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Report

to the Government 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 2 to 13 May 2016

The Government of the Netherlands has requested the publication of this report.

Strasbourg, 19 January 2017

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Copy of the letter transmitting the CPT's report

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Strasbourg, 25 November 2016

Dear Mr 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 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 2 to 13 May 2016. The report was adopted by the CPT at its 91st meeting, held from 7 to 11 November 2016.

The various recommendations, comments and requests for information formulated by the CPT are highlighted in bold type in the body of the report and the Committee requests the authorities of the Netherlands 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 authorities of the Netherlands to provide, in their response, reactions to the comments and requests for information formulated in this report.

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

Yours sincerely,

Mykola Gnatovskyy
President of the European Committee for the
Prevention of Torture and Inhuman
or Degrading Treatment or Punishment

EXECUTIVE SUMMARY

In the course of the sixth periodic visit to the Netherlands, the CPT reviewed the situation of persons held in police custody and in several prison establishments. Particular attention was also paid to patients held in penitentiary psychiatric centres and, for the first time, a visit was made to two civil psychiatric establishments where patients were deprived of their liberty.

The CPT's delegation received excellent co-operation from the authorities throughout the visit, with the sole exception of Scheveningen Prison, where its work was obstructed by the attitude of the managerial staff.

Law enforcement establishments

Many persons interviewed by the CPT stated explicitly that they had been treated correctly by the police and appreciated their politeness and professionalism. However, a few isolated allegations of unduly tight handcuffing were received.

The CPT attaches particular importance to three safeguards against ill-treatment. As regards access to a lawyer, the CPT welcomes the fact that persons in police custody now have, in principle, the possibility to be assisted by a lawyer prior to questioning by the police. It is, however, critical of the fact that 16 and 17 year old juveniles were not always provided with a lawyer and a trusted adult prior to questioning. As to notification of custody, many persons claimed that their request for a third person to be contacted had been rejected by the police. There were also some problems with access to a doctor being filtered by police officers and medical confidentiality not being respected.

Material conditions in most of the police establishments visited were very good, notably at Houten Police Detention Facility, the biggest police establishment in the country. However, specific improvements should be made in certain police establishments visited regarding artificial lighting at night, access to natural light and the use of CCTV cameras in cells.

Prison establishments

The CPT welcomes the considerable decrease of the prison population in the course of the last decade, a situation almost unique in Europe. As was the case during the 2011 visit, the delegation did not receive a single allegation of physical ill-treatment by staff in the prisons visited, De Schie, Krimpen aan den IJssel and Zuyder Bos. Also, inter-prisoner violence appeared to be limited and dealt with appropriately when detected.

As regards material conditions, the prison buildings visited were well maintained and operated below their maximum capacity, and inmates were, in general, held in individual well-equipped cells. However, many complaints were heard about the pre-packed frozen food provided to inmates at two establishments and the CPT encourages the authorities to follow the model operated at Zuyder Bos Prison where inmates could cook for themselves. The basic regime provided to prisoners was generally good with the possibility of engaging in activities, work and outdoor exercise. Nevertheless, educational programmes and vocational training should be improved. The CPT is also concerned about the impact of the current budget reductions on the regime, notably the closure of prison libraries and the reduction in time of the open door regime.

The delegation gained a very good impression of the Extra Care Provision unit (EZV), present in every Dutch prison, where vulnerable prisoners are provided with appropriate care. As regards the "terrorist" unit in De Schie Prison, placement and risk assessment procedures should be reviewed and the applicable regime improved.

The CPT considers that a fundamental review of the health-care services in prisons should be made, notably by giving a more active role to doctors. Further, the presence of general practitioners in the three establishments visited should be doubled. Improvements could also be made to the medical screening of newly arrived prisoners and to addressing drug-related problems in a less punitive manner. More generally, the CPT invites the Dutch authorities to consider the possibility of bringing prison health-care services under the Ministry of Health.

The CPT welcomes the Dutch authorities' intention to introduce a review mechanism for prisoners sentenced to life imprisonment, and it recommends that necessary legislative and administrative measures be taken rapidly to provide these persons with both a prospect of release and a possibility of review, based on objective criteria, after a defined time period. As regards discipline, the Committee considers that the current procedures do not comply with due process requirements, and should be reviewed, including the role of health-care staff.

Penitentiary Psychiatric Centres (PPC)

The CPT emphasises at the outset that its general assessment of the PPC concept is rather positive, in particular as regards the situation observed by its delegation at Zwolle; PPCs represent a more suitable environment for prisoners suffering from mental disorders than ordinary prisons.

In the two PPCs visited, no allegations of deliberate physical ill-treatment of patients by ward-based staff were received. In this context, it should be noted that the CPT's delegation gained a favourable impression of the attitude of the frontline carers working daily in direct contact with the patients as well as the training provided to them. However, in both establishments, a few patients met by the delegation alleged that they had been ill-treated by members of the special intervention teams (IBT), in some cases prior to their transfer to the PPCs. All members of special intervention teams in the Netherlands should be reminded that no more force than is strictly necessary and proportionate should be used to bring an agitated and/or violent patient or prisoner under control.

Material conditions in both PPCs were in all respects of a very high standard. As regards the regime, the CPT finds it positive that patients in both PPCs could participate in some work, sports, and education, and could associate with other patients in a spacious common room. That being said, in both PPCs visited, patients spent up to 17 hours a day locked in their individual rooms (and those held under an "individual regime" up to 22 hours), without any contact with staff or other patients. In this respect, the PPC regime falls seriously short of the standards of a psychiatric hospital and the CPT recommends that the regime and lock-up times be reviewed.

Due to the problem of cooperation referred to above, at *Scheveningen*, the CPT's delegation could not obtain a complete picture of the establishment. However, on the basis of information received through interviews with staff and patients alike, the CPT formulates several recommendations, including increasing staffing levels of certain categories of staff, widening the range of therapeutic options offered to patients and drawing up comprehensive individual treatment plans for patients. As regards the situation observed at *Zwolle*, psychiatric treatment was generally very good. Patients participated in the drawing up and modification of their treatment plans and a wide range of non-pharmacological treatment was available to them. However, there is a need to review the staffing levels of certain categories of staff. Concerns are also expressed regarding both establishments about a lack of medical examination of patients after they had been subjected to the use of force and, more generally, about an incomplete recording of patients' injuries.

The principal means of restraint used in both establishments visited were seclusion and chemical restraint. Patients were placed in seclusion for relatively short periods of time, ranging from several hours to a few days. However, the CPT expresses concerns about the frequent deployment of

special intervention teams (IBT) in full protective gear in the context of the transfer of patients to seclusion and the routine practices of handcuffing and strip-searching secluded patients; further, inmates should not be required to undress in sight of custodial staff of the opposite sex, which had occurred at Zwolle.

The use of chemical restraint could only be examined by the delegation at Zwolle and particular attention is paid in the report to the use of rapidly acting tranquillisers on the basis of *pro re nata* (PRN) prescriptions. The CPT highlights the associated risks and emphasises that such use should be very exceptional and that any PRN prescription should only be conditional, meaning that a medical doctor must be contacted and must confirm the prescription prior to its use. The Committee also sets out safeguards which should accompany the use of a PRN prescription for rapid tranquillisers and, more generally, the use of any means of restraint.

As regards disciplinary sanctions, the CPT acknowledges the efforts made in both PPCs visited to keep resort to disciplinary solitary confinement to a minimum; however, it expresses general reservations about the use of disciplinary sanctions vis-à-vis psychiatric patients and encourages the authorities to abolish disciplinary sanctions in PPCs.

Civil psychiatric institutions

The CPT's delegation received no allegations, and found no other indications, of ill-treatment of patients by staff at either the Psychiatric centre "Rielerenk" in Deventer or the Kastanjehof building of the "Zon en Schild" Psychiatric Hospital in Amersfoort.

Material conditions were of a very high standard in both establishments. As regards the regime, it is positive that in neither establishment were patients locked in their rooms during the day or at night and instead were free to move about their wards and associate with other patients.

The CPT underlines that the staff met were competent, dedicated and well-trained, and displayed considerable professionalism in their attitude towards patients. That being said, the number of psychiatrists at Kastanjehof should be increased.

Psychiatric treatment provided to patients in both establishments visited was generally of a high quality, with a range of therapeutic activities being offered to the majority of patients. However, at Kastanjehof, the offer of activities to patients who were under a closed ward regime was limited. Moreover, in this establishment, patients were not always involved in the drawing up and subsequent modification of their treatment plan; these shortcomings should be remedied.

As regards the use of means of restraint, the CPT finds it positive that mechanical restraint was not applied in either of the two establishments; if necessary, patients could be subjected to seclusion and/or chemical restraint, which appeared to be used as a last resort and not excessively. However, at Kastanjehof, restraint measures should be recorded in a central register.

As regards recourse to *pro re nata* (PRN) prescriptions of rapidly acting tranquillisers at Kastanjehof, reference is made to the Committee's considerations in respect of the PPCs.

It is a matter of concern for the CPT that in both establishments, police officers (or private security guards) were at times called upon to intervene when very agitated patients could not be controlled by health-care staff. The Committee recommends that this practice be stopped and that appropriate training be provided to nursing staff. Moreover, patients who were involved in a violent episode, most notably in the context of interventions by the police, were not systematically examined for injuries. The CPT emphasises the need for such examinations and for systematic recording of injuries.

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 visit to the Netherlands from 2 to 13 May 2016. It was the Committee's sixth periodic visit to the Netherlands.[1]

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

- James McManus, Head of Delegation
- Dagmar Breznoščáková
- Matthías Halldórsson
- Julia Kozma
- Esther Marogg
- Hans Wolff.

They were supported by 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.

B. Establishments visited

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

Law enforcement establishments

- Alkmaar Police Station (Head Office)
- Amersfoort Police Station
- Baarn Police Station
- Deventer Police Station
- Houten Police Detention Facility
- Zwolle Police Station

- Court House detention facility, Alkmaar

[1] The reports on previous CPT visits to the Netherlands and related Government responses are available on the Committee's website: http://www.cpt.coe.int/en/states/nld.htm.

Prison establishments

- De Schie Prison, Rotterdam
- Krimpen aan den IJssel Prison
- Nieuwersluis Prison, Utrecht (targeted visit on remand prisoners)
- Scheveningen Prison, The Hague (visit to the Penitentiary Psychiatric Centre)
- Zuyder Bos Prison, Heerhugowaard
- Zwolle Prison (visit to the Penitentiary Psychiatric Centre)

Civil psychiatric establishments

- High and Intensive Care Ward of the Psychiatric Centre "Rielerenk", Deventer
- Kastanjehof building of "Zon en Schild" Psychiatric Hospital, Amersfoort.

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

4. In the course of the visit, the CPT's delegation held consultations with Klaas Dijkhoff, State Secretary of Security and Justice, and with senior officials from the Ministry of Security and Justice, as well as from the Ministry of Health, Welfare and Sport.

Further, the CPT's delegation met Reinier van Zutphen, the National Ombudsman. Meetings were also held with representatives of the National Preventive Mechanism and of the Human Rights Institute, as well as non-governmental organisations active in areas of concern to the CPT.

The CPT appreciates the fact that the Dutch authorities decided to invite the National Ombudsman and representatives of the Human Rights Institute to attend the final meeting held in The Hague on 13 May 2016.

A list of the national authorities and organisations met by the delegation is set out in the Appendix to this report.

5. With one serious exception, the co-operation received by the delegation throughout the visit, from both the national authorities and staff at the establishments visited, was excellent. The delegation enjoyed rapid access to all the establishments it wished to visit (including those which had not been notified in advance), was able to interview in private persons deprived of their liberty and was provided with the information it needed to accomplish its task. The CPT would also like to express its appreciation for the assistance provided before and during the visit by the CPT's liaison officer, Martin Kuijer, and his deputy, Clarinda Coert, of the Ministry of Justice and Security.

6. The one exception mentioned above concerned the Penitentiary Psychiatric Centre of Scheveningen Prison where the work of the delegation was obstructed by the attitude of managerial staff. The staff claimed not to be able to provide the delegation with simple information concerning the establishment, such as the average number of annual admissions, number of life sentenced prisoners being held in the establishment at the time of the visit, or information on deaths and other extraordinary events in recent years. The information provided was often inaccurate or vague and requests by the delegation were met with considerable delays. For example, in response to the request made on the first day of the visit, and repeated several times thereafter, to receive information on recent violent incidents and use of force in the establishment (including the date, names of prisoners and staff members involved and action taken), the delegation was presented, two days later, with printouts of a general PowerPoint presentation with aggregated statistical data for 2014 which contained no information whatsoever on the individual incidents.

In addition, on the second day of the visit to that establishment, an interview being carried out in private with a seriously disturbed patient was interrupted by staff, reportedly upon the order of the management of the establishment, and the delegation members had to stop their work for half an hour. This is not only unacceptable from the perspective of the CPT's mandate but such an abrupt interruption of an interview can have negative effects on the patient concerned.

Further, despite efforts made by the delegation, no working solution was found to grant it unconditional access to medical files of patients. This is all the more regrettable since the delegation received allegations of excessive use of force by staff on patients which could not be followed up.

Consequently, despite the intervention of the liaison officer the delegation was placed in a position where it could not effectively carry out the Committee's mandate and was forced to interrupt its visit to the establishment.

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

7. More generally, the issue of unconditional access to medical records of persons deprived of their liberty for members of the CPT's delegations has been the subject of long-standing dialogue between the CPT and the Dutch authorities. As the Dutch authorities are well aware, the prevention of torture and other forms of ill-treatment under an international treaty ratified by the Netherlands must not be subordinated to national legislation. In the past, the Dutch authorities recognised the principle of such access and its importance for the effectiveness of the work of the Committee. In their response to the report on the 2011 visit to the country, the authorities informed the Committee that legislation explicitly confirming the CPT's right of access to personal medical data was pending in the Parliament. It is regrettable to note that, almost five years later, no legislative amendments providing for such access have yet been adopted.

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

D. National preventive mechanism

8. The Netherlands ratified the Optional Protocol to the United Nations Convention against Torture (OPCAT) in September 2010, and in December 2011 it designated four bodies to compose the National Preventive Mechanism.[2]

In addition, four institutions were designated as "Associates": the National Ombudsman, the Commissions of oversight for penitentiary institutions (*CvT*), the Commissions of oversight for police custody (*CTA*) and the Detention Areas Supervisory Commission of the Royal Netherlands Marechaussee. However, this last body has never participated in any NPM activity.

9. The CPT's delegation was informed during its initial meetings that the National Ombudsman had stopped its cooperation with the NPM in 2014 disapproving of its functioning and structure, and raising concerns about the independence of the work carried out. Further, it appeared that the Health Care inspectorate (IGZ) is not taking an active role in monitoring health care in prison. The CPT also notes that the Dutch NPM still does not have a mandate to visit places of deprivation of liberty in the Caribbean part of the Kingdom despite the announced intention of the authorities to analyse this possibility in their reply to the report on the 2014 visit.[3]

More generally, the NPM representatives acknowledged that certain difficulties of communication existed between the different monitoring mechanisms and that there was a lack of joint output and overall vision.

In its recent report on the Netherlands, the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) considered that "proximity of the inspectorates to the ministries, both in their establishment and their functioning, threatens the NPM's credibility." It recommended that "the State party clearly separate the mandate of its inspectorates and the RSJ from that of the NPM or identify segregated NPM functions within these institutions which can be performed completely autonomously, in line with the NPM Guidelines".[4]

The CPT was informed that, following the reply of the Dutch authorities to this report, one of the designated bodies composing the NPM, the RSJ, has subsequently decided to stop its participation in NPM activities.

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

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2 The Inspectorate of Security and Justice, (Inspectorate VenJ), acting as coordinating body; the Health Care Inspectorate, (IGZ); the Inspectorate for Youth Care, (IJZ); and the Council for the Administration of Criminal Justice and Protection of Juveniles, RSJ.

3 CPT/Inf (2015) 28, page 16.

4 Report on the visit made by the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment for the purpose of providing advisory assistance to the national preventive mechanism of the Kingdom of the Netherlands, 16 March 2016, CAT/OP/NLD/R.1

II. FACTS FOUND DURING THE VISIT AND ACTION PROPOSED

A. Law enforcement establishments

1. Preliminary remarks

10. Since 2012, the national police force has been reformed and centralised. It now consists of 10 regional units (there were previously 25 regional forces), the Central Unit and the Police Services Centre.

11. At the time of the visit, the applicable laws regarding the deprivation of liberty by the police were unchanged since the CPT's previous periodic visit in 2011.

Detention by the police of foreign nationals (*vreemdelingenbewaring*) under aliens' legislation can last up to five days.

The Code of Criminal Procedure (CCP) provides that a person can be held in a police station for the purpose of identification (*ophouden voor onderzoek*)[5] for a period of six hours, renewable once.

This deprivation of liberty can be followed by police custody (*inverzekeringstelling*)[6] that can last three days and may, exceptionally, be extended by a further three days.[7]

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

12. The CPT regrets that, despite its previous recommendations, the law still provides for the possibility of holding a person (over 16 years old) on remand in a police cell for up to ten days.[8] The decision to keep a person on remand in a police cell after the expiration of police custody is made by the selection officer (*selectie functionaris*) of the prison service. During the visit, the delegation received confirmation that this possibility was occasionally resorted to. The Committee considers that police facilities, generally, do not offer suitable accommodation for lengthy periods of detention, particularly as concerns juveniles.

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

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5 Article 61 of the CCP.
6 Article 58 of the CCP.
7 The prolongation must be decided by a prosecutor after having heard the person.
8 Article 15a of the Penitentiary Principles Act and Article 16a of the Juvenile Detention Principles Act.

2. Ill-treatment

13. The CPT notes positively that hardly any person interviewed by the visiting delegation who was or who had in the recent past been in police custody complained about ill-treatment by the police. On the contrary, many persons with whom the delegation spoke stated explicitly that they had been treated correctly and respectfully by the police and appreciated their politeness and professionalism.

That said, a few isolated allegations were received of unduly tight handcuffing of persons apprehended by the police. In one case, the delegation could still observe parallel linear-shaped red marks on the wrist which were consistent with the allegations made. **The CPT recommends that police officers be reminded that where it is deemed necessary to handcuff a person at the time of apprehension or during the period of custody, the handcuffs should under no circumstances be excessively tight[9] and should be applied only for as long as is strictly necessary.**

3. Safeguards against ill-treatment

a. introduction

14. The CPT attaches particular importance to three rights for persons deprived of their liberty by the police, namely the right of those concerned to have the fact of their detention notified to a close relative or third party of their choice, the right of access to a lawyer and the right of access to a doctor. The Committee considers that these three rights are fundamental safeguards against the ill-treatment of persons deprived of their liberty, which should apply from the very outset of their deprivation of liberty. In addition, all persons deprived of their liberty should be explicitly informed of these rights as from the very outset of their deprivation of liberty.

b. notification of custody

15. Unlike the situation observed during the 2011 visit, only a few persons interviewed by the delegation confirmed that they had been granted the right to notify a third person of the fact of their detention at the outset of their deprivation of the liberty by the police.[10] On the contrary, many persons (not subjected to the regime of Section 62 (2) of the Code of Criminal Procedure (CCP) (see the next paragraph)) claimed that their request that a third person be contacted had been rejected by the police and that a third person had only been informed after the first interrogation by the police or once the detained person had been remanded in custody and transferred to a prison. Several police officers met by the delegation during the visit confirmed the accuracy of these claims; they stated that no such right applied to adult persons in police custody.[11]

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9 It should be noted that excessively tight handcuffing, as well as causing local lesions, can have serious medical consequences (for example, sometimes causing a severe and/or permanent impairment of the hand(s), such as sensory loss and/or vascular and motor damage).

10 In these cases, the notification was carried out by police officers.

11 In contrast, in the case of juveniles in police custody, the family was notified shortly after apprehension.

These assertions by police officers are all the more surprising given that the right to have a member of the family or household informed of one's detention by the police is explicitly mentioned in an information leaflet which is to be provided to persons in police custody.[12]

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

16. Moreover, despite repeated recommendations by the CPT on the subject, it still remains the case that by virtue of Section 62 (2) of the CCP, the right of notification of custody may be postponed "in the interest of the investigation".

The CPT acknowledges that the right to notify one's deprivation of liberty could be made subject to certain exceptions designed to protect the legitimate interests of the police investigation, provided those exceptions are clearly circumscribed and made subject to appropriate safeguards. In particular, it must be ensured that the reasons for postponing contact with others are in order to protect evidence and not to create hardship and to put pressure on the detained person. In addition, any delay in notification of custody should be recorded in writing with the specific reasons therefor, should require the approval of a senior police officer unconnected with the case at hand or a public prosecutor and should be made subject to an explicit time-limit by the relevant legislation.

However, as noted on several occasions in the past, in the CPT's view, the current criterion "in the interest of the investigation" is too vague. Moreover, the application of such an exception is not subject to an explicit time-limit.

The CPT notes in this context the argument advanced by the Dutch authorities in their response to the report on the CPT's 2011 visit to the country, namely that the information on the deprivation of liberty may be conveyed by the detained person's lawyer (to whom the person concerned may have access from the beginning of his/her detention by the police). The CPT considers, however, that the right of notification of custody is an additional safeguard which cannot be substituted by the right of access to a lawyer (see also paragraph 14).

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

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

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[12] Information sheet "You are suspected of a criminal offence" (*Informatieblad "U wordt verdacht van een strafbaar feit*").

c. access to a lawyer

17. In the report on its 2011 visit, the CPT noted the positive development that all police detainees were entitled to contact a lawyer prior to the first questioning by the police on the substance of the case and to meet him/her in private. However, lawyers were in principle not allowed to attend the police questioning.[13]

At the time of the 2016 visit, the situation had further evolved. Following the decision by the Dutch Supreme Court of 22 December 2015, as of 1 March 2016, lawyers are now allowed to be present during every police questioning.

Indeed, all persons interviewed by the CPT's delegation during the visit confirmed that they had been offered the opportunity to consult a lawyer in private before their questioning by the police and that the lawyer could be present during the questioning. The Committee welcomes this development.

However, several interlocutors indicated to the delegation that the exact role of a lawyer during the questioning was yet to be defined. In particular, it was unclear at the time of the visit whether lawyers were entitled to intervene in the course of the questioning. Moreover, the issue of remuneration of *ex officio* lawyers participating in a questioning was still open. **The CPT would like to be informed by the Dutch authorities whether these issues have now been resolved.**

18. As noted in the 2011 visit report, persons, including juveniles, suspected of "C category offences" (the minor offences under the Criminal Code) were still not entitled to free legal assistance. The CPT must recall in this respect that 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. **The CPT reiterates its recommendation that the restriction on access to free legal aid for persons suspected of "C category offences" be removed.**

19. As regards the specific situation of juveniles in police custody, the delegation could not obtain a clear picture of the current practice concerning their obligatory legal representation.[14] Several police officers met during the visit stated that all juveniles detained by the police must have a lawyer appointed.

However, other police officers indicated that obligatory legal representation of juveniles only applied to those aged 12 to 15 and suspected of having committed a "very serious" or a "serious" criminal offence, as well as to those aged 16 and 17 and suspected of having committed a "very serious" criminal offence. Such arrangements were also described in the specific information leaflet to be given to juveniles in police custody.

Moreover, juveniles were free to choose whether or not they wished a trusted adult person (other than the lawyer) to be present during police questioning.

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13 With the exception of the questioning of a minor or a person suspected of a very serious criminal offence.

14 As opposed to the issue of the right to consult with a lawyer in private before the first questioning by the police and to have the lawyer present during the questioning (see paragraph 17).

As a consequence, in certain situations, juveniles could be questioned by the police in the absence of both a lawyer and a trusted adult person.

20. The CPT considers in this respect that a detained juvenile should never be subjected to police questioning or be requested to make any statement or to sign any document concerning the offence(s) he/she is suspected of having committed without the presence of a lawyer and, in principle, a trusted adult person; the option "does not wish to see a lawyer" should not apply to juveniles. The point of such specific arrangements for juveniles is to protect this vulnerable age group and to provide them with adult support so that they do not have to make decisions with important legal implications on their own. If the onus is placed on the juvenile to request the presence of a lawyer and/or a trusted person, this defeats the object; such a presence should be obligatory (cf. also Section 15 of the Recommendation Rec(2003)20 of the Council of Europe's Committee of Ministers concerning new ways of dealing with juvenile delinquency and the role of juvenile justice[15]).

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

d. access to a doctor

21. As was the case during previous visits, access to a doctor for persons in police custody did not pose a major problem, with one exception (see the following paragraph). Upon a detainee's request, or if considered necessary by police officers, a medical doctor was called to examine the detained person.

22. However, at Deventer Police Station, if a medical examination was requested by the detained person, police officers merely consulted a medical doctor on the phone and dispensed medication themselves, including psychotropic medication. Moreover, some of the medication in stock at the police station, including the aforementioned psychotropic medication, was well beyond its expiry date.

In the CPT's view, a request by a detained person to see a doctor should always be granted; it is not for police officers, nor for any other authority, to filter such requests. Moreover, the CPT considers that it is not within the competence of police officers to dispense prescription medication and dispensing expired medication is a potentially dangerous practice which should be stopped forthwith.

The CPT recommends that the Dutch authorities ensure that these precepts are effectively implemented in practice at Deventer Police Station and, where applicable, also in other police establishments in the Netherlands.

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15 "(…) While being questioned by the police they should, in principle, be accompanied by their parent/legal guardian or other appropriate adult…"

23. Moreover, although the Houten Police Detention Facility was equipped with a medical consultation room, the findings of the CPT's delegation indicate that most medical interviews/examinations took place in the cells, with the cell door open and police officers standing nearby, within earshot.

The CPT considers in this respect that all medical examinations should be conducted out of the hearing and - unless the doctor concerned expressly requests otherwise in a given case - out of the sight of police staff. The presence of police staff during medical examinations of detained persons could discourage a detained person who has been ill-treated from saying so and, more generally, is detrimental to the establishment of a proper doctor-patient relationship. **The CPT recommends that these precepts be effectively implemented in practice at Houten Police Detention Facility.**

24. No improvement was observed by the delegation as regards access to a doctor of one's own choice, guaranteed by Section 32(2) of the Official Instructions for the Police, the Royal Military Constabulary and Special Investigating Officers.[16] Police officers in several of the police establishments visited were unaware of any such right of detained persons. In the CPT's view, allowing detained persons to consult a doctor of their own choice is important regarding continuity of care and can provide an additional safeguard against ill-treatment.[17] **The CPT reiterates its recommendation that police officers be reminded of the right of persons in police custody to be examined by a doctor of their own choice.**

e. information on rights

25. Virtually all persons met by the delegation during the visit who were, or recently had been, in police custody confirmed that they had been informed of their rights by police officers verbally upon apprehension and had been provided with a comprehensive information leaflet shortly after their arrival at a police station. The leaflets were available in a range of languages and a specific version existed for juveniles.

Further, the information gathered during the visit indicates that foreign nationals were provided with the services of an interpreter when necessary.

However, many persons claimed that the verbal information did not include their right to notify a third person of their deprivation of liberty. Reference is made in this context to the remarks and recommendation set out in paragraph 15.

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16 See also the response of the Dutch authorities to the report on the CPT's 2007 visit (doc. CPT/Inf (2009) 7, page 8).

17 It being understood that an examination by a doctor of the detained person's own choice may be carried out at his/her own expense.

4. Conditions of detention

a. police establishments

26. Material conditions in most of the police establishments visited were very good.

The police custody cells seen by the delegation (all single-occupancy) were in a satisfactory state of repair, clean and had sufficient access to ventilation and artificial lighting. They were adequately equipped (a call bell, a bed/sleeping platform with a mattress and freshly laundered sheets and clean blankets, a table and a chair, as well as a toilet and usually a washbasin) and were, with the exception of Alkmaar Police Station, sufficient in size (a minimum of some 6m²) for individual accommodation not exceeding the duration of police custody (i.e. 3 days; see paragraph 11). Most of the cells had some access to natural light through windows fitted with translucent glass bricks.

Police detainees were provided with food at regular intervals and were given the opportunity to take a shower daily. They could also benefit from outdoor exercise (usually twice a day for 30 minutes).

The delegation gained a particularly positive impression of the functioning of the Houten Police Detention Facility, the biggest police establishment in the Netherlands (a capacity of 106 cells), which was built in 2008 as the first step of a project to create several facilities of this kind throughout the country. The delegation was particularly pleased to note that a medical doctor and a pharmacy assistant were on duty or on call at all times and that the facility contained a pharmacy and a medical consultation room, both of which were adequately equipped.

That said, some detained persons interviewed by the delegation complained that artificial lighting in the cells could not be turned off completely at night. **The CPT considers that lights in a cell should be switched on at night only if there is a clear need to do so.**

27. By contrast, the cells at Alkmaar Police Station measured only 5.4 m² and had no access to natural light. The delegation was informed during the visit that a major refurbishment of the detention area was planned. Following the visit, the Dutch authorities confirmed that in the context of the refurbishment, which was scheduled to start in November 2016 and last at least nine months, the cells would be enlarged and provided with access to natural light. In addition, the outdoor exercise area would be equipped with a means of rest. **The CPT welcomes this development.**

28. Some cells at Baarn and Deventer Police Stations were equipped with CCTV cameras which also covered the in-cell toilets**. The CPT considers it essential that when it is deemed necessary to place a detained person under video-surveillance, his/her privacy should be preserved when he/she is using a toilet, for example by pixelating the image of the toilet area.**

29. At Houten Police Detention Facility, the delegation examined vehicles used for the transport of detained persons. All the vehicles were of a similar design, with two compartments for two persons and one compartment for three, located in the back of the vehicles. The compartments were under video-surveillance and were equipped with a call bell and an intercom. However, the delegation observed that the vehicles did not possess seat belts in the compartments for detained persons, which represents a safety hazard. **The CPT recommends that this shortcoming be remedied.**

b. Court House detention facility in Alkmaar

30. The detention facility consisted of 18 cells (two double-occupancy and 16 multiple-occupancy). One of the cells was specially equipped to accommodate claustrophobic persons – the walls separating the cell from an adjacent common area were made of glass, thus providing less of an impression of an enclosed space. All the cells were in a good state of repair, clean and were adequately ventilated and equipped; access to artificial lighting was sufficient (there was no access to natural light). Male and female persons, as well as adults and juveniles, were held separately.

In principle, persons were held in these cells during court working hours and never overnight. The CPT considers that the conditions of detention in the facility were suitable for placement for such periods of time and do not call for particular comments.

Detained persons had ready access to drinking water and a sanitary facility. Food was normally provided by the establishment from which the persons concerned were transferred to the court detention facility. However, complaints were received about the amount of food provided to detained persons coming from police stations, which staff confirmed was an issue. **The CPT invites the Dutch authorities to review this matter.**

B. Prison establishments

1. Preliminary remarks

31. In the course of the last decade, the prison population has considerably decreased in the Netherlands. At the time of the May 2016 visit, there were 8,519 persons being held in Dutch prisons including in the psychiatric penitentiary centres (PPC) compared to 16,230 in 2006.[18] According to interlocutors of the delegation, this decrease was caused in particular by the reduction in the number of crimes committed, changes in penal policies and an increase in resort to probation and other non-custodial alternatives. The CPT wishes to highlight this situation, almost unique in Europe. As a consequence, the Dutch authorities have closed a number of prisons in recent years and most of the individual cells which had been transformed into double-occupancy cells in the early 2000s are now again being used for single accommodation.

To prevent the closure of too many establishments, the Netherlands has rented out prison premises, together with custodial staff, to other European states: Belgium has been renting Tilburg Prison since 2010 to accommodate up to 650 sentenced persons;[19] and Norway has been renting Norgerhaven Prison (located in Veenhuizen) since 2015, an establishment with a capacity of 242 places.

32. According to the Dutch authorities' forecasts, the prison population should continue to decrease in the coming years and a further eight prisons are slated to close in the coming years; the exact list of establishments concerned was not known at the time of the visit (see paragraph 67). The delegation was informed of current and future reductions in the budget of the prison administration (*Dienst Justitiële Inrichtingen*, DJI) which have had, or will have, direct consequences on the applicable regime in detention (see paragraph 43).

33. The delegation visited for the first time Krimpen aan den IJssel and Zuyder Bos (Heerhugowaard) Prisons. It also examined the situation at De Schie Prison (Rotterdam).[20] Additionally, it carried out a targeted visit to Nieuwersluis Prison (Utrecht) to interview newly arrived remand prisoners.

Opened in 1996, **Krimpen aan den IJssel Prison** is one of the largest prisons in the Netherlands. Located in an industrial area next to Rotterdam, the establishment can accommodate 560 remand and sentenced prisoners. At the time of the visit, 390 persons were being held in the prison, half of them on remand.

There were 254 persons held at **De Schie establishment**, part of Rotterdam prison. The building was specially designed to provide an attractive atmosphere with a maximum of natural light. It has a capacity of 298[21] and can accommodate remand and sentenced male prisoners.

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18 Overall, there were 10,635 persons held in establishments under the responsibility of the DJI including persons held under a TBS order ("*terbeschikkingstelling*") and young offenders' centres.

19 The establishment was visited by the CPT in 2011, see CPT/Inf (2012) 19.

20 The establishment was visited in 1992 and 2007, see CPT/Inf (93) 15 and CPT/Inf (2008) 2.

21 The prison has 44 double cells which were all at single occupancy at the time of the visit.

Zuyder Bos Prison is part of Heerhugowaard prison. Opened in 1994, the establishment is situated on the outskirts of Alkmaar. The establishment has 242 places, and was almost at its maximum capacity at the time of the visit, accommodating remand and sentenced persons, notably ten prisoners sentenced to life imprisonment and several others serving long sentences.

The delegation also visited two penitentiary psychiatric centres in Scheveningen and Zwolle Prisons. The findings relating to these institutions are dealt with in section C of the present report.

2. Ill-treatment

34. As was the case during the previous visit, the delegation did not receive a single allegation of physical ill-treatment by staff in any of the establishments visited. On the contrary, relations between prisoners and staff appeared to be generally good, and staff displayed professionalism and engagement in their interaction with prisoners. However, as was the case during the last periodic visit, several inmates complained about strip searches (see paragraph 76).

Inter-prisoner violence appeared to be limited. The delegation received a few allegations of insults, intimidation and on occasion fights among prisoners, notably with regard to use of the telephone booths at Krimpen aan den IJssel Prison exercise yards (see paragraph 70). These incidents were generally dealt with appropriately when detected by staff. The measures taken by the custodial staff in this context consisted notably of increased supervision, the transfer of problematic prisoners to another part of the establishment and/or disciplinary procedures. **The CPT encourages the Dutch authorities to continue their efforts to prevent any form of verbal or physical violence among prisoners.**

3. Conditions of detention

a. material conditions

35. The delegation observed that the prison buildings were well maintained and necessary investments were made in a timely manner in order to prevent the deterioration of the premises. Further, all the establishments visited operated below their maximum capacity which contributed to maintaining suitable material conditions for inmates.

36. Except in exceptional circumstances, all inmates were held in individual cells of at least 10 m² (including the sanitary facilities).[22] The cells were well-equipped, including a bed, table and chairs, shelves, TV, refrigerator and microwave (see paragraph below) and the sanitary facilities were partitioned. They had appropriate access to natural light and good ventilation and artificial lighting. Further, it should be highlighted that inmates at Krimpen aan den IJssel and Zuyder Bos Prisons had a shower in their cells. At De Schie Prison, prisoners had access to a shower every second or third day on average and could benefit from additional access after taking part in sports activities.

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[22] However, several cells in the women's ward at Nieuwersluis Prison had double occupancy, despite there being empty cells available elsewhere in the establishment.

37. As was the case during the previous periodic visit, almost all the inmates at De Schie and Krimpen aan den IJssel Prisons complained about the pre-packed frozen food provided by an external caterer, in respect of both quality and quantity. The delegation witnessed that a large quantity of food remained untouched and was thrown away.

In this context, the approach developed at Zuyder Bos Prison should be welcomed. In this establishment, prisoners had the possibility of choosing between pre-packed frozen meals or cooking for themselves the food provided by the outside caterer, usually collectively. This possibility was welcomed by the inmates as it improved the quality of their meals, stimulated social interaction and enabled them to practise daily life skills. **The CPT encourages the authorities to see this practice as a model to be replicated in other establishments.**

38. All the establishments visited had several yards for outdoor exercise equipped with rain-shelters and benches. They were well-maintained and sufficiently large to practise collective sports; some yards even possessed fitness equipment.

However, a metal container, of some 12 m², placed in an outdoor area at Krimpen aan den IJssel Prison was used as an "exercise yard" for remand prisoners who had to be kept separated from other inmates following a decision of a judge.[23] Access to natural light was limited to a hole in the ceiling of the container and there was no proper means of rest. The CPT considers that this arrangement is not acceptable as it cannot be considered as a suitable area for outdoor exercise. **The Committee recommends that the metal container be taken out of service and all outdoor exercise facilities be sufficiently large to allow prisoners to exert themselves physically (as opposed to pacing around an enclosed space), less oppressive in design (e.g. allowing a horizontal view of the outside) and equipped with means of rest and shelter against inclement weather.**

b. ordinary regime

39. Article 1 of the Regulation on classification, placement and transfer of detainees *(Regeling selectie, plaatsing en overplaatsing van gedetineerden*) provides for a detailed progressive regime of earned privileges to be applied to remand and sentenced prisoners, notably in respect of the number of visits and access to the fitness rooms. Depending on their behaviour, remand and sentenced prisoners are allocated to one of three categories (red, orange and green – prisoners start on category green). They may subsequently be promoted or demoted, by a multidisciplinary board, according to the assessment, made every six weeks, of their behaviour and attitude. The delegation did not receive any complaints regarding the way this progressive regime was implemented.

40. The basic regime provided to prisoners in the establishments visited was generally good. Almost from the moment of their arrival, prisoners could be out of their cell for some eight hours engaged in several activities and provided with access to outdoor exercise (for at least one hour per day).

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[23] None of the prisoners were under this regime at the time of the visit.

41. All prisoners were offered work – a compulsory activity for sentenced persons – and the vast majority worked for some 20 hours per week. A variety of work was offered, some of which led to a professional qualification.[24] While welcoming the possibility to work, almost all inmates met by the delegation complained about the salary they received, often less than one euro per hour. The CPT would like to recall that Rule 26.10 of the European Prison Rules provides that "[i]n all instances there shall be equitable remuneration of the work of prisoners".

Further, the CPT notes that the Government's proposal to make prisoners pay for the cost of their detention[25] was not adopted by Parliament.

The Committee invites the Dutch authorities to ensure an equitable remuneration of the work of prisoners.

42. Prisoners were offered educational and recreational activities (notably basic education, English, driving theory and art). They also had access to dedicated fitness rooms at least once a week, in all the establishments visited. At De Schie Prison, particular attention was paid to offering targeted activities for short-term prisoners. Further, the management of this establishment aimed at improving the socialisation of prisoners from the moment of their arrival.

However, in all the establishments visited, prisoners indicated that the range of activities was limited; this was also observed by the delegation. More educational/vocational programmes could be offered to sentenced prisoners, particularly those serving long sentences. **The CPT recommends that the authorities further improve the educational programmes and vocational training in the establishments visited.**

At Krimpen aan den IJssel Prison, following the decision of the Prison management, seven sentenced prisoners[26] were accommodated in a separate unit which had recently been established, called "the Company". They benefited from improved material conditions (such as a pool table in their corridor), had the possibility to be out of their cell all day long and participated in the organisation of their daily life.

43. In the course of the visit, the delegation was informed that the applicable regime to all prisoners had recently been reduced following budget reductions. One immediate consequence of this reduction was the decrease in the number of hours of open door regime in the evening.[27] Further, a decision had been made to close prison libraries in order to reduce costs. These decisions are regrettable as they limit prisoners' possibilities to interact and to have access to culture. However, the delegation was also informed that the authorities were considering the possibility to introduce tablet computers allowing prisoners to read e-books and to have access to the internet (see also paragraph 69). **The CPT invites the authorities to reconsider the decrease in the number of hours of the open door regime and to keep the prison libraries open.**

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24 Notably as regards metal work and cooking.

25 It was proposed that prisoners would pay €16 a day for a maximum of two years.

26 The management of the establishment aimed to progressively increase the number of inmates in this unit to 30 persons.

27 Inmates had less opportunity to be out of their cell from 5 to 7.30 pm.

44. The CPT welcomes the fact that every prison in the Netherlands has an Extra Care Provision (*Extra Zorgvoorziening* - EZV)[28] unit where vulnerable prisoners or those with particular needs (notably sex offenders or persons with physical and/or mental impairment) are provided with appropriate care including psycho-social support. Prisoners were placed in these units following a decision by the prison director based on the inmates' behaviour or request or upon medical request.

The EZV units were governed by the same rules as the rest of the prison. However, an additional effort was made to create a more homely environment with the presence of plants, additional decoration and on occasion pets. Specific activities were offered to these inmates and efforts were made to limit the time spent in cell. Further, the inmates were gathered in small groups, generally of 12 persons, with a designated supervisor/mentor, from the prison staff, for each inmate. EZV units had a higher staff/prisoners ratio, dedicated and trained custodial staff who worked in cooperation with psychologists and social workers. The delegation gained a very good impression of the way in which these units were managed and the inmates treated; it could serve as a model for other countries.

c. special regimes

45. In the course of its visit to De Schie Prison, the delegation paid particular attention to the "terrorist" unit (*Terrorismeafdeling*) and the unit for detainees posing management problems (*Beheersproblematische Gedetineerden* – BPG). These two units, each composed of seven cells, were located in the same corridor and were under the responsibility of common dedicated custodial staff. Remand and sentenced persons could be held in these units. At the time of the visit, seven persons were detained in the "terrorist" unit and six in the BPG unit.

46. A first "terrorist" unit at Vught Prison was created in September 2006. A second "terrorist" unit opened in mid-January 2007 at De Schie prison. [29] In establishing these units, the authorities wished to prevent proselytism leading towards terrorism in the name of religion.[30]

The Netherlands is one of the European countries where the question of radicalisation in prison has been an issue for prison authorities for several years. This issue was recently addressed by the Council of Europe in its Guidelines for prison and probation services regarding radicalisation and violent extremism.[31]

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28 EZV replaced the "special care unit" (BZA) that previously existed.

29 The CPT made an initial analysis of the "terrorist" units in De Schie and Vught Prisons in the report on its 2007 periodic visit to the Netherlands, CPT/inf (2008) 02, paragraphs 39 to 53.

30 For further elements regarding the history of these units, see CPT/Inf (2008) 02, paragraph 39.

31 Guidelines adopted by Council of Europe Committee of Ministers on 2 March 2016.

47. The procedure for the placement of a prisoner in the unit has not substantially changed since the 2007 visit. Article 20a of the Regulation on classification, placement and transfer of detainees provides that a person charged with, or sentenced for, a terrorist offence, or who is spreading a message of extremism among fellow inmates, may be placed in a "terrorist" unit by order of the selection officer of the prison service. As was the case during the 2007 visit, the placement appeared to be automatic for any person charged or convicted of a terrorist offence. Despite the CPT's previous recommendation, no comprehensive individual risk assessment was carried out before the initial placement.

The placement decision is taken for an initial period of 12 months and may be extended for a further 12 months by decision of the selection officer. The delegation was informed that a sounding board (*klankbordgroep*) composed of representatives of the Prosecutor, the selection officer, the prison administration (national and local) and the Dutch intelligence services, met monthly to discuss the situation of the persons currently in the "terrorist" units. Every six months, the sounding board officially reviewed the case of the persons placed in these units. However, the persons concerned were not informed prior to the meeting, did not have the possibility to be heard (directly or through a representative) and were not notified of the decision taken.

48. The regime in the "terrorist" unit at De Schie Prison was very poor. The seven prisoners were split into two groups, one of five and one of two, the two prisoners having been identified as wishing to distance themselves from the others. They spent 22 hours a day in their cells and were only out of their cell for one hour of exercise (in a large secure dome, open to the elements but with cover and seating available) and a second hour for recreation, both in their respective groups. No work was offered to them. They could attend a "de-radicalisation" programme twice a week. As a result, they spent most of their day watching television and reading various books and newspapers.

49. On 12 August 2016, the State Secretary of Security and Justice informed the Parliament of policy changes regarding the "terrorist" units. According to the State Secretary's letter to the Parliament,[32] the Dutch authorities now use a new method to centralise and exchange information which facilitates risk assessment. According to the authorities, this should also allow them to better identify the most radicalised inmates. A risk assessment is now carried out upon arrival of the inmates in the unit and their regime is adapted to their profile. The Secretary of State also indicated that preventive and de-radicalisation programmes, as well as rehabilitation activities, will be proposed to the inmates concerned.

50. The CPT considers that the risk of indoctrination and radicalisation is not, in principle, any greater in places of deprivation of liberty than in the outside world, as long as detention takes place in decent conditions and constructive and motivating activities enabling prisoners to spend a large part of the day outside their cell are on offer. On the other hand, as stressed by the Council of Europe Guidelines, inadequate detention conditions and overcrowding can be factors exacerbating the risk of radicalisation, as can disproportionate measures, particularly with regard to the use of force or disciplinary sanctions.

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32 The CPT has received a copy of this letter.

This means that addressing radicalisation in prison requires not only well-managed prisons but also adequate resources: sufficient activities, adequate numbers of trained staff and the introduction of dynamic security.[33] Tools should also be developed to enable front-line prison staff to identify any sign of excess on the part of prisoners. If necessary, special programmes involving a multidisciplinary team (social workers, psychologists and possibly religious representatives) should be established for prisoners identified in this manner, as well as for those requesting them.

Finally, in the event that it is envisaged to group prisoners together or treat them differently, there should be an individual analysis based on the behaviour of the prisoner in question and the risks they pose to themselves and to others. The offence for which they have been placed in detention, and specifically their link with a terrorist undertaking, cannot be the sole criterion justifying segregation. Furthermore, their situation should be reviewed on a regular basis in the framework of an adversarial procedure.

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

51. The regime in place at the BPG unit was slightly better than that in the "terrorist" unit, inmates could spend one or two additional hours outside their cells socialising or using a fitness room. However, it remained unsatisfactory that they spent most of their locked up in their cells.

The persons concerned were notified of the initial placement decision in this unit taken by the selection officer. However, they were not informed about or involved in the review process that took place every six weeks. Therefore, **the above recommendations as regards the regime and the placement procedure apply equally to prisoners placed in the BPG unit.**

4. Health-care services

52. In De Schie Prison, the health-care facilities were satisfactory as regards the consultations area. This was not the case in Krimpen aan den IJssel and Zuyder Bos prisons, where health-care staff had to work in cramped conditions, lacking rooms for medical appointments and examinations. Further, none of the three establishments was equipped with an ECG, which is a standard equipment in general health-care facilities.

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

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[33] According to the guidelines, dynamic security should be defined as "a concept and a working method by which staff prioritise the creation and maintenance of everyday communication and interaction with prisoners based on professional ethics. It aims at better understanding prisoners and assessing the risks they may pose as well as ensuring safety, security and good order, contributing to rehabilitation and preparation for release. This concept should be understood within a broader notion of security which also comprises structural, organisational and static security (walls, barriers, locks, lighting and equipment used to restrain prisoners when necessary)".

53. It is of concern that, in all the establishments visited, the isolation rooms for disciplinary sanctions were also used for seclusion for medical reason. In the CPT's view, this practice should be immediately discontinued as these two types of isolation are fundamentally different and should not be confused in the minds of prisoners – or staff. Moreover, it may also undermine the doctor/patient relation and could affect the quality of health care. Other arrangements should be found for prisoners requiring medical or psychiatric care and such persons should be placed in rooms equipped for this purpose.

The CPT recommends that a health-care unit be provided with adequate premises in light of the above remarks, in the three establishments visited and in other prisons in the country if appropriate.

54. As regards medical staff, the presence of specialised doctors for somatic disorders was generally acceptable; dentists visited on a regular basis and appointments with other specialists were organised as required. However, there was only a 0.4 full-time equivalent (FTE) post of psychiatrist at each of the three establishments visited, which was insufficient at Krimpen aan den IJssel Prison considering the number persons held at this prison. Further, the presence of general practitioners was insufficient in the three establishments visited, amounting in each case to a presence of a half-time equivalent post; the delegation received several complaints from inmates regarding delays in access to the doctor. Medical doctors only treated prisoners and did not play a role in ensuring public health monitoring or coordinating the health-care unit. **The Committee recommends that the presence of general practitioners in the establishments visited be doubled and that the presence of a psychiatrist be increased notably at Krimpen aan den IJssel Prison.**

55. The CPT considers that health-care staff should also play a central role in the organisation of health care and interact regularly with prison directors. Prison medical services should also be concerned with mental hygiene, i.e. by preventing the harmful psychological effects of certain aspects of detention. In the absence of a specialised service, it is also the responsibility of medical staff – in conjunction with the competent authorities – to supervise catering arrangements (quality, quantity, preparation and distribution of food) and conditions of hygiene (cleanliness of clothing and bedding; access to running water; sanitary installations) as well as the heating, lighting and ventilation of cells. In addition, work and outdoor exercise arrangements should be taken into consideration. **A fundamental review of health-care services in Dutch prisons in general and the role of health-care staff in particular should be undertaken.**

56. In the prisons visited, there were between four and nine FTE posts of nurses who ensured a presence during the day, five days a week. Emergency services were called, when needed, at night and during the weekend. **The Committee recommends that steps be taken to ensure that a person competent to provide first aid is always present in every prison establishment, including at night and on weekends; preferably, this person should be a qualified nurse.**

57. In the establishments visited, nurses wore prison administration uniforms which did not allow inmates to properly distinguish them from custodial staff. **The CPT recommends that this practice be changed.**

58. Medical screening of the newly arrived inmates was carried out by a nurse, reporting to a doctor usually within 24 hours, if the admission took place during week days. This screening was delayed when the detained persons arrived during the weekend. Screening for tuberculosis was regularly carried out but there was no systematic screening for other infectious diseases, even for high-risk inmates such as drug users. **The CPT recommends that a systematic examination of all prisoners be carried out within 24 hours of their arrival in detention, including voluntary testing for infectious diseases (HIV, hepatitis C, etc.).**

59. According to health-care staff interviewed, traumatic injuries were not properly recorded, if at all, and no systematic transmission to the investigating authorities took place when there were indications of possible ill-treatment, notably fights among prisoners. Further, there was no register of traumatic injuries.

The CPT considers that prison health-care services can make a significant contribution to the prevention of ill-treatment of detained persons, through the systematic recording of injuries and, when appropriate, the provision of information to the relevant authorities.

The Committee recommends that necessary measures be taken to ensure that the record drawn up after the medical screening contains:

i) an account of statements made by the person which are relevant to the medical examination (including his/her description of his/her state of health and any allegations of ill-treatment),

ii) a full account of objective medical findings based on a thorough examination, and

iii) the health-care professional's observations in the light of i) and ii), indicating the consistency between any allegations made and the objective medical findings.

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

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

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

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

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

60. Medical confidentiality during consultations appeared to be respected and medical files were generally well-kept.

Inmates' medication was prepared by external pharmacies and its distribution was carried out by custodial staff who checked that inmates indeed swallowed their prescribed opioids and psychiatric medications. Inmates in the three establishments visited indicated that they had occasionally received the wrong medication, that of their neighbour for example, due to a lack of attention by the custodial staff.

Medication and its dosage were clearly visible to the custodial staff, and sometimes to other inmates. Such a practice could compromise medical confidentiality requirements 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. In any event, a list of medication to be distributed only by health-care staff (such as anti-psychotics, methadone and antiretroviral drugs) should be established.**

61. As regards drug-related problems, the approach of the prison administration was primarily punitive. In each establishment, a few prisoners benefited from a substitution programme. Mandatory drug testing was carried out every six weeks and a disciplinary procedure was systematically opened if the test was positive. Several inmates, who were using drugs in detention, indicated that they were denied the assistance they requested.

The CPT recognises that providing assistance to persons who have drug-related problems is far from being a straightforward matter, particularly in a prison setting; there is no simple or single answer as regards the approach to be followed. However, prevention of drug abuse should be vigorously pursued and should aim at both demand and harm reduction. Admission to prison is an opportunity to address a person's drug-related problem and it is therefore important that suitable assistance is offered to all persons concerned; consequently, appropriate health care must be available in all prisons. The assistance offered to such persons should be varied, detoxification programmes with substitution programmes for drug-dependent patients should be combined with genuine psycho-social and educational programmes for patients with drug related problems who are unable to stop taking drugs. Finally, all health-care staff (and prison staff generally) should be given specific training on drug-related issues.

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

62. Transfers to and treatment in outside hospitals is an issue of concern. The use of restraint during medical transfers or examinations was common, as was the presence of escorting officers during medical examinations or acts, in some cases despite objections from health-care staff. By way of example, prisoners indicated that security staff were present during scanner, x-ray or colonoscopy examinations in the hospital. Intimate examinations carried out in the presence of escorting staff may be humiliating and might amount to degrading treatment.

It is vital for all health-care structures liable to receive prisoners to have an appropriate room designated for this purpose in order to preserve the confidentiality of medical examinations and treatment. Among other things, this room should be secure, i.e. it must be fitted out in such a way as to limit risk of escape. Moreover, the examination or treatment of prisoners subject to coercive measures is a highly questionable practice from both ethical and clinical aspects; the final decision on this point should lie with the health-care staff involved. In this context, sessions to raise awareness of the need to take risks into account and respect confidentiality and dignity should be proposed to both escort staff and doctors and nurses dealing with prisoners in hospital facilities.

The CPT recommends that the Dutch authorities take the necessary steps, including at normative level, to ensure that medical transfers (transport, escort and supervision) of prisoners are geared to the above considerations and recommendations.

63. More generally, in the Netherlands prison health care remains under the responsibility of the Ministry of Security and Justice which ensured the recruitment and payment of health-care staff.

The on-going policy trend in Europe has favoured prison health-care services being placed either to a great extent, or entirely, under Ministry of Health responsibility.[34] In principle, the CPT supports this trend. In particular, it is convinced that a greater participation of health ministries in this area (including as regards recruitment of health-care staff, their in-service training, evaluation of clinical practice, preventive measures regarding public health certification and inspection) will help to ensure optimum health care for prisoners, as well as implementation of the general principle of the equivalence of health care in prison with that in the wider community.

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

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[34] See, for example, Recommendation No R (87) 7 of the Committee of Ministers of the Council of Europe to member States concerning the ethical and organisational aspects of health care in prison.

5. Other issues

a. prisoners sentenced to life imprisonment or to long sentences

64. In the Netherlands, life imprisonment really means imprisonment for the rest of one's life. A person sentenced to life imprisonment can only be released following a King's pardon which may be granted only if there are "changed circumstances", for instance health reasons. The Judicial Information Service reviews all pardon applications. An application may be submitted by the prisoner, his/her lawyer, a probation officer or a family member. The number of persons sentenced to life is rather limited; at the time of the visit, there were 33 persons serving a life sentence in the Netherlands. The delegation met several of them in different establishments.

The CPT has always been very attentive to the situation of life sentenced prisoners. In its latest general report,[35] it clearly indicated that all life-sentenced prisoners should have a review at a pre-determined stage of the sentence, and regularly thereafter, which genuinely offers the possibility of conditional release for those no longer posing a danger to society. This review should be based on individualised sentence-planning objectives defined at the outset of the sentence. The recent decision of the European Court of Human Rights in *Murray v. the Netherlands*[36] takes a similar approach.

65. On 2 June 2016, Klaas Dijkhoff, State Secretary for Security and Justice, addressed a letter to the Dutch Parliament indicating his intention to introduce a review mechanism for life sentences.[37] The minister's plan would mean that criminals serving life sentences would have their detention assessed after 25 years. This assessment will be carried out, in consultation with the victims, by an Advisory Board composed of five independent members (lawyers and psychiatrists/psychologists) after a psychiatric evaluation by the Pieter Baan Centrum (part of the Netherlands Institute for Forensic Psychiatry and Psychology). In the event of a negative decision, the Advisory Board should indicate when the next review would be carried out. The CPT welcomes the establishment of an independent review mechanism.

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

66. During its visit to Zuyder Bos Prison, the delegation met persons who were transferred in June 2015 from a dedicated unit for long sentences and life sentenced prisoners in Norgerhaven Prison (following the closing of this establishment; see paragraph 31). In the latter establishment, they had benefited from an enhanced and open door regime. When transferred to the current establishment, they were promised that they would benefit from a similar regime which did not appear to be the case at the time of the visit. The regime offered to them was relatively ordinary, with no open door regime. **The CPT invites the authorities to improve the situation in light of the above remarks.**

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35 25th General Report on the CPT's Activities, CPT/Inf (2016) 10, paragraphs 67-82.

36 Grand Chamber judgment of 26 April 2016, application no. 10511/10.

37 The CPT has received a copy of this letter.

b. prison staff

67. In all the establishments visited, the number of custodial staff were sufficient for the number of persons held and they appeared to be appropriately trained. However, the recent decrease in the prison administration budget led to a reduction of available staff, an issue of concern for custodial staff but also certain inmates, notably the most vulnerable ones. Several interlocutors feared that the announced further reductions (see paragraph 32) will have a negative impact on the staffing levels which could lead to a decrease in the quality of the work. According to media reports, Zuyder Bos Prison was listed as a possible prison to be closed in the near future, a situation which generated anxiety among staff. **The CPT would like to receive the comments of the Dutch authorities on these issues.**

68. In each establishment visited, there was, on average, one case officer for 30 inmates. Their role was to see newly arrived remand prisoners within 12 days and to deal with urgent welfare matters. They also participated in the grading of prisoners regarding the applicable regime (see paragraph 39) and developed sentence plans with inmates, as well as preparing reports for conditional release or open or semi-open conditions. The delegation received, in the three establishments visited, a large number of complaints regarding the lack of effectiveness of care officers. Several sentenced persons indicated that their possibility to benefit from conditional release was delayed by the lack of reactivity of their case officer. **The CPT would like to receive the comments of the authorities on this matter.**

c. contact with the outside world

69. All the prisoners in the establishments visited had the right to receive visits for at least one hour per week.[38] These visits took place in a large room around a U-shape table with some 12 other inmates; physical contact was allowed, under the supervision of custodial staff. Additionally, sentenced prisoners could be granted, depending on their behaviour, unsupervised visits for up to two hours per month.

The CPT welcomes the fact that a tablet computer with a Voice over Internet Protocol software (such as Skype) was available for some inmates who could use it for 30 minutes per month. This access to modern technology facilitated communication and further helped prisoners, notably those with family members living far away or abroad, to maintain contact. Inmates could also receive a printed copy of e-mails sent to them (via the prison administration's mailbox).

[38] Article 38 of the Penitentiary Principles Act.

70. The law provides that detained persons may make telephone calls for at least 10 minutes a week.[39] In the establishments visited, telephones were placed in the exercise yards or in some corridors, allowing, in theory, inmates to use them for a longer period of time. However, the delegation received a number of complaints that the number of available phones was insufficient to satisfy the needs of all the inmates, particularly at Krimpen aan den IJssel Prison, which generated tensions and on occasion violence (see paragraph 34). Further, numerous complaints were heard about the high price of telephone calls in the three prisons visited, a problem acknowledged by several prison staff with whom the delegation spoke.

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

d. discipline

71. Disciplinary sanctions are imposed by the prison director or his/her deputy after having received a report drafted by a custodial officer. 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 Council for the Administration of Criminal Justice and Protection of Juveniles (RSJ).

The delegation carried out an in-depth analysis of the disciplinary procedure and participated in a couple of disciplinary hearings. As a result, the CPT considers that there is a need for certain procedural amendments to be introduced. Before their hearing, prisoners were not given a detailed charge sheet. They were questioned by the adjudicator within 24 hours of the alleged offence, but not given the opportunity to cross-examine witnesses against them, present witnesses of their own or obtain legal advice or representation. The hearing was mostly formalistic and prisoners had limited possibility to defend themselves, present their arguments or be assisted by a legal representative.

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

72. As regards disciplinary sanctions, Article 51 of the Penitentiary Principles Act (PPA) provides for a list of sanctions, the most severe being solitary confinement in a punishment or other cell for a maximum period of two weeks (see also paragraph 61).

At De Schie and Krimpen aan den IJssel Prisons, disciplinary sanctions appeared to be proportionate and not overused. In the latter establishment, the management had introduced a policy to limit the use of the disciplinary isolation cells to the most severe offences such as violence against staff or other inmates. For other offences, less severe sanctions were used, notably confinement to their own cell without access to a television. At Zuyder Bos Prison, the delegation observed that there had been a high resort to disciplinary procedures in the recent past leading to the placement in disciplinary confinement of 58 inmates in just four months. **The CPT would like to receive the comments of the Dutch authorities on this issue.**

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[39] Article 39 of the PPA.

73. If solitary confinement lasts more than 24 hours, the prison director must inform the prison doctor and the prison supervisory committee of this measure.[40] Prison doctors or other health-care staff have no obligation to regularly visit persons placed in solitary confinement. In practice, inmates in disciplinary solitary confinement received such visits on an irregular basis.

The CPT considers that health-care staff should be very attentive to the situation of prisoners placed under solitary confinement and should visit such prisoners immediately after placement and thereafter at least once per day, and provide them with prompt medical assistance and treatment as required.

The Committee recommends that steps be taken, including at legislative level, to ensure that the role of health-care staff vis-à-vis persons held in solitary confinement is reviewed, in the light of the above remarks. In so doing, regard should be had to the European Prison Rules, in particular, Rule 43.2, and the comments made by the Committee in its 21st General Report.[41]

74. As regards material conditions, isolation cells had sufficient access to natural light and were appropriately ventilated in all the prisons visited. They were equipped with a toilet, a call system and soft foam blocks serving as a bed and table. **The CPT recommends that cells used for disciplinary solitary confinement, in the three establishments visited and in other prisons of the country if appropriate, be equipped with a table and chair, if necessary fixed to the floor, in addition to a proper bed.**

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

e. security related issues

76. Strip searches can be ordered by the prison director when the prisoner enters/leaves the establishment, receives visits or when deemed necessary. They are carried out by custodial staff, if possible staff of the same sex, in a dedicated area.

In all the establishments visited, the inmates required to be strip searched, usually after visits, were obliged to undress totally. The CPT has repeatedly stated that this is a potentially degrading measure and that detained persons who are searched should not be required to remove all their clothes at the same time. The person should be allowed to remove clothing above the waist and then put it back on before removing clothing below the waist. Further, such an intrusive measure should only be carried out in front of custodial staff of the same sex. Regrettably, this was not always the case in the prisons visited. **The Committee recommends that the regulations and the practice applicable to strip searches be changed accordingly.**

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40 Article 55 of the PPA.

41 See CPT/Inf (2011) 28, paragraphs 62 and 63.

77. At De Schie and Krimpen aan den IJssel Prisons, fixation beds with straps used for the immobilisation of agitated prisoners were stored in full view in the isolation area. The delegation was told that they had not been used in the recent past. However, no register of their use existed. **The CPT encourages the Dutch authorities to abandon the resort to fixation beds in prisons.**

78. Each establishment visited had a special intervention team (IBT) composed of custodial staff from the prison that usually intervened in full protective gear (helmets, body armour, shields and truncheons). At De Schie Prison, the delegation gained the impression that the IBT was being overused. The team, in full protective gear, was frequently requested to escort unresisting inmates within the prison or during transfers to the hospital. In the CPT's view, all staff should be trained to cope with these situations and the special intervention team be utilised only for serious situations. **The Committee would like to receive the comments of the authorities on this issue.**

f. complaints procedures and expression of prisoners' views

79. The positive situation in this area has remained unchanged since the 2011 visit. There are several avenues of complaint for prisoners and different specific monitoring bodies exist. In addition to a Complaints Committee for each prison and its supervisory Committee at national level, detained persons can address complaints to the National Ombudsman and the RSJ. Despite the fact that some inmates indicated that the Complaints Committee was not always reactive, it appeared that these different avenues were functioning properly overall.

80. According to Article 50 of the European Prison Rules,[42] prisoners should be allowed and encouraged to express their views on matters relating to their conditions of detention. The CPT supports this approach; any endeavour to promote dialogue between prisoners and the prison management and/or staff can only foster constructive relations and, more broadly, a healthy environment in prisons.

Each establishment visited had a Prisoners' Committee (*Gedeco*) composed of prisoners elected by their peers. The Committee raised the concerns of fellow prisoners and proposed possible improvements to the prison's management. It met weekly and had regular meetings with the prison director, as well as with the shop managers; agendas were prepared in advance and minutes published. The CPT considers it to be a good practice which could be replicated in other countries.

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42 "Subject to the needs of good order, safety and security, prisoners shall be allowed to discuss matters relating to the general conditions of imprisonment and shall be encouraged to communicate with the prison authorities about these matters."

C. Penitentiary psychiatric centres

1. Preliminary remarks

81. In the course of the 2016 visit, the CPT's delegation reviewed, for the first time, the situation of patients held in penitentiary psychiatric centres (PPCs) in the Netherlands. To this end, it visited Scheveningen[43] and Zwolle Prisons. However, due to the problem of cooperation mentioned above (see paragraphs 6 and 7), the delegation was not able to assess fully the functioning of the PPC in Scheveningen.

The first PPCs were established in 2009 as a response to the need to improve the provision of psychiatric care in prisons to the growing number of prisoners with psychiatric conditions and with a view to replacing smaller units which existed in various prisons. PPCs are an integral part of the prison system, accommodating primarily remand and sentenced prisoners who need psychiatric care and whose mental disorder makes it difficult or impossible to manage them under normal prison conditions. Other persons deprived of their liberty, such as immigration detainees, may also be placed in PPCs. The key elements of the concept which distinguish PPCs from other prison establishments are the higher staff/inmate ratio, the involvement of several categories of health-care professionals and specific training for custodial staff for working with patients suffering from mental disorders.

At the time of the visit, PPCs were located at Over-Amstel Prison in Amsterdam,[44] Scheveningen Prison near The Hague, Vught Prison and Zwolle Prison. The overall capacity of the PPCs was approximately 620 places.

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

82. The CPT must emphasise already at the outset that its general assessment of the PPC concept is rather positive, in particular as regards the situation observed by its delegation at Zwolle. In the Committee's opinion, PPCs represent a more suitable environment for prisoners suffering from mental disorders than ordinary prisons. Another positive element is the training provided to prison officers and nurses working as frontline carers directly with patients. However, the staffing levels of psychiatrists and therapists, as well as the use of special intervention teams in PPCs should be urgently reviewed. Moreover, as regards the amount of time that patients are locked in their rooms, the PPC regime falls seriously short of psychiatric hospital standards.

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

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43 Scheveningen Prison belongs, together with Zoetermeer Prison, to Penitentiary Institution Haaglanden.

44 The Over-Amstel PPC was scheduled to be moved to a new location in June 2016.

83. *Scheveningen Prison*, located on the northern outskirts of The Hague, contained a PPC, a Judicial Centre for Somatic Care (capacity 56 places) and a minimum security facility (capacity 24 places). In addition, in a separate part, the prison accommodated prisoners under the jurisdiction of international tribunals (capacity of some 90 places).[45] With an official capacity of 132 places divided into 11 units, the PPC accommodated 114 adult male patients at the time of the visit, all of whom were remand or sentenced prisoners.[46] Staff estimated that most patients stayed in the PPC between four to six months.

Zwolle Prison occupied a purpose-built complex located in the south-eastern part of the town of Zwolle and contained separate sections for remand and sentenced prisoners (capacity of 81 and 142 places, respectively), as well as an Extra Care Provision Unit (EZV) - intended for vulnerable prisoners (27 places), a Repeat Offenders' Section (22 places) and a PPC. The PPC held 95 male and 36 female patients (all of whom were remand or sentenced prisoners) for an official capacity of 132 places (96 for male and 36 for female patients). In 2015, some 290 patients were admitted to/discharged from the PPC and the average length of stay was 176 days.

In both PPCs visited, the majority of patients suffered from psychotic and/or substance-related disorders.

84. To transfer a prisoner to a PPC, a request must be made by the medical services of the prison where the person concerned is held to the Netherlands Institute of Forensic Psychiatry and Psychology (NIFP). If approved, the prisoner is allocated by the selection officer of the prison service to one of the PPCs. The transfer may be made against the will of the prisoner concerned.

2. Ill-treatment

85. The delegation received no allegations of deliberate physical ill-treatment by ward-based staff in the two PPCs visited. At Zwolle Prison, staff were described by patients as acting in a correct and professional manner and the delegation observed that there was substantial interaction and human contact between staff and patients. Several patients stated explicitly that their needs were better met by staff in the PPC than in a regular prison. Moreover, management and all staff referred to persons held in this establishment as "patients" which, in the CPT's opinion, demonstrates the right approach.

However, in both establishments visited, a few patients met by the delegation alleged that they had been ill-treated by members of the special intervention teams (IBT), in some cases prior to their transfer to the PPCs. The alleged ill-treatment consisted mainly of kicks and baton blows to the legs after the patients had been transferred to an isolation room, handcuffed behind their back, placed prone on the floor and brought under control. Accounts were also heard of IBT members using force against patients who offered no resistance. Reference is also made in this context to paragraphs 108 and 109.

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45 UN detention unit of the ICTY, Detention Centre of the ICC, Detention Facility of the Special Tribunal for Lebanon.

46 The delegation was informed that as of June 2016, it was planned to decrease the capacity of the PPC to 120 places.

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

86. At Zwolle, the delegation was informed that a female patient had lodged a formal complaint with the police and the prison supervisory committee about excessive use of force by IBT members. The incident had occurred in the EZV of the prison establishment in early December 2015. Allegedly, following a quarrel with the ward-based staff, the IBT was called to transfer her to the isolation unit. The patient concerned actively resisted the transfer and the IBT members pushed her face-down on her bed, handcuffed her behind her back and forcibly transferred her to the isolation unit; the patient allegedly received repeated baton blows to counter her resistance throughout the IBT intervention, including the transfer. In the isolation unit, she was allegedly forcibly undressed by male members of the IBT (see in this context also paragraphs 102, 109 and 110). According to the patient, the supervisory committee concluded that there was no wrongdoing on the part of the IBT members.

The CPT would like to be informed of the outcome of the police investigation into this case.

87. Instances of inter-patient violence in the two PPCs visited appeared to be rather rare and staff acted in a professional manner to prevent any escalation (see also paragraph 100).

3. Patients' living conditions

88. Material conditions in both PPCs visited were in all respects of a very high standard; all the premises were in an excellent state of repair and cleanliness.

Patients were accommodated in single-occupancy rooms which were sufficient in size,[47] had good access to natural light, and artificial lighting as well as ventilation were adequate. Rooms were equipped with a bed, mattress and bedding, a table, chairs, a wardrobe and shelves, as well as with a refrigerator, a TV and a coffee machine/electric kettle. In addition, each room had a call bell/intercom, combined with a radio.

At Zwolle, patients' rooms contained a fully partitioned sanitary annexe (toilet, basin and shower). At Scheveningen, rooms were fitted with a semi-partitioned toilet and a basin; showers, located in each unit, could be accessed by patients every day.

[47] Some 10 m² at Scheveningen and 9 m² (excluding the fully partitioned sanitary annexe) at Zwolle.

89. As regards the regime, it is positive that patients in both PPCs visited could participate in work (one hour a day), in a sports class (twice a week for 45 minutes), had access to a library and a multi-confessional prayer room, and could opt for some educational classes. In addition, during recreation time (in principle, every day for two to four hours), they had access to a spacious common room on each ward where they could associate with other patients. The common rooms were furnished with tables, chairs, sofas and a television, and, at Zwolle, with a kitchenette where the patients could cook for themselves. Various board games and cards were also available to patients.

90. That being said, in both PPCs visited, patient rooms were in principle locked at night between 8 p.m. and 7.40 a.m. and for several shorter periods of time during the day (each usually lasting between 30 minutes and two hours), such as at lunch time or when patients under "individual regime" accommodated on the ward had their recreation time.[48] Moreover, successive budgetary restrictions have further limited time spent by patients out of their rooms. Thus, on three days every week, patients were locked in their rooms at 4.45 or 5.30 p.m. In sum, every day, patients spent up to 17 hours locked up in their individual rooms, without any contact with staff and other patients. This can hardly be considered a therapeutic regime, a point of view shared by senior staff at Zwolle.

The situation was even more worrying in respect of patients held under "individual regime" who had more restricted access to activities and could spend up to 22 hours a day locked up in their rooms.

The CPT notes that the stated aim of the PPC concept is to provide psychiatric treatment for prisoners needing in-patient care at a level equivalent to that in civil psychiatric hospitals. In some aspects, this has been achieved, notably in terms of staff attitudes towards patients and material conditions. However, as regards the amount of time that patients are locked in their rooms, the PPC regime falls seriously short of the standards of a psychiatric hospital. This restricts therapeutic activities and interactions. For some patients, the policy of systematically locking rooms may even cause distress and anxiety.

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

91. In both PPCs, outdoor exercise was offered to patients for a minimum of one hour a day in spacious yards equipped with benches, chairs, tables and shelters, as well as some sports equipment (e.g. table tennis tables, horizontal bars, volleyball courts, handball goal, basketball hoops). The CPT's delegation was particularly impressed with the outdoor exercise areas at Zwolle: the imaginative use of shrubs, fruit trees and the presence of small animals and birds provide a truly therapeutic experience for patients, which they greatly appreciated. **The CPT encourages the Dutch authorities to ensure that patients are offered as much time as possible in the fresh air as this is positive for their health and well-being.**

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[48] I.e. patients who were, for various reasons, segregated from other patients.

4. Staff and treatment

92. At *Scheveningen*, the delegation could not obtain an exact picture as regards staffing levels; the information received was contradictory and the staffing tables provided to the delegation by the management of the prison could be explained neither by the management nor the staff of the establishment.

According to the information provided verbally, there were four psychiatrists (covering together a total of 2.7 FTE posts) providing psychiatric care to patients in the PPC.[49] However, three of the psychiatrists worked in the establishment on a temporary basis. Moreover, one full-time and one part-time psychiatrist were leaving the PPC around the time of the visit. As a minimum, one psychiatrist was present in the establishment between 8.30 a.m. and 5.30 p.m. on weekdays; during the rest of the time, a duty psychiatrist from NIFP could be contacted in case of need.

In addition, health-care staff comprised 11 psychologists, two social psychiatric nurses and some 10 treatment coordinators. The frontline carers included 94 prison officers with a two-year training in taking care of psychiatric patients (*ZBIWer – Zorg Behandel Inrichtingswerkers (*"care and treatment facility workers")) and 18 prison officers who were fully qualified psychiatric nurses (*verpleegkundigen ZBIWer* ("nursing care and treatment facility workers")). However, there were no dedicated therapists for music and other non-verbal therapeutic activities.[50]

93. The CPT considers that the number of psychiatrists was insufficient for an establishment with a capacity of 132 places. This situation was further exacerbated by the instability of the psychiatric team and deleterious effects of temporary appointments of psychiatrists to the PPC, which also undermined the development of proper patient-doctor relations. Moreover, the limited presence of psychiatrists in the establishment entailed the need to consult NIFP duty psychiatrists who did not necessarily know the establishment and almost certainly did not know the patients. Several interlocutors met by the delegation during the visit confirmed these observations.

As regards other categories of staff, the Committee noted that budgetary cuts already mentioned in paragraph 90 reduced the number of ZBIWers and nursing ZBIWers working in the establishment, which in turn impacted negatively on the time spent by patients out of their rooms. The absence of trained therapists for non-verbal therapeutic activities is also a matter of concern.

94. Conflicting information was received during the visit from various members of staff as regards individual treatment plans for patients; while some of them stated that treatment plans were drawn up shortly after admission and then reviewed at regular intervals by a multi-disciplinary team, others admitted that such plans in principle only concentrated on psychotropic medication. It is noteworthy in this context that a number of patients interviewed by the CPT's delegation were not aware whether a treatment plan had been drawn up for them and did not recall being consulted on the development of any plans. The CPT's delegation could not form an opinion as its members were not granted access to medical files.

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[49] One additional post was occupied by the Director of Care who carried out managerial and administrative functions. In both PPCs visited, all psychiatrists were seconded by the NIFP.

[50] Primary health care was provided by staff working in the Judicial Centre for Somatic Care which was part of the prison establishment.

95. Likewise, the delegation could not obtain a clear picture of the psychiatric treatment provided to the patients. The information gathered during interviews with staff and patients indicated that the psychiatrists concentrated on admissions, crisis situations and involuntary treatment procedures. For many patients in the non-crisis units, the goal of having an individual session with a psychologist once a week and a consultation with a psychiatrist once a month was not achieved, a fact confirmed by staff. As for non-pharmacological therapies, a small number of prisoners benefited from a group "aggression regulation training" and individual psychotherapy. Attendance in the music therapy room was supervised by staff with no specialised training.

96. In the light of the above-described findings at Scheveningen PPC, **the CPT recommends that the Dutch authorities:**

- **take urgent steps to strengthen the leadership and to stabilise the psychiatric team, as well as to increase the number of psychiatrists working in the establishment;**

- **thoroughly review the number of ward-based staff and therapists;**

- **ensure that a wider range of therapeutic options is introduced;**

- **ensure that an individual treatment plan is drawn up for every patient, including pharmacotherapy and a broad range of therapeutic, rehabilitative and recreational activities and indicating the diagnoses, the treatment goals, the therapeutic means used and the staff member responsible; the treatment plan should also contain the outcome of a regular review of the patient's mental health condition and a review of the patient's medication. Patients should be involved in the drafting of their individual treatment plans and be informed of their progress.**

97. At *Zwolle*, the health-care team consisted of 3.5 FTE of psychiatrists,[51] 4.2 FTE of psychologists, 9 treatment coordinators, 2.9 FTE of social psychiatric nurses and 2.2 FTE of creative therapists. The frontline carers included 91 ZBIWers and some 20 FTE nursing ZBIWers. Additional four or five posts of ZBIWers were vacant at the time of the visit. Further, there were four full-time general practitioners and six nurses who provided somatic care for the whole prison establishment. The delegation's findings indicate that leadership of staff providing psychiatric care to patients was well-informed and effective.

98. Psychiatric treatment at Zwolle was generally very good. Patients participated in the drawing up and modification of their treatment plans (which corresponds to exemplary psychiatric practice) and a wide range of non-pharmacological treatment was available to them, including cognitive behavioural therapy, EMDR[52] and anger control. However, although some non-verbal therapies (art, music and psycho-motor therapy) were offered in well-equipped and spacious rooms, only some 45 patients could participate, which was insufficient to meet the needs and the interest expressed by the patients. Moreover, it became clear during the visit that the establishment would benefit from a higher number of psychiatrists; the current staffing level (3.5 FTE) appeared to be insufficient for a capacity of 132 places.

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51 In addition, there was 1 FTE occupied by the Director of Care.

52 Eye movement desensitisation and reprocessing.

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

99. Most patients at Zwolle received psychotropic medication which generally appeared to be used in an appropriate manner and patients were aware of the medication they were taking. However, in respect of a small number of patients, the number of medications prescribed seemed to be excessive. For example, one patient was prescribed four different psychoactive medications (methylphenidate, escitalopram, quetiapine and diazepam[53]). Another patient was receiving four different psychoactive medications, including an anti-psychotic (risperidone both as a depot and as daily oral medication) as well as anti-depressants, a benzodiazepine and dexamphetamine. **In the CPT's opinion, the necessity for polypharmacy used for some patients at Zwolle PPC should be reviewed.**

100. In both PPCs visited, the delegation gained a favourable impression of the attitude of the ZBIWers and nursing ZBIWers, the frontline carers working daily in direct contact with the patients. In particular, the training provided to ZBIWers equipped them with adequate skills to address challenging behaviour by patients, including verbal aggression and non-compliant behaviour, as the result of the mental disorder. Their response to such behaviour was de-escalation and a non-confrontational approach; the staff displayed a good level of understanding of diagnoses, treatment modalities, common side-effects of medication and common psychiatric symptoms. The distribution and the administration of medication were carried out in a professional manner and, at Zwolle, daily observations were properly recorded in the patient files.

At Zwolle, the management gave considerable emphasis to in-service training for all staff, in particular ZBIWers who had to attend at least 5 courses each year (in addition to their basic training), covering a wide range of subjects.[54]

101. The provision of primary health care to patients was only examined by the CPT's delegation at Zwolle. A general practitioner was present in the facility on a half-time basis on weekdays and several nurses during weekday working hours. During the remaining periods of time, health-care was provided by the nursing ZBIWers who were present on each shift. In the case of emergency, a patient would be transferred to the local hospital by ambulance. The medical service was well-equipped and had an adequate stock of medications. Patients' computerised individual medical files were well-maintained. These arrangements appeared to be satisfactory.

102. On the other hand, the delegation found that there was no systematic medical examination of patients after they had been subjected to the use of force and that, more generally, there was an incomplete recording of patients' injuries; these are matters of concern to the CPT.

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53 Diazepam at a dose of 60 mg per day, with a possibility to prescribe a further 20 mg.

54 For example, psycho-pharmacology, group dynamics, a 5 minute model for restraining patients involuntarily, suicidal tendencies and auto-mutilation, autism, psychosis, epilepsy.

At *Scheveningen*, staff claimed that after each use of force, patients are examined for injuries by health-care staff. However, several patients interviewed by the delegation reported that no such examination had been carried out after force had been used against them by staff. The delegation was not in a position to establish the veracity of these claims or to examine the quality of recording of injuries in patients' individual medical files.

With regard to *Zwolle*, the delegation's findings indicate that patients against whom force had been used were either not examined at all by health-care staff or medical records contained only an incomplete description of injuries sustained.

For example, in one case, a patient interviewed by the delegation displayed visible injuries[55] which had allegedly been sustained when he had actively resisted transfer to the isolation unit by members of the special intervention team (IBT) three to four weeks prior to the CPT's visit. In his medical file, there was no record of any medical examination relating to this incident (or any other incident involving the use of force).

Another patient, whose case has already been briefly described in paragraph 86, sustained injuries while actively resisting her transfer to the isolation unit by IBT members on the evening of 5 December 2015. The patient concerned was only examined the following day and the note in the medical file stated "right eye and temple blue, swollen. No symptoms of possible concussion." On 7 December, she was seen by a psychologist and the day after, a nurse made the following note in the medical file: "subjective – seen in seclusion – black eye and bruises on shin. She did not cooperate in placement. Her head was pushed down and she was hit on the shin with truncheons; objective - right eye black, blue/yellow bruise." A note made on 9 December in the medical file states that a request by the patient to receive a medical statement of her injuries, and have photos taken of her body, was rejected by staff. Apparently, the patient was advised to contact an independent doctor through her lawyer.

The CPT notes that while the case file did include a brief account of the patient's description of the incident, the description of the traumatic lesions was incomplete, without measurements and without a description of the lesions present on one or both of her lower limbs, and there was no conclusion concerning the consistency between the patient's account and the lesions observed. Moreover, in the Committee's opinion, the attitude of the medical service in refusing to draw up a medical certificate is fundamentally flawed.

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

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55 A bluish-yellow lesion on the left upper lip, around 0.8cm in diameter and situated partly on the lip itself and partly on the adjacent skin and a visible lesion on the left forehead, oval, 2cm by 3cm, dark red in colour.

104. In both PPCs visited, as a general rule, treatment was provided on the basis of free and informed consent. Involuntary treatment was only possible under circumstances defined in Section 46a *et seq.* of the Penitentiary Principles Act (PPA).[56] It is possible (a) if a patient poses a danger to him/herself, to others or property due to a mental disorder from which he/she suffers and without the treatment, the danger cannot be removed within a reasonable time ("involuntary treatment A"), or (b) if the treatment is strictly necessary to avert an acute danger which a patient poses in the establishment and which is due to a mental disorder of the patient ("involuntary treatment B").

The decision to start an involuntary treatment is taken by the governor of the prison[57] and must be reported to the Supervisory Committee of the prison and the Health Care Inspectorate (IGZ). In the case of involuntary treatment A, the governor must obtain a second opinion from a non-treating doctor and the prisoner concerned may lodge an appeal with the Council for the Administration of Criminal Justice and Protection of Juveniles (RSJ); the lodging of an appeal has suspensive effect.

The delegations' findings indicate that the procedures laid down by law were followed at Zwolle PPC. The delegation was unable to assess this issue at Scheveningen, for the reasons explained in paragraph 6 and 7.

5. Means of restraint

105. The principal means of restraint used in both establishments visited were seclusion and chemical restraint. Means of mechanical restraint to control agitated patients were rarely used (with the exception of the use of handcuffs to transport prisoners to the isolation unit – see below).[58] Resort to means of restraint was recorded in a central register.

106. By virtue of Section 24 PPA, the decision authorising the placement of a patient in seclusion as a "good order measure" (rather than a disciplinary punishment – see paragraph 113) is taken by the governor of the establishment, based on the proposal of the treating doctor and in consultation with the frontline staff, for a maximum of two weeks and may be renewed. Any seclusion lasting longer than 24 hours must be notified to the Supervisory Board. In addition, prison officers may impose time-out on an agitated patient, for a maximum of 15 hours (Section 24(4) PPA).

The findings of the visit indicate that in both PPCs, patients were placed in seclusion for relatively short periods of time, ranging from several hours to a few days.[59] The measure was re-evaluated on a daily basis and could be terminated at any time. Patients were given a written reasoned decision imposing the measure and could lodge a complaint with the Complaints Committee of the Supervisory Board.

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56 Additional details were provided for in Section 21 *et seq.* of the Penitentiary Rules (*Penitentiaire maatregel*, a Decree of 23 February 2008).

57 For a maximum of three months (involuntary treatment A) and two weeks (involuntary treatment B).

58 In 2015, one patient at Scheveningen was restrained with a leather belt with plastic handcuffs on the sides for 24 hours; at Zwolle, there were two incidents of mechanical restraint – foam helmets were placed on the heads of the patients and wrist bands were fastened to a waist belt, for an average duration of 24 hours.

59 It should also be noted that patients may ask to be placed in seclusion voluntarily, e.g. during night time.

In addition, short time-out periods of up to 15 minutes in patients' own rooms were imposed by frontline staff; they were considered part of the treatment rather than a formal measure of seclusion.

It is positive that at Zwolle, dedicated time-out cells were located on each ward and a certain degree of flexibility was applied to the seclusion regime; the patients concerned could thus remain in the environment of their unit and had access to selected parts of the treatment regime, as decided by the frontline staff in consultation with a psychologist.

107. Material conditions in the seclusion units were very good in both PPCs visited. At Scheveningen, the unit (known as "crisis plus unit") consisted of 12 cells; at Zwolle, there was one unit with three detoxification cells and five seclusion cells and another unit which contained three cells and was used exclusively for female patients. In both establishments, the cells measured some 10 m², had access to natural light and were adequately equipped (a call bell, a mattress on the floor and a blanket, as well as a toilet). Patients placed in seclusion were offered one hour of outdoor exercise every day.

That said, the seclusion cells were equipped with CCTV cameras which also covered the in-cell toilets**. The CPT considers it essential that when it is deemed necessary to place a detained person under video-surveillance, his/her privacy should be preserved when he/she is using the toilet, for example by pixelating the image of the toilet area.**

108. The CPT does have some concerns about the transfer of patients to the seclusion units, in particular at *Scheveningen*.

In this establishment, special intervention teams (IBT)[60] were deployed each time a patient had to be transferred to the seclusion unit, even when the patient concerned had asked to be transferred[61] or if he had indicated that he would be fully cooperative. IBT members routinely intervened in full protective gear (helmets, body armour, shields, truncheons and pepper spray) and patients were always handcuffed. At night, due to the small number of ward-based staff present, IBT was deployed whenever cell doors had to be open.

In addition, all patients placed in seclusion were obliged to completely undress during a strip-search and were obliged to wear a rip-proof gown. The interventions of the IBT were said by staff to take place approximately two to three times a week.

109. The approach at *Zwolle* was more differentiated. According to the particular situation, patients could be transferred to the seclusion unit either by ward-based staff or by IBT, the latter intervening with or without protective gear.[62] As a result, the deployment rate of the IBT (one or two interventions a week) was significantly lower than at Scheveningen, although both establishments had virtually the same capacity and occupancy levels. Moreover, patients were not always handcuffed during the transfer and were obliged to wear rip-proof clothing while in seclusion only if a psychiatrist considered it necessary.

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60 According to the information provided to the CPT's delegation by senior staff in both PPCs, IBT members received specific training in the handling of psychiatric patients.

61 E.g. if they were afraid of self-harming or felt they were becoming agitated.

62 At night, however, all transfers to the seclusion unit were carried out by the IBT, due to the small number of ward-based staff on duty.

It was however also the case at Zwolle that as part of a routine strip-search before placement in seclusion, patients were obliged to undress completely. Moreover, the legislation in place[63] does not strictly require that a strip-search always be carried out by staff of the same sex as the prisoner/patient; it merely provides that this should be done "if possible". Although efforts were apparently made at Zwolle to ensure that patients were strip-searched by staff of the same sex (or that female staff shielded the patient with a sheet so that a direct view of the patient was prevented), it happened that female patients who had to be transferred to the seclusion unit were exceptionally forcibly undressed by male members of the IBT (see paragraph 86).

110. The CPT considers that a strip-search is a very intrusive and potentially degrading measure; resort to this measure should be based on an individual risk assessment and subject to rigorous criteria and supervision and be carried out in a manner respectful of human dignity. Every reasonable effort should be made to minimise embarrassment; detained persons who are searched should normally not 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 redress before removing further clothing. Further, inmates should not be required to undress in sight of custodial staff of the opposite sex.

Moreover, if a patient is placed in seclusion, he/she should not be obliged to wear rip-proof clothing as a matter of routine but only where necessary (e.g. in cases of self-harm).

111. Moreover, the CPT notes that the frequent deployment of IBT (in particular in full gear) was disruptive for the functioning of the wards and had a lasting, intimidating effect on the patient concerned and also on other patients who witnessed and/or heard the intervention. Efforts should be made to reduce the number of IBT interventions, in particular in full protective gear. Further, the application of handcuffs to patients who are being transferred to seclusion should be based on an individual security risk assessment; normally, the transfer ought to be carried out by staff using manual holds only. A thorough debriefing of the intervention team and assessment of the intervention should be made after every deployment to evaluate whether the deployment was proportionate to the risk posed by the patient and whether the *minimum* force necessary to ensure compliance was applied. A full written record of the debriefing should be made to keep track of such interventions and of lessons learned. In addition, it is essential that a debriefing of the patient (and other patients who have witnessed the measure) take place after the intervention.

To reduce the need to deploy the IBT, the number of frontline staff present in the units might need to be increased, in particular during night hours. At Scheveningen, consideration might be given to creating time-out rooms on the ordinary wards to avoid transfers to the seclusion unit.

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

63 Section 29(3) of the Penitentiary Principles Act.

112. The use of chemical restraint could only be examined by the delegation at Zwolle. According to the protocol applied in this establishment, *pro re nata* (PRN, "*zonodig* – if necessary") prescriptions drawn up by the treating psychiatrist authorised nurses to administer injections of rapid tranquillisers in cases of psychomotor agitation, serious threats or actual violence. However, the delegation's findings indicate that a psychiatrist was either not informed in such cases, or did not come immediately to see the patient concerned.

The CPT must underline in this context that the injection of rapidly acting tranquillisers is a form of chemical restraint which is associated with significant risks to the health of the patient, in particular life-threatening cardiac arrhythmia, low blood pressure and respiratory depression. Their use therefore requires close medical supervision and adherence to strict protocols by all staff involved, as well as the necessary skills, medication and equipment. The application of rapid tranquillisers on the basis of a PRN prescription without the explicit re-confirmation by a medical doctor might place too much responsibility on nurses as regards the assessment of the patient's mental state and the provision of an adequate response, in the absence of a medical doctor, to potential complications. It may also reduce the nursing team's motivation to attempt de-escalation of the situation by other means and consequently open the door for abuse.

In the Committee's opinion, in the event of a patient presenting a state of agitation which cannot be dealt with by the nursing staff, the patient's psychiatrist (or the duty psychiatrist) should be called immediately and intervene promptly to assess the state of the patient and issue instructions on the action to be taken.

Only in exceptional situations, when a patient's agitation cannot be controlled by nursing staff and the intervention of a psychiatrist is not possible within minutes, may the administration by nursing staff of rapid tranquillisers under a "conditional" PRN prescription be justified, meaning that a medical doctor must be contacted (e.g. by phone) and must confirm the prescription prior to its use. Further, a medical doctor must arrive without delay to monitor the patient's response and deal with any complications.

Moreover, the use of a PRN prescription for rapid tranquillisers must be accompanied by specific safeguards: as a minimum, any such PRN prescription should be drawn up by an experienced doctor after having thoroughly assessed the patient's physical status, should only be valid for a limited time (i.e. weeks rather than months) and should be re-assessed each time it is used or where there is any change in the patient's medication.

Indeed, other more general safeguards accompanying any use of means of restraint in psychiatric settings (such as the existence of comprehensive policy on restraint, the use of restraint as a measure of last resort and the choice of the most proportionate method, as well as the recording of the event in the patient's medical file and in a central register of restraint measures and a debriefing of those involved) should also apply when rapid tranquillisers are administered on the basis of a PRN prescription.

The CPT recommends that these precepts be effectively implemented in practice at Zwolle PPC and, where applicable, in other PPCs in the Netherlands.

6. Other issues

113. As regards disciplinary sanctions, the same rules applied in PPCs as in normal prisons. Namely, the most severe sanction that may theoretically be imposed on a patient was solitary confinement for a maximum period of two weeks (Section 51 PPA).

The findings of the visit indicate that resort to solitary confinement as a disciplinary sanction (as opposed to seclusion imposed as a security measure – see paragraph 106) was very rare. In principle, such a sanction would only be imposed for violent incidents and the use of illicit drugs (up to three days for soft drugs and up to five days for hard drugs). According to the staff, the mental state of the patient would always be taken into account to carefully evaluate whether the act was not the result of the patient's mental disorder. At Zwolle, and in some cases also at Scheveningen, solitary confinement would be served in the patients' own room, at times with the door to the corridor open.

The CPT acknowledges the efforts made in both PPCs visited resort to disciplinary solitary confinement to keep to a minimum and to alleviate the conditions under which it is served. Nevertheless, as a matter of principal, it has reservations about the use of disciplinary sanctions vis-à-vis psychiatric patients. Such measures aim at sanctioning patients' behaviour, which is often likely to be related to a psychiatric disorder and should be approached from a therapeutic rather than a punitive standpoint. **The Committee encourages the Dutch authorities to abolish disciplinary sanctions vis-à-vis patients in PPCs.**

114. Moreover, it would appear that not all patients could clearly distinguish between seclusion imposed as a security measure and as a disciplinary sanction. The CPT's delegation noted in this context that written decisions provided to the patients appeared the same whether they concerned a measure or a sanction and that security measures were imposed for a set number of days. In addition, at Scheveningen, the disciplinary sanction of solitary confinement was occasionally served in the seclusion unit (which in most cases served for seclusion of agitated patients as a measure).

The CPT recommends that clear distinction be made between the "good order measure" of seclusion and disciplinary solitary confinement. The latter should not be implemented in the seclusion units; if disciplinary solitary confinement needs to be executed outside the patients' own rooms, care should be taken to use dedicated and adequately-equipped cells.[64]

115. Arrangements concerning contact with the outside world of patients were satisfactory in both PPCs visited. Patients could send and receive letters, could make phone calls from pay phones located on the wards (in principle without limits during recreation time) and could receive visits for a minimum of one hour a week, as a rule under open conditions (i.e. without partitioning). If the same person came to visit a patient several times,[65] the patient concerned could request an unsupervised visit.

Visiting facilities seen by the delegation were spacious, in a good state of repair and clean, and some of them were equipped with small play areas for children and/or vending machines for coffee/beverages. These material conditions call for no particular comments.

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64 I.e. with a table and adequate seating for the daytime, as well as a proper bed and bedding at night.

65 Five times at Scheveningen and three times at Zwolle.

116. At Zwolle, newly arrived patients were provided with verbal information on the arrangements in the establishment and with a copy of the house rules. At Scheveningen, the management indicated to the delegation that upon arrival, patients were orally informed about the functioning of the establishment and that additional information was gradually provided by two mentors appointed for each patient. However, according to the management, no information was supplied in writing.

The CPT considers in this respect that all newly arrived PPC patients should be systematically informed upon their arrival of the establishment's arrangements verbally and in writing. To this end, they should be supplied with an information brochure, describing in a straightforward manner the main features of the establishment's regime, their rights and duties, complaints procedures, basic legal information, etc.

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

117. The avenues of complaint open to PPC patients and inspection procedures of the PPCs did not significantly differ from those in regular prisons. Apart from the possibility to complain directly to staff and the management of the establishments, patients could also address their individual complaints to the Complaints Committee of the Supervisory Boards established at each prison and the national Council for the Administration of Criminal Justice and Protection of Juveniles (RSJ). It is noteworthy in this context that in establishments where psychiatric care is provided, the membership of the Supervisory Board should include a psychiatrist.[66]

In addition to the general inspections carried out by the Inspectorate of Security and Justice (*Inspectorate VenJ*), as regards the quality of health care provided to patients, PPC could be inspected by (and patients could address their complaints to) the Health Care Inspectorate (IGZ), subordinated to the Ministry of Health.

However, the delegation was somewhat surprised to find that while the Judicial Centre for Somatic Care of Scheveningen Prison was visited by the IGZ twice in 2016, the PPC had received the last visit two years previously. **Given that the PPCs are a relatively new and developing concept, more attention from the IGZ may well be appropriate.**

118. As regards the role and functioning of the NPM, reference is made to paragraphs 8 and 9.

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66 See Section 11(4) of the Penitentiary Rules.

D. Civil psychiatric institutions

1. Preliminary remarks

119. For the first time, the CPT examined the situation of civil psychiatric patients in the Netherlands.

The basic legal framework governing the situation of civil involuntary patients, including procedures for their involuntary admission and subsequent discharge, voluntary and involuntary treatment and the use of means of restraint, is laid down in the Psychiatric Hospitals Compulsory Admissions Act (*Wet bijzondere opnemingen in Psychiatrische Ziekenhuizen* – BOPZ).

At the time of the visit, two new bills intended to replace BOPZ were pending before the Dutch Parliament, namely the Compulsory Mental Health Care Bill and the Care and Compulsion (Psychogeriatric and Intellectually Disabled Patients) Bill.[67] The main objective of the new legislation is to make a distinction between persons suffering from psychiatric disorders, on the one hand, and patients suffering from an intellectual disability or dementia on the other, and to better cater to their different needs. The new legislation should minimise recourse to the use of means of coercion and strengthen the legal position of patients. It also envisages the possibility of providing involuntary treatment in the community. Certain existing principles, such as the distinction between involuntary placement and involuntary treatment, as well as judicial control of involuntary placement, will be retained in the new legislation. It is hoped that the new legislation might enter into force in January 2018.[68]

The CPT welcomes the increased patient-oriented objectives of the new legislation and would like to be informed once the new legislation has been adopted.

120. The delegation visited the Psychiatric Centre "Rielerenk" in Deventer and the "Zon en Schild" Psychiatric Hospital in Amersfoort.

The *Psychiatric Centre "Rielerenk"* (part of the Foundation "Dimence") consisted of four wards for psychiatric patients, each with a capacity of 11 beds. The delegation focused on the closed "high intensive care ward", which accommodated, at the time of the visit, four male and six female patients. Of these 10 patients, four were voluntary, four had been admitted under the procedure for an involuntary admission under a court order and two under the emergency involuntary admission procedure (see also paragraph 140).

The *"Zon en Schild" Psychiatric Hospital* belonged to "*GGz Centraal*" (Mental Health Care – Centre), an organisation providing mental health services in the central part of the Netherlands. The hospital was located on the outskirts of Amersfoort and comprised several buildings surrounded by a large park. It provided care in particular to patients with psychotic, depressive, anxiety and personality disorders and their combinations. The overall capacity of the hospital was some 250 beds.

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67 In addition, a Bill on Forensic Care was also pending in the Parliament.

68 It is noteworthy that the new legislation explicitly recognises the CPT's right to unconditional access to medical records.

The delegation visited Kastanjehof building which had an official capacity of 100 beds distributed among ten mixed-sex wards, of which six wards were closed.[69] At the time of the visit, Kastanjehof accommodated 101 adult patients[70] (58 men, 43 women): seven were under the emergency involuntary admission procedure, 75 under the procedure for an involuntary admission by a court order and four forensic psychiatric patients;[71] the remaining 15 were voluntary patients.

121. It should be underlined at the outset that the delegation received no allegations, and found no other indications, of ill-treatment of patients by staff at either of the two civil psychiatric establishments visited. On the contrary, many patients interviewed by the delegation stated explicitly that they were treated correctly by staff and appreciated their professionalism, and the delegation observed a respectful and caring attitude on the part of staff.

Instances of inter-patient violence were very rare and the information gathered during the visit indicates that staff intervened appropriately and rapidly, with a view to de-escalating the situation.

2. Patients' living conditions

122. Material conditions were of a very high standard in both establishments visited. All patients were accommodated in single-occupancy rooms which were generous in size (17 m² excluding the fully partitioned sanitary annexe), had very good access to natural light through large windows and access to artificial lighting and ventilation was also very good. The rooms were equipped with a bed, table, chairs and wardrobe; the fully partitioned in-room sanitary facilities contained a toilet, a washbasin and a shower. All the rooms and other premises visited in the two establishments were in an excellent state of repair and hygiene.

Further, patients were provided keys to lock their rooms and/or wardrobes if they so wished and could wear their own clothes and keep personal belongings in their rooms, which fostered a sense of security and autonomy. That being said, some corridors and rooms on the wards at Kastanjehof appeared somewhat impersonal and austere (despite the existence of notice boards in patients' rooms on which patients could place pictures/posters); **at Kastanjehof, long-term patients in particular should be encouraged by staff to personalise and decorate their rooms.**

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69 These six wards were the only closed wards in the hospital.

70 Despite the number of patients slightly exceeding the official capacity, each patient had his own single-occupancy room due to spare capacity on some wards.

71 These four patients were held under a TBS order ("*terbeschikkingstelling*") which 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.

123. As regards the regime, it is positive that patients in both establishments visited were not locked in their rooms during the day or at night[72] and were free to move about their wards. Patients could associate in common areas which were equipped with sofas, tables, chairs and a television (at *Kastanjehof* also with a table tennis table and piano) and where patients could watch television, play board games or cook for themselves and/or eat together. Patients also had access to fitness rooms. In addition, at *Kastanjehof*, a number of patients were offered work (e.g. producing candles and textile work).

Depending on their clinical state, patients at *Kastanjehof* were allowed to go to the town or to the park surrounding the establishment, which contained a shop and a cafeteria (this applied to the majority of patients at the time of the visit). At *Rielerenk*, some patients were authorised by the treating staff to go into the local town.

124. In both establishments visited, patients had in principle unrestricted access to spacious outdoor exercise areas attached to the wards, which were equipped with tables and chairs, as well as a shelter.

3. Staff and treatment

125. The CPT must underline at the outset that at both hospitals visited, its delegation met competent, dedicated and well-trained staff who displayed considerable professionalism in their attitude towards patients.

126. At *Rielerenk*, the health-care team responsible for the whole psychiatric centre consisted of five psychiatrists and four assistant physicians who were training to become psychiatrists; they were present every weekday during the day time; the rest of the time, there was one psychiatrist and one assistant doctor on call. As for nurses, as a minimum, there were two on each ward during the day (three in the high intensive care ward) and one on nightshift. All the nurses were fully qualified mental health nurses.

127. At Kastanjehof, in addition to a full-time psychiatrist and a senior nurse who were part of the management, there were four fully trained psychiatrists (covering together approximately three FTE posts) and three full-time assistant physicians who were training to become psychiatrists. The hospital also employed a psychologist (2/3 FTE). The nursing team comprised 3 team managers and some 100 trained nurses. At least 22 nurses were on duty during the day for some 100 patients and eight at night.

The CPT considers that the number of psychiatrists is somewhat insufficient for an establishment with 100 patients and constitutes a limiting factor in the provision of psychotherapy to patients (see paragraph 129). **The CPT recommends that the number of psychiatrists at Kastanjehof be increased.**

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[72] Unless a patient became agitated, in which case he/she could be locked up for a brief period of time in his/her own room to avoid transfer to and seclusion in an isolation unit.

128. Psychiatric treatment provided to patients in both establishments visited was generally of a high quality. The vast majority of patients were aware of the medication they were taking, psychotropic medication appeared to be used in appropriate doses and the delegation did not observe any signs of overmedication of patients. Pharmacotherapy was supplemented by a range of therapeutic activities, either on an individual basis or in groups, such as art therapy in a creative room, cognitive-behavioural therapy and treatment for PTSD (at *Kastanjehof*) and creative therapy[73] (at *Rielerenk*). As regards work and leisure activities offered to patients, reference is made to paragraph 123.

129. That said, at *Kastanjehof*, the offer of activities to patients who were under a closed ward regime[74] was limited to watching TV, board games and some recreational activities. **The CPT recommends that patients held under a closed ward regime at Kastanjehof be offered a range of therapeutic activities.**

Moreover, although patients at Kastanjehof were seen by a psychiatrist or junior doctors every week, the current staffing levels were insufficient to provide psychotherapy to most patients on a regular basis.[75] **The implementation of the recommendation made in paragraph 127 should enable this shortcoming to be remedied.**

130. An individual treatment plan was drawn up for every patient shortly after admission and regularly updated. It included a diagnosis, the aims of treatment and the different treatment modalities proposed, notably medication, psychotherapy and other therapeutic activities. At *Rielerenk*, patients were involved in the development of their treatment plans.

However, at *Kastanjehof*, patients were not always involved in the drawing up and subsequent modification of their treatment plan and were thus not fully aware of its existence. **The CPT recommends that patients at Kastanjehof be involved in the drafting of their individual treatment plans and their subsequent modifications, and that they be informed of their therapeutic progress.**

4. Means of restraint

131. It is positive that no means of mechanical restraint were used in either of the two civil psychiatric establishments visited; if necessary, patients could be subjected to seclusion and/or chemical restraint.

If the use of means of restraint on voluntary patients was necessary, an emergency involuntary admission procedure (see paragraph 140) had to be started without delay.

The information gathered from interviews with patients and staff in both establishments visited, as well as from an examination of the computerised register of restraint at Rielerenk (see in this context the following paragraph) indicates that seclusion and chemical restraint were used as a last resort and that recourse to them was not excessive. Placement of a patient in seclusion or the use of chemical restraint was ordered by a medical doctor (see however, paragraph 137).

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73 Such as drawing and music.

74 I.e. patients who were not allowed to leave their ward, usually during the initial stage of their hospitalisation.

75 Therapeutic consultations with individual patients were in principle held once a week (two or three times on the acute crisis unit) but apparently only lasted some 15 to 20 minutes.

132. According to the central register of restraint maintained at *Rielerenk*, in the six months preceding the CPT's visit, the number of instances of seclusion ranged between zero and 13 per month[76] and the average duration of seclusion was some ten hours (the maximum duration was between 24 and 48 hours in two cases). Chemical restraint was applied six times in the three months preceding the visit.

However, the computerised system of medical records at *Kastanjehof* did not give a meaningful overview of the frequency and/or duration of the actual use of seclusion and forced medication, a fact acknowledged by the management of the establishment.

The CPT considers that a register giving such overview should be maintained to record all instances of recourse to means of restraint (including rapid tranquillisation), in addition to the information contained within the patient's personal medical file. This will greatly facilitate the management of such incidents, the oversight into the extent of their occurrence, the identification of risk situations and the prevention of similar incidents in the future, as well as the introduction of policies for decreasing resort to the means of restraint. 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 doctor who ordered or approved it; staff who participated in the application of the measure; and an account of any injuries sustained by patients or staff.

In order for a central register on the resort to means of restraint to be useful as a monitoring tool, **the CPT recommends that the register maintained at Kastanjehof and, where applicable, in other psychiatric establishments in the Netherlands, be modified in line with the above-mentioned considerations.**

133. As regards more particularly the seclusion of agitated patients, at *Rielerenk*, secluded patients were checked every 30 minutes by staff; at *Kastanjehof*, several members of staff were continuously present in the isolation unit and, depending on the patient's mental state, could alleviate the seclusion by keeping the door of the seclusion room open, allowing the patient free movement within the isolation unit or allowing the patient access to an outdoor corridor adjacent to the isolation rooms.

134. In both establishments, material conditions in the seclusion units were satisfactory.[77] In particular, the rooms were devoid of any sharp edges and ligature points, had good access to natural light and were equipped with a soft foam bed and a rip-proof blanket, as well as with a call bell, a clock and a CCTV camera. At *Kastanjehof*, the rooms had direct access to a narrow outdoor corridor surrounded by high walls. Patients presenting a suicide risk placed in the seclusion units were obliged to undress and wear rip-proof clothing; other patients were allowed to keep their own clothes.

That said, in both establishments, the seclusion rooms were fitted with toilets which were covered by CCTV cameras. **The CPT considers it essential that when it is deemed necessary to place a patient under video-surveillance, his/her privacy should be preserved when he/she is using a toilet, for example by pixelating the image of the toilet area.**

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[76] With the exception of one month where the number was higher (24) due to brief episodes of seclusion of a particularly challenging patient.

[77] At Kastanjehof, the unit consisted of three "recovery rooms" (for patients who were confused and needed extra care) and three "seclusion rooms" (for patients who posed a danger to themselves or others). At Rielerenk, there were two seclusion rooms.

135. Unless there was a clear medical contraindication, secluded patients had daily access to outdoor exercise. However, the outdoor exercise yard of the seclusion unit at *Kastanjehof* did not have a shelter against inclement weather. **This deficiency should be remedied.**

136. At both establishments, there were plans to refurbish the seclusion units to allow for more direct contact between staff and patients. At *Kastanjehof*, the plans also included the creation of "comfort rooms" directly on the wards (to enable agitated patients to stay on their wards) and the establishment of a de-escalation team on each shift, which would intervene as a third party not involved in a possible conflict between health-care staff and an agitated patient. **The CPT welcomes this approach and would be interested to receive an update on future developments.**

137. As regards chemical restraint, for a small number of patients at *Kastanjehof*, there were PRN (*pro re nata*) prescriptions issued by the treating psychiatrist, which authorised nurses to administer rapid tranquiliser injections in case of acute agitation. Consequently, the medication could be administered by decision of the nursing staff, without the patient's doctor/duty doctor being consulted beforehand. Moreover, although nursing staff were required to immediately notify a psychiatrist when the medication was applied and the latter, according to the protocol established in the hospital, should come and see the patient within 30 minutes, it became clear during the visit that in particular at night and on weekends, the psychiatrist was often not able to see the patient for several hours.

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

138. It is a matter of concern that in both establishments, police officers (or private security guards) were at times called upon to intervene (including to assist with the application of chemical restraint) when very agitated patients could not be controlled by health-care staff. The police would take charge of the situation and decide whether to transfer the patient to a seclusion room or to remove the patient to a police station. In either case, the patient would be handcuffed. It is noteworthy in this context that at *Kastanjehof*, one patient complained that after the police had taken him to a seclusion room, they stripped his clothes off his body forcibly and he was lying completely naked for several minutes before nurses intervened to place him in anti-suicide clothing.

In the CPT's view, such interventions are inappropriate and frightening for the patient concerned as well as for other patients observing them. Moreover, police officers are not trained to manage psychiatric patients and their presence and use of force could well result in a patient being traumatised. Psychiatric establishments should have a sufficient number of properly trained staff to manage agitated patients with psychiatric disorders. It is particularly problematic to remove agitated psychiatric patients from a psychiatric setting to police custody. **The CPT recommends that the Dutch authorities put an end to the practice of involving police officers or private security guards in managing agitated patients in psychiatric establishments.** Further, **all nursing staff in psychiatric establishments should be trained in the appropriate ways of managing agitated patients and refresher courses should be organised at regular intervals.**

139. In addition, patients who were involved in a violent episode, most notably in the context of interventions by the police, were not systematically examined for injuries.

The importance of thorough somatic examinations and systematic recording of injuries in such cases has already been emphasised and explained in detail in paragraph 59. Moreover, a full written record should be kept in the establishment of every violent episode, including those that have involved a police intervention.

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

5. Safeguards

a. initial placement and discharge

140. As regards involuntary placement, persons may be admitted to a psychiatric establishment against their will if they suffer from a psychiatric disorder and they pose a danger to themselves or others which is caused by the disorder and which cannot be averted by other means.

If the danger posed by the person concerned is imminent, an emergency involuntary admission *(Inbewaarstelling – IBS)* procedure may be initiated (Section 20 BOPZ): the mayor of the municipality where the person is present issues, on the basis of a medical opinion, an admission order. Subsequently, the relevant public prosecutor must be informed and must decide, at the latest the following working day, whether the person should be discharged from the hospital or whether continued hospitalisation is necessary. In the latter case, the prosecutor submits a request for continued hospitalisation to the court which has three days to take a decision on continued hospitalisation, for a maximum of three weeks. Following this period, the patient must be discharged or the procedure for the involuntary admission by a court order must be initiated.[78]

If the danger posed by the person to be involuntarily admitted is not imminent, the procedure for an involuntary admission by a court order (*Rechterlijke Machtiging – RM*) may be initiated (Section 2 BOPZ): the person concerned must be examined by a psychiatrist who has not been involved in his/her treatment and the psychiatric opinion is submitted to a prosecutor who may request the court to issue a court order for involuntary admission, for a maximum period of six months.[79] Following this period, if the conditions for involuntary placement continue to be met, the court may extend the placement by renewable one-year periods (two-year periods following the first five years of hospitalisation of the person in a psychiatric establishment). The request for such an extension must be accompanied by an expert opinion from a psychiatrist who has not been involved in the patient's treatment.

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78 Once the procedure is initiated, the involuntary hospitalisation continues until a decision is issued by the court, at the latest in three weeks.

79 If the person concerned is already in a psychiatric establishment (either under the emergency involuntary admission or as a voluntary patient wishing to leave against the opinion of the treating staff), the request must be submitted to the court by the prosecutor within two weeks and the court must take a decision within three weeks.

In both of the above-described involuntary admission procedures (including the court proceedings for the extension of the placement beyond the first six months), the person concerned must be heard in person by the judge before the court decision is taken. Further, each person must be provided with a lawyer. There is no possibility to appeal against the decision; however, a request for the decision to be overturned may be lodged with the Supreme Court (Sections 9(5) and 29(5) BOPZ).

141. The examination of the relevant administrative files and information obtained from patients revealed that the procedures laid down by law were scrupulously followed. In particular, the deadlines were met, patients were represented by a lawyer during procedures for involuntary placement or its extension, were heard in person by a judge (hearings often took place in the establishment where the patients were held) and, where required by the relevant legislation, a medical opinion from a non-treating doctor was submitted to the court. Court decisions contained reasons for the involuntary placement or its extension and were delivered to the patient concerned.

It should also be placed on record in this context that the administrative files examined by the delegation in both establishments visited were very well kept.

142. Involuntary patients must be discharged from a psychiatric establishment once conditions for their involuntary hospitalisation cease to be met or upon the expiry of the period for which the court ordered involuntary hospitalisation (Section 48 BOPZ). In addition, patients may submit a request for a discharge to the medical director of the facility who has to take a decision within two weeks. If the request is dismissed, the patient may request the prosecutor to file a motion for his/her discharge with the court.[80] The court must hear the patient (who has to be represented by a lawyer) and must take a decision within three weeks.

143. Overall, the CPT considers that the relevant legislation and the way it is being implemented in principle provide sufficient guarantees of independence and impartiality, as well as of objective medical expertise.

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

In addition, **the CPT would be interested to receive information as to the professional training provided to judges responsible for hearing psychiatric patients to ensure meaningful judicial assessment with a real possibility of release when the criteria for involuntary placement are not met.**

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[80] The prosecutor does not, however, file such a motion with the court if the request is manifestly inadmissible or if the same request has been made by the patient in the last four months and the new request does not contain any new facts.

b. safeguards during placement

144. Involuntary treatment of psychiatric patients is regulated by Section 39c BOPZ:[81] it may only take place with the aim of removing the danger caused by the patient as a result of his/her mental disorder and a) in so far as without the treatment, the danger cannot be removed within a reasonable time, or b) to the extent the treatment is strictly necessary to remove the danger caused by the person within the establishment.

145. At *Kastanjehof*, the delegation learned that civil involuntary patients may exceptionally be transferred to a nearby forensic psychiatric clinic,[82] for example, if they were highly disruptive, if the isolation unit of the hospital was fully occupied or for their "risk assessment" by a specialised forensic psychiatric team.

The CPT notes that the involuntary placement decisions issued by courts and seen by the CPT's delegation did not specify a particular establishment in which the patient concerned should be hospitalised. Moreover, according to the information provided by the staff of Kastanjehof, the forensic clinic in question was licensed to accommodate civil involuntary psychiatric patients.

However, the Committee also notes that the transfer of a patient could potentially be carried out against his/her will and was subject to no written decision or possibility of appeal. In these circumstances, the Committee considers that transfers of civil involuntary patients to forensic settings should be surrounded by additional safeguards, such as the possibility to challenge the transfer decision. **The CPT would like to receive the comments of the Dutch authorities on this issue.** In addition, **the Committee would like to be informed, for the years 2015 and 2016, of the number of civil involuntary patients transferred to forensic settings from all psychiatric establishments in the Netherlands.**

146. Arrangements concerning patients' contact with the outside world were satisfactory in both establishments. Patients could send and receive letters, were allowed to keep and use their mobile phones and could make phone calls from payphones located in the establishments. Visitors could come every day between 10 a.m. and 10 p.m. at *Rielerenk* (arrangements were also made so that visitors could stay overnight); at *Kastanjehof*, visits were allowed every day between 7 p.m. and 9 p.m. and additional visiting hours (2 p.m. to 5 p.m.) were available on weekends. In both establishments, visitors were allowed to enter the wards where patients were accommodated.

It should be added in this context that by virtue of Section 40 BOPZ, certain restrictions may be imposed on the patients' rights to receive visits and make phone calls if they have a serious adverse effect on the patient or disrupt order in the hospital or if this is required for the prevention of criminal activity.[83] Patients may lodge a complaint against the restrictions imposed (see the following paragraph). However, the delegation's findings indicate that such restrictions were hardly ever imposed on patients in either of the establishments visited.

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81 The issuing of involuntary placement decision in itself does not authorise involuntary treatment of the patient.

82 De Voorde Forensic Clinic immediately adjacent to Kastanjehof.

83 These restrictions, however, do not apply to contacts with, for example, a lawyer, judicial authorities and the Health Care Inspectorate.

147. Patients may lodge complaints, including as regards their individual treatment plans, involuntary treatment, use of means of restraint or limitations on their contact with the outside world, to the management of the establishment. A complaints commission established by the management must deal with the complaint within two (or, in some cases, four) weeks and reply to the complainant. The commission may, *inter alia*, quash the challenged decision and set a deadline for a new decision to be taken.

In addition, every psychiatric establishment must appoint a patient advocate (*patiëntenvertrouwenspersoon – pvp*) whom patients can contact and who should help them with filing complaints with the complaints commission.. The advocate may also accompany the patient to the hearings before this body.

148. As regards inspections, the main body which regularly visits health-care establishments is the Health Care Inspectorate (IGZ). However, the delegation was informed that the IGZ did not deal with individual complaints lodged by patients. **The CPT would like to receive the clarification of this issue from the Dutch authorities.**

As regards the role and functioning of the NPM, reference is made to paragraphs 8 and 9.

c. some remarks concerning the situation of "voluntary patients"

149. In both establishments visited, several voluntary patients were being accommodated on closed wards. As confirmed both by staff and the patients concerned, most of them were free to leave the wards and the establishments whenever they liked.[84]

However, at Kastanjehof, the CPT's delegation met one patient, formally registered as voluntary, who was in fact not allowed to leave the ward on which he was being accommodated.[85] The delegation considered that this patient was *de facto* deprived of his liberty without benefiting from the relevant legal safeguards. At the end of its visit to the establishment, the delegation shared these concerns with the management and suggested that the situation of this patient be reviewed and, if appropriate, an involuntary placement procedure be instituted. **The CPT would like to receive an update on the legal situation of the patient concerned. More generally, the Committee considers that any patient in such a situation should be regarded as involuntary and thereby benefit from the relevant legal safeguards.**

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84 If voluntary patients wished to leave the establishments but the staff considered their hospitalisation necessary, the involuntary placement procedure would be instituted.

85 The patient concerned was known for pathological travelling and on several occasions in the past had been brought back to the hospital by the police from remote places, including from abroad. During the time outside the hospital, he seriously neglected himself and could possibly become aggressive towards others.

150. Moreover, in both establishments visited, some voluntary patients were held under a so-called "closed ward regime", usually during the initial stage of their hospitalisation, and were consequently not allowed to leave their ward. According to the information provided by staff and the patients concerned alike, during their admission interview, these patients agreed to such arrangements which became a part of the "treatment contract" between them and the establishment and were recorded in the patients' individual medical files. However, the patients concerned were apparently not informed in writing about their legal status as voluntary patients, or about their right to leave the establishment or of the fact that an emergency admission procedure might be instituted in order to keep them in the establishment.

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

The CPT would like to receive the comments of the Dutch authorities on this subject. Moreover, **the Committee would like to be informed how this issue will be regulated in the new legislation.**

APPENDIX
LIST OF THE NATIONAL AUTHORITIES, OTHER BODIES AND NON-GOVERNMENTAL ORGANISATIONS MET BY THE CPT'S DELEGATION

A. National authorities

Ministry of Security and Justice

Klaas DIJKHOFF	State Secretary of Security and Justice
Martin KUIJER	CPT Liaison Officer, Legislation Department and Legal Affairs
Clarinda COERT	Senior legal adviser, human rights law, Legislation Department and Legal Affairs
Angeline VAN DIJK	Director, Division of prison administration/temporary custody of foreign nationals
Monique SCHIPPERS	Deputy director, Division of prison administration/temporary custody of foreign nationals
Edwin MULDER	Head of unit, Facility and Information Management
Meije JEURENS	Senior officer, detention policy, Directorate for Implementation of Sanctions and Youth
Ritske ZUIDEMA	Senior policy officer, forensic care, Directorate for Implementation of Sanctions and Youth
Maykel BOUMA	Specialist, migration law
Frans BOONE	Legal adviser, Division of prison administration/temporary custody of foreign nationals

Ministry of Health, Welfare and Sport

Merel BAAS-VAN VLOTEN	Deputy director, Department of international affairs
Ina GORTER	Policy adviser, long-term care
Margre JONGELING	Policy adviser, curative care
Liesbeth MOLENAAR	Policy adviser, curative care
Jaap VAN DEN BERG	Coordinating policy adviser, youth
Swana VAN SCHAARDENBURG	Adviser, international affairs

B. Other bodies

National Ombudsman

Reinier VAN ZUTPHEN	National ombudsman of the Netherlands
Stephan SJOUKE	Head, International Affairs

National Preventive Mechanism (NPM)

Jan Paul MATZE	Member, Commission of Oversight for Police Custody
Annejet MEIJLER	Program Director, Inspectorate of Security and Justice
Hans MERKUS	Strategic Inspector, Inspectorate of Security and Justice
Paul MEVIS	Member, Council for the Administration of Criminal Justice and Protection of Juveniles
Kees REEDIJK	Strategic Inspector, Health Care Inspectorate
Jitkse VAN DER LEEDE	Adviser, Inspectorate of Security and Justice
Edwin VAN HOUTEN	Head of Department, Health Care Inspectorate
Hendrik VIS	Chairman, Commission of Oversight for Penitentiary Institutions

Netherlands Institute for Human Rights

Adriana C.J. VAN DOOIJEWEERT	President of the Netherlands Institute for Human Rights
Anne VAN EIJNDHOVEN	Policy adviser

C. Non-governmental organisations

Amnesty International

Dutch Association of Asylum Lawyers (VAJN)

Dutch Section of the International Committee of Jurists (NJCM)

Forum Levenslang