

25 November 2024

Confidential

**Ad hoc visit to the Netherlands by a delegation<sup>1</sup> of the  
European Committee for the Prevention of Torture  
and Inhuman or Degrading Treatment or Punishment (CPT)**

**(7 to 12 October 2024)**

**Preliminary Observations**

Dear Secretary of State Karremans,

We are grateful that you have accorded us the opportunity to share our first impressions from the visit which we undertook to the Netherlands in October. The usual practice for CPT delegations is to present the preliminary findings on the visit to the political authorities at the end of the visit. Unfortunately, in this instance, this was not feasible.

The full report on the visit will be shared with the Dutch authorities following its adoption by the Committee in March 2025.

Under the terms of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, this visit to the Netherlands was one which the Committee considered to be “required by the circumstances” (Article 7.1) and is referred to as an “ad hoc visit”. The underlying reason for the visit relates to the prevalence of violence in closed residential youth care institutions (*Jeugdzorg Plus*).

Background

Almost 10 years ago, in 2015, the Government of the Netherlands commissioned Micha de Winter, then Professor of Social Education and Youth Policies at Utrecht University, to study the occurrence of violence in youth care, including closed residential youth care, in the period since 1945. In 2019, the De Winter Committee<sup>2</sup> published its conclusions

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1. The delegation consisted of Gunda Wössner (Head of Delegation) and Tom Daems, members of the CPT; Marco Leidekker (Head of Division) of the CPT Secretariat, and two experts: Ursula Kilkelly, Professor of International Children’s Rights Law (Ireland) and Heidi Hales, Consultant Psychiatrist in Adolescent Forensic Psychiatry and Forensic Psychiatry Researcher (United Kingdom). Our two experts, Professor Kilkelly and Dr Hales, are not with us today.

2. “Commissie Onderzoek naar Geweld in de Jeugdzorg”.

and recommendations,<sup>3</sup> including that the authorities of the Netherlands had failed to protect young persons under the state's care. The Netherlands' Government acknowledged its failure to protect, offered its apologies and initiated several measures aimed at just satisfaction, the preservation of a collective memory of the suffering of youth placed in care, and at preventing future harm. The last set of measures includes limiting the placement of young persons in closed residential settings, and the nomination of persons of confidence within closed residential youth establishments.

Despite these efforts, Dutch media continue to report on cases of violence within *Jeugdzorg Plus* establishments. For instance, the use of chokeholds in the *Lindenhorst*<sup>4</sup> and allegations of sexual abuse and the application of pain-inducing restraint techniques at *Woodbrokers*.<sup>5</sup> Further, of course, there is "*Eenzaam gesloten*", the report by Jason Bhugwandass on the former Zykos departments in Harreveld and Zetten.

### Cooperation received

In light of this information, the CPT decided to visit the Netherlands, to assess the state of affairs in a few institutions, on the understanding that, in certain cases, the reported violence may amount to a violation of Article 3 of European Convention on Human Rights (ECHR). Here, the CPT took into account that only 11 institutions are authorised to offer closed residential youth care.<sup>6</sup>

Before I continue, please allow me to explain that the CPT operates in the spirit of cooperation and confidentiality, and that it is fully aware of the political sensitivity of the subjects we are discussing today. The purpose of the visit is to contribute to our common objective: the prevention of violence against young persons in *Jeugdzorg Plus* establishments, or in CPT wording: the strengthening of the protection of these young persons from inhuman or degrading treatment or punishment. We would therefore welcome any comments you or your colleagues may have prior to the report being adopted in early March.

During its six-day visit, this delegation visited *Schakenbosch* in Leidschendam, *iHub location Oost Gelre* in Harreveld and *ViaJeugd* in Cadier en Keer.<sup>7</sup> Without exception, the delegation was very well-received, with great openness and hospitality. It had access to all documentation it asked to consult, and could speak in private with all persons it wished to interview, staff and young persons alike. We wish to extend our particular thanks to Nelleke Koffeman, the CPT's liaison officer, as well as her colleagues, for their crucial role in preparing this visit.

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3. "Onvoldoende beschermd: Geweld in de Nederlandse jeugdzorg van 1945 tot heden".

4. "Met mes op verlof, nekklem en wurggreep: zo ervaren jongeren jeugdinstitution Lindenhorst", Algemeen Dagblad, 14 October 2022.

5. [www.omropfryslan.nl/misstanden-bij-zorginstelling-woodbrokers](http://www.omropfryslan.nl/misstanden-bij-zorginstelling-woodbrokers);  
[www.omropfryslan.nl/pijnprykkels-en-isoleren-was-heel-normaal-in-woodbrokers](http://www.omropfryslan.nl/pijnprykkels-en-isoleren-was-heel-normaal-in-woodbrokers)

6. At the time of the visit, one of these establishments ('s Heerenloo in Ermelo) did not offer *jeugdzorg plus*, despite having received the authorisation to do so. A second institution, Woodbrokers, had been closed.

7. The delegation spent one day in Schakenbosch, and two days in iHub location Oost Gelre and in ViaJeugd.

As you know, the text of Article 3 ECHR speaks of torture and inhuman or degrading treatment or punishment. I say this to explain that the scope of Article 3 goes beyond physical ill-treatment, and that, besides acts of deliberate physical ill-treatment such as punching or kicking, or abuse of a sexual nature, negligent professional interventions, such as the painful application of means of restraint, or forcing young persons to undergo certain humiliating procedures may also fall within its scope, as do forms of violence between young persons themselves when insufficient measures are taken to prevent such violence.

### The findings of the visit

In the three establishments the delegation visited, there was much positive that attracted its attention. This includes the dedicated staff and the overall outstanding material conditions on most of the units visited, with real efforts to create a pleasant and home-like environment, despite the carceral buildings in which some were located. Furthermore, the delegation encountered some examples of what it considers a good practice, such as the synergetic relation with the education system and the frequent presence of persons of confidence on the units (*JeugdStem*). That said, the focus of the visit was the protection against violence, and for the remainder of my presentation, this is what I will focus on.

During this visit, no allegations of deliberate physical ill-treatment or abuse of a sexual nature by staff of the young persons in their care were received by the delegation; it appeared that the establishments visited acted upon accusations brought to their attention by opening internal investigations. However, the delegation wishes to share with you today that it did hear from young people some concerns about the rough handling they experienced. Violence between young persons occurred, but in general, staff intervened rapidly.

In respect of negligent professional interventions, mainly the application of means of restraint, the situation was more complex. On 1 January 2024, the Youth Law (*Jeugdwet*) was amended<sup>8</sup> to include rules on restrictive measures (“*vrijheidsbeperkende maatregelen*”),<sup>9</sup> which includes the application of two types of means of restraint: segregation<sup>10</sup> (placement in the juvenile’s own, unlocked room<sup>11</sup> or placement in a “safe space”<sup>12</sup>) and manual restraints (holding “*vasthouden*” and grabbing “*vastpakken*”).<sup>13</sup>

The delegation welcomes this law, which is intended to fill the vacuum in which means of restraint were applied without a proper legal framework. The delegation also subscribes to limiting the legally authorised means of restraint to segregation and manual restraint, and the requirement on institutions to report the use of restrictive measures to the Inspectorate.

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8. Wet rechtspositie gesloten jeugdhulp.

9. Article 6 (3) *Jeugdwet*.

10. Article 6 (3) a *Jeugdwet*.

11. Article 6.3.3. (2) e *Jeugdwet*.

12. Article 6.3.3. (2) f *Jeugdwet*.

13. Article 6 (3) d *Jeugdwet*.

However, already from the outset it was clear that *Jeugdzorg Plus* establishments did not consider themselves to be ready for full implementation of the law. In this context, notably safety concerns were mentioned despite having themselves initiated its drafting and the law having been largely based on their own proposals. Therefore, although no longer legal, certain longstanding practices, notably locking young persons in their own room, including at night, continue and are tolerated.

Dutch law stipulates that it is the responsibility of the establishments offering *Jeugdzorg Plus* to ensure that manual restraints be applied in a proportional and responsible manner, and it restricts the right to their use to those who have been trained in such proportionate and responsible application.<sup>14</sup> In practice, however, it appears that the institutions visited are struggling with the introduction of the proportionate and responsible use of manual restraint techniques.

For instance, although restraint techniques causing pain are prohibited, from interviews with young persons and staff it became clear that such techniques are indeed in use. In the view of the CPT, the use of pain-inflicting restraint techniques where alternatives are available may very well qualify as a possible violation of Article 3 ECHR. In this context, the delegation notes that many of its interlocutors reported a lack of clarity as to which manual restraint techniques are considered legal and which are not (an area in which the representatives of the establishments visited, said to be open to receive guidance). This unclarity lead to hesitation, uncertainty, and reluctance on the unit floor.

It was also indicated that in certain institutions, due to the high numbers of temporary staff, it was not guaranteed that all those applying manual restraints would have received the necessary training.

In the CPT's view, when a young person is injured during the application of means of restraint it is incumbent upon an institution to establish whether that application was proportional and responsible. In *Schakenbosch*, a girl had sustained a broken arm during a restraint procedure. From the cursory internal reporting, it was not possible to understand the sequence of events, or whether the injury was caused by the unskilled application of a manual restraint technique, or by an unfortunate fall during its application. Surprisingly, the girl's medical file does not contain the outcome of the medical examination carried out by the hospital where the girl was treated for her injury, and indeed contains no reference at all to the broken arm.<sup>15</sup> Although the incident was duly reported to the Inspectorate, at the time of the delegation's visit, one month after the incident, the internal investigation had not yet begun. **The CPT would like to be informed about the outcome of this investigation.**

In the view of this delegation, it should be considered part of the duty of care of an institution to investigate immediately and comprehensively the cause of any injuries sustained by a young person under its care, in particular when the injury is associated

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14. Article 6.2.3 Besluit Jeugdwet.

15. When asked for an explanation, the delegation was told that the report of the hospital might have been sent to the girl's general practitioner.

with the physical intervention of a staff member “necessary to preserve the safety for the juvenile and for others”<sup>16</sup>. Besides establishing the proportionality of the intervention and whether the use of restraint was responsible, such investigation also provides important information to management as to the aptitude of staff to intervene appropriately during moments of agitation and aggression and how young people experience being subjected to means of restraint.

More generally, as application of restraints may lead to injuries, the CPT recommends a medical check by a nurse or doctor after every incident of restraint. Such medical examination is for the benefit of the juvenile, as it prevents certain harmful techniques from being used, and would lead to an investigation in the event that injuries are detected. This also protects the institution. For example, in 2023 in *ViaJeugd* a youth filed a complaint with the complaints committee about injuries sustained pursuant to the application of means of restraint. The young person said he was injured in the face and on his arms and legs. Whilst the complaints committee started an investigation, it interrupted its work before it had come to a decision, as the complaint was withdrawn.

The medical record of this juvenile did not make reference to any injury. Neither did it contain any information on a visit by a medical professional following the incident. In other words, if the young man would have pursued his complaint, the institution, most likely, would not have been in a position to defend its proper handling of the situation. Further, the delegation considers that, in this case, the establishment should have opened an investigation *ex officio*, even when the complaint was ultimately withdrawn.

Incidentally, for institutions to be able to investigate, the quality of daily reporting would need to improve significantly. On several occasions the delegation found that the reporting was lax, unclear and, at times, simply wrong. In the view of the delegation, such defective reporting seriously impedes effective management of these closed establishments.

Allow me now to say a few words about “placement in a safe space”. The CPT welcomes the detailed requirements as to the safe space contained in the legislation.<sup>17</sup> However, it appears that fulfilling these requirements may demand substantial investments, which are not always made, due to the persistent uncertainty as to the future of certain establishments. For instance, one institution visited requested funding for four safe spaces and received money for one, which it constructed on the ground floor of the two-storey building. This institution is unable therefore to use the safe space for young persons remaining on the top floor as it is prohibited to transfer a restrained young person down a flight of stairs. Consequently, the institution improvises and locks young persons up in one of the many empty bedrooms.

Dear Secretary of State, as we come to the end of these preliminary observations, please allow me to share with you one final issue. Under the terms of the Youth Act, a young

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16. Article 6.3.1 (1) Jeugdwet.

17. Article 6.2.5 and 6.2.6 Besluit Jeugdwet.

person may be searched for contraband.<sup>18</sup> To this end, they may be asked to undress, but the law stipulates that these young persons shall always remain in their underwear. Again, at times the practice was different from the letter of the law. In *ViaJeugd*, in case of a suspicion of possession of illicit substances, youth were required to dress a gown and subsequently to remove all other clothes. Then, they were required to repeat movements such as squatting, bending over, and jumping with spread legs, for any contraband hidden inside the body to fall out. Besides clearly being in violation of the Youth Act, such a procedure as described by the young persons spoken to could be considered as degrading.

The delegation discussed this practice with staff. Apparently, this procedure is used in respect of one unit only, and once again safety for staff and other young persons was given as the reason.

As a very last observation, for this delegation it has become clear that concerns for safety, both for staff and the young persons under their care, have a significant impact on the reform objectives included in the 2024 law.

Thank you for your attention.

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18. Article 6.3.4 (2) a Jeugdwet.