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Reporting requirements for offences committed by forensic patients

Process evaluation of the manual

WODC (Research and Documentation Centre), Ministry of Security and Justice
Barneveld, 9 October 2014
Reference: AW/mu/13.462
Version: 1.1
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Management Summary

Background and Research Question

01 If a forensic patient (a patient detained under a hospital order, '*tbs-gestelde*' in Dutch) commits an offence that qualifies for remand in custody[1], the head of the institution must report this to the police within 24 hours. This is laid down in Section 53, paragraph 2 and Section 57, paragraph 4 of the Hospital Orders (Care) Regulations, which were amended to that effect on 26 June 2008. Moreover, an 'exceptional incident' report must be made to the Forensic Care Department of the Custodial Institutions Agency. The institution head or deputy head must cancel all leave for the forensic patient at once. Authorisation for leave ceases to apply by law if the Public Prosecution Service designates the forensic patient as a suspect in an offence qualifying for remand in custody. If an assessment by the Public Prosecution Service later shows the designation of the forensic patient as a suspect of such an offence to have been wrong, the leave authorisation comes into effect again and leave can be resumed. In the case of forensic patients without leave authorisation, the offence may be taken into account in any future requests for leave.

02 These regulations relating to mandatory reporting for forensic patients were evaluated in 2011[2]. This evaluation showed that while reporting had increased, the regulations were not being implemented as intended. For example, not all offences that should be reported were actually being reported, the deadline for reporting offences (24 hours) was not always being met and the relevant partners (the police and the Public Prosecution Service) did not always carry out the intended tasks. In practice, the different clinics (forensic hospitals) seemed to vary in their implementation of the regulations.

03 In response to this evaluation, a manual was compiled at the request of the State Secretary of Security and Justice (hereinafter: 'State Secretary') in which further clarification is given of the rules and an explanation is given of the steps to be taken by the relevant parties. In addition, one change was made to the regulations: the deadline for making the report was extended from 24 to 48 hours. This manual became available in November 2013 and was sent to the relevant organisations. The aim of the manual is to clarify what the organisations have to do to comply with the duty to report. The manual can not only help improve compliance with the duty to report offences, it can also help achieve a greater degree of equality before the law. After all, the duty to report had previously not been strictly observed by the institutions and consequently there had been disparity in its implementation.

04 The aim of the current study is to ascertain whether the rules concerning the cancellation by law of the authorisation for leave and trial leave (Hospital Orders (Care) Regulations, Sections 53 and 57) are currently being carried out as intended.

[1] This concerns offences for which an order to remand the suspect in custody may be given. Time on remand is possible for crimes for which the law stipulates a prison sentence of four years or more and for certain specific crimes (such as threats, assault and dealing in soft drugs) that are specified in Section 67, paragraph 1, subparagraphs b and c of the Code of Criminal Procedure.

[2] Jong, B.J. de and A.E. van Burik (2012). *Evaluation obligatory reporting punishable offences in detention under a hospital order*. Woerden: Bureau Van Montfoort.

05 To examine whether the (amended) regulations are being implemented as intended, research questions were formulated regarding compliance with the regulations based on the manual. The questions concern:

a. Implementation of the manual;
b. The process within the clinics when assessing the offence, making the report and cancelling leave;
c. The handling of the report by the police;
d. Assessment by the Public Prosecution Service of the designation of the patient as a suspect and the decision whether to prosecute;
e. Assessment of the consequences for leave by the Custodial Institutions Agency's Leave Unit;
f. The communication between clinics, the forensic patient, the police, the Public Prosecution Service and the Custodial Institutions Agency.

Research Approach

06 The research was carried out in three phases:

a. The first phase focused on reviewing the current status of the implementation of working agreements (in the criminal justice chain) following the introduction of the manual. To this end, exploratory interviews were held with people involved in compiling the manual. Clinics and some public prosecutors charged with responsibility for forensic patients (hereinafter 'forensic patient prosecutors') were interviewed by phone. Furthermore, two group interviews were held with people from clinics, the police and the Public Prosecution Service.
b. The second phase was aimed at obtaining more in-depth information by collecting recorded data and holding interviews to examine compliance with the rules and the intended procedure as laid down in the manual.
    i. We held a second round of interviews in which we visited all the clinics and conducted phone interviews with the forensic patient prosecutors and the police contact officers.
    ii. Furthermore, a case register was set up. All 'exceptional incident' reports were included in the study that concerned or might have concerned an offence qualifying for remand in custody3 and were made to the Leave Unit between 1 November 2013 and 1 July 2014. The degree of compliance with the manual was determined for each report. In the period studied, there were a total of 74 reports of exceptional incidents that were or might have qualified for remand in custody. Additional data on cases was obtainable in varying degrees from clinics (78%), the police (59%) and the Public Prosecution Service (27%).
c. The focus in the third phase was on analysing the qualitative and quantitative information and combining the analyses to arrive at answers to the research questions and reach conclusions. The results were assessed in a group meeting with representatives from the parties concerned.

[3] There are more situations where the clinic is expected to report an exceptional incident. For instance, 'exceptional incident' reports should also be made in the event of hunger strikes, infectious diseases, attempts to abscond during leave and the death of a forensic patient. The only reports included in this study are those that the Leave Unit considers to have concerned an offence that qualified or could possibly have qualified for remand in custody.

'Duty to report' manual

07 Following the evaluation of the duty to report in 2011, the State Secretary promised the Lower House of the Dutch Parliament that a manual would be compiled explaining the steps to be taken by the various relevant parties when a forensic patient commits an offence that qualifies for remand in custody[4]. The aim of the manual is to improve people's understanding of the rules and to safeguard their correct implementation. The manual was compiled in 2013 by a nationwide working group that included representatives of the clinics[5], the police, the Public Prosecution Service and the Custodial Institutions Agency as well as the Ministry of Security and Justice. The clinic representatives were from Forensic Psychiatric Centres. The working group did not include any staff from Forensic Psychiatric Clinics.

08 The manual clarifies the regulations and specifies the responsibilities of each partner in the criminal justice chain at each point in the process. The manual also discusses a number of 'points for further attention' for each partner in the criminal justice chain.

09 The manual content can be summarised as follows:

a. The manual states that the clinic should contact the local police contact and the public prosecutor responsible for forensic patients quickly after the incident so that all parties have been informed of the incident. In consultation, they can 'determine jointly whether this is indeed an offence that qualified for remand in custody, and if possible make an (initial) assessment as to whether the person involved should be designated as a suspect'.[6]
b. The clinics must always report offences to the police that qualify for remand in custody, and do so within 48 hours. In such cases, leave is cancelled with immediate effect pending an announcement from the Public Prosecution Service as to whether the patient has been designated a suspect for an offence qualifying for remand in custody. In addition, the clinic must always send an 'exceptional incident' report to the Forensic Care Department, stating whether the clinic has filed a police report or will be doing so.
c. The Public Prosecution Service must always inform the clinic (in writing) when a forensic patient is designated a suspect (or no longer designated a suspect) for an offence that could result in remand in custody. This also applies to the final decision on whether or not to prosecute.
d. The leave authorisation ceases to apply by law as soon as the Public Prosecution Service announces that the patient has been designated a suspect for an offence that qualifies for remand in custody. The leave authorisation resumes effect in cases where the Public Prosecution Service, in deciding whether to prosecute, concludes that there was no offence that qualified for remand in custody or that the forensic patient is not to be designated as a suspect of such an offence after all.

[4] Lower House 2012-2013, 29 452, no. 155.

[5] In this report we use 'clinics' or 'institutions' to refer to both Forensic Psychiatric Centres and Forensic Psychiatric Clinics. The Forensic Psychiatric Centres are FPC 2landen, Pompestichting, FPC Dr. S. van Mesdag, Van der Hoeven Kliniek, Oostvaarderskliniek, De Rooyse Wissel, Oldenkotte, De Kijvelanden and Veldzicht, and the Forensic Psychiatric Clinics are Inforsa (Arkin), Trajectum (Hoeve Boschoord), GGZ Drenthe and De Woenselse Poort.

[6] Manual, page 8. This consultation was repeatedly termed the 'tripartite consultation' in interviews with individuals involved at the policy level. Although this term is not used in the manual, we are using it in this report to refer to the 'preliminary consultation' between the clinic, the police and the Public Prosecution Service.

e. There should be short lines of communication between the institutions, the police and the Public Prosecution Service, and designated contacts should be used where possible so that people know whom to contact and matters can be dealt with quickly.

Findings and Conclusions

The manual's aim has been partially achieved

10 The aim of the manual is to improve people's understanding of the rules and to safeguard their correct implementation. The manual has clarified matters concerning the appropriate procedure and the responsibilities of the various criminal justice chain partners in that procedure. Distributing the manual has helped make people more aware of the regulations and encouraged joint discussions about the regulations and compliance. The manual had not yet been fully implemented in the study period; the scope of the duty to report offences was still the subject of debate and the duty to report was still not being carried out in a fully uniform manner.

Differences in the extent and speed of implementation of the manual

11 The Ministry of Security and Justice distributed the new manual to the clinics, the police and the Public Prosecution Service at the end of October 2013. These organisations were asked to distribute the manual internally among those staff charged with implementing the duty to report. By November 2013, all the lawyers who implement the manual’s contents on behalf of the clinics were familiar with the manual except for those from two Forensic Psychiatric Clinics. The fact that some of the Forensic Psychiatric Clinics were not aware of the manual could be due to them not being directly involved in compiling the manual. All the 'forensic patient' prosecutors within the Public Prosecution Service have the manual. Within the police, it turns out that the manual has not always been passed on to the individuals who are the designated contacts for the clinics and Public Prosecution Service. In practice, contacts between the clinics and the community police officers are so good that the *clinics* informed the police officers of the manual and its contents.

12 The manual was supposed to apply with effect from 1 November 2013. In practice, the organisations concerned turned out to need time to implement the procedures in the manual before they could comply with the manual. For example, not all clinics already had good contacts in place with the 'forensic patient' prosecutors. As a result, the intended 'preliminary consultation' between the clinic, the police and the Public Prosecution Service could not always be put into practice immediately.

13 Debate about the scope of the duty to report offences has also affected implementation.

a. Some of the Forensic Psychiatric Clinics are of the opinion that the duty to report does not apply to Forensic Psychiatric Clinics and that they therefore do not need to implement the manual. They base this argument on the wording in Section 53, paragraph 2 of the Hospital Orders (Care) Regulations, which states that the duty to report lies with 'the head of the institution', referring to the head of a Forensic Psychiatric Centre. However, the Ministry of Security and Justice says that the duty to report does also apply to Forensic Psychiatric Clinics insofar as the Hospital Orders (Framework) Act and Hospital Orders (Care) Regulations apply to forensic patients in the clinic's care.

b. The manual states that the duty to report also applies to 'other patients' in the clinic. This is disputed by the clinics and the public prosecutors on the basis of the Psychiatric Hospitals (Compulsory Admissions) Act and the Hospital Orders (Framework) Act. The Ministry of Security and Justice also says that the duty to report does not apply formally if the individual's legal position is pursuant to the Psychiatric Hospitals (Compulsory Admissions) Act, but that it does apply for the 'other patients'. However the ministry recommends treating all patients staying in a clinic in the same way, including patients covered by the Psychiatric Hospitals (Compulsory Admissions) Act.

14 Clinics are not yet being notified systematically by the Public Prosecution Service of the designation of a patient as the suspect of an offence qualifying for remand in custody or of decisions on whether to prosecute. Not all prosecutors take the approach of designating someone as a suspect in a very early stage. Some argue that they can only designate a forensic patient as a suspect once the police investigation has been completed. They say that the possibility of a false accusation can only be ruled out at that stage and that it is therefore never possible to designate someone as a suspect based purely on the report filed with the police.

Serious offences qualifying for remand in custody are being reported

15 All parties endorse the benefit of reporting serious incidents and the need to do so. In practice this means that both Forensic Psychiatric Centres and Forensic Psychiatric Clinics always report serious offences - those, for example, that have a major impact on the victim. However the consequence of a report for the forensic patient's leave is seen as disproportionate where less serious offences are concerned. As a result, minor offences are not always reported in practice.

16 Many factors play a part for both clinics and the Public Prosecution Service in the decision whether or not to report the incident. These factors include the severity of the incident, whether the forensic patient exhibited diminished responsibility and the extent to which the incident is related to the offence for which the hospital detention order was issued. The factors taken into consideration vary from case to case depending on the clinics, the police officers and the public prosecutors involved. Consequently, similar borderline cases are not always treated in the same way, which means that the intended equality before the law is not yet being achieved for these borderline cases. Some examples of such borderline cases are verbal threats, inappropriate touching, theft of a packet of crisps, vandalism and the possession of drugs.

The preliminary consultation has added value for incidents where qualifying for remand in custody is in doubt

17 A preliminary consultation between the clinic, police and Public Prosecution Service is included as a process step in the manual. In this preliminary consultation, the parties can discuss whether an incident qualifies for remand in custody, and an initial assessment can be made (where appropriate) as to whether the patient should be designated as a suspect. In practice, clinics vary in the extent to which such a 'tripartite consultation' has been implemented. Where it does take place, discussions are generally bilateral[7], take place by phone, and are restricted to incidents where there is some doubt.

[7] Between the clinic and the Public Prosecution Service, and between the police and the Public Prosecution Service.

Clinics and the Public Prosecution Service in particular find the preliminary consultation adds value in incidents where the eligibility for remand in custody is in doubt. However, public prosecutors feel there is relatively little leeway in the assessment of the duty to report offences as qualifying for remand in custody is officially the only criterion. In practice, whether the report would be opportune is taken into account in varying degrees, or else there is a wish to be able to do this more explicitly. One point for attention is the need to clarify the role of the preliminary consultation regarding the option (desired by the parties concerned) of not reporting an incident even when it does qualify for remand in custody.

Reports filed by third parties are a complicating factor

18 The head of the institution is charged with the duty to report, even if a report has already been made to the police by a third party. If a forensic patient on leave commits an offence qualifying for remand in custody, the clinic may not be informed of that fact. At present, the police do not systematically note whether a suspect is a forensic patient. Respondents think that by no means all suspects are checked at the ZSM locations (for the fast-track handling of cases) to see whether they are forensic patients.

19 If the clinic *is* informed of an offence that has been reported by a third party, the clinic does not always file a report with the police. Clinics see a risk of forensic patients making false reports against one another out of spite, with leave being cancelled immediately as a result. If the clinic does decide to file its own report, that is usually possible from the point of view of the police, even though recording 'duplicate reports' properly requires some creativity on the part of the police. The police in particular are not always convinced of the benefit of duplicate reports.

Throughput times are longer than intended

20 The deadline for making the report was extended from 24 to 48 hours. In practice, making a report even within this extended deadline turns out not to be feasible for the clinics. The main reasons the clinics give for this are as follows:

a. The clinics give priority to due care over and above speed;
b. Consultation within the clinic to reconstruct the circumstances of the incident is not always possible immediately in view of the availability of the staff and forensic patients involved;
c. Consultation with the Public Prosecution Service depends on the diaries of the public prosecutors, who are often busy;
d. The clinic cannot always contact the police immediately to make a report.

21 The period between the offence and settlement of the case can easily be several months. The steps for making a report, drawing up an official record, assessing whether the offence qualifies for remand in custody and taking the decision whether to prosecute all take time. The process for most of the reports made in the study period of eight months was still ongoing at the end of that period, waiting for a decision by the Public Prosecution Service. Forensic patients who are the subject of a report are unable to go on leave throughout that entire process. The clinics see this as a significant problem, particularly for cases that are ultimately dismissed.

Reducing the throughput times is a point that needs attention in order to keep the interval between the cancellation of leave and possible reinstatement of leave as short as possible. This can help minimise any negative consequences for leave.

The quality of the collaboration is variable

22 Compliance with the duty to report depends partly on the quality of the collaboration between the clinic, the police, the Public Prosecution Service and the Custodial Institutions Agency. After all, the parties are expected to keep each other informed. In practice, the collaboration varies depending on the clinic and the process step:

a. In general, the coordination between the clinic, the police and the Public Prosecution Service prior to a possible report goes well;
b. Clinics generally send an 'exceptional incident' report to the Forensic Care Department for every offence that has been reported to the police;
c. If the clinic cancels leave following an offence, it notifies the Leave Unit of this. After an 'exceptional incident' report, the Leave Unit reminds the clinic of the requirement to cancel leave but does not verify whether the clinic has actually cancelled leave, as stipulated in the manual. It is however not clear how the Leave Unit should carry out such verification in practice;
d. The police are supposed to deal with the report and send the official record to both the Public Prosecution Service and the clinic. Some clinics have the impression that the police give a low priority to their reports;
e. The Public Prosecution Service is supposed to inform the clinic whether the forensic patient has been designated as a suspect and what decision is taken regarding prosecution. In practice, forensic patient prosecutors do not always provide this information spontaneously. Clinics say they often proactively ask the Public Prosecution Service for this information;
f. The clinics generally inform the Leave Unit of the designation as a suspect and the decision whether or not to prosecute by the Public Prosecution Service, provided the clinic has been informed of this by the Public Prosecution Service. However, the Leave Unit does see room for further improvement in this area.

Uncertainty about the consequences for leave

23 If an offence has been committed, the rules state that the consequence is 'one year without leave'. Determining whether an offence has been committed can lead to practical problems. In principle, it is up to the court to judge whether an offence has been committed. However most offences do not end up in court; instead, they are settled by the Public Prosecution Service or dismissed. In such cases, the Leave Unit assesses whether an offence has been committed. However, the regulations and manual do not make sufficiently clear what the basis should be for the decision about the consequences for leave. A working method has developed in practice but the clinics are not sufficiently familiar with it. As a result, the clinics do not really know when a new leave request is worthwhile and when not. Clarification of the consequences for leave in these cases is an area that needs attention.