Inspectorate of Justice and Security
Ministry of Justice and Security

Upon Closer Inspection

Reflective supervision in the practice of Justice and Security

The resilience and resistance of Justice and Security chains

Contents

Summary

This is the first edition of a new series: Upon Closer Inspection. In this series, the Inspectorate of Justice and Security ('the Inspectorate' below) puts reflective supervision into practice. This document serves to bridge the gap between supervisory practice on the one hand and science, policy and politics on the other. By adopting a theme-based approach, the document considers the Justice and Security domain from a new perspective. The first edition of this series centres around resilience and resistance.

Resilience and resistance in general

Generally speaking, resilient and resistant chains and organisations are able to continue functioning during a crisis. They will continue to perform their tasks effectively and achieve most if not all of their goals even under (highly) disruptive circumstances.

In the scientific literature, various factors have been identified that explain why they succeed in this. Examples include having effective staff policies, having direct access to the right financial and material resources, an effective external network, and taking preparatory measures such as drafting protocols and scenarios (and actually adhering to them *during* a crisis). Factors such as these enable organisations and chains to continue functioning even in very stormy weather. While the literature does not offer a concrete list of factors that are helpful, appropriate or effective, overall it recommends any measure that ensures continued performance before, during and after a crisis. For example, many authors agree that employees with a strong sense of norms and values have a 'constructive conceptual orientation' that enables them not only to pick up, interpret and respond to signals from their environment, but to cope with setbacks in a constructive manner, to act flexibly and to improvise if necessary.

Crucially, moreover, organisations and chains need to be prepared to learn from crises, incidents and disruptive events and to adapt their work processes and organisational structure in response to the insights thus gained. Merely having the right scenarios in place should a crisis occur is clearly not enough. Such scenarios will only work if employees, resources and relationships are all geared to ensuring the continuity of operations whatever the circumstances. The most important insight provided by the literature is that all these factors are closely interrelated and should be conceived as a *cycle*. Preparatory measures influence actions during an actual crisis, and the learning outcomes after the crisis are used to adapt the preparatory measures.

The resilience and resistance of Justice and Security chains

We used this conceptual framework as the basis for an analysis of some 50 of the Inspectorate's reports to determine the resilience and resistance of the chains in the Justice and Security domain. While showing countless examples of resilient and resistant action, the analysis has revealed four structural problems across the full width of the Justice and Security domain.

First, many chains appear to be unable to mobilise enough staff to recognise and fight a crisis, and many of the staff members they do find lack the required level of education and training for this purpose. Second, and partly as a result of this, the quality of the information (and hence the ability of chains to really understand the crisis) is substandard. So while information, *in theory* at least, is the key to success, in practice it appears that the Justice and Security chains do not have up-to-date and comprehensive information about their environment. They fail to collect information, or collect the wrong type of information. Proper registration of information is also lacking, and the chains are unable to share their information with all relevant partners.

Third, all of this is connected to another problem: poor collaboration within the chains. In practice, many chains are still looking for the best way to structure collaboration. Protocols, coordination agreements and scenarios are either poorly documented, or not adhered to in practice. This seriously reduces the effectiveness of the chains – both prior to and during a crisis.

Finally, it also appears that the chains have problems learning from their experiences during crises. They

fail to systematically examine why things have gone wrong, and they lack a reflective environment with a clear management focus on answering that question. The evaluations they do carry out often fail to result in clear improvement measures – which is an important factor according to the literature on resilience and resistance. After all, by learning and making improvements organisations are more likely to respond earlier or more effectively to future crises, which equals a higher degree of resilience and resistance. This provides them with a better view of recurring problems in the Justice and Security domain and how those problems combine to undermine resilience and resistance.

This should result in a clear picture of the most persistent problems that obstruct resilient and resistant action. Not only does this improve transparency for citizens, it also helps the chains themselves identify the issues they need to address in order to become more resilient and resistant. In addition, it helps the Inspectorate assist the chains in their efforts to increase resilience and resistance – an objective that is also recognised in Projects Guidance and Regular Supervision Guidance. Finally, the picture thus achieved also identifies the responsibilities in the political and policy fields, as the politicians and policymakers set out the frameworks within which chains in the Justice and Security domain are required to operate. This means that they, too, influence the resilience and resistance of the chains, both directly and indirectly.

1: Introduction

Upon Closer Inspection

The COVID-19 outbreak

On 27 February 2020, a male patient in a hospital in Tilburg is diagnosed with COVID-19. It is the first reported case in the Netherlands. While the virus has dominated the headlines since January, most of the earlier reports were about the situation abroad – in China, where the virus originated, and other countries in which has emerged. In the next few weeks the number of infections in the Netherlands rapidly increases, partly because many people celebrate carnival as usual. COVID-19 is declared to be a pandemic. Nevertheless, the number of deaths and seriously ill patients continues to rise at an alarming rate. In March 2020, more than 150 people die from COVID-19 every day. Society grinds to a complete standstill, as though somebody had pulled the emergency brake.

The outbreak took the country by surprise, despite the fact that we had known for years that an (influenza or other) pandemic might break out. For example, the 2019 Comprehensive Risk Analysis, drawn up by the National Security Analysts Network for the National Coordinator for Counterterrorism and Security (NCTV), contains a 'scenario for a serious influenza pandemic'. An outbreak of a 'humane infectious disease' is 'probable' and its impact will be enormous, the analysts warn. The worst-case scenario predicts 'more than 10,000 deaths' and 'a very large number (40,000-50,000) of hospital admissions'. It also predicts 'pressure on the medical sector, and disruptions of daily life due to the large number of people falling ill'. The country will face 'sickness absences on a massive scale' that may cause education and other sectors to come to a complete standstill.[1]

Resilience and resistance

Despite this scenario, the contingency plans and the preparatory measures, the crisis proved to be larger, faster and more unpredictable than anticipated. In fact this applies to any crisis. Crises are often characterised by unexpected events with major consequences. However, some organisations can deal with crises, system disruptions and incidents better than others – especially if they are resilient and resistant. Resilience is a celebrated concept in Dutch public administration, where it is used to denote characteristics such as flexibility and agility. In the Dutch dictionary, it is defined as 'the strength of the body and the mind to recover rapidly'. The term 'resistance' implies similar characteristics, but also has a military connotation in denoting the ability to fend off an attack. Academics in a wide range of disciplines tend to project these material and human characteristics on to organisations, chains and institutional systems. Often, the terms are used to indicate the extent to which organisations, chains, networks and systems are able to survive disruptions such as crises, disasters and system failures and bounce back to their former or a new default position while learning from the experience.

The societal importance of resilient and resistant organisations is huge. Citizens should be able to rely on the continued performance of the chains, networks and organisations under the Inspectorate's supervision even during crises, serious incidents or other disruptions of daily practice. This is consistent with their mandate, which requires them to implement policy in their respective fields, also in turbulent times. This explains the Inspectorate's interest in these characteristics. It hopes to 'stimulate resilience by investigating the level of preparation for unexpected events, such as a crisis or disaster or a major change in a chain'.[2]

[1] Analysts' Network, commissioned by the National Coordinator for Counterterrorism and Security, 2019 Comprehensive Risk Analysis, pp. 25, 27 and 36. Internet: Geïntegreerde risicoanalyse Nationale Veiligheid I Rapport I Rijksoverheid.nl.
[2] Multi-Annual Perspective 2021-2024, Inspectorate of Justice and Security (published on 11 February 2021), p. 9.

At the same time, many of the Inspectorate's reports reveal the numerous problems that prevent organisations, chains and networks in the Justice and Security domain from doing their job effectively. In many cases coordination is lacking, parties fail to share essential information, make written agreements but fail to observe them in practice or do not have enough staff who are properly equipped for their task. This raises questions regarding the extent to which frequent problems of this type affect the resilience and resistance of the chains in this domain.

This document, therefore, presents an analysis of the level of resilience and resistance in the Justice and Security domain, based on the Inspectorate's reports. The overarching objective of 'Upon Closer Inspection: reflective supervision in the practice of Justice and Security' is to put the Inspectorate's ambition to carry out reflective supervision into practice.[3] In this first edition, we will consider the chains in the Justice and Security domain from the thematic perspective of resilience and resistance. We will analyse these two concepts based on the relevant scientific literature and use them as a conceptual framework for examining the Justice and Security domain.

In this way we will present Dutch citizens, and Dutch society in general, with a realistic picture of the extent to which these specific government entities can cope with crises effectively – a desired form of transparency.[4] The chains themselves also stand to benefit from these insights. Both the framework created on the basis of the literature and its application to the Inspectorate's reports can help them examine their own resilience and resistance, thus enabling them to identify potential weaknesses and find solutions. For the Inspectorate, this first edition of 'Upon Closer Inspection' is a good opportunity to further its ambition to strengthen resilience and resistance. And finally, politicians and policymakers too will benefit from a perspective on resilience and resistance. After all, they direct the chains and set the conditions that must be fulfilled for them to function properly. The insights from this report will give politicians and policymakers a better understanding of exactly what is needed to stimulate resilience and resistance.

Resilience and resistance

Resilience and resistance in the scientific literature

In the scientific literature, resilience and resistance are interpreted in various different ways. The central notion is that is 'disruptive changes' can never be anticipated in full. While crises that are expected and more or less known allow a fair amount of planning, in fact most crises are not, or not entirely, knowable. One can never be certain in advance whether a particular 'weak signal' points to a serious crisis or only to a minor disruption of daily practice. One question, therefore, is whether organisations and chains should focus on anticipation – the ability to recognise an imminent crisis – or on resilience and the strength to cope with crises that cannot be avoided anyway.[5] Many authors have tried to identify the most effective combination of anticipation and resilience. They try to pinpoint exactly what it is that enables some organisations, chains and systems to deal with crises better than others. In this context, the following features have been identified: 'robustness' (recognising that shocks are inevitable, and preparing for them), but also 'agility' (evading the unexpected just in time) and 'anti-fragility' (anti-fragile organisations actually become stronger when exposed to shocks), as demonstrated by public administration expert Martijn van der Steen in his inaugural lecture.[6]

[3] 'Toezien op publieke belangen', *Netherlands Scientific Council for Government Policy* (2013); 'Toezicht door Inspectie Justitie en Veiligheid bij toenemende maatschappelijke complexiteit', Research and Documentation Centre (2020); Multi-Annual Perspective 11.
[4] Public confidence in the government has fallen sharply in recent times. For example, see: Knowledge Workshop for Liveable Neighbourhoods, 'De laag-vertrouwen-samenleving: de maatschappelijke impact van COVID-19 in Amsterdam, Den Haag, Rotterdam & Nederland Vijfde meting (The low-trust society: the societal impact of COVID-19 in Amsterdam, The Hague, Rotterdam and the Netherlands (November 2021).
[5] For example: A. Wildavsky, *Searching for safety* (New Brunswick 1988).
[6] M. van der Steen, *Tijdig bestuur: strategisch omgaan met voorspelbare verrassingen (inaugural address)* (Rotterdam 2016) pp. 53, 55 and 57.

Resilience is a similar kind of characteristic. Sometimes it is defined as one element of resistance, alongside adaptability, for instance. Other authors use a range of concepts to define resilience, including 'agility'. Resilient organisations are able to circumvent anticipated crises, while resistant organisations 'stand firm' and 'push back'.[7]

In a general sense, however, both resilience and resistance appear to refer to the concept of 'resilire', which is Latin for 'bounce back' and denotes the ability to return to a presumed default status after a disruptive event such as a crisis, disaster or system failure. So a resilient organisation is one that is able to recover and, especially, to learn from disruptions and improve its ability to anticipate and avert future crises – or cope with them more effectively.[8] This involves a wide variety of things: the abilities or capacities of organisations, their characteristics, the outcomes of their actions, processes, behaviour, strategy, approach and result.[9]

In an extensive overview of resilience and crisis management literature, organisation theory scientist Trenton Williams and a number of his colleagues have attempted to impose order on this chaos and listed the main empirical and theoretical insights into resilience.[10] Their work has revealed that this tends to be approached from a system perspective that recognises an existential link between organisations and chains on the one hand, and their environments on the other. An organisation's survival depends on its ability to respond to and move along with its environment, to embrace or resist developments as required. Put differently, organisations and chains are part of larger institutional systems and will not survive *unless* they are resilient and resistant. Those that survive have been able to continue achieving their organisational objectives, for example by rapidly adjusting to changes in their environment and by building relationships, even in turbulent times.

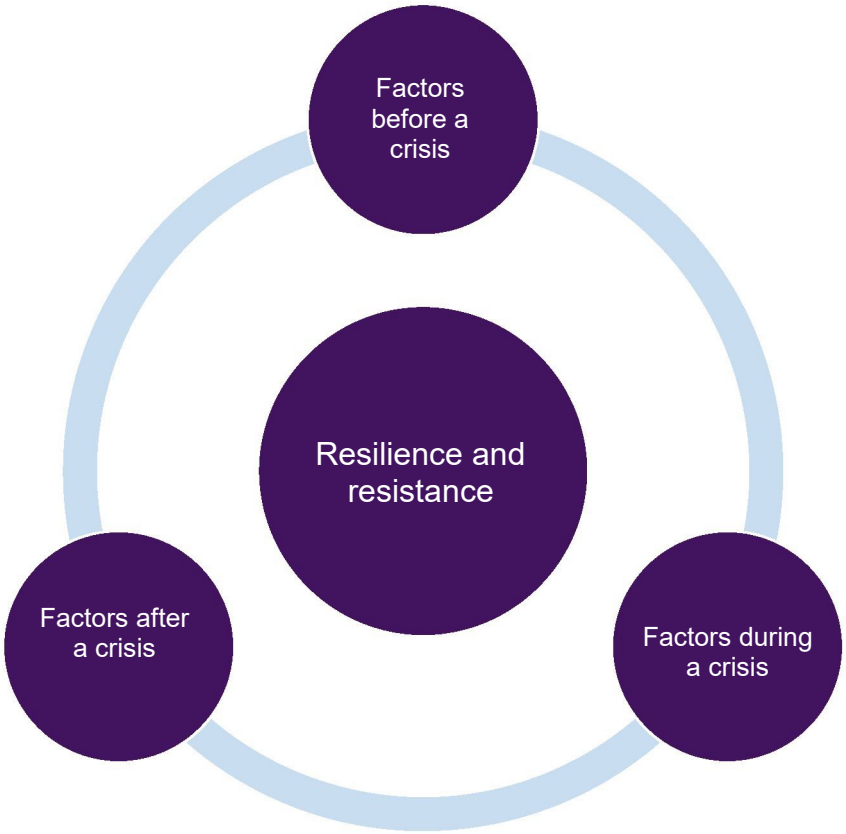
One important point for discussion in this context is exactly what default position organisations are bouncing back to. Of course the organisation, chain or system itself may have contributed to the crisis in which it finds itself. In that case, bouncing back to the old default status is rather like pressing the 'repeat' button. According to some authors, true resilience means that an organisation or chain bounces back to a *new* default status. For this to happen – and on this point many authors integrate the literature on organisational learning in their argument – organisations and chains also need second and third-order learning strategies: they should wonder not only whether they are getting things right but also whether they are doing the right things, identify those things and define their own identity. According to Martijn van der Steen, the concept of resilience precludes this approach, as it essentially is a 'conservative mechanism' that is tied to a specific route and does not question the system as such. However, other authors do include these other types of learning and, in explaining their notion of resilience and resistance, give pride of place to the concept of *change*. They identify the capacities, practices, processes and routines of organisations and chains before, during and after a disruptive change. These authors only speak of resilience and resistance if those capacities undergo such a disruptive change.[11]

[7] M. van der Steen and M. van Twist, 'Weerbaar of wendbaar zijn? Strategische opties in de voorbereiding op de drie decentralisaties', Beleid en Maatschappij 2014 (41) 1, pp. 58-64.
[8] Boin and P. 't Hart, 'Between Crisis and Normalcy: The Long Shadow of Post-Crisis Politics,' in U. Rosenthal, R.A. Boin and L.K. Comfort, *Managing crises: threats, dilemmas, opportunities* (Charles C. Thomas: Illinois 2001) 28-46; Arjen Boin and Michel J.G. van Eeten (2013) The Resilient Organization, Public Management Review, 15:3, pp. 429-445.
[9] J. Hillmann and E. Guenther, 'Organizational resilience: a valuable construct for management research?', *International journal of management reviews,* vol. 23, 2021, pp. 7-44, q.v. 8.
[10] T.A. Williams, D.A. Gruber, K.M. Sutcliffe, D.A. Shepherd, and E. Yanfei Zhao, 'Organizational Response to Adversity: Fusing Crisis Management and Resilience Research Streams,' *Academy of Management Annals* 11 (2) 2017, 733-769.
[11] Hillman and Guenther, 'Organizational resilience', 8-9.

Williams shows that a great deal of literature tells us *why* organisations, chains and systems actually go through those changes. Effectively, it lists the necessary conditions for resilience.[12] Entities need to have information, financial resources and the right mindset to be able to respond effectively to violent, shocking and disruptive events. Resilient and resistant organisations and chains are able to anticipate and respond to crises and will not grind to a halt. They manage to mobilise assistance from external sources and evaluate their own actions. They will not hesitate to adapt their own routines and processes if they believe that this will help them to identify future crises at an earlier stage or respond to them more effectively.

Williams has classified these types of studies according to the stage of the crisis concerned. He distinguishes between factors that play a role before, during and after a crisis. Interestingly, his work has shown that resilience and resistance depend on a wide variety of factors which, moreover, are strongly interconnected. This makes it worthwhile to consider those factors in some more detail.

Figure 1. Before, during and after a crisis: resilience and resistance as a cycle



Factors before a crisis

Before a disruption or a crisis, it is important for organisations and chains to mobilise resources. For example, US airlines with ample financial reserves proved to be better positioned to absorb the shock of the 9/11 attacks (and the tightened security measures and drop in air traffic following those attacks).[13] Note that resources are understood to also include less tangible assets such as mission, vision, creativity and flexibility. Generally speaking, only flexible organisations that have a clear mission and stimulate their employees' creativity are capable of 'rapidly identifying and interpreting signals of potential disruptions'. In addition, they have made sure to embed this capability in their organisation by means of training programmes, protocols and dedicated HRM policies.[14] While this may sound obvious, in practice it proves

[12] We should add, perhaps superfluously, that the literature covers a whole range of approaches. While some studies are theory-driven and formulate specific assumptions about resilience and resistance, others are more empirical in design and appear to answer the question of *how* certain factors promote resilient and resistant action.
[13] Williams et al. 2017, 745.
[14] Williams et al. 2017, 744-745.

to be extremely complicated. This is because a ‘clear vision’ may turn into a tunnel vision and obstruct truly open and creative interpretations. Also note that a crisis is never fully 'knowable’ in advance. As we do not know what the next crisis will be, we cannot tell what a particular disruption may be a signal of. This is a persistent problem. The trick is for organisations to deploy the right personnel, with the right equipment, in the right institutional setting, thus strengthening their ability to interpret ambiguous signals (in an organisational context).[15]

More specifically, this means that resilient and resistant organisations have employees who can be deployed as required and are sufficiently equipped, educated and trained for their tasks. It is important for employees to have the expertise and skills needed to keep track of external developments and ensure the early detection of signals that might point to an imminent crisis. This enables them to mobilise colleagues and the necessary resources.

Another very important factor is the organisational culture. If the prevailing mentality within an organisation is such that it enables individuals to discuss and cope with setbacks, this will strengthen the crisis response. Organisations where discussing *why* an error was made is more important than handing out punishment create the conditions for such a reflective mentality to develop. Relationships with partners in the environment can also help to promote resilient and resistant action. Preventive measures such as creating networks, setting out roles in protocols and entering into coordination agreements are no less important, as is resilience and resistance training for individual employees. For instance, it could be useful to train employees’ improvisation skills so as to enable them to *deviate* from existing scenarios and protocols when the circumstances of a crisis so demand.[16]

Factors during a crisis

During a crisis it is important to continue operations with support from these types of resources and capacities. This is difficult, as crises are characterised by uncertainties on many fronts. It is difficult to form an idea of the nature of the problem, circumstances can change rapidly and it is hard to decide on the right response. Innovative strength and continuous adaptation to changing circumstances should enable an organisation or chain to ‘identify changes in its environment, interpret and analyse those changes and formulate responses to them'. Crucially, those responses should go beyond the 'mere survival’ mode. The intention should be to keep trying to attain the organisation's objectives. The machinery should not be allowed to come to a standstill.[17] Sometimes the ‘before’ factors mentioned above provide sufficient opportunities for this. In other cases, new roles may have to be filled and new routines organised *during* a crisis, and it may also be necessary to reorganise the work. Such a dynamic adjustment to its environment, which may also involve seeking other parties’ assistance, reflects the organisation's resilience and resistance.

Factors after a crisis

Most authors agree that after a crisis, organisations and chains should *learn* from their experiences. Employees of organisations and chains that have gone through a crisis will have learned a great deal, in a short period of time, about utilising resources and capacities, about organising and about adapting to, preparing for and responding to adversity. It is very important to explicitly discuss those insights and perspectives in the aftermath of the crisis. This exercise may result in a reconsideration of existing operational processes and procedures. Perhaps it turns out that the right resources or capacities were not available, or had not been organised effectively before the crisis. If so, work routines and other operational processes will have to be modified. As pointed out above, this works best if combined with second and preferably also third-order learning strategies, to avoid the risk of organisations, like army generals, ‘preparing for the previous war’. Although other authors make a distinction between anticipating a crisis and responding to it, in this context – and based on Williams' article – ‘anticipation’ is included in the definition of resilience and resistance. This is because learning strategies focus both on anticipation *and* response: while crises can never be anticipated in full (so chains should not be expected to have this ability), an effective learning process could support the earlier detection of subsequent crises. This, in turn,

[15] Van der Steen, *Tijdig bestuur,* 54.
[16] Williams et al. 2017, 744-745.
[17] Williams et al. 2017, 747.

should enable a more effective response to such crises.

Conceptual framework

The literature clearly shows that resilience and resistance depend on a range of resources, capacities and activities before, during and after a crisis. So in theory, for a thorough review of resilience and resistance in the Justice and Security domain, all these aspects should be considered. That would be a very complicated exercise. After all, we would often be comparing apples and oranges: while some authors claim to have found *necessary conditions* for resilience and resistance, others merely outline the general features of resilient and resistant organisations, and while some notions are assumed to be of importance *theoretically*, others have been examined *empirically*. As a result, many of these disparate features – ranging from concrete aspects such as budget, suitable staff and equipment to intangible and less measurable aspects such as flexibility and mindset – cannot be studied equally successfully.

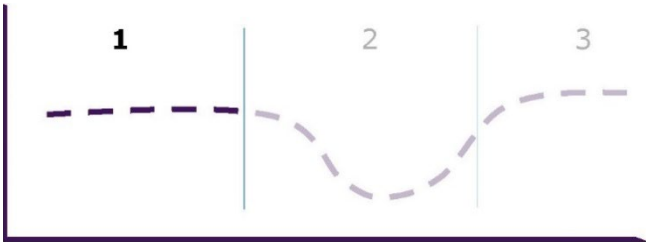
This is why we have condensed this multiplicity of influences, features and conditions into a small number of *factors.* The assumption is that those factors, if present, will strengthen an organisation's resilience and resistance. So, in very general terms, we could say that if an organisation can rely on a sufficient number of employees with the right tools and connections, whose actions before and during a crisis are responsive and adaptive, and if it encourages them to engage in in-depth reflection after the crisis on what did and did not work well, that organisation can be said to be highly resilient and resistant. Without such employees or such reflection, the organisation's level of resilience and resistance will be lower. This is because such organisations and chains will be less successful in continuing to perform (and reach their objectives) during a crisis.

To study this, we have distilled four factors from the literature that exert an influence before, during and after a crisis: employees, resources, relationships and working methods. Afterwards, we studied the factors of learning/evaluation and adaptations in more detail. As such, while not including all insights from the literature, the framework does reflect the ones that are the most prominent (and have to be operationalised). For practical reasons, we have operationalised the factors in the form of questions. While the literature does explore basic conditions for resilience and resistance, there is no clear checklist of criteria that organisations and chains have to satisfy in order to be resilient and resistant.

Within the context of this document, therefore, we have opted for a practical interpretation and converted the factors into questions and comments. Note, however, that these do not always fully reflect the wide range of subjects they cover in the scientific literature. For instance, the 'relationships' factor mainly denotes the instrumental relationships that employees, financial resources or information can offer, despite its wider meaning in the literature. So the questions serve as searchlights to uncover information in the reports about the presence or absence of the factor concerned. For each factor, the framework below presents a brief description and a question. For the sake of convenience, ‘bouncing back’ as a topic has been left out of the figure – visually, the third phase now resembles the first, but note that, in line with the relevant literature, this is also deemed to cover bouncing back to the ‘new norm’.

1: Before

What tools are available to the chains in the Justice and Security domain to help them anticipate a crisis and perform during a crisis?



Employees
Employees must be available in the right locations. They should be stress-resistant and have relevant expertise. 'Expertise' refers to the ability to detect problems, awareness of agreements on how to respond to those problems, the ability to come up with alternative approaches if required etc.

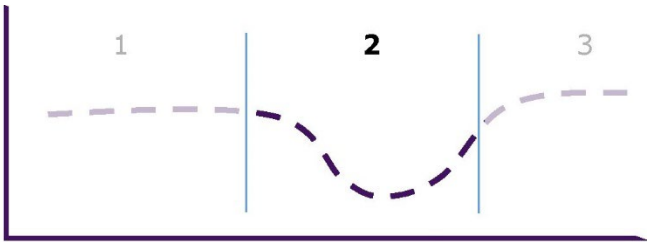
Means and resources
The financial and material resources available must be sufficient. This includes the right technology and information quality (comprehensive, accurate ...).

Relationships
If an organisation itself does not have the two elements above in sufficient quantities, it should be able to obtain staff or other resources from elsewhere (or acquire additional resources). For that purpose, an organisation needs connections. External relationships are also an important source of information.

Working method
Prior to the crisis the organisation has already thought about how to act in the event of (conceivable and unknown) crises. For example, it has adopted specific procedures or coordination agreements.

2: During

How do the Justice and Security chains perform during an actual crisis?



Employees
Did they have enough employees? And were those employees sufficiently knowledgeable?

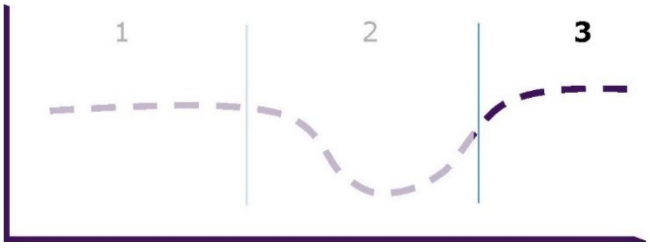
Means and resources
Did they have enough money, materials and information to act? Were the materials and systems effective?

Relationships
Was it possible for the organisation to obtain assistance from other organisations or to attract additional resources? Were the right partners involved?

Working method
Did the approach that had previously been laid out prove to be sufficient? Was it necessary to look for alternative strategies?

3: After

To what extent does the organisation reflect on its own actions before and during the crisis, and to what extent does this result in adaptations within the chains?



Learning and evaluating
Does the organisation engage in reflection/evaluation? Does it tackle the obstacles identified?

Adaptations
A resilient and resistant organisation is able to adapt itself after a shock, if necessary (by reorganising, modifying its processes etc.). To what extent does the organisation do so?

Study design and execution

In line with the literature, we approach resilience and resistance from a system philosophy, based on the interconnectedness of the Justice and Security chains and their broader environment. Avoiding a debate about precise definitions, we regard resilience and resistance as features that enable organisations and chains to mobilise people, resources and working methods to ensure they can continuously adapt to their environment. The purpose of such adaptation is to ensure continuity of operations before, during and after a crisis.[18]

Chains as research objects

The separate elements from the framework are not new in and of themselves. Matters such as staff policies, information gathering, collaboration and learning have always featured in the Inspectorate's reports. However, the framework outlined above shows how, as an interconnected set of factors, they are linked to resilience and resistance.

To make the framework work in practice, we will have to delineate the study. To start with, we have decided to focus on chains, rather than individual organisations, as the objects of study. A chain is conceived as a partnership of organisations which, in addition to their own objective, pursue one or more shared objectives either selected by them or imposed on them by the government. While the partners in a chain are independent entities that are usually also funded individually, they do depend on each other when it comes to achieving their shared objectives. The chains we are concerned with here are those in the migration, security, disaster relief, and emergency and care domains.

Social crises

Next, we looked for examples of social crises in which chains played a role – for example in crisis prevention, relief or resolution. A social crisis may consist of a '(shocking) event or series of events that causes considerable social unrest and attracts a very large amount of media attention'.[19] To cover a sufficiently large number of reports, the term 'crisis' has been given a broad interpretation. This explains why the study, in addition to examining evident crises at a national security level (such as the crash of emergency number 112 and the terrorist attack in a tram in Utrecht in 2019), also covers smaller-scale incidents (such as (uncontrolled) fires, a diving incident and an act of violence by a person detained under a hospital order). While these latter incidents involve crises on a smaller scale, the associated reports still offer valuable information about the resilience and resistance of chains within the Justice and Security domain.[20]

Applying the framework

In the context of these crises, one study question concerned the extent to which the factors that are deemed to be *in the public interest* inform the *specific* working practices of chains in the Justice and Security domain. We tried to answer this question mainly by means of an in-depth study of around 50 of the Inspectorate's reports. See Appendix 1 for some more detail on how we conducted this analysis. It is important to remember that this analysis of the Inspectorate's own reports provides a general picture of the domain in its entirety. Further research is required to focus on the various sub-areas and specific developments within them. In the current phase, however, we have opted to present an overall picture of the situation in recent years.

In that picture we have assessed the extent to which factors considered to be important in the literature are reflected in the reports, per phase. We should emphasise that this is a qualitative and argued assessment. In the reports we have found *examples* that say something about the factors from the

[18] Williams et al. interpret resilience as 'the process by which an actor (i.e., individual, organization, or community) builds and uses its capability endowments to interact with the environment in a way that positively adjusts and maintains functioning prior to, during, and following adversity'. Williams, 742.
[19] Hotspots of the Ministry of Justice and Security 2019-Version 1.0 Date 18 December 2020 Status Adopted in the SIO of 17 December 2020. Note that the Inspectorate naturally also maintains a strong focus on crises in its supervision of crisis control efforts by the security regions. For example, the Regular Review on Disaster Relief and Crisis Management (May 2020) says the following (on page 5): 'Incidents and crises not only concern the more "traditional" crises such as a fire or the release of dangerous substances, but are also about the role of the security regions in relation to the functional chains and the social domain.'
[20] This study does not differentiate according to type or scale of the crisis. Whether specific types of resilience are particularly suited to respond to specific types of crisis is an interesting question for a follow-up study.

conceptual framework and, as such, also about the resilience and resistance of chains in the Justice and Security domains. This is why these reports are mentioned in the footnotes to the analysis in chapter 2. Collectively, the examples give a good impression of the level of resilience and resistance.

The factors are discussed separately in the analysis. For clarity's sake, the relevant section of the conceptual framework is indicated above each paragraph, per phase. The texts in the boxes present examples from the Inspectorate's reports that relate to the factors.

2: Resilience and resistance in the Justice and Security domain

Before a crisis

The overarching sub-question regarding the 'preliminary phase' of a crisis concerns the measures the Justice and Security chains took prior to a crisis. To present a picture of those measures, below we will discuss the factors of employees, resources, relationships and working method.

Employees

Conceptual framework:

Employees must be available in the right locations. They should be stress-resistant and have relevant expertise. 'Expertise' refers to the ability to detect problems, awareness of agreements on how to respond to those problems, the ability to come up with alternative approaches if required etc.

Availability of staff

Implementation practice in the Justice and Security domain largely depends on employees. Often it turns out that chains in this domain did not have enough staff in the period prior to a crisis. One clear example of a quantitative staff issue can be found in the young-offenders institutions and the associated schools. The Inspectorate has been aware for some time that this sector is struggling with staff shortages. For years, work pressure has been increasing as professionals are asked to work longer and extra shifts. Combined, not surprisingly, with very high sickness absence levels, this results in even larger staff shortages - a full vicious circle.[21]

Quantitative staff issues also exist within the prison system and the social domain. For example, inspection reports on the prison system and the custody regimes in particular (from 2018) showed that checks and cell inspections could not be carried out due to staff shortages. On top of that, lack of funds has resulted in austere day programmes within the custody regimes. This means, among other things, that staff have little contact with detainees who may be in need of care. This in turn results in a failure to launch suitable care programmes and impedes re-integration efforts.[22] Staff increasingly feel they are being overtaken by developments as important signals remain undetected.

The same phenomenon can be observed in forensic care services. Staff at most forensic psychiatric centres (FPCs) point to recent or persistent staff shortages. Most certified institutions (youth protection and rehabilitation institutions) lack the capacity they need to ensure high-quality and timely execution of youth protection and rehabilitation measures. They can only do so if the workforce is sufficient and has enough capacity to respond to unforeseen situations. Most certified institutions do not have such over-capacity, and have trouble assigning youth protection officers to children as soon as intake figures rise. Similarly, the Child Care and Protection Board has a hard time processing cases that involve protection studies or studies in connection with divorce and visiting arrangements.

[21] Inspectorates' letter to the Custodial Institutions Agency (DJI), request for periodic report on measures to alleviate acute pressure on young offenders institutions, 7 July 2021; Progress report regarding intensive supervision of young offenders institutions and schools, letter dated 28 October 2021.
[22] Out of balance - An investigation into the quality of performance in six locations within the prison system (report published on 26 April 2018); The custody regime, a precarious balance - Thematic study (report published on 4 June 2018).

One important cause of this is the Board's lack of experienced investigators, which is resulting in long waiting lists and more children in unsafe situations.[23]

In the summer of 2018, the Inspectorate found that the staff situation at the forensic psychiatric unit in Franeker was 'not stable'. Due to high staff turnover, many employees had not been able to build long-term working relationships with each other. This could potentially adversely affect the institution's ability to anticipate and cope with incidents. An incident investigation by the Inspectorate revealed that this had contributed to several errors of judgement [Incident investigation report, FPC De Oostvaarderskliniek 2019 (report published on 14 October 2020)].

Within the disaster relief and crisis management domain, the number of volunteer firefighters has been decreasing for years. It is proving difficult to find new colleagues. Besides volunteer firefighters, the availability of crisis management officers cannot always be guaranteed. For example, the contingency coordinator (CaCo) of the security region training centre should officially be available '24/7', but approximately half of all security regions fail to meet this requirement.[24]

A lack of staff has adverse effects on the resilience and resistance of an organisation or chain. Smart deployment of existing staff resources can help to reduce those effects. For example, due to the limited availability of firefighters during the summer months, the Utrecht security region decided to shift the deployment of existing volunteers. This made it possible to guarantee representative fire services despite the shortages [Fire at Herenweg 6 in Houten, 25 July 2015 (report published on 9 March 2016)].

Staff quality

In the Justice and Security domain, there is a clear correlation between quantitative and qualitative staff issues. The huge outflow and absenteeism of staff has resulted in the hiring of both temporary and permanent new employees. Generally speaking, these new colleagues tend to be less experienced, which can lead to problems. For example, new staff members in forensic care often lack the level of knowledge required to deal with the highly complex target group of persons detained under a hospital order. Combined with the high pressure of work, this means that these new employees are not sufficiently able to recognise risks.[25]

The Inspectorate has observed similar problems elsewhere, for example among certified institutions.[26] When an organisation is understaffed, the risk is that it asks more from inexperienced employees than they are able to offer, and has less time to provide proper guidance. So even if they manage to find enough staff, organisations may end up in a situation where the numbers of permanent and suitably qualified staff remain inadequate. Moreover, for municipal officers disaster relief and crisis management are secondary tasks for which no statutory performance requirements have been defined – an issue that was already noted back in 2013.[27] More recently, too, the security regions were found to lack sufficient insight into their own 'performance capacity' and that of their partners in the chain.[28]

Training programmes, refresher courses and drills are organised to improve and guarantee the quality of staff. This concerns language skills, professional training, system operation and specialist technical

[23] The waiting list of the Child Care and Protection Board: Do the measures taken by the Board result in a better view of the safety of the child and to they help to reduce the risks? (report published on 19 February 2019); View of Safety How does the Child Care and Protection Board monitor the safety of children on its waiting list? Spring action plan (published on 25 March 2021).
[24] Regular Review on Disaster Relief and Crisis Management, May 2020 (report published on 2 July 2020).
[25] 'Nowhere to go' - An investigation into the obstacles and dilemmas in the rehabilitation of detained persons under a hospital order (report published on 14 October 2020).
[26] Insufficient protection for vulnerable children, national report for 2021, follow-up supervision (report published on 5 July 2021).
[27] The State of Disaster Relief, 2013 (parts A and B) (report published on 22 May 2013). This issue has not been solved, as reflected in a report published by the Security Regions Act Evaluation Committee (Security Regions Act Evaluation Committee, *Evaluatie Wet veiligheidsregio's naar toekomstbestendige crisisbeheersing en brandweerzorg,* report published on 4 December 2020). On page 13 of this report we read the following: 'The Security Regions Act fails to clarify what civil care and defence is understood to mean and how it relates to municipal crisis management efforts. Nor does the act describe any objectives or performance requirements for civil care and defence.'
[28] Regular Review on Disaster Relief and Crisis Management, May 2020 (report published on 2 July 2020), p. 14.

expertise, for example.[29] In some cases, staff training levels were found to be substandard.[30] A case study in response to the unexpected death of a baby in the province of Zeeland in 2017, for example, revealed that one of the organisations involved had deployed 'an insufficiently qualified professional' and, as such, had failed to meet the 'standard for responsible staff allocation' - which standard, moreover, had not been adequately monitored either.[31] The police is another sector characterised by frequent issues in organising large-scale training programmes of sufficient quality.[32]

The emphasis on staff drills in the disaster relief and crisis management domain results from the statutory obligation to practice with a variety of scenarios. While this is a good thing on the one hand – after all, staff do get a lot of training – it does, on the other, make it difficult for security regions to apply a proper learning cycle. Because the drills focus on a variety of *different* aspects, the interval between two drills of the same type may be quite long. This causes the learning effects from one drill to be followed by those from another without having been properly consolidated first. Note, incidentally, that not all requirements are being met. Over the past few years, the Inspectorate has repeatedly found that not all security regions conduct the compulsory annual system test. And while it is true that more and more multidisciplinary drills have been organised in recent years, some parties are more active and involved than others.[33]

In other domains, too, some questions remain. For instance, in 2018 the Inspectorate found that staff at penal institutions, due to labour shortages, regularly had to cancel scheduled staff training sessions.[34] In addition, training programmes covering the full spectrum of organisations in the migration system were not always up to standard, and there had been concerns for a while about training in some specific methodologies.[35]

For example, in response to a violent incident at De Kijvelanden Forensic Psychiatric Centre in 2020, the Inspectorate made the following observation: 'To make sure that department staff can implement access control in accordance with the policy, they need to be properly equipped for that purpose. However, the Inspectorate notes that not all staff members have been trained to check goods and perform body searches. This was one of the factors that impeded an effective response to the hostage-taking crisis [FPC De Kijvelanden incident investigation (1 March 2020) (report published on 3 December 2020)].

[29] For example: Shooting incident in Bonaire (report published on 27 November 2017); Investigation report on a house fire in Weesp (report published on 14 November 2018); Case study Nissewaard - Case study in response to the unexpected death of a young person (report published on 7 December 2017); Investigation into the disaster relief system on the BES islands Incident investigation following hurricanes Irma, Jose and Maria (report published on 27 June 2018); Evaluation of stabbing incident in Maastricht on 14 December 2017 - Timeline and account of the facts (report published on 22 March 2018); Case study Limburg - Investigation following the suicide of a young person. Investigation report by the Health and Youth Care Inspectorate and the Inspectorate of Justice and Security in response to the death of a young person in the province of Limburg (report published on 3 July 2017); Case study Zeeland - Investigation in response to the unexpected death of a baby. 'Healthy Confidence' (report published in November 2017); Incident investigation FPC De Kijvelanden (1 March 2020) (report published on 3 December 2020); The State of Disaster Relief 2013 (parts A and B) (report published on 22 May 2013).

[30] Case study Limburg - Investigation following the suicide of a young person. Investigation report by the Health and Youth Care Inspectorate and the Inspectorate of Justice and Security in response to the death of a young person in the province of Limburg (report published on 3 July 2017); Case study Zeeland - Investigation in response to the unexpected death of a baby. 'Healthy Confidence' (report published in November 2017); Incident investigation FPC De Kijvelanden (1 March 2020) (report published on 3 December 2020); The State of Disaster Relief 2013 (parts A and B) (report published on 22 May 2013).

[31] Case study Zeeland - Investigation in response to the unexpected death of a baby. 'Healthy Confidence' (report published in November 2017).

[32] For example, see the annual reviews of police education.

[33] The State of Disaster Relief, 2013 (parts A and B) (report published on 22 May 2013); The State of Disaster Relief, 2016 Annual Review (report published on 7 December 2016).

[34] 'Out of Balance' - An investigation into the quality of performance in six locations within the prison system (report published on 26 April 2018); The custody regime, a precarious balance - Thematic study (report published on 4 June 2018).

[35] Migration System Monitor, 2014 (report published on 23 May 2014); Migration System Monitor II (report published on 12 May 2015); The quality of sheltered reception for minor aliens (report published on 7 March 2016); Moving on independently? Reception and guidance services for unaccompanied minor aliens (report published on 20 December 2018).

Means and resources

Conceptual framework:

The financial and material resources available must be sufficient. This includes the right technology and information quality (comprehensive, accurate ...).

Since the chains operating in the Justice and Security domain cover such a vast field, they use a huge variety of resources. For example, it is essential for firefighters to have the right extinguishing agents and to be able to practise with them.[36] And by the same token, ambulance staff need resources that protect them against violence.[37] The De Kijvelanden Forensic Psychiatric Centre mentioned in the box on the previous page lacked adequate organisational, constructional and electronic resources, as a result of which it was unable to cope with a hostage-taking crisis: building sections had not been compartmentalised and there was no lock-gate system.[38]

Information and communication facilities

There are two types of resources that play a role across the full width of the Justice and Security domain. The first of these is information. Accurate, comprehensive and relevant information enables organisations to identify imminent crises or potential incidents and take action accordingly. To ensure information of this type is available, staff will have to collect, register and share data on the outside world. This is easier said than done. It is not uncommon for incoming information to be registered only in part, despite the existence of relevant protocols.[39]

The National Crisis Management System (LCMS) serves to maintain and share an up-to-date operational picture, supporting netcentric collaboration among its users. Initially, LCMS was used by the security regions, the National Crisis Centre (NCC) and the National Operational Coordination Centre (LOCC). In recent years, the number of organisations that use the system has been growing steadily. Over 70 organisations from a variety of sectors now engage in netcentric collaboration using LCMS. In October 2021, the Minister of Justice and Security officially changed LCMS into the National Crisis Management Facility (LVCb). In doing so, the Minister encouraged a wide group of crisis partners to engage in netcentric collaboration and use LCMS to ensure effective crisis management [Letter to the House of Representatives on the National Crisis Management System as a nationwide crisis response facility, sent on 1 October 2021].

In many cases, substandard registration can be linked to the absence of suitable physical and digital facilities for storing, processing and sharing information. In some cases, the ICT facilities that are available are outdated. For example, several National Police units have been struggling with obsolete and incompatible equipment for years.[40]

Sometimes the system is unable to perform certain tasks it should be able to perform. For example, in some systems used by the police, the Royal Netherlands Marechaussee (KMar) and the Public Prosecution Service, 'foreign nationals in the criminal justice system' cannot be registered as such. As a result, it is difficult to gain a reliable picture of this group.[41] Conversely, sometimes an ICT system automatically performs a task it is *not* supposed to perform. Take the Alexander Dolmatov case, for example. He was a foreign national who committed suicide in 2013 while being detained. The Immigration and Naturalisation Service system (INDiGO) had not been informed that detention is suspended when an appeal is lodged. So even though Dolmatov's lawyer had instituted appeal proceedings and Dolmatov should have been released pending the outcome of his appeal, INDiGO automatically registered him as 'deportable'. According to the system, therefore, his stay in the Netherlands had become unlawful, which

[36] Fire at Kelders, Leeuwarden (report published on 2 July 2014).
[37] Example: Shooting incident in Bonaire (report published on 27 November 2017); Evaluation of shooting incident in Maastricht, 14 December 2017 - Timeline and account of the facts (report published on 22 March 2018).
[38] Incident investigation FPC De Kijvelanden (1 March 2020) (report published on 3 December 2020).
[39] Investigation into the death of an asylum seeker at the Rotterdam Detention Centre (report published on 18 February 2016); The death of Alexander Dolmatov (report published on 12 April 2013).
[40] Example: Investigation into the performance of duties at the National Police Unit Partial Investigation 1: National Police Information Unit (DLIO) (report published on 28 January 2021).
[41] Foreign Nationals in the Criminal Justice System (VRIS). An investigation into the transfer of information between partners in the chain (report published on 6 September 2021).

is why he was detained. Dolmatov had the right to await the outcome of the appeal against the IND's decision in freedom but was detained unlawfully due to this ICT error, with tragic consequences.

The case also showed that all organisations had their own OCT systems without proper interconnections between them. To share information, some partners in the chain had to rely on communication by fax or manual typewritten reports. This ‘multiplicity of only partly interconnected systems’ ‘seriously obstructed efforts to share information'.[42]

Other investigations confirm that getting and keeping information up to date is a complicated matter. In The State of Disaster Relief for 2019, the Inspectorate concluded that one third of security regions had difficulties 'getting and keeping their information management up to date'. While it is true that many security regions are investing in the requisite technology and associated staff training programmes, 'the fruits of these efforts are not yet evident everywhere'.[43]

The same applies to communication equipment in a broader sense. Equipment that was used during a crisis to retrieve the right information or send it to the right place was found to be dysfunctional or highly outdated.[44] It is not uncommon for multiple problems to play a role at the same time. For example, in response to a shooting incident in Bonaire in 2016, the Inspectorate concluded that the control room equipment involved was more than seven years old ‘and needed replacement’. In addition, at the time of the incident the Geographic Information System did not work. This meant that the control room could not monitor movements of staff in the streets and 'black spots' occurred with zero signal reception for police officers' walkie-talkies and mobile telephones.[45]

Financial resources

Financial resources are discussed extensively in the scientific literature. The availability of sufficient funds is crucial not only for effective information and communication services, but also for hiring suitable staff. In many studies, financial resources are found to be lacking, undermining the efforts of organisations to maintain the requisite level of resilience and resistance. This also applies to the cases investigated here. For example, for several years the Inspectorate has been warning about the adverse effects of continuous spending cuts on the quality of the prison system. According to the Inspectorate, in 2016 the 'unrelenting trend of capacity reduction' compromised the capability of prisons to manage unsafe situations.[46] Additionally, the actual implementation of measures to reintegrate individuals in society depends on the availability of sufficient financial resources.[47]

The State of Disaster Relief for 2013 likewise points to a lack of financial resources. The 'way in which the security regions are being funded’ resulted in 'tensions'. Municipalities imposed more and more tasks on the security regions, whose budgets were not increased accordingly. This caused the security regions to introduce spending cuts which may have had 'a negative effect' 'on operational performance’.[48] In 2020, a lack of funds is given as one reason not to perform system tests.[49]

[42] The death of Alexander Dolmatov (report published on 12 April 2013).
[43] Regular Review on Disaster Relief and Crisis Management, May 2020 (report published on 2 July 2020), pp. 11-12.
[44] Example, Power failure in North-Holland, 27 March 2015 - Lessons from crisis management and telecommunications Report of the Inspectorate of Security and Justice and the Radiocommunications Agency Netherlands on their investigation into the power failure in Diemen on 27 March 2015 (report published on 7July 2016).
[45] Shooting incident in Bonaire (report published on 27 November 2017).
[46] Annual Report of the Inspectorate of Security and Justice, 2016 (report published on 15 June 2016).
[47] Action Plan, Joining Forces to Make a New Start (published on 23 July 2021).
[48] The State of Disaster Relief, 2013 (parts A and B) (report published on 22 May 2013).
[49] Regular Review on Disaster Relief and Crisis Management, May 2020 (report published on 2 July 2020).

Youth protection and youth rehabilitation institutions are facing similar levels of financial uncertainty.[50] As a result, certified institutions are having to cope with staff shortages, with some having very few resources left and actually facing bankruptcy.[51] In 2021, many institutions still lacked the financial scope they needed to be able to invest in the expertise and job satisfaction of their staff. On top of that, budgets are now so tight that institutions are no longer able to provide specialist care services for clients who need them. Services of this type are expensive and seldom survive the spending cuts.[52]

Relationships

Conceptual framework:

If an organisation itself does not have employees and resources in sufficient quantities, it should be able to obtain them from elsewhere (or acquire additional resources). For that purpose, an organisation needs connections. External relationships are also an important source of information.

Resilient organisations and chains can also use their connections as a tool. Good external relationships are important. They can offer solutions during times of crisis. Since chains are a key focus of this document, we discussed collaboration within the chain under 'working method'. Our focus in the present section is on the *external* connections of chains. One example is a secure hospital which, due to staff shortages, decides to hire external employees.[53]

The crisis management and disaster relief domain offers ample evidence of how difficult it is to forge ties with the right players. For example, in 2013 the security regions 'still had to consider their relationships with other security organisations, including the municipal health services, the national police force and, as regards supervision of high-risk companies, the regional implementing agencies (RUDs)'. Another area of concern was the relationship with the local authorities.[54] Collaboration has since ‘begun to take shape'. The security regions are also intensifying their mutual contacts and undertaking more and more joint activities also at the interregional level. In the border regions, security regions are forging ties with their counterparts in Germany and Belgium.[55]

Working method

Conceptual framework:

Prior to the crisis, the organisation has already thought about how to act in the event of (conceivable and unknown) crises. For example, it has documented specific procedures or coordination agreements.

The case studies present a wide range of activities and methods prior to crises or incidents. For example, in order to prevent demonstrations from getting out of hand, the police performs risk estimates and develops scenarios before and during an actual demonstration so as to coordinate its intervention strategy. Control rooms direct and coordinate the basic police services, while firefighters are trained in rescuing trapped individuals during fire extinguishing and rescue operations, and health and safety officers perform evacuation drills. Security regions keep records on fire-extinguishing water and fire hydrants. On the BES islands, all parties involved in disaster relief develop plans for specific response strategies during natural disasters and undergo regular training to boost their resistance to crises.[56]

[50] 2020 Annual Report (annual report published on 18 May 2021).
[51] Vulnerable children receive insufficient protection - Supervision at youth protection and youth rehabilitation services (report published on 8 November 2019).
[52] Vulnerable children receive insufficient protection - National report for 2021, follow-up supervision (report published on 5 July 2021).
[53] Stabbing incident FPC De Kijvelanden - Incident investigation by the Inspectorate of Justice and Security and the Health and Youth Care Inspectorate (report published on 26 April 2018).
[54] The State of Disaster Relief, 2013 (parts A and B) (report published on 22 May 2013).
[55] Regular Review on Disaster Relief and Crisis Management, May 2020: Collaboration. Partial investigation of the Regular Review on Disaster Relief and Crisis Management (report published on 2 July 2020).
[56] Demonstrations in times of COVID-19 (report published on 5 November 2020); Shooting incident in Bonaire (report published on 27 November 2017); Fire at Kelders in Leeuwarden (report published on 2 July 2014);

This type of preparatory action is not necessarily effective, for instance because the agreements and plans do not comply with statutory requirements. In some cases it turned out that no such agreements and plans had been made in the first place.[57] The most serious challenge in this regard in the Justice and Security domain is to ensure effective collaboration within the chain. While it is true that in a considerable number of cases further agreements and joint assessments for follow-up steps were made, in even more cases the parties in the chains failed to formulate clear agreements.[58]

In many cases there is no integral common plan and no sufficient coordination or multidisciplinary consultation.[59] What is lacking is a comprehensive overview, a shared vision of how the work should be organised (and how crises should be prevented or dealt with) or a sufficient degree of coordination across the entire chain.[60] Crucial partners in the chain have also been known to skip or cancel meetings or not to have been properly involved or informed.[61] Regarding the treatment of Michael P., the murderer of Anne Faber in a much-publicised crime case in 2017, there was uncertainty with respect to the roles and responsibilities of the chain partners involved in the process of placing prisoners in mental healthcare institutions. Similar uncertainties existed with regard to the roles and responsibilities of the chain partners involved in the granting of freedoms. Neither did chain partners have a clear view as to which criteria governed the granting of such freedoms to prisoners.[62]

These problems were caused by factors associated with the design or implementation of collaboration structures. For example, the Inspectorate discovered that sometimes work agreements were totally absent during the period under investigation. One example of this is found in the report on the investigation into a suicide case in Heerlen, published in 2017.[63] Work agreements can also be ineffective in terms of how they are formulated, for example where agreements 'on the division of tasks and responsibilities between GPs, practical nurses and surgery assistants' are unclear or absent.[64] Collaboration agreements may be insufficient or pose risks right from the start.[65] In still other cases, collaboration is never actually put into practice. While good intentions to ensure close collaboration exist and are even laid down in formal documents and the associated protocols, it turns out they have never actually been implemented.[66]

Supply of fire-extinguishing water in connection with the fire of St. Urban's Church in Amstelveen (report published on 24 April 2019); Investigation into the disaster relief system on the BES islands Incident investigation following hurricanes Irma, Jose and Maria (report published on 27 June 2018).

[57] Investigation into a power failure in Amsterdam and environs on 17 January 2017 (report published on 27 July 2017); The State of Disaster Relief, 2013 (parts A and B) (report published on 22 May 2013).

[58] Process leading up to the departure of Armenian children (August-September 2018) (report published on 5 November 2019); Evaluation of stabbing incident in Maastricht, 14 December 2017 - Timeline and account of the facts (report published on 22 March 2018); Case study Zeeland - Investigation in response to the unexpected death of a baby. 'Healthy Confidence' (report published in November 2017); Incident investigation into Udo D. (report published on 18 August 2018).

[59] Process leading up to the departure of Armenian children (August-September 2018) (report published on 5 November 2019); Case study Drenthe Investigation in response to the death of a child (report published on 21 May 2016); Social Domain Supervision - Calamity investigation Epe/Hattem (report published on 28 June 2016); Case study Nissewaard - Investigation in response to the unexpected death of a young person (report published on 7 December 2017); Case study Zeeland Investigation in response to the unexpected death of a baby. 'Healthy Confidence' (report published in November 2017).

[60] Social Domain Supervision - Calamity investigation Epe/Hattem (report published on 28 June 2016); Case study Nissewaard - Investigation in response to the unexpected death of a young person (report published on 7 December 2017); Case study Zeeland Investigation in response to the unexpected death of a baby. Healthy Confidence (report published in November 2017); Investigation by the Inspectorate into the measures to address stalking by Bekir E. (report published on 9 October 2019).

[61] Case study Zeeland - Investigation in response to the unexpected death of a baby. 'Healthy Confidence' (report published in November 20); Progress of the sentence of Udo D. (report published on 28 March 2019).

[62] Progress of the sentence of Michael P. (report published on 28 March 2019).

[63] Social Domain Supervision - Focus on young persons - Heerlen suicide case (report published on 30 July 2017).

[64] Further investigation into the care provided to Renata A. (report published on 28 April 2017).

[65] Process leading up to the departure of Armenian children (August-September 2018) (report published on 5 November 2019); Investigation in response to a calamity in Overijssel (report published on 1 May 2015); Social Domain Supervision - Calamity investigation Epe/Hattem (report published on 28 June 2016); Further investigation into the care provided to Renata A. (report published on 28 April 2017).

[66] Process leading up to the departure of Armenian children (August-September 2018) (report published on 5 November 2019); Incident investigation FPC De Kijvelanden (1 March 2020) (report published on 3 December 2020); Incident investigation Udo D. (report published on 18 August 2018); The death of Alexander Dolmatov (report published on 12 April 2013); The State of Disaster Relief, 2013 (parts A and B) (report published on 22 May 2013).

During the crisis

The more the chains succeed in mobilising assets of this type, the more they should be able to withstand crises. This section focuses on the extent to which chains in the Justice and Security domain are capable of continuing operations during a crisis. Again, this will be examined with reference to staff, resources, relationships and working methods.

Staff

Conceptual framework:

Did they have enough employees? And were those employees sufficiently knowledgeable?

During a crisis, it is important for deployable staff to be available on call. Staff members need to have the requisite level of education and practical training to continue performing effectively during a crisis. In addition, they will have to act with the appropriate level of professionalism. The first aspect, deployability, is crucial for chains in the Justice and Security domain. It is essential, for instance, in the context of company emergency response and firefighting operations.[67]

The police have set up a 'police network team'. This team operates at the national level and comprises several networks, such as the Caribbean network, the Moroccan network, the Football unit and Pink in Blue. These networks can support other colleagues within the police force by offering specific knowledge and expertise on cultural (and inter-cultural) issues. The police network team was deployed, for example, during the Black Lives Matter demonstrations in early June 2020. They were called upon specifically to help ensure a connective response and prevent escalation. During the demonstrations, the measures to ensure connection between the police on the one hand and the organisers and protesters on the other proved successful. Both the police and the Inspectorate are positive in their evaluation of this deployment [Demonstrations in times of COVID-19 (report published on 5 November 2020)].

However, the chains in the Justice and Security domains are not always able to deploy the available staff – far from it. During a gas supply failure in Velsen-Noord in 2015, for example, not all officials from the 'flexible deployment' pool who should have been involved were in fact involved. This was principally due to the fact 'that officials were simply not available', according to the report: 'In those cases, there was zero response from the pool so nobody turned up.'[68] Whether staff issues occur also depends on the length of a crisis. When hurricanes hit the BES islands in 2017, some teams were forced to continue working for 20 days in a row. It proved impossible to mobilise enough people to support and replace the teams on duty.[69]

[67] Fire at Kelders, Leeuwarden (report published on 2 July 2014).
[68] Gas supply failure in Velsen-Noord (report published on 27 January 2016).
[69] Case study Drenthe Investigation in response to the death of a child (report published on 21 May 2016).

Not surprisingly, when a thematic or in-depth investigation shows that a particular sector is coping with quantitative and qualitative staff problems, these are reflected in the Inspectorate's investigation reports for the sector concerned. The investigation into a stabbing incident in FPC De Kijvelanden on 3 February 20017 is a case in point. On that date, a person detained under a hospital order repeatedly stabbed an employee with a pair of scissors. The incident took place in department IX of the FPC. The Inspectorate of Justice and Security and the Health and Youth Care Inspectorate concluded that this department had been coping with staff shortages with negative effects on environmental therapy and relational security. This contributed to a situation in which the monitoring of persons detained under a hospital order was less than perfect.

It was in that context that a new employee without any experience with forensic patients started his new job as a social therapist. Due to the shortage of staff, the induction protocol was not adhered to, resulting in the new employee ending up in situations and performing tasks that he could not be expected to be able to cope with at that stage of his introduction. As he had only just been employed, he could not be expected either to be able to recognise and interpret certain behaviours of forensic patients as signals. This new employee was attacked by a forensic patient with a pair of scissors and died of his injuries [Stabbing incident FPC De Kijvelanden - Incident investigation by the Inspectorate of Justice and Security and the Health and Youth Care Inspectorate (report published on 26 April 2018)].

As pointed out above ('Before a crisis'), it is important for staff to have the level of education, training and practical skills they need to be able to respond effectively during a crisis or incident. Several case studies confirm that properly educated, trained and skilled employees are able to continue performing their tasks during a crisis quite effectively.[70] However, there are more cases where proper education and training were lacking, causing employees to be insufficiently prepared for their tasks.[71] No doubt the overall picture is biased by the fact that the Inspectorate only investigates cases where things went wrong (as explained in Appendix 1), but the fact remains that *if* things go wrong, this can often be attributed to the level of education, training and practical skills of the employees involved. For example, in the crisis management domain it is essential that drills are set up properly and involve all the relevant parties – which is not always the case in practice.[72] When employees lack the necessary training and equipment, the consequences can be serious.[73]

There are also cases where staff failed to show the required level of professionalism *during* a crisis. Education has a supply side (the employer) and a demand side (the employee). The latter should have a certain amount of self-criticism and wonder whether they are able to secure a good information position and collaborate effectively – and if they are not, how they could be better equipped.[74] Although this is often actually the case, [75] incidents in the social domain in particular tend to be associated with a lack of effective or appropriate action, and self-criticism, on the part of the employees involved.[76] This may be due to failure

[70] Example: Shooting incident in Bonaire (report published on 27 November 2017); Fire at the Rotterdam Detention Centre (report published on 28 August 2017); Investigative report on a house fire in Weesp (report published on 14 November 2018); Evaluation of stabbing incident in Maastricht, 14 December 2017 - Timeline and account of the facts (report published on 22 March 2018).
[71] Shooting incident in Bonaire (report published on 27 November 2017); Fire in the Rotterdam Detention Centre (report published on 28 August 2017); Investigative report on a house fire in Weesp (report published on 14 November 2018); Investigation into the disaster relief system on the BES islands Incident investigation following hurricanes Irma, Jose and Maria (report published on 27 June 2018); Evaluation of stabbing incident in Maastricht, 14 December 2017 - Timeline and account of the facts (report published on 22 March 2018); Case study Limburg - Investigation following the suicide of a young person. Investigative report by the Health and Youth Care Inspectorate and the Inspectorate of Justice and Security in response to the death of a young person in the province of Limburg (report published on 3 July 2017); Case study Zeeland Investigation in response to the unexpected death of a baby. Healthy Confidence (report published in November 2017); Incident investigation FPC De Kijvelanden (1 March 2020) (report published on 3 December 2020); The State of Disaster Relief 2013 (parts A and B) (report published on 22 May 2013).
[72] The State of Disaster Relief, 2013 (parts A and B) (report published on 22 May 2013).
[73] Case study Zeeland - Investigation in response to the unexpected death of a baby. 'Healthy Confidence' (report published in November 2017).
[74] Investigation into the death of an asylum seeker in the Rotterdam Detention Centre (report published on 18 February 2016); Case study Drenthe Investigation in response to the death of a child (report published on 21 May 2016); Social Domain Supervision - Calamity investigation Epe/Hattem (report published on 28 June 2016); Case study North-Brabant - Investigation following the death of a baby (report published on 5 February 2019); Case study Nissewaard - Investigation in response to the unexpected death of a young person (report published on 7 December 2017).
[75] For example, Further investigation into the care provided to Renata A. (report published on 28 April 2017); Incident investigation Udo D. (report published on 18 August 2018).
[76] Process leading up to the departure of Armenian children (August-September 2018) (report published on 5 November 2019); Case study Drenthe Investigation in response to the death of a child (report published on 21 May 2016); Investigation in response

of those employees to remain up to date on the legal framework and the division of tasks, and to their limited view of their own responsibilities .[77]

Means and resources

Conceptual framework:

Was there enough money, materials and information for the parties to act? Were the materials and systems effective?

Information is a resource that plays a major role in any crisis. Effective action requires a clear view of the crisis and up-to-date information about exactly what is going on in the broader environment. This is why the chains in the Justice and Security domain are deemed to have access to accurate, relevant and up-to-date information about that outside world.[78] In reality, however, such information is often lacking, and the available data prove to be incomplete or obsolete.[79] Problems occur when information is gathered, shared, interpreted and secured.

The challenge of obtaining the right information

The information required concerns, for example, the problem itself – a fire, demonstration, natural disaster or violent incident.[80] However, there is also a need for information about what other partners in the chain are (supposed to be) doing, their working methods and the regulatory framework within which they act. The various partners within a chain often appear to be unaware of each other's tasks, responsibilities and mandates.[81] In many cases, the chains in the Justice and Security domain appear to lack a thorough knowledge of their own regulatory context and that of their partners in the chain. This also explains why gaps in the existing frameworks often go unnoticed.[82] For example, in 2019 a person detained under a

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to a calamity in Overijssel (report published on 1 May 2015); Social Domain Supervision - Focus on young persons - Heerlen suicide case (report published on 30 July 2017); Case study Limburg - Investigation following the suicide of a young person. Investigative report by the Health and Youth Care Inspectorate and the Inspectorate of Justice and Security in response to the death of a young person in the province of Limburg (report published on 3 July 2017); Social Domain Supervision - Calamity investigation Epe/Hattem (report published in 28 June 2016); Case study North-Brabant - Investigation in response to the death of a baby (report published on 5 February 2019); Case study Nissewaard - Investigation in response to the unexpected death of a young person (report published on 7 December 2017); Case study Zeeland Investigation in response to the unexpected death of a baby. Healthy Confidence (report published in November 2017); Investigation by the Inspectorate into the measures to address stalking by Bekir E. (report published on 9 October 2019); Progress of the sentence of Michael P. (report published on 28 March 2019); Incident investigation FPC De Kijvelanden (1 March 2020) (report published on 3 December 2020).

[77] Case study Drenthe Investigation in response to the death of a child (report published on 21 May 2016); Social Domain Supervision - Calamity investigation Epe/Hattem (report published in 28 June 2016); Case study Zeeland Investigation in response to the unexpected death of a baby. Healthy Confidence (report published in November 2017); Progress of the sentence of Michael P. (report published on 28 March 2019); Incident investigation FPC De Kijvelanden (1 March 2020) (report published on 3 December 2020); The State of Disaster Relief 2013 (parts A and B) (report published on 22 May 2013).

[78] Fire at Kelders, Leeuwarden (report published on 2 July 2014); Fire at the Rotterdam Detention Centre (report published on 28 August 2017); Case study Drenthe Investigation in response to the death of a child (report published on 21 May 2016); Investigation in response to a calamity in Overijssel (report published on 1 May 2015); Social Domain Supervision - Focus on young persons - Heerlen suicide case (report published on 30 July 2017); Social Domain Supervision - Calamity investigation Epe/Hattem (report published on 28 June 2016); Case study Nissewaard - Investigation in response to the unexpected death of a young person (report published on 7 December 2017); Further investigation into the care provided to Renata A. (report published on 28 April 2017); Case study Zeeland Investigation in response to the unexpected death of a baby. Healthy Confidence (report published in November 2017); Stabbing incident FPC De Kijvelanden - Incident investigation by the Inspectorate of Justice and Security and the Health and Youth Care Inspectorate (report published on 26 April 2018); Incident investigation Udo D. (report published on 18 August 2018); The death of Alexander Dolmatov (report published on 12 April 2013).

[79] Case study Drenthe Investigation in response to the death of a child (report published on 21 May 2016); Case study Nissewaard - Investigation in response to the unexpected death of a young person (report published on 7 December 2017); Further investigation into the care provided to Renata A. (report published on 28 April 2017); Case study Zeeland Investigation in response to the unexpected death of a baby. Healthy Confidence (report published in November 2017); Stabbing incident FPC De Kijvelanden - Incident investigation by the Inspectorate of Justice and Security and the Health and Youth Care Inspectorate (report published on 26 April 2018); The death of Alexander Dolmatov (report published on 12 April 2013).

[80] For example, Stabbing incident FPC De Kijvelanden - Incident investigation by the Inspectorate of Justice and Security and the Health and Youth Care Inspectorate (report published on 26 April 2018); Incident investigation FPC De Kijvelanden (1 March 2020) (report published on 3 December 2020).

[81] Mustard gas GRIP-3 incident evaluation, Ede (report published on 8 April 2014); Investigation into the disaster relief system on the BES islands; Incident investigation following hurricanes Irma, Jose and Maria (report published on 27 June 2018); Investigation into the power failure in Amsterdam and environs, 17 January 2017 (report published on 27 July 2017); Evaluation of stabbing incident in Maastricht, 14 December 2017 - Timeline and account of the facts (report published on 22 March 2018); Gas supply failure in Velsen-Noord (report published on 27 January 2016); The State of Disaster Relief, 2013 (parts A and B) (report published on 22 May 2013).

[82] Case study Drenthe Investigation in response to the death of a child (report published on 21 May 2016); Social Domain Supervision - Calamity investigation Epe/Hattem (report published in 28 June 2016); Case study Zeeland Investigation in response to the unexpected death of a baby. 'Healthy confidence' (report published in November 2017); Progress of the sentence of Michael

hospital order was able to commit a violent crime because there were no 'clear frameworks for arranging trial leave in cases where extra-mural leave is no longer possible'.[83]

Various explanations have been offered as to why the gathering of information is so problematic. Sometimes the chains simply do not have enough time. Some other constraints however are related to the information source itself. For example, the police only have limited options to gather information on social media, for example about demonstrations or other events. According to the Inspectorate, this must be attributed to ‘the measures to protect the privacy of the users of the various social networks, to legal restrictions and to the volatility of information on some social networks'. It has also proved to be difficult to assess the impact of influencers.[84] Human sources of information have their own weaknesses. For example, during a fire at a detention centre in Rotterdam in 2016, when police offers arrived at the scene they were unable to ascertain whether the fire in one of the cells had already been extinguished. In addition, ambulance staff were unable to find out who occupied the cell that was thought to be on fire at that moment, and the medical officer had no insight into the medical situation.[85]

Sharing information

Individual partners in the chain are expected to share their information as necessary. Sometimes they do so quite effectively,[86] but in many other cases they don't.[87] They often tend to prioritise their own information process and, due to pressure from the crisis, are less interested in finding out who they are supposed to share it with.[88] For example, in a case of domestic violence that resulted in the death of a woman, in 2019, the conclusion was that ‘the parties involved had often failed to share tell-tale signs of an unsafe situation’, or ‘shared them with the wrong party’. And 'where they did share signs of an unsafe situation, they failed to check what other parties did with them'.[89]

For example, in an incident with mustard gas in Ede, in 2013, while the authorities did 'collect, validate, analyse and filter enough information’, they did not 'pass on and record all information in an effective way'.[90] And at a fire in Houten in 2015, it turned out that the municipality had information about the condition and layout of certain buildings, but the fire department did not. The municipality had failed to share that information. As a result, the fire department was unaware of the existence of certain openings inside the buildings that were on fire, so that the fire could spread faster than had been expected.[91]

P. (report published on 28 March 2019); Incident investigation FPC De Oostvaarderskliniek, 2019 (report published on 14 October 2020); Incident investigation FPC De Kijvelanden (1 March 2020) (report published on 3 December 2020); The State of Disaster Relief 2013 (parts A and B) (report published on 22 May 2013).

[83] Incident investigation FPC De Oostvaarderskliniek, 2019 (report published on 14 October 2020).

[84] Demonstrations in times of COVID-19 (report published on 5 November 2020).

[85] Fire at the Rotterdam Detention Centre (report published on 28 August 2017).

[86] Investigation in response to a calamity in Overijssel (report published on 1 May 2015); Social Domain Supervision - Calamity investigation Epe/Hattem (report published on 28 June 2016); Incident investigation Udo D. (report published on 18 August 2018).

[87] Investigation into the death of an asylum seeker at the Rotterdam Detention Centre (report published on 18 February 2016); Social Domain Supervision - Focus on young persons - Heerlen suicide case (report published on 30 July 2017); Social Domain Supervision - Calamity investigation Epe/Hattem (report published on 28 June 2016); Case study Nissewaard - Investigation in response to the unexpected death of a young person (report published on 7 December 2017); Further investigation into the care provided to Renata A. (report published on 28 April 2017); Investigation by the Inspectorate into the measures to address stalking by Bekir E. (report published on 9 October 2019).

[88] Investigation into the disaster relief system on the BES islands Incident investigation following hurricanes Irma, Jose and Maria (report published on 27 June 2018).

[89] Social Domain Supervision - Calamity investigation Epe/Hattem (report published on 28 June 2016).

[90] Mustard gas GRIP-3 incident evaluation, Ede (report published on 8 April 2014).

[91] Fire at Herenweg 6 in Houten, 25 July 2015 (report published on 9 March 2016).

Poor direction or coordination to ensure effective dissemination of information (due, for example, to a multiplicity of informal contacts) can lead to 'a lack of clarity and overview', as was the case during the gas supply failure in Velsen-Noord in 2015.[92] Similarly, during the disaster relief effort following the hurricanes on the BES islands, information was not shared from a central location. In addition, *too much* information was shared, obscuring the view of what exactly was going on in the outside world.[93]

Interpreting information

The quality of information in the Justice and Security domain is also influenced by differences in interpretation.[94] For example, the Inspectorate has observed a strong tendency towards compartmentalisation in care and emergency assistance. So while detecting signals within their respective spheres, the chains fail to interpret them in a joint and coherent framework – and, as a result, often fail to recognise the urgency of the problem concerned.[95] Also note that information always requires a degree of interpretation, and that different authorities can receive different signals about the same issue. This is unavoidable, which makes it all the more difficult for chain partners to formulate a joint assessment of a crisis.

Information management and communication equipment

Finally, problems in connection with information management and communication equipment have negative effects on the quality of information. For example, due to a power failure crucial communication tools may be unavailable, so that information cannot be shared during a crisis.[96] Under such circumstances, information systems are inaccessible (or are not being used).[97] During the fire at St. Urban's Church in Amstelveen, in 2018, it turned out that the local fire department did not have an unambiguous information system at its disposal. The system showed fire hydrants that did not actually exist and caused firefighters to rely on defective hydrants, which slowed down their response.[98]

Sometimes specific pieces of information cannot be shared, such as during a fire in Leeuwarden in 2014: 'The Google Earth photo of the MKNN buildings cannot be shared with parties in the field. Combined with the layout of the residential building, this has made it very hard for the fire department to gain a picture of the location and accessibility of the house concerned and to ensure the targeted deployment of rescue efforts.' [Fire at Kelders, Leeuwarden (report published on 2 July 2014)].

Failure to share all the relevant information in the correct way makes it impossible for the chain to gain a good overview of the crisis as it develops.[99] Under such circumstances, the required information is unavailable either because the wrong sources were consulted or because the information was not shared with the right authorities. The importance of this can hardly be underestimated: if no accurate information is available in time during a crisis, resilient and resistant action as the crisis develops is practically

[92] Gas supply failure in Velsen-Noord (report published on 27 January 2016).
[93] Investigation into the disaster relief system on the BES islands Incident investigation following hurricanes Irma, Jose and Maria (report published on 27 June 2018).
[94] Case study Drenthe Investigation in response to the death of a child (report published on 21 May 2016); Case study Nissewaard - Investigation in response to the unexpected death of a young person (report published on 7 December 2017); Inspection investigation into the measures to address stalking by Bekir E. (report published on 9 October 2019); Incident investigation into FPC De Kijvelanden (1 March 2020) (report published on 3 December 2020).
[95] Case study Drenthe Investigation in response to the death of a child (report published on 21 May 2016); Social Domain Supervision - Focus on young people Heerlen suicide case (report published on 30 July 2017); Social Domain Investigation - Calamity investigation Epe/Hattem (report published on 28 June 2016); Case study Zeeland Investigation in response to the unexpected death of a baby. Healthy Confidence (report published in November 2017).
[96] Power failure North-Holland 27 March 2015 - Lessons learned from crisis management and telecommunications (report published on 7 July 2016).
[97] Investigative report on a house fire in Weesp (report published on 14 November 2018); Mustard gas (GRIP-3) incident evaluation, Ede (report published on 8 April 2014); Investigation into the disaster relief system on the BES islands Incident investigation following hurricanes Irma, Jose and Maria (report published on 27 June 2018).
[98] Supply of fire-extinguishing water in connection with a fire at St. Urban's Church in Amstelveen (report published on 24 April 2019).
[99] Mustard gas (GRIP-3) incident evaluation, Ede (report published on 8 April 2014); Gas supply failure in Velsen-Noord (report published on 27 January 2016).

impossible.

Relationships

Conceptual framework:

Was it possible for the organisation to obtain assistance from other organisations or to attract additional resources? Were the right partners involved?

The aspect of external relationships – i.e., relationships external to the parties in the chain – is not discussed very often. Still, the overall picture is that the chains in the Justice and Security domain are quite successful in calling in external assistance or contacting parties in their wider environment during a crisis. In some cases, relationships outside the chain have yet to take shape, but many chains are now mobilising assistance as required. There are many examples: a forensic hospital hiring external staff,[100] police seeking contact with the organisers of a demonstration,[101] the Leeuwarden fire department calling in the help of an asbestos abatement firm, and a neighbouring region being called to help put out a house fire in Weesp.[102]

In the case of the power failure in North-Holland, in March 2015, the security region did not hesitate to contact a range of parties in the area in order to 'gain insight into the potential impact of the power failure from a public safety perspective' (see the text in the small box below).

'The fact that multiple security regions are involved in the power failure has made it necessary to coordinate steps among the security regions and between security regions and other organisations. This essentially concerns the need for information exchange. The security regions involved are all looking for the same information about the power failure: the geographical area affected, the effects of the failure and its expected duration. This gives rise to multiple lines of communication within the main operational structure.' [Power failure in North-Holland, 27 March 2015 (report published on 7 July 2016)].

In this connection, it has proved to be difficult to draw a distinct line between the group of direct chain partners and parties in the wider environment. For example, many security regions had to 'consider their relationships with other security organisations, including the municipal health services, the national police force and, as regards supervision of high-risk companies, the regional implementing agencies (RUDs)'. In addition, their relationships with the municipal authorities have yet to be fully defined.[103]

Working method

Conceptual framework:

Did the approach that had previously been laid out prove to be sufficient? Was it necessary to look for alternative strategies?

Working practices adopted during a crisis (or at least the basic principles underlying such practices) can be expected to have been determined pursuant to, or inspired by, partnership agreements, protocols and coordination arrangements formulated in advance. For example, in response to a stabbing incident that took place in Maastricht in December 2017, an evaluation validated by the Inspectorate concluded that the 'emergency services had responded in accordance with the usual procedures'.

[100] Stabbing incident FPC De Kijvelanden - Incident investigation by the Inspectorate of Justice and Security and the Health and Youth Care Inspectorate (report published on 26 April 2018).
[101] Demonstrations in times of COVID-19 (report published on 5 November 2020); Shooting incident in Bonaire (report published on 27 November 2017).
[102] Investigative report on a house fire in Weesp (report published on 14 November 2018).
[103] The State of Disaster Relief, 2013 (parts A and B) (report published on 22 May 2013).

'Standard work agreements had been followed' and the parties had acted in accordance with or 'in the spirit' of protocols drawn up in advance.[104]

However, in many other cases it turned out that the chains in the Justice and Security domain did *not* adhere to pre-defined protocols.[105] One possible explanation is that those protocols and agreements proved to be unclear or unworkable in practice.[106] For example, as regards the gas supply failure in Velsen-Noord, in January 2015, the Inspectorate found that it was 'not clear nor had it been clearly established in writing' which 'administrative and policy decisions' had to be submitted to the policy team.[107] There are also cases where the parties involved disagreed on the prescribed division of roles and argued about that during a crisis. This was the case, for example, during disaster relief operations on the BES islands in connection with the hurricanes in 2017. A conflict on the division of powers between two Dutch government ministries had major consequences for emergency response operations on the BES islands during and after the hurricanes.[108]

Another explanation is that parties may sometimes forget to act in the prescribed way. For some chains, a crisis can be so overwhelming that they focus entirely on acute action. One example is the mustard gas incident in Ede (2013), when the dynamics of the incident made the security chain interfere with operational matters, instead of focusing on policy and management.[109] Parties were similarly overwhelmed by the power failure crisis in Amsterdam in 2017. Key players across the board turned out not to have done what they had agreed to do in advance, possibly because the disruptive effect of the power failure was such that they could not have achieved those targets anyway.[110]

The idea was that it can sometimes be a good idea to put all those scenarios, protocols and learning points aside. Indeed, during a crisis an improvisational approach can be a great strength, and could support the continuity of operations – and resilient and resistant action. There are several examples of this, too. In the mustard gas incident in Ede, in 2013, the security region concerned issued a 'silent GRIP-1' (incident response procedure), meaning that the actual nature of the problem was not disclosed to the public. That was a clever, improvised decision. The silent GRIP-1 did not actually exist; it was invented during the crisis to ensure effective intervention:

> *It was decided to issue a 'silent GRIP-1'. That was a balanced decision. It helped ensure that the incident was kept out of the news, so that preparations could be made without disturbance. Mustard gas and other chemical combat gases trigger associations with the First World War as well as more recent conflicts in Iraq and Syria. Publicising the situation could have caused serious concern and panic among residents and could potentially have disturbed preparations for the evacuation.' [Mustard gas (GRIP-3) incident evaluation, Ede (report published on 8 April 2014).*

[104] Evaluation of stabbing incident in Maastricht, 14 December 2017 - Timeline and account of the facts (report published on 22 March 2018).
[105] Investigation into a power failure in Amsterdam and environs, 17 January 2017 (report published on 27 July 2017); Gas supply failure in Velsen-Noord (report published on 27 January 2016); The State of Disaster Relief, 2013 (parts A and B) (report published on 22 May 2013).
[106] Power failure in North-Holland, 27 March 2015 - Lessons learned from crisis management and telecommunications (report published on 7 July 2016).
[107] Gas supply failure in Velsen-Noord (report published on 27 January 2016).
[108] Investigation into the disaster relief system on the BES islands Incident investigation following hurricanes Irma, Jose and Maria (report published on 27 June 2018).
[109] Mustard gas GRIP-3 incident evaluation, Ede (report published on 8 April 2014).
[110] Investigation into the power failure in Amsterdam and environs, 17 January 2017 (report published on 27 July 2017).

Evaluating and looking ahead

One key component of resilience and resistance is that an effort is made after the crisis to evaluate its cause and development. Resilient and resistant organisations are generally deemed to facilitate reflection and offer space for evaluation and retrospection. Ideally, an organisation *learns* from mistakes or errors of judgement so as to understand why they failed to anticipate a crisis, or carefully analyse their own actions during a crisis. Ideally, this should help them understand the roles of key factors such as staff, resources, relationships, working methods (and priorities) before and in the course of the crisis.

In practice however, this type of learning seems to be quite rare. This is due in part to the nature of the Inspectorate's investigations. In a very large number of cases, the Inspectorate's report is the initial reflection of a specific type of learning. This means that the report itself is the first, and often the only, analysis of events that is made. At the time of writing the report, it is often too early to make statements about any learning process.

Learning and evaluating

Conceptual framework:

Does the organisation engage in reflection/evaluation? Does it tackle the obstacles identified?

Even so, there is a fair amount of internal evaluation going on, especially among parties within the disaster relief and crisis management chain.[111] They also conduct internal audits and incident investigations. Also note that the Inspectorate sometimes organises learning sessions to promote evaluation and retrospection, possibly in collaboration with the Health and Youth Care Inspectorate.[112] In recent years, this type of learning is seen more and more often – a trend particularly common in the disaster relief and crisis management sector.[113] For example, in The State of Disaster Relief, 2019 the Inspectorate points out that the security regions are systematically evaluating their activities within the context of 'multidisciplinary education, training and drills' and incidents.[114]

However, evaluations do not necessarily result in a profound understanding of events leading up to a crisis, incident or disruption, or of the response to them. In practice, it proves to be difficult for organisations to actually learn, not least because they often lack a clear definition of exactly what they are supposed to learn.[115] The quality of internal evaluations and evaluation methods also varies considerably in practice.[116] Sometimes this is because the points discussed result in conclusions that are not properly substantiated. Moreover, as pointed out, it is not always clear what the purpose of the evaluation and learning is. For example, the disaster relief and crisis management sector organises frequent drills (to prepare everybody for a disaster or crisis) - so many, in fact, that some claim it is not clear what exactly they are supposed to learn from the individual drills.[117] Poor registration of the drills, and failure to share them with partners in the chain, can also limit their learning effect.[118]

[111] Investigative report on a house fire in Weesp (report published on 14 November 2018); Mustard gas (GRIP-3) incident evaluation, Ede (report published on 8 April 2014); Investigation into the disaster relief system on the BES islands Incident investigation following hurricanes Irma, Jose and Maria (report published on 27 June 2018); Attack in a tram in Utrecht, 18 March 2019 (report published on 21 May 2021).
[112] For example, Social Domain Supervision - Focus on young persons - Heerlen suicide case (report published on 30 July 2017); Incident investigation FPC De Oostvaarderskliniek, 2019 (report published on 14 October 2020).
[113] The State of Disaster Relief 2016 Annual Review (report published on 7 December 2016); Regular Review on Disaster Relief and Crisis Management, May 2020 (report published on 2 July 2020).
[114] Regular Review on Disaster Relief and Crisis Management, May 2020 (report published on 2 July 2020).
[115] The State of Disaster Relief, 2013 (parts A and B) (report published on 22 May 2013).
[116] Attack in a tram in Utrecht, 18 March 2019 (report published on 21 May 2021); The State of Disaster Relief, 2013 (parts A and B) (report published on 22 May 2013).
[117] The State of Disaster Relief, 2013 (parts A and B) (report published on 22 May 2013).
[118] Diving accident in Koedijk, 4 August 2014 (report published on 27 March 2015).

Many evaluations actually fail to tackle the real obstacles.[119] For example, especially in a chain context it can be useful to turn collaboration itself into a learning objective, but collaboration is an aspect that is often ignored. As a result, many organisations fail to truly understand what their partners in the chain are doing and how all could benefit from collaboration.[120] Ambiguities are not resolved,[121] and the causes of a possible lack of resilience and resistance are not discussed.[122]

This is balanced by examples where organisations, according to the Inspectorate, actually learn a great deal. In these examples, the insights from evaluations are carefully documented and widely shared.[123]

Adaptations in response to learning

Conceptual framework:

A resilient and resistant organisation is able to adapt itself after a shock, if necessary (by reorganising, modifying its processes etc.). To what extent does the organisation do so?

Many evaluations result in improvement measures. Evaluations or learning moments also encourage chains to draw up a crisis manifesto or plan of action.[124] Security regions adapt their plans, arrangements and training programmes to reflect the outcomes of specific evaluations.[125] Frequently, reports point out that the 'experiences' gained during a previous incident were 'taken into account' when responding to a new incident.[126] For example, well after a hostage-taking incident in forensic hospital De Kijvelanden in 2019, it turned out that several concrete adaptations had been made that were supposed to increase the level of resilience and resistance. Access control and the gatekeeper team were strengthened, and the hostage incident protocol and training programmes were adapted.[127]

Security regions secure the evaluation outcomes. They use these outcomes to draw up or tighten procedures, plans, agreements, training programmes and the like. However, not all organisations have as yet adopted a structured approach to formulating concrete improvements and monitoring them. It turns out that the intended effect of the improvement actions is not sufficiently demonstrable. (...) The security regions share the outcomes of GRIP evaluations with the crisis response officers concerned, who in turn share them both within their own segment and with other crisis response officers. These arrangements are laid down in procedures only to a limited extent, but in a structured manner because the crisis response officers have an intrinsic motivation to learn from incidents' [Regular Review on Disaster Relief and Crisis Management, May 2020 (report published on 2 July 2020)].

In many cases, however, the key tasks, activities and relationships with local players are not changed or only to a very limited extent.

[119] The State of Disaster Relief, 2016 Annual Review (report published on 7 December 2016).
[120] Regular Review on Disaster Relief and Crisis Management, May 2020 (report published on 2 July 2020).
[121] Investigative report on a house fire in Weesp (report published on 14 November 2018).
[122] Diving accident in Koedijk, 4 August 2014 (report published on 27 March 2015).
[123] The overall picture that chains are slow to learn is confirmed by other studies into organisational learning. One interesting example is a study into the way in which public authorities learn from the COVID-19 crisis. This study has revealed several pitfalls, which also appear to affect learning processes in a broader sense. When trying to learn from COVID-19, public authorities often appear to be reviewing the situation with the benefit of hindsight. They strive for clarity instead of ambiguity and tend to over-emphasise the ability to anticipate a crisis rather than focus on the best ways to respond. Neither are they inclined to compare a particular crisis with other types of crises. These tendencies limit their learning capacity. H. de Bruijn and M. van der Steen, 'Leren van Covid-19' (Essay for the Netherlands School of Public Administration) (The Hague, 2020).
[124] Power failure in North-Holland, 27 March 2015 - Lessons learned from crisis management and telecommunications (report published on 7 July 2016); Social Domain Supervision - Calamity investigation Epe/Hattem (report published on 28 June 2016); Case study in North-Brabant - Investigation following the death of a baby (report published on 5 February 2019); Stabbing incident FPC De Kijvelanden - Incident investigation by the Inspectorate of Justice and Security and the Health and Youth Care Inspectorate (report published on 26 April 2018); Incident investigation FPC De Oostvaarderskliniek, 2019 (report published on 14 October 2020); Incident investigation FPC De Kijvelanden (1 March 2020) (report published on 3 December 2020); Attack in a tram in Utrecht, 18 March 2019 (report published on 21 May 2021).
[125] Inaccessibility of 112 emergency line on 24 June 2019 (report published on 25 June 2020); Regular Review on Disaster Relief and Crisis Management, May 2020 (report published on 2 July 2020).
[126] Gas supply failure in Velsen-Noord (report published on 27 January 2016).
[127] Incident investigation FPC De Kijvelanden (1 March 2020) (report published on 3 December 2020).

In such cases, for example, the Inspectorate's reports express concern about the extent to which an organisation or chain is able to link concrete improvement actions to crises or incidents where the response effort was problematic.[128] In such cases, moreover, the response to known problems is either ineffective or not forthcoming, so that the measures taken did 'not produce the desired result'.[129] In a number of cases, there is no truly structured approach to defining and monitoring improvement actions.[130]

[128] Case study in North-Brabant - Investigation following the death of a baby (report published on 5 February 2019).
[129] Incident investigation FPC De Kijvelanden (1 March 2020) (report published on 3 December 2020).
[130] The death of Alexander Dolmatov (report published on 12 April 2013); Regular Review on Disaster Relief and Crisis Management, May 2020 (report published on 2 July 2020).

3: Conclusion: the resilience and resistance of Justice and Security chains

Resilience and resistance should not be taken for granted. Nor do they depend on any single resource, such as budget. This document shows that resilience and resistance require routines, attitudes and characteristics in a broader sense, which organisations and chains can shape and improve proactively. Specific factors before, during and after a crisis can be identified that have a *positive* effect on the resilience and resistance of a chain. By the same token, their absence has a *negative* effect. The conceptual framework used shows that these factors need to be viewed with due regard for their interconnections. When we regard these characteristics fundamentally as determinants of the extent to which organisations and chains influence and are influenced by their environment, we become aware of the action/reaction effects involved. Actually *seeing* the outside world is crucial – which explains why information, in this line of reasoning, is the key to success.

Resilience and resistance in general

This line of approach is based on the premise that chains and their immediate environment are closely connected. Organisations and chains need resources and knowledge from their environment, but also have to compete with other players in that same environment. By their actions, individuals and organisations can disrupt the routines of chains and organisations. In light of these interdependencies, resilience and resistance can be seen as the characteristics that enable organisations and chains to find their way in this complex and changeable environment.

They cannot survive unless they are able to minutely monitor events and developments in their environment. While the future cannot be predicted and crises can never be fully known in advance, successful organisations and chains are able to pick up signals continuously, about social issues for example, or about the actions of other players in their field. They have designed their structure and processes to ensure effective operations both under normal circumstances and in the case of disruptions. They use staff policies and resources such as technology, expertise and money to promote creativity and flexibility and create an organisation where people are allowed to make mistakes and encouraged to reflect. They also enter into relationships within and outside of their own chains, build networks, make agreements and draw up protocols to divide roles and tasks during a crisis or disruption.

All of this should enable them to identify an imminent crisis at an early stage and take preparatory measures, if possible. While crises can seldom be foreseen, chains that are alert to potential crises can at least take action in a timely manner and brace themselves for rapid and drastic changes. And if the crisis does erupt, they will be able to continue performing their tasks even under extreme pressure – either by carefully implementing the plans and protocols drawn up in advance, or sometimes by ignoring them. Whatever the case, they always evaluate and sit down with their staff to review the crisis management approach and the experiences gained. And if they conclude that they need to adapt in order to improve their ability to detect a crisis at an early stage or respond more effectively, they accept the consequences. Resilient and resistant organisations and chains will not hesitate to overhaul their staff policies, resource allocation, relationship management and working methods if necessary to be better prepared for the next crisis.

Of course this is the ideal situation. Within the Justice and Security domain, as in other domains, it is very difficult to obtain a good picture of a crisis. Reality is complex and signals of an impending crisis are never totally unambiguous.

And even if there are clear signals, organisations and chains have a tendency to revert to existing scenarios, structures and routines from the past. Once a picture of the environment and the organisation or chain itself has been established, it is very difficult to adapt it. When an event occurs that is inconsistent with the preconceived picture, it depends on the individual, organisational or political preferences at play whether the accuracy of that picture can be questioned – and whether the signals of a potential crisis can be recognised.

Indeed, the main insight from the conceptual framework is that resilience and resistance cannot be reduced to a single factor, such as an effective ICT system or ample financial space. A chain will never be highly resilient and resistant unless staff have been properly trained to work with those systems and instructed to detect signals and share them as required, and unless staff keep abreast of all work arrangements and protocols, have sufficient professional judgment to decide whether to follow or deviate from existing scenarios during a crisis, and are supported by a consistent management focus on learning from experiences and changing the organisation where necessary.

This conceptual perspective also leads to the insight that resilience and resistance require a different logic than the normally dominant efficiency principle. Chains, organisations and systems need to be more than just efficient; they also need reserve capacities and resources to help them weather a storm. They must be able to incur losses and postpone activities in order to recover from a setback and get things back on track. This is an important fact, also in terms of the expectations at the political, policy and social level.

In short, the framework shows how strongly resilience and resistance depend on a much larger number of strongly interdependent factors. This perspective also reveals the multiple and persistent implementation issues that prevent chains from becoming resilient and resistant. At the same time, as it helps us locate and identify those problems it also shows us what improvements are required to increase resilience and resistance.

- *Resilient and resistant organisations never lose touch with their environment.*
- *For example, despite the ambiguities and questions at any given moment (what sort of crisis are we facing, what capabilities do we need?), they practise their skills in anticipating important events and, especially, their ability to continue operations during such an event and bounce back afterwards.*
- *Alternatively, they succeed in creating a new baseline situation if it proves to be more beneficial for them to adapt so as to improve their ability to anticipate or respond more effectively to a crisis or incident.*

Resilience and resistance in the Justice and Security domain

This line of reasoning served as a basis for an assessment of the resilience and resistance of chains in the Justice and Security domain. The central question concerned the extent to which the various factors that influence resilience and resistance in a *general* sense can be found *specifically* in the implementing practices of Justice and Security. While further research is required, the present analysis does reveal a number of important points.

First, across the Justice and Security spectrum examples have been found that confirm the presence of at least one resilience and resistance factor. For example, some chains were found to have properly trained and educated staff, in sufficient numbers, who were well equipped to form a picture of their environment. There are also examples of chains that collaborate effectively and do not hesitate to ask for assistance, e.g. from a neighbouring security region, if they themselves lack the resources or methods required during a crisis. In one case, a chain was found to have improvised effectively by proclaiming a scale-up level that did not actually exist. Especially within the disaster relief and crisis management domain there were signs of fairly consistent evaluation – followed up in some cases by the necessary adjustments.

However, across the board the analysis has highlighted four concerns: four matters that have so far not been properly addressed.[131] These concerns were brought to light thanks to the use of the conceptual model. They do not coincide entirely, therefore, with the factors listed in the model. While 'staff issues' obviously corresponds with the factor 'staff', information and chain collaboration are *examples* of the factors 'resources' and 'working method', respectively. And the learning issue discussed under this heading is a key component of the factors discussed in the box entitled 'After a crisis'. For safety's sake, this has been placed in brackets in the headings.

Properly trained and educated staff must be available, in sufficient numbers ('staff' factor)

First and foremost, the reports highlight the crucial importance of sufficient and properly equipped staff. While the terms 'sufficient' and 'properly equipped' are difficult to define in the period leading up to a crisis, the reports do clearly show that inadequacies in these fields can have severe consequences. The analysis has revealed that chains are struggling with a variety of quantitative – and the resulting qualitative – staff issues. It seems plausible that there is a strong correlation between staff shortages and financial resources. In fact, a small number of Inspectorate's reports leave little doubt about that: the chains in the prison system, disaster relief and crisis management, and youth protection and rehabilitation domains have been struggling with unduly tight budgets for years. This has contributed to staff shortages.

And as custodial institutions, forensic psychiatric centres, certified institutions and fire departments are unable to deploy staff in the numbers required, they are unable to respond to a crisis or incident effectively. For example, security regions do not have enough employees from the 'flexible deployment' pool, and disaster relief teams on the BES islands are known to have had to work for 20 days on end. Incidents in forensic hospitals also appear to be linked to staff shortages. The resulting increase in work pressure causes more cases of illness and long-term absenteeism among existing staff, fuelling a vicious circle of shortages and absence. This insight has far-reaching consequences: if politicians, administrators and society really want these chains to be resilient and resistant, they will have to accept that cost efficiency is not the key criterion. Resilience and resistance cost money, in the form of investments in staff and equipment for the long term.

The lack of sufficient staff also, and automatically, results in qualitative staff issues. As chains are forced to hire external employees and recruit new employees on a more or less permanent basis, a great deal of expertise, knowledge and experience – crucial resources for resilient chains – are lost. This results in situations in which relatively new employees are expected to work with a complex group of forensic patients in an environment that they are not very familiar with. And despite the wide range of education, refresher training and skills training options available for staff, many lack the required linguistic skills, professional training or system expertise. Also note that quantity is no guarantee for quality: the frequent drills in the disaster relief sector are a case in point. Those drills do not always build on learning points from previous sessions or levels. In addition, professionalism in a broader sense – which transcends specialist expertise – was lacking in many of the cases studied. Staff members were found to be insufficiently aware of their own weaknesses. Sometimes the lack of time (and staff) had prevented them from attending the necessary training courses, and in other cases, due to a lack of in-depth knowledge of existing laws, regulations, agreements and protocols, staff failed to do what they were expected to do.

This alone obstructs the capability for resilient and resistant action. After all, if the workforce is too small, lacks the required knowledge or equipment and fails to act as prescribed, it has little chance of recognising signals and taking the right measures before and during a crisis.

[131] The 'finance' resource has not been included. The reason is that the number of reports in the study that discuss this aspect is fairly limited. While there are indications, obviously, that a lack of financial resources plays a significant role in specific chains, such as care and emergency assistance, this would also have to be studied for the other chains.

This leads us to a second concern: information quality.

There are numerous quantitative and qualitative staff problems.

- *Chains are having to cope with staff shortages in various fields. In many cases, those shortages have existed for a while.*
- *This means that the chains lack enough staff to detect and fight a crisis, but also that chains are forced to recruit and hire external staff, causing a great deal of expertise, knowledge and experience – crucial resources for resilient chains – to be lost.*

Information quality can be improved significantly ('resources' factor)

In many cases, the information available to the chains is of insufficient quality. While it is true that information about the outside world is collected across the Justice and Security domain, and that there is a distinct management focus on setting up the right infrastructure for storing, processing and sharing that information, many chains are having to cope with inadequate communication and information services. Their information systems are either unable to do things they are supposed to do (such as registering and sharing specific information) or do things they are *not* supposed to do (as in the Alexander Dolmatov case). In addition, many chain partners appear to have their own information systems that do not support the mutual exchange of data; some are even having to type in information manually to send it to a partner. Control room, site or telephone equipment is often seriously obsolete.

As a result, a correct, comprehensive and up-to-date picture of the outside world is often lacking before and during a crisis. Sometimes staff do not have enough time to collect that information. And the Inspectorate has found that if they do, the sources they consult are often inadequate. For example, information on social media is difficult to access, highly volatile and hard to interpret. In other cases, the wrong persons were approached to provide specific information. With hindsight, the chains should have supplemented information from the sources they consulted with information from other sources.

Even where there are no problems in collecting information, it is not always registered effectively in practice. This makes it virtually impossible to do anything with the information concerned. A much greater problem still is the sharing of information. Most chains are not very effective in sharing the information they have collected with the right individuals. They tend to do so on an informal, ad hoc basis without any direction or coordination. Under such conditions, it is easy for chains to miss signals or fail to assess them in relation to others. This is a complicated matter, as information always needs context. In many chains, moreover, a compartmentalised approach encourages each chain partner to assess signals from within its own discipline. They all tend to stick to their own perspective and, as a result, fail to pick up relevant signals. On top of all this, information and communication systems regularly crash during crises. In short, it is clear that chains that need a comprehensive and up-to-date picture of their environment in order to take appropriate measures before or during a crisis have to overcome all sorts of obstacles.

This greatly impedes their ability to act in a resilient and resistant manner. They fail to detect crises at an early stage and have no clear view of the outside world during a crisis, incident or disruptive event. As a result, they also fail to obtain a clear and reliable picture of the problem at hand – a fire, demonstration, violent incident, power failure, terrorist attack or pandemic – and are even less aware of what their partners in the chain or other players are (or should be) doing. Without enough properly equipped staff, it will become even harder for chains to respond to rapid changes in their environment. So as the crisis unfolds they fail to respond, or respond in the wrong way. No mitigating measures are taken and the chain is unable to 'stand firm'. This complex problem is further exacerbated by a third concern: collaboration within the chain.

The information is often substandard.

- *Many problems have been identified in connection with collecting, registering, processing, analysing and sharing information.*
- *Sometimes the wrong sources are consulted, in other cases poor communication and information facilities obstruct the effective registration and accessibility of information.*
- *Sometimes the technology is obsolete, sometimes systems are mutually incompatible or simply unstable.*
- *Another factor that plays a role is the 'registration behaviour' of the employees involved.*
- *It has also proved to be extremely difficult to share information with the right players.*
- *As a result, a correct, comprehensive and up-to-date picture of the outside world is often lacking before and during a crisis.*

Chain collaboration can be improved ('working method' factor)

One explanation for ineffective information sharing within chains is a lack of clear procedures for collaboration. Sometimes partners within a chain are not sufficiently keen to contact each other to begin with, and to acquaint themselves with other parties' responsibilities and activities. As a result, there is no joint, integral plan, not even on paper, and individual organisations within a chain do not properly coordinate their activities. And even if there is such a plan, it proves difficult to formulate clear agreements that take account of potential risks, and to get them approved by all parties in the chain. Neither do discussions always take place with the right parties.

If the chain parties manage to overcome all of these obstacles, they will still have to follow up the agreements made. They themselves will have to get things going and schedule regular consultations. This may also involve organising joint drills – in the crisis management sector for instance. Some chains appear to have been successful in carefully fleshing out agreements, protocols and scenarios and translating them into concrete activities. Those that fail to do so lack the capability to respond effectively during an actual crisis. It may also be the case that prior agreements turn out to be impractical or, under the pressure of an actual crisis, fuel dispute among the parties. Sometimes the agreements made turn out to have been insufficiently clear. But chain partners are also known to have simply forgotten to act as previously agreed, due to the pressure of the crisis.

Occasionally chain parties deliberately deviate from such predefined plans and agreements, especially when these prove to be insufficient to withstand the crisis and they have to improvise; see the example of the proclamation of a non-existent GRIP level. In fact, this is one of the most important - and rarest - of all skills typical of resilient and resistant chains: their sense of timing. How long should you adhere to agreed frameworks and protocols, and when should you decide to set them aside and start improvising? This is an extremely complex decision, not least because every crisis is different, meaning that the moment of that decision cannot be predicted. The literature on resilience and resistance offers no ready-made instructions in this regard, but it does emphasise the importance of *learning.* The more parties reflect on these matters, the better a chain will be equipped to face the next crisis.

Overall, collaboration within chains remains problematic. While chain partners lack sufficient staff and a proper picture of a crisis, they also struggle to find a coherent joint approach during the crisis. This makes it even more difficult for them to 'continue functioning under adverse circumstances' – a key notion in academic reasoning on resilience and resistance. The chains do what they can to keep going, but may no longer be able to do their job properly.

There is considerable room for improvement when it comes collaboration within the chains.

- *Chain partners often fail to clearly define and flesh out their collaboration. There is no joint plan, or during a crisis it turns out that the existing plan is inadequate.*
- *The Inspectorate also frequently encounters situations in which the plans and agreements for collaboration look fine on paper, but are ignored in practice by the partners.*
- *This undermines their joint action during a crisis and, as such, weakens their resilience and resistance.*

Learning should become a fixed component ('learning and improving' activity)

One way for resilient and resistant organisations to remedy these defects is to devote a lot of time and attention to *learning* from crises, incidents and disruptive events. Incidentally, in this particular context the focus is on 'evaluation' rather than on 'learning'. The evaluation reports and incident investigations available suggest that chains in the disaster relief and crisis management domain are quite serious about this, but the social, migration and execution chains are far behind. There is not much to suggest that they attempt to *learn* in any structured manner. In many chains there is no mental space, as standard, where discussing the causes of errors takes priority over dealing out punishments, nor a reflective attitude that encourages structural feedback following a crisis or incident.

And even chains that do evaluate do not appear to be interested in truly (inter)organisational learning. While the literature refers to second and third-order learning (in which an organisation's principles and even its fundamental values are up for discussion, in the reports studied truly profound insights in a chain's organisation often remain absent. Obstacles, such as inadequate chain collaboration, and the underlying norms and 'value systems' are not discussed. In most cases, moreover, any insights gained rarely lead to real change. Any follow-up intervention is not monitored structurally, so there is no awareness of whether it actually results in improved performance. As a result, there is no genuine analysis of staff, information and chain problems, so those problems are not addressed.

There is little in-depth and structured learning.

- *While the disaster relief and crisis management chain conducts frequent evaluations, obstacles and underlying problems are seldom discussed.*
- *This is why any insights gained rarely result in changes.*
- *This means that one important element of resilience and resistance, namely the ability to adapt the factors before and during a crisis, is missing.*

This observation completes the circle. A lack of learning means that there will not be any real change in any of the factors – staff, resources, relationships and working method. To the extent this concerns the matters that chains can control themselves (they cannot decide about their own budgets, for example) and no effective measures are introduced based on a thorough problem analysis, the chains are unlikely to become more resilient and resistant. As such, they will continue to make too little effort to anticipate and possibly avoid crises at an early stage, and will not be able to truly improve their effectiveness during a crisis.

These insights call for an in-depth response: further study, possibly also on an individual chain and domain basis, in order to detect more specific trends. Even at this stage, however, two things have become abundantly clear. First, the conclusions about the lack of properly equipped staff offer food for thought among politicians, administrators and society at large. In light of the COVID-19 crisis – when extra IC capacity proved difficult to create – these conclusions once more highlight the tension between resilience and resistance on the one hand, and a focus on *efficiency* on the other. Chains that are designed to maximise cost efficiency lack everything they need to be able to act effectively before, during and after a crisis. They have no reserves, tend to be introspective and lack the space they need to improvise and learn.

Second, the superficiality of learning processes found in the chains studied raises the question of whether politicians, administrators and society offer them enough space for second and third-order learning. Policy-making processes seem to be subject to increasing public scrutiny, sometimes as part of a parliamentary inquiry or other type of investigation. While this is a very welcome development from a transparency point of view, it does not help to create a safe learning environment nor encourage a reflective attitude. This means it also has direct consequences for a chain's potential resilience and resistance.

Different players can benefit from these insights. Interested citizens, for example, gain a more realistic picture of the complicated practice of policymaking. There are broad social and political choices to be discussed as regards efficiency and transparency. The chains themselves should also be able to deal with this. The analysis clearly shows the risks involved and identifies the tools available to detect and address existing problems. By approaching their own resilience and resistance in the terms proposed (i.e. as the ability to continue functioning during a crisis) and focusing on the complex of factors involved, chains will be able to coordinate their improvement plans more effectively. In the end, this is also of importance to the Inspectorate. Tailoring its supervision, the Inspectorate will be able to advise chains and intervene if necessary from a wider perspective of resilience and resistance. Likewise, these insights will be helpful for politicians and policymakers. They should find ways to ensure that the chains receive at least the minimum financial means that they need. They can also consider ways of guiding chains in terms of effective information processing and chain collaboration. They could even assume an active role in promoting the learning process within chains. Such a joint effort will eventually benefit the resilience and resistance of the chains.

Bijlage 1: Study design and execution

Selection of the Inspectorate's reports

For the purpose of this study we listed all the reports published by the Inspectorate since its foundation in 2012 in an Excel document. Based on the title and, if necessary, the content of each report we made a selection of reports covering small or large-scale crises. We tried to cover as many reports as possible so as to include cases across the entire spectrum of the Inspectorate's supervision and over a long period of time.

We also included 'social' cases.[132] These provide insight into the ways in which care and emergency assistance chains try to avoid incidents and, by extension, prevent crises. It is also quite instructive to examine ways in which major incidents are addressed and whether any follow-up adaptations are made. These considerations resulted in a selection of approximately 40 reports that say something about a particular case, either directly or indirectly. We added some 10 thematic studies to this selection.

Another important consideration regarding the selected Inspectorate's reports is that they are usually about things that went wrong. Examples of aspects that are satisfactory, or at least in part, were investigated less intensely - only to the extent they appear in the reports studied. While this does not diminish the relevance of information concerning resilience and resistance in the reports, our perspective does include a certain bias from cases in which the conditions for resilient and resistant action were generally not in place.

Analysis of the reports

We studied the reports and listed the information in them that relates to the factors from the conceptual framework in formatted documents.[133] We then prepared an overview document that systematically presents information from the reports per factor (staff, resources, working method, relationships, learning/evaluation and adaptations) and phase (before, during and after a crisis). Next, we clustered this information to see what topics are discussed in the Inspectorate's reports, per factor. This overview document is the basis of our analysis.

When filling in the formatted documents it was not always easy to decide whether specific information should be classified under 'before', 'during' or 'after'. Crises, incidents and disruptive events come in all shapes and sizes and it is not always clear what stage they are in – for the parties involved nor for investigators afterwards. As a rule of thumb, we decided that every action performed to ensure that things went *well* should be classified as a preparatory action. For example, the provision of effective care and assistance qualifies as an attempt to prevent accidents and excesses.

Unlike national security crises, such incidents do not have a 'during' stage: these are incidents or events that last seconds or minutes at most (a death, a suicide), so 'respond as prescribed by the literature' is not a relevant criterion. Even so, there is some degree of similarity between 'real' crises such as a power failure or terrorist attack and the actions of professionals with respect to, say, a problem family. Both show the extent to which professionals have been able to actually deploy, in practice, the staff, resources, relationships and working methods available to fight potential crises so as to perform their tasks effectively. Like the resources, means and working methods that the security chains have in place in preparation for a crisis to ensure effective action *during* that crisis, those general measures should enable forensic hospital staff, for instance, to do their job effectively. So for the purpose of comparison, in the cases without a distinct 'before' we have included all *general* policy, organisational and institutional measures under 'before', and all *specific* measures and actions to deal with the case concerned under 'during'. Where necessary, we have added comments about this in the completed formats.

[132] Most case studies and incident investigations in the social domain were carried out in conjunction with the Health and Youth Care Inspectorate (and its precursors) or in the framework of Social Domain Supervision (TSD).
[133] Based on the literature we also added the 'priority' factor in the formats, indicating the extent to which chains sufficiently prioritise the topic concerned. Since the reports give too little information about this aspect, it is not included in the analysis in chapter 2.

Bijlage 2: List of consulted texts

Inspectorate's reports[134]

1. The death of Alexander Dolmatov (report published on 12 April 2013)
2. The State of Disaster Relief, 2013 (parts A and B) (report published on 22 May 2013)
3. Mustard gas (GRIP-3) incident evaluation, Ede (report published on 8 April 2014)
4. Fire at Kelders, Leeuwarden (report published on 2 July 2014)
5. Immigration System Monitor, 2014 (report published on 23 May 2014)
6. Diving accident in Koedijk, 4 August 2014 (report published on 27 March 2015)
7. Investigation in response to a calamity in Overijssel (report published on 1 May 2015)
8. Immigration System Monitor II (report published on 12 May 2015)
9. Gas supply failure in Velsen-Noord (report published on 27 January 2016)
10. Investigation into the death of an asylum seeker at the Rotterdam Detention Centre (report published on 18 February 2016)
11. The quality of sheltered reception for unaccompanied minor aliens (report published on 7 March 2016)
12. Fire at Herenweg 6 in Houten, 25 July 2015 (report published on 9 March 2016)
13. Case study Drenthe - Investigation in response to the death of a child (report published on 21 May 2016)
14. Annual report of the Inspectorate of Security and Justice, 2016 (report published on 15 June 2016)
15. Social Domain Supervision - Calamity investigation Epe/Hattem (report published on 28 June 2016)
16. For example, Power failure Noord-Holland, 27 March 2015 - Lessons learned from crisis management and telecommunications Report of the Inspectorate of Security and Justice and the Radiocommunications Agency Netherlands on their investigation into the power failure in Diemen on 27 March 2015 (report published on 7July 2016)
17. The State of Disaster Relief, 2016 Annual Review (report published on 7 December 2016)
18. Further investigation into the care provided to Renata A. (report published on 28 April 2017)
19. Case study Limburg - Investigation following the suicide of a young person Investigative report by the Health and Youth Care Inspectorate and the Inspectorate of Justice and Security in response to the death of a young person in Limburg (report published on 3 July 2017)
20. Investigation into the power failure in Amsterdam and environs, 17 January 2017 (report published on 27 July 2017)
21. Social Domain Supervision - Focus on young persons, Heerlen suicide case (report published on 30 July 2017)

[134] Including reports published in conjunction with the Health and Youth Care Inspectorate (and its precursors) and reports published within the Social Domain Supervision framework.

22. Fire at the Rotterdam Detention Centre (report published on 28 August 2017)
23. Case study Zeeland - Investigation in response to the unexpected death of a baby. 'Healthy Confidence' (report published in November 2017)
24. Shooting incident in Bonaire (report published on 27 November 2017)
25. Case study Nissewaard - Investigation in response to the unexpected death of a young person (report published on 7 December 2017)
26. Evaluation of stabbing incident in Maastricht, 14 December 2017 - Timeline and account of the facts (validation study by the Inspectorate, published on 22 March 2018)
27. Stabbing incident at FPC De Kijvelanden - Incident investigation by the Inspectorate of Justice and Security and the Health and Youth Care Inspectorate (report published on 26 April 2018)
28. Out of Balance - An investigation into the quality of work at six locations within the prison system (report published on 26 April 2018); The custody regime, a precarious balance - Thematic study (report published on 4 June 2018)
29. Investigation into the disaster relief system on the BES islands Incident investigation following hurricanes Irma, Jose and Maria (report published on 27 June 2018)
30. Incident investigation into Udo D. (report published on 18 August 2018)
31. Investigative report on a house fire in Weesp (report published on 14 November 2018)
32. Move on independently? Reception and guidance services for unaccompanied minor aliens (report published on 20 December 2018)
33. Case study in Noord-Brabant - Investigation following the death of a baby (report published on February 2019)
34. The waiting list of the Child Care and Protection Board: Do the measures taken by the Board result in a better view of the safety of the child and do they help to reduce the risks? (report published on 19 February 2019)
35. Progress of the sentence of Michael P. (report published on 28 March 2019)
36. Supply of fire-extinguishing water in connection with the fire at St. Urban's Church in Amstelveen (report published on 24 April 2019)
37. Investigation by the Inspectorate into the measures to address stalking by Bekir E. (report published on 9 October 2019)
38. Process leading up to the departure of Armenian children (August-September 2018) (report published on 5 November 2019)
39. Vulnerable children receive insufficient protection Supervision at youth protection and youth rehabilitation services (report published on 8 November 2019)
40. Inaccessibility of 112 emergency line on 24 June 2019 (report published on 25 June 2020)
41. Regular Review on Disaster Relief and Crisis Management, May 2020 (report published on 2 July 2020)
42. Regular Review on Disaster Relief and Crisis Management, May 2020: Collaboration. Partial investigation of the Regular Review on Disaster Relief and Crisis Management (report published on 2 July 2020)

43. Incident investigation at FPC De Oostvaarderskliniek, 2019 (report published on 14 October 2020)
44. Nowhere to go, an investigation into the obstacles and dilemmas in the rehabilitation of persons detained under a hospital order (report published on 14 October 2020)
45. Demonstrations in times of COVID-19 (report published on 5 November 2020)
46. Incident investigation at FPC De Kijvelanden (1 March 2020) (report published on 3 December 2020)
47. Investigation into the performance of duties at the National Police Unit Partial Investigation 1: National Police Information Unit (DLIO) (report published on 28 January 2021)
48. Multi-Annual Perspective 2021-2024, Inspectorate of Justice and Security (published on 11 February 2021)
49. View of Safety - How does the Child Care and Protection Board monitor the safety of children on its waiting list? Spring action plan (published on 25 March 2021)
50. 2020 Annual Report (annual report published on 18 May 2021)
51. Attack in a tram in Utrecht, 18 March 2019 (report published on 21 May 2021)
52. Vulnerable children receive insufficient protection 2021 National Report, follow-up supervision (report published on 5 July 2021)
53. Inspectorates' letter to the Custodial Institutions Agency (DJI), request for periodic report on measures to alleviate acute pressure on young offenders institutions, 7 July 2021
54. Joining Forces to Make a New Start (action plan published on 23 July 2021)
55. Foreign Nationals in the Criminal Justice System (VRIS) - An investigation into the transfer of information between partners in the chain (report published on 6 September 2021)
56. Progress report regarding intensive supervision of young offenders institutions and schools, 28 October 2021

Other publications

1. A. Boin and P. 't Hart, 'Between Crisis and Normalcy: The Long Shadow of Post-Crisis Politics,' in U. Rosenthal, R.A. Boin and L.K. Comfort, *Managing crises: threats, dilemmas, opportunities* (Charles C. Thomas: Illinois 2001) 28-46
2. Arjen Boin and Michel J.G. van Eeten (2013) The Resilient Organization, Public Management Review, 15:3, 429-445.
3. 'Toezien op publieke belangen', *Wetenschappelijke Raad voor het Regeringsbeleid* (2013)
4. A. Wildavsky, *Searching for safety* (New Brunswick 1988)
5. M. van der Steen, *Tijdig bestuur: strategisch omgaan met voorspelbare verrassingen (inaugural address)* (Rotterdam 2016)
6. M. van der Steen and M. van Twist, 'Weerbaar of wendbaar zijn? Strategische opties in de voorbereiding op de drie decentralisaties', Beleid en Maatschappij 2014 (41) 1, 58-64
7. J. Hillmann and E. Guenther, 'Organizational resilience: a valuable construct for management research?', *International journal of management reviews,* vol. 23, 2021, 7-44
8. H. de Bruijn and M. van der Steen, 'Leren van Covid-19' (Essay for the Netherlands School of Public Administration) (The Hague, 2020)

9. H. Duijnhoven, B. Boonstra, Johanna Helena Kerstholt, M. van der Lindt, I. Trijssenaar, 'Meetmethoden weerbaarheid: TNO Report R1169 (commissioned by NCTV), The Hague, 3 December 2014, 3. Internet: 2342-volledige-tekst tcm28-73073.pdf (wodc.nl)

10. T.A. Williams, D.A. Gruber, K.M. Sutcliffe, D.A. Shepherd, and E. Yanfei Zhao, 'Organizational Response to Adversity: Fusing Crisis Management and Resilience Research Streams,' *Academy of Management Annals* 11 (2) 2017, 733-769

11. Analysts' Network, commissioned by the National Coordinator for Security and Counterterrorism, 2019 Comprehensive Risk Analysis, pp. 25, 27 and 36. Internet: Geïntegreerde risicoanalyse Nationale Veiligheid I Rapport I Rijksoverheid.nl

12. 'Toezicht door Inspectie Justitie en Veiligheid bij toenemende maatschappelijke complexiteit', Wetenschappelijk Onderzoek en Documentatiecentrum (2020)

13. Hotspots of the Ministry of Justice and Security 2019-Version 1.0 Date 18 December 2020 Status Adopted in the SIO of 17 December 2020. Note that the Inspectorate naturally also maintains a strong focus on crises in its supervision of crisis control efforts by the security regions.

14. Security Regions Act Evaluation Committee (Security Regions Act Evaluation Committee, *Evaluatie Wet veiligheidsregio's naar toekomstbestendige crisisbeheersing en brandweerzorg,* report published on 4 December 2020)

Inspectorate of Justice and Security
Supervision, because justice and security cannot be taken for granted.

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