007 visit, the CPT invited the Dutch authorities to introduce an absolute time-limit for the detention of foreign nationals under aliens' legislation; such a time-limit is a requirement under the EU Return Directive[19]. The delegation was informed that a legislative proposal was pending in Parliament and that, in practice, a maximum time-limit of 18 months was applied for the administrative detention of aliens. **The CPT would like to receive updated information concerning the above-mentioned legislative proposal.** Further, **with reference to Article 15 (3) of the EU Return Directive, the CPT would like to be informed of the review periods of the detention order, either on application of the foreign national concerned or *ex officio*, and of the authority involved.**

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17 The criteria relating to border detention are laid down in the Aliens Decree 2000 (*Vb 2000*).

18 Also referred to as "immigration detention pending deportation".

19 Directive 2008/115/EC of the European Parliament and the Council of 16 December 2008 on common standards and procedures in Member States for returning third country nationals who are staying illegally. Member States were to comply with the Directive by 24 December 2010.

Further, the delegation heard from several sources that it was not uncommon for the police to re-arrest aliens shortly after they had been released from detention (on the expiry of the 18 month time-limit), if they had not left the country in the meantime. It should be recalled here that a "territorial detention" order can only be considered valid when there is a reasonable prospect of expulsion of the foreign national concerned. **The CPT would like to receive the comments of the Dutch authorities on this point.**

55. The CPT is pleased to note that, in line with the recommendation made in the report on its previous visit (see CPT / Inf (2008) 2, paragraphs 57-58), the boats used as facilities for holding immigration detainees have been taken out of service. In the same context, the delegation was informed that the Rotterdam Airport Expulsion Centre visited in 2007 was to be taken out of use before the end of 2011. **The CPT would like to receive confirmation that this has been done.**

56. In the course of the visit, the CPT's delegation heard several reports that immigration detainees in the Netherlands were routinely handcuffed whenever they left the detention facility (e.g. to appear in court, to be transferred to a hospital, etc.). In the CPT's view, **applying handcuffs as a matter of routine to immigration detainees whenever they leave their detention facility is disproportionate; the Committee recommends that the use of means of restraint be considered on individual grounds and based on the principle of proportionality.**

57. Further, the delegation was informed during its visit to the Netherlands that in several establishments for immigration detention, detainees on hunger (or thirst) strike were systematically segregated or even transferred to isolation cells (including under constant CCTV monitoring) and obliged to wear rip-proof pyjamas. They were apparently subjected to the same limitations on their daily regime as those applied to persons isolated on disciplinary grounds. The CPT examined the guidelines and procedures in force as regards the management of detainees on hunger (or thirst) strike and, more precisely, the multidisciplinary approach (legal and medical) followed in these circumstances[20]. It also took note of a recent decision taken by the National Ombudsman concerning foreign detainees on hunger strike at Zeist Detention Center for foreigners.[21]

58. The management of detained persons on hunger (or thirst) strike and the issue of force feeding are very sensitive issues that raise many fundamental questions, in particular of a legal, medical, deontological and ethical nature[22]. The CPT considers that placing a person on hunger (or thirst) strike in a segregation or isolation cell should not be systematic. Further, any such placement, envisaged with the clear purpose of better monitoring of the person concerned, should not be accompanied by measures of a punitive character (such as placing the person in a cell devoid of any furniture or equipment or heating, or forcing him/her to wear a rip-proof clothing ("*scheurkleding*")). The person concerned should be accommodated in a cell equipped with the necessary, usual, furniture (such as a bed, a table, a chair, a television, etc.).

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20 See the "Circulaire Gedetineerden in hongerstaking" issued on 4 December 1985 by the State Secretary of Justice and « Honger naar recht – Honger als wapen », Handleiding voor de medische en verpleegkundige begeleiding van hongerstakingen, 3de druk, 2000, Johannes Wier Stichting.

21 Dutch Ombudsman Report N° 2010/353, 14 December 2010.

22 See in particular the study "Dwangvoeding aan gedetineerden: een conflict tussen enerzijds het recht of leven en anderzijds het verbod op foltering en onmenselijke en vernederende behandeling en bestraffing", Mirsida Jasarevic, Tilburg University, juni 2011.

Furthermore, he/she should benefit from a daily regime as normal as possible (including access to shower facilities, outdoor exercise and recreation). To place a person on hunger strike in a "naked" isolation cell (with access to water and the toilets sealed in case of thirst strike), under a strict disciplinary regime, might well generate a reaction from the prisoner that is exactly opposite to the one which is sought (i.e. to bring the hunger - or thirst - strike to an end without detrimental effects for the person concerned and putting the order and security in the establishment at risk). **The CPT would like to receive the comments of the Dutch authorities on the above remarks.**

59. Detention under aliens' legislation in the Netherlands is not covered by specific regulations; instead, detention and expulsion centres for foreign nationals are governed by the same rules as those applicable to the prison system. It has always been the CPT's view that, in those cases where it is deemed necessary to deprive persons of their liberty for an extended period under aliens' legislation, they should be accommodated in centres specifically designed for that purpose, offering material conditions and a regime appropriate to their legal situation and staffed by suitably-qualified personnel. One of the logical consequences of that precept is that the facilities in question should be governed by a distinct set of rules. **The CPT invites the Dutch authorities to examine the possibility of drawing up such rules.**

2. Rotterdam Airport Detention Centre for foreigners

a. introduction

60. The Rotterdam Airport Detention Centre for foreigners, located in the southern part of the Rotterdam Airport premises and east of the main airport terminal, is a new detention facility that was brought into service in July 2010. The Centre has an overall capacity of 608 places (including two blocks each with 64 places, assigned to accommodate female detainees and families with children). Unaccompanied minors and convicted criminals are not held in the Centre. Some 450 immigration detainees were held at the time of the visit, the average length of detention being three months.

The Centre had 250 custodial staff, of which 40 % were women. Half of the staff were officers employed by the National Agency for Correctional Institutions of the Ministry of Security and Justice, the remainder being employees of a private security company.

The delegation received no allegations of physical ill-treatment of immigration detainees by staff. On the contrary, the immigration detainees spoke very positively about the attitude of staff and the delegation observed that staff displayed professionalism and engagement in their interaction with the detainees.

61. According to the relevant legislation, families with children may be placed in immigration detention only when there is likelihood that deportation can take place within two weeks. Their detention can be extended to 28 days if they obstruct deportation. However, the delegation found that on a number of occasions, families with children had been held at the Detention Centre for considerably longer periods (in two cases up to 60 days). **The CPT recommends that the Dutch authorities avoid, as far as possible, detaining families with children. If, in exceptional circumstances, detention cannot be avoided, its period should not exceed the maximum duration provided by law i.e. 28 days.**

b. material conditions

62. Material conditions at the Centre were of a high standard. The bulk of the cells were designed for double-occupancy; they measured some 13.5m² and had sufficient access to natural light as well as good artificial lighting and ventilation. In the family unit, two adjacent cells could be joined together, enabling larger families with children to be accommodated together. The sanitary annexes (with a washbasin, toilet and shower) were fully partitioned from the rest of the cells. The cells were very well-equipped, including a bunk-bed, a wardrobe, shelves, a table and chairs, a fridge, a TV set, a telephone, a call bell, a microwave oven and an electric kettle.

Upon admission, an internal bank account with a 10 EUR starting credit was opened for every detainee, with an additional 10 EUR added every week. Detainees or visitors could put additional funds in the account. Electronic terminals by means of which various items, such as groceries and cigarettes, could be ordered were located in the living units and the ordered items were delivered within 24 hours. The funds on the internal account were also used to cover the cost of phone calls made by the detainees.

However, as regards food, the delegation heard complaints identical to those received in the prison system i.e. the fact that the main meal was delivered frozen and had to be heated by microwave before being served. **The request for information made in paragraph 34 is therefore also applicable to the Centre.**

c. regime

63. The vast majority of the detainees accommodated at the Centre were held under Article 59 of the Aliens Act 2000 (territorial detention). However, families with children were occasionally held at the Centre pursuant to Article 6 of the same Act (border detention) and were accommodated in the family units[23]. The legal status of the foreigners had no influence whatsoever on their daily regime.

All immigration detainees benefited from an open-door regime during the day and could move freely within their units from 8 a.m. to noon and from 1 p.m. to 4:45 p.m. In the family ward, additional open-door time was provided from 6 p.m. to 9 p.m. to families with children. The CPT cannot see any justification for locking up children in their cells when a communal area equipped with toys and table tennis in front of the cells is available and the family ward can be secured and its entrance locked. Families could always lock themselves in their own cells if they felt need for privacy. **The CPT recommends that the practice of locking up children in their cells be reviewed accordingly.**

[23] Male and female foreign nationals in border detention would be accommodated at Schiphol Airport Detention facility.

64. The CPT is pleased to note that, in comparison with the findings made during its 2007 visit to the detention boats (see CPT/Inf (2008) 2, paragraph 60), the activities offered to immigration detainees at the Centre were varied and stimulating. By way of example, in their living units, immigration detainees could cook together in kitchens, watch TV and play board games, table tennis or badminton in a spacious area in front of their cells. In the family ward, a play room with direct outdoor access and equipped with a variety of toys and items for creative activities, as well as a computer room, was available to children. Three hours of sports activities were offered every week and the sport facilities (including a gymnasium and fitness rooms), were modern and clean. A well-equipped library could be visited for one hour every week; both children's and adult books were available, as well as 14 different newspapers in various languages, supplemented by a printed internet news overview prepared by the librarian in additional languages. Creative activities were organised for an hour and a half a week and a multimedia room could be used for one hour a week.

65. No education or work activities (apart from small maintenance jobs, such as cleaning, offered to a limited number of detainees) were available to detainees. According to the management, this was mainly due to the limited time of presence of the detainees at the Centre. However, the CPT noted that large numbers of detainees stayed at the Centre for prolonged periods[24]. By way of example, at the time of the visit, 112 the detainees had spent up to one month at the Centre, 93 between one and two months, 49 between two and three months, 51 between three and four months, 36 between four and five months and 71 between five and eight months; 29 detainees had stayed even longer (the longest stay being 420 days). In the light of the above, **the CPT invites the Dutch authorities to explore the possibility of offering some education to immigration detainees at the Centre. Emphasis should be placed on the possibility for the detainees concerned to acquire skills that may prepare them for reintegration in their countries of origin upon their return.**

d. health-care services

66. The health-care team at Rotterdam Detention Centre consisted of one FTE post of medical doctor which was covered by three GPs working on rotation and 18 nurses. One of the three GP's was present every working day (between 8 a.m. and 5 p.m.) at the Centre. Several nurses working in shifts were present daily (between 7.30 a.m. and 10 p.m.). The Centre had also engaged a dentist, a psychiatrist, three psychologists and a psychotherapist. Nurses specialised in caring for children and women were also available. A psycho-medical team (consisting of a GP, a psychologist and the psychiatrist) met once a week to discuss special cases. It is also noteworthy that the distribution of medication was carried out by a nurse.

The CPT considers that the current staffing level as regards general practitioners is not sufficient for an establishment with a capacity of 600 detainees and which was accommodating some 450 persons at the time of the visit indeed, the delegation received a number of complaints from the detainees concerning delayed access to medical care. Under the circumstances just described, the Centre requires at least 1.5 FTE posts of medical doctors. **The Committee recommends that the medical staffing level be increased accordingly.**

[24] According to the Centre's statistics for October 2011.

67. The delegation was informed that every newly-arriving detainee would be interviewed and examined by a nurse on the day of arrival and that a doctor would systematically examine children and those he considered it necessary to see on the basis of the information provided by the nurse. However, several detainees spoken to by the delegation alleged that they had been seen by a member of the health care team only several days after their arrival. The CPT wishes to stress that every newly-admitted detainee should be properly interviewed and physically examined by a medical doctor, or a fully qualified nurse reporting to a doctor, as soon as possible after admission. The interview/examination should be carried out within 24 hours of admission, including at week-ends. This preventive health-care measure is in the interests of both detainees and staff. **The CPT recommends that the current practice at the Centre be reviewed in the light of the above remarks.**

68. The delegation was informed that a number of detainees had been diagnosed with severe psychotic disorders such as schizophrenia, severe personality disorders, mental disability and PTSD. Many detainees also suffered from anxiety disorders or mild to moderate depressive conditions. For at least some detainees, the Centre did not offer the possibility to deploy the necessary care and treatment. The CPT wishes to underline that persons requiring psychiatric assessment and/or treatment, whatever their legal status, should preferably be assessed and/or treated in a suitably equipped and staffed medical facility. **The Committee recommends that measures be taken to transfer detainees suffering from the most severe forms of psychotic disorders to an appropriate psychiatric facility.**

Further, **detainees diagnosed with severe psychiatric disorders but who are in remission should benefit from a special regime of activities conducive to their psychosocial rehabilitation, including more out-of-cell time.**

e. safeguards during deprivation of liberty

69. Under the present aliens' legislation, the initial detention order issued by the Immigration Service can be appealed in court by the foreign national concerned. If he/she does not lodge such an appeal, the Immigration Service is under a legal obligation to notify the competent District Court within 28 days after the initial detention order has been issued. The detention order is then automatically reviewed by a judge. The decision on the extension of the detention order is taken by the Repatriation and Departure Service of the Ministry of the Interior and Kingdom Relations. It can be appealed to the court. The extension decision is delivered to the detainee in Dutch, if necessary, with the help of interpreters (phone interpretation). However, the extension decision is not translated; further, it appears that the extension decision does mention the possibility and the deadline for the detainee concerned to lodge an appeal. **The CPT recommends that steps be taken to ensure that foreign nationals receive a written translation in a language they understand of the decisions concerning their detention, as well as of the modalities and deadlines to appeal against such decisions.**

70. On admission to the Centre, foreign nationals were informed about their rights and the house rules and written information in several languages was available in the units. Access to a lawyer and the possibility to inform a third person about the placement to the centre was not limited, as the cells were all equipped with phones. On request, the foreign national concerned could benefit from consular assistance.

71. That said, the delegation heard a number of complaints about the lack of information provided to foreign nationals regarding the status of their individual cases. The delegation was given to understand that this fact was a significant contributor to the unrest that broke out on 25 August 2011 in four units for male detainees and during which the special intervention team had to be deployed. **The CPT recommends that steps be taken to ensure that foreign nationals detained at the Centre are duly and regularly informed about the status of their case in a language they understand (if necessary, through phone interpretation).**

f. contact with the outside world

72. At Rotterdam Detention Centre, detainees could benefit from two hours of visits a week. Those of them who would otherwise not receive visits could be visited by external volunteers. The visiting room was adequately equipped and clean. However, unsupervised visits (the so called "partner visits") were not foreseen, although many foreign detainees had family links in the country. **The CPT recommends that the Dutch authorities provide the possibility of unsupervised visits for detainees at the Centre**, as it is the case in the prison system (i.e. for two hours once every four weeks).

73. All cells were equipped with a telephone and detainees could consequently make phone calls 24 hours a day, provided that they had enough funds; incoming calls were directed to the central desk, where detainees could be brought by the staff. The delegation was also informed by the management that rates charged for international calls had been recently re-negotiated and significantly decreased.

3. Deportation of foreign nationals by air

74. One of the objectives of the 2011 visit to the Netherlands was to examine in depth the instructions and procedures followed as regards the deportation of foreign nationals by air. In order to do so, the delegation had access to copies of the relevant instructions and directives and partly followed one removal operation. It also obtained copies of many other documents (statistics on deportation operations, escort assignment orders, escort assignment reports, incident reports, reports in the context of legal proceedings, medical certificates, etc.) and examined the restraint equipment used during deportation operations. It also interviewed those in charge of deportation operations as well as prospective deportees, some of whom had been brought back to holding facilities after an abortive deportation attempt.

75. During the interviews it carried out both at the airport or at detention and/or expulsion centres, the Committee's delegation received no allegations of ill-treatment of deportees by the KMAR officers responsible for effecting the deportation.

The delegation was informed that two out of the five KMAR teams present at Schiphol Airport were involved in the expulsion process.[25] To escort deportees on return flights, KMAR officers had to be at least 23 years old, to follow both theoretical and practical escort courses, and successfully pass an exam. After one year of operations, they could take additional course to become escort leaders. The delegation gained an overall positive impression of the professionalism of the KMAR officers concerned.

[25] The three other teams are respectively responsible for identity check of asylum seekers, the fight against human smuggling and trafficking and the fight against drug trafficking.

76. The deportation procedure is covered by several comprehensive KMAR operating instructions: Operating instruction for Detainee and Transfer Detainee Unit (APW) staff, Operating instruction for staff of the Reception unit and Operating instruction for escort staff. In practice, a deportee is brought to the airport from the place of detention approximately three hours before the flight by the Transport and Support Service (DV&O)[26] and handed over to the KMAR officers. The deportee is then searched and placed in a cell. He/she is allowed to make a free phone call to his relatives or a lawyer and is provided with the opportunity to dispose of any documents related to his possible asylum application. He/she then boards the plane, usually before other passengers.

77. According to the KMAR operating instructions, only the following means of restraint may be used during deportation operations: steel handcuffs to affix hands and/or feet; a belt combined with handcuffs to affix wrists in front of the body (a body-cuff), optionally combined with ankle straps; Velcro straps to affix hands and/or feet; tie raps (synthetic strips to affix hands and/or feet); a light rigid helmet to prevent the deportee from injuring himself or others; and facial screen to protect escort officers and/or passengers from biting and/or spitting. It should be noted that the facial screen in use did not in any way obstruct the airways of the deportee. Further, the operating instructions forbid bending the deportee forward to control him or to cover or tape his mouth, even in case he is shouting or spitting. The application of means of restraint and their removal is decided by the escort leader, escort officers are not allowed to wear masks and the forced administration of medication, such as tranquilizers, is strictly forbidden.

The delegation was also informed that the use of gas is not allowed; however, it noted that the form on the use of force[27] filled in by the escort leader contains a reference to a possible use of the pepper spray. **The CPT would like to receive clarification from the authorities on this point.**

78. The delegation also noted that pursuant to the Operating instruction for Detainee and Transfer Detainee Unit (APW) staff, an intake of a deportee by the unit includes a search of that person. The same instruction states that under certain circumstances, the intake of a female alien can be carried out by a male staff member. The CPT wishes to emphasise in this respect that persons deprived of their liberty should only be searched by staff of the same sex and that any search which requires an inmate to undress should be conducted out of the sight of custodial staff of the opposite sex. Consequently, **the CPT recommends that the necessary steps to be taken to meet these requirements.**

79. It is essential for every deportation operation to be duly documented, in the interest of both the deportee and the escort officers. At the KMAR Airport Detachment, all the relevant information was entered into a comprehensive electronic system ("VBS") from where an incident report was generated and kept in hardcopy form for every return flight. The report contained information on whether and what kind of force and/or means of restraint were used, the reason for it, the time and place of the measure (including the termination of the use of means of restraint), the persons who ordered the use of means of restraint, the consequence of the measure and possible injuries sustained.[28] Moreover, personal deportation files contained, for example, pre-departure briefings for the escort or an incident form to be filled in, the file being kept for 5 years after deportation.

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26 *Dienst Vervoer en Ondersteuning;* DV&O falls under the authority of the National Agency for Correctional Institutions of the Ministry of Security and Justice and ensures transportation of detainees, prisoners and foreign nationals.

27 *Meldingsformulier geweldsaanwending bij uitzettingen.*

28 The delegation examined in detail the register of incident reports for September 2011 with the following results: on 21 flights, force and/or means of restraint was used while force and/or means of restraint was not used on 47 other flights.

80. The delegation was informed that when medical examination of deportees in order to certify their fitness to travel ("fit to fly" certificate) is carried out, it was done prior to the handover of the detainee to KMAR escort officers. However, KMAR staff brought to the delegation's attention that neither such an examination, nor an examination after a failed removal attempt, was carried out systematically. In its 13th and 15th General Reports, the CPT stressed the importance that should be attached to medical examinations in the context of deportation operations, all the more so when such operations have been interrupted due to the resistance of the foreign national concerned.[29] The Committee of Ministers of the Council of Europe did likewise when adopting its Twenty Guidelines on Forced Return in 2005.[30] In the light of the above, **the CPT recommends that the Dutch authorities take the necessary steps to ensure that:**

- **any foreign national to be deported is given the opportunity to be medically examined prior to the removal operation;**
- **all foreign nationals who have been the subject of an abortive deportation operation undergo a medical examination as soon as they are returned to detention**. By doing so, it will be possible to verify the state of health of the person concerned and, if necessary, establish a certificate indicating any allegations made by that person and attesting any injuries. Such a measure could also protect escort staff against unfounded allegations.

81. Independent monitoring of deportation operations is carried out by the Committee for the Integral Supervision of Return (CITT)[31], a body set up in 2007 with a mission that is not limited to monitoring actual expulsions, but extends to the supervision of the deportation process as a whole. To this end, the CITT consists of three chambers, one responsible for return facilities, another for the return process, and the last one for the actual expulsion arrangements, including safety, security and efficiency in individual cases. The CITT's annual inspection report is submitted to the Minister of the Interior and then forwarded to Parliament with his comments and made public. However, reports on individual expulsion cases remain confidential.

In its 13th General Report, the CPT stressed the importance of the role to be played by monitoring systems in an area as sensitive as deportation operations by air. Consequently, the Committee welcomes the establishment of the CITT. **It also considers that in the interest of transparency, it would be desirable for reports on individual expulsion cases to be made public** (on his/her request, the identity of the foreign national concerned could be kept confidential).

82. The KMAR had at its disposal several detention facilities at Schiphol Airport. The detention unit used for deportation operations was located in the secure zone of Terminal 3. It consisted of four individual cells (measuring between 6.75 and 10.5 m² each), a room that could be used for medical consultations or as a waiting room for children, and three waiting rooms measuring some 75 m² each. The individual cells were equipped with a shower, a bench along one of the walls and a CCTV, and had sufficient access to ventilation and artificial light. The waiting rooms (one used for male detainees, another for female detainees and the last one for transit detainees) were each equipped with several showers and toilets which were partitioned from the rest of the room, as well as washbasins and benches. Artificial light and ventilation was sufficient and one of the rooms had access to natural light.

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29 CPT/Inf (2003) 35, paragraph 39, and CPT/Inf (2005) 17, paragraph 47.

30 CM (2005) 40, 4 May 2005, Principle 16.

31 *Commissie Integraal Toezicht Terugkeer*, http://www.commissieterugkeer.nl/.

83. The Detention and Expulsion Centre for foreigners at Schiphol-Oost included several units accommodating different groups of detainees, such as asylum seekers, foreign nationals on remand, foreign nationals placed under the border detention regime or those suspected of smuggling drugs inside their body (so called "body packers").

84. In the course of its very brief visit to this facility, the delegation met a drug addicted detainee who had been sharing needles and had contracted hepatitis C. On arrival at the Detention and Expulsion Centre Schiphol-Oost, his request for HIV test was refused by the medical service on the ground that the person concerned had recently had sexual intercourse with several women and that a test would only be done in November 2011, after a three months incubation period.

In the CPT's view, the speculation about the origin of a possible HIV infection (be it the sharing of needles or multiple sexual intercourse with different partners) is irrelevant. Such a person, suffering from hepatitis C, should immediately be tested for HIV in order to establish whether or not he is infected,[32] and a second test should be carried out after three months. This particular case was brought to the attention of the Director of the Centre and the doctor, who assured the delegation that the relevant tests would be carried out. **The CPT would like to receive confirmation that the HIV tests in question have been carried out as well as information on the follow-up given to the case.**

[32] In this context, the CPT makes reference to the 2004 UNAIDS/WHO Policy Statement on HIV Testing which suggests that "Client-initiated HIV testing to learn HIV status provided through voluntary counselling and testing, remains critical to the effectiveness of HIV prevention. UNAIDS/WHO promote the effective promotion of knowledge of HIV status among any population that may have been exposed to HIV through any mode of transmission." (http://www.who.int/rpc/research_ethics/hivtestingpolicy_en_pdf.pdf)

D. Mental health institutions

1. Preliminary remarks

85. The delegation visited three mental health institutions, namely the Forensic Psychiatric Centre (FPC) Dr van Mesdag in Groningen, the "long stay" wards for "terbeschikkingstelling" (or TBS) patients of the Pompe Institute in Zeeland, and the Forensic Psychiatric Department for mentally disabled patients in Oostrum. The visit to the FPC Dr van Mesdag was of a follow-up character, as the CPT had already visited this establishment in 1997 (see CPT/Inf (1998) 15).

86. The FPC Dr van Mesdag is one of the 13 mental health institutions in the Netherlands catering for patients detained under a TBS order[33]. It offers a high level of security and therefore accepts patients considered to present a high level of dangerousness and/or risk of escape. At the time of the visit, some 240 patients were held in the establishment. However, a new building (offering 55 extra beds) was expected to enter into service one month after the visit.

The "long stay" wards for TBS patients of the Pompe Institute are located in Zeeland (Limburg)[34] and Vught. With the FPC Veldzicht, the Pompe Institute is the only establishment with such wards. At the time of the visit, the establishment was accommodating 88 patients (i.e. working at full capacity).

The Forensic Psychiatric Department for mentally disabled patients is a pioneering project designed for the management and treatment of such persons, the first establishment of its kind in the Netherlands. Located in Oostrum, close to a TBS psychiatric hospital, it had been brought into service a few months before the visit. Twenty-six patients were accommodated in the FPD (total capacity: 28 beds) at the time of the visit.

2. Ill-treatment

87. The CPT's delegation heard no allegations of ill-treatment of patients by health-care or custodial staff in any of the mental health institutions visited. On the contrary, the relations between patients and staff appeared to be very good, and staff displayed professionalism, engagement and a caring attitude in their interaction with patients.

Nevertheless, the CPT wishes to stress the importance for the authorities of regularly reviewing the procedures and techniques used by staff to restrain violent or otherwise agitated psychiatric patients. Indeed, any shortcomings in this area can quickly lead to serious incidents (see paragraph 106).

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[33] A "TBS" order is designed to respond to the special needs created by mentally disordered persons who have committed serious offences and who are considered likely to re-offend if no treatment is applied. Under Book I, Section IIa, Subsection 2 of the Dutch Criminal Code (Sections 37b and 38c), a judge may issue a TBS order in respect of anyone who has committed a serious crime and is found to have "defective development" or "a pathologic disturbance of his mental faculties".

[34] These facilities were previously used as a youth detention centre ("de Corridor").

3. Follow-up visit to the FPC Dr van Mesdag

a. introduction

88. At the outset, it should be stressed that important changes have taken place at the FPC Dr van Mesdag since the CPT's last visit some fourteen years ago. It is therefore useful to review the most significant developments before going into further details. The CPT is pleased to note that nearly all the recommendations made by the Committee in 1997 had been the subject of an adequate response. They will be highlighted in the present report.

89. The first significant change concerns the legal status of the establishment. A few months after the CPT visit in 1997, the Dr van Mesdag Clinic became a private foundation with an independent management board[35]. However, the Ministry of Justice remained the exclusive source of funding for the establishment. In this regard, it should be noted that the system of financing is in constant evolution. The previous principle that a fixed amount was paid per patient per day - with this amount being reduced after six years under TBS, as was the case in the past - has now been changed and is now supplemented with a system of tenders. By way of example, as from 2012, the FPC will benefit from a "guaranteed" basic financial amount covering about 180 TBS beds. This amount will be supplemented through bids[36] made when the Ministry of Justice opens a call for tenders (for specific categories of patients or therapeutic programmes). Such a bid was recently won for the provision of treatment for a dozen patients with learning difficulties. On the other hand, the FPC is not always successful in bidding and units may well be closed (as it is expected to be the case in 2012 for four residential units used in temporary buildings). Under this new - evolving - financial environment, the FPC has to produce a business plan and negotiate bank loans to cover investments (for example, the previously mentioned new building), is considered a private employer (so that staff no longer have the status of civil servants), and has to take steps to remain within the budget imposed by the income generated (a situation which has already had a negative effect on staff resources, see paragraph 101).

90. Important changes also took place as regards the FPC's management. In 1997, the Dr van Mesdag Clinic was placed under the direction of a psychiatrist with a psychoanalytical orientation. A few years later he was replaced by a medical director with a more eclectic approach, introducing cognitive-behavioural approaches and more extensive treatment by medication. For several years now, the FPC has a dual (or collegial) direction; it is managed by a director of general affairs with training in business administration and a medical director with training in forensic psychiatry.

91. Significant developments have also occurred as regards the capacity of the institution. It has risen from 159 beds in 1997 to 240 beds at the time of the visit. Furthermore, a new building - offering 55 extra beds - was under construction at the time of the visit. However, the provision of new beds was to be accompanied by the closure of some beds in existing units. The new total capacity of the FPC in the spring of 2012 will be 256 beds, in other words, an increase of 60% since 1997. However, this increase in capacity has been accompanied neither by a concomitant increase in workshops and communal therapeutic activities (see paragraph 96), nor by additional staff resources (see paragraphs 100-101).

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35 Until 1997, it was a State run hospital placed under the direct control of the Ministry of Justice.

36 The FPC competes directly with other TBS establishments when tendering for contracts.

92. The procedure for requesting leave and discharge to a less secure environment or an open institution has become more and more complex and restrictive, following the recommendations formulated by the "Visser Commission" in 2006 and several other subsequent parliamentary debates. All requests for leave now require prior approval from the Ministry of Justice, accompanied leave cannot be approved until a patient has been in the FPC for at least three years, the frequency of accompanied leave has been reduced (partly due to difficulties in getting approval from the Ministry and partly due to shortages of staff), unaccompanied leave has become all but impossible until a patient has been in the FPC for at least 5 years and often longer; discharge from the FPC is still decided by a judge, but this will not even be considered until the patient has had several successful unaccompanied periods of leave. As a result, the average length of stay in the FPC is now well over seven years[37] (and this figure only takes into account patients that have been discharged from the FPC) and there is considerable and growing frustration among patients that leads to negative attitudes and demotivation. As a result, a growing number of patients at the FPC Dr van Mesdag have spent 10 years or more in the institution, even though the establishment does not have a "long stay unit" as such.

93. More generally, as a result of a previously negative opinion within Dutch society and related media coverage, the proper functioning of the TBS system is apparently jeopardised. Lawyers are increasingly reticent to recommend TBS measures to their clients[38] and it has become very difficult to recruit psychiatrists to work at the FPC Dr van Mesdag, as well as in other TBS establishments in the country. The global economic crisis has generated further budgetary restrictions in the TBS system, putting the quality of treatment and even security at risk.

b. patients' living conditions

94. The material conditions for patients in the "old remand prison" facilities, dating from the 19th century, were criticised in the report on the 1997 visit, in particular as regards hygiene (no water in the cell, "slopping out" procedure, etc.). The CPT is therefore pleased to note that, thanks to an extensive refurbishment programme, the facilities have been upgraded in an imaginative way. The living units now have individual rooms, with a screened-off sanitary area (shower, toilet and washbasin), adequate natural light, ventilation and heating. Moreover, all rooms are equipped with a television. The common areas of these units are also pleasantly furnished, relatively spacious and offer some recreational activities (for example, table tennis), and the areas for outdoor exercise are now adequate. Furthermore, the practice of using the segregation cells in the intensive care area as ordinary accommodation has ceased.

As regards the other parts of the establishment, the situation remained as described in the 1997 visit report. To sum up, the material conditions offered to all patients throughout the establishment were very good.

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37 The Ministry of Justice website mentions an average length of stay at national level of 9.8 years. The above-mentioned figure for the FPC is calculated taking account only of patients that have actually been discharged; the tendency is in fact for much longer stays, if the patients who have been in the clinic for more than 10 years, with no discharge in sight, are taken into account.

38 It has indeed become quite common for prisoners on remand to refuse assessment at the Pieter Baan Centrum, thus blocking a possible TBS measure. As a result, persons who have committed serious crimes related to their psychiatric state receive determinate sentences without a TBS measure. They are therefore released at the end of their sentence without adequate psychiatric treatment or assessment (see also paragraph 124).

95. One of the recommendations made after the 1997 visit concerned taking of steps to maintain the quality of treatment offered at the FPC, notwithstanding the increasing number of patients. In this regard, the delegation noted that patients were still allocated to units according to their psychiatric pathology - the main division being between psychotic conditions and personality disorders[39] - and that they are still being assigned tasks on a daily basis within their living unit. Efforts were also being made by the management to offer all patients a daily programme of activities adapted to their needs. In addition, for many patients, the regime remained remarkably open: they have a key to their own room and a magnetic card that gives them freedom of access to large parts of the FPC.

96. However, as already indicated (see paragraph 89), the FPC's infrastructure has not kept pace with the increased capacity of the establishment, and this has placed significant strain on the workshops and communal therapeutic activities (such as music, creative activities, recreational facilities and sports). This trend will be exacerbated when the 55 extra beds are brought into service. As a result, with one exception[40], most of the patients spend less and less time in activities and more time in their rooms (from 9.45 p.m. until 8.15 a.m., and, at weekends, until 11.00 a.m.) or in their units[41]. **The CPT recommends that the necessary steps be taken at the FPC to further develop workshops and other communal therapeutic activities, in parallel with the rising number of patients. This will require both infrastructure development and additional staff resources.**

97. The CPT must stress the difficult situation affecting a significant minority of patients who benefit from an extremely limited regime, in particular patients in Units Eems 1 and 2, and Units Dollard 1 and 2. For example, the six patients in Unit Eems 2 - all presenting acute disturbance in the context of a psychotic disorder and displaying regularly aggressiveness and violence - have virtually no freedom of movement, no contact of any kind with other patients and spend most of their time in their rooms. They have only two hours of activities outside their rooms per day (in the presence of staff) and one hour of outdoor exercise. Further, at the time of the visit, two of the patients had been maintained under this highly restricted regime for over two years. It should be added that despite being seen almost daily by a psychiatrist and the prescription of antipsychotic medication, their psychotic state had not improved. Similarly, five out of the six patients in Unit Dollard 2 did not leave their unit at all, except for outdoor exercise periods in the adjoining garden.

The CPT acknowledges that these patients present a major therapeutic challenge. However, the Committee believes that these patients require more intensive individually based therapy. This means more staff with specific therapeutic skills, in particular psychiatric nurses, to treat patients with severe psychotic disorders. **The CPT recommends that appropriate measures be taken in the light of the above remarks.**

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39 In addition, Unit Dollard 2 accommodates several patients with severe learning disabilities and Unit Zuiderdiep 2 accommodates a number of patients with autistic disorders.

40 The exception in question concerns autistic patients at Unit Zuiderdiep 2, who are taking part in a new activity – tending an extensive vegetable garden - developed in the yard surrounding the church.

41 By way of example, the average time spent in workshops or group activities by the twelve patients on Zuiderdiep 1 was three half days a week.

98. Reference should also be made to some of the newly admitted patients, categorised as "instroom" patients. Usually very disturbed, they were placed "under observation" and then "stabilised". Such a process does not usually take more than three months and most patients with a diagnosis of personality disorder were transferred to a "doorstroom"[42] unit within this period. However, the delegation noted that ten psychotic patients had remained in the "instroom" process for more than a year. This is a worrying phenomenon, as such seriously ill psychotic patients - almost all paranoid schizophrenics - require intensive psychiatric care involving a high staff/patient ratio (preferably, 1 to 1). The medical director acknowledged the problem, but indicated that he did not have the staff resources to provide more intensive care. **The CPT recommends that urgent measures be taken in order to address adequately the situation of the above-mentioned patients (see also the recommendation made in paragraph 97).**

99. Some problems were also identified as regards the nine patients in the "uitstroom" regime. All expressed impatience and frustration with the slowness of their progress through the TBS system. Indeed, in this regard, the delegation noted that frequency of interviews with the psychiatrist in charge - on average one interview every six months - was inadequate. Individual interviews with a socio-therapist were carried out once every two weeks. Further, these patients had usually waited between four and six years for their first unaccompanied leave; seven patients out of the nine had experienced at least one planned leave cancellation due to shortage of staff (several times on the morning of the planned leave) and four of them had already been transferred to a lower security forensic clinic only to be returned to the FPC because of a relatively minor disciplinary problem. Both patients and staff confirmed that once a patient has been in the FPC Dr van Mesdag, the threshold for a return was very low.

More generally, the institution had a powerful stigmatising effect, not only among the general public but also among staff in other forensic clinics and in non-forensic settings. There is a clear trend to limit psychiatric supervision and this is of particular concern in relation to patients suffering from schizophrenia. As a point of comparison, most community care programmes for patients with stabilised schizophrenia receiving anti-psychotic medication would provide for direct contact with a psychiatrist at least once a month, as well as follow up by a psychiatric nurse. It is striking that, in an inpatient setting like the FPC Dr van Mesdag, less psychiatric supervision is offered than in such programmes. The principle of "equivalence of care" for persons deprived of their liberty is now widely recognised among member States; in the CPT's view, that principle should be applied equally when assessing the quality of psychiatric care for patients in forensic settings (compared to non-forensic psychiatric settings). **The CPT would like to receive the comments of the Dutch authorities on the above remarks.**

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42 "Doorstroom" implies transfer to a unit with much more freedom of movement within the FPC, as well as regular workshop sessions. The next stage is "uitstroom", when patients have regular periods of leave. The last and final stage is the "resocialisation" unit, where the rooms are open at night. At the time of the visit, 13 such patients were living in accommodation outside the FPC ("transmuraal") remaining under the responsibility of the institution.

c. staff

100. At the FPC Dr van Mesdag, all patients had an individual treatment plan - which was regularly updated and, in principle, reviewed every six months - and their files were well kept. However, significant shortages of psychiatrists (only three FTE posts of psychiatrists out of five were filled, which included the post of medical director) had a detrimental effect on the level of psychiatric coverage[43].

Such a shortage of psychiatrists (i.e. more than 80 patients per psychiatrist) represents a serious problem for the establishment, which is catering for some 240 patients, many of whom receive psychotropic medication which requires close supervision. Furthermore, prospects of recruitment of psychiatrists appeared poor, as the FPC Dr van Mesdag no longer received psychiatrists in training. The three fully trained clinical psychologists and two clinical psychologists in training working at the FPC did not compensate for the insufficient time of presence of psychiatrists. Fully aware of the situation, the management spared no efforts to remedy this shortcoming. **The CPT recommends that the Dutch authorities pursue vigorously their efforts to fill the vacant posts of psychiatrists. More generally, the Committee calls upon the Dutch authorities to train more forensic psychiatrists in the Netherlands.**

101. In addition, 17 FTE posts of socio-therapists were cut in the 2010 budget. This represents in practice the loss of one post from among the "first-line" staff working in close contact with the patients at any given time in every unit at the FPC. Socio-therapists play an important role at the FPC; they are present on all units and organise the patients' care programmes. For some patients, such as the patients in "doorstroom" and "uitstroom" regimes (who are rarely seen by the psychiatrist) they even replace the psychiatrist. **The CPT recommends that measures be taken to ensure an increase in the number of posts for socio-therapists at the FPC Dr van Mesdag.**

d. means of restraint

102. The legal framework and procedures in force as regards segregation ("afzondering") and isolation ("separatie") of patients at the FPC Dr van Mesdag were described in detail in the report on the 1997 CPT's visit (see CPT/Inf (1998) 15, paragraphs 122 to 127).[44] Two specific recommendations were made: to set up a central register in which these measures would be recorded (in addition to the record in the patient's individual file), including the times at which the measure began and ended, the circumstances of the case and the reasons for resorting to it; and to offer every patient subject to segregation/isolation at least one hour of outdoor exercise every day.

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43 By way of example, there was a striking discrepancy in the frequency of psychiatric consultations. Priority was given to acutely disturbed patients, who were seen at least twice a week by a psychiatrist who made detailed observations and assessments. Other patients - such as in Units Zuiderdiep 1 and 2 - were seen by a psychiatrist once or twice a year, even though it would be preferable for their status to be reviewed at least every few weeks. Further, it should be noted that the establishment had 9 psychiatrists in 1997.

44 On 1 March 2012, the CPT received a new policy document entitled "Gedwongen Herstellen" highlighting the vision and management concerning the implementation of the means of restraint and forced medication at the FPC Dr van Mesdag.

103. In 2011, the delegation noted that a specific report is drawn up by the Head of the Security Team when a patient is put in isolation. This form indicates the reason for the measure, the time, and a brief account of the measure given. Specific questions (with "yes" or "no" answers) being dealt with are: use of physical force against the patient; violence by the patient against staff; use of special means (handcuffs, shields, batons, protective gear).

A further report is completed for each day the patient remains in isolation. Copies of these reports are sent to the legal department of the institution, the Supervisory Board and the patient's file (the patient also receives a copy, on request). Moreover, a register of isolation measures is kept at the legal department. Similar administrative procedures were set in place as regard segregation measures. The CPT welcomes the steps taken by the management to implement the first of its recommendations referred to in paragraph 102.

104. The management informed the delegation that special efforts had been made to reduce the recourse to isolation to the absolute minimum. This was also part of a campaign launched, with success, by the Health Inspectorate at the national level. At the FPC Dr van Mesdag, 132 isolation measures were taken in the first nine months of 2011 (ranging from 9 - 21 cases each month), a situation which represents less than half the rate observed at the time of the 1997 visit (with 150 patients). Further, only 46 isolation measures were applied for more than 24 hours (the longest being 22 days).

Most of the measures were taken vis-à-vis patients accommodated in the units for the most difficult patients (Eems 1, 2 and 3 and Dollard 1 and 2), and the delegation noted that the reasons given for the measure were not always clear. About 20% were said to be at the patient's request and 20% were in respect of suicide risks, while the commonest reasons can be grouped as violence, threats, aggressiveness and provocation. In four cases, the reason given for isolation was the "administration of forced medication" (see below).

To sum up, the CPT is pleased to note that the recourse to isolation has fallen significantly since the previous CPT visit. However, **the rate of "separatie" for patients in "instroom" units is still rather high and the 22-day isolation measure mentioned above is difficult to justify**.

Further, the delegation noted that patients subject to this measure were still not routinely offered outdoor exercise (see paragraph 102). **The CPT recommends that steps be taken in order to remedy this shortcoming.**

105. As regards material conditions, the delegation noted that the two isolation cells located on the ground floor of the "old remand prison" had undergone some renovation work (installation of a stainless steel toilet, an interphone and a call bell; CCTV monitoring system, etc.) and that the padded cell ("separatie N°1") was now being used as a store room. However, these two isolation cells were still poorly lit and oppressive in design. The management informed the delegation that they intended to take them out of service. **The CPT would like to receive confirmation that these two cells have been definitively taken out of service**.

106. A serious incident occurred on 8 June 2007, at 7.20 pm, while an agitated patient[45] held in the isolation unit (*separatie afdeling*) of the "old remand prison" was being restrained by four members of the security team. After having initially offered some resistance to the security staff, the patient lost consciousness while under control on the ground with a neck hold (*nekklem*), lying face down, his ankles and wrists handcuffed. He had a first cardiac arrest and a resuscitation procedure was immediately performed, with the support of the nurse on duty. An ambulance was called and the patient was transferred at 8.20 pm to the local hospital (UMGC), once his situation had stabilised. During the transfer, he had a second cardiac arrest, was resuscitated again, was transferred upon arrival at the hospital to the intensive care unit, where he had a third cardiac arrest at 1.30 am. He underwent another resuscitation procedure and died at 2 am.

The delegation studied in depth the information at hand (including the incident reports, the isolation unit log-book, the patients' administrative and medical files, copy of the files of the "*Rijksrecherche*", etc.) and interviewed several members of staff (including the head of the security team) about the incident. The information gathered shows that the handling of the situation as from the moment the patient lost consciousness was adequate, and that a quick and professional response was given. However, some aspects relating to the prior intervention (in particular, the technique that was used to control the patient and the CCTV monitoring of the incident) deserve some comments since, as far as the delegation could ascertain, no review of the procedures and/or the restraint techniques was made after the incident.

Firstly, it is confirmed that a neck hold (and, more precisely, a "*half bloed-half ademklem*") was applied by one staff member[46] in order to control the patient. In this context, the CPT would like to stress the risks inherent in the use of certain restraint techniques (in particular, the use of the neck hold) in order to control agitated patients, as well as the need to avoid immobilisation techniques that might quickly lead to positional asphyxia. This is all the more valid for such an overweight patient with a serious cardiac history. Secondly, one would have expected the security staff present at the Central Command Post to record the incident[47] as from the moment the alarm went off.

The CPT recommends that the restraint/immobilisation techniques used vis-à-vis agitated patients at the FPC Dr van Mesdag be reviewed, in the light of the above remarks, and that the training of the security team is adapted accordingly.

Further**, steps should be taken with a view to systematically recording the events, as captured by the CCTV system, whenever an incident occurs in the facility.**

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45 The patient weighed 148 kg, was diabetic, and had had a heart attack in 2001 (with a subsequent elevated cardiac risk factor).

46 Former sports' instructor for the "*Koningklijke Marine*", where he had been serving for nine years, the staff member concerned had been recruited by the hospital two months before the incident, and was working with a "mentor". He indicated while being interrogated by the "*Rijksrecherche*" that he had developed the above-mentioned control technique for the Dutch commandos sent to Afghanistan.

47 The two staff members concerned indicated to the "*Rijksrecherche*" that they had watched the whole scene on the CCTV system until the patient left the FPC Dr van Mesdag to go to the UMGC.

e. forced medication/consent to treatment

107. In principle, the consent of psychiatric patients to their treatment (including medication) should be sought on the basis of full information of the reasons for the proposed treatment and the possible side effects. The majority of patients interviewed at the FPC Dr van Mesdag appeared to have given such informed consent to their treatment. However, certain very disturbed patients (by way of example, some of those seen on Units Eems 1 and Dollard 2) were not mentally competent to give informed consent. The psychiatrist in charge believed that there was no other treatment alternative. The procedure followed in such cases has already been described in the previous visit report (see CPT/Inf (1998) 15, paragraph 131).

A special committee ("Commissie voorbehouden beslissingen") chaired by a psychiatrist, and made up of psychiatrists, socio-therapists, clinical psychologists, treatment coordinators and a general practitioner met every two weeks in order to discuss the issue. The request for forced medication was made by the treating psychiatrist and minutes of the meetings are taken including the decisions taken indicating the medication(s) approved and the doses and a brief summary.

The delegation reviewed the minutes of the meetings over the preceding six months. At any one time, between 20 and 25 patients at the FPC Dr van Mesdag were receiving forced medication (i.e. roughly 10% of the patients) and this proportion remained stable. No requests by psychiatrists were refused, although on a number of occasions, the special committee reviewed one or two cases and held over the decision until the following meeting. The medications concerned were almost all anti-psychotic. Eight of the patients concerned received forced medication in the form of a long-acting injection ("depot" or "retard" injections). Most of the forced medication had been administered over a long period[48].

The CPT considers the procedure followed as regards forced treatment at the FPC Dr van Mesdag to be an appropriate way to tackle a difficult problem. However, it is hoped that patients come to accept their treatment as their condition improves. Therefore, continuous forced medication for more than a year should be subject to a further review by an independent psychiatrist from outside the institution. **The CPT recommends that appropriate measures be taken in this regard.**

108. The delegation was informed that libido-suppressant medication was prescribed to some ten patients and that this treatment could only be applied with the consent of the patient concerned (i.e. no such treatment was discussed during the meetings of the special committee described above). However, such consent was only given orally. Furthermore, some of the patients met by the delegation expressed their dissatisfaction with the fact that, although they decided to take such medication, sometimes for lengthy periods, they were not offered any of the benefits promised during the initial interview with their psychiatrist. **If such a libido-suppressant treatment is proposed, the terms of the "therapeutic contract" agreed upon by the psychiatrist and the patient should be recorded in writing and signed by the patient concerned and kept in the patient's file.**

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48 The length of forced medication, without interruption, was: more than 5 years: 2 patients; from 4 to 5 years: 3; from 3 to 4 years: 3; from 2 to 3 years: 6; from 1 to 2 years: 1; from 6 to 12 months: 5; from 3 to 6 months: 2; less than 3 months: 1.

4. The "long stay" wards for TBS patients of the Pompe Institute in Zeeland

a. introduction

109. The concept of "long stay" wards for TBS patients dates back to April 1999, when a new type of facility was introduced at the FPC Veldzicht in Balkbrug. The "long stay" wards were developed as a highly secured residential facility for TBS patients who are considered permanently dangerous, as their mental state does not show substantial improvement despite many years of treatment. It is expected that such patients will stay in a maximum-security environment for many years and, for some, for the rest of their lives. As a rule, intensive psychiatric care is no longer provided to such patients.[49]

The aims of the "long stay" wards are three-fold: to protect society from the risk of criminal offences by these patients; to provide care for the patients in order to optimise their quality of life and minimise the risk of re-offending; to provide care at a lower cost than a regular treatment unit[50]. Four criteria are used for the selection of "long stay" patients': during the TBS measure, the patient has been treated in a TBS establishment for at least six years; the treatment took place in at least two different FPC's; the treatment did not result in a substantial decrease of the risk of committing a serious offence; the patient cannot be admitted to a less secure environment.

110. About 180 patients out of the total number of 1800 TBS patients in the Netherlands fall under the category "long stay TBS" (currently called "Long-Term Forensic Psychiatric Care"). As already indicated, the primary aim for them is not resocialisation or social rehabilitation, but long-term care in order to stabilise their condition and optimise their quality of life. In other terms, preparation for independent living is not the primary goal. However, the delegation was informed that resocialisation is not totally excluded as an option. Indeed, a multidisciplinary review carried out every year enables some 10 % of the patients to move back to "regular" TBS establishments (or even to a "normal" psychiatric establishment)[51].

111. As already indicated, there are currently two establishments in the Netherlands with "certified" long stay wards. The first one is the Pompe Institute, with two different sites (the unit in Zeeland, with an official capacity of 88 places, and another unit in the PI Vught, with 48 places). The second one is the FPC Veldzicht in Balkbrug (with an official capacity of 60 places). The unit in Zeeland opened in 2006. It is a former youth detention centre, situated in the countryside near the village of the same name. The unit is situated in spacious grounds, with a small farm, gardens and recreational areas. The premises are surrounded by two electrified fences.

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49 The majority of patients had a negative attitude towards the idea of "therapy", having had the experience of repeated relapses and failures during their extended stay in TBS.

50 The current yearly budget per patient at the FPC is around 100000 EUR (including the renting and the maintenance of the facilities, and staff salaries).

51 Such a transfer to the mainstream mental health system is particularly difficult to obtain, given the importance of the "TBS stigma".

The Zeeland unit accommodates only male patients. Their main psychiatric diagnoses are personality disorders (some 50 %) and schizophrenia (some 30 %); other diagnoses include attention deficit, paraphilia (associated with sexual offences), mild or moderate mental handicap. 70% of the patients have double or multiple diagnoses and about 15% receive medication for epilepsy. The upper floor of the building accommodates psychotic patients, whilst the four units on the lower floor (the ground floor) accommodate mostly patients with diagnoses of a non-psychotic nature (i.e. personality disorders with or without an additional diagnosis).

112. Risk management is a concept of crucial importance in the establishment. However, the staff considers that it is not enough to "detain" the patient; efforts should be made to try to change the patient's behaviour and attitudes, ways of thinking and acting. Safety is clearly a priority: safety of the public in the first place, but also the safety of the patients held in the institution. The notion of "treatment" is replaced by the notion of "care" and that of "therapeutic activities" by "conversation" or "work". The emphasis is placed on "individual care plans" rather than group treatment.

b. patients' living conditions

113. The material conditions for the patients accommodated in the institution are very good. The new residential two-storey building (squared shape around a large patio) offers sufficient space for the 88 patients held in the establishment. Patients are accommodated in individual rooms, measuring 12m². All rooms have good access to natural light, are well ventilated and equipped (including screened sanitary facilities) and have a small balcony. Each patient also has a mailbox in front of his cell and his own room key. In addition to the communal areas in each unit (equipped with a small kitchen), there is a separate facility for recreational activities in the patio. Well-equipped workshops (such as a bicycle repair shop) are located in a separate building at some distance from the residential compound. Recreational rooms are also available (such as a music room with many instruments, a library, etc.). There are also well-organised agricultural areas, as well as a farm with domestic animals and outside areas for recreational/sports activities.

114. Patients' daily lives are organised in groups, but they can separate themselves from the group if they so wish (for example, about 1/3 of patients prefer to eat in their own rooms rather than communally). The regime is described as: "slow tempo, undemanding, no pressure and respect of refusals to participate actively". As regards the daily regime, the patients are allowed to move freely within the compound during the day (see also paragraph 113).

c. "care" and staff

115. Long term forensic psychiatric care was provided in the form of medication. In this regard, the delegation noted that a choice of medication (including psychotropic drugs of the latest generation) was available. No signs of overmedication were observed or otherwise identified in the medical files. The delegation also noted that four patients had undergone a libido-suppressant treatment at the time of the visit. The recommendation in paragraph 108 applies accordingly.

Apart from pharmacotherapy, efforts are made to respond to the needs expressed by the patients themselves. The overriding principle in terms of care is not to put the patients under pressure, while trying to offer them a good quality of life. In this context, it should be noted that some 80% of the patients participated in working activities within the institution (usually for 12 to 20 hours a week, but some patients were working up to 36 hours a week).

116. A committee of independent experts evaluates patients every two years. In addition, a multidisciplinary team carries out internal evaluations at least once a year.

A global review of the status of all "long stay" TBS patients was also underway at the national level at the time of the visit. Every patient has to be evaluated by two independent experts from the National Institute of Forensic Psychiatry (the Pieter Baan Centrum). The experts interviewed every patient, had access to the patients' files and received a report and recommendations from the TBS clinics. Recommendations for a possible re-classification are made to a Ministry Committee, which makes the final decision. The patient can appeal this decision. The declared expectation is that about 50% of current long stay patients will be re-classified. **The CPT would like to receive a copy of the results of this review (number of the patients concerned, with details of the decisions taken: proposed return to normal TBS regime, confirmation of "long stay" status, etc.).**

117. As regards staff, two (occasionally three) members of staff (usually socio-therapists) are present during the day within each living unit (of eleven patients each). At night (from 10.15 pm to 08.00 am), patients are locked in their rooms with four members of staff present in the institution. In the case of emergency (day or night), a member of staff calls the Security Team attached to a prison nearby.

118. The institution has a total of 70 FTE posts. The "first line" staff consists of four multidisciplinary teams (one for two living units or 22 patients). Each team consists, at least in principle, of a treatment co-ordinator (a psychologist), a care manager (a nurse), several socio-therapists and an occupational therapist. A total of around sixty posts of trained socio-therapists are filled, as well as five posts of treatment co-ordinators (including two on training), four posts of care managers, three posts of occupational therapists and three posts of social workers. The above-mentioned staffing levels for the categories of staff concerned can be considered as just about sufficient to care for the number of patients held in the establishment.

119. However, the CPT is very concerned by the limited time of presence of psychiatrist(s) in the institution. Reportedly, one part-time psychiatrist (0,2 FTE) visits the institution every week. For the rest, psychiatric care (for some 20 hours a week) is provided by a medical doctor (i.e. not a psychiatrist) "with many years of psychiatric experience" who works in a nearby psychiatric hospital. An establishment with about 90 TBS patients - many of whom are severe psychotics - should benefit from at least one FTE post of fully trained psychiatrist. **The CPT recommends that immediate steps be taken to ensure the equivalent of one FTE post of fully trained psychiatrist at the "long stay" wards of the Pompe Institute in Zeeland.**

d. means of restraint

120. As in other psychiatric settings, segregation (called "afzondering" or "room programme") and isolation ("separatie") measures are used in case of incidents or at the patient's request. Such measures are decided by the doctor (either after carrying out an assessment or retroactively, after an emergency segregation or isolation measure has been taken by staff).

121. There were two isolation sections, one on either side of the residential building, with two cells each. Each isolation section has its own bathroom (equipped with a bathtub and a sink), an anteroom where the patient changes clothes and takes his meals, and an adjacent (small) exercise yard. The isolation cells are of standard size (some 12m²) and design (concrete platform with a mattress, stainless steel toilet, intercom, CCTV camera). Ventilation and artificial lighting are both adequate; however, **there is only limited access to natural light (through a semi-transparent glass).**

Patients in isolation are directly monitored by staff through the hatch of the cell door, every two hours (in addition to CCTV). A daily programme is visible on the cell door; reference is made in particular to the visit time by the staff, the meals, and the outdoor exercise period (at least one hour per day). The CPT was pleased to note, as was the case in the FPC Dr van Mesdag, an important decrease in the use of isolation measures in recent years (see paragraph 104).

e. contact with the outside world

122. About 50 % of the "long stay" TBS patients occasionally go out for supervised leave. At the outset, it is made clear to the patient that this has a humanitarian aim and is not considered as therapeutic or preparing for release. Two staff members accompany the patient and such leave is usually granted for 1 to 2 hours (and never exceeds 9 hours). As a principle, such patients are not granted unsupervised leave or "transmural" stay (overnight leave). Consequently, most of the contacts with the outside world take the form of visits from families and friends, phone calls or an exchange of letters. Visits take place in the little patio or in the patient's room.

f. the TBS "long stay" wards concept

123. One of the fundamental principles of the TBS system is the foreseeable resocialisation of persons who committed a criminal act (see Article 2, paragraph 1, of the TBS Act). The main idea is that a therapeutic process should be offered to such persons, in a secure environment, leading, step by step, to a return to the community. The "long stay" TBS model deviates from this precept, as the therapeutic goal of resocialisation is explicitly abandoned. The aim is to provide TBS patients with a secure and humane environment and the best quality of life possible within a closed setting. In other terms, the goal has become humanitarian rather than therapeutic. Such an option reflects the current realities of the TBS process in general, which has become restricted. The TBS system is indeed suffering from multiple bottlenecks (notably as regards the granting of leave and maintaining a momentum towards resocialisation). There is also a clear tendency to overreact to relatively minor incidents; in this regard, it should be stressed that it is self-defeating to adopt a "zero tolerance" attitude to non-compliant behaviour in the early steps towards resocialisation. The above-mentioned bottlenecks are further compounded by staff shortages and the progressive growth of "TBS stigma" both within the psychiatric care system and outside. Therefore, the situation observed in the "long stay" wards in Zeeland is only the consequence of an upstream, systemic, failure.

124. A similar conclusion was drawn by the RSJ[52] in its report "Longstay" (opinion dated 1 February 2008)[53]. In this report, the RSJ highlighted a series of serious deficiencies of a qualitative and quantitative nature stating that the "longstay management had come to a cross-roads" and that radical measures had to be taken. The RSJ stressed in particular the need for adequate "treatment" of TBS patients on "long stay" units, as well as the risk of applying a "lower cost policy" to such units. Two possible ways of solving the problems were mentioned by the RSJ: to reinforce the protection of the rights of the patient (mostly during the admission and prolongation procedures) and/or to look for a better integration and de-institutionalisation of TBS patients. An urgent appeal was made for a new policy and management of the TBS system.

125. On 17 February 2011, the State Secretary for Security and Justice wrote a letter to Parliament[54], describing the future policy of the government concerning the TBS system. This policy will introduce a "further tightening of the TBS policy", in particular: the possibility for experts and judges to access past psychiatric data from persons who refuse to cooperate in observation examinations at the Pieter Baan Centrum; a shorter period of treatment in TBS clinics, followed by a the transfer to a suitable and cheaper facility; a greater austerity at "long stay" wards; a prohibition of supervised leaves for TBS-convicted persons with an average or high security risk; the power to issue a TBS order for the State Secretary to be expanded; an independent review of the status of the TBS patient to be carried out every three years (instead of every two years); the instauration of a life-long supervision of TBS-convicted persons for patients convicted for a sex crime (currently limited to nine years). If implemented, such a policy may, for some patients at least, lead to a situation akin to inhuman treatment. **The CPT would like to receive the comments of the Dutch authorities on this matter.**

5. The Forensic Psychiatric Department for mentally disabled patients in Oostrum

a. introduction

126. In addition to its visits to two TBS establishments, the delegation carried out a brief visit to the Forensic Psychiatric Department "de Knooppunt" in Oostrum, an establishment that provides an alternative to prison custodial sentences for mentally impaired patients. "De Knooppunt" is located in the countryside, in the vicinity of a TBS Clinic ("de Roze Wissel"). This brand new purpose-built facility, inaugurated on 1 April 2011, has an official capacity of 28 beds. At the time of the visit, it accommodated 26 patients (both men and women); 24 of them were so-called "criminal court" patients, while the two remaining ones were admitted under the "AWBK" legislation[55]. The FPD "de Knooppunt" is part of a bigger private company ("Dichterbij") that provides treatment and care, at the regional level, for some 4500 patients.

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52 RSJ = *Raad voor Strafrechtstoepassing en Jeugdbescherming.*

53 Reference should also be made to a previous study, "De longstay afdeling van Veldzicht" – Een evaluatie", Wetenschappelijk Onderzoek-en Documentatiecentrum, Ministerie van Veiligheid en Justitie, 2003.

54 "Tenuitvoerlegging van de TBS-maatregel", Brief van de Staats Secretaris van Veiligheid en Justitie aan de Tweede Kamer der Staten-Generaal, N° 138, 29 452.

55 "Algemene Wet Bijzondere Kosten" of 1967 (or "Exceptional Health Expenses Scheme").

127. The vast majority of the patients were placed in "de Knooppunt" following criminal proceedings. However, the criminal detention measure, which is usually for one year, can be prolonged, if necessary, by a civil placement measure. The commonest offences committed by patients before their admission were theft, arson, and minor sexual offences (such as exhibitionism). 60 to 70% of the patients have an associated problem of alcohol or drug abuse. Many patients have also co-morbidity factors, with associated psychotic symptoms. It should be noted that although the FPD was intended for patients with IQs in the range from 70 to 85, at least three patients have an IQ in the range from 50 to 70.

128. The first eleven patients were admitted on 1 April 2011. After this first intake, most of the patients have been admitted to "de Knooppunt" immediately after their criminal court hearing. The delegation was also informed that there already was a waiting list of four patients, all of them held in Psychiatric Penitentiary Centres (PPC) in remand prisons. In this context, the Director of the FPD made clear that in his view, many mentally disabled persons are not detected during the criminal procedure and are sent to prison. Consequently, in his view, there was an enormous potential demand for this kind of institution in the Netherlands.

129. The delegation was informed that one patient in the FPD would have to go to prison after completing his treatment. Such a transfer appears to be in contradiction to the principle that the FPD is an alternative to a custodial prison measure. **The CPT would like to receive the comments of the Dutch authorities on this issue.**

130. The selection of possible candidates for a transfer to "de Knooppunt" is carried out by the National Institution of Forensic Psychiatry and Psychology (NIFP), in close co-operation with the management and the psychiatrist of the FPD. In this regard, it should be noted that all patients' costs are financed by the Ministry of Justice (except for those patients placed under the "AWBK" legislation). The amount of financing is linked to the type and level of care provided to every patient (which is graduated from type "1" to "7"). Most of the patients have guardians.

b. patients' living conditions

131. The patients' living conditions at the FPD are among the best ever seen by the CPT in a mental health institution; they can be considered as providing a model therapeutic environment. The patients, male and female, are accommodated in an "L" shaped building that offers excellent material conditions. Both sides of the "L" are each subdivided into two smaller living units, each accommodating 6 patients at the time of the visit[56]. The patient's rooms were equipped with all the necessary furniture, the in-cell sanitary facilities were impeccably clean, and the ventilation and access to natural light adequate. Moreover, the patients each had their own badge to open the door of their rooms. To leave their room, they had to press a button on the wall next to the door. The doors of the residents' rooms have hatches that can be opened from the corridor. Furthermore, the whole building has many glass walls that provide very pleasant view of the surroundings.

[56] No differentiation is made between the four units regarding the patients' diagnoses, the level of disability or the regime, or the living conditions. The maximum capacity of each unit was seven beds.

In addition to the four living units and the adjacent communal areas, the FPD has at its disposal a "therapeutic building", specially designed for occupational and vocational activities. This building is equipped with state of the art equipment, providing for an extensive range of workshops, recreation and sports activities (such as music therapy, bicycle repair, carpentry, theatre, fitness, bakery, drawing/art therapy, etc.). This "therapeutic building" is open from Mondays to Fridays (except on public holidays). Specialised staff is available for all of these activities.

c. treatment and staff

132. Each patient at the FPD has an individual treatment plan, drawn up after a two-week initial assessment period. The plans are discussed with "Reclassering Nederland", the Rehabilitation Agency (RAMJ), and reviewed each month. It should be noted that patients participate in the definition of their plan. Two members of the socio-pedagogic staff follow each patient and the evolution of his/her treatment plan.

The FPD's staff had been in post since 1 March 2011 and several induction courses were organised before the arrival of the first patients, one month later. The FPD's Director has undergone training in behavioural psychology. He is supported by a visiting psychiatrist (0.7 FTE) and two behavioural psychologists (1.8 FTE)[57]. The daily activities are organised by a team of socio-pedagogical staff working in shifts. The (two) day shifts consist of 2 or 3 persons per unit, thereby enabling a close monitoring of all patients. There is an overlap between shifts, to ensure an adequate transmission of information and duties. At night time, four socio-pedagogical staff are present in the facilities. **The CPT would like to receive confirmation that the second post of behavioural psychologist has now been filled.**

133. As already indicated, some 50 % of the patients suffer from co-morbid psychotic psychiatric disorders. About 40 % of them regularly receive neuroleptics; however, the treatment is on a voluntary basis[58]. The visiting psychiatrist follows these patients in particular and reviews their medication on a regular basis, together with the behavioural psychologist(s), and is kept informed about the progress made in their resocialisation activities. As regards somatic care, a GP visits the FPD once a week, and also a dentist. In case of need, the FPD can rely on the medical services of the neighbouring TBS Clinic.

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57 One post was vacant at the time of the visit, but a selection/recruitment procedure was underway.

58 One case of forced medication has been reported to the delegation since the opening of the FPD. The opinion of an independent psychiatrist was sought and his agreement obtained before the forced medication measure was implemented.

d. means of restraint

134. A patient presenting difficult/dangerous behaviour is first spoken to ("verbal control technique") by staff. If this does not succeed, he/she is sent to his/her room by the socio-pedagogical staff to "cool down" ("afzondering" or segregation). However, the door is not locked, unless the situation escalates further. In any case, such a patient is still allowed outdoor exercise every day, for at least one hour. The patient concerned is then progressively allowed to (re)join the group for meals and to go to the communal area. In the most serious cases, a patient can be subjected to an isolation measure ("separatie"). This measure can only be taken by senior members of staff (director, psychiatrist or behavioural psychologist). The isolation order is valid for 24 hours and can be renewed. It should be noted that the local municipal authority (the "Burgemeester") has to be informed of any isolation measure taken at the FPD. Six such measures had been taken since the opening of the institution, for periods of usually two to three days. The psychiatrist informed the delegation that such a measure was particularly difficult - if not impossible - to implement as regards patients with low IQs (50 or lower).

135. No centralised register of segregation/isolation measures was kept at the time of the visit at the FPD. However, relevant information was found in patients' individual files and the unit's logbook. Moreover, a special form was filled in and sent to the RAMJ in every isolation case. The CPT considers that a specific register should be established at the FPD to record all instances of recourse to means of restraint and, in particular, to segregation and isolation measures. The entries in the register should include the time at which the measure began and ended; the circumstances of the case; the reasons for resorting to the measure; the name of the senior member of staff who ordered or approved it; and an account of any injuries sustained by patients or staff. Patients should be entitled to attach comments to the register, and should be informed of this; at their request, they should receive a copy of the full entry. Furthermore, a comprehensive, carefully developed, policy on the use of means of restraint should be developed. The involvement and support of both staff and management in elaborating the policy is essential. **The CPT recommends that measures be taken in order to implement the above-mentioned requirements at the FPD.**

136. Both wings of the FPD have an isolation section, consisting of an isolation cell (15 m²), connected with an anteroom and a separate exercise yard. The cell was equipped with a mattress (on the floor), a stainless steel toilet and a CCTV camera. It had sufficient access to natural light and adequate artificial lighting and ventilation. The anteroom contained a table, a chair, a washbasin and a shower. Secluded patients' had their meals in this room. The small exercise area (13 m²) was covered with a metal grille. The delegation was informed that patients in isolation are seen every 30 minutes by the staff on duty. In the CPT's view, **the isolation cells at the FPD are very oppressive and should not be used vis-à-vis patients with low IQs (50 or lower).** Furthermore, **they should be equipped with a bed, a table and a chair, if necessary fixed to the floor.**

137. One female patient alleged that, in order to pass a security check prior to her placement in the isolation cell, she had to undress in front of male staff in the anteroom. The CPT wishes to emphasise that patients should only be searched by staff of the same sex and that any search which requires a patient to undress should be conducted out of the sight of staff of the opposite sex. **The CPT recommends that the necessary steps be taken at the FPD to meet these requirements.**

APPENDIX I

LIST OF THE CPT'S RECOMMENDATIONS, COMMENTS AND REQUESTS FOR INFORMATION

Co-operation

comments

- the CPT trusts that the Dutch authorities will take appropriate steps to ensure that, in future, visiting delegations enjoy access without delay to all places of deprivation of liberty, and that visiting delegations are provided with full information on all such places (paragraph 6);

- the CPT trusts that the Dutch authorities will take appropriate steps to ensure that, in future, visiting delegations enjoy unconditional access 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 (paragraph 7).

National Preventive Mechanism (NPM)

comments

- care should be taken to ensure that all elements of the NPM's structure and all the personnel concerned comply with the requirements laid down by the OPCAT and the Guidelines established by the United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) (paragraph 9).

Law enforcement agencies

Preliminary remarks

comments

- the CPT trusts that the positive trend observed as regards the length of stay of persons in police detention facilities will be maintained. In addition, the CPT invites the Dutch authorities to consider revoking Articles 15a of the Penitentiary Principles Act and 16a of the Juvenile Detention Principles Act (paragraph 13).

requests for information

- updated information concerning the reorganisation of the Dutch police forces and, in particular, on any changes that might affect deprivation of liberty by the police (legal framework, police holding facilities and detention units, monitoring bodies entrusted with visiting detention facilities, etc.) (paragraph 11).

Safeguards against ill-treatment

recommendations

- to amend Article 62 of the Code of Criminal Procedure in order to circumscribe more precisely the possibility to delay the exercise of a detained person's right to notify his/her deprivation of liberty to a third party and to set a time-limit on the application of such a measure (paragraph 15);

- to remove the restriction excluding persons suspected of "C category offences" from legal assistance paid by the Legal Aid Board (paragraph 18);

- to remind all police officers of the purpose and content of Article 32 (2) of the Police Guidelines relating to access to a doctor of one's own choice (paragraph 20).

comments

- the CPT trusts that further steps will be taken to ensure the full recognition of the right of access to a lawyer for all detained persons as from the outset of their deprivation of liberty. In addition to the right to talk to the lawyer in private, the person concerned should also, in principle, be entitled to have a lawyer present during any interrogation conducted by the police. Naturally, this should not prevent the police from beginning to question a detained person in those exceptional cases where urgent questioning is necessary, even in the absence of a lawyer (who may not be immediately available), nor rule out the replacement of a lawyer who impedes the proper conduct of an interrogation (paragraph 17).

requests for information

- for the years 2010-2011, the number of cases in which Article 62 (2) b was invoked vis-à-vis criminal suspects (paragraph 15).

Conditions of detention

recommendations

- to take steps to ensure that cells at Apeldoorn Police Station respect Article 6 (1) of the Regulation on police cell complexes (paragraph 22);

- to strictly limit the use of the cubicles described in paragraph 23 to very brief waiting periods, either immediately prior to the questioning of the suspect or immediately before his transfer to a suitable detention facility. The total time actually spent in these facilities should never exceed 6 hours. Furthermore, such cubicles should never be used as overnight accommodation (paragraph 23);

- cubicles of the kind described in paragraph 23 to be fitted with secured translucent doors to avoid as much as possible their oppressive effect and enable direct monitoring of the detained persons (paragraph 23).

comments

- the Dutch authorities are invited to establish whether all police cells in the Netherlands comply with Article 6 (1) of the Regulation on police cell complexes and, if necessary, to remedy any shortcomings. Further, this provision should be taken into account when refurbishment or construction of police stations is carried out in the future (paragraph 22).

requests for information

- the progress of the official investigation that was launched concerning a suspected suicide that occurred at the Hague Central Court detention facility the day before the CPT's visit (paragraph 25).

Prison establishments

Preliminary remarks

comments

- lifers and other long-term prisoners should not be systematically segregated from other prisoners (paragraph 28).

requests for information

- the Dutch authorities' comments concerning the implications of the increase in the female prison population for the prison system (capacity of the female detention units, female staff resources, etc.) (paragraph 26);

- updated information on the evolution and implementation of the "Prison system modernisation project" ("MGW") (paragraph 27);

- updated information on the pilot project aimed at placing lifers and other long-term prisoners in special units in the prison system (paragraph 28).

Ill-treatment

recommendations

- to draw the attention of management and staff working in all establishments under the responsibility of the National Agency for Correctional Institutions to the ministerial circular of 9 January 2003 (ref. 5195514/02/DJI) (paragraph 31);

- to take steps to ensure that the principles outlined in paragraph 32 as regards strips searches are applied throughout the prison system in the Netherlands (paragraph 32).

Conditions of detention

recommendations

- to review the programme of activities available to foreign prisoners with "VRIS" status, in particular in respect of education, vocational training, and re-socialization activities, with a view to ensuring that they are not disadvantaged in comparison with the general prison population in the Netherlands (paragraph 36).

requests for information

- measures taken in order to address the complaints made by prisoners about the food provided to them (paragraph 34).

Health care services

recommendations

- to increase the medical staffing level at Veenhuizen penitentiary establishment to two full time equivalent (FTE) posts of medical doctor (paragraph 37).

comments

- medication should preferably be distributed by health-care staff (paragraph 39);

- the Dutch authorities are invited to draw up a list of medication that should in every case be distributed by health-care staff (such as anti-psychotic and anti-retroviral drugs and methadone) (paragraph 39).

Other issues

recommendations

- to equip the disciplinary cells at Arnhem-Zuid Prison with a table, adequate seating for the daytime (i.e. a chair or bench), and a proper bed and bedding at night (paragraph 43);

- to provide proper "outdoor exercise" facilities for prisoners placed in the disciplinary unit at Arnhem-Zuid Prison (paragraph 43).

comments

- the Dutch authorities are invited to remedy the potentially oppressive effect of the frosted glass installed in the windows in disciplinary cells in both prison establishments visited (paragraph 43);

- visits around a table (with no partition) should be the rule and visits with partitions the exception, based on an individual risk assessment (paragraph 45);

- the Dutch authorities are invited to amend Article 37 of the Penitentiary Principles Act to include the CPT in the list of institutions/bodies with which any prisoner might communicate on a confidential basis (paragraph 48).

requests for information

- the measures taken or envisaged to address the issue of "emotional work stress" of staff at Veenhuizen – Esserheem Prison (paragraph 40);

- Dutch authorities' comments on the information received that, in some prison establishments in the Netherlands, there was a tendency to delegate the disciplinary power to lower level management (as opposed to the governor or his deputy themselves), including for the imposition of the most severe disciplinary sanctions, such as solitary confinement in a punishment cell (paragraph 42);

- the comments of the Dutch authorities on the impossibility for prisoners to made cheaper international calls by using pre-paid phone cards (paragraph 47);

- clarification as to whether the Inspectorate for Implementation of Sanctions' mandate covers the investigation of allegations of ill-treatment and issues related to prison disturbances (paragraph 50).

Foreign nationals held under aliens' legislation

Preliminary remarks

recommendations

- the use of means of restraint to be considered on individual grounds and based on the principle of proportionality (paragraph 56).

comments

- applying handcuffs as a matter of routine to immigration detainees whenever they leave their detention facility is disproportionate (paragraph 56).

- the Dutch authorities are invited to examine the possibility of drawing up a distinct set of rules for facilities accommodating foreign nationals detained under aliens' legislation (paragraph 59).

requests for information

- further information about the implementation of the legislation according to which an illegal stay in the Netherlands would be regarded as a misdemeanour and could be punished accordingly, and its foreseeable impact as regard the country's prison population (paragraph 53);

- updated information concerning the legislative proposal pending in Parliament and providing for a maximum time-limit for the administrative detention of aliens (paragraph 54);

- with reference to Article 15 (3) of the EU Return Directive, the review periods of a detention order, either on application of the foreign national concerned or *ex officio*, and of the authority involved (paragraph 54);

- the comments of the Dutch authorities on the practice of re-arresting aliens shortly after they had been released from detention (on the expiry of the 18 month time-limit), if they had not left the country in the meantime (paragraph 54);

- confirmation that the boats which had been used as facilities for holding immigration detainees and the Rotterdam Airport Expulsion Centre visited in 2007 have been taken out of service (paragraph 55);

- the comments of the Dutch authorities on the remarks in paragraph 58 as regards the approach to be followed in cases of hunger (or thirst) strike (paragraph 58).

Rotterdam Airport Detention Centre for foreigners

recommendations

- to avoid, as far as possible, detaining families with children. If, in exceptional circumstances, detention cannot be avoided, its period should not exceed the maximum duration provided by law i.e. 28 days (paragraph 61);

- to review the practice at the Centre of locking up children in their cells, in the light of the remarks in paragraph 63 (paragraph 63);

- to increase the medical staffing level at the Centre to at least 1.5 FTE posts of medical doctors (paragraph 66);

- to review the current practice as regards health-care screening of newly-arrived detainees, in the light of the remarks in paragraph 67 (paragraph 67);

- to take measures to transfer detainees suffering from the most severe forms of psychotic disorders to an appropriate psychiatric facility (paragraph 68);

- to take steps to ensure that foreign nationals receive a written translation, in a language they understand, of the decisions concerning their detention as well as of the modalities and deadlines to appeal against such decisions (paragraph 69);

- to take steps to ensure that foreign nationals detained at the Centre are duly and regularly informed about the status of their case in a language they understand (if necessary, through phone interpretation) (paragraph 71);

- to provide the possibility of unsupervised visits for detainees at the Centre (paragraph 72).

comments

- the Dutch authorities are invited to explore the possibility of offering some education to immigration detainees at the Centre. Emphasis should be placed on the possibility for the detainees concerned to acquire skills that may prepare them for reintegration in their countries of origin upon their return (paragraph 65);

- detainees diagnosed with severe psychiatric disorders but who are in remission should benefit from a special regime of activities conducive to their psychosocial rehabilitation, including more out-of-cell time (paragraph 68).

requests for information

- measures taken in order to address the complaints made by detainees about the food provided to them (paragraph 62).

Deportation of foreign nationals by air

recommendations

- to take the necessary steps to ensure that persons deprived of their liberty are only searched by staff of the same sex and that any search which requires an inmate to undress is conducted out of the sight of custodial staff of the opposite sex (paragraph 78);

- the necessary steps to be taken to ensure that:
  - any foreign national to be deported is given the opportunity to be medically examined prior to the removal operation;
  - all foreign nationals who have been the subject of an abortive deportation operation undergo a medical examination as soon as they are returned to detention (paragraph 80).

comments

- in the interest of transparency, it would be desirable for CITT reports on individual expulsion cases to be made public (paragraph 81).

requests for information

- clarification on the possible use of pepper spray by escort leaders (paragraph 77);

- confirmation that the HIV tests concerning a drug addicted detainee met by the delegation at the Detention and Expulsion Centre Schiphol-Oost have been carried out and information on the follow-up given to the case (paragraph 84).

Mental health institutions

Follow-up visit to the Forensic Psychiatric Centre (FPC) Dr van Mesdag

recommendations

- to take the necessary steps to further develop workshops and other communal therapeutic activities, in parallel with the rising number of patients. This will require both infrastructure development and additional staff resources (paragraph 96);

- to take appropriate measures so that more staff with specific therapeutic skills, in particular psychiatric nurses, treat patients with severe psychiatric disorders in Units Eeems 1 & 2 and Dollard 1 & 2 (paragraph 97);

- to take urgent measures in order to address adequately the situation of ten psychotic patients who had remained in the "instroom" process for more than a year (paragraph 98);

- to pursue vigorously efforts to fill the vacant posts of psychiatrists (paragraph 100);

- the Dutch authorities to train more forensic psychiatrists in the Netherlands (paragraph 100);

- to take measures to ensure an increase in the number of posts for socio-therapists at the FPC (paragraph 101);

- to take steps to ensure that patients who are the subject of an isolation measure are offered outdoor exercise on a daily basis (paragraph 104);

- to review the restraint/immobilisation techniques used vis-à-vis agitated patients, in the light of the remarks in paragraph 106, and adapt the training of the security team accordingly (paragraph 106);

- to take steps with a view to systematically recording the events, as captured by the CCTV system, whenever an incident occurs in the FPC (paragraph 106);

- to ensure that continuous forced medication for more than a year is the subject of a further review by an independent psychiatrist from outside the institution (paragraph 107).

comments

- the rate of "separatie" for patients in "instroom" units is still rather high and the 22-day isolation measure referred to in paragraph 104 is difficult to justify (paragraph 104);

- if a libido suppressant treatment is proposed, the terms of the "therapeutic contract" agreed upon by the psychiatrist and the patient should be recorded in writing and signed by the patient concerned and kept in the patient's file (paragraph 108).

requests for information

- comments of the Dutch authorities on the remarks in paragraph 99 concerning the application of the principle of "equivalence of care" when assessing the quality of psychiatric care for patients in forensic settings (paragraph 99);

- confirmation that the two cells located on the ground floor of the "old remand prison" have been definitively taken out of service (paragraph 105).

The "long stay" wards for TBS patients of the Pompe Institute in Zeeland

recommendations

- to take immediate steps to ensure the equivalent of one FTE post of fully trained psychiatrist at the "long stay" wards of the Pompe Institute in Zeeland (paragraph 119).

comments

- there is only limited access to natural light (through a semi-transparent glass) in the cells in the two isolation sections (paragraph 121).

requests for information

- a copy of the results of the global review of the status of all "long stay" TBS patients (number of the patients concerned, with details of the decisions taken: proposed return to normal TBS regime, confirmation of "long stay" status, etc.) (paragraph 116);

- the comments of the Dutch authorities on the potential detrimental effect of the envisaged "further tightening of the TBS policy" (paragraph 125).

The Forensic Psychiatric Department (FPD) for mentally disabled patients in Oostrum

recommendations

- to take measures in order to set up a centralised register on the use of means of restraint (including isolation) as well as to develop a policy on such use (paragraph 135);

- to take the necessary steps to ensure that patients are only searched by staff of the same sex and that any search which requires a patient to undress is conducted out of the sight of staff of the opposite sex (paragraph 137).

comments

- the isolation cells at the FPD are very oppressive and should not be used vis-à-vis patients with low IQ's (50 or lower). Furthermore, they should be equipped with a bed, a table and a chair, if necessary, fixed to the floor (paragraph 136).

requests for information

- the comments of the Dutch authorities on the patient referred to in paragraph 129 (paragraph 129);

- confirmation that the second post of behavioural psychologist has now been filled (paragraph 132).

APPENDIX II

LIST OF THE NATIONAL AUTHORITIES, NON-GOVERNMENAL ORGANISATIONS AND OTHER PERSONS MET BY THE CPT'S DELEGATION

A. National authorities

Ministry of Security and Justice

Mr Ivo Willem OPSTELTEN, Minister
Mr Fredrik TEEVEN, State Secretary
Ms E.M. TEN HOORN-BOER, Director General, Directorate of Prevention, Youth and Sanctions
Mr J.T. BOS, Director of the Legislation Department
Mr P. WAGEMAKER, Head of Unit Sanctions and Probation Policy, Department of Sanctions and Prevention
Mr A. BRUSSARD, Sanctions and Prevention Policy Division
Ms M. de GROOT, Judicial Youth Policy Division
Mr N. BULTS, Forensic Care Division
Ms M. JANSSEN, Police expert
Ms A. RAAPHORST, Police expert

Mr Martin KUIJER, Liaison Officer
Ms Joyce DREESSEN, Deputy Liaison Officer

Ministry of the Interior and Kingdom Relations

Mr W. STEVENS, Deputy Director of the Immigration Policy Division
Ms K. BORSBOOM, Repatriation and Departure Service
Mr E. NIJMAN, Special Facilities Division

Ministry of Defence / KMAR

Major J. de BRUYN
Lieutenant Colonel R.J.M. COSTONGS
Mr I.M.L. MAGNEE

Ministry of Health, Welfare and Sport

Mr K. VAN DER BURG, Deputy Director, General Longterm Care
Mr B. VAN DEN BERG, Senior Advisor, International Affairs Department
Ms T. FRAANJE, Psychiatric Hospitals - Compulsory Admissions Act
Ms B. VERHAGE, Long term care
Mr W BRUNENBERG, Long term care
Ms A. VERVAET, Patient’s rights
Mr F. WIERDA, legal officer
Ms M. LIMPENS, closed youth care
Professor CURFS, Chairman Denktank Complexe Zorg

Representatives of the Minister of Immigration, Integration and Asylum

Ms L. MULDER, Director General, Directorate of Migration Policy
Mr P. DIEZ, Deputy Director, Directorate of Migration Policy

National Agency for Correctional Institutions of the Ministry of Security and Justice (DJI)

Mr B. de BOER, Director
Mr J. de JONG, Legal Advisor
Mr E. NIJMAN – Special Facilities Division (aliens detention)
Mr J. GROENEVELD, Prison System Division
Mr G. FORNARO, Juvenile Institutions Division

Prison Inspectorate (IST)

Mr M.P. TUMMERS, Acting Superintendent
Ms A. IJZERMAN, Inspector
Mr J.J. MERKUS, Inspector

Health Care Inspectorate (IGZ)

Ms A.M.M. JONKERS, Programme Director Care for the Elderly
Ms M.A. SCHIPPERS, Programme Director Mental Health

Committee for the Integral Supervision of Return (CITT)

Mr J.S.L. GUALTERIE VAN WEEZEL, Chairman
Mr J. WILZING, Member
Mr N.P. HASPELS, Secretary of the Committee

National Ombudsman

Mr A.F.M. BRENNINKMEIJER, National Ombudsman
Mr F.J.W.M. van DOOREN, Substitute Ombudsman

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

Ms S. JOUSMA, Coordinator – administration of justice
Mr A. VAN BOMMEL, Senior Advisor
Mr L.M. MOERINGS, Chairman – section prison system
Mr J. BRAND, Member – section prison system
Mr P.A.M. MEVIS, Member – section prison system
Mr P.H. VAN DER LAAN, Member – section juveniles

B. Non-governmental Organisations and other persons

Ms Friederycke HAIJER, Chair of the Dutch Section of the International Commission of Jurists (NJCM)
Professor Caroline FORDER, Member of NJCM Working Group on Youth and Family Law
Ms Mieke KUIPERS, Member of NJCM Working Group on Immigration Law
Franka OLUJIC, Secretary of the NJCM

Ms Sabine PARK, Senior Political Affairs Officer, Amnesty International
Ms Annemarie BUSSER, Project Officer Migration, Amnesty International

Mr Maartje BERGER, Legal Expert on Juvenile Justice, Defence for Children

Dr Marjolein VAN VLIET, Vilans
Ms Marjolein HERPS, Vilans

Dr Jan VOSTERS, Johannes Wier Foundation

Mr Frans-Willem VERBAAS, Lawyer, Collet Advocaten Alkmaar