

FIRE AT THE DETENTION CENTRE SCHIPHOL OOST

26th October 2005

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THE DUTCH SAFETY BOARD

The Dutch Safety Board has been set up under statute law with the responsibility to investigate and establish what the causes or probable causes are of individual or categories of occurrences in all sectors. The sole objective of such an investigation is to prevent future accidents or occurrences and, if the results of this should give cause to do so, to attach recommendations to these findings. The organization consists of a Board with five permanent members and has a number of permanent committees. Specific advisory committees are formed for specific investigations. A staff of investigators and secretarial reporters support the Dutch Safety Board.

N.B:

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	J.G.M. Alders
	J.D. Berghuijs
	Ms. A.H. Brouwer-Korff
	Prof. dr. B.P.M. Gersons

Project manager: D.J. Smeitink

Visitors address: Anna van Saksenlaan 50
2593 HT The Hague

Postbus 95404
2509 CK The Hague
The Netherlands

Telephone: +31 (0)70 333 7000
Internet: www.safetyboard.nl

Fax: +31 (0)70 333 7077

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CONSIDERATION

Introduction

On the night of 26 October 2005 and in the early morning of 27 October 2005, eleven people lost their lives in a major fire at the Detention Centre Schiphol-Oost. The guards were no longer able to free these people from their cells. However, they did succeed in opening 21 of the 26 cells thus rescuing 32 occupants from their cells. A total of fifteen people suffered injury, including guards and cell occupants, and a wing of the building was destroyed. Following the fire, accommodation was found at other locations for the majority of the 298 cell occupants of the Detention Centre. A great many of these have petitioned for (psycho-social) counselling.

The following questions formed the foundation for the Safety Board's investigation:

"How could eleven cell occupants die during the fire?" and

"Which arrangements were made for the relief and aftercare of the other people involved in the occurrence?"

In asking these questions, the Safety Board has restricted itself to the circumstances that contributed to this fire's fatal turn of events and the consequences that the fire has had on those directly involved.

Fires are commonplace occurrences. In 2004, a total of 43,000 fires in buildings were recorded in the Netherlands, 145 of which were in cellblocks. Each year in the Netherlands, approximately 70 to 80 people die from fires. In the last century (as far as is known), five people died in two fires in cellblocks. By Dutch standards, the loss of such a large number of victims, as in the case of this fire at Detention Centre Schiphol-Oost, can be regarded as quite exceptional. The Board accepts that the possibility of a fire breaking out can never be completely ruled out, but also firmly believes that occurrences of this type should not turn out as disastrously as was the case in the night of the 26th October at Schiphol-Oost.

Responsibilities of the parties involved

Learning lessons from serious occurrences such as this fire occurs only when the parties involved are aware of existing structural safety deficits and know that they are not being judged. Therefore, the Board has also included in its analysis the circumstances under which the events took place. This investigation refers clearly to responsibilities, although the Board is thoroughly aware of the dilemmas with which individuals and administrative bodies are sometimes confronted and the difficult circumstances under which executive bodies have to operate. In making reference to responsibilities, the Board wishes to maximize the opportunity to learn lessons from such occurrences without stepping into the territory of who is to blame. The legislature has recognized that determining the distinction between independent safety investigation and criminal investigation can at times be difficult. For that reason, documents compiled by the Board cannot be used as evidence in criminal, disciplinary or civil proceedings.

Responsibilities were also discussed in the investigations into the café fire in Volendam¹ and the firework disaster in Enschede². The investigating committee into the firework disaster, the Oosting Committee, has already stated that an analysis in which multiple responsibilities arise imposes a risk that all parties involved will stress that their part was only a limited one. In this investigation by the Board, it appeared that the bodies involved were tempted to focus on the responsibilities of others, thereby disregarding their own responsibility. In addition, it became clear to the Board that the parties involved lacked a critical attitude towards their own responsibilities and how to function accordingly. The special nature of the fire in Detention Centre Schiphol-Oost was that it did not concern the division of responsibilities between government and civilians. Instead the responsibilities were, in essence, divided between three governmental bodies, each of which had its own role and responsibilities.

1 Fire at café "T Hemeltje, Volendam, 31 December 2000 in which 13 people died and 180 were injured

2 Fireworks disaster at Enschede, 13 May 2000 in which 22 people died and 950 were injured.

This involved:

- The Custodial Institutions Agency (DJI) as the party having drafted the Programme of Requirements for the building contractor. DJI is the user of Detention Centre Schiphol-Oost and was responsible for the safety of the detainees;
- The Government Buildings Agency (RGD) as commissioner of the construction work and as the owner of the Detention Centre Schiphol-Oost; and
- The Municipality of Haarlemmermeer as the licensing authority for construction work and usage, as the supervisory and enforcement body, and being responsible for the fire brigade.

The report shows the extent to which the government bodies involved realized their responsibilities. Unfortunately, the Board is forced to conclude that they carried out their responsibilities inadequately. This however does not mean that, in reference to the disastrous outcome, the contribution of each body was equally significant.

The Custodial Institutions Agency (DJI)

The user/lessee of the building (being private parties in the cases of 'Enschede' and 'Volendam') was a government body in the case of the fire at the Detention Centre Schiphol-Oost. The government considers safety to be one of its core responsibilities. Therefore, it might well be expected that that same government would observe the legislation and regulations, as well as unofficial regulations, in respect of (fire) safety. This is partly in view of the fact that it is a function of government to set an example and also because this case involved people who were confined and thus unable to save themselves in case of an emergency.

DJI is the authority that bears responsibility for the confinement of people. DJI is the sole authority able to oversee detention circumstances as a whole and effectively coordinate utilization in accordance with the properties of the building and any shortcomings that it might have. After all, while the owner/builder needs to determine and assess the building's properties, the way in which it will be used is, ultimately, a co-determining factor for safety levels. This means that high standards must be imposed on the DJI's internal organization. After all, when a fire breaks out, the in-house emergency and first-aid service (BHV) must initially deal with the situation entirely on its own, because the premise in the standards is that the fire brigade can be deployed fifteen minutes after being called out (arrival time plus deployment time). Experience shows that life-threatening situations may already have arisen by that time. Therefore, the BHV has to be able to rescue a large number of people on its own in an extremely short period of time which demands requisite preparations.

The investigation has shown that the DJI had made an inadequate assessment of the risks that a fire in the Detention Centre Schiphol-Oost would involve. This is all the more conclusive given the fact that a building was involved with a high-risk function which contained people whose ability to save themselves was extremely limited. They had to be released from their cells and even then independent action was limited by the next (closed) door. The Board also discovered that the emergency plan was not sufficiently realistic on a number of crucial points and that the staff was unaware of the contents and requirements of the emergency plan. Furthermore, additional risks were introduced for which no compensation was provided. For example, relatively long, wide corridors were decided upon for J and K Wing with many cells within one wing. These wings were added as extensions to the Detention Centre in 2003. As a result of this, the distance to escape to a safe place was further and the number of cells to be opened was greater than, for example, in the adjacent A and D Wing, which have been fitted with a partition wall and an intermediate door half way along the wing. In addition, the guards on duty in the night of the fire had received inadequate instruction, training and exercise drills, although all of them had undertaken a brief BHV training. They had never been part of any drill exercise at the Detention Centre Schiphol-Oost, partly because, as was reported, there are three teams a day seven days a week and due to the large influx and circulation of personnel. Finally, there was a lack of effective coordination between the user organization and the fire brigade. The impression at the DJI was that the rescue of all the cell occupants would not have to be carried out solely by the guards, particularly at night – given that physically speaking the fire brigade "was nearby". However, in reality, the fire brigade was not close by. Through proper coordination and joint exercises, clarifications could have been made sooner concerning the length of time that the BHV team would have to be detailed on its own and the importance of well defined assistance of the BHV team upon arrival of the fire brigade to ensure rapid deployment of the fire fighting services.

It is the opinion of the Board that the internal organization's limited preparations and arrangements is particularly caused by the fact that, in every-day practice, the Site Manager and his personnel's attentions were focussed largely on locking up detainees and keeping them locked up within the applicable detention regime (treatment, facilities, etc.). Matters such as tuition about, performing exercises for and the reading of an emergency plan may then soon fall outside of these daily, usually hectic, routine.

Under prevailing legislation (Prisons Act and Working Conditions Decree), the director of any penitentiary institution, and thus also of this Detention Centre, is assigned a heavy responsibility as far as daily management, the treatment of cell occupants and safety are concerned. It appears from the investigation that a discrepancy exists between statutory responsibilities on the one hand and daily practice in fulfilling these responsibilities on the other. The Board has established that the responsibilities of the director as provided for in law are exercised by the director of the facility as well as the Head of the Temporary Special Facilities Directorate and the remainder of the directorate of the DJI. In practice, the division of responsibility between them is diffuse. One example of this is that the director is responsible for the BHV team but has to use people for this assignment who originate from a (central) DJI pool containing personnel not in his employment. The prevailing policy does not allow rejection of these people, because, in the director's opinion, they might, for example, be unsuitable or lack sufficient education. In addition, the building was released to a staff department at the directorate of the DJI. The Site Manager played no direct role in this, yet he does bear responsibility for (fire) safety for employees and cell occupants.

The preconditions that the directorate of the DJI should create are important in respect of interpreting the statutory responsibilities of the director of the facility. However, an established policy of fire safety was absent and, when the implementation of policy was verified, there was no specific attention to fire safety. The Board concludes that the directorate of the DJI was inadequate in its fulfilment of this role in respect of the Detention Centre Schiphol-Oost.

The Government Agency (RGD)

It is not only the DJI's user organization that determines the safe use of the Schiphol-Oost Detention Centre. The building itself and the design decisions in the construction plan also affect fire safety. As far as the construction of J and K Wing at the Schiphol-Oost Detention Centre was concerned, it appears from the investigation that they were not compliant with construction legislation and the Directive on "Cells and Cell Blocks Fire Safety".

The Government Buildings Agency (RGD) constructs many buildings for central government and owns and manages the majority of the penitentiary institutions built in the Netherlands. Despite the aforementioned ultimate responsibility of the DJI for the safety of the cell occupants, the Board holds the opinion that it might be expected of the RGD that this agency is in a position to build a fire-resistant Detention Centre that complies with construction legislation and – as far as appropriate to a temporary structure – that has as much as possible been equipped with modern technical features to guarantee fire safety. However, this was not what the Board has observed. Moreover, the RGD did not communicate in writing the observed deviations from the Buildings Decree in the building application to the licensing authority and to the user. The Board wonders whether the RGD's (new) main objective, a "Satisfied Client", as stated in the agency's quality manual, suits the high-risk nature of penitentiary institutions. The secondary attention given to fire safety at the RGD, as encountered in respect of the Detention Centre Schiphol-Oost, may have been partly caused by this fact and is perhaps not an exception considering the investigation of the Government Inspectorates into other comparable temporary penitentiary institutions.

The Municipality of Haarlemmermeer

The Board observed negligence in respect of granting permits for J and K Wing. The Municipality of Haarlemmermeer carried out assessments based on too limited an amount of information. It has been noted in the investigation that this information was insufficient to be able to determine whether (fire) safety had been adequately guaranteed for the building and its use. The Board recognizes reports of considerable time pressure, complex deliberations and an influential permit applicant, but this does not discharge the Municipality from its responsibility for granting permits correctly. The municipal executive should be convinced of the fact that sufficient capacity and

resources are available for this, both in quantitative as well as qualitative terms. Apart from this, the Board wonders in more general terms whether local government has sufficient knowledge and capability to be able to assess complex buildings with high-risk functions, such as a Detention Centre, without relying on external expertise. With regard to this, the Board wishes to raise the possibility of combining expertise on a national level in respect of complex buildings such as penitentiary institutions and to make this expertise accessible to all (licensing authority) municipalities.

Furthermore, the danger exists of a municipality acting as a consultant in respect of fire safety in the preliminary stages of an application for a permit. This can result in a subsequently less critical analysis in the permit-granting process in respect of those matters on which advice has been given previously in the process. In the Board's opinion this is an undesirable situation. In addition to this, it appeared from the responses on the draft version of the report that a risk of losing sight on the clear distinction of roles and responsibilities exists. Those involved in the process of issuing the Building and Occupancy Permits were inclined to rely on and point to the expertise of the fire brigade. This was done while the fire brigade had not substantively evaluated a number of matters, because it relied on the expertise of the co-governing bodies, in this case the RGD and the DJI.

It appeared from the investigation in relation to municipal responsibilities in respect of fire fighting that there were insufficient advance coordination, preparation and exercise drills between the Haarlemmermeer fire brigade and the Detention Centre. Thus each body had its own expectations about the action taken by the other. During the fire on the night of 26 October and morning of 27 October 2005 it transpired that these expectations could not be met. The arrival of the fire brigade at the Detention Centre Schiphol-Oost was delayed for a number of reasons. This was directly attributable to the aforementioned lack of coordination and preparation. The fire brigade cannot be expected to test all the BHV teams entirely on the degree to which they are prepared for fires. In principle, the initiative for collaboration lies with the user/DJI. Nevertheless, a more active and critical attitude might be expected from the fire brigade as a safety organization given the high-risk nature of this building.

Legislation, regulations and directives

In view of the indicated deficiencies of the detention centre in relation to the Buildings Decree, the Board conducted a further analysis into the applicability of the available legislation and regulations, as well as the available complementary standards and directives.

Analysis of the building regulations for buildings serving as cellblocks shows the regulations to be complicated and open to interpretation in a variety of ways. This is reinforced by the presence of the so-called 'equivalence article' in building regulations. This article, with innovation in mind, makes it possible to deviate from requirements when the building permit application demonstrates that the structural alternative is equivalent as far as fire safety is concerned. As a result, this introduces additional (and occasionally difficult) assessments, which require expertise and knowledge of the fire safety risks in penitentiary institutions. Given that this expertise has been found to be insufficient both at the RGD and the Municipality of Haarlemmermeer, the Board has cause for concern regarding other penitentiary institutions, especially now it has been shown that the parties involved had been insufficiently aware of this.

The Board understands that the complexity of some situations may be such that the legislature is not able to formulate requirements in an accessible, unambiguous way. In such cases, the Board advocates that the required guidance is provided on the introduction of this legislation, for example, in the form of training and tuition.

In addition, the Board believes that whether cell occupants have been locked up in a temporary or permanent construction should not make any difference to their safety. Consequently, the Board advocates a critical analysis of the safety levels of temporary constructions (including containers for detention centres, student accommodation, etc.).

In its investigation, the Board has indicated a lack of clarity in terms of legal status as far as the Directive of 'Cells and Cell Blocks Fire Safety' is concerned. The Board emphasises the importance of establishing best practices in such Fire Safety Schemes. However, it is undesirable for the parties involved to refer to these unofficial regulations as 'non-negotiable standards' or alternatively emphasise their 'optional character', depending on the circumstances. In practice,

this gives rise to confusion about the status of these unofficial rules – a fact that the Board has come across in other sectors as well. In addition to reflection on the status of the Directive of 'Cells and Cell Blocks Fire Safety', it would appear to be necessary to update and substantively reconsider its content. Among other matters, the fire-load aspects require further study. Notably, the approach taken by the Buildings Decree is different from that in the Directive of 'Cells and Cell Blocks Fire Safety'. The consequences of the above mentioned along with the fact that, according to the current directive, the fire brigade has to be ready for deployment only after fifteen minutes, should also be more explicitly clarified than presently is the case.

Supervision

If government organizations should fail in their role as owner and user in respect of fire safety, correction mechanisms by means of supervision appear to deliver inadequate results. Shortcomings in respect of fire safety concerning the building, its use as well as the in-house emergency and first-aid service (BHV) remained unnoticed. A variety of bodies could have provided an effective role in supervising the Detention Centre (the Labour Inspectorate, the VROM Inspectorate and the DJI, including its subdivision, the Sanctions Application Inspectorate and the Inspectorate for Public Order and Safety). The absence of coordination between these organizations and a limited understanding of the responsibilities involved resulted in a situation in which shortcomings went unnoticed, particularly as far as the BHV was concerned. In this respect, the Board envisages a future role for the Sanctions Application Inspectorate, which, with the cooperation of 'specialist' supervisors, could operate as an integral supervisory body. More cooperation between the inspectorates and inter-administrative supervision is presently under scrutiny by the central government. Once again, the Board underlines the great importance of this subject and considers achievement of results in this area to be an urgent matter.

Relief and aftercare

In general, the after care for the guards, emergency personnel and next of kin after the fire in the Detention Centre Schiphol-Oost proceeded well. However, the aftercare for the cell occupants was inadequate. The Board holds the opinion that the shortcomings were largely attributable to lack of preparation by the DJI in terms of relief, registration and aftercare for the disaster victims.

The (medical) registration of the cell occupants and their transfers took place in an unstructured fashion. Consequently, uncertainty persisted for too long about who was to be found where, and about who had received aftercare and when and how this was accomplished. In addition, because responsibility for aftercare had been placed with the receiving facilities, there was no unequivocal pattern to the (quality of) care given to the cell occupants. The standard care of these institutions had not been set up to provide aftercare to such large groups of people. The Board holds the opinion that the DJI should have assumed its responsibility by guaranteeing aftercare to the cell occupants. Unlike ordinary citizens, cell occupants are not in a position to visit a doctor or psychologist on their own accord. The approach employed by the institutions insufficiently ensured that care would be swiftly and appropriately following this harrowing experience.

Due to the transfers and (possibility of) deportations in the months following the fire, the conditions under which people's experiences during and after the fire had to be dealt with were far from ideal. However, the Board does not consider these less-than-ideal conditions to be an excuse for professionals not to start any treatment at all. In view of the fact that trauma-related complaints can arise even months after an occurrence, the Board regrets that a number of cell occupants were deported before the consequences of the fire on the mental health of these people could be properly established.

Conclusion

The general conclusion is that the government bodies involved gave too little attention to safety, and to fire safety in particular. On a variety of points, they neglected to implement prevailing legislation and regulations in relation to fire safety. The same applies for not formally established directives like the Directive for 'Cells and Cell Blocks Fire Safety'. This is a disappointing conclusion given that guaranteeing the safety of citizens is an unquestioned core duty of the government.

Correction mechanisms, by means of bodies that have to supervise the application of this legislation and regulations (the municipality and government inspectorates in the first and second line of control) also functioned inadequately.

In consideration of the above mentioned, the Board considers it justified to assume that there would have been fewer or no victims if the bodies involved had focussed their attention on fire safety. More specifically:

- The organization of DJI's in-house emergency and first-aid service should have been thought through more thoroughly, better prepared and trained, including its collaboration and coordination with the fire brigade.
- The RGD should have built J and K Wing of the detention centre as laid down in the Buildings Decree.
- The Municipality of Haarlemmermeer should have more adequately substantiated its responsibilities as a licensing authority, supervisory body and agency of enforcement.

In the Board's opinion, the investigation shows that the bodies involved showed insufficient self-criticism in respect to their own responsibilities. These responsibilities were also inadequately communicated and coordinated in relation to the responsibilities of other parties involved. Within that context, the Board has also noted that the parties involved were of the opinion that they could rely on the expertise of the other parties involved, each of whom, unfortunately, felt the same way. The consequence of this is that the parties involved did not assume their own responsibilities or minimised them, causing an inadequate recognition of risks in terms of fire safety and an inadequately critical assessment when accepting alternative solutions.

This pattern of inadequately discharging individual responsibility for safety also appears in previous reports made by the Board and in the investigations into the café fire in Volendam and the fireworks disaster in Enschede. However, in this case, not assuming individual responsibility gives the Board all the more reason for concern, because the parties involved in this investigation were principally government bodies which might be expected to give a high priority to safety and to act by setting an example in relation to adherence to legislation and regulations.

The Board is aware of the fact that these constitute firm conclusions in respect of the functioning of the government. However, they are conclusions that do justice to all of those who perished in this fire, their surviving relatives and to all of those who suffered and continue to suffer as a result of this catastrophe. It is hoped that these conclusions will also contribute towards the possibility of avoiding such a catastrophe in the future.

Recommendations

In view of the shortcomings identified, it would be possible to make a great many recommendations. However, the Board prefers to restrict the number of its recommendations to the main issues and refers to the report with regard to other safety deficits, given that the findings speak for themselves.

1. The Board recommends to the Minister of Justice that:

- Within one year, all penitentiary institutions be investigated on fire safety (including the arrangements with the fire brigade) and the in-house emergency and first-aid organization, this be put in order as necessary and the results be reported to the House of Representatives;
- (Fire) safety be made an explicit point of policy regarding management of the institutions working under its authority and that the recently appointed Sanctions Application Inspectorate be given an integral supervisory role (employing the expertise of other inspectorates, supervisory committees, etc.) and that periodic reports be made on the state of (fire) safety;
- The allocation of responsibility within the Ministry of Justice, particularly within the DJI between central and local management, be subjected to a critical enquiry and review, focussing especially on the responsibility of site management, and that the conclusions of such an enquiry be clearly established;
- The emergency plans of receiving facilities and penitentiary institutions be subjected to a critical assessment in terms of their degree of usability in day-to-day practise. Also that particular attention is devoted to the relief and aftercare of detainees and its supra-local coordination be vested explicitly with DJI.

2. The Board recommends to the Minister of Housing, Spatial Planning and Environment (VROM) that:

- The building regulations for special building complexes be made more accessible. In addition, the Board asks attention to be given to advice, instruction, regular tuition, etc. to support the correct application of the building regulations and the advancement of national expertise.
- In view of the indicated shortcomings of the Detention Centre Schiphol-Oost as a building, the role and responsibility of the Government Buildings Agency be subjected to a more detailed specification such that construction quality can be guaranteed at all times and the discharge of its service provision duty is not at the cost of the quality delivered.
- In the case of temporary constructions, in which the 2003 Buildings Decree sets lower requirements on construction plans for buildings with high-risk functions, additional conditions are set so that safety levels are equivalent to permanent constructions.

3. The Board recommends to the Municipality of Haarlemmermeer that:

- It ensures sufficient expertise such that building applications, which depart from the Buildings Decree but which do propose equivalent structural alternatives, (can be) are subjected to thorough assessment.
- It avoids acting as a consultant for the permit applicant thus not endangering the independence necessary to undertake the specific supervisory role.
- The fire brigade and in-house emergency and first-aid teams be carefully coordinated regarding high-risk subjects and to have them perform joint exercises.

4. The Board recommends to the Minister of The Interior and Kingdom Relations (BzK) that:

- In consultation with the Minister of Justice as the party responsible for legislation and regulations, reconsider whether the status of unofficial regulations, such as the Directive for Cells and Cell Blocks Fire Safety, is adequate for safety risks.
- The content of these unofficial regulations be updated.
- It be ascertained with the Association of Netherlands Municipalities how, in practice, municipalities are able to discharge their role as a supervisory body professionally in the case of buildings with high-risk functions, such as a Detention Centres. Combining expertise on and experience with specific buildings should be taken into consideration in this regard. In line with safety practices in other sectors, turning around the onus should be considered, thus expecting permit applicant organizations to demonstrate that they operate as safely as possible.

Finally, the Safety Board wishes to make just one reference to the premature publication in the press of its draft report. The right for involved parties to be heard by the Board has been included in the legislation that constitutes the foundation of the Board's operations. Based on a ruling from the European Court of Human Rights, the legislature infers that the parties, on whom criticism is laid, even when it does not concern bringing criminal charges against them, should be given the opportunity to respond to the content of a report constituted by the Dutch Safety Board. The preliminary report was made public by a third party in the course of this process. This draft report inevitable contained deficiencies and inaccuracies, which have been amended following receipt of the comment, thus enabling a final report to be published that was as carefully balanced as possible. No negotiations concerning conclusions have taken place during this process.

A handwritten signature in black ink, appearing to read 'Pieter van Vollenhoven', written over a circular stamp.

Prof. Pieter van Vollenhoven
Chairman of the Dutch Safety Board

A handwritten signature in black ink, appearing to read 'M. Visser', written in a stylized, cursive manner.

Ms. M. Visser
General Secretary

LIST OF ABBREVIATIONS

A

AFO	Airport Fire Officer
AI	Labour Inspectorate
AMC	Academic Medical Centre hospital, Amsterdam
AMV	Respiratory Minute Volume
APD	General Police Service of the Royal Military Constabulary
ARBO	Working Conditions Decree
AZC	Asylum Seekers' Residential Centre

B

BAD	Offenders' Reception Department
BBC	Fire Safety Scheme
BGA	Asylum Seekers' Healthcare Bureau
BHV	In-house emergency and first-aid service
BIAB	Building Permit Application (Submission Requirements) Decree
BMA	Medical Advice Bureau
BMI	Fire Alarm System
BOT	In-house Reception Team
B&W	Municipal Executive
BVS	Fire Safety Survey
BWT	Building and Housing Inspectorate
BZK	Ministry of the Interior and Kingdom Relations

C

C2000	Digital Communications System for Emergency Services
COA	Agency for the Reception of Asylum Seekers
CP	Switchboard (guard's office)
CPA	Central Ambulance Switchboard
CP DJI	Ministry of Justice Switchboard
CP KMar	Royal Military Constabulary (KMar) Switchboard
CTPI	Occurrence Site Coordination Team
CvT	Supervisory Committee

D

DG	Director-general
DGPJS	Directorate-general for Prevention, Juveniles and Sanctions
DJI	Custodial Institutions Service
DPU	Submersible Pump Unit
DV&O	Transport and Support Service

E

EN	European Standard
EPS	Polystyrene foam

G

GGD	Municipal Health Service
GGZ	Mental Health Service
GHOR	Medical Assistance for Accidents and Disasters
GWT	Bulk Water Transport

H

HIS	Information System for general practitioners
HOvD	Commanding Officer (Fire Brigade)
HOvDP	Senior Duty Police Officer
HPL	High Pressure Laminate
HRR	Heat Release Rate (output)
HsGHOR	Chief Division for Emergency Medical Services in the event of Accidents and Disasters
HV	Rescue engine
HW	Hydraulic platform

I

IGZ	Inspectorate for Healthcare
IND	Immigration and Naturalisation Service
IOOV	Inspectorate for Public Order and Safety
IST	Sanctions Application Inspectorate

K

L	KMar	Royal Military Constabulary
	LNV	Ministry of Agriculture, Nature and Food Quality
M	MK	Emergency Control Room
	MOA	Medical Reception of Asylum Seekers
N	MvT	Explanatory Memorandum
	NEN	Dutch Standard issued by the Netherlands Standardization Institute
	NFI	Netherlands Forensic Institute
	NFPA	National Fire Protection Association (USA)
	NIBHV	Netherlands Institute for In-house Emergency and First-Aid Services
	Nibra	Netherlands Institute for Fire Services and Disaster Management
	Nifv	Netherlands Institute for Physical Safety/Nibra
	NTA	Netherlands Technical Agreement
O	OCW	Ministry of Education, Culture and Science
	OM	Public Prosecutions Department
	OvD	Officer in Charge
	OvDG	Medical Officer in Charge
P	OvV	The Dutch Safety Board
	Pbw	Prisons Act
	PI	Penitentiary Institution
	ppm	parts per million
	PSHO	Psychosocial Assistance and Relief
	PSHOR	Psychosocial Post-disaster Care
	PTSS	Post-traumatic Stress Disorder
	PVC	Polyvinyl chloride
R	PvE	Schedule of Requirements
	PZI	Personal Location and Alarm System
	RAC	Regional Emergency Control Room (fire brigade)
	RGF	Regional Medical Officer
	RGD	Government Buildings Agency
	RIE	Risk Assessment and Evaluation
	RSJ	Council for the Application of Criminal Law and Youth Protection
	RSP	Rate of Smoke Production
S	RWA	Smoke and Heat Exhaust Ventilation System
	SG	Secretary-general
	SMH	Emergency Medical Services
	SZW	Ministry of Social Affairs and Employment
T	TAC	Technical Advice Centre
	TDBV	Temporary Special Facilities Directorate
	THR	Total Heat Release
	TKF	Repatriation Official
	TNO	Netherlands Organization for Applied Scientific Research
	TR	Scientific Investigation Department
	TS	Appliance
	TSP	Total Smoke Production
V	Vheq	Pinewood equivalent
	VI	VROM Inspectorate
	VNG	Association of Netherlands Municipalities
	VROM	Ministry of Housing, Spatial Planning, and the Environment
	VWS	Ministry of Health, Welfare and Sport

W

WABO	Spatial Permit (General Provisions for the Environment Act)
WBDBO	Resistance to fire spread
Wgbo	Medical Treatment Contracts Act
WRZO	Disasters and Major Accidents Act
WTS	Water Transport Scheme

1 INTRODUCTION

At around midnight on the night of 26 October and early morning of 27 October 2005, a fire broke out in Cell 11 of K Wing in the Detention Centre Schiphol-Oost³. Eleven cell occupants lost their lives as a result of this fire, and fifteen people were injured (guards and cell occupants). The Dutch Safety Board has conducted an investigation focussed on the following questions:

"How could eleven cell occupants die during the fire?" and

"Which arrangements were made for the relief and aftercare of the other people involved in the occurrence?"

This investigation focuses on the causes or suspected causes of the fire and the extent of its effects. The objective of the conclusions attached to the investigation is to prevent similar occurrences from arising in the future or to limit the consequences of such occurrences.

The Safety Board is of the opinion that, while the possibility of a fire can never be ruled out, this fire should never have had the disastrous outcome that it did. Keeping people under detention, means assuming responsibility for their safety.

This report has been compiled as follows. Chapter 2 focuses in brief on particular aspects of the Detention Centre Schiphol-Oost, such as its chosen type of construction, the personnel in attendance, the cell occupants and how buildings fire fighting was organized.

Next, Chapter 3 explains in outline what occurred in the detention centre on the night of 26 October and early morning of 27 October 2005.

Chapter 4 describes this investigation's analytical framework. The analytical framework consists of three parts, notably: relevant legislation and regulations, the sector-related documentation available and the way in which one's own responsibility for safety management should be interpreted and executed according to the Dutch Safety Board.

Chapter 5 places the focus on the parties involved and their responsibilities. In Chapters 6, 7 and 8 analyses and evaluations on the basis of the analytical framework are described.

Chapter 6 analyses and evaluates in succession the development of the fire, the rescue and the fire fighting. At the core of this chapter is the subsidiary question: *How did the fire in the Detention Centre Schiphol-Oost develop, and how did the rescue and fire fighting progress?* Analysis of the fire's development provides answers to the question concerning why a fire that originated in one of the cells was able to develop into a major fire in a relatively brief period of time. That question is relevant because individual cells must be able to resist the spread of a fire for some time, thus enabling cells to be evacuated. The second part of Chapter 6 evaluates the way in which the guards reacted and attempted to bring as many cell occupants as possible to safety. Finally, the third part of Chapter 6 consists of an analysis concerning the arrival of the fire brigade and a brief examination of some of the problems surrounding the fire brigade's actions.

To be able to answer the investigation's central question concerning the reasons why there were eleven fatalities and fifteen people injured during the fire in K Wing, a more detailed investigation is made into the construction and use of J and K Wing at the detention centre. Moreover, specific attention is focussed on the organizations involved. In connection with this, Chapter 7 answers three subsidiary questions. Firstly, compliance with construction legislation and whether the permits should have been issued for J and K Wing is evaluated. Secondly, the degree in which the most significantly involved parties assumed their responsibilities is evaluated. Finally, it is determined what the effect was of compliance or non-compliance with legislation, as well as the way in which the parties involved assumed their responsibilities.

3 The official name for the Detention Centre Schiphol-Oost is the Schiphol-Oost/Oude Meer Detention and Deportation Centre.

The following subsidiary question lies at the heart of Chapter 8: *How was the relief and aftercare for the other parties involved in the occurrence provided for?* Investigation is carried out into whether the relief and aftercare complied with the requirements provided for in legislation and regulations and, furthermore, whether official arrangements and procedures were followed. Moreover, an analysis is made of whether the relief and aftercare provided complied with what might be expected of (after)care during and after a major occurrence on the basis of broadly accepted and implemented (inter-)national standards in respect of safety management. Answers are also given concerning the issue of whether the parties involved acted on their responsibilities in the correct manner.

Chapter 9 provides a summary of the findings and the conclusions from two other investigations that were conducted in response to the fire in the detention centre. These concern the investigation of the government inspectorates into fire safety in other penitentiary facilities and the investigation of the independent committee for municipal responsibilities, which was conducted for the Municipality of Haarlemmermeer.

Chapters 10 and 11 illustrate respectively the summarised conclusions and recommendations of the investigation into the fire in the detention centre at Schiphol-Oost.

The account of the investigation has been included in Appendix 1. This appendix also includes some responses from the parties involved. These concern responses to facts that the Board has not adopted, including the justifications for not adopting these facts.

2 FACTUAL INFORMATION

2.1 Reasons for the construction of the Detention Centre Schiphol-Oost

For years, Amsterdam Schiphol Airport has been faced with the illegal import of drugs that have been concealed in cargo and are transported by means of couriers. Dating from the beginning of the 1990s, measures were put in place to detect these drugs and to bring arrested suspects to trial as quickly and efficiently as possible. A sharp fall in the number of drugs hauls from freight traffic was recorded following the implementation of special scanning equipment (a container scan) in October 2000. Simultaneously, there was evidence of an increase in the number of drugs couriers, including so-called "drugs swallowers". In 1999, on average 50 couriers a month were being arrested, while that number had risen to approximately 150 by the end of 2001. Due to the increasing number of drugs couriers and "drugs swallowers", the judicial authorities' law enforcement system and cell capacity at Schiphol came under great pressure.

Political pressure on the former Minister of Justice to adopt effective measures also mounted between December 2001 and January 2002. Reports appeared in the media that, due to capacity problems (too few cells and not enough available personnel), people suspected of drug smuggling, including "drugs swallowers", were being released out of necessity. This concerned a total of eleven releases in December 2001. In a letter to the Dutch House of Representatives dated 18 January 2002, the former Minister of Justice described his deep regret at these releases, which, according to him, should not have arisen⁴. In the parliamentary debate about this letter and other matters, which took place subsequently on 23 January 2002, the minister was placed under fire by all parties and survived a motion of censure⁵. The minister stated that only by taking far-reaching measures the undesirable situation at Schiphol could be resolved. It was to that end that the Schiphol Drug Trafficking Plan of Action was drafted,⁶ part of which stated that the number of cells needed to be expanded.

At the beginning of 2002, the former Minister of Justice promised the House of Representatives that a large number of cells for drugs couriers would be built at Schiphol within a number of months (at first, over 96 ordinary cells and 10 observation cells). This promise resulted in the construction of the Detention Centre Schiphol-Oost's wings A to H (see Figure 1).

The construction of the deportation centres for aliens had commenced in 2003 in order to reduce pressure on the Netherlands' standard institutions for accommodating aliens and its police cells. The deportation centres were intended for short periods of residence for the purposes of remanding aliens in custody pending their deportation. Within that context, the Detention Centre Schiphol-Oost was extended by means of J and K Wing.

At the time of the fire, the detention centre was being used for ordinary police duties, for confinement of drugs swallowers and for the temporary detention of aliens.

2.2 Specific features of the Detention Centre Schiphol-Oost

In comparison with non-penitentiary institutions, the Detention Centre Schiphol-Oost is a building with a high-risk nature in respect of fire safety. Three factors are of significance in this regard. Firstly, the detention centre is suitable for a large number of occupants (approximately four hundred). Secondly, the occupants of the detention centre are locked up. Thus, as far as protection from (the effect of) fire is concerned, the cell occupants are dependent on the properties of the building, the actions of the guards and the means of assistance at their disposal for reaching a safe refuge in the event of a fire. Thirdly, from the point of view of detention, the intention is not that cell occupants should leave the complex by themselves in the event of a fire (alarm). The functional requirements imposed on the detention centre and the user organization

4 House of Representatives, year of session 2001-2002, 28192, no. 2. For an overview of the releases in the second half of 2001 see: House of Representatives, year of session 2001-2002, 28192 and 24587, no. 7.

5 Official Report of the House of Representatives, year of session 2001-2002, 23 January 2002, TK 41.

6 Schiphol Drug Trafficking Plan of Action, House of representatives, year of session 2001-2002, 28192, no. 1.

must be such that cell occupants remain confined while being transferred to another location within the centre. At odds with this is the necessity to make it possible for emergency personnel, such as fire fighters, to gain access if required.

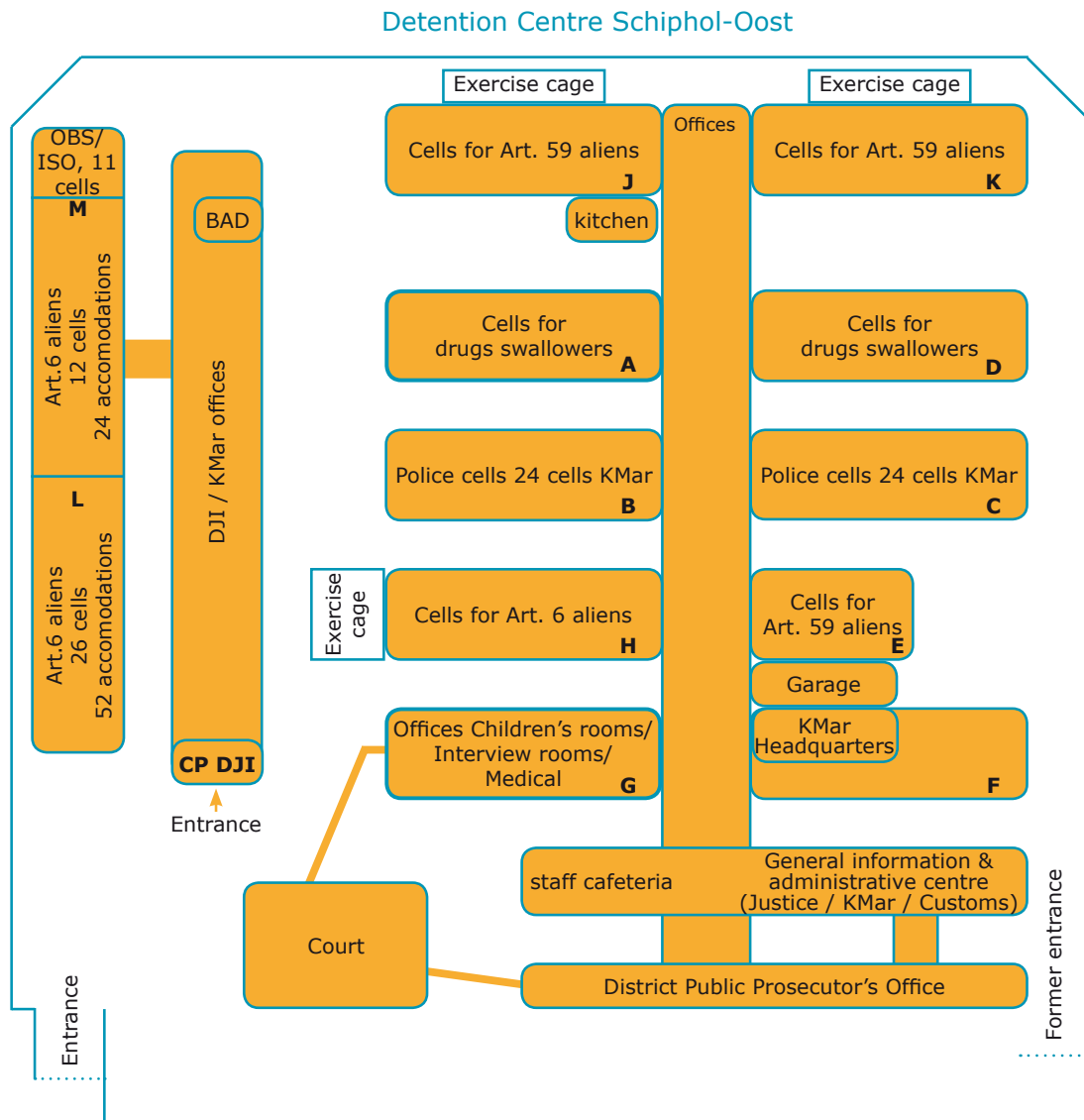


Figure 1: Diagrammatic overview of the Detention Centre Schiphol-Oost.

The Detention Centre Schiphol-Oost consists of several wings (see Figure 1). B Wing consists of Royal Military Constabulary (KMar) police cells. People accommodated in this wing are in particular those who have been arrested at Schiphol and who are suspected of having committed a criminal offence. A and D Wing contain the "drugs swallows" who may still be carrying packages of narcotics inside of their bodies. The regime in respect of these people aims to ensure that packages containing narcotics are eliminated from the body as quickly and safely as possible. Both A and D Wing come under the responsibility of the DJI, but collecting and securing the narcotics is the responsibility of the KMar.

2.3 Cell construction administered in K Wing

Figure 2 shows an aerial view of K Wing where a fire broke out in Cell 11 on the night of 26 October and early morning of 27 October 2005. The wing consists of a corridor (approximately fifty metres in length) that can be accessed by means of a door from the hall located between J and K Wing. Cells are located on either side of this corridor intended for a maximum of two persons each.



Figure 2: Diagrammatic aerial view of K Wing with its corridor and the cells on either side

Figure 3 shows a cross section of K Wing's basic construction. The cells themselves are containers (originally sea containers) that have been converted into cells including a cell door, a window and sanitation facilities. These cell containers form the basis of the building. 26 of these containers are used as cells in K Wing. A shell construction is built around the cell containers.

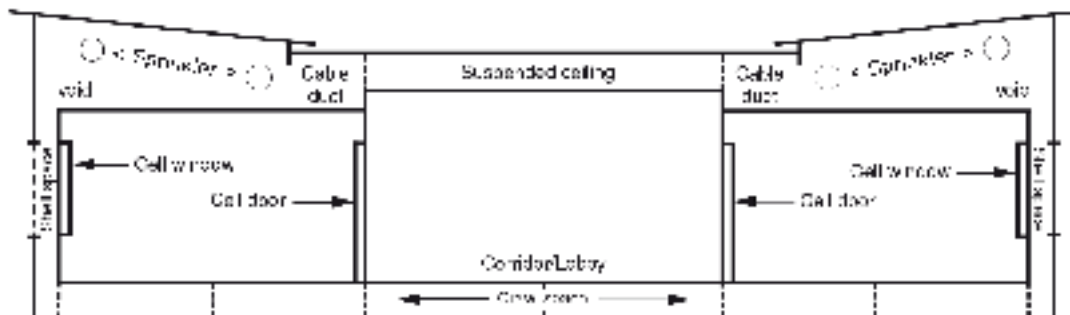


Figure 3: Diagrammatic cross section of a cell container showing shell construction

A number of systems and facilities are present in K Wing. A dry sprinkler duct is installed in the space above the cells (see Figure 3). This system does not work automatically; however, in the event of a fire, the Fire Brigade can link these ducts to a water source. The sprinkler system's sprinkler ducts are fitted with sprinkler heads in which an ampoule is mounted. This ampoule will rupture at a temperature of 80 degrees Celsius and set the sprinkler into action as long as the duct has been connected to a water source.

In addition, a ventilation system is present with supply and exhaust ventilation pipes. The system is connected to each individual cell and provides the cell with ventilation; air is pumped into the cell and extracted. A Smoke and Heat Exhaust Ventilation (RWA) system has been fitted in the corridor, consisting of two hatches in the roof of the corridor and air-inlet grilles on either side of the emergency exit door at the far end of K Wing, which must open automatically during a fire. In the event of fire, this system must ensure that smoke, heat and poisonous gases in the corridor are discharged to the outside to a degree that allows the cells to be evacuated. The detention centre has also been fitted with a fire alarm system. This consists of a fire alarm centre at the Royal Military Constabulary (KMar) switchboard and subordinate fire alarm centres in the various team stations. The system involves automatic fire sensors placed in the individual cells, in the ceiling space above the cells, in the corridors and in the other rooms. Manual fire alarms are also located in the corridors and in the team stations. The fire alarm centre at the KMar switchboard processes all incoming signals and forwards these on to a separate fire alarm panel located at the Custodial Institutions Service (DJI) switchboard.

All of the cells have been provided with a window in the (outer) wall and a door to the corridor. The security guards have to open and close the cell doors manually; the cell doors are not self-locking and do not have a central unlocking system.

2.4 Personnel and organization

The Detention Centre Schiphol-Oost comes under the Temporary Special Facilities Directorate (TDBV), together with the detention centres in Rotterdam (the so-called "clink boats") and Zeist and the Rotterdam Airport deportation centre. This directorate forms a part of the Custodial Institutions Service of the Ministry of Justice. The TDVB employs a total of approximately 140 guards in the Detention Centre Schiphol-Oost. Roughly 100 of them are recruited from the so-called "DJI pool", which consists of employees who can be flexibly deployed at a variety of the TDBV's locations. The other 40 guards employed by the directorate are recruited and deployed through the external security firm Securicor⁷. Employees of the Royal Military Constabulary (KMar) are also employed in the Detention Centre Schiphol-Oost in addition to the employees deployed there by the DJI.

On the night of the fire at 26 October 2005, a total of sixteen people were working at the Detention Centre Schiphol-Oost: seven guards from the DJI pool, two employees from Securicor, six employees from the KMar and one employee from the medical service for the detention centre.

2.5 Switch boards and fire alarm alerts

A team station is located in each of the wings at the Detention Centre Schiphol-Oost (see Figure 2). In addition, there are two more switchboards located elsewhere in the complex. These are the KMar switchboard and the DJI switchboard (see Figure 1). A detention centre employee mans these switchboards at all times. The team stations in J and K Wing are unmanned at night from efficiency point of view.

If a fire alarm from the detention centre's fire alarm system goes off, the alert arrives simultaneously at the team station in the wing concerned and at the KMar switchboard. During the night shift, an emergency alert arriving in J and K Wing should be observed immediately at the KMar switchboard. KMar personnel then hear an acoustic signal and see on the display that this refers to a fire alarm, of which the location in the detention centre is also indicated. KMar personnel should then alert the DJI Duty Officer. On arriving at the KMar switchboard, the fire alarm is also transferred automatically and immediately to the DJI switchboard⁸. The KMar switchboard has to alert the Fire Brigade if a fire arises in B Wing. The DJI switchboard is charged with this task if fires arises in any of the other wings of the Detention Centre Schiphol-Oost.

2.6 The cell occupants in the Detention Centre Schiphol-Oost

The Detention Centre Schiphol-Oost can accommodate a maximum of 412 detainees; on the night of the fire, 298 occupants were being detained there. These cell occupants can be placed into the following three categories:

1. Aliens held on the grounds of Art. 6 or Art. 59⁹ of the Aliens Act.
2. People who were suspected of committing criminal offences at Schiphol Airport.
3. Drugs swallows.

7 Officially, guards are only employees from the DJI pool. Securicor employees are detention supervisors. Due to the narrow distinction in practice between detention supervisors and guards, this investigation will refer to guards or security guards when reference is made to both employees from the DJI pool and from Securicor.

8 This connection between the KMar switchboard and the DJI switchboard was not put in place when the fire alarm system was first installed. The connection was installed subsequently.

9 Art. 59, par. 1, Aliens Act: "If it should further the interests of public order or national security to do so, with a view to deportation, Our Minister will remand aliens in custody who:

(a) have no lawful right of residence; (b) who have a lawful right of residence on the grounds of Section 8, under f, g and h." Par. 2: "If the required documentation for the repatriation of the alien is in the alien's possession, or will be in the alien's possession within a short period of time, it is deemed to further the interests of public order to remand the alien in custody, unless the alien has had lawful right of residence on the grounds of Section 8, under a to e inclusive and under I." Par. 3: "An alien is not remanded in custody if, and a custodial remand is ended once, he or she announces the wish to leave the Netherlands and the opportunity to do so is also open to him or her." Par. 4: "A custodial remand, pursuant to Par. 1, under b, or Par. 2, should in no case exceed four weeks. If, prior to the decision on the application, Section 39 is applied, a custodial remand, pursuant to Par. 1, under b, will in no case not exceed six weeks."

The aliens who had been accommodated in the Detention Centre Schiphol-Oost can be placed into two categories, each of which was subject to detention under different regimes. H, L and M Wing contained aliens detained on the grounds of Art. 6 of the Aliens Act. C, E, J and K Wing contained people who were being held on the basis of Art. 59 of the Aliens Act. These people were resident in the Netherlands illegally and had been picked up when their papers were checked when performing work, committing an offence or during routine checks. Both groups of aliens had been detained in the Detention Centre Schiphol-Oost pending their deportation.

On the night of the fire, 85 people were being detained in J and K Wing, eight of whom were women and 77 men. Their age range was between 18 and 62 years old. According to the data from the detention centre, this group of cell occupants encompassed a total of 35 different nationalities (see Figure 4).

Nationality	N	Nationality	N	Nationality	N
Afghan	5	Indian	1	Pakistani	1
Albanian	1	Indonesian	1	Romanian	5
Algerian	5	Israeli	1	Senegalese	1
Angolese	2	Iraqi	1	Sierra Leonean	2
Brazilian	1	Iranian	1	Sudanese	2
Bulgarian	6	Yugoslav	1	Sri Lankan	1
Chinese	3	Lebanese	2	Surinamese	3
Colombian	1	Libyan	4	Tunisian	2
Dominican	3	Lithuanian	2	Turkish	6
Egyptian	1	Malaysian	1	Unknown	3
Ethiopian	1	Moroccan	4		
Georgian	3	Nigerian	4		
Ghanaian	1	Ukrainian	3	Total	85

Figure 4: Overview of the nationalities of the cell occupants in J and K Wing

2.7 Organization of fire fighting for buildings at Schiphol

In collaboration with Amsterdam Schiphol Airport, the Municipality of Haarlemmermeer has a group of people at its disposal who are especially involved with fire services provision for the buildings at the airport. Personnel from the Schiphol Fire Brigade have been added to the municipal Fire Brigade in order to prevent and fight fire in buildings at Schiphol. The buildings fire prevention team is stationed at Post Sloten. Half of the team consists of personnel from the Schiphol Fire Brigade¹⁰ and the other half is made up of personnel from the Haarlemmermeer Municipal Fire Brigade. Eight members of staff are permanently on site to fight fire in buildings at Schiphol. The group uses an appliance and a rescue engine.

In the event of a fire alarm in one of the buildings at the airport, the emergency centre Schiphol is responsible for the initial deployment of the Fire Brigade. In the event of any scaling up¹¹, the Amsterdam and District Regional Emergency Control Room (RAC) takes over operations¹². When the emergency centre Schiphol is alerted, the standard procedure for the emergency centre Schiphol is to alert the vehicles required from Schiphol (Post Sloten) and also to transmit the alarm to the RAC.

10 This is an in-house fire service.

11 An expansion of the number of emergency workers and/or emergency services involved.

12 Unless the Duty Officer decides otherwise, coordination rests with Schiphol's emergency control room up to a medium-scale fire.



Figure 5: Overview of Schiphol Airport showing the detention centre and the two fire stations that played a significant role on the night of the fire. Post Rijsenhout is four kilometres to the south of the detention centre and lies beyond the geographical limits of this plan. VBB= aeroplane fire fighting.

3 COURSE OF EVENTS

3.1 Introduction

This chapter presents the course of events during the fire at the Detention Centre Schiphol-Oost on the night of 26 October and early hours of 27 October 2005. In order to be able to answer the central question of why eleven people lost their lives, answers are given to questions such as: where did the fire start, and how did the fire proceed? Which actions did the members of staff present in the detention centre take? What was the course of events relating to the deployment of the Fire Brigade, and what emergency action was undertaken by the Fire Brigade?

The information on the course of events on the occurrence consists of three parts, each of which is dealt with in a separate section. Part of the development and fighting of the fire and of the action taken by the guards is illustrated in each section. The three episodes arising from this are described in the order in which they occurred.

The central issue addressed in Section 3.2 is the time from which the fire started up to the time that the guards attempting rescue left K Wing. Section 3.3 describes the situation in the period from the time that the guards left K Wing up to after the first attempt by the Fire Brigade to enter K Wing. Section 3.4 considers the subsequent action taken by the Fire Brigade after 00.30 hours: the time when the Fire Brigade entered K Wing for the second time and when the victims had presumably deceased¹³.

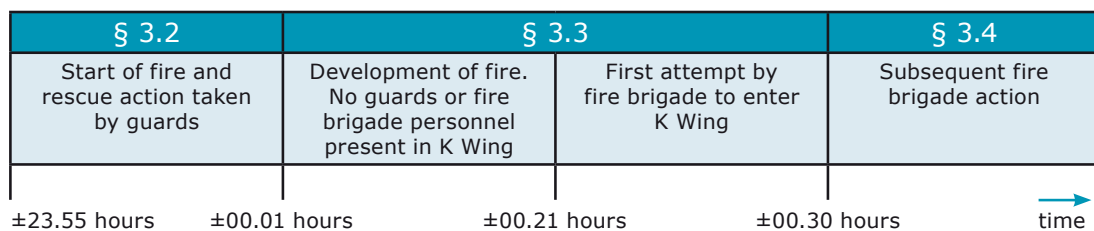


Figure 6: Structure of the circumstances of the occurrence

3.2 The start of the fire and the rescue action taken by the guards

3.2.1 The start of the fire in K Wing

Around midnight on the night of 26 October 2005, all 298 of the cell occupants in the Detention Centre Schiphol-Oost had been locked in their cells. In K Wing, where the fire was to break out that night, most of the cells contained two occupants. One occupant was locked in Cell 11 that night.

At 23.55 hours, the detention centre fire alarm system (BMI) detected a fire in K Wing¹⁴. Approximately one minute later, the occupant of Cell 11 pressed on the intercom attention button¹⁵. Almost simultaneously, smoke could be seen coming through the chinks of the door to Cell 11¹⁶.

13 Section 3.3.6 details smoke penetration in the locked cells and the deaths of the victims.

14 The fire alarm system component that recorded in which of the K Wing cells a smoke alarm was first affected was lost during the fire.

15 This point in time has been established based on the fact that when using the attention button in a cell a white/red light bulb is simultaneously illuminated on the exterior of the cell. The images from one of the camera monitors show that the light bulb for Cell 11 lit up at 23.56.14. This means that the attention button had been pressed in the cell. Cell occupants are able to alert security guards by using the attention button.

16 This expulsion of smoke is visible on video images from K Wing.

3.2.2 Internal alert sequence ¹⁷

A fire alarm went off at the Royal Military Constabulary (KMar) switchboard at the moment that the fire alarm system detected fire at 23.55 hours. The fire alarm centre operator accepted the alarm after twelve seconds. The system indicated that the alarm came from K Wing. On arrival at the KMar switchboard, the fire alarm was sent on automatically to the Custodial Institutions Service (DJI) switchboard, where the code "5002" appeared on the display. This code corresponded to K Wing, but the list explaining the codes that was present at the DJI switchboard stated that 5000 codes usually came from D Wing. Nevertheless, code 5002 did relate to K Wing. As a result of this, the two guards manning the DJI switchboard at that time thought that the alarm was coming from D Wing. In other words, guards working at the KMar and DJI switchboards had been alerted to the fire alarm at the same time. However, each of them believed the fire alarm to be coming from a different location. Once the fire alarm had been received, the guards from both the KMar and DJI switchboards set the internal alarm process in motion. The guards at the DJI switchboard, who were under the assumption that the fire alarm was coming from D Wing, contacted the guard who was in attendance there by means of walkie-talkie. This guard reported that there was no question of any fire in D Wing. At 23.56.41 hours¹⁸, the DJI Duty Officer telephoned the DJI switchboard from the Offenders' Reception Department (BAD) and said that it was a false alarm and that the Fire Brigade had to be called.

The KMar operator, who had interpreted the alarm as indeed coming from K Wing, accepted the fire alarm twelve seconds after it was received (23.55.12 hours). As a result of this, he initiated a three-minute delay period before the alarm was transmitted automatically to the emergency centre Schiphol¹⁹. These three minutes had been built into the system so that, in the event of a fire alarm, the detention centre personnel could verify whether there was an actual instance of fire.

Once the KMar switchboard operator had accepted the fire alarm, he alerted a member of staff at the A Wing team station via the intercom (this occurred between 23.55.12 and 23.55.27 hours)²⁰. He also alerted the DJI Duty Officer by telephone (at 23.56.00 hours). Two KMar employees, who were located at the KMar switchboard at that time, progressed to K Wing to investigate. The guard on duty at A Wing, who had been informed about the fire alarm by the KMar switchboard, in turn alerted the guard in D Wing. This guard firstly telephoned the guard in C Wing and subsequently ran with this colleague to K Wing, where they arrived a bare two minutes after the fire alarm had gone off (at 23.56.52 hours). The two KMar employees, who had progressed in the direction of K Wing from the KMar switchboard after the fire alarm, arrived at the entry door to K Wing shortly afterwards. One of them turned back immediately to the KMar switchboard to inform the switchboard operator that a fire had genuinely broken out in K Wing. The other KMar employee went to B Wing to inform the group commander and to fetch a fire extinguisher.

17 For a diagrammatic illustration of the internal alert sequence, see Figure 7.

18 The time of this telephone conversation is based on data from the KMar.

19 The Board has not been able to establish unequivocally which telephone or walkie-talkie conversation it was in which the Duty Officer was advised that there was no fire in D Wing.

20 Since there is no personnel in attendance in J and K Wing at night, the guard at the KMar switchboard alerted the guard at A Wing.

3.2.3 Rescuing the occupant of Cell 11

After the DJI guards from C and D Wing arrived at K Wing, one of them unlocked the entry door to K Wing and ran inside, followed by the second guard. The guard who was first to enter the wing, initially ran to Cell 3 at the beginning of the corridor. The attention light above the cell door was illuminated, which indicated that the occupant of this cell had called on the guards for help. The guard opened the hatch, looked inside, then looked towards the end of the corridor and next proceeded to run to Cell 11.

The occupant of Cell 11, according to his own words, was making noise by screaming, banging on the door and by slamming the door to the toilet cubicle²¹. The guard tried to open the door to Cell 11, but this was difficult to do because the lock was stiff. However, the other guard, who had been second to enter the wing, subsequently succeeded in opening the cell door using the first guard's keys. The two guards opened the door to Cell 11 (at 23.57.14 hours) over 2 minutes after the fire alarm had gone off. The occupant of the cell fell out through the doorway. The guards stated that smoke was issuing from the cell occupant's hair at that time. It appears from the cell occupant's medical file that he had burns to his arms, hands and on his heel.

As the cell door was opened, a large quantity of thin, black smoke emerged from the cell. This smoke spread through the final eight to ten metres of the corridor in K Wing²². After the two guards had taken out the occupant of Cell 11, they left the door to this cell open. In an explanation, one of them submitted that they possibly did this because it was not clear to them whether or not a second person was in the cell. A few seconds after opening the cell door, another quantity of smoke emerged from the cell, which advanced in a wave below the ceiling of the corridor in the direction of the entry door to K Wing. Approximately thirty seconds after opening the door, the smoke was half way along the corridor. Approximately another 50 seconds later the smoke reached the entry door. The hatches of the Smoke and Heat Exhaust Ventilation (RWA) system, which the fire alarm system should have opened automatically at the time of the fire alarm, remained closed. Consequently, smoke advanced uninterrupted. It took less than one and a half minutes for a dense layer of smoke to form below the entire length of the corridor's ceiling in K Wing.

One of the two guards ran ahead of the smoke in the direction of the hall between J and K Wing and waited further along the corridor for the other guard and the occupant of Cell 11. After the second guard, who was accompanying the cell occupant, had reached the first guard – who had run ahead – he handed over his key ring to his colleague because the first guard's keys remained in the door to Cell 11. The second guard led the occupant of Cell 11 to the hall between J and K Wing. Together with a third guard, who had arrived in K Wing in the meantime, the first guard began to open the doors to the other cells. They worked starting from the entry door to K Wing, which is where they were located at that time, towards the rear of the wing.

Actual time	Time in relation to automatic fire alarm	Time in relation to opening of Cell 11 door	Event
			Fire originates in Cell 11
23.55.00	00.00	-02.14	Automatic fire alarm
23.56.14	01.14	-01.00	Cell 11 occupant presses attention button
23.57.14	02.14	00.00	Cell 11 door opened
23.57.42	02.42	00.28	Smoke half way along corridor
23.58.08	03.08	00.54	Guards start to open cell doors
23.58.31	03.31	01.17	Smoke reaches corridor entry door
23.58.42	03.42	01.28	Smoke issuing outside at far end of wing / right-hand side wall
23.59.01	04.01	01.47	Flames breaking out of Cell 11

Figure 8: Significant times on the initial development of the fire.

21 Other cell occupants have stated hearing noise.

22 Viewed from the vantage point of the hall between J and K Wing.

3.2.4 *Rescuing the K Wing occupants*

Three minutes after the automatic fire alarm, and barely a minute after rescuing the occupant of Cell 11, two guards began to open the other cells in K Wing. Each of the guards took one side of the wing and opened the cell doors, starting from the beginning of the wing's corridor²³. As a result of this, they freed 31 detainees from their cells.

In the meantime, the DJI Duty Officer²⁴, together with the "BAD chief", ran from the BAD²⁵ around the outside of J and K Wing in the direction of K Wing's end wall. He established contact with one of the switchboards²⁶. The Duty Officer telephoned three minutes after the fire alarm to the emergency centre Schiphol and announced: Emergency Schiphol-Oost' (23.58.01 hours). Thirty seconds after this brief telephone call, the Duty Officer again had contact with the emergency control room in which he announced that there was a fire at the Detention Centre Schiphol-Oost²⁷.

Having reached K Wing, the Duty Officer was able to look through its windows. In his recollection, he saw that Cell 11 was on fire. The Duty Officer saw that the RWA's air-inlet grilles²⁸ to the left and right of the wing's emergency exit were closed²⁹. The Duty Officer opened the K Wing emergency exit from the outside using his key³⁰. He heard cell occupants screaming and saw two guards opening cell doors. Simultaneously, he saw parts of the ceiling falling down in flames. As a result of opening the emergency exit, smoke issued outside through the doorway, followed by flames soon after. Direct access to K Wing via the emergency exit was barred due to the open fire.

During the opening of the cell doors the guards shouted 'brand' (in Dutch. 'fire' in English), sending the cell occupants in the direction of J Wing. Approximately a minute after the two of them had started their rescue action, they saw flames issuing from the doorway to Cell 11. After that time, the increasing smoke and heat began to cause problems for the guards. Breathing became increasingly difficult, vision became poorer; they could no longer see the exit to the wing. In the meantime, the smoke³¹ emanating from Cell 11 and advancing below the ceiling had reached the beginning of the corridor. Subsequently, the smoke rotated and advanced towards the two guards. At the point of Cells 8 and 15, no more than eight metres away from the burning Cell 11, both guards withdrew from K Wing out of necessity (at around midnight). Cells 9 and 10 on the left of the wing and Cells 12, 13 and 14 on the right of the wing remained unopened.

As they fled from K Wing to the hall between J and K Wing, the smoke completely deprived the two guards of any visual sense. They found their way to the entry door by touch. The cell occupants who were last to be freed encountered the same problem. Some of them crashed against the table tennis table standing at the beginning of the corridor. The personnel present in the hall between J and K Wing urged the freed cell occupants to walk in their direction and also made attempts to enter K Wing with a fire hose. These attempts had to be abandoned due to the smoke. One guard, who had freed cell occupants, told colleagues in the corridor that there were still people trapped in their cells.

In the meantime, the group commander of the KMar³² had run to K Wing and saw that the entry door between the corridor and K Wing was open. The group commander advanced an estimated metre into the wing, but the smoke was so thick and vision so poor that it was impossible to help with evacuation. One of the KMar employees called the group commander back. It was from that moment that he considered it too dangerous to enter K Wing and decided to turn away everyone who still wanted to go into the wing.

23 Viewed from the vantage point of the hall between J and K Wing.

24 Referred to as the Duty Officer throughout the remainder of this chapter.

25 Offenders' Reception Department.

26 It is most likely that he attempted to establish contact with the DJI switchboard.

27 He telephoned the DJI switchboard yet again immediately afterwards.

28 Air-inlet grilles form a part of the Smoke and Heat Exhaust Ventilation (RWA) system; see also Section 2.3.

29 This information is based on an interview with the Duty Officer. At around midnight, the Duty Officer recalled that cell occupants could still be seen standing behind the windows to cells 12, 13 and 14 in K Wing.

30 Only the Duty Officer possessed a key to the emergency doors in the wings' end walls; the guards did not.

31 The tests showed this smoke to contain a high concentration of CO; see Appendix 2.

32 Person employed by the Royal Military Constabulary who (in the detention centre) is in charge over a group of KMar employees.

At some point after the group commander, who was the last to leave, had left K Wing, an explosive combustion probably occurred of the gases packed together in the corridor. A flashover flame spread along the entire length of the corridor, starting from the region of Cell 11 and extending to the entry door³³.

3.2.5 Alert and arrival of emergency services

Alert of Schiphol's emergency centre

Two minutes after the fire alarm went off in the Detention Centre Schiphol-Oost, the DJI switchboard telephoned Schiphol's emergency centre to report it as a false alarm. At that time, the automatic fire alarm had not yet transmitted from the KMar switchboard to the emergency centre due to the fire alarm system's delay time that was still in operation.

Following this first contact with the DJI switchboard, two telephone calls and an automatic fire alarm were received from the detention centre within a minute (23.58 hours) which confirmed that there in fact was a fire in the detention centre.

The first telephone call to be received was by the Duty Officer, but this call resulted in confusion at the emergency centre (23.58.01 hours)³⁴. Next, the automatically forwarded transmission of the fire alarm was received at Schiphol's emergency centre (23.58.12 hours)³⁵. Subsequently, a telephone call followed from the KMar switchboard. At 23.59.28 hours, even before this conversation had finished, Schiphol's emergency centre alerted the Fire Brigade at Post Sloten and indicated that there was a fire that had been confirmed by telephone. Almost immediately after Post Sloten had been informed about the fire, the Duty Officer confirmed by telephone that there was a fire in the Detention Centre Schiphol-Oost (23.59.40 hours).

One minute after Post Sloten was alerted, the announcement was received that two vehicles had been turned out from this fire station in the meantime: an appliance and a rescue engine (at 00.00.32 hours)³⁶. The Airport Fire Officer (AFO³⁷) in attendance at Post Sloten followed these first two vehicles. The AFO was the first managing officer to arrive on the night of the fire. During the drive towards the Centre, the fire officer in charge³⁸ requested the support of the Hoofddorp hydraulic platform³⁹. The emergency centre Schiphol hailed the hydraulic platform via the Regional Emergency Control Room (RAC). The RAC alerted a second appliance as well⁴⁰. During the outward journey, the AFO requested more information, meanwhile scaling up to "large fire" status took place.

Alert via KMar emergency control room to regional emergency control room

The KMar switchboard at the detention centre has the responsibility of alerting the Fire Brigade if there is a fire in its 'own' B Wing; the DJI Duty Officer should be alerted in all other cases. The DJI switchboard bears responsibility for alerting the Fire Brigade if there is a fire in the other wings, since they are the responsibility of the DJI. Nevertheless, on the night of the fire, it was the KMar switchboard that was first to take the initiative of alerting the emergency services. Despite the fact that the KMar emergency control room had been alerted two minutes before the emergency centre Schiphol, this did not result in the Fire Brigade units being alerted any sooner.

One minute after the fire alarm, the KMar switchboard contacted the KMar emergency control room (23.56 hours), which, in turn, telephoned the Kennemerland police emergency control room with the request to alert the Fire Brigade. It was by this means that the RAC was informed four minutes later (at 00.00.07 hours). By that time, the emergency centre Schiphol had already alerted the first vehicles from Post Sloten. The RAC was informed about this shortly afterwards.

33 Nobody observed this, because the corridor had been abandoned at the time of the flashover. The probability that an explosive combustion (deflagration) did take place is made clear from computerised simulations used to reconstruct the spatial development of the fire.

34 The Duty Officer announced: 'Emergency Schiphol-Oost'.

35 At least three minutes after the fire alarm had been received at the KMar switchboard.

36 Appliance (TS) 641 and Rescue Engine (HV) 686.

37 The Airport Fire Officer is a management officer for the Schiphol fire brigade. His role is comparable with that of the Officer in Charge (OvD).

38 The Fire Officer in charge manages an appliance crew. In addition to himself, the crew consists of a driver/pump operator and four firemen.

39 Hydraulic Platform (HW) 651.

40 The TS 649 from Post Rijsenhout.

This parallel alert from the KMar switchboard was not received sooner than the alert from the emergency centre Schiphol.

3.3 Development of the fire and arrival of the Fire Brigade following cessation of guards' rescue attempt

3.3.1 *The fire's progress*

The flames shot outside through the doorway shortly after the Duty Officer had opened the emergency exit from the outside. The fire intensified. At 00.05 hours, ten minutes after the automatic fire alarm had gone off, the KMar operator reported to the emergency centre Schiphol that the flames were already reaching out above the roof. The emergency centre Schiphol passed this information on to the fire brigade, which was still on its way at that time.

The fire was raging in three tracks along the length of K Wing: notably, through the ceiling space above the cells on the left-hand side, through the ceiling space above the cells on the right-hand side and in K Wing's corridor. Most of the combustion heat generated from the fire was concentrated in the upper ceiling space above the two rows of cells (see Figure 3).

A reconstruction based on computerized simulations of the fire's spatial development indicates that the accumulated smoke gasses in the corridor very probably led to an explosive combustion. This was manifested by a large flashover that spread along the length of the corridor up to the entry door.

Combustion of the smoke gases must have taken only a few seconds and did not result in the entire corridor catching fire. In the subsequent phase, the fire remained concentrated at the rearmost (end) section of the corridor.

The suspended ceiling above the burning part of the corridor fell apart, allowing the fire free access to the section of the space between ceiling and shell located above the cells.

The fire raged half way along the wing in the ceiling space above the cells on the left-hand side. The walls of the recreation room⁴¹ at the rear end of the corridor gave way. This recreation room and the team station located before they were entirely destroyed. After this the fire was held up by the wall between the team station and the first recreation room. The fire never reached this recreation room and the left-hand row of cells to the front (Cells 1 to 6 inclusive).

The fire spread along the entire length of the wing in the ceiling space above the cells on the right-hand side. This happened at an early stage. The fire was held in check at the point of K Wing's entry door by a fireproof partition wall that had been incorporated between K Wing and the hall between J and K Wing. At only one spot in this partition wall there was evidence of the beginnings of fire penetration⁴².

3.3.2 *Guard's relief of cell occupants*

Immediately after having been rescued from Cell 11, the injured cell occupant was brought to A Wing by a third guard. The detainee was placed under the shower. After the occupants of J and K Wing had been placed in the exercise cage, one of the guards who had opened the K Wing cells proceeded to A Wing. The occupant of Cell 11 was still in that wing at that time. The guard handed him over to the ambulance personnel and requested that the medical service stay with him.

After their cell doors were opened, the cell occupants were sent to the adjacent J Wing (see Figure 1), where a number of the cell occupants from K Wing attempted, in panic, to open the emergency exit door at the far end of J Wing and by that means escape from the fire. However, this door was locked. Anxiety and panic also ensued among the cell occupants of J Wing, who were still locked inside their cells, and they banged on their cell doors.

The guards in attendance tried to calm down the K Wing cell occupants and wanted to move them through the recreation room to the J Wing exercise cage. Some of the cell occupants resisted

41 Viewed from the vantage point of the hall between J and K Wing.

42 The spread of a fire from one particular area to another area other than by airborne means.

this and caused some wreckage. At approximately a quarter past midnight, the guards began to free the J Wing cell occupants from their cells. The guards tried to conduct these detainees through the recreation room to the exercise cage as well. Two of the guards who were among the cell occupants had their keys snatched. The cell occupants and guards continued to feel threatened by the situation. Only once the guards and KMar employees in attendance received outside reinforcements (the General Police Service of the Royal Military Constabulary) did the guards succeed in moving all of the detainees from J and K Wing into the J Wing exercise cage. In addition, the KMar banged their truncheons on the furniture. A KMar employee from the General Police Service⁴³ – an external KMar employee who had been called in for assistance – pulled out his firearm and pointed it at the cell occupants⁴⁴. In total, some 73 people were locked in the J Wing exercise cage. Some from this group of detainees tried to escape from the exercise cage⁴⁵.

3.3.3 *Arrival of first fire brigade unit and J Wing entry*

Nine and a half minutes after the emergency centre Schiphol had called out Post Sloten, appliance (TS) 641 reported on site at – what later turn out to be – the former entrance to the Detention Centre Schiphol-Oost (00.08.54 hours)⁴⁶. The rescue engine (HV 686) and a passenger van with the AFO arrived simultaneously. The former entrance to the detention centre consisted of two gates. When the Fire Brigade arrived at this former entrance, the KMar switchboard opened the first gate, after which the Fire Brigade drove inside. The Fire Brigade then came to a halt by the second entrance gate. However, this gate had been closed with a chain lock.

An employee rushing up to them from the detention centre redirected the Fire Brigade to go back outside to the correct (main) entrance. In the meantime, several KMar vehicles had arrived at the former entrance in addition to the fire engines. These vehicles stood behind the fire engines and, consequently, blocked their free passage backwards. Once these were able to reverse, they proceeded to the main entrance. This entrance also consisted of two entrance gates (fences) with locks. The second gate can be opened only once the first gate has been closed behind an incoming vehicle.



Over four minutes after they had arrived at the former entrance, the vehicles from Post Sloten drove into the gate lock to the main entrance (at 00.13 hours). An ambulance arriving at the same time joined the queue and jammed activation of the lock gate. Consequently, the first gate could not be closed, which meant that the second gate could not be opened. An employee from the KMar sweep team⁴⁷ then rushed up to assist with admitting the vehicles. At that time, the employee was using an intercom system to communicate with the DJI switchboard from which the lock was operated by remote control. By this means, all of the vehicles waiting in the queue were let in two by two. At 00.15 hours, the first two fire engines drove on to the grounds. Once inside, the crew of these first attending vehicles asked the KMar employee to open both gates for the vehicles following. The KMar employee indicated that this was not possible⁴⁸.

Figure 9: Vehicle behind lock gate at the main entrance to the detention centre.

43 The KMar employees at the detention centre are not permitted to carry weapons in the complex.

44 The Ministry of Justice has conducted an investigation into the lawfulness of this action. See also Letters GWA 11/2005 M1-06 and M2-06 dated 10 May 2006 from Public Prosecutor I.J.M. Monsma, Master of Law, Arnhem District Public Prosecutor's Office (source: response of Minister of Justice to draft report, see Appendix 1).

45 For more information about the relief and aftercare of the cell occupants see Chapter 8.

46 See Figure 1.

47 The "sweep team" is a group of KMar employees responsible for collecting and securing the packages of narcotics that drugs swallows have ingested.

48 The lock was fully opened only at approximately 01:45 hours.

Appliance TS 641 from Post Sloten drove to J Wing. There was too much smoke and fire on the road at the far end of K Wing (the end of the wing where the fire had started) to be able to drive alongside it. For that reason, the Fire Brigade unit mobilised appliance TS 641 and the rescue engine at the far end of J Wing in the vicinity of a fire hydrant. The Crew Commander, who was familiar with the building, explored outside. He saw approximately seventy cell occupants standing in the exercise cage at J Wing in what he described as an agitated state.

The AFO of the Schiphol Fire Brigade, who occupied the position of First Officer in Charge for the municipal Fire Brigade in the case of this fire, had followed behind the first appliance. On the basis of external evaluation, he established there was a developed fire at K Wing, involving a great deal of smoke and fire. In vain, he tried to find an employee who could give him information about any victims. In consultation with the Crew Commander of TS 641, it was decided to deploy an fire attack inside via J Wing with "rescue" as the objective.

In other words, the Fire Brigade unit from Post Sloten wished to enter the centre through the emergency exit at the far end of J Wing. However, this door was locked. Both the members of staff located at the J Wing emergency exit and an employee who stood outside indicated that they could not open the door. At approximately 00.18 hours, it was announced that the door would be broken open. The Fire Brigade cut open the latticework and broke through a door window. Subsequently, the Post Sloten attack team entered J Wing through the forced emergency exit (at around 00.20 hours⁴⁹). Simultaneously, a guard handed over a key with which the now forced emergency exit door was opened. The Crew Commander in Charge then entered J Wing. Once inside, he indicated that J Wing had to be evacuated due to the smoke and heat. The AFO remained outside. Inside, Fire Brigade personnel consulted with the guards in attendance about victims who might still be located in K Wing. They did not obtain any useful information about possible victims and their locations. Using one set of keys, that the team had obtained, the attack team walked on to K Wing.

3.3.4 Arrival of second Fire Brigade unit

The second Fire Brigade unit to arrive at the detention centre was a unit from Post Rijsenhout (the TS 649). This unit arrived at around a quarter past midnight at the former entrance to the detention centre. The gate was still closed with a chain. Nobody was there to receive the unit, because the entrance was not in use. The detention centre's employee who had spoken to the first Fire Brigade unit was no longer present at the former entrance by now.

Via walkie-talkie, the Crew Commander from Post Rijsenhout heard from the crew of the appliance from Post Sloten (TS 641) already on site that there were possibly still people inside and that a rescue was to be implemented. The Post Rijsenhout unit cut through the gate's chain and proceeded to drive to the far end of D Wing. Initially, the vehicle took up position within the detention centre fencing; however, it took up position next to the ditch outside of the gate almost immediately afterwards. The Crew Commander sent six firemen inside to reconnoitre the building and to rescue people if necessary. The firemen had breathing protection with them but no fire extinguishing equipment. When a guard from D Wing walked outside, the attack team made use of the opportunity to enter the building through that door (at 00.21.18 hours). Later, the unit used the outside door between D and K Wing as an entry door.

3.3.5 Subsequent progress of the fire

Ultimately, the fire in K Wing reached the interior of the cells from the "three tracks" (see Section 3.3.1). The fire in the ceiling spaces on either side of the corridor penetrated the shell void behind both of the wing's side walls causing a large number of the cell windows⁵⁰ to give way. The fire spread from the corridor to the cells through the mostly open cell doors. The cells at the end of the corridor that had not been opened were also attacked on either side by the fire, with the exception of Cell 9. This cell suffered relatively minor fire damage.

The final spread made by the fire occurred from the ceiling space to the front right of the corridor (at the point of Cells 20 to 26 inclusive). The fire spread along the ceiling of the corridor in the direction of the cells opposite (Cells 1 to 5 inclusive). However, the fire did not reach these cells.

49 This time is an estimate.

50 In particular, it was the transom window in the window frame that appeared to be a weak element in the cell window's construction.

3.3.6 Smoke penetration in the locked cells and the death of the victims

The acting guards who took action opened a total of 21 of the 26 cells in K Wing. With the exception of one person (from Cell 5), all of the occupants from the opened cells were brought to safety. Five cells (Cells 9, 10, 12, 13 and 14) remained unopened. These cells contained a total of ten detainees, all of which died in the fire. It appears from their autopsies that all of the victims died as a result of carbon monoxide poisoning. The Dutch Safety Board has attempted to determine the times around which the cell occupants in the unopened cells died⁵¹.

The Safety Board has based its estimates of times of death on a number of assumptions, the accuracy of which is as well supported as possible by the fire tests carried out. It was by this means that the following reconstruction was produced.

From the time that the fire moved from Cell 11 to the corridor, substantial quantities of smoke penetrated within the neighbouring cells via the chinks in their doors throughout a period of approximately five minutes. At some point in the subsequent five minutes, the fire reached the ceiling space above the cells. The combusting smoke gases heated the tops of the cell containers to the extent that the pine beams situated underneath began to gasify⁵² and pyrolytic gases, including carbon monoxide, were forced into the cell. Five to eight minutes later, the flexible pipe components of the air-conditioning system burnt through thus creating a link between the burning ceiling space and the cell interiors via the vents. From that moment onwards, the cell no longer provided any protection whatsoever against penetrating smoke. Therefore, the giving way of the window frame not long afterwards did not play a significant role to play in this.

By this means, smoke density in the cells must have passed through a number of stages, whereby the concentration of carbon monoxide within the cells rose until it was equal to the concentration outside⁵³. On the basis of this process and in combination with physiological data concerning the way in which the human body reacts to carbon monoxide, it can be concluded that ten of the eleven victims probably died between 00.10 and 00.30 hours.

The above reasoning does not apply to the occupant of Cell 5. The cell's location was relatively distant from the fire. Therefore, it is probable that this person remained alive for longer than the other victims. Just how much longer could not longer be ascertained. At around 01.15 hours, the Fire Brigade found the mortal remains of Cell 5's occupant.

3.3.7 First attempt of fire brigade to enter K Wing

Equipped with breathing protection and one high-pressure hose⁵⁴, the first attack team from Post Sloten walked from J Wing to the hall between J and K Wing. At approximately 00.21 hours,⁵⁵ the team opened the entry door to K Wing and tried to enter the wing. Due to the heat, the team withdrew to the hall between J and K Wing and closed the door to K Wing.

In the meantime, the Post Rijsenhout appliance (the TS 649) had been moved to the ditch outside the gate to the detention centre to get a water supply (at around 00.22 hours). To gain access to the complex, the Fire Brigade cut open the perimeter fence to set up a water supply area.

In addition to the Fire Brigade units from Post Sloten and Post Rijsenhout, a third Fire Brigade

51 For an analysis of this see Appendix 2.

52 Solid organic matter releases gases and vapour when heated. This process is called degasification or pyrolysis. Wood principally produces water vapour at a temperature of between 100 and 200°C; between 200 and 280°C, carbon monoxide constitutes the most significant component of pyrolytic gas.

53 An (estimated) concentration of 10,000 ppm.

54 Narrow, flexible hose which enables to fight an inside fire quickly or to support a rescue. The hose is 60 metres in length and is connected to the water appliance.

55 The precise time at which the fire brigade began its assembly for attack in K Wing is unknown. The deployment time employed in this report is derived from other data. It has been established that the fire brigade arrived on site at the former entrance at 00.08.54 hours, arrived at the new entrance at 00.13 hours and drove on to the site of the detention centre at 00.15 hours. Subsequently, the fire brigade drove to J Wing (driving time is estimated to be 1 minute), reconnoitred and decided to enter J Wing, which had been locked. At around 00.18 hours, a KMar employee in situ reported to the KMar emergency control room that the fire brigade going to break the door open. The fire brigade broke open the door to J Wing (the time is estimated to be between 1-2 minutes), entered J Wing at approximately 00:19/00:20 hours, requested information and, with a high-pressure hose, walked through the 50-metre length of J Wing (where a tense situation was in evidence) to K Wing between 00.20 and 00.22 hours (the time is estimated to be 1-2 minutes). Furthermore, it appears from fire brigade statements that the attack team from the Post Sloten appliance was at the entrance to K Wing earlier than the Post Rijsenhout [team] (at 00.23 hours). In other words, it is estimated that the fire brigade assembled for attack between 00.20 and 00.22. For the sake of readability, the Dutch Safety Board is employing the time of 00.21 hours in this report.

unit, the crash tenders⁵⁶ from Post Rijk, played a role throughout the first half hour of fire fighting. After arriving at the detention centre, Post Rijk crash tenders had driven to the far end of K Wing and, on the orders of the AFO, and mobilised an attack on the roof of K Wing from the side of its end wall using their roof monitors (a type of water cannon). This deployment took place between 00.15 and 00.30 hours. The crash tenders were in the smoke. The crew could see little except for a red glow from the roof of K Wing. Extinguishing operations had a temporary effect on that glow.

3.4 Subsequent action of the fire brigade after 00.30 hours

From 00.30 hours onwards, the Fire Brigade concentrated mainly on three activities. An fire attack inside was undertaken in K Wing from the hall between J and K Wing, which the AFO coordinated. A CTPI⁵⁷ was also mobilised, which included coordinating the actions of the various services with each other. The (limited) information about the victims and the evacuation was a significant concern with regard to this coordination. The Fire Brigade Commanding Officer (HOvD) coordinated interdisciplinary activities; the second HOvD coordinated Fire Brigade deployment. The third activity related to setting up bulk water transport coordinated by the Haarlemmermeer Officer in Charge (OvD).



Figure 10: Positioning of the fire brigade at around 00.20 hours and the route taken by the units from Post Sloten and Post Rijsenhout

3.4.1 Fire attacks in K Wing and the supporting actions undertaken

After the fire brigade unit from Post Sloten had abandoned its first attempt to enter K Wing due to the great heat in that wing, it met in the hall between J and K Wing with the attack team from Post Rijsenhout that had arrived in the meantime. Following consultation, it was decided to make a joint fire attack inside. At approximately 00.30 hours⁵⁸, the Sloten and Rijsenhout attack

56 A fire brigade vehicle with a large water tank (9,000 or 12,500 litres) that is deployed especially for aircraft blazes. As a rule, crash tender crews are deployed only for fighting aircraft fires.

57 CTPI is the Occurrence Site Coordination Team.

58 The time mentioned is an estimate.

teams jointly undertook an attempt to enter K Wing with low-pressure jets⁵⁹. They were able to force their way in by a few metres and checked the first cells (the first three on either side of the corridor). They withdrew due to the enormity of the heat.

The two attack teams also discussed how they could best release heat from the building. A contingent of the crew from the Post Sloten attack team went outdoors and tried to make a hole from the outside in a window at the K Wing exercise cage to enable the heat to be diverted out by that means (00.45 hours⁶⁰). While the attack team was occupied with this, a pane of glass of the door of the exercise cage collapsed, rendering this action unnecessary.

In the meantime, the crash tenders' Crew Commander had decided on his own initiative to operate from a different location and thus take up a better position in relation to the fire. One of the crash tenders was deployed from adjacent grounds at Schiphol Airport (see Figure 10). The other two crash tenders drove to and fro a hangar elsewhere on the grounds of the airport to fetch water. This driving back and forth took approximately five to ten minutes per journey. The crash tenders' Crew Commander was unfamiliar with the detention centre site. In consultation with the AFO, the crash tender crew removed a section of the airfield fencing and made a hole in the detention centre fencing to gain access to the site. This was laborious and took a great deal of time, because the crash tenders did not have the correct equipment available. Once a passage through had been achieved, low-pressure conduits (known as "hand lines") were put in place leading from the crash tender. Dividing equipment and two hoses were connected to this. It was attempted to supply K Wing's sprinkler system using one of the hoses. With the other hose, the fire was fought through holes that had appeared in the K Wing wall.

At the same time, the Post Sloten attack team walked on towards the far end of K Wing and, together with other fire brigade personnel, connected K Wing's dry sprinkler ducts to a hose line from the Post Rijsenhout and crash tenders' vehicles. This did not produce the desired result. The hose lines were disconnected again.

While a contingent from the Post Sloten attack team was occupied outside with making the hole and assisting with connecting up the sprinkler, two firemen from different teams were deployed in rotation in the hall between J and K Wing. They were ordered to extinguish from the hall to stop the fire from spreading to the other wing. In the course of these operations, a fireman with a thermal-imaging camera joined his colleagues in the hall between J and K Wing. By using this camera, the fire brigade was able to verify whether or not the blaze was moving over their heads and tried to prevent the blaze from surrounding them. By using this camera, it could be determined where the heat was at its greatest and extinguishing operations could be focussed accordingly.

The fire attack inside was resumed. At approximately 01.15 hours, the AFO assembled firemen from the Teunis appliance unit from Amsterdam for an fire attack inside. They entered K Wing and searched through the cells on the left-hand side of the wing (viewed from the vantage point of the hall). They discovered a victim in Cell 5. The unit brought the victim outside and handed the body over to the Post Rijsenhout fire brigade unit.

3.4.2 CTPI consultation and coordination

The Senior Duty Officer (HovD) arrived at the location at 00.25 hours while the first two units were occupied within with an fire attack inside. The HOvD coordinated the multidisciplinary consultations (CTPI). Coordination between the two fire brigade units did not proceed ideally. On his arrival, the HOvD consulted with the officers who were in attendance there: the AFO, the Kennemerland Police Superintendent, the Medical Officer in Charge and a nurse from the detention centre medical service. No other people from the detention centre were present during this consultation. Thereafter, CTPI consultations took place every fifteen minutes and, later, every half an hour. Also present was a representative from the KMar. The Director of the Temporary Special Facilities Directorate (TDBV) was present from the second consultation onwards. During subsequent consultations, the Site Manager for the Detention Centre Schiphol-Oost was also present. Specific information in respect of the location of cell occupants left behind in K Wing was not forthcoming in any of the consultations.

59 The time mentioned is an estimate.

60 This time is an estimate.

A number of communication problems arose. The C2000 system walkie-talkies did not work during deployment within the building, making any contact impossible, including that with the pump operator⁶¹. Furthermore, firemen located on the K Wing side were unable to establish radio contact with firemen on the J Wing side. Consequently, the AFO, and subsequently the HOvD as well (who were on the J Wing side), for some time had no knowledge of the activities being undertaken by Post Rijsenhout at the far end of K Wing.

Furthermore, the walkie-talkie with which Post Rijk Crew Commander was able to communicate with the AFO had been lost. The AFO coordinated deployment of the fire brigade to K Wing from the far end of J Wing.

3.4.3 *Scaling up to crisis management team*

The Management Team was convened following a consultation at around 01.15 hours between the Deputy Mayor, the Regional Chief Fire Officer and a representative from the KMar⁶². The municipal management team first convened at 02:15 hours and afterwards met a further three times that night (successively at 03.00, 06.00 and 07.40 hours) and once the next day at 16.00 hours. The following persons/organizations were present at these meetings: the Deputy Mayor, the Regional Chief Fire Officer, the Regional Medical Officer (RGF) for Amsterdam and District Medical Assistance for Accidents and Disasters (GHOR), representatives from the Custodial Institutions Service (DJI), the Kennemerland Police, the KMar, the Public Prosecutions Department (OM), spokesmen from the Municipality of Haarlemmermeer, the KMar, the Ministry of Justice and support from the Municipality of Haarlemmermeer.

The crisis management team focussed on gathering and exchanging information, communications and evacuation of the complex.

Fire fighting was not scaled up and operations continued to function at CTPI level. The GHOR coordinated the deployment of ambulances and activated the core team for the purpose of psychosocial care. This was not scaled up further, because the cell occupants were to be transferred to other detention centres. The DJI undertook the relief and aftercare of the cell occupants (see also Sections 8.5.5 and 8.5.6 in respect of the scaling up of GHOR within the context of relief and aftercare and its evaluation). Press conferences were held at 04.00 hours and 06.30 hours.

3.4.4 *Setting up bulk water transport*

After the Haarlemmermeer Duty Officer had arrived at the far end of J Wing, the HOvD made him responsible for supplying water to the far end of K Wing (00.45.04 hours). To combat large fires, which require a lot of water, water needs to be transported on a large scale in order to have sufficient water available for extinguishing purposes over an extended period. Bulk water transport (GWT) must always be supplied from open water sources, because the capacity of the water supply system is insufficient to supply the large quantities of water required over an extended period of time⁶³. The setting up of bulk water transport on the night of the fire at the detention centre had no effect on the occurrence's fatal outcome but did influence the time required for the final extinguishing of the fire.

Hydraulic platforms also had to be supplied with water by means of bulk water transport. The hydraulic platforms had already been put in position on either side of J Wing at an early stage. The first hydraulic platform (HW 651) stood next to K Wing; the second (HW 652) stood between J and A Wing. The HOvD⁶⁴ decided to carry out bulk water transport with the assistance of submersible pumps (these are used to pump water from open water sources) and by having the attendant crew and appliances in readiness for deployment if the fire should spread to the rest of the building. The first submersible pump unit reported at the site at approximately 00.30.47 hours, while the second submersible pump unit (DPU 935) reported at the site at 00.57.16 hours.

61 According to the Municipality of Haarlemmermeer, this failure was caused by a regional fire brigade relay transmitter that had been additionally incorporated at a later date and had not yet been properly synchronised.

62 An Operational Team was also set up in addition to the CTPI and the Management Team; this was headed by the General Commander of the KMar (Source: response of Minister of Justice to draft report). The Dutch Safety Board has not included this in its investigation.

63 Source: Netherlands Institute for Fire Services and Disaster Management [Nibra] Operational Performance Guidelines et al., version 4.0, 20 August 2001.

64 Source: interview.

The GWT was set up almost one and a half hours after the arrival of the first submersible pump unit. Water could be supplied to the first hydraulic platform (HW 651)⁶⁵ at around 01.55.45 hours; according to the fire brigade statement, the second hydraulic platform (HW 652) was supplied with water at around 02.45 hours.

At 02.55.05 hours, the HOvD transmitted the message “fire under control” to the Regional Emergency Control Room.

3.4.5 Recovering the deceased victims

The Amsterdam fire brigade discovered the first victim in Cell 5 at around 01.15 hours. The fire brigade stated that the door to this cell was open at that time. However, on the grounds of traces discovered, the Safety Board considers it probable that the door was closed during a large part of the fire⁶⁶. Discovery of the victim was reported to the Regional Emergency Control Room at 01.39 hours.

At around 02.45 hours, the fire brigade entered K Wing through the far end. The fire brigade team concerned discovered two victims in the first cell on the left-hand side of the wing, viewed from the far end of the wing. A total of ten victims were found in the cells on either side of the corridor in the vicinity of Cell 11. At approximately 04.00 hours, the CTPI reported that a total of eleven fatalities had been recovered.

3.5 Identification of the deceased

Initially, identification of the deceased proceeded with difficulty. At first, the victims were laid outside, next to the far end of K Wing. However, the cell in which each of the victims had been was unclear, because the firemen who had brought their remains outside from the cells had not indicated this.

It was also unclear who was responsible for arranging a medical examiner⁶⁷. A medical examiner was still not in attendance at Schiphol-Oost at 06.00 hours. The GHOR then arranged for two medical examiners from the Amsterdam Municipal Health Service (GGD) to come to the detention centre. The first GGD medical examiner arrived at 06.30 hours, followed a little later by a second one.

Following a post-mortem examination and toxicological testing by the Netherlands Forensic Institute and the Dutch Safety Board, the bodies of the eleven victims were ultimately released in the first week of November 2005.

65 Source: exterior video images.

66 Information available on this has been included in Appendix 3. It has not become clear whether the cell door was locked or only closed, or why the victim was left behind in the cell.

67 Source: evaluation of operational medical emergency services in the fire at Schiphol-Oost Detention Centre on 27 October 2005, Amsterdam and District GHOR Regional Office.

4 FRAME OF REFERENCE

4.1 Introduction

This chapter outlines the frames of reference on the basis of which analyses have been carried out in the following chapters in respect of the fire fighting and rescue on the night of the fire, as well as the construction and use of the Detention Centre Schiphol-Oost. The frame of reference consists of three components:

- Relevant legislation and regulations (Section 4.2)
- Supplementary standards and directives (unofficial regulations, Section 4.3)
- Individual responsibility for safety management (Section 4.4)

4.2 Relevant legislation and regulations

This section clarifies the legislation and regulations either directly or indirectly connected to the fire in the Detention Centre Schiphol-Oost. The table below provides an overview of the relevant legislation and regulations that was in force at the time of the fire.

Relevant legislation, regulations and decrees in relation to the fire of 26-10-2005	
Penitentiary legislation	<ul style="list-style-type: none">• Custodial Institutions Act• Prison rules• Requirements for Accommodation in Penitentiary Institutions Regulations
Legislation in respect of incarceration of aliens	<ul style="list-style-type: none">• Police Act 1993• Aliens Act 2000• Border Accommodation Regime Regulations• Regulations on police cell complexes• Decree of 15 December 1967 in conjunction with Article 539n of Code of Criminal Procedure
Working Conditions legislation	<ul style="list-style-type: none">• Working Conditions Act 1998• Working Conditions Decree• Working Conditions Provisions
Construction legislation	<ul style="list-style-type: none">• Housing Act• 2003 Buildings Decree• 2003 Buildings Decree regulations• Municipality of Haarlemmermeer building regulations• Planning Application (Submission Requirements) Decree• Building and Occupancy Permits
Spatial planning legislation	<ul style="list-style-type: none">• Spatial Planning Act• Spatial Planning Decree 1985
Fire services legislation	<ul style="list-style-type: none">• Fire Services Act 1985 (Netherlands Civil Code)• Disasters and Major Accidents Act (WRZO)• Regulation on Fire Safety and Emergency Services

Figure 11: Overview of relevant legislation, regulations and decrees

The established emergency plans, procedures, instructions and work practices for action undertaken in cell blocks in general and in K Wing in particular are relevant within the context of the above legislation and regulations. This relates to the action taken in the event of fire, disasters and major accidents by:

- the on-site emergency services, the remainder of the personnel and the cell occupants of the Detention Centre Schiphol-Oost;
- the municipal and regional fire brigade and Schiphol's (in-house) fire brigade;
- the other emergency services that were involved with fire fighting, evacuation, rescue and providing emergency services.

4.2.1 Penitentiary legislation

Provisions are made for the enforcement of custodial punishments and measures in the Custodial Institutions Act (Pbw). The Pbw provides for the powers of government in relation to penitentiary institutions and the rights and obligations of detainees. The Minister of Justice allocates penitentiary institutions. He has supreme authority and can issue national regulations. Executive supreme authority is mandated to the Director of the Custodial Institutions Service (DJI).

The director of a penitentiary institution has a number of specific powers on the grounds of the Pbw. For example, he can impose disciplinary punishments and take measures for order. The director also determines the way in which detainees are accommodated in the institution or in a ward. He assigns a cell to every detainee. The director is directly accountable to the Minister of Justice⁶⁸ regarding the exercise of his administrative duties and the powers related to them. Directors must observe the policy rules issued by the Minister in their daily administration.

The concepts underlying the Pbw are: safety, dignity and suitability. The "Requirements for Accommodation in Penitentiary Institutions Regulations" regulates the requirements with which the accommodation for detainees in penitentiary institutions (including cells) must comply. Accommodation is effected and equipped in such a way that it fulfils the requirements imposed on it due to the nature of the institution, the Working Conditions Decree and the fire safety regulations⁶⁹.

4.2.2 *Legislation in respect of the detention of aliens*

Aliens can be deprived of their liberty on the grounds of the Aliens Act 2000. This does not relate to a deprivation of liberty under criminal law but an administrative measure in which frontier detention or the detention of aliens for the purpose of deportation or extradition can be imposed. Frontier detention is based on Art. 6 of the Aliens Act, which determines that the alien to whom entry to the Netherlands has been denied be obliged to reside in an appointed area or place that can be secured against unauthorised departure. The detention of aliens is based on Art. 59 of the Aliens Act, which makes it possible, in the interest of public order or national security, to detain aliens who do not have any (satisfactory) right of residence so that they can be deported.

The Border Accommodation Regime Regulations apply to the enforcement of frontier detention. On the grounds of Art. 1 of the Pbw, the detention of aliens is equivalent to a custodial measure. The Pbw applies to its enforcement. On the grounds of Art. 15a of the Pbw, the detention of aliens for the duration of less than ten days can also be enforced in a police cell. The regulations laid down for police detention centres apply in such cases.

The Border Accommodation Regime Regulations⁷⁰ determine that the Minister of Justice has supreme authority over border accommodation and can impose further regulations to the standing rules for the execution of and to complement the regulations. The Directorate of the DJI exercises this responsibility. The Site Manager, appointed by the Minister of Justice, is charged with (daily) administration. In accordance with the regulations⁷¹, it is the Site Manager's responsibility to assure the residence of aliens in the border accommodation and to maintain safety and order there. The Site Manager is authorised to issue orders such as are necessary to officials and other employees with a view to the exercise of this responsibility.

4.2.3 *Working conditions legislation*

The Working Conditions Decree provides for (the improvement of) working conditions. The Act focuses primarily on employers and employees.

Working conditions policy

The Working Conditions Decree prescribes that the employer should pursue the best possible working conditions policy. The employer must organize work in such a way that it does not have any adverse effect on the health and safety of employees, unless this cannot be required of the employer in reasonableness. He must adopt measures to prevent or limit as far as possible the dangers and risks to employees' health or safety⁷². To achieve this, the employer must in part ensure that authority and responsibility have been distributed properly among the employees. Furthermore, the employer must ensure that the working conditions policy is regularly assessed and adjusted as necessary.

68 House of representatives documents II, 24 263, no. 3, Explanatory Memorandum part 6, under b.

69 Pbw, Art. 2, par. 4

70 Section 3

71 Art. 3, par. 3

72 Art. 3, par. e

The Working Conditions Decree also assigns obligations to employees. In connection with their work, employees must exercise due care and prudence and, according to their ability, be responsible for their own health and safety and that of others⁷³.

Risk assessment and evaluation

Art. 5 of the Working Conditions Decree states that an employer should have a Risk Assessment and Evaluation (RIE). This sets down in writing the risks involved in the work that (particular categories of) employees are to perform, the dangers that can arise and the risk-limitation measures to be taken. An inventory is to be maintained listing the nature of and data on accidents at work. The period within which proposed measures are to be taken is also laid down. The RIE is to be amended when acquired experience, a change in working practices or working conditions give cause to do so. The employer must ensure that each employee at his disposal is given time to become acquainted with the RIE. If the nature of the work is likely to present any danger to the health or safety of third parties, the employer should take effective measures to prevent this danger⁷⁴. Third parties are understood to include cell occupants.

In respect of his obligations on the grounds of Art. 13 of the Working Conditions Decree, the employer will seek the assistance of one or more expert employees, of expert persons or a combination of both. In respect of the assessment of and advice given on the RIE⁷⁵, a qualified person or Occupational Health and Safety service official must assist employers⁷⁶.

In-house emergency and first-aid service

Art. 2.17 of the Working Conditions Decree imposes further requirements on the organization of the in-house emergency and first-aid service. The nature, size and location of the company must be taken into account, as well as possible dangers and fire scenarios, the number of employees and persons expected to be present who would be unable to reach safety independently during a fire, the availability and mobilisation time of the fire brigade and other emergency service bodies, and the infrastructure.

Concerning the operationality, accessibility, availability and presence of the in-house emergency and first-aid service, Art. 2.18 states that this must be organized in such a way that in-house emergency service duties can be fulfilled effectively within a few minutes of the occurrence of an accident or fire and that emergency service organizations are assisted effectively⁷⁷. In connection with this, it is also important for sufficient in-house emergency personnel to be in attendance⁷⁸. The statutory obligation for an in-house emergency and first-aid service is provided for primarily in Art. 15 of the Working Conditions Decree; the Working Conditions Decree elaborates upon this in more detail. Art. 15 of the Working Conditions Decree provides that the employer be assisted by one or more employees appointed by him as emergency service personnel. Among the responsibilities of these employees/emergency service personnel are: to alert and evacuate all employees and other persons in the company or institution in emergency situations.

The general explanatory notes to Section 4 in Chapter 2 of the Working Conditions Decree state that the employer must provide "proportionate care" in respect of organizing the in-house emergency and first-aid service. This principle is not entered into in more detail due to the differences existing in practice. Nevertheless, the required level of facilities must be determined in part on the basis of the RIE. The factors referred to in Section 2.17, for example, determine the expertise required of in-house emergency service personnel. The employer can be advised by an Occupational Safety and Health service official or another expert. The explanatory notes to Section 2.17 states that the fire safety schemes can be used when compiling the RIE. Moreover, it is repeated that proportionate care is required when organizing the in-house emergency and first-aid service. This must take into account the anticipated number of employees and third parties unable to reach safety independently. In some buildings, such as prisons, employees also bear responsibility, in addition to the employer, for the safety of third parties unable to reach safety independently. Therefore, they must possess specific expertise and resources to provide assistance safely. In addition, timely arrangements must be made with the fire brigade and

73 Art. 11

74 Art. 10, par. 1

75 Art. 14, par. 1a

76 Legislation on this point has been relaxed since 1 July 2005: under certain conditions (Art. 14), employers can also have an expert represent them instead of a qualified Working Conditions service.

77 Art. 2.18, par. 2

78 Art. 2.19, par. 1

other emergency service organizations within the context of the outpost function⁷⁹ of in-house emergency service personnel. In part, these arrangements relate to the way in which in-house personnel are to assist these emergency services.

Building occupancy

With working conditions in mind, the Working Conditions Decree obliges employers to occupy a building only if the building complies with the conditions in the Buildings Decree relating to the building's designated use.

Training and drills

Pursuant to the Working Conditions Decree, in-house emergency personnel must have expertise, experience and equipment and must be organized in such a way that they are able to take action in the event of an accident or fire⁸⁰. The Working Conditions Decree states that in-house emergency personnel must be trained to a degree that guarantees the provision of in-house emergency assistance⁸¹. According to the explanatory notes to this section, training is required in this respect that focuses on the responsibilities of the in-house emergency and first-aid service.

The Working Conditions Decree states that, in order to maintain in-house emergency and first-aid services at the required level, refresher courses, drills or other activities must be organized for in-house emergency service personnel⁸². It is preferred that drills be conducted in the actual environment or in one that simulates the situation as closely as possible. The employer must provide the opportunity for this.

4.2.4 Construction legislation

2003 Buildings decree

Technical regulations have been drafted covering the construction of buildings pursuant to the Housing Act. These regulations are contained in the 2003 Buildings Decree⁸³, which is updated periodically. The Buildings Decree in force when J and K Wing at the detention centre were built was that which came into effect in January 2003⁸⁴.

In addition to performance requirements, which indicate the requirements that must be fulfilled to guarantee functionality, the Buildings Decree also contains the "equivalence article". This means that if the applicant departs from the performance requirements, he must demonstrate that the alternative decided upon 'provides, at the least, the same degree of safety, health protection, utility, energy-efficiency and environmental protection'.

Building regulations

The Municipal Council of the Municipality of Haarlemmermeer is required to adopt building regulations on the grounds of Art. 8 of the Housing Act. In part, the building regulations contain regulations in respect of fire safety usage. Municipalities base their building regulations on the 1992 Model Building Regulations by the Association of Netherlands Municipalities (VNG).

Building permits

In principle, anyone wishing to build requires a building permit. To that end, the applicant must submit an application to the municipality. Anyone can submit the application. The Planning Application (Submission Requirements) Decree lays down the information and documentation that must be provided. Subsequently, the Municipal Executive compares the application with the 2003 Buildings Decree, the municipal building regulations, the zoning plan and the necessary requirements regarding the external appearance of buildings. The Municipal Executive must issue the building permit if the application complies with legislation, unless there is a ground for

79 The book entitled "basic training for in-house emergency and first-aid service personnel" states that one of the in-house emergency persons is to act as an "outpost officer". This means that this person must show the way to external emergency service personnel (accident services) in – in this case – the detention centre. This person must therefore indicate where emergency service personnel can enter the site, and he or she must be in readiness at the entrance (or ensure that another member of staff is at the entrance to receive the emergency service personnel).

80 Art. 15, par. 3

81 Art. 2.21

82 Art. 2.22

83 Referred to henceforth as the Buildings Decree

84 Bulletin of Acts, Orders and Decrees 2001: 410; Bulletin of Acts, Orders and Decrees 2002: 203, 516 and 518.

deferment as provided for in the Housing Act (the necessity for an environmental permit, the necessity for a hospital permit, etc.). Pursuant to the Housing Act, the obligation rests with the builder to build according to the permit and, moreover, to observe the building regulations.

Occupancy Permit

Some buildings, detention centres included among these, require an Occupancy Permit pursuant to the municipal building regulations. The Occupancy Permit oversees safe occupancy of the building with regard to fire and contains regulations in respect of this. When applying for the permit, information must be submitted to show that a building can be used in a manner that respects fire safety. A building for which an Occupancy Permit is required may be occupied only once the permit has been granted. The party to whom the Occupancy Permit has been granted must ensure compliance with the fire safety regulations laid down in the Occupancy Permit and the municipal building regulations.

The Occupancy Permit⁸⁵ states as follows with regard to fire safety instructions and the evacuation plan:

- a) The owner of the building must draw up fire safety instructions for the purposes of personnel in consultation with the Chief Fire Officer.
- b) Personnel should be instructed on the fire safety instructions applicable to their positions.
- c) The owner of the building must compile an evacuation plan for the purposes of the persons present in the building in consultation with the Chief Fire Officer.

General standards have been developed for evacuation plans in the form of, in this case, a Netherlands Technical Agreement (NTA). These standards can be more quickly adjusted to social developments than the so-called NEN standards. The NTA contains a detailed example of an evacuation plan⁸⁶.

4.2.5 Spatial planning legislation

The Spatial Planning Act relates to spatial planning in the Netherlands and obliges administrative bodies to make periodic plans in that regard. This obliges the government to shape national town and country planning policy. In turn, the provinces must make spatial planning policy, and they can draw up regional plans. Finally, municipalities must make structural and zoning plans.

It can be determined in a zoning plan that the Municipal Executive may grant exemption from regulations in the zoning plan. Additional requirements can also be imposed that may not exceed a five-year period – the so-called Art. 17 Procedure – which provides the opportunity of granting temporary exemption from the zoning plan. Such cases involve temporary construction (less than five years). For the purposes of realizing a project, the Municipal Council can also grant exemption for an indefinite period pursuant to Art. 19 of the Spatial Planning Act.

4.2.6 Fire services legislation

The 1985 Fire Services Act relates to fire service bodies. The Fire Services Act prescribes that each municipality must have a fire brigade. Pursuant to Art. 1, it is the responsibility of the Municipal Executive 'to prevent, confine and fight fires, to limit the danger of fire, to prevent and limit accidents from fire and everything so associated'.

Pursuant to the 1985 Fire Services Act, it is the responsibility of the fire brigade to combat disasters and major accidents as referred to in the Disasters and Major Accidents Act. Within that context, municipalities are obliged to set up collaborative relationships with other municipalities. Among the duties of the public body (the administration of the regional fire brigade) are:

- to advise municipal administrations on the subject of fire prevention;
- to advise municipal administrations in respect of preparatory measures on the subject of fire fighting and fire limitation regarding particular subjects.

85 Appendix B in the 2003/0570 permit.

86 NTA 8112-4 (Guidelines for an evacuation plan - Part 4)

The Municipality of Haarlemmermeer participates in the Amsterdam and District Regional Fire Brigade's collaborative provisions. The Municipal Council is obliged to adopt Fire Safety Regulations. Any matters already provided for in the Housing Act are not to be included.

4.3 Supplementary standards and directives (unofficial regulations)

In 1994, the Ministry of the Interior and Kingdom Relations (BZK) developed the Cells and Cell Blocks Fire Safety Scheme⁸⁷.

The general Fire Safety Scheme gives an impression of the stumbling blocks regarding fire safety in cells and cell blocks' and provides information on safeguarding cells and cell blocks by means of fire safety measures and fire safety provisions. It is intended to serve as a guideline for the designers, builders and users of cell blocks. Parties involved with evaluating fire safety can use the fire safety scheme to obtain an understanding of the coherence between fire safety measures and fire safety provisions.

The fire safety scheme is not legally enforceable legislation. In a letter to the House of Representatives⁸⁸, the Minister of BZK stated as follows in respect of its status: "Officially, the fact is that the guidelines and auxiliary material published by or on behalf of my Ministry have no legal status given that they do not arise directly from legislation and regulations. However, there is no substantive case of freedom from obligation, because, in practice, the auxiliary material, guidelines and directives provide an important framework for action and accountability which also applies to the addressee". The Firework Disaster Investigation Committee⁸⁹ had already confirmed this position previously, concluding that, in practice, subordinate levels of government should also conform to guidelines and auxiliary material provided by Central Government in addition to official legislation and regulations.

In addition to the government's recommendation of these regulations, which, although unofficial, are not without obligation, the Labour Inspectorate uses these Fire Safety Schemes as a frame of reference during supervision.

As far as the Cells and Cell Blocks Safety Scheme is concerned, an exploratory investigation has been performed under the direction of Professor Tops into the practical execution and meaning of this type of "unofficial regulation". After all, many other manuals and directives without a mandatory status exist on the subject of fighting fires and disasters.

Prof. Tops et al observe in this regard that: "following a disaster, the responsible bodies and administrators must also be able to account politically and in terms of administration concerning the extent to which they have used the knowledge that was at their disposal. Therefore, information that can be employed to improve the quality of handling disasters is never without obligation".

As previously indicated by the Minister in the letter to the House of Representatives as cited above, the Cells and Cell Blocks Fire Safety Directive constitutes an important framework for evaluation, and that is therefore also the case in this investigation by the Board.

4.4 Discharge of individual responsibility for safety management

In addition to legislation and regulations (Section 4.2) and the supplementary sector-related standards and directives (Section 4.3), the Board is employing a third component in its analytical framework. This encompasses the Board's expectations in respect of the way in which the parties involved fulfil their personal responsibility for safety and safety management.

In principle, numerous avenues of approach can be taken to appraise and assess the way in which an organization fulfils its individual responsibility for safety. Consequently, there is no single, universal guide to apply to all situations. Therefore, the Board has selected five safety priorities of its own that indicate the factors that (to a greater or lesser extent) can have a role to play.

87 The Ministry of the Interior and Kingdom Relations took the initiative for the range of Fire Safety Schemes. Those that worked together on the Cells and Cell Blocks Fire Safety Scheme were: the Ministries of Justice, Defence, Agriculture, Education, Social Affairs, and Housing, the Association of Netherlands Municipalities, the Netherlands Fire Service Federation and the Association of Insurance Companies.

88 Letter dated 9 February 2005, 2004-2005, 26 956, no. 29

89 House of representatives documents II, 2000-01, 27157, no. 20

The Board is of the opinion that this choice is justified in view of the fact these safety priorities have been included in numerous examples of (inter)national legislation and regulations and in a large number of widely accepted and implemented standards and principles. For example, the Working Conditions Decree includes fundamental principles, which include the possession of a risk assessment and evaluation. The fundamental principles employed by the Board are an expansion of these in more detail.

It has been shown from various accidents in the past that the structure of the safety management system and the way in which this is interpreted by the parties involved play a crucial role in the management, safeguarding and continual improvement of safety. Safety management relates to the way in which organizations interpret safety in addition to the available legislation and regulations. If concerns, for example, the way in which the risks for the parties involved are mapped out and managed in a structured manner. Structure is necessary within the organization in order to execute this entire process and make it transparent, and to create the opportunities for continual improvement. That structure is referred to as the safety management system.

The Board has sent a letter the Minister of the Interior and Kingdom Relations to inform him about this⁹⁰. The Board employs the priorities referred to below in all of its investigations.

1. Acquiring demonstrable insight into the risks relating to safety as the foundation for the approach to safety:

The starting point for achieving the required level of safety is:

- an exploration of the entire system and
- an inventory of the corresponding risks.

The dangers that should be managed and the preventive and repressive measures that are necessary in that regard will be established on the basis of this.

2. A demonstrable and realistic approach to safety:

A realistic and practically applicable approach to safety (or safety policy) must be established to prevent and manage undesirable events.

This approach to safety is based on:

- relevant, current legislation and regulations (Section 4.2);
- available standards, directives and best practices from the sector, the organization's own insights and experiences, and the safety objectives specifically compiled for the organization.

3. Execution and enforcement of the approach to safety:

Execution and enforcement of the approach to safety and management of the risks identified is done by means of:

- a description of the way in which the employed approach to safety is to be executed with a focus on the specific objectives and including the preventive and repressive measures arising from it;
- transparent, unambiguous and universally accessible division of responsibilities in respect of safety in the workplace as far as the execution and enforcement of safety plans and measures are concerned;
- clearly establishing the required deployment of personnel and expertise for the various tasks;
- the clear and active centralised coordination of safety activities;
- realistic drills and testing of the approach to safety.

4. Fine-tuning the approach to safety:

The approach to safety should be subject to continual evaluation and fine-tuning on the basis of:

- conducting (risk) analyses on the subjects of safety, observations, inspections and audits (pre-emptive approach) periodically or, at least, in the event of every change to the underlying principles;

- a system of monitoring and investigation of near accidents in the complex and an expert analysis of these (reactive approach). Evaluations will be carried out and points for improvement will be brought to light on the basis of this on which action can be taken.

5. Management control, involvement and communication:

The management of the parties/organization involved should:

- ensure internally that expectations are clear and realistic in respect of safety ambitions, ensure there is a climate of continual improvement of safety in the workplace;
- communicate clearly externally about general working practices, the way in which they are tested, procedures in the event of anomalies, etc. on the basis of clear and established arrangements with the environment.

5 THE PARTIES INVOLVED AND THEIR RESPONSIBILITIES

This chapter deals in brief with the most important parties involved and their responsibilities in relation to the fire at the detention centre, notably:

- The Ministry of Justice (Section 5.1)
- The Ministry of Housing, Spatial Planning and the Environment (Section 5.2)
- The Ministry of the Interior and Kingdom Relations (Section 5.3)
- The Ministry of Defence and the Royal Military Constabulary (Section 5.4)
- The Municipality of Haarlemmermeer (Section 5.5)
- Various Inspectorates (Section 5.6)

5.1 The Ministry of Justice

The Ministry of Justice consists of⁹¹ the following components:

- Departmental sections under the direct remit of the Secretary-General (SG)⁹².
- The Directorate-General for International and Alien Affairs.
- The Directorate-General for Prevention, Juveniles and Sanctions (DGPJS), including under it the Custodial Institutions Service (DJI).
- The Directorate-General for Legislation, the Administration of Justice and Legal Aid.
- The Directorate-General for Law Enforcement.
- The National Coordinator for Combating Terrorism.

The Ministry of Justice operates according to an official chain of command model. This means that the Secretary-General and the Directors-General bear linear responsibility for all the results of their management teams and departments.

5.1.1 The Minister of Justice

The Minister of Justice has ultimate (political) responsibility for the ministry. All of the duties carried out by civil servants come under the political responsibility of the Minister. The Minister of Justice is responsible for legislation in the field of Justice, including penitentiary legislation. The Minister of Justice designates penitentiary institutions⁹³. The Minister determines⁹⁴ the authorised use of each institution or ward and imposes regulations for the placement and transfer of detainees. Moreover, the Minister can also designate parts of an institution as wards with separate authorised uses.

The Minister of Justice has ultimate responsibility for the implementation of custodial measures (in a penitentiary institution). The Minister of Alien Affairs and Integration has ultimate responsibility for the execution of aliens-related legislation, including the deportation of these aliens.

Mandates are usually given for the Minister's powers (delegated down the chain of command). In theory, all of the powers in respect of the primary process and administration are passed on to the overall manager (general mandate), either with or without provisos (special mandate). The party thus mandated must consider at all times whether the Minister, in person, or the party who delegated the mandate, should make the decision⁹⁵.

5.1.2 The Secretary-General

The Secretary-General (SG) has ultimate official responsibility for the management of all departmental sections. The SG also has overall responsibility for policy formulation and administration of the departmental sections immediately under his jurisdiction. On behalf of the Minister of Justice and on behalf of the Minister for Alien Affairs and Integration, the SG has been granted the power to take decisions (mandate), to perform legal acts governed by private law and to perform other acts (authorization). The SG has delegated some of this power by mandate.

91 Organizational arrangement of the Ministry of Justice 2005

92 Prior to 24-5-2005, the Justice New Buildings project department came under this prior to 24-5-2005; see Organizational arrangement of the Ministry of Justice 2002

93 Custodial Institutions Act, Art. 3, par. 1

94 Custodial Institutions Act, Art. 8

95 Mandate arrangements for the Ministry of Justice, February 2003

5.1.3 The Director-General for DGPJS

The Director-General (DG) for DGPJS is charged with and has overall responsibility for policy formulation and administration of the departmental sections relating to DGPJS. Schedules, whether of a temporary nature or otherwise, can be lodged with the DG. In turn, insofar as is applicable, the powers delegated to the DG of the DGPJS are delegated by him by mandate to the managers (directors).

5.1.4 Custodial Institutions Service (DJI)

The Custodial Institutions Service (DJI) is charged with and responsible for the implementation of custodial sentences and custodial measures on behalf of the Minister⁹⁶. In part, the DJI must ensure that cell capacity is sufficient. In the event of the construction of a penitentiary institution, the DJI operates as the initiator for the construction in respect of the Government Buildings Agency. Among other things, and with that in view, it is customary for the DJI to draw up the Schedule of Requirements (PvE).

The DJI is an accrual accounting department (also referred to as an "agency"). Accrual accounting departments are executive departments within central government that employ a results-oriented management model underpinned by accrual accounting. Their formation is designated as "internal privatisation". Ministerial accountability remains in full force despite the special position of an accrual accounting department within the Ministry⁹⁷.

The agency model has been laid down in the Government Accounts Act. The criteria in the Government Accounts Act and the Agencies Institution Procedure describe precisely the conditions under which an organization is eligible to become an agency, as well as what an agency may and may not do. In other words, a certain degree of management-related autonomy exists but, as mentioned earlier, ministerial accountability remains in full force. The most important features of the agency model⁹⁸ are the commercial-style management model (a clear relationship between the commissioner and the commissionee plus management and funding in relation to output) and an accrual accounting administration. With regard to accommodation, materials, information and documentation, and security, the DJI adheres to regulations and arrangements above ministerial department level and to statutory (EU) provisions. The same mandated powers apply to the DJI that apply to a specialist-field department within the Ministry of Justice. The transformation of the DJI into an agency signifies a distinction between policy development and policy implementation. The core ministry is responsible for developing policy in outline and determining the framework within which it is to be implemented. The DJI is responsible for effective implementation of tasks assigned to it⁹⁹.

In addition to three sub-directorates (the Prison Service, Custodial Institutions for Juveniles and Hospital Order Detentions), the DJI has a Temporary Special Facilities Directorate (TDBV). The director of the DJI is supported by staff directorates (Policy Implementation and Administration central staff) and is in charge of the three sector directorates and the temporary directorate. Together with the director-in-chief, these six directorates constitute the Directorate of the DJI. The TDBV has four detention centres at its disposal to receive drugs swallows and drugs couriers: in Heerhugowaard, Zeist, Roermond and at Schiphol-Oost. Two deportation centres are available for aliens: in Rotterdam and at Schiphol-Oost. The intention of these centres is for the short-term accommodation of aliens arrested by the police in concentrated, large-scale campaigns and who have had to be placed in custody. Aliens who have committed criminal offences and do not have a residence permit are also accommodated there. This relates to aliens who are to be deported in the short term.

96 Organizational arrangements 2005 of the Ministry of Justice

97 Based in part on a report by the DJI entitled 'A certain independence', dated July 2001

98 (i) House of representatives, year of session 2005–2006, 28 737, no. 11. (ii) House of representatives, year of session 2003–2004, 29 200 and 28 737, no. 46; (iii) Agencies: powerful organizations in need of modernisation? Ronald van Oosterom and Sandra van Thiel, public administration, volume 13, November 2004, number 7.

99 Arrangement of the position of the DJI within the Ministry of Justice, November 1994

The predecessor of the Temporary Special Facilities Directorate arose in 2002 out of the project organization set up to make it possible to accommodate the sharp growth in the number of drugs couriers, including drugs swallows, who were entering the country via Schiphol. Its expansion was first given shape in a separate project organization with the assistance of DJI expertise under the management of an executive project manager. Up until 1 July 2003, “the Project Manager for the temporary accommodation of drugs couriers” had a mandate in respect of supervising the day-to-day execution of general management, and “the Project Supervisor for the temporary accommodation of drugs couriers” had the powers necessary to comply properly with the day-to-day implementation of general management. The Project Manager and Project Supervisor were accountable to the SG of the Ministry of Justice, who had been given a mandate for general management from the Minister as far as the facilities were concerned on the grounds of the Interim Act. The Detention Centre Schiphol-Oost (A to H Wing inclusive) was also brought about in that period. From 1 July 2003, the project organization was transferred to the DJI, and the Temporary Special Facilities Directorate appeared, under which came detention and deportation centres with their own local management. The Detention Centre Schiphol-Oost is one of those centres.

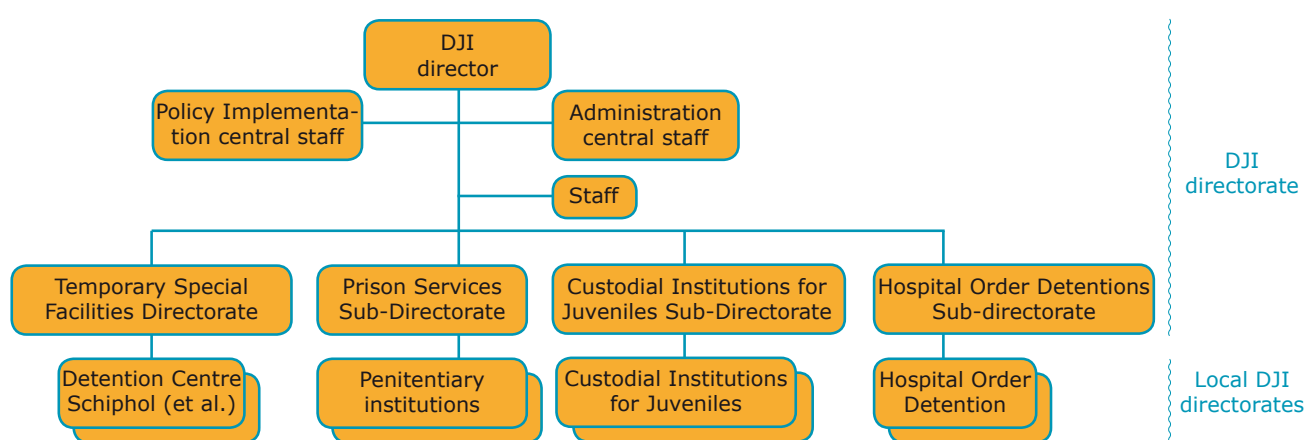


Figure 12: Organigram of the Custodial Institutions Service (DJI)

5.1.5 Temporary Special Facilities Directorate (TDBV)

The Temporary Special Facilities Directorate (TDBV) is a directorate in the DJI chain of command which has an integral place alongside the existing sub-directorates and central staffs. The TDBV is steered in a chain of command from the top downwards by the DJI Director (Figure 12)¹⁰⁰. In theory, the TDBV is involved in all areas of the DJI’s operations on the instructions of the Director of the DJI.

The detention of aliens measure pertaining to administrative law is implemented within the DJI almost entirely under the direction of the TDBV sub-directorate. The TDBV concerns itself with accommodation facilities and related organizational issues.

The DJI Pool comes under the Prison Services Sub-directorate. This is a project bureau that, after the development of the TDBV, came to operate as an organization with a flexible workforce within the DJI. The project bureau is responsible for the deployment of sufficient numbers of guards at the locations within the remit of the TDBV and is responsible for the recruitment, selection and training of guards. Securicor¹⁰¹ also recruits, selects and trains guards. The DJI Pool and Securicor each provide one half of the employees within the TDBV’s facilities.

¹⁰⁰ Based on the Organization and formation of the Temporary Special Facilities Directorate, dated 12 March 2003

¹⁰¹ Group4Securicor, referred to hereinafter as Securicor

5.1.6 The Site Manager

On the grounds of Art. I, par. 1 under a, of the Working Conditions Decree, the employer is the party for whom another party is obliged to perform work pursuant to an appointment governed by public law. This means that it is the Minister who is officially the employer within the meaning of the Working Conditions Decree. The Custodial Institutions Act states that supreme authority for a penitentiary institution lies with the Minister of Justice, but that its management lies with the Site Manager of the institution (assignment)¹⁰². The Site Manager is responsible for the running of operations from the perspective of both the Working Conditions Decree and the Custodial Institutions Act. The Site Manager bears responsibility for the safety of employees and cell occupants pursuant to the Working Conditions Decree, the Custodial Institutions Act and the Aliens Act. The DJI has to shape the framework for this at a central level, has to ensure conditions that make this possible and has to supervise that this is done effectively. A horizontally structured chain of command with many operational responsibilities and powers delegated to Site Managers is specific to organizations operating within the remit of the TDBV¹⁰³. The Custodial Institutions Act assigns some specific powers to the Site Manager, such as imposing disciplinary punishments and making internal rules.

An analysis in greater detail follows below on the way in which duties and responsibilities are apportioned with regard to a number of operational matters.

Construction Legislation and permits

With the division of roles between the Directorate of the DJI and the Site Manager in mind, it is obvious that the Site Manager of an institution is primarily responsible for observing construction legislation requirements insofar as they relate to the institution's use. This means that site management must comply with the requirements of the Occupancy Permit and observe the requirements imposed by the building regulations on an institution's use¹⁰⁴.

From the perspective of working conditions, the Working Conditions Decree¹⁰⁵ obliges employers to occupy a building only if it complies with the provisions in the Buildings Decree in relation to its user function¹⁰⁶. First and foremost, this obligation aims to protect employees in such institutions; however, it also relates to third parties who make use of the building.

In-house emergency and first-aid service

The Site Manager is responsible for working conditions-related matters on site and for an in-house emergency and first-aid service. He bears responsibility in the event of disasters¹⁰⁷. The employer should also compile an inventory of risks¹⁰⁸. The Working Conditions Decree lays down the requirements as regards content. In part, the in-house emergency and first-aid service must be organized to provide an emergency service in the event of a fire. Compliance with this requirement is primarily in the hands of the Site Manager. The in-house emergency service is to be organized such that in-house emergency service responsibilities can be fulfilled effectively within a few minutes of an accident or fire occurring¹⁰⁹. Provision is made in all events that technical and organizational measures are taken with regard to escape routes and emergency exits such that custodial personnel and cell occupants are able to reach safety. The manager must ensure that cell occupants are provided with proper medical care.

Employees and cell occupants

The employer must organize work in such a way that it has no adverse effect on the health and safety of employees¹¹⁰. The employer ensures that employees are informed effectively about the work to be performed and the risks attached to it and about the measures that have been put

102 Custodial Institutions Act, Art. 3, par. 3

103 Occurrence Investigation Inspectorate Report by the Sanctions Application Inspectorate (IST) and the Council for the Application of Criminal Law and Youth Protection (RSJ) into the Rotterdam Detention Centres, Merwehaven location (May 2006).

104 Haarlemmermeer Building Regulations, Art. 12.1

105 Art. 3.1b

106 Art. 15.2

107 Ministry of Justice letter 5198346/502/PI dated 22/11/02

108 Working Conditions Decree, Art. 5

109 Art. 2.18, par. 1, Working Conditions Decree

110 Art. 3, Working Conditions Decree

in place to prevent or minimise these risks¹¹¹. A number of provisions in the Working Conditions Decree, including Art. 10, apply only to work performed by custodial personnel 'insofar as no infringement is made regarding order, safety or the proper procedure in the institution or regarding the undisturbed process of enforcing the deprivation of liberty and other restrictions that have been imposed pursuant to any statutory provision by the competent authorities in that regard'¹¹². The Manager of the detention centre bears responsibility for employees and cell occupants¹¹³. On the grounds of Working Conditions legislation, the Manager also bears responsibility for the safety of third parties, including cell occupants.

Relief and aftercare

The DJI is responsible at the central level for coordinating relief and aftercare and should be prepared for occurrences¹¹⁴. The Site Managers of the institutions are responsible for implementing this. According to the Custodial Institutions Act, the Site Manager bears responsibility for care in respect of cell occupants¹¹⁵.

The evacuation of institutions in the event of a disaster or an impending disaster constitutes an occurrence. Strategies in respect of this must be available at a variety of levels within the DJI. If an institution has to be cleared and occupants have to be evacuated, a crisis team must go into operation at the DJI headquarters. This team must be at the centre of coordinating the evacuation. The Director of the DJI and the managers of institutions are obliged to make coordinated arrangements in their own organizations and to set these out in a planned strategy. Managers compile an evacuation strategy. This evacuation plan must dovetail with local/regional disaster plans and the evacuation plan must form part of these municipal/provincial plans.

The manager of a relief centre is to draw up a strategy that includes the way in which medical provision can be made for detainees.

Medical care

Management of a detention and deportation centre rests with the manager of the location concerned. On the basis of this responsibility, the manager must ensure that proper provision is made for the medical care of cell occupants. The Explanatory Memorandum on European Prison Rules indicates the minimum that must be provided under "medical care": '*medical care in penitentiary institutions must be organized according to standards that are comparable in terms of quality with those in society at large*'¹¹⁶.

Art. 42, par. 1 of the Custodial Institutions Act provides cell occupants with the right to care from a doctor attached to the institution or from his/her deputy. The manager is responsible for cell occupants being placed in a position to exercise their right to care. A cell occupant must have not only access to a doctor, but that access must also be offered to him or her within a reasonable period of time¹¹⁷. Furthermore, the manager should ensure that medicines and diets prescribed by the doctor are provided, that treatments prescribed by the doctor are carried out and that cell occupants who have to be treated elsewhere are transferred to the institution concerned (such as a hospital, for example)¹¹⁸.

5.2 The Ministry of Spatial Planning, Housing and the Environment

The Ministry of Spatial Planning, Housing and the Environment (VROM) consists of:

- Departmental sections under the direct remit of the Secretary-General (SG)
- The Directorate-General for Housing
- The Directorate-General for Spatial Planning
- The Directorate-General for the Environment
- The VROM Inspectorate
- The Government Buildings Agency

111 Art. 8, Working Conditions Decree

112 Working Conditions Decree, Art. 1.22, par. 1

113 Pursuant to the Working Conditions Decree, the Custodial Institutions Act and the Aliens Act, the Site Manager bears responsibility for employees and cell occupants.

114 Framework Arrangements for the Evacuation of Judicial Institutions.

115 Custodial Institutions Act, Art. 42

116 Explanatory Memorandum on European Prison Rules, Recommendation No. R (87)3.

117 Moerings & Zandbergen, 2001. (BC 18 January 2000, A 99/564/GM).

118 Kelk, 1998. (Art. 42, par. 4, Custodial Institutions Act).

The Ministry of VROM operates according to an official chain of command model. This means that the Secretary-General and the Directors-General (DGs) bear linear responsibility for all the results of their management teams and departments.

5.2.1 The Minister of VROM

Subject to the political accountability of the Minister of VROM, the Ministry of VROM is responsible for the development and updating of building regulations in the Housing Act and the Buildings Decree. This responsibility also relates to construction-related regulations in the area of the fire safety of buildings. The Ministry of VROM is the point of contact for building regulations in which construction-related aspects of fire safety are regulated. Within that context, part of the Ministry of VROM's responsibility is for the quality of these regulations (including regular adjustments to them) and ensuring that the fire safety aspect is incorporated within these regulations correctly.

In the main, mandates are given for the Minister's powers (delegated down the chain of command). In theory, all of the powers in respect of the primary process and administration are passed on to the overall manager (general mandate), either with or without provisos (special mandate).

5.2.2 The Government Buildings Agency (RGD)

The Government Buildings Agency (RGD) is an agency under VROM. The RGD is under the management of the Director-General.

The RGD manages the State's buildings portfolio, which consists of over 1,800 buildings. The RGD has a staffing level of approximately 950, most of which are found at its headquarters in The Hague. In addition, the RGD has five regional branches. The RGD acts as a consultant, project manager and administrator for its 'clients'. As far as the construction of the detention centre is concerned, the RGD, acting as a commissioner of contracting parties for its realization (contractors, architect, etc.), is responsible for compliance of the buildings with the requirements imposed on construction work by construction legislation¹¹⁹. The RGD is also responsible for building permit applications and ensures construction work does not depart from the terms of such permits¹²⁰.

The RGD can be divided into five directorates:

- Front office
- Advice and Architects
- Property
- Projects
- Management

The directorates are supported by a staff (Policy and Strategy, Building Policy Coordination, Personnel and Organization, Legal Advice, Administration).

The Director of the Projects Directorate and the departmental heads for Project Management have a combined responsibility for the projects and programmes. Within the local departments for Project Management, project managers execute projects under the responsibility of the departmental head. The Detention Centre Schiphol-Oost is an example of such a project that was undertaken by the Haarlem Project Management team.

119 Housing Act, Art. 2

120 Housing Act, Art. 40, par. 1

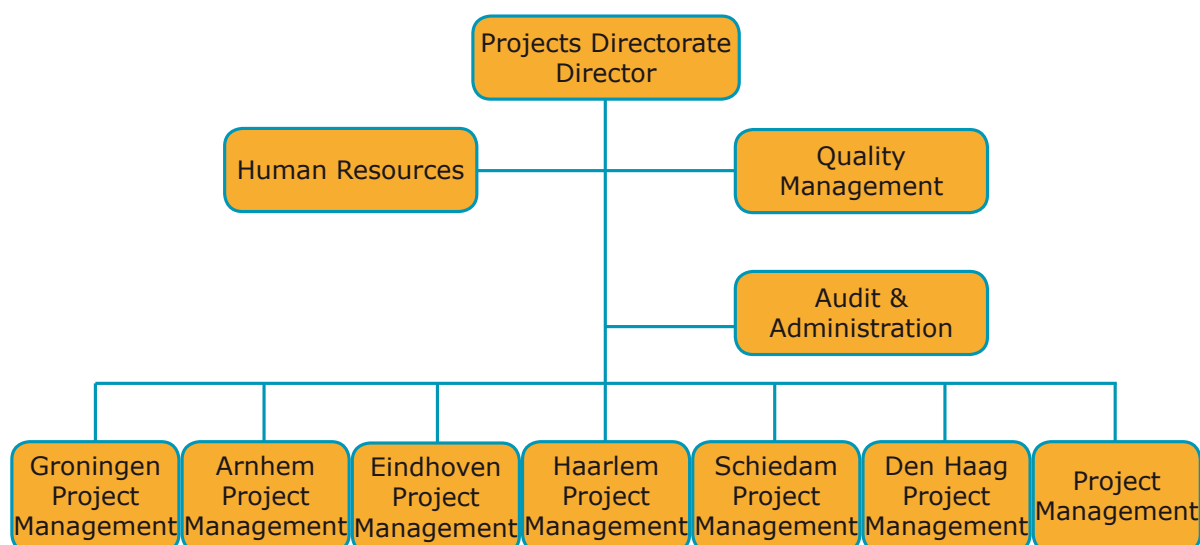


Figure 13: Organigram of the Projects Directorate

5.3 The Ministry of the Interior and Kingdom Relations (BZK)

5.3.1 The Minister of BZK

One of the duties within the remit of the Minister of the Interior and Kingdom Relations (BZK) is to promote public order and safety. The Minister of BZK is the minister in charge of coordination in terms of crisis management (including disasters). The system-related responsibility of BZK for fire safety involves including an adequate level of fire safety in regulations and providing a facilitating and promotional role in respect of the implementation of fire safety by municipalities: for example, by drawing up guides and advice, such as the Prevention Activities Plan (Prevap) manual and fire safety schemes¹²¹. The Minister of BZK is also responsible for the administrative structure of the GHOR (Medical Assistance in the Event of Accidents and Disasters).

5.3.2 Nifv/Nibra¹²²

The 1985 Fire Services Act¹²³ provides for the Netherlands Institute for Physical Safety (Nifv/Nibra). The statutory duties of the Nifv/Nibra relate primarily to training. In addition, the Nifv/Nibra has the job of developing, maintaining and putting at disposal expertise in relation to the fire brigade and handling disasters. By way of an agreement the Minister of BZK has laid down the management by Nifv/Nibra of a restrictive number of documents (including the Cells and Cell Blocks Fire Safety Scheme) on the subject of the fire brigade, GHOR, crisis management and handling disasters. The Ministry of BZK indicates the documents that the Nifv/Nibra must archive, as well as those that it must update. The Nifv/Nibra is to perform this work in close collaboration with BZK, the Fire Brigade Editorial Board and the sector collectively under the umbrella of safety, devoting special attention to the way in which the material is developed and given substance.

¹²¹ See House of representatives Document 27 575, no. 6, question and answer 1

¹²² Since 1 July 2006, Nibra (the Netherlands Institute for the Fire Service and Disaster Management) has been called the Netherlands Institute for Physical Safety/Nibra (Nifv).

¹²³ Fire Service Act, Art. 18 a and f.

5.4 The Ministry of Defence and the Royal Military Constabulary (KMar)

Since 5 September 2005, the KMar has no longer been an independent part of the Ministry of Defence from an organizational point of view. Since then, the KMar has formed one of the four operational commands of the Ministry of Defence¹²⁴. Each of these four operational commands is responsible for the execution of their primary duties. Regarding the execution of 80 per cent of its duties, the KMar comes under the authority of other ministries, including the Ministries of the Interior and of Justice.

The KMar carries out policing duties at Schiphol Airport and at other airport sites as indicated by the Ministers of Justice, the Interior and Defence. In part, it is responsible for maintaining public order, rendering assistance, crime prevention, projects to prevent common types of crime, implementing spot checks/traffic surveillance, taking statements and investigating offences that have been committed. The KMar is also responsible for carrying out policing duties at the detention centre. People who are arrested at Schiphol in that connection are incarcerated in the Schiphol-East detention centre¹²⁵.

5.5 The Municipality of Haarlemmermeer

Haarlemmermeer has a population of 130,000 and is among the twenty largest municipalities in the Netherlands. It consists of 26 towns and villages spread across an area of 18,500 hectares. Schiphol Airport and the Detention Centre Schiphol-Oost lie within the borders of the Municipality of Haarlemmermeer.

The municipal administration consists of a council, a Municipal Executive and a Mayor¹²⁶. The municipal council determines policy in outline and scrutinises the executive. The municipal council enacts municipal regulations insofar as the power to do so has not been assigned by or pursuant to law to the executive or the Mayor¹²⁷.

In part, the municipal executive is authorised to conduct the day-to-day administration of the municipality, to prepare and execute the council's decisions (unless the Mayor has been charged with this by or pursuant to law) and to lay down rules concerning the municipality's administrative organization¹²⁸.

In addition to a number of supervisory and representative duties,¹²⁹ it is the Mayor's duty to maintain public order,¹³⁰ and he is charged with supreme command in the event of fire and accidents other than fires, insofar as the fire brigade also have a duty in that respect¹³¹.

In addition to the Municipalities Act, a variety of other acts assign particular duties and powers to municipalities. Regarding relevant legislation within the context of this investigation (Section 4.2), this concerns the Housing Act with regard to granting building permits and Occupancy Permits, the 1985 Fire Services Act¹³² with regard to the organization and duties of the fire brigade¹³³ and the Disasters and Major Accidents Act (WRZO, 1985) with regard to preparations for combating disasters, combating disasters even under extraordinary circumstances and the powers of the various administrative bodies.

124 The other three Operational Commands are the Naval Forces Command (CZSK), the Land Forces Command (CLAS) and the Air Forces Command (CLSK).

125 For the division of responsibilities between the DJI and KMar see Appendix 25.

126 Municipalities Act, Art. 6

127 Municipalities Act, Art. 147, par. 1

128 Municipalities Act, Art. 160, par. 1

129 Municipalities Act, Art. 170 and Art. 171

130 Municipalities Act, Art. 172

131 Municipalities Act, Art. 173

132 Fire Services Act 1985: Art. 1, par. 4a 'The Municipal Executive are responsible for preventing, restricting and combating fire, minimising the risk of fire, preventing and limiting accidents by fire and whatsoever in that connection'. In accordance with Art. 12, and with regard to these duties, the municipal council 'enacts the regulations by means of regulations ... insofar provision has not been made for this in or pursuant to the Housing Act or any other Act'.

133 Both in a preventive sense, as well as concerning preparation and repression in relation to combating the source and effects.

At the time of the fire, the Municipality of Haarlemmermeer had the following seven departments:

- The administration department
- The general and technical department
- The fire brigade
- Spatial planning, housing and economy
- Public works and the environment
- Welfare, education and culture
- Programme management

The internal organization of the municipality is regulated in outline by the 1998 Organization Regulations, which also lay down the mandate arrangement. Decisions taken by an official thus delegated by mandate have validity as decisions by the authorised administrative body¹³⁴ for which the mandatory, the municipal executive, remains responsible legally and in terms of administration. The municipal executive enacted the 1998 Mandate Decree in a decree dated 31 March 1998. The Mandate Decree was updated in 2002 and 2003.

The municipal executive is permitted to grant building permits pursuant to Art. 40, par. 1, of the Housing Act. In the 1998 Mandate Decree, the power to grant building permits was delegated by mandate to the Director of the Public Works department, and, in turn, the Director granted a mandate to the Departmental Head of Building Permits. In view of the 1998 Mandate Decree, the Chief Fire Officer was authorised to grant Occupancy Permits on behalf of the municipal executive¹³⁵.

5.5.1 Haarlemmermeer Fire Brigade

The Haarlemmermeer Fire Brigade consists of three sections: Pre-Emption/Prevention, Professional Operations and Volunteer Operations. In total, the services number approximately eighty professional employees and over one hundred volunteers. The fire brigade is under the command of a Chief Fire Officer.

The Haarlemmermeer Fire Brigade stationed at seven locations within the borders of the municipality. Two professional fire stations are stationed in Hoofddorp and at Post Sloten at Amsterdam Airport Schiphol (working in collaboration with the Schiphol Fire Brigade at Post Sloten, Schiphol). In addition, there are five voluntary depots in Badhoevedorp, Lissersbroek, Nieuw-Vennep, Rijsenhout and Zwanenburg.

In addition to combating the sources and effects of fire, and granting Occupancy Permits on behalf of the municipal executive, it is the duty of the fire brigade to advise the municipal executive and/or other departments for the Municipality of Haarlemmermeer about granting building permits in respect of buildings in the catchment area (including the detention centre). Moreover, the fire brigade supervises compliance with the conditions in the Occupancy Permit and prepares itself for deployment in the event of possible fires.

5.6 Miscellaneous Inspectorates

In addition to supervision carried out by municipalities within the context of building and Occupancy Permits and the planning and control cycle within the DJI itself concerning its own organization, the following Inspectorates are relevant in terms of the construction and use of the Detention Centre Schiphol-Oost.

5.6.1 The VROM Inspectorate

The VROM Inspectorate conducts the inter-administrative (referred to as 'second-line') supervision of municipalities and assesses whether they are executing their statutory duties adequately. To that end, the Inspectorate investigates each municipality once every four years, evaluating all areas of responsibility in so doing (environment, housing, spatial planning). In

134 National Social Security Assistance Act, Art. 10, par. 2

135 Municipality of Haarlemmermeer building regulations, Chapter: Fire Safety.

the event of inspections and supervising municipalities, the applicable statutory framework is the frame of reference. In view of the fact that there are some 458 municipalities, the VROM Inspectorate conducts selective monitoring, and the nature of its supervision is primarily procedure-based. This means that the VROM Inspectorate prioritises situations in which there is a high risk to citizens and compliance is poor. The Inspectorate conducts an evaluation in the event of a specific notification, which did not arise in the case of the Municipality of Haarlemmermeer.

In part, the Inspectorate assesses the way in which municipalities grant Building Permits and Occupancy Permits. The Inspectorate uses an "effective level" checklist as a guideline and on that basis tests the procedure for policy, programmes and implementation. In case of doubt, the Inspectorate tests the issue of Building Permits in terms of content. A specific module has been developed for that purpose. At present, work is in progress on a similar instrument for testing the issue of Occupancy Permits. This is separate from the development to establish intended use requirements within the context of the national intended use decree that is to be introduced as of 1 January 2007.

5.6.2 The Inspectorate for Public Order and Safety (IOOV)

In accordance with the Minister of Justice, the Minister for the Interior and Kingdom Relations instituted the Inspectorate for Public Order and Safety (IOOV) with effect from 1 May 2002. The IOOV conducts inter-administrative (referred to as 'second-line') supervision on the operation of municipalities in respect of combating fires and disasters, including aftercare. This supervision is restricted to the arrival of the fire brigade in the event of fires and other calamities. The IOOV also performs investigations and conducts thematic studies. On behalf of the Minister of BZK, the IOOV monitors the way in which municipalities, fire brigade regions, provinces and central government discharge their duties on the subject of, for example, fire safety. A distinction can be made between the following types of investigation¹³⁶.

- Systematic investigation: this is a standardised investigation method in which an opinion is given on quality concerning the way in which duties are executed at the level of the individual organization (police force, educational institution, etc.).
- Thematic investigation: this type of investigation derives from the findings from the systematic investigation, current political/social events or occurrences.
- Occurrence investigation: the IOOV can decide to conduct an investigation in response to an occurrence, accident or disaster. This is to take into account the duties and powers of the Dutch Safety Board that may be concurrent in respect of this type of investigation.
- Advice and occurrence investigation: citizens, companies, operational services and co-governing authorities are increasingly requesting the IOOV to express an opinion on specific safety issues.

5.6.3 The Labour Inspectorate (AI)

The Minister of Social Affairs and Employment is responsible for legislation on the subject of working conditions. The AI is responsible for monitoring implementation of the duties assigned to employers and employees under the Working Conditions Decree. Within the context of this investigation, the most important duties that the AI monitors are the drafting of a risk assessment, policy for risk reduction, the organization of the in-house emergency and first-aid service and the evacuation plan. The AI has the authority to issue binding directives.

The AI supervises the compliance with statutory regulations by employers and employees by means of project-related inspections. The inspections focus on sectors where the majority of abuses are anticipated and/or where the greatest risks to employees' health and safety are present¹³⁷.

136 See IOOV website: www.ioov.nl.

137 This is called "risk-based" inspection.

5.6.4 The Supervisory Committee (CvT)

The Supervisory Committee (CvT) is responsible for monitoring correct observance of penitentiary legislation in particular (Custodial Institutions Act, Penitentiary measures) and regulations relating to deportation centres (Aliens Act, Aliens Decree; Regulations on Regime for Border Accommodation). In addition, the Committee is responsible for dealing with the complaints of detainees. Apart from these, a complaints committee set up specifically for the purpose at the KMar in The Hague handles complaints from people in police cells. Among the members of the Supervisory Committee are experts from the social work sector in the fields of case law and medicine; the presence of this expertise on the committee is prescribed by law. The Committee does not have fire-related expertise at its disposal and is not involved with fire safety. A Supervisory Committee is attached to each penitentiary institution.

5.6.5 The Sanctions Application Inspectorate (ISt)

The Sanctions Application Inspectorate (ISt) was officially founded on 1 January 2005. In terms of its organization, this independent Inspectorate is a part of the Ministry of Justice. The ISt 'monitors the effectiveness and quality of implementation, particularly in respect of treatment and security'. The area within which the Sanctions Application Inspectorate works encompasses all probation and aftercare service establishments and all national services and institutions under the remit of the DJI. The headquarters of the probation and aftercare services and the DJI are not the primary subject of investigation but, nevertheless, can be involved in a (thematic) investigation.

The duties of the ISt are:

- to monitor the effectiveness and quality of implementation, particularly in respect of treatment and security;
- to signal risks in local implementation;
- to supervise compliance with legislation and regulations;
- to coordinate and dovetail with other supervisory bodies and to evaluate the operation and completeness of other supervisory arrangements.

6 ANALYSIS OF THE DEVELOPMENT OF THE FIRE, RESCUE EFFORTS AND FIREFIGHTING

6.1 Introduction

The following questions are central to this chapter: how did the fire in the Detention Centre Schiphol-Oost develop, and how did the rescue and fire fighting efforts progress? The evacuation of the complex will be considered in Chapter 8.

The present chapter is structured as follows: Section 6.2 discusses an analytical framework. This framework consists of five elements used in the analysis of the role of the fire brigade and the internal organization. Section 6.3 deals with the various parties involved and their responsibilities. Section 6.4 looks at the structure of the analysis. The start and development of the fire are analysed in Section 6.5. The following Section contains an analysis of the manner in which the personnel staffing the detention centre behaved on the night of the fire. This is followed in Section 6.7 by an analysis of the role of the fire brigade. Finally, the most significant conclusions of the investigation into the development of the fire, the fire fighting and the rescue efforts are set out in Section 6.8.

6.2 Specific analytical framework in relation to rescue efforts and firefighting

6.2.1 Introduction

This section presents a description of the analytical framework used with specific application to fire fighting and rescue, in supplement to the general analytical framework set out in Chapter 4. This framework has been used in the assessment of the efforts to fight the fire in the Detention Centre Schiphol-Oost on the night of 26-27 October 2005 and the attempts to rescue the cell occupants. In drawing up this analytical framework the investigators have made reference to the legislation and regulations and other source documents which can be assumed to have been known to the persons and organizations charged with fire safety tasks and responsibilities from the start of the construction of the detention centre in 2002 and during subsequent years. These source documents consist of formal and informal, general and specific rules at both central and local government levels. Additional information on the reference material is included in Appendix 20.

Section 6.2.2 presents response times. The following Section, 6.2.3, looks at the preparations made by the fire brigade. Section 6.2.4 subsequently examines the control of the fire fighting efforts by the Detention Centre Schiphol-Oost (emergency) organization. The fire fighting activities of the fire brigade are the focus of Section 6.2.5, followed by a description in Section 6.2.6 of the responsibilities of the Custodial Institutions Service (DJI) for the employed personnel. Preparations made by the internal organization are covered in Section 4.2.3 and Appendix 20 rather than in this Chapter.

6.2.2 Response times

The speed with which the emergency services arrive at the scene and go into action is of great significance for the effectiveness of fire fighting. The services' arrival time¹³⁸ and deployment time¹³⁹ and the internal timings are summarised here. Figure 14 shows a timeline for the fire brigade's actions and those of the internal organization, from the moment the fire alarm was received at the fire brigade's emergency control room ($t = 0$) to the time when the actions should have been completed. The fire brigade's timeline is based on the standards set down in the Fire Safety Scheme for Cells and Cell Blocks. The standard for the fire brigade's arrival time is eight

138 The time between the arrival of the incoming fire alarm at the services' switchboard ($t = 0$) and the arrival of the fire brigade at the site ($t = 8$).

139 The time between the fire brigade's arrival on site ($t = 8$) and the time when they are ready for deployment ($t = 15$).

minutes while the standard for deployment time is seven minutes¹⁴⁰. Alongside the standards set out in the Fire Safety Scheme (1994), the Fire Brigade Manual (1992) also discusses standards for arrival times. Since this is earlier in date and less specific, the Fire Safety Scheme will be used for the purposes of this report. This subject will be revisited in Section 6.7.6.

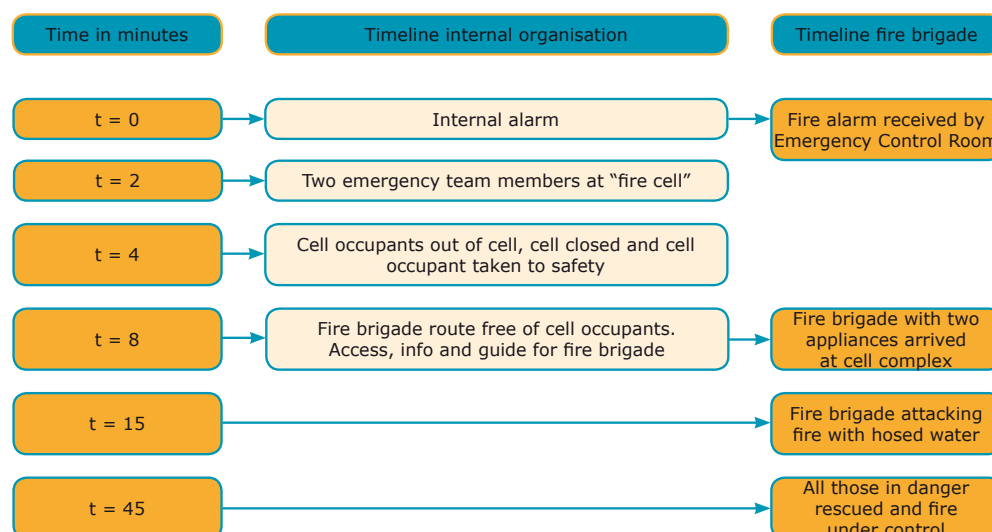


Figure 14: Normative fire brigade timeline from the Cells and Cell Blocks Fire Safety Scheme

6.2.3 Preparations by the fire brigade

Successful control operations by the fire brigade require good preparation. In order to meet the need for local information, in certain circumstances a so-called access map or a (more detailed) Action Plan is used.

CCRB¹⁴¹ Bulletin no.5, "Action Plans, Manual for Action Plans and Access Maps" includes requirements for access maps and fire brigade action plans. Access maps must be up to date and must provide written information about access, fire prevention systems such as smoke and heat exhaust systems, special procedures, means of gaining access, information about key-holders and variant water supplies. The access map should also include a sketch of the building and its surroundings. This drawing should be to scale, and must, among other things, show the access for the fire brigade, other entrances and exits, water provision and possible deployment positions.

Action Plans are particularly intended for sites where there are predictable fire scenarios and/or exceptional risks, including the presence of persons incapable of independent self-rescue. The benefit of an Action Plan is that, in addition to the information in the access map, scenarios applicable to the site are worked through.

The Cells and Cell Blocks Fire Safety Scheme recommends¹⁴² that the fire brigade should draw up an effective¹⁴³ Action Plan. The Action Plan must be compatible with the site's occurrence response plan.

The reception of the fire brigade (and their Crew Commander) and the provision of information to them by the site emergency team must be set down unambiguously, both in the fire brigade's

¹⁴⁰ Art. 6.7.1 looks in more detail at these standards.

¹⁴¹ CCRB: College Commandanten Regionale Brandweren - former liaison body for Regional Fire Brigade Commanders, now absorbed into the Netherlands Institute for Fire Service and Disaster Management.

¹⁴² Cells and Cell Blocks Fire Safety Scheme pages 55 and 59. This is a standard recommended by experts and not a legal standard (see also Art. 4.3). See also CCRB bulletin no. 5.

¹⁴³ An Action Plan is devised for special sites such as hospitals, chemical plants and large cinemas. The Action Plan sets out how the fire brigade should act and deploy their various emergency vehicles in the event of a major occurrence. Drawings and text are used to describe the location of entrances, stairways and lifts, where large numbers of people might be located, storage locations for hazardous substances, means of access to spaces and the availability of firewater. Fire-fighting scenarios may also be discussed. The Action Plan is an extended version of the access map (Source: Manual on Preparations for Occurrence Control, June 2003).

Action Plan and in the occurrence response plan held, in the present case, by the Detention Centre Schiphol-Oost. The fire brigade takes an initiating, coordinating and monitoring role in the harmonization of the Action Plan and the site occurrence response plan. The occurrence response plan will, among other things, include fire safety instructions and an Evacuation Plan prescribed by the municipality in their Occupancy Permit. It is expected that the fire brigade will check that both are coordinated. The Occupancy Permit states that the site must liaise with the fire brigade commander when drafting the fire safety instructions and the Evacuation Plan.

If an access map¹⁴⁴ exists, the fire brigade must be able to consult it while travelling to the site¹⁴⁵. The detention centre's walkie-talkies must be ready at the gatehouse, switched to the correct channel, and must be handed over to the Crew Commander.

6.2.4 Control measures by the detention centre's internal (emergency) organization

The response actions of the internal organization at the Detention Centre Schiphol-Oost in the event of fire are set out in the fire procedure included in the detention centre's occurrence response plan. This occurrence response plan dated from January 2004 and was out-of-date. It was just about to be revised when the fire occurred. Nevertheless, it is included in this analytical framework, since it was the most recent plan. The occurrence response plan is based on the previous situation where the gatehouse security staff were located at the Royal Dutch Constabulary (KMar) switchboard. At that time, the Custodial Institutions Service (DJI) switchboard served wings L and M only. At the time of the fire this had changed and gatehouse security staff were located at the DJI switchboard, which served all wings except B. The main entrance had also been moved and was served by the central DJI switchboard. The former entrance, served by the KMar switchboard, was closed.

The text in italics has been taken directly from the occurrence response plan. Where necessary, a brief explanation by the Board follows.

0. *The alarm is sent to the Switchboard (CP)*¹⁴⁶.
The steps set down in the procedure for the internal organization are based on alarms coming in via the automatic fire alarm installation. An alarm coming in by telephone or walkie-talkie will be regarded as being correct (point 3). Alarms triggered manually are immediately sent on to the fire brigade (point 4).
1. *The Duty Officer will initiate investigations as to the accuracy of the alarm. When it is confirmed that such a check will be carried out, the gatehouse will switch off the acoustic signal within one minute; otherwise the alarm will automatically be passed on to the fire brigade.*
Automatic fire alarms should be reported directly to the fire brigade¹⁴⁷.
2. *In the case of a false alarm (for example a technical fault), the switchboard is required to return the installation to its normal condition (to reset it) within 3 minutes.*
3. *In the case of a real alarm, the fire can be reported to the fire brigade within 3 minutes using the manual alarm,¹⁴⁸ otherwise this will take place automatically after 3 minutes. The local police force will also be alerted in case their attendance is required.*

144 The Municipality will draw up an access map for sites with an elevated (fire) risk or which are difficult to access. The map will indicate how the emergency services (the first fire appliances to arrive) can reach the site, where the firewater valves are located, how buildings are to be entered and so on (Source: Manual on Preparations for Occurrence Control, June 2003).

145 Fire Brigade Teaching Materials IIIa - points 3 and 5.

146 The plan does not make clear which switchboard is intended here. The joint response during the ministerial inspection was that this still referred to the "old" switchboard, i.e. the KMar switchboard.

147 Cells and Cell Blocks Fire Safety Scheme, page 56, Detention centre Building Permit, NEN 2535: 1996/A.1:2002, Fire Safety in Buildings - Fire Alarm Installations - System and quality requirements and project guidelines. However, the word "directly" is capable of several interpretations; it might also mean directly in a physical sense, by means of a fixed telephone line which is always open; there is no Schedule of Requirements which sets out detailed requirements in relation to delays. The NEN standard leaves room for delay periods.

148 The occurrence response plan has the following apparently inaccurately edited or incomplete text covering this point: "... passed on via the to the fire brigade...".

4. *All staff will be alerted via the "Personal Location and Alarm System". They will then be able to take measures in advance of the arrival of the fire brigade.*
The in-house emergency and first-aid service (within the detention centre) should be properly informed within one minute of the discovery of a fire, immediately after point 1¹⁴⁹.
- 4a. *In the case of a fire in a single cell, the staff should first secure the rescue of the persons detained in that cell, and subsequently switch off the electrical supply to the cell.*
- 4b. *Fire fighting using extinguishers may then be commenced by the appropriately trained personnel. The cell door must be kept closed as much as possible while fire fighting with extinguishers is in progress in order to prevent the spread of flames and smoke. It is preferable for the cell door hatch to be used for extinguishing activities as this can prevent large amounts of smoke from escaping and great volumes of oxygen from entering.*
- 4c. *In the event of a fire involving several cells or in one or more other spaces, the wing in question is to be evacuated. The staff of the establishment should carry out these evacuation and rescue tasks. Fire fighting is to be carried out by the fire brigade in these cases. The fire brigade should in principle only commence extinguishing activities once the relevant wing is free of cell occupants. The fire brigade will take part in the rescue work only where the staff of the establishment are not able to carry out this task due to forces beyond their control (heavy smoke and similar).*
- 4d. *The switchboard on site should always make preparations for evacuation in the event of a fire alarm*¹⁵⁰.
5. *Gatehouse Security will contact the Royal Dutch Constabulary (KMAR) and the fire brigade via 8222. The fire brigade will be informed by Gatehouse Security of the location, nature and extent of the fire and the actions already taken by staff*¹⁵¹.
6. *The Duty Officer is to deal with reception of the fire brigade at the entrance gate, he will also hand over an additional walkie-talkie to the services (or have it handed over) and will accompany them to the location of the fire. The Duty Officer will remain at his post.*
The fire instructions for the group commander of the KMar at the switchboard also state that the fire brigade will be provided with a safety map. Another section of the occurrence response plan states that there are two master keys¹⁵² at the switchboard. The fire brigade's access map states under "address for keys" that a master key is available (from the in-house emergency service member).
7. *At the location of the fire the Duty Officer with first in line responsibility will make contact with the highest-ranking fire brigade officer present (white helmet with coloured band).*
8. *The Duty Officer will alert the Directors as quickly as possible.*

Site emergency team

In order to foster the best possible occupational safety and health policy,¹⁵³ the employer will have the assistance of one or more employees appointed as members of the in-house emergency and first-aid service¹⁵⁴. Art. 15 of the Working Conditions Decree describes the tasks of the in-house emergency service member as follows:

149 Cells and Cell Blocks Fire Safety Scheme page 53.

150 It is not apparent from the plan itself which "switchboard" is intended here.

151 At the time of the fire the Gatehouse Security Officer was located at the central DJI office. However, the switchboard being discussed here was actually KMar switchboard. At the time of drafting of the occurrence response plan the DJI switchboard served Wing L and M only.

152 It is not stated here which switchboard is referred to.

153 Art. 3.

154 Art. 15, par. 1.

- administering First Aid in the event of accidents;
- limitation and fighting of fires and prevention and limitation of accidents;
- alerting and evacuation of all employees and other persons within the company or installation;
- alerting and collaborating with the emergency services in connection with the activities described in the previous three points.

Members of the in-house emergency and first-aid service must have the appropriate expertise, experience and equipment and must be sufficient in number, available for sufficient time and be organized in such a way that appropriate levels of assistance can be provided¹⁵⁵.

The in-house emergency and first-aid service serves as an advance guard for the professional emergency services. Their task includes directing the police, fire brigade and ambulance personnel to the location of the occurrence. When delivering an alarm message, the in-house emergency service member will provide information on the best parking location for the emergency services. An in-house emergency service member must be ready at that location to meet the emergency services and to accompany them to the site of the occurrence¹⁵⁶.

Having arrived on site, the professional emergency worker needs certain information from the in-house emergency service member. In the fire fighting manual for Crew Commanders the services are instructed to request information on the following matters:

- presence of casualties;
- number of casualties;
- location of casualties;
- access routes;
- special hazards;
- nature and location of the seat of the fire, leaks and similar;
- possibilities of spread;
- layout of the site.

The training for in-house emergency and first-aid workers discusses the "advance guard" role of the site emergency team and its importance. Further instructions must be included in a local occurrence response plan. The in-house emergency and first-aid team must consult this plan.

In the explanatory notes to the articles of the Working Conditions Decree, the requirement in Article 2.18 for first aid to be provided "within a few minutes" is specified as meaning that first aid should be provided within three minutes, unless otherwise prescribed by the Cells and Cell Blocks Fire Safety Scheme. The safety scheme states that in the case of a "standard" fire, at least two members of the in-house emergency and first-aid service should arrive at the cell involved in the fire within two minutes, that the cell occupant must then be taken to a place of safety within two minutes, and that the door of the cell in question should be closed¹⁵⁷. In the case of a fire in a prison the assumption is that where the situation justifies it, the guards will release the occupants from their cells in safe circumstances and bring them to a place of safety.

Training and drills

The Fire Safety Scheme for Company First Aid drawn up by the Ministry of the Interior and Kingdom Relations in collaboration with the Ministry of Social Affairs and Employment has among its objectives the provision of clarity with respect to the minimal knowledge and competencies required of in-house emergency and first-aid service members. The following categories of tasks are distinguished: first aid, limitation and control of an initiating fire, evacuation and communications. The Fire Safety Scheme for Company First Aid serves to structure training.

Respiratory protection

No personnel present in the detention centre had respiratory protection available. Nor was any member of staff trained to use such equipment correctly. By deciding not to have certificated breathing apparatus users available in the detention centre, the Site Manager chose to depend on the fire brigade to respond to fires which were not limited to a single cell¹⁵⁸.

155 Art. 15, par. 3.

156 Source: NIBHV, 2005.

157 Cells and Cell Blocks Fire Safety Scheme, page 34.

158 The joint response of the Ministers following their vision on the draft report showed that the Site Manager was observing an internal DJI guideline. See Appendix I the Account of the Investigation.

6.2.5 Fire brigade response: from the alarm to arrival on site

The following description of the actions at the fire brigade's emergency control room and the arrival of the fire brigade on site ready to fight the fire is based on the turn-out and deployment procedure set out in the "Crew Commander - Repression" training manual¹⁵⁹ and the fire brigade switchboard operator basic training module¹⁶⁰. The text in italics is taken directly from the procedure in case of fire. A brief explanation is included where necessary.

At the emergency control room (AC)

0. The emergency centre Schiphol:
The reception of alarm reports, alerting the fire brigade, gathering and distribution of information and notification of the regional fire brigade emergency control room. It is important to know whether persons are still within the building or are missing. The fire brigade's Regional Emergency Control Room will take over support of the occurrence control activities if necessary. The emergency centre Schiphol will coordinate up to medium-scale fire level. The standard turn-out would be an appliance and a rescue engine, with a hydraulic platform coming from Hoofddorp.

In the fire station:

1. *(Receive the alarm and start gathering information (occurrence, time, weather, route to site, obstacles)).* For the Crew Commander at Post Sloten this means taking the alarm notification out of the (fax) printer and scanning it to determine the nature of the notification, the location of the fire alarm installation and the units alerted.
2. *Determine the strength of the initial turn-out on the basis of the notification.* The initial turn-out should consist of two appliances: one for pumping and one in the event that the fire brigade are, after all, required (also) to perform rescue duties¹⁶¹. The turn-out strength is stated on the alarm notification.

During the journey and on arrival:

3. *Request further information from the switchboard and consult the Action Plan.*
4. *Make a provisional choice of extinguishant: high or low pressure, powder or foam.*
The Cells and Cell Blocks Fire Safety Scheme assumes fire fighting with low pressure jet¹⁶². The distances involved in detention centres are almost always so long that high pressure jetting is impossible.

On arrival on site:

5. On arrival, the fire brigade should briefly inquire about the presence, number and location of casualties, access routes, special hazards, the nature and location of the seat of the fire, the possibilities of spread and the layout of the site.
6. The Crew Commander will receive a deployment order from the Officer in Charge once the Officer in Charge arrives on the scene, or sooner if the Officer in Charge deems it necessary while the journey to the site is in progress.

¹⁵⁹ Fire Brigade Teaching Materials III

¹⁶⁰ Nibra, 2004.

¹⁶¹ Cells and Cell Blocks Fire Safety Scheme, page 60. The turn-out strength for Schiphol therefore deviates from the manual.

¹⁶² Cells and Cell Blocks Fire Safety Scheme pages 57 and 58.



Figure 15: Discussions at the far end of J Wing

6.2.6 **DJI responsibilities with regard to hiring of personnel**

The DJI hired in security staff for the Detention Centre Schiphol-Oost from a security company, Securicor. The Working Conditions Decree states that the employer is “a person to whom another is made available for the purpose of carrying out work”¹⁶³. The DJI is therefore formally the employer of the security company personnel and therefore responsible for all the employer’s duties specified in the Working Conditions Decree. However the security company must inform themselves as to the working conditions for the personnel they provide. The DJI must inform the security company of the risks to the personnel to be hired in, on the basis of the Risk Assessment¹⁶⁴.

Guards in the employment of the DJI as well as others in the employment of Securicor work at the Detention Centre Schiphol-Oost. The following requirements apply to the Securicor personnel in view of the (shared) employer status¹⁶⁵.

- Security must make it clear to the DJI what (basic) competencies are available among the hired staff.
- The DJI must provide the necessary supplementary information and provide the necessary training or have it provided, so that staff can function in the specific working conditions in the location.
- The DJI must ensure that the safety instructions and control measures are applied in the case of both their in-house staff and the hired-in personnel.

163 Working Conditions Decree 1998, Art. 1, par. 1a under 2*.

164 Art. 5, par. 5.

165 This is the interpretation of Health and Safety legislation on this point as approved by the Ministry of Employment and Social Affairs.

- If it appears that the hired-in personnel do not possess the required (basic) qualifications, the DJI must ensure that such personnel cease their activities. The DJI must then investigate whether replacement personnel do satisfy the requirements. Also, in the event that they have doubts about other criteria, the DJI must determine the extent to which those criteria are met. In addition, Securicor must investigate whether the DJI is keeping to the agreements and is discharging its (above-mentioned) responsibilities.

6.3 The interested parties and their responsibilities in relation to rescue and firefighting

6.3.1 Introduction

In addition to some of the parties mentioned in Chapter 5, the following parties also played a role in attempts to prevent and combat the fire in the Detention Centre Schiphol-Oost:

- parties employed at the Detention Centre Schiphol-Oost
- the Schiphol fire brigade
- the regional fire brigade for Amsterdam and environs

6.3.2 Parties involved

Those working at the Detention Centre Schiphol-Oost

The in-house emergency and first-aid service (BHV) forms part of the Detention Centre Schiphol-Oost organization. The BHV is led by a Chief BHV. There are also four BHV coordinators. They are not guards but rather members of the technical department¹⁶⁶. Around half of the guards and detention supervisors had a basic Emergency and First Aid certificate. The Site Manager is responsible for the organization of the in-house emergency and first-aid service. The Head of the BHV is subordinate to the Head of Department¹⁶⁷.

Because of the flat organizational structure, the role of Chief of Department within the Detention Centre Schiphol-Oost is pivotal in the operational process. The Chief of Department is responsible for the course of affairs within his department, conducts discussions about work with the staff employed in his department and acts as the contact officer for example for the external service provider organizations and the Supervisory Committee. The Chief of Department is an operational manager without authority in the area of personnel management. The Chief of Department is ultimately responsible for the tasks of the Duty Officer, whom he supports, directs and coordinates.

Staff from the department(s) deal with the day-to-day tasks as set out in the program. The Duty Officer oversees this. Acting as Duty Officer is one of the tasks of DJI guards. The Duty Officer takes a steering role in the event of emergencies. That is to say, he coordinates the deployment of personnel, maintains contact with the responsible Head of Department about actions to be taken, steers implementation and assesses the chosen methodology and the course of the emergency with the responsible Head of Department.

Schiphol Fire Brigade

Schiphol airport has its own fire fighting organization, the Schiphol Fire Brigade. In addition to aircraft fires at the airport, this fire brigade also fights fires throughout the entire Schiphol area, and therefore not exclusively the airport site. The fighting of fires falls under the responsibility of the Municipality of Haarlemmermeer, on the basis of a covenant between the Municipality and the airport.

The airport has its own emergency control room, known as the emergency centre Schiphol. This receives incoming fire alarms from all the around eighty connected businesses in the Schiphol catchment area.

¹⁶⁶ These individuals were not present at the time of the outbreak of the fire but were subsequently called in.

¹⁶⁷ Head of Department: personnel are in principle linked to a department or wing, with a Head of Department for each department or wing, or in some cases for two departments or wings.

As part of Municipality of Haarlemmermeer, the Schiphol service area falls within the Kennemerland police region. Where the Fire Brigade and the Medical Assistance in Accidents and Disasters organization are concerned, Schiphol falls within the Amsterdam and environs region.

Regional fire brigade for Amsterdam and environs

Fire services in the Netherlands are primarily the responsibility of the municipality. Legislation also determines that the municipal fire brigades collaborate regionally. The tasks of regional fire brigades include:

- the setting up and maintenance of a regional fire brigade emergency control room;
- the acquisition and management of shared equipment;
- preparations for the coordination of the control of major occurrences and serious accidents;
- the provision of personnel and equipment;
- preparation of the organization for the deployment of the fire brigade in special conditions and operational direction during the control of disasters and serious accidents.

It is of relevance to this investigation that the regional Fire Brigade for Amsterdam and environs maintains an Emergency Control Room with a regional role. Manpower and equipment can be brought in from the entire region if necessary in the case of a fire. Their deployment in that event will be coordinated by the Regional Emergency Control Room (RAC).

6.4 Structural analysis

The central question in the investigation into the fire at the Detention Centre Schiphol-Oost is: Why did 11 cell occupants lose their lives in the fire? The investigation shows that a number of factors affected the course of the fire. These factors relate to the start and development of the fire, including the fire hazard characteristics of K Wing (Section 6.5) and the actions of the detention centre staff and the fire brigade (Sections 6.6 and 6.7).

6.5 Analysis of the start and development of the fire

This Section contains the analysis of the start and development of the fire. Three possible scenarios for the start of the fire are sketched out in Section 6.5.1. Sections 6.5.2 to 6.5.6 consider five factors which affected the further development of the fire. These factors are considered in the following sequence: the door to Cell 11 being left open; smoke in the corridor; the fuel load; the geometry of the building; the smoke resistance of the cells.

6.5.1 How did the fire start?

Like any other fire, the fire in the Detention Centre Schiphol-Oost resulted from the combination of fuel, oxygen and a source of ignition. Since oxygen was available at the start of the fire, only the fuels and sources of ignition will now be considered.

It is certain that the fire started in Cell 11. The two guards who released the occupant from that cell at 23.57 both later stated that smoke appeared from the gaps around the door to Cell 11, and only there. Their statement is supported by images from the security cameras.

The Board has not been able to establish definitively what took place in Cell 11 prior to 23.57. The only witness, the occupant of the cell, claims that the fire started accidentally (unintentionally). It is also possible that the fire started when flammable material in the cell was ignited. Thirdly, a technical cause for the fire cannot be excluded in advance, since electrical equipment was present in the cell, including a television.

The three possible scenarios for the cause of the fire - accidental, intentionally ignited and technical - are considered separately here.

Scenario 1: Fire caused accidentally

In his statement the occupant of Cell 11 made a connection between the start of the fire and one or more discarded cigarettes which he threw in the direction of the foot of the bed, while he lay on the bed. The cell occupant then fell asleep. He woke with a start at around 23.56 because he felt heat around his feet and saw that the bedding at the foot of his bed was on fire.

Smoking in bed is known to be frequent cause of fires,^{168 169} although not every cigarette that falls among the bedding will cause a fire. The heat generated by the average cigarette is fairly minor, and it is therefore necessary that the glowing tip comes into contact with the fuel (for example a sheet) in a particular way. If the cigarette falls on top of the bedding, it will cause a singe-mark at most. The probability of flames increases if the cigarette falls into a fold in the sheets and is then covered by a single layer of textile. Thermal insulation then occurs, so that the temperature in the vicinity of the glowing tip rises in such a way that ignition follows. A continued supply of fresh air is a prerequisite here¹⁷⁰.

The occupant of Cell 11 said in his statement that a bundled-up sheet lay at the foot of his bed. It is therefore feasible that a discarded cigarette fell into a fold in that sheet. A partly unrolled roll of toilet paper also lay by the sheet. That toilet paper might also have been the first material ignited. Many cellulose products, including toilet paper, are vulnerable to ignition by cigarettes, again on condition that the contact and the geometry are favourable¹⁷¹.

If the fire had started on the lowest mattress on the bunk bed, as in the cell occupant's evidence, the fire would in the first instance have spread to the other materials present on the bed, namely two mattresses, bedding and clothing. By determining the flammability characteristics of these materials, and also by means of fire simulation tests on made-up beds and on fully furnished cells (Appendix 4), the Board has investigated whether, given this initial situation, the fire could have developed to such an extent that all combustible materials in the cell were involved in the fire¹⁷².

The tests revealed that it is indeed possible that the fire developed along a chain of fuels (sheet-blanket-mattress-wall coverings), where each link in the chain produced sufficient combustion heat to ignite the next. The presence of a different type of mattress, with a lower heat yield, would have interrupted the development of the fire.

In the initial fire simulation tests this initial development of the fire, from the time of the automatic fire alarm to flashover, took rather longer than in the actual circumstances of the Schiphol fire, but the minor discrepancy between the simulation and the reality can be explained by small differences in the starting position (see Appendix 4).

Scenario 2: Fire caused by the setting on fire of flammable materials

Fires caused by detained persons setting fire to materials in their cells are a regular occurrence¹⁷³. Small fires started by cell occupants have also occurred during the brief history of the detention centre at Schiphol-Oost. In part because the occupants of K Wing were permitted to have lighters in their possession, the obvious question is whether such a lighter could have been used in initiating the fire in Cell 11. The Board therefore carried out comparable fire simulation tests in a "bonfire scenario", where as much of the available combustible material (paper, textiles, mattress) as possible was brought together in order to effectively start a fire.

These tests showed that the initial development of the fire could also have been the result of the tested. The fire simulation tests proceeded faster than the actual course of the Schiphol fire, but in this case too relatively small modifications to the starting position would provide a better simulation of the reality (Appendix 4).

168 Miller, A.L. (1994) – The US home product report, 1987-1991: forms and types of materials first ignited in fire - NFPA, Quincy, MA.

169 According to data from the Central Bureau for Statistics there were 406 fires in detention centres, of which 37 (9%) were caused by smoking.

170 DeHaan, J.D. (2002) - Kirk's Fire Investigation - 5th edition, p.139.

171 Holleyhead, R. (1999) - Ignition of solid materials and furniture by lighted cigarettes: a review - Science & Justice 39-2, pp. 75-102.

172 "full room involvement".

173 According to data from the Central Bureau for Statistics there were 406 fires in cell blocks, of which 165 (41%) were started intentionally.

Scenario 3: Technical cause for the fire

Electrical equipment was present in the cell which could in principle have caused a fire. The following components are involved:

- permanent electrical facilities (cabling, wall sockets, switches).
- lighting (incandescent bulb in the toilet area and fluorescent fitting in the cell)
- refrigerator
- television

The first two components can be excluded as a cause of the fire, since virtually all components of the electrical installation were still in place, and no trace of electrical arcing could be found. The refrigerator in the cell was attacked by the fire, from the outside; the internal electrical components were still more or less intact.

In theory, it cannot be excluded that a technical defect in the television set may have caused the fire. Nevertheless the Board found this implausible, based on the following rationale: Had the television been the cause of the fire, this would then not have been caused by the actions of the cell occupant. The cell occupant would then logically have no interest in telling a different story (fire in the bed) to what he had actually seen (the burning television). Since the television was at a quite different location than the foot of the bed, he could also not have been mistaken in locating the primary seat of the fire.

Other indications relating to the start of the fire

The Board discovered traces of fire in several locations in Cell 11, resulting from burning and marks caused by combustion gas flows up the walls of the cell. These traces of fire are analysed in Appendix 4. The outcome of the analysis is that no relationship with a primary fire seat can be demonstrated for any of the traces of fire in Cell 11. These traces of fire therefore also provide no information about the manner in which the fire in Cell 11 was caused.

The lack of a prohibition on smoking in K Wing in any case facilitated the start of the fire. K Wing was the only wing where smoking was allowed. Cell occupants had lighters and cigarettes in their cells. This increased the probability of a fire starting in a cell. Even in the case of a prohibition on smoking, the possibility would remain of detainees smuggling smoking articles into their cells, but general fire safety would nevertheless have been improved. The management of the detention centre proposed to introduce a prohibition on smoking on K Wing. This had already taken place on J Wing shortly before the fire.

6.5.2 The role in the further development of the fire of the door of Cell 11 being left open

From its initial location, probably the lower mattress of the bunk bed in Cell 11, the fire spread in stages until it eventually involved a large part of K Wing.



Figure 16: The initial phase of the development of the fire within Cell 11

Following the tripping of the automatic fire alarm, the door of Cell 11 remained closed for another 2¼ minutes.

Fire tests (Appendix 4) showed that in those circumstances, the stage where the bed was fully alight could not be attained. With the door closed there would be insufficient oxygen entering to maintain such a fire.

Aside: fire in a closed cell

The cell has a volume of around 30 m³¹⁷⁴. Air contains 20.9 vol% oxygen, so that there is around 6 m³ of oxygen available in the cell (the Board is leaving the effect of the air conditioning installation¹⁷⁵, which refreshes around 2% of the air in the cell per minute, out of consideration here). As a rule of thumb, the combustion of solid fuels leads to the release of around 17.1 MJ of heat for each cubic meter of oxygen consumed. This means that not much more than 100 MJ of heat can be developed by a fire in a closed cell, in the theoretical event that all the oxygen is consumed. However a fully combusted bed in an open space develops around 350 MJ of heat (Appendix 4, bed test 2). This means that the fire would moderate rapidly in a closed cell due to the falling oxygen content. As long as the door remains closed the fire will be unable to develop or to spread outside the cell through its own action.

The fact that the cell door was opened and never re-closed (in real time two minutes and fourteen seconds after the automatic fire alarm) therefore played a crucial role in the development of the fire. It was only from the time when the door was opened that the fire could develop freely and, once the upper bunk bed mattress had caught light, could give off enough energy to create the conditions for flashover (Appendix 4).

Aside: The phenomenon of flashover

The phenomenon of flashover is caused when uncombusted waste gases¹⁷⁶, which accumulate high up in the room, reach such a temperature that they ignite. The hot waste gases give off so much radiant heat that objects elsewhere in the room start to give off gas and subsequently ignite. Flashover is defined by the American NFPA¹⁷⁷ as the transitional phase leading on to a fully developed fire¹⁷⁸, where all combustible objects in the room are involved more or less simultaneously in the fire. This expansion of the fire therefore includes not only the furniture and contents of the room but also fixed materials such as wall and floor coverings, which form part of the structure. Flashover is coupled with a major increase in the development of smoke¹⁷⁹.

The flashover heralded an acceleration in the progress of the fire. A short time later the first flames began to pass through the open cell door. The two guards, who were still engaged at that time in opening cell doors, observed flames reaching as far as the cells opposite (cells 12 and 13). This expansion in the fire took place in the fifth minute following the sounding of the automatic fire alarm.

174 The internal dimensions of the cell are l x w x h = 5.8 x 2.1 x 2.4 m.

175 The air conditioning system is an independently operating element of the technical provisions on K Wing. The main component of the air conditioning installation is the heat recovery equipment located on the roof. Air for circulation flows via ducting to the air-inlet grilles in the various rooms and is subsequently removed by suction through exhaust ventilation grilles. The incoming air stream is physically separated from the outgoing air. The air is not recirculated once used. Investigation has revealed that the system is not automatically switched off by the fire alarm installation.

176 The waste gases consist of a mixture of air, pyrolytic and combustion gases (including carbon monoxide) and liquid and solid smoke particles.

177 National Fire Protection Association (NFPA) 921 (2004) - Guide for fire and explosion investigations, 3.3.72.

178 Full room involvement.

179 National Fire Protection Association (NFPA) 921 (2004) 5.6.9.



Figure 17: The development of the fire in the rearmost section of the corridor

6.5.3 The role of smoke in the corridor in relation to the further development of the fire

Accelerated smoke development due to flashover in Cell 11

The acceleration in the development of the fire as a consequence of flashover meant that the fire also began to produce more smoke. While a considerable amount of smoke was already flowing into the corridor through the open door before the flashover, with the fire still restricted to the bed in Cell 11¹⁸⁰, the production of smoke increased steeply from the moment when all combustible materials in the cell were involved in the fire.

Calculations based on the smoke production, measured during the cell fire tests carried out by the Safety Board (Appendix 5), show that visibility in the corridor was considerably reduced in particular from the moment the flashover took place. In this phase it is no longer the nature of the materials which determine the quantity of smoke, but primarily the quantity of material involved in the fire and the degree to which oxygen is able to reach the fire¹⁸¹.

In the initial phase of the fire a limited amount of oxygen was able to enter Cell 11 through the doorway¹⁸². The entrance to the cell was relatively narrow, due to the presence of the shower and toilet to the left of the door, so that the incoming flow of fresh air was hindered by the outgoing flow of combustion gases (see figure 18).

180 The cores of the mattresses consisted of polyurethane, a material known to produce large amounts of smoke when burned.

181 National Fire Protection Association (NFPA) 921 (2004) - 5.6.2

182 The effect of the air conditioning installation is negligible.

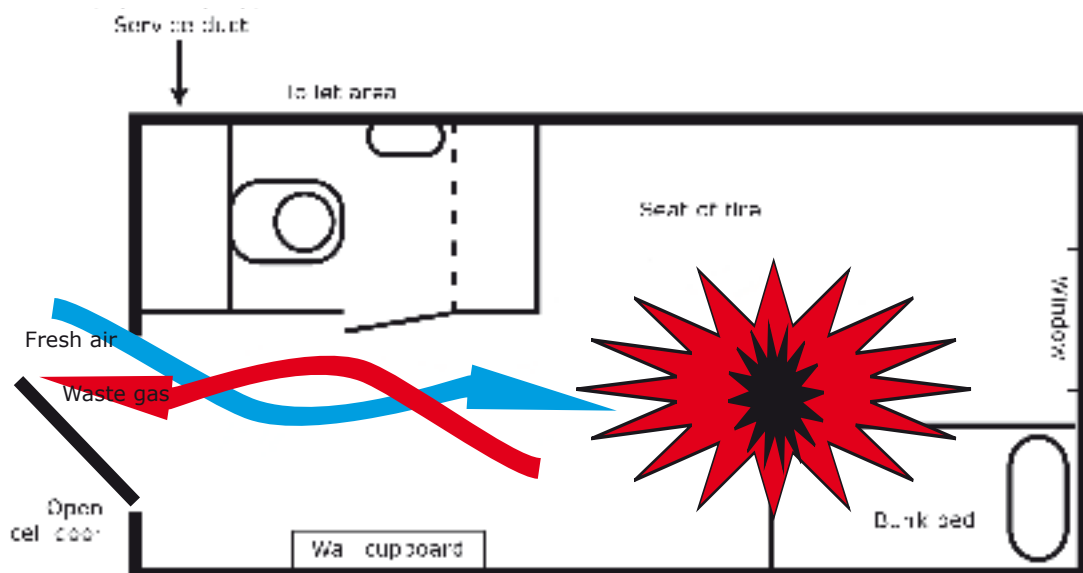


Figure 18: Schematic representation of fire in Cell 11. Outgoing flow of combustion gases "hinders" the incoming flow of fresh air.

Only a part of the waste gases released within Cell 11 was combusted. The remainder flowed uncombusted via the narrow entrance to the cell through the door opening and into the corridor. The limited supply of fresh air to the fire in Cell 11 also led to a high carbon monoxide content in the escaping smoke¹⁸³. The smoke in the corridor was therefore not only flammable but also toxic to a high degree, so that the two guards engaged in rescue work were in an extremely hazardous situation. Loss of orientation as a result of restricted visibility could have led to unconsciousness and subsequently to death in a short time.

In summary, it can be stated that the flashover in Cell 11, made possible by the substantial heat generated by the burning bunk bed, drastically elevated both the volume and the toxicity of the smoke flowing out of Cell 11 and into the corridor. This development meant that the two guards were forced to withdraw from the corridor, so that five cells remained unopened.

Failure of the Smoke and Heat Exhaust Ventilation System

The corridor of K Wing had a Smoke and Heat Exhaust Ventilation System, the purpose of which was to transport smoke and heat to the outside at an early stage of a fire. During the fire on the night of 26 to 27 October this system did not operate and its air inlet grilles¹⁸⁴ to the right and left of the wing's emergency exit, and in the roof hatches, remained closed. At an early stage the corridor could no longer be entered by staff due to the rapid generation of smoke.

Technical investigations have shown that no documented regular maintenance of the Smoke and Heat Exhaust Ventilation System had taken place since its installation, while according to the building regulations, annual maintenance should have been carried out, including a functional test of the system. Secondly, the Smoke and Heat Exhaust Ventilation System was fitted with the wrong type of control valves, which could not open the hatches automatically in the event of loss of the power supply. Additionally, on the day following the fire the emergency batteries were found to be completely discharged. Finally, other than the components in the relevant part of K Wing which were affected by the fire, no defects were identified in the pneumatic section of the Smoke and Heat Exhaust Ventilation System.

The intended "fail safe" principle¹⁸⁵ for the installation was negated through the use of the wrong control valves. However, this is not an adequate explanation for the Smoke and Heat Exhaust Ventilation System hatches remaining closed, since the mains supply was available at the time of the fire alarm and for ample time thereafter. The completely depleted emergency batteries

183 National Fire Protection Association (NFPA) 921 (2004) - 5.6.2

184 Air inlet grilles formed part of the Smoke and Heat Exhaust Ventilation System.

185 Where both the mains supply and the emergency power supply are lost, the intention was that the roof hatches and ventilation hatches would open automatically in accordance with the "fail safe" principle.

may indicate that the electrical supply to the Smoke and Heat Exhaust Ventilation System control cabinet had been interrupted some considerable time before the fire, for example because the relevant main switch was in the “off” position. In that event the Smoke and Heat Exhaust Ventilation System would switch over to the emergency batteries until these were exhausted. The hatches should then have opened automatically, but this did not happen because of the use of the incorrect type of control valve, so that the interrupted power supply went undetected (Appendix 6)¹⁸⁶.

While the Smoke and Heat Exhaust Ventilation System was not sufficiently powerful in view of the dimensions of the corridor of K Wing (Appendix 6), a functioning installation would have been able to remove part of the smoke (albeit a small amount). It is possible that the two guards engaged in rescue activities might have been able to open more cells if the Smoke and Heat Exhaust Ventilation System had operated.

6.5.4 The role of fuel load in relation to the further development of the fire

The fuel load of the type of cell used on K Wing is substantial, in particular because of the large quantities of HPL¹⁸⁷ and wood included in the wall coverings. Together with the floor coverings, the doors and the furnishings each cell is estimated to contain 140 kg of combustible material per m² of floor area (Appendix 23). Such a fuel load is several times higher than the 5 -20 kg of pinewood equivalents per m² adopted as a standard for cells in the Cells and Cell Blocks Fire Safety Scheme¹⁸⁸.

Aside: the concept of fuel load

The total calorific value of a quantity of fuels is indicated by the term fuel load. The fuel load determines the heat of combustion which can be released in a fire.

Fuel load is customarily expressed in 'kilograms of pinewood per m²'. The reason for the use of this rather odd unit is a practical one: since most solid substances containing cellulose differ little in their calorific value per unit of mass, the fuel load in a particular space can easily be approximated by estimating the total quantity of combustible material per square metre.

Following the flashover the high fuel load manifested itself through high and extended production of heat and combustion gases by the burning cell. The Safety Board conducted cell burning tests with fully furnished cells in order to collect quantitative and qualitative data in this regard (Appendix 4).

Calculations based on the production of smoke measured during the cell burning tests (Appendix 5) showed that visibility in the corridor was greatly reduced even before the flames exited Cell 11 through the doorway. In that phase it was primarily the two mattresses on the bunk bed in Cell 11 which led to the rapid development of the fire and the associated smoke production. The restricted entry of oxygen into Cell 11 (only through the doorway) meant that only part of the combustion gases released within Cell 11 were burned. The remainder flowed through the doorway to the outside and was ignited in the corridor or elsewhere in K Wing. This mechanism contributed to the rapid expansion of the fire.

The cell burning tests made it clear how important the fuel load of the cell interior was in determining the rapid development of the fire. In the three tests the heat of combustion generated reached a peak of 3000kW within five to eight minutes of ignition¹⁸⁹. In the American NFPA classification this would be classified as “ultra-fast fire development” (Appendix 5).

186 However, it is not possible to establish this scenario with certainty, since the fire brigade turned off electrical switches in the machine room before the technical investigators were on site.

187 HPL = (High Pressure Laminate)

188 Cells and Cell Blocks Fire Safety Scheme, page 82

189 Unit of energy.

6.5.5 *The role of the geometry of the building in relation to the further development of the fire*

As long as the doorway was the only route for fresh air to enter the cell, the degree of ventilation of the fire was a limiting factor. In view of the dimensions of the doorway it is probable that only part of the combustion energy produced after the flashover was generated through combustion in the cell itself. The remaining energy was produced in the corridor, where the flow of unburned combustion gases from Cell 11 was finally ignited.

The transfer of combustion energy from Cell 11 to the corridor explains the very rapid ignition of the combustible materials in the corridor (ceiling tiles, floor coverings, HPL panels). The fibre tiles in the suspended ceiling in particular took some considerable punishing initially. Because of the nature of the material, namely wood fibres in cement with a permeable structure, the tiles quickly came free from their fixings. The Duty Officer, who arrived on K Wing at an early stage and looked in via the emergency door, stated that while the guards were still engaged in opening the cell doors, the first tiles were falling from the ceiling.

The collapse of the suspended ceiling marked a significant moment in the development of the fire, since this opened the way for the spread of the fire into the shell void. In particular it rendered the ceiling areas above the two rows of cells on the left and right of the wing easily accessible to the fire.

Shortly after the first flames exited Cell 11 the Duty Officer arrived outside the building. He opened the door in the end wall of K Wing, thereby initiating a ventilated blaze. The generation of heat in the rearmost part of the corridor led quickly to the destruction of the windows in the end wall, allowing still more oxygen to enter the rear of the corridor¹⁹⁰.

Whilst in these circumstances the fire in the rearmost part of the corridor could develop with great intensity, an unimpeded supply of oxygen was not present in the front part. The supply of fresh air was largely limited to the unglazed window openings to the right of the wing, the fire in the ceiling void above the cells on the right in particular being fed from this source. The combustion gas/air mixture formed there ignited instantaneously in the corridor itself¹⁹¹. The oxygen content in the corridor subsequently remained so low that there was little further development of the fire in the direction of the access door. The spread of the fire in the corridor came to a halt somewhere around the front recreation room.

Television images of the later phases of the fire show that the fire in the rearmost part of the corridor, around the area of cells 11 and 12, decreased in intensity due to exhaustion of fuel. In this way the centre of the fire moved forwards. However, because the limited ventilation in the central area of the corridor continued to impede its spread, the extent of the fire as a whole decreased.

190 It is probable that this situation was attained within a few minutes: the first photograph of the fire, made by an amateur photographer, showed that at 00.12 hours the end of the building was already well ablaze.

191 This explosive combustion of the gases in the corridor and the subsequent oxygen depletion has been reconstructed on the basis of computer simulations of the development of the fire on K Wing.

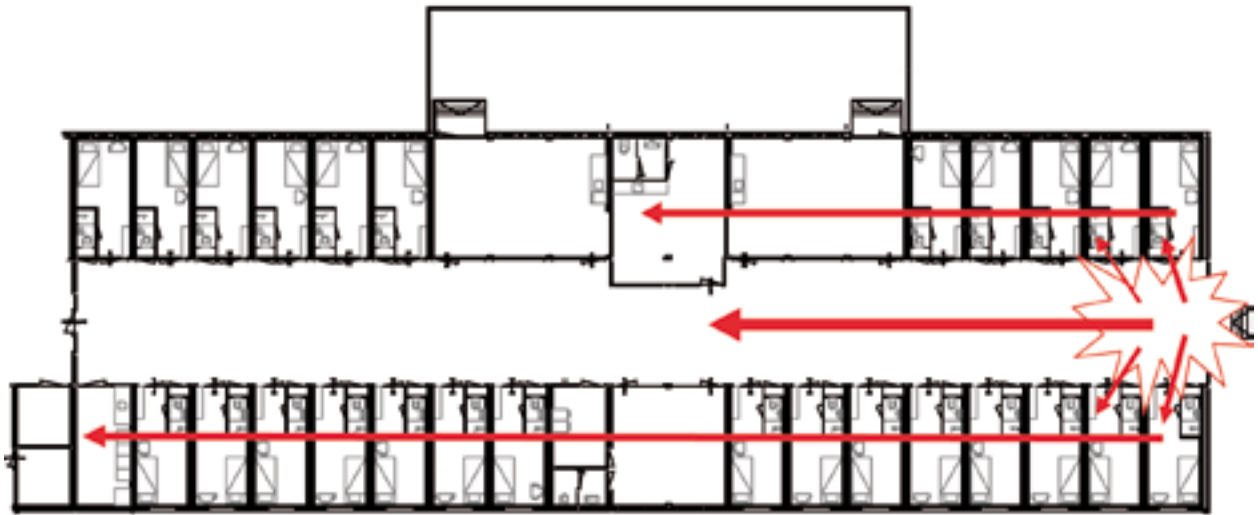


Figure 19: Spread of the fire along three routes: the corridor and the ceiling voids above the rows of cells on opposite sides of the wing.

The fire in the ceiling voids above the two rows of cells

Following the collapse of the suspended ceiling, large quantities of partially burned combustion gases found their way to the highest parts of K Wing, namely the ceiling voids above the two rows of cells on the right and left of the wing. Particularly above the cells on the right of the wing (viewed from the hallway), where the unglazed window openings in the right-hand façade allowed fresh outside air to penetrate the shell void, the combustion gases found sufficient oxygen to allow after-burning. This allowed the fire to run in a short time along the entire length of the corridor above the row of cells on the right, up to the fire resistant partition between K Wing and the central corridor of the Detention Centre Schiphol-Oost. A witness from the adjacent Fokker complex factory site took a photograph at 00.16 hours showing flames shooting out of the ceiling void above K Wing cells 12 to 15. The ceiling voids contained no fuel apart from the PVC cables lying in cable trays: the continuing fire in the ceiling voids must therefore also have been fed to a significant degree by the incoming combustion gases which formed elsewhere in K Wing.

In the ceiling void above the cells on the left the fire advanced less far than on the right. In addition to the lower degree of ventilation on this side of K Wing (the window openings in the shell were glazed here), this was also related to the fact that the ceiling void on this side was interrupted by a recreation area, a team station and then a further recreation area. The walls between these rooms extended up to the ceiling, so that the fire had a number of barriers to get through. The hot combustion gases will also have spread themselves around these relatively large spaces, so that their temperature and thereby their penetrative capacity will have decreased. In any event, the fire no longer extended to the front recreation area and cells 1 to 6 in front of that area.

The last phase of the spread of the fire to the front part of the corridor

The fire raging along the whole length of the ceiling void above the right-hand row of cells (seen from the hallway) received its oxygen via the unglazed window openings in the right-hand side wall, located close to this part of the shell void. Thanks to this supply of air the fire in the front right of the ceiling void could now develop sufficient intensity to allow it to break through the HPL panels separating the ceiling void from the corridor.



Figure 20: Last phase of the spread of the fire to the front part of the corridor

This last expansion of the fire was the first area to be extinguished by the fire brigade. Around 01.00 hours, a fire brigade unit that had forced its way into K Wing via the access door directed its low pressure water jets onto the advancing fire above the cells to the right of the wing. This intervention was necessary as passing the seat of the fire during reconnaissance of K Wing would have entailed too great a risk.

Seen from the air, a pattern can be detected on the flat area of the roof of K Wing, reflecting the temperature distribution above the corridor. The roof covering contained a layer of expanded polystyrene, which had melted above those areas of the corridor where high temperatures prevailed¹⁹². The final phase in the spread of the fire described above can be recognized on the roof as a lobe extending from the row of cells on the right of the wing towards the far side of the corridor (see aerial photograph, Figure 21).

The fire reached the interior of the cells through a variety of routes. In the case of the cells opened by the two guards engaged in rescue efforts, the doorway was the most straightforward access route. The hot waste gas layer which spread from the seat of the fire through the corridor, entered the cells through the doorways. This can be seen from the soot deposits on the highest parts of the cell interior, which are typical of such a waste gas layer (see Figure 22).

¹⁹² Research is currently being conducted into the fire behaviour of expanded polystyrene by the Technical University in Eindhoven on behalf of the Ministry of the Interior and Kingdom Relations.



Figure 21: The roof of K Wing showing the patterns of melted expanded polystyrene



Figure 22: Interior of Cell K-1 with waste gas layer marks on walls

From the burning ceiling voids above the cells (on the left above cells 7 to 11 and on the right along the entire length of the wing) the fire penetrated the shell void behind both side walls. This caused a large number of cell windows to fail. Above the row of cells at the front on the left (cells 1 to 6) the ceiling void remained free of fire. Where the ceiling void did burn the flexible air conditioning installation connecting pipes were destroyed, so that smoke and heat could also enter the cells via the ventilation openings. Eventually most of the cells in the rearmost part of the corridor were burned to a greater or lesser degree. Notable exceptions were cells 9 and 14 which exhibited relatively minor fire damage. The cause of this may be the presence of inspection hatches in the side walls above these cells, which allowed the heat to escape and limited the thermal load on these cells.

6.5.6 The role of the smoke resistance of the cells in relation to the further development of the fire

The guards engaged in rescue efforts opened a total of 21 of the 26 cells in K Wing. Cells 9, 10, 12, 13 and 14 remained unopened. A total of ten cell occupants were in these cells, all of whom lost their lives in the fire.



Figure 23: Smoke penetration into a cell during the fire resistance test carried out on the cell door.

An analysis of the cause of death of these casualties is included in Appendix 2. The analysis shows that all these casualties died due to the inhalation of carbon monoxide. The time at which this occurred cannot be determined exactly in retrospect. Too many unknown factors came into play, in particular pressure differences between the corridor space, the shell void and the cells, which played a role during the fire. However, the Board has made an attempt to produce the best possible estimate of the period of time during which the casualties probably died. This estimate is also set out in Appendix 2. Ten of the eleven victims probably died between 00.10 and 00.30 hours. The eleventh casualty, who was discovered in Cell 5, probably died later than that.

The analysis shows that the cells did not offer protection to their occupants for an extended period. After only a short time, smoke was already entering the cells via the door, the window and the connections to the air conditioning installation. Timber structural elements in the ceiling of the cells also began to give off toxic combustion gases after a short time (Appendix 2).

6.6 Analysis of the actions of personnel within the detention centre

Leaving the door of Cell 11 open following the release of the cell occupant contributed to the severity of the consequences of the fire. It allowed a large amount of smoke to enter the corridor of K Wing within a minute, so that the guards were no longer able to open cells 9, 10, 12, 13 and 14. The situation which arose also caused difficulties for the fire brigade for a considerable time.

The central question in the analysis of the actions of personnel is: How could it happen that the staff involved in the fire left the door of the burning cell open?

A variety of sources confirm the importance attached by the Board to the closing of the cell door. The closing of doors is explicitly specified in the Cells and Cell Blocks Fire Safety Scheme. The Detention Centre Schiphol-Oost occurrence response plan also states that the door of a burning cell should be closed whenever possible, among other things in order to prevent:

- the fire being supplied with additional oxygen so that it increases in extent;
- the fire spreading to other areas, and
- the smoke spreading to other areas.

The closing of a cell door after the release of the cell occupants is also a prerequisite for:

- the evacuation of adjacent cells;
- the control and, if possible, the extinguishing of the fire using the hose reel, with the aim of keeping the fire manageable for the fire brigade;
- the continued monitoring of the situation and continued action by the installation's staff in accordance with the plan;
- limiting panic among the cell occupants and additional pressure on personnel;
- limiting hazards to installation staff and the fire brigade, for example smoke production.

As already described in the preceding discussion of the development of the fire, the rapid development of toxic smoke after the door to Cell 11 was left open meant that the corridor was no longer accessible for staff from an early stage. The smoke generation and the fact that it was not extracted led to a situation in the corridor of K Wing in which the opening of cell doors could only be performed by persons equipped with breathing apparatus. However, the equipment to protect against these physically difficult conditions was lacking¹⁹³. This was the consequence of choices made by the management¹⁹⁴ of the Detention Centre Schiphol-Oost. The guards, who attempted to rescue as many people as possible, took a great risk in view of the circumstances. When the smoke and heat became too severe the personnel was obliged to leave K Wing. Five cells in K Wing remained unopened.

The assumptions of the Fire Safety Scheme do not anticipate a situation in which a fire can develop which extends beyond the cell. The safety scheme does explicitly state that it has happened more than once that the door to a burning cell has not been re-closed. It is not realistic to assume that the personnel will close the cell door under all circumstances. One of the specified indicative scenarios is that the in-house organization is unable to extinguish the fire. Nevertheless, the safety scheme assumes an attendance time and deployment time of 15 minutes in total, so that the staff face the task "alone" during that period. Ideally therefore, this period should be "bridged", for example by making breathing apparatus or other provisions available to staff. The DJI was insufficiently aware of this problem.

The question why the guards did not close the door cannot be answered unequivocally. Did physical conditions hinder the closing of the door? Were the staff shocked by the large quantity of smoke? Or did the personnel find it difficult to attend simultaneously to two tasks, fire fighting and First Aid, and did their care of the cell occupant who had suffered burns demand all their attention? What went on in the heads of the guards immediately following the opening of Cell 11 cannot be determined. However, the working environment of the staff employed in the Detention Centre Schiphol-Oost can be mapped out. This environment was a determining factor in the actions of the personnel. The Board's investigations reveal inadequate knowledge and competencies, shortcomings in the safety organization, inadequate supervision, incomplete information on cell occupants and a lack of night-time security on K Wing. These underlying causes will be considered in Sections 6.6.1 to 6.6.5.

6.6.1 Underlying cause of the failure to re-close the cell door: inadequate knowledge and competencies

The closing of a door after a cell occupant has been released from a burning cell is a specific safety action which personnel must carry out in the event of a fire in a cell. In order to be able to carry out this action in an emergency it is important that staff are aware of this procedure in the first place¹⁹⁵. Secondly, it is important that staff have sufficient practice in actually carrying out the procedure¹⁹⁶. The more realistic the practice, the better the operation will be carried out in a real emergency¹⁹⁷. In their joint response to the draft report, Ministers recorded that the occurrence response plan was brought to the attention of the guards during their training, and that the detention centre also later requested guards to take note of the occurrence response plan.

Three factors contributed to the inadequacy of knowledge and expertise among staff.

193 Staff were also not trained in the use of such breathing supplies.

194 As described in Chapter 5, the site (the Schiphol-Oost detention centre) is under the control of a Site Manager.

195 Wagenaar, 1986; 1992

196 Canter, 1990

197 Boer, Van den Bosch & Janssen, 2006.

Firstly, the manner in which personnel was trained to act in the case of fire was inadequate. The standard “In-house emergency response” course for DJI staff did cover fire fighting both in theory and practice, but was of limited scope, was not standardised¹⁹⁸ and did not specifically concentrate on the fighting of a fire in a cell block. It was stated during the training that the doors of burning rooms must be re-closed quickly after opening, but there were no practical drills in the context of the working environment¹⁹⁹. Personnel was inadequately trained to allow them to perform the desired actions in practice.

Secondly, only limited emergency response drills were carried out at the Detention Centre Schiphol-Oost. The Site Manager interpreted the legislatively prescribed rehearsal of drills in the most general terms. The drill of releasing occupants from their cells and transferring them to a central point was carried out on a single occasion per year²⁰⁰. This meant that by no means all staff, who after all worked 7 days a week in 24 hour shifts, could take part in the drill. There is also a large turnover of staff at this detention centre. Most of the staff were only employed there after the drill in question had been carried out. This is how it came to be that the two guards who opened Cell 11 had not yet taken part in a drill at the Detention Centre Schiphol-Oost.

Thirdly, the staff of the Detention Centre Schiphol-Oost had no concrete knowledge of the emergency procedures in the detention centre. An analysis carried out by TNO on behalf of the Safety Board showed that staff failed to follow the procedures in case of fire because they did not know what they were²⁰¹. The staff involved in the fire had not yet practiced the emergency procedures and occurrence response plans at work or discussed them with one another²⁰². The Detention Centre Schiphol-Oost has had an occurrence response plan since 2004. This plan replaced the so-called “emergency plan” and the “J and K temporary evacuation plan” which formed part of the Occupancy Permit(s). The staff had read the Detention Centre Schiphol-Oost occurrence response plan to a limited extent only, so that they had little or no understanding of the instructions in the plan. Staff lacked periodic discussions of their work and there were many inexperienced personnel in the detention centre who lacked proper training. In a questionnaire completed prior to the fire, staff had indicated in relation to their working situation that they needed emergency response and first-aid refresher courses²⁰³. Interviews with personnel from the Detention Centre Schiphol-Oost conducted by the Safety Board also revealed that staff generally was insufficiently informed about the emergency procedures. No structure was in place at the detention centre to ensure that all staff took part in practical exercises covering actions in case of fire.

In view of the relative ignorance of the content of the occurrence response plan, the Board will not give further consideration to the quality of this plan. However, it is clear that the plan was no longer up-to-date (see also Section 6.2.4), and it was being revised at the time of the fire. It took insufficient account of reality, in the sense that in difficult circumstances it would not always be possible to re-close a cell door, and there was no solution in that situation. It offered personnel too little to go on in deciding how to act in the event of a fire.

198 By “not standardized” is meant that it depended on the teacher whether the topic was covered or not.

199 This also applies to the handling of hose reels, as advised in the “In-house Emergency and First-aid Service Basic Training” course book (NIBHV, 2005).

200 Source: interviews. The Ministers’ joint response following their consideration of the draft report mentioned two drills, one (documented) on 12 February 2004 and one (undocumented) on 17 December 2004. Documentation on the first drill, including an evaluation, was provided by the Minister following the period allowed for consideration of the report. During the investigation the Site Manager was unable to indicate when the drills were carried out, and no relevant documentation was available. It appears from the documentation that the drill did not relate to fire, and was an internal exercise.

201 There is also some contradiction between the instructions in the Detention Centre Schiphol-Oost occurrence response plan and four DJI overheads shown during the standard in-house first aid course for DJI staff (see Appendix 7), but this played no meaningful role, since virtually all the staff involved were ignorant of the occurrence response plan.

202 The detention centre had no permanent in-house emergency and first-aid teams in place. The in-house emergency service members therefore worked together with whatever guards were on duty and in the vicinity of the burning cell at the time of the fire. To start forming a team in the event of a fire would also have caused delay. The occupational safety and health legislation sets down no requirements for the formation of teams. There are installations where such teams are in place.

203 Prior to the fire a questionnaire was completed by the staff of the Detention Centre Schiphol-Oost. An opportunity was provided for them to comment on the working situation at the detention centre.

6.6.2 Underlying cause of the failure to re-close the cell door: shortcomings in the safety organization

The detention centre Site Manager and/or DJI main directorate gave insufficient priority to fire safety in the Detention Centre Schiphol-Oost. The Board bases this finding on the following findings.

Firstly, the Board has established, on the basis of the assessment of staff training and interviews with those involved, that there was insufficient monitoring within the detention centre of the effectiveness of the training and drills programme. The Site Manager and/or the DJI, and also inspection agencies such as the Health and Safety Inspectorate and the Haarlemmermeer Fire Brigade, did not carry out adequate checks²⁰⁴. Around half of the guards present on the night of the fire had taken part in the annual in-house emergency and first-aid service refresher training. The Site Manager for the detention centre assumed that the DJI main directorate would ensure that the competencies of the personnel, including training and refresher training, would be appropriate for their tasks in the working environment. However, the Site Manager for the Detention Centre Schiphol-Oost did not check to see if this was the case.

Secondly, a major fire was not anticipated, and the possibilities had not been thought through. The Site Manager of the detention centre had not anticipated a fire of the kind that broke out during the night of 26-27 October, and people and resources were therefore not prepared for such an event. The Site Manager assumed that a fire would be discovered at a stage when staff with in-house emergency and first-aid training could extinguish it, or keep it under control until such time as the fire brigade arrived. The fire brigade could then fully extinguish the fire.

Thirdly, the risk assessment was inadequate. The Site Manager had not drawn up a Risk Assessment. On the other hand, the DJI main directorate might be expected to have set up some framework for their Site Managers, on the basis of which the Managers could draw up an occurrence response plan and manage the deployment of the in-house emergency and first-aid service. The DJI main directorate had drawn up no such framework.

Finally, the Detention Centre Schiphol-Oost has an officer in its employ who has very little time left over for his subsidiary task as "Head of In-house Emergency and First-aid Service" (BHV). The Head of In-house Emergency and First-aid Service is expected to organize and coordinate the site emergency team among the workers. The Head had undergone the necessary training. Four hours per month were set aside for the performance of this task. According to the Head of BHV for the Detention Centre Schiphol-Oost's own statement a relatively large amount of his work concerned one particular part of the detention centre (the Public Prosecution Service building). This focus on one particular part of the complex was partly determined by previous experiences with cell fires on the complex. Two of the three previous cell fires²⁰⁵ which were more serious in extent than the so-called "wastepaper bin fires" could be extinguished immediately²⁰⁶. For that reason the Site Manager saw no justification to give additional attention to the site emergency team. According to the Head of BHV, even the fire brigade had provided positive feedback about the way personnel had approached earlier fires in other parts of the detention centre. He took this as a reason to direct his attention towards a part of the complex which had received less attention (the District Building).

In addition, during the initial period of the detention centre's existence, the Head of BHV devoted a large amount of his time to the drafting of the then current emergency plan and also to obtaining permits for use. Four hours per month does not appear adequate for the proper planning of emergency team projects and tasks such as drawing up scenarios for exercises, planning, conducting and evaluating exercises, collaborating with the fire brigade, defining objectives, providing feedback to personnel and so on. On the basis of the very limited amount of time available for these tasks, the Board concluded that no high priority was being placed on fire safety and the in-house emergency and first-aid service.

204 For further information on the role of these inspection agencies see Art. 6.5.6 and Art. 6.6.3.

205 There had been other fire alarms (see the following Chapter) but these were false alarms or minor occurrences such as wastepaper bin fires.

206 The third fire was a major blaze which needed the fire brigade with several teams of fire fighters to extinguish it. The detention centre had not yet been taken into use at the time of this fire.

6.6.3 Underlying cause of the failure to re-close the door: inadequate supervision

Five agencies had limited roles in the supervision of the user organization for the detention centre.

The Ministry of Justice exercised its limited supervision in two forms.

Firstly, there was a weekly management discussion between the TDBV (Temporary Special Facilities Directorate) and the Site Manager for the detention centre, in the context of a TDBV line management responsibility. This discussion can be seen as a form of planning and control. Prior to the fire, fire safety was not a topic of discussion during these discussions²⁰⁷.

Secondly, the Sanctions Application Inspectorate (IST) had a supervisory role. However the Detention Centre Schiphol-Oost was never the subject of investigations by the IST²⁰⁸.

Thirdly, the Municipality had a limited supervisory role. In principle, supervision of fire safety is the Municipality's responsibility. This is done by means of the granting or refusal of an Occupancy Permit, together with possible inspections of relevant buildings. The Municipality of Haarlemmermeer, which was charged with this duty in relation to the Detention Centre Schiphol-Oost, did not note shortcomings in the training and level of practice of the staff, neither did they regard this as their task. The fire brigade's supervision centred on visually observable matters such as doors left open. Delays in raising an alarm received no supervisory attention. Supervision also did not extend to the manner in which the emergency organization was managed, including the reception of the fire brigade. The investigation by Nibra following the fire in C Wing at the end of 2002 did see the setting of requirements for the in-house emergency and first-aid organization as a necessity.

Fourthly, the Health and Safety Inspectorate exercised no supervision over the Detention Centre Schiphol-Oost. The Health and Safety Inspectorate did not investigate the working conditions of the detention centre personnel, for example in the area of training and practice.

Fifthly, as far as the internal Supervisory Committee is concerned, reference is made to Section 7.4.3.

Taken together, the supervisory activities, in the Board's opinion, were inadequate in the sense that they did not contribute towards an adequately prepared organization. Due to the limited supervision exercised by the DJI and the Municipality of Haarlemmermeer and the absence of supervision by the Health and Safety Inspectorate of the quality and level of practice of the in-house emergency and first-aid organization, supervision was, on balance, inadequate. This while the in-house emergency and first-aid organization had a crucial role to play, namely the evacuation of all cell occupants from a wing where a fire was not confined to a single cell. It was necessary that one of the parties responsible for supervision should take a more in-depth approach to this task. The investigation did not show that these parties had satisfied themselves that the others had substantially investigated the structure and performance of the in-house emergency and first-aid service, and therefore its shortcomings remained undetected.

6.6.4 Underlying cause of the failure to re-close the door: incomplete information on cell occupants

The failure of the guards to close the door of Cell 11 after they had released the cell occupant may have been related to the fact that there was insufficient knowledge on K Wing about the

207 The response following the period for consideration of the draft report was as follows: "The DJI main directorate checked whether there was an occurrence response plan approved by the local fire brigade, whether there was an Occupancy Permit, what manning levels had been adopted, whether there were sufficient trained staff, and so on". These were not the findings of the Board's investigations.

208 Neither could the IST reasonably be expected to have carried out such an investigation, in view of the fact that the Inspectorate was formally created on 1 January 2005. A predecessor of the IST, the RSJ (Council for the Application of Criminal Law and Youth Protection), did visit the detention centre on 15 April 2004 and produced a report. In their response the Ministers noted that no shortcomings were reported in the area of fire safety. This was also not the aim of the inspection.

number of persons in the cells. One of the guards did cite this as a reason when questioned about it later. The Board has therefore investigated this further. No more than two occupants may be locked in the cells at the Detention Centre Schiphol-Oost. It is of great importance to the safety of the cell occupants that, at the time of an emergency, the staff know how many occupants are in a cell. The personnel must be able to find this out in a straightforward way, even if there is smoke in the building, or some parts of it. No such information was available on K Wing at the time of the fire. There was no indication on or adjacent to the cell doors as to the number of occupants in the cells. Signs were affixed to the cell doors, but bore no names because the occupants changed so often. With view tot promoting economic efficiency there had been no staff present on K Wing at night from the start of 2005 onwards. It is possible that the guards who opened the door of Cell 11 did not know whether there was a second occupant in the cell. Cell occupants streamed in and out 24 hours a day, while the staff worked shifts. It is conceivable that the guards were faced with a dilemma, and did not close the door for that reason.

6.6.5 *Underlying cause of the failure to re-close the door: lack of night security on K Wing*

The absence of personnel on K Wing during the night hours delayed the reaction of the internal organization to the fire alarm. Had staff arrived at the cell immediately following the automatic fire alarm and immediately opened the door, the fire would still have been limited in scope. The fire alarm installation was on a relatively sensitive setting, so that the report of fire was made relatively quickly. While the guards arrived at the cell within the applicable standard times, they found a cell filled with smoke two minutes after the fire alarm had sounded, because the fire had developed further. Further, a warning was sounded prior to the actual alarm, only on the wing itself. Had guards been present, they could have responded to the early warning.

In order to avoid delay, at least two guards should have been present in all cases. According to the internal instructions, if only a single staff member had been present he could not have opened the door of the cell before a second member of staff had arrived. In their joint response following their consideration of the draft report, the Ministers stated that security of the wing was carried out by means of video monitoring, which is in accordance with the legislation. They also noted that this did not lead to any delay in the response to the fire alarm, and that on the night of the fire the standard of two minutes for the evacuation of a burning cell was met. The Board does not intend to pass judgement on the degree of effectiveness of camera monitoring versus physical presence of guards, but would observe that there is a difference between the meeting of the standard for timing, and the travel times actually required. The distance to be covered and the time taken are, after all, much longer if the guards are not present on K Wing.

6.7 Analysis of the fire brigade's performance

This analysis of the fire brigade's performance sets out the specific working conditions which affected that performance. The emphasis in this analysis is on the time lost by the fire brigade on the way to the fire and the preceding problems with preparations. The loss of time had an impact on the rescue efforts. It is difficult to establish how large those effects were.

Standards play an important role in assessing the delay. Nevertheless, the Board wishes to pay particular attention to the causes of the delay. The most significant factors playing a role in the delays which affected the fire brigade are set out in the following Sections:

- there were delays in raising the alarm with the fire brigade (see Section 6.7.2);
- the fire brigade's arrival time was long (see Section 6.7.3);
- the fire brigade arrived at the wrong entrance and had to drive around (see Section 6.7.4);
- the fire brigade was not met by staff from the detention centre (see Section 6.7.5)

The underlying causes of three of these factors must be sought with the detention centre and not with the fire brigade itself. This will be further elucidated below.

It is stated in Section 6.7.6 that the standard for attendance times assumes self-rescuing capacity on the part of cell occupants, and that that assumption may only be adopted if that capacity is guaranteed by the in-house emergency and first-aid service. Finally, Section 6.7.7 deals with the performance of the fire brigade at the site. The expectation of the fire brigade is that even in this sort of difficult situation they will prevent casualties. However, it is not expected that the fire

brigade will be able to rectify or compensate for all shortcomings (in preparation, for example). The following Section sets out how long the fire brigade's delay was in comparison with the standard times.

6.7.1 When should the fire brigade have arrived, according to the standards?

Standards for arrival time and deployment time apply to the fire brigade. The actual times are compared with the standard times below. The Board has adopted the standards set out in the Cells and Cell Blocks Fire Safety Scheme as their frame of reference.

Section 6.7.6 also discusses the assumption of self-rescuing capacity and the associated standard in the Cells and Cell Blocks Fire Safety Scheme with regard to arrival time.

Comparison of direct alarm with the alarm which actually took place

It was agreed between the fire brigade and the owner (RGD) that following an internal report of fire in the Detention Centre Schiphol-Oost, an alarm would be sent automatically to the fire brigade. The Building Permit stated that the fire alarm installation must pass on alarms automatically. A delay of three minutes was built into the detention centre fire alarm installation. The automatic fire alarm installation detected the fire at 23.55 hours. This alarm was passed on automatically to the emergency centre Schiphol at 23.58.12 hours. This delayed transmission of the alarm led to a delay of around three minutes.

Comparison of standard with actual arrival time

The fire brigade was alerted at 23.58.12 hours, three minutes after the automatic fire alarm came in to the KMar switchboard where the fire alarm installation was located.

The fire brigade arrived at 00.08.54 at the former entrance to the detention centre²⁰⁹.

The total arrival time was therefore almost 11 minutes. The standard in the Fire Safety Scheme is 8 minutes. There was therefore a delay in arrival time of nearly 3 minutes with reference to the standard in the Fire Safety Scheme. This difference can almost all be explained by the travel time. This was not because the fire brigade was delayed on their way to the site, but because of the distance between the fire station and the building.

Comparison of standard with actual deployment time

A total of around 12 minutes had elapsed between the time the fire brigade arrived at the former entrance to the complex (00.08.54 hours), drove to the new entrance (arrival time 00.13.00 hours) and the time when the deployment actually got underway (around 00.21 hours)²¹⁰. The total deployment time on the night of the fire was 12 minutes. According to the standard in the Fire Safety Scheme this should have been 7 minutes²¹¹. The delay as compared with the standard was therefore around 5 minutes.

Conclusion on performance in comparison with standards

The delay was eleven minutes in total. If direct reporting had taken place and actions were taken within the standard times, the fire brigade would have arrived at around 00.03 hours and would

209 Following consideration of the draft report, the Municipality of Haarlemmermeer observed in this regard that the data showed that the attendance time was 7.57 minutes. The account of the investigation sets out the Board's reasons for rejecting this reading. The Municipality also observed that the automatic alarm must not be taken as the starting point for the attendance time. The Board set out in the account of the investigation why this interpretation is also rejected.

210 The exact time when the fire brigade began its deployment at K Wing is unknown. The deployment time adopted in this report has been derived from other data. It has been established that the fire brigade arrived on site at the former entrance at 00.08.54 hours, that it arrived at the new entrance at 00.13 hours and drove onto the detention centre site at 00.15 hours. The fire brigade subsequently drove to J Wing (the driving time was estimated at 1 minute) assessed the situation and wished to enter J Wing, which was locked. Around 00.18 hours a KMar staff member reported to the KMar control room that the fire brigade was going to break open the door. The fire brigade broke open the door to J Wing (the time required was estimated at between 1 and 2 minutes) and entered J Wing around 00.19/00.20 hours, asked for information, and ran with a high pressure hose through the 50 metre long J Wing (where the situation was said to be tense) towards K Wing between 00.20 and 00.22 hours (the time taken was estimated at 1-2 minutes). It also appears from fire brigade statements that the crew of the appliance from Post Sloten arrived earlier at the entrance to K Wing than Post Rijsenhout (at 00.23 hours). The fire brigade therefore estimated to have deployed between 00.20 and 00.22. For reasons of readability the Board will adopt the timing 00.21 hours for the purposes of this report.

211 The Board has adopted this standard from the Fire Safety Scheme, since that is more specific and of more recent date than the Fire Brigade Manual, and the latter does not indicate a standard for deployment time.

have been ready to deploy on K Wing at 00.10 hours. Taking account of the probable time of death of the cell occupants who were left behind (between 00.10 and 00.30 hours), the delayed reporting and the late arrival and deploy ability of the fire brigade can be described as serious. Had arrival and deployment been timely, the fire would have been able to develop less extensively and the chance of rescuing casualties would have been greater. It is therefore important to know how the fire brigade was delayed. However, it should be said here that the services' performance is to a large extent dependent on the performance of the on-site emergency team.

6.7.2 Factor 1: delay in alerting the fire brigade

The Municipality generally requires that buildings occupied by persons who are unable to rescue themselves should be provided with an automatic fire alarm installation²¹². The aim of the fire alarm installation is to detect a fire which has started while it is still at an early stage. This allows the fire to be fought in good time while measures can be taken to prevent or limit damage resulting from the fire. An automatic fire alarm installation was in place at the Detention Centre Schiphol-Oost²¹³. A delay was built into this installation.

When a fire is detected automatically the guards at the Detention Centre Schiphol-Oost KMar Emergency Control Room hear an acoustic signal. They will then be able to accept the alarm and start investigations. If the guards accept the alarm within one minute, the report will then not be passed on to the fire brigade's Emergency Control Room (at the emergency centre Schiphol) but a period of three minutes will automatically begin to tick off. During these three minutes the detention centre personnel are able to investigate if there is actually a fire. If the fire alarm installation is not reset within three minutes, the report will still be automatically transmitted to the fire brigade. This means that in the worst case the fire brigade will receive the alarm with a delay of four minutes. On the night of 26 to 27 October 2005 the KMar Emergency Control Room accepted the report after 12 seconds, at 23.55.12 hours. The fire brigade received the alarm at 23.58.12 hours. A delay of three minutes and twelve seconds arose as a result of the delayed transfer of the alarm.

Underlying cause: the detention centre introduced a delay time to prevent false alarms

Such delay times are not unusual in the Netherlands. There are no existing directives for detention centres regarding whether or not to delay the alarm to the fire brigade. Nor are there checks as to whether installations have incorporated a delay or not. No records are kept in the Netherlands about the number of buildings with a delay in passing on the alarm. It is estimated that such a delay is in place in around half of the larger buildings in the Netherlands.

A delay is often incorporated into a fire alarm installation in order to reduce the number of false alarms. Detention centres need to avoid unnecessary disturbances to the cell occupants and disruption to the detention centre, while false alarms are a problem for the fire brigade since they create unnecessary work.

The delay was incorporated in the Detention Centre Schiphol-Oost fire alarm installation because the user deemed it desirable, and not because the fire brigade had asked for it. Where the Schiphol fire brigade is concerned, a delay is generally built in at the request of the user, and not at the request of the fire brigade. The detention centre introduced the delay period, but did not actively inform the fire brigade about this and did not associate this with any consequences. A delay means that the fire brigade arrives later. Apparently this was not seen as a problem, and the fire brigade was not consulted. It also appears from the responses following the period of consideration of the draft report that those involved each point to the others as being responsible for the delay time, and that it was not acknowledged what problems would be created through the introduction of a delay time.

212 Automatic detection occurs by means of fire detectors which send a signal to a fire alarm installation. These fire detectors were set so sensitively that they sent a signal during daytime on 26 October 2006 when two cell occupants were smoking in a single cell.

213 In this context a fire alarm installation is taken to mean the following: "an assembly of harmonized equipment, cabling and cable accessories necessary for the detection of fires, the reporting of fires and the provision of control signals for use by other installations". Source: www.brandweer.nl.

Underlying cause: lack of attention paid by the Detention Centre Schiphol-Oost to the risk introduced

The management of the detention centre, who introduced the delay, might be expected to inform the fire brigade and to take additional measures to compensate for the risks associated with a delay. No evidence of this emerged during the investigation.

However the Ministers' joint response to the draft report indicated that this had indeed occurred, through the introduction of sprinkler pipes and the roistering of a larger number of in-house emergency and first-aid staff than the usual 1 in 50²¹⁴. The Board's investigation did not reveal that the number of guards present was a consequence of the introduction of the delay. In addition, the Board's opinion is that the absence of the fire brigade would not be compensated by greater numbers of in-house emergency and first-aid team members. The fire brigade can, after all, operate in conditions where the personnel no longer could (using breathing apparatus in the smoke), and the dry sprinkler piping could only be connected by the fire brigade once it had arrived.

Underlying cause: corrective measures failed to operate due to lack of practice in their use

Located halfway along K Wing was a manual fire alarm which could be used to summon the fire brigade immediately, and nullify the delay. The guards who arrived first at the burning cell immediately tripped the alarms on their PZIs (personal location devices). Every guard carried such a personal alarm. This alarm is a general and internal call for assistance, to which colleagues would respond by hurrying to provide help. No one set off an alarm using the manual equipment, which would have cut short the delay in passing on the alarm. It is possible that a lack of practice with the manual alarm equipment played a role in this.

The actions to be taken in the case of a fire or other alarm are set out in a procedure. Such a procedure would ensure that people are ready to carry out scenarios for action, in some cases fairly complex scenarios²¹⁵. Regular drills are required, however, otherwise these competencies will be lost²¹⁶. Time-critical tasks, such as the implementation of an emergency plan, appear to be particularly quickly unlearned. The detention centre guards were aware that they must press a manual fire alarm as soon as they saw a fire. However they had never practiced this procedure.

Underlying cause: limited supervision by the Municipality dependent on the information supplied

The Municipality's supervision of fire safety involved, among others:

- the granting of a building permit and Occupancy Permit;
- responding to signals.

The delay ought to have been part of a permit

It was agreed between the fire brigade and the owner (RGD) that a certificated fire alarm installation should be installed in the detention centre, by means of which overall detection would be achieved. The agreement further required that the fire brigade would be automatically alerted following an internal fire alarm. The Building Permit stated that the installation must report alarms directly.

The Municipality granted an Occupancy Permit, but was not aware of the inclusion of a delay time. In the comments received by the Board following the period of consideration of the draft report the Municipality stated: "The occurrence response plan received later included conflicting and inconsistent messages regarding delays in raising the alarm (Detention Centre Schiphol Oost operating plan page 3, and Staff Fire Instructions Booklet pages 4 and 5). Evacuation plans, emergency plans and the like do not fall under the Submission Requirements Order and were therefore not appended to the application". These documents were in the Municipality's possession, but their content was unknown and was not officially required to be known. The Municipality states that the user has a duty to bring forward information and therefore it did not seek out such information itself.

214 The Working Conditions Decree requires at least 1 in-house emergency team member for every 50 employees. This is a minimum requirement for all buildings, and therefore also for office buildings, where people are not locked in.

215 Kieras, 1990.

216 Christina & Bjork, 1991.

The Board did not come across any documentation in the course of its investigations which would indicate that the detention centre had informed the fire brigade about the delay. This does not indicate that that did not happen and/or that the fire brigade would have intervened if it had happened. However, the view of the Board is that a verbal notification is not sufficient, and that this point ought to have been brought emphatically to the attention of the fire brigade by the user.

The “emergency plan for use by the Detention Centre Schiphol-Oost in-house emergency and first-aid service” was signed off by the fire brigade. The RGD took this signature to indicate that the fire brigade was aware of the delay^{217 218}. Since the delay is not mentioned in this document, the RGD’s conclusion is, in the Board’s opinion, incorrect.

One condition set at the time the Building Permit was issued was that the Schedule of Requirements for the fire alarm installation should be handed over at a later stage. The Municipality did not inspect this Schedule of Requirements, nor was it requested when the Occupancy Permit was issued. The inclusion of a delay time in a fire alarm installation is required to be specified in the Schedule of Requirements²¹⁹. However, no Schedule of Requirements was drawn up for the fire alarm installation.

Underlying cause: no action on the part of the Municipality and the detention centre following indications

Between 30 November 2002 and 26 October 2005 the Schiphol fire brigade recorded nine fire alarms from the Detention Centre Schiphol-Oost which required the attendance of the fire brigade. Three of these fires were more serious in nature than a so-called “wastepaper-bin fire”. Two of these three fires (in July and December 2003) came to a satisfactory conclusion. Each arose inside a cell, but they were extinguished in good time and did not spread outside the cell in question. The role of the fire brigade was in these cases limited to damping-down activities. These fires did not provide any motivation for the fire brigade and the detention centre to devote attention to the delay time.

The third fire, on 30 November 2002, was a large blaze requiring the attendance of the fire brigade with several units. The detention centre had not been taken into use at that time. As a result of this fire in C Wing of the detention centre the Netherlands Institute for Fire Service and Disaster Management²²⁰ carried out an investigation on behalf of the Municipality of Haarlemmermeer. One of the recommendations was that an Occupancy Permit should only be granted if there was direct reporting to the fire brigade’s Regional Emergency Control Room and if a Schedule of Requirements had been drawn up. The Municipality adopted this recommendation only in the case of building sections L and M (the deportation centre). The Occupancy Permit for the J and K Wing was not a topic for discussion as part of the Nibra investigation, and during the inspection visits the matters looked at included whether doors were left open or not and the method of opening them (visual inspections), and did not include the delay time in the fire alarm installation²²¹.

6.7.3 Factor 2: the fire brigade’s arrival time

The standard arrival time in the Fire Safety Scheme was not achieved. The fire brigade’s arrival time is comprised of the following:

- processing time in the control room;
- the turn-out time: the time taken to get into the vehicle;
- the driving time until the emergency services arrive on site.

217 It was only in the “Staff Fire Instructions Booklet” that the delay was clearly specified, not in the other documents. The information supplied by the installation company to the fire brigade in October 2003 stated “not applicable” against delay time.

218 Source: Joint response of Ministers to the draft report.

219 Appendix A of NEN 2535: “In order to arrive at an appropriate fire alarm installation, the assumptions adopted by the competent authority must be set out unambiguously in the Schedule of Requirements in accordance with the model Schedule of Requirements in A.3. This model Schedule of Requirements may be expanded with supplementary assessment criteria or specific assumptions, provided the structure and sequence of the existing requirements are not modified. Any additions must be elucidated in a separate appendix to the Schedule of Requirements. The Schedule of Requirements must be completed in full and then approved by an authorized person.”

220 The Nibra is an independent steering body for training and research in the field of fire and occurrence control.

221 Source: response of Haarlemmermeer fire brigade to written questions from the Board.

Deployment time starts when arrival time ends: this is the time from arrival at the site up to actual operational action²²².

The fire brigade had already needed eight minutes to drive the nine kilometres from Post Sloten to the detention centre. The processing time and turn-out time still need to be added to that. Ultimately the arrival time in this case amounted to almost eleven minutes²²³. This is three minutes longer than the standard set out in the Fire Safety Scheme.

Underlying cause: the hazardous status of the detention centre played no part in the determination of arrival times

Like any other organization, the fire brigade must deploy manpower and resources as efficiently as possible. This means that the greatest possible area must be served by the lowest possible number of fire stations and fire appliances. This always involves a consideration of the costs of additional fire stations and vehicles and the benefits in the form of serving as many premises as possible as quickly as possible. Those involved work on the basis of the type of premises which occur most frequently. In general these will be domestic premises, for which an arrival time of eight minutes applies²²⁴. The selected standard for arrival time for the area where the detention centre was located was therefore eight minutes.



Figure 24: Aerial photograph of detention centre and immediate surroundings

However it was recognized that the standard of eight minutes for the area where the detention centre was situated was not feasible given the available resources²²⁵. A municipal memo included the observation that the presence of a single appliance at Post Sloten was inadequate in view of the required capacity in the case of occurrences as well as the excessively long arrival times for the non-domestic sites at Schiphol-Rijk, Schiphol-Oost and Oude Meer (where the detention centre was located). As of 1 March 2006 an amendment was therefore introduced to the requirements on the fire brigade and an additional vehicle was stationed at the Schiphol-Rijk fire

222 Source: Fire Safety Scheme.

223 Having considered the draft report on this point the Municipality of Haarlemmermeer stated that the data showed that the attendance time amounted to 7:57 minutes. The account of the investigation sets out the Board's reasons for rejecting this reading. The Municipality also observed that the automatic alarm must not be taken as the starting point for the attendance time. The Board set out in the account of the investigation why this interpretation is also rejected.

224 This attendance standard must be regarded as a maximum which must not be exceeded more frequently than in 80% of cases. Source: Fire Brigade Manual.

225 In that area the attendance time was calculated to be eight to ten minutes; Source: SAVE report on attendance standards.

station, which covered the area where the detention centre was located, among others²²⁶. The approach described above meant that no attention was paid to buildings for which variant arrival requirements applied. Where premises with an elevated risk were located in an area where most buildings had an average risk, then the standard selected was that for premises with an average risk, for reasons of economy and efficiency. The alternative, after all, would have been the introduction of a new fire station.

With reference to the consideration of the draft report it has been noted in this regard that the Municipality is to ensure that the standard for attendance time must be met for 80% of buildings²²⁷.

Underlying cause: the long arrival time was not dealt with

Had the municipal authorities been aware of the problem with arrival times for this high-risk detention centre, they might possibly have realized that on the estate in question there was a building for which the recommended arrival times for the fire brigade could not be achieved. Since the Municipality is the only party with knowledge of this situation, the Board's opinion is that in any event the Municipality had a "duty to inform" in this regard²²⁸ and certainly where buildings with an elevated risk are concerned. However, the Board has found no indications that the Municipality or the fire brigade brought this problem to the attention of the detention centre. The detention centre could therefore assume that the fire brigade would arrive in good time. This is how the impression was created that arrival time had not been reflected upon. No responses to the contrary were received following the period of consideration of the draft report.

6.7.4 Factor 3: the fire brigade arrived at the wrong entrance

On arriving at the Detention Centre Schiphol-Oost on the night of the fire, the fire brigade drove to the former entrance. From there they were directed to the correct entrance. The fire brigade was not aware that the former entrance to the detention centre was locked. The fire brigade followed the directions received from personnel. As stated above, this led to a delay of around four minutes.

Underlying cause: the former entrance had been closed off by the detention centre

Because of its history of creation in phases, the Detention Centre Schiphol-Oost had had several entrances for some time. This was undesirable for the detention centre from a security perspective. The aim therefore was to move to a central main entrance, and this was achieved by the end of May 2005. The remaining entrances were then closed and no longer used²²⁹. The former entrance was locked with a padlock and chain.

The owner of the premises, the RGD, made preparations for the new (and now only) main entrance, the so-called "speedgate". The RGD did apply for a permit for this speedgate, but the Municipality did not receive the application. The permit was a separate issue from the relocation of the main entrance and the locking of the remaining entrances.

The fire brigade personnel attending on the night of the fire were familiar with the former entrance through previous visits to the Detention Centre Schiphol-Oost and through the fire in 2002. They were used to the former situation and were not aware of the scale of the changes²³⁰. It is the case that the access map for the detention centre (Appendix 8) showed both the new and the old entrances, but it was not stated that the old entrance was no longer useable. It has not been possible to establish clearly whether the closing of the former entrance was communicated to the fire brigade. According to the detention centre, this was indeed the case. The fire brigade states that it was known that there was a new entrance, but that it was not known that the former entrance was locked. In their joint response to the draft report the Ministers indicated that the fire brigade had been on site three times since the new gate had come into use. This information was not known during the investigation; it is unclear which fire brigade units were

226 Source: Board Proposal 2005/16441, Assent to Fire Brigade Requirements for Schiphol, dated 21-6-2005.

227 Source: Fire Brigade Manual.

228 According to one response following the period for consideration of the draft report, the Municipality could do no more than this, since the Municipal Building Regulations do not allow requirements to be set down on buildings or their use on the grounds of control actions on the part of the fire brigade.

229 There was a single exception: a pedestrian-only entrance for the Military Police.

230 The information supplied by the Haarlemmermeer fire brigade showed that four of the fire brigade staff who attended the fire had previously been involved in a deployment at the detention centre. However, none of them had been deployed there since March 2005.

involved. The fire brigade stated that it was known that there was a new entrance, but not that the former entrance was locked.

Underlying cause: the fire brigade did not appreciate the risks associated with the premises and were insufficiently prepared

It appears from the preparations made by the fire brigade that it did not appreciate the risks. No scenarios had been worked out in an Action Plan, the information on the access map was inadequate and little practice had taken place.

No Action Plan

According to the Fire Safety Scheme for Cells and Cell Blocks the fire brigade²³¹ should have had an effective Action Plan in place. This plan was to be compatible with the company emergency plan and is a common concern for both the fire brigade and the organization itself. The Action Plan must therefore also be seen as an integral part of the company emergency plan²³².

Action Plans are intended particularly for sites where there are predictable fire scenarios and/or exceptional risks, including the presence of persons incapable of independent self-rescue. 233The benefit of an Action Plan is that in addition to the data provided on an access map and information about the layout of buildings, scenarios applicable to the premises are worked through, so that fire brigade deployment has been considered in advance²³⁴. The drafting of an Action Plan does however cost a great deal more time, attention and expertise than is the case with an access map. The Municipality and/or the Haarlemmermeer fire brigade felt that an Action Plan for the detention centre would be unnecessary, because the Municipality only prepared Action Plans for situations associated with risk, for example in the case of premises storing hazardous substances. The Municipality did believe that an access map was necessary.

The information on the access map had little operational value and it was difficult to consult

The access map dated from the period when the detention centre was still under construction and was not modified to take account of the subsequent situation (see Appendix 8). The map contained scant information. The former entrance to the detention centre was still shown and the entrances to buildings and wings were missing, among other matters. The presence of open water was also not stated on the access map. The access map therefore had little operational value.

Additionally, the access maps were not available during the journey to the site. They were in the vehicle under the Crew Commander's seat, to the right of the driver²³⁵. The maps could therefore not be consulted during the journey, but only upon arrival on site.

The modification of access maps is a task for the fire brigade's Pro-active and Prevention Department. The fire brigade adopts a review period of two years in this instance. This period had not yet expired²³⁶. Interim revisions took place if amendments were passed on to the fire brigade, for example by fire brigade units who noted changes during a visit, or by the owner/user. So far as the Board has been able to establish, the fire brigade had not been on site since the change to the entrance²³⁷. There were some reported fires but these proved to be false alarms and the fire brigade began to turn out but then returned to base²³⁸. From the fact that a standard review period of two years was adopted, in combination with the lack of joint practice drills, the Board concludes that the fire brigade did not consider the risks of the detention centre to be such that more frequent updating would be required. The Municipality is of the opinion that significant modifications should be brought to its attention, and that it is therefore not required to "go searching" for them.

231 Drawn up by the Interior Ministry's Fire Services and Occurrence Control Prevention Policy Article.

232 Source: CCRB bulletin no. 5: Action Plans, Manual on Action Plans and Access Maps, page 16.

233 Source: CCRB bulletin no. 5: Action Plans, Manual on Action Plans and Access Maps, page 18.

234 Source: CCRB Bulletin no. 5: Action Plans, Manual on Action Plans and Access Maps, page 15.

235 Source: Site visit by the Public Order and Safety Inspectorate.

236 The access map was dated 22-12-2003, see Appendix 8.

237 In their joint response to the draft report the Ministers noted that the fire brigade had visited the complex on 21 June and 28 July 2005. During the investigation the detention centre were unable to provide information on the visits of the fire brigade. The Minister stated that one of the visits involved the prevention department. The Board has not been able to establish the nature of the remaining visits or which fire brigade units were involved.

238 This has changed following the fire: the fire brigade would now continue to the site even in the case of a false alarm.

The fire brigade followed the directions of personnel

The Sloten fire brigade was turned away from the former entrance by the personnel, despite the fact that they were at a distance of 100 metres from the fire and had a good view of it. At the time when the fire brigade personnel were at the former entrance it was not known that people were still locked in. One or more of the Detention Centre Schiphol-Oost staff told the fire brigade that the site must be entered from the other entrance. It is not usual to force an entry to a particular site against the instructions of a member of staff. In the case of a detention centre, a site which in principle may only be entered if that can be done safely, it is understandable that the fire brigade should follow the directions of the personnel²³⁹. In retrospect, entering the site via this entrance would have gained a good deal of time. However the Municipality/fire brigade are of the opinion that the fire brigade cannot be expected to ignore the directions of personnel, and furthermore that in retrospect it can be seen as an advantage that the fire brigade arrived via the new entrance, since that meant that the problem of the persons locked in the exercise yard in J Wing could be seen immediately.

The detention centre staff knew that gate 1, the old entrance, had not been an entrance for some months. Given their experience it is understandable that they directed the fire brigade towards the new entrance.

6.7.5 Factor 4: the fire brigade were not met at the entrance

Having come in via the correct entrance, the fire brigade experienced delays at the speedgate. The fire brigade also had difficulties in gaining access to the building. The search for information also cost time, among other things after they had entered J Wing. Taken all together the reception of the fire brigade was unsatisfactory, which led to a delay of around one minute in comparison with the standard²⁴⁰. The Board would observe here that, given a properly functioning in-house emergency and first-aid service, the deploy ability of the fire brigade would have been several minutes shorter than the time prescribed by the standard. For this reason the issue of the reception at the entrance will receive more detailed consideration below, despite the minor delay caused in comparison with the standard.

Additional consequence: lack of information on casualties

The investigation has shown that various persons had concrete information on the cell occupants left behind. This information reached the fire brigade only in a very fragmentary form. Once inside J Wing the fire brigade received information from the personnel present there about the presence of casualties. Certain members of staff reported that not everyone had been evacuated, while others indicated that they did not know about this. No one was able to specify possible locations of persons, or their number²⁴¹.

Nor was there any concrete and unambiguous provision of information outside the building. Representatives of the detention centre²⁴² did not state at any time during the Occurrence Site Coordination Team meeting that there were certainly casualties²⁴³. The leadership of the fire brigade units assumed that there were still people within the burning wing, until such time as the contrary had been demonstrated with certainty, and the Justice department had shown with certainty that everyone had been evacuated from the burning wing²⁴⁴. Potential casualties were an ongoing topic of discussion in the Occurrence Site Coordination Team meeting. In the absence of information the fire brigade by their account took rescue action and continued to do so.

239 Source: Nibra investigation on behalf of the Board (see Appendix 1, Account of the Investigation).

240 This delay of one minute has been determined as follows: the standard for deployment time in the Fire Safety Scheme prescribes that this may amount to 7 minutes. The total deployment time for the fire services amounted to 12 minutes. That is, from the moment the fire brigade arrived at the former entrance to the moment that they were ready for deployment (00.21 hours). The total delay in the deployment time was five minutes (12-7 = 5). As has been explained in Section 6.7.4 the fire brigade experienced a delay of four minutes at the old entrance. That means that from the time of their arrival at the correct entrance they experienced an additional delay of one minute (5-4 = 1).

241 Source: Interviews and statements from the fire brigade and guards.

242 In the first instance these were the Duty Officer and later the Head of the Temporary Special Facilities Directorate.

243 In retrospect it appears that even the Schiphol-Oost detention centre representatives in the Occurrence Site Coordination Team meeting from a certain point onwards had less reliable information available than did the rescue team.

244 Source: Interviews and statements from the fire brigade and guards.

There was frequent discussion on site about the evacuation of the various wings. At one point shouts were heard: "it's empty!" and "everyone is out of there". While the leadership of the fire brigade did not accept this at face value and continued to focus on rescue activities, they were dismayed when casualties were discovered, after all, later that night.

Underlying cause: detention centre personnel not adequately prepared

The Detention Centre Schiphol-Oost occurrence response plan and the relevant fire brigade access map indicated that the detention centre's in-house emergency and first-aid service would ensure that the fire brigade:

- was met at the entrance;
- was accompanied to the location of the occurrence;
- was provided with a master key;
- was provided with a walkie-talkie.

The Detention Centre Schiphol-Oost occurrence response plan also stated that the Duty Officer was to be responsible for the reception of the fire brigade at the access gate. He was the most appropriate person to carry out the task of guide, or to delegate that role to someone else. On the night of the fire at the Detention Centre Schiphol-Oost the fire brigade was not guided and did not receive any information on the situation, neither from the Duty Officer nor from any other guard representing him.

The Duty Officer of the detention centre was faced with his task as first point of contact for the first time on the night of 26 to 27 October 2005. The Duty Officer could not discharge his role as first point of contact or in-house emergency and first-aid service member as he had no experience with these tasks as set out in the occurrence response plan, and could not estimate their importance.

A Duty Officer fulfils a role outside office hours when the managers of the detention centre are absent. One of his most significant tasks in the first minutes of a major occurrence is to alert the "on-call" manager²⁴⁵. The role of Duty Officer is allocated to the most experienced guards. However, they have only limited equipment for their task. The Duty Officer is just one of the guards, albeit with specific instructions as to his duties.

The importance of a good first point of contact appeared not to have been recognized within the Detention Centre Schiphol-Oost. The role of Duty Officer during the fire was never practiced. The Duty Officer did make enquiries of the other Duty Officers, but had no specific training. The training introduced the notion of a first point of contact, but provided no guidance as to concrete actions. This was not worked through further by the detention centre. The occurrence response plan was never practiced. The Duty Officer was therefore unable to fall back on ready knowledge of his coordinating role.

According to the occurrence response plan the Duty Officer was to arrange for the reception of the fire brigade. The plan was not entirely clear on this point: It stated that the Duty Officer was to meet the fire brigade at the access gate, but also that he must remain at his post. The fire brigade was therefore also to be provided with a walkie-talkie so that it could contact the Duty Officer. This did not happen.

Underlying cause: the organization was oriented towards daily care

The attention of the staff in a prison is in the first place oriented towards the daily care of cell occupants rather than the quality of the emergency organization. Care for cell occupants is daily routine, while fire fighting occurs only very occasionally. Regular training is necessary in order to ensure that the personnel are also able to carry out occasional tasks correctly. This did not take place.

This daily care also led to the fire brigade being faced with the locked door to J Wing when it wished to enter the building. This led to a loss of valuable time. The emergency doors on the end wall of the wings would normally be opened automatically via the fire alarm installation. This was

245 The Heads of Department share the on-call duties. The Duty Officer is required to telephone the Head of Department who is on call.

countermanded because the detention centre found that situation undesirable. An organizational measure was substituted. The Duty Officer, the Heads of Departments and the switchboard were provided with keys. However the fire brigade had not been met, and had no key available.

The guards and the Duty Officer devoted considerable attention to preventing the escape of cell occupants. This can be seen for instance from the following two examples. Having opened the door of Cell 11, the guards remained with the injured but walking occupant and accompanied him to the corridor between J and K Wing. Despite the loss of time involved they did not allow him to walk unaccompanied to the corridor. The second example relates to the speed gate. In order to reach the site, the fire brigade had to pass through a "lock", an access arrangement involving two gates. The gates were operated from the switchboard. Such a "lock" is a functional arrangement for a prison, but hinders rapid access by the emergency services. It was possible to open both gates at once, but this did not happen. The staff member at the switchboard was unfamiliar with the method of opening both gates simultaneously. This can also be attributed to unfamiliarity with emergency procedures and a lack of training.

Underlying cause: limited supervision

As has already been said in Section 6.6.3, supervision by the fire brigade was oriented towards such visually observable matters as doors left open, and not towards the manner in which the emergency organization was controlled, such as the reception of the fire brigade. The setting of requirements for the in-house emergency and first-aid service was seen as necessary by the Nibra investigation following the fire in C Wing at the end of 2002. For the remaining supervisory bodies, please refer to Section 6.6.3.

6.7.6 *The self-rescuing capacity described in the standard assumes facilitation by the in-house emergency and first-aid service*

Because of the elevated risk, special standards for arrival time by the fire brigade apply to cell blocks²⁴⁶ and prisons. Two relevant standards frameworks are:

- the Cells and Cell Blocks Fire Safety Scheme (1994);
- the Fire Brigade Manual (1992).

As has been said, neither of these standards frameworks is mandatory.

The standards set out in these frameworks differ. The Fire Safety Scheme assumes a longer arrival time for the fire brigade than does the Fire Brigade Manual. In the Fire Safety Scheme the standard for the arrival of the first and the second appliance is eight minutes in each case. In the Fire Brigade Manual the standard is five minutes for the arrival of the first appliance and seven minutes for the second. Account must additionally be taken of the time required to prepare for deployment. The Fire Safety Scheme adopts a standard of seven minutes for this.

The variation between the standard times arises because the Fire Safety Scheme assumes self-rescuing capacity. According to the Fire Safety Scheme, cell occupants who are locked in are capable of self-rescue, except for the fact that they are locked in. The assumption here is that they will be released in good time by the guards²⁴⁷ and will then be in the same situation as self-rescuing persons who were not locked up. This would mean that the fire brigade is not required to carry, support or transport these persons using special vehicles, as would for example be the case where the fire brigade needs to carry out a rescue in a hospital²⁴⁸.

Alongside the argumentation in the Fire Safety Scheme, the Board would add the observation that the cell occupants, using their own self-rescuing capacity, can only move as far as the next locked door²⁴⁹. Cell occupants can only escape from danger with the assistance of guards. This therefore does not constitute self-rescuing capacity. Any self-rescuing capacity is entirely dependent on the performance of the emergency organization.

246 This arrival time is composed of the processing time in the fire brigade's Emergency Control Room, the turn-out time and the driving time until the emergency services arrive at the occurrence site.

247 It is assumed that the emergency response team will arrive at the burning cell in good time, that those locked in will be taken to a place of safety in good time, and that the door of the burning cell will be closed.

248 Cells and Cell Blocks Fire Safety Scheme page 35.

249 The Transport Safety Board's report on the Hercules disaster included the following observations on rescue and self-rescuing capacity: "The Board has consciously elected to use the term 'self-rescuing capacity', since in general the common term 'evacuation' is used in air transport to mean 'evacuation by cabin staff'; while here (in the Hercules disaster) we are concerned with the self-rescue of the trained occupants without assistance from outside."

The central question then is how the BHV can compensate for the lack of self-rescuing capacity. As noted in the Fire Safety Scheme, one of the indicative scenarios is that the fire cannot be quickly extinguished by the in-house organization²⁵⁰. The outcome can only be good if the in-house organization can carry out the evacuation swiftly, even along an exit route filled with smoke. This condition was not satisfied in the case of the detention centre. That condition can only be met where the personnel are appropriately equipped, trained and practiced.

Given the limited self-rescuing capacity and the heavy demands this imposes on the emergency organization, good coordination between the deployment of the BHV on the one hand and the fire brigade on the other is crucial. The limitations on the capacities of the BHV make a long arrival time a risky matter for the fire brigade. The stricter standard for arrival times in the Fire Brigade Manual, which has often thrown up problems in practice, underlines the risk associated with cell block buildings. The Board does not intend to express a preference for either of the two standards, but would observe that a gap exists when the BHV organizers are powerless while the fire brigade has not yet arrived on site due to long arrival times. The consequences of this gap had not been thought through, neither in the Fire Brigade Manual nor in the Fire Safety Scheme.

6.7.7 The performance of the fire brigade on site (control)

It is not only the speed of performance by the fire brigade that is important for the effectiveness of fire fighting, but also the quality of its efforts. The time of death of the cell occupants left behind was probably between 00.10 and 00.30 hours. The fire brigade (the fire fighting component) is estimated to have reached the entrance to K Wing at 00.21 hours, and then had only a short time to rescue any survivors. It is not possible for the Board to reach any conclusions on the basis of the investigation about the feasibility of successful rescue efforts. It can however be determined that a large number of conditions must be met in order to achieve such success within a brief time without excessive risk to own safety.

Brief consideration is given in this Section to the question regarding the contribution the fire brigade might have made on site to the rescue of the cell occupants left behind on K Wing. Certain problems relating to the performance of the services which were not directly connected to the cell occupants who perished are also considered.

The fire brigade “rescued whoever was there to be rescued”

At the time when the fire brigade arrived at J and K Wing there was already a developed fire outside the cell. Once the brigade, following all the delays, actually began its deployment on K Wing (initially at around 00.21 hours, with a second deployment at around 00.30 hours) it had learned that there were probably cell occupants left behind on the wing.

In its deployment the fire brigade concentrated primarily on the rescue of casualties. To this end the brigade elected several times for an internal approach via the adjacent J and D Wing, through the corridor to K Wing. At its first attempt the fire brigade barely penetrated K Wing because of the great heat. At its second attempt the brigade came no further than the first three cells. Even its special protective clothing was insufficient. The temperature was too high for rescue efforts via the corridor. The fire therefore needed to be doused before a rescue from the inside could be carried out. A large quantity of water in the form of several low pressure jets and/or a water cannon is required to bring a developed fire under control and to extinguish it. Some time was expended on the setting up of several low pressure jets. If the cell occupants were still alive, their chances of survival declined further during that time. Furthermore, the conditions for persons in a fire worsen if water is introduced²⁵¹.

The fire brigade did not change its tactics after the two failed attempts to enter K Wing²⁵². The Board’s investigations have not lead to an unambiguous answer to the question whether such an alternative approach would have been possible, or whether such an alternative tactic would

250 Fire Safety Scheme, page 100.

251 The conditions deteriorate as a consequence, among other things, of the fact that water introduced to an environment where high temperatures have prevailed for some time will evaporate almost immediately. More than 1.6 m³ of steam will be generated for each litre of firewater. This steam will drive off the available air and cause the asphyxiation of anyone who is present without breathing apparatus. Additionally, the relative humidity of the space will rise, so that the human skin becomes more sensitive to heat and burn injuries are caused.

252 The group of crash tenders (Post Rijk) did use low pressure jets on the end wall of K Wing, on their own initiative. However this was not a coordinated action.

have lead to the rescue of the cell occupants left behind²⁵³. It is theoretically conceivable that the following dilemma might have played a role in the consideration of the alternatives. As time elapsed it is probable that the anticipated benefit of alternative tactics would decline further in the view of the fire brigade. Various fire brigade members stated that the chances of survival of those remaining behind in such a large fire were, in their view, slight to non-existent. This belief was reinforced when the fire brigade shouted to the occupants on entering K Wing, received no response, and were then obliged to withdraw themselves because of the heat. The fire fighters assumed that any persons present were in any event no longer conscious. Since experience has shown that survivors are still encountered even in unlikely cases, the fire brigade must press on with the search for casualties. This they did in the present case.

Problem areas related to the performance of the fire brigade

The performance of the fire brigade was affected by two significant problem areas, coordination and water supplies. Both of these issues are general in nature and according to the Board are important enough to be reported, even if they had no effect on the rescue of victims.

Coordination

The first problem area related to coordination, which should be taken to include both the taking of an overview and also communications. The fire brigade deployed on two sides of the building. During the initial period the Airport Fire Officer was the senior officer in command. He was located at J Wing and was unaware of the presence of the unit which was deployed through D wing via the corridor²⁵⁴. This meant that the AFO was unable to issue them with any orders²⁵⁵.

According to the fire brigade this faulty coordination was caused by communication problems,²⁵⁶ and could have led to a hazardous situation for the fire brigade officers themselves. While the crash tenders were discharging large quantities of water onto the roof, and later on were spraying from the end wall of K Wing, units were also busy investigating the first cells, on the other side of K Wing. The delivery of water from outside can have risks for fire brigade personnel inside a building.

In the comments on the draft report it was emphasised that safety of the deployed personnel is one of the top priorities, but it was also observed that raising the level of coordination automatically leads to loss of time. However it does appear to be a minimal requirement for coordination that when more than one unit is working, agreements must be made as quickly as possible about who is doing what, where, and with what aim. In this case that minimal condition was not satisfied, or was only met at a relatively late stage. Normally a Duty Officer would be in place within 15 minutes and would take on the coordinating role. In this case the AFO (the Duty Officer) arrived much earlier, namely simultaneously with the first unit. He should therefore also have taken the coordination of deployment presently under discussion as his primary task, until the arrival of a senior commander (Head Duty Officer).

Shortage of large quantities of water

The initial shortage of water probably played no role in the first minutes, when the fire brigade set about the task of rescuing casualties. The lack of substantial quantities of water did in any event affect the time required by the services to extinguish the fire. Much time was lost in setting up the large scale water supply using submersible pumps. This was partly caused by the lack of control of the unit used for the large-scale water supply, the submersible pump unit. There were also problems in rolling out the fire hoses. Holes were made in the gate in order to get these fire hoses onto the site of the complex.

253 Of all the possibilities the Board sites two: 1) The fire might have been extinguished (at least partly) in order to allow persons to be rescued and 2) the cell windows might have been forced. However the question is whether these tactics would have been effective.

254 The unit did not report to the AFO, and the other members of the fire brigade did not initially believe that it would be possible to walk to the end wall of K Wing along the outside of J Wing, because of the heavy smoke.

255 At a later stage there was also a Duty Officer on the "K" side, while a second Chief Duty Officer was specially tasked with the direction of the entire performance of the fire brigade (on both sides).

256 In the joint response to the draft report the Municipality stated that a badly adjusted C2000 mast was involved.

According to the standard, bulk water transport must be operational within one hour. A maximum time for this operation of 45 minutes is adopted within the region. In view of the limited distance to be covered between the open water and the complex, a bulk water supply ought to have been available well within the set time despite the problems with the gate²⁵⁷.

Since the supply of firewater with submersible pump units was seen as a problem, the pump capacity of the appliances already available on site could be used to provide large quantities of water. The appliances could then have supplied the hydraulic platforms with water via a booster arrangement using the WTS 200 system (with appliances supplying one another). This is described in the Guidance to Fire Brigade Units and elsewhere.

6.8 Specific conclusions: development of the fire, rescue and fire fighting

6.8.1 Start and development of the fire

1. The fire started shortly before midnight on 26 October 2005 in the bed in Cell 11 of K Wing. A technical cause for the fire can be virtually ruled out. It is possible that a discarded cigarette caused the fire.
2. Fire tests have demonstrated that the initial development of the fire may have proceeded along a chain of fuels (bedding, mattresses, wall coverings), where each link provided sufficient energy to ignite the next. The two mattresses played an essential role in the involvement of the entire cell in the fire.
3. The spread of the fire within a short time can partly be attributed to the large quantity of flammable material in the cell, including in particular the wall coverings.
4. The opening and leaving open of the door to Cell 11 accelerated the development of the fire and made it possible for smoke and flame to spread beyond the cell. Had the door been re-closed, the development of the fire would have been interrupted.
4. The accelerated development of the fire which occurred after the second mattress on the bunk bed had caught fire was associated with a sudden increase in smoke production. This increased production of smoke, which is characteristic of a fire in the flashover phase, was primarily caused by an increasing shortage of oxygen in the burning room; the nature of the burning materials is then of less significance.
5. The accelerated development of smoke in the corridor made it physically impossible for the guards to release all the cell occupants from their cells. The Smoke and Heat Exhaust Ventilation System, which should have removed smoke and heat during a fire, failed to operate.
6. The fire was able to spread from the corridor in particular via the shell construction. The fire remained stationary in the corridor itself, due to the limited supply of fresh air, except in the case of the end wall of K Wing, where the entry of air was possible via the opened emergency door.

6.8.2 Casualties

1. The cells offered inadequate protection to the cell occupants locked inside. The penetrating smoke in particular played a fatal role.
2. All the fatalities were due to carbon monoxide poisoning.
3. The probability is that ten of the eleven casualties died between 00.10 hours and 00.30 hours, the eleventh casualty (in Cell 5) probably later.

6.8.3 Personnel and organization

1. The Site Manager for the installation gave insufficient attention to aspects of safety such as training and practice exercises. Moreover, the Site Manager had not drawn up a Risk Assessment and Evaluation (RIE).
2. The DJI Board ought to have set up a framework for the drafting of emergency plans, a Risk Assessment and Evaluation and the arrangements for the emergency organization,

257 Source: Nibra investigation on behalf of the Board (2006).

on behalf of the Site Managers of detention and deportation centres. This did not happen.

3. The staff of the detention centre was insufficiently trained, instructed, equipped and practiced to perform adequately in the event of a fire. The re-closing of doors as quickly as possible in the event of a fire was taught as a theory, but was not anchored in any practice (drills).
4. The supervision of fire safety at the detention centre by the DJI Board and the Municipality was too limited. This is evidenced, among other things, by the absence of a Risk Assessment and Evaluation and the existence of gaps in planning and the training and level of practice of staff. The Health and Safety Inspectorate had not carried out any inspections, neither (as yet) had the recently formed Sanctions Application Inspectorate.
5. The absence of personnel on K Wing during the night hours delayed the response of the internal organization to the fire alarm. This led to Cell 11 being filled with smoke when hurrying staff arrived at the cell.
6. It cannot be guaranteed that the door of a cell where a fire rages will always be re-closed. It is not realistic to assume that staff will always carry out this action in stressful circumstances.

6.8.4 The fire brigade

1. The fire brigade was ready to begin the fighting of the fire 11 minutes later than the standard time set down in the Cells and Cell Blocks Fire Safety Scheme. There were several causes for this delay:
 - delay in alerting the fire brigade;
 - lengthy arrival time on the part of the fire brigade;
 - the fire brigade was required to drive around to the proper entrance;
 - the fire brigade was not (properly) received by the personnel of the detention centre.The underlying causes for this are to be attributed to the detention centre:
 - the fire alarm installation for the detention centre incorporated a delay time, which had not been made known to the fire brigade and which was not identified when the permit for construction and use was granted. The risk associated with the delay time was not compensated for, even following the occurrence of warning signs;
 - adequate and current information about the situation on site was lacking, the fire brigade not familiar with the new situation, personnel were insufficiently prepared; organization was oriented towards the day-to-day course of events, there was no coordination of the on-site emergency response organization and no experience of joint practice exercises.An underlying cause can be attributed to the Municipality:
 - the structure of fire fighting resources in the Municipality of Haarlemmermeer was such that no provision had been made for timely access to the detention centre, a fact of which the detention centre management was unaware; the Municipality of Haarlemmermeer failed to take account of the elevated risk presented by this type of premises. In this context the Board would observe that there are a variety of standards relating to arrival time, with that in the Cells and Cell Blocks Fire Safety Scheme assuming self-rescuing capacity on the part of cell occupants. The Board will not express a preference for either of the two standards, but would observe that a gap exists when the in-house emergency and first-aid service are powerless while the fire brigade has not yet arrived on site due to long arrival times. The consequences of this gap had not been thought through, and also not in the Fire Safety Scheme.
2. Since ten of the eleven casualties of the fire had probably lost their lives prior to 00.30 hours, the fire brigade had little opportunity left it to rescue these casualties, taking account of the time when their efforts actually got under way (around 00.21 hours).
3. Having elected to attack the fire via the access door to K Wing, the fire brigade did not consider any alternative deployment strategy. In view of the rapidly decreasing survival chances of the casualties it is probably also the case that the adoption of a new approach would not have delivered any result.
4. The delay in setting up the bulk water transport had no effect on the possibility of rescuing casualties, but did affect the duration of the total fire fighting operation.

7 ANALYSIS OF THE DISCHARGE OF RESPONSIBILITIES IN RELATION TO THE CONSTRUCTION AND USE OF J AND K WING

7.1 Introduction

The manner in which the parties involved discharged their responsibilities with regard to the construction and use of J and K Wing is analysed and assessed in this Chapter. The compliance of J and K Wing with construction legislation and the question whether the permits were properly granted are also evaluated. Lastly, the effects of compliance or non-compliance with the legislation are determined, as well as the effect of the ways in which those involved discharged their own responsibilities in relation to the fire.

The specific analytical framework relating to the construction and use of J and K Wing, supplementing the general analytic framework set out in Chapter 4, is described in Section 7.2. This provides the basis for the present assessment.

The parties involved and their responsibilities are described in Section 7.3, supplementing the information in Chapter 5. The three most significant responsible parties identified on this basis are:

- (i) the Custodial Institutions Service (DJI) as the user and as the author of the Schedule of Requirements issued to the Government Buildings Agency (RGD);
- (ii) the RGD as the commissioner for the construction of the building and owner of the detention centre;
- (iii) the Municipality of Haarlemmermeer as the licensing, supervising and enforcing authority.

The analysis is divided up into four parts. Firstly, Section 7.4 analyses the extent to which the DJI discharged its responsibility as the user. The extent to which and the manner in which the DJI made advance preparations for an occurrence of this type is of significance here. Secondly, Section 7.5 analyses the extent to which the RGD discharged its responsibilities as owner of the detention centre. The section of the analysis discusses whether K Wing complied with the legislation, and the extent to which the RGD as owner took sufficient account of fire safety in the construction plan, and whether this had ultimately been ensured in the building itself. Thirdly, Section 7.6 analyses the extent to which the Municipality of Haarlemmermeer discharged their responsibilities as the inspecting and enforcing authority. The central issues here are the Building Permit and the Occupancy Permit. Finally, the underlying factors affecting the developing situation during the fire, and which are of relevance to more than one responsible party, are analysed in Section 7.7. The implementation of safety management and the accessibility of the building regulations are also considered here.

Section 7.8 sets out the specific conclusions on issues of fact with regard to the discharge of responsibilities in relation to the construction and use of J and K Wing.

7.2 Specific analytical framework in relation to the construction and use of J and K Wing

Supplementing the general analytical framework described in Chapter 4, a number of aspects are identified here which specifically relate to the analysis of the manner in which the parties discharged their responsibilities with regard to construction and use.

7.2.1 2003 Building Decree

As discussed in the analytical framework set out in Chapter 4, detailed technical requirements are set down for the construction of buildings, in accordance with the Housing Act. These requirements are contained in the periodically updated Buildings Decree. In addition to performance requirements indicating what must be achieved to ensure functionalities, the Buildings Decree also include the so-called "Equivalence Article".

An applicant who wishes to rely on “equivalence” must demonstrate to the satisfaction of the municipal authority that the chosen solution meets the objectives of the performance requirement(s) from which he is deviating. This means that:

- in his application for a Building Permit he must set out the points on which his construction plan deviates from the stated performance requirements;
- he must indicate the means by which his construction plan nevertheless satisfies the requirements relating to the point on which he deviates;
- where considerations from other sections (apart from the section containing the relevant performance requirement) are woven into the performance requirement in question, then those considerations must also be included in assessing whether the solution is indeed equivalent.

An example to clarify the Equivalence Article:

- The owner of a factory who is also an applicant for the Building Permit is aware that the 3000m² area of the factory does not meet the performance requirement in Art. 2.105-4 of the Buildings Decree.
- The objective of this performance requirement is to prevent the aggressive propagation of fire. By installing an adequate sprinkler system, he meets the objective of the performance requirement.
- He also checks that the excessively large space does not lead to other problems, for example in relation to escape. It appears that this is not the case and his construction plan therefore meets the Buildings Decree by virtue of the Equivalence Article.

The Municipality of Haarlemmermeer is required to enact building regulations by Art. 8 of the Housing Act. Municipalities base their building regulations on the 1992 Model Building Decree, drafted by the Association of Netherlands Municipalities (VNG). The Municipal authorities must also assess the application against the municipal building regulations. The Municipality of Haarlemmermeer's building regulations include rules about the use of buildings²⁵⁸. The building regulations set out requirements for fire compartments in the form of requirements on resistance to fire penetration and fire spread between spaces in the detention centre. It is required that the wings of the detention centre, and in this case K Wing, must be a fire compartment. Within the fire compartment constituted by K Wing, each cell must be a separate fire sub-compartment.

Figure 25 briefly summarises the requirements as set out in the legislation, distinguishing between permanent²⁵⁹ and temporary detention centres (like Schiphol)²⁶⁰. This indicates that the requirements for temporary construction must be met, because of the temporary nature of the Detention Centre Schiphol-Oost. These requirements are less stringent than would be the case if the detention centre had been constructed for an indeterminate period²⁶¹.

Resistance to fire penetration and fire spread	Resistance to fire penetration and fire spread	
	Permanent detention centre	Temporary detention centre
Fire compartment (K wing)	60 min	20 min
Fire sub-compartment (individual cell)	30 min	20 min

Figure 25: Summary of legislative requirements for resistance to fire penetration and fire spread

258 The municipal building regulations deal among other matters with the following: (i) prohibitions on smoking and open flames, (ii) dry firewater lines, fire brigade lifts, fire alarm systems, fire extinguishing systems, (iii) pump systems for use with hose reels, automatically operating emergency exit doors (iv) emergency doors and stairwells with overpressure condition, quality of signage, bottled gas systems, (v) smoke and heat exhaust ventilation systems and (vi) fire brigade access, records, works not associated with normal business operations.

259 The legislation refers here to existing versus newly-built. The requirements apply to all construction works which are not non-permanent construction works. The Board has adopted the term “permanent”.

260 A permit of a temporary nature (for a maximum of five years) was granted to the Detention Centre Schiphol-Oost in 2002 for the construction of Wing A to H.

261 Bulletin of Acts and Decrees 1995, 295: “On the grounds of Art. 45 of the Housing Act, the Municipal Executive shall include a period in the Building Permit for a temporary work of construction, following the expiry of which that work of construction may no longer remain in place. This refers to the structure remaining in the same location. This period may be five years at most. In view of this relatively short period it would not be reasonable to subject temporary construction works to the full requirements for new buildings”.

According to the Buildings Decree the following requirements apply to the Detention Centre Schiphol-Oost (with a temporary permit) (see Figure 25):

- Each cell, considered as a fire sub-compartment, must have a Resistance to Fire Penetration and Fire Spread of 20 minutes²⁶² from one cell to another and/or to the corridor. This requirement applies from the cell to the corridor, and not from the corridor to a cell.
- K Wing as a fire compartment must have a Resistance to Fire Penetration and Fire Spread of 20 minutes²⁶³ with regard to the central corridor separating J and K Wing.

In practice this means that each cell must have a Resistance to Fire Penetration and Fire Spread of 20 minutes with respect to the adjacent rooms. When a fire starts in a cell, the legislation requires that the fire will be confined to this cell for 20 minutes, allowing sufficient time to bring persons in other cells to safety before the fire penetrates or spreads. The requirement applies to the propagation of the fire from the cell to another space, and not from outside the cell to inside the cell. It is also subsequently required that it should be 20 minutes before the fire could spread from K Wing (as a fire compartment) to another fire compartment. However, when issuing the Building Permit for J and K Wing the Municipality assumed a Resistance to Fire Penetration and Fire Spread requirement of 30 rather than 20 minutes²⁶⁴. With reference to the legislative requirements²⁶⁵ the construction plan on the basis of which the Building Permit was issued is normative.

7.2.2 Explanation of definitions relating to fire and smoke compartmentalization

Explanation of fire compartmentalization

Buildings are divided into fire compartments and fire sub-compartment. This means that in the event of a fire in one space it will take some time before the fire is able to spread to another space. Four different concepts are identified in discussing the propagation of a fire²⁶⁶:

1. *Fire Spread*: "propagation of a fire from one space to another exclusively via open air". For a detention centre this might for example be from one cell to another via the windows (red arrow in Figure 26).
2. *Fire Penetration*: "propagation of a fire from one space to another other than via open air". For the detention centre this might for example be from the cell to the corridor via the door (green arrow in Figure 26).
3. *Resistance to Fire Penetration and Fire Spread*: "the shortest time required by a fire to propagate from one space to another". In the case of the detention centre this might for example refer to the time elapsing before the fire in a cell enters the corridor or another cell.
4. *Fire resistance*. In the context of separation capacities, fire resistance indicates the period for which a separating element (wall, floor or element thereof) can offer resistance to the propagation of the fire. This is in order to prevent a fire on one side from being able to spread to the other. An example would be the fire resistance of the door itself, between the cell and the corridor.

262 In many cases there is a legislatively determined Resistance to Fire Penetration and Fire Spread for fire sub-compartment of 30 minutes. However this applies to permanent construction. The Detention Centre Schiphol-Oost was a temporary construction, which means a Resistance to Fire Penetration and Fire Spread of 20 minutes applied.

263 In many cases there is a legislatively determined Resistance to Fire Penetration and Fire Spread for fire compartments of 60 minutes. However this applies to permanent construction. The Detention Centre Schiphol - Oost was a temporary construction, which means a Resistance to Fire Penetration and Fire Spread of 20 minutes applied.

264 The content of the Cells and Cell Blocks Fire Safety Scheme differs from the Buildings Decree with regard to Resistance to Fire Penetration and Fire Spread (Appendix 23).

265 See Art. 40, par. 1 of the Housing Act

266 According to NEN 6068

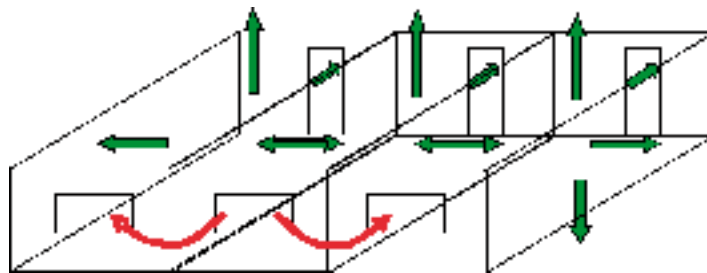


Figure 26: Schematic representation of fire spread (red arrow) and fire penetration (green arrow)

Explanation of smoke compartmentalization

For the purposes of Dutch legislation smoke resistance between spaces is determined by reference to NEN 6075. This does not determine the actual degree of resistance to smoke of a partition, rather smoke resistance is equated to 1.5 times the fire resistance. It is set down that the duration for which a structure can adequately resist smoke shall be at least 1.5 times as long as the duration for which a structure can adequately resist fire. The selection of the value of 1.5 is not further supported.

7.3 The different parties and their responsibilities in relation to construction and use

The various parties involved and their responsibilities are identified in this Section. On the basis of this, the three most significant responsible parties are identified in Section 7.3.2.

7.3.1 General overview of the parties and their responsibilities

The Board has chosen to deal with the different parties in order of the period of their involvement (moving from the party involved in the initiative to expand the detention centre with the addition of J and K Wing, through implementation and on to the granting of permits and the use of the complex). This is set out schematically in Figure 27.

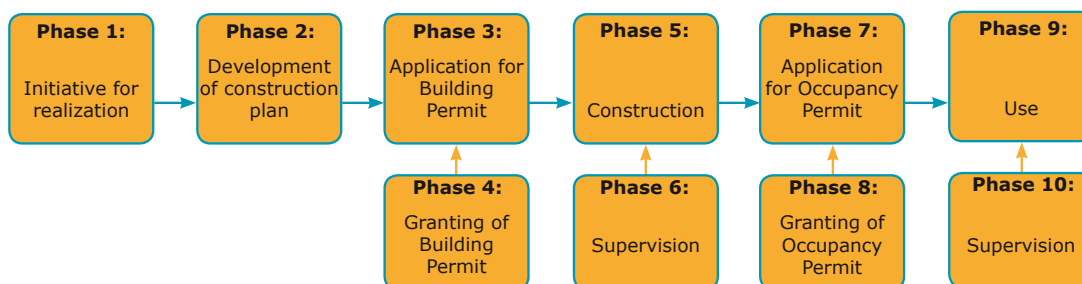


Figure 27: Flowchart showing activities from initiative to use

Phase 1: DJI - Realization of initiative

In the event of the construction of a penal institution, the DJI takes the initiative for new construction in dealings with the RGD. It is usual that the DJI would among other things draw up the Schedule of Requirements²⁶⁷.

²⁶⁷ A Schedule of Requirements indicates the requirements which, in the opinion of the commissioner, must be met by a detention centre (or other building); it is in fact a description of the commissioner's wishes.

Phase 2:

RGD - Development of construction plan

As commissioner dealing with the parties taking on the tasks involving realization (the Contractor, Architect, Installer etc.), the RGD is responsible for the building's compliance with requirements imposed on new-build construction work by the construction legislation²⁶⁸. The RGD is also responsible for the application of a Building Permit and ensures that construction is in accordance with the Building Permit²⁶⁹.

Architect - development of the construction plan

Architects are bound by the contract issued to them and by the applicable general terms and conditions²⁷⁰. In carrying out his contract the architect is required amongst others to take account of "the regulations in public and private law which are of significance to his contract"²⁷¹. In other words, in his construction plan the architect must take account of the requirements set down by the construction legislation and must ensure that the drawings and other documents he prepares also meet those requirements. He is responsible for this to his commissioner, in this case the RGD. The level of detail of these documents will depend on the orders issued to the architect. A code of conduct for architects is set down by the BNA, the professional association for architects in the Netherlands, which determines how BNA members will behave professionally and with regard to society, their commissioners and their colleagues²⁷². The code of conduct states that the architect shall take account of the consequences of his exercise of his profession for society and the environment²⁷³. The architect is also to ensure that his practice has sufficient expertise, professional competence and capacity to carry out contracts, or will engage sufficient expertise from outside²⁷⁴.

Phase 3:

RGD - Building Permit application

As commissioner, the RGD is required to ensure that any permits or waivers required for the construction are obtained. As the applicant for the Building Permit, the RGD is responsible for ensuring that the new-build construction work to which the application applies satisfies the requirements of the Building Decree and the municipal building regulations. As applicant, the RGD is responsible (to the Municipality) for ensuring that the application for a Building Permit satisfies the Submission Requirements Order for Building Permit Applications²⁷⁵. The applicant is obligated to provide the information indicated by the Submission Requirements Order for Building Permit Applications, which is in the opinion of the Municipal Executive necessary to demonstrate that the building in question satisfies the building regulations.

Phase 4:

Municipality of Haarlemmermeer - Granting of Building Permit

Municipalities exercise both preventive and repressive supervision over the construction and use of buildings²⁷⁶. Prior to the commencement of construction work, preventive supervision in relation to construction consists of the assessment of the construction plan against the requirements of the Housing Act. Where the construction plan meets the requirements, a Building Permit must be issued.

The Municipal Executive and/or the department within the Municipality charged with the supervision of construction and occupation of premises must in the first instance assess whether sufficient information has been submitted with the application for a Building Permit to allow the application to be considered. The Submission Requirements Order indicates what information and documents must be supplied. A period of four weeks is available for the purpose of this admissibility test. Where the application is incomplete the Municipal Executive must set a period

268 Housing Act, Art. 2

269 Housing Act, Art. 40, par. 1

270 Legal Relationship of the Commissioner to the Architect, Engineer and Consultant, 2005

271 Legal Relationship of the Commissioner to the Architect, Engineer and Consultant, 2005, Art. 11, par. 4.

272 The main principle adopted is that "the architect shall be obligated to assist the commissioner by acting as independent and expert confidential advisor". The architect will "represent the commissioner's interests to the best of his knowledge and ability, understanding that he is responsible not only to the commissioner but also to society, the environment and his colleagues".

273 Code of conduct for architects: Art. 2.2 "Society and the Environment"

274 Code of conduct for architects: Art. 3.1 'Commissioner'

275 Submission Requirements Order, Art. 2 and Art. 4

276 Housing act, Art. 100, par. 1

within which the missing items of information are to be submitted (up to a maximum of four weeks). Another possibility (in the case of certain topics) is to decide that the missing information can be provided later (during construction). Conditions may be attached to the permit to cover this point. The Municipal Executive are authorised to declare the application inadmissible if the requested information is not provided, so that the application will not be considered further.

The subsequent task of the Municipal Executive is to fully assess the information and documents provided against all aspects of the legislation. The Municipality must in particular test the application against the special rules in the Housing Act²⁷⁷ and the Buildings Decree, the municipal building regulations, the zoning plan and the reasonable requirements of general aesthetics²⁷⁸. Where in the opinion of the Municipality the application satisfies the legislation, they must grant the Building Permit, unless there are grounds for withholding it²⁷⁹.

Haarlemmermeer Fire Brigade²⁸⁰- recommendations on the Building Permit

In the area of fire safety the Haarlemmermeer fire brigade takes an advisory and assessment role during the process of granting a Building Permit, at the request of the Municipality's Public Works Department. It is also possible that the Building and Housing Supervision department may request further information (during a period of four weeks). The Submission Requirements Order does not affect the fire brigade. The fire brigade will assume that the Building and Housing Supervision department has sufficient understanding of fire safety to assess whether sufficient information has been submitted.

Phase 5: Contractor - construction

Contractors and installers are required to carry out construction work in accordance with the drawings and other documents provided with the order. The contractor is responsible to his commissioner (RGD) for this. The commissioner (RGD) is responsible for the content of the orders given to the contractor and installer. Additionally, the contractor and the installer may not build in conflict with the building regulations.

The UAV and the UAVTI²⁸¹ assume that contractors and installers will work in accordance with a specification. A specification is taken to mean²⁸²: the description of the work, the associated drawings, the terms and conditions applicable to the work, the memorandum of information and the report of instructions. Contractors, subcontractors and technical installers are deemed to be familiar with "the governmental stipulations and orders of significance in the implementation of the works, insofar as these have come into force on the day of award of contract". The Contractor is obligated to carry out the work in accordance with the contract (the order) and in accordance with the drawings provided and approved by management²⁸³.

Phase 6: Municipality of Haarlemmermeer - supervision during construction

During the construction the Municipality supervises (or may supervise) construction in accordance with the Building Permit. Preventive and repressive supervision is carried out on the basis of Art. 100, par. 1 and 2 of the Housing Act. The Municipal Executive may carry out enforcement by means of Art. 125 of the Municipalities Act (administrative enforcement) and the General Administrative Law Act (enforcement order with associated penalty).

RGD - handover of the building

The RGD is ultimately responsible for the building. The RGD will also assess whether the building complies with the construction plan and the specification upon handover by the contractor, and whether the agreements made during construction have been correctly implemented. From

277 Art. 44a

278 Housing Act, Art. 44

279 Unless there are grounds to withhold it

280 According to Art. 1 of the Fire Services Act the Municipal Executive is responsible for the Fire Service. The Haarlemmermeer fire brigade is a municipal service, and thereby fall under the Municipality's responsibility. In order to allow an explicit distinction to be made in relation to the implementation of roles, the following section of the report nevertheless maintains a distinction between the fire brigade and the Municipality.

281 Uniform administrative conditions for the carrying out of works 1989 (UAV) and the uniform administrative conditions for the carrying out of technical installation works 1992 (UAVTI) (• 6, under 11)

282 Uniform administrative conditions for the carrying out of works 1989, Art. 1.

283 UAV, par. 6, points 1 and 2.

the moment of handover of the Detention Centre Schiphol-Oost, the RGD was the owner of the building and as such responsible for it.

Phase 7:

DJI - application for Occupancy Permit

It is prohibited to have in use or to keep in use a building without obtaining an Occupancy Permit from the Municipal Executive and in conflict with the stipulations for use set down in the municipal building regulations²⁸⁴. The applicant is required to supply the required information with the application. The Municipality of Haarlemmermeer's building regulations indicate what items of information are to be supplied (in all cases)²⁸⁵. Fire safety is also overseen in the granting of an Occupancy Permit.

Phase 8:

Municipality of Haarlemmermeer - assessment of application for Occupancy Permit

The Municipal Executive must in the first instance assess whether sufficient information has been provided with the application for an Occupancy Permit in accordance with building regulations. Just as with the Building Permit, the Municipal Executive may set a deadline for the applicant if they find that insufficient documents and information have been supplied.

The Municipal Executive must assess whether the building can be used safely with regard to fire, and must determine what conditions are to apply²⁸⁶. The building itself, its use and the requirements of the building regulations are considered during the assessment. Conditions restricting use may be attached to the Occupancy Permit²⁸⁷. The Municipality of Haarlemmermeer's building regulations²⁸⁸ include a prohibition on the taking into use of a work of construction where the construction has not been in accordance with the Building Permit.

Haarlemmermeer Fire brigade - Granting of an Occupancy Permit

The Municipality of Haarlemmermeer has devolved its role in the assessment and eventual granting of Permits for Use entirely to the fire brigade. The municipal department supervising Construction and Occupation plays no part in the granting of Permits for Use²⁸⁹.

The fire brigade also has the task of carrying out fire safety inspections, and is responsible for enforcement in accordance with the Municipality of Haarlemmermeer's Fire Safety Implementation Memorandum where any breach is discovered. The fire brigade must also monitor the results of enforcement and analyse the extent of compliance with agreements in the area of fire safety. Around 1500 inspections are carried out annually by the Haarlemmermeer fire brigade.

Phase 9:

Custodial Institutions Service (DJI) - use of the detention centre

The Site Manager of a penal institution exercises day-to-day management of the institution by virtue of the Prisons Act. Maintenance of safety and order²⁹⁰ form part of this. Employers must moreover so organize the work that there are no negative effects on the health and safety of employees²⁹¹. Employers are to ensure that employees are properly informed about the work to be carried out and the associated risks, as well as the measures intended to prevent or control such risks²⁹². Employers are also required to ensure that third parties are not placed at risk.

Phase 10:

Implementation of supervisory activities during use by the DJI, on the part of the enforcing agencies identified in Section 5.6.

284 Art. 6.1.1 and Art. 6.2.1 of the Municipality of Haarlemmermeer building regulations

285 Art. 6.1.2

286 Haarlemmermeer Building Regulations, Art. 6.1.5

287 Haarlemmermeer Building Regulations, Art. 6.1.1, Par. 2

288 Art. 4.14

289 This was set down by a mandate of the Council Officers of the Municipality of Haarlemmermeer (1998), whereby the Fire Brigade Commander was authorized to process applications and to grant Permits for Use (as well as being granted Authorization to sign documents on behalf of the Council Officers The Commander may delegate (sub-mandate) this authority to the Head of Prevention.

290 Prisons Act, Art. 3, par. 3

291 Art. 3 of the Working Conditions Decree

292 Art. 8 of the Working Conditions Decree

7.3.2 The most significant responsible parties

Following the café fire in Volendam, the Government made the following observations in a letter to the House of Representatives dated 16 July 2001:

"Citizens, businesses, institutions and government agencies must comply with safety requirements set out in acts and regulations. Owners and operators of areas open to the public have a heavy responsibility to take preventative measures and measures to limit the consequences of fire. Municipalities should be expected to maintain an active supervisory and enforcement policy where fire safety is concerned".

Based on the quotation above and the parties and their responsibilities as set out in Section 7.3.1, the three most significant responsible parties are: (i) the DJI as the author of the Schedule of Requirements issued to the RGD and as the user, (ii) the RGD as the commissioner for and owner of the detention centre and (iii) the Municipality of Haarlemmermeer as the licensing, supervising and enforcing authority. All parties must act in accordance with the applicable acts and regulations. This is set out schematically in Figure 28.

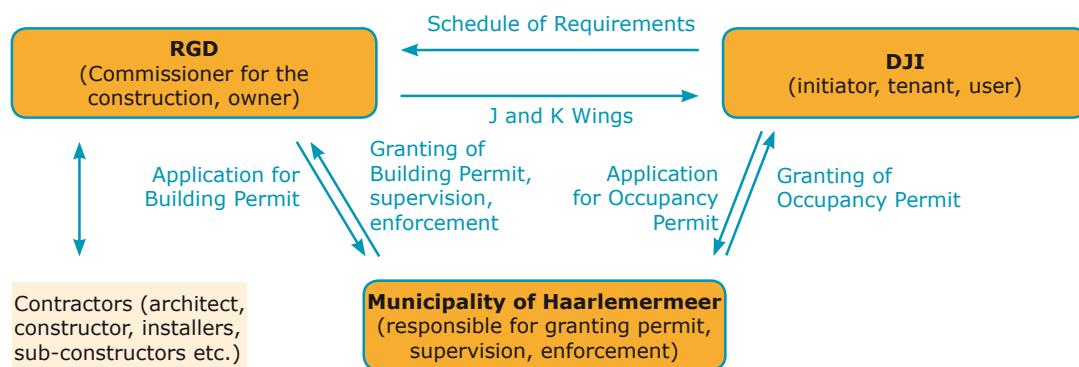


Figure 28: Schematic summary of the most significant responsible parties.

7.4 Analysis of the discharge of their responsibilities by the Custodial Institutions Service

This section contains an assessment of the manner in which the Custodial Institutions Service discharged its responsibilities. The assessment is based on the applicable acts and regulations, as well as a consideration of what might be expected of the DJI as a professional organization. The analysis focuses on the drawing up of the Schedule of Requirements (Section 7.4.1), the arrangements and preparations made by the DJI user organization with regard to fire safety (Section 7.4.2), the existence of indications of shortcomings in relation to fire safety in the detention centre (Section 7.4.3), the assessments carried out by the DJI during the taking into use of the detention centre (Section 7.4.4) and the DJI's fire safety policy (Section 7.4.5).

7.4.1 Drafting of Schedule of Requirements

In the event of the construction of a penal institution, the DJI functions as that the party taking the initiative for the construction work in dealings with the RGD. It is usual that the DJI's central staff department would draw up a Schedule of Requirements to be satisfied by the relevant penal institution.

No specific Schedule of Requirements was drawn up for the expansion of the Detention Centre Schiphol-Oost with the construction of J and K Wing. A general "Schedule of Requirements for a secure penal institution" is available within the DJI's central staff department. The Ministers' joint response to the draft report states the following in this connection: "Specific schedules of requirements are drawn up where the penal regime deviates from what is usual, for example where women are held, or detainees with psychiatric disturbances. The penal regime for the group held at the Detention Centre Schiphol-Oost falls within the category of "usual" regimes. The Schedule of Requirements was specifically drawn up for penal installations and is also applicable to buildings of the type represented by the Schiphol detention centre. This general Schedule of Requirements had been provided to the RGD in the past. The Schedule of Requirements makes reference to the Buildings Decree and the Fire Safety Scheme."

As indicated above, this general Schedule of Requirements focuses primarily on the detention regime. Fire safety as a total concept is not differentiated where the use of the building is concerned. Certain specific requirements were set down for J and K Wing of the detention centre by the DJI. One example is that the corridor of J and K Wing must be wider than in the other Wing (A to D) in order to allow greater freedom of movement for the target group to be held here. The effect on fire safety of these requirements, which led to a larger area for that fire compartment, was not determined, due to the absence of a specific Schedule of Requirements.

7.4.2 Arrangements and preparations made by the user organization in relation to fire safety

The Manager for the detention centre is responsible for the day-to-day management of the detention centre by virtue of the Prisons Act and the Aliens Act²⁹³. Further, the detention centre Site Manager is responsible in his role as employer for compliance with health and safety legislation, and must organize the work in such a way that there are no negative effects on the health and safety of employees²⁹⁴. Employers are also required to ensure that third parties are not placed at risk. The Health and Safety legislation states that the on-site emergency response arrangements must be such that adequate emergency action can be taken within a few minutes of the occurrence of an accident or fire²⁹⁵. The employer is also required to draw up a list of risks²⁹⁶. The detention centre Site Manager bears responsibility for employees and cell occupants²⁹⁷. In the opinion of the Board, the DJI Board must provide the context and create the conditions whereby the Site Manager can discharge his responsibilities. Both the Site Manager and the DJI Board have failed to adequately discharge the above-mentioned responsibilities. This meant that they were inadequately equipped and prepared for the fire²⁹⁸. This is illustrated by the following facts.

Firstly, insufficient account was demonstrably²⁹⁹ taken of the risks associated with the incarceration of around 400 persons, considered as a basis for the arrangements for and preparation of the user organization. The concern here is with risks inherent in a building with detention in cells as its function, such as the fact that cell occupants are not capable of self-rescue in the event of occurrences, and are therefore reliant upon the user organization. In concrete terms this means that the guards must open the cell doors to release the cell occupants. The consequence of this is that the user organization must be structured in such a way that it is physically in a position to release all cell occupants in a short time and to bring them to safety. There is also the question for example of the risks which flow directly from choices made during the process of designing the detention centre (the absence of automatically closing doors, the absence of automatic cell door opening in the event of occurrences, the relatively long corridors, and so on).

Secondly, the (theoretical) occurrence response and evacuation plans did not adequately reflect the practical situation. It is important that it should be demonstrably considered in advance what can reasonably be expected of guards during emergencies. These expectations must subsequently be translated into realistic plans. According to the building regulations, the Municipal Executive may set down conditions for the user organization relating to fire safety instructions and the Evacuation Plan, working on the basis of the existing internal organization³⁰⁰. The Haarlemmermeer Building Regulations require an Evacuation Plan to be available³⁰¹. An occurrence response plan was available at the detention centre at the time of the fire. This included the following instruction: "Keep the door of the burning room closed". It could have been anticipated that in certain situations, such as occurred during the fire on the night of 26 to 27 October 2005, the guards would first take the person in the burning cell to safety, as he was in a situation

293 Prisons Act, Art. 3, par. 3

294 Working Conditions Decree, Art. 3

295 Working Conditions Decree Art. 2.18, par. 1

296 Working Conditions Decree, Art. 5

297 The Custodial Institutions Service bear responsibility for employees and cell occupants by virtue of the Prisons Act, the Aliens Act and the Working Conditions Decree.

298 The Hendrikx Committee made the following observations in this regard in their report dated 15-12-2005): "The operator/user may be expected to take responsibility independently for the safe use of the system."

299 "Demonstrably" is taken by the Board to mean that it can be shown, in a transparent manner and with the aid of documentation, whether and how a process or activity has been thought through and/or organized.

300 Model Building Regulations, Art. 6.1.1, par. 2.

301 Model Building Regulations, Art. 9, from Appendix 3.

presenting an immediate threat to life. That guards in stressful circumstances might possibly not re-close the cell door is firstly conceivable from a human perspective, and is furthermore to be expected under such difficult conditions, given the lack of adequate instructions and practice.

Thirdly, no demonstrable supplementary measures were taken with regard to the user organization to compensate for the limitations arising from the building as handed over by the RGD. Account should have been taken of the detention centre as actually handed over in the setting up of and the arrangements for the user organization (including the development of emergency plans). Section 7.2 describes how no legislative requirements are set down in relation to the spread of fire from the corridor to the cells, but only from the cell to the corridor (requirement for resistance to fire penetration and fire spread of 20 minutes). The consequence of this is that if a cell door remains open (a situation which must be taken into account), the fire may theoretically spread relatively quickly from the corridor to all the cells adjacent to the corridor, without contravening the legislation. In this way the safety of the remaining detainees is jeopardised more quickly. No requirements were set down in any event, so that it cannot be posited that the cell occupants in the remaining and still locked cells were protected against fire, smoke and toxic gases. Neither were any measures taken to take account of the fact that no requirements were set down in the Building Regulations in relation to the furnishings (a prohibition on smoking for example).

Fourthly, no properly supported consideration was given to the matter of the non-self-closing cell doors. Art. 2.124 of the Buildings Decree³⁰² makes an exception in the case of cell doors to the general rule that doors in (public) buildings must be self-closing. This exception dates back to before 1992 and is related to workplace safety rather than fire safety. Two arguments underlie the exception: firstly, the locking of guards into cells must be prevented. Secondly, account is taken of the fact that at times when the occupants are able to move freely around the wing, a relatively small number of staff is required to supervise what is going on in the cells, without the cell doors being opened. These measures, which are specifically related to the issue of detention and which optimise the safety and efficiency of the guards' activities, impose a considerable strain on the DJI in its responsibility for the safety of the cell occupants. No sign can be found of a demonstrably supported consideration by the DJI of non-self-closing cell doors. The starting point is the legislation, and compensatory safety measures were not taken.

Fifthly, the assumption in the occurrence response plan that two persons would be present on each wing during the night was not put into practice. In the event, physical night-time security on each wing was reduced to zero, and the wing was monitored by means of video. The information that guards would no longer be physically present on the wing was not explicitly communicated to the Municipality. A single guard supervised several wings, the occurrence response plan was not adapted to take account of this, and the fire brigade was not informed of this situation (see Section 6.6.5).

One way to ensure that actions are taken in accordance with the occurrence response plan in the event of a fire would be to carry out exercises based on that plan. The Haarlemmermeer Building Regulations require an annual practice of the occurrence response plan³⁰³. An exercise was carried out at the detention centre on a single occasion during the year³⁰⁴. In view of the high risk nature of the detention centre, the DJI in setting out the framework might have been expected to require that more practice exercises should be carried out than required by the Building Regulations, involving all the detention centre employees. An occurrence response plan should be tested against reality by means of exercises, and can be continuously improved by means of periodic evaluation.

302 Model Building Regulations, Art. 6.1.1, par. 2

303 Haarlemmermeer Building Regulations, Art. 9, from appendix 3

304 The Ministers' joint response to the draft report discussed two exercises, one (documented) on 12 February 2004 and one (undocumented) on 17 December 2004. The Minister provided documents, including an evaluation, in relation to the first exercise. Even if the two exercises had indeed taken place, only a minimal element of the staff would have been involved because of high levels of turnover and the shifts worked (7 days a week and 24 hours a day).

Exercises might have provoked a fundamental reconsideration, and possible modifications to the design of the detention centre. Exercises could have led to the realization that fire safety in the relevant detention centre could not be ensured, and that the Site Manager would be unable to properly discharge his responsibility for employees and all cell occupants³⁰⁵.

7.4.3 The presence of indications of shortcomings in relation to fire safety in the detention centre

The DJI made insufficiently demonstrable use of indications pointing to shortcomings in fire safety at the detention centre.

Lack of any demonstrable follow-up of indications from Nibra and TAC

Following the fire on C Wing in November 2002, the Netherlands Institute for Fire Service and Disaster Management, Nibra, carried out an investigation on behalf of the Municipality of Haarlemmermeer. Its conclusions were as follows: *"In reality the building failed (in our opinion) to comply with requirements in the legislation on a number of crucial (structural) points"*. Recommendations of a technical and procedural nature were made (see Appendix 9). One example was the recommendation that an automatic fire extinguisher system should be installed, or that a minimal level of fire resistance should be achieved. The Technical Advice Centre (TAC) responded to the Nibra report by issuing recommendations on behalf of the RGD. The TAC shared Nibra's conclusion that *"the building is still in need of modifications"*. Such conclusions in relation to fire safety were available and should have provided the DJI with sufficient grounds to conduct a more detailed analysis of fire safety in the building (in view of its responsibility to take a building into use only where it complies with legislation³⁰⁶ as well as its responsibility for employees and cell occupants). The DJI limited itself to the supposition that the building as constructed by the RGD was safe with regard to fire, and saw no reason to carry out further assessment (in broad terms) of the fire safety of the building.

Lack of any demonstrable follow-up of indications from the Supervisory Committee

On 4 September 2000 the Minister of Defence introduced the Supervisory Committee Scheme for Places of Detention for the Schiphol district of the Royal Military Constabulary. This Committee was chaired by Mr Siepel. The Committee began its supervisory activities at the end of November 2000. The Committee were tasked with supervision of the accommodation, safety, care and treatment of cell occupants in places of detention falling under the authority of the Schiphol district of the Royal Military Constabulary. At the start of 2004 the Committee reported on the period from November 2000 to December 2003 (see Appendix 10).

Where Nibra identified shortcomings in the structural condition of the detention centre, the Committee concentrated primarily on the organizational aspect of fire safety. The report shows that the Committee made five visits to the Detention Centre Schiphol-Oost during the reporting period. Since J and K Wing were only completed on 3 December 2003, it is plausible that the five visits by the Committee related to the original detention centre (A to H) Wing.

Both the DJI Board and the detention centre Site Manager took insufficient action in response to the Committee's disturbing conclusion that *"fire safety here gives rise to concern"*³⁰⁷. It was further stated in a report on one of the five visits (on 3-9-2003) that: *"On the basis of these findings I can only conclude that a large number of cell occupants would lose their lives in the event of a fire"*. This report was discussed with the Site Manager of the detention centre, with a record kept of the discussion (see Appendix 10).

305 In their report dated 15-12-2005 the Hendrikx Committee made the following observations on this topic: *"It is recommended that the user be obliged to report that this requirement has been satisfied and what points for action or improvement were noted. It is recommended that the internal organization should actively fulfil their obligation to carry out annual practices in order to establish whether the plans are workable"*.

306 Working Conditions Decree, Art. 3.1b: *"A place of work within a building as specified in Art. 1, par. 1c of the Housing Act shall be taken into use only where the building meets the requirements set down by or by virtue of the 2003 Buildings Decree in relation to the applicable intended use in the sense of that term imported by the Regulations"*.

307 In relation to fire safety the Supervisory Committee under Mr Siepel stated: *"Fire prevention is unacceptable: the personnel are not aware of the Evacuation Plan, there are no exercises and no facility for the central unlocking of cells"*.

7.4.4 Assessment by the DJI at the time of taking into use of the detention centre

The Municipality of Haarlemmermeer's building regulations³⁰⁸ include a prohibition on the taking into use of a structure which has not been built in accordance with the Building Permit. The Working Conditions Decree³⁰⁹ states that an employer may only take a building into use where it complies with construction legislation in relation to its intended use.

In view of the responsibility borne by the user for personnel and cell occupants by virtue of the Prisons Act, the Aliens Act and the Working Conditions Decree, the user ought, in the Board's opinion, to satisfy himself that the construction legislation has been complied with.

The construction legislation and the manner in which it is complied with has a direct influence on the manner in which the user organization is set up. A few examples are included here. Firstly, according to the Buildings Decree³¹⁰ a cell constitutes a fire sub-compartment. As an exception to the requirements for all other doors in a fire sub-compartment, the Buildings Decree does not require cell doors to be self-closing³¹¹. Secondly, because of the (legislatively permitted) absence of central unlocking for cell doors, the required evacuation time following an alarm is dependent on the number of cells to be opened and the number of staff members available. In order to limit the required evacuation time, the Buildings Decree imposes requirements in relation to the walking distance to a place of safety (a different smoke or fire compartment) for each type of structure, namely a distance less than 22.5 metres for a room intended for use as a cell. For temporary cell buildings the Buildings Decree additionally requires a maximal fire compartment area of 500m² and the presence of two emergency exit doors leading to a different fire compartment³¹². The area of K Wing³¹³ exceeds 500m² while there is only a single door leading to a different fire compartment. The maximum walking distance from a cell door to a different fire compartment exceeds 54 metres in the case of K Wing (from Cell 11 to the door leading to another wing). The 22.5 metre requirement is therefore exceeded. An understanding of the foregoing limitations in the building is of direct influence on the user organization.

When the Detention Centre Schiphol-Oost was taken into use the DJI assumed that the RGD had constructed a fire safe detention centre. It would be usual when the DJI Board submits a request (Schedule of Requirements) for the creation of a detention centre to the RGD that it would not be explicitly stated that the detention centre must be fire safe. On the basis of the legislation discussed above, the DJI did bear the responsibility for taking the detention centre into use only if it complied with the Buildings Decree. This was not the case with the detention centre (for supporting evidence see Section 7.2). According to the same regulation in the Working Conditions Decree³¹⁴, an assessment must be carried out to establish whether the manner in which the DJI intended to use the detention centre matched the detention centre as built. On a strict interpretation of the Buildings Decree³¹⁵, the user must also assess whether the building is in accordance with the Building Permit. No such assessment was carried out by the DJI prior to the taking into use. The DJI's Central Accommodation Staff Department was present at the handover of the detention centre, when the assessment was limited to the basics. Fire safety was not specifically assessed. In view of the role of the RGD as described in Section 7.5, the Agency could be expected to hand over a detention centre that complied with construction legislation. However the DJI might also be expected to take a critical attitude during the development phase of the construction plan, so that for example the above-mentioned visible³¹⁶ shortcomings would be identified, and that if it was decided to take possession of the detention centre, the Service might be expected to introduce measures to compensate. The Board's investigation did not find sufficient evidence of this (see Chapter 6.6).

308 Working Conditions Decree, Art. 4.14

309 Working Conditions Decree, Art. 3.1b

310 Buildings Decree, Art. 2.121

311 Buildings Decree, Art. 2.124. The Article which requires self-closing doors within fire sub-compartments to which a Resistance to Fire Penetration and Fire Spread requirement applies does not apply to structures intended to be used as cells.

312 Where a wing (a fire compartment) is larger than 50m².

313 K Wing considered as a whole constitutes a single fire compartment and a single smoke compartment; this is inclusive of the cells, and the area in question is around 850m².

314 Working Conditions Decree, Art. 3.1b

315 Art. 4.14

316 For example the length of the corridor, the number of exit routes or the surface area of the wing.

7.4.5 The DJI's fire safety policy

The DJI Board did not have any demonstrable fire safety policy setting out the Custodial Institutions Service's vision with regard to fire safety and including amongst others a description of its objectives, assumptions and the manner of central control in relation to detention centres. This policy ought to have been translated into a Schedule of Requirements for the proposed construction of a penal institution, of the kind which the DJI Board drafted and submitted to the RGD. Additionally there was no annual learning cycle, whereby fire safety matters relating to user organizations and buildings could be evaluated and continuously improved.

The above-mentioned three factors are in the Board's opinion remarkable, given that the Temporary Special Facilities Directorate have a total of five penal institutions in use in the Netherlands, a staff of 1500 and responsibility for the safety of more than 3500 cell occupants. The starting point in considering fire safety is the Buildings Decree. No single well-considered principle could be found which related to buildings intended to be used as cells, which was included in the policy and was normative for all buildings used as cells. An example is the choice whether or not to use central door unlocking. DJI management informed the Board that central unlocking of doors is superfluous and *"can also be regarded as undesirable"* from a health and safety at work perspective³¹⁷. According to the DJI central door unlocking is superfluous, since the site emergency team members are trained to immediately re-close the cell door, so that staff have 30 minutes³¹⁸ to evacuate the rest of the cells. The Board has not discovered documentation or any records relating to the background to these deliberations within the DJI.

7.5 Analysis of the discharge of responsibilities by the Government Buildings Agency

This section investigates the manner in which the Government Buildings Agency discharged its responsibilities as owner of the complex. The assessment is based on the applicable acts and regulations, and takes account of what may be expected of the RGD as a professional organization. The analysis focuses on the development of the construction plan and the account taken of risks (Section 7.5.1) the compliance or non-compliance of J and K Wing with the construction legislation (Section 7.5.2), the influence of the building on the course of events (Section 7.5.3), the application for a Building Permit for J and K Wing (Section 7.5.4), the manner in which the indications of shortcomings in fire safety in the detention centre were dealt with (Section 7.5.5), follow-up and checks on fire safety matters (Section 7.5.6), the degree to which contractors' fire safety expertise was monitored by the commissioner, by the RGD (Section 7.5.7) and its monitoring of fire safety in its capacity as commissioner and owner (Section 7.5.8).

7.5.1 The development of the construction plan and the account taken of risks

The RGD as commissioner for and owner of all 103 penal institutions could be expected to have drawn up a properly thought-out construction plan³¹⁹ (dealing among other things with fire safety). Apart from the manner in which the DJI would use the detention centre, the construction plan must be based on the legislation and on the consideration of risk. This ties in with the observations of the Hendrikx Committee³²⁰: *"In more general terms the committee would place question marks against the suggestion that limitations in the area of physical safety can be sustainably compensated for by means of internal organizational measures, since human action will always remain a vulnerable element"*. In the development and consideration of the construction plan, the RGD took insufficient account of the elevated fire risk within the complex and of the possible presence of around 400 persons (in the entire complex) who were locked in (and might be asleep). The RGD failed demonstrably to take sufficient advance account in the

317 By e-mail, with an appended letter drafted by the Head of the Temporary Special Facilities Directorate dated 12-6-2006.

318 In their explanatory memorandum to the Board, the Custodial Institutions Service incorrectly assumed that the cells as a fire sub-compartment were fire resistant for 30 minutes. The Buildings Decree actually sets the requirement for temporary structures as 20 minutes rather than 30.

319 The construction plan is taken to mean the performance specification, including all design drawings, as developed by the architect.

320 Hendrikx Committee, evaluating quick-scan, in the report dated 15-12-2006.

construction plan of the possible risk in at least three areas (see below). The risks were also not adequately communicated to the user (no demonstrable “user manual”).

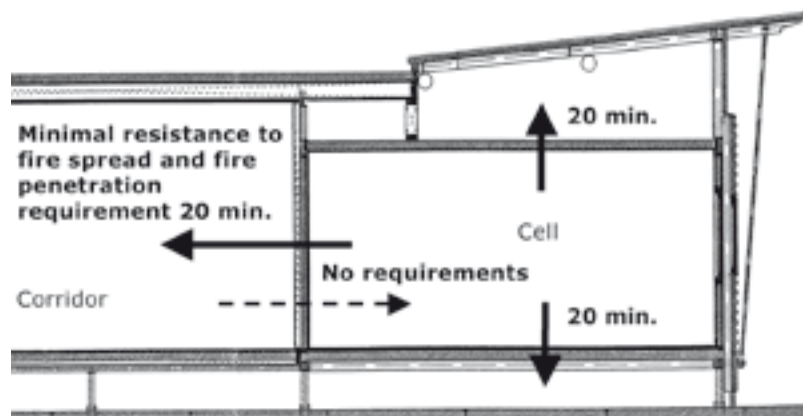


Figure 29: Schematic drawing of requirements in relation to cells, which apply only in the direction “interior to exterior”

Firstly, the walls, doors, floors and ceilings of temporary structures are required to have a Resistance to Fire Penetration and Fire Spread to adjacent rooms of at least 20 minutes. The requirements set down apply only from the interior of the cell in the direction of another space, for example the corridor. No requirements are set down in relation to propagation from the corridor to the cell (see Figure 29). The assumption in the construction plan was that the doors of the cells would remain closed. It was also stated in the emergency response plan for the detention centre that the doors must remain closed as far as possible. Should a fire break out in one of the cells, then the cell occupants in the cell containers immediately adjacent to the burning sub-compartment would be protected against fire for at least 20 minutes. This time was to be enough to allow the rescue of the cell occupants. During the fire on the night of 26 to 27 October 2005, the door was not re-closed after the cell occupant was released from Cell 11 where the fire broke out. The fire was able to spread to the corridor. The fire sub-compartment ceased to exist once the door was opened and not re-closed. In the absence of requirements in Resistance to Fire Penetration and Fire Spread from the corridor in the direction of the cells, it is therefore possible that because of the failure to close a single cell door the entire wing would burn down, threatening the safety of the remaining cell occupants.

Secondly, it appears that insufficient account on risk was taken in the way in which the tests of the cell containers were carried out by the TNO’s Fire Safety Centre on behalf of the RGD. The cell containers were tested against the WBDBO requirements for Resistance to Fire Penetration and Fire Spread, which are expressed as the number of minutes for which the fire separation function of the compartmentalization (in this case the cell) remains intact. Two aspects of these tests are of significance.

The first relates to the value which can be attached to the test results. The RGD decided to test the cell containers themselves rather than the actual structure as a whole, as it was installed at Schiphol-Oost (cells combined with the shell structure). As a general rule the entire structure (a cell container together with the roof structure) should be tested to allow a value to be attached to the results of the fire test and a reliable judgement to be formed as to fire safety. The Fire Safety Centre concluded that the container tested complied with the WBDBO requirements for Resistance to Fire Penetration and Fire Spread. According to the Fire Safety Centre this conclusion does not indicate that a building with a shell structure around the containers would meet the WBDBO requirements. A fire might for example spread via the window to the shell structure above.

The second aspect relates to the selected test set-up. In deviation from what is set down in NEN 6069, TNO did not subject the structural elements to separate fire resistance tests, but tested the cell container in its entirety by simulating a fire in the cell interior. In the test set-up the window was removed from the rear wall, with the aim of achieving a sufficient supply of fresh air to the fire. One objection to this method however is that the fire will be concentrated in the vicinity of the window opening, since the oxygen supply is optimal there. The front part of the cell, including the door, will thereby receive only a limited thermal load. TNO’s conclusion that the entire cell including the door meets the required fire resistance standard is therefore

insufficiently supported. A test on a cell door carried out by the Board resulted in a Resistance to Fire Penetration and Fire Spread of only 10 minutes (see Appendix 2).

Thirdly, insufficient account was taken in advance of certain characteristics displayed in the construction plan. The most significant deviations from the legislation included the compartment or wing area of 850m² (larger than 500m²), the Resistance to Fire Penetration and Fire Spread between the cell and the corridor, and via ventilation (less than 20 minutes), the maximum walking distance of 54 metres (longer than 22.5 metres) and the provision for an emergency exit (less than two emergency exit doors leading to a different fire compartment). Of these, only the extended walking distance (longer than 22.5 metres) was compensated for, with the installation of a Smoke and Heat Exhaust Ventilation System as an equivalent solution (see Section 7.5.2).

7.5.2 Compliance of J and K Wing with the construction legislation.

The RGD issues orders to several parties for the construction of the detention centre (Architect, Main Contractor, Installers, Subcontractors etc), and are also the owner of the building. The RGD also obtains the necessary licences and/or waivers for the construction. As the applicant, the RGD is responsible for ensuring that the building, as described in the application, meets the requirements of the Building Decree and the municipal building regulations. Since it is prohibited to build without or in deviation from a Building Permit issued by the Municipal Executive³²¹, the RGD as commissioner is responsible for ensuring that the detention centre satisfies the requirements of the construction legislation. Even where the RGD hires in experts or others it will still remains responsible for ensuring that building is in accordance with the legal requirements. Two conclusions can be drawn from a comparison of J and K Wing against the building regulations. Firstly, J and K Wing did not comply with the law³²². Secondly, it appears from the circumstances that a limited number of components were critical in the initiation and development of the fire in the detention centre as well as the evacuation.

J and K Wing did not comply with the construction legislation

J and K Wing did not satisfy all the performance requirements for non-permanent structures in the Buildings Decree. The following performance requirements were not satisfied³²³:

- 1 *Maximum area of fire compartment:*
 - Requirement: The maximum area of a fire compartment (in this case the wing³²⁴) must be less than 500m² (Art. 2.105-10, Art. 2.200).
 - Actual situation on J and K Wing: the area of K Wing was around 850m² and the requirement was therefore not satisfied.
- 2 *Resistance to Fire Penetration and Fire Spread from the cell to the corridor:*
 - Requirement: The Resistance to Fire Penetration and Fire Spread from a fire sub-compartment (in this case the cell) to the corridor must be longer than 20 minutes (Art. 2.123-1);
 - Actual situation on J and K Wing: The Resistance to Fire Penetration and Fire Spread was less than 20 minutes because of the fire propagation path "cell - window - cavity - void - corridor" (see Chapter 3). The occurrences of penetration through the ceilings of the cell containers in the vicinity of the ventilation inlet and outlet openings were not fire resistant. This meant that the Resistance to Fire Penetration and Fire Spread from a cell to open space and the corridor was less than 20 minutes³²⁵.
- 3 *Walking distance from cell:*
 - Requirement: The walking distance between a point in a space where persons may reside which is not a common space (the cell) and an exit from the smoke compartment

321 Art. 40, par. 1 of the Housing Act

322 TNO report on behalf of the Board, dated April 2006.

323 In the interests of readability the non-conformities with the 2003 Buildings Decree are worded as simply as possible. When describing the requirements, the space to which a requirement applies in the specific situation in the detention centre is given in brackets.

324 Both wings constitute separate fire and smoke compartments; the boundary of the fire compartment coincides with the boundary of the smoke compartment and of the wing itself.

325 During the period for consideration of the draft report it emerged that there is a lack of clarity about the course of the spread of the fire via the void above the cells. However the TNO have demonstrated that, in part because of the presence of glass in the window construction, the fire was not led to the void via the external space, and that the legislation was therefore not complied with.

(the wing³²⁶) is to be less than 22.5 metres (Art. 2.136-5), where the walking distance through the space where persons may reside (the cell) is to be multiplied by 1.5.

- Actual situation on J and K Wing: the walking distance between the cell and the exit from the wing amounted to: (i) assuming two exits from each wing, 28 metres³²⁷ and (ii) assuming a single exit for each wing, 54 metres³²⁸.

4 Exits from wings:

- Requirement: A smoke-free exit route must lead to a different fire compartment (Art. 2.161-3). This means that only a door which leads to a different fire compartment may be regarded as an exit.
- Actual situation on J and K Wing: only the door to the lobby led to a different fire compartment. The door in the end wall did not lead to a different fire compartment but directly to the outside. According to the Buildings Decree each wing therefore had only a single exit, leading to the central lobby and not outside. This would be permitted provided a large number of additional performance requirements were satisfied, but this was not so in the present case (for an explanation in relation to the emergency door in the end wall, see Appendix 11).

Performance requirements may be deviated from if an equivalent solution achieves the same result as that intended by the performance requirements (see Appendix 12 for an explanation of “equivalence”). An equivalent solution was devised only in the case of exceeding the 22.5 metre requirement, namely the Smoke and Heat Exhaust Ventilation System. The RGD as the commissioner for the construction and the owner did not identify that other requirements were not satisfied. No measures were taken to meet those performance requirements. The Equivalence Article is not explicitly referred to in either the Building Permit or in the application for a Building Permit. Furthermore, the solution of providing a Smoke and Heat Exhaust Ventilation System was in practice not equivalent. According to the TNO, the Smoke and Heat Exhaust Ventilation System in question would not be able to achieve equivalent conditions for escape to deal with the exceeding of the 22.5 metre walking distance. Additionally, the assumptions made were insufficiently stringent, according to the TNO. This meant that the calculated capacity of the Smoke and Heat Exhaust Ventilation System was too low in practice by a factor of 3 in comparison with the required capacity, in view of the geometry of J and K Wing (see Appendix 6).

Additionally, it appears from the response to the Board’s draft report that there was a lack of clarity about the number of available emergency exits, in part because of the presence of the door in the end wall of the wing. The question is whether the fencing surrounding the entire detention centre can be regarded as an equivalent solution in response to the requirement in the legislation that the exit route must lead to a different fire compartment. If the fencing around the penal site had indeed been consciously selected as an equivalent solution in response to the failure to comply with the performance requirement³²⁹, then this ought to have been included in the Building Permit. All penal institutions must have an enclosed external space in place (see Article 3 of the Police Detention centres Regulations). The Buildings Decree did not deem the exit to the external space to be an exit leading to a smoke-free exit route. The appeal to equivalence is therefore not well-founded.

7.5.3 The effect of the building on the course of events

In relation to the above-mentioned, it is relevant to consider the extent to which the course of events might have been affected by the building if:

- a. the legislation had been complied with;
- b. the detention centre had been constructed in accordance with the “state of the art”³³⁰;
- c. the detention centre as it stood was as described in the construction plan for the building for which the permit was granted.

326 Both wings constitute separate fire and smoke compartments; the boundary of the fire compartment coincides with the boundary of the smoke compartment and of the wing itself.

327 28 metres = (6m through the cell x 1.5) + (19m through the corridor, from the middle of the wing)

328 54 metres = (6m through the cell x 1.5) + (45m through the corridor from the last cell at the end of the wing)

329 Art. 2.161-3

330 In the Board’s opinion, “state of the art” would mean that the detention centre was provided with modern technical facilities.

On point a): what would have been different if the legislation had been complied with
the ways in which the deviations from the legislation affected the course of events are set out below. Attention will primarily focus on the following non-conformities, which were the most significant and which on the one hand affected the manageability of the fire, and on the other hand affected the number of persons involved in the fire:

- If the walking distances within K Wing and its area had complied with the construction legislation and had (therefore) been smaller, the required evacuation time would have been shorter³³¹.
- If the existing Smoke and Heat Exhaust Ventilation System (which in this case was too small in dimensions by a factor of 3, and which was unsuitable for the geometry of K Wing)³³² had functioned correctly after the fire alarm (see Appendix 6), the conditions under which the guards were required to open the cell doors would probably have remained workable for a longer period.
- If the walking distance requirement of 22.5 metres found in the legislation had been satisfied, and assuming the building was in its then existing state, then the conditions for escape would still have been inadequate³³³.
- Had the emergency door in the end wall led to a different fire compartment, any cell occupants would have remained locked within the detention centre and would not have found their way directly to the outside, and this door could have been used in the event of fire, or fire alarms. In this specific case this door could have played a role in the evacuation of the occupant of Cell 11 (which was against the end wall). The guards could then have taken the occupant directly to a different compartment rather than having to pass through the 50-metre long wing. This would have saved time.
- Had the windows and the ventilation satisfied the requirement for Resistance to Fire Penetration and Fire Spread of 30 minutes during the fire³³⁴, then in this specific case the course of events would not have substantially changed.

On point b) The difference had the detention centre been "state of the art"

A professional organization like the RGD can be expected to construct a "state of the art" detention centre, one that would therefore be provided with modern technical facilities to ensure fire safety. According to the TNO a variety of technical facilities are available which for example would activate self-closing of cell doors only in the event of fire. A modern central door unlocking system could also have been installed which would operate only in the event of fire. No clear understanding has been gained of the risks arising from the failure to apply up-to-date fire safety alternatives, or of why available modern techniques have not been applied.

On Point c) The difference if the detention centre as it stood had been as described in the construction plan for the building for which the permit was granted

An investigation has been carried out into the possible differences between the actual detention centre as it stood at Schiphol-Oost on 26 October 2005 and the description in the construction plan against which the permits were granted. These differences are explained in Appendix 13.

331 The expansion of the fire compartment increased the number of detainees who would be directly threatened by a fire and who would need to be brought to safety by staff and emergency workers. Furthermore, because of the smaller volume of the section of corridor it would be filled more quickly by smoke developing in or entering the space. The guidance on the Buildings Decree states the following in this context: *"The aim of fire compartmentalization is to limit the unhindered spread of a fire to one section of a building. This provides the users who are not in the section which is on fire with an opportunity to escape in safety. The same applies to the users of neighbouring buildings. At the same time the fire is prevented from spreading in a short time to the extent where it can no longer be controlled by the fire brigade"*. The guidance on Art. 7.2.5 of the Bulletin of Acts and Decrees 1998, 618, further states: *"The requirement for fire compartmentalization of a cell building contained in Section 1 will mean that in the event of fire, only a limited number of cells will need to be evacuated."* The Board's conclusion is that not only the manageability of a fire has a role to play here, but also the limitation of the number of persons involved in a fire.

332 The TNO repeated the calculations for the Smoke and Heat Exhaust Ventilation System on behalf of the Board. On the basis of these calculations the TNO concluded that the dimensions of the Smoke and Heat Exhaust Ventilation System as installed on K Wing were too small and was based on incorrect assumptions (see Appendix 6).

333 For example the Resistance to Fire Penetration and Fire Spread requirement of 20 minutes would not have been met, which would directly affect the conditions for escape from the lobby.

334 As set out in the construction plan against which the Building Permit was granted, despite the fact that the legislation calls for 20 minutes.

7.5.4 Building Permit application for J and K Wing

As commissioner, the RGD is required to ensure that any permits or waivers required for the construction are obtained. As the applicant, the RGD is responsible for ensuring that the building, as described in the application, meets the requirements of the Buildings Decree and the Haarlemmermeer Building Regulations. As applicant, the RGD is responsible (to the Municipality) for ensuring that the application for a Building Permit satisfies the Submission Requirements Order for Building Permit Applications (Biab, Articles 2 and 4). The applicant is obligated to provide the information and documentation indicated by the Submission Requirements Order for Building Permit Applications, which are, in the opinion of the Municipal Executive, necessary to demonstrate that the building in question complies with the Housing Act.

Based on an analysis of the documents submitted by the RGD for assessment by the Municipality of Haarlemmermeer in order to obtain a Building Permit, three of the findings appear relevant. Firstly, it appears that an assessment against the building regulations was not possible on the basis of the drawings supplied by the RGD with the application for a Building Permit. The intended method of compartmentalization and the path of the various escape routes could not be derived unambiguously from the drawings. The status of the escape routes was also not provided (smoke free or fire and smoke free). It is essential to know what type of escape route passes through a particular space for the following reasons:

- the requirements for Resistance to Fire Penetration and Fire Spread between these spaces and others are dependent on this;
- the requirements relating to the behaviour of materials in fires depend on this;
- this information is used to determine how much of the total area in use on the escape route can be identified as a smoke compartment (will a single escape route suffice or are at least two routes required?).

Since compartmentalization and the provision of secure escape routes are essential aspects of a construction plan and the assessment of construction plans, it could be expected that the Submission Requirements Order for Building Permit Applications would be interpreted in such a way that these matters at least should be capable of being unambiguously derived from the drawings. The same applies in the case of the definitions of user functions, residential areas and residential spaces. Without this information, an assessment against the Buildings Decree 2003 is not really possible, even in broad terms. Neither an assessment of the construction plan on the basis of the available drawings nor proper enforcement would be possible without making all kinds of assumptions and working through a range of variations.

Secondly, it appears that there was insufficient documentation available on the materials to be used in J and K Wings. This meant that assessment of and enforcement relating to materials usage was not possible. Finally, with the exception of the cell containers, insufficient documentation was available in relation to the structures used, such as the construction of walls. This made it impossible to assess these structures in connection with the building application, for example with regard to fire resistance. In view of these shortcomings it can be asserted that the RGD as applicant failed adequately to discharge its responsibilities in relation to the application for a Building Permit for J and K Wing.

7.5.5 The presence of indications of shortcomings in relation to fire safety in the detention centre

The RGD made insufficient use of the available information and recommendations from previous fire safety investigations, and failed to take account of the expansion of the building, which might have been of significance in the prevention or limitation of the consequences of the fire (namely smoke and toxic gases).

In developing the construction plan for J and K Wing in mid-2003, the RGD had access to a number of relevant reports and analyses, namely (in order of publication date): (i) the TNO test report on a cell container of the type used on J Wing³³⁵, (ii) the Nibra report³³⁶ in response to the

335 November 2002 - ref: 2002-CVB-R06365

336 Nibra, on behalf of the Municipality of Haarlemmermeer, December 2002

fire of 30-11-2002, (iii) the Technical Advice Centre report³³⁷ in response to the Nibra report and (iv) the TNO test report³³⁸ on a cell container of the type as used on K Wing.

However the RGD did not demonstrably make sufficient use of this available information prior to the construction of J and K Wing. It further appears that the Nibra recommendations, which were both procedural and technical in nature, were complied with only partially (see Appendix 9). Setting aside the fact that, in general, no direct relationship can be established between the failure to implement the recommendations and the fire on the night of 26 to 27 October 2005, no demonstrable use was made of this information, and no demonstrable learning cycle was put in place in relation to improvements in the field of fire safety. One example of a recommendation where such a direct relationship to the course of events can be established is in relation to a procedural recommendation from the Technical Advice Centre. This recommendation related to the presence of air-fed breathing apparatus on the complex which ought to have been available to personnel. This recommendation was not adopted.

7.5.6 Follow-up on fire safety matters and checks on these by the RGD

The fire safety of the detention centre was discussed in relation to the provision of J and K Wing, but the RGD as owner did not ensure that fire safety matters, as discussed between the various parties (the architect, contractors and subcontractors) were actually implemented in practice. The RGD carried out insufficient checks as to the practical implementation of fire safety provisions³³⁹. This amongst others can be seen from the following.

The construction of J and K Wing was based on the performance specification set down on 15 May 2003. With regard to the ventilation of the cell containers, this specification explicitly states that fire seals must be included in accordance with the requirements. The fitting of fire resistant seals was also discussed during preparations for the construction of J and K Wing. As well as including them in the specification, the RGD also for example explicitly noted the need for these seals on the occasion of a construction management meeting. The claimed provision of fire resistant gratings by a subcontractor was never a topic of discussion. It is therefore remarkable that the subcontractor in question indicated in a letter to the Board that these gratings had been installed, while the Board's further investigations show that these gratings were not installed in the cell containers on K Wing which were burnt out. A quite different type of ventilation grating was discovered, which lacked any fire-resistant properties. During the handover, the RGD did not note any irregularities in relation to the provision of fire seals and/or fire resistant seals.

7.5.7 Monitoring by the RGD of contractors' fire safety expertise

The RGD is responsible for the construction of all government buildings in the Netherlands. In this capacity the RGD is also the owner/commissioner of the detention centre. The RGD maintains a Quality Manual. The core concept of that handbook is that the client takes the central role. The RGD's policy in relation to fire safety is not described in the Quality Manual. "Quality" and "Risk" are defined, but fire safety is not included here, and is not specially differentiated here. According to the RGD, the construction plan and the construction itself would be dictated by the Buildings Decree. If those requirements were met, then according to the RGD the detention centre would be fire safe.

The architect intended to design J and K Wing in such a way that the Buildings Decree was complied with. As previously indicated, the architect is required to ensure that he has at his disposal (or will obtain from elsewhere) sufficient expertise, professional competence and

337 Technical Advice Centre (TAC) Report on behalf of the Government Buildings Agency, dated 20-1-2003 ref: 200103/01/TAC.

338 Experimental investigation of the resistance to fire spread and fire penetration of a detention cell, K Wing type, dated April 2003, ref: CVB-R0109.

339 In this context, the Ministers' joint response to the draft report indicates that the Government Buildings Agency had themselves recognized the need to ensure implementation of a number of matters when they made a start on ISO and NEN certification. It has been reported in this context that from the start of 2006, a separate Safety and Integrity directorate has been established within the RGD, which as well as considering fire safety will also monitor the total safety concept of sensitive state accommodation. The Board did not take cognisance of this development during their investigations, but would emphasise its continuing importance.

capacity to carry out the contract³⁴⁰. A sufficiently full and current understanding of the fire safety requirements which apply specifically for this building, with its function as detention cells, was not identified in the case of this architect. Neither did the architect hire in specific external expertise in relation to the construction legislation relating to buildings with a function as cells, to the Cells and Cell Blocks Fire Safety Scheme, or to the specific risks. Additionally, and by his own account, the architect worked on the basis of an assumed expertise on the part of the fire brigade in relation to the assessment of the fire safety of J and K Wing.

The main contractor carried out the construction work in accordance with the performance specification, but in accordance with the contract did not concern himself with the details of fire safety. Like the architect, the main contractor by his own account assumed expertise on the part of the fire brigade with regard to fire safety. It was assumed that as long as the fire brigade approved fire safety matters in the course of the supervisory and enforcement procedure, there was no reason to carry out additional analyses or to implement modifications. In its role as commissioner, the RGD did not adequately ensure that sufficient specific and current expertise was available to and applied by its contractors, either in connection with the relevant construction legislation or in connection with the specific risks associated with the detention centre.

7.5.8 Monitoring of fire safety by the RGD as commissioner and owner

As the commissioner for the development and implementation of the construction plan, the RGD was responsible for the delivery of a fire-safe building to the DJI. In order to deliver a fire-safe building, the whole sequence from initiative through to handover must be gone through with care. Even where works were contracted out to third parties, the RGD was the party required to ensure that all the various steps were gone through. J and K Wing were constructed on the basis of a construction plan which had only been worked through to a limited degree, and where fire safety matters had not received detailed consideration.

In the context of the construction of J and K Wing the architect had been awarded the contract for:

- the preparation of sketch drawings for the purpose of the building application and
- the preparation of a provisional and a finalized design.

Based on the contract, the architect drew up what is referred to as a performance specification. The performance specification included a technical description to be associated with the finalised construction plan.

The RGD's instructions to the main contractor read as follows: *"the completion of the works indicated in the letter of 14 July 2003 in accordance with the attached specification"*. The RGD accepted the drawings supplied with this order, which had been prepared by the architect.

The drawings as prepared by the architect did not include detail with regard to fire safety, since the RGD's instructions were limited and were not oriented towards the drafting of a worked-out specification including details of fire safety. The RGD accepted these drawings and made the application for the Building Permit on their basis, thereby taking responsibility for the quality of the drawings. The architect did not take the opportunity to draw the RGD's attention to the limitations of the performance specification, since this was not yet detailed with respect to fire safety. The absence of such a warning was to be expected, since the architect was aware that the RGD is an expert party.

An analysis of the available documents shows that the RGD did not sufficiently consider safety from a risk perspective. The mechanisms which come into play during a fire whereby detainees require assistance and the entire complex cannot be evacuated are broadly comparable across all buildings functioning as cells. However this is not to say that a single (fire safety) concept exists which can be universally applied, possibly with local modifications on some points. Nor is this the case with the Cells and Cell Blocks Fire Safety Scheme, which includes a large number of different possibilities. A new construction plan must be thought through for all the various buildings in the Netherlands functioning as detention centres, and specific choices must be made, for example in relation to the control of ventilation through the fire alarm control system, the Smoke and Heat Exhaust Ventilation System, the transmission of alarms to the fire brigade, the unlocking of emergency doors or cell doors, the sprinkler system and so on.

340 Code of conduct for architects: Art. 3.1 "Commissioner"

7.6 Analysis of the discharge of irresponsibilities by the Municipality of Haarlemmermeer

The Municipality of Haarlemmermeer is required to deal adequately with the granting of a Building Permit and Occupancy Permit for the detention centre, and to supervise and enforce with respect to compliance during its use. This Section provides an analysis of the manner in which the Municipality of Haarlemmermeer discharged these roles - the granting of permits, supervision, and enforcement. The analysis also includes the granting of the Building Permit for J and K Wing (7.6.1), the granting of the Occupancy Permit (7.6.2), supervision and enforcement of the permits and compliance with them (7.6.3) and supervision of the use of the building (7.6.4).

7.6.1 The granting of the Building Permit for J and K Wing

Within the Municipality of Haarlemmermeer, the Building and Housing Supervision department is responsible for granting the Building Permit for the detention centre, whereby they would carry out an assessment against the legislation³⁴¹. The following findings are relevant to the granting of the Building Permit for the detention centre by the Municipality of Haarlemmermeer.

Firstly, the information supplied by the RGD with the application for the construction of J and K Wing was limited with only five drawings attached. Other documents, such as those in relation to fire safety set out in the list in the Submission Requirements Order, were not submitted by the RGD³⁴². There was a lack of information on the drawings, for example on the exact intended use of each room and the exact method of fire and smoke compartmentalization and sub-compartmentalization. The Building and Housing Supervision department ought to have assessed whether sufficient data and documents had been supplied, and ought to have returned the request within four weeks for the missing information to be supplied. The department did not demonstrably make use of either of these options. The Building and Housing Supervision department passed on the limited information to the fire brigade for the assessment of fire safety. On the basis of this limited information the fire brigade carried out its assessment and provided its recommendations to the Building and Housing Supervision department.

Secondly, the granting of the Building Permit was not based on a full test of the content against the Buildings Decree covering non-permanent cell buildings. Only a limited test was performed out. The failure to comply with the 22.5 metre walking distance was identified as an issue which must be compensated for via an equivalent solution. The failure to meet a number of other performance requirements was not identified (see also Section 7.5.2).

Thirdly, insufficient current expertise was available within the Haarlemmermeer fire brigade's prevention department at the time of the granting of the Building Permit, on the one hand with regard to the fire safety legislation and on the other hand, concerning the specific risks associated with the detention centre (the large number of persons locked in, their psychiatric condition and so on) to allow a proper test to be carried out. "Sufficient current expertise" is taken to mean the following:

- Sufficient expertise to allow a judgement whether the information necessary for the assessment was included in the application for construction as submitted (the drawings).
- Sufficient expertise (i) to test a specific and unusual building like a temporary detention centre against the applicable building regulations, (ii) to identify any required equivalent solutions, and subsequently to assess compliance with the assumptions underlying the performance requirements in the Buildings Decree and (iii) to set all this down in the Building Permit with a supported rationale.
- Sufficient expertise to match the Occupancy Permit to the specific use, rather than simply placing the usual requirements in the Occupancy Permit.

In connection with this, the Municipality of Haarlemmermeer in its response to the draft report stated that it had in fact considered the risks: *"The fire brigade was for example informed that*

341 The Housing Act, the Buildings Decree, the Municipal Building Regulations, the zoning plan and the reasonable requirements of general welfare.

342 No. 01: Declarations of equivalence; No. 20: Provisions for ventilation; combustion gases and combustion air; No. 21: Fire safety and production of smoke No. 22: Fire and smoke compartmentalization; No. 23: Escape routes and fire safety provisions and No. 43: Fire safety systems

automatic unlocking of doors was not in place in any detention facility in the Netherlands, and also that this would never be the case. On this point the fire brigade took account of the expertise and the specialist role of a fellow government agency”.

Fourthly, insufficient effective use was made of the available information and documents (the Nibra report, the TAC report and the test report on the cells). The fire brigade was aware only of TNO's finding that the cell containers satisfied the Resistance to Fire Penetration and Fire Spread requirements. Valuable information and knowledge for example about the maximal compartment size of 500m² were not involved in the process of granting the Building Permit. By its own account the fire brigade did not take the test reports into account in its assessment. The fire brigade assessed the entire structure, including the cell containers, for fire safety. It worked on the basis of a "sealed box" structure for each cell, where a resistance to fire penetration of 30 minutes would be present in all directions, and therefore also in the direction of the external facade. However it was stated in the test reports that the rear façade was not involved in the test. It was also explicitly indicated that the test results related solely to the cell container. The shell structure was not involved in the test. The possibility that smoke and toxic gases would enter the void via the window and through the cavity was not foreseen by the Fire Brigade. Neither did it foresee that smoke and toxic gases could enter the other cells via the ventilation system.

Lastly, conditions were attached to the Building Permit³⁴³. However no period for compliance with these conditions was set down, so that enforcement was made difficult³⁴⁴. It is the case that the Municipality is empowered to impose deadlines for the satisfaction of conditions.

Based on the above findings, the Board concludes that the Building and Housing Supervision department of the Municipality of Haarlemmermeer wrongly granted the Building Permit for J and K Wing of the Schiphol detention centre. The process in relation to the application for the construction ought not to have gone ahead. This is on the grounds that the applicant had provided insufficient information with the application to allow the Municipality to come to a judgement. On this point the Board does not share the sub-conclusion of the Hendrikx Committee³⁴⁵ that *"by imposing rules and conditions the Municipality and the fire brigade did what could reasonably be expected of a Municipality"*.

The Hendrikx Committee also discussed the *"increasing information asymmetry"* between applicants for permits and the Municipality which is required to assess such applications. The Board acknowledges this information asymmetry, but would state that (i) this does not remove the applicant's responsibility to submit a complete application for a permit, which is based fully on the risks and on the law; (ii) this does not remove the Municipality's responsibility to make a proper and factually correct assessment based on sufficient information; and (iii) this does not remove the Municipality's responsibility to assess the application with the aid of sufficient internal or external expertise before granting a Permit.

7.6.2 The granting of the Occupancy Permit for J and K Wing

An Occupancy Permit is a dispensation granted by the Municipality which includes a judgement allowing the use of a building as being fire safe. The Municipality of Haarlemmermeer has

343 Examples of these conditions include: (i) that the calculations for the Smoke and Heat Exhaust Ventilation System should be checked; (ii) that the fire alarm system must be certified, provided with a Schedule of Requirements and that it must comply with NEN 2535; (iii) that there must be Schedule of Requirements for the evacuation alarm system satisfying NEN 2575; and (iv) that materials must satisfy requirements set down for production of smoke.

344 The Housing Act system operates on the understanding that express permission is granted by the Local Authority prior to the construction or elements thereof. Where conditions are included in a Building Permit requiring elements of the construction plan to be assessed later than the time of granting of the Building Permit, this assessment must take place prior to commencement of the construction of that element. Otherwise permission can no longer be granted in advance, which would be in conflict with the system. For the same reason, Art. 59 of the Housing Act includes the possibility of withdrawing the Building Permit if any condition on the Building Permit is not satisfied. It is emphatically not the intention that the building should first be allowed to be constructed and that it should then be checked on completion whether the construction has taken place in accordance with the conditions of the Building Permit. This intention is set down in the Building Permit by virtue of Art. 40, par. 1 of the Housing Act, and no longer in the 2003 Buildings Decree or the Municipal Building Regulations. Where it has not been determined in advance what requirements apply, then there can be no check whether or not the construction has been in accordance with the Permit. This leaves no room for the interpretation proposed by the Municipality.

345 The independent "Municipal Responsibilities in Relation to the Schiphol Cell Fire Committee" chaired by Mr J A M Hendrikx conducted an "evaluatory quick scan" at the request of the Municipality of Haarlemmermeer in response to the cell fire (report dated 15-12-2005), see also Section 9.3 and Appendix 27.

devolved the task of assessing applications and granting Permits for Use on the fire brigade³⁴⁶. When assessing the application for an Occupancy Permit, the fire brigade will first check to see if the building has a Building Permit. It will subsequently investigate the intended uses of the building, the classification of the level of occupation, and whether existing building regulations are complied with. The Board has identified the following shortcomings in relation to the granting of the Occupancy Permit.

Because of the absence of sufficient information for its fire safety assessment, the fire brigade did not become aware that the requirements of the Buildings Decree had not been satisfied.

As second important factor in this context is that the Occupancy Permit for J and K Wing was granted before the conditions set down in the Building Permit had been completely satisfied. One example of these conditions is that the fire alarm system was to be designed and installed in accordance with a Schedule of Requirements to be approved by or on behalf of the Municipal Executive. The question whether a building can be used safely with regard to fire depends amongst others on the manner in which these conditions in the Building Permit are met.

An overview drawing of J and K Wing, dated 5 August 2003, was provided together with the Permit. It is plausible that this drawing was submitted along with the application for the Occupancy Permit, and was eventually stamped in as forming part of the Occupancy Permit. This drawing was extremely sketchy. For instance it was not indicated where and in what manner the fire prevention equipment was installed (no manual alarms, fire annunciators, extinguishers, fire alarm centre etc were shown). The assumption³⁴⁷ was that a certified fire alarm system would be installed in the detention centre, which would achieve complete monitoring³⁴⁸. A delayed transmission of the alarm to the fire brigade was also mentioned, which could only be introduced in liaison with the fire brigade, and which was required to be included in the schedule of requirements for the fire alarm system. The fire alarm system was not accompanied by a Schedule of Requirements approved by the fire brigade, as was required by a condition on the Building Permit and by the municipal building regulations. Because there was no Schedule of Requirements, significant assumptions concerning the fire alarm system (such as control functions, any delayed transmission of the alarm, the locations where reports would be received and so on) were not documented.

Additionally, it appears that the application for the Occupancy Permit for J and K Wing was not completed in full. One point to note in this context is for example the heading on the application form "*Fire Safety Instructions and Evacuation Plan*". The phrase "*applicable*" had been filled in. However the Instructions and the Evacuation Plan were not appended and no reference was made to them in the application. The presence of emergency response plans and evacuation plans drawn up by the DJI was taken by the fire brigade as sufficient grounds for the granting of the Occupancy Permit. No assessment of their content had demonstrably taken place.

7.6.3 Supervision over and enforcement of compliance with the permits for J and K Wing

With regard to supervision and enforcement carried out by the Municipality of Haarlemmermeer, a broad distinction can be made between its activities (i) during the construction of J and K Wing in the context of the Building Permit and (ii) during the use of J and K Wing.

The Municipality supervises compliance with the requirements of the Housing Act by virtue of Article 100 of that Act. Both construction (Building Permit, Buildings Decree, Building Regulations) and use (Occupancy Permit, Building Regulations) are covered. The level of supervision exercised by the Municipality depends on the Municipality's policy decisions. The Board's investigations reveal that the Municipality exercised supervision over the detention centre as a whole where compliance with the Building Regulations and the Occupancy Permit were concerned.

346 In the context of the granting of Occupancy Permits it should be noted that developments are currently underway which would result in the requirements on use being dealt with under a nationwide scheme which will come into effect on 1 January 2007.

347 Building Permit for J and K Wing

348 Building Permit for J and K Wing

Supervision by the Municipality of Haarlemmermeer during the construction of J and K Wing

The Municipality maintained computer records of inspection activities in relation to the construction of J and K Wing. These show that an official of the Municipality visited the site on at least six occasions. One of these inspections was carried out jointly with the fire brigade. Few records have been found showing the manner or depth of these inspections.

It was noted that the construction work had started before the construction drawings and calculations had been submitted. The Building Permit included a condition that this information must be submitted no later than three weeks before work started on the structural element in question. It can be determined from the dating of the successive phases that this condition was not observed, and that the Municipality maintained insufficient supervision in this regard. The Municipality granted an Occupancy Permit on 7 November 2003, while the Building and Housing Supervision department carried out its final inspection of the building on 3 December 2003.

Supervision of the use of J and K Wing by the Municipality of Haarlemmermeer

It can be documented that the fire brigade (unaccompanied by the Building and Housing Supervision department) carried out a (full) inspection involving J and K Wing on at least two occasions, namely on 1 December 2003 and 21 October 2004. In neither case were any observations made in relation to J and K Wing.

To the extent that the available documentation allows an impression to be gained of the supervisory activities carried out, the emphasis during the inspections was on visually observable breaches in relation to use, such as the leaving open of fire doors or the unlocking of emergency exits. On the basis of the available information, the Board's conclusion is that limited administrative supervision took place. This means for example that the fire brigade did not investigate whether the required (mandatory) certificates, reports, logbooks etc. relating to the construction, maintenance and inspection of the fire protection systems for J and K Wing were in place. Neither had the fire brigade assessed the content of such documents. The presence of the required records from the evacuation alarm system³⁴⁹, showing the inspection and maintenance activities carried out on the system, was not demonstrated. Nor was it demonstrated that the required inspection and maintenance activities had been carried out in relation to penetrations through fire resistant partitions. The same applies in the case of the dry sprinkler pipe work. However this is not specified in the Haarlemmermeer Building Regulations, so that no concrete requirements are set down with regard to this inspection.

7.7 Analysis of the underlying factors relating to the manner of construction and use

Alongside the factors identified in previous chapters in relation to the most significant responsible parties, a number of underlying factors are of relevance to the construction and use of J and K Wing.

7.7.1 Acts and Regulations relating to cell buildings

The Ministry of Housing, Spatial Planning and the Environment (VROM) is responsible for the building regulations, including fire safety. Where fire safety is concerned, the Ministry of the Interior and Kingdom Relations (BZK) are also involved. BZK advises VROM in relation to fire safety. VROM will incorporate the recommendations of BZK in the legislation (the Housing Act and the Buildings Decree), but the former are ultimately responsible for the stipulations in relation to fire safety. When drafting construction legislation VROM will adopt the BZK recommendations on fire safety. The role of BZK in the area of fire safety is to advise, to make policy and to coordinate. The starting point in the Netherlands is that the 458 municipalities will independently provide their own content in the area of fire safety. Partly because of the principle of equivalence, as expressed in the law, as well as the complexity of the legislation, the municipalities themselves are required to undertake complex considerations and assessments in relation to fire safety, and must decide for themselves about the hiring in of (fire safety) expertise in certain situations. It is for the applicant for a Building Permit to demonstrate that the principle of equivalence has been complied with. This procedure applies not only for small-scale applications for Building Permits but also for buildings functioning as cells.

349 A silent alarm via the Personal Location System

The construction legislation as a starting point

The construction legislation is also the starting point in the case of the construction of a detention centre³⁵⁰. According to VROM, the construction legislation in fact constitutes the minimum level to be achieved. The correct application of the construction legislation for buildings functioning as cells requires specific expertise, in particular in relation to the performance requirements and the "principle of equivalence". The RGD as a professional commissioner may be expected to have the required current expertise on both the legislation and the specific risks associated with a detention centre. Should sufficient expertise not be available, then the RGD should be expected to hire in external expertise.

The Equivalence Article and specific expertise

Performance requirements to be satisfied by works of construction are included in the construction legislation. The Equivalence Article has also been included so as not to impede flexibility and innovation in relation to construction and works of construction. Where an objective can be achieved other than by means of the proposed performance requirements, this is permitted through the application of the principle of equivalence.

When recourse is made to the Equivalence Article in the construction of a building, the applicant for a Building Permit must demonstrate to the satisfaction of the Municipal Executive that his construction plan satisfies the objectives of the requirement. In his application for a Building Permit he must explicitly show the points on which his construction plan deviates from the stated performance requirements and must indicate the manner in which he will nevertheless satisfy the requirement, despite that deviation.

The opportunity exists to consult the Building and Housing Supervision department for the relevant Municipality on the matter. The Building and Housing Supervision department will advise the Municipal Executive about its decision as to equivalence. In this way the applicant can discover in advance whether his solution has a reasonable chance of being accepted, and in what way he will be expected to demonstrate that his proposed solution will meet the objectives and the demands of the performance requirements from which he is deviating.

As set out in the Buildings Decree³⁵¹, alternative construction methods (= performance requirements) may be applied. This is in order that a situation is achieved whereby the objectives of the requirements are met at an equivalent level in the areas of safety, health, usability, energy efficiency and sustainable building. With reference to the Housing Act³⁵² and the Buildings Decree³⁵³ it appears that only structural measures may be taken.

In their joint response to the draft report the Ministers made the following observations in relation to equivalence:

"In the present case it was proposed (in order to satisfy the requirements of the Buildings Decree on this point) that equivalence should be achieved by means of:

- the fitting of a dry sprinkler system in the void above the cells;*
- the immediate readiness for deployment of all staff, by arranging that they could be immediately alerted with the aid of a Personal Location System;*
- The 24 hours a day manning of the KMar post by 2 persons (in the event of an alarm, matters would be dealt with directly from within the detention centre)."*

The Personal Location System and the manning of the KMar post could not form part of the "equivalence", since these are not structural alternatives. As regards the dry sprinkler line as an intended equivalent solution, it can be stated that the dry extinguisher line only became active once the fire brigade had arrived and connected up the pipe work. The release of detainees and their safe escape needed already to have been achieved by then, so that the measures taken did not contribute to the safe escape of the persons directly threatened. The latter was precisely the main objective of the reduction in size of the fire compartments to 500m²³⁵⁴.

350 The Hendrikx Committee made the following observations in this regard in their report (dated 15-12-2006): "The permit applicant and the permit issuer acted primarily in accordance with the letter of the law, and less with an eye to the conceptual thinking underlying the system of fire safety as envisaged in the Fire Safety Scheme. The legislation assumes as minimal level of fire safety, no additional margin for safety is built into the legislation".

351 Art. 1.5 and Guidance Note.

352 Articles 2, 4, 8 and 4.4.

353 Art. 2, par. 1.

354 See the guidance on Art. 7.2.5 in the Bulletin of Acts and Decrees 1998, 618

Additionally, the analysis of the course of the construction of J and K Wing shows that the architect and the Municipality (the fire brigade) would have difficulty in assessing the equivalence of the construction plan. One important reason for this is that the Buildings Decree is insufficiently concrete as to the desired objective. In the case of J and K Wing, an equivalent solution was proposed solely in connection with the exceeding of the mandatory 22.5 metre escape distance (the distance was around 54 metres), and this was not achieved. In order to obtain equivalent solution for the long escape distance a supplementary system was introduced namely the Smoke and Heat Exhaust Ventilation System. Nobody recognized that other significant performance requirements in the Buildings Decree, such as 1) the area of K Wing, 2) the mechanisms for the spread of fire (via the window - cavity - void - corridor route) and 3) the number of emergency exits, had not been satisfied. No measures were therefore taken to meet those performance requirements, and neither were any equivalent measures applied. Another factor relates to the fact that no requirements were set down to prevent or delay the spread of fire from outside the cells to the inside. In retrospect it has emerged that none of the parties involved were aware of this, while the mistaken interpretation of these requirements would have led to a fundamentally different assessment of the fire safety of the detention centre.

The question however is how this situation arose. The reason is that specialized knowledge is required for an understanding of the legislation, and to allow an assessment to be made of the equivalence of a proposed alternative with regard to the specified performance requirements³⁵⁵. More generally, it can be stated that the Buildings Decree in relation to buildings functioning as cells are wide-ranging and complicated to apply, and capable of a range of interpretations³⁵⁶.

An analysis of the construction legislation has also led to the observation that, as can be seen to some extent from Figure 25, a distinction is made in the legislation between permanent detention centres and temporary detention centres (like Schiphol-Oost). From this it can be seen that, because of the temporary nature of the Detention Centre Schiphol-Oost, it was the requirements for temporary structures, which are less stringent than those for permanent structures, which were to be complied with.

7.7.2 The Cells and Cell Blocks Fire Safety Scheme

The objective of the Cells and Cell Blocks Fire Safety Scheme published by the Ministry of the Interior and Kingdom Relations in 1994 was *"to provide a context for legislation"*. The safety scheme was therefore intended by the Ministry as a supplementary framework, and not as legislation. With the Scheme, the BZK attempted to set out and to explain the basic principles of fire safety. This document is the only framework of standards presently available.

The Fire Safety Scheme was drawn up by the Ministry of the Interior and Kingdom Relations, the Ministry of Housing, Spatial Planning and the Environment, the Justice Ministry, the Ministry of Education, Culture and Science, the Ministry of Social Affairs and Employment, the Defence Ministry, the Association of Netherlands Municipalities, the Association of Insurers and the Netherlands Federation of Fire Brigades, and was presented to the Municipal Executives, the managements of the regional fire brigades, the Chief Constables of Police and the Chief Public Prosecutors.

The following extract from the Buildings Decree is relevant to the legal status of the Fire Safety Scheme³⁵⁷:

"...Reference to the abovementioned Fire Safety Scheme is to be recommended in itself, although the structural matters included therein will play no role in the assessment of a construction plan since performance requirements for the different classes of building are now provided in this Decree".

355 The Hendrikx Committee made the following observations in this regard in their report (dated 15-12-2005): "The application of this legislation with its objective-setting aspects calls for a very thorough understanding of the field of fire engineering where more complex and unusual buildings are concerned".

356 Comparison of the level of requirements for permanent and non-permanent cell buildings, Construction Legislation Expertise Centre, 2006-ERB-M020/snn, 8-3-2006

357 Bulletin of Acts and Decrees 1998, 618. (Phase 2 Buildings Decree, cf. the former Buildings Decree referred to in the 2003 Buildings Decree).

The foregoing statement in the current construction legislation made the legal status of the Fire Safety Scheme of 1994 even less clear to those involved. The status of the document was actually removed with the introduction of the Buildings Decree.

The safety scheme included a large number of design possibilities and various "fire safety concepts". It did therefore not provide a single considered, risk-based fire-safety principle which would apply generically to all buildings functioning as cells. The Board's view is that such a principle should be broadly consistent. Proper consideration ought to be given centrally to the specific characteristics of buildings functioning as cells (a large number of persons locked in, who may be sleeping, in a particular psychological condition etc.) and to the minimal necessary provisions flowing from these characteristics. The necessary provisions will require continual updating in the light of new knowledge. The Fire Safety Scheme does not provide for this, and has not been updated since its drafting in 1994.

7.7.3 The time factor in the construction of J and K Wing

Time played a significant role in the completion of the expansion to J and K Wing. This can be seen amongst others from the following.

The DJI opted for prefabricated cell containers, which are less durable than the usual (block work) structures, but can be completed more quickly. Speed was of overriding importance for the detention centre. Even before the RGD was involved in the project, the DJI had already ordered some of the cell containers.

As described in Section 7.4.1, the DJI had not drawn up a specific Schedule of Requirements for the Construction of J and K Wing. As described in Section 7.5.8, the RGD elected not to award the architect the contract for the full detailed working out of the drawings and the implementation of the phase preparatory to construction. In this preparatory phase detailed assessments against the Buildings Decree can be carried out, specific selection of materials can be made and structural and installation elements can be matched to one another. Neither did the Contractor receive any explicit order to carry this out. The reason for the selection of this method of contract award by the RGD lay in all probability in an attempt to achieve time savings required by the DJI.

It is relevant in this context to mention that the starting point for the RGD is the client. Its Quality Manual states that the "*Main Objective is: A satisfied client*". Interviews with the RGD also revealed that the client is central. In order to satisfy the DJI as a client, the RGD followed a variant working process in the construction of J and K Wing. Normally the RGD would prepare for large-scale projects in close collaboration with the commissioner, before these projects were contracted out for implementation. For an expansion to a building with the provision of such wings, the normal completion time according to the RGD and the DJI might be one or more years. In this case however, J and K Wing were completed in a few months. In the traditional construction process, the RGD would pass through several phases, working through each process carefully and in sequence, on the basis of an internal Quality Manual in the interests of the eventual quality of the building. In order to complete the detention centre in a short time, the RGD did not follow the normal procedures, but had various activities running in parallel rather than in sequence.

The Board has found no concrete indications that the time factor in the expansion involving J and K Wing had any effect on the eventual structure. Neither does it appear that the RGD as the builder had taken supplementary compensatory measures in order to ensure quality, and specifically fire safety. During the process of awarding the contract for the design of J and K Wing, the discussions to a large extent made reference to the construction of Wing A to H, completed the previous year. An active approach to fire safety should however have been expected on the part of those involved, in particular because of a variety of indications (see 7.4.3 and 7.5.5) coming from the direction of Nibra, the Technical Advice Committee and the Supervisory Committee under the direction of Mr Siepel, that the fire safety of the detention centre left something to be desired. No evidence of such an active approach has emerged. Finally, in the Board's opinion, the focus on the client may be desirable from the perspective of the RGD's role as a service provider, but with regard to quality assurance for the finished product, in this case the detention centre, this focus is undesirable, for example where fire safety is concerned.

7.7.4 Second-line supervision by means of inspection

The inter-agency supervision carried out by inspectors from the Ministry of Housing, Spatial Planning and the Environment (referred to as second-line inspection) was for the most part limited to the assessment of processes and procedures.

The VROM inspectors supervise the activities of the municipalities and examine whether they are carrying out their statutory roles adequately. The inspectorate inspects each Municipality once in every four years, assessing all fields of activity (the environment, housing and spatial planning). The frame of reference for the inspection and supervision of municipalities is the current legislative framework.

The assessment of municipalities also relates to the manner in which they grant Building Permits and Permits for Use. The inspectorate uses an "adequate level" checklist as its guideline in assessing the policy process, the program of work and its implementation. In the case of doubt the inspectorate may decide to undertake an in-depth investigation. A special module has been developed for this purpose in the case of the granting of Building Permits. Work is currently in progress to prepare a similar tool for the assessment of the granting of Permits for Use. This is a separate issue from the development of the requirements on use to be included in the national scheme to be introduced on 1 January 2007.

In view of the fact that there are 458 municipalities, second-line supervision is limited to broad issues and deals primarily with process. In the case of a specific concern, which had not arisen in the case of the Municipality of Haarlemmermeer, the Inspectorate would carry out an inspection looking into matters of substance.

Inspections of the Municipality of Haarlemmermeer were carried out in 2001 and 2004. The Municipality drew up an action plan for improvements in response to the findings of the 2001 inspection. In 2004 the opinion of the VROM inspectors was that the Municipality had achieved considerable improvements. However it appears that there were also fresh elements where there was room for improvement by the Municipality. A new action plan for improvements was drawn up in response to these findings, dealing with the fields of activity involving spatial planning, the environment and construction. In response to the Board's draft report, the VROM indicated that *"the improvement measures had been virtually completed in the interim"*. Only the updating of zoning plans was still underway.

The intended purpose of the inspections carried out by the Ministry of Housing, Spatial Planning and the Environment, that is to say the realization of improvements in a number of significant areas involved in the process of granting permits, was in this case not adequately achieved in 2003, in view of the observed shortcomings in the granting of permits for J and K Wing.

7.8 Specific conclusions in relation to the construction and use of J and K Wing

7.8.1 The Custodial Institutions Service(DJI)

1. No established fire safety policy exists within the DJI.
2. The DJI did not provide the Government Buildings Agency with a specific Schedule of Requirements for J and K Wing.
3. The DJI did not demonstrably take account of the risks associated with the detention centre as the basis for the structure of the user organization and the drafting of emergency response plans.
4. The DJI did not take supplementary measures to compensate by means of the user organization for the limitations arising from the construction plan.
5. No measures were taken in relation to the user organization to take account of the fact that no requirements on furnishings were set down in the municipal building regulations (on smoke production, toxic gases and so on).
6. The DJI undertook no demonstrably supported consideration of the non-self-closing status of the cell door.
7. The condition assumed in the occurrence response plan that two members of staff per wing would be present during the night was not satisfied.

8. There had not been sufficient or effective practice exercises carried out in the detention centre since the construction of J and K Wing, and not all detention centre employees had been involved in the practice exercises. There was no demonstrable evidence of feedback on the exercises or of lessons being drawn.
9. No evidence was found of an annual learning cycle, whereby fire safety matters relating to the user organizations and buildings could be assessed and continuously improved.
10. No evidence was found of a structured learning cycle in relation to fire safety or of any differentiation of fire safety in for example policy, annual planning or annual reports.

7.8.2 The Government Buildings Agency (RGD)

1. J and K Wing did not meet the fire safety requirements of the construction legislation.
2. The capacity of the Smoke and Heat Exhaust Ventilation System, which ought to have offered an equivalent alternative compensating for the length of the corridor (54 metres rather than 22.5 metres), was too small in dimensions by a factor of 3 in comparison with the capacity required in view of the geometry of the wing, and did not function during the fire.
3. The RGD did not take demonstrable or adequate advance account of the risks to fire safety during the development and consideration of the construction plan.
4. The risks were not adequately communicated to the user (no demonstrable "user manual" was delivered to the DJI).
5. Prior to construction, the RGD made insufficient use of the available information produced in response to the fire in 2002 on C Wing (the Nibra and TAC reports) and the available test reports.
6. Fire safety was considered during the construction process (the construction plan and the construction itself) but the RGD as owner did not ensure that the fire safety matters discussed between the various parties were actually adequately implemented in practice.
7. The RGD incorrectly assumed that the TNO test of the cell container would ensure the fire safety of the entire wing. The implicit expectation also existed within the RGD that the fire brigade, in the context of its activities in relation to enforcement and to the granting of permits, would assess whether fire safety had been adequately ensured.
8. In its role as commissioner, the RGD did not ensure that adequate specific current expertise was available to its contractors (the architect, the contractor etc.) about either the relevant building regulations or the specific risks associated with the detention centre. Sufficient full and current understanding of the fire safety requirements applying specifically to a building functioning as a detention cell was not identified on the part of the architect, despite the fact that the professional code of conduct required this.
9. J and K Wing were constructed on the basis of a construction plan which had only been worked through to a limited degree, and where fire safety matters had not received detailed consideration.
11. The application for a Building Permit could not be adequately tested against the Building Regulations on the basis of the construction plan submitted by the RGD.
12. No evidence was found of a structured learning cycle in relation to fire safety, or of any differentiation of fire safety in, for example policy, annual planning or annual reports.
13. The fire alarm system was not provided with a Schedule of Requirements approved by the fire brigade as was required as a condition of the Building Permit. The delayed transmission of the alarm should have been included in the Schedule of Requirements.
14. The client takes the central place in the discharge of its role by the RGD, as is stated amongst others in the Agency's Quality Manual.

7.8.3 The Municipality of Haarlemmermeer

1. Based on the limited information supplied with the application for the construction of J and K Wing, the fire brigade carried out an assessment; various documents prescribed in the Submission Requirements Order were not supplied with the application for the Building Permit.
2. The fire brigade had insufficient current expertise about fire safety legislation and the specific risks associated with the detention centre to allow them to carry out a proper assessment for the purpose of the granting of the Building Permit.
3. The granting of the Building Permit was not based upon a full assessment of matters on substance against the requirements of the Buildings Decree with regard to non-

- permanent cell buildings. J and K Wing did not comply with the building regulations.
4. The Smoke and Heat Exhaust Ventilation System, as an equivalent solution compensating for the length of the corridor (54 metres rather than 22.5 metres), was inadequate. The Smoke and Heat Exhaust Ventilation System should have been assessed by TNO in accordance with the Building Permit. This assessment was not carried out because TNO had not received an order to carry it out.
 5. The Municipality exercised a supervisory role during the construction of the detention centre. Few records could be found in relation to the manner and depth of this supervision.
 6. The fire brigade granted the Occupancy Permit on the basis of the presence of documents, without assessing their content.
 7. The fire brigade granted the Occupancy Permit before the conditions set down in the Building Permit had been fulfilled.
 8. The Municipality exercised limited supervision over the Occupancy Permit. In practice, this supervision was directed towards visible shortcomings. The fire brigade did not investigate whether the necessary (mandatory) certificates, reports, logbooks and so on relating to the provision, monitoring and maintenance of the fire protection systems within J and K Wing were in place, neither did it assess the content of these documents.

7.8.4 Underlying factors

1. The requirements of the Buildings Decree in relation to buildings functioning as cells are wide-ranging, complicated to apply and capable of various interpretations, in particular because of the involvement of performance requirements and the “principle of equivalence”. It has also emerged that the legislative requirements for temporary structures, as applicable to the Detention Centre Schiphol-Oost, are less stringent than those for buildings constructed for an indeterminate period.
2. Those involved did not have at their disposal the required experts or expertise or current knowledge about either the fire safety requirements in the legislation or the specific risks associated with a detention centre.
3. The existing Cells and Cell Blocks Fire Safety Scheme did not contain a single considered, risk-based fire safety principle which would apply to all buildings functioning as cells.
4. J and K Wing were completed under substantial pressure of time, of a political nature. Nevertheless, no concrete evidence has been found that the time factor in the expansion involving the construction of J and K Wing had a direct influence on the completed building.
5. The intended purpose of the inspections carried out by the Ministry of Housing, Spatial Planning and the Environment, that is to say the realization of improvements in a number of significant areas involved in the process of granting permits, was in this case not adequately achieved in 2003, in view of the observed shortcomings in the granting of permits for J and K Wing.

8 RELIEF AND AFTERCARE

8.1 Introduction

The central focus of this chapter is how the relief and aftercare was organized for the cell occupants, guards, emergency personnel and surviving relatives after the fire in the detention centre at Schiphol-Oost. It will investigate whether 1) the relief and aftercare offered met the requirements set by law and in regulations, whether 2) it was in line with the formal agreements and procedures and whether 3) the care was in line with what may be expected of aftercare during and after a large-scale event. Another question to be answered is whether 4) the parties involved assumed their responsibilities in the correct manner.

This chapter will provide a detailed description of the relief and aftercare which were offered during the first three months after the fire, specifically that provided to the group of cell occupants who were incarcerated in the J and K Wing of the detention centre during the fire³⁵⁸. The investigation focused on the organizational and process-related aspects of the relief and aftercare provided. The Board did not investigate the physical condition of the persons involved, nor did it examine the question regarding whether the care provided was sufficiently appropriate in this context. The care provided by the medical emergency personnel at the site of the occurrence (the ambulance service) and the aftercare provided more than three months after the occurrence fall outside the scope of this investigation³⁵⁹. The investigation will look at whether a plan of action was drawn up for the care to be provided starting three months after the fire.

The structure of this chapter is as follows. Section 8.2 will explain what is meant by relief and aftercare following a large-scale occurrence, and how these processes are incorporated into the disaster relief structure. The analysis framework is set out in Section 8.3, on the basis of which the Safety Board will analyse and evaluate the relief and aftercare provided. The next section, 8.4, focuses on the parties involved in the organization of the relief and aftercare for the persons affected, and the responsibilities of these parties. Section 8.5 will then look in detail at a reconstruction of the facts of the relief and aftercare for cell occupants, guards, emergency personnel and surviving relatives. The analysis of the relief and aftercare is interwoven throughout this section. The main sub-conclusions may be found in Section 8.6.

8.2 Relief and aftercare in the case of serious accidents and disasters

8.2.1 *Medical, psychosocial and material care*

The Safety Board deems the terms relief and aftercare to mean the deployment of personnel and resources after a large-scale occurrence in order to return to a stable situation, so that normal life can continue again. The investigation into the relief and aftercare for the persons involved in the fire in the detention centre focuses on aspects such as the registration of persons affected and their medical data, providing information, provision of medical, psychosocial and material care.

The term medical care is deemed in this investigation to mean the provision of general medical (non-specialized) care at a generalized general practitioner level.

Psychosocial care is aimed at restoring the feeling of safety in the persons involved, helping them regain control of their lives, stimulating mutual help between the persons involved, and encouraging them to cope on their own. The initial purpose is to alleviate suffering and offer support. A safe environment, the support of trusted people and information about frequently occurring reactions after large-scale occurrences are of great importance in the recovery of

358 It has been decided to focus the investigation on the group of cell occupants from J and K Wing, in view of the fact that they experienced the fire at close quarters. This does not mean, however, that the cell occupants from the other wings do not need aftercare, and could not develop any complaints. Appendix 16 looks at the aftercare for cell occupants in detention centre 't Nieuwe Lloyd and for cell occupants left behind at Schiphol-Oost. This appendix will also be looking in greater detail at the relief of and aftercare for emergency personnel.

359 See Appendix 1 for more information about the demarcation of the investigation of the Safety Board into the fire in the detention centre in Schiphol-Oost.

the sense of having control of one's own living situation. Secondly, psychosocial care is used to try to recognize which persons involved urgently need professional help, and this help is then offered to the persons in question. The persons involved who are at an increased risk of serious complaints are followed for a long period of time, and if necessary are referred to a psychologist or psychiatrist for treatment.

The provision of material care could include compensation for or the return of clothing and personal property, payment of funeral expenses of the deceased victims and airline tickets for the next of kin, and providing survivors with the means and opportunity to contact lawyers and family members.

8.2.2 Relief and aftercare in disaster relief

At the moment that a serious accident or disaster takes place in the Netherlands, a disaster relief organization is set up, in the context of the Disasters and Serious Accidents Act 1985, in accordance with the principle of scaling up. The disaster relief organization focuses on multidisciplinary coordination and co-operation between the fire brigade, police, municipality and Medical Assistance for Accidents and Disasters (GHOR). The control and executive tasks, powers and responsibilities in the disaster relief processes, such as combating the occurrence and its direct effects, are divided between the above-named parties. In the case of scaling up, the scale of the organization of the disaster relief is adapted to the scale of the occurrence or the disaster and the disaster relief measures. The greater the scale of the occurrence, the greater the number of emergency relief organizations, and the more changes which are made to the composition of the bodies and officials involved³⁶⁰. The Mayor has administrative leadership from a specific level of scaling up.

The GHOR coordinates the deployment of medical services during accidents and disasters. This involves cooperation between various government bodies, private organizations and individual professionals, ranging from hospitals and ambulance facilities to psychosocial assistance bodies. Two other processes relevant to this investigation which fall under the GHOR are the Psychosocial Post-disaster Care (PSHOR) and the Urgent Medical Assistance (SMH)³⁶¹.

Two other disaster relief processes, for which the municipality is responsible, are 'relief and care' and 'aftercare'. The 'relief and care' process involves the municipal organization of the Municipality in which the occurrence has taken place handling the relief of and providing care for the persons involved. This involves offering shelter and providing primary necessities of life (food, drink, money). The 'aftercare' process is geared towards creating a stable situation, so that normal life can resume. One example of this is restoring the power supply after a power cut. During this process, problems are also solved in the spiritual, physical and social areas. This can also include arranging compensation payments.

The aftercare offered to persons involved in a (large-scale) occurrence consists of various phases. The Psychosocial Post-disaster Care (PSHOR) process makes a distinction between acute aftercare (which lasts a maximum of seven days), the first phase of aftercare (which runs from the end of the acute phase to 3 months after the occurrence), and the second aftercare phase (see figure 30). This last phase starts three months after the occurrence, and can last for up to several years.

The municipal disaster relief processes and the PSHOR process are linked to one another. If one or both of the municipal processes are standard, the PSHOR process is usually also activated.

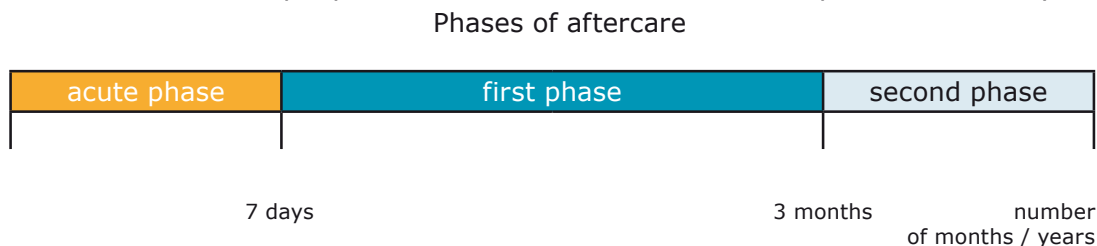


Figure 30: Graphic depiction of the various phases of aftercare

360 All the parties involved can set a scaling up in motion, if they deem this necessary in view of the situation.

361 Model description Ministry of the Interior and Kingdom Relations, Medical assistance in accidents and disasters, general.

In the event that civilian victims are required to leave their homes as a result of an occurrence (evacuation), the municipality establishes a relief centre during the acute phase, at a safe location away from the disaster site. This could be a sports hall or community centre, for example. This is where uninjured and slightly injured victims are received and cared for while waiting for the opportunity to return to their own homes or alternative accommodation. With the aid of spiritual and psychosocial counsellors, those affected are given the opportunity to recover and are provided with the primary necessities of life.

The acute phase is followed by the first aftercare phase. The assistance during this period is primarily preventive in nature, and group-oriented. Informational meetings are organized, for example. An assessment is also made of which people need urgent psychosocial help. During the acute phase, the GHOR is responsible for coordinating deployment of the medical assistance, and deployment of the PSHOR process may also be initiated.

Employers also have a role in relief and aftercare, in the context of the Working Conditions Decree. Employers prepare themselves for possible emergencies by means of a company emergency plan and accompanying organization, such as a company relief team.

As a result of the above detailing of the phasing in the aftercare, the following can be stated with regard to the aftercare following the fire in the detention centre at Schiphol-Oost. A key target group to which aftercare had to be provided, the cell occupants, was an exceptional population. Persons who are being detained by law cannot simply be set free after a large-scale occurrence. In the event of an evacuation, they will have to be held in detention at a different location. On the basis of the duty of care which is established in the Prisons Act and the responsibilities allocated by the Working Conditions Decree to the employer - including to third parties - penitentiary institutions have their own responsibility to prepare themselves and to ensure that relief can take place within the institution. This also applies to any evacuation to another institution, and to the aftercare. As described in Chapter 5, the relief and aftercare in a detention centre falls under the responsibility of the Site Manager.

The relief and aftercare provided to emergency personnel and the guards do not fall under the responsibility of the disaster relief organization during an occurrence, but under the responsibility of the employer. The deployment of the GHOR and the PSHOR process may be called on for the provision of this care.

8.2.3 Health effects of large-scale occurrences and disasters

After large-scale occurrences and disasters, the people involved need practical, social and emotional support. Psychosocial care during the acute phase is therefore practical and not medicalized. The most important aspects during the first days after an event are restoring a sense of safety, recovering control, encouraging mutual help among the persons affected, establishing contact and reuniting relatives, and encouraging those affected to cope on their own.

Psychosocial care can make a contribution to this by providing psycho-education³⁶² and sound risk and crisis communication, such as providing factual information about the large-scale occurrence and the consequences of it for the people involved³⁶³. In addition, an assessment must be made of whether there are people who also need medical or psychosocial care; these people do not necessarily need to have been involved in the occurrence.

Acute psychological trauma assistance is offered after shocking events, as part of a broader package of psychosocial care, also known as early psychological interventions or debriefings. This covers a broad range of interventions in the first days after experiencing a shocking event. The effectiveness and efficiency of the majority of the interventions have not been properly studied, however. What is clear is that one-off early interventions, known as single-session debriefings, are not effective, and in some cases can even be damaging to the health of the persons involved.

People are by nature extremely resilient, and are well able to handle shocking events and to resume their lives after a period of time. In the case of a small but significant group of people,

362 Psycho-education in the event of trauma-related complaints consists of providing information on the stress reactions which people involved can expect in themselves and/or their relatives, and what they can do about this.

363 Rooze & De Vries, 2006.

however, health and psychological problems continued to exist, such as fear, depression, post-traumatic stress disorder³⁶⁴, and symptoms such as exhaustion, headaches, stomach aches, for which no somatic background can be shown. These symptoms can occur immediately after the event, but it can also take months or years before the symptoms become apparent and/or are recognized.

Ethnic minorities or migrants, including refugees, asylum seekers and illegal immigrants, form a high-risk group in this context. Asylum seekers and recognized refugees are, on average, in a poorer physical and psychological state of health than other groups of migrants upon arrival in the Netherlands. Asylum seekers (without resident status) are more likely to suffer from psychological problems than refugees (with resident status). Then there are also often differences in the language and culture.

Illegal immigrants are uninsured and have poor access to the care³⁶⁵. Research has shown that the health problems of illegal immigrants are primarily of a psychological nature. Problems are often more serious than that seen with other patients³⁶⁶. The effectiveness of the assistance can suffer as a result. Research into the detention of asylum seekers is scarce, but does reveal negative effects on psychological health (see Appendix 14).

8.3 Specific analysis framework with regard to aftercare

The analysis framework that the Safety Board has established in order to allow it to assess the relief and aftercare of the persons involved consists of seven parts. One part relates to general standards for relief and aftercare, and each of the other six parts focuses on one of the parties involved. The analysis framework is based on the current legislation and regulations, and on formal and informal rules at the central and local (municipal) level. It also looks at rules, guidelines and recommendations specific to detention situations³⁶⁷. The analysis framework describes the requirements with which the relief and aftercare must comply for the various target groups as a minimum.

8.3.1 General points of departure

The relief and aftercare must be targeted at the provision of basic essentials of living, providing medical care and promoting the recovery of psychological and physical wellness.

On the basis of international treaties, the Constitution, penitentiary and health legislation and regulations, the point of departure taken is that all people (therefore including residents of prisons, alien detention centres and asylum seeker centres) are entitled to the same quality of care. A distinction can be made in this respect between the question regarding which care should be provided to which involved parties on the one hand, and how this care should be offered on the other, taking into account the specific circumstances, such as the fact that cell occupants cannot go to their doctors or to Accident & Emergency on their own. The point of departure in custodial institutions is that this requirement is met as long as its implementation does not impinge on public order, safety, proper procedure in the institution or the undisturbed process of execution of the deprivation of liberty.

8.3.2 Standards for deployment of PSHOR³⁶⁸

- The Regional Medical Officers (RGF) for the safety regions involved in a disaster or large-scale occurrence must take a decision on whether or not a coordinated

364 We refer to post-traumatic stress disorder (PTSD) if someone has had a shocking experience and if a certain combination of physical and psychological symptoms do not disappear within one month after the end of this experience, or if these symptoms occur much later. Three groups of symptoms are typical for PTSD: reliving, avoidance and irritability.

365 Staat van de gezondheidszorg 2005 (State of the health care), IGZ

366 Den Brok, 1997 and Nivel, "Gezondheidsklachten van Illegalen" (Health Problems of Illegal Immigrants), 2001.

367 The primary source documents are listed for the standards in the analysis framework. These include treaties, legislation, regulations, case law, procedural plans and guides, protocols and guidelines, and literature studies. See Appendix 15 for a summary of the source documents. The list of source documents should not be seen as exhaustive.

368 The analysis framework below is based on the various sources, including the Manual for Preparation for Disaster Relief and the National Model Process Plan for Psychosocial Assistance in Accidents and Disasters.

deployment is needed in the area of psychosocial care, and must coordinate this care at the supra-regional level.

- If the RGF considers psychosocial care to be desirable, it must initiate a PSHOR procedure to this end.
- A post-traumatic stress core team must provide leadership for the deployment.
- If necessary, relief teams must be deployed.
- The PSHOR deployment must be scaled down after a maximum of 7 x 24 hours.
- An evaluation must take place, and an evaluation report drawn up, which is sent to the RGF and the directorates of the chain partners.
- After the deployment of 7 x 24 hours, the work is taken over by the regular care organizations.

8.3.3 Standards for tasks of management of the Custodial Institutions Service (DJI) and Site Manager³⁶⁹

- The management of the Custodial Institutions Service (DJI) must develop policy for relief and aftercare after an occurrence.
- The management of the Custodial Institutions Service (DJI) must develop policy for a supra-institution evacuation.
- The management of the Custodial Institutions Service (DJI) is responsible for the coordination of a supra-institution evacuation.
- The Site Manager must have a plan of action for the relief and aftercare for the cell occupants.
- The Site Manager must have a supra-institution evacuation plan and must harmonize this with the municipal disaster plans.
- The Site Manager must ensure sufficient qualitative and quantitative medical and psychosocial care for the cell occupants.

8.3.4 General standards for relief and aftercare³⁷⁰

- Information must be provided on the current situation.
- The safety and sense of control of the people involved must be restored.
- Contact with relatives must be restored.
- Information on the occurrence and the consequences or possible consequences of the occurrence must be provided to the persons involved.
- Practical problems must be solved.
- The fact that they have been affected must be recognized, the consequences of being affected must be recognized, serious attention must be given, the persons involved must be treated correctly and reassured as much as possible.
- Sufficient food and drink must be provided to the persons involved.
- Medical assistance must be offered.
- The people involved must be given the opportunity to receive social support from others who have been affected, from family members and/or from third parties.
- An assessment must be made of whether there are factors which can lead to post-traumatic psychopathology³⁷¹, and whether the accompanying interventions must take place.
- An inventory must be drawn up of the need for assistance with regard to the return home, to family or other relief.
- A listening ear must be lent as needed.
- Clothing and toiletries must be provided.
- Some form of relaxation must be offered.
- Aftercare must be offered.

369 The analysis framework below is based, among other things, on the Standard Minimum Rules for the Treatment of Prisoners, the Prisons Act and the General Rules Governing Evacuation of the DJI.

370 This framework is based, among other things, on the Victim Assistance in the Netherlands Guide, the PSHOR National Model Process Plan, the Constitution, the Disasters and Major Accidents Act, the Disaster Management (Quality Improvements) Act and the Medical Assistance (Accidents and Disasters) Act.

371 Psychological disorders or psychological suffering as a result of shocking events.

The psychosocial care must be targeted at the following points:

- The natural recovery process must be promoted by organizing, mobilizing and strengthening social support from the direct surroundings of the persons involved, and by means of psycho-education. If the persons involved are placed outside of their trusted environment and network, this point needs to be given additional attention, for example by keeping people who know one another together as much as possible.
- People in need of urgent psychological psychiatric assistance must be identified. The necessary assistance must be provided to them.
- Affected persons who are at an increased risk of developing trauma-related problems must be identified and monitored.
- Post-traumatic psychopathology must be recognized at an early stage, and suitable treatment thereof must be encouraged.

8.3.5 Standards for the relief and aftercare of cell occupants³⁷²

The following supplementary standards apply to aftercare for cell occupants.

Relief during the fire³⁷³

- The cell occupants must be given information about the evacuation.
- The cell occupants must be given acute care (First Aid, blankets, water).
- The cell occupants must be assessed at the site of the occurrence in terms of their need for somatic care (triage), and treated if necessary.
- A clear overview must exist within the DJI and the IND regarding where the cell occupants are located (including after a transfer³⁷⁴).
- The penitentiary institution must know how many cell occupants it must receive and under which regime these residents fall.

Accessibility of medical care³⁷⁵

- The medical care for the cell occupants affected by the fire must comply with the same medical standards as those that apply to any other person, within the possibilities of the detention regime.
- In providing care, the language, religious beliefs and culture of the persons involved must be taken into account.

Supply and demand of care³⁷⁶

- On the day of their arrival in the penitentiary institution in which the cell occupants are housed after the fire, they must be given a consultation with a nurse.
- Within one day after their arrival in the institution, the cell occupants must be given a consultation with a doctor.
- A nurse responsible for the guidance set can decline the cell occupant's request to speak to the doctor. The cell occupant must agree to this decision.
- A request of a cell occupant to speak to a doctor must be evaluated by a nurse with

372 For an overview of the rights of cell occupants and the obligations of the Site Manager on the basis of the Prisons Act, see Appendix 17.

373 The standards for the relief during the fire are based, among other things, on the Standard Minimum Rules for the Treatment of Prisoners, Disasters and Major Accidents Act, Medical Assistance in Accidents and Disasters Act, Prisons Act, European Prison Rules and the Guidelines on the Applicable Criteria and Standards Relating to the Detention of Asylum Seekers of the UNHCR.

374 The Safety Board defines a transfer as when cell occupants are transferred to different detention centres or asylum seeker centres.

375 The accessibility of medical care is subject to the standards based on the Minimum Rules for the Treatment of Prisoners, the Guidelines on the Applicable Criteria and Standards Relating to the Detention of Asylum Seekers of the UNHCR, the Constitution, European Prison Rules, Medical Assistance in Accidents and Disasters Act, the Prisons Act, Basic Principles for the Treatment of Prisoners and the Principles of Medical Ethics.

376 The supply and demand of care in the various institutions where the cell occupants were housed after the fire is subject to the standards based on the Minimum Rules for the Treatment of Prisoners, the Guidelines on the Applicable Criteria and Standards Relating to the Detention of Asylum Seekers of the UNHCR, European Prison Rules, the Prisons Act, the Principles of Medical Ethics and the National Model Process Plan for Psychosocial Assistance in Accidents and Disasters.

responsibility for a guidance set³⁷⁷. The assessment of this request must take place no later than 24 hours after the request has been submitted.

- The doctors and nurses have the professional obligation to provide necessary medical and psychological care, if this is deemed acutely necessary.
- During the first weeks, the psychosocial care must be targeted at groups and be primarily informative, taking into account any language/cultural problems.
- Cell occupants who need psychological or psychiatric assistance must be identified and be given assistance.
- Cell occupants who are at an increased risk of developing trauma-related problems must be identified, monitored and supervised.
- Cell occupants are entitled to psychosocial care.

Quality of the regime³⁷⁸

- The cell occupants must be offered opportunities for social contact.
- The cell occupants must be offered opportunities for relaxation.

Continuity in medical care and assistance³⁷⁹

- In the event of a transfer, the head of the medical service must ensure that the cell occupant's dossier is present at the new location on the day the cell occupant arrives.
- In the event of release or deportation, medical data of the person involved must be transferred to the care providers at the next place of residence.
- Medical dossiers must be adequately maintained.
- The medical dossiers of the Detention Centre Schiphol-Oost must be delivered to the detention centres in Rotterdam and Zeist within two days after the fire.
- The Detention Centre Schiphol-Oost must forward information concerning special cases (including those relating to persons with medical needs) on the day that cell occupants are transferred to the relief locations.

Information and communication³⁸⁰

- A decision must be taken, in consultation with the cell occupant, as to whether the deployment of an interpreter is needed for contact with the medical service or care providers.
- Cell occupants must be informed about their transfer in a language they understand.

Clothing and belongings (material care)³⁸¹

- Cell occupants must be provided with the clothing they require within one day.
- Cell occupants must have access to their own clothes and other possessions within one week after their transfer after a large-scale occurrence.

Contact with the outside world

- Cell occupants are entitled to contact and visits³⁸².

377 Based on the MOA guidance set containing agreements on the division of tasks between the nurses and the doctors. The guidance set is a non-binding recommendation from the Committee of Ministers of the Council of Europe, the Medical Treatment Contracts Act, the Public Health (Preventive Measures) Act, the Prisons Act and the Care Institutions (Quality) Act. The development recommendation is used within the DJI as a basis for the development of a quality care system.

378 The standards for the quality of the regime are based, among other things, on the Standard Rules for the Treatment of Prisoners, UNHCR's Guidelines on the Applicable Criteria and Standards relating to the Detention of Asylum Seekers and the Prisons Act.

379 With regard to the continuity of the medical care and assistance, standards have been established in part on the basis of Recommendation No. R (98)7 of the Committee of Ministers to member states concerning the ethical and organizational aspects of health care in prisons, Medical Treatment Contracts Act, the Public Health (Preventive Measures) Act, the Prisons Act and the Care Institutions (Quality) Act.

380 The standards for information and communication are based, among other things, on the Field Standards for Interpreter Use in Care, 2005 (IGZ), European Prison Rules, Prisons Act, Standard Minimum Rules for the Treatment of Prisoners.

381 The provision of food and clothing is subject in part to the standards based on the Prisons Act, the Standard Minimum Rules for the Treatment of Prisoners and the European Prison Rules.

382 On the basis, among other things, of the Prisons Act, the Standard Minimum Rules for the Treatment of Prisoners, UNHCR's Guidelines on the Applicable Criteria and Standards relating to the Detention of Asylum Seekers and the European Prison Rules.

8.3.6 Standards relating to relief and aftercare of guards (DJI, Securicor and KMAR)

The following supplementary standards apply to aftercare for guards³⁸³.

- The employer is required to ensure that relief and aftercare is provided to the guards.
- After a shocking event, a debriefing must take place within 24 hours.
- The debriefing must take place before any interrogation.
- The debriefing must be carried out by trained colleagues or care providers.

8.3.7 Standards Relating to the Relief and aftercare for emergency personnel (Fire brigade and ambulance)

The following supplementary standards apply to aftercare for emergency personnel³⁸⁴.

- Employers are required to ensure that there is a good relief policy for involved staff in place, so that the work does not have any negative effects on safety and health.
- Immediately after the deployment during the fire, the immediate superior must carry out a relief interview with the deployed personnel, either individually or as a group.
- The highest ranking staff member must activate the company relief team (BOT).

8.3.8 Next of kin

The Safety Board applies the following standards to aftercare for surviving relatives³⁸⁵:

- Surviving relatives must be notified of the death of their relative within 24 hours of identification.
- Surviving relatives must be notified of the circumstances in which death occurred.
- The management of the site at which the emergency occurred is responsible for notifying the surviving relatives.
- The management of the site in which the emergency occurred is responsible for organizing the relief and aftercare for surviving relatives.
- The management can be supported by a spiritual counsellor affiliated with the site in its contact with the surviving relatives.
- The surviving relatives must be given the opportunity, as quickly as possible, to visit the site of the victim's death.
- The management must facilitate the possibility for the surviving relatives to pay their last respects to the victim, taking into account possible religious beliefs and cultural aspects.
- The management must take care of repatriation of the victim's body to the country of origin.
- The management must take care, in a respectful manner, of the transfer of any personal possessions of the victim to the surviving relatives.
- The management must ensure a professional transfer of the care for surviving relatives to external care providers (family, spiritual counsellors, institutions).

8.4 Parties involved and their responsibilities regarding relief and aftercare

This section provides an overview of the parties who - apart from the parties already named in section 5³⁸⁶ - were involved in the relief and aftercare for the cell occupants, guards, emergency personnel and surviving relatives. It also describes the responsibilities of each of the parties in the area of offering relief and providing aftercare.

383 These standards are also based on the 1988 Working Conditions Decree as applicable on 1 March 2006 (a new Working Conditions Decree will be appearing in 2007) and the trauma relief appendix from the staff manual of the Ministry of Justice. These are internal policy rules for the implementation of working conditions policy. The rules are binding.

384 These standards are based on the 1998 Working Conditions Decree and the Ambulance Care Company Relief Team manual.

385 The analysis framework for relief of and aftercare for surviving relatives is based on the suicide protocol of the DJI.

386 See sections 5.1.5 (TDBV) and 5.1.6 (Site Manager) with regard to responsibilities for 'relief and aftercare' and 'medical care'. DJI must create the framework for this, and monitor adequate implementation.

8.4.1 Head of medical service

Each custodial institution has a medical service, consisting of one or more part-time doctors supported by nurses. The medical service, which has a consultation and treatment room, has consulting hours each day³⁸⁷.

The head of the medical service is responsible for the day-to-day running of the medical service, and consults with the nurses and other disciplines. Cell occupants can submit complaints and questions to the head of the medical service. The head is also responsible for ordering materials and medication for the general stock and is the only person permitted to have contact with the cell occupants' lawyers. The head of the medical service is also responsible for issuing medical dossiers to third parties.

The Site Manager must ensure that cell occupants receive proper medical care³⁸⁸.

8.4.2 Immigration and Naturalization Service (IND)

The Immigration and Naturalization Service (IND) is responsible for the implementation of aliens' policy in the Netherlands. This means that the IND assesses all applications from foreigners wishing to reside in the Netherlands or assume Dutch nationality. The IND is an executive organization. The IND is therefore not responsible for the content of the policy or the conditions which apply.

The IND is part of the Ministry of Justice and operates under the responsibility of the Minister for Aliens Affairs and Integration. After the fire in the Detention Centre Schiphol-Oost, the IND formed part of the crisis team which received and counselled the surviving relatives of the victims who died. It was also responsible for the implementation of the deportations and the transfer of cell occupants to Ulrum and Geeuwenbrug.

BMA

The Medical Advice Bureau (BMA) issues advice regarding aliens who have submitted an application to the Immigration and Naturalization Service for residence or a deferred departure. The bureau works primarily with external medical advisors. After the fire in the Detention Centre Schiphol-Oost, the Medical Advice Bureau assessed whether the cell occupants were in sufficiently good condition, from a medical point of view, to be deported, and whether the cell occupants were eligible for transfer to Ulrum. In a number of cases, the BMA issued medical advice after transfer to Ulrum; it was established which people were eligible for placement outside the closed setting.

8.4.3 Central Agency for the Reception of Asylum Seekers (COA) and Medical Relief of Asylum Seekers (MOA)

COA

The Central Agency for the Reception of Asylum Seekers (COA) is the central organization in the Netherlands for the reception and supervision of asylum seekers, refugees and specific groups, such as unaccompanied minor asylum seekers (UMA's). The COA offers them temporary accommodation at the instructions of the Ministry of Justice, and supports them in preparing for their future, in the Netherlands or elsewhere. The COA is an executive organization with reception sites throughout the Netherlands.

The COA has two types of reception locations:

- an asylum seekers centre (AZC) which focuses on orientation and integration;
- an AZC which focuses on repatriation.

This distinction offers clarity to asylum seekers. This is because the phase in the asylum procedure determines in which type of AZC the asylum seeker will reside.

The tasks of the COA are laid down in the Central Reception Organization for Asylum Seekers Act. This act also determines that the Minister for Aliens Affairs and Integration can instruct the COA to perform other tasks related to the reception of asylum seekers or other categories of aliens.

387 Kelk, 2001.

388 DJI, 1995

The tasks of the COA are:

- Accommodation for asylum seekers
- The provision of supervision, guidance and information to asylum seekers
- The supply of goods to asylum seekers
- Arranging access to care for asylum seekers
- The payment of the weekly allowance to asylum seekers
- The acquisition, management and closure of reception locations
- The maintenance of safety in the reception locations

In order to implement its tasks adequately, the COA works together with organizations such as the IND, the Aliens Police and the Royal Military Constabulary.

MOA

The COA has entered into contracts with the care insurance company VGZ for curative medical care for asylum seekers. The Health Care Bureau for Asylum Seekers (BGA) purchases preventive care services from the Medical Reception of Asylum Seekers (MOA). The MOA also takes care of the guidance of asylum seekers with health problems to the standard care of a general practitioner or dentist, for example. The MOA in Ulrum is part of the regional foundation MOA North (Groningen, Friesland, Drenthe) and is controlled by the coordinator of MOA North. The staff of the COA and the MOA in Ulrum regularly consult with one another regarding the day-to-day operations.

8.4.4 Medical assistance in accidents and disasters (GHOR)

The GHOR coordinates the deployment of medical services ('the white column') during disasters and major accidents. The Regional Medical Officer (RGF) is in charge of the GHOR chain, and under the Medical Assistance (Accidents and Disasters) Act bears main responsibility for the correct implementation of the GHOR processes in an operational sense, under GHOR circumstances. The GHOR is responsible for the following three disaster relief processes:

Somatic medical help

This process involves the treatment and coordination of injured persons from the moment of alerting to rehabilitation, and the deployment and coordination of the ambulances and medical combination (in the case of large numbers of victims).

Psychosocial assistance in accidents and disasters (PSHOR)

This process involves the collective relief of victims immediately after the disaster, and the provision of psychosocial assistance. During the acute phase and the first aftercare phase, the tasks of the psychosocial assistance in accidents and disasters are:

- the identification of persons in need of urgent psychological or psychiatric assistance, and providing or arranging for this assistance;
- the identification of victims who are at an increased risk of a processing disorder;
- the early recognition of processing disorders and the encouragement of proper treatment of them;
- the organization, mobilization and strengthening of social support from the immediate vicinity of the people affected.

Preventive public health care

This process is targeted at protecting public health in the case of accidents or disasters which endanger people and the environment, in order to minimise the number of injuries and prevent a worsening of the injuries.

The medical assistance in the case of accidents and disasters is based on the principle of scaling up from the day-to-day care. This means that the organizations responsible for the assistance in day-to-day accidents are also responsible for relief in the case of large-scale accidents and disasters.

8.4.5 Fire brigade and medical emergency services

Under the Working Conditions Decree, the employer is obliged to ensure the relief and aftercare for its employees. The responsibility for the relief of the emergency personnel member initially lies with that person's immediate superior. He carries out the debriefing, individually or as a group. The superior can also bring in the In-house Relief Team (BOT). Employers are required to have a BOT.

8.5 Reconstruction and analysis

This section contains a reconstruction of the relief and aftercare for the cell occupants (Sections 8.5.1 to 8.5.23), guards (Sections 8.5.24 and 8.5.25), emergency services personnel (Section 8.5.26 and 8.5.27) and surviving relatives (Sections 8.5.28 and 8.5.29) who were affected by the fire in the detention centre at Schiphol-Oost³⁸⁹. In addition, an analysis is made of the extent to which the relief and aftercare provided to the persons involved in the fire complies with the analysis frameworks drawn up for this purpose by the Safety Board. An analysis is also performed to determine whether the parties fulfilled their responsibilities in a correct manner with regard to the relief of and provision of aftercare to the persons involved.

There is a major discrepancy in the figures and data on relief and aftercare which the Safety Board has received from the Temporary Special Facilities Directorate (TDBV), on the basis of interviews with emergency service personnel, and from the medical dossiers³⁹⁰. The Board has taken the data of the TDBV as point of departure for the description of the relief and aftercare, supplemented by information from the interviews with emergency personnel. The figures do not provide quantitative data on the availability of the care, but the figures given indicate which percentage of the people affected made use of the care, according to the registered data. The vision of the cell occupants regarding relief and aftercare is interwoven in the various sections³⁹¹.

8.5.1 Reconstruction of initial relief of cell occupants immediately after the fire broke out

In the night of 26 to 27 October 2005, at about midnight, 32 cell occupants of K Wing were rescued from their cells in the Detention Centre Schiphol-Oost, after fire had broken out in that wing. Many cell occupants indicated in interviews that they did not know what was going on before their cell doors were opened. Most of them thought that the sounds they were hearing were not 'normal'. Some cell occupants saw smoke coming under their cell doors and suspected that there was a fire. A number of cell occupants panicked, screamed and hammered on their doors, in order to attract the attention of the guards. Other cell occupants were sleeping at the time the fire started. Two guards opened the cell doors in K Wing, where there was already serious smoke development³⁹². As a result, many cell occupants had trouble finding their way towards the exit from the wing and suffered from breathing problems.

After their cell doors were opened, the cell occupants were sent to the adjacent J Wing (see Figure 31)³⁹³. Many of the cell occupants were panicking, because they were aware of the fire and of the fact that they had only just managed to escape the fire. They had heard the screams

389 This reconstruction has been made on the basis of interviews held with the people involved, documentation on the relief and aftercare provided by the institutions involved, dossiers on the cell occupants from the Temporary Special Facilities Directorate of the Custodial Institutions Service, the medical dossiers of the cell occupants of J and K Wing who have given permission for these to be viewed, film and photographic material and transcripts of the emergency control rooms.

390 See Appendix 16 and Figure 34 for an overview of the various data. It is not clear whether all the work/treatments carried out by external emergency personnel (of the PSHOR) have been included in the medical dossiers by the institution in question. The Safety Board only encountered the note 'spoke to crisis service' in the medical dossiers once.

391 Appendix 16 contains an extensive description of the relief and aftercare in the detention centers in Zeist and Rotterdam. A summary description of the relief and aftercare in these centers is given in the main report.

392 See chapters 3 and 6 for more information on the fire and smoke development, rescue and evacuation.

393 According to the disaster plan, the cell occupants should have been evacuated diagonally. This means that they should have been brought to A Wing and not J Wing.

of the other cell occupants. Some cell occupants knew that there were still cell occupants in the burning cell block. These cell occupants were shocked by the fact that the guards did not make any further rescue attempts after opening 21 of the 26 cell doors.

A number of cell occupants from K Wing panicked and attempted, once they had arrived in J Wing, to open the emergency door in the rear wall of this wing, so that they could escape outside through this route. This door was locked, however. Fear and panic also spread among the cell occupants of J Wing, who were still locked up, and who started hammering on their doors. The guards present tried to reassure the cell occupants of K Wing and wanted to move them to the recreation room, and later to the exercise cage in J Wing. A section of the cell occupants resisted being locked up again. During the attempt of the guards to move the cell occupants of K Wing, the residents caused damage and a number of them threw chairs and billiard balls in the direction of the guards.

At about a quarter past midnight, the guards started 'locking out' the cell occupants from J Wing³⁹⁴. The guards also tried to lead these cell occupants via the recreation room to the exercise cage of J Wing. Two of the guards, who were mingling with the cell occupants in an attempt to calm them, had their key rings taken. This created the impression among some of the guards that the fire was linked to an escape attempt. Only after the Royal Military Constabulary (KMar) officers and guards present got reinforcement from the General Police Service of the KMar were they able to move all the residents of J and K Wing to the exercise cage of J Wing. While doing so the KMar used their truncheons to hit furniture. In addition, a Royal Military Constabulary officer drew his firearm and aimed it at the cell occupants³⁹⁵.

Many of the cell occupants experienced the events in the exercise cage as threatening. They saw the smoke and fire coming towards them from K Wing, but could not escape. The guards also experienced the events in J Wing as threatening. They had the impression that the cell occupants were turning against them, with a possible mass escape attempt as the result.

While the fire in K Wing continued to spread, a number of cell occupants attempted (unsuccessfully) to break out, by destroying the bars of the exercise cage in J Wing. Some cell occupants had taken a chair and several billiard balls with them from the recreation room into the exercise cage. The behaviour of several cell occupants also appeared threatening to the fire fighters that had arrived in the mean time; some of the cell occupants were sitting at the top of the cage by this point.

At approximately 00.30 hours, the Head of the Temporary Special Facilities Directorate of the DJI decided to evacuate ten of the twelve wings of the detention centre. This did not apply to Wing L and M, because these were not connected to Wing A through to K, and the fire did not pose a threat to the cell occupants in this part of the complex.

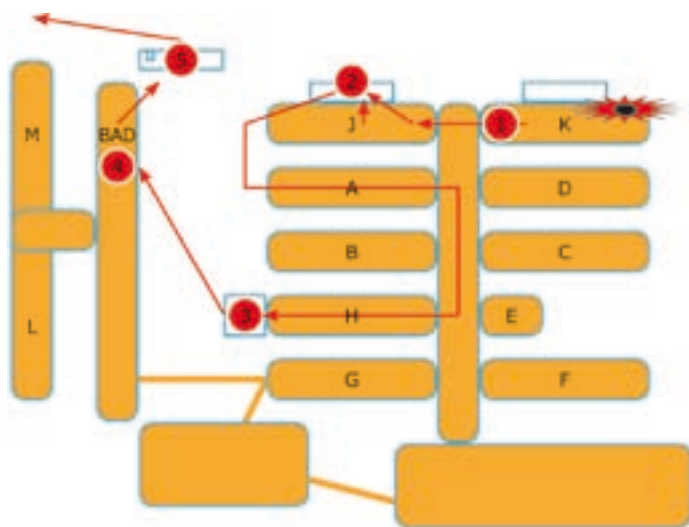
The staff members of the DJI, Securicor and the KMar started evacuating the exercise cage of J Wing from approximately 00.45 hours. The cell occupants were handcuffed in twos and brought to the large exercise cage near H Wing. Cell occupants from other wings were placed in this exercise cage, along with the cell occupants from J and K Wing. Not all the cell occupants who were in the complex that night were brought to the exercise cage near H Wing. The residents of B, C and E Wing were moved to F Wing^{396 397}.

394 Due to a missing functional component of the recording system, no camera recordings took place in J Wing.

395 When all the cell occupants had eventually been moved to the exercise cage of J Wing, there were around 73 people locked up in an area of approximately 40 m2.

396 Tapes from the KMar showed that cell occupants who did not wish to cooperate were brought to the F unit.

397 During the night that the cell occupants were placed in the exercise cage of H Wing the weather outside was 13 - 14 degrees Celsius, cloudy, dry and with a force 3 wind.



- 1) Cell occupants from K Wing were rescued and led to J Wing (after 23.57 hours).
- 2) The freed cell occupants from J and K Wing were locked in the exercise cage of J Wing (after 00.15 hours).
- 3) The cell occupants were moved from the exercise cage of J Wing to the exercise cage of H Wing (\pm 00.45 hours).
- 4) The cell occupants were assessed by the medical service (after 03.00 hours).
- 5) The cell occupants were transferred by bus to detention centres in Zeist and Rotterdam (after 03.00 hours).

Figure 31: Diagram of layout of the Detention Centre Schiphol-Oost. The arrows indicate the route by which the cell occupants were moved from J and K Wing.

At approximately 01.00 hours, the staff of the detention centre distributed blankets to the cell occupants who were in the exercise cage of H Wing. Shortly after 02.00 hours, extra blankets, drinks and cigarettes were distributed. Nurses attempted to calm the cell occupants in the exercise cage from outside, and where necessary distributed paracetamol and sedatives. Members of the Riot Squad, who had been called out earlier that night because a disturbance had occurred in J Wing, had now taken up positions outside the exercise cage of H Wing, armed with truncheons and shields.

At approximately 01.30 hours, the director of the Temporary Special Facilities Directorate (TDBV) took the decision that the cell occupants must be moved to another penitentiary institution. He did not consult with other parties in this matter, such as the fire brigade and deputy mayor. There appeared to be sufficient room available in the detention centres in Zeist and Rotterdam to house the cell occupants³⁹⁸. After the decision to transfer the cell occupants was taken, a request was made to the Transport and Support Service of the Ministry of Justice to send vehicles, so that the cell occupants could be transferred to other detention centres. The majority of the cell occupants indicated in interviews that they were not informed during the evacuation as to the detention centre to which they were being transferred.

From 03.00 hours, the security personnel of the Detention Centre Schiphol-Oost started evacuating the complex. Guards moved cell occupants from the exercise cage of H Wing to the Offenders' Reception Department (BAD)³⁹⁹. Three nurses from the detention centre assessed the cell occupants there. They primarily paid attention to physical problems. On the basis of this assessment, which took place before the transfer to another detention centre, two cell occupants of K Wing were taken to hospital, and admitted with smoke inhalation symptoms⁴⁰⁰. After the cell occupants had been assessed by the medical service, they were searched, taken to the transport bus and transported to other locations - primarily detention centres⁴⁰¹.

398 These two detention centres were chosen at that moment because they fall under the same directorate within DJI and the capacity of and available places at these centres were known to the Temporary Special Facilities Directorate.

399 Offenders' Reception Department: the department where the detainees are brought on arrival in a detention centre and where their personal property is stored.

400 One cell occupant of K Wing had already been taken to hospital; one cell occupant of another wing had been taken away with a broken wrist.

401 See Figure 32 for an overview of the transfers of cell occupants from Schiphol-Oost to other detention centers during the night of the fire. The persons who escaped were all later recaptured. The last escapee was handed over to the Netherlands by Sweden in mid-January, in the context of the Dublin Convention.

Wing L and M were fully evacuated by approximately 06.00 hours. The cell occupants from these wings were transferred to the Rotterdam-Merwehaven detention centre and Rotterdam Airport Deportation Centre. The cells in Wing L and M had been converted into 'swallowers' cells', so that drugs swallowers could be housed there.

Drugs swallowers who still had narcotics packages in their bodies were housed in A Wing. Drugs swallowers are given special treatment, in view of the risk of the packages breaking. If one or more package breaks, this results in an overdose and often death. Due to the health risks, drugs swallowers are not transported. The cell occupants of A Wing were initially moved to the Offenders' Reception Department after the outbreak of the fire. After L and M Wing had been evacuated and set up for the arrival of drugs swallowers, the cell occupants of A Wing were moved to L and M Wing.

From 01.00 hours that night, various ambulances brought injured persons (both cell occupants and guards) from the Detention Centre Schiphol-Oost to various hospitals in the region⁴⁰². The last ambulance left at approximately 06.00 hours, taking two cell occupants to hospital. In total, four cell occupants were taken from Schiphol-Oost to hospital⁴⁰³.

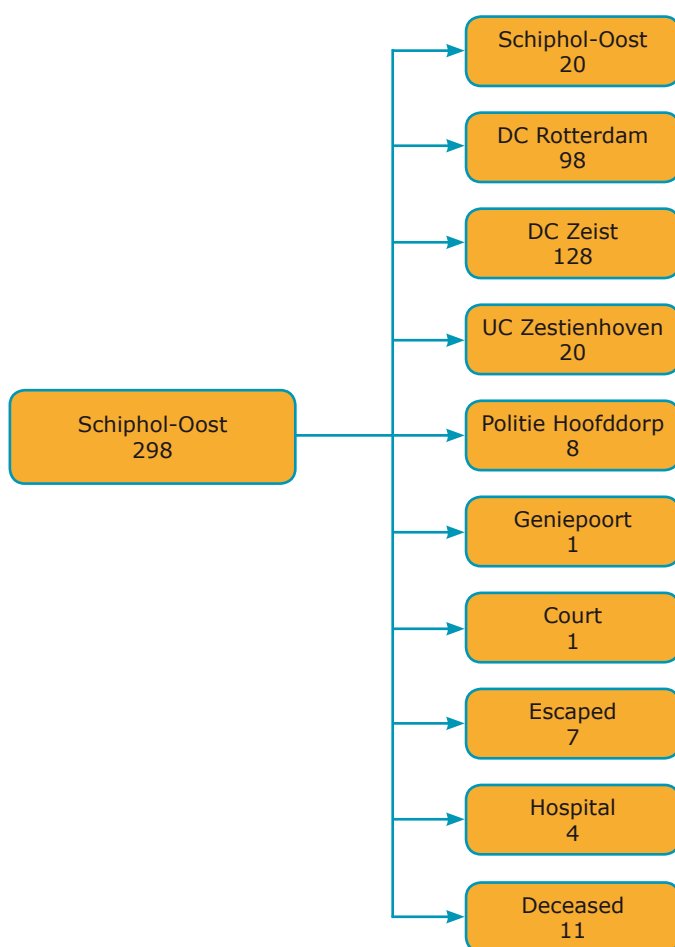


Figure 32: Overview of the transfers of the cell occupants from Schiphol-Oost. The data originates from the Site Manager of the Detention Centre Schiphol-Oost

In total, eleven guards were identified as needing hospital treatment as a result of the fire. One of these refused transport to hospital. Ten slightly injured guards were transported to hospital by ambulance⁴⁰⁴. There were also a number of slightly injured guards who could be treated on site. This treatment consisted primarily of the administration of extra oxygen.

⁴⁰² VU Medical Centre Amsterdam, Sint Lucas Andreas Hospital, Onze Lieve Vrouwen Gasthuis Hospital, Academic Medical Centre, Slotervaart Hospital and Spaarne Hospital.

⁴⁰³ Two people had breathing problems, one person had burns and one person had a broken wrist. One of the injured cell occupants was the occupant of Cell 11, the room in which the fire started.

⁴⁰⁴ All of the guards had breathing problems.

8.5.2 Analysis of the initial relief of cell occupants immediately after the fire broke out

The primary concern in the relief and aftercare for the people involved after experiencing a large-scale occurrence is ensuring a sense of safety. It is important to restore, as much as possible, the feeling of control that people have over their own living situation. The evacuation of the cell occupants from K Wing to J Wing and the relief of the cell occupants of J and K Wing in the exercise cage of J Wing did not contribute to this. The cell occupants had the impression that they would be burned alive in the exercise cage. They did not understand why they were locked up again during the fire, and why they were treated - in their eyes - as criminals. The threat with a firearm⁴⁰⁵, the deployment of the riot squad, equipped with helmets, shields and truncheons, and the use of handcuffs during the transfer from the exercise yard to H Wing did not contribute to the restoration of a sense of safety among the cell occupants. The evacuation of the cell occupants did not take place in accordance with the diagonal method contained in the emergency plan. The cell occupants should have been housed temporarily in A Wing.

Up to the moment at which the cell occupants of J and K Wing were transferred to the detention centres in Rotterdam and Zeist, only very little attention was paid to possible health problems which they may have had as a result of the fire. The cell occupants received acute care, such as drink and blankets. The medical staff of the Detention Centre Schiphol-Oost kept an eye on the cell occupants from outside the exercise yard. The dilemma of keeping the cell occupants locked up on the one hand and the provision of care on the other may have played a role in this. The two cell occupants with breathing problems could have been identified earlier that night. All cell occupants were assessed for acute physical complaints before the transport to the reception location (from 03.00 hours on). No distinction was made, however, between the cell occupants originating from J and K Wing and the other cell occupants. No decision was made, therefore, to prioritize the cell occupants who had gone through the most that night.

Only very few of the cell occupants of J and K Wing were given information at Schiphol-Oost on possible victims of the fire. This information could have confirmed, reduced or removed their concerns about the outcome of the fire. Virtually all of the cell occupants interviewed indicated that they did not receive any information on the fire during the initial relief at Schiphol-Oost.

8.5.3 Reconstruction of registration of cell occupants and transfer of information

At the time when the cell occupants were to be transferred⁴⁰⁶ to the other detention centres, two guards took up position at the buses with lists of names. The cell occupants were asked to identify themselves before they entered the bus. If a cell occupant gave a name which was not on the list of names, the name was added to the list. It was from that point that it became clear how many people were missing. It was not known initially whether these people had escaped or had died as a result of the fire.

On the basis of the list of names, the staff of the Detention Centre Schiphol-Oost brought or faxed the detention dossiers to the various locations on Thursday 27 October. As many cell occupants had given different names or aliases, detention dossiers were sent to the wrong location or were not sent at all. According to data made available by the Safety Board, a total of 57 of the 248⁴⁰⁷ cell occupants brought to Rotterdam and Zeist gave a different name or alias⁴⁰⁸.

Various data is available on the total number of detainees being housed at Schiphol-Oost on the night of the fire⁴⁰⁹. According to the information from the Detention Centre Schiphol-Oost, the number of cell occupants was 296. According to the unit lists of Schiphol-Oost, Rotterdam-Merwehaven and Zeist, this number was 298, and the dossiers of the TDBV show a figure of 289.

405 The firearm, helmet, shield and truncheon do not form part of the standard equipment of the guards.

406 The Safety Board deems a transfer to be when cell occupants are transferred to a different detention centre or asylum seekers' centre.

407 Apart from the 246 cell occupants who were transferred to Zeist and Rotterdam during the night of the fire, another 2 cell occupants were transferred to the detention centre in Rotterdam after their stay in hospital.

408 These figures originate from the Temporary Special Facilities Directorate of the DJI.

409 These figures are from DJI. There is no clarity concerning the exact numbers, because apart from the DJI list there are other lists circulating which differ from one another. See Figure 32 for an overview of the transfers.

The Safety Board has taken the number of cell occupants on the unit list (298) as the point of departure for the investigation.

Most of the 298 cell occupants who were incarcerated on the night of the fire were transferred to other detention centres in the country that night⁴¹⁰. The majority were transferred to the detention centre in Zeist (128 people, including 41 from J and K Wing), Rotterdam-Merwehaven detention centre⁴¹¹ (98 people, including 30 cell occupants from J and K Wing) and to Rotterdam Airport Deportation Centre (20 people, all from Wing L and M⁴¹²).

Of the cell occupants who were placed in Rotterdam and Zeist, almost half were transferred again to a detention centre or asylum seekers' centre during the first three months after the fire. A number of cell occupants were even transferred two additional times after having been moved to Zeist and Rotterdam. One cell occupant was transferred three times. Eventually, almost one-third of the cell occupants from J and K Wing ended up in the asylum seekers' centre in Ulrum. One cell occupant from J Wing was deported the day after the fire, on 28 October 2005. Another cell occupant from J Wing was released the same day. In the three months after the fire, a quarter of the cell occupants from J and K Wing were deported, either voluntarily or involuntarily. For two-thirds of the cell occupants of J and K Wing, the detention was withdrawn within the first three months after the fire⁴¹³.

A number of matters were unclear to the detention centres in Zeist and Rotterdam.

- nobody knew how many cell occupants to expect;
- nobody knew which regime applied to the cell occupants;
- nobody knew the names of the cell occupants.

The detention centres also did not have the medical dossiers of the cell occupants.

After the cell occupants had arrived in the detention centres in Zeist and Rotterdam, staff of the IND attempted to establish which cell occupants were in the detention centres in question. They did this using a list showing photos of the cell occupants detained in the Detention Centre Schiphol-Oost on the night of the fire. In this way, they attempted to identify the cell occupants who had given a false name during the transfer from Schiphol-Oost.

8.5.4 Analysis of registration of cell occupants and transfer of information

On the basis of the general points of departure for relief and aftercare, such as the creation of a safe environment, keeping the involved persons together and the continuity of the care, the Safety Board has reached the following conclusions regarding the transfers, for the benefit of the analysis. Transfers of cell occupants to other facilities or deportation of cell occupants from the detention centres during the first three months after a fire should only take place after information from the attending doctors and emergency workers has been weighed up. The cell occupants should be informed in advance regarding their destination.

As a result of the transfer to the other detention centres, the cell occupants did not feel that they had been given control of their own lives. The cell occupants were held in a similar type of institution and under equivalent conditions. They were again locked up in a small space, and if another life-threatening situation had occurred (such as a fire), the cell occupants would again have to depend on others to be rescued. Only in the detention centre in Rotterdam were the cell occupants informed about the fire safety of the penitentiary institution. No attention was paid to this in Zeist.

410 With the exception of the cell occupants who had to stay behind at Schiphol-Oost in the context of drugs packages in their bodies, several cell occupants who were transferred to other detention centers and the cell occupants who were taken to hospital.

411 A prison ship.

412 Wing L and M contained people who had been detained on the grounds of Art. 6 of the Aliens Act; aliens who had been refused entry to the Netherlands at the border.

413 The Safety Board has decided not to give specific figures. Dossiers made available to the Board by the TDBV in March were requested again in August in response to the reactions of the Ministry of Justice to the draft final report. The dossiers received in August contained amended or new figures. These dossiers therefore no longer matched point for point the dossiers provided to the Safety Board in March. The Safety Board did not carry out any further investigation into the question of which figures and data are correct.

The cell occupants were not transferred as a group from the detention centre at Schiphol-Oost to a single other location, but were split into small groups and divided randomly between various detention centres. The cell occupants from J and K Wing were also not kept together as a group. It was not possible to keep the cell occupants from these two wings together, because the evacuation of the two wings and the implementation of the decision to evacuate the entire detention centre overlapped one another.

The investigation revealed that the management of the Custodial Institutions Service (DJI) did not have a clear overview of which cell occupants had been transferred where. The available data from the TDBV and the data from the locations where the cell occupants were housed after the fire contain discrepancies in names⁴¹⁴ and locations of cell occupants. For example, certain documents indicated that a cell occupant was located in Zeist, but after contacting the DC Zeist it became apparent that the cell occupant had never been there. It is not clear whether information was available on the location of the cell occupants at the moment of the fire and after the fire, nor who had this information. In addition, the Board deemed it conceivable that, as a result of the chaos and upheaval on the night of the fire, information on the cell occupants was not always recorded in the correct manner.

During the inspection period for the report, the DJI indicated that a control team was formed in the head office immediately after the fire. The Safety Board has not found a single reference in any interview or document to a DJI team which performed a control function. The Safety Board concludes from this that the central notifications to the detention centres from this team were extremely limited, and the team was primarily involved in creating a record of the care received.

8.5.5 *Scaling up the GHOR in the context of relief and aftercare*⁴¹⁵

Schiphol

Medical Assistance for Accidents and Disasters (GHOR) Amsterdam and area is responsible for the coordination of Medical Assistance in the event of Accidents and Disasters at Schiphol. On the night of the fire, the Regional Medical Officer (RGF) was informed at 00.50 hours by the Head of the GHOR section (HsGHOR) that scaling up had taken place to Occurrence Site Coordination Team (CTPI) level.

At approximately 01.45 hours, the emergency control room received a request for an RGS, with which was probably meant an RGF. The HsGHOR and the RGF then proceeded to the location in order to participate in the Operational Team and the Policy Team respectively. With regard to the deployment of psychosocial assistance, the HsGHOR decided, in consultation with the Municipality of Haarlemmermeer, to advise the RGF to alert Psychosocial Post-disaster Care (PSHOR). The PSHOR core team was then alerted in this context.

From approximately 04.00 hours, the PSHOR core team was present with the Operational Team at Triport. At the request of the head of the Schiphol-Oost medical service, the Operational Team decided to deploy the PSHOR personnel to look after all the guards. The PSHOR's work with the guards was completed on Tuesday, 2 November 2005.

At approximately 04.30 hours, in consultation with the Royal Military Constabulary, the Duty Medical Officer and the head of the Schiphol-Oost medical service, the decision was made not to scale up the psychosocial aftercare for the uninjured cell occupants any further, since the cell occupants were being transferred to other detention centres. A possible deployment of the PSHOR in Zeist and in Rotterdam was discussed with the Site Manager of Schiphol-Oost, and proposed to the medical service of Schiphol-Oost.

At approximately 06.00 hours, notification was given by the Kmar that they did not need any additional assistance from the PSHOR and were able to complete the initial relief themselves.

⁴¹⁴ The names of the cell occupants of J and K Wing were correct from the start of the investigation.

⁴¹⁵ Sources are the GHOR Amsterdam evaluation (report on operation medical care, Schiphol-Oost detention centre fire on 27 October 2005) and GHOR Utrecht (report on and evaluation of deployment of PSHOR in Zeist detention centre, 27 October - 2 November 2005).

The management at the Detention Centre Schiphol-Oost was responsible for the relief and aftercare for guards and cell occupants. The evaluation by the GHOR Amsterdam and area shows that the GHOR Amsterdam was made aware of the division of responsibilities between the detention centre and the GHOR Amsterdam and area with regard to psychosocial care for the guards and the cell occupants following consultation with the detention centre. It offered its services a number of times, but the management of the detention centre did not avail themselves of these with regard to the cell occupants. The PSHOR of the GHOR Amsterdam and area did provide the initial care for guards.

Zeist

After a request from the head of the medical service of the Zeist detention centre the PSHOR was deployed in DC Zeist to their GHOR Utrecht for additional psychosocial assistance⁴¹⁶. The HsGHOR on duty notified the core team duty leader. He decided to involve the PSHOR. The RGF was notified, which in turn notified the mayor of Zeist. The mayor of Utrecht (as chair of the board of directors of the Safety Region Utrecht) was also notified that the PSHOR process plan was being introduced. Initially, a reconnaissance team was sent to the detention centre in Zeist to evaluate the situation. On 27 October at approximately 15.00 hours, it was decided to bring in assistance.

Normally speaking, the deployment of the PSHOR follows other disaster relief processes, with the GHOR being involved from the start. In Zeist, not only the start of the assistance deviated from the normal procedure, but also the location at which assistance had to be provided. In the evaluation of the GHOR Utrecht, the assistance is characterised as 'structured improvisation' within the framework of the PSHOR process plan. It was also shown that the division of responsibilities between the PSHOR and the Zeist detention centre for aftercare for the people involved was not clear in relation to the scaling up to the people involved. It was also not clear to the GHOR who had the final responsibility for the care. The advice of the emergency workers was not followed in every case.

8.5.6 Analysis of the scaling up of the GHOR in the context of relief and aftercare

During the fire in the Detention Centre Schiphol-Oost, the RGF (as part of the management team) called out the PSHOR core team to provide psychosocial assistance. For a number of hours, it was unclear for whom the PSHOR would be deployed. Eventually it was decided to deploy the PSHOR for aftercare for the guards of the DJI and Securicor. The management of the KMar had indicated that they did not wish to make use of the services of the PSHOR, because they themselves were able to provide the care for their own staff. In view of the decision to transfer the cell occupants to other centres, the head of the medical service of the Detention Centre Schiphol-Oost did not have a good overview of the need for aftercare, and for psychosocial assistance in particular. Against this background, the HsGHOR decided not to scale up the PSHOR process for cell occupants any further.

The deployment of the PSHOR proceeded in accordance with the procedure laid down in the analysis framework. The PSHOR then scaled down the procedure within 7 x 24 hours, and the assistance was left to the DJI psychologist after that point. The GHOR Amsterdam and area carried out an evaluation of the operational medical assistance after the fire in the Detention Centre Schiphol-Oost. As no scaling up took place at the supraregional level, there was no coordination between the GHOR regions of Amsterdam, Utrecht and Rotterdam.

Likewise, in the detention centre in Zeist and in the asylum seekers' centre in Ulrum, the PSHOR's services were utilized in providing aftercare to cell occupants⁴¹⁷. GHOR Utrecht evaluated the deployment of the PSHOR in the detention centre in Zeist. The PSHOR was not deployed at the detention and deportation centre in Rotterdam.

The evaluation of GHOR Utrecht showed that the division of responsibilities between the detention centre for the aftercare and the task of the GHOR in terms of the psychosocial care for cell occupants was not clear to them. The professional responsibility for care versus the framework set by the custodial regime presented a dilemma when it came to offering effective care to the people involved.

416 The head of the medical service in Zeist called the Municipal Health Service. They then immediately put him through to the GHOR Utrecht.

417 The GHOR was not deployed in the detention centre in Rotterdam for relief and aftercare.

8.5.7 *The approach to relief and aftercare from management of the DJI and by the Site Managers*

The DJI has a framework arrangement for the Evacuation of Custodial Institutions. This states what must be arranged in the event of a supra-institutional evacuation. The Temporary Special Facilities Directorate has not provided any further elaboration of this framework arrangement. This also applies to the Site Manager of the Detention Centre Schiphol-Oost and the Site Managers of the penitentiary institutions in Zeist and Rotterdam. The Site Manager of Schiphol did not have a supra-institutional evacuation plan prior to the fire, nor a policy plan for how to provide relief and aftercare for the people involved after an emergency. After the fire, the main directorate of the DJI did not draw up any guidelines and did not make any agreements with the Site Managers involved regarding the relief and aftercare for the cell occupants. The Site Managers were given the freedom to organize the relief and aftercare as they saw fit. The director of the TDBV authorized the Site Managers to incur additional expenses if necessary for the purpose of organizing the aftercare.

8.5.8 *Analysis of the approach to relief and aftercare from the DJI main directorate and by the Site Managers*

The management of the Custodial Institutions Service (DJI)

After the fire, the director of the TDBV issued a mandate to the directors of the detention centres to make use of additional resources, if necessary for the organization of the relief and aftercare for the cell occupants. The main directorate of the DJI did not provide the Site Managers with frameworks for the provision of relief and aftercare. Nor did it draw up any policy on aftercare. The main directorate of the DJI did not address the subject of aftercare for the cell occupants affected in an unequivocal and coordinated manner. This resulted in the aftercare becoming vulnerable to (political) debates and ad hoc decisions. This led to various forms of and approaches to aftercare in the various detention centres.

Site Managers

The framework arrangement for the Evacuation of Custodial Institutions states that the Site Managers must be prepared for a supra-institutional evacuation and the accompanying relief and aftercare of the people involved. At the time of the fire, the Site Managers of the detention centres in Zeist, Rotterdam and Schiphol-Oost did not have access to a scenario or plan of action for the provision of aftercare to people involved. In addition, none of the locations had a supra-institutional evacuation plan. The interviews showed that the management did not view the relief of large numbers of cell occupants as a problem, but as its day-to-day work.

8.5.9 *The structure of the relief and aftercare in Zeist*⁴¹⁸

According to the management in Zeist, it took an excessively pragmatic approach to the need for arranging aftercare for the cell occupants after the fire in the detention centre. It had not drawn up a plan of action for aftercare. Consultations between care providers were carried out on an ad hoc basis. At the request of the head of the medical service of the Utrecht Municipal Health Service, the GHOR Utrecht Region was called in for the relief and aftercare for cell occupants. The RGF office of the GHOR Utrecht Region provided psychosocial assistance to the cell occupants from Thursday morning 27 October to 2 November⁴¹⁹.

In addition, people who were staff members of the detention centre were called upon, including nurses, spiritual counsellors, a doctor and a psychologist. A psychologist from another detention centre also offered additional support, and a number of nurses from the Detention Centre Schiphol-Oost were called on to help. The cooperation between the various disciplines and the external and internal care providers was organized in an ad hoc manner. None of the care providers of the GHOR had worked in a detention centre before.

418 Sources used in the reconstruction of the facts included the GHOR Utrecht.

419 The psychosocial assistance took place in accordance with the Psychosocial Assistance for Accidents and Disasters (PSHOR) process plan.

8.5.10 The relief and aftercare for cell occupants in Zeist⁴²⁰

Relief and medical care

On the night of the fire, the first two coaches containing cell occupants from Schiphol-Oost arrived in Zeist at approximately 05.00 hours in the morning. The men and women, who had spent most of the night in an exercise cage in the Detention Centre Schiphol-Oost, were received in separate departments. The male cell occupants were initially placed randomly together in a cell in a section which was sparsely fitted out as a result of renovation works. This resulted initially in cell occupants being put together in a cell who should have been held under different regimes⁴²¹. It was also not known who was in which cell, and what the names of the cell occupants were. The cell occupants were later put together according to language and regime. After arrival in Zeist, the women were put into cells, six to a cell, on the basis of language and nationality.

At the start of the daily programme in Zeist on Thursday 27 October, the cell occupants from Schiphol-Oost were issued cigarettes, telephone cards and clothing. Cell occupants were also given an extra 15 minutes of outdoor exercise, and were allowed to receive visitors until 23.00 hours. With the exception of the cell occupants who were in the observation cell, all of the cell occupants were given the opportunity to telephone their family and/or lawyers. The cell occupants were able to contact the repatriation officer for information.

Twenty per cent of the cell occupants from J and K Wing were able to consult with a nurse within one day after arrival in the detention centre in Zeist. This percentage of the number of consultations, stated by the TDBV, differs however from the data laid down in the medical dossiers in the matter (72%)⁴²². What has been established from documents is that not all the cell occupants in Zeist had contact with a nurse on the first day⁴²³. On the basis of the medical dossiers, it has further been shown that the cell occupants who were not seen immediately by a nurse on the first day spoke to a nurse for the first time in a period varying from three to 14 days after the fire. However, the care providers in Zeist indicated that all cell occupants originating from Schiphol-Oost were seen on the day of arrival by a nurse and that in the days after the fire they had a medical consultation.

After the first consultation with a nurse or doctor, a large proportion of the cell occupants were given follow-up appointments with a nurse, doctor and/or psychologist. Nevertheless, the medical dossiers show that, in some cases, assistance was delayed, or that assistance was not offered in all cases at the moment that it was urgently needed. This included a cell occupant in a crisis situation who was put in isolation, and to whom the psychiatrist could not get access as a result of the regime, and the non provision of prescribed medication.

Summary of the regime in detention and deportation centres (based on the house rules of the Schiphol-Oost detention and deportation centre)

In detention centres, the cell occupants are entitled to one 10-minute telephone call per week, and one 1-hour visit once a week. An application for a visit must be submitted in advance. The cell occupants each receive €7.50 pocket money per week. The Art. 59 aliens are locked in from 12.00 to 13.00 and from 17.00 to 08.00.

The Art. 6 aliens (persons who have been refused entry at the border and who have not been granted access to the Netherlands) are locked in from 12.00 to 13.00 and from 21.00 to 08.00. In the period that they are not locked in, cell occupants can make use of leisure possibilities (for example, billiards) and library facilities. They are also entitled to a minimum of one hour per day of open-air exercise in an exercise cage, and two periods of 45 minutes each per week of sport.

420 See Figure 33 for detailed information of the relief and aftercare provided to cell occupants from J and K Wing in Zeist and Rotterdam.

421 The Safety Board has not seen any indication that this had negative consequences for the cell occupants.

422 For the purpose of the investigation, the Safety Board had access to 18 medical dossiers of cell occupants from J and K Wing who were transferred to Zeist. With regard to the completeness of these dossiers, it must be noted that the identification of the cell occupants was a problem on the first day, as a result of the fact that cell occupants gave aliases and false names. Medical checks and treatment therefore took place on people whose identity had not been established. The dossiers of these people, however, could not be updated at that time for the above reason.

423 See Figure 33 par. 8.5.14.

Psychosocial assistance

Just under three quarters of the cell occupants originating from J and K Wing received psychological assistance within a week of arrival in Zeist⁴²⁴. During the first two days after the fire, the external care providers held group and, where necessary, individual interviews with cell occupants. On the basis of the group discussions, and at the recommendation of nurses, it was determined which residents required the most attention⁴²⁵. An analysis by the PSHOR shows that the psychosocial assistance available in the period that the GHOR was deployed was sufficient.

In the weeks after the fire, the psychologist of the detention centre carried out a psychological assessment of all the cell occupants originating from the Detention Centre Schiphol-Oost. The nurses and guards in Zeist could indicate which cell occupants needed to be assessed first. During the assessment, the cell occupants were asked for their experiences on the night of the fire, and to indicate any problems they were suffering from. The assessment of all the cell occupants lasted a total of approximately three weeks. On the basis of this, it was determined that between thirty and forty residents needed more assistance. Twenty of them spoke to a psychologist, the other cell occupants spoke to a social worker. The psychiatrists were deployed on an individual case basis. It is not clear how often this occurred.

In addition to interviews held with the cell occupants by psychologists and social workers, the team of spiritual counsellors organized additional prayer and contemplation meetings in the weeks after the fire, and individual interviews and group discussions were held.

Problems encountered during the realization of relief and aftercare

A number of problems arose during the provision of relief and aftercare to the cell occupants in Zeist. Firstly, language formed an obstacle in many cases in the contact between cell occupants and care providers, although the care providers did not experience this as such. In the contact with the doctors, nurses and psychologist, telephone interpreters were used, or the assistance of other cell occupants and guards was called in. Guards and other cell occupants do not have a professional code of secrecy regarding information revealed in interviews between doctors/nurses and cell occupants. Language formed a problem during the meetings and interviews with the spiritual counsellors. Notes from the medical dossiers of cell occupants in Zeist also show that, in eleven cases, the care provider contact did not proceed well or had to be stopped due to the lack of an interpreter. The external care providers also made limited use of interpreters during the interviews they carried out. According to them, they were able to manage during the interviews with the languages that they themselves spoke.

Another problem was the sense that the care providers of GHOR had that they were hindered in providing care by the fact that the cell occupants were in detention. For example, on Sunday 30 October, two external care providers (one socio-psychiatric nurse and a psychiatrist) were called in to the Zeist detention centre to provide care to four cell occupants. Two of these cell occupants were in an observation cell, one of whom was found to be in a wretched condition. The care providers were only able to observe this through the window in the door of the cell. The cell was not opened, and the recommendations given by the care providers could also not be followed at that moment.

Both internal and external care providers who spoke to the cell occupants gave recommendations to the management of the detention centre about the regime. For example, they advised that the cell occupants be allowed out of the cells for longer periods, and be offered more opportunities for sport and library facilities. The management in Zeist tried to increase the sense of safety of the cell occupants by applying the regime more flexibly. During the first days after the fire, for example, the lights were left on and the shutters of the cells left open. In other areas, the regime was not modified.

8.5.11 Analysis of the relief and aftercare for cell occupants in Zeist

Pursuant to the Custodial Institutions Act and other legislation, cell occupants are entitled to a certain regime. The Safety Board takes the position that a stricter application of this regime

424 Based on data from the TDBV.

425 In total, external care providers held 35 individual interviews with cell occupants up to 2 November. This number relates to all cell occupants from the Schiphol-Oost detention centre who were housed in Zeist after the fire.

after transfer is not permissible, in view of the fact that the cell occupants have not been given a different status as a result of the transfer. The regime at the relief location must therefore be at least equivalent to the regime at the Detention Centre Schiphol-Oost. As there was no overview of the transfers of cell occupants, the management of the penitentiary institution in Zeist did not know how many and which cell occupants they had to receive, under which regime. They could have been aliens, but could also have been people who had been imprisoned for criminal acts. Cell occupants with different detention regimes were initially placed together in the same cells, as a result of which some cell occupants were incarcerated under the wrong regime⁴²⁶. It should be noted in this respect that the identification process was hampered by the fact that not all cell occupants were cooperative, and had given false names, for example. Work in Zeist was not carried out in a structured manner, and the various disciplines worked together on an ad-hoc basis. No structural plan was made for the approach to the provision of care. The aftercare in this institution appears to be organized on the basis of a general offer, and not initiated on the basis of the intake. Neither the data from the intake (as far as it was available) nor the interviews held with the psychologists resulted in policy being drawn up for the care provision to cell occupants (treatment plan). In addition, the effectiveness of the deployment of the GHOR suffered as a result of the fact that care providers from the detention centre, on the one hand, and the care providers of the GHOR on the other, were unfamiliar with one another's work. The deployment of the PSHOR itself in Zeist proceeded in accordance with the PSHOR process plan. GHOR Utrecht evaluated the deployment of the PSHOR in the detention centre in Zeist.

The medical dossiers and the data from the TDBV seem to indicate that not all the cell occupants were seen by a nurse within 24 hours in Zeist (72 and 20% respectively). In addition, it has been established in individual cases that requests from the cell occupants to speak to a doctor were not complied with promptly. On the basis of the medical dossiers, a number of examples can be given of situations in which cell occupants had to wait an unnecessarily long time for medical care.

For the purpose of this analysis, the Safety Board has assigned a quantitative requirement to psychosocial care, whereby cell occupants must receive an offer of psychosocial care within two days after arrival in the penitentiary institution, and that cell occupants who have submitted a request to see a psychologist must be able to see him/her within one week.

On the day after the fire psychological assistance was available in Zeist thanks to the deployment of the PSHOR. The first psychological care was targeted at groups. A psychologist then spoke to cell occupants individually who may have developed problems in connection with the fire. Cell occupants who needed psychological assistance were identified initially. No individual care plans were drawn up for cell occupants with an increased risk of developing problems.

Data from the medical dossiers shows that several weeks after the fire, cell occupants usually had to ask for psychological assistance themselves. In a single case, another consultation was advised after a week.

8.5.12 The structure of the relief and aftercare in Rotterdam

Before the fire, the management at the detention centre in Rotterdam⁴²⁷ did not have a policy plan for offering aftercare to cell occupants after a large occurrence. The management of the Rotterdam-Merwehaven detention centre and the Rotterdam Airport Deportation Centre was a team of three, consisting of a director and two Site Managers. With regard to the relief and aftercare for the cell occupants from Schiphol-Oost, the management decided to apply a joint approach to both sites, with the same care providers being deployed.

In Rotterdam, the management and the medical service of the detention centre held a crisis meeting after it became known that cell occupants from Schiphol-Oost were to be received, and would need psychosocial assistance. After this meeting, a policy plan was drawn up and a plan was made for the intake of the cell occupants. The medical personnel was notified about this. In order to support the staff of the detention centre, evaluation meetings were organized the day

⁴²⁶ The Safety Board has not seen any indication that this had negative consequences for the cell occupants.

⁴²⁷ The Rotterdam detention centre has two locations: Merwehaven location (known as the prison boats) and Rotterdam Airport Deportation Centre ('Zestienhoven'). As the same care providers were deployed for the relief and aftercare for cell occupants from Schiphol-Oost, and the same approach was used, this report will refer to the Rotterdam detention centre with regard to the approach to relief and aftercare.

after the fire. Staff members were notified about the state of affairs and about fire safety during the daily briefings. The main objective of these meetings was to clarify that the cell occupants originating from Schiphol-Oost had a specific position within the detention centre.

In contrast to the detention centre in Zeist, the management in Rotterdam did not call in the help of the GHOR, but made use of the permanent staff of the detention centre. These were nurses, spiritual counsellors, a doctor and a psychologist. Repatriation officers also offered support⁴²⁸. These people were familiar with working in a detention centre, with all the accompanying limitations resulting from the detention regime. The doctor and a psychologist also had experience in providing medical care after disasters and looking after trauma victims. Rotterdam did not deploy any additional care providers for the relief and aftercare for cell occupants from Schiphol-Oost. Rotterdam did, however, bring in the Institute for Psychotrauma to give advice. The staff and management of the detention and deportation centre were not aware of the possibility of calling in the GHOR. Cooperation between the staff went well.

There was no harmonization between the detention centres in Zeist and Rotterdam concerning the way in which the relief and aftercare could be organized. The detention centres did decide jointly to translate information bulletins on trauma into six languages. The bulletins were handed out to the cell occupants. The bulletin gave the telephone number of the medical service of the detention centre in question, so that cell occupants could also phone the medical centre with their questions if their detention was withdrawn or they were deported⁴²⁹.

8.5.13 The relief and aftercare for cell occupants at Rotterdam⁴³⁰

Relief and medical care

The first cell occupants from Schiphol-Oost arrived at the detention centre in Rotterdam-Merwehaven on Thursday 27 October at around 07.30 hours. A nurse performed an initial assessment there. One cell occupant with breathing problems was taken to hospital by ambulance⁴³¹. The other cell occupants were housed on the detention boat, four to a cell. Attempts were made to place cell occupants from Schiphol-Oost together in the same cell as much as possible. The residents were able to indicate who they wanted to share their cells with⁴³². The cell occupants were initially placed under the wrong regime⁴³³. It was ensured that the cell occupants from Schiphol-Oost were housed on the detention boat with sprinkler system⁴³⁴. The cell occupants were also notified on arrival about the fire safety of the detention centre.

The spiritual counsellors and the repatriation officers were busy on the first day after the arrival of the cell occupants making the arrangements for many necessities, such as blankets, sheets, sandals, food, replacement clothing, telephone cards and pocket money. On the first day, the cell occupants were allowed to phone friends, acquaintances and lawyers at no cost, through the repatriation officer. The cell occupants were also given telephone cards in order to be able to make phone calls. The repatriation officers spoke to all the cell occupants from Schiphol-Oost about the fire, and explained the house rules of the Rotterdam detention centre. The cell occupants from J and K Wing were given priority in this above the other residents from Schiphol-Oost.

On the day the cell occupants arrived in Rotterdam, teams of nurses performed a medical intake. During the intakes, the nurses were able to consult a doctor and a psychologist. A second

428 The normal tasks of the repatriation officer, in the context of his or her position, include notifying cell occupants about the current situation regarding their deportation, explaining the various procedures and the consequences depending on whether or not cell occupants cooperate in their deportation.

429 The English version of the information bulletin is enclosed in Appendix 18.

430 Detention centre Rotterdam has two locations: Merwehaven and Rotterdam Airport Deportation Centre ('Zestienhoven'). Both sites were led by the same management. In the context of the relief of and aftercare for victims of the fire at Schiphol-Oost, the same care providers were deployed and the same approach taken. The two sites are therefore not dealt with separately.

431 It became apparent in the hospital that this person was suffering from stress-related hyperventilation.

432 On the Monday after the fire, the management of the Rotterdam detention centre received information on the cell occupants and on the regime under which they were being detained at Schiphol-Oost. On the basis of this information, the cell occupants were regrouped and the people who were being detained under the same regime were put together.

433 The Safety Board has not seen any indication that this had negative consequences for the cell occupants.

434 Detention centre Rotterdam-Merwehaven has two detention boats, the Reno and the Bibi, one of which is fitted with a sprinkler system.

psychologist and a psychiatrist could also be consulted by phone. Only the urgent cases - the cell occupants who clearly needed immediate medical assistance on the basis of the intake - were seen by the doctor on the first day. A list⁴³⁵ was drawn up during the intake of the names of the cell occupants and the location in which they had been detained in Schiphol-Oost. On the basis of this list, the care providers could see which of the cell occupants were directly and indirectly involved in the fire.

Information from the TDBV shows that all the cell occupants from J and K Wing had a consultation with a nurse within one day. The majority of this group also spoke to a doctor within one day after the fire⁴³⁶. Where people did not have contact with a doctor, there was no indication from the nurses of the need for such a consultation. This percentage of the number of consultations, stated by the TDBV, differs from the information encountered in the medical dossiers in the matter⁴³⁷. According to what was recorded in the medical dossiers, two-thirds of the cell occupants from J and K Wing had a consultation with a nurse on the first day after arrival in Rotterdam. Those cell occupants who were not seen by a nurse immediately on the first day spoke to a nurse for the first time in a period varying from two to nine days after the fire. After the first consultation with a nurse or doctor, a large proportion of the cell occupants were given follow-up appointments with a nurse, doctor and/or psychologist in the subsequent weeks. The care providers in Rotterdam indicated in interviews that all the cell occupants originating from Schiphol-Oost had a medical consultation on the day after arrival.

Psychosocial assistance

The psychologist, the spiritual counsellors, the repatriation officers and the medical service spent time among the cell occupants on the first day after the cell occupants arrived in Rotterdam, to see how they were doing and to talk with them. The imam⁴³⁸ organized a prayer service / group discussion for the muslim cell occupants on the first day. A large proportion, but not all, of the cell occupants from J and K Wing spoke to a psychologist in the first weeks after the fire⁴³⁹. Where cell occupants did not see a psychologist, there was no indication from the nurses that such a visit was needed.

The cell occupants were able to speak to the spiritual counsellors, repatriation officers, heads of department and the medical service for a long period. Both the pastor and the imam were involved in organizing religious services and prayer meetings, group discussions and individual interviews in the first weeks after the fire.

Problems encountered during the realization of relief and aftercare

As was the case in Zeist, language formed a problem in Rotterdam during the care provision. Telephone interpreters were used during the contacts with the doctor and nurses. There were also staff members in the detention centre who spoke some of the languages, as a result of which language was not felt to be a problem during the intakes, according to the management. However, guards do not have a professional code of secrecy regarding the information revealed in interviews between doctors/nurses and cell occupants.

In a number of cases in Rotterdam, notes were made in the medical dossiers regarding the problems resulting from the lack of an interpreter. According to the medical dossiers, in a number of cases the care was provided too late in Rotterdam. For example, two residents were sent to hospital with breathing problems more than two weeks after the fire.

In addition, the regime for cell occupants was only relaxed in several areas and for a short period in Rotterdam. The cell occupants were not locked in during the afternoon of the first day after

435 The list was therefore not intended to identify who was who, but served as a resource for determining the need for care.

436 See Figure 33, after par. 8.5.14.

437 For the purposes of this investigation, the Safety Board had access to fifteen medical dossiers of cell occupants from J and K Wing of the Detention Centre Schiphol-Oost who were transferred to Rotterdam. With regard to the completeness of these dossiers, it must be noted that the identification of the cell occupants was a problem on the first day, as a result of the fact that cell occupants gave aliases and false names. Medical checks and treatment were therefore performed for people whose identity had not been established. The dossiers of these people, however, could not be updated at that time for the above reason.

438 One of the two spiritual counselors present.

439 See Figure 33.

the fire. In the evening, the cell occupants were given extra time for outdoor exercise and phone calls. There was also a possibility to receive visitors that day. During the period following this, the regime was not relaxed and no additional activities were developed for cell occupants from Schiphol-Oost.

8.5.14 Analysis of the relief and aftercare for cell occupants in Rotterdam

The management, doctor, psychologists, heads of department, repatriation officers and spiritual counsellors in the detention centre in Rotterdam worked and drew up plans together. The medical, psychosocial and material care was provided in a cohesive framework. Particular attention was paid to the cell occupants of J and K Wing. The medical service drew up a general plan of action for the care for the cell occupants. Nevertheless, a number of shortcomings were identified, which will be discussed in this subparagraph.

Pursuant to the Custodial Institutions Act and other legislation, cell occupants are entitled to a certain regime. The Safety Board takes the position that a stricter application of this regime after transfer is not permissible, in view of the fact that the cell occupants have not been given a different status as a result of the transfer. The regime at the reception location must therefore be at least equivalent to the regime at the Detention Centre Schiphol-Oost.

As there was no overview of the transfers of cell occupants, the management of the penitentiary institution in Rotterdam did not know how many and which cell occupants they had to receive under which regime. They could have been aliens, but could also have been people who had been imprisoned for criminal acts. Cell occupants with different detention regimes were initially placed together in the same cells, as a result of which cell occupants were incarcerated under the wrong regime⁴⁴⁰. It should be noted in this respect that the identification process was hampered by the fact that not all cell occupants were cooperative, and had given false names, for example.

The medical dossiers show that not all cell occupants were seen within 24 hours by a nurse in Rotterdam (67% were seen). According to the data of the TDBV, all the residents saw a nurse on the day of arrival in Rotterdam. It has been established in individual cases that requests from the cell occupants to speak to a doctor were not complied with promptly. On the basis of the medical dossiers, a number of examples can be given of situations in which cell occupants had to wait an unnecessarily long time for medical care.

For the purpose of this analysis, the Safety Board has assigned a quantitative requirement to psychosocial care, whereby cell occupants must receive an offer of psychosocial care within two days after arrival in the penitentiary institution, and that cell occupants who have submitted a request to see a psychologist must be able to see him/her within one week.

The cell occupants in Rotterdam were offered an interview with a psychologist during the first weeks after the fire. The psychologist spoke to cell occupants both in a group context and individually. The nurse drew up an indication for this, with additional attention being given to the cell occupants from J and K Wing. With regard to cell occupants with an increased risk of developing symptoms relating to the fire, no individual care plans were drawn up, as was also the case in Zeist. Again, cell occupants generally had to ask for psychological assistance themselves after the initial relief, according to data from the medical dossiers.

Norm	Zeist	Rotterdam
Consultation by a nurse on the day of arrival	20% (72%)	100% (67%)
Consultation with the doctor within one day	5%	90%
Consultation with a psychiatrist (individually or in a group) within one week	68%	87%
Possessions received within one week	76%	84%

Figure 33: Data on consultations with nurse, doctor and psychologist on the basis of TDBV data for the cell occupants of J and K Wing. The data is from 41 cell occupants in Zeist and 32 cell occupants⁴⁴¹ in Rotterdam. The percentages on the basis of the medical dossiers are shown between brackets⁴⁴².

440 The Safety Board has not seen any indication that this had negative consequences for the cell occupants.

441 These are thirty cell occupants who were brought to Rotterdam on the night of the fire, and two cell occupants who were taken to Rotterdam from the hospital at a later date.

442 The percentages shown in this table do not form a yardstick for the availability of the care, but only indicate which percentage of the cell occupants involved availed themselves of the care, according to the registered data.

Care	DC Zeist	DC Rotterdam
Received medical care	62%	91%
Need for more medical care	35%	48%
Received psychosocial care	58%	61%
Need for more psychosocial care	23%	30%
Received spiritual care	23%	56%
Received possessions	31%	35%
Received clothing	46%	65%
Had contact with family	62%	100%
Had contact with lawyer	54%	52%

Figure 34: Data on relief and aftercare on the basis of interviews with cell occupants. These interviews took place between three and five weeks after the fire. The data is from 26 cell occupants in J and K Wing in Zeist and 23 cell occupants in Rotterdam data originates from 26 cell occupants from J and K Wing in Zeist and 23 cell occupants in Rotterdam⁴⁴³.

8.5.15 Return of property to cell occupants in Zeist and Rotterdam

The day after the fire, the property and clothing of cell occupants were collected from all the wings in the Detention Centre Schiphol-Oost, with the exception of the possessions which were in Wing D, J and K⁴⁴⁴. The personal possessions of the cell occupants which were stored by the Detention Centre Schiphol-Oost in the BAD department were transferred by bus to the new locations of the cell occupants, the day after the fire. As it was not entirely clear which cell occupants had been transferred to which location, and some of the cell occupants had given false names, some possessions were originally sent to the wrong location.

Figures from the TDBV show that the vast majority of the cell occupants who were moved to detention centres in Zeist or Rotterdam had their luggage returned within a week after the fire. The cell occupants signed for receipt of these possessions.

8.5.16 Analysis of the return of property to cell occupants in Zeist and Rotterdam

The majority of the cell occupants, in both Zeist and Rotterdam, received their property back from the BAD in Schiphol-Oost within a week, and signed for receipt. However, during the interviews with the Safety Board, almost half of the cell occupants declared that they had not yet received their possessions⁴⁴⁵. From the point of view of the cell occupants, it took too long for their personal belongings to be returned.

8.5.17 The relief and aftercare for the transferred cell occupants in Ulrum

The transfer of cell occupants to Ulrum

In November, at the request of members of the House of Representatives, Mrs. Verdonk, the Minister for Alien Affairs and Integration took the decision to transfer a number of cell occupants from the detention centres in Zeist and Rotterdam to an asylum seekers' centre (AZC). The IND implemented Minister Verdonk's decision and initially transferred cell occupants who possibly had trauma-related symptoms (such as PTSD)⁴⁴⁶ to the asylum seekers' centre in Ulrum⁴⁴⁷. The detention of these cell occupants was withdrawn at the same time as this transfer. After the first arrivals of cell occupants, the Ulrum COA (asylum seekers' centre) made use of the Geeuwenbrug

⁴⁴³ The figures do not provide quantitative data on the availability of the care, but the figures given indicate which percentage of the people affected availed themselves of the care, according to the registered data.

⁴⁴⁴ In the context of the investigation, these wings had not yet been given the all-clear after the fire by the Public Prosecutor's Office and the Safety Board. On 15 November, the Safety Board inventoried the personal possessions and clothing in the cells of J and D Wing, inasmuch as these had survived the fire, and took photographs of them. On 21 November, two staff members of the Schiphol-Oost detention centre collected these personal possessions.

⁴⁴⁵ It may be the case that the residents were talking about the personal possessions which were in their cells on the night of the fire. The possessions in the cells of K Wing were destroyed by the fire, and the possessions from the cells in J Wing were only released three weeks later, in the context of the investigation by the Public Prosecutor's Office and the Safety Board.

⁴⁴⁶ Post-Traumatic Stress Disorder.

⁴⁴⁷ For more information on this selection process, see Appendix 16.

AMOG centre⁴⁴⁸. The cell occupants were received in Geeuwenbrug and prepared for the transfer to the asylum seekers centre. Ulrum also received (medical) information from Geeuwenbrug on the cell occupants to be received. As of the end of November, 21 cell occupants were housed in the AZC in Ulrum, Groningen⁴⁴⁹. Three months after the fire, a total of 24 persons were placed in Ulrum⁴⁵⁰.

The organization of the relief of the cell occupants in Ulrum

After it was made known in November that survivors of the Schiphol-Oost fire would be transferred to Ulrum, the reception manager of the Agency for the Reception of Asylum Seekers (COA), Groningen cluster, called in the Medical Reception of Asylum Seekers (MOA) North. MOA North then called in the GHOR, due to the expected number of cell occupants. The GHOR in Ulrum brought in the Groningen Mental Health Service (GGZ), including the PTSD Knowledge Centre North Netherlands⁴⁵¹, along with a freelance psychologist, for the purpose of providing relief to the cell occupants. The freelance psychologist was brought in because there was a waiting list for a GGZ psychologist.

The relief and aftercare for the cell occupants in Ulrum

The first group of residents arrived in Ulrum in a Ministry of Justice coach, on Wednesday 30 November. Staff and residents in Ulrum did not know whether the new group of residents included people with a criminal background⁴⁵². According to the care providers, the cell occupants from the first group were not aware of the fact that their detention had been withdrawn. They had not received information on the place to which they were being transferred, or what the reason was for the transfer. According to the DJI, all the cell occupants were informed about their transfer. The Safety Board deems it possible that there was some degree of miscommunication.

The COA foresaw problems with the relief of the second group of cell occupants. This group was due to arrive on a Friday (after 30 November), but after 17.00 hrs and in the weekend, no staff is present at the AZC in Ulrum (apart from security personnel). The COA therefore took the ad-hoc decision to transfer this group to the AZC Ulrum via the AZC Geeuwenbrug. This is due to the fact that there are staff present 24 hours a day in the AZC Geeuwenbrug⁴⁵³. The COA then decided that all former cell occupants of the Detention Centre Schiphol-Oost would, from that point on, be brought to Ulrum via Geeuwenbrug⁴⁵⁴. Neither the MOA in Geeuwenbrug nor the MOA in Ulrum were initially informed of this decision.

The COA arranged meetings for the cell occupants (apart from the first group) in order to provide information on the provision of care, the consultations to be held and on practical matters such as money, food and clothing.

Psychosocial assistance

After the first five cell occupants arrived at Ulrum on Wednesday 30 November 2005, interviews were held with each of them. A staff member of the GHOR was present at the time of arrival of the cell occupants. At the request of the GGZ, the freelance psychologist started carrying out intake interviews with the first cell occupants from Schiphol-Oost a week after arrival. The GGZ and the PTSD Knowledge Centre North Netherlands took over the psychologist's tasks in mid-December.

In Ulrum, the care providers held consultations every day. The GGZ was of the opinion that the victims of the fire primarily needed to be offered diversion in the form of activities and sport. However, the COA received the survivors in the same way that this normally takes place. The COA offered extra care through the deployment of an additional social nurse (and the deployment of the GHOR) and (as of 1 February) two additional staff members, and also deployed additional

448 An AMOG centre is a temporary reception centre for asylum seekers with problematic behavior. The staff at Geeuwenbrug is prepared for possible crisis situations, 24 hours a day.

449 The Ulrum AZC is one of the relief centres of the Central Agency for the Reception of Asylum Seekers (COA).

450 21 of these occupants originated from J and K Wing, three people came from the other wings of the Detention Centre Schiphol-Oost.

451 The Knowledge Centre is part of the GGZ Groningen.

452 Following a request from the COA, the DJI issued information on the cell occupants who were being transferred, and had already been transferred, to Ulrum.

453 Staff is present in Geeuwenbrug all day long, because there is a special department there for asylum seekers with behavioural problems.

454 Most cell occupants stayed in Geeuwenbrug for two to three days, before they were transferred to Ulrum.

security for the cell occupants from Schiphol. In Ulrum, limited activities were possible, such as site maintenance, technical maintenance and the supervision of activities for children. Due to the imminent closure of the centre, there were not many possibilities for organizing activities.

From mid-December, the PTSD Knowledge Centre North Netherlands offered follow-up treatments for trauma-related problems. These follow-up treatments consisted primarily of carrying out individual interviews and group discussions.

In Ulrum, a long-term plan was initially drawn up for the relief and aftercare. Due to the lack of clarity regarding the length of the residents' stay, this plan was not used.

8.5.18 Analysis of the relief and aftercare for transferred cell occupants in Ulrum

The majority of the cell occupants from J and K Wing were transferred to an asylum seekers' residential centre, pursuant to a decision of Minister Verdonk, because better care could be offered there. The possibility of organizing effective care provision in Ulrum for cell occupants who could develop trauma-related complaints must be put into perspective. The possible positive effect of the transfer - the cell occupants would gain a certain degree of freedom⁴⁵⁵ - was limited by the fact that the Ulrum site was located at a very large distance from the area where most of the cell occupants would be able to find possible social support. Very limited activities were organized for the residents in Ulrum.

The cell occupants were given insufficient information about the transfer to Ulrum in the detention centres. They did not know which decision lay at the basis of the transfer, and what the cell occupants could expect in the AZC.

8.5.19 General analysis regarding the relief and aftercare of cell occupants

Medical and psychosocial care

With regard to the medical and psychosocial care, there is a major discrepancy between the figures and data which the Safety Board received from the TDBV, from the care providers and the figures which can be derived from the medical dossiers⁴⁵⁶. It can be concluded that there was no unequivocal recordkeeping of the care received by the cell occupants, as a result of which it is impossible to say with certainty which care the cell occupants actually received.

The point of departure for care provision is that all cell occupants affected by the fire receive the same quality care as anyone else, inasmuch as this is possible within the detention regime. However, a detention regime has a restrictive effect on the access to care. Cell occupants cannot visit the doctor independently, but have to submit a request slip to the nurse. The nurse assesses the request and arranges an appointment with the doctor. This results in different care than civilians would receive after a large-scale disaster. In addition, institution officers are given the job of assessing whether cell occupants should be given priority access to the doctor. The large number of arrivals in Zeist and Rotterdam overloaded this system. Forms of screening were applied at the gate and triage⁴⁵⁷. There was also contact with groups of cell occupants. All this was organized in order to guarantee the medical care for those who had an urgent need for it. This method had consequences for the quality of the care. There was an unnecessary delay before some of the problems were treated. Arranging the right glasses or dentures can sometimes take weeks.

During the interviews carried out by the Safety Board, it became clear that medical and psychosocial care was available in the Rotterdam-Merwehaven detention centre and in Zeist. The cell occupants had access to the medical service, and via this service to a doctor, psychologist and/or psychiatrist. Spiritual counsellors, repatriation officers and social workers also played a role in the relief of and provision of aftercare to cell occupants.

A majority of the interviewed cell occupants from J and K Wing indicated that they had received medical care⁴⁵⁸. This percentage was higher in Rotterdam than in Zeist. Almost half of those

455 The residents must report in person to Ulrum each week.

456 See Figure 33, after par. 8.5.14.

457 Selection and ranking of victims on the basis of the need for care.

458 See Figure 34, after par. 8.5.14.

interviewed needed more medical care at the time of the interview with the Safety Board. Also, more than half of the cell occupants interviewed indicated that they had received psychosocial assistance in Zeist or in Rotterdam.

The interviews revealed that many residents had repeatedly asked for a consultation with a doctor or a psychologist (via request slips). Many residents in Zeist and Rotterdam suffered from problems such as headaches, stress, difficulty sleeping, lack of appetite and intrusive images of the fire. In interviews with the Safety Board they indicated that they had received insufficient care for these problems.

Detention regime

In the eyes of many care providers and management staff, the detention regimes are not supportive of dealing with traumatic events. No action was taken with regard to this fact. The detention centres were not able to create sports activities or provide the target group with the opportunity to participate in other organized activities several times a week. In Ulrum, requests for the organization of activities could only be met to a limited extent. It is not clear why more activities could not be organized. It was indicated that no staff were available for organizing sports activities. In Ulrum it was suggested that this was due to the closure of the AZC, which was due in the near future. The suggestion of care providers to extend the lunch periods, so that the cell occupants could spend more time in the fresh air was only able to be met to a minimum degree. It was only possible to modify the regime to the needs and problems of the cell occupants to a very limited extent. The institutions were far too inflexible.

In Zeist and Ulrum there were care providers who felt so restricted in their treatment possibilities due to the conditions⁴⁵⁹ in which they had to work that they felt that they were unable to provide adequate assistance. In addition, the external care providers felt that little or nothing was done with their recommendations. Some care providers wrongly held back with regard to treating cell occupants, because they felt that a detention setting was not a place where treatment was possible.

Continuity of the care

Due to the transfers of the cell occupants from Schiphol-Oost, many intakes and screenings took place. As a result, treatments were started which had already been started at a previous location. This may have taken place unnecessarily often. Care providers were unnecessarily called on to carry out the double intakes. In addition, a switchover of doctors took place within the TDBV on 15 January (as the result of a new contract). The interviews reveal that the cell occupants of Schiphol-Oost were not taken into account, and that no transfer of information took place between the 'old' and the 'new' care providers.

Decisions and external interventions interfered with a planned method of working on relief and aftercare. It does not appear that the people implementing the care had any influence on this. Among other things, this involved screening by the Medical Advice Bureau of the IND (cell occupants must be seen by a doctor before withdrawal from detention or deportation) and the transfer to Ulrum. As a result, new activities such as screening, needs assessment, information rounds and treatment starts were used, which may have put the continuity of the care at risk.

Information and communication

The cell occupants spoke a great many different languages. Telephone interpreters were used for the care provision in Zeist and Rotterdam, as well as cell occupants and guards. Both in Rotterdam and Zeist, the Safety Board interviewed cell occupants who had not yet been able to speak in their own languages from the fire to the moment of the interview. The cell occupants were not involved in the decision to bring in an interpreter. There are also indications that the communication between the cell occupants, institution staff and care providers was insufficient, because no interpreters were deployed.

The information from interviews with care providers and cell occupants gives the distinct impression that cell occupants were not aware with whom they were speaking (doctor, psychologist, interviewer) or what they should expect. They also did not recognize the intentions of the care providers.

459 These conditions included treatment administered through the hatch window of the cell of people in crisis in an observation cell, the refusal of the institution to provide prescribed medication, and the uncertainty regarding the cell occupants' length of stay.

Material care

Cell occupants are entitled to contact and to visits, on the basis, among other things, of the Custodial Institutions Act, the Standard Minimum Rules for the Treatment of Prisoners, UNHCR's Guidelines on the Applicable Criteria and Standards relating to the Detention of Asylum Seekers and the European Prison Rules. For the purpose of this analysis, the Safety Board applies the following quantitative approach to this right. Cell occupants are to be given the opportunity to notify their families and lawyers about their welfare and new place of residence on the day after their arrival at the reception location. They are also to be given the opportunity to receive visitors within one day.

The cell occupants were given the opportunity to have telephone contact with family and friends in the penitentiary institution in which they were housed after the fire. They were also offered additional opportunities to receive visits from family and friends. Within four weeks after the fire, the interviewed cell occupants in Rotterdam and Zeist had had contact with their family, and half of them had had contact with their lawyers. It cannot be determined on the basis of the interviews and collected documents whether this contact took place within one day after arrival at the location, as is determined in the reference analysis. The cell occupants are of the opinion that these possibilities were insufficient.

On the day of arrival, additional visiting hours were made available, without appointment, in the detention centre in Rotterdam. The cell occupants in Zeist were given the possibility to receive visitors on the first day. After this, the rule of one hour of visits per week came back into effect.

The care providers in Zeist and Rotterdam indicate that they provided the cell occupants with clothing. The cell occupants related various stories about this. Some of them indicated that they had received clothing from the penitentiary institution, others said that they had borrowed clothing from cellmates or that they had received clothing from their families, and yet other residents said that they had not received any clothing. On the basis of this conflicting information, it is not possible to determine whether all the cell occupants received clean clothing on the day of arrival.

Appreciation of the relief and aftercare

The cell occupants, care providers and Site Managers had a different appreciation and assessment of the care provided. Generally speaking, the cell occupants feel that they received insufficient care, the management and care providers feel that they did provide sufficient care.

Recognition

In view of the nature of the events, the cell occupants should have received greater attention and recognition. Recognition means that it is recognized that the people were involved, and that what they went through was harrowing. Positive attention and recognition could have been expressed, for example, by providing the aftercare in a planned and coordinated manner, taking additional measures, offering diverting and amusing programmes or organizing creative or sports activities, which could have reduced the sense of having lost control of one's own life. The recognition could also have been expressed by giving all cell occupants the opportunity to attend the memorial service as a group, in person or at a distance, in the detention centre where they were staying. Only a limited number of cell occupants in Zeist were allowed to watch the memorial service on television.

Second phase of aftercare

None of the reception locations drew up a plan for the second phase of aftercare, the period from three months after the fire. The offer of material, psychosocial and medical aftercare to the cell occupants forms part of the standard care which is provided to all cell occupants.

8.5.20 Transfer of medical dossiers to Zeist, Rotterdam and Ulrum

On the morning of Thursday 27 October, and Schiphol-Oost, printouts were made from HIS⁴⁶⁰ of all medical dossiers⁴⁶¹. The dossiers were also sent to the detention centres in Zeist and Rotterdam⁴⁶². The medication for the cell occupants from Schiphol-Oost was transferred to the other detention centres on Thursday 27 and Friday 28 October. Some dossiers were initially sent to the wrong detention centre. Most of the medical dossiers were in the possession of the receiving locations within two days. The medical services for the receiving locations were also notified of special cases (such as cell occupants in the observation cell) on the day of their arrival in these detention centres.

Eventually, the detention centre in Zeist received the medical dossiers of all the cell occupants from Detention Centre Schiphol-Oost. The detention centre in Rotterdam did not receive a medical dossier from Schiphol-Oost for 48 of the cell occupants. It is not clear why the transfer of data to the detention centre in Rotterdam did not proceed properly.

The transfer of the medical dossiers from the detention centres in Zeist and Rotterdam to the AZC in Ulrum was delayed. A number of medical dossiers from the first group of cell occupants to arrive in Ulrum were delivered from Rotterdam to Ulrum six days after their arrival. As the entire dossier of medical data was too large to fax, it was decided at the time of the transfer to only fax the medication list from Rotterdam to Ulrum. According to the Ministry of Justice, the medical dossiers were sent along with the cell occupants at the moment of transfer, and handed over to the COA. According to the Ministry of Justice, the transfer of the medical dossiers took place at all times via the COA to the MOA.

The medical information on survivors of the fire who were transferred via Geeuwenbrug to Ulrum was provided by telephone and fax. The medical dossiers from Geeuwenbrug were also sent on to Ulrum. These included the medical dossiers originating from the detention centres in Zeist and Rotterdam. The Geeuwenbrug AZC also ensured that the residents had several days of medication with them at the moment of transfer to Ulrum.

8.5.21 Analysis of the transfer of medical dossiers to Zeist, Rotterdam and Ulrum

The first step in ensuring good continuity of care is the transfer of medical data. Of the 49 dossiers requested from Schiphol-Oost, Zeist, Rotterdam and Ulrum, nine dossiers (20%) were not received. It has also become apparent that the Schiphol-Oost medical service generally did not have access to the medical data of the cell occupants before their arrival at Schiphol-Oost.

The cell occupants originating from J and K Wing were transferred from the reception location one, two or three times within three months. The transfer of medical dossiers and the provision of medication did not always take place correctly during these transfers.

Finally, in cases of deportation or withdrawal of detention, it is unclear whether the reception location transferred the medical dossiers of the cell occupants to their (future) general practitioners.

The second step for good continuity of care is carrying out adequate intake interviews. On the basis of the medical dossiers inspected, it can be concluded that in 23 of the 40 cases, essential questions were not asked either in Schiphol-Oost, Zeist or Rotterdam for the purpose of ensuring an adequate medical intake, as a result of which no answers were recorded regarding problems, need for assistance, medication and prior history. It is also noteworthy that no specific notation was made in the dossiers that the cell occupants had experienced the fire at Schiphol-Oost.

460 HIS is the electronic patient dossier of the GP, which was introduced in the 1990s. Authorization for use of the system is limited to authorized GPs and assistants. The staff of the medical service of Schiphol-Oost is connected to the national database containing HIS information. No information can be transferred to other facilities in the chain through this system. The dossiers must be printed out, sent by post and re-entered in the system by the receiving party. It should be noted in this respect that it is not possible for standard GPs to send patients' medical dossiers on to other colleagues through the HIS. The patient must give permission for the transfer of the data.

461 The term medical dossier is deemed to mean a hard copy (printout) of the patient's dossier from the HIS system, with the supplementary hard copy information from previous attending doctors.

462 It is not clear how many printouts this involved.

It was difficult for the investigators to gain a picture of what had happened at the reception locations on the basis of the medical dossiers. In many cases abbreviations were used to denote positions, but officials were also regularly referred to only by their initials or first name. These medical dossiers were therefore poorly accessible to other care providers after the transfer. Maintaining dossiers is important, also in view of the large number of changes in the doctor/care provider - patient relationship.

8.5.22 Media attention

From the beginning, the survivors of the fire attracted a great deal of attention from the media. Several days after the fire, it was announced that many of the survivors could not be located by their families, friends and lawyers. In the week after the fire, the news focused primarily on the reception of the survivors in other detention centres, and in the period following this on the aftercare which they were - or were not - receiving. The survivors themselves did not always experience this constant media attention as something positive. Several of them indicated that they found it to be stressful. One thing that is certain is that the news media's attention to the survivors had an influence on the course of the aftercare. Reporting on the victims resulted, on a number of occasions, in political debates and changes relating to the aftercare.

8.5.23 Analysis of media attention

The media attention was initially not targeted at the recovery of control by and recognition of the victims, but on exposing the failure of the system. Or the attention focused more on demonstrating that the cell occupants were being given proper support. The - sometimes premature - comments of politicians in the media caused a great deal of unrest. The comments relating to a general pardon, in particular, gave the cell occupants false hope.

8.5.24 Relief and aftercare with regard to the guards in Detention Centre Schiphol-Oost⁴⁶³

The organization of the relief and aftercare⁴⁶⁴

Initially, it was decided to organize the relief for the guards jointly on site. In this context, a number of consultations took place initially between care providers of the DJI, KMar and the GHOR.

The KMar stated that they were capable of handling the relief effectively within their own organization (Ministry of Defence) and decided after the fire in the detention centre to organize the relief and aftercare of their own KMar staff who had worked in the Detention Centre Schiphol-Oost on the night of the fire. The team of care providers which received the staff members on the morning after the fire consisted of three spiritual counsellors, a colleague assistance team, two social workers and a staff doctor.

No plan was included in the emergencies plan of the Detention Centre Schiphol-Oost for the provision of aftercare to staff. It was initially decided to use the GHOR Amsterdam and area for the aftercare for the guards of the DJI and Securicor, and to use a coordinator (who was also a psychologist) for the relief and aftercare of Ministry of Justice staff. As of 28 October, a psychologist was used full-time for two weeks for the supervision of these guards. The external care providers finished off their work on Tuesday 2 November. After the departure of the external care providers, the Institute for Psychotrauma was brought in. The relief and aftercare coordinator continued the work, together with two psychologists, for the purpose of providing aftercare to the guards.

The first relief of guards

On the morning after the fire, KMar personnel received care in the KMar School, which is located near to Schiphol-Oost. That same day, a number of group sessions were organized, in which the

463 Employees from three organizations were working at the Schiphol-Oost detention centre: The Custodial Institutions Service (DJI), Securicor (contracted by DJI) and the Royal Military Constabulary (KMar). Where the services applied the same approach to relief and aftercare, no distinction is made between organizations. Where the guards received relief and aftercare in different ways, a distinction is made between DJI and Securicor on the one hand, and the KMar on the other.

464 The evaluation of operational medical assistance in the fire at the Schiphol-Oost detention centre 27 October 2005 of the GHOR Amsterdam and area was used for the reconstruction of the facts.

KMar guards were able to tell their stories. Spiritual counsellors, the social workers and the staff doctor supervised these groups.

On the morning after the fire, GHOR personnel arranged a meeting for guards of the DJI and Securicor who had experienced the fire in the detention centre. The staff of the medical service at the Detention Centre Schiphol-Oost also attended this meeting. As far as is known, four guards of the DJI and Securicor missed the first relief; two of them because detectives were interviewing them at that time. Two other guards missed the meeting because they were in hospital. The external care providers arranged two psychiatric consultations for them. After this initial meeting, another four information meetings were held on Thursday 27 October for the staff of the DJI and Securicor who started their shift on 27 October.

The Minister of Justice, together with the Minister for Alien Affairs and Integration also visited on 27 October at approximately 09.30 hrs. Both ministers spoke to various guards at that time.

Aftercare to guards after the first day following the fire

In the days after the fire, a number of meetings were organized for the KMar personnel, which were also open to others. Both individual interviews and group discussions were held with the personnel. The spiritual counsellors conducted many interviews on the work floor with the KMar personnel involved. Those who needed supplementary aftercare were referred, via the staff doctor or a spiritual councillor, to the individual care provision section.

Approximately ten days to two weeks after the fire, a special edition was published of the KMar journal "Markering" about the fire. This contained stories from people and telephone numbers of people and bodies to which guards could turn for help. The KMar also distributed an information leaflet about aftercare at the meeting with the mayor and a general.

Two of the KMar guards interviewed went to hospital in the months after the fire for a check-up and a one-off lung inspection. Three of the KMar guards went on sick leave. Due to a shortage of staff, some of them guarded K Wing - as a crime scene. The KMar personnel in question experienced this as unpleasant.

Individual interviews and group discussions were held with the guards of the DJI and Securicor. Just under a week after the fire, on Tuesday 2 November, the DJI organized a group session for all guards who were present in the detention centre during the fire. In interviews with the Safety Board, a number of the KMar personnel indicated that they would have liked to have taken part in the meeting, but were not given an opportunity to do so.

The main memorial service, organized by the DJI, took place on 8 November. This service was attended by the Ministers of Justice and Alien Affairs, the mayor of the Municipality of Haarlemmermeer and the commander of the Royal Military Constabulary. A number of the guards from the DJI, Securicor and KMar were also present.

After 8 November, the psychologists of the Ministry of Justice carried out individual interviews with the guards of the DJI and Securicor. The job supervisors had a different role in the subsequent course of the first aftercare phase⁴⁶⁵. They visited the guards at home⁴⁶⁶.

On 15 November, the Ministry of Justice visited the guards who had been working in the detention centre on the night of the fire. This involved guards of the DJI, Securicor and KMar.

On 6 December, the KMar organized a meeting for the KMar guards, which was attended by the Mayor of the municipality of Haarlemmermeer, the commander of the KMar and the commander of the KMar in the district of Schiphol.

Three guards who were working for the DJI and Securicor on the night of the fire went on sick leave. Approximately half of the guards suffered problems during the first aftercare phase. These problems mainly involved difficulty sleeping, a sore throat and diarrhoea. These problems were all related to the fire. During the course of the first aftercare phase, two guards were referred to the Institute for Psychotrauma, due to possible post-traumatic stress disorder (PTSD).

465 Job supervisors are personnel coordinating officers who work for a DJI pool.

466 The job supervisors were supported by the two psychologists from the Ministry of Justice in their role in the provision of aftercare.

All the guards interviewed indicated that they had had a great deal of support during the initial relief and also in the subsequent aftercare from informal contact with their direct colleagues. The guards and care providers indicated in interviews that the continuous attention paid to the fire and the negative stories in the media were stressful for them.

8.5.25 Analysis of relief and aftercare for guards in Detention Centre Schiphol-Oost

The guards of Schiphol-Oost risked their own lives in attempting to bring cell occupants to safety on the night of the fire. From an emotional point of view, they experienced this situation as unsafe. The guards suffered from fear, primarily during the events in J Wing. They felt threatened, because cell occupants were throwing things at them. The extra support of colleagues, and the possibility to go home after the end of their work once the fire was out, helped contribute to restoring the guards' sense of safety. Most of the guards went back to work in Schiphol-Oost or in 't Nieuwe Lloyd after this.

The interviews showed that the guards were aware of the need to share their experiences in their circle of colleagues and family. They were also aware of the possibilities to make use of additional assistance in dealing with their experiences during the fire.

The KMar organization took care of its own personnel. The KMar's own spiritual counsellors and psychologists conducted interviews with the personnel involved in the fire. The GHOR and the psychologist of the Ministry of Justice were called upon for the relief and aftercare for personnel of the DJI and Securicor. The biggest difference between the relief and aftercare for the personnel of the KMar and that provided to the guards of the DJI and Securicor was not so much the content of the care provided, but rather who provided the aftercare. The personnel in question from KMar, the DJI and Securicor were not given the opportunity to participate in one another's meetings. All the interviewees who were asked questions about the aftercare indicated that they had been offered assistance.

The guards experienced the interrogations in the context of the criminal investigation by the Public Prosecutor's Office as stressful (this was indicated by both the guards themselves and by the care providers). Several guards were interrogated before they had had an initial debriefing. This is in conflict with the norm set within the reference analysis that the first debriefing must take place before any interrogation by the police.

Media stories about the role of the guards on the night of the fire were experienced as extremely stressful.

After the fire, all the guards were given a booklet with information about dealing with shocking experiences and the possibilities for getting help with this. A room with information about aftercare and PTSD was set up in the Detention Centre Schiphol-Oost for the personnel of the DJI/Securicor.

8.5.26 Relief and aftercare for emergency personnel

All the emergency personnel interviewed are satisfied with the relief and aftercare which they received. There are also no signs that there were structural safety shortcomings in the relief and aftercare for the emergency personnel. For this reason, the Safety Board decided not to investigate the relief and aftercare for emergency personnel in detail. For this reason, only a very brief summary of the relief and aftercare for emergency personnel is given below⁴⁶⁷.

An in-house relief team (BOT) was set up on the night of the fire for the fire brigade and ambulance personnel.

All the ambulance personnel who were on site on the night of the fire were given a debriefing, carried out by the BOT team and the duty medical officer. All fire brigade personnel were provided with care in the form of a debriefing and/or group discussions with the BOT team. Two of the interviewed fire brigade personnel missed the first debriefing. After the debriefing, the emergency personnel could call on the BOT team for individual discussions.

467 For a detailed description of the relief and aftercare, see Appendix 16.

The interviews reveal that there was a lack of clarity about relief and aftercare for switchboard operators and management.

8.5.27 Analysis of relief and aftercare for emergency personnel

The immediate superiors of the emergency personnel from both GHOR and the fire brigade activated the relief and aftercare. Debriefings were held, and if necessary the BOT team was deployed. This is in line with the norms set for relief and aftercare for emergency personnel.

8.5.28 Relief and aftercare for surviving relatives⁴⁶⁸

Immediately after the fire, a crisis team for surviving relatives was put together at the request of the DJI, consisting of personnel of the DJI and the IND, a spiritual counsellor and a nurse.

Identification

On Thursday 27 October, it was clear who had been in which cell and which cells had remained unopened. On the basis of this, a determination could be made of which cell occupants had not survived the fire. This identification had to be formally confirmed, however.

Ten of the eleven bodies could be identified on the basis of external characteristics⁴⁶⁹ and/or fingerprints. One of the bodies had to be identified on the basis of a DNA test. Only after presumed family members of the victim had agreed to the provision of DNA could all the bodies be identified and released.

The surviving relatives were informed about providing DNA and the identification by the head investigator of the KMar, with the help of an interpreter. One family could not believe that the mere provision of mucus from the cheek could result in a 100% identification, and is still not convinced about the death of their family member.

Due to the time required for the identification and the investigation into the cause of death, it was not possible to comply with the Islamic tradition of burying a dead person within one day. One family initially experienced this as extremely painful. Apart from this, maximum account was taken - and understanding shown for - the traditions of the deceased and their relatives.

After the identifications, all the relatives were informed within 24 hours by members of the crisis team.

Notification

Immediately after the fire, lawyers, family members and friends, among others, had a need for information about the fire and about the cell occupants who were in the detention centre and Schiphol-Oost. In order to properly structure the supply of information, the Red Cross opened a telephone line on 27 October, at the request of the DJI. 'Postbus 51' (public information department) was then brought in to register telephone enquiries and forward them to the DJI.

Members of the crisis team visited the families of the deceased. In addition, the embassies of Surinam, Ukraine, Turkey, Libya, the Dominican Republic, Bulgaria, Romania and Georgia were informed that one or more of their citizens had died in the fire.

Bringing over family

The relatives of the deceased, to the first and second degree, were issued a visa for one month to come over to the Netherlands, if they wished. The costs of the flights to and from the Netherlands, accommodation and visa fees were reimbursed for family members in the first degree. In the case of family members in the second degree, consultation was carried out between the Dutch representation in the country of origin and the Aliens Policy Directorate of the Ministry of Justice, before a decision was taken in the matter⁴⁷⁰. Once they arrived in the Netherlands, the surviving relatives had access to an interpreter.

468 The description of the relief and aftercare for the surviving relatives is based on data from the IND. Two contact persons for surviving relatives were also interviewed.

469 On the basis of Art. 8, par. 3 of the Burial and Cremation Act, identification can be made by two persons who knew the deceased during his/her life.

470 Letter from DJI to the House of Representatives, 1 November 2005 (5383522/05/DJI).

Dutch representation in the country of origin was made available to make it possible for the families to travel to the Netherlands. They issued visas and laissez-passers to family members who did not have a passport. Personnel from the crisis team accompanied the families at Schiphol-Oost. During their stay in the Netherlands, the families were given rooms at the Hilton Hotel Schiphol. The costs of this accommodation were paid for them. This included the costs of the room, transport, food and drink and telephone costs.

Memorial service

A memorial service was held on 8 November 2005 for the eleven victims of the fire. More than two hundred people, including eighty relatives, were present at the service, which was held in a hangar near the detention centre at Schiphol. Speakers at the memorial service included the Ministers of Justice and Alien Affairs and the Mayor of the Municipality of Haarlemmermeer. The coordinators of the wake read the nationalities of the people who died in the fire. A minute's silence was also held, and white ribbons bearing the names of the victims were unfurled.

Not all the surviving relatives felt the need to attend the memorial service.

Return of personal possessions

The personal possessions of the deceased persons and the money in their current accounts were returned to the surviving relatives. They signed a declaration of receipt for these. It is unclear whether the possessions ended up with the right people.

Repatriation and burial

The IND took care of repatriation of the bodies of the victims of the fire to their countries of origin, so that they could be buried there. The DJI paid for the costs of the funerals.

8.5.29 Analysis of relief and aftercare for next of kin

The DJI put together a crisis team to arrange relief and aftercare for the next of kin. The team worked on arranging aftercare for the next of kin from the moment of the fire until at least three months thereafter.

All surviving relatives were notified about the death of their family member within 24 hours after identification, in accordance with the norm set under the reference analysis. The surviving relatives were offered the opportunity to come to the Netherlands to attend the memorial service, and to accompany the body of the deceased family member to the country of origin. The relief and aftercare offered in the form of saying goodbye, repatriation and transfer of the possessions took place generally in accordance with the norms set in the reference analysis. It is not clear whether or not the cultural aspects of the next of kin were taken sufficiently into account.

Although information was obtained from the appropriate embassies concerning cultural aspects, a number of next of kin found the memorial service to be very 'Dutch', without room for emotion. It is also not clear whether the possessions ended up with the right people in all cases.

The funeral in the country of origin was structured in accordance with the family's wishes, and paid for by the DJI. Advice was obtained from the appropriate embassies regarding the cultural customs surrounding funerals in the country of origin, and the costs thereof. On the basis of this advice, consultations were held with the family regarding which costs were realistic.

8.6 Subconclusions regarding relief and aftercare

8.6.1 Relief and transfer of cell occupants

1. Cell occupants from J and K Wing did not feel physically safe during their relief in the exercise cage of J Wing.
2. The unrest which broke out in J Wing shortly after the fire hampered the transfer of the cell occupants.
3. The cell occupants were informed insufficiently about the current situation during the fire and during their transfer to the other detention centres.
4. During the relief at Schiphol-Oost on the night of the fire, the cell occupants were offered acute care. Attention should have been paid to possible medical problems

which had already arisen during the first hours after the fire. This related primarily to breathing problems.

5. The registration of cell occupants during their transfer from the Detention Centre Schiphol-Oost to the other detention centres was not clear.
6. The Site Manager of the Detention Centre Schiphol-Oost did not have a previously drawn up plan of action for an evacuation of the entire complex in the event of a large-scale occurrence (emergency).
7. Both the main directorate of the DJI and the Site Manager of the Detention Centre Schiphol-Oost clearly had no clear overview of which cell occupants had been transferred to which detention centres.
8. It was initially unclear at the detention centres in Zeist and Rotterdam which cell occupants had been housed with them and on the basis of which regime these persons had to be detained.
9. Establishing the identity of cell occupants in the detention centres in Zeist and Rotterdam was hampered by the fact that not all cell occupants were cooperative and gave false names, for example.

8.6.2 The organization of the aftercare

1. The Site Managers at Schiphol-Oost, Rotterdam in Zeist were not prepared for the organization of the relief and aftercare after the fire in the Detention Centre Schiphol-Oost.
2. After the fire in the detention centre, the main directorate of the DJI did not take control of the organization of the relief and aftercare, and did not draw up a policy framework for the Site Managers with regard to aftercare to be provided to the cell occupants.
3. As a result of this lack of a policy framework for the organization of the relief and aftercare, the care provision was too dependent on ad-hoc measures, cooccurrenceal circumstances, individual preferences and experiences. The aftercare in the detention centre in Rotterdam was provided within a cohesive framework. A plan of action was drawn up there for the aftercare to be provided. In the Zeist detention centre, the work was carried out on a less planned basis, and the various disciplines worked together on a more ad-hoc basis.
4. The effectiveness of the deployment of GHOR in Zeist was reduced as a result of the fact that the care providers of GHOR and the personnel of the detention centre were not familiar with one another's work. Moreover, the care providers of GHOR had the feeling and the experience that they could not offer adequate assistance to the cell occupants as a result of the restrictions of the detention regime. Their advice was not followed, for unknown reasons.
5. There is still a lack of clarity for the people involved regarding the deployment and the (substantive) division of responsibility of PSHOR in a detention regime.

8.6.3 The care provision in the detention centers in Zeist and Rotterdam

1. The cell occupants had a more negative image of the aftercare provided than the care providers and Site Managers. The impression held by the cell occupants is that they were not offered any physical safety on the night of the fire, that practical problems were solved too late, that opportunities for contact with family members were too limited, and that the care was insufficient. The care providers felt that they did what they could considering the possibilities available to them.
2. The quality of the relief and aftercare provided was negatively affected as a result of the fact that the system for standard care provision in the detention centres in Zeist and Rotterdam was overloaded by the arrival of a large number of cell occupants, and by a lack of information.
3. The medical dossiers show that the medical and psychosocial care was not provided promptly and in accordance with the norms set in the analysis framework in all cases.
4. The care providers attempted to identify cell occupants who may have needed psychiatric help. No individual care plan was drawn up for this group of cell occupants, however.
5. The regime was applied insufficiently flexible for the purpose of the aftercare to cell occupants. No possibilities for relaxation were offered for the cell occupants at any of the relief locations. There was also too little attention paid to restoring contact between those affected. Insufficient attention was paid to restoring the cell occupants' sense

of control and the recognition that they had been affected. This may have hampered dealing with any trauma-related complaints.

6. Both in Zeist and Rotterdam, insufficient use was made of interpreters in the provision of care. Using guards as informal interpreters in care provision contacts breached the obligation of professional secrecy.
7. The detention centres and the Ulrum COA did not draw up a plan of action for the second phase of aftercare.
8. In view of the fact that PTSD or other trauma-related complaints could not be diagnosed immediately after the fire, it is possible that a number of cell occupants were deported before the complaints manifested themselves.

8.6.4 Continuity of care

1. The transfer of medical dossiers did not take place in a correct manner in all cases, immediately after the fire but also two months thereafter. Dossiers were either not transferred to the new institution or to the asylum seekers' centre, or were transferred too late. In exceptional cases, however, information on the cell occupants in question was forwarded promptly to the new institution.
2. The creation of intakes and dossiers was below an acceptable level of quality.
3. The manner of transferring medical dossiers and the limited creation of dossiers had a negative influence on the continuity of the provision of care to the cell occupants.
4. As a result of the many transfers and faulty creation of dossiers, the continuity of the care provision was hampered.

8.6.5 The relief and aftercare for guards and emergency personnel

1. The personnel of KMar were cared for by their own organization, and also received aftercare from the KMar itself. The GHOR was called in for the provision of aftercare to guards working for the DJI and Securicor. The aftercare for the emergency personnel was organized in a proper manner. The services of the In-house Relief Teams (BOT) were utilized and the employers organized debriefings for the employees involved.
2. The guards experienced the interrogations by the police as stressful. These interrogations should only have been permitted to take place after the first debriefing. This was not the case in several instances.
3. All the guards were informed about dealing with shocking events, and the possibilities for getting assistance with this.

8.6.6 Relief and aftercare for surviving relatives

1. Generally speaking, the aftercare for surviving relatives went well.
2. The surviving relatives were given the opportunity to collect the bodies of the victims in the Netherlands and to bury them in their home countries in a suitable manner.
3. Greater account could have been taken of cultural aspects in the relief and aftercare for the surviving relatives.

9 OTHER INVESTIGATIONS

9.1 Introduction

In addition to the investigation carried out by the Safety Board into the fire in the Detention Centre Schiphol-Oost, several other investigations have been carried out on the basis of this occurrence. These were 1) the criminal investigation of the Public Prosecutor's Office, 2) the investigation into municipal responsibilities carried out by a commission set up by the Municipality of Haarlemmermeer, and 3) an investigation by three state inspectorates into fire safety in comparable penitentiary institutions. This chapter will be looking at the findings and conclusions of the second and third of the three investigations listed above, with the central focus being what the main similarities and differences are between the findings and conclusions of those investigations and those of the Safety Board.

9.2 Fire safety of detention centres' (state inspectorates)

9.2.1 Reason, objective and structure

Reason and objective

The question asked by both the House of Representatives and the Safety Board was concerned the quality of fire safety in the other detention centres. After consultations between the Safety Board, the VROM inspectorate, the Health and Safety Inspectorate and the Public Order and Safety Inspectorate, it was decided that these state inspectorates would carry out a joint investigation under the direction of the VROM inspectorate⁴⁷¹. The Safety Board was involved in drawing up the frame of reference and choosing the detention centres to be inspected, and was given access to the investigation results.

The objective of the investigation of the state inspectorates went beyond the initial investigation question, and was threefold, namely 1) to gain insight into fire safety of detention centres generally ('is it safe?'), 2) to find out whether fire safety is sufficiently guaranteed, also after the actions of the RGD and the DJI after the fire at Schiphol-Oost ('will it be safe?'), and 3) to gain insight into possible hindrances to the improvement of fire safety.

Structure of investigation

For the purpose of the investigation, the state inspectorates drew up a frame of reference, consisting of the Housing Act, the 2003 Buildings Decree (existing, new and temporary construction), the VNG model construction regulations, the Fire Services Act, the Working Conditions Decree and the Fire Safety Concept for Cells and Cell Buildings. The Safety Board also submitted several investigation questions. Use was also made of the fire safety scan being developed by the RGD, and a desk study was performed for the involving organizations.

The frame of reference used addresses the following aspects:

- Fire safety of structure
- Construction safety
- Fire detection and protection (Occupancy Permit)
- Usage requirements of municipal building regulations
- In-house Emergency and First-Aid Service (BHV)
- Preparation of fire brigade
- Sanction policy custodial institutions
- New construction requirements
- Requirements on temporary structures

The research concentrated initially on the institutions with a temporary status and/or detention centres with unit construction (24 institutions in total). This is because of the great similarities with the detention centre at Schiphol-Oost. In the first phase of the investigation, five locations

⁴⁷¹ Sanctions Application Inspectorate was also invited, but did not take part in the investigation. It did provide background information for the inspectorate investigation.

were selected (Lelystad, Doetinchem, Balkbrug, Zeist and Rotterdam) covering boat, wood frame and metal sea container construction types.

The Inspector-General of the Ministry of Housing, Spatial Planning and the Environment (VROM) adopted the investigation report by the state inspectorates on 27 July 2006. The management summary of this investigation is included in full in Appendix 26 of this report.

9.2.2 Comparison of conclusions of state inspectorates and the Safety Board

Conclusions of state inspectorates

The state inspectorates uncovered important shortcomings regarding fire safety, with the emphasis on the structural and personal aspects (BHV) followed by the user requirements and preparation of the fire brigade⁴⁷².

Other examples are:

- The fire resistance of materials cannot always be established with certainty, and requires further investigation. Structural modifications were observed, however, with regard to which no account or insufficient account was taken of the required fire resistance (of ducts, for example).
- The emergency plan is not or insufficiently being practiced in drills.
- Dossiers are not kept properly by municipalities and the bodies responsible for fire safety, the DJI and RGD.
- There has been insufficient compliance with the requirements in the area of fire safety, due to too little awareness of fire safety and specific knowledge.
- The supervision by municipalities of occupancy (user) requirements is inadequate both in terms of quantity and quality (permit process not geared towards detention centre fire safety risks and failure to follow permit procedures, among other things).

Nevertheless, the state inspectorates conclude that no patently unsafe situation exists in the detention centres investigated. The state inspectorates deem 'not patently unsafe' to mean: *"The totality of the shortcomings does not lead to a situation in which use of the institution must be ended, and therefore no immediately life-threatening situation exists (no acute danger). The point of departure is that this situation must not continue for too long, but that the shortcomings must be remedied in the short-term."*

In addition, the state inspectorates concluded that the legal frameworks are sector-oriented and that this makes the system surrounding fire safety complex, and contributes to fragmentation with regard to both the issuing of permits and monitoring. While they are positive about the introduction of the new Occupancy Decree (possibly from January 2007), this fragmentation is felt to be a hindrance to improvement. A low awareness of safety and lack of knowledge, both at the DJI and on the work floor at the penitentiary institutions, are also seen as a hindrance to the introduction of improvements.

According to the state inspectorates, the results and conclusions are representative for all detention centres with unit construction.

Conclusions of Safety Board

The investigation of the state inspectorates reveals shortcomings with regard to fire safety, as does the investigation of the Safety Board into the Detention Centre Schiphol-Oost. In addition, it has become clear that in the case of the Detention Centre Schiphol-Oost, as well as in the other five detention centres, 1) the permit process is not geared towards the large and specific fire safety risks which are inherent in the accommodation of large groups of people in detention centres, and 2) the DJI, RGD and municipalities do not follow the permit procedures according to 'the book'.

472 The investigation of the state inspectorates only looked at the preparation and deployment of the fire brigade and the quality of the in-house emergency and first-aid service from an administrative point of view (such as the existence of a plan of action, availability of in-house emergency service members) as no actual deployment took place. The inspectorates visited the locations in the context of the investigation and spoke with employees of the locations.

Another significant similarity between the investigation by the inspectorates and the investigation into the fire at Schiphol-Oost relates to the personnel aspects (quality of the In-house Emergency and First-Aid Service (BHV) organization). It has been shown that the BHV organizations in the five detention centres inspected and at Schiphol-Oost were insufficiently prepared (in terms of planning, instruction, training and practice) for a fire.

Finally, both the investigation by the inspectorates and the investigation of the Safety Board indicate that the supervision by the municipalities of compliance with the fire safety measures in detention centres leaves a lot to be desired.

In view of the similarities between the findings (including the underlying factors) and in view of the effect on the results of a fire such as the one at the Detention Centre Schiphol-Oost, the Safety Board is of the opinion that the qualification 'not patently unsafe' of the state inspectorates does insufficient justice to the alarming situation in the area of fire safety at the other institutions with a unit construction.

The Safety Board - like the state inspectorates - recognizes the fragmented legislation and regulations, and the problems ensuing from this with regard to first and second-line supervision. The Safety Board also concurs with the desirability of an integrated evaluation of all aspects relating to fire safety. According to the Board, the DJI and/or the Site Manager are responsible for this, and also - or should be - the body/person best equipped to do so. In the Board's opinion, the proposed approach is separate from the need on the part of all the parties involved to correctly exercise their own responsibility within the given tasks, authorizations, responsibilities and resources.

In light of this, the Safety Board understands the state inspectorates' positive expectations regarding the introduction of the Occupancy Decree, but the Board points out that the parties involved properly exercising their own responsibilities is an essential condition in this respect for ensuring (fire) safety, and that it is this aspect in particular which has been identified as a problem.

The Safety Board therefore concludes that the result of the investigation by the joint state inspectorates generally concurs with the findings and conclusions of the Safety Board. These conclude that this was not simply an occurrence, but that there are structural safety shortfalls. In addition, the Board regrets that the investigation of the state inspectorates has not resulted in the Health and Safety Inspectorate, among others, re-evaluating its choices regarding inspection policy.

9.3 'Fire in the Detention Centre Schiphol-Oost' report (independent commission on municipal responsibilities)

9.3.1 Reason, objective and structure

Reason and objective

Pursuant to Art. 10g of the Disasters and Major Accidents Act, municipalities are obliged to institute an investigation into a disaster or major accident which occurs in the municipality. If the Safety Board institutes an investigation, this obligation to investigate lapses. Municipalities, however, still have the authority to institute an investigation themselves in such cases⁴⁷³.

Shortly after the fire in the Detention Centre Schiphol-Oost, the Municipality of Haarlemmermeer - within whose municipal boundaries the complex was located - decided to institute an external commission which could carry out an investigation into the question regarding whether the Municipality had correctly exercised its tasks and responsibilities in the area of fire safety and fire prevention. The municipal council concurred with the importance, from a social point of view, of realizing a broader establishment of the truth, but was of the opinion that the length of time

⁴⁷³ The analysis is still taking place of the extent to which it is desirable that various investigations are carried out at the same time, and will form a part of the evaluation of this investigation by the Board.

needed for the investigation of the Safety Board was too long, in view of their objective⁴⁷⁴. The municipal council wanted to realize investigation results in the short term, so that there could be a quick response to the lessons to be learned with regard to exercising municipal responsibilities on fire safety and fire prevention.

On 10 November, the Municipality instituted the Independent Commission on Municipal Responsibilities with regard to the Schiphol Cell Fire (hereinafter referred to as the Hendrikx Commission). This commission was made up of mr J.A.M. Hendrikx and mr J.D. Berghuijs. On 15 December the Hendrikx Commission published its evaluative 'quick scan'.

The assignment the Municipality gave the Hendrikx Commission was as follows:

"The investigation will focus in particular on the question regarding what lessons we can learn from the fire in the detention centre. The investigation will have to make clear the extent to which the implementation of the municipal tasks and responsibilities with regard to fire safety and fire prevention was carried out in a correct manner, and in which ways these can be improved."

Structure of the investigation

The investigation of the Hendrikx Commission had a limited focus compared to the investigation of the Safety Board, and lasted approximately one month. The investigation focused on giving a (provisional) opinion about the exercise of municipal responsibilities and learning lessons for the future. In view of the short period within which the investigation had to take place, the limited scope of the investigation and the lack of specific powers, it was not possible for the commission to reach a full and detailed reconstruction of, or to establish the truth of all the events in the night of 26/27 October, and the period leading up to it. For example, the commission did not have access to the log files of the fire brigade's emergency control room, because the Public Prosecutor's Office had impounded these in the context of the criminal investigation⁴⁷⁵.

The commission made use of available documents, such as the account of the facts of the Municipality of Haarlemmermeer. The commission also requested supplementary information relating, among other things, to the process of granting permits and compliance. The commission drew up an investigation framework based on the municipal responsibilities, on the basis of which interviews were held with persons directly involved from the official organization of the municipal council, the fire brigade, those with administrative responsibility and investigators from Nibra. The commission could not share any factual information with the Safety Board, as a result of which it was forced, in a number of cases, to work with assumptions.

The commission indicated that the assessment, the conclusions and recommendations it reached on the basis of the quick scan could 'only be a provisional assessment. After all, there is a certain relationship between depth and available time', states the report.

9.3.2 Comparison of conclusions with those of the Safety Board

Conclusions of Hendrikx commission⁴⁷⁶

The commission concludes that 'the Municipality of Haarlemmermeer took all responsibilities which may reasonably be expected of a municipality in the process of granting permits for the Detention Centre Schiphol-Oost'. The commission also concluded that 'the Municipality has applied an active supervision and compliance policy. The repressive deployment of the fire brigade was the right one, in the opinion of the commission. Nevertheless, this did not result in the prevention of such a dramatic fire.'

'The recommendations of the Nibra following the fire in 2002 (fire resistant partition, detection) were, in any event, taken into account in the realization of J and K Wing of the detention centre, in the context of the granting of permits and of the drawings. The commission did not determine whether these were also realized correctly, but has no concrete cause to doubt this.'

474 The Safety Board made every effort to publish the investigation report within one year after the fire. The Safety Board can issue an interim notice if findings are made during the investigation which are of an urgent nature, on the basis of which the Board wishes to issue a warning.

475 The Safety Board did have access to this data.

476 For an overview of the most important conclusions of the Hendrikx Commission, see Appendix 27.

Conclusions of the Safety Board

Despite the short period of time available for the investigation, the Hendrikx Commission was able to sketch out a reconstruction of the events of the night of the fire which is generally in line with the reconstruction of the Safety Board. The commission also identified a number of shortcomings which agree with the findings of the Board. For example, both the Hendrikx Commission and the Board determined that the fire brigade had a long arrival time which was partially to be blamed on the delayed - not direct - notification to the emergency control room built into the fire alarm system. The fact that the emergency doors on the far walls of J and K were not automatically unlocked also hampered access to the complex for the fire brigade. Both the Board and the commission found shortcomings in the manner in which the organization of the detention centre was prepared and set up for acting in the event of a fire. In addition, both the Board and the commission were of the opinion that greater importance should have been given to the fact that there were non-self-reliant people located in the complex.

Nevertheless, the findings of the Safety Board reached conclusions which differed in a number of points from those of the Hendrikx Commission. In particular, with regard to one of the main conclusions of the Hendrikx Commission, namely that *'the Municipality of Haarlemmermeer took the responsibility which may reasonably be expected of a municipality in the process of granting permits for the Detention Centre Schiphol-Oost'*, the Board reached a different conclusion. With regard to the implementation of the municipal tasks and responsibilities for granting permits, the Safety Board - in contrast with the Hendrikx Commission - concludes that the Municipality exercised its task inadequately. The Board reaches this conclusion because, in its opinion, the Municipality should not have granted the Building and Occupancy Permits. The permits were granted on the basis of limited information and a building plan which was not in line with legislation.

In the Board's opinion, this difference is primarily due to the fact that an investigation of a limited duration will primarily address procedural aspects, and only a limited evaluation of the details of the course of events will be possible. A more in-depth investigation, paying attention not only to procedural aspects but also detailed aspects, could put the course of events in a totally different light. And that is what has happened in this case.

The Board concurs with the approach of the Hendrikx Commission that all the parties involved have their own separate responsibilities. The Board also concurs with the finding of the Hendrikx Commission that there was an information imbalance between the applicants for permits and their specialized advisors on the one hand, and the expertise available in the Municipality on the other. However, apart from the responsibility of the applicant to submit a full application based on the risks and the law, it remains the Municipality's responsibility as licensing authority to make an adequate and correct evaluation on the basis of sufficient information, and if necessary to enforce this. In addition, the information imbalance observed does not remove the responsibility of the Municipality to evaluate the application with sufficient expertise (internal or external) before granting a permit.

The Municipality also, in the Board's opinion, did not exercise its tasks with regard to supervision and compliance to its fullest extent. This conclusion is based on findings of the Safety Board that supervision by the Municipality of compliance with the conditions set in the Occupancy Permit displayed insufficient depth. Reports on inspections were too limited, and administrative supervision was carried out in too limited a manner.

In terms of compliance with the recommendations made by Nibra after the fire in the detention centre in 2002, the Safety Board determined that these recommendations were not realized on a large number of points.

In addition to general recommendations, in its report the Hendrikx Commission made a number of recommendations to the Safety Board concerning the investigation to be carried out. The Board attempted to take these recommendations into consideration as much as possible in its investigation.

With regard to the recommendation to use J Wing as a test setup for a full and representative reconstruction, the Safety Board was forced to abandon this due to the risks involved in such a large-scale reconstruction. The Safety Board did, however, attempt to reconstruct the fire and the events surrounding it to the best possible extent using fire tests in fully fitted cell containers, and

with the help of as many information sources as possible (audio tapes, camera footage, photos, interviews, official reports, data from the fire alarm system, etc.).

In summary, it can be stated that one of the main conclusions of the Hendrikx Commission, namely the conclusion relating to the exercising of the municipal responsibilities and the manner in which the Municipality of Haarlemmermeer implemented its supervision and compliance policy, differs from the appropriate conclusion of the Safety Board with regard to these points. The Board is of the opinion that the Municipality of Haarlemmermeer exercised its responsibilities inadequately in the area of granting permits, supervision and compliance.

With regard to the other findings of the Hendrikx Commission, it can be stated that a large number of these generally concurred with the findings of the Safety Board.

10 SUMMARY OF CONCLUSIONS

This chapter contains the summary of the conclusions of the investigation carried out by the Safety Board into the fire in the detention centre at Schiphol-Oost. The conclusions relate to the analysis of the development of the fire, rescue and fire fighting (section 10.1), the way in which the various parties handled their responsibilities in terms of the construction and use of the detention centre (section 10.2) and the relief and aftercare for those involved (section 10.3).

10.1 Conclusions with regard to the development of the fire, the rescue and fire fighting

Conclusion 1:

In the night of 26 to 27 October 2005, the detention centre at Schiphol-Oost was struck by a large fire shortly before midnight. Eleven cell occupants died in their cells during the fire, as a result of carbon monoxide poisoning. Due to the fact that a cell door was left open after the rescue of one of the cell occupants, and a large quantity of flammable material was present in the cell, a large amount of smoke developed in the corridor and the fire was able to develop further.

Exemplification conclusion 1:

- The fire occurred on 26 October 2005 shortly before midnight on the bed in Cell 11 of K Wing. A technical cause of the fire has virtually been eliminated. It is possible that a discarded cigarette caused the fire.
- Fire tests have shown that the initial development of the fire may have proceeded along a chain of fuels (bedding, mattresses, wall covering), with each link providing sufficient energy for the ignition of the next. The two mattresses played an essential role in the entire cell catching fire.
- The opening and leaving open of the door of Cell 11 accelerated the development of the fire. Smoke and fire was able to spread outside the cell. If the door had been closed again after it was opened, the fire development would have been interrupted.
- The size into which the fire developed in a short period of time can be partly explained by the large quantity of flammable material in the cell, including in particular the wall covering.
- The accelerated fire development which occurred after the second mattress of the bunk bed caught fire was coupled with a sudden increase in smoke production. This increased smoke development, which is characteristic of a fire in the flashover phase, is primarily caused by an increasing shortage of oxygen in the room on fire; the nature of the burning materials is of less importance in this respect.
- Due to the accelerated spreading of smoke in the corridor, it was physically impossible for the rescuing guards to release all the cell occupants from their cells. The Smoke and Heat Exhaust Ventilation System, which should ensure exhaust ventilation of smoke and heat, was not working during the fire.
- The fire was able to spread spatially from the corridor primarily because of the shell construction. In the corridor itself, the fire remained stationary due to the limited supply of fresh air, with the exception of the far wall of K Wing, where open air was able to enter through the open emergency door.
- The cells offered insufficient protection to the trapped cell occupants. The penetrating smoke, in particular, played a fatal role.
- All the fatal casualties were killed by carbon monoxide poisoning.
- Of the eleven victims, ten probably died between 00.10 and 00.30 hrs, the eleventh victim (in cell 5) probably later.

Conclusion 2:

The organization of the Detention Centre Schiphol-Oost was insufficiently prepared and set up for an outbreak of fire, as a result of which the staff members on duty were faced with a virtually impossible task. The Site Manager did not draw up any risk inventory in advance, and did not sufficiently think through how the staff should act in the event of fire. The main directorate of the Custodial Institutions Service (DJI) did not provide any framework and/or create any conditions for this. In addition, supervision was limited.

Exemplification conclusion 2:

- The Site Manager of the detention centre paid insufficient attention to drawing up an inventory of risks and drawing up measures and instructions regarding these risks. As a result, staff were insufficiently trained, instructed, equipped and practiced to be able to act adequately in the event of fire. The Site Manager assumed, wrongly, that the fire brigade would be extremely close at hand in the event of an emergency, without coordinating this sufficiently.
- The absence of staff on K Wing during the night-time hours slowed the responses of the internal organization to the fire alarm. As a result, Cell 11 was already full of smoke when the guards arrived at the cell.
- There is no guarantee during a fire that a cell door will be closed in all circumstances. It is not realistic to assume that staff always does this under stressful conditions.
- The main directorate of the DJI must establish a framework on the basis of which the Site Managers of detention and deportation centres can draw up emergency plans and a risk inventory and evaluation, and can set up the emergency organization. This did not happen.
- Supervision of the way detention centre use is organized was limited.
The main directorate of the DJI carried out limited supervision of the Site Manager. The same applies to Haarlemmermeer Municipal Council with regard to supervision of the use. The Health & Safety Inspectorate did not carry out any inspections of the detention centre. In view of the fact that the Sanctions Application Inspectorate (IST) has only been in operation since 1 January 2005, no concrete inspection has taken place to date.

Conclusion 3:

The fire brigade arrived relatively late at the fire. The reasons for this lie both with the fire brigade and with the management of the detention centre. The automatic fire alarm system did not notify the fire brigade immediately of the fire, the detention centre was not prepared for the arrival of the fire brigade and the fire brigade was insufficiently prepared for the situation at the detention centre. Insufficient harmonization had taken place between the fire brigade and the detention centre, as a result of which it was not ascertained that, based on the Fire Safety Concept for Cells and Cell Buildings, the fire brigade would only be on site and ready to deploy after 15 minutes, and that until that time, the in-house emergency and first-aid team would have to cope on its own. In view of the late hour and the actual deployment of the fire brigade and the stage at which the fire was at that moment, the chances that the eleven victims could still be saved were small.

Exemplification conclusion 3:

- The fire brigade were able to start fighting the fire eleven minutes later than the standard time stated in the Fire Safety Concept for Cells and Cell Buildings. The delayed arrival and deployment were the result of a number of different direct and underlying causes.
 - There was a delay in alerting the fire brigade.
The management of the detention centre decided to apply a delay to the fire alarm system, thus attempting to limit the number of false alarms. The detention centre did not attach any consequences to the fact that this created an increased risk.
 - The fire brigade had a long arrival time
The Haarlemmermeer Municipal Council had not set up the fire brigade in such a way that the detention centre could be reached within the standard time. The Municipal Council did not attach any consequences to the fact that this type of building, a detention centre, involves an increased risk.
 - The fire brigade had to take a detour from an old entrance to the correct entrance.
The detention centre took insufficient care to ensure that the Fire Brigade was aware of the closure of the former entrance. The new situation had been insufficiently coordinated between the two parties, and there was no joint drill experience.
 - The fire brigade was not (properly) received by the in-house emergency and first-aid team.
Due to the poor reception, the fire brigade had problems entering the detention centre and the building, and lost time searching for information about the situation and the possible presence of victims. There was a lack of adequate and current information on the situation.

- As ten of the eleven victims probably died before 00.30 hrs, and given the fact that the fire brigade started its actual deployment at 00.21 hrs, there were few opportunities to save these victims. This does not mean that, in the case of large fires, victims are always dead within half an hour.
- The Board has observed a gap in situations in which the in-house emergency and first-aid service is put in a powerless position, while the fire brigade is still not on site, due to long arrival times. The consequences of this gap have not been thought through, including in the Fire Safety Scheme (BBC).
- The fire brigade, once deployed, did what it could, in view of the advanced stage of the fire and the rapidly decreasing chances of survival of the victims. There were problems setting up the bulk water transport and with coordination. This did not have any influence on the rescue, but it did affect the total time needed to get the fire under control.

10.2 Conclusions on responsibilities with regard to construction and use of J and K Wing

Conclusion 4:

The three main parties responsible for the fire safety of K Wing of the Detention Centre Schiphol-Oost were: 1) the Custodial Institutions Service, 2) The Government Buildings Agency and 3) the Haarlemmermeer Municipal Council. The Board considers the DJI to be the party primarily responsible for fire safety.

Exemplification conclusion 4:

- The Custodial Institutions Service bears statutory responsibility for the safety of the cell occupants and the staff, as user of the detention centre. The DJI bears responsibility to the Government Buildings Agency for drawing up the Schedule of Requirements for the building. The DJI is ultimately the party under whose responsibility persons are incarcerated, and can exercise a direct influence on safety (including fire safety), and therefore bears primary responsibility.
- As commissioner for the construction and later as owner of the detention centre, the Government Buildings Agency bears responsibility for the realization of a detention centre which can be used in a fire-safe manner.
- The Municipal Council of Haarlemmermeer issues the building and Occupancy Permits, and bears responsibility for supervision and compliance during the construction and use of the detention centre.

Conclusion 5:

The management of the DJI bears responsibility for the safety of cell occupants and staff. At the day-to-day practical level, the Site Manager of the detention centre bears statutory responsibility for safety, including fire safety, but did not discharge this task sufficiently. He paid insufficient attention in advance to the risks connected with the use of the building as a detention centre. The organization was also not set up for an emergency of this scale. In order to discharge the responsibilities referred to, the DJI main directorate must create a suitable framework and possibilities. The main directorate of the DJI did not do this in a sufficiently concrete manner, and took insufficient account in the Schedule of Requirements of the risks in terms of fire safety.

Exemplification conclusion 5:

- The management of the DJI did not make a specific Schedule of Requirements for J and K Wing available to the RGD, despite the fact that J and K Wing are different from the adjacent A and D Wing.
- The Site Manager organized an insufficient structure for the use of the Detention Centre Schiphol-Oost, and prepared it insufficiently for a fire of this size. For substantiation of this conclusion, reference is made to the substantiation of conclusion 2. It can also be stated that neither the main directorate of the DJI nor the Site Manager demonstrably took into account in advance the risks attached to 1) incarcerating a large number of persons, including overnight 2) choices made in the construction plan (no automatically closing doors, no automatic door release, relatively long corridors, etc.) as a basis for organizing the use and setting up emergency plans. No additional measures were taken to compensate for the limitations arising from the construction plan or in the realized building.

- Both the main directorate of the DJI and the Site Manager made insufficiently demonstrable use of the signals present regarding shortcomings in the fire safety of the detention centre, including those following earlier fires.
The supervisory committee of the Royal Military Constabulary (KMar) for district detention centres at Schiphol visited the detention centre five times in 2003, and concluded that *"fire prevention in that place gives cause for concern"*. Reports by the Nibra and the Technical Advice Centre were also available following an earlier fire in 2002 in C Wing. In view of its responsibility to only use a building if the building, in combination with the emergency organization and competencies of the staff, is safe (including in the event of fire), such signals should have been a reason for the DJI to carry out a further analysis of the fire safety of the building. The DJI, however, restricted itself to the assumption that the building, as it was built by the RGD, was fire safe. The DJI did not see any reason to carry out demonstrable further testing of the fire safety.
- Both the main directorate of the DJI and the Site Manager were insufficiently critical in their assessment of the fire safety on the transfer and taking into use of K Wing. The user did not recognize that a number of visible characteristics of K Wing clearly did not comply with construction legislation. For example, the surface area of K Wing was larger than permitted by law (850m² instead of 500m²), the maximum walking distance from the cell door was 54 metres, which is considerably more than the maximum permitted distance of 22.5 metres, and there was only one emergency door present instead of the two emergency doors required by law. Despite the fact that the DJI could not be expected to test the entire detention centre in detail for fire safety prior to taking it into use - that is what the main directorate of the DJI engages the RGD to do, after all - the DJI should have been expected to recognize the above-mentioned (visible) shortcomings and, if it decided to move into the detention centre, to take demonstrable (compensatory) measures.
- The policy of the main directorate of the DJI does not contain any general, well-considered principle with regard to the fire safety of buildings with a cell function. Within the main directorate of the DJI there is no recorded fire safety policy in which the vision of the DJI is described with regard to fire safety, and in which the objectives, starting points, manner of central control, etc., are described with regard to detention centres. This is remarkable, in view of the fact that the Temporary Special Facilities Directorate has five custodial institutions in use in the Netherlands, has approximately 1500 staff members and is responsible for the safety of more than 3500 cell occupants. A safety management system with an annual 'learning cycle', in which fire safety aspects relating to user organization and buildings are evaluated and continually improved, does not apparently exist.

Conclusion 6:

On the basis of its responsibility for a fire safe building, the RGD has insufficiently discharged its role, in view of the fact that K Wing did not comply with the Buildings Decree. Prior to the construction, insufficient account was demonstrably taken of the risks regarding fire safety, and these were not made known to the DJI on completion of the building.

Exemplification conclusion 6:

- J and K Wing did not comply with the fire safety requirements in construction legislation.
The main anomalies with regard to the law related, among other things, to the compartment/wing size, the resistance to fire penetration and fire transfer between cell and corridor and through ventilation, the walking distances and the escape possibilities. Only in respect of exceeding the maximum walking distance of 22.5 metres was an equivalent alternative foreseen in the form of a Smoke and Heat Exhaust Ventilation System, which in practice was also too limited in design and did not function during the fire.

- The RGD, when developing and thinking through the building plan in advance, did not take sufficient or sufficiently demonstrable account of the risks relating to fire safety. It also insufficiently communicated the risks to the user (no demonstrable user manual).
Opening the cell door removes the fire subcompartmentalization of the cell. The result of this can be that the lack of requirements with regard to fire resistance from the corridor to the cells results in the entire wing burning down due to a single cell door not being closed.
- Prior to the construction, the RGD made insufficient use of the available information following the earlier fire in 2002 in C Wing (Nibra report, Technical Advice Centre report) and the available test reports.
It has become clear that the recommendations of the Nibra - both those of a procedural and of a technical nature - were only partly complied with. That the test reports only relate to the cell containers and not to the entire construction was not recognized.
- The fire safety of J and K Wing was insufficiently ensured by the RGD.
Fire safety was addressed during the realization (construction plan and construction) of J and K Wing, but the RGD as owner did not ensure that the fire safety aspects, which were discussed between the various parties were also sufficiently realized. One example of this is that ventilation grilles with fire-resistant properties - which a subcontractor claims were installed - were not encountered in K Wing by the Board. The RGD wrongly assumed that the TNO test of the cell container guaranteed the fire safety of the entire wing. As commissioning party, the RGD did not demonstrably ensure that its contracted parties (architect, contractor, etc.) had sufficient specific current knowledge about both the relevant construction regulations and about the specific risks of the detention centre. The Smoke and Heat Exhaust Ventilation System should have been tested by TNO, in accordance with the building permit. In respect of this, TNO did not receive any order, and the test did not take place. Full current insight into the fire safety requirements which apply specifically to a building with a cell function was insufficiently encountered with respect to the architect, for example, despite the fact that this is required under the professional code. K Wing was built on the basis of a construction plan which had only been developed to a limited extent, and in which the fire safety aspects were not detailed.
- On the basis of the construction plan submitted by the RGD, the Municipal Council of Haarlemmermeer was insufficiently able to test the building permit application against construction regulations in the area of fire safety. The solution - apparently intended to be equivalent - of the Smoke and Heat Exhaust Ventilation System was also not explicitly made known in the application for the permit.

Conclusion 7:

The Municipal Council of Haarlemmermeer discharged its role insufficiently, in terms of its responsibility for granting permits, supervision and compliance. It should not have issued the permits (the permits were granted on the basis of limited information and a building plan which was in breach of construction legislation) and its supervision was too superficial.

Exemplification conclusion 7:

- The Building Control Department of the Municipal Council of Haarlemmermeer wrongly issued the building permit for J and K Wing of the Detention Centre Schiphol-Oost. K Wing did not meet the construction regulations.
The fire brigade carried out an assessment on the basis of information which was too limited;
Various documents which are required by the Planning Application (Submission Requirements) Decree were not submitted.
In addition, the provision of the building permit was not sufficiently based on a complete substantive evaluation on the basis of the Buildings Decree for nonpermanent cell buildings.
The capacity of the Smoke and Heat Exhaust Ventilation System, which was intended to provide an equivalent alternative for the length of the corridor (54 metres instead of 22.5 metres) was too low by a factor of three with regard to the required capacity, in view of the geometry of the wing.

The fire brigade had insufficient current knowledge about the regulations on the one hand and the specific risks of the detention centre on the other to be able to make a correct assessment.

Finally, the Building and Housing Inspectorate insufficiently applied the available information following the earlier fire in 2002 (Nibra, TAC), the test reports and the report of the VROM Inspectorate when granting the building permit.

- The following shortcomings were encountered in the issue of the Occupancy Permit. Due to the lack of sufficient data for the evaluation of the fire safety, the fire brigade did not realize that the requirements of the Buildings Decree had not been met. The Occupancy Permit was issued before the conditions laid down in the building permit had been met. The fire brigade issued the Occupancy Permit without substantively evaluating the underlying documents.
- The Municipal Council carried out supervision of the construction and utilization of the detention centre. Few records relating to the construction supervision have been found concerning the method of inspection and the depth thereof. With regard to the supervision during occupancy, it has become apparent that the emphasis was on visible shortcomings, and administrative supervision was carried out insufficiently (analysis certificates, reports, logbooks on the inspections and maintenance, etc.).
- The intended objective of the VROM inspections, to realize improvements in a number of important aspects with regard to the permit issuing process, was in this case realized insufficiently in 2003, in view of the shortcomings in the issuing of the permit for J and K Wing.

10.3 Conclusions with regard to relief and aftercare of persons involved

Conclusion 8:

In view of the insufficient preparation for relief and aftercare, the eventual quality of the relief and aftercare of the cell occupants after the fire were - with the exception of a number of good local ad hoc measures - inadequate in important areas.

Exemplification conclusion 8:

- During the relief at Schiphol-Oost on the night of the fire, the cell occupants were offered acute care.
- Attention should already have been paid to possible medical problems in the first hours after the fire. This related primarily to respiration complaints.
- The cell occupants from J and K Wing did not feel physically safe during their stay in the exercise cage of J Wing.

After the rescue from K Wing, the cell occupants of K Wing were locked in the exercise cage of J Wing, together with the cell occupants of J Wing. This was located close to where the fire was burning at its most intense at that moment, however.

- The cell occupants were informed insufficiently about the current situation during the fire and during their transfer to the other detention centres.
- The registration of cell occupants during their transfer from the Detention Centre Schiphol-Oost to the other detention centres was not clear.
- Contrary to the advice of the emergency services, the detention regime was adapted to the circumstances on only a limited number of points and only for a short period of time.

No additional activities were developed for the cell occupants, no permission was given for more extensive visiting hours and no extra attention was paid to the cell occupants of J and K Wing. This may have hampered dealing with any trauma-related complaints.

- The transfer of medical dossiers did not take place in a correct manner in all cases, immediately after the fire but also in the two months thereafter. Dossiers were transferred to the new centre or to the asylum seekers' centre too late or not at all.
- The medical dossiers show that the medical and psychosocial care was not provided promptly or in accordance with the standards laid down in the reference framework in all cases.

The detention centres were not properly prepared for the large influx of cell occupants. They attempted to receive the cell occupants through the standard care system. However, this system was not yet set up for such a large demand for care.

- The language problem was insufficiently recognized during the relief and aftercare in the detention centres in both Rotterdam and Zeist. Insufficient use was made of interpreters during the care provision.
- In the Rotterdam detention centre, there was good cooperation and planning between the management and care providers of the institution. In the Zeist detention centre, the work was carried out on a less well-planned basis, and the various disciplines worked together on a more ad hoc basis.

Conclusion 9:

The Site Manager of the Detention Centre Schiphol-Oost was insufficiently prepared for the supra-institution evacuation of cell occupants. Equally, the management of the DJI did not develop a policy framework for relief and aftercare. After the fire, no direction was given to setting up the aftercare and the coordination between the receiving centres of the aftercare to be provided to cell occupants.

Exemplification conclusion 9:

- After the fire in the detention centre, the management of the DJI did not take control of the organization of the relief and aftercare, and did not draw up a policy framework for the Site Managers with regard to the aftercare to be provided to the cell occupants.
- As a result of the many transfers and faulty dossier formation, the continuity of the care provision was hampered.
- The manner in which the registration took place was inadequate in the case of a large-scale evacuation.
It was not sufficiently clear to the detention centres in the initial days after the fire which cell occupants from Schiphol-Oost were being housed in their centre at that moment. As a result, some cell occupants were initially incarcerated under the wrong regime. As a result of the incorrect registration, medical and detention dossiers were not sent, or were sent to the wrong detention centres.
- There was a lack of clarity among the persons involved regarding the deployment of and the division of responsibilities regarding psychosocial assistance in the event of serious accidents and disasters in a detention regime.
- In view of the fact that post-traumatic stress syndrome or other trauma related complaints could not be diagnosed immediately after the fire, it is possible that a number of cell occupants were deported before the complaints manifested themselves.

Conclusion 10:

Generally speaking, the aftercare for guards, emergency personnel and surviving relatives was good.

Exemplification conclusion 10:

- The staff of the KMar involved in the fire in the Detention Centre Schiphol-Oost received and were given guidance by their own organization.
- Aftercare for staff of the DJI and Securicor involved in the fire took place initially via the GHOR. The aftercare was then taken over by the DJI.
- The management of the ambulance and fire brigade crews organized briefings and relief by the In-house Relief Team (BOT).
- The surviving relatives were given the opportunity to collect the bodies of the victims in the Netherlands and to bury them in their home countries in an appropriate manner.

11 RECOMMENDATIONS

In view of the shortcomings identified, a large number of recommendations can be made. However, the Board has decided to make a limited number of recommendations relating to main aspects, and with regard to the other safety deficiencies refers to the report, in view of the fact that the findings speak for themselves.

- 1. The Board issues the following recommendations to the Minister of Justice:**
 - To carry out audits of all penitentiary institutions within one year on the state of fire safety (including agreements with the fire brigade) and in-house emergency and first-aid organization, to put these right if necessary and to report on the results to the House of Representatives.
 - To make safety - including fire safety - an explicit policy point in the management of the institutions which operate under his responsibility and to give the recently set up Sanctions Application Inspectorate an integrated supervisory task (making use of the expertise of other inspectorates, supervisory committees, etc.) and to provide periodic reports on the state of safety, including fire safety.
 - To submit to critical investigation and revision the division of responsibilities within the Ministry of Justice, in particular within the DJI between central and local management, focussing particularly on the responsibility of the site management, and to record clearly the conclusions of such an investigation.
 - To subject the emergency plans of the reception centres and penitentiary institutions to a critical assessment in terms of whether these are realistic or not, and to pay particular attention to the relief and aftercare for detainees, and to put responsibility for the supra-local coordination of this explicitly in the hands of the DJI.
- 2. The Board issues the following recommendations to the Minister for Housing, Spatial planning and the Environment:**
 - To make the building regulations for special building complexes more accessible. In addition, the Board requests that attention be paid to information provision, instruction, periodic training, etc., in support of the correct application of the building regulations and the accumulation of national expertise.
 - In view of the shortcomings identified of the detention centre as a building, the role and responsibility of the Government Buildings Agency must be specified in greater detail, so that the quality of the construction is guaranteed at all times, and the fulfilment of the service provision task is not at the cost of the quality delivered.
 - In the case of temporary construction, where building plans for buildings with high-risk functions were subjected to lower requirements under the 2003 Buildings Decree, to impose supplementary conditions, so that the safety level is equivalent to that of permanent construction.
- 3. The Board issues the following recommendations to the Municipal Council of Haarlemmermeer:**
 - To ensure that it has sufficient expertise to be able to subject building applications which depart from the Buildings Decree, but for which equivalent structural alternatives are offered, to a thorough assessment.
 - To avoid acting in an advisory capacity to the permit applicant, so that it does not jeopardise the independence needed for the realization of its own supervisory role.
 - To ensure that the fire brigade and in-house emergency and first-aid teams of high-risk buildings are carefully coordinated with one another, and to have them carry out exercises together.
- 4. The Board issues the following recommendations to the Minister for the Interior and Kingdom Relations:**
 - To reconsider, in consultation with the Minister of Justice, as the party responsible for legislation and regulations, whether the status of informal regulations, such as the Fire Safety Concept for Cells and Cell Buildings, is adequate for safety risks.
 - To modernize the content of these unofficial regulations.
 - To ascertain, together with the Association of Netherlands Municipalities, how the municipalities can professionally fulfil their role of supervisory body in the case of buildings with a high-risk function, such as a detention centre. Consideration should be

given to bundling expertise on and experience with specific buildings. Analogous to the safety practices in other sectors, consideration should also be given to reversing the 'burden of proof', and to require organizations applying for permits to show that they are functioning as safely as possible.

GLOSSARY OF TERMS

A

Access map (Bereikbaarheidskaart)

The municipality draws up an access map for locations at increased risk (from fire) or which are difficult to access. The map indicates how the emergency services (the first attending fire brigade vehicles) can reach the subject, the location of, for example, fire hydrants, and how one is able to gain entry to a location.

Acute aftercare phase (acute nazorgfase)

Psychosocial aftercare is categorized in phases in the event of dealing with a disaster. The acute aftercare phase relates to the provision of psychosocial care during the first seven days following a disaster or (major) occurrence.

Alien

A person who does not have Dutch nationality and is not regarded as a citizen of the Netherlands on the grounds of a statutory provision. Aliens can be divided up into asylum seekers and standard foreign nationals. The latter group of people comes to the Netherlands for reasons other than those in the Geneva Convention on Refugees, such as to visit family, to go on holiday, or to start or reunify a family.

Amsterdam Regional Emergency Control Room: RAC Amsterdam

Regional emergency control room of the Amsterdam and District fire brigade region.

Appliance (Tankautospuut)

Basic fire brigade vehicle that is furnished with almost all of the standard equipment to allow initial operations to be undertaken. The vehicle has a 6-man crew.

Asylum seeker (asielzoeker)

People who have fled their country and asked for asylum in another country, meaning the right to be recognized as refugees, including the statutory protection and material assistance that this status would afford them. Asylum seekers have yet to establish whether well-founded reasons exist for their request for asylum. Consequently, they are not (yet) in possession of a residence permit.

Attack plan (aanvalsplan)

An attack plan is made for special subjects, such as hospitals, chemical plants, prison buildings and large cinemas. The plan indicates how the fire brigade must act using several vehicles in the event of a disaster. Text and drawings describe the location of entrances, stairs and lifts, as well as where many people can be found, where hazardous materials are stored, how rooms can be reached and the location of water sources for putting out fires. The plan also describes possible fire-fighting scenarios. It is a more detailed variant of the access map.

Attendance / arrival time (Opkomsttijd)

The period between the time that the fire alarm is received at the fire brigade's emergency control room and the time that the fire brigade arrives on site.

B

BAD

The Offenders' Reception Department (*Binnenkomst Afdeling Delinquenten: BAD*) is the department where detainees are brought on arrival at a detention centre and where their personal effects are kept.

BAD chief (BAD-meester)

The officer in charge in the Offenders' Reception Department (*BAD*).

C

Calorific potential (Calorische potentiaal)

See *Fuel load*.

Central Ambulance Switchboard / Ambulance Service Emergency control room (Centrale Post Ambulancevervoer / Meldkamer Ambulancezorg)

Organization responsible for coordinating ambulance transport and providing emergency personnel in the event of accidents and disasters within a particular region. The Netherlands has 25 Ambulance Service Emergency control room regions.

Crash tender

A fire brigade vehicle carrying large quantities of water (9,000 or 12,500 litres) which is specially deployed in the event of aircraft fires.

Crew Commander (Bevelvoerder)

The party in charge of a fire brigade crew (e.g. for an appliance).

D

Debriefing

Debriefing refers to the first occasion on which persons affected and rescue workers are received and offered psychosocial help.

Delivery rate/discharge (Debiet)

Capacity of a water source or water main in m³/second.

Deployment time (Inzettijd)

The period between the time when the fire brigade arrives on site and the time when the fire brigade is in place to start operations.

Duty Officer (Custodial Institutions Service) (Wachtcommandant)

Duty Officer is a job function for a Custodial Institutions Service (DJI) guard. The Duty Officer is the primary point of contact in a penitentiary institution with regard to overseeing the service. He coordinates all deployment and operational aspects in relation to the daily schedule. During disasters, the Duty Officer acts in a directional capacity. He coordinates the deployment of personnel, directs operations, reports to the responsible departmental head in respect of the action to be undertaken and evaluates the operational method decided upon and the progress of the occurrence with the departmental head.

E

Energy output (Energetisch vermogen)

The amount of energy produced per unit of time by an appliance or by a fire expressed in Watts (W).

Equivalence article (Gelijkwaardigheidsartikel)

An option provided by the Buildings Decree to replace fire-prevention facilities or measures with alternatives on the proviso that an equivalent level of fire safety is attained by so doing.

Evacuation (Evacuatie)

The relocation of groups of people and/or animals by order of the government (either compulsory or otherwise and often under supervision). Frequently, this relates to a long-term, large-scale clearance of a particular area. Registration, (transit) supervision, admittance, care and so forth are classed as belonging to the evacuation process.

Evacuation plan (Ontruimingsplan)

A number of measures that determine precisely the circumstances under which a building must be abandoned, under whose leadership this must be done and the route that must be taken by those present. These measures also include organization of notification, alarms and communication.

Expanded polystyrene (EPS)

Synthetic material with extremely low density, sometimes popularly referred to as 'polystyrene foam'. In this connection, EPS is used as thermal insulation.

F

Fire fighting (Brandbestrijding)

Restricting or extinguishing a fire and restricting its effects.

Fuel load (Vuurbelasting)

The calorific value of a quantity of fuel expressed in equivalent kilogrammes of pinewood/m².

Fire penetration (Branddoorslag)

Spread of a fire from one particular room to another room other than by airborne means.

Fire-resistance period / resistance to fire penetration (Brandwerendheid / weerstand tegen branddoorslag)

The resistance to fire in terms of time that a partition between two rooms is able to provide. (The time during which a fire does not spread from one room to another.)

Fire transfer (Brandoverslag)

Spread of a fire from one particular subject to another subject exclusively by airborne means.

First phase aftercare (Eerste fase nazorg)

The aftercare phase subsequent to acute aftercare and lasting up to 3 months after an occurrence.

Flashover

Transitional phase to a full blaze in which all flammable objects located in a space begin to form part of a fire more or less simultaneously.

G

GHOR: Medical Assistance in the Event of Accidents and Disasters

A part of the disaster relief organization that coordinates the deployment of medical services (the "white column") during disasters and major accidents.

Guidance (Toegeleiding)

Facilitating a link between an asylum seeker's care requirements and what the standard health service can provide during an asylum seeker's stay in a central reception centre for asylum seekers.

H

Heat Release Rate

Amount of heat released from a fire per unit of time (*energy output*).

Hyperthermia

Hyperthermia is a physical condition in which the body is no longer able to cool itself down enough to reach a normal temperature (overheating).

I

Illegal alien (Illegaal)

A foreign national who does not possess a valid right of residence and who is thus obliged to depart the Netherlands.

In-house Emergency Plan (Bedrijfshulpverleningsplan)

This plan describes the procedures for raising alerts and evacuation and also describes the responsibilities of the in-house emergency personnel and staff during a disaster. In addition, it describes the technical facilities that are present (such as fire alarm systems, emergency lighting and means of communication), maps, fire-extinguishing equipment and first-aid resources.

Injuries Holding Unit (Gewondennest)

An injuries holding unit is the first place where injured individuals are brought together in the event of major accidents and disasters, where first aid is given to them and where they are categorized according to their level of urgency. At first, victims are given the

best treatment possible and are then relocated according to the seriousness of their injuries.

J

K

KMar Group Commander (Groepcommandant KMar)

Person in charge of the Royal Military Constabulary (KMar) who presides over a group of KMar personnel (in the detention centre).

L

M

Material care (Materiële zorg)

Care that includes providing remuneration for or the return of clothing or personal effects and the payment of victims' funeral expenses.

Medical records (Medische dossiers)

Medical records are understood to mean a hard copy (print-out) of the patient's records from the General Practitioner Information System (HIS) with supplementary hard-copy information from doctors who supplied treatment previously.

N

O

Officer in Charge (OvD - Officier van Dienst)

The fire brigade official in charge immediately above the rank of Crew Commander. The Officer in Charge (OvD) is in charge of at least two and no more than four fire brigade units.

P

Polystyrene

See *Expanded polystyrene*.

Polyurethane (PUR)

Synthetic material with a multitude of applications. One of the material's uses is as soft foam filling in pillows, mattresses and upholstery.

Polyvinylchloride (PVC)

Synthetic material with a multitude of applications, such as window frames, ducts, pipes, cabling and flooring.

Post Rijk

A Schiphol fire station, which is also where crash tenders are stationed.

Post Rijsenhout

Fire station for the volunteers working for the Municipality of Haarlemmermeer fire brigade.

Post Sloten

A Schiphol fire station, where Schiphol's buildings fire fighting vehicle is stationed.

Post-traumatic stress disorder: PTSD

Post-traumatic stress disorder (PTSD) refers to someone who has undergone a disturbing experience and whose physical and psychiatric symptoms have not subsided a month following that experience or when these symptoms return once more much later. Three groups of symptoms are characteristic of PTSD: reliving the experience, avoidance and irritability.

Professional Practice regarding Individual Healthcare Act (Wet BIG)

The intention of this Act is to promote and safeguard the quality of Professional Practice regarding Individual Healthcare and to protect the patient against incompetent and negligent action by professional practitioners. The Act refers to a number of activities that are subject to approval. These may be performed only by professional practitioners qualified in that respect to prevent unacceptable health risks to patients from arising as a result of incompetent action.

Psycho-education

Psycho-education in cases of trauma-related conditions involves providing information about the stress-related responses that those directly affected and/or their relatives can expect and what they can do about this.

Psychosocial care

Group therapy with psychologists, social workers or the provision of psychiatric help.

Q

R

Relief and aftercare (Opvang en nazorg)

The deployment of personnel and resources following a disaster or major accident in order to return to a normal situation. The assistance rendered may include setting up reception centres, releasing information and providing medical care. Aftercare can be divided into somatic, psychosocial and material care.

Refugee

Someone who resides outside of his or her own country and cannot return due to a well-founded fear of reprisal on the grounds of race, religion, nationality, political opinions or membership of a particular social group, or someone who has fled a (civil) war. Refugees are in possession of a residence permit.

Rescue

The release of occupants/detainees from their cells by professional emergency personnel (trained staff or firemen) under threatening circumstances (see also *Evacuation*).

Resistance to fire movement (WBDBO)

Resistance to fire penetration and fire transfer. The time that a fire requires in order to spread from one room or object to another.

Risk Inventory and Evaluation (Risico Inventarisatie en Evaluatie)

Art. 5 of the Working Conditions Decree states that an employer must have a Risk Inventory and Evaluation (RIE) at his disposal. This establishes in writing the risks to (particular categories of) employees associated with the work to be performed, the dangers that can arise and the risk-prevention measures that can be taken.

S

Scaling up (Opschaling)

The process of adjusting the administration and/or operational services to the level required to combat a particular disaster or major occurrence.

Schiphol Airport Service (Havendienst Schiphol)

Service that supervises order and safety at Schiphol (airside).

Schiphol Control Room (Regiekamer Schiphol)

Schiphol Airport's control room used in part to process fire alarms.

Somatic care

Relief and care of the wounded, the objective of which is to save human life and to keep injuries to a minimum. It also refers to standard care.

Speedgate

A gated area for vehicles.

Submersible pump (Dompelpomp)

A pump that operates underwater.

Sweep team (Veegteam)

A group of KMar personnel responsible for collecting and securing packages of narcotics that drugs swallows have ingested.

T

Transport and Support Service: DV&O (Dienst vervoer en ondersteuning (DV&O))

The Transport and Support Service (DV&O) is a national service provided by the Custodial Institutions Service (DJI) responsible for transport, relief and support-related duties within the Ministry of Justice. Among other things, the DV&O provides transport that is to be protected for the purposes of the judicial process, the transport of detainees and national assistance including at times when disasters arise.

Triage

The first selection of victims in which they are classified among categories of emergency from T1 to T4 inclusive (ranging from minor injuries to seriously wounded victims). Emergency category T4 concerns victims beyond treatment. This category is not used in peacetime and only in special circumstances. Observations are made on the basis of a quick assessment of vital bodily functions.

U

V

W

X

Y

Z