Royal Commission into
Victoria's Mental Health System

# WITNESS STATEMENT OF GLENN WEIR

I, Glenn Weir, Assistant Commissioner of Victoria Police, of 420 Burwood Highway Wantirna South, say as follows.

1. This statement is true and correct to the best of my knowledge and belief.

2. The views I express in this statement are in my capacity as an Assistant Commissioner of Victoria Police and I have been authorised to speak on behalf of Victoria Police in answer to the questions of the Royal Commission into Victoria's Mental Health System ('the Royal Commission').

## *BACKGROUND*

***Q 1. Please detail your background and experience, including your qualifications?***

3. I am a sworn member of Victoria Police of the rank of Assistant Commissioner.

4. I hold a Graduate Certificate in Advanced Management and a Graduate Diploma of Leadership and Management (Policing) and I have also attended the Australia and New Zealand Police Leadership Strategy program. I sit on the Steering Committee overseeing the Victoria Police Forensic Mental Health Training Project and I am also a member of the Police Procurement Board, Chair of the Victoria Police Seniors Portfolio Reference Group and Chair of the Regional Leadership and Governance Committee.[1] Outside of policing, I have a long history of community and sporting club service and currently sit on the board of a not for profit body focusing on at risk youth in the Western Suburbs.

5. I joined Victoria Police in 1980 as a police cadet and graduated as a police member in 1981. Since that time, I have had a variety of roles with a strong focus on operational policing.

6. At the start of my career I served in the inner suburbs of Melbourne, mainly in uniform general duties. In 1990, I was promoted to the rank of Sergeant, performing general duties and specialist supervision roles before being promoted to Senior Sergeant in 2000. As a Senior Sergeant I worked at Frankston Police Station, one of the busiest 24-

[1] The Regional Leadership and Governance Committees are Victorian Government forums established to create collaboration between Victorian Government Departments and Local Governments across Victoria's eight administrative regions to identify and address critical issues for the regional areas.

hour police stations in the State and an area that, at the time, was significantly affected by alcohol and other drug use as well as homelessness and mental health.

7. In 2006, I had a lead role in the largest police operation ever conducted in Victoria, the Melbourne 2006 Commonwealth Games, as Deputy Commander for Policing Operations in the Public Domain. After performing an assignment as a member of a corporate project team, I was promoted to Inspector in 2006. In 2010, I was appointed as the Local Area Commander in the Bass Coast Police Service Area in South-East Victoria. Whilst at Bass Coast, I had command of several international events including the Australian Moto GP and World Super Bike events.

8. In 2012, I was promoted to Superintendent. I worked as the Divisional Commander for the Brimbank Division of Victoria Police's North West Metro Region in Melbourne's western suburbs until November 2015. I was then transferred to take command of the Frankston-Mornington Peninsula Division. In 2017, I was promoted to Commander of People Development Command and in November 2018, I was promoted to my current role as Assistant Commissioner of Eastern Region.

9. Like most police, throughout my career, I have engaged with members of the community and colleagues that are impacted by their own or others' experiences of mental health issues. I have seen first-hand and through my members the impact that mental health has on policing and the key role that Victoria Police currently plays in the mental health system.

***Q 2. Please describe your current roles and responsibilities.***

10. I am currently the Assistant Commissioner responsible for the Eastern region of Victoria. In that role I have responsibility for the delivery of policing services, to the Eastern part of the State which covers an area extending from Hawthorn in the eastern part of the Melbourne metropolitan area, through to the border with New South Wales, and eastward covering the rural divisions of Shepparton, Wangaratta, Wodonga, Bairnsdale, Morwell, Warragul, and Phillip Island.

11. As part of the Regional Leadership and Governance Committee, I work closely with community, private industry and corporate sector leaders to improve service delivery, prevent crime and enhance community safety. My top priority is 'people' and ensuring that we deliver our services to the local community in a manner that is safe, respectful and fair.

12. The Eastern Region is a unique geographical and cultural region covering in excess of 2,900 sworn police members and VPS personnel. These staff work across a number of stations and specialised units including:

    i. 25 twenty-four hour police stations;

    ii. 54 non-twenty-four hour police stations;

    iii. 31 one-person police stations;

    iv. 3 winter-only police stations (Mt Buller, Mt Hotham, and Falls Creek);

    v. 21 Criminal Investigation Units;

    vi. 19 Highway Patrol Units;

    vii. 10 Sexual Offence and Child Investigation Teams; and

    viii. 6 Family Violence Investigation Teams.

***Q 3. What is the role of Victoria Police in the mental health system? Where does Victoria Police fit within the mental health system?***

13. The general role of Victoria Police is to serve the Victorian community and uphold the law so as to promote a safe, secure and orderly society.[2]

14. Section 9 of the *Victoria Police Act 2013* (**VPA**) provides that the general functions of Victoria Police include:

    i. preserving the peace;

    ii. protecting life and property;

    iii. preventing the commission of offences;

    iv. detecting and apprehending offenders; and

    v. helping those in need of assistance.

15. In performing the above functions, police officers routinely interact with members of the general public in the Victorian community. This means that police frequently engage with people experiencing mental health issues in the course of their duties, given the prevalence of people experiencing mental health issues in the Victorian community.

16. The way in which Victoria Police engages with the mental health system includes:

[2] *Victoria Police Act 2013*, s 8.

i. connecting people for assessment, treatment or other support;

ii. responding to requests for assistance from mental health services; and

iii. as consumers using the system.

***Connecting people with the mental health system for assessment, treatment or other support***

17. Police may encounter people experiencing mental health issues in a range of circumstances.

18. Sometimes it will be clear as soon as a request for police assistance comes in, that the person is experiencing a mental health issue. For example, when a police unit is called to respond to a mental health crisis. In other cases, a mental health issue may not be an obvious driver of a call to police, but police officers may identify that a person is experiencing mental health issues through their interactions with the people involved.

19. As first responders, police officers are not mental health clinicians, but are expected to make decisions about the appropriate police response to these types of events, including whether or not to engage other services.

20. The Department of Health and Human Services (**DHHS**) – Victoria Police Protocol for Mental Health (**the Protocol**) provides some guidance to police, by clarifying the respective roles, responsibilities and procedures for interactions between them and mental health clinicians.

    Attached to this statement and marked '**GW-1**' is a copy of 'The Department of Health and Human Services – Victoria Police Protocol for Mental Health.'

21. In practice, police officers in Victoria have two main options to connect a person with the mental health service system:

    i. *Via a referral* – Police can make a referral where a person appears to be experiencing mental health issues but is not in crisis.

       Victoria Police will typically do this through the Victoria Police e-Referral (VPeR) system. VPeR is a consent-based, non-crisis, non-family violence referral system which was introduced in 2014. It provides referral options for 26 issue types that police frequently encounter, including mental health issues. While only one category can be chosen at any one time, the model operates a 'no-wrong door' policy which supports re-referral when required.

Referrals are made electronically. Monash Health receives all mental health referrals made via VPeR. Once a referral is received, Monash Health calls the individual who has been referred and provides that person, and their families and carers where appropriate, with immediate, short-term, solutions-focused support and access to information and advice.

ii. *By apprehending the person under section 351 of the Mental Health Act 2014 (**MH Act**)* – Police officers and Protective Service Officers (**PSOs**) have authority to apprehend a person under section 351, of the MH Act.[3] This legislation has been operationalised by Victoria Police in partnership with DHHS, by way of the Protocol. The Act states that police may apprehend a person under section 351 of the MH Act where:

   a. they are satisfied a person appears to have mental illness; and

   b. because of the person's apparent mental illness, they need to be apprehended to prevent serious and imminent risk of harm to themselves or to another person.

22. According to the Protocol, being 'satisfied' the person appears to have mental illness is based on the person's behaviour and appearance and any other relevant information including information from the family and carers if appropriate.[4]

23. Once a police officer identifies that a person requires assessment under section 351 of the MH Act, they then have two main options:

   i. they may seek the attendance of a Mental Health and Police Response (**MHaP**) unit (also known as PACER) to conduct an assessment in the field (further description of the MHaP/PACER initiative is provided at Q 13); or

   ii. they may arrange for the person experiencing mental health issues to be transferred to an emergency department, hospital or designated mental health service for an examination.

24. For suspected offenders in Victoria Police custody who are experiencing mental health issues, other processes also apply:

[3] *Mental Health Act 2014*, s 351(1).

[4] Department of Health and Human Services (DHHS) –Victoria Police protocol for mental health, p. 8.

i. *Prior to interview* – If police wish to interview a person who appears to be experiencing mental health issues, they are required to seek clinical advice from a Forensic Medical Officer (FMO), via the Victorian Institute of Forensic Medicine, to determine the person's fitness for interview.

ii. *Interview process* – If a police officer suspects a person to be interviewed has a cognitive impairment (including a mental health issue) which affects their ability to communicate and understand information, they must seek an independent third person (ITP) to be present during the interview.

An ITP can be a volunteer from the Office of the Public Advocate (a trained ITP), a parent, guardian, relative or close friend of the person.

iii. *In police cells* – When a person comes into police custody, police officers must assess them against a Medical Checklist.

Where that checklist identifies that the person may be experiencing a mental health issue or it is otherwise disclosed, police are directed to contact the Custodial Health Advice Line (CHAL) for advice. Custodial Nurses are available 24 hours a day to help care for persons in custody.

***Responding to requests for assistance from mental health services***

25. Victoria Police serves the mental health system by responding to requests for assistance from clinicians, including where:

i. a welfare check is required;

ii. a person is missing and there are fears for their safety and/or welfare;

iii. a police presence is required for safety reasons, for example, where there is a genuine and immediate risk of self-harm or harm to another person. This includes within designated mental health services;

iv. there are reports of criminal offending;

v. a compulsory patient is absent without leave under section 352 of the MH Act;

vi. an interstate patient requires apprehension under section 326 of the MH Act;

*vii.* emergency apprehension under section 30 of the Crimes (*Mental Impairment and Unfitness to be Tried) Act 1997;*

viii. where assistance with transportation is required.

26. The Protocol provides specific guidance about how and when police are expected to respond to calls for assistance from clinicians.

***As consumers using the mental health system***

27. As an employer, Victoria Police provides staff with access to the mental health service system.

28. The organisation knows that, although a majority of employees and volunteers in the police and emergency services sector report good levels of mental health and wellbeing, employees in the police and emergency services sector have substantially higher rates of psychological distress and lower levels of positive wellbeing compared with the general adult population in Australia.[5]

29. To reflect the organisation's commitment to promoting and protecting staff mental health, Victoria Police has developed the 'Mental Health Strategy and Wellbeing Action Plan 2017–20' (**Mental Health Action Plan**). This document follows the independent review into the mental health and wellbeing of Victoria Police employees in 2016.

    Attached to this statement and marked '**GW-2**' is a copy of the 'Mental Health Strategy and Wellbeing Action Plan 2017–20.'

30. The Police Psychology Unit is one mechanism through which the organisation facilitates employees' access to mental health services, which include:

    i. confidential counselling service for employees and their immediate families;

    ii. 24-hour on call service for urgent matters involving employee wellbeing; and

    iii. psychological assistance after critical incidents.

31. A specific example arises from the specialised mental health and wellbeing support provided to investigators and other employees working in areas such as: sexual offending, child abuse, crime analytics and family violence.

32. After the Family Violence Royal Commission and Mental Health Review (recommendations 33 and 35), Family Violence Command introduced a clinical team, the Specialist Investigators Support Unit (**SISU**), to support the mental health and wellbeing of Victoria Police employees working in Sexual Offences and Child Abuse

[5] Beyondblue, *Answering the call national survey: Beyondblue's National Mental Health and Wellbeing Study of Police and Emergency Services – Final report* (2018) 115.

Investigation Teams (**SOCITs**) and Family Violence Investigation Units (**FVIUs**) specifically.

33. The specialised services provided by the SISU are available to employees working in SOCITs and FVIUs in addition to those available through Victoria Police Wellbeing Services and the external Employee Assistance Program (EAP) providers.

***Q 4. What are the challenges for Victoria Police in dealing with people affected by mental illness?***

34. General duties police officers interact with people experiencing mental health issues in a range of circumstances, including:

    i. *Offence-based interactions* – Where a suspect or victim of crime is experiencing a mental health issue.

    ii. *Custody management* – Where a suspect is in Victoria Police custody, including where they are detained in police cells.

    iii. *Responding to requests for assistance, including where people are in crisis* – Where police are called to ensure an individual's safety, or support that individual in some way. This includes circumstances where police are called by members of the public, service providers, or family/friends/carers, when a person appears to be experiencing a mental health issue and is in need of urgent attention.

35. A significant challenge facing Victoria Police is the increasing reliance on policing responses for people experiencing a mental health crisis. While police officers will always respond to critical incidents including those involving mental health issues, we consider there should be more emphasis on mental health interventions and primary care to prevent the need for police involvement. See Q 18 for more detail on training.

36. The organisation's view is consistent with the observations made in the 2016 report, *State of Policing: The Annual Assessment of Policing in England and Wales,* that "by the time the police become involved; many opportunities to intervene – to prevent mental ill-health deteriorating to the point at which people are in danger – will already have been missed."[6]

[6] Her Majesty's Chief Inspector of Constabulary, *State of Policing: The Annual Assessment of Policing in England and Wales*, (2016) 8.

Attached to this statement and marked '**GW-3**' is a copy of '*State of Policing: The Annual Assessment of Policing in England and Wales.*'

37. More specific challenges arising in the course of policing interactions with people experiencing mental health issues are:

    i. identifying the most suitable operational response; and

    ii. getting timely access to the mental health service system.

***Identifying the most suitable response to an incident***

38. As mentioned at paragraph 19, general duties police officers are not mental health clinicians but are required to make decisions about the appropriate police response to events involving people experiencing mental health issues.

39. To assist these decisions, Victoria Police has been working since 1996 to build the capability of its members to respond to people experiencing mental health issues. Training has evolved to adapt to the changing environment and challenges and has also been enhanced over time in response to member feedback. Each training package is developed in close consultation with internal and external experts, including mental health practitioners and education specialists.

40. Police decision-making before and during incidents involving people experiencing mental health could be assisted by greater access to clinical expertise.

41. An example of Victoria Police's response to this challenge is the Enhanced Critical Response Program (**ECRP**). ECRP is a joint initiative between NorthWest Mental Health and Victoria Police. This program enhances the response of the Critical Incident Response Team (**CIRT**) to high-risk situations (including sieges and persons threatening self-harm) by providing CIRT with relevant and appropriate mental health information and advice that can inform the police response and negotiation plans.

42. In 2018, the Melbourne Health and Victoria Police CIRT ECRP information sharing project received the Minister for Mental Health's award for excellence in supporting the mental health and wellbeing of Victorians.

***Timely access to the mental health service system***

43. In cases where a police officer apprehends a person under section 351 of the MH Act, the officer cannot delegate responsibility until the person is taken for examination by a registered medical practitioner or mental health practitioner (in community, an

emergency department, hospital or designated mental health service) and the receiving party has formally accepted care of that person.

44. As I mention at paragraph 23 above, police officers typically have two main options to arrange for a person's examination:

    i. call for a MHaP/PACER unit to attend; or

    ii. arrange for their transfer to a hospital emergency department or designated mental health service.

45. This decision may depend on the availability of a MHaP/PACER unit to attend – see paragraph 87 for further description on the hours of operation.

46. Where police officers are required to arrange a transfer to a hospital, police can experience delays in transporting people. While Ambulance Victoria is responsible for providing emergency health related transport, there are occasions where an ambulance may not be available or may be delayed and police undertake the transfer via the police divisional van.

47. Once police get to the hospital, there can be long wait times to handover custody of a person to an appropriately authorised clinician. Victoria Police data does not detail the length of time taken for each specific component of the mental health transfer, however, we record total time of police involvement. There have been some positive reductions in the average time taken at these events, but police officers are still frequently involved in these events for more than two hours at a time on a very regular basis. There are also circumstances where police officers can be involved for up to, or more than, six hours.[7]

48. As demonstrated in the first case study in Appendix A, these delays can have adverse consequences for the person experiencing mental health issues, and on other aspects of police service delivery more generally.

[7] Data extracted from CAD and LEAP, Corporate Statistics, Victoria Police. Note: Mental Health Transfers data is reliant on police compiling the appropriate LEAP forms accordingly and characteristics of this data is based on its modus operandi data. The data only captures time involvement of the event but does not capture the number of police who may be engaged throughout either all or part of that event. The quality of the data is also affected by members not filling out the forms correctly and missing time attribution information. Approximately 28% of forms are not completed fully in terms of time attribution.



***Q 5. Please provide two (anonymised) examples of case studies of Victoria Police's experience with people with mental health problems, which illustrate the complexities faced by Victoria Police?***

49. Case studies are included in Appendix A.

***Q 6. What proportion of member time is spent assisting people affected by mental illness? How is this measured?***

50. As previously noted, police officers encounter people experiencing mental health issues in a range of circumstances.

51. In some cases, a mental health issue may prompt a person's interaction with police; in other cases, the issue is identified subsequent to the apparent or initial reason for the police contact. This means it is difficult for me to conclusively determine how much police time is spent on this work because the data capture on some of these interactions is limited.

52. The organisation does, however, capture data about specific types of contact between police and people experiencing a mental health issue as follows. During 2017–18:

    i. Police officers were dispatched to approximately 43,000 events coded as psychiatric crisis and suicide attempt or threat.[8]

    Averaged across the year, this means that Victoria Police responded to a mental health call out of this nature approximately every 12 minutes during 2017–18.

[8] Data extracted from CAD and LEAP, Corporate Statistics, Victoria Police

ii. The number of attending police units (vehicles) who attended these events is as follows:

Table 1: Number of police vehicles dispatched per event in 2017/18

| Number of police vehicles dispatched per event | Total number of events | Event Type | |
|---|---|---|---|
| | | Psychiatric crisis | Suicide attempt/threat |
| 1 | 21,916 | 12,714 | 9,202 |
| 2 | 12,560 | 6,636 | 5,924 |
| 3 | 5,455 | 2 761 | 2 694 |
| 4 | 1,795 | 827 | 968 |
| 5 | 630 | 234 | 396 |
| Over 5 units | 602 | 194 | 408 |

iii. Police officers facilitated approximately 14,000 transfers to an emergency department or designated health facility under section 351 of the MH Act.[9]

iv. Police officers made 6,774 mental health referrals via VPeR.[10] In the same timeframe, 36,783 VPeR referrals were received in total across all 26 referral categories.

53. Victoria Police does not capture time attributions for all forms of these engagements, but members do complete a Mental Disorder Transfer form (**Transfer form**) when they transfer a person under section 351 of the MH Act.

54. While there are some limitations with this data,[11] of the approximately 10,000 transfers where members completed the time attribution section of the Transfer form in 2017–18, around one third of these events took over two and a half hours to complete. Almost 500 took five or more hours to complete.[12]

[9] Data extracted from CAD and LEAP, Corporate Statistics, Victoria Police. Note: Mental Health Transfers data is reliant on police compiling the appropriate LEAP forms accordingly and characteristics of this data is based on its modus operandi data. Therefore there may be instances where one incident may contain more than one modus operandi codes
Mental Health transfers occur in instances where assessment indicates that the person experiencing a mental health issue is demonstrating acute symptoms and high risk behaviours that are a threat to theirs and/or others safety and is apprehended by police under section351, MH Act for assessment.
[10] Provided by the Victoria Police Victims Advisory Unit on 26 June 2019.
[11] The data only captures time involvement of the event but does not capture the number of police who may be engaged throughout either all or part of that event. The quality of the data is also affected by members not filling out the forms correctly and missing time attribution information. Approximately 28% of forms are not completed fully in terms of time attribution.
[12] Data extracted from LEAP by Corporate Statistics.

***Q 7. What are the trends in relation to the:***

***a. number of mental health incidents that Victoria Police respond to?***

***b. complexity of the mental health incidents that Victoria Police responds to?***

***c. duration of mental health call outs?***

55. While I am unable to provide data on trends across all forms of Victoria Police's interaction with people experiencing mental health issues (for reasons I outlined in paragraph 51), I am able to comment on trends relating to police responses to events coded as psychiatric crisis and suicide attempts/threats, as well as mental health transfers.

56. In relation to the former, there has been an 87.9% increase between from 2014–15 and 2017–18 for psychiatric crisis alone, and a 32.2% increase over the same period for psychiatric crisis and suicide attempt/threats combined.

57. There has also been a 172% increase in mental health eReferrals through VPeR, by Victoria Police between 2014–15 and 2017–18.[13]

58. There has been a similar upward trend in mental health transfers. As above, in 2017–18, police officers facilitated approximately 14,000 Mental Health Transfers' under section 351 of the MH Act. This was a 169% increase from the approximately 5,200 'Mental Health Transfers' undertaken in 2010–11, and a 24% increase from 2016–17.

59. I am also unable to provide data on trends in relation to complexity for reasons I outlined in paragraphs 51 and 55. I further note that, while Victoria Police captures calls for service, we do not generally capture data on the underlying drivers associated with these calls above that which is identified as the priority reason for the call.

60. In relation to statistics showing the duration of police attendance at mental health call outs, I only have data relevant to mental health transfers. While there have been some positive reductions in the proportion of transfers involving police officers for more than three and a half hours since 2012–13, police are still regularly involved in transfers which take two or more hours.

***Q 8. Does the amount of time Victoria Police spends on mental health issues impact on the remainder of policing work? If so, in what ways?***

61. As noted at paragraph 51, it is difficult to conclusively determine how much of Victoria Police time is spent on 'mental health issues', and subsequently the impact of this on

[13] Data provided by the Victoria Police Victims Advisory Unit

other parts of police work. However, an indication of the impact can be demonstrated by the extent to which police vehicles (which each carry two police members) are dispatched to events coded as psychiatric crisis or suicide attempt/threat.

62. In 2017–18, of the almost 43,000 of these event types, just under half involved two or more police vehicles.[14] This does not take into account those events that were not coded as a psychiatric crisis or suicide attempt/threat at the time of dispatch, but upon attendance entailed a mental health component.

63. Another way to illustrate how the demands on Victoria Police's resources can have a cumulative effect, and place significant strain on an area's capacity to respond to other incoming requests for assistance, is through the following example:

> *In May 2019, a hospital sought police assistance for an extremely agitated in-patient with a history of mental health issues who was posing a significant risk to hospital staff and other patients.*
>
> *At the time of the call, the local police command had five police units (consisting of five vehicles with two police members per vehicle) in operation. All five units were in attendance at other incidents; three of these units were already attending incidents involving persons experiencing mental health issues.*
>
> *This meant that there were no available local police units to attend the hospital and a police unit from a neighbouring location had to be dispatched.*

64. This impact can be particularly acute in regional Victoria where distances (and therefore travel times) between locations are greater.

65. In responding to this question, I think it is important to reiterate that responding to the needs of vulnerable Victorians will always be a priority for Victoria Police.

***Q 9. Of the people in police custody, what proportion of those has a diagnosed mental illness?***

66. The Australian Institute of Health and Welfare states that almost half of prison entrants (49%) report being affected by a mental health issue.[15] All of these people will have entered the criminal justice system via contact with police and will therefore have been in police custody.

[14] Data extracted from CAD, Corporate Statistics, Victoria Police
[15] Australian Institute of Health and Welfare, *The health of Australia's prisoners* (2015) Cat. no. PHE 207.

67. Victoria Police does not have ready access to information regarding mental health diagnoses of individuals. Victoria Police's Custodial Health Service (**CHS**) provides nursing, medical and pharmacy services and assistance to people in police custody. This includes services in relation to people experiencing mental health issues.

68. When a person comes into Victoria Police custody, police must assess them against a Medical Checklist.[16] Where a mental health issue is identified or disclosed, police are directed to contact the Custodial Health Advice Line (**CHAL**) for advice. Custodial Nurses are available 24 hours a day to help care for persons in custody, although this advice is subject to the accuracy of the information provided over the phone and/or any previous medical records regarding the individual that the CHAL can access. This can make it difficult to determine the extent to which individuals in police custody have a diagnosed mental illness.

69. In terms of the scale of detainees' needs, the CHS 'HR Assist Health' database (**the database**) categorises individual's mental health issues by level of risk and care requirements. The following extract from that database shows that between 2016 and 2018, 1,253 detainees fell into the highest category of care: *P1 – Serious Psychiatric Condition Requiring Intensive and/or Immediate Care*. This extract also identifies that many other detainees needed other forms of mental health assessment or treatment, which presents capacity and resourcing challenges for police and mental health services alike.

Table 2: Prisoners in Police Custody - Mental Health Risks & Forensicare Referrals[17]

| Categories | Yearly Totals | | |
|---|---|---|---|
| | 2016 | 2017 | 2018 |
| P1 - Serious Psychiatric Condition Requiring Intensive and / or Immediate Care | 343 | 366 | 544 |
| P2 - Significant Ongoing Psychiatric Condition Requiring Psychiatric Treatment | 565 | 612 | 845 |
| P3 - Suspected or Stable Psychiatric Condition Requiring Appointment or Continuing Treatment | 2836 | 3079 | 3543 |
| PA - Suspected Psychiatric Condition Requiring Assessment | 665 | 631 | 610 |
| Mental Health Referrals - Forensicare Assessment Requested | 1112 | 1176 | 1333 |

[16] Victoria Police, 'Victoria Police Manual – Guidelines – Safe management of persons in police care or custody'.
[17] Data sourced on 1 May 2019 from CHS HR Assist Health database.

***Q 10. What is community policing? Is it relevant to people with mental illness? If so, how?***

70. The community is at the centre of policing as we uphold the rights of every individual. Although there are many different definitions of community policing, the Victoria Police Manual describes it as the delivery of policing services through central community engagement programmes.

71. Community policing enables police to proactively engage with people with lived experience of mental health issues, and their carers, to understand their community safety and policing concerns.

72. From a structural perspective, the Priority Communities Division (**PCD**) within Victoria Police acknowledges that people experiencing mental health issues can be overrepresented in their contact with police; and, most importantly require a tailored response to their needs.

73. One of the specific community engagement initiatives established by PCD is the Victoria Police Mental Health Portfolio Reference Group (**Mental Health PRG**). Victoria Police also has other Portfolio Reference Groups, for example relating to the Aboriginal community, LGBTI community, culturally and linguistically diverse communities, people with disability and seniors.

74. Within its membership, the Mental Health PRG includes: peak bodies; mental health services; community stakeholder organisations; advocates; representatives of the alcohol and other drugs, and homeless sectors; and people with lived experience of mental health issues and carers.

75. The Mental Health PRG meets on a quarterly basis and works collaboratively with Victoria Police by providing advice on projects, policies and initiatives which impact on people experiencing mental health issues.

76. Another specific community policing initiative relating to people experiencing mental health issues is Mental Health Liaison Officers (**MHLOs**). First established in 2007, the role of MHLOs includes: collaboration with local service providers; supporting police officers with advice and awareness of emerging issues and trends regarding mental health issues; and working with their local Emergency Services Liaison Committee (**ESLC**). This role is not a gazetted role; rather it is a portfolio role that a police member may hold while also carrying out their operational duties. Victoria Police is currently

working to enhance this role and provide support and guidance to enable more consistency of the role across the state.

***Q 11. How could interagency coordination be improved?***

77. When people experiencing mental health issues are in crisis, police cannot solve the issue alone. Interagency collaboration and coordination is critical to meet their often complex needs.

78. Victoria Police has established, or contributes to, a range of partnerships which promote information sharing and multiagency responses to common and high-risk issues.

79. I have found that these partnerships are strongest when they apply shared practice principles, such as is found in the Protocol.

80. While partnerships generally operate well, interagency coordination could be improved through:

    i. increased opportunities for information sharing at local and state-wide levels (for example, from Emergency Services Liaison Committees through to the DHHS–Victoria Police Relationship Governance Committee);

    ii. improved reporting between local and state-wide partnerships to identify any systemic issues and create greater efficiencies and effectiveness across services; and

    iii. potentially expanding the application of multi-agency partnerships to comprise health, education, employment and social service responses.

***Q 12. What support does Victoria Police need from mental health services?***

81. The concern for Victoria Police is that people experiencing mental health issues receive appropriate and sustained support and services at the earliest opportunity, preferably before the escalation to an acute crisis that results in the need for a police response.

82. For circumstances where crisis responses and/or police engagement is required to support people experiencing mental health issues, the following 24/7 support from mental health services would be of benefit:

    i. access to clinical expertise to inform police decision-making and triage;

    ii. capacity for in-field clinical assessments;

    iii. timely handover between first responders and the health service system; and

iv. capacity to respond to the mental health needs of people in Victoria Police custody.

***Q 13. What is PACER?***

***a. Has the use of PACER affected mental health outcomes for consumers? If so, in what ways?***

***b. Has the use of PACER affected the amount of time Victoria Police spends on mental health issues?***

83. The Police, Ambulance and Clinical Early Response (**PACER**) is a local mental health crisis intervention program, operating as a joint venture between adult Area Mental Health Services (**AMHSs**) and Victoria Police. This initiative is funded by DHHS and is also known as the Mental Health and Police (**MHaP**) Response initiative; the terms PACER and MHaP are used interchangeably for the same service model.

84. PACER/MHaP's purpose is to provide a targeted and timely response to individuals who have come to the attention of Victoria Police and are experiencing, or appear to be experiencing, an acute mental health issue requiring an urgent mental health response.

85. The initiative was originally piloted in 2007 in response to an increasing prevalence of mental health crises in the community and resulting increase in demand for police, ambulance and hospital emergency department mental health assessment services.

86. In 2014, DHHS committed funding for a progressive roll out of the initiative across all adult AMHSs in Victoria, with one PACER unit to be established per AMHS. Whilst funded through adult AMHSs, some PACER units are able to respond where a call is received relating to a young person as outlined in their local area's PACER operating guidelines and agreements.

87. There are currently 19 PACER/MHaP response units operating within Victoria, each with its own operating guidelines and practices, based on local needs and service practices. As a general rule, PACER/MHaP shifts typically operate from 2pm - 10pm, seven days per week, with some variation across locations.

88. The initiative operates on the basic premise of a secondary response which is activated on request by the police first responder unit. It is delivered by a joint team comprising a police officer and a mental health clinician. Telephone advice and support can also be provided through PACER. Guidance for police officers on when to contact PACER is provided in the Protocol and in each local area's PACER operating guidelines and practices.

89. Upon attending the incident location, the clinician undertakes a mental health assessment and determines the appropriate response for that individual. Where the clinician determines that a more comprehensive assessment is required, the attending police officers will arrange for the individual to be transferred to an emergency department, hospital or designated mental health service.

90. Although there has not been an evaluation since the full rollout of the initiative, a 2012 evaluation on the pilot found that PACER offered:[18]

    i. more timely access to mental health assessment;

    ii. a more integrated approach to management of mental health crises through improved agency information sharing and communication;

    iii. the improved use of agency resources including Ambulance Victoria as the preferred mode of transport for transferring individuals, avoidance of hospital emergency department presentations and reduced use of Victoria Police resources to transport persons; with the flow on benefits for individuals; and

    iv. fewer referrals to emergency departments accompanied by increased direct referrals to psychiatric facilities.

91. Anecdotally, many police officers, mental health clinicians, people with lived experience of mental health issues, carers and family members have echoed the positive findings of the pilot evaluation. Some issues with the operation of the program have also been identified, including:

    i. inconsistent models across Victoria;

    ii. lack of availability in all locations or at all times;

    iii. lack of available mental health clinicians to support PACER shifts on some occasions; and

    iv. misalignment of police service areas and AMHSs creating difficulties for collaborative service delivery.

92. Without a contemporary evaluation of PACER, it is difficult for me to comment on its effectiveness and/or impact. I note however that the 2012 pilot evaluation did find more

[18] The Allen Consulting Group, *Police, Ambulance and Clinical Early Response (PACER) Evaluation: final report* (2012).

timely clearance of Victoria Police first responder units, resulting in their efficient use and availability for other police duties.

***Q 14. Does Victoria Police use any other innovative models to assist/link people with a mental health crisis to mental health treatment? If so, what do they involve?***

93. As I noted in paragraph 77 above, when people experiencing a mental health issues are in crisis, police alone cannot solve the issue. People experiencing mental health issues, particularly those in crisis, need expert and timely treatment and support in an appropriate setting. To facilitate this, Victoria Police works closely with other agencies and partners.

94. At a local level, agencies work together, building local arrangements to address local needs. At a state-wide level, there are a number of joint initiatives between Victoria Police, Ambulance Victoria, mental health service providers and other relevant service providers to enhance interventions and, ultimately, outcomes for people experiencing mental health issues who have contact with police. Examples of these initiatives include:

    i. Embedded Youth Outreach Program (EYOP) – A youth worker is paired with a police officer to provide an immediate evidence-based assessment and referral for young people in contact with police. The EYOP refers to a range of youth-specific services, including mental health and alcohol and other drug supports. In acknowledgement of the challenges faced in converting a referral to actual engagement with a service, the EYOP also provides follow-up support for young people. The EYOP is currently operating in the areas of Wyndham and Dandenong.

    ii. Victorian Fixated Threat Assessment Centre (VFTAC) – Established in 2018, this initiative aims to identify and respond to fixated individuals, many of whom have a mental illness, before a crisis occurs. Victoria Police, together with mental health experts embedded within police operations, identify and conduct risk assessments of persons who have complex needs who may pose a serious threat to the community. The team determines appropriate interventions based on the risk assessment, which may include mental health treatment.

    iii. Mental Health and Police Response Initiative (MHaP) – Also known as PACER, see question Q 13.

    iv. Victoria Police eReferral Program (VPeR) – See paragraph 21 above.

v. Victoria Police Enhanced Clinical Response Program (ECRP) – See paragraph 41 above.

vi. Emergency Services Liaison Committees (ESLC) – Comprising representatives from Victoria Police, hospital emergency departments and AMHSs, ESLCs create significant opportunities for collaborative and coordinated responses for individual case management, particularly for individuals who present frequently to emergency services and/or who have multiple and complex needs, and to address operational service issues. There is one ESLC per AMHS.

vii. Risk Assessment and Management Panels (RAMP) – A key initiative to improve responses to high-risk family violence victims. High-risk cases are identified by family violence units and referred to local area RAMP, which includes representatives from Victoria Police and DHHS, specialist family violence agencies, child protection, and drug and alcohol, mental health and other service providers.

viii. Emergency Management Liaison Officers (EMLOs) – The Victoria Police Transit Safety Division provides an EMLO to the Metro Trains Control Centre to assist with the safe and efficient resolution of rail disruptions that require police assistance, including suicides and suicide attempts.

95. For Victoria Police, strong partnerships are critical. It is through partnerships such as the above that police are able to refer and connect people experiencing mental health issues to services, support and treatment.

***Q 15. Are there limitations of the current models Victoria Police uses to deal with a mental illness? If so, what are they?***

96. While not specific to all of the models above, there are some general limitations that Victoria Police experiences in relation to models that are developed to support Victoria Police when engaging with people experiencing mental health issues including:

i. The models are not consistently available across all of Victoria, noting that the distance to be covered in large catchment areas in rural and regional locations, and the limited number of police officers and mental health clinicians in these areas, can make implementation of standardised models difficult.



ii. AMHSs catchment areas are not aligned with boundaries for Local Government Areas or Victoria Police service areas, creating difficulties in coordinating services across agencies.

iii. There can be inconsistency in approach where models are rolled out to different local areas.

iv. There can be a lack of available mental health clinicians to support the models.

v. There can be difficulties in establishing evaluations to ascertain the effectiveness of the models; in particular where these models are joint collaborations.

vi. In some instances, there is limited engagement with Victoria Police when developing models that directly involve police, which can create issues for model efficacy and effectiveness as well as resourcing considerations.

***Q 16. What are some examples of best practice for police linking people with mental illness to mental health services, from a systems perspective?***

97. As I stated previously, an optimum outcome would be individuals receiving appropriate mental health care before they come to Victoria Police's attention. Where a requirement for police engagement remains, many other police jurisdictions have established models to support police officers in their role and to enhance the outcomes for people experiencing mental health issues. Some of these are evidence-based, and some have yet to be robustly evaluated. Where evaluations have been conducted, they have generally shown that each model has its advantages and challenges.

98. I suggest that there are not currently established 'best practice' models for policing interventions in mental health crises. This is an evolving area both nationally and internationally as policing jurisdictions respond to the increasing and changing demands for their services. In terms of Victoria Police, we examine our operational practices and methods of engagement in a model of continuous improvement. Notwithstanding, there are a number of non-exhaustive initiatives from other jurisdictions which may provide benefits in Victoria:

i. *Embedded clinicians in call centres* – Mental health clinicians have been embedded in some Australian police call and dispatch centres to support more clinically informed decisions through improved information sharing.

For example, in Western Australia, mental health practitioners are co-located in the Police Operations Centre (POC). A recent evaluation found that the presence of the mental health practitioner in the POC resulted in "a reduction in risk for both individuals experiencing a mental health crisis and police officers as police were better prepared to respond to the incident".[19]

ii. *Co-response models* – 'Co-response' is a collaborative approach between mental health services and police that has been used in varying ways across Australia, the United States, the United Kingdom and Canada.

Co-response models provide police with direct access to clinical information and clinical decision-making, and provide opportunities for direct access to clinical information and clinical decision-making through improved information sharing, and for in-field assessments which deliver a range of more positive outcomes for individuals and police officers alike compared to stand-alone hospital transfers. Further, where individuals are still required to be transferred to hospital, the mental health clinician can often facilitate a more efficient handover process.

PACER, see question Q 13, is an example of a co-response model in Victoria. Other national and international policing jurisdictions have successfully implemented various forms of co-response models and these evaluations consistently report the effectiveness of these models in responding to individuals in crisis, including preventing unnecessary transportation to hospital.

99. I am also aware of other jurisdictions' work to establish specialist facilities to better support people who are in mental health crisis or to help support the management of these individuals in hospitals. One such example was implemented in Niagara, Canada, in 2013 whereby a unit consisting of a four-bed psychiatric emergency service (PES) was established. The aim of the unit was to reduce emergency department wait-times for police officers and reduce exposure for the person experiencing mental health issues to the chaotic and overstimulating emergency environment. A procedure was established to bring the individuals into a different entrance from the main emergency services entrance for triage, prior to being moved into the PES, thereby reducing the amount of time that police officers have to remain at the hospital. The average emergency department wait

[19] P Henry and N Rajakaruna, *WA Police Force Mental Health Co-Response Evaluation Report* (The Sellenger Centre for Research in Law, Justice and Social Change, Edith Cowan University, 2018).

time was reduced from 242 minutes in 2011, to 103 minutes, in 2013, which was a reduction of 57%.[20]

100. I note that the development of specialist facilities, while possibly beyond the scope of the question of policing interventions, may deliver benefits for Victoria Police, particularly where they facilitate timelier handover between the apprehending police and clinicians. I also note the recent establishment of the Mental Health Hubs within emergency departments in Victoria which may be similar to those established in other jurisdictions.

***a. Why are those programs successful?***

101. In general, the above programs or models share similar elements, and police access to clinical advice and support is seen as critical to all the models. Crucially, they are all focused around collaboration, recognising that police cannot respond to people experiencing mental health issues in isolation from other services.

102. These models also demonstrate potential benefits of giving police better and more widespread access to clinical expertise to inform operational decision-making and facilitate access to treatment.

***b. What are the principles underpinning those systems?***

103. The existing Protocol provides that the principles of collaboration, person-focused approach, least restrictive practices, timely responses and confidentiality and exchange of information are critical for day-to-day responses to people experiencing mental health issues.

104. These principles may be useful considerations for any model aimed at addressing the needs of people experiencing mental health issues who come into contact with police.

***c. Could this be implemented in Victoria? Why or why not?***

105. As I referred to in paragraph 95, Victoria Police suggests that there are no currently established 'best practice' models for policing interventions in mental health crises and that examining models of policing practice and its intersection with mental health would benefit from more intense focus and consideration.

[20] B Pizzingrilli, 'A protocol to reduce police wait times in the emergency department' (2015) 28(4) *Healthcare Management Forum* 134, 134–8.

***Q 17. What (if anything) is Victoria Police doing to better understand the needs of the mentally ill and the underlying factors that lead to encounters between mentally ill persons and police?***

106. Victoria Police is continuing to increase its understanding of the drivers of contact between police and people experiencing mental health issues; the Mental Health PRG described at paragraph 73 is one example of how Victoria Police is doing this.

107. Victoria Police also sits on a large number of interdepartmental committees that focus on mental health and suicide prevention.

108. Further, Victoria Police includes people with lived experience of mental health issues, and their family/carers, in elements of police training to develop police members understanding of the underlying factors that could lead to encounters between police and people experiencing mental health issues.

109. Victoria Police has been working to continuously improve its provision of police services to people experiencing mental health issues for some time. These initiatives have included the development of the strategic directions under 'Peace of Mind' (2006) and the Australian Research Council Grant with Monash University and Forensicare, Project PRIMeD: 'Police responses to the Interface with Mental Disorder' (2008).

110. Victoria Police also recently commissioned research through Swinburne University in which key stakeholders were asked to share their perception of why police involvement in mental health transfers has been increasing over time. Included in this research were people with lived experience of mental health issues, carers, mental health service providers, homelessness service providers, advocates and representatives from the alcohol and other drug sector. This research is still ongoing and results are not yet available.

***Q 18. What education and training do members receive in relation to mental health, and in particular in relation to mental health risk assessment and crisis intervention?***

- ***a. What de-escalation and communication skills training do members receive?***
- ***b. Are there any gaps in the current training, if so what are they?***
- ***c. How does Victoria Police support its members to deal with people with mental health issues in the community?***

111. Victoria Police has taken significant steps to improve its training of police members in relation to police interventions in mental health crises. This has included specific mandatory training packages on communication and critical incidents involving people

experiencing mental health issues, as well as voluntary training packages such as Mental Health First Aid training.

112. Training for police has been integrated throughout the biannual Operational Safety and Tactics Training (**OSTT**) since 1996. All operational members are required to complete OSTT in order to remain operational. Over the years there has been a strong focus in OSTT packages on mental health, tactical communications and de-escalation techniques to support police when engaging with individuals experiencing mental health issues, including scenario training; and police officers have also received dedicated mandatory training packages on responding to critical incidents involving people experiencing mental health issues.

113. As I mentioned in paragraph 39, Victoria Police training has evolved to adapt to the changing environment and challenges and has also been enhanced over time in response to member feedback, to make scenarios as relevant and contemporary as possible. Training packages are developed in close consultation with internal and external experts, including mental health practitioners and education experts along with people with lived experience of mental health issues.

114. Currently, police officers and PSO recruits undertake dedicated training related to mental health literacy, the MH Act and responding to critical incidents involving persons experiencing mental health issues. Additionally, there are sessions throughout the recruit and PSO training that refer to mental health case studies, scenarios or role plays.

115. Some further examples of current training opportunities offered by different areas within Victoria Police are:

    i. An extensive range of training opportunities to members of Victoria Police delivered by mental health clinicians and police from the VFTAC, including presentations on lone actor grievance fuelled violence, abnormal fixation and radicalisation.

    ii. The Negotiator Awareness Package which has been developed to provide regional members with communication strategies when dealing with persons of interest who are experiencing mental health issues while waiting for trained negotiators to arrive. This training is delivered by Regional Training Officers directly to police members.

iii. Training for police members who are seeking promotion to higher ranks within the organisation (Senior Sergeant and Inspector level) which focuses on community engagement and addressing a scenario relating to mental health interventions.

116. Victoria Police includes communication and de-escalation training as a standard part of the twice-yearly mandatory OSTT.

117. Victoria Police is also currently developing a further two-day specialist mental health education and training package for all police officers to improve their capability to manage incidents involving persons experiencing mental health issues. Communication and de-escalation will be further explored and expanded upon in this package. Input from people with lived experience of mental health issues, and carers, has been sought during the development of this training.

118. Another example of the way in which Victoria Police is seeking to better support its members to deal with mental health issues in the community is by making sure that its own employees are healthy. As I refer at paragraph 29, much of this work is documented in the Mental Health Action Plan, arising out of the 2016 independent review into mental health.

119. The organisation is continuing to review particular mental health related matters relevant to its members, including with respect to police veterans where Victoria Police believes it is time to consider them in a similar light to Defence veterans; providing them with a system that recognises their service and the ongoing mental health support that they require. This may include improving access to specialist psychiatric care at facilities dedicated to police veterans, either through the establishment of a new facility or by expanding existing facilities such as those provided by Austin Health. We also advocate for the establishment of a benefits card that provides access to discounted health and wellbeing services for police veterans.

***Q 19. Are there ways in which you think the demand for Victoria Police's services to respond to people in crisis because of mental health issues, is changing or will change significantly in the future? If so, what do you think the most significant changes are likely to be?***

120. Victoria Police expects that the mental health system will experience reform as a result of the Royal Commission.

121. The resulting impact on police services is difficult to ascertain although it is hoped that these reforms will lead to reduced reliance on police responses to events that may benefit from a health, rather than law enforcement, intervention.

122. The ways in which Victoria Police responds to people in crisis with mental health issues may also be refined through other policies and plans which set the Victorian government's long-term vision to improve the mental health and wellbeing of all Victorians and provides a foundation for mental health reforms.

123. Nevertheless, in light of current trends, Victoria Police anticipates incidents involving mental health issues and crises will continue to increase.

***Q 20. What changes do you think would bring about lasting improvements to help people affected by mental illness, in relation to crisis response?***

124. Unnecessary contact between police and people experiencing mental health issues should be minimised as this can compound stigma and add to their trauma, leading to suboptimal outcomes.

125. For circumstances where crisis responses and/or police engagement is required, Victoria Police suggests that there are opportunities to support the police response to these events, and result in better outcomes for Victorians, as described at paragraph 82.

126. As I have already outlined, Victoria Police believes that the optimal outcome for Victorians experiencing mental health issues would be timely access to appropriate and sustainable mental health interventions, prior to a situation escalating to police attention. There are opportunities through greater emphasis on mental health interventions in community and primary care to both reduce the reliance on police attendance at matters not requiring a crisis response, and prevent the escalation of circumstances that result in an emergency law enforcement intervention.

sign here ► Glenn WEIR
Assistant Commissioner

print name Glenn Weir

date 5 July 2019

***Appendix A***

**Scenario One**

At 11:30 on a Friday evening, "000" received a call from the parents of a 22 year old person (B) who had expressed thoughts of ending her own life.

The parents advised the "000" call taker that B was agitated but did not want to go to hospital. Despite their best efforts they had been unable to convince B to accompany them to the hospital and they were now very concerned for her welfare.

Police attended the home of the parents where B was residing. They spoke with the parents and B and through these discussions determined that B was at imminent risk of harm to herself, thus meeting the criteria for section 351 MH Act.

As there was no PACER/MHaP shift at that time of the evening, police requested an ambulance to transport B to hospital for a mental health assessment.

Police waited with the parents and B for 40 minutes for an ambulance to arrive. When an ambulance did not arrive within this time, police requested an estimated time of arrival and were informed the wait would be approximately a further hour.

B became increasingly agitated during this time and police were concerned about the risk of harm to her. Following a risk assessment, police decided to transport B in the police divisional van rather than continue to wait for an ambulance to arrive. Police advised the parents where they would be taking her.

Police and B arrived at the hospital emergency department (**ED**) approximately 15 minutes later. ED staff advised the police members that they were unable to undertake a mental health assessment of B on arrival due to a backlog in the ED.

ED staff requested that police wait in the ambulance bay with B until otherwise directed.

Police waited in the ambulance bay with B. For safety reasons, B remained in the back of the divisional van while police monitored them. During this time, B continued to deteriorate to the point that police were very concerned for her safety.

After approximately one hour, and police highlighting that B was rapidly deteriorating, ED staff attended to her and police were released to return to other duties.

The time of police involvement was approximately three hours.

**Scenario Two**

At 10pm, police receive a call from person C. C is concerned about the behaviour of D and C tells the call taker that D is in possession of a lighter and a can of petrol and is threatening to harm himself.

Police attend the residence of D. Upon arrival and assessment of D, the police determine that D is at serious risk of harm to himself and others and meets the criteria for a s351, MH Act, apprehension.

As there is no PACER unit at this time of the evening, police apprehend D and call for an ambulance to transfer D to hospital for a mental health assessment. Due to D's state of agitation, one of the police members rides in the ambulance with D and the paramedics, while the other police member escorts the ambulance in the police divisional van. Once at the hospital, police hand over custody of D to a medical practitioner and return to their duties.

Two days later at 3:30pm, police receive another call from C who is again concerned about the behaviour of D. Police attend the location. Upon arrival, C advises the police that D has barricaded himself in the shed and made some significant threats. Due to the nature of the situation, police request the involvement of the Critical Incident Response Team (CIRT) who are trained to deal with incidents involving this level of risk.

The CIRT attend and negotiate with D in an attempt to resolve the situation peacefully. When this is not successful, and the safety of D and others is at high risk, the CIRT force entry. D is apprehended under section 351, MH Act. Given the situation, police transport D to hospital where emergency department staff request that police remain while they undertake an assessment of D due to the risks D is presenting. Police remain and are subsequently advised by the emergency department staff that D is substance affected and has an extremely high blood alcohol concentration. Police are released to return to their duties.

Two days later, at approximately 10pm, C calls police stating that D is threatening to take his own life. Due to the previous nature of police interactions with D, which is known to the police through warning flags on the LEAP database, two police units are deployed to attend. The supervising police member for this shift is also contacted to attend. Upon attendance at the residence police observe that D is harming himself. Following unsuccessful negotiation with D, and due to the increasing escalation of D's behaviour, the attending police members

conduct a risk assessment and determine that the safest resolution is to physically apprehend D. Police further determine that D is at imminent risk of harm to their self and/or others and meets the criteria for section 351 of the MH Act.

Police then apprehend D and transport them directly to hospital in the police divisional van. Once at the hospital, D is triaged by the emergency department staff, and police then hand over custody of D to the hospital whereby they are released to attend to their other duties.

** D has a history of criminal convictions and family violence, and police were advised that D also has a history of substance and alcohol misuse. Subsequent to the three calls described above, police received further calls to attend to siutations involving D behaving in ways that indicated the prescence of a mental health issue and/or threatening self-harm.*

***Scenario Three***

Person A had been coming to repeat police and PSO attention for a number of years. LEAP records indicated more than 50 recorded incidents of Mental Health Transfers, including 21 incidents in the most recent two year period. Among other behaviour, A would frequently attend railway stations and attempt or threaten to end her own life. A's behaviour had escalated over time, with one of the most recent incidents involving A pointing a replica firearm at police officers, effectively attempting to force police officers, in response to A's behaviour, to use lethal force to end A's life.

The pattern of A's behaviour meant that police officers, PSOs and Ambulance Victoria spent extended periods of time with A, de-escalating the situations and transporting her to hospital for mental health assessment pursuant to section 351. Sometimes A would return to police or PSO attention the same day for another mental health episode, following release from hospital.

In consideration of the risks A's behaviour posed to herself, to responding police officers, PSOs and potentially to members of the public, and the resource intensive nature of the incidents, Sergeant X determined that A could benefit from a Priority Target Management Plan (**PTMP**). While not standard practice for managing individuals experiencing mental illness, Sergeant X determined that a PTMP might enable a more coordinated and targeted police and mental health service response to A's unique presentation.

To initiate the development of the plan Sergeant X sought agreement from A, who agreed and signed a medical release form allowing Sergeant X to speak with A's mental health provider.

To develop the PTMP, Sergeant X liaised with A, her immediate family, her mental health provider, the local hospital and local police. The Sergeant outlined the PTMP initiative, garnered support, and coordinated services to enable A to receive appropriate on-going treatment and support to mitigate potential mental health crises and divert A away from the need for emergency service responses.

LEAP records indicate only one incident involving A requiring an emergency services response after implementing the PTMP.

Royal Commission into
Victoria's Mental Health System

# ATTACHMENT GW -1

This is the attachment marked 'GW-1' referred to in the witness statement of Glenn Weir dated "5 July 2019" .

# Department of Health and Human Services–Victoria Police protocol for mental health

A guide for clinicians and police


VICTORIA POLICE

VICTORIA State Government | Health and Human Services

To receive this publication in an accessible format email mentalhealthreform@dhhs.vic.gov.au

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.



Where the term 'Aboriginal' is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.

ISBN 978-0-7311-6949-8 (online)

Available at https://www.health.vic.gov.au/mental-health/practice-and-service-quality/service-quality

# Contents

# 1. Introduction

This protocol sets out the agreed arrangements for interactions between Victoria Police and mental health clinicians when supporting people with mental illness.

Throughout this protocol 'mental health clinician' is used to describe all clinicians who support people with mental illness. This includes psychiatrists, registered medical practitioners, nurses and mental health practitioners. Where the protocol refers specifically to registered medical practitioners and mental health practitioners, only the specifically named practitioner has the legislative power to act.

For queries relating to the application of this protocol, contact:

Assistant Director, Programs and Performance
Mental Health Branch
Department of Health and Human Services
Email: mentalhealthreform@dhhs.vic.gov.au

or

Portfolio Manager, Mental Health, Priority Communities Division
Victoria Police
Telephone: 9247 6666

## 1.1. Objectives

The objectives of the protocol are to:

- clarify the respective roles, responsibilities and procedures for interactions between police and mental health clinicians;
- give people with mental illness, their families and carers certainty and confidence in the responses of police and mental health clinicians; and
- provide a framework for developing local agreements.

## 1.2. Legislation and policy framework

Collaboration between mental health clinicians and police requires effective working arrangements within existing legislative and policy guidelines.

The protocol does not alter existing internal agency legislative and policy guidelines. The protocol only applies to situations where either the police or a mental health clinician has requested assistance from the other.

The primary governance legislation for Victoria Police is the *Victoria Police Act 2013.*

The primary legislation underpinning this protocol is the *Mental Health Act 2014* (the Act).

All section references are to the Act, unless otherwise stated.

The Act (section 11) contains a number of principles to guide the provision of mental health services. Any person performing a duty or function or exercising any power under the Act must have regard to the mental health principles. The principles state that persons with mental illness should:

- Be provided assessment and treatment in the least restrictive way possible, with voluntary assessment and treatment preferred.
- Be provided services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life.
- Be involved in all assessment decisions, treatment and recovery and be supported to make or participate in those decisions, with their views and preferences respected.
- Be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk.
- Have their rights, dignity and autonomy respected and promoted.
- Have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to.
- Have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to.

The principles also acknowledge:

- Aboriginal people receiving mental health services should have their distinct culture and identity recognised and responded to.
- Children and young people receiving mental health services should have their best interests recognised and promoted as a primary consideration, including receiving services separately from adults, whenever this is possible.
- Children, young people and other dependents of people receiving mental health services should have their needs, wellbeing and safety recognised and protected.

- Carers (including children) for people receiving mental health services should:
  - be involved in decisions about assessment, treatment and recovery, whenever this is possible; and
  - have their role recognised, respected and supported.

These statutory principles recognise the special vulnerability of children and young people both as service users and carers for people receiving mental health services.

## 1.3. Practice principles

The following principles underpin this protocol and should inform day-to-day decision-making:

**Collaboration:** collaboration between police and mental health clinicians is critical to help people with mental illness receive treatment, support recovery and participate safely in the community. Collaboration means respecting professional judgment, independence and applying a problem-solving approach to requests for assistance. Where differences occur, an attempt will be made to resolve them at the earliest convenience.

**Person focused:**. The safety and welfare of a person with mental illness and of any others present will be a primary consideration in decision-making. This means using the necessary professional judgement for the situation and upholding the human rights of the individual, while having regard to duty of care considerations. It is acknowledged that many people with mental illness have experienced a range of trauma (including physical and sexual abuse).

**Least restrictive practices:** police and mental health clinicians will respond to the needs of people with mental illness in the least restrictive means practical to minimise any interference with that person's human rights, including their liberty, privacy and dignity. .

**Timely response:** police and mental health clinicians will attend situations as soon as practicable and without undue delay. This also means recognising the importance of releasing staff from the other service as soon as they have performed their function and are no longer required.

**Confidentiality and exchange of information:** police and mental health clinicians will share information only with the consent of the person (where that person has capacity to consent) or where authorised by legislation.

## 1.4. Review

The protocol will be reviewed within two years of its commencement; or following relevant legislative changes (such as the implementation of the recommendations of the Royal Commission into Family Violence (2016)); whichever occurs first.

# 2. Police requests for assistance from mental health clinicians

## 2.1. Apprehension by police under section 351

Section 351 of the Act permits police to apprehend a person to determine if an Assessment Order should be made for that person.

Protective Services Officers (PSOs) working at a designated place have limited power to apprehend under section 351. As soon as practicable after apprehension, a PSO will transfer custody of the person to the police.

The use of section 351 does not limit any other custody powers, obligations or legislative requirements that police or PSOs may have in relation to an apprehended person.

### 2.1.1. Criteria for apprehension

Police and PSOs may only apprehend a person under section 351 if they are satisfied:

- the person appears to have mental illness; and
- because of the person's apparent mental illness they need to be apprehended to prevent serious and imminent harm to themselves or to another person.

Being 'satisfied' the person appears to have mental illness is based on the person's behaviour and appearance and any other relevant information including information from the family and carer if appropriate.

Police and PSOs are not required to exercise any clinical judgment on whether a person has mental illness.

'Serious' and 'imminent' are to be given their ordinary meanings. In the case of imminent, this means about to happen or impending.

If the criteria for apprehension under section 351 do not apply but welfare concerns exist see part 2.4: 'People presenting to police with welfare concerns'.

### 2.1.2. Other factors influencing the person's presentation

A person apprehended under section 351 may be drug or alcohol-affected, have a cognitive impairment or a medical condition that mirrors mental illness.

A person who is intoxicated or has cognitive impairment can still be examined under section 351 where the criteria for apprehension is satisfied. The registered medical practitioner or mental health practitioner who examines the person will prioritise the person's needs. For example, they may make a referral to an appropriate disability service.

### 2.1.3. Planning the apprehension

A decision by police to apprehend a person under section 351 should be informed by:

- a person check on LEAP;
- general mental health information about how to approach and apprehend the person (contact the local mental health triage or Mental Health and Police (MHaP) response for support with this); and
- specific mental health information about the person to be apprehended when that information can be disclosed (see part 5.2 'Disclosure by mental health service providers').

### 2.1.4. Entering premises to apprehend

Under section 353, police may use reasonable force to enter any premises to apprehend someone under the provisions of the Act.

The decision whether reasonable grounds exist to force entry is a police decision, although it is preferable for a mental health clinician to contribute to the risk assessment.

Before using reasonable force to enter premises under section 353 police must:

- be satisfied that the criteria for apprehension under section 351 apply to the person;
- have reasonable grounds for being satisfied the person may be at the premises;
- undertake a risk assessment and (unless urgent entry is required) obtain authority from a sub-officer before using force; and
- announce to any person at the premises that they are authorised to enter under sections 351 and 353 and give the person the opportunity to let the police enter.

If entry is not permitted, reasonable force may then be used to enter the premises.

On entering, police must identify themselves to the person to be apprehended, explain why they are to be apprehended and inform them where they will be taken.

Police procedures apply for securing the premises and reporting any property damage. The police policy on reimbursement of costs applies to forced entry under section 353.

### 2.1.5. The apprehension

Police will document the circumstances of the person's apprehension under section 351 in the *Mental Disorder Transfer* (VP Form L 42) and provide a copy to the registered medical or mental health practitioner to help them conduct an examination.

### 2.1.6. Power to search the apprehended person

Police have power under section 354 to search an apprehended person before taking the person to be examined. The search power under the Act can only be used in prescribed circumstances (see part 4.3 'Powers associated with transport').

A common law search power may be applicable when a person is detained by a PSO.

## 2.1.7. Arranging a mental health examination for an apprehended person

As soon as practicable after apprehending a person under section 351, police must arrange for them to be taken to a registered medical practitioner or mental health practitioner in the community, or an emergency department, hospital or designated mental health service for an examination. The examination must be conducted in person.

Where practical, examination in the community (including the person's home) is preferred because it is least restrictive of the individual's rights. It also avoids unnecessary transport.

### 2.1.7.1. Examination in the community

To arrange for a practitioner to examine a person in the community contact either:

- the MHaP response; or
- the nearest mental health triage.

If a practitioner is not available the person should be taken to an emergency department, hospital or designated mental health service for an examination.

Police should provide relevant information to the examining practitioner. This may include incident details, safety and risks (like threats, family violence and firearms), drug and alcohol history, intervention orders, family court proceedings and family circumstances. Critical information not recorded on the *Mental Disorder Transfer* (VP Form L 42) should be recorded in the clinical notes. The disclosure of personal information must be with the person's consent (where that person has capacity to consent) or be authorised by legislation (see part 5.4: 'Disclosure by police').

If there is no operational need, police will not take a person to a cell or interview room at a police station for assessment. Examination in a police cell should only occur when it is necessary for the safe examination of the person after all reasonable less restrictive options have been tried or considered unsuitable.

Police are required to remain until the registered medical practitioner or mental health practitioner completes the examination. After examination, the practitioner will either make the person subject to an Assessment Order (Inpatient or Community) or advise police to release the person. At this point, the person will no longer be in police custody, unless arrested for criminal offences (permitted by section 464A(2) and (4)(i) *Crimes Act 1958*).

Where the person is made subject to an Inpatient Assessment Order, they are in the custody of the practitioner and the order is sufficient authority for them to be taken to a designated mental health service and detained for assessment. The practitioner responsible for making the order will determine which authorised person(s) will be responsible for transport.

A person who is released may still need help (see part 2.4: 'People presenting to police with welfare concerns').

#### 2.1.7.2. Examination at a hospital

Where an examination is to occur at a hospital, the apprehended person should be taken to the hospital emergency department that covers the location where the apprehension occurred. This should happen whether the person is an existing client or they live outside the catchment area. Where possible, police should alert the relevant mental health triage of the apprehension and provide an estimated time of arrival (ETA).

Before handover, police should provide clear and comprehensive verbal information to the accepting hospital clinical staff. This includes details of the incident, safety and risk factors (such as threats, family violence and firearms), drug and alcohol history, intervention orders, family court proceedings and family circumstances. The disclosure of information by police must be with the person's consent (where that person has capacity to consent) or be authorised by legislation (see part 5.4: 'Disclosure by police').

Before custody transfer to the hospital, police should complete the *Mental Disorder Transfer* (VP Form L 42), including the name of the attending registered medical practitioner or mental health practitioner, date and time of release and provide a copy to the mental health clinician who has accepted responsibility for the person. Critical information not recorded on the VP Form L 42 should be recorded in the clinical notes.

Handover of a person can only occur when police and hospital clinical staff agree it is safe and in line with the practice principles (see part 1.3: 'Practice principles'). For example, a person can be released from police custody if there are no significant safety risks or concerns for themselves or others. Consistent with the practice principle of timely response, the release of a person from police custody is to be initiated as soon as police are no longer required.

Police may be asked by clinical staff to remain until the person can be examined if the person is acting aggressively or is otherwise considered to be a risk. Police are then responsible for monitoring the person's safety until the hospital's clinical staff accept custody.

Police cannot delegate custody of the person to a hospital security guard, receptionist or administration staff. Nor can they leave a person who is still in police custody in a secure room within a hospital if the hospital has not formally accepted care of that person.

A person examined at a hospital emergency department will no longer be in police custody when responsibility for that person is transferred to the care of a mental health clinician at the hospital. After transfer, the mental health clinician/hospital is responsible for the treatment and security of the person.

### 2.1.8. Threats

If an apprehended person threatens to hurt anyone it is expected a risk assessment will be carried out at the time to determine the appropriate safety measures to be taken and to assess whether to notify the person who has been threatened. Depending on the circumstances, the risk assessment will be conducted by police and/or mental health clinicians.

Apparent mental illness does not prevent the person being charged in relation to a threat.

Police and mental health clinicians should be aware of increased risk where family violence is evident or intervention orders exist. After a threat, the conditions of any existing intervention should be reviewed. If no intervention order exists consideration should be given to obtaining an order.

If police need advance notice of a patient's discharge from hospital due to safety concerns, a written request can be made to the hospital emergency department or mental health service provider (see part 5.3: 'Advance notice to police of patient discharge').

If a threat is made after custody of the person is transferred to a mental health clinician, they may advise the threatened person to seek police assistance. If the identity of the person threatened or their contact details are not known, the threat should be reported directly to police.

The disclosure of personal and health information must comply with the relevant legislation (see part 5: 'Disclosure of information').

### 2.1.9. Licence review

Risk mitigation may include a review of whether a person should hold a driver's, firearm or other licence. To suspend or cancel firearms licences, send a report to the Manager, Regulation Support Unit (03 9247 3217) at the Licensing and Regulation Division.

Police who suspend or cancel a licence should notify the patient's mental health clinician so their record can be updated.

### 2.1.10. Where an apprehended person escapes from police custody or absconds from hospital

If an apprehended person escapes or absconds before being formally released or before an Assessment Order is made for them, the police may apprehend that person again if section 351 criteria apply to them at the time.

If an apprehended person escapes or absconds after an Assessment Order is made for them, an authorised psychiatrist or their delegate may request the police apprehend the person under section 352 if they are 'absent without leave' (AWOL) from the service. This can only occur if the person is subject to an Inpatient Assessment Order.

## 2.2. People engaged in siege or high risk situations

Police are responsible for incident control and the safety of everyone at high-risk incidents such as a siege or hostage situation in the community.

Where section 351 is not engaged and it becomes apparent that a person has mental health issues, police should contact their local mental health triage for general clinical advice on communication and response strategies. Mental health clinicians may provide police with contact details for family and carers able to provide additional background information where permitted by legislation.

Police should keep the relevant mental health triage informed of the situation so they can monitor the need for onsite attendance, plan for the deployment of clinical staff or advise on changes in the person's behaviour. Police will only request a mental health clinician to attend if it is safe.

Mental health clinicians cannot act as negotiators.

If police seek mental health information about a person, in the absence of that person's consent a mental health service provider may only disclose mental health information to the police in compliance with the Act (see part 5: 'Disclosure of information').

For example, section 346(2) (e) may permit the disclosure of health information to police to reduce or prevent:

- a serious and imminent threat to the person's life, health, safety or welfare; or
- a serious threat to public health, safety or welfare.

Only health information necessary to achieve this purpose may be disclosed.

## 2.3. Offenders and suspects in police custody

Police are responsible for the health and safety of those in their custody. If a suspect or offender appears to have mental illness, reveals suicidal thoughts or tries to self-harm while in custody, police have a duty of care to ensure that person's safety and arrange appropriate care.

If appropriate assistance is provided and risk mitigation occurs, apparent mental illness or suicidal thoughts do not prevent police continuing the investigation.

A person is considered to be in police custody while they are:

- under arrest or apprehended;
- in the company of a police officer awaiting interview or being interviewed;
- being transported by Victoria Police or its delegate; or
- detained or remanded in a police gaol.

### 2.3.1. Police interviews

#### 2.3.1.1. Fitness for interview

If a person to be interviewed seems to be experiencing mental illness, has a physical condition that mirrors mental illness and/or is suicidal or self-harming, police should get clinical advice from a forensic medical officer (FMO) to determine that person's fitness for interview.

A FMO may attend to examine the person or provide telephone advice. The FMO will not undertake an assessment for treatment, advise police on the person's criminal responsibility or assess fitness for bail or remand hearings.

Police should not request a mental health clinician (including the person's treating clinician) to determine their fitness for interview.

If the person is a patient of a designated mental health service, with the person's consent the FMO may consult with their treating mental health clinician to form a view regarding the person's fitness for interview. In the absence of consent, a mental health service provider may only disclose health information to the FMO in compliance with the Act (see part 5: 'Disclosure of information').

If an FMO says the person is unfit for interview, the investigation and disposition of an offender may still continue without an interview.

If a person is to be remanded, their ongoing safety, assessment and treatment are the responsibility of the Custodial Health Service (see part 2.3.2: 'Detainees and prisoners in police gaols').

If there are still mental health concerns after the person's release from custody, police may apprehend them using section 351, if the criteria apply (see part 2.1: 'Apprehension by police under section 351').

#### 2.3.1.2. Independent third person

If police suspect a person to be interviewed has some kind of cognitive impairment that affects their ability to communicate and understand information, an independent third person (ITP) must be arranged to be present during the interview; likewise when a statement is being made by victims and witnesses. Police should not ask mental health clinicians (including the person's treating clinician) to perform this role. For more information, see the Victoria Police and Office of the Public Advocate ready reckoner titled *Responding to a person who may have a cognitive impairment.*

### 2.3.2. Detainees and prisoners in police gaols

Police must call the Custodial Health Advice Line (CHAL) for help to manage a person in custody who appears to be presenting with mental illness (including feeling suicidal) and where other medical assistance is required. CHAL can be contacted 24/7 on 1300 681 926.

CHAL is provided by the Victoria Police Custodial Health Service, a state-wide service for the health and risk management of persons in police custody and prisoners remanded in police gaols. The service supports frontline policing through the provision of medical, nursing and pharmaceutical services. They provide mental health and general medical assessments, advice on drug and alcohol issues, fitness for custody, medication queries and first aid (including emergencies). They do not undertake fitness for interview assessments.

## 2.4. People presenting to police with welfare concerns

Police routinely interact with people who need help with various health and welfare issues.

Where someone appears to have mental illness, police may get advice and assistance from MHaP or their local mental health triage if not in an area covered by MHaP. Where other welfare issues arise, police may use the Victoria Police e-Referral system (VPeR) to refer the person to specialist support services.

VPeR is not appropriate for people with apparent mental illness who are in crisis.

# 3. Mental health clinician requests for assistance from police

## 3.1. Welfare checks and missing persons

Where a mental health clinician has serious concerns about the welfare of a patient being treated in the community, and where the conduct of a welfare check on that person is a risk to the clinician or to others, the clinician may ask police to assist with a welfare check.

The purpose of engaging police is to locate the person and ensure that they are safe.

Before getting police to do a welfare check, there is an expectation that a mental health clinician has attempted to contact the person's family or carer.

It is expected that a clinician will be available to accompany police on a welfare check so they can assess the mental health needs of the person and make arrangements for them to receive appropriate services. Police are not clinicians and cannot undertake a mental health assessment. If a welfare check does not locate the person, the relevant mental health clinician remains responsible for determining what further action should be taken. This may include making further inquiries to try to locate the person or making a missing person report.

### 3.1.1. Urgent welfare requests

Clinicians may request urgent police assistance with a welfare check (see part 3.2 'Urgent requests for police attendance' for the urgent request criteria). Clinicians should call Police Communications directly on '000' (not the local police station) and provide relevant information about the urgency of the request.

### 3.1.2. Non-urgent welfare requests

Clinicians should contact the station nearest to where police attendance is required. Arrangements may be made for attendance through a Mental Health Liaison Officer, duty sergeant or senior member in charge at the time, as police often require notice to respond to these requests.

It is not appropriate for a clinician to fax a request directly to a police station without any preliminary discussion of the need for police involvement.

Police require the following information for a welfare check:

- the name, date of birth and address(es) of the patient;
- the type of premises;
- name and contact phone numbers of clinicians who will meet police at the address;
- the nature and urgency of the welfare concerns, giving as much notice as possible;
- details of the compulsory treatment orders applicable to the patient including expiry date;
- the circumstances when the patient was last seen;
- attempts made to contact the patient, family or carer;
- the known current risks/triggers for the patient;
- typical behaviours and communication strategies; and
- any known medical conditions.

### 3.1.3. Apprehension options

If a person located by a welfare check requires assessment or treatment, it may be necessary for police to apprehend them under section 351 or section 352 if they are subject to a compulsory treatment order and are absent without leave (see part 2.1: 'Apprehension by police under section 351' and part 3.4: 'Compulsory patients absent without leave').

If there are welfare concerns but the criteria for apprehension under section 351 or 352 do not apply, police may use their common law powers to enter premises if they believe it is necessary to help the person. In circumstances when police and/or mental health clinicians cannot make direct contact with the person, reasonable forced entry may be used to enter premises.

### 3.1.4. Community treatment orders

If a person subject to a Temporary Treatment Order or a Treatment Order in the community doesn't comply with treatment under their order, a police station should not be used as a venue for a mental health clinician to administer medication. If the person's treatment cannot take place in the community, the mental health clinician should consider varying the order to an inpatient order.

### 3.1.5. Missing person report

Police will accept a missing person report in relation to any patient (whether compulsory or not) if:

- their whereabouts are unknown; and
- genuine fears are held for their safety or welfare.

To make a report, mental health clinicians must complete a printed copy of the *Victoria Police Missing Persons' Report* (VP Form L18A), phone a local police station to initiate the report and then fax the form to the attending or nominated police officer for recording on LEAP.

The mental health service must notify police if they locate a missing patient. This will enable police to update their missing person records, end the active investigation and minimise the risk of a future unauthorised apprehension.

The mental health service must also update police on any change to the status of the patient. If the patient is no longer a compulsory patient, the police have no apprehension power under section 352 and will treat the patient as any other missing person.

If the missing person is a voluntary patient and there are no welfare concerns when they are located, police cannot compel them to return to the mental health service. Police can only notify the service that the patient has been located. Police cannot divulge the patient's whereabouts without their consent. Section 351 remains an option for missing persons located by police where section 351 criteria are satisfied.

### 3.1.6. Long term missing person

If a compulsory patient is not located within a reasonable time, the mental health clinician should again involve the patient's family/carer in discussions about further action to try to locate the person. For example, requesting consent to disclose relevant medical records to police or asking the family/carer to provide to police with DNA samples, such as a hair or toothbrush (see part 5: 'Disclosure of information').

## 3.2. Urgent requests for police attendance

In most circumstances, mental health clinicians will manage any challenging behaviours by persons requiring assessment or treatment. However, clinicians may request urgent police attendance where:

- there is a genuine and immediate risk of self-harm or injury to anyone;
- a person is causing significant damage to property;
- a person is committing or has just committed a criminal offence;
- a person is armed with a weapon;
- the clinician knows about or has experienced a person's recent history of violence and a police presence is considered necessary for the safety of those present; or
- the clinician believes that due to the location, time or nature of the situation, a police presence is necessary for safety.

Police will prioritise attendance as they do any other emergency call.

Clinicians should call Police Communications directly on '000' (not the local police station) and give relevant information, including details to assist police to identify the person (name, date of birth, address) and any other information to help police manage the incident and determine an appropriate response.

Police Communications will allocate the request to the relevant police unit or supervisor; give an estimated response time and advise on risk management strategies until police arrive.

### 3.2.1. Police attendance

Police should be briefed about the incident when they arrive. If the person is a compulsory patient, police must verify their patient status under the Act and the authority of the relevant clinical staff.

Police are responsible for decisions about managing and investigating the incident, according to their operational procedures.

Mental health clinicians are responsible for:

- ensuring compliance with the requirements of the Act;
- assisting police to return to other duties as soon as is reasonable;
- notifying the family and/or carers and keeping them informed of the patient's current health status (subject to liaison with police and the patient's consent); and
- arranging support and debriefing patients affected by the incident.

Once the incident is resolved, police should consider reviewing whether the person should hold a driver's, firearm or other licence (see part 2.1.9: 'Licence review').

When required, the most senior police member present and mental health clinician should arrange for staff directly involved in the incident to participate in a joint debriefing and forward a report to the relevant Emergency Services Liaison Committee.

### 3.2.2. Police involvement in bodily restraint of a patient

Only specified clinicians under Part 6 of the Act can authorise the bodily restraint of a person at a designated mental health service. The relevant clinician is also responsible for ensuring any bodily restraint is carried out in accordance with the Act.

Police assistance with bodily restraint (including restraint to administer treatment such as an injection) may only be requested in circumstances where there is a genuine and immediate risk of self-harm or injury to anyone.

When police assist with bodily restraint, the intervention remains the responsibility of the relevant clinician. Police should consider the directions of the clinician responsible for the restraint. However these directions must be balanced with operational safety principles to ensure the safety of police and those around them, including the patient. Ultimately, police are responsible for their operational decisions.

The use of handcuffs is a police decision and must be only for operational purposes. Police must submit a *Use of Force* form when using handcuffs.

### 3.2.3. Carriage of police operational equipment

Carrying police operational equipment is a police decision based on an operational risk assessment. However, health and mental health services prefer that police do not carry operational equipment (such as firearms, capsicum spray or foam) when attending hospitals, inpatient services and community mental health services. This is because of the perceived risk of injury associated with such equipment. Where police assess that there is no operational need to carry their equipment, they should store these appropriately in the police equipment safe available in most hospitals and inpatient facilities. If no safe loading unloading device facility is available, police must follow Operational Safety Tactics Training procedures for unloading firearms in an open area.

## 3.3. Reporting of criminal offences

Police encourage reporting of all crime, including threats. A victim may be a patient, mental health clinician or other staff members of a mental health service, emergency department or hospital.

When deciding to report an incident to police, consider:

- the nature and seriousness of the incident; and
- whether the victim or another person on their behalf intends to report the matter to police.

To get advice, clinicians should call their local police station and speak to the Mental Health Liaison Officer, duty sergeant or senior member in charge at the time. Police may offer options, such as making a formal report, referral (which may include counselling) and civil pathways. However, once a crime is reported the police will be responsible for the investigation and decision to prosecute.

Police will support victims of crime throughout the reporting process. Specialist police units can help clinicians and patients with more complex matters, such as family violence, sexual assault and child abuse.

## 3.4. Compulsory patients absent without leave

Police assistance can only be sought to apprehend a compulsory inpatient who is absent without leave (AWOL) from a designated mental health service under section 352 where a current risk assessment and knowledge of the patient indicates safety issues.

Police assistance can only be requested after reasonable steps have been taken to notify the nominated person, guardian, carer (if satisfied that the person's absence will directly affect the carer and the carer's relationship) or parent (if the patient is under the age of 16 years) to try to locate the person.

### 3.4.1. Requesting police to apprehend

A mental health clinician should directly notify local police by telephone and then fax a completed form MHA 124 *Apprehension of patient absent without leave* to police. When police receive the MHA 124, they will arrange for the patient's details to be entered into LEAP. Dependant on the local arrangements, mental health clinicians may also be required to fax a completed *Missing Person Report* (VP Form L 18A).

The completed MHA 124 must include the expiry date of the patient's order so police can verify that the patient is AWOL at the time of apprehension.

Police must be notified immediately if the patient's status changes under the Act. If the person is no longer a compulsory patient, police have no power of apprehension under section 352 and will treat them as any other missing person.

It is essential that the mental health service notify police if they locate the patient. This will enable police to update the LEAP records, end the active investigation and minimise the risk of a future unauthorised apprehension.

### 3.4.2. Planning the apprehension of an AWOL patient

A decision by police to apprehend a patient under section 352 should be informed by:

- a person check on LEAP;
- the MHA 124; and
- any other relevant factors.

The Act requires an apprehended person to be returned to a designated mental health service. Not all hospitals are designated mental health services. The preferred location for the return of the patient should be discussed with the mental health clinician requesting the apprehension.

### 3.4.3. Apprehending an AWOL patient under section 352

If the apprehension is planned, it is expected that a mental health clinician will be present to assess the patient's current mental health needs and make arrangements for the person to receive appropriate services. The police are responsible for the apprehension as well as the safety of everyone present.

If the apprehension under section 352 is not planned and a mental health clinician is not present, police will advise the relevant mental health triage when they have custody of the patient and their estimated time of arrival at the designated mental health service.

Whether the apprehension under section 352 is planned or not, police will document the circumstances of the person's apprehension in the *Mental Disorder Transfer* (VP Form L 42) and provide a copy to the clinician at the receiving designated mental health service.

Mental health clinicians and police should collaborate wherever possible to facilitate the least restrictive means of apprehension to minimise the risk of force being used. In certain circumstances police may use reasonable force to enter premises to return the patient to the designated mental health service. This may involve using bodily restraint and search powers to enable the patient's apprehension and safe transport (see part 2.1.4: 'Entering premises to apprehend' and part 4.3: 'Powers associated with transport').

### 3.4.4. After apprehension

Where possible, police will return the patient to their treating designated mental health service, provided it does not prolong the time the patient is in police custody (for example if the police locate the patient a considerable distance from their home). Otherwise, police should take the patient to the nearest designated mental health service. It is the responsibility of the patient's service of origin to locate an inpatient bed.

At handover, police should provide the *Mental Disorder Transfer* (VP Form L 42) and all other relevant information to the accepting clinical staff, including incident details, safety and risks (such as threats, family violence, firearms), drug and alcohol history, intervention orders, family court proceedings and family circumstances. Critical information not recorded on the VP Form L 42 should be recorded in the clinical notes. The disclosure of personal information by police must be with the consent of the person or be authorised by legislation (see part 5: 'Disclosure of information').

## 3.5. Apprehending interstate patients and others

### 3.5.1. Interstate patients

A compulsory patient who is AWOL from an interstate mental health facility may be apprehended in Victoria under section 326.

An interstate compulsory patient can be apprehended in Victoria if the patient:

- is AWOL from a state or territory with a cross-border agreement with Victoria under section 315; and
- could be apprehended under the law of the 'home' state or a warrant or other document has been issued in that state that authorises the person's apprehension – such as an interstate apprehension order.

Victoria currently has cross-border agreements with New South Wales, South Australia and the Australian Capital Territory. More information about Victoria's cross-border ministerial agreements is available on the department's website <http://www.health.vic.gov.au/mental-health/practice-and-service-quality/service-quality/working-across-service-boundaries>.

The home state will complete an Interstate Apprehension Order and nominate who will apprehend the person in Victoria. Only authorised persons in Victoria and those authorised by the law of the 'home state' may apprehend the person. The list of authorised persons includes police and ambulance paramedics (see part 7: 'Definitions').

In most cases, the interstate mental health facility will negotiate directly with a Victorian designated mental health service regarding the return of the interstate person, without the involvement of Victoria Police.

### 3.5.2. Process

Where the interstate mental health facility's risk assessment indicates a need for police involvement, the interstate facility will deal directly with Victoria Police. They should contact the Victoria Police Records Services Division on (03) 9247 5928 or (03) 9247 5957 and then fax the completed interstate apprehension order to (03) 9247 5968. Records Services Division operates 24/7. There is no requirement for police to lodge the documents at court.

Records Services Division will create and record a *Person Whereabouts Desired* (VP Form L12) and *Person Physical Description* (VP Form L10) report on LEAP.

Before apprehending the individual, police will:

- confirm with the interstate mental health facility or Records Services Division that there is current legal authority for the apprehension;
- confirm the person's identity; and
- tell the person why they are being apprehended.

After apprehension police will:

- notify the local mental health triage of the Victorian designated mental health service where the person is being taken and the ETA;
- arrange for the documents to be faxed to the receiving designated mental health service if it is impracticable to have a copy of the documents in their possession on arrival at the designated mental health service; and
- complete the *Execution Details* form and provide copies to both Records Services Division to update LEAP and the receiving designated mental health service.

Police will take the person to the Victorian designated mental health service closest to the place where they were apprehended. On arrival, police will transfer responsibility for the patient to a mental health clinician as soon as practicable. There is no requirement for police to retain custody of the patient pending an assessment or examination by the service.

An authorised psychiatrist of the receiving designated mental health service will ensure that:

- the interstate mental health facility and any other persons nominated to apprehend the patient are notified of the apprehension; and
- arrange timely return of the patient to their home state.

For information on responsibility for costs associated with the return of the patient to their home state (see part 4.4: 'Transport costs').

### 3.5.3. Persons on Non-Custodial Supervision Orders

Designated mental health services supervise people on Non-Custodial Supervision Orders (NCSO). NCSOs allow a person found not guilty of an offence due to mental impairment to reside in the community subject to reporting and treatment conditions (see section 26, *Crimes (Mental Impairment and Unfitness to the Tried) Act 1997*).

The designated mental health service supervising a person on a NCSO may request that the person be apprehended by police if they fail to comply with their order and their safety or that of the public will be seriously endangered unless they are apprehended.

The power to apprehend under the *Crimes (Mental Impairment and Unfitness to the Tried) Act 1997* cannot be used to apprehend a person subject to a Community Temporary Treatment Order or a Community Treatment Order under the Act. The power to apprehend under the Act cannot be used to apprehend a person subject to a NCSO.

Where a person is subject to both a NCSO and a compulsory treatment order under the Act, the treating clinician must decide which order to use to apprehend the person.

# 4. Transport

## 4.1. General principles

The following principles apply to the transport of people under the Act.

### 4.1.1. Least restrictive

Consistent with the objectives of the Act, transport to or from any location under the Act should be by the least restrictive means practical and in a way that provides for the care of the person with a mental illness and minimises interference with that person's human rights including their liberty, privacy and dignity.

'Least restrictive' means consideration by the mental health clinician of whether a person can be safely transported by family, friends, mental health staff using an agency vehicle or a non-emergency patient transport (NEPT) vehicle or ambulance.

### 4.1.2. Use of an ambulance

Part 4 of this protocol should be read in conjunction with the *Protocol for the transport of people with mental illness* (2014), which details arrangements for the ambulance transport of people with mental illness.

Ambulance Victoria is responsible for providing emergency transport for people with mental illness under the Act. An ambulance must be used to transport a person who has concurrent serious physical health needs.

An ambulance must also be used if the person requires sedation or restraint for safe transport unless an NEPT vehicle is available with an authorised person on board to monitor sedation or restraint under the Act. NEPT staff are not authorised persons under the Act.

## 4.2. Requesting police involvement in transport

Mental health clinicians can ask police to assist with the transport of people with apparent mental illness, when they pose a serious and imminent risk of harm to anyone. The clinician's decision to request police assistance should be based on a clinical risk assessment of the person's current and past behaviour. It should also be informed by awareness that involving police in transport may aggravate past trauma.

Clinicians may request police involvement in transport by calling Police Communications ('000').

If police and ambulance are both required, the mental health clinician should contact police and ambulance concurrently and arrange to meet at a common location. This might be at a different location to the person requiring transport. The arrival of police at the meeting point before ambulance should not result in a downgrade in the urgency of the ambulance response.

Police decide the extent of their involvement in transport, but cannot delegate responsibility for a person in their custody (for example responsibility for a person apprehended under section 351 cannot be given to ambulance paramedics).

Police involvement in transport may include:

- accompanying the person in another vehicle (for example an ambulance or NEPT vehicle);
- escorting another vehicle (for example an ambulance or NEPT vehicle); and
- as a last resort, transporting the person in a police vehicle.

Following the transfer of custody of the person to a mental health clinician at the destination, police are not responsible for providing transport to second mental health service if there is no bed available at the first destination. In those circumstances, the receiving mental health service is responsible for the person until an ambulance, NEPT or agency vehicle arrives to transport to the second destination.

However police involvement in the second transport may be requested due to the risk of harm as set out above.

### 4.2.1. Using a police vehicle

If based on clinical advice, police determine that transport in a police vehicle is necessary, they will:

- ensure at least two police are involved;
- ensure the person is under constant observation throughout the journey;
- avoid prone restraint (face down) to support the person's ability to breathe;
- use handcuffs only when necessary;
- never transport a person sedated under the Act or who has serious physical health needs;
- wherever possible, comply with local protocols and notify the nearest mental health triage or its equivalent of their ETA via Police Communications; and
- transport the person to the nearest hospital emergency department or designated mental health service.

Prone restraint should not be used. All restraints are high risk and prone restraint has been identified as a significant risk factor in deaths arising from positional asphyxia.

## 4.3. Powers associated with transport

### 4.3.1. Sedation and bodily restraint for safe transport

Section 350 authorises the use of sedation and bodily restraint for the purpose of safe transport. Sedation and bodily restraint may only be used for transport if:

- all reasonable and less restrictive options have been tried or considered and found to be unsuitable; and
- it is necessary to prevent serious and imminent harm to the person or others.

Sedation may only be administered by a registered medical practitioner or a registered nurse /ambulance paramedic directed by a registered medical practitioner. Ambulance paramedics and registered nurses may also administer sedation within the scope of their ordinary practice. The person administering the sedation must document its use and provide a handover to responsible clinical staff at the destination.

Police and other authorised persons are empowered to use bodily restraint for safe transport. If bodily restraint is necessary, it is preferable that police hand-cuffs are not used. The use of police issue handcuffs should therefore be a last resort and a police decision based on operational purposes. An authorised person who uses bodily restraint must document its use.

### 4.3.2. Searching persons

Section 354 empowers police and other authorised persons to search someone before they take them to or from a designated mental health service (or other location) if they reasonably suspect that person to be carrying something that:

- presents a danger to the health and safety of the person or others; or
- could be used to help that person escape.

Search means:

- quickly running hands over outer clothing;
- passing an electronic metal detection device over outer clothing,
- requiring the person to remove only their overcoat, coat, jacket or similar clothing and any gloves, shoes and hat and examining those items of clothing; or
- requiring the person to empty their pockets or allow their pockets to be searched.

Where the person is 16 years or under the search must be conducted in the presence of a parent or another adult (if it is not reasonably practicable for a parent to be present).

As far as practical, searches must be conducted by an authorised person of the same gender or someone of the same gender under the direction of an authorised person.

Trans and gender diverse or intersex people should be searched by a person of the gender with which the person to be searched identifies.

Whenever necessary, reasonable efforts should be made to locate a person of the appropriate gender to conduct the search.

The person conducting the search must:

- explain the purpose of the search;
- ask for the person’s cooperation and provide reasonable privacy;
- inform them whether they will be required to remove clothing and why it is necessary;
- conduct the search as quickly as possible; and
- conduct the least invasive kind of search possible.

Where a young person is admitted to hospital on the basis of the consent of their parent(s) or guardian, the cooperation of a parent or guardian and the young person should be sought before a search.

### 4.3.3. Seizing and detaining property

Section 356 allows police and other authorised persons to seize and detain property found as a result of a search, if they are satisfied the item:

- presents a danger to the health and safety of the person or others; or
- could be used to help the person escape.

If police are given illegal items (such as drugs or firearms) seized by other authorised persons during a search, they are to be handled according to Victoria Police policy and guidelines. Refer to section 356 for more information.

## 4.4. Transport costs

### 4.4.1. Transport within Victoria

#### 4.4.1.1. Using an ambulance

Where an ambulance is used to take a person to a designated mental health service under the Act, Ambulance Victoria bears the cost of the journey and there is no charge to Victoria Police or mental health services. However, where an ambulance is used for transport between hospitals, the sending hospital may be liable for the cost of the ambulance.

Information on responsibility for the payment of fees for inter-hospital and other journeys provided by ambulance or licenced NEPT providers, is available on the department's website <www.health.vic.gov.au/hospitals-and-health-services/patient-care/ambulance-and-nept/ambulance-payment/payment-responsibilities>.

#### 4.4.1.2. Using a police vehicle or escorts

There is no charge to mental health services for the use of a police vehicle or police escorts for transport under the Act.

### 4.4.2. Transport outside Victoria

If an interstate person is apprehended in Victoria under an Interstate Apprehension Order, the interstate mental health facility requesting the person's return is responsible for the cost of the person's transport home, unless otherwise agreed between the Victorian mental health service and the interstate mental health facility. Costs may include airfares and escort fees.

# 5. Disclosure of information

The consent of the person should be sought before any disclosure of their personal or health information.

If the person consents, then the disclosure is permitted to the extent agreed by the person. Mental health clinical staff and police should document the disclosure of information and the consent in the appropriate record.

Where a person cannot consent or refuses to consent, in specified circumstances legislation may allow information to be disclosed.

## 5.1. General principles

The decision to disclose information requires the following consideration:

- What is the purpose for disclosing the information?
  - Can the purpose be served by providing de-identified information?
  - What is the minimum information necessary to serve the purpose?
- Does the person consent to disclose their information?
- Without consent, is the disclosure authorised by law? If not, the information must not be disclosed.

A decision to disclose information that takes into account these factors and is made in good faith will be consistent with the Victorian *Charter of Human Rights and Responsibilities Act 2006*.

**Personal information** means information or opinion (including information or an opinion forming part of a database) about an individual whose identity is apparent or can reasonably be ascertained from the information or opinion, but does not include information to which the *Health Records Act 2001* applies.

Examples include the information police collect to perform their law enforcement or community functions, such as names, dates of birth, addresses, contact details, intervention orders and criminal histories.

**Health information** means personal information or opinion about:

- the physical, mental or psychological health (at any time) of an individual;
- a disability (at any time) of an individual;
- an individual's expressed wishes about the future provision of health services; or
- a health service that is provided to an individual.

Health information also includes other personal information collected when providing health services. For example information about a person's compulsory treatment order or the date they are due to be discharged from hospital.

## 5.2. Disclosure by mental health service providers

Section 346 of the Act is the principal law regulating the disclosure of health (including mental health) information to police. The *Health Records Act 2001* is the principal law governing the collection and use of health (including mental health) information by mental health service providers.

A mental health service provider who discloses information to police must document the disclosure on the client's clinical record, including the reasons for disclosure. When clinically appropriate, a clinician should communicate the disclosure to the person.

### 5.2.1. Disclosure with consent

Section 346(2) (a) permits the disclosure of health information with the consent of the person receiving services.

### 5.2.2. Disclosure without consent

Section 346 (2) allows mental health service providers (including staff, contractors, volunteers and board members) to disclose health information without the consent of the person in certain circumstances. The following subsections are most relevant to the disclosure of health information to police.

#### 5.2.2.1. Reduce or prevent a serious and imminent threat

Section 346(2) (e) of the Act allows a mental health service provider to disclose health information to police to reduce or prevent:

- a serious and imminent threat to a person's life, health, safety or welfare; or
- a serious threat to public health, safety or welfare.

The information must only be disclosed to someone who can act to prevent or lessen the threat, such as the police or Vic Roads. For example, where dangerous driving is threatened or has occurred. Only information necessary to achieve that purpose can be disclosed.

#### 5.2.2.2. Person is deceased, missing or suspected to be deceased or missing

Section 346(2) (e) of the Act allows a mental health service provider to disclose health information to police if the person:

- is suspected to be or is deceased;
- is suspected to be missing or is missing; or
- has been involved in an accident or other misadventure and is incapable of consenting to the disclosure.

The disclosure of information in these circumstances should only be to help identify the individual or locate family members for compassionate reasons.

If the individual is missing or has been involved in an accident or misadventure, the disclosure should not be against the expressed wishes of the individual before they disappeared or became incapable of consenting. However, if police know or suspect the individual is deceased, the wishes of the individual expressed before their disappearance should not prevent clinicians from disclosing health information.

#### 5.2.2.3. Required to carry out functions or exercise powers under an Act

Section 346(2) (c) of the Act allows a mental health service provider to disclose health information to police if the information is needed for the mental health service provider to carry out functions or exercise powers under the *Mental Health Act 2014* or any other Act.

For example, providing health information to police to enable them to return an AWOL patient.

#### 5.2.2.4. Permitted by other legislation

Section 346(2) (d) allows a mental health service provider to disclose health information to police if the disclosure of information is permitted by an Act other than the *Health Records Act 2001*.

For example, section 183 of the *Firearms Act 1996* states that a health professional, as defined, is immune from civil and criminal liability if they notify police that they believe a client who has a firearms licence or intends to apply for a licence is not a fit and proper person to possess, carry or use a firearm.

## 5.3. Advance notice to police of patient discharge

Police may request advance notice of the imminent release of a patient.

Discharge information is health information within the meaning of the Act, so advance notice to police requires the patient's consent. It is the responsibility of police to seek consent.

In the absence of consent, advance notice may only be given if the disclosure is allowed under section 346(2). For example:

- to reduce or prevent a serious and imminent threat to a person's life, health, safety or welfare;
- to question the person to determine their involvement in a criminal offence directly related to the person's current assessment or admission (permitted by section 464A(2) &(4)(i) *Crimes Act 1958*); or
- to execute a warrant of apprehension for a criminal offence.

The request for advance notice must be in writing to the person nominated by the emergency department or the Director of Clinical Services where the person is being assessed or receiving treatment. To avoid the person being surprised on discharge, police must ensure the person is informed of the request.

The request should include:

- the full name and date of birth of the person;
- whether the person has consented to the request;
- sufficient information about the basis for the request for example, the alleged serious and imminent threat, the alleged crime or the existence of an apprehension warrant, to enable the mental health clinician to determine if advance notice can be given; and
- the investigation officer's contact details and alternate contact details for a station supervisor or officer in charge.

The emergency department nominee or Director of Clinical Services must notify police of their decision. Both the request and decision must be added to the patient's hospital admission record as a priority.

The investigating police member or in their absence, the alternate officer must be given reasonable notice of the patient's discharge time. If police cannot be contacted at least six hours before discharge, as a last resort, the clinician should give notice to police by calling '000'. Details of the notification must be recorded in the clinical notes.

The police officer who made the request must complete a *Person Whereabouts Desired* form (VP Form L 12) and get it approved by a supervisor and recorded on LEAP. This enables other police to follow up if the requesting officer is unavailable.

## 5.4. Disclosure by police

Police may need to disclose information about a person to mental health clinicians, ambulance paramedics, family, carers and other persons who might be at risk.

Two laws govern the disclosure of information by police; the *Privacy and Data Protection Act 2014*, which covers personal information and the *Health Records Act 2001*, which covers health information.

### 5.4.1. Disclosure with consent

Both Acts allow police to disclose information with consent.

### 5.4.2. Disclosure without consent

Both Acts allow police to disclose information without the consent of the person in certain circumstances.

The following is most relevant to the disclosure of personal and health information to mental health clinicians.

#### 5.4.2.1. Reduce or prevent a serious and imminent threat

The privacy principles under both Acts allow police to disclose information to mental health clinicians to reduce or prevent:

- a serious and imminent threat to a person's life, health, safety or welfare; or
- a serious threat to public health, safety or welfare.

The information may only be disclosed to someone who can act to prevent or lessen the threat, for example, a mental health clinician. This is not a blanket exemption, police must base each decision to disclose on the specific circumstances of the situation. Only information necessary to achieve that purpose can be disclosed.

These criteria may permit the disclosure of information about threats, family violence and the existence of intervention orders, firearms, current family law proceedings or a history of violence.

## 5.5. Reportable deaths

### 5.5.1. Obligations of mental health service providers

The *Coroners Act 2008* requires mental health service providers to notify of a 'reportable death' and to provide information to police as part of the investigation into the death. Hospitals and designated mental health services must immediately report any death that occurs in care to police via Police Communications ('000').

All deaths of inpatients and persons who are compulsory, security or forensic patients or subject to a Non-Custodial Supervision Order must also be reported to the Chief Psychiatrist. The Chief Psychiatrist's guideline on *Reportable Deaths* is available on the department's website <www.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/reportable-deaths>.

If a death occurs on the premises of a metal health service, clinicians should not disturb the scene. They should help police with information on the client's history, circumstances before their death and interactions with any potential witnesses. The Director of Clinical Services at the designated mental health service is the key contact for police.

Section 103 of the *Coroners Act 2008* makes it an offence for any person to hinder or obstruct a Coroner or a person acting under a Coroner's authority (for example police) in exercising powers under this Act.

### 5.5.2. Police obligations

Police will investigate the circumstances surrounding a person's death and compile an inquest brief for the Coroner.

As part of their investigation, police may contact the mental health triage nearest to the deceased person's residence to determine if they were a mental health service client. If the person was a client, triage should refer police to the authorised psychiatrist or their delegate to get the required information. Under sections 39 and 40 of the *Coroners Act 2008*, a Coroner may authorise in writing a member of the police force to enter, inspect, copy and/or take possession of specified documents or items, including medical records, reports or opinions on behalf of the Coroner.

# 6. Governance and liaison

## 6.1. Emergency Services Liaison Committees

Emergency Services Liaison Committees (ESLCs) address local issues arising from emergency responses by mental health services, ambulance and police to improve service delivery to shared clients. ESLCs:

- develop, deliver and update local protocols for inter-agency service collaboration and coordination;
- address operational service issues, including the use of force, restraint and transport (ambulance and police);
- agree on joint case plans for shared consumers/patients, particularly those who present frequently and/or who have multiple and complex needs (case planning);
- arrange inter-agency training and information sessions to share knowledge and skills (including induction sessions and 'ride-alongs'); and
- inform the Relationship Governance Committee of ongoing or systemic issues requiring attention, local initiatives/achievements and any recommendations.

There are 21 local ESLCs with additional committees in sub-regional/rural areas.

## 6.2. Relationship Governance Committee

The Relationship Governance Committee (RGC) is co-chaired by the department and Victoria Police. The RGC identifies policy, systemic and operational issues at a state level for joint attention. It also promotes consistency and capability in delivering joint operational responses.

## 6.3. Dispute resolution

Disputes between mental health clinicians and police should be resolved as early as possible, in a way that ensures the rights of the person with mental illness are promoted.

When a dispute arises, staff should seek a resolution in accordance with their respective organisational policies and this protocol. The organisations involved should use all reasonable endeavours to resolve the dispute through negotiations and if necessary, mediation.

If the issues require more intervention to reach resolution, then staff should formally engage their ESLC. If the issue has policy implications, the ESLC should refer the matter to the RGC.

The Secretary, Department of Health and Human Services and the Chief Commissioner of Police must be informed about significant issues that may affect collaboration between mental health service providers and police.

# 7. Definitions

All section references refer to the *Mental Health Act 2014* (the Act), unless otherwise stated.

| | |
|---|---|
| **Area mental health service (AMHS)** | A geographic catchment in which triage, inpatient and community mental health services are delivered. Each AMHS includes a designated mental health service able to provide acute inpatient treatment. A list of adult AMHS catchments, including relevant local government areas, is available on the department's website <http://www.health.vic.gov.au/mentalhealthservices/>. |
| **Assessment Order** | Enables an authorised psychiatrist to examine a person to determine whether they have mental illness and require compulsory mental health treatment (section 28). Made by a registered medical practitioner or mental health practitioner. Assessment may be conducted in an inpatient setting or in the community. The making of an inpatient Assessment Order authorises the person to be taken to a designated mental health service for examination. |
| **Authorised person** | Is defined under the Act (section 3) as:<br>• a police officer;<br>• an ambulance paramedic;<br>• a registered medical practitioner employed or engaged by a designated mental health service;<br>• a mental health practitioner; or<br>• a member of a class of prescribed persons (none have been prescribed to date). |
| **Authorised psychiatrist** | A psychiatrist appointed as an 'authorised psychiatrist' for a designated mental health service by the governing body of that service (section 150). The authorised psychiatrist has specific powers, duties, functions and immunities under the Act. |
| **Bodily restraint – physical and mechanical** | A form of physical or mechanical restraint that prevents a person having free movement of his or her limbs, but does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's ability to get off the furniture (section 3).<br>Part 6 prescribes the use, authorisation and monitoring of bodily restraint in a designated mental health service.<br>Section 350 outlines the use of bodily restraint for the safe transport of a person under the Act. |
| **Chief Psychiatrist** | A psychiatrist appointed (section 119) by the Secretary, Department of Health and Human Services with responsibilities under the Act to provide clinical leadership and promote continuous improvement in the quality and safety of mental health services. |
| **Compulsory patient** | A person subject to an Assessment Order, Court Assessment Order, Temporary Treatment Order or a Treatment Order (section 3). |

| | |
|---|---|
| **Custodial Health Service** | The Victoria Police Custodial Health Service coordinates the welfare of persons in police custody and prisoners remanded in police gaols. The service does not assess fitness for interview. The service:<br>• provides on-call nursing care and assessment services for persons in custody;<br>• provides on-call medical care and assessment for persons in custody through a network of medical officers;<br>• provides medical opinions on fitness to be detained;<br>• advises on the management of people with mental illness or disability in custody;<br>• delivers prisoner health care training programs for police, at all levels; and<br>• promotes public awareness of prisoner health care. |
| **Department** | Department of Health and Human Services. |
| **Designated mental health service** | A hospital or public health service prescribed in schedule 1 of the *Mental Health Regulations 2014*. Forensicare is also a designated mental health service.<br>A list of designated mental health services is available on the department's website <www.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook/compulsory-treatment/designated-mental-health-services>. |
| **Emergency Services Liaison Committees** | Are local committees that address issues arising from emergency responses. Their membership includes representatives from Victoria Police, hospital emergency departments, designated mental health services and Ambulance Victoria . |
| **Forensicare** | The trading name for the Victorian Institute of Forensic Mental Health. Forensicare is a designated mental health service that provides secure inpatient services for forensic patients and security patients at the Thomas Embling Hospital. |
| **Forensic Medical Officer** | Is a police officer who is responsible for advice and assessment about whether a person in custody is fit for interview. Forensic Medical Officers are also responsible for the collection of medical evidence from victims and offenders and the presentation of expert evidence in court. |
| **Forensic patient** | A person found by a court to be unfit to stand trial or not guilty of an offence by reason of having a mental impairment (section 350). A mental impairment includes mental illness. |
| **Independent third person** | Maybe an adult, relative or friend of a person to be interviewed by police provided the person is not associated with the police inquiry. They may also be a volunteer trained by the Office of the Public Advocate. More information about independent third persons is available on the Public Advocate's website <http://www.publicadvocate.vic.gov.au/our-services/volunteer-programs>.<br>When police propose to interview a person they believe has a cognitive impairment, they must arrange for an independent third person to be present. The requirement for an independent third person applies whether the person to be interviewed is a witness, victim or suspect. |

| | |
|---|---|
| **LEAP** | The Law Enforcement Application Package (LEAP) is the primary Victoria Police computer system used by frontline members. It contains information on people who are witnesses, victims and offenders of crime and other incidents in which police are involved. |
| **Mental Health and Police (MHaP) response (formerly PACER)** | MHaP response teams combine a mental health practitioner and a police member who respond to a mental health crisis, rather than it escalating unnecessarily and involving an emergency department. The MHaP response is being progressively rolled out across Victoria. Contact the local mental health triage or police for more information.<br>Unless there are significant safety issues, there is no requirement for the police who first respond to remain at the scene after handing over care of a person with mental illness to MHaP. An individual MHaP member (practitioner or police) may request police remain at the scene if they have safety concerns. |
| **Mental health clinician** | Is not a defined term in the Act. For the purposes of the protocol, 'mental health clinician' is used to mean staff with professional qualifications and experience in working with people with mental illness. It includes mental health practitioners, nurses, registered medical practitioners and psychiatrists. |
| **Mental illness** | A medical condition that is characterised by a significant disturbance of thought, mood, perception or memory (section 4). Specific symptoms and signs will vary depending on the type of mental illness and the person's age. Police do not have to make a clinical judgement when exercising powers under the *Mental Health Act 2014*. |
| **Mental health liaison officers** | Are police members located across the state who:<br>• foster communication and collaboration with local mental health service providers;<br>• are aware of current mental health policy and procedures, local initiatives and protocols and referral agencies;<br>• support local members with mental health-specific advice, information and education;<br>• report issues and suggestions to the local Emergency Services Liaison Committees;<br>• develop and promote prevention, early intervention and other mental health response strategies;<br>• provide a first point of contact for members of the community on mental health-related issues; and<br>• promote mental health work at internal and external forums.<br>Contact the nearest police station to identify the local liaison officer. |
| **Mental health practitioner** | A registered nurse, registered psychologist, social worker or registered occupational therapist who is employed or engaged by a designated mental health service (section 3). |
| **Mental health service provider** | A designated mental health service or a publicly funded mental health community support service (section 3). |

| | |
|---|---|
| **Mental health triage (formerly known as Psychiatric triage service)** | A service provided by public mental health services 24 hours a day, seven days a week. Triage is a clinical function. The role of the triage clinician is to conduct a preliminary screening prior to a person being examined to assess the nature and urgency of the response required. Police may contact their nearest mental health triage to request advice on:<br>• communication and response strategies to assist with managing the person's presenting behaviours; and<br>• referral options.<br>Information about mental health triage is available on the department's website <http://www.health.vic.gov.au/mental-health/mental-health-services/support-and-intervention/acute-community-intervention-service>. |
| **Mental Health Tribunal** | An independent tribunal established under the Act (section 152). The tribunal makes compulsory treatment orders, hears applications for the revocation of orders, applications against transfers, applications for electroconvulsive treatment and neurosurgery for mental illness. The tribunal also periodically reviews the orders of security patients. |
| **Non-emergency patient transport** | Non-emergency patient transport (NEPT) includes high, medium and low acuity road and air transport provided under the *Non-Emergency Patient Transport Act 2003* and the regulations made under that Act. NEPT practice is guided by these clinical protocols published by the Department of Health and Human Services.<br>People receiving mental health services who are assessed as suitable and stable for transport may be transported by NEPT services regardless of their level of acuity. The legal basis for transport, will determine who is required to accompany the person.<br>NEPT staff are not authorised to use restraint or sedation. If restraint or sedation is required, the person being transported must be accompanied by and under the care of a person able to use restraint or administer sedation in accordance with the Act.<br>NEPT may be booked through Ambulance Victoria by calling 1300 366 313 or by contacting a licenced provider. |
| **PACER (Police and Clinician Emergency Response)** | Refer to the definition of MHaP in this glossary. |
| **Police stations** | A list of police stations and Police Service Areas is available on Victoria police website <http://www.police.vic.gov.au/content.asp?Document_ID=7 |
| **Psychiatric triage service** | Refer to Mental health triage. |
| **Registered medical practitioner** | A doctor registered under the Health Practitioner Regulation National Law to practice in the medical profession other than as a student. A psychiatrist is a registered medical practitioner. |
| **Seclusion** | The sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave |

| | |
|---|---|
| | (section 3).<br>The use, authorisation and monitoring of seclusion for persons receiving mental health services in a designated mental health service is prescribed by Part 6 of the Act. |
| **Temporary Treatment Order** | Enables a person to be compulsorily:<br>• treated in the community; or<br>• taken to, detained and treated in a designated mental health service (section 45).<br>An authorised psychiatrist may make a TTO for a person if they are satisfied that the criteria in section 5 apply to the person.<br>The maximum duration of a TTO is 28 days. |
| **Treatment Order** | Enables the person to be compulsorily:<br>• treated in the community; or<br>• taken to, detained and treated in a designated mental health service (section 52).<br>The Mental Health Tribunal may only make a TO for a person if they are satisfied that all of the treatment criteria apply to the person. These are the same as the criteria for making a TTO (section 5).<br>The maximum duration of a TO for a person under 18 years of age is three months. For a person 18 years or older the maximum duration of a Community Treatment Order is 12 months and for an Inpatient Treatment Order is six months. |
| **Triage** | Refer to Mental health triage. |
| **Victoria Police e Referral system (VPeR)** | Victoria Police IT referral system. It provides referrals for individuals in need of non-crisis, non-family violence assistance to appropriate support services. VPeR mental health referrals require the consent of the person referred. Police provide the person's contact details to the relevant agency through VPeR and the agency will attempt to make contact with the person to provide advice or support. |
| **Voluntary patient** | A person who is not subject to a compulsory treatment order under the Act but who voluntarily receives mental health treatment. |

Royal Commission into
Victoria's Mental Health System

# ATTACHMENT GW -2

This is the attachment marked 'GW-2' referred to in the witness statement of Glenn Weir dated "5 July 2019" .

VICTORIA POLICE

VICTORIA POLICE

# Mental Health Strategy and Wellbeing Action Plan 2017–2020

# Foreword

I am very pleased to launch the *Victoria Police Mental Health Strategy and Wellbeing Action Plan 2017-2020*.

This Strategy establishes a comprehensive framework for promoting and protecting the mental health of employees across Victoria Police. A career in policing is extremely rewarding but, as with all first responder work, it is a challenging and highly demanding environment.

The Strategy complements the outcomes of the independent Mental Health Review, published in 2016, that helped us better understand mental health issues in Victoria Police. Our people are confronted with distressing and complex circumstances on a daily basis – and we know that this can take a heavy toll on our wellbeing.

One of the most important things we have learned is that the stigma associated with mental health issues can hold people back from asking for help. We know that early help-seeking can be a very effective intervention in responding to mental health issues.

Most importantly, the Strategy will make sure that we support our employees across the full lifecycle of their careers with Victoria Police and into post-employment.

I encourage everyone to reach out for help if you feel you're not coping.

**Graham Ashton AM**
**Chief Commissioner**

# Contents



# About the Strategy

The *Victoria Police Mental Health Strategy and Wellbeing Action Plan 2017-2020* (Strategy) reflects Victoria Police's commitment to promoting and protecting the mental health of employees.

*The Strategy* presents background information, an organisational vision, strategic objectives, a Mental Health and Wellbeing model, and an Action Plan. It identifies how we will measure success to enable us to assess, continually refine, and improve our approach.

*The Strategy* serves as a road map to a future state in which Victoria Police continues to support the mental health of employees who work as policing first responders or support delivery of policing services. A diagrammatic representation of the framework for *The Strategy* is also presented.

The Mental Health and Wellbeing model presented in this *Strategy* recognises the unique nature of policing, and that the needs of an employee may change. It provides direction, and ensures continuity in improving the mental health and wellbeing of employees across the lifecycle of their careers and beyond.

*The Strategy* is a key component of our work to expand our suite of occupational health and safety practices and initiatives. An overview of existing wellbeing support services is presented in **Appendix 1**.

*The Strategy* forms a component of Victoria Police's Zero Harm Health and Safety Vision, which looks to every Victoria Police employee to be personally committed to the health and safety of themselves, their fellow employees and the community in which they serve.

*The Strategy* also complements the outcomes from the *Mental Health Review (Review)* that assisted Victoria Police to better understand the effectiveness of current approaches to supporting the mental health needs of our employees.

Importantly, it is underpinned by the *Victoria Police Capability Plan 2016-2025* that is guiding long term, staged and planned capability growth for the organisation. Specifically the commitments in the *Strategy* are in alignment with the 'Enabling Capabilities' in the People Management category. These include Leadership, Workforce Planning, Occupational Health and Safety, Training/Professional Development, People Performance Management and Employee relations. Through a contribution to the maturation of these capabilities, as aligned to the Blue Paper Transformation Pathway of Safety, the *Strategy* will help develop an organisation that is safer, professional and more agile for Victoria Police employees and the wider community they serve.

# What is mental health?

According to the World Health Organisation (WHO), mental health is *"a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".*[1]

Work undertaken as part of the *Review* and development of *The Strategy* has informed understanding about a Mentally Healthy Workplace for Victoria Police.

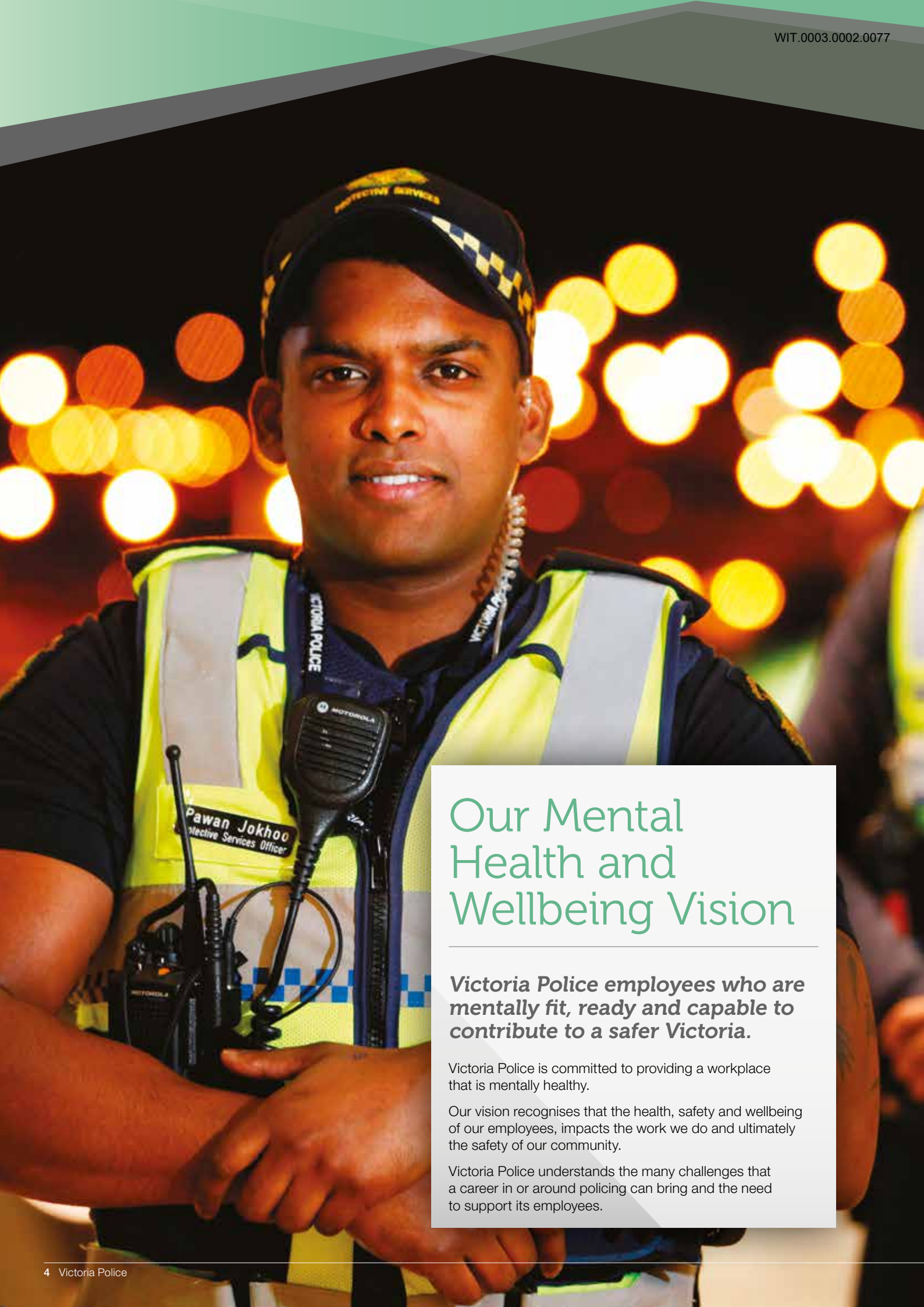
## A mentally healthy Victoria Police workplace:

- Promotes mental health and wellbeing through supportive leadership.
- Promotes ongoing psychological wellbeing.
- Encourages a shared responsibility for mental health.
- Proactively addresses psychological risk.
- Reduces stigma and supports strong mental health literacy.
- Promotes creativity and productivity.
- Encourages pro-social behaviour.
- Develops positive relationships.
- Promotes increased physical health.

[1] World Health Organisation. Mental health: a state of well-being (Updated August 2014)

## A mentally healthy workplace requires a focus on:

- Building resilience.
- Reducing risks by building workplace protective factors.
- Encouraging and supporting early help-seeking behaviour.
- Ensuring multiple pathways to access help.
- Enhancing recovery when impacts do occur.




# Our Mental Health and Wellbeing Vision

***Victoria Police employees who are mentally fit, ready and capable to contribute to a safer Victoria.***

Victoria Police is committed to providing a workplace that is mentally healthy.

Our vision recognises that the health, safety and wellbeing of our employees, impacts the work we do and ultimately the safety of our community.

Victoria Police understands the many challenges that a career in or around policing can bring and the need to support its employees.

# Why is mental health important?

Policing is rewarding but can also be a challenging career. Constantly evolving expectations from the community, the nature of policing, and continuously striving to respond to changing crime patterns, has seen increased demands on organisational adaptability and our employees.

Many of our employees face situations that the majority of the community do not see, and this exposure can result in varying degrees of psychological impact. For some, these effects persist well after their career with Victoria Police has ended.

Mental health matters.

Victoria Police has long been committed to the overall health and safety of its employees. The focus on psychological safety, health and the way we support mental health and wellbeing has not always been as visible or as well communicated as physical and operational safety.

## What do we know?

Emergency service employees face a complex range of mental health risks[2]. In addition to a range of internal and external drivers (refer to framework page 9), the *Review* commissioned by Victoria Police sought to critically examine the current psychological risks and needs of our organisation and our employees. It also reported on how we can best deliver mental health and wellbeing services to support people throughout their careers and into their post-employment life.

The *Review* found that Victoria Police faces increasing risks to occupational health and safety due to an evolving policing environment, workplace conflict, and higher levels of recurrent exposure to traumatic events compared with other industry sectors. Therefore, it is likely that mental health related issues in Victoria Police are more common than available information suggests.

Contributing factors to mental health, whether they are personal, workplace or operational, interact in complex ways to cause varying degrees of impact. Stigma, low rates of help-seeking, and access to a variety of supports outside the organisation means it is difficult to obtain an accurate profile of the psychological needs of our employees.

With improved awareness of mental health, the implementation of the current *Strategy* and reduction of stigma, help-seeking and reporting of mental health is likely to increase, at least in the immediate term.

We welcome this increase as it provides us with the information we need to better prevent injury, build resilience, provide support and enhance recovery where impacts do occur.

Given the importance of mental health in an employee's overall health, safety and wellbeing, as well as their operational capacity and capability, it is essential that Victoria Police employees feel safe to speak up when they do need help and know that help will be available.

This *Strategy* sets out our commitment to supporting the mental health of our employees.

### Mental health at Victoria Police:

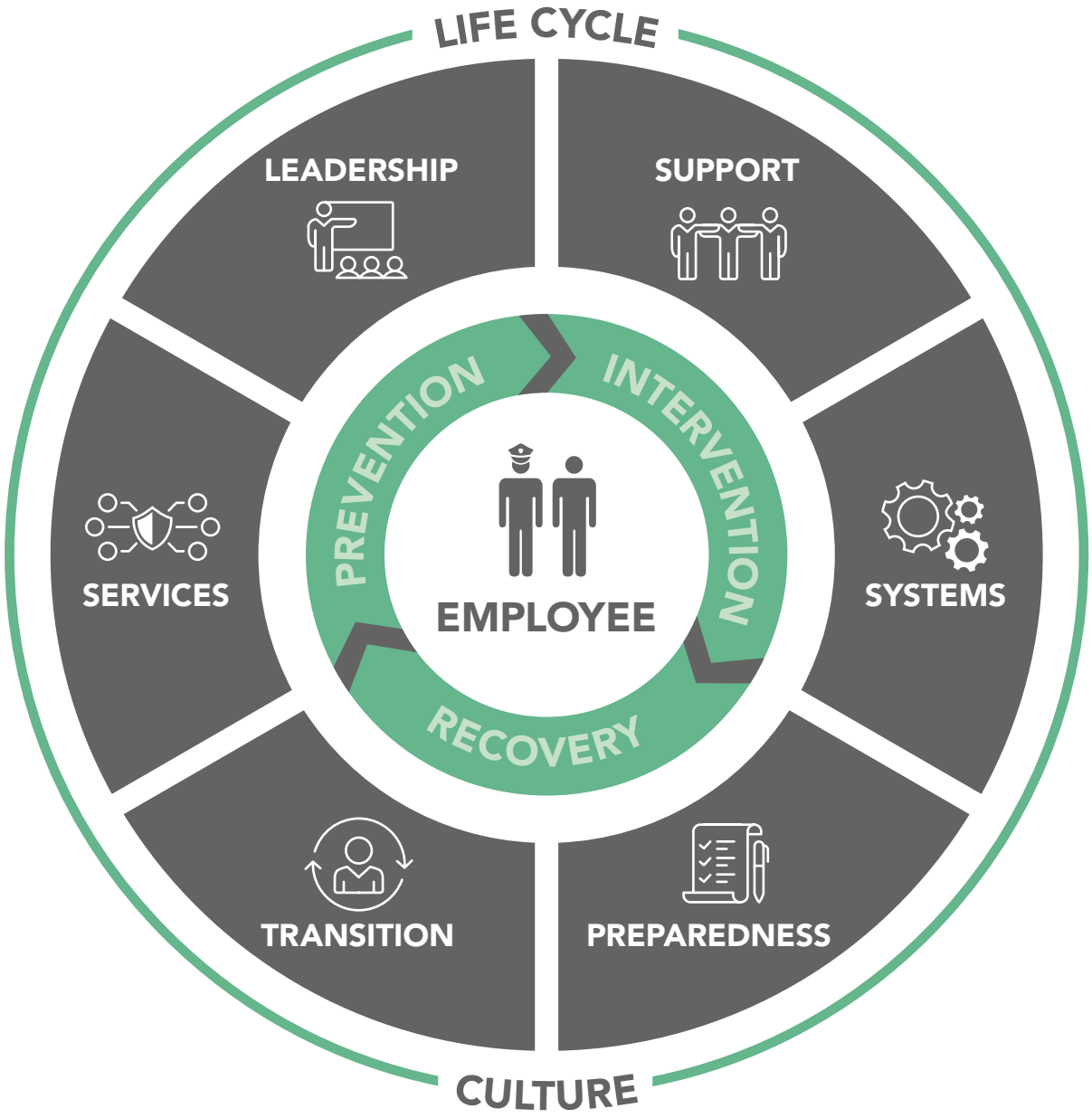
- On average employees who have a psychological injury claim are away from the workplace for 103.23 shifts.
- Mental health related injuries make up 28% of WorkCover claims yet account for 70% of total claim costs.
- Our rate of returning people with psychological injury to work is 64%, while for physical injury it is 93%.
- 46% of counselling referrals indicate a work related matter as the primary reason, which includes exposure to trauma.
- The remaining 54% present with 'personal' issues, of which 14% are classified as mental health related conditions or concerns, such as anxiety, depression, and personal stress.

(Source: GB Monthly Report for claims up to April 2017; Data from the Police Psychology Unit (PPU) and our Employee Assistance Provider, Davidson Trahaire Corpsych.)

[2] beyondblue. Good practice framework for mental health and wellbeing in first responder organisations (2016)

# The Victoria Police Mental Health and Wellbeing Model

Our Mental Health and Wellbeing Model is the basis for achieving our Vision. We place the employee and their health, safety and wellbeing at the centre. We recognise that the needs of our employees change throughout their careers and beyond. As a result, we take a life cycle approach to employee mental health and wellbeing. We define the life cycle stages as including pre-employment and recruitment, career and work life, transition to exit, and post-exit.



The model also acknowledges the different stages in responding to mental health problems and includes a three tier approach to meeting the needs of our employees, namely prevention, intervention and recovery. These foundations allow us to ensure that at every opportunity, career stage, and transition point, we are focused on prevention and early intervention as much as response. Furthermore, we aim to use a strength-based approach to build skills and personal strengths, while reducing risks to mental health and wellbeing. This should take place at the individual, as well as the organisational level.

## Prevention – Be aware, then prepare

**This means being aware** – aware of the risks in the work environment, and putting in place initiatives that will reduce the risks of mental health injury. It also means developing and strengthening the skills and capability of our people to prepare and equip them to undertake their roles.

This includes effective selection strategies, increasing mental health literacy, engaging families, building leadership skills, enhancing resilience and coping abilities, developing confidence in operational skills, developing more streamlined and integrated work systems, and developing a robust suicide prevention framework.

## Intervention – Spot the signs and act

**This means being ready** – that at the earliest signs and stages, we are ready to provide effective and accessible early intervention to employees and their workplaces. This includes increasing awareness, encouraging people to speak up, supporting help-seeking behaviour, educating managers and improving all aspects of mental health services.

## Recovery – Respond, recover and grow

**This means being responsive** – maintaining a person-centred approach to provide the right care at the right time that meets the employees' needs. Response and intervention should support employees to not only recover, but to reclaim their mental health and wellbeing, grow, and be able to participate in a fulfilling life and career. This includes accountability for return to work programs, flexible employment options, and a culture that upholds the role of family and support networks in the recovery process.

The Victoria Police Mental Health and Wellbeing Model is underpinned by six (6) strategic objectives Leadership, Preparedness, Support, Systems, Services and Transition.

These objectives are further defined in the framework (page 9).

### Mentally healthy workplace definition (beyondblue):

"A mentally healthy workplace is one that actively minimises risks to mental health, promotes positive mental health and wellbeing, is free of stigma and discrimination, and supports the recovery of workers with mental health conditions, for the benefit of the individual, organisation and community."[3]

[3] beyondblue. Good practice framework for mental health and wellbeing in first responder organisations (2016)

# Framework for the *Mental Health and Wellbeing Strategy*

## What

**Our Mental Health and Wellbeing Vision**

Victoria Police employees who are mentally fit, ready and capable to contribute to a safer Victoria.

## Why

The Victoria Police *Zero Harm* strategy, *Health, Safety and Wellbeing Strategy* and the *Mental Health Review*, along with high profile media support for mental health have supported the development of *The Strategy* and Action plans. The increasing number of employees presenting with mental health issues, claim costs and the need for a responsive and resilient workforce, make this a priority for Victoria Police and its employees.

### Internal Drivers

- *Zero Harm* strategy and program of works.
- Victoria Police *Mental Health Review.*
- Victoria Police Worker's Compensation Premium.
- *Victorian Equal Opportunity and Human Rights Commission Report.*
- Increased demand for psychological services.
- Victoria Police Corporate Advisory Group.
- safe-t-net Early Invervention Wellbeing System.

### External Drivers

- Victorian Government/Whole of Victorian Government *Mental Health and Wellbeing Charter.*
- Community Expectations.
- Family.
- The Police Association Victoria.
- Community and Public Sector Union.
- *Community Safety Statement 2017.*
- Victorian Occupational Health and Safety Legislation.

## How

The strategic objectives that underpin the *Mental Health and Wellbeing Strategy and Action Plan 2017-2020* will guide the actions and initiatives across the complete employee life cycle from prevention, to intervention, and to recovery.

### Leadership

Building confidence, capability and accountability at all leadership levels across the organisation to support a culture of mental health.

### Support

Building a culture that supports safe workplaces where all employees can recognise, reach out and respond to the mental health needs of themselves and their colleagues without stigma.

### Preparedness

Preparing our employees and their families to meet and manage the psychological demands of their roles.

### Systems

Provide work environments and systems that reduce risks to mental health, including suicide.

### Services

Provide timely access to quality assessment, support and evidence-based professional care and intervention.

### Transition

Support our employees and their families through the career life cycle and transition, and provide continuity of care for mental health and wellbeing post-employment.

# How will we achieve better mental health in Victoria Police?

An emphasis on people-focused leadership is essential to ensure managers have the skills required to assist and support employees experiencing difficulties in the workplace. This includes recognising that performance discussions are multi-faceted and include wellbeing.

There needs to be an ongoing focus and continued intervention provided for employees (for example, critical incidents, and cumulative exposure to events), to ensure that they receive access to the right support at the right time.

The *Review* highlights the need to be explicit and visible in the way that we discuss and support mental health and to ensure all employees know, now more than ever, mental health matters.

The audience for this work are all of our current and former employees, particularly those who may experience a mental health condition.

Our initiatives are for those who seek help for their difficulties, and importantly, for those who have not yet put their hand up for assistance. Our initiatives via the use of online resources will provide material for the families, friends and support networks of our employees.

*The Strategy* serves as a roadmap for how to address the main issues that impact mental health and wellbeing in our organisation. It will also provide a direction for how to psychologically support our employees and families across the life cycle of their careers with Victoria Police, now and into the future.

*The Action Plan* describes how we will enact each objective, how we will measure the success of the actions and which part of the organisation will work towards achieving this.

### What we know about our mental health injuries

- 44% increase in shifts lost against mental health injuries.
- 31% of all WorkCover claims are mental health injuries.
- 78.58% of the total claim cost are for mental health injuries.
- Lost Time Injury Frequency Rate (LTIFR) is 6.76 for mental health injuries.

All figures are for the 12 months ended April 2017

# Our Priorities

The Victoria Police *Mental Health and Wellbeing Strategy and Action Plan 2017-2020* builds on the work of the *Review* by highlighting the critical areas of focus for the next four years.

The 39 recommendations of the *Review* are configured into a Program of Works, which will be implemented during the life of *The Strategy*. The Human Resource Department has been given the responsibility to deliver the below objectives however, the organisation as a whole has an obligation to ensure all the actions listed are implemented and achieved. The priority areas include:

- Leadership Culture Change Program
- Mental Health Literacy
- Mental Health and Wellbeing Services
- Employee Lifecycle Initiatives

In order to gain additional and accurate data, a prevalence study will be commissioned on the mental health and suicide risk profile of the organisation.

By understanding the factors that prevent, protect and promote mental health, and with early intervention, we can minimise the incidence of mental health conditions and their effects when they do occur.

### The importance of a Leadership Culture Change Program

Police leadership has typically had its origins in operational incident management, which has carried over into the non-operational work environment. Command and control models of leadership used outside of an operational incident setting can have negative impacts such as reduced morale and engagement.

People-focused leadership positively impacts employees through building supportive and engaged team-based structures and practices. Psychologically healthy environments are associated with improvements in wellbeing and reductions in mental health and risk of psychological injury.

# Mental Health and Wellbeing Action Plan

Victoria Police is committed to providing a mentally healthy workplace. Our Vision recognises that the health, safety and wellbeing of our employees, impacts the work we do and ultimately the safety of our community. Victoria Police understands the many challenges that a career in or around policing can bring and the need to support its employees.

## Objective: 1 – Leadership

**What we know:** The gap in people-focused leadership skills regarding the management of mental health has resulted in the development of more targeted programs such as, Healthy Minds @ Work (HM@W) for Managers, ASSIST, Manager Assist, and Resilience for leaders and teams.

People-focused leadership needs to be part of a broader leadership framework that is embedded across the organisation. This will significantly contribute to the prevention of mental health issues arising, as employees will feel more supported and valued in their role.

| What we're doing | Baseline | Indicators | Outcomes |
|---|---|---|---|
| We will increase our People Leadership Capability by:<br>People Leadership Uplift Program from level 1 and 2 Leaders;<br>The re-organisation and update of all leadership programs; and<br>The development of a people focused leadership framework across the whole of organisation. | Feedback on existing programs such as HM@W, ASSIST, etc.<br>Climate/Pulse survey. | • Leadership program participation.<br>• Feedback via People Matters Survey, Climate Survey and Pulse Surveys.<br>• Individual leadership performance measures. | Increased understanding and decreased stigma attached to mental health across all levels of the organisation in a psychologically healthy and positive workplace environment.<br>Mental health and wellbeing as a workplace priority.<br>Increased people-related accountabilities for leaders. |

## Objective: 2 – Preparedness

**What we know:** There has been a long-standing focus on physical preparation, but psychological preparation needs to be given more attention during recruit training, and continuing throughout the life cycle, as career and life needs change.

Public service employees have often not been provided strategies to prepare for their roles, or what they are exposed to whilst working alongside sworn officers.

Families have not been fully included despite the important role they play as a support network. In addition to including them as a support mechanism, they also need to be prepared and made aware of the requirements of the job their loved one is undertaking.

| What we're doing | Baseline | Indicators | Outcomes |
|---|---|---|---|
| We will enhance individual and family preparedness and response by:<br>The development of a mental health literacy plan across the employment life cycle, and involvement from families in these programs;<br>Allocation of sufficient resources to specialist psychology units;<br>The development of a model for various wellbeing monitoring options; and<br>The development of an online mental health intranet to support individuals and families to access quality psychological information. | New initiative – baseline to be determined.<br>Rates of completion of self-care plans.<br>Prevalence study will contribute to baseline data. | • Feedback from employees and their families.<br>• Completion of preparedness training and self-care plans during recruit training. | Increased mental health literacy and resilience.<br>Increased individual skills and workplace strategies to manage emerging risks to mental health.<br>Employees who feel prepared, confident and mentally fit to undertake their roles.<br>An increase in the number and quality of supportive workplace conversations and improved help-seeking behaviour around operational incidents.<br>Increased family engagement to increase and strengthen support networks.<br>Reduced psychological injury. |

**Acronyms:** Police Psychology Unit (PPU); Mental Health Program Office (MHPO); Professional Standards Command (PSC); Performance & Development Unit (PDU); People Development Command (PDC); Independent Broad-based Anti-corruption Commission (IBAC); Health Safety and Deployment (HSD); Medical Advisory Unit (MAU); Sexual Offences and Child Abuse Investigation Team (SOCIT).

# Mental Health and Wellbeing Action Plan (continued)

## Objective: 3 – Support

**What we know:** Entrenched stigma is a barrier to help-seeking, therefore people are still reluctant to seek help.

There are low levels of mental health literacy.

Support and awareness has to occur at all levels for people to be able to recognise the signs and feel safe enough to reach out for support.

The range of support services is effective at providing support and intervention when activated.

Many employees, as well as their families, are unaware of how and where to get help when they need it.

| What we're doing | Baseline | Indicators | Outcomes |
|---|---|---|---|
| We will increase mental health literacy across the organisation to reduce stigma or discrimination by:<br>Undertaking an environmental scan to determine best practice;<br>Development of an organisational wide mental health literacy program;<br>Revision and enhancement of existing mental health program content;<br>Resilience training included in recruit curriculum; and<br>Inclusion of suicide prevention initiatives as part of the mental health literacy program. | Wellbeing services and Employee Assistance Program (EAP) data.<br>WorkCover data (Time lost, injury rates and Return to Work (RTW) rates).<br>Prevalence study will contribute to baseline data.<br>Climate/Pulse survey. | • Feedback via People Matters survey, Pulse Surveys and Mental Health Prevalence Survey.<br>• Monitor Wellbeing services and EAP data.<br>• Reductions in time lost and injury rates, coupled with improvements in return to work rates. | Normalising common mental health conditions and the stigma associated, thus increasing help-seeking behaviour.<br>To improve early identification of suicide risk and prevent suicide.<br>High levels of mental health literacy through improved awareness.<br>Workplace culture where help-seeking is validated and supported without discrimination.<br>Work options for those who may be experiencing mental health issues.<br>A comprehensive and consistent internal approach to mental health, aligned to evidence-based and best practice guidelines and recommendations. |
| We will continue to support employees across the organisation with particular focus on those who have experienced potentially traumatic events, disciplinary action or who are routinely exposed to explicit materials, by:<br>Continuing to promote and provide psychological services across the organisation;<br>Development of specific programs to support specialist areas such as SOCIT, and individuals going through disciplinary processes; and<br>Continuation of the trauma therapy group. | | | |
| We will support employees returning to work who have been deployed by military or emergencies services (i.e. ADF) where there is a potential for exposure to traumatic events by:<br>Development of an organisational wide policy to support the return of employees upon completion of their duties/response. | | | |
| We will increase involvement with the CPSU and TPAV by:<br>Mental Health Strategy development and endorsement by CPSU and TPAV; and<br>Identification of project involvement and collaboration opportunities with Union partners. | | | |

## Objective: 4 – Systems

**What we know:** Organisational factors (including systems and structures), play a significant role in employee health and wellbeing.

Some organisational systems can have significant negative impact on mental health and wellbeing.

Our employees frequently report that organisational factors have more of a negative impact than operational events, which they feel better equipped to deal with.

Many of our employees that have presented with significant mental health risks have been involved in, and impacted by, organisational systems and processes that have an additional negative impact.

| What we're doing | Baseline | Indicators | Outcomes |
|---|---|---|---|
| We will provide integrated and co-ordinated functions to support mental health by:<br>Implementation of electronic Case Management System and co-location of MAU and PPU. | RTW rates.<br>New initiative – baseline to be determined.<br>Climate/Pulse survey. | • User experience feedback.<br>• Reductions in injury data.<br>• Improvements in return to work rates.<br>• Faster resolution of issues. | A reduction in risk to mental health and reduced psychological injury.<br>Improvements in access to support and care.<br>Clear accountability for people outcomes and consideration of systemic risks to psychological health.<br>Proactive management of risks.<br>Enhanced mental health service delivery.<br>Integrated and co-ordinated functions. |
| We will determine mental health risks and mitigation strategies in our existing organisational processes and systems (i.e. Professional and Development Assessments (PDA)), and we will provide tools and support for line managers to have quality conversations with employees about mental health and wellbeing by:<br>Review of policies and the PDA process with the introduction of mentally healthy approaches; and<br>Core mandatory mental health literacy components embedded into recruit training at all levels of leadership programs. This will include content tailored specifically for managers. | | | |
| We will develop clear accountabilities for mental health by:<br>Aligning PDA process to support organisational safety value and associated behaviours. | | | |
| We will recognise the importance of psychological health through Victoria Police Values and Expected Behaviours and Honours and Awards by:<br>Revision of Values and Expected Behaviours and organisational wide honours and awards system to recognise the importance of psychological safety. | | | |

**Acronyms:** Police Psychology Unit (PPU); Mental Health Program Office (MHPO); Professional Standards Command (PSC); Performance & Development Unit (PDU); People Development Command (PDC); Independent Broad-based Anti-corruption Commission (IBAC); Health Safety and Deployment (HSD); Medical Advisory Unit (MAU); Sexual Offences and Child Abuse Investigation Team (SOCIT).

# Mental Health and Wellbeing Action Plan (continued)

## Objective: 5 – Services

**What we know:** Stigma and poor help-seeking mean that employees at times do not get the care they need.

Some employees are reluctant to seek help from Victoria Police internal services.

Existing services have not been adequately staffed to meet the increasing demand across the organisation.

There is a need for more specialised care for certain mental health conditions.

In some cases, service gaps in regional areas have resulted in employees not having access to care in a timely manner.

There is a need to access services for early assessment and diagnosis.

| What we're doing | Baseline | Indicators | Outcomes |
|---|---|---|---|
| We will enhance internal service functions by:<br>Recruitment and realignment of additional mental health professionals into a coordinated and integrated service;<br>The establishment of an external network of specialist mental health providers; and<br>Provision of supervision for mental health workers in the organisation. | Wellbeing services and EAP data.<br>Prevalence study will contribute to baseline data.<br>safe-t-net data.<br>Climate/Pulse survey. | • Increase in resources that provide services to our employees.<br>• Reduction in case numbers and an increase in case resolution and client satisfaction and feedback.<br>• Prevalence study data.<br>• Reducing timeframes in accessing treatment.<br>• Improved return to work rates.<br>• Increased uptake of training and education. | Services that are able to meet organisational demand.<br>Improved integration of services to support individual employee needs.<br>Provision of high-quality, integrated services that employees feel able to access, free from stigma or uncertainty.<br>Readily available quality mental health services in rural and remote locations.<br>Flexible treatment models and options that are responsive to individual needs.<br>Professional and peer supervision for employees working within the support services to reduce mental health risks and ensure they can continue to provide high quality care to employees. |
| We will provide an integrated physical and mental health Fitness for Duty approach by:<br>Review of existing psychological fitness for duty process and development of process more aligned with organisational needs. | | | |
| We will provide professional mental health support in all locations by:<br>Implementation of a state-wide mental health specialist provider network; and<br>Implementation of E-treatment services to support rural locations. | | | |
| We will reduce mental health risks for employees working in support based services by:<br>Introduction of peer supervision processes; and<br>Introduction of Peer Support processes, to support our mental health professionals team. | | | |

## Objective: 6 – Transition

**What we know:** Many employees continue to experience the psychological impacts of their policing career long after they leave the organisation.

Those who experience long term absence from the workplace due to mental ill health often feel isolated, disconnected and unsupported.

Services for former Victoria Police employees' mental health have been lacking.

Employees leave the organisation in a range of ways, some not of their own choosing, therefore leaving the organisation can be a high risk time for mental health.

Leaving the organisation can mean leaving behind strong collegial support networks.

For some, leaving behind their professional identity after a long career can be challenging.

| What we're doing | Baseline | Indicators | Outcomes |
|---|---|---|---|
| We will engage in employee lifecycle management to support mentally healthy career choices by:<br>Development of a pilot career break model and career break options to support mental health;<br>Review of transition programs for end of career exiting employees; and<br>Enhancement of retired peer support network. | New initiative – baseline to be determined.<br>Climate/Pulse survey. | • Implementation of care plans for different exit paths.<br>• Screening and care plans implemented for all exiting employees.<br>• Feedback and satisfaction.<br>• Increase in help-seeking rates as indicated by clinical and service usage data. | An awareness of mental health needs of employees as they leave the organisation.<br>Services that can respond to the varying need of exiting employees.<br>Continuity of care prior, during and after their exit from the organisation.<br>Improved accountability for the management of employees on long term absence.<br>Reduction in poor mental health and mental health risks.<br>Adequate redeployment options.<br>Appropriate career break options. |

**Acronyms:** Police Psychology Unit (PPU); Mental Health Program Office (MHPO); Professional Standards Command (PSC); Performance & Development Unit (PDU); People Development Command (PDC); Independent Broad-based Anti-corruption Commission (IBAC); Health Safety and Deployment (HSD); Medical Advisory Unit (MAU); Sexual Offences and Child Abuse Investigation Team (SOCIT).

# Appendix 1: Overview of Existing Services

## Existing Services

The *Mental Health and Wellbeing Strategy and Action Plan 2017-2020* provides organisational direction that builds upon the existing services and structures to provide a more holistic and integrated level of care and intervention for all employees. Our wellbeing support services provide prevention, intervention, and response services:

### 24 hour Crisis and Critical Incident On-call Service

Professional psychological support is available 24/7 through our on-call service, which is staffed by the Police Psychology Unit and Police Welfare, and further supported by Chaplaincy and Peer Support. This service provides crisis support to individuals and workplaces, risk assessments, management advice regarding mental health in the workplace and support for other matters of psychological concern. This service also provides formal critical incident response and follow up to operational incidents and other workplace events.

### Counselling and Referrals

Confidential counselling is available to all employees, and their partners and children. The Police Psychology Unit provides referrals to experienced mental health clinicians state-wide through our Employee Assistance Program (EAP), as well as, some internal counselling. Where counselling or treatment is not required, the Police Psychology Unit and Police Welfare continue to provide emotional support, monitoring, consultation, and advice to people experiencing difficulty.

### Case Managers

The core duty of the case manager role is to provide assessment and intervention for clients in need of support. The case management process begins with development of a working relationship between employee and case manager. The case manager takes a systemic view and will identify and work with key stakeholders and nominated support people to contribute to positive outcomes for the employee.

### safe-t-net

*safe-t-net* is an early intervention wellbeing support system designed to identify, record, and monitor our employees' exposure to events that have the potential to impact their wellbeing. *safe-t-net* has been developed to provide our employees with the opportunity to talk with their manager about the current impact, or cumulative impacts a particular event or series of events is having on their wellbeing and enable access to appropriate support. *safe-t-net* focuses on the relationship between the manager and the employee with "one conversation at a time".

### equipt

*equipt* is a free wellbeing smart phone application developed by Victoria Police and The Police Association Victoria, alongside our employees and Phoenix Australia – Centre for Posttraumatic Mental Health. *equipt* is designed for current and former sworn officers, all Victoria Police employees, and their families.

*equipt* provides tools that can help our employees strengthen their physical, social, and emotional wellbeing. It can measure and track wellbeing over time and put our employees in touch with support if or when they need it. The *equipt* app is completely confidential, available anytime, and free to download from the App Store and Google Play.

### Organisational Workplace Support

The Police Psychology Unit provides a range of workplace services that include consultation, coaching, advice, and support, with the aim of creating psychologically healthy workplaces. This includes a service for managers within the organisation to access information, coaching, advice, and support on managing mental health issues that present in their workplaces. In line with the Mental Health Review recommendations an additional thirteen (13) psychologists have been employed to assist employees' access to prompt help and support.

### Training and Education

Victoria Police provides educational programs and services on a range of topics relating to mental health and workplace functioning. Such programs range from mental health literacy aimed at individuals, to skill development for managers, to the resilience of teams. Two educators have been employed to provide greater training and education. Current programs include:

- Healthy Minds @ Work
- Healthy Minds @ Work – Managers
- ASSIST (Psychological First Aid for Managers)
- Resilience @ Work (Individual, Team, and Leader programs)
- Working Well, Preventing Stress
- Separating with Support and Safety
- Handling Heavy Workloads
- Change @ Work
- Understanding and Improving Unplanned Leave
- Critical Conversations

### Peer Support

The Peer Support Program is a strong network of volunteers across the organisation, who undertake their roles in addition to their normal duties. They are trained to assist fellow employees with personal or work-related matters at the local level. They are often the first point of contact for employees in the workplace, and can provide support, referrals and information, and help people to access other supports and services. Our peer support officers are overseen by the Peer Support Co-ordination Unit.

### Internal Witness Support

The Internal Witness Support Unit is located within Police Welfare, and is staffed by police officers who perform a dedicated welfare role. This is a dedicated, confidential service provided specifically to employees reporting or providing information in relation to alleged corruption, criminality or misconduct by another employee. Internal Witness Support Unit accepts referrals in relation to any sworn, Victorian Public Servants, Protective Services Officer or recruit who has made a protected disclosure under the *Protected Disclosure Act 2013*, who are an internal source or a police witness.

### Chaplaincy

Our Chaplaincy network comprises of senior chaplains who are supported by a network of chaplains across the state. They provide a range of pastoral care services to employees and their families, and are available 24/7. Our chaplains represent a range of denominations to support the diverse spiritual needs of our employees, and are available for visits, as well as performing a range of ceremonies and formal duties.

## External and Related Services:

The following external support services are also available to the employees of Victoria Police:

### The Police Association Victoria

The Police Association Victoria provides access to free, confidential counselling to employees and their families through an EAP, and has welfare officers that can support employees.

### Community and Public Sector Union

The Community and Public Sector Union provides comprehensive support for both current and retired public servants. A Retired Officers Division can also support employees.

### The Retired Police Association

The Retired Police Association co-ordinates a range of activities that facilitate former sworn employees to keep in contact.

### Retired Peer Support Program

The recently established Retired Peer Support Program consists of former employees who have volunteered to undertake a formal peer support role for former sworn employees, thereby providing continuity of the peer based support model for people in their post-Victoria Police lives. This program will be supported and expanded as part of the *Mental Health and Wellbeing Strategy Action Plan 2017-2020*.

## Acknowledgement of traditional owners

Victoria Police pay our respect to the traditional owners of lands on which we live and work.

We pay our respects to Elders and all Aboriginal and Torres Strait Islander peoples who continue to care for their country, culture and people.

Authorised and published by Victoria Police
Victoria Police Centre
637 Flinders Street
Docklands, VIC, 3008

Published by Victoria Police July, 2017



Print managed by Finsbury Green

This document is available online in PDF format at **www.police.vic.gov.au**

## Disclaimer

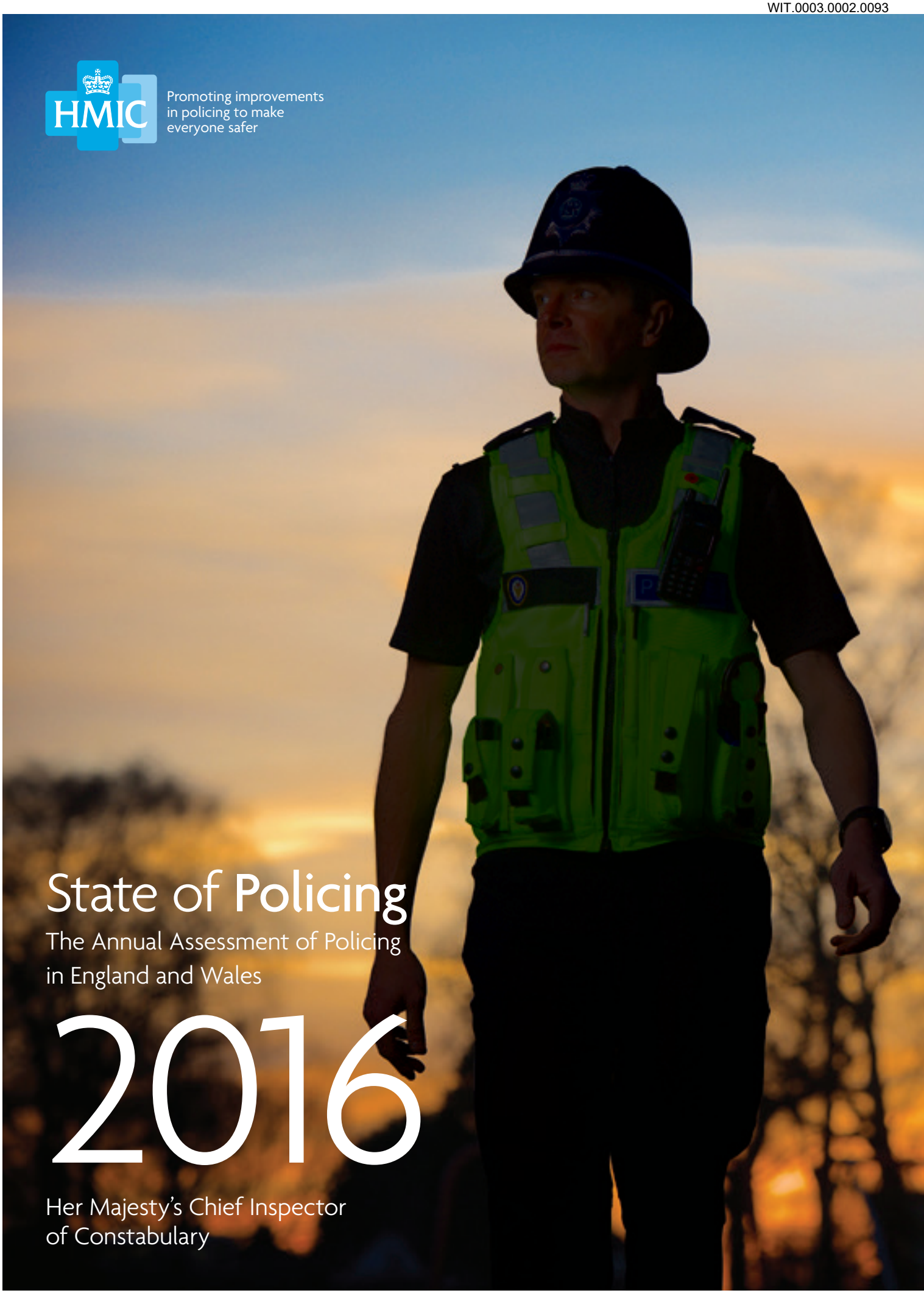
This publication may be of assistance to you but the State of Victoria and its employees do not guarantee that the publication is without flaw of any kind or is wholly appropriate for your particular purposes and therefore disclaims all liability for any error, loss or other consequence which may arise from you relying on any information in this publication.

VICTORIA POLICE

Royal Commission into
Victoria's Mental Health System

# ATTACHMENT GW -3

This is the attachment marked 'GW-3' referred to in the witness statement of Glenn Weir dated "5 July 2019" .




# State of Policing

## The Annual Assessment of Policing in England and Wales

# 2016

Her Majesty's Chief Inspector of Constabulary

Designed by The Domarn Group

Any enquiries regarding this publication should be sent to us at:
HMIC,
6th floor,
Globe House,
89 Eccleston Square,
London SW1V 1PN.

Email: contact@hmic.gsi.gov.uk

Follow us on Twitter@HMICgov

This report is available from HMIC's website at:
www.justiceinspectorates.gov.uk/hmic/

ISBN: 978-1-78655-390-4


Promoting improvements
in policing to make
everyone safer



# State of Policing – The Annual Assessment of Policing in England and Wales 2016

## Her Majesty's Chief Inspector of Constabulary

Presented to Parliament pursuant to section 54 of the Police Act 1996

# Contents

This year – for the first time – we have been able to compare year-on-year performance for each police force.

# Foreword

This is my report to the Secretary of State under section 54 of the Police Act 1996. It contains my assessment of the efficiency and effectiveness of policing in England and Wales, based on the inspections which HMIC carried out between February 2016 and March 2017.

This reporting period has seen the second complete round of PEEL (PEEL: police effectiveness, efficiency and legitimacy) inspections, which consider the efficiency and effectiveness of police forces, and assess their legitimacy in respect of their discharge of their obligations, that is, how they behave and treat people. These inspections provide the basis for our comprehensive analysis of the way in which each police force in England and Wales has performed in 2016, and will continue to do so on an annual basis.

Last year, our PEEL inspections enabled us to compare performance on a force-by-force basis. This year – for the first time – we have been able to compare year-on-year performance for each police force, and therefore assess the direction of travel for each force and the police service as a whole. An assessment of this nature is particularly valuable to police and crime commissioners, police leaders, policymakers, and others in the criminal justice

system, as well as those – principally the public – who rely on its efficient operation.

We will continue to develop and refine the PEEL model in the years to come. Continuing to build year on year, our PEEL inspections provide an in-depth and growing bank of information about how well each of the 43 police forces in England and Wales is policing the communities that it serves, so that areas of concern can be identified, evaluated and tackled. The assessments also identify good practice in a force which other forces should consider adopting.

I have taken full advantage of the fact that all our published reports are available on HMIC's website[1] and throughout this report there are easy-to-use web links to the relevant sections on that site.

This year's report follows a similar structure to that of previous years.

Part 1 provides my assessment of the state of policing in England and Wales. It draws together the principal themes from the inspections HMIC carried out in 2016 and in previous years. HMIC does not operate in isolation; where relevant, I have also drawn on findings and reports from other organisations. In so doing, I have taken the opportunity to set out a broader view of the major problems which I believe confront the police service now and which it will have to tackle in the years to come. Those problems include the need for continued reform, the treatment and protection of vulnerable people, the erosion of neighbourhood policing and the fragmented police use of technology.

I should make it clear that, overall, in our inspections the judgments which we make in relation to the efficiency and effectiveness of the police are predominantly about how well the police uses its money and other resources, not about how much funding forces have at their disposal.

Part 2 provides an overview of the findings of the inspections we have carried out between February 2016 and March 2017, including a summary of our PEEL inspections.

Part 3 sets out the full list of our inspections and other work.

The year 2016 was an eventful one in policing and at HMIC. In May 2016, elections took place for police and crime commissioners. New and re-elected commissioners have now taken up their four-year appointments and are holding chief constables to account for the effectiveness and

© Northumbria Police

efficiency of their forces. In planning and carrying out our inspections, HMIC has taken and will continue to take full account of the priorities that police and crime commissioners set for their chief constables in their police and crime plans. These plans constitute extremely important democratically established instruments of police accountability, and it is essential that all concerned understand and give full weight to their significance.

In August 2016, Rear Admiral Matthew Parr CB was appointed as one of Her Majesty's Inspectors of Constabulary. HMI Parr has considerable expertise and experience from and in his Royal Navy service; their great value in the work of HMIC is already apparent. I warmly welcome him to this role. He takes over from HMI Stephen Otter QPM, who left HMIC in May 2016 after four years' distinguished service. I wish here to place on record my own and the Inspectorate's very great debt of gratitude and thanks to Stephen Otter for his considerable achievements and immensely hard work in all the affairs and concerns of HMIC. The public will probably never know how much they owe to him for the very many things he did which have directly and so substantially made them safer. His outstanding record of public service stands high to his credit.

In November 2016, we published HMIC's organisational strategy[2] which sets out – for our staff, the public, the police and others with whom we work – who we are as an organisation; our purpose and objectives; and what we intend to achieve by 2020. The strategy will be reviewed every year.

I should like to place on record my thanks to the other organisations and inspectorates that have worked with HMIC over the past year. They have made a significant contribution, and I look forward to working with them again in the future.

I am proud of what we have achieved over the past year, but the real credit should go to my fellow HMIs and the staff of HMIC who remain just as loyal, hard-working and diligent as ever. My thanks and admiration go to them for all that they do for HMIC, for policing and for the public.

**Sir Thomas P Winsor**
Her Majesty's Chief Inspector of Constabulary

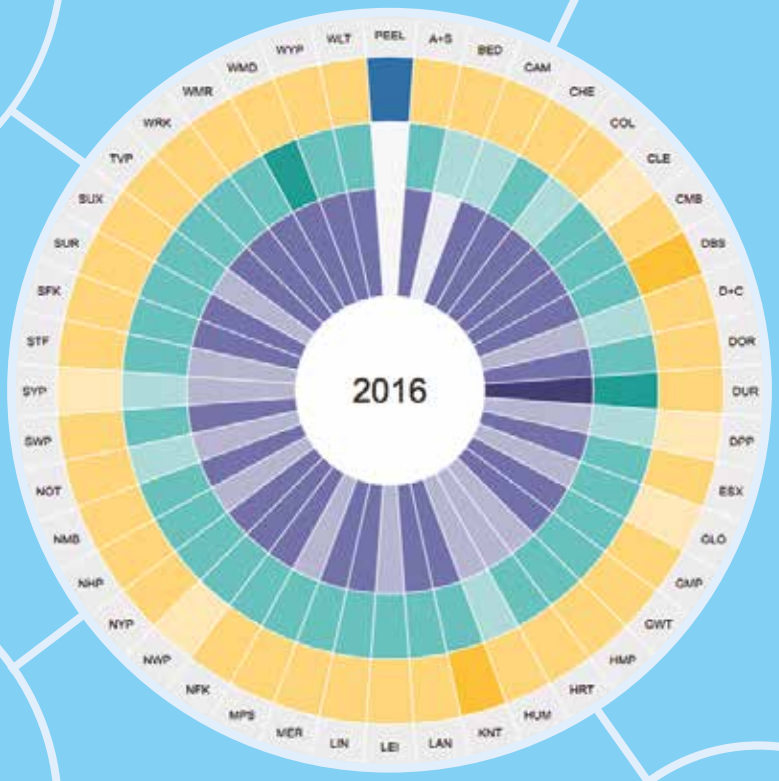
# HMIC website

www.justiceinspectorates.gov.uk/hmic

**194,775**
current users on the website – over
**35,000**
increase on last year


**HMIC**
@HMICgov

| TWEETS | FOLLOWING | FOLLOWERS |
|---|---|---|
| 400 | 378 | 8,098 |




Top **5** reports (non-PEEL):

- Crime data integrity 1
- National child protection inspection (Metropolitan)
- Ipsos MORI public views of policing survey
- Rape Monitoring Group digests
- Crime data integrity 2

We present information about police forces' performance (known as the PEEL assessments) in an interactive and accessible way

## USERS


**Efficiency**
3 November 2016 – 2,638 users

**Legitimacy (and Leadership)**
8 December 2016 – 3,830 users

**Effectiveness**
2 March 2017 – 11,048 users


© Thames Valley Police


# Part 1: Overview

The vast majority of frontline police officers and staff continue to do a very difficult job well.

# Overview

The inspections that HMIC has carried out during the reporting period reveal two principal themes. The first is that the vast majority of frontline police officers and staff continue to do a very difficult job well, under demanding and often harsh circumstances. The second is that, while there are examples of excellence, police leaders need to focus on what matters most, plan properly for the future, ensure that their officers and staff are properly trained, supported and equipped, and improve the pace of change significantly.

With the second complete cycle of HMIC's PEEL[3] programme, this is the first year that we have been able to compare the performance of all forces year on year. While the performance of some forces has improved, regrettably the performance of others has deteriorated. For the most part, where the performance of individual forces has changed, it has been for the better. But the pace of improvement needs to rise. Moreover, there is still far too much variation between forces; the poor performers lag too far behind the best.

Some of the improvements are encouraging. These include the ways in which the police deal with and protect vulnerable people; in some cases, the standard of policing has been exemplary, but in others not. This is reported upon in Part 2.

The police service is not the only public service charged with meeting the needs of vulnerable people, but it is being used increasingly as the service of first resort. This is particularly true in respect of people suffering from mental ill-health.

Until mental health is given the same priority as physical health, in resources including funding, the police will continue to play too large a role in dealing with people with mental health problems. By the time the police become involved, many opportunities to intervene – to prevent mental ill-health deteriorating to the point at which people are in danger


© Suffolk Constabulary

– will already have been missed. This is ineffective and expensive. In a well-ordered and compassionate society, we should not rely on law enforcement officers to support people who need medical care. The severe problems in mental health provision in this country are not only failing those who need treatment; they also create an unacceptable strain on the police, and imperil public safety.

It is, on the whole, frontline officers who feel this strain most acutely. Their jobs require them to deal with difficult, uncertain and often dangerous situations as a matter of routine. Every day and every night, police officers do things that most of us go out of our way to avoid. They do this professionally, conscientiously, compassionately and without complaint, and they deserve our grateful thanks.

It is not only the safety of private citizens arising from their ill health or the ill health of others which is a matter of material concern to the police. The job that frontline officers do takes its toll on their own physical and mental health. Increasingly, police leaders understand the importance of workforce well-being and are taking steps to improve it. However, the level of support that forces provide for their officers and staff varies considerably, as does the capability of supervisors to identify and meet the needs of individuals. I do not believe that the general public fully realises the risks which police officers and staff take, or the sometimes severe adverse effects which the strain of policing can have on them, both mentally and physically.

Forces also need to do much more to manage the performance of individuals. As well as contributing to perceptions of unfairness among the workforce, weak

Devising a sound force management statement requires clarity of purpose and honesty about performance.


© British Transport Police

performance management is likely to have an adverse effect on the efficiency, effectiveness, integrity and leadership of forces. This is a symptom of a wider problem.

In policing, management is too often seen as a necessary chore, rather than a fundamental part of providing a good service. For too long, police leaders have relied on the professionalism and dedication of their officers and staff, without giving them the best support, supervision and management. In other areas of public service, management is a professional specialism in its own right; the same should also be true in policing.

This does not mean the imposition of bureaucratic procedures or centrally imposed targets. Neither does it mean recruiting large numbers of administrators. But until police leaders at all ranks and grades fully understand the importance of good management, the police will remain too slow to change and the variation in performance between forces will remain too great.

Good management starts with a sound understanding of organisational purpose, the activities an organisation will undertake and the resources available to it. For the police, that means an understanding of current and future demand, as well as the capacity, capability and security of the assets that will be used to meet that demand, including the skills and experience of officers and staff. I believe that each force should follow the example of other safety-critical essential

public services and set these things out in a published statement, known as a force management statement, modelled on the network management statements of other services such as transport and energy.

There are many benefits to this approach, which I set out in last year's *State of Policing 2015* report.[4] Devising a sound force management statement requires clarity of purpose and honesty about performance, two essential elements for high-performing organisations. The statements will also help forces to improve their decision-making, based on tried and tested methods. Done well, they should also provide a good foundation for early and better discussions about priorities between police and crime commissioners and chief constables. I look forward to the introduction of force management statements later in 2017.

Any discussion about demand needs to start with a clear understanding that, given the range of activities the police carry out, we cannot possibly expect them to meet every conceivable demand we might make of them. Ultimately, the police are public servants and we need to have an informed public debate about what we want them to do, and what we do not want them to do. Then it becomes the job of police leaders to decide how they are going to meet the public's legitimate expectations. This is no more, and certainly no less, than we require of other public sector organisations; for too long and in too many respects, the police have lagged far behind.

The police are particularly far behind many other organisations in the way they use technology. There are good examples of forces using innovative technology or making innovative use of existing technology, but these are too few and far between.

There are good examples of forces using innovative technology or making innovative use of existing technology, but these are too few and far between.


© West Midlands Police

Until we have dissolved to nothing the remaining technological and human barriers that prevent law enforcement agencies from obtaining and using the information that others of them hold, lives could yet be shattered or even lost.

For too long, a culture of insularity, isolationism and protectionism has prevented chief officers from making effective use of the technology available to them. This needs to change.

Policing is no longer all local. There have never been 43 best ways to specify, acquire or use technology. Used well, modern technology should give the police an unprecedented ability to exchange, retrieve and analyse intelligence. But that is only possible if the intelligence is made available in the first place. We saw the consequences of failing to exchange intelligence all too clearly in 2002 in Soham, when Holly Wells and Jessica Chapman were murdered by Ian Huntley. Failures to make reliable and timely intelligence available across force boundaries meant that opportunities to prevent these murders were missed.

It is high time for a network code: a service-wide decision-making mechanism in which police and crime commissioners and chief constables pool their sovereignties in order to maximise the effective use of technology through the timely establishment of sound common standards, with the overriding purpose of affordable interoperability at its heart. Until we have dissolved to nothing the remaining technological and human barriers that prevent law enforcement agencies from obtaining and using the information that others of them hold, lives could yet be shattered or even lost.

## The context of policing in 2016

In many respects, UK policing remains the envy of the world. The principle of policing by consent has stood the test of time and very substantially contributes to levels of public trust and confidence in the police that remain high.

We know from research carried out by Ipsos MORI[5] that three times as many people say they are satisfied with the police as say they are dissatisfied. The proportion of people who speak highly of the police is increasing. The figure is even higher among people who regularly see a uniformed officer in their local area. Among the public, the strongest advocates for the police are people who have frequent interaction with police officers or police community support officers (PCSOs).

This is all the more impressive when it is recognised that, since 2010, the police have been through a period of reform that has been more intensive and extensive than at any time since 1829, when Sir Robert Peel established the Metropolitan Police. In each of the past six years, the police service in England and Wales has had significant reductions in its funding, with the level falling every year in cash terms. The police workforce has been reduced from 243,900 officers, PCSOs and other staff in 2010 to 200,600 in 2016 – an 18 percent reduction.[6]

The 2015 spending review maintained central government funding for the police in real terms. This was a better financial settlement than many forces had been expecting, and I am concerned that, as a result, some forces are no longer pursuing reform with the levels of determination that once they were. This is unacceptable. The scale of necessary reform has not diminished, and forces are still expected to reduce costs in the long term. I do not underestimate the financial pressures that forces will continue to face over the coming years, and neither should they. The cherished principle of policing by consent and the hard-won levels of public trust will be jeopardised if the police do not continue to pursue reform with imagination and resolve.

The neighbourhood policing model of small teams of officers dedicated to particular communities has also played an important part in developing the confidence and trust of the public and keeping people safe. In last year's *State of Policing 2015* report,[7] I warned that the neighbourhood policing model was under threat; that remains the case. I will return to this theme later.

I am pleased to report that, overall, police forces in England and Wales treat the people they serve with fairness and respect, and police leaders are good at ensuring that their workforces act ethically and lawfully. Contrary to attempts by the media and others to paint a different picture, levels of corruption among police officers and staff remain relatively low. Nonetheless, HMIC continues to identify forces that are not taking the abuse of authority for sexual gain seriously enough; this is another theme to which I will return.

Stories about firearms officers (or the shortage of them) have continued to

I do not underestimate the financial pressures that forces will continue to face over the coming years, and neither should they.

Constant exposure to threatening, confusing and often violent situations undoubtedly takes its toll on frontline officers and staff, mentally as well as physically.

make headlines during the last year, but the reality is that the very great majority of police officers in the UK do not routinely carry firearms. In fact, fewer than 5 percent of police officers in the 43 Home Office forces are authorised to carry and use firearms; the number of times they discharge their firearms each year is fewer than ten.[8]

Over the last year, we have witnessed shocking terrorist attacks on mainland Europe, and we have witnessed the bravery and selflessness of those who responded to them. The threat of terrorism in the UK remains real and should not be underestimated, but we should not forget the full range of dangerous situations that confront the public and with which police officers deal on a daily basis. Levels of hate crime recorded by the police have increased over the past year, with a particular spike in July 2016, after the EU referendum. And in the run-up to the vote, a young woman and Member of Parliament – Jo Cox – was brutally murdered. Police officers were, as always, at the forefront of dealing with these incidents.

There has been a number of recent attempts to quantify the overall level of violence, insults and threats directed towards the police. The estimates vary and some paint a particularly alarming picture, but we do not need statistics to tell us that frontline police officers and staff routinely deal with incidents that most of us go out of our way to avoid. Constant exposure


© West Midlands Police

to threatening, confusing and often violent situations undoubtedly takes its toll on frontline officers and staff, mentally as well as physically.

It is in the nature of inspection that inspectors tend to focus on identifying those areas where performance needs to improve. This should not overshadow the excellent, often unrecognised, work that individual officers and staff are doing on a daily basis. As in previous years, I would like to pay tribute to the integrity and bravery of police officers and police staff. Overwhelmingly they are good, committed people who are doing their best under difficult conditions.

Every year, there are individual police officers who show conspicuous bravery and who put themselves at enormous risk in order to help others; their actions are an example to us all. So too are the actions of every officer who turns up for work each day to protect others, knowing that on their shifts they may well be threatened, intimidated, assaulted or insulted. Their endurance and forbearance in the face of these dangers and provocations stand high to their credit.

Among police forces in other countries, such restraint is often absent, with tragic consequences. We must never forget the work that these men and women do for us; they deserve our wholehearted gratitude and support.

While police officers continue to do their jobs to the best of their abilities, crime (and our understanding of crime) continues to evolve. We have seen growth in cyber-crime, fraud and offending against the vulnerable.

There are individual police officers who show conspicuous bravery and who put themselves at enormous risk in order to help others; their actions are an example to us all.


© South Wales Police

Forces need fully to understand the nature and potential scale of online offending to ensure that more is done to protect children, elderly people and others from harm, and bring perpetrators to justice.

Keeping up with the pace of change is a major test for the police; the public need to be confident about the ability of the police to pass that test.

For instance, dealing with child sexual exploitation in the digital dimension requires a model of policing quite different from the conventional methods of the past. Forces need fully to understand the nature and potential scale of online offending to ensure that more is done to protect children, elderly people and others from harm, and bring perpetrators to justice. New approaches must be developed to reflect this contemporary demand on policing services.

The ability to understand, predict and meet demand is a principal theme of this report. It has never been sufficient for forces only to react to 999 calls from the public. They need to be able to predict the levels of demand they are likely to face, and they need to identify demand that may not immediately be obvious. Latent demand may be just as important as patent demand. Sometimes it will be more serious because victims are afraid or prevented from approaching the police, and the abuse and other types of offending to which they are subject may be the more severe because the perpetrators are confident they will never be caught. This arises particularly in cases of modern slavery and forced labour, child abuse, so-called honour-based violence, female genital mutilation and forced marriage, and in communities or parts of communities where traditionally the police are trusted less. The police service's duty to protect in these cases is just as strong, and often stronger

© Greater Manchester Police

because of the vulnerability and fear of the victims.

HMIC has been working with the London School of Economics to develop a statistical model that can with considerable accuracy predict demand for police services. The model will allow forces to plan effectively at a force-wide level, taking account of variations in demand at a local level. Predicting levels of demand in these areas, together with an analysis of the types of incidents that constitute that demand, will help the police to establish the capacity and capability necessary to do much more to prevent such incidents from happening, or to respond effectively to them after they have occurred. The model is being improved and has been made available to the police service. I urge forces to make use of it.

Understanding current and future demand, both latent and patent, is important but it is only half the battle. It is also crucial that forces are able to deploy their resources effectively, in order to deal with the demand they are facing. Most forces know their current workforce capacity in terms of costs and numbers of staff. However, very few forces have a sufficient understanding of the skills of their workforces, or how to develop the skills necessary to meet future demand. Too many forces have reduced the numbers in their workforces to meet reductions in their budgets without properly understanding how that may affect current and future capability. This is a recurring theme throughout our inspections and is particularly acute in respect of the capability to investigate online crime.

Performance management also remains too weak in many forces. The majority of forces do not manage the performance of their officers and staff well enough, and many forces do not have processes for promotion that are sufficiently open or clearly explained. While most forces have now set out clear expectations of leadership, these are rarely included as part of individual performance reviews.

Recruitment and retention of specialists is a problem for many forces. We have long been aware of the national shortage of firearms officers. The shortage of detectives has reached a point at which the Metropolitan Police Service has a shortfall of nearly 700, or 13 percent.[9] This clearly has a detrimental effect on the force's ability

The majority of forces do not manage the performance of their officers and staff well enough.

There needs to be a well-informed and mature debate about what the police should be expected to do and, just as importantly, what they should not do.

to investigate crime and needs urgent remedy. All forces need to think more creatively about how to recruit, train and retain specialist officers including, where appropriate, recruiting people directly into specialist roles and providing accelerated training programmes.

The police are lagging too far behind in the way they manage their workforces and in their understanding of demand.

We cannot realistically expect the police to meet every possible demand we might make of them. There needs to be a well-informed and mature debate about what the police should be expected to do and, just as importantly, what they should not do. This dialogue must start with a clear and reliable assessment of demand, capacity and capability, now and in the future.

I believe that force management statements will be an important part of the assessment that is required to inform this debate. They will also help forces to improve their decision making, based on tried and tested methods drawn from other safety-critical public services. They will benefit others too; done well, they should also provide a good foundation for early and better discussions about priorities between police and crime commissioners and chief constables.

In last year's *State of Policing 2015* report, I provided a detailed explanation of the characteristics of force management statements and set out the benefits of the approach.[10] Since then, with the helpful contribution of chief constables, police and crime commissioners and others, a cohort of pilot forces has worked with HMIC to develop and refine the concept. We continue to do so and I look forward to the introduction of force management statements later in 2017.

## Vulnerability

The cuts in public spending over the last six years have inevitably affected the ability of the police – and other public services – to make provision for those who often need their services the most: vulnerable people. This state of affairs strengthens the case for more efficient ways of working; by working more efficiently, forces will be able to do more to protect people, even in the face of reduced resources.

Vulnerable people are often at the greatest risk of harm. The police, like other


© Northamptonshire Police

organisations, has a duty to give them the protection and support they need.

It is not always easy for frontline officers to provide this protection and support, not least because cases involving vulnerable victims are often both complex and sensitive. Neither is it always easy to identify people who may be vulnerable, particularly for officers under pressure to attend other incidents or who are not in possession of all the facts. Nonetheless, HMIC has found many examples of officers and staff at all ranks and grades who have with consummate professionalism and great humanity and compassion protected and cared for vulnerable people, often in the most demanding and distressing of circumstances.

Police leaders need to do more to recognise this, and to bring all of their officers up to the level of the best. In part, this means adopting deployment models that give officers enough time to meet the needs of vulnerable people. It also means providing appropriate levels of training, supervision and support.

Vulnerable people include children, elderly people, disabled people, and those with learning difficulties or mental health problems. These are disparate groups, but they all include people whose voices are often not heard, and whose needs are not recognised or met by other public services with obligations towards them. The College of Policing uses a definition of vulnerability that focuses on the risk that an individual faces, specifically the risk of becoming a victim of child abuse, child sexual exploitation, domestic abuse, female genital mutilation, forced marriage, so-called honour-based violence, modern slavery, prostitution, serious sexual offences or stalking and harassment.[11] Again, these are disparate groups. Many of them consist of people who live, work and socialise in communities across the country, all too often showing no outward sign of their grotesque mistreatment at the hands of others. Such people are concealed in plain sight. It is the job of the police – with others – to find and protect them.

We have seen what happens when the risks faced by vulnerable people, or vulnerable people themselves, are ignored or

Forces have now recognised that the service they provide for vulnerable people is not good enough.

not recognised. In places such as Rotherham, Rochdale and Oxfordshire, hundreds of children have been subjected to horrific abuse, much of which could have been prevented if the agencies of the state had understood their plight and discharged their obligations.

We should not lose sight of the fact that vulnerable people are at risk from a wide range of other crimes too. The 2016 National Trading Standards Board *Consumer Harm Report*[12] points out that illegal money lenders "usually target people in vulnerable situations who struggle to access credit through other means" and that criminals impersonating officials are also likely to target people in vulnerable situations, such as older people living alone.

The report also states that the average age of a victim of a postal scam is 75. Research conducted by the Home Office shows that people in this group are most likely to take advice from someone they already know, which highlights the importance of building relationships within communities – a theme to which I will return in the section on neighbourhood policing.

Looking back two years, vulnerability was the area of HMIC's 2015 PEEL: effectiveness inspection in which forces were weakest. No force was found to be outstanding and the majority required improvement or were inadequate. Of the four forces graded as inadequate, our inspection revisits in 2016 have found evidence of good progress in only two of them.

It is worth noting that forces have now recognised that the service they provide for vulnerable people is not good enough and that police leaders are committed to making improvements. To reflect the increasing priority that is being given to vulnerability, many forces are changing their structures, realigning their spending and resources, and adapting their approaches in areas such as staff promotion.

These improvements are welcome. In no small part, they have come about because forces are acting on the recommendations in last year's reports. In particular, forces are now showing real resolve to improve their handling of domestic abuse. However, more needs to be done and these improvements have not come easily. It has taken years of pressure from charities, politicians and HMIC for police leaders

to recognise the need for change. Constant vigilance will be required to ensure that the current level of focus on domestic abuse is maintained.

The College of Policing intends to devise a system that requires officers leading investigations into complex crimes against vulnerable people to hold a licence to practise.[13] This is an encouraging step among a wider set of measures intended to transform the service provided to vulnerable people.[14]

As I have said, there are many frontline officers who provide exemplary service to vulnerable people, including children at risk, often despite difficult conditions. But we are still finding weaknesses in the overall approach to keeping vulnerable people safe.

Police leaders, while recognising the need to improve, lag some way behind their officers and staff in their understanding of what it takes to meet the needs of vulnerable people. Until frontline officers and staff are given the tools (and the time) they need to do their jobs properly, improvement in this area will be too slow. Therefore, I expect HMIC inspections to continue to focus on vulnerability in 2017.

## The police's duty to protect children

In early 2016, as part of our rolling programme of child protection inspections, we inspected the Metropolitan Police Service. The resulting report was the most severely critical that HMIC has published about any force, on any subject, ever. In short, we found significant errors of judgment, unacceptable delays and a lack of leadership which meant that children were not being protected properly. There is no place in civilised society for the police to neglect their duty towards children in this way, and it is deeply troubling that it has been happening to such a significant extent in the largest force in the country.

Today's children are growing up in a digital world. They face pressures from social media that simply did not exist as recently as a decade ago. Many children suffer cyber-bullying from which even their homes provide no safe haven. Their exposure to extremely upsetting and damaging material, and their vulnerability to online grooming and predation, should alarm and spur into action every parent and carer, every teacher, every health professional and every other member

Today's children are growing up in a digital world. They face pressures from social media that simply did not exist as recently as a decade ago.

No one should be wilfully or negligently ignorant or dismissive of the very great dangers to which our children are now exposed.

of the community. No one should be complacent; no one should be wilfully or negligently ignorant or dismissive of the very great dangers to which our children are now exposed. Those dangers are often greater and more prevalent in the online world than they are in the physical world. As the Children's Commissioner for England pointed out in a recent report, the internet is an extraordinary force for good, but it is not designed with children in mind.[15] It is also a vehicle for very great numbers of the worst and most dangerous offenders, who use it to obtain unimpeded access to those with the greatest vulnerability and who have the most to lose. Our children in particular enter, occupy and play in places exponentially more hazardous than any into which their parents ever could have ventured. Neither is the internet designed with the police in mind; indeed, parts of it are designed to evade the attentions and techniques of law enforcement.

Home Office research[16] shows that the group of people at the highest risk of cyber-fraud and financial crime are also the most likely to have anti-virus software installed on their computers and so assume they are safe.

© South Wales Police

It is their over-reliance on a basic and inadequate level of protection and their willingness to take risks that put them in danger. Police and parents need to know how to deal with the risks that come with the unprecedented ability to communicate, create and exchange information and false information that is now part of our digital lives.

Parental controls on internet use are not enough; education about online risks is vital. Parents need to be able to spot warning signs and they need to satisfy themselves that their children understand the risks they face, and can avoid them. This is not always easy, but there is support available for parents, including the Child Exploitation and Online Protection Centre www.thinkuknow.co.uk website and other online resources such as those provided by the NSPCC.[17] Commercially-available software which allows parents to monitor and control their children's use of internet-connected technology – to see what they are doing, and to block or restrict access – is now well advanced and extraordinarily inexpensive. No parent should disregard it.

This is not just important in relation to the risks that children face online; it is also important that parents (and anyone who works with children) understand how technology can be used to facilitate crime offline.

Many criminals are adept at exploiting opportunities presented by new technology, and continuous vigilance is required to keep up with the risks that the misuse of technology poses. Parents, for example, need to be aware that the ease with which stored-value cards, such as gift cards, can be purchased with cash means that they have become attractive to drug dealers (among others) as a form of anonymised electronic currency. There are, of course, perfectly legitimate reasons for children to have such cards, but their unexplained or excessive use is a warning sign that a child could be being drawn into danger.

This generation of children are digital natives, but senior leaders in the police are at least two generations behind, and are not recruiting enough people with the right skills to police the internet, to investigate digital crime or to make effective use of new technology. Rapid technological change

This generation of children are digital natives, but senior leaders in the police are at least two generations behind.

The provision of mental healthcare has reached such a state of severity that police are often being used to fill the gaps.

creates new opportunities to investigate crime and apprehend suspects, but forces are all too often overwhelmed by it, leading to backlogs of digital devices waiting to be examined and evidence waiting to be assessed. Forces urgently need to recruit and train a workforce that is fit for a digital future. The public – especially the vulnerable – cannot afford for the police to be left behind.

## Mental health

The police have often been used as the service of last resort. In some areas, particularly where people with mental health problems need urgent help, the police are increasingly being used as the service of first resort. While the financial settlement for the police in the most recent spending review was welcome, cuts in other public services can increase demand on the police significantly. In some forces, police officers end up acting as first responders when no ambulances are available. With ambulance services across the country being stretched, this is a worrying trend that makes it all the more important for police leaders to understand the full range of demand – including of course the nature of demand – they are facing.

We are still finding cases of mentally ill people – who have not committed any crime – spending the night in a police cell. This is because they are too vulnerable to be left alone but there is no bed for them in a healthcare facility. The provision of mental healthcare has reached such a state of severity that police are often being used to fill the gaps that other agencies cannot. This is an unacceptable drain on


© Greater Manchester Police

police resources, and it is a profoundly improper way to treat vulnerable people who need care and help, not incarceration among criminals. Recently-enacted legislation to deal with this problem is very welcome, but it will only be effective if adequate provision is made available elsewhere.[18]

The first obligation of the police is to prevent crime. This is not only because this makes society safer – both in reality and in perception – but also because it is far cheaper to prevent a crime than it is to investigate and arrest the offender after the event. The same is true of mental ill-health, which is not a crime. It is an old adage that an ounce of prevention is better than a pound of cure, and this is particularly true when the cure fails and an emergency intervention is required to protect the safety of an individual in distress and, often, people nearby. By the time depression or some other mental disorder has been allowed to advance to the point that someone is contemplating suicide, or engaging in very hazardous behaviour, many opportunities to intervene will have been missed by many organisations. When that intervention takes place on a motorway bridge or railway line, or when someone is holding a weapon in a state of high distress, the expense to all concerned is far higher than it should be. The principal sufferer is the person who is ill, especially when it is realised that his or her suffering could have been much less or even avoided altogether.

Then there is the economic cost in terms of the expenditure of time and effort by the police and other public services, as well as the expense and trauma sustained by those adversely affected by the crisis at the time. The economic arguments for earlier intervention intensify the health and moral ones already in play. Furthermore, research, carried out by Ipsos MORI for HMIC, shows that only two percent of people think that the police service has the greatest responsibility for the safety of people with mental ill-health or learning difficulties.

With an estimated one in ten young people having a mental health problem, this is not a matter for the police alone.[19] The inadequacy of mental health provision and the lack of parity with physical health provision in this country should disturb everyone. It should never be the case that someone who requires treatment, for any

I have longstanding concerns that the bedrock of neighbourhood policing is being eroded.

condition, should become the responsibility of the police simply because other agencies do not have the resources to act.

## Neighbourhood policing continues to be eroded

I have longstanding concerns that the bedrock of neighbourhood policing is being eroded. A dedicated neighbourhood policing team in a local community is able to build trust and confidence in a much deeper way than response officers will ever be able to. A local presence is also a vital part of understanding the risks and threats faced by a community, and is a critically important part of preventing crime.

As the resources available to neighbourhood policing teams dwindle, the ability of officers to devote time to local communities diminishes. This necessarily leads to a significant reduction in the numbers of times that members of the public see a uniformed police officer. Since 2015, there has been a substantial drop in the proportion of people who say they have seen the police, on foot or in a police car, regularly, in their area. Our research shows that, now, fewer than one in five people feel there is a regular uniformed police presence in their area.

Where neighbourhood teams exist, police officers are routinely taken away from their local areas to meet demands in other parts of the force area, leaving a reducing number of PCSOs as the mainstay of community teams. Such teams can do excellent work with other local public services. They often have a strong understanding of the policing needs of the

© Thames Valley Police

communities they serve, but they need to be properly and consistently supported in their work. This support must include the availability of warranted officers.

Most people understand that neighbourhood policing can be a powerful force for protecting the vulnerable and tackling the petty crime and anti-social behaviour that blight people's lives. But neighbourhood policing also provides the eyes and ears in communities that can gather the intelligence necessary for disrupting serious and organised crime and terrorism.

Where the work of neighbourhood teams is inconsistent, unstructured or insufficiently supported, it leads to a patchy understanding of threat, harm and risk within communities. Without the intelligence provided by neighbourhood teams, forces cannot properly analyse and exploit data from other services.

Poor neighbourhood policing leads to community engagement that the public finds limited, frustrating and confusing. There is recognition among forces that engagement needs to evolve, but all too often we find a general lack of clarity about how to work closely with local communities, obtain their views and communicate information to them. There are instances of good and creative work, but these are rarely joined up or supported by resources from across the wider force. The ways that forces use social media, including those channels specifically aimed at local communities, are highly variable, and most forces have much to learn from the best.

Overall there is no sufficiently consistent approach to tackling local problems in a structured way, or to adopting and adapting approaches that have proved to be successful elsewhere. Forces are not routinely applying tried and tested techniques, and they are not evaluating their approaches to find out what works in order to promote good practice to others. This results in too much activity that is reactive and self-planned rather than directed by intelligence. Much more use could be made of predictive analytical techniques to help deploy increasingly scarce resources more effectively.

Finally, powers to tackle anti-social behaviour are too often being used inconsistently. Some forces are ten times more likely than others to use

As the resources available to neighbourhood policing teams dwindle, the ability of officers to devote time to local communities diminishes.

their anti-social behaviour powers, once population size is taken into account. Some variation between forces is to be expected, but there is no convincing case that can be made for such wide variations. This is a problem that needs further investigation and is one that HMIC will return to during 2017.

## Use of technology remains poor

I have said before that the oxygen of effective policing is information. But information is useless if it cannot be found and used at the time and in the circumstances in which it is needed. In an increasingly connected and fast-moving world, timely access to accurate information has never been more important. Any organisation that fails to make effective use of ICT to collate, manage and analyse information will not make effective decisions and will get left behind.

The history of police use of ICT is not a distinguished story. A persistently weak approach to the adoption and implementation of technology is a longstanding problem, particularly with regard to timely access to high-quality intelligence. For more than 20 years, successive reports from the Police Information Technology Organisation, the Home Office Police Research Group, the Association of Chief Police Officers and HMIC have highlighted major concerns about police ICT systems

and the information held on them.

Too many forces have large numbers of bespoke systems that only a small number of individuals know how to maintain. To address this, forces need to give deep thought to the ICT architecture that they are designing. This is more important, and more difficult, than the effective procurement of individual devices. Too many forces invest very significant amounts of money in devices and systems that their ICT architecture cannot handle efficiently.

This is not just a problem of forces buying the wrong technology. In general, forces do not have enough officers and staff with the necessary expertise to make good use of technology, or the confidence to know what they need. Very few forces are focusing on developing the digital skills of their officers and staff, despite a universal acceptance that digital skills are an increasingly important part of police work. Fewer still ensure that ICT and new technology are at the heart of their day-to-day work. In most cases, forces' ICT was designed to support their existing processes, rather than shaping new

© Northamptonshire Police

and more efficient ways of working.

There are, of course, some examples of good practice. Many forces are making good use of mobile devices which, when used effectively, can enable officers and staff to remain within the community without having to return to a police station to process information.

Cleveland Police is using data from several organisations to produce maps that reveal geographical locations with high demand or high risk. Using the geo-locators within police vehicles and radios, the system can also be used to analyse intervention work in an area.

In Cumbria, frontline officers have hand-held tablets with internet access and digital maps for locating incident

The equipment used by the majority of forces still lags far behind the technology that officers use in their own homes and cars.

scenes quickly. Using the tablets, officers can update the constabulary's command and control systems, access their emails and circulate photographs of missing people. Essex Police recently won an award for its use of telematics in its vehicle fleet to identify underused vehicles and opportunities to improve the deployment of resources, leading to reduced maintenance and mileage costs.

These examples are encouraging, but the technology involved is hardly cutting edge. The equipment used by the majority of forces still lags far behind the technology that officers use in their own homes and cars. Internet-enabled tablets, for instance, have been available for years in every high street in the country.

The absence of an effective collective decision-making mechanism at the national level militates against progress and leaves us with a culture of insularity, isolationism and protectionism. This is not to say that chief constables do not act in the interests of their forces and communities, but disseminating intelligence and common ways of working have not been high enough on their agendas.

As discussed earlier, we saw the result of failing promptly and efficiently to communicate intelligence all too clearly in Soham in 2002 when Ian Huntley murdered Holly Wells and Jessica Chapman. These failures to make intelligence available across force boundaries meant that opportunities to stop Ian Huntley were missed.

Police forces are not in competition with each other, and there is no reason for them not to work together. We know that adopting a common approach is possible and can lead to improvements. In the wake of the Bichard Inquiry into child protection procedures in Humberside Police and Cambridgeshire Constabulary,[20] a nationally consistent framework for the Management of Police Information (MOPI) was implemented.

In HMIC's 2013 review[21] into allegations and intelligence material concerning Jimmy Savile, we found that, when MOPI is followed, the system works as intended. However, we also found that implementation did not match expectations, partly due to the discretion that MOPI afforded to individual chief officers.

The picture painted in the Bichard inquiry's report was alarming:

"There was, and remains, no uniformity of approach. Each of the 43 police forces has a variety of IT systems, which are used for a variety of different purposes. The interfaces between systems at local force-to-force level are almost non-existent. Even within forces, the interface between systems has been patchy at best."

Much has changed since 2002; but accurate, comprehensive and nationally accessible law enforcement information systems are still some time away. The principles of perfect, timely and affordable interoperability need to be applied by all agencies concerned with public safety, not only the police. Given that not enough in law enforcement has changed, it is possible that offenders could still be slipping through the net.

Despite the patchy national picture in law enforcement, at the regional level there are examples of collective decision-making working well. Hampshire Constabulary and Thames Valley Police already have a shared chief technology officer and there are plans to include Surrey and Sussex in the arrangement, which will include common project management rules. The aim is to ensure that things are done only once, on common systems. Similarly, Hertfordshire, Cambridgeshire and Bedfordshire have pooled their ICT budgets and have a single ICT lead for all three forces.

None of this means that every police force should have exactly the same ICT system. There is considerable scope for variation, provided that systems can efficiently and seamlessly connect to one another and exchange information. However, bespoke solutions tend to be more expensive, and the police service as a whole would benefit from having access to some 'off-the-shelf' products that would simplify procurement, reduce costs and increase consistency.

The Police ICT Company[22] has achieved some positive results with individual suppliers, but currently lacks the mandate and resources to bring about the level of change that is desperately needed in this area. Equally, the work of the National Police Chiefs' Council on digital contact with the public, investigations and links to the wider criminal justice system has the potential to change things for the better.

ICT systems, even those that are fully interoperable, are only as good as the data they contain. As far back as 1996, an internal report by the Police Information Technology

Forces must accelerate the move away from insularity and dissolve to nothing the barriers to sharing information.

Organisation highlighted differences in the way forces entered information into intelligence systems. This was also a principal theme in the Bichard Inquiry's report, which found that differing practices in the 43 police forces increased the likelihood that information would be lost.

There have been some improvements since 2004, most notably the creation of the Police National Database (PND). But even so, a number of police forces do not routinely supply the PND with all the intelligence that the system is designed to handle.

Some progress has also been made by individual forces. For instance, Avon and Somerset Constabulary recently has invested in a new record management system that links the preparation of custody and case files with intelligence recording and crime management. The new system is also compatible with the force's command and control system. As a result, multiple ICT platforms are updated automatically. Cleveland Police has made a successful bid to the Police Innovation Fund to buy a new system for data matching, leading to identification and deletion of duplicate records. The force estimates it has matched or deleted 200,000 records, a task which would otherwise have taken years to complete. Elsewhere, some forces are joining elements of their ICT together on a regional and inter-regional basis.

Forces must accelerate the move away from insularity and dissolve to nothing the barriers to sharing information. Criminals are more than capable of taking advantage of information highways, and it is essential that law enforcement does the same. In today's digitally-connected world, interoperability is not just important: it is essential. Chief constables must fully commit to working collaboratively with each other and the Police ICT Company to bring about radical improvements to the use, design, interoperability and procurement of ICT systems.

The *Strategic Policing Requirement* (SPR) requires, among other things, connectivity between forces and emphasises the need for consistency. Police and crime commissioners and chief constables are all required to have regard[23] to it. The chronic lack of interoperability between forces' ICT systems clearly demonstrates that "having

regard to" the SPR is not enough and that forces need to go much further.

Interoperability is a problem that has largely been solved in safety-critical, essential public services such as energy and transport. When these services were being restructured, a network code was established for each, specifying common operating procedures for things which had to be done the same way, to ensure quality and continuity of service. Common technical standards, and an obligation to adhere to them, have been efficiently, economically and fairly established, and they work well as a result.

These other public services were starting from a single entity (or a very few) and created their network codes before they were split up. In the case of the police, the problem is approached from the opposite end – we have forces which are already separate (and have never been one) and now need to join their systems together in a way that respects local accountability but acquires, maintains and exploits all the benefits of a single networked system.

© Cambridgeshire Constabulary

Until the police service has a fully functional, interoperable system of ICT networks, efficiency and effectiveness are impaired, public safety is imperilled.

In these respects, the principles are the same, and the techniques of other public services can be adapted to meet the needs of law enforcement. This is a problem about which I have commented many times during my tenure as Her Majesty's Chief Inspector of Constabulary.

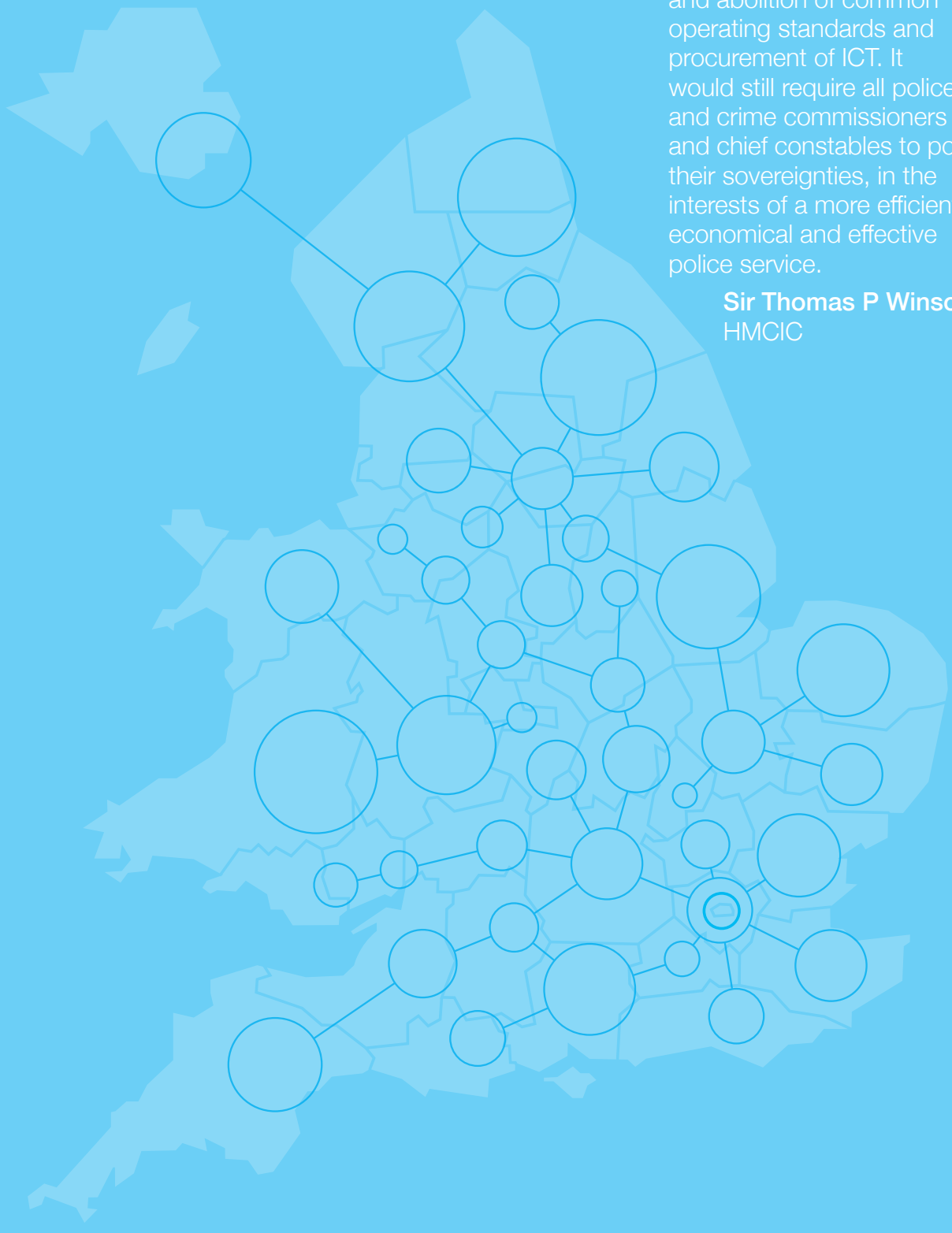
The solution I have proposed is a network code: a decision-making mechanism for the establishment, revision and abolition of common operating standards and procurement of ICT. It would still require all police and crime commissioners and chief constables to pool their sovereignties, in the interests of a more efficient, economical and effective police service.

This is an opportunity for them to improve policing, not a threat to their independence. Policing is no longer all local and there have never been 43 best ways to specify, acquire or use ICT.

Of course, the requirements of each force are not all exactly the same. There needs to be a well-developed procedure for the proposal, analysis and consideration of standards and new ways of working with ICT, so everyone has a say, and everyone's individual circumstances are taken fully into consideration. There is also a role for ICT suppliers to ensure the practicalities and economies of ICT development are properly understood, at the right point in time.

Until the police service has a fully functional, interoperable system of ICT networks, efficiency and effectiveness are impaired, public safety is imperilled.

# Connection and collaboration



The solution I have proposed is a network code: a decision-making mechanism for the establishment, revision and abolition of common operating standards and procurement of ICT. It would still require all police and crime commissioners and chief constables to pool their sovereignties, in the interests of a more efficient, economical and effective police service.

**Sir Thomas P Winsor,** HMCIC


© Thames Valley Police

# Part 2: Our inspections

We assess and make graded judgments about how well each police force keeps people safe and reduces crime.

# Our PEEL inspections

In 2016, we made our second complete PEEL assessment of the 43 police forces in England and Wales. As part of the PEEL programme, we assess and make graded judgments about how well each police force keeps people safe and reduces crime. The PEEL programme consists of three pillars: effectiveness, efficiency and legitimacy.

PEEL: effectiveness is an assessment of whether appropriate services are being provided by each police force and how well those services work; it considers the range of the force's responsibilities, such as cutting crime, protecting the vulnerable, tackling anti-social behaviour, and dealing with emergencies and other calls for service.

PEEL: efficiency is an assessment of whether the manner in which each force provides its services represents value for money, and how well the force understands and matches its resources and assets to the demands for its services, both in the present and in planning for the future.

PEEL: legitimacy is an assessment of whether, in providing services, each force operates fairly, ethically and within the law. This includes the treatment of those to whom services are provided by the police and the treatment of the people who work in police forces.

In addition, our PEEL assessment includes an examination of how leadership is understood, developed and displayed in each of the 43 English and Welsh forces.

The challenge of providing services throughout an entire police force area is a function of many things including the area's size, topography, road network and, most importantly, the people who live, work and spend time there. Taken together, these and other considerations are often referred to as the operating context. We take account of the operating context for each force, and we recognise that differing operating contexts create markedly different needs for policing.

At the end of the PEEL year (in March 2017),


© West Midlands Police

HM Inspectors of Constabulary produce a rounded annual assessment of each force, drawing on the PEEL assessments and other sources of information. We call these the HMIs' assessments and we publish them on our website.[24] We also publish national summary reports for each pillar of the PEEL programme, as well as supplementary reports on significant themes such as leadership.

It is important to understand that police forces are not in competition with each other. Inevitably, there will be those who want to re-order our graded judgments into a form of league table. Nonetheless, a more sophisticated approach is required to represent the breadth and complexity of police performance and to understand the context in which services are provided. Similarly, it is important to read beyond the headline graded judgments and consider the reasons why some forces have been graded more highly than others. These more nuanced judgments are to be found in the individual force reports that are presented on our website.[25]

# PEEL judgments table

| | Effectiveness | | | | | Efficiency | |
|---|---|---|---|---|---|---|---|
| | How effective is the force at preventing crime, tackling anti-social behaviour and keeping people safe? | How effective is the force at investigating crime and reducing re-offending? | How effective is the force at protecting those who are vulnerable from harm, and supporting victims? | How effective is the force at tackling serious and organised crime? | **Effectiveness pillar** | Since 2015 | How well does the force understand the current and likely future demand? |
| **Avon and Somerset** | Good | Good | Good | Requires improvement | **Good** | ↑ | Outstanding |
| **Bedfordshire** | Inadequate | Requires improvement | Inadequate | Requires improvement | **Inadequate** | ↓ | Requires improvement |
| **Cambridgeshire** | Good | Requires improvement | Good | Good | **Good** | ↑ | Requires improvement |
| **Cheshire** | Good | Good | Good | Good | **Good** | ↔ | Outstanding |
| **Cleveland** | Good | Good | Requires improvement | Good | **Good** | ↑ | Good |
| **Cumbria** | Good | Good | Requires improvement | Good | **Good** | ↑ | Requires improvement |
| **City of London** | Requires improvement | Good | Good | Requires improvement | **Good** | ↔ | Good |
| **Devon and Cornwall** | Requires improvement | Requires improvement | Good | Good | **Requires improvement** | ↓ | Requires improvement |
| **Derbyshire** | Good | Good | Good | Outstanding | **Good** | ↔ | Good |
| **Dorset** | Good | Good | Good | Good | **Good** | ↔ | Good |
| **Dyfed-Powys** | Good | Requires improvement | Requires improvement | Good | **Requires improvement** | ↔ | Requires improvement |
| **Durham** | Outstanding | Good | Good | Outstanding | **Outstanding** | ↔ | Outstanding |
| **Essex** | Good | Good | Requires improvement | Good | **Good** | ↑ | Good |
| **Gloucestershire** | Requires improvement | Requires improvement | Requires improvement | Inadequate | **Requires improvement** | ↔ | Good |
| **Greater Manchester** | Good | Requires improvement | Requires improvement | Outstanding | **Good** | ↔ | Good |
| **Gwent** | Good | Good | Good | Requires improvement | **Good** | ↔ | Good |
| **Hampshire** | Good | Requires improvement | Requires improvement | Good | **Requires improvement** | ↓ | Good |
| **Hertfordshire** | Good | Requires improvement | Inadequate | Good | **Requires improvement** | ↓ | Requires improvement |
| **Humberside** | Good | Requires improvement | Inadequate | Good | **Requires improvement** | ↔ | Requires improvement |
| **Kent** | Good | Good | Good | Good | **Good** | ↔ | Outstanding |
| **Lancashire** | Good | Good | Good | Good | **Good** | ↔ | Good |
| **Leicestershire** | Good | Requires improvement | Requires improvement | Good | **Requires improvement** | ↓ | Good |

↑ **Improved** ↔ **Unchanged** ↓ **Declined**

## Legitimacy

| How well does the force use its resources to manage current demand? | How well is the force planning for demand in the future? | **Efficiency pillar** | Since 2015 | To what extent does the force treat all of the people it serves with fairness and respect? | How well does the force ensure that its workforce behaves ethically and lawfully? | To what extent does the force treat its workforce with fairness and respect? | **Legitimacy pillar** | Since 2015 |
|---|---|---|---|---|---|---|---|---|
| Good | Good | **Good** | ↔ | Good | Good | Good | **Good** | ↔ |
| Requires improvement | Requires improvement | **Requires improvement** | ↔ | Good | Requires improvement | Good | **Good** | ↔ |
| Good | Requires improvement | **Requires improvement** | ↓ | Good | Requires improvement | Good | **Good** | ↔ |
| Good | Good | **Good** | ↓ | Good | Good | Good | **Good** | ↔ |
| Good | Good | **Good** | ↑ | Requires improvement | Requires improvement | Requires improvement | **Requires improvement** | ↔ |
| Good | Good | **Good** | ↔ | Good | Good | Requires improvement | **Good** | ↔ |
| Requires improvement | Inadequate | **Requires improvement** | ↓ | Good | Good | Requires improvement | **Good** | ↔ |
| Requires improvement | Requires improvement | **Requires improvement** | ↓ | Good | Requires improvement | Good | **Good** | ↔ |
| Good | Good | **Good** | ↔ | Outstanding | Outstanding | Good | **Outstanding** | ↑ |
| Good | Good | **Good** | ↑ | Good | Requires improvement | Good | **Good** | ↔ |
| Requires improvement | Requires improvement | **Requires improvement** | ↔ | Requires improvement | Requires improvement | Requires improvement | **Requires improvement** | ↔ |
| Outstanding | Outstanding | **Outstanding** | ↔ | Good | Requires improvement | Outstanding | **Good** | ↔ |
| Good | Good | **Good** | ↔ | Good | Good | Good | **Good** | ↔ |
| Good | Good | **Good** | ↔ | Good | Requires improvement | Requires improvement | **Requires improvement** | ↓ |
| Good | Good | **Good** | ↔ | Good | Good | Good | **Good** | ↔ |
| Good | Good | **Good** | ↔ | Good | Good | Good | **Good** | ↔ |
| Good | Good | **Good** | ↔ | Good | Good | Requires improvement | **Good** | ↔ |
| Good | Good | **Good** | ↔ | Good | Requires improvement | Good | **Good** | ↔ |
| Requires improvement | Requires improvement | **Requires improvement** | ↑ | Good | Good | Requires improvement | **Good** | ↔ |
| Good | Good | **Good** | ↔ | Outstanding | Good | Outstanding | **Outstanding** | ↔ |
| Good | Good | **Good** | ↓ | Good | Requires improvement | Good | **Good** | ↔ |
| Good | Good | **Good** | ↔ | Good | Requires improvement | Good | Good | ↔ |

# PEEL judgments table

| | Effectiveness | | | | | | Efficiency |
|---|---|---|---|---|---|---|---|
| | How effective is the force at preventing crime, tackling anti-social behaviour and keeping people safe? | How effective is the force at investigating crime and reducing re-offending? | How effective is the force at protecting those who are vulnerable from harm, and supporting victims? | How effective is the force at tackling serious and organised crime? | **Effectiveness pillar** | Since 2015 | How well does the force understand the current and likely future demand? |
| **Lincolnshire** | Good | Good | Requires improvement | Good | **Good** | ↑ | Good |
| **Merseyside** | Good | Good | Good | Outstanding | **Good** | ↔ | Good |
| **Metropolitan Police** | Good | Requires improvement | Inadequate | Requires improvement | **Requires improvement** | ↔ | Good |
| **Norfolk** | Outstanding | Good | Good | Good | **Good** | ↔ | Outstanding |
| **Northamptonshire** | Requires improvement | Requires improvement | Requires improvement | Requires improvement | **Requires improvement** | ↔ | Good |
| **Northumbria** | Good | Requires improvement | Good | Good | **Good** | ↔ | Good |
| **Nottinghamshire** | Requires improvement | Good | Inadequate | Good | **Requires improvement** | ↓ | Good |
| **North Wales** | Good | Good | Requires improvement | Good | **Good** | ↑ | Good |
| **North Yorkshire** | Good | Good | Good | Requires improvement | **Good** | ↔ | Good |
| **Suffolk** | Good | Good | Good | Good | **Good** | ↔ | Good |
| **Staffordshire** | Good | Requires improvement | Requires improvement | Requires improvement | **Requires improvement** | ↔ | Good |
| **Surrey** | Good | Requires improvement | Good | Good | **Good** | ↑ | Requires improvement |
| **Sussex** | Requires improvement | Requires improvement | Requires improvement | Good | **Requires improvement** | ↓ | Good |
| **South Wales** | Good | Good | Good | Good | **Good** | ↔ | Outstanding |
| **South Yorkshire** | Requires improvement | Requires improvement | Requires improvement | Good | **Requires improvement** | ↔ | Requires improvement |
| **Thames Valley** | Good | Good | Good | Good | **Good** | ↔ | Good |
| **Wiltshire** | Good | Good | Good | Good | **Good** | ↔ | Good |
| **West Midlands** | Good | Good | Requires improvement | Good | **Good** | ↔ | Outstanding |
| **West Mercia** | Requires improvement | Good | Good | Requires improvement | **Good** | ↑ | Good |
| **Warwickshire** | Requires improvement | Good | Requires improvement | Good | **Good** | ↑ | Good |
| **West Yorkshire** | Requires improvement | Good | Good | Good | **Good** | ↔ | Good |

**↑ Improved** **↔ Unchanged** **↓ Declined**

## Legitimacy

| | How well does the force use its resources to manage current demand? | How well is the force planning for demand in the future? | **Efficiency pillar** | Since 2015 | To what extent does the force treat all of the people it serves with fairness and respect? | How well does the force ensure that its workforce behaves ethically and lawfully? | To what extent does the force treat its workforce with fairness and respect? | **Legitimacy pillar** | Since 2015 |
|---|---|---|---|---|---|---|---|---|---|
| | Good | Requires improvement | **Good** | ↑ | Good | Requires improvement | Good | **Good** | ↔ |
| | Good | Good | **Good** | ↔ | Good | Good | Good | **Good** | ↔ |
| | Requires improvement | Good | **Good** | ↔ | Good | Requires improvement | Good | **Good** | ↔ |
| | Good | Good | **Good** | ↓ | Good | Good | Good | **Good** | ↔ |
| | Good | Requires improvement | **Good** | ↑ | Good | Good | Good | **Good** | ↔ |
| | Good | Requires improvement | **Good** | ↔ | Good | Requires improvement | Good | **Good** | ↑ |
| | Requires improvement | Inadequate | **Requires improvement** | ↓ | Good | Good | Requires improvement | **Good** | ↔ |
| | Requires improvement | Good | **Good** | ↔ | Good | Requires improvement | Requires improvement | **Requires improvement** | ↓ |
| | Good | Good | **Good** | ↔ | Good | Good | Good | **Good** | ↔ |
| | Good | Good | **Good** | ↔ | Good | Good | Good | **Good** | ↔ |
| | Good | Requires improvement | **Good** | ↔ | Good | Good | Good | **Good** | ↔ |
| | Good | Good | **Good** | ↑ | Good | Good | Good | **Good** | ↔ |
| | Requires improvement | Good | **Good** | ↔ | Good | Good | Good | **Good** | ↔ |
| | Good | Good | **Good** | ↔ | Good | Good | Requires improvement | **Good** | ↔ |
| | Inadequate | Requires improvement | **Requires improvement** | ↔ | Requires improvement | Good | Requires improvement | **Requires improvement** | ↓ |
| | Good | Good | **Good** | ↔ | Good | Requires improvement | Good | **Good** | ↔ |
| | Good | Good | **Good** | ↔ | Good | Good | Outstanding | **Good** | ↔ |
| | Good | Outstanding | **Outstanding** | ↔ | Good | Good | Requires improvement | **Good** | ↔ |
| | Good | Good | **Good** | ↔ | Good | Good | Good | **Good** | ↑ |
| | Good | Good | **Good** | ↔ | Good | Good | Good | **Good** | ↑ |
| | Good | Good | **Good** | ↔ | Good | Good | Good | Good | ↔ |

# PEEL 2016: Summary of grades for each pillar

**Effectiveness**: One force (Durham) was graded outstanding, 28 were graded as good, 13 were graded requires improvement and one force (Bedfordshire) was graded inadequate.

**Efficiency**: Two forces (Durham and West Midlands) were graded outstanding, 33 were graded as good, 8 were graded requires improvement and no forces were graded inadequate.

**Legitimacy**: Two forces (Kent and Derbyshire) were graded outstanding, 36 were graded as good, 5 were graded requires improvement and no forces were graded inadequate.

# Changes since last year

Across all three pillars of the PEEL programme, the majority of forces have been graded the same in 2016 as they were in 2015.

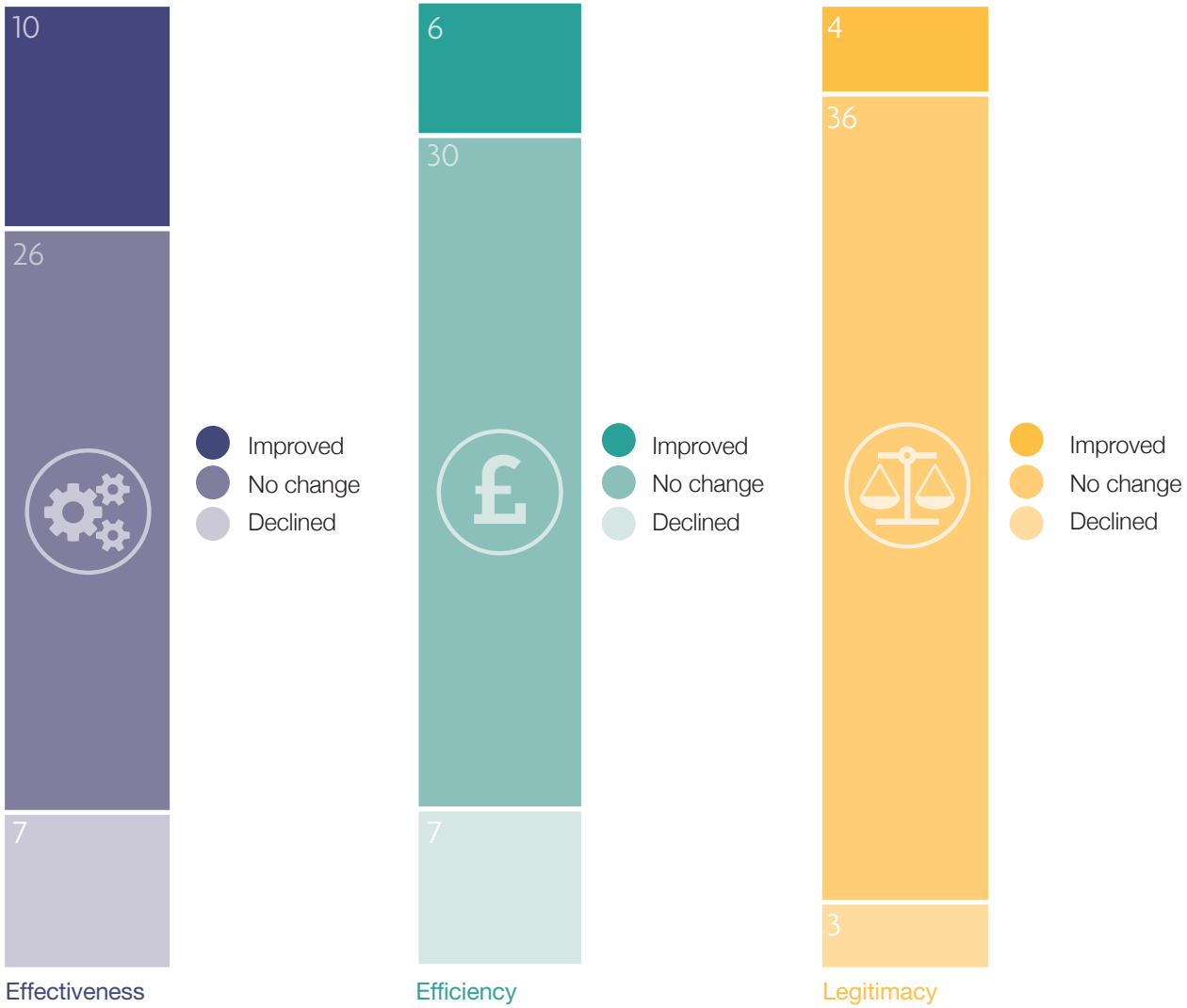
The effectiveness pillar had the largest movement in grades: 10 forces were graded higher than the previous year; 7 forces declined in grade.

For the efficiency pillar: the grades for 30 forces remained the same, 6 improved and 7 declined.

The legitimacy pillar had the least movement in grades compared with last year: the grades for 36 forces remained the same, 4 improved and 3 declined.

One force (Bedfordshire) received different grades in 2016 in all of the three pillars, but this is unusual. Of the 20 forces that received different grades this year, the vast majority (19) only received a different grade in one pillar; 23 forces received the same grade in all three pillars.

**Changes since last year in the number of forces at each grade, for each pillar of the PEEL programme**



Most forces, slightly more than last year, are providing a good service to the public.

# PEEL: effectiveness

In our PEEL inspections, our assessment of the effectiveness of forces centres on how well they carry out their responsibilities, including cutting crime, tackling anti-social behaviour, and conducting investigations and managing offenders. We were particularly interested in how forces identified people who are most vulnerable and how services were tailored to meet their needs.

As a result of our PEEL effectiveness inspections, one force (Durham) was graded outstanding, 28 forces were graded as good, 13 were graded as requiring improvement and one force (Bedfordshire) was graded inadequate.

Most forces, slightly more than last year, are providing a good service to the public. Police leaders, officers and staff should be commended for this. We judged two forces to be outstanding at crime prevention and four as outstanding at tackling serious and organised crime. In particular, there has been considerable improvement in the protection of vulnerable victims and keeping them safe. This is to be welcomed. However, HMIC is concerned that, despite this broadly positive overall picture, there are some worrying practices in some police forces and risks to the public in the service that is being provided.

Some forces have struggled to respond to reductions in the level of resources available to them, changes

## Effectiveness

- Outstanding
- Good
- Requires improvement
- Inadequate

**Effectiveness**

Overall judgments

How effective is the force at preventing crime, tackling anti-social behaviour and keeping people safe?

1 28 13 1

2 30 10 1

© Sussex Police

in the demand they face and the need to provide a better service for vulnerable people. Some of the changes that forces have made are poorly-conceived short-term responses to current pressures, and do little to address the need to make adequate plans for acquiring or enhancing the capabilities that will be essential for the future.

In a small number of forces, these changes are putting vulnerable people at serious risk of harm. Fewer arrests are taking place, suspects are not being pursued or apprehended and, in some forces, a large number of crimes are being effectively written off rather than pursued to an appropriate conclusion for the victim and the community. This could be by downgrading the severity of calls for assistance from the public, by setting a quota for the number of cases to be referred for specialist assistance, or by not analysing and recording all of the known organised crime groups in a local area.

The result is that some forces are not doing many of the fundamental things that are required to reduce crime and keep people safe.

As shown in figure 1, in England and Wales, 47 percent of investigations into all recorded offences are closed without identifying a suspect. However, this ranges from 24 percent in some forces to 60 percent in others. For violent offences, the proportion of cases that forces close without identifying a suspect ranges between 3 percent and 53 percent.

© Northamptonshire Police

How effective is the force at investigating crime and reducing re-offending?

0 26 17 0

How effective is the force at protecting those who are vulnerable from harm, and supporting victims?

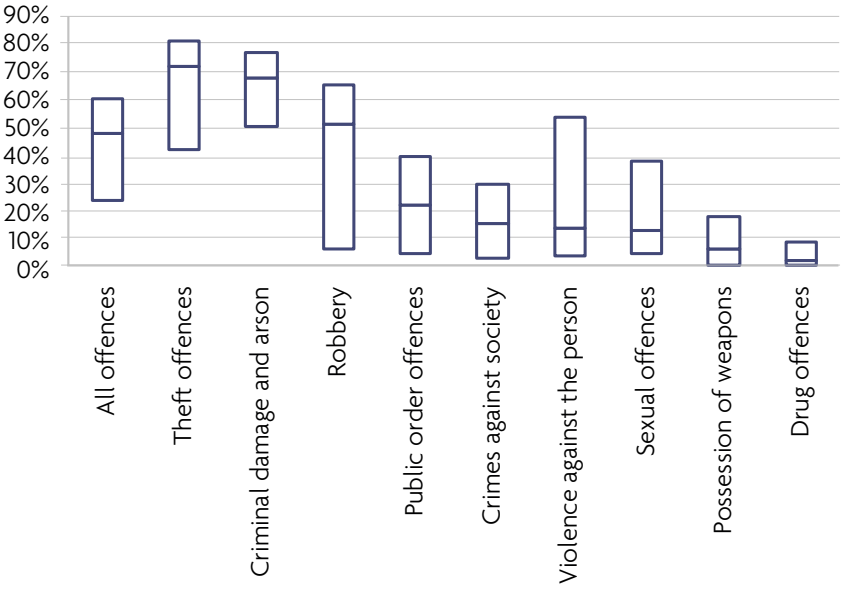
0 22 16 5

How effective is the force at tackling serious and organised crime?

4 29 9 1

Police forces are not keeping pace with the way technology is transforming people's lives and changing their experience of crime.

Figure 1:
Proportion of investigations in the 12 months to 30 June 2016 that were completed without identifying a suspect




Proportion of offences that are assigned to outcome 18: investigation complete, no suspect identified. Range between forces in England and Wales. Mid line shows England and Wales rate.

Source: Home Office (2016) Crime Outcomes, 12 months to 30 June 2016
Note: The proportion of outcomes is displayed as a range covering all forces in England and Wales. The centre line is the England and Wales rate. Dorset has been excluded from the chart as problems with the validity of the data were discovered during the inspection.

HMIC continues to be concerned by the erosion of neighbourhood policing. Officers who are visibly and frequently present in a local community are more readily able to gain the trust and confidence of the people in that community. This, together with a detailed understanding of the risks and threats each community faces, is critical in preventing crime and anti-social behaviour. Effective local policing teams are also valuable assets in the fight against organised crime and play an important role in keeping vulnerable people safe.

Too many forces are failing to match the capacity and capability of their workforce to the demands they face. Police forces need to develop their structures, capabilities and operating models in order to allocate work appropriately. In particular, there is a national crisis in the recruitment of detectives, which is leading to some complex investigations being carried out by officers who lack the necessary training, skills

© West Midlands Police

and experience. There are also still problems with the way investigations are supervised.

Police forces are not keeping pace with the way technology is transforming people's lives and changing their experience of crime. Last year, one in ten adults was a victim of fraud and computer misuse at least once.[26] New statistics from the Office for National Statistics suggest that in the 12 months to June 2016, at least 31 percent of blackmail offences, 45 percent of obscene publication offences and 11 percent of both stalking and harassment and child sexual offences were committed online in full or in part.[27, 28] This is an issue that worries the public: 82 percent think online crime is a big problem and 68 percent think the same for online anti-social behaviour.[29] However, 42 percent do not feel confident that their local police could deal with online crime.[30]

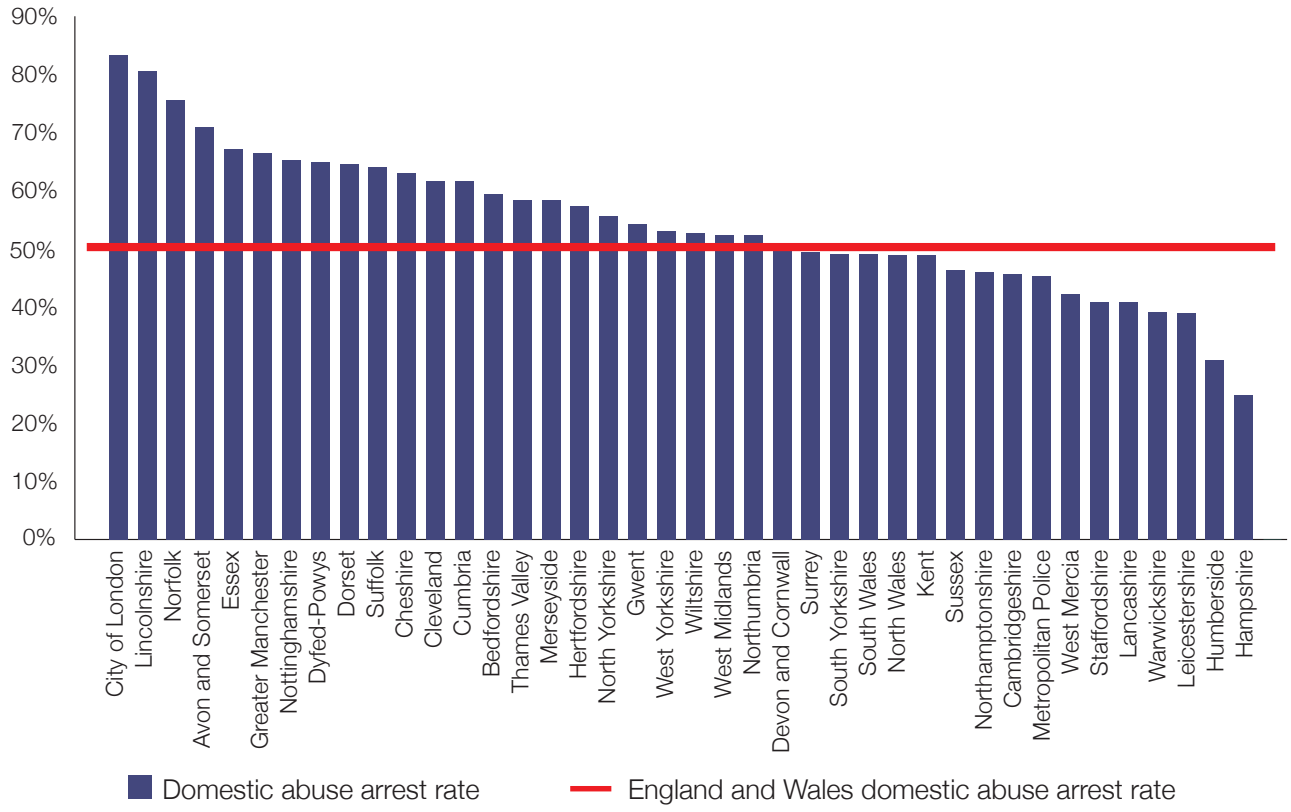
HMIC has concerns about the extent to which the public is being put at risk because of the limited capacity within many forces to manage dangerous offenders. The most dangerous offenders are managed through a multi-agency process

Forces cannot successfully fight serious and organised crime in isolation.

known as MAPPA,[31] which includes an assessment of the risk posed by each offender. Some forces were struggling to complete these risk assessments as they require substantial input from a range of agencies. In some forces, there are also significant delays in assessing the risks posed by registered sex offenders and carrying out supervisory visits to those offenders, visits that are required in order to keep communities safe. Across England and Wales, the risk presented by some 2,700 registered sex offenders has yet to be assessed. This means that forces are failing to understand and manage the risk to the public.

The variation in the extent to which forces use their powers and pursue criminal justice outcomes is currently unexplained and unacceptable. For instance, the rate of arrest for domestic abuse crimes ranges from 25 percent to 83 percent (see figure 2).

**Figure 2:**
**Domestic abuse arrest rate in the 12 months to 30 June 2016**




Source: HMIC effectiveness data collection
Note: Three forces (Derbyshire, Durham and Gloucestershire) were unable to provide domestic abuse arrest data.

Most forces are good at tackling serious and organised crime. However, a shift in approach is needed if forces are to maintain and improve this level of effectiveness as organised crime becomes more complex.

When a force identifies an organised crime group, it assesses the group's criminal intent and capability by carrying out a nationally standardised procedure known as mapping. This procedure enables forces to understand the threat posed by organised crime groups, and informs decisions about which groups to tackle first, and which tactics to use.

While mapping provides a helpful structure for assessing many aspects of organised crime, it is poorly suited to assessing the intent and capability of groups involved in newer threats such as cyber-crime, or criminal networks whose membership, activity and locations change quickly. HMIC believes that the mapping methodology needs to be improved and the function should be transferred to regional organised crime units.

Forces cannot successfully fight serious and organised crime in isolation. They need to work more closely with regional organised crime units and other agencies to identify the full extent of organised criminal networks, rather than simply targeting mid-level criminals. Intelligence needs to be shared, priorities need to be established and regional-level specialist capabilities need to be used where relevant.

Similarly, we are concerned at the inconsistent approach to assessing risk in relation to the criminal use of firearms.

Without a consistent process for assessing risk, it is possible that forces are unable to plan properly and therefore cannot be certain that they have sufficient resources available to meet the threat they face. The ability to assess demand and plan accordingly is a recurring theme throughout HMIC's reports, but the consequences of failing to do this where firearms are concerned would be severe enough to merit special mention.

As with organised crime mapping, HMIC believes that the national methodology for assessing firearms risk needs to be further developed.

Many forces said that they were worried about significant increases in future demand for policing.

# PEEL: efficiency

In our PEEL inspections, our assessment of the efficiency of forces centres on how well they provide value for money to the communities they serve. In particular, we examine how well forces understand the demand for their service, both now and in planning for the future, and how well they match their resources to that demand.

As a result of our 2016 PEEL efficiency inspections, two forces (Durham and West Midlands) have been graded as outstanding, 33 forces as good and eight forces as requiring improvement. No force has been graded as inadequate. As with last year, the majority of forces have been graded as good. Three fewer forces have been graded as outstanding compared with last year.

We inspected how well forces understand the full range of their demand, from how well they reacted to 999 calls, crime reports and other calls for service, to how well they uncovered demand that might otherwise go unreported or unnoticed. We have also inspected the extent to which police forces understand how their demand and the expectations of them are likely to change in the future.

As with last year, most forces have a good understanding of the current demand for their services, and are focusing on this demand to help them understand their work. For example, most forces have a good awareness of the number and nature of

## Efficiency

- Outstanding
- Good
- Requires improvement
- Inadequate

**Efficiency**

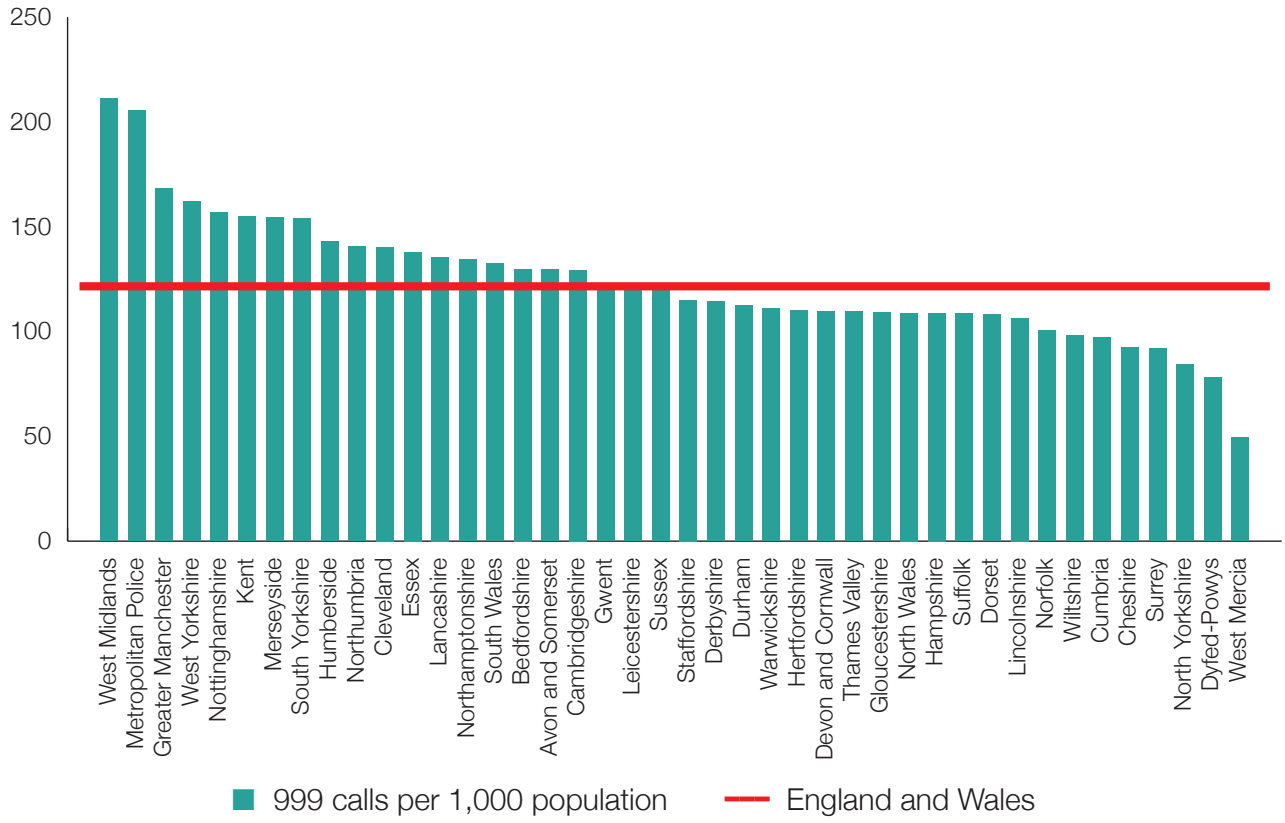
Overall judgments

2 33 8 0

How well does the force understand the current, and likely future, demand?

7 27 9 0

Figure 3:
Emergency 999 calls recorded by each force in the 12 months to 31 March 2016, per 1,000 population




Source: Home Office annual data requirement
Note: City of London Police does not directly receive 999 calls because these are received by the Metropolitan Police Service on behalf of City of London Police.

their 999 calls, the number of which varies hugely across forces in England and Wales (see figure 3). It is, however, important that forces proactively seek out demand that may otherwise be hidden. Most forces have plans in place to meet some of this demand, but only the best have a detailed strategy.

Many forces said that they were worried about significant increases in future demand for policing, partly as a result of greater numbers of crimes such as child sexual exploitation and partly as a result of cuts to other public sector organisations. However, forces are making very broad assessments of likely trends for the future on the basis of limited evidence; only a few could provide detailed evidence that they were gathering relevant

How well does the force use its resources to manage current demand?

1 32 9 1

How well is the force planning for demand in the future?

2 29 10 2

The quality and ambition of the plans that forces have for their futures are highly variable.

information from other sources and assessing the potential implications of these trends. This detailed work is essential if forces are to prepare efficiently for the future.

Most forces have reflected their developing understanding of demand in the way they assign and allocate resources. The best-performing forces have sophisticated software models that analyse demand and can match available resources to current and predicted demand for their services. In contrast, the poorest-performing forces do not have effective systems to analyse demand and this regularly leaves them without enough officers or staff available to respond quickly to calls from the public.

Most forces' ability to match resources to demand is limited by an incomplete understanding of the skills (and skills gaps) of their workforces. Although many forces have some form of database for recording workforce skills, it is often limited in scope and few forces can demonstrate that they make consistent use of the available information when allocating roles. This limits the ability of forces to identify gaps in staffing and to use external recruitment to fill these roles. Consequently, forces find it harder to manage the demands placed on them.

Most forces have change programmes in place, but only a few higher-performing forces can establish that their programmes have made them more efficient. Many forces focus on successfully

reducing overall costs rather than making the most of the full benefits of change. Few forces have a sophisticated understanding of any unintended consequences (positive or negative) for their workforces as a result of change programmes.

The quality and ambition of the plans that forces have for their futures are highly variable. The highest-performing forces have impressively coherent and ambitious plans for developing the size, skills and background of their workforce, plans for improving their ICT systems, and plans for managing continuing financial pressures. However, many forces are only able to plan separately for each of these areas and so do not scrutinise sufficiently how all of the individual plans are likely to affect each other.

A few forces have good plans that focus on specific areas, such as greater integration with other organisations (often the fire and rescue service) or improved ICT. Few forces


© Northamptonshire Police

have workforce plans that are particularly innovative. Many forces are recruiting new officers, but with a limited understanding of the skills those officers will need to have. Some forces are seeking transferees from other forces to increase the number of their detectives who have experience of working with vulnerable people. We had hoped to see much more innovative use of police staff, PCSOs, special constables and volunteers to bring new and under-represented skills into the police workforce.

Most forces still plan to make savings this financial year, largely by continuing previous change programmes, but we found evidence to indicate that some forces have reduced the pace and ambition of their plans since last year.

Most forces have made sensible mid-term financial provisions. However, HMIC continues to believe that rapid changes in demand and public expectations of policing mean that more work is needed to identify, at an earlier stage, those forces that could struggle to respond quickly enough to these changes.

Last year, we reported that forces were not making the most of opportunities to work with each other, and combining resources to save money played only a small part in forces' financial planning. This year, we found that a few forces have very impressive and innovative plans to work with other forces, other emergency services and other agencies in their local areas. However, a similar number of forces have little ambition to increase their joint working beyond a few disparate projects, often focused on a specific function such as firearms policing or forensics.

We commented last year that the best forces had good working relationships with health authorities to cope with demand from people with mental health problems. Nearly all forces now have some services in place; the best have good access to mental health expertise within their control rooms and on the front line, and therefore are able to manage demand more efficiently. While this represents positive progress, it will take a sustained effort on the part of both police and other local public services to make sure demand related to mental health is managed appropriately.

Last year, as in previous years, we noted that forces' ICT was generally weak and ageing. Some forces have impressive projects under

way to increase their digital capabilities, but very few forces have a coherent plan to transform the way they provide services using all of their ICT systems. In most cases, forces' ICT was designed to support their existing ways of working, rather than influencing the design of new ways of working. Very few forces focus on developing the digital skills of their officers and staff, or ensuring that the exploitation of new technology is at the heart of their day-to-day work. Some forces have struggled to implement new ICT systems.

Last year, we also drew attention to the problem of the deleterious effects of older ICT systems. This is still a significant problem. Some forces have large numbers of individual, bespoke legacy systems that only a small number of individuals know how to maintain. To fix this, forces need to give serious thought to the ICT architecture that they are designing. This is more important – and more difficult – than the effective procurement of individual devices. It is still too common for forces to invest very significant amounts of money in devices and systems that their ICT architecture cannot handle.

Bespoke solutions tend to be more expensive and the police service as a whole would benefit from having access to 'off-the-shelf' products that would simplify procurement, reduce costs and increase consistency. That does not mean that every police force should have the same ICT system. There is considerable scope for variation, provided that systems can connect to one another and exchange information; interoperability is essential.

The Police ICT Company[32] has achieved some positive results with individual suppliers, but currently lacks the mandate and resources to bring about the level of change that is desperately needed in this area. It is essential that all police leaders commit to working collaboratively with the Police ICT Company to bring about radical improvements to the use, procurement, interoperability and role of information technology systems.

# PEEL: legitimacy

In our PEEL inspections, our assessment of the legitimacy of forces centres on whether they operate fairly, ethically and within the law. In particular, we examine how forces treat people. These things are essential to the maintenance of public support and co-operation; they are the cornerstone of the British model of policing by consent.

This year, we asked specific questions about how well forces are dealing with the problem of police officers or staff abusing their positions of authority for sexual gain. This is a serious form of corruption that betrays the trust of the public and preys upon some of the most vulnerable people in society, often at a time when they have turned to the police for help.

The results of this year's PEEL legitimacy inspection were largely positive, though there were some areas where forces can improve. We graded two forces (Derbyshire and Kent) as outstanding, 36 as good and five as requires improvement. None was graded as inadequate. This is largely consistent with last year's results.

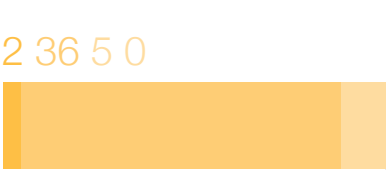
Overall, the police forces of England and Wales are good at treating the people they serve with fairness and respect. As figure 4 shows, victims' satisfaction with their treatment by the police remains high; more than 93 percent of victims are satisfied with how they were treated by the police in the 12 months to 31 March 2016.

## Legitimacy

- Outstanding
- Good
- Requires improvement
- Inadequate

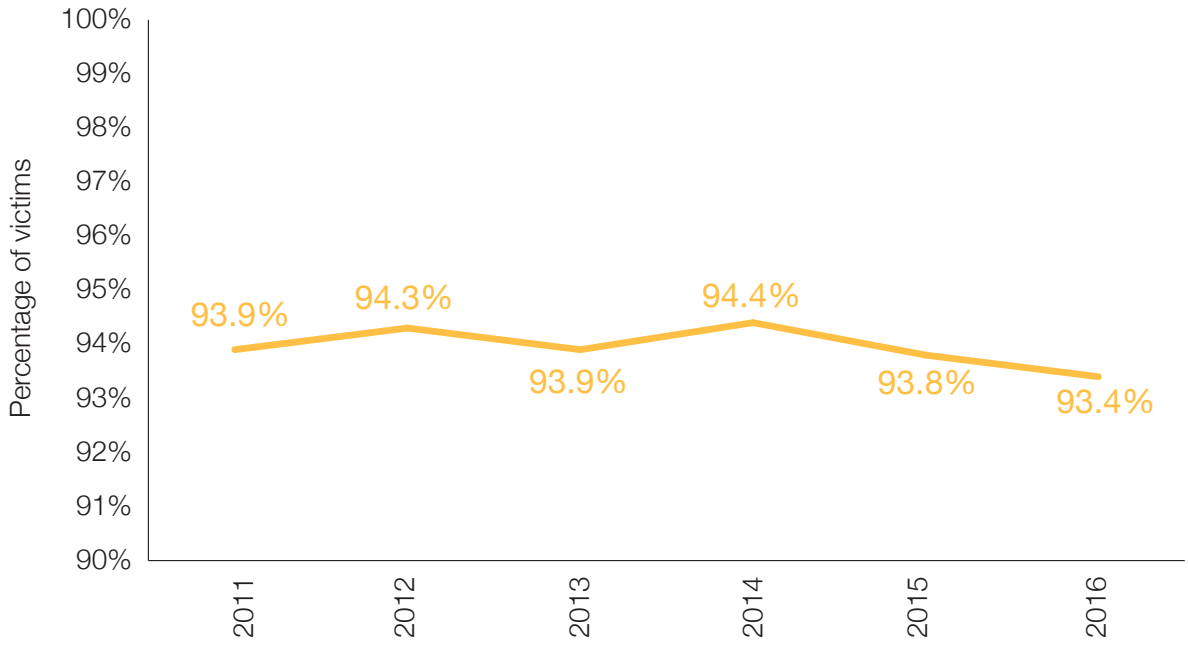
**Legitimacy**

Overall judgments




To what extent does the force treat all of the people it serves with fairness and respect?

Figure 4:
Percentage of victims in England in Wales satisfied with overall treatment, for the 12 months to 31 March 2016




Source: Home Office annual data requirement

Victim satisfaction has been stable in recent years.

Officers and staff understand the importance of treating people with fairness and respect, and understanding of the *Code of Ethics*[33] has improved.

Forces use various techniques to seek feedback and challenge

How well does the force ensure that its workforce behaves ethically and lawfully?

1 26 16 0

from the public about a range of events and types of behaviour that affect perceptions of fair and respectful treatment. Some forces rely too heavily on public complaints and channels such as community meetings or social media. These forces could do more to obtain feedback in different ways,

To what extent does the force treat its workforce with fairness and respect?

3 28 12 0

particularly from those people who are less likely to complain or who have less trust and confidence in the police.

In order to identify and understand the issues that affect public perceptions of fair and respectful treatment, most forces analyse public surveys, complaints and their use of stop and search powers. However, many forces need to be more systematic in the way they collect and analyse feedback, and wider management information and learning, to identify trends and prioritise areas for improvement.

Police officers and staff abusing their authority for sexual gain is a serious form of corruption and it needs to be completely eradicated.

Many forces were able to provide examples of improvements they had made to their services in response to feedback from individuals. However, forces sometimes struggled to show clear and consistent links between identifying a problem, making effective improvements, and demonstrating to the public that they had done so.

Overall, most police forces in England and Wales are good at ensuring their workforces act ethically and lawfully, but improvement is still required in more than a third of forces.

We are concerned that a significant number of forces are failing to comply with national vetting policy,[34] in particular with the requirements to re-vet individuals after ten years of service, and to undertake vetting reviews before promotion or posting to high-risk units. These forces are vulnerable to corruption among their officers and staff.

Forces are generally good at monitoring whether officers and staff are complying with integrity policies. Forces are also good at assessing and developing intelligence about corruption once they receive it. However, many forces need to improve their ability to seek out intelligence and intervene early, rather than waiting for problems to be reported. This need for improvement is particularly serious in relation to forces' ability to tackle the abuse of authority for sexual gain.

Police officers and staff abusing their authority for sexual gain is a serious form of corruption and it needs to be completely eradicated. It exploits some of the most vulnerable people who come into contact with the police and it violates public trust. Despite this, some forces are still failing to recognise it as a form of serious corruption, so cases are not always being referred to the Independent Police Complaints Commission (IPCC).

The abuse of authority for sexual gain is not an isolated problem that only affects a few forces. Data provided by forces in England and Wales[35] show that, in the 24 months to 31 March 2016, all but one force had at least one reported allegation of abuse of authority for sexual gain. Over a third (39 percent) of the allegations involved victims of domestic abuse.[36]

Since 2012, the IPCC, ACPO and HMIC have all examined and reported on the problem of abuse of authority for sexual gain.[37] The fact that forces have made such limited progress towards eradicating this problem suggests that we need a coherent and comprehensive national policing response. Police officers and staff need to take the abuse of authority for sexual gain very seriously and there can be no excuse for forces failing to ensure that this happens.

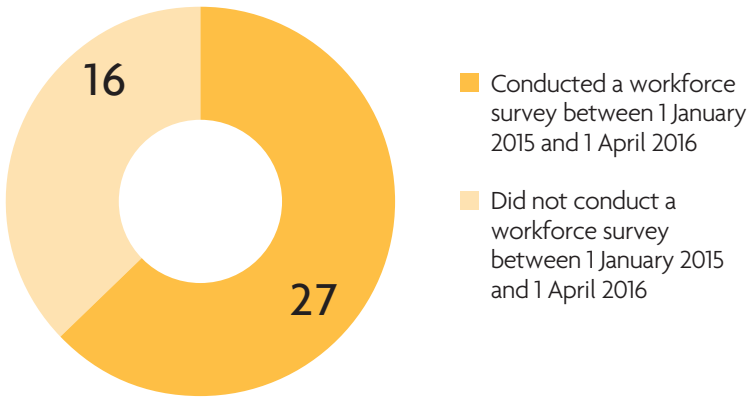
More positively, nearly all forces now communicate the outcomes of gross misconduct and corruption cases to the public, as well as to officers and staff. Some forces need to do more than just fulfil basic requirements of openness, so that the consequences of misconduct and corruption are clear to everyone.

Overall, the police forces of England and Wales are good at treating their workforces with fairness and respect. We were pleased to find that most forces use a range of communication channels, such as workforce surveys (see figure 5), for seeking feedback from their workforces and can provide evidence of taking action where it is needed. However, many forces could do more to demonstrate this action to their workforces, and should seek more involvement from officers and staff in making improvements.

We found that most forces recognise the importance of workforce well-being, including psychological well-being and mental health, and take steps to improve it. However, the provision of occupational health services is shrinking and there is an increasing dependence on supervisors to identify and support the well-being needs of individuals. We remain concerned that supervisors do not always have the knowledge and confidence to recognise and respond to mental health problems.

We were disappointed to find that most forces do not have fair and effective processes for managing the individual performance of officers and staff. In many cases, reliance on the diligence of individual supervisors has resulted in processes – or lack of processes – that may be unfair and ineffective. This is an area that needs to improve significantly, particularly given that it has wider implications for the integrity, efficiency and leadership capability within policing.

**Figure 5:**
**Proportion of police forces in England and Wales that conducted a workforce survey between 1 January 2015 and 1 April 2016**




Source: HMIC legitimacy data collection

Police leaders need to have the flexibility and skills to meet not just current demands, but to respond to future challenges.

# PEEL: leadership

In our PEEL inspections, we examine the degree to which leadership is understood within policing, how forces work to develop leadership capability and how well leadership is displayed by each force.

The inspection considered the following three questions:

- How well does the force understand leadership?
- How well does the force develop leadership?
- How well does the force display leadership?

Our approach is aligned with the principles set out in the *Guiding Principles for Organisational Leadership,*[38] which was published recently by the College of Policing. We have inspected leadership at all ranks and grades, not just at the most senior levels in each force.

The leadership element of PEEL is ungraded, as leadership is a theme which cuts across the other three pillars of the PEEL programme. HMIC acknowledges that there is no single definition of good leadership in policing; this inspection does not aim to provide or promote a single model.

© Northamptonshire Police

Police leaders carry substantial levels of responsibility, and effective leadership is a critical part of ensuring that forces maintain the trust of the public that they serve. Police leaders need to have the flexibility and skills not only to meet current demands, but also to deal with future problems. In an increasingly complex policing environment that includes the significant financial cuts of recent years, rapid advances in technology and shifting demographics, it has never been more important for the police service to identify and develop capable leaders.

The best forces are able to demonstrate a sophisticated understanding of the effectiveness of leadership in different areas and use this understanding to support and improve leadership skills throughout the force. These forces also show the outward signs of good leadership: openness to new ideas, an ability to react quickly to new trends and a willingness to challenge constructively the way things are done. There is a growing consensus among senior leaders within policing that the development of leadership is an area that requires more attention.

## Understanding leadership

In this year's inspection, we found that most forces have set out what they expect of their leaders, although the extent to which these expectations are understood by the workforce varies considerably. Generally, they are linked to the objectives that each chief officer team has for the force. The best-performing forces turn these expectations into a strong common purpose for all members of the force, and explain clearly how this should affect actions, types of behaviour and values. Most of the chief officer teams that have not yet set clear expectations are working to develop them in close consultation with their workforces.

Effective communication of leadership expectations to all ranks and grades is important, so that each member of the workforce knows how these expectations affect their role and day-to-day actions. This is an area where we have observed progress from last year, though more should be done to include police staff, constables and sergeants, not just the middle-ranking officers who lead them.

## Developing leadership

HMIC expects forces to use an open and accessible system to identify and select talented individuals and prepare them for promotion through high-potential or talent schemes. Very few forces were able to demonstrate this, or provide a robust assessment of the potential barriers to any member of the workforce seeking to access these schemes, despite the fact that some forces recognised this as a problem. The development of the workforce more widely (particularly in the case of police staff) also remains inconsistent.

High-performing forces have well-publicised development schemes, with clear application processes. High-performing forces also encourage personal responsibility for professional development. In most forces, the system for identifying and developing leaders is still being developed. Consequently, many forces cannot be confident that they are identifying and developing talented individuals whose leadership styles and approaches are different from those of their peers or managers. Last year, we recommended that forces

invested in this area; we are concerned that not enough forces have done so.

Self-assessment and mentoring are fairly well established in most forces as a way of developing future leaders. In many forces, senior officers act as mentors, but only a small number of forces were able to demonstrate a coherent process for identifying people who would benefit from being mentored. It is therefore likely that many senior officers are only mentoring people who have directly approached them or have been referred to them by colleagues.

© Sussex Police

As well as developing talented officers and staff within the workforce, better-performing forces know how to attract talented people from outside the force, and will understand how to make best use of the people they attract. Although many forces are making use of programmes such as Police Now,[39] Direct Entry[40] and Fast Track[41] to improve the diversity of their leadership teams, only a minority of forces are evaluating the way that different leadership styles can improve effectiveness.

## Displaying leadership

Understanding and developing good leadership is important. All forces can demonstrate some form of innovation and challenge, but high-performing forces seek out new ways of working from a range of sectors, and are much more open to internal and external questions.

One area in which we seek evidence of positive leadership is the extent to which a force identifies and implements better ways of working, especially through the use of technology. The strongest forces are fostering innovation, encouraging challenges from officers and staff and allowing them to suggest and test new ways of

working. Strong forces also identify practices that work well across the police service and from outside policing.

We found many examples of forces working closely with academia, industry and the voluntary sector to develop and implement better ways of working. The forces that do this most effectively are not only implementing change within their own force areas, but are working closely with other forces to encourage change at a regional or even national level; Durham Constabulary is a notable example of a force that is doing this well.

All forces are aware of the need to increase the skills, background and experience of their workforces. Higher-performing forces understand that leadership teams that vary in their style, approach and experience can be more effective at questioning existing processes and coming up with new ideas.

However, many forces were not able to demonstrate an ability to understand or influence the composition of individual leadership teams to this level of detail. In previous efficiency inspection reports, and the *State of Policing 2015* report,[42] we found that too many forces focused on ensuring vacancies are filled, rather than making a considered judgment about the person with the best skills and leadership style for a particular role. We recognise that in many cases the options available to forces will be limited and we do not want forces to put bureaucratic processes in place. However, even a relatively light-touch approach supported by improved performance assessment processes would allow forces to make better-informed decisions about individual appointments.

© Greater Manchester Police

Forces are still failing to record many reports of crimes and those failings are depriving victims of the services to which they are entitled.

# Our specialist inspections

## Crime data integrity

In 2014, HMIC inspected all 43 forces in England and Wales to establish the extent to which police-recorded crime information could be trusted. In our report[43] of this inspection we said:

"Reliable crime-recording is essential if police are to be able to make sound decisions on the deployment of their resources, and to operate with the highest practicable levels of efficiency. They need to know what are the patterns of criminal behaviour in their force areas, and the intensity and severity of that offending.

"Police and crime commissioners need this information too because they hold their chief constables to account, and they in turn are held to account by the public. The public's right to know is important; none should be misled, whether through negligence or otherwise. Trust in what the police tell people about crime is part of the essential trust which the public must have in the police.

"Even more importantly, failures in accurate crime-recording can also increase the risks to victims and the community of the denial of justice, and may imperil public safety. The police therefore need to take this subject very seriously."[44]

These statements are as valid today as they were in 2014.

In 2014, our inspection found that, at a national level, the police were failing to record 19 percent of crimes reported to them. We found the problem was greatest for violent crimes and sexual offences, where the under-recording rates were 33 percent and 26 percent respectively. In addition, we found failings in the recording of rape, although it is worth noting that some forces had exemplary records in this respect.

We recognise that police-recorded crime does not represent the whole picture of crime in this country. Other government agencies and departments, financial institutions and organisations also have crimes reported to them

and work with victims of crime. Not all of this is reported to the police. In addition, the Crime Survey of England and Wales[45] reports trends in relation to crime experienced by victims, again not necessarily all reported to the police. However, none of this absolves the police of the responsibility to record accurately the crime which is reported to them.

Given the importance of the subject, in April 2016 we started a new programme to inspect all 43 forces in England and Wales on a rolling basis and over a number of years. We are auditing and reporting on their overall recording accuracy, as well as accuracy for the two categories of crime found to be particularly poorly recorded in 2014: those of violence against the person and sexual offences. In addition, the programme includes: dip-sampling reports directly received by departments that deal with vulnerable victims; a test of the accuracy of recording of reports of rape; how well modern slavery crimes are recorded; and an examination of decisions made to amend crime reports to show that no crime had been committed. To date, we have completed and published the findings of crime data integrity inspections of seven police forces.

Inspections in these seven forces have shown that, despite the commitment and dedication of senior police leaders and many officers and staff to achieve crime-recording accuracy, deficiencies remain. For the seven forces inspected so far, we have produced weighted estimates of overall crime-recording accuracy. The combined recording accuracy[46] for all reported crime was 87.8 percent (with a confidence interval[47] of +/– 0.7 percent), for violent offences it was 82.5 percent (with a confidence interval of +/–1.4 percent) and for sexual offences 91.5 percent (with a confidence interval of +/–1.0 percent). In terms of their crime data-recording, the seven forces inspected so far are not necessarily representative of all police forces. The reasons for this include the fact that each audit covers a different recording

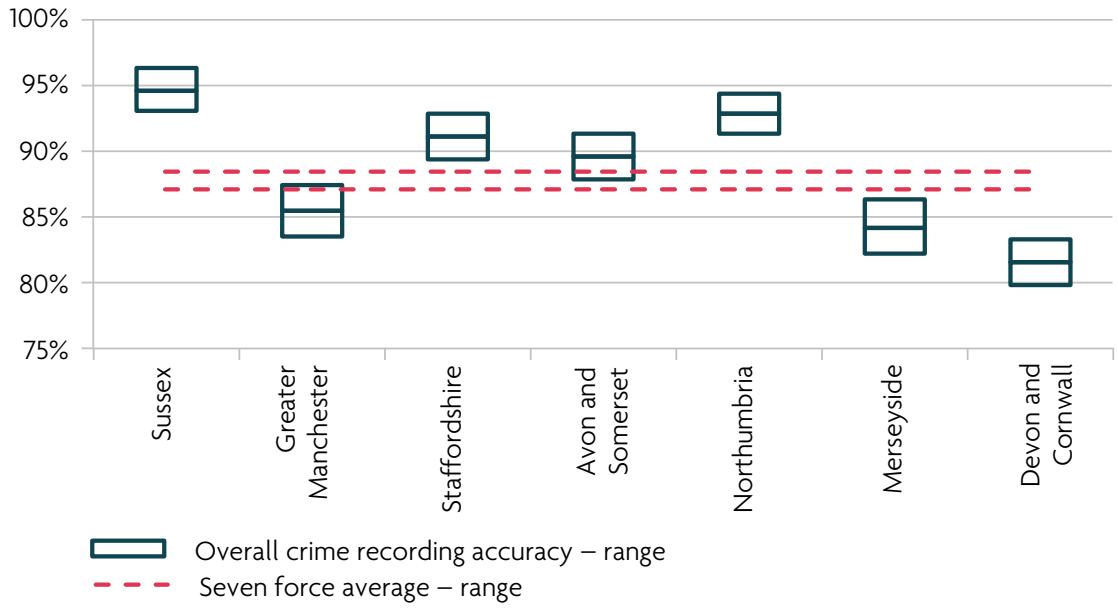
© Cambridgeshire Constabulary

period and the forces audited are not selected completely at random, in order to avoid unnecessary repetition. However, the results for these seven forces do provide evidence of the need for further improvements.

As figure 6 shows, there remains a wide variation in the quality of decision-making associated with crime-recording. Some improvement has been made, but more needs to be done. Forces are still failing to record many reports of crimes and those failings are depriving victims of the services to which they are entitled, and denying the community the justice and, in some cases, the safety to which it is entitled.

This spread illustrates that some – but not all – forces achieve good levels of recording accuracy. There is no single factor which results in forces consistently making good crime-recording decisions, but the factors that have the most effect are: leadership; intrusive and proportionate supervision and quality assurance of crime-recording decisions; and skilled people – particularly a force crime registrar who is scrupulously objective and has strong influence over local crime-recording decisions.

**Figure 6:**
**Overall crime-recording accuracy by force[48]**




Note: Forces are displayed in the order the inspections were undertaken.
Note: The overall crime-recording accuracy is displayed as a range for each force. The middle line is the central estimate within this range.

© Devon and Cornwall Police

Where a combination of solutions is put in place, standards improve. Both Sussex Police and Northumbria Police have small teams of staff to check that reports of crime are being identified and recorded. This acts as a safety measure to ensure that reported crime is recorded, but can be a costly solution to the alternative of ensuring that correct recording decisions are taken at the outset. Where forces record crime at the time it is reported to them, rather than recording it later, standards of crime-recording are better.

We have found problems with the recording of crime in forces that use appointment systems. Where there is a delay between the original report and an officer speaking to the victim, it is not uncommon for the report to go unrecorded. Moreover, delaying attendance by an officer can often cause the victim to become disillusioned with the process and distance himself or herself from it, meaning the original report is filed without any further contact with the victim. Forces that use appointment systems need to ensure that crimes are recorded properly and victims receive the level of service they deserve.

Worryingly, not all forces accurately record all reported allegations of rape, and in some cases there is no investigation into the reports. Reporting a rape is very often an extremely difficult step for a victim, and when such allegations are made it is imperative that crime records are created and thorough investigations are carried out in order to bring offenders to justice. All forces need to take urgent action to ensure that this is the case.

Encouragingly, since our 2014 report, we have found that the vast majority of officers and staff have made appreciable progress in placing the victim at the forefront of their crime-recording decisions. Nevertheless, on some occasions this is still not happening and victims of crime are not always being treated in the way they deserve when they report crimes to the police. Also, we have found a belief among some senior officers that unrecorded crimes are merely 'administrative failures' and that victims receive the usual standards of care and safeguarding even when a crime has not been formally recorded.

Children are still being detained unnecessarily at police stations when they have been charged with a criminal offence and denied bail.

Some victims of unrecorded reports of crime receive a good service from the police, but many receive no service at all. The formal recording of every crime is a very important step towards protecting victims and ensuring that they receive the service to which they are entitled.

In 2014, there was widespread public concern that performance pressures were affecting the quality of police-recorded crime data, including suggestions that performance pressure was affecting crime-recording decisions. In our 2014 report, we found that "there remains an undercurrent of pressure not to record a crime across some forces."[49] In our latest round of inspections, we noted a welcome improvement: officers and staff are clear that they no longer feel under any pressure to help meet performance targets by minimising the number of crimes they record.

Looking ahead, we intend to inspect the remaining 36 forces. We will build a better understanding of the factors that affect the accuracy with which forces record crimes, identify what works well, and we will assess the extent to which recommendations from our 2014 crime-recording inspection report have been implemented.

### National child protection inspections

Between April 2014 and December 2016, 16 forces were inspected as part of the National Child Protection Inspection programme. A further ten forces were revisited to assess what progress had been made to implement the recommendations we made in previous inspections.

Senior leaders and staff in these forces have a clear and unambiguous commitment to improving the protection of vulnerable children. In the forces we revisited, it was evident that at least some progress had been made to improve the outcomes for children at risk of harm.

There have been some improvements in the arrangements for children suspected of being mentally ill, with a significant decrease in the number of children being brought to a police station as a 'place of safety'[50] rather than being taken to a hospital. However, despite some progress, children are still being detained unnecessarily at police stations when they have been charged with a criminal offence

and denied bail. In such circumstances, the local authority is responsible for providing appropriate accommodation.

In all but the most exceptional circumstances, it is not in a child's best interests to remain in a police station. Although forces are using alternatives to detention (such as bail) more effectively, children are still being detained for too long, largely because of a lack of alternative accommodation.

Straightforward cases of child abuse and neglect are almost always dealt with promptly and efficiently. However, more complex investigations are often beset by delay. Some complex cases are allocated to staff who lack the necessary skills and experience to carry out an effective investigation.

We found that although the initial response to locate missing children was often given a high priority, opportunities for early intervention and long-term inter-agency planning to protect children were not sufficiently well considered. Officers did not always recognise that children who regularly go missing from home may be at risk of being groomed for sexual abuse. This is indicative of a wider failure to understand the full nature and extent of the risks of sexual exploitation that children face.

### Counter-terrorism

During 2016, we undertook a thematic inspection of police counter-terrorism work and, for the first time, counter-terrorism also formed part of our PEEL inspection programme.

The thematic inspection examined the role of the police counter-terrorism (CT) commander. We visited 17 police forces and interviewed all the chief officers who make up the national cadre of CT commanders. It is these officers who will be called on by the Senior National Co-ordinator[51] to lead the response of the police and other agencies in a terrorist attack.

Over the last decade, the police in England and Wales have developed a set of command arrangements and capabilities that are world class. The CT

© Sussex Police

© Sussex Police

commanders play a central role in these arrangements and, when deployed, unify command arrangements for local police, national CT police and other organisations to deal with deadly terrorist attacks. We found there were sufficient CT commanders available to respond and sustain the command and control arrangements that would be necessary to deal with a series of simultaneous terrorist attacks.

The level of responsibility ascribed to CT commanders is very high, and it is important that they are able to carry out their duties to a very high standard. Initial training, continuous professional development (CPD) and a programme of training exercises all provide realistic scenarios that enable CT commanders to test and update their skills and experience. All current CT commanders meet a sensible and pragmatic set of role requirements, but there are opportunities to improve the continuing development of CT commanders through the CPD programme.

Among officers we spoke to, there was generally a good level of understanding about the role of the CT commander, but we think more can be done to increase knowledge of the role within forces and within the national CT network.[52]

Because of the sensitive nature of CT work and legal constraints on HMIC that are in place to protect national security, we did not publish the full report.

**Best Use of Stop and Search (BUSS) scheme**

In 2014, the Home Office and the College of Policing launched the Best Use of Stop and Search (BUSS) scheme, which aims to "achieve greater transparency, community involvement in the use of stop and search powers and to support a more intelligence-led approach, leading to better outcomes."[53]

The features of the scheme are data-recording and publishing, introduction of lay observation policies, introduction of a community complaints trigger, reducing the use of 'no-suspicion' stop and search encounters,[54] and monitoring the impact of stop and search, particularly on young people and people from black and minority ethnic groups.

In 2015, as part of our PEEL legitimacy inspection, HMIC assessed the 43 forces' compliance with each feature of the BUSS scheme. We found that only 11 forces were complying with all five features of the scheme, 19 forces were not complying with one or two features of the scheme and 13 forces were not complying with three or more features.

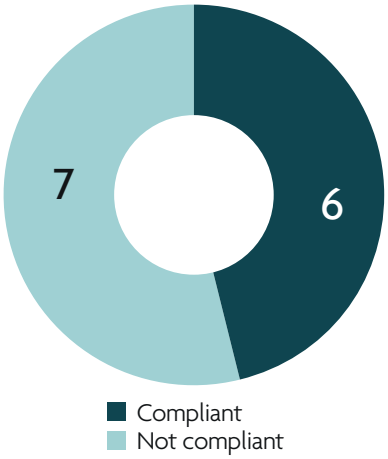
In our 2015 report, we committed to revisiting the 13 forces not complying with three or more of the features. In February 2016, the Home Secretary suspended these 13 forces from the scheme.[55]

**Findings of our revisit to 13 forces**

Between 24 June 2016 and 5 August 2016, HMIC reviewed the 13 force websites, the police.uk website and documents submitted to us by the 13 forces, to reassess each force's compliance with each of the five features of the scheme.

© Thames Valley Police

We intend to revisit the subject of stop and search powers as part of our PEEL inspection programme in 2017.



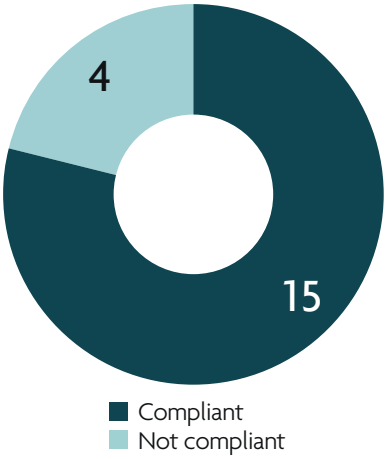

We found that six of the 13 forces were compliant with all features of the BUSS scheme: Cambridgeshire Constabulary, Cheshire Constabulary, Lancashire Constabulary, Northumbria Police, Warwickshire Police and West Mercia Police.

We were disappointed to find that six forces were not compliant with one feature of the scheme and one force – Gloucestershire Constabulary – was not compliant with two features of the scheme. However, improvements made since our revisit mean that we are now satisfied that all 13 forces have achieved compliance with all features of the scheme.

We believe that the scheme would benefit from clarification or amendment in some areas and we have, therefore, made recommendations to the Home Office and the College of Policing for them to consider as part of their current review of the scheme.

**Findings of our revisit to 19 forces**

In November 2016, following a commission from the Home Secretary, we revisited the 19 forces that we had assessed in 2015 as not complying with one or two features of the BUSS scheme.[56]




We found that 15 of the 19 forces were complying with the feature(s) with which they had not been previously complying. However, the remaining four forces were still not complying with one feature of the scheme.

Derbyshire Constabulary, Northamptonshire Police and South Yorkshire Police were not complying with the feature relating to recording and publishing outcomes, including the number of stop and search encounters in which the outcome was connected

to finding the item that was being searched for. Since our revisit, South Yorkshire Police has published the required information on its website and we are satisfied that the force is now compliant.

Greater Manchester Police was not complying with the feature which requires that 'no-suspicion' stop and search encounters are authorised by an officer above the rank of chief superintendent. Additionally, the form used to record authorisations had not been amended to be compliant with the scheme. Since our revisit, the force has amended its policy, updated its authorisation forms and communicated the amendments to relevant officers. We are satisfied that the force is now compliant.

We intend to revisit the subject of stop and search powers as part of our PEEL inspection programme in 2017.

**Joint Emergency Services Interoperability**

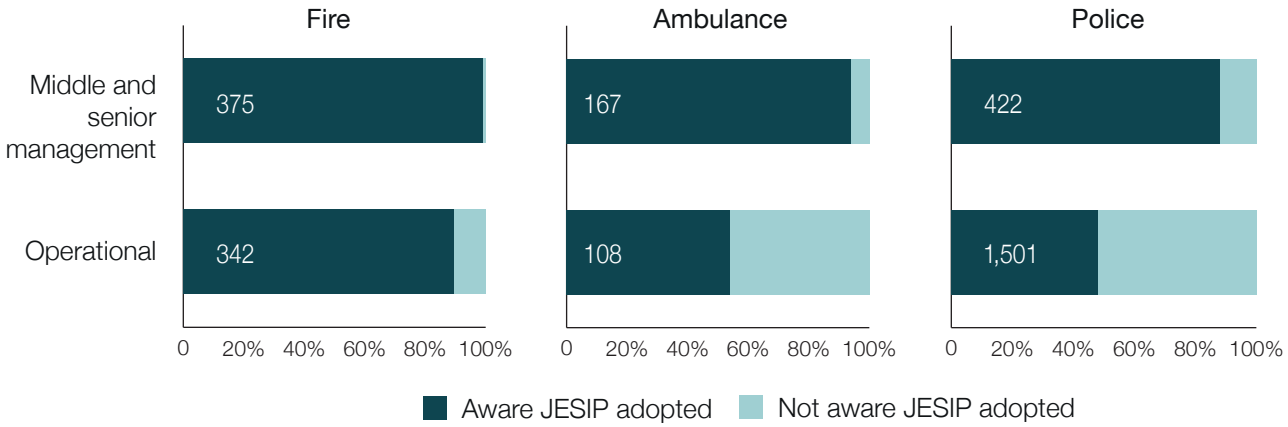
In times of emergency the 'blue light' services of ambulance, police and fire and rescue must work together to protect the public and save lives.

In April 2016, HMIC published a review into how effectively the Joint Emergency Services Interoperability Principles – known as JESIP – had been embedded into the work of the three emergency services. The review team was made up of representatives from HMIC, the police service, the Association of Ambulance Chief Executives, the Chief Fire Officers' Association, and a representative of the Chief Fire and Rescue Adviser.

We found that understanding of JESIP among commanders was good, but it was poor among frontline operational staff. In all of the emergency services, the majority of middle and senior managers were aware that their service had adopted the JESIP joint doctrine; however, the same was only true among 48 percent of operational police officers (see figure 7).

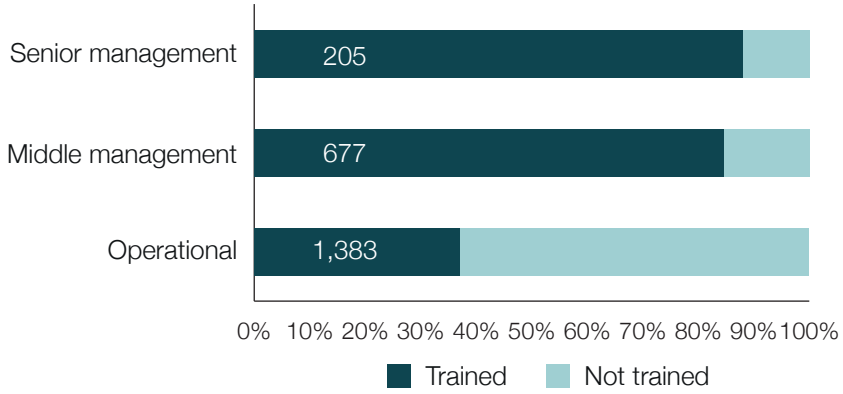
We found a similar picture in relation to training: the majority of operational level staff, particularly in the police, had not received any JESIP training. Only 37 percent of operational staff across the three emergency services had received some form of JESIP training,

Figure 7:
**The proportion of respondents within the three services who were aware that their service had adopted JESIP joint doctrine, by level of seniority**




Source: Joint Emergency Services Interoperability Principles (JESIP): HMIC survey 2015

Figure 8:
The proportion of survey respondents from the three blue light services who have received some form of JESIP training, by level of seniority




Source: Joint Emergency Services Interoperability Principles (JESIP): HMIC survey 2015

compared with 85 percent of middle managers and 88 percent of senior managers (see figure 8).

JESIP's development has provided a structure and framework for the three services to work together. One of its successes has been the ministerial oversight of the programme. With a centrally-funded team due to complete its work in the next two years,

© Thames Valley Police

this strong oversight needs to continue. Overall, there is a nationally consistent commitment to joint working but this needs to be fully incorporated into the culture of each service.

**National Crime Agency**

In 2016, we published two inspection reports on the National Crime Agency (NCA). We inspected:

- the progress[57] made by the NCA in response to the recommendations and areas of improvement we identified in our 2015 inspection;[58] and
- the efficiency and effectiveness of the UK International Crime Bureau (UKICB) and its management of risk.[59]

## Progress in relation to the findings of our 2015 inspection

We found that two out of the four recommendations made in our 2015 inspection report had been addressed. These were that efforts had been made to improve sharing of communications data capacity, and defining roles and responsibilities for strategic governance groups and co-ordinating committees.

At the time of our fieldwork, the remaining two recommendations (which concerned the lack of detail in strategic action plans and the lack of a process for monitoring progress against those plans) had not progressed sufficiently and therefore could not be discharged. However, work to address these recommendations was under way, and in December 2016 we judged that sufficient progress had been made also to discharge these recommendations.

In addition to making four recommendations, our 2015 inspection report listed 19 areas for improvement, aligned with four thematic areas (technology and intelligence analysis, information management processes, leading the national response, and internal communication and engagement). We found that appreciable progress had been made in all four thematic areas since our last inspection, and good progress had been made against many of the 19 areas that we identified as needing improvement.

Overall, we found that the NCA has been improving gradually since our 2014 inspection.

Overall, we found that the NCA has been improving gradually since our 2014 inspection.

## The UKICB report

Our UKICB report concluded that, in general, the efficiency and effectiveness of the UKICB is good and improving. We also concluded that the efficiency of some aspects of the United Kingdom's extradition arrangements requires improvement.

Our report highlighted some areas of general concern and made recommendations for improvement in 13 specific areas. Of these, the areas of greatest concern related to the UKICB's limited use of the Police National Database and inefficiencies in extradition processes which involve the NCA, police forces and other organisations.

## The Police Service of Northern Ireland

The Northern Ireland Minister of Justice commissioned HMIC to carry out an efficiency and effectiveness (vulnerability) inspection of the Police Service of Northern Ireland (PSNI) in 2015/16, based upon the relevant aspects of PEEL methodology.

### Efficiency

The demands on policing in Northern Ireland are more wide-ranging than those experienced by most forces in England and Wales. Nonetheless, we found that the PSNI understood most of the demands it faced. The PSNI had more work to do with other organisations to understand hidden demands from people in local communities, in particular those who are vulnerable.


© West Midlands Police

On the whole, the PSNI's operating model matched resources to demand. The PSNI assessed demand and aimed to deploy its resources accordingly, in line with its organisational priority to keep people safe. However, the workforce model in place at the time of the inspection was unsustainable and relied heavily on overtime to meet short-term demands associated with security, and longer-term demands resulting from high sickness levels.

The service recognised this in its 2013 review of capability and resilience. Over the next three years, the PSNI's resilience will weaken; more than 20 percent of police officers will become eligible to retire and the PSNI is unclear about the skills that will be lost, and those that will be required from its workforce in the future.

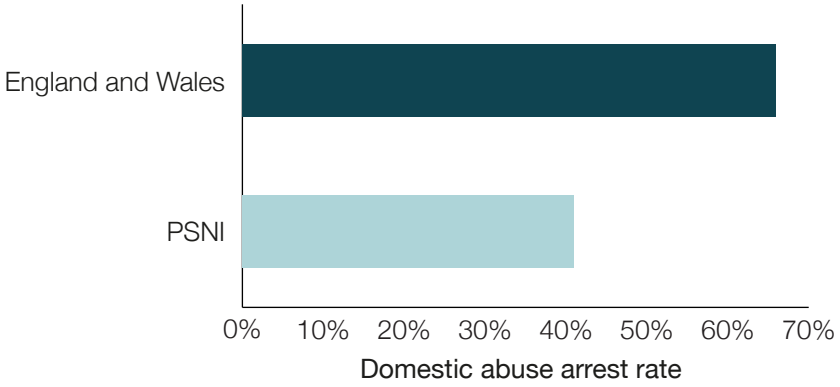
**Effectiveness (vulnerability)**

The PSNI chief officer team has made the protection of vulnerable people a clear priority. Police officers and staff understood and shared this commitment. To translate this priority into practice, the PSNI has invested in the parts of its organisation which support vulnerable people, creating a dedicated public protection branch. However, the PSNI's response to missing children was not consistently good, nor was its response to domestic abuse.

Arrest rates for domestic abuse incidents were much lower for the PSNI than they were in England and Wales (see figure 9). The PSNI has identified tackling domestic abuse as a strategic priority, and officers and staff throughout the organisation recognised its importance. However, the PSNI needed

Arrest rates for domestic abuse incidents were much lower for the PSNI than they were in England and Wales.

**Figure 9:**
**Arrest rates for domestic abuse incidents in the 12 months to 31 March 2015 in England and Wales and Northern Ireland**



to improve in a number of important respects, including: clarifying who has responsibility for making referrals to other agencies; improving partnership working in multi-agency risk assessment conferences for high-risk domestic abuse victims; and establishing clear responsibility for safeguarding duties in relation to medium and standard-risk victims.

Despite efforts that the PSNI has made to understand child sexual exploitation, we found that more work was required. Work was needed to train specialists and frontline staff, and to develop links with private sector companies including hotels, fast-food outlets and taxi drivers; all have a part to play in gathering intelligence and preventing child sexual exploitation.

**Royal Gibraltar Police**

HMIC was invited by the Gibraltar Police Authority to inspect the Royal Gibraltar Police. Our terms of reference were to conduct:

a) a review of leadership and associated human resources working practices including the complaints procedure, provision for the well-being of staff and an ethical culture;

b) a review of crime prevention and investigation performance, an audit of crime-recording, and an assessment of victim care and support; and

c) an assessment of demand, of resource capacity and capability, and how resource is matched to meet demand.

We found that the Royal Gibraltar Police was generally well led. Senior officers were visible and had good oversight of policing activity. There was a committed workforce, actively engaged with the public, with a strong sense of pride, a clear direction and, as it was described to us, a 'one-team' culture.

Also, we found that, generally, the prevention and investigation of crime and care for victims was effective. However, there were five areas in which we found scope for the force to make improvements. These areas were: auditing of crime records; recording practice for detected crime; supervision of investigations; identification of vulnerable and repeat victims; and the extent of partnership working.

We found that the Royal Gibraltar Police was committed to meeting all demands, which led to high levels of public confidence and satisfaction but placed major pressures on the workforce.

The force was not well placed to understand the demands it faced due to the limitations created by paper-based systems and computer databases that were not integrated. In addition, in an environment where the economy is growing rapidly and where it can reasonably be expected that demand for policing will also grow, we found several constraints on how the Royal Gibraltar Police can use its budget. The force needs guidance that sets out the funding formula, including the associated criteria, thresholds and conditions that need to be met for the force to receive the resources it needs.

**Royal Navy Police**

This inspection focused on three areas: the strategic leadership and direction of the Royal Navy Police (RNP); oversight to ensure that investigations are kept free from improper interference; and how well the RNP uses the National Intelligence Model.[60]

We found that the role of the RNP was comprehensively and consistently defined in various documents. We spoke to RNP personnel who understood their role. The Provost Marshal (Navy) had circulated to RNP personnel comprehensive guidance on his expectations for the quality of investigations.

However, we found limitations in the command arrangements because the Provost Marshal (Navy) did not have control of most RNP personnel. We found some evidence that supported concerns

There were five areas in which we found scope for the Royal Gibraltar Police to make improvements.

In October 2016 alone, 11.3 million PNC checks were carried out.

raised by RNP personnel in relation to a lack of clarity and understanding of their role across the wider Royal Navy; the Royal Navy needs to understand the full extent of tasks RNP personnel undertake.

We found that the RNP had an in-house training programme in which the identification and care of victims featured strongly, although we did not find any evidence of the RNP seeking to obtain feedback from victims on the quality of service provided. The range of training courses provided by the RNP was sufficient, although the courses would benefit from accreditation.

We considered that succession planning was not always adequate and that extended tenure arrangements should apply to certain posts that require considerable investment in training.

The RNP has well-established management structures and effective reporting systems. RNP personnel and commanding officers elsewhere in the Royal Navy understood their responsibilities. The Provost Marshal (Navy) made good use of various internal and external governance arrangements to provide him with assurance, but the RNP would benefit from the introduction of a structured process by which the independence and overall quality of its investigations are reviewed by other relevant professionals.

RNP meetings were well structured and complied with the National Intelligence Model *Code of Practice*.[61] Personnel had a good understanding of the National Intelligence Model and they had ready access to policies and documents. The RNP's analytical products provided clear direction and guidance in relation to force priorities, but the force strategic assessment did not identify future demands adequately. The Strategic Tasking and Co-ordination Group identified priorities that influenced planning and resourcing in the short term but not the long term.

**Use of the PNC by non-police organisations**

The Police National Computer (PNC) is an essential law enforcement tool. It is used by all police forces and various non-police organisations, giving them access to records for six million people and 46 million vehicles. In October 2016 alone, 11.3 million PNC checks were carried out.

Following a 2011 review by the Government's independent adviser on

criminality information,[62] we included in our inspection programme the non-police organisations which also use the PNC. In May 2016, we published reports on our inspections in ten such organisations:

- Royal Mail Group Ltd (pilot inspection only)
- Post Office Ltd
- National Air Traffic Control Service (NATS Holdings Ltd)
- Gangmasters Licensing Authority
- Natural Resources Wales
- Children and Family Court Advisory Support Service (Cafcass)
- Scottish Society for the Prevention of Cruelty to Animals (SSPCA)
- Environment Agency
- Financial Conduct Authority
- Thurrock Council.

These inspections revealed that the supply agreements[63] were out of date and in urgent need of review. We advised the Home Office, which has taken remedial action.

Overall, we found that the organisations we inspected have good security in place to protect the PNC data and that most – but not all – have strong audit procedures to check that their staff are accessing the PNC for legitimate purposes.

By December 2016, eight forces had been inspected, focusing on child sexual exploitation and those children living with domestic abuse.

In all our inspections, we observed respectful and positive interactions between custody staff and detainees.

# Our joint inspections

### Joint targeted area inspections

In 2015, a programme of joint targeted area child protection inspections was launched by Ofsted, the Care Quality Commission (CQC), HMIC and Her Majesty's Inspectorate of Probation (HMI Probation). These short, targeted inspections are carried out on a multi-agency basis. The inspections test the effectiveness of arrangements and services for children in need of help and protection in local authority areas in England.

By December 2016, eight forces had been inspected, with a focus on child sexual exploitation and those children living with domestic abuse. Findings from the inspections have shown that effective joint work to support children at risk of sexual exploitation and domestic violence is possible but more needs to be done to ensure that all children and young people receive consistently good support from all agencies and in all areas. Poor practice by some professionals and agencies means that some children at risk of exploitation and abuse still do not get the response they need quickly enough.

© Cambridgeshire Constabulary

### Youth Offending Services inspections

We have continued our joint inspections of Youth Offending Services, led by Her Majesty's Inspectorate of Probation.[64]

Youth Offending Services are multi-agency teams, co-ordinated by local authorities, with the aim of reducing re-offending by young people. Police forces have a statutory responsibility to provide

resources to the teams. By its very nature, a Youth Offending Service will deal with some of the most vulnerable young people.

In our inspections of the police contribution to the work of the Youth Offending Services in six force areas, we found that in general there was a good understanding of the importance of the commitment to provide resources.

Our recurring concerns include the lack of systems for making police intelligence available to partner organisations, which often leads to important errors and omissions. We are also concerned that in some Youth Offending Services, the police officers had not received training in MAPPA (described earlier in this report; see PEEL effectiveness section), and the most dangerous offenders were not necessarily being referred to MAPPAs when they should have been.

**Custody**

Since March 2016, we have published ten reports as part of our rolling programme of police custody inspections with Her Majesty's Inspectorate of Prisons. In April 2016, we introduced a revised version of *Expectations for police custody*[65] – the standards by which we inspect outcomes for detainees in police custody. Our inspections now have an increased focus on the use of force and the response to vulnerable people and children.

A number of police forces we inspected had invested in, or reduced and replaced, their custody suites, resulting in an improved environment for detainees. However, we continued to find ligature points[66] in many cells and communal areas, which forces were not always aware of.

In all our inspections, we observed respectful and positive interactions between custody staff and detainees. We found an increased understanding of how to meet the needs of children and vulnerable adults, although further improvement is needed to translate this into consistent practice. In general, the approach to risk assessment for detainees had improved and was leading to a good standard of detainee care.

We found that appreciable progress continued to be made in working with other organisations to deal with detainees with mental health problems. However, the number of people detained in custody as a place of safety under section 136 of the Mental Health Act 1983, although reducing, was still too high in some forces. Furthermore, people were waiting too long for transfer to beds in healthcare facilities. Also, we found that people detained for committing offences but who also displayed signs of mental health problems spent too long in custody waiting for mental health assessments.

Forces demonstrated a strong focus on avoiding children entering custody, making good use of alternatives such as voluntary attendance or community resolutions. However, despite some positive joint working with local authorities, alternative accommodation was rarely available for those children who were taken into custody, leading to children spending the night in a cell.

One of our principal concerns, resulting in recommendations for improvement in all but one of the forces we inspected, was the continuing lack of effective management systems for the scrutiny and oversight of the use of force. There was no, or very limited, monitoring of this to demonstrate to the forces' senior management teams, police and crime commissioners or the wider community whether the use

of force was justified and proportionate.

### Achieving justice in a digital age

The digitisation of the criminal justice system is intended to result in a more modern, efficient and effective system. The aim is that the information about an offence recorded by an officer at the scene of a crime can flow through the system without any need for it to be rekeyed, copied, pasted or reworked.

This joint inspection[67] involved fieldwork in six forces to test how well digitisation is working, which included interviews with interested parties and observation of court cases.

A number of improvements have been made in these forces, and the criminal justice system has been modernised to some extent, but there remains a lot of work to be done to make the system fully digital.

There have been a number of very positive benefits as a result of digitisation, such as the installation of Wi-Fi in magistrates' courts, an online charging facility that allows the police and the Crown Prosecution Service (CPS) to prioritise workloads, and an app for prosecutors which enables cases to be updated online from the court in real time.

However, multiple ICT systems are still in use by the police, which means that information is transferred to the CPS in different ways. Digital media such as photographs, CCTV and body-worn video footage, and recordings of interviews and 999 calls are still having to be transferred using discs rather than online, leading to significant security risks. Furthermore, agencies still have to input some paper documents manually, creating a duplication of effort.



# HMIC's monitoring arrangements

In addition to our programme of inspections, HMIC routinely monitors police forces in order to promote improvements in police practice. We use performance information from a variety of different sources to do this. These include our time spent in police forces, documents and data provided by police forces, media stories, research and assessments made by other organisations.

On occasion, analysis of this information will identify a concern about a force's performance. Should this happen, one of the HMIs will raise the concern with the relevant chief constable and the police and crime commissioner.[68] If the concern about performance persists or deepens, the HMI may apply a greater level of scrutiny.

The HMIs are supported in the monitoring arrangements by representatives of organisations that include the National Police Chiefs' Council (NPCC), the College of Policing, the Association of Police and Crime Commissioners (APCC) and the Home Office. Representatives of these organisations meet to consider those forces that are of the greatest concern to HMIC; this group is called the crime and policing monitoring group.

During 2016, we undertook a detailed review of our monitoring arrangements, which identified several opportunities for improvement. We have therefore started work to refine our monitoring arrangements and align them more closely with our inspections, including the PEEL programme. As part of this work, we will clarify the roles and responsibilities of those who operate the monitoring arrangements, those who participate in monitoring and those who are subject to monitoring.

The new arrangements will remain a tiered approach. Decisions about the level of scrutiny required for a particular force will be taken by the responsible HMI, drawing on input from the members of the crime and policing monitoring group.

HMIs will broker support and advice for both the chief constables and police and crime commissioners of those forces that become subject to the higher levels of scrutiny. HMIC is working with the College of Policing, the NPCC and the APCC to develop this support and incorporate it into the monitoring arrangements.

This work will help ensure that our monitoring arrangements remain open and clear and that they continue to serve HMIC's purpose: promoting improvements in policing to make everyone safer.


© Derbyshire Constabulary

# Part 3: HMIC reports

439

reports published

# HMIC reports

## During the reporting period, HMIC published 439 reports, all of which are available on our website.

In addition to our work with the 43 Home Office forces, and the other inspectorates, HMIC carried out various other inspections. These formed part of our statutory duties to inspect non-Home Office police forces and certain other law enforcement agencies. We provided our reports to the relevant Secretaries of State, who laid them before Parliament. Subsequently, these reports were placed on the HMIC website www.justiceinspectorates.gov.uk/hmic/

HMIC also carried out a non-statutory inspection of the Royal Gibraltar Police. We provided this report to the Gibraltar Police Authority, which published it. Subsequently, we placed it on the HMIC website www.justiceinspectorates.gov.uk/hmic/

© Sussex Police

In the pages that follow, we have set out the following details of the reports:

- the title of each inspection report;
- a short description of the inspection's focus;
- the names of the other inspectorates, for inspections carried out with other inspectorates;
- publication date of the report; and
- the name of the Inspector of Constabulary responsible for the inspection.

In addition, HMIC carried out the following assessments and reviews:

- two reviews of applications made by police and crime commissioners for Home Office Special Grant funding. Provisions for such funding exist to help forces to meet additional costs that would be incurred from policing unexpected and exceptional events within their areas;
- 13 assessments of the forces that were not complying with three or more features of the Best Use of Stop and Search (BUSS) scheme; and
- 19 assessments of the forces that were not complying with one or two features of the BUSS scheme.

The reports in respect of these reviews and assessments have been given to the commissioning bodies and feedback has been provided to the relevant forces.

HMIC also sat on the board which makes the recommendation to Ministers about the level of resources that should be agreed for eight forces under Home Office Special Grant funding.

Key

- PEEL inspection
- Specialist inspection
- Joint inspections
- Commission
- Non-inspection publication

# Reports published 24 February 2016 to 23 March 2017

## PEEL inspections

**Published:**
7 July 2016

### PEEL: Police effectiveness 2015 (vulnerability) revisit

A revisit inspection to four forces that were graded as inadequate during the PEEL effectiveness 2015 (vulnerability) inspection: Essex Police, Bedfordshire Police, Staffordshire Police and Surrey Police.

**PEEL inspection**
Lead HMI: Zoë Billingham

**Published:**
4 August 2016

### PEEL: Police effectiveness (vulnerability) – Police Service of Northern Ireland

An inspection to look at PSNI's effectiveness at protecting from harm those who are vulnerable, and how it supports victims. HMIC looked at how the service responds to and supports missing children and victims of domestic abuse.

**PEEL inspection**
Lead HMI: Mike Cunningham

**Published:**
4 August 2016

### PEEL: Police efficiency – Police Service of Northern Ireland

An inspection to assess how the force makes the best use of its available resources with the overall question: How efficient is the force at keeping people safe and reducing crime?

**PEEL inspection**
Lead HMI: Mike Cunningham

**Published:**
22 September 2016

### Best Use of Stop and Search (BUSS) scheme

The findings of an HMIC revisit to the 13 forces that were not complying with three or more features of the Best Use of Stop and Search scheme during PEEL: Police legitimacy 2015.

**PEEL inspection**
Lead HMI: Mike Cunningham

**Published:**
3 November 2016

### PEEL: Police efficiency 2016

An inspection of 43 forces to examine how well forces understand the demand for their service and how well they match their resources to that demand; and an assessment of their efficiency.

**PEEL inspection**
Lead HMI: Mike Cunningham

**Published:**
8 December 2016

### PEEL: Police legitimacy 2016

An inspection of 43 forces to look at the extent to which forces treat people with fairness and respect; ensure their workforces act ethically and lawfully; and whether those workforces feel they have been treated with fairness and respect by forces.

**PEEL inspection**
Lead HMI: Mike Cunningham

**Published:**
8 December 2016

### PEEL: Police leadership 2016

An inspection of 43 forces to explore the degree to which leadership, at all ranks and grades, is understood within policing, how forces work to develop leadership capability and how well leadership is displayed by each force.

**PEEL inspection**
Lead HMI: Mike Cunningham

**Published:**
2 February 2017

### Best Use of Stop and Search (BUSS) scheme

The findings of an HMIC revisit of the additional 19 forces that were not complying with one or two features of the Best Use of Stop and Search scheme during PEEL: Police legitimacy 2015.

**PEEL inspection**
Lead HMI: Mike Cunningham

**Published:**
2 March 2017

### PEEL: Police effectiveness 2016

An inspection of 43 forces to assess the effectiveness of police forces in relation to how they carry out their responsibilities including cutting crime, protecting vulnerable people, tackling anti-social behaviour, and dealing with emergencies and other calls for service.

**PEEL inspection**
Lead HMI: Zoë Billingham

# Specialist inspections

**Published:**
8 March 2016 – 20 July 2016

### National Child Protection Post-Inspection Review

Inspections to review the progress made in three forces (West Yorkshire Police, South Wales Police and Devon and Cornwall Police) since publication of their National Child Protection Inspection reports.

**Specialist inspection**
Lead HMI: Wendy Williams, Mike Cunningham

**Published:**
23 March 2016

### Missing children: who cares? – The police response to missing and absent children

As part of the PEEL: Police effectiveness 2015 inspection, we assessed the police response to missing and absent children. In addition, we looked at forces' preparedness to tackle child sexual exploitation, because children who go missing are at greater risk of becoming a victim of this kind of offending.

**Specialist inspection**
Lead HMI: Wendy Williams

**Published:**
23 March 2016

### Children's voices research report – Children and young people's perspectives on the police's role in safeguarding

Results of a research project commissioned by HMIC, carried out by the University of Bedfordshire, exploring the experiences of 45 children who had come into contact with the police because of concerns about their safety or wellbeing.

**Non-inspection publication**
Lead HMI: Wendy Williams

**Published:**
24 March 2016 – 26 January 2017

### National Child Protection Inspection

Three inspections into child protection work in Essex Police, the Metropolitan Police Service and Cumbria Constabulary. These are part of a rolling programme of inspections to examine child protection in police forces in England and Wales.

**Specialist inspection**
Lead HMI: Wendy Williams, Zoë Billingham, Matt Parr, Mike Cunningham

**Published:**
12 April 2016

### The tri-service review of the Joint Emergency Services Interoperability Principles (JESIP)

An inspection of the extent to which the three emergency services have incorporated the principles of joint working into their preparation for responding to major incidents. The JESIP Ministerial Board commissioned an HMIC-led tri-service review across the three emergency services.

**Commission**
Lead HMI: Mike Cunningham

**Published:**
10 May 2016

### Use of the Police National Computer by non-police organisations

An inspection into the use of the Police National Computer (PNC) by 10 non-police organisations which have access to the PNC. HMIC assessed whether the level of PNC access was appropriate for each organisation's needs, whether they were complying with the security operating procedures and whether they were making efficient and effective use of the PNC.

**Specialist inspection**
Lead HMI: Stephen Otter

**Published:**
15 July 2016

### Royal Gibraltar Police: An inspection of leadership, crime management, demand and resources

An inspection of the force leadership, vision, values and culture; an assessment of crime prevention, investigation and victim care, and also a review of the demand on its services and resources.

**Specialist inspection**
Lead HMI: Stephen Otter

**Published:**
21 July 2016

### An inspection of the National Crime Agency

An inspection of the National Crime Agency's progress against the recommendations made by HMIC in its 2015 report and the 19 areas for improvement described in the 2015 report.

**Specialist inspection**
Lead HMI: Mike Cunningham

**Published:**
21 July 2016

### An inspection of the UK International Crime Bureau

An inspection of the UK International Crime Bureau (UKICB) – a function of the National Crime Agency. HMIC looked at whether risks are identified and mitigated in a timely and prioritised manner, and the efficiency and effectiveness of the UKICB.

**Specialist inspection**
Lead HMI: Mike Cunningham

**Published:**
25 August 2016 – 9 February 2017

### Crime data integrity inspection 2016

A rolling programme of inspections to assess the progress made by forces against recommendations set out in HMIC reports following a 2014 inspection of crime-recording in all police forces in England and Wales. Findings from seven forces have been published.

**Specialist inspection**
Lead HMI: Dru Sharpling, Matt Parr

**Published:**
15 September 2016

### Royal Navy Police – An inspection of the leadership of the Royal Navy Police in relation to its investigations

An inspection of the effectiveness of strategic leadership, direction, oversight and governance to ensure investigations are kept free from improper interference, arrangements for monitoring investigations, and the use of the National Intelligence Model to identify strategic priorities.

**Specialist inspection**
Lead HMI: Dru Sharpling

**Published:**
30 January 2017

### Royal Air Force Police – An inspection of the leadership of the Royal Air Force Police in relation to its investigations

An inspection of the effectiveness of strategic leadership, direction, oversight and governance to ensure investigations are kept free from improper interference, arrangements for monitoring investigations, and the use of the National Intelligence Model to identify strategic priorities.

**Specialist inspection**
Lead HMI: Dru Sharpling

**Published:**
9 February 2017 – 23 February 2017

### National Child Protection Inspection Re-Inspection

Re-inspections of Surrey Police and Essex Police following their National Child Protection Inspection reports, published in December 2015. These assessed the progress made by the forces.

**Specialist inspection**
Lead HMI: Wendy Williams, Zoë Billingham

# Joint inspections

**Published:**
23 March 2016 – 1 March 2017

### Report on an unannounced inspection visit to police custody suites

A rolling programme of police custody inspections carried out jointly with HMI Prisons to evaluate strategy, treatment and conditions, individual rights and healthcare of people in custody.

**Joint inspection by HMI Prisons and HMIC**
Lead HMI: Dru Sharpling

**Published:**
5 April 2016 – 1 February 2017

### Joint targeted area inspection of the multi-agency response to abuse and neglect

A series of joint inspections of the multi-agency response to abuse and neglect in eight local authority areas carried out by Ofsted, the Care Quality Commission (CQC), HMIC and HMI Probation. These inspections included a 'deep dive' focus on the responses to child sexual exploitation and children missing from home, care or education.

**Joint inspection by Ofsted, CQC, HMIC, HMI Probation**
Lead HMI: Wendy Williams

**Published:**
13 April 2016

### Delivering justice in a digital age

A joint inspection undertaken by Her Majesty's Crown Prosecution Service Inspectorate (HMCPSI) and HMIC to assess the progress made to date in the introduction of digitised case file information.

**Joint inspection by HMCPSI and HMIC**
Lead HMI: Wendy Williams

**Published:**
12 May 2016 – 23 February 2017

### Full joint inspections of youth offending work

A series of joint inspections carried out with HMI Probation into youth offending teams that are considered to have causes of concern. Youth offending teams in seven force areas were inspected.

**Joint inspection by HMIC and HMI Probation**
Lead HMI: Wendy Williams

**Published:**
29 September 2016

### 'Time to listen' – a joined up response to child sexual exploitation and missing children

An overview of five joint targeted area inspections into child sexual exploitation and missing children, published from February to August 2016.

**Joint inspection by Ofsted, CQC, HMIC, HMI Probation**
Lead HMI: Wendy Williams

# Non-inspection publications

**Published:**
22 March 2016

### Inspection Programme and Framework 2016/17

HM Chief Inspector of Constabulary's 2016/17 Inspection Programme and Framework – prepared under Schedule 4A to the Police Act 1996.

**Inspection Programme and Framework**
Lead HMI: Sir Thomas Winsor

**Published:**
31 August 2016

### Public views of policing in England and Wales

Results of the Ipsos MORI survey commissioned by HMIC covering the public's views and experiences of local policing.

**Survey**
Lead HMI: Mike Cunningham

**Published:**
13 October 2016

### Rape Monitoring Group Local Area Data for 2015/16

A total of 42 local area digests that provide datasets which enable thorough analysis of how rape is dealt with in particular areas of England and Wales.

**Data digest**
Lead HMI: Wendy Williams

**Published:**
17 November 2016

### HMIC Value for Money Profile 2016

A set of 43 full profiles based on data provided by the forces of England and Wales, which offers comparative analysis of a wide range of policing activities and highlights differences in expenditure and performance between forces.

**Data profiles**
Lead HMI: Mike Cunningham

**Published:**
17 November 2016

### HMIC Summary Value for Money Profile 2016

A set of 43 summary profiles based on data provided by the forces of England and Wales, which provides comparative data on a wide range of policing activities and highlights differences in expenditure and performance.

**Data profiles**
Lead HMI: Mike Cunningham

**Published:**
23 March 2017

### HMI assessment of forces

The overall assessments of 43 forces drawing together the assessments of effectiveness, efficiency and legitimacy with other insights gained during 2016. Also considers the operating context of each force and sets out each HMI's expectations for 2017 and beyond.

**PEEL inspection**
Lead HMI: Zoë Billingham, Mike Cunningham, Matt Parr, Wendy Williams

**Published:**
23 March 2017

### State of Policing: The Annual Assessment of Policing in England and Wales 2016

A report on the carrying out of inspections under section 54(4A) of the Police Act 1996 (as amended by the Police Reform and Social Responsibility Act 2011), including Her Majesty's Chief Inspector of Constabulary's assessment of the efficiency and effectiveness of policing in England and Wales for the year 2016.

**Annual assessment**
Lead HMI: Sir Thomas Winsor

# References


1. HMIC website www.justiceinspectorates.gov.uk/hmic/
2. *Organisational Strategy 2016–2020*, HMIC, November 2016. Available from: www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/hmic-organisational-strategy-2016.pdf
3. PEEL: Police effectiveness, efficiency and legitimacy.
4. *State of Policing: The Annual Assessment of Policing in England and Wales 2015*, HMIC, London, February 2016, page 64. Available from: www.justiceinspectorates.gov.uk/hmic/publications/state-of-policing-the-annual-assessment-of-policing-in-england-and-wales-2015/
5. *Public Views of Policing in England and Wales*, Survey conducted for HMIC by Ipsos MORI, July–August 2016.
6. *Police Service Strength England and Wales, 30 September 2010*, Home Office, London, January 2011 and *Police Workforce, England and Wales: 30 September 2016*, Home Office, London, January 2017. Both available from: www.gov.uk/government/collections/police-workforce-england-and-wales
7. *State of Policing: The Annual Assessment of Policing in England and Wales 2015*, HMIC, London, February 2016. Available from: www.justiceinspectorates.gov.uk/hmic/publications/state-of-policing-the-annual-assessment-of-policing-in-england-and-wales-2015/
8. *Police Use of Firearms Statistics, England and Wales: April 2015 to March 2016*, Home Office, London, July 2016. Available from: www.gov.uk/government/publications/police-use-of-firearms-statistics-england-and-wales-april-2015-to-march-2016/police-use-of-firearms-statistics-england-and-wales-april-2015-to-march-2016
9. Figures for December 2016, provided to HMIC by the Metropolitan Police Service.
10. *State of Policing: The Annual Assessment of Policing in England and Wales 2015*, HMIC, London, February 2016, page 64. Available from: www.justiceinspectorates.gov.uk/hmic/publications/state-of-policing-the-annual-assessment-of-policing-in-england-and-wales-2015/
11. *Protecting Vulnerable People*, College of Policing. Available from: www.college.police.uk/What-we-do/Learning/Curriculum/Pages/Protecting-Vulnerable-People.aspx
12. *Consumer Harm Report 2015–2016*, National Trading Standards, Basildon, 2016. Available from: www.nationaltradingstandards.uk/site_assets/files/NTS%20Consumer%20Harm%20Report%202016.pdf
13. *New approach to vulnerability for policing announced*, College of Policing, 30 November 2016. Available from: www.college.police.uk/News/College-news/Pages/New_approach_to_vulnerability_for_policing_announced.aspx
14. *Home Secretary's College of Policing speech on vulnerability*, Home Office, 30 November 2016. Available from: www.gov.uk/government/speeches/home-secretarys-college-of-policing-speech-on-vulnerability

15. *Growing Up Digital: A Report of the Growing Up Digital Taskforce*, Children's Commissioner for England, London, January 2017. Available from: www.childrenscommissioner.gov.uk/sites/default/files/publications/Growing%20Up%20Digital%20Taskforce%20Report%20January%202017_0.pdf
16. *Serious and Organised Crime Protection: Public Interventions Model*, Home Office, London. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/502960/Gov.uk_Serious_Organised_Crime_deck_vF.pdf
17. NSPCC website www.nspcc.org.uk
18. Section 81 of the Policing and Crime Act 2017 amends the Mental Health Act 1983 to place restrictions on places (including police stations) that may be used as a place of safety; see also *CentreForum Commission on Children and Young People's Mental Health: State of the Nation*, Emily Frith, London, April 2016, page 26. Available from: http://centreforum.org/live/wp-content/uploads/2016/04/State-of-the-Nation-report-web.pdf
19. *Op cit*., page 5.
20. *The Bichard Inquiry Report*, HC 653, June 2004. Available from: http://library.college.police.uk/docs/homeoffice/bichard-inquiry-report.pdf
21. *"Mistakes Were Made". HMIC's Review into Allegations and Intelligence Material Concerning Jimmy Savile Between 1964 and 2012*, HMIC, London, March 2013. Available from: http://www.justiceinspectorates.gov.uk/hmic/publications/mistakes-were-made/
22. The Police ICT Company is a private company established by police and crime commissioners to support policing to make the public safer through better IT.
23. It is not uncommon for legislation to require public bodies to "have regard to" guidance, codes of practice or other material. The effect is that the PCC and chief constable should follow the SPR unless they are satisfied that, in the particular circumstances, there are good reasons not to. The *Strategic Policing Requirement* is available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/417116/The_Strategic_Policing_Requirement.pdf
24. HMI assessments www.justiceinspectorates.gov.uk/hmic/peel-assessments/peel-2016/
25. HMIC website www.justiceinspectorates.gov.uk/hmic/
26. *Crime in England and Wales: year ending June 2016*, Office for National Statistics, June 2016. Available from: www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingjune2016
27. In April 2015, it became mandatory for all forces to return quarterly information to the Home Office on the number of crimes identified as being committed online (in full or in part). There are large variations in the proportion of offences identified by each force and there is anecdotal evidence to suggest that the electronic marker for identifying online crimes is currently underused. Work is continuing to improve the quality of the data submitted. It is likely that the proportion of offences committed online will increase.
28. *Crime in England and Wales: Year ending June 2016*, Table E15: Offences recorded by the police in England and Wales which were flagged as online crime, year ending June 2016. These are experimental statistics undergoing testing and are not yet fully developed.

29. *Public Views of Policing in England and Wales*, survey conducted for HMIC by Ipsos MORI, July–August 2016.
30. *Op cit*.
31. Multi-agency public protection arrangements: a process through which the police, probation and prison services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public. Available from: https://mappa.justice.gov.uk/connect.ti/MAPPA/groupHome
32. The Police ICT Company is a private company established by police and crime commissioners to support policing to make the public safer through better IT.
33. *Code of Ethics: A Code of Practice for the Principles and Standards of Professional Behaviour for the Policing Profession of England and Wales*, College of Policing, July 2014. Available from: http://www.college.police.uk/What-we-do/Ethics/Documents/Code_of_Ethics.pdf
34. ACPO/ACPOS National Vetting Policy for the Police Community. Available from: www.northants.police.uk/files/documents/Freedom%20Of%20Information/ac%5EACPO%20National%20Vetting%20Policy.pdf
35. Excluding British Transport Police.
36. 'Incidents involving victims of domestic abuse' does not mean allegations that resulted from domestic abuse incidents, but that one or more of those involved other than the perpetrator was a victim of domestic abuse.
37. *The abuse of police powers to perpetrate sexual violence*, jointly published by IPCC and ACPO (now the National Police Chiefs' Council), September 2012. Available from: www.ipcc.gov.uk/sites/default/files/Documents/research_stats/abuse_of_police_powers_to_perpetrate_sexual_violence.PDF and *Integrity matters: An inspection of arrangements to ensure integrity and to provide the capability to tackle corruption in policing*, HMIC, January 2015. Available from: www.justiceinspectorates.gov.uk/hmic/publications/integrity-matters/
38. *Guiding principles for organisational leadership*, College of Policing, HMIC, NPCC, February 2017. Available from: www.college.police.uk/What-we-do/Development/Promotion/police-leadership-guiding-principles/Pages/Police-leadership-guiding-principles.aspx
39. Available from: www.policenow.org.uk/
40. Available from: http://recruit.college.police.uk/Officer/leadership-programmes/Direct-Entry-Programme/Pages/Direct-Entry-Programme.aspx
41. Available from: http://recruit.college.police.uk/Officer/leadership-programmes/Fast-Track-Programme/Pages/Fast-Track-Programme.aspx
42. *State of Policing: The Annual Assessment of Policing in England and Wales 2015*, HMIC, February 2016. Available from: www.justiceinspectorates.gov.uk/hmic/publications/state-of-policing-the-annual-assessment-of-policing-in-england-and-wales-2015/

43. *Crime-recording: making the victim count*, HMIC, London, November 2014. Available at: www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/crime-recording-making-the-victim-count.pdf
44. *Op cit*, paragraphs 1.24 and 1.25.
45. *Crime Survey in England and Wales: year ending Sept 2016*, Office for National Statistics, September 2016. Available from: www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingsept2016
46. To produce the seven force figures, simple weighting was applied to the individual force-recorded crime figures.
47. The confidence interval provides an estimated range of values within which the given population being examined is likely to fall. For example, if an audit found that 85 percent of crimes were correctly recorded with a confidence interval of +/– 3 percent, then we could be confident that between 82 percent and 88 percent of crimes were correctly recorded for the period being examined.
48. Direct comparisons cannot be made with the 2014 inspection findings at this stage, as these were not completed to a statistically robust level in each force, but for England and Wales only. The 2016 methodology provides for a statistically robust recording accuracy rate by force, but not for England and Wales.
49. *Crime-recording: making the victim count*, HMIC, November 2014, paragraph 7.92. Available at: www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/crime-recording-making-the-victim-count.pdf
50. Section 136A of the Mental Health Act 1983 (inserted by the Policing and Crime Act 2017) allows a police officer to remove an apparently mentally disordered adult (but not a child) from a public place to a police station as a place of safety. Police stations should only be used in exceptional circumstances and it is preferable for the person to be taken directly to healthcare facilities such as a hospital; *Code of Practice: Mental Health Act 1983*, Department of Health, 2008, paragraph 10.21. Available from: http://webarchive.nationalarchives.gov.uk/20130123193537/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597
51. There are national policing arrangements in England and Wales to counter the threat of terrorism. Chief constables have agreed, under certain circumstances, to cede control of their resources to a police commander working on their behalf: the Senior National Co-ordinator for counter-terrorism ('the SNC'). The SNC in turn appoints a police counter-terrorism commander to lead the response by police and counter-terrorism agencies.
52. A series of regional counter-terrorism policing units that have been established across England and Wales. Their role includes gathering intelligence and evidence to help prevent, disrupt and prosecute terrorist activities.
53. *Best Use of Stop and Search Scheme*, Home Office and College of Policing, 2014, page 2. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/346922/Best_Use_of_Stop_and_Search_Scheme_v3.0_v2.pdf

54. Section 60 of the Criminal Justice and Public Order Act 1994 allows a police officer, in places authorised by an officer of inspector rank, to stop and search people without having reasonable grounds to suspect the person to be searched is in possession of a stolen or prohibited item.
55. The 13 forces: Cambridgeshire Constabulary, Cheshire Constabulary, Cumbria Constabulary, Gloucestershire Constabulary, Lancashire Constabulary, Leicestershire Police, Lincolnshire Police, Northumbria Police, Staffordshire Police, South Wales Police, Warwickshire Police, West Mercia Police and Wiltshire Police.
56. The 19 forces: City of London Police, Cleveland Police, Derbyshire Constabulary, Devon and Cornwall Police, Dorset Police, Durham Constabulary, Essex Police, Greater Manchester Police, Hertfordshire Constabulary, Humberside Police, Kent Police, Merseyside Police, Metropolitan Police Service, Northamptonshire Police, North Wales Police, North Yorkshire Police, South Yorkshire Police, Surrey Police and West Midlands Police.
57. *An inspection of the National Crime Agency's progress against outstanding recommendations made by HMIC and areas for improvement*, HMIC, July 2016. Available at: www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/progress-report-of-national-crime-agency.pdf
58. *An inspection of the National Crime Agency*, HMIC, March 2015. Available at: www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/an-inspection-of-the-national-crime-agency.pdf
59. *An inspection of the UK International Crime Bureau: A function of the National Crime Agency*, HMIC, July 2016. Available at: www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/inspection-of-the-uk-international-crime-bureau.pdf
60. The National Intelligence Model is a well-established and recognised model within policing that managers use for setting strategic direction and various other purposes. Available at: https://ict.police.uk/national-standards/intel/
61. *National Intelligence Model Code of Practice*, Home Office and National Centre for Policing Excellence, 2005. Available at: http://library.college.police.uk/docs/npia/NIM-Code-of-Practice.pdf
62. *A Common Sense Approach: a review of the criminal records regime in England and Wales, Report on Phase 2,* Sunita Mason, 30 November 2011, page 35: *"... once access has been granted, it is vital to have effective auditing arrangements to check it is being used appropriately and in line with the agreed conditions. HMIC has strong expertise in this area and their audit role should be extended to cover all PNC users, with the users agreeing to meet the cost of the audit."*
63. A supply agreement is a document signed by the Home Office and each individual organisation agreeing to PNC access. The document includes the responsibilities of each party to ensure that access to the PNC continues. There is a review date included in each supply agreement.
64. Other inspectorates covering health, children's social care, education and training are also involved.

65. *Expectations for police custody: Criteria for assessing the treatment of and conditions for detainees in police custody*, HMIC, April 2012. Available from: www.justiceinspectorates.gov.uk/hmic/publications/expectations-police-custody-criteria/
66. A ligature point is a point which could be used to support a noose or other strangulation device. Such points represent major risks to suicidal detainees.
67. *Delivering justice in a digital age: a joint inspection of a digital case preparation and presentation in the criminal justice system*, HM Crown Prosecution Service Inspectorate and HMIC, April 2016. Available at: www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/delivering-justice-in-a-digital-age.pdf
68. Different arrangements apply concerning the leadership and oversight of the two London police forces. Should concerns be identified in respect of the Metropolitan Police Service, they will be raised with the Commissioner of Police of the Metropolis and the Mayor's Office for Policing and Crime. Should concerns be raised in respect of the City of London Police, they will be raised with the Commissioner of City of London Police and the City of London Police Committee.


© Lancashire Constabulary

# ANNEXES


© Greater Manchester Police

# ANNEX A:
## Police force areas

HMIC was established in

1856

# ANNEX B: About HMIC

## History

Her Majesty's Inspectorate of Constabulary was established in 1856, under the same statute that required every county and borough which had not already done so to establish and maintain a permanent salaried police force (the County and Borough Police Act 1856).

The 1856 Act authorised the appointment of three Inspectors of Constabulary in England and Wales, whose duty it was to "inquire into the state and efficiency of the police" (section 15). It also introduced the concept of annual inspection.

The first Chief Inspector of Constabulary was appointed in 1962, as part of a major package of reforms to improve police governance and expand the role of the Inspectorate.

The Inspectorate's role and influence have evolved over the last century and a half. Most of its current functions are set out in the Police Act 1996 (as amended by the Police Reform and Social Responsibility Act 2011 and the Policing and Crime Act 2017).

HMIC is independent of both the police service and the Government. Both its independence and inspection rights are vested in Her Majesty's Inspectors, who are Crown appointees (section 54(1), Police Act 1996).

## Statutory responsibilities

**Inspection of territorial police forces in England and Wales**

HMIC has statutory powers to inspect and can be commissioned to inspect as follows:

- HMIC must inspect and report on the efficiency and effectiveness of every police force maintained for a police area (section 54(2), Police Act 1996).
- The Secretary of State may at any time require the Inspectors of Constabulary to carry out an inspection of a police force maintained for any police area (section 54(2B), Police Act 1996).
- The Home Secretary may also from time to time direct the Inspectors of Constabulary to carry out such other duties for the purpose of furthering

police efficiency and effectiveness as she may specify (section 54(3), Police Act 1996).

- The local policing body for a police area may at any time request the Inspectors of Constabulary to carry out an inspection of a police force maintained for the police area in question (section 54(2BA), Police Act 1996).

**Inspection of other police forces and agencies**

HMIC also has statutory duties to inspect other police forces and agencies, whose remits are not limited to a particular territorial area. Instead, they police specific areas of infrastructure or particular types of crime. In these cases, HMIC's report is given to whichever government body is responsible for the activity in question.

HMIC has a duty to inspect the following:

- Armed Forces Police – Royal Navy, Royal Military, Royal Air Force Police (section 321A, Armed Forces Act 2006 inserted by section 4 of the Armed Forces Act 2011);
- British Transport Police (section 63, Railways and Transport Safety Act 2003);

Police Act

1996


© Nottinghamshire Police

- Civil Nuclear Constabulary (section 62, Energy Act 2004);
- HM Revenue and Customs (section 27, Commissioners for Revenue and Customs Act 2005, and the Revenue and Customs (Inspections) Regulations 2005 (SI 2005/1133));
- Ministry of Defence Police (section 4B, Ministry of Defence Police Act 1987);
- Police Service of Northern Ireland (section 41, Police (Northern Ireland) Act 1998, subject to appointment by the Department of Justice, Northern Ireland);
- National Crime Agency (section 11, Crime and Courts Act 2013); and
- Customs functions (section 29, Borders, Citizenship and Immigration Act 2009, and the Customs (Inspections by Her Majesty's Inspectors of Constabulary and the Scottish Inspectors) Regulations 2012 (SI 2012/2840)).

The Policing and Crime Act 2017 which received Royal Assent on 31 January 2017 will enhance the democratic accountability of police forces and fire and rescue services, improve the efficiency and effectiveness of emergency

© Northamptonshire Police

services through closer collaboration, and build public confidence in policing.

Provisions have been included in the Act to strengthen powers to inspect fire and rescue services currently contained in the Fire and Rescue Services Act 2004. HMIC was asked to develop options for how it would take on the inspection of fire and rescue services. A detailed proposal has been submitted to the Home Office. This contemplates a risk-based and proportionate programme of inspections focusing on the effectiveness, efficiency and leadership of fire and rescue services. We expect Ministers to make a decision in 2017 as to whether HMIC should be asked to assume and discharge this additional responsibility.

**Powers in relation to inspections by others**

Where HM Chief Inspector of Constabulary (HMCIC) considers that a proposed inspection by another specified inspectorate, relating to matters within HMCIC's remit, would impose an unreasonable burden on the body to be inspected, he may require the other body not to carry out that inspection, or not to do so in a particular manner (paragraph 3 of Schedule 4A to the Police Act 1996).

© West Midlands Police

**Collaborative working**

The long history of collaborative working between the criminal justice inspectorates – of Constabulary, the Crown Prosecution Service, Prisons and the National Probation Service – was placed on a statutory footing through the Police Act 1996 (as amended by the Police Reform and Social Responsibility Act 2011).

Schedule 4A to the 1996 Act provides that the Inspectors of Constabulary:

- must cooperate with other specified inspectorates where it is appropriate to do so for the efficient and effective discharge of their functions (paragraph 4);
- may draw up a joint inspection programme with other specified inspectorates (paragraph 5); and
- may give notice to other specified inspectorates not to carry out an inspection, or not to do so in a specified manner, where HMCIC considers that such inspection would impose an unreasonable burden (paragraph 3).

**Publication of reports**

HMIC must arrange for all reports prepared under section 54 of the Police Act 1996 to be published in such a manner as appears to the Inspectors to be appropriate (section 55(1), Police Act 1996).

HMIC must exclude from publication anything that the Inspectors consider would be against the

interests of national security or might jeopardise the safety of any person (section 55(2), Police Act 1996).

HMIC must send a copy of every published report to the Secretary of State, the local policing body maintaining the police force to which the report relates, the chief officer for that police force and the police and crime panel for that police area (section 55(3), Police Act 1996).

HMCIC must in each year submit to the Secretary of State a report on the carrying out of inspections and (HMCIC) must lay a copy of this report before Parliament (section 54(4), Police Act 1996). The report must include HMCIC's assessment of the efficiency and effectiveness of policing in England and Wales for that year (section 54(4A), Police Act 1996).

**Production of the HMIC inspection framework**

HMCIC has a duty from time to time to prepare, consult on and publish an inspection framework (paragraph 2 of Schedule 4A to the Police Act 1996). HMCIC must obtain the approval of the Home Secretary to the inspection framework, and then lay

this framework before Parliament (paragraphs 2(2A) – (2B) of Schedule 4A to the Police Act 1996).

**Monitoring complaints**

It is the duty of every Inspector of Constabulary, carrying out his functions in relation to a police force, to ensure that he is kept informed about all matters concerning complaints and misconduct in relation to that police force (section 15(1), Police Reform Act 2002).

The Policing and Crime Act 2017 contains provisions for the establishment of a system of super-complaints.


© Northumbria Police

© West Midlands Police

A super-complaint is a complaint made to HMCIC that a feature, or combination of features, of policing in England and Wales by one or more than one police force is, or appears to be, significantly harming the interests of the public. The regime will also apply to the National Crime Agency.

Only a body designated by the Home Secretary may make a super-complaint. The Act provides for the Home Secretary to make regulations about which bodies may be designated, and the criteria to be applied in making such decisions.

The Act also makes provision for the involvement of the College of Policing and the Independent Police Complaints Commission in super-complaints. Although super-complaints must be made first to HMIC, there will be a process – to be set out in regulations – specifying how super-complaints are to be dealt with and who will deal with them.

**Misconduct proceedings**

In misconduct proceedings for chief constables and other senior officers above the rank of chief superintendent, HMCIC or an HMI nominated by him will sit on the panel for misconduct meetings and misconduct hearings (Police (Conduct) Regulations 2012 (SI 2012/2632), regulation 26). For all chief officer ranks (including chief constables), HMCIC or an HMI nominated by him will sit on any police appeals tribunal – Police Act 1996, Schedule 6, paragraph 1.

© Northamptonshire Police

**Removal of senior officers**
If a police and crime commissioner is proposing to call upon a chief constable or other senior officer to retire or resign, he is required to invite HMCIC to provide (who must then provide) written views on the proposed removal and the police and crime commissioner must have regard to those views (Police Regulations 2003 (SI 2003/527), regulations 11A and 11B).

The police and crime panel may consult HMCIC before making a recommendation to the police and crime commissioner on the dismissal of a chief constable (Police Reform and Social Responsibility Act 2011, Schedule 8, paragraph 15).

**HMIC's powers**
Amendments made by the Police Reform and Social Responsibility Act 2011 to the Police Act 1996 have strengthened the inspectorate's role as a policing body independent of both the Government and the police, making it more fully accountable to the public and to Parliament.

### Access to documents and premises

The chief officer of police is required to provide Inspectors with information, documents, evidence or other things that the Inspector may specify as are required for the purposes of inspection (paragraph 6A of Schedule 4A to the Police Act 1996). The chief officer is also required for the purposes of inspection to secure access for Inspectors to premises occupied for the purposes of that force and to documents and other things on those premises (paragraph 6B of Schedule 4B to the Police Act 1996).

Further powers for HMIC to obtain information and access to police premises are created by section 36 of the Policing and Crime Act 2017.

### Power to delegate functions

An Inspector of Constabulary has the power to delegate any of his functions to another public authority (paragraph 1 of Schedule 4A to the Police Act 1996).

### Power to act jointly with another public body

HMIC can act jointly with another public body where it is appropriate to do so for the efficient and effective discharge of its functions (paragraph 5(1) of Schedule 4A to the Police Act 1996).

### Power to provide assistance to any other public authority

HMCIC may, if he thinks it appropriate, provide assistance to any other public authority for the purpose of the exercise by that authority of its functions. Such assistance may be provided under such terms (including terms as to payment) as HMCIC sees fit (paragraph 6 of Schedule 4A to the Police Act 1996).

### Staffing

HMIC's workforce comprises the Inspectors of Constabulary, civil servants, police officers and staff secondees. In addition to these staff, HMIC has a register of associate inspectors.

© Northamptonshire Police

The biography for each of the Inspectors of Constabulary can be found on HMIC's website:

www.justiceinspectorates.gov.uk/hmic/about-us/who-we-are/

# Who we are

## Her Majesty's Chief Inspector of Constabulary

**Sir Thomas Winsor**
In October 2012, Sir Thomas was appointed as Her Majesty's Chief Inspector of Constabulary. He is the first holder of that office to come from a non-policing background.

## Her Majesty's Inspectors of Constabulary

**Zoë Billingham**
Zoë Billingham is Her Majesty's Inspector for the Eastern Region.

**Michael Cunningham**
Michael Cunningham QPM is Her Majesty's Inspector for the Northern Region.

**Matt Parr**
Matt Parr CB is Her Majesty's Inspector for the National and London Regions.

**Dru Sharpling**
Dru Sharpling CBE is Her Majesty's Inspector and also sits on the panel of the Independent Inquiry into Child Sexual Abuse.

**Wendy Williams**
Wendy Williams is Her Majesty's Inspector for the Wales and Western Region.

# Accountability

The County and Borough Police Act 1856 provided for the appointment of the first Inspectors of Constabulary, and required them to inspect and report on the efficiency and effectiveness of most of the police forces in England and Wales. HMIC's principal role has not changed materially since then, except that its remit now covers the 43 forces in England and Wales, and a number of other forces and agencies, either automatically or on request. Its principal empowering statute is now the Police Act 1996.

There are currently six Inspectors of Constabulary; they are neither civil servants nor police officers. They are appointed by the Crown for a fixed term of up to five years. HMIC is therefore independent of the police, Government, police and crime commissioners (and their London equivalents), other agencies in the criminal justice system and all outside parties. However, independence does not mean that there is a lack of accountability. HMIC is accountable in the following ways:

Independence does not mean that there is a lack of accountability

- its statutory duties, enforceable through judicial review or by action for breach of statutory duty;
- its obligation to submit an annual report to the Home Secretary under section 54 of the Police Act 1996; each report must be published and laid before Parliament: section 54(4), Police Act 1996;
- its obligation to lay before Parliament a copy of each inspection programme and inspection framework: Police Act 1996, schedule 4A, paragraph 2(2A)(a));
- written Parliamentary questions;
- its obligation to give written and oral evidence to Committees of Parliament, including the Home Affairs Select Committee, the Public Accounts Committee and any other select committee which may require HMIC to give evidence;
- its obligation to carry out other duties as the Home Secretary may direct: section 54 (3), Police Act 1996;
- its obligation to comply with the rules of administrative law and the rules of good public administration, enforceable in the High Court by judicial review.

As a public body, HMIC is also subject to the legal obligations imposed on public authorities, including:

- Official Secrets Acts 1911 and 1989;
- Health and Safety at Work etc. Act 1974;
- Data Protection Act 1998;
- Human Rights Act 1998;
- Freedom of Information Act 2000;
- Equality Act 2010.

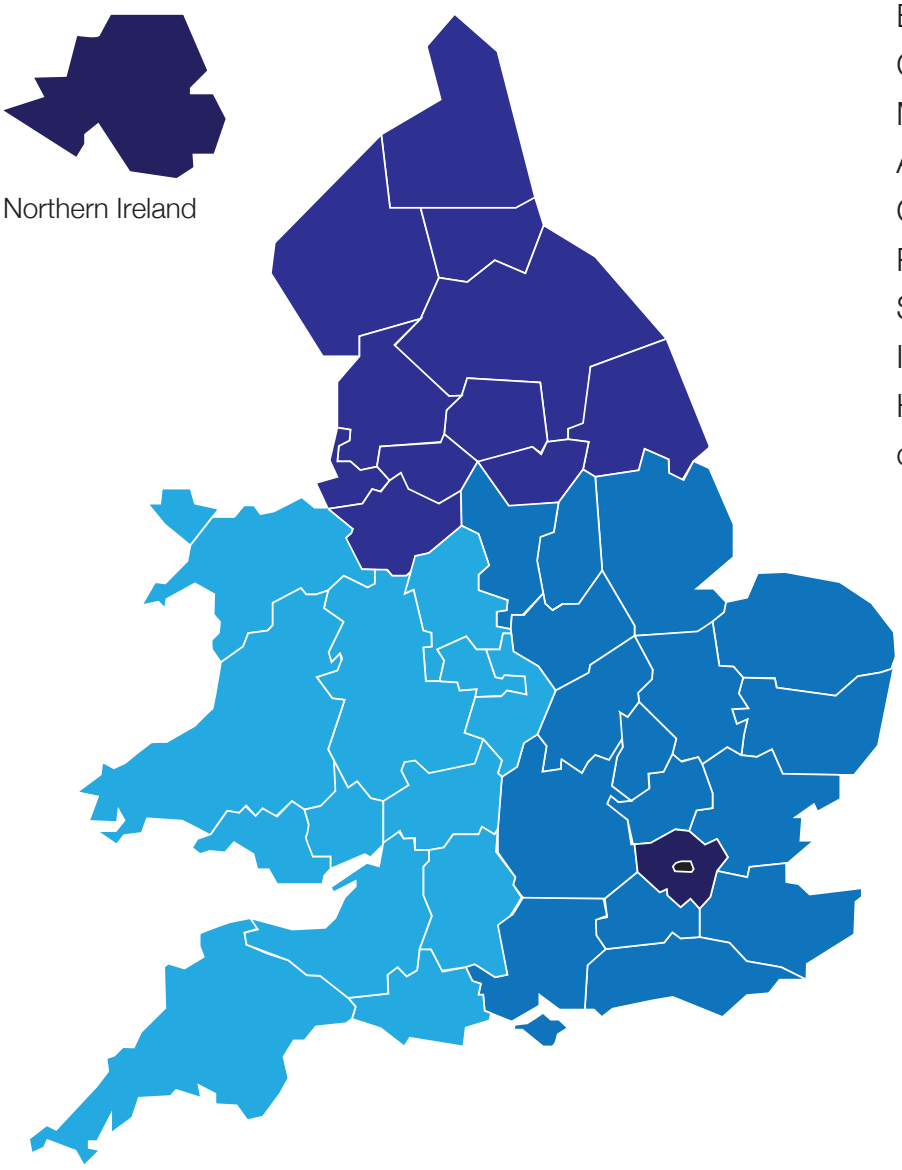
HMIC receives funding from the Home Office and is accountable to the Home Office for its expenditure even though it is neither a subsidiary nor a part of the Home Office.

HMIC has established a number of concordats with others which set out the relationship or working arrangements between them. These are:

- a concordat with the Home Office which explains the material parts of the relationship between the two organisations. The concordat specifies at a high level the role of each organisation in relation to the other, and the responsibilities of the principal individuals involved in running, sponsoring and overseeing HMIC's affairs. The concordat is published on HMIC's website;
- a concordat with the College of Policing. As both have complementary purposes and different powers by which those purposes are to be achieved, the concordat specifies the common understanding and intended approach of each body in its relations with the other in respect of their roles and responsibilities;
- a concordat with the College of Policing and the Independent Police Complaints Commission. The concordat specifies the common understanding and intended approach of each body in its relations with the other in respect of their roles and responsibilities.

In addition, HMIC has a statutory duty to co-operate with the other criminal justice inspectorates, namely those concerned with the Crown Prosecution Service and the probation and prisons services, and the other named inspectorates set out in paragraph 4, Schedule 4A, Police and Justice Act 2006. Our obligations with regard to joint inspections are set out in paragraphs 2–5 of that schedule and those inspections are reported on earlier in this assessment.

# HMIC regions



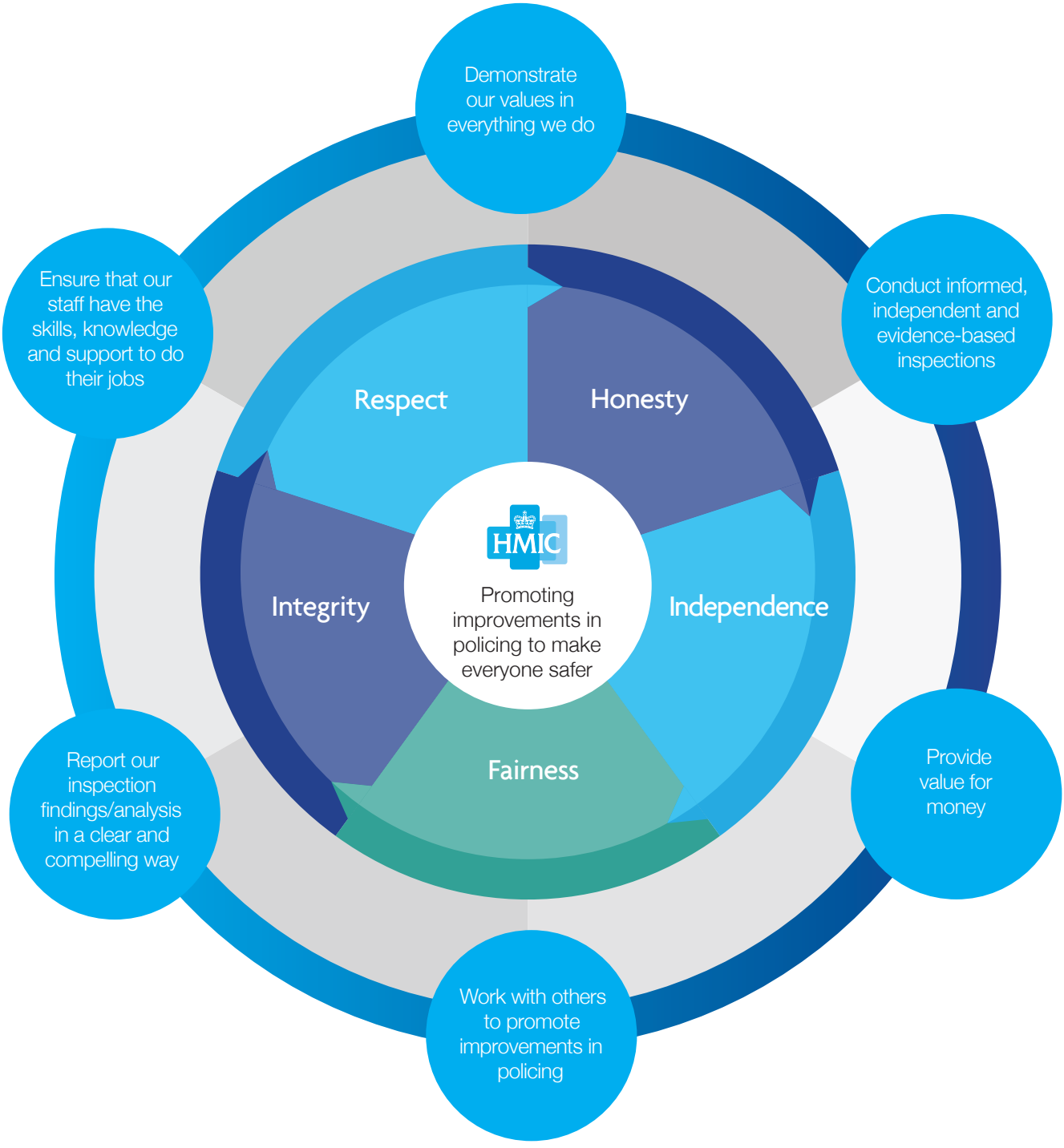

- Northern region
- Eastern region
- National and London regions
- Wales and Western region

## The National and London regions' responsibilities include:

Metropolitan Police Service
City of London Police
National Crime Agency
British Transport Police
Civil Nuclear Constabulary
Ministry of Defence Police
Armed Forces Police
Guernsey Police
Royal Gibraltar Police
States of Jersey Police
Isle of Man Constabulary
HM Revenue and Customs
others by invitation.

# HMIC purpose, values and objectives

Strong, clear values provide the foundation for a strong organisation. Our values of respect, honesty, independence, integrity and fairness are at the heart of how we operate; they act as a touchstone to help both individuals and HMIC as a whole to make decisions.



**Sir Robert Peel** became Home Secretary in 1822 and in 1829 established the first full-time, professional and centrally-organised police force in England and Wales, for the Greater London area. The reforms were based on a philosophy that the power of the police comes from the common consent of the public, as opposed to the power of the state. This philosophy is underpinned by nine principles which have shaped HMIC's approach when assessing forces.

# ANNEX C: Peelian Principles

1. The basic mission for which the police exist is to **prevent crime and disorder**.
2. The ability of the police to perform their duties is dependent **upon public approval** of police actions.
3. Police must **secure the willing co-operation of the public** in voluntary observance of the law to be able to secure and maintain the respect of the public.
4. The degree of **co-operation of the public** that can be secured diminishes proportionately to the necessity of the use of physical force.
5. Police seek and preserve public favour not by pandering to public opinion but by constantly demonstrating absolute **impartial service to the law**.
6. Police use **physical force to the extent necessary** to secure observance of the law or to restore order only when the exercise of persuasion, advice and warning is found to be insufficient.
7. Police, at all times, should **maintain a relationship with the public** that gives reality to the historic tradition that the police are the public and the public are the police; the police being only members of the public who are paid to give full-time attention to duties which are incumbent on every citizen in the interests of community welfare and existence.
8. Police should always direct their action strictly towards their functions and **never appear to usurp the powers of the judiciary**.
9. The test of **police efficiency is the absence of crime and disorder**, not the visible evidence of police action in dealing with it.

82%

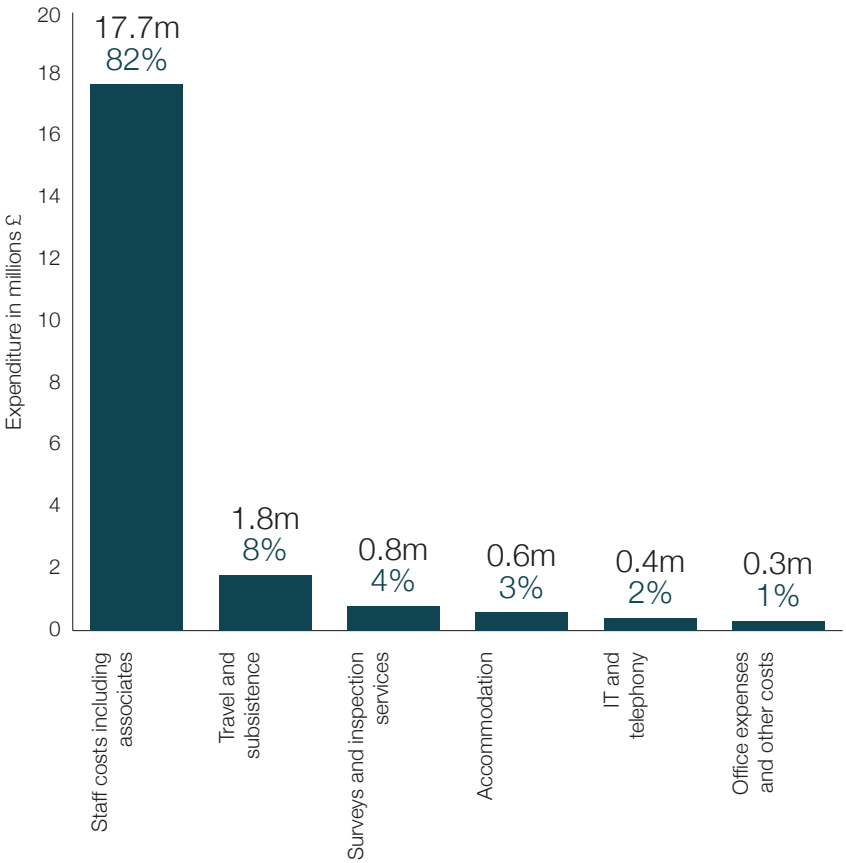
of HMIC's funding is spent on its workforce

# ANNEX D: Finances

HMIC is funded principally by the Home Office. In addition, HMIC receives funds for inspections commissioned by others (such as the Police Service of Northern Ireland).

HMIC spends 82 percent of its funding on its workforce, with the remainder spent on travel, subsistence, accommodation and other expenses.

**Expenditure breakdown 2015/16**

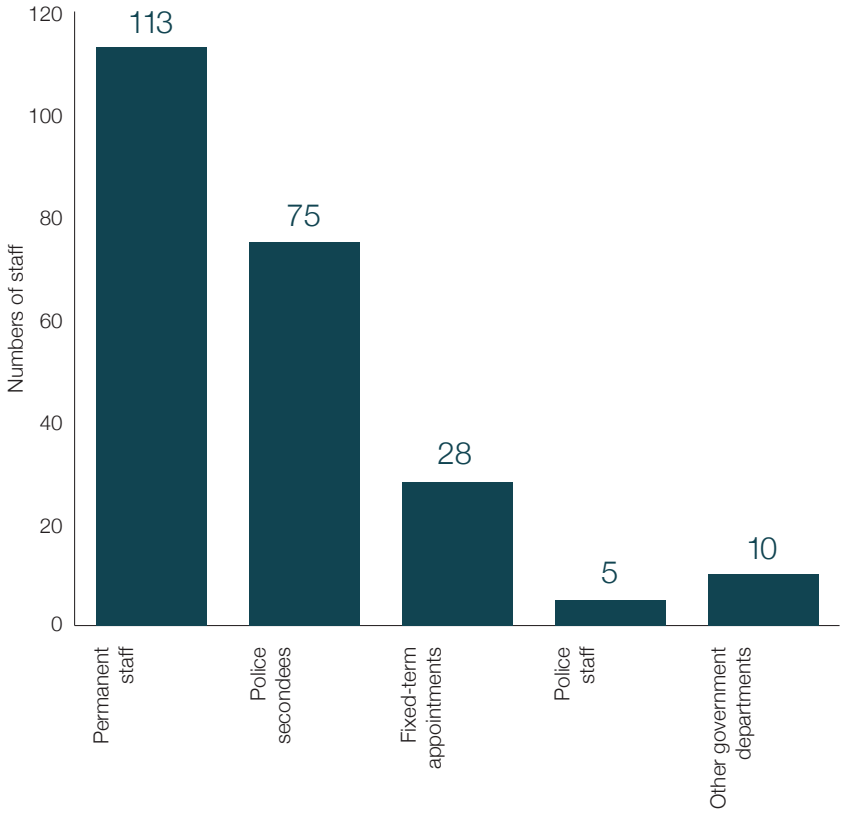


# Staffing

HMIC's workforce comprises the Inspectors of Constabulary, civil servants, police officers and staff secondees. In addition to these staff, HMIC has a register of associate inspectors.

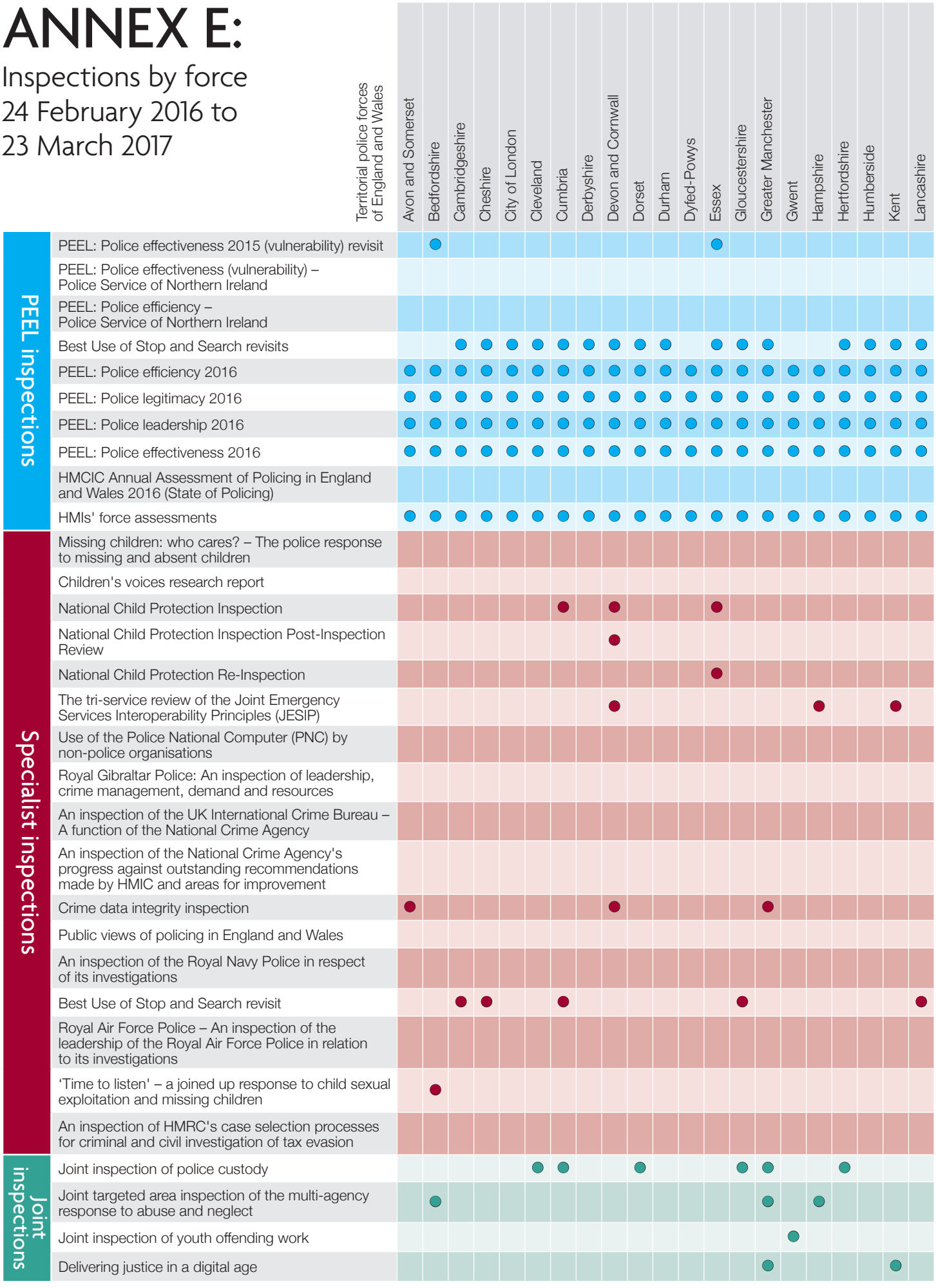
**231**
members of staff

### Staffing breakdown 2015/16



# ANNEX E:

## Inspections by force 24 February 2016 to 23 March 2017



Leicestershire
Lincolnshire
Merseyside
Metropolitan
Norfolk
Northamptonshire
Northumbria
North Wales
North Yorkshire
Nottinghamshire
South Wales
South Yorkshire
Staffordshire
Suffolk
Surrey
Sussex
Thames Valley
Warwickshire
West Mercia
West Midlands
West Yorkshire
Wiltshire
Other police forces and agencies
Border Force
British Transport Police
Civil Nuclear Constabulary
National Crime Agency
Police Service of Northern Ireland
Royal Gibraltar Police
Royal Navy Police
Royal Air Force Police
Thematic and other reports
Various police forces/agencies
Non-inspection reports
Various police forces/agencies

# Promoting improvements in policing to make everyone safer

Her Majesty's Inspectorate of Constabulary (HMIC) independently assesses police forces and policing across activity from neighbourhood teams to serious crime and the fight against terrorism – in the public interest.

In preparing our reports, we ask the questions which citizens would ask, and publish the answers in accessible form, using our expertise to interpret the evidence. We provide authoritative information to allow the public to compare the performance of their force against others, and our evidence is used to bring about improvements in the service to the public.


Promoting improvements
in policing to make
everyone safer

Her Majesty's Inspectorate of Constabulary
6th floor
Globe House
89 Eccleston Square
London SW1V 1PN

www.justiceinspectorates.gov.uk/hmic/