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# Lessons Learned Review

Wiltshire Police

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## Executive summary

### **Purpose of the review**

This review was undertaken at the request of Wiltshire Police Authority following the death of Wiltshire Deputy Chief Constable David Ainsworth on 22 March 2011. It has been designed to identify and learn lessons from the management of events both leading up to and following the death of Mr Ainsworth.

HM Inspectorate of Constabulary (HMIC) recognises the deeply tragic circumstances from which this review has arisen and the impact events have had on all those involved.

The intention of this review is not to apportion blame, nor to act in judgement or in arbitration on the range of views that exist around these events and their management. The Force and Police Authority were presented with an exceptional set of circumstances, centred on the tragic death of their Deputy Chief Constable. Both before and after the death of Mr Ainsworth the scale and speed of events that unfolded could not have been readily predicted, and consequently decisions were made with limited precedent or guidance.

The report has purposely adopted a factual approach in order to identify constructive lessons that assist in moving forward. As was clear from the outset (and was confirmed by documentary material and interviews), there are still strong feelings and a diverse range of views about individuals and decisions made. HMIC would be failing in its duty if we were to engage in an emotional debate; our job is to determine from the facts available the key lessons to be learnt.

It is to the credit of the Force and Police Authority that they commissioned and engaged fully in this review process to learn lessons. A genuine commitment has been shown to learn from the management of these events and move their organisation forward.

HMIC committed to produce a report by the end of October 2011. This was achieved; but publication has been delayed in the interim period while an Independent Police Complaints Commission (IPCC) investigation took place (conducted after a number of complaints were made to them). However, following the Coroner's inquest into the death of Mr Ainsworth, we have reviewed this decision in conjunction with the IPCC.

## **Review methodology**

The review sought contributions not just from affected staff but also from staff associations and individuals who played a professional role in these events. The Chief Constable, Police Authority Chair and Chief Executive were interviewed by Her Majesty's Inspector and all members of the gold group were invited to participate in the review.

HMIC invited views from the family of Mr Ainsworth, both through the family liaison officers and with some direct contact with those who agreed to be involved.

The review consisted of a total of 41 face-to-face meetings, nine telephone interviews, three written submissions and approximately 300 documents.

The report is set against six key themes: organisational culture; leadership and governance; policies; systems and processes; people and skills; and audit and performance. In each area we have drawn out the key learning points, based upon the facts as we understand them, actions of parties involved and a review of available established practice.

## **Key findings**

### **Roles and responsibilities of the Police Authority and Chief Constable**

The review found that there was a lack of clarity about the division of responsibility and accountability between the Chief Constable and the Police Authority. There would have been a benefit in the Police Authority providing

clarity, at an early stage, of its governance and oversight responsibilities and communicating them to all those involved.

The Chief Constable provided clear and 'hands-on' leadership, following due process in dealing with the misconduct allegations, and taking personal responsibility for the management of events.

However, the role of the Police Authority was not well understood by review participants. The Authority was perceived to take no visible role and they lacked an overarching strategy to inform their governance and oversight of events.

The Police Authority was the 'appropriate authority' for the purposes of the misconduct investigation. Its responsibilities included ensuring that a proportionate and balanced investigation was carried out as soon as possible after alleged misconduct came to its attention, and that the investigation was carried out as quickly as possible (allowing for the complexity of the case).

During the period of the misconduct investigation, the Police Authority considered whether or not to suspend Mr Ainsworth. There is little evidence that the authority exercised clear oversight or gave proper consideration as to whether the redeployment arrangements were workable. The matter was delegated to the Chief Constable to resolve. Many have commented that the resultant redeployment arrangements created an unsatisfactory situation for all parties, including Mr Ainsworth, whose duties were significantly curtailed due to the restrictions placed upon him.

### **The management of communication**

The review found that an overarching communication strategy was not in place and should have been at an early stage to ensure communication was appropriate and tailored to individual needs. Whilst the Chief Constable took personal responsibility for informing staff of key events, on occasions his approach inadvertently lacked a full grasp of individual sensitivities.

As events unfolded the Police Authority increasingly relied on legal advice, which apparently impeded their ability to communicate with those involved. The Chair of the Police Authority and individual members were profoundly aware of the impact the events were having on the individuals concerned, and looked to act appropriately throughout. However, the Police Authority, as a governing body, became increasingly restricted in their management of events as a result of their reliance upon legal advice. Outwardly, this gave the perception that the Police Authority lacked understanding and compassion.

There was a lack of clear communication around how the misconduct process operated, its timescales, and the status of individuals within it. This caused confusion and distress to those involved.

### **Welfare arrangements**

A strategic welfare coordination group was established at an early stage. This was perceived as helpful; however, it would have benefitted from independent chair, possibly a chief officer from another force or an HR professional.

Welfare provision for employees was given due consideration, but would have benefitted from being tailored to individual need and extended to those who had left the organisation.

The review found that there was considerable welfare provision available to Mr Ainsworth; however responsibility for providing this was shared between a number of individuals. Whilst there was a lack of structure and coordination between those providing welfare assistance to Mr Ainsworth, it is acknowledged that confidentiality arrangements made it extremely difficult to share information.

There is no formalised structure at a national level for the welfare needs of chief officers. A reference point for the Chief Constable and Police Authority would assist in terms of guidance and experience. This was acknowledged by HM Coroner during the inquest and he stated his intention to write to the Association of Chief Police Officers (ACPO) highlighting the issues.

**This report expands upon these findings and identifies key learning points against the six key themes.**

**It is hoped that lessons identified will go some way to assisting the organisation to move forward. It also provides opportunities for a wider audience to review current practice and policy and to inform strategies for the management of events in the future.**

# 1. Introduction

- 1.1 This review has been undertaken at the request of Wiltshire Police Authority following the death of Wiltshire Deputy Chief Constable David Ainsworth on 22 March 2011. The review has been designed to identify and learn lessons from the management of events leading up to, and following the death of Mr Ainsworth. The request from the Police Authority and feedback from many involved advocated a desire for independent review in circumstances where various aspects have already been subject of external investigation and review.
- 1.2 We recognise the deeply tragic circumstances from which this review has arisen and the impact events have had on all those involved.
- 1.3 At the time of his death, Mr Ainsworth was under investigation for a number of allegations made about his behaviour at work (Operation Yellowstone). A formal investigation was being led by South Wales Police. Following the death of Mr Ainsworth this investigation concluded and a report was submitted to the Police Authority by South Wales Police. At the time of writing, the Police Authority is engaged in deciding what, if any, further action to take in relation to the South Wales Police report.
- 1.4 A gold group, chaired by Chief Constable Moore, was established following Mr Ainsworth's death to manage the welfare needs of staff, coordinate communications and identify learning. In May 2011, Wiltshire Police invited staff affected by the death of Mr Ainsworth to participate in a confidential communication exercise to identify any issues that remained outstanding for them. This exercise was undertaken at the request of the Police Authority.
- 1.5 The findings from that exercise, based on a small sample, were presented to the gold group in early July 2011, when members agreed to invite HMIC to conduct an independent lessons learned review.



- 1.6 Our role is to independently assess police forces and policing activity in the public interest. In preparing our reports, we ask the questions that informed citizens would ask, and publish the answers in accessible form, using our expertise to interpret the information. We also provide high-quality, professional advice to police to identify the 'best practice' which all forces can aspire to. We act in the public interest to encourage progress and value for money, and to drive improvements in the service to the public.
- 1.7 It is not the role of this review to apportion blame, nor to act in judgement or in arbitration on the range of views that exist around these events and their management. Strong and diverse views have been expressed, at times based on limited information and an incomplete picture of the complexities involved. It is within the scope of the review to try and explain the sequencing and context of events to assist understanding. To aid this process, a chronology of significant events is attached at Appendix A.
- 1.8 It is hoped that the lessons learned from this review will assist the Force, Police Authority and all those involved, in moving forward, as well as providing a wider audience with opportunities to inform strategies for the management of events in the future.

## 2. Terms of reference

- 2.1 The terms of reference and methodology adopted for the review set out our approach to the process. We have examined the activities of the Force and Police Authority and listened to a range of views from those affected, as well as those responsible for the leadership and governance of events.
- 2.2 In order to ensure that the review delivered in the timescales, and to avoid disappointing the varied audiences involved, the review team has sought rigorously to remain within the terms of reference which were agreed with the Police Authority.
- 2.3 The terms of reference were:
- i. To examine the events surrounding the death of David Ainsworth and how they were managed by the Force and Police Authority.
  - ii. To identify lessons to be learnt and opportunities for improving the management of such events.
  - iii. To produce a written report, open to the organisation, detailing lessons learnt and suggesting a way forward.
- 2.4 It was not within the scope of the review to re-examine the South Wales Police investigation or to enquire into the specific circumstances of Mr Ainsworth's death, which are matters to be addressed through the coronial process.
- 2.5 The coroner's inquest into the death of Mr Ainsworth took place in Trowbridge, Wiltshire between 11 and 13 June 2012. During his summing up, HM Coroner for Wiltshire and Swindon, Mr David Ridley, documented his intention to write to ACPO concerning welfare provision for chief officers. HM Coroner was satisfied that there were multi-layered welfare arrangements in place for Mr Ainsworth and that there was no cause to engage Article 2 of the European Convention of Human Rights.

HM Coroner concluded that Mr Ainsworth had taken his own life whilst suffering from depression.

2.6 The terms of reference for the review specifically relate to our examination of events as managed by Wiltshire Police and Wiltshire Police Authority. However, during the course of the review Wiltshire Police Authority raised an issue outside the terms of reference – and hence the scope of the review – relating to Mr Ainsworth’s previous employment. This is a matter that HMIC may consider separately in light of the pending report of the Independent Police Complaints Commission.

2.7 HMIC approached the review in the expectation that it would:

- i. Develop an understanding of the events that led to the present situation.
- ii. Develop an understanding of the response to those events.
- iii. Review relevant policies and structures in place in Wiltshire Police and Wiltshire Police Authority and establish the level of compliance.
- iv. Examine national best practice and determine how this affected the management of events.
- v. Reflect on whether there are lessons that can be learnt from the response to these events.
- vi. Provide an opportunity for those involved in the matter, within the scope of this review, to have received answers to questions which still persist.
- vii. Look at possibilities for moving on, for both the individuals and organisations involved.

2.8 It was felt that these expectations balanced the desire to acknowledge the past, detail individual and organisational issues in the present and set out ideas for a framework for the future.

### 3. Review methodology

- 3.1 The first phase of review activity consisted of a literature review of relevant documentation provided by the Force and Police Authority concerning the management of events. Additional documentation was received from participants and considered as part of the review process.
- 3.2 The second phase of review activity consisted of fieldwork and meetings held in Wiltshire between 12 and 22 September 2011. HMIC attempted to contact all those who had been involved in Operation Yellowstone, including those who had since left employment with Wiltshire Police or Wiltshire Police Authority, to invite them to participate in the review.
- 3.3 The review sought contributions not just from affected staff but also from staff associations and individuals who played a professional role in these events. The Chief Constable, Police Authority Chair, and Chief Executive were interviewed by Her Majesty's Inspector and all members of the gold group were invited to participate in the review.
- 3.4 The review invited views from the family of Mr Ainsworth both through the family liaison officers and with some direct contact with those who agreed to be involved.
- 3.5 The review consisted of a total of 41 face-to-face meetings, nine telephone interviews, three written submissions and approximately 300 documents.
- 3.6 The review framework consisted of six themes in which information was gathered from meetings, written submissions and documentary material:
  - organisational culture;
  - leadership and governance;
  - policies;

- systems and processes;
- people and skills; and
- audit and performance.

3.7 This analytical approach ensures that important messages are identified and can be used to inform future learning, recognising that the emotional aspects of events need to be placed into the learning context. A deliberately clinical approach has been adopted in order to draw constructive conclusions amid the diversity and polarity of perspectives that surround the management of events.

3.8 It is our commitment to be transparent, a theme that has been reaffirmed by many of those who have contributed to this review.

## 4. What we found

### 4.1 Organisational culture

4.1.1 The organisational culture of Wiltshire Police has been described as 'a close-knit community', with long-established relationships and traditional ways of working. Prior to the appointment of Chief Constable Moore, the Force had seen a significant increase in crime, and the Police Authority was clear in its intention to appoint a Chief Constable capable of improving Force performance.

4.1.2 Chief Constable Moore was appointed in January 2008. His immediate focus on business and performance improvement was recognised as necessary to bring about required sustainable change.

4.1.3 The review found that the organisation still has some way to go to embed emotional intelligence within its culture and create a professional environment that empowers and enables staff to contribute fully. It was clear that many members of the organisation have found it difficult to adapt to the scale and pace of change embarked upon in recent years.

4.1.4 In addition to this change in culture and approach, it should be recognised that the Force also saw the appointment of two new chief officers during this period. This period of instability has contributed to a perception amongst some members of the organisation that the chief officer team lack empathy for the traditional 'Wiltshire way', as described by a number of those interviewed.

4.1.5 This context is important in understanding the difficulty in dealing with the events as they were to unfold. The polarity of views that already existed amongst some senior staff, combined with pre-conceived ideas around how the chief officer team would be likely to act, created an environment where transparency and trust would be hard to achieve. No matter how

well intentioned, some participants described a position where any decisions made at a senior level would attract adverse criticism.

4.1.6 The Force and Police Authority are committed to understanding the issues of their staff and conduct bi-annual staff surveys to identify and address concerns. Deputy Chief Constable (now temporary Chief Constable) Geenty has undertaken a programme of work to promote a set of organisational values that aim to positively enhance the change in organisational culture.

**Key learning point:**

- **Organisational staff surveys are good practice and should be continued so as to benchmark progress.**

## **4.2 Leadership and governance**

4.2.1 The review found that the Chief Constable provided clear, visible and 'hands-on' leadership, both prior to and following the death of Mr Ainsworth. He promoted a strong and consistent message with respect to standards of integrity and conduct, reinforced through a series of roadshows across the Force. Leadership and governance from the Police Authority was found to be less visible and there was a lack of clarity about the division of responsibility.

4.2.2 In October 2009, a grievance was raised about Mr Ainsworth's behaviour in the workplace. This was investigated by another force and resulted in management action in the form of an agreed action plan for Mr Ainsworth in November 2009. The action plan was monitored directly by the Chief Constable and Police Authority, and included in Mr Ainsworth's personal development review (PDR).

4.2.3 In August 2010, a second grievance was referred to the Police Authority by the Chief Constable. At this time a decision was taken by the Police Authority that this was not a misconduct matter. Shortly after, further

reports about the appropriateness of Mr Ainsworth's behaviour were reported to the Chief Constable. This was reinforced by correspondence from UNISON referring to the same concerns.

4.2.4 The concerns regarding Mr Ainsworth's conduct led to the Police Authority (as the 'appropriate authority' for the purposes of the relevant police conduct regulations)<sup>1</sup> convening a misconduct panel meeting in early September 2010. The Police Authority panel made the decision to instigate a misconduct investigation. HMIC and IPCC were consulted in this decision. It was agreed that South Wales Police would conduct the investigation.

4.2.5 In each instance, when an allegation was made, the Chief Constable immediately acted and satisfied himself as to the position before referring the matters to the Police Authority.

4.2.6 The review found no evidence of any unwillingness by the Chief Constable to deal with specific matters raised.

4.2.7 The role of the Police Authority in these events was not generally well understood by review participants. Many expressed the view that the Police Authority played no visible role, were slow to react to events and were ill-prepared and ill-equipped to deal with a fast-evolving situation.

4.2.8 The review found that the Police Authority lacked any formalised strategy or meeting process to consider the issues as further information came to light. A formal meeting of the Police Authority's misconduct panel had taken place on 02 September 2010. The review team were advised that informal meetings between Police Authority members operated outside of a formal structure and were not minuted. At this time, the chair of the Police Authority reluctantly accepted that he could not take an active

<sup>1</sup> Police (Conduct) Regulations 2008



role, recognising that he may be required to lead in later discipline proceedings.

4.2.9 In the absence of an overarching strategy, the Police Authority relied heavily upon legal advice, one consequence of which was a severe restriction on their communication with the Force and with those involved in Operation Yellowstone. There is a perception that this reliance upon legal process came at the expense of a more people-orientated approach on the part of the Police Authority.

4.2.10 A communication was sent from the Police Authority to the Chief Constable at the end of January 2011, setting out respective roles and responsibilities in relation to the investigation. This was disseminated as part of the Operation Yellowstone communications. Earlier communication on the respective roles and responsibilities of the Police Authority and the Chief Constable in terms of the oversight and governance of the investigation would have assisted wider organisational understanding.

4.2.11 In the immediate period following Mr Ainsworth's death many participants commented that the Chief Constable provided much-needed visible leadership. He took responsibility for communicating the death both internally and externally. A gold group was established to manage the welfare needs of staff, coordinate communications and identify learning.

**Key learning points:**

- **When dealing with complex welfare issues, the strategic governance and leadership role of the Police Authority should be clarified at the earliest opportunity.**
- **Although a detailed understanding of the relevant legal framework is necessary, the Police Authority should adopt a people-orientated approach by recognising the distress that an incident of this nature causes to those inside and outside the Force.**

## 4.3 Policies

### Overview

- 4.3.1 The review examined relevant Wiltshire Police and Police Authority policies in the areas of vetting; suspension; equality and diversity; misconduct; welfare; critical incidents; and death in service. National guidance and best practice was used to inform our critique of these activities and policies.
- 4.3.2 A review of the documents disclosed a range of policies and procedures that adhered to national guidance and best practice. These were found to be readily accessible and participants displayed a good understanding across all areas. The review found some concern that when relevant Force policies were acted upon, it was not always in a timely and consistent manner.
- 4.3.3 National guidance on welfare for chief officers as a specific group is not published in a unified document. Staff associations operate to provide support in this area to federated and superintending ranks, but there is no formalised arrangement at chief officer level. There was no established reference point for the Chief Constable and Police Authority to draw upon for guidance.
- 4.3.4 The standards of conduct and behaviour of chief police officers is defined under *Police (Conduct) Regulations 2008*, and associated guidance and the same expectations apply to all ranks. The policies and guidance place a duty on staff to behave appropriately, make relevant disclosures, and report and challenge inappropriate or unacceptable conduct.
- 4.3.5 A practical delivery plan to embed equality and diversity into the core of the organisation and its culture, supported by appropriate accountability structures, would provide clarity and transparency in the operation of policy and practice. The introduction of a dedicated 'whistle-blowing' policy that allows issues to be reviewed in a timely and transparent

manner, promoting trust and confidence in the organisation, should be included as part of any delivery programme.

**Key learning points:**

- **A dedicated ‘whistle-blowing’ policy should be developed.**
- **A distinctive and practical delivery plan addressing equality and diversity issues across the force would promote trust and confidence.**
- **ACPO should consider developing guidance on the welfare arrangements for chief officers.**

**Vetting**

4.3.6 The Association of Chief Police Officers’ (ACPO’s) *National Vetting Policy 2010* sets out common standards for vetting and personnel security. This policy has been adopted within Wiltshire Police where the responsibility for vetting sits with the professional standards department.

4.3.7 The level of vetting required is determined by the nature of the role and the level of restricted information that is regularly accessed, not the rank of the officer. It should be completed on appointment to a new role that requires a different level of vetting, or at the regular review periods set out in vetting arrangements.

4.3.8 There were apparent failures in the operation of the vetting system in Mr Ainsworth’s case. As a result of inaction on the part of both Mr Ainsworth and Wiltshire Police this remained unresolved at the time of Mr Ainsworth’s death, a period of 18 months. The review team were surprised that both the Chief Constable and Police Authority had ‘assumed’ that vetting had been correctly conducted and completed. However, the review found that this is not an issue singular to Wiltshire Police. Senior officers across a number of forces believe that vetting processes occur automatically.

4.3.9 Application forms for ACPO positions do not consistently include details of vetting levels. Vetting status was not a requirement in the application forms Mr Ainsworth completed for various chief officer positions.

**Key learning points:**

- **Force vetting procedures should be reviewed.**
- **ACPO should consider reviewing national chief officer vetting policy and procedures and how they are applied.**

### **Suspension**

4.3.10 The Police Authority is regarded as the 'appropriate authority' in relation to decisions about the suspension of Chief Officers. Regulation 10 of the *Police (Conduct) Regulations 2008* sets out the conditions that must be met if an 'appropriate authority' is to decide to suspend a police officer. While suspension is a neutral act which affords protection to both the individual and organisation, the uniquely visible and high profile position of chief officers may require consideration.

4.3.11 The Police Authority convened to consider the allegations against Mr Ainsworth in early September 2010. They convened a misconduct panel to determine the appropriate handling of the most recent allegation. Members decided that the matter raised a prima facie case of misconduct and that an investigation should take place. They determined that, in accordance with their responsibilities and pending a report from the senior investigating officer, Mr Ainsworth would not be suspended. The Police Authority recommended that Mr Ainsworth be moved to an alternative work location at the discretion of the Chief Constable.

4.3.12 This arrangement was problematic to implement. Mr Ainsworth found that he could not attend force headquarters on a regular basis, his 'on-call' duties were removed and his portfolio responsibilities were distributed to others. He wrote expressing his concern to the Chief Constable, believing he was unable to fulfil his contractual duties. Those who were involved in the investigation were concerned about meeting

with Mr Ainsworth on the occasions he attended force headquarters. During this time, the Chief Constable made every effort to respond to a diverse range of demands and continue to carry out the business of the force.

4.3.13 In early November 2010, UNISON wrote to the chair of the Police Authority complaining that Mr Ainsworth had not been suspended and of the impact this had on some of their members. The Police Authority confirmed their decision in writing and alternative deployment arrangements made for Mr Ainsworth.

4.3.14 The redeployment issue was a cause of concern to many, including Mr Ainsworth, who was in effect suspended from duty due to the restrictions placed upon him. He was left in the position where he was required to personally negotiate with the Chief Constable around his continuing role within Wiltshire. This situation must have been difficult for both parties and placed an inevitable strain upon their professional relationship.

4.3.15 Whilst the Police Authority followed a process on 02 September 2010, they left the Chief Constable to implement their decision. Whilst the Chief Constable made every effort to find Mr Ainsworth meaningful work, the Police Authority had a responsibility to support the Force in finding Mr Ainsworth a role that ensured both that confidence was maintained by staff and that Mr Ainsworth was able to feel gainfully employed. As it was, the arrangement proved unsatisfactory for all concerned.

4.3.16 The review found that the decision regarding Mr Ainsworth's temporary redeployment to alternative duties was not formally reviewed. The Police Authority state that fortnightly discussions were held with the Chief Constable to discuss redeployment arrangements. In early February 2011 members of the Police Authority professional standards committee and the chief executive met to discuss a legal strategy to deal with the events surrounding the South Wales Police report. At this meeting, a decision was taken that the matter was now to be considered as potential

gross misconduct and that they would reconvene to consider suspension when the senior investigators' report from South Wales Police was available.

4.3.17 It is unclear to the review team as to why the Police Authority did not undertake a further review on or around the 16 December 2010, when the second Regulation 15 notice was served on Mr Ainsworth. Given the number of new allegations contained in that notice, this was a key juncture in the misconduct process. Whilst it is accepted that informal discussions took place, it is unclear what steps the Police Authority took to meet its responsibilities as the 'appropriate authority'.

4.3.18 A more regular review of the redeployment decision would have assisted in providing clarity to all parties, including Mr Ainsworth, and provided a framework in which associated risks could be assessed, acted upon and communicated in a timely manner. Events and trigger points should be identified and risk assessed, mitigating action taken, and decisions accurately recorded.

**Key learning point:**

- **A clear, structured and timely review process of temporary redeployment as an alternative to suspension assists in the management of deployment, and brings clarity for those deployed from normal duty and for those members of staff who are affected by that arrangement.**

## **4.4 Systems and processes**

### **Communication**

4.4.1 Communication was a common theme identified across many aspects of the management of the process. As a result, information in this section is drawn from many strands of the review activity. Views on communication were diverse and ranged from those who felt well informed by

appropriate communication to those who felt that communication was too general and not appropriate to their needs. The review accepts that there were issues of confidentiality which may have hampered the identification of those who were either victims or witnesses within the investigation.

4.4.2 There was significant support for the view that written communications could have been better targeted to different audiences. In this situation there were a number of parties (both internal to the force and external) with specific interests and needs. For example: Mr Ainsworth and his family; those who had made allegations; those who had been interviewed as witnesses in the investigation; and those whose role brought them into contact with Operation Yellowstone. Several review participants commented upon the Chief Constable's style and approach, which they felt was well intentioned but, at times, lacking in an emotional understanding of their needs.

4.4.3 The absence of an overall communication strategy meant that there was confusion about who was responsible for providing information to interested parties. As a result some people received uncoordinated information from both the Force and South Wales Police, which caused some confusion and upset at a sensitive time.

4.4.4 External communications and media interest caused concern for both Mr Ainsworth and his family and those who had made complaints. A more strategic – rather than reactive – approach may have alleviated some of these concerns. Nevertheless the Chief Constable took personal responsibility from an early stage for ensuring that participants were regularly updated and for ensuring that Mr Ainsworth's death was communicated appropriately and in a timely fashion.

4.4.5 The responsibility for communications was included in the gold group terms of reference which were established following the death of Mr Ainsworth. Although there were potential benefits to communications

being coordinated by such a group, acting as a central clearing point, the disadvantage is that the messages were not focussed on the needs of individuals. This resulted in some individuals feeling ill-served: for example, those who viewed themselves as concerned for Mr Ainsworth perceived that communication was predominantly 'victim-orientated', and those who had made complaints perceived that the seriousness of their allegations had not been recognised. A communication strategy that clearly recognised different interest groups would have been able to address many of these concerns.

4.4.6 Contact with Mr Ainsworth's family was conducted through Gloucestershire Police, which had been appointed to undertake the inquiry into Mr Ainsworth's death on behalf of the Coroner. Family liaison officers from external forces were appointed to look after the information needs of the family groups. In the circumstances of this case it was appropriate to outsource the family liaison provision, and this approach was welcomed by family members who participated in this review.

4.4.7 Some family members reported their disappointment at the limited contact they received, and at the style and tone of communications from the Police Authority.

**Key learning points:**

- **A communication strategy is required when dealing with situations of this kind. It must be sufficiently flexible to accommodate individual need within and outside the force.**
- **The use of external family liaison support represents good practice.**

**Welfare**

4.4.8 The delivery of welfare support for those who had made complaints was considered at an early stage. As a result of this, a strategic welfare



coordination group was put in place and individual welfare leads were assigned.

4.4.9 The Chief Constable chose to chair the welfare coordination group himself, because he believed that he had to have oversight of all aspects in order to consider the health and wellbeing of his staff. Despite his best intentions, the review team found that this arrangement was problematic for a number of reasons. Review participants expressed concerns around independence, confidentiality and trust. Some felt that confidential issues would be reported directly to the Chief Constable and that this could affect their future careers. The formation of the welfare coordination group, while in itself a positive development, would have benefitted from an independent chair with the professional skills to deal with complex welfare arrangements.

4.4.10 The Chief Constable instigated a status check of welfare provision during December 2010 and January 2011. Whilst this demonstrated his commitment to welfare provision for staff, it was perceived by some as lacking independence, since it was undertaken by a previous head of human resources.

4.4.11 The provision of occupational health services in Wiltshire Police was acknowledged positively by many involved. The exceptional circumstances of varied and evolving demands was a significant challenge to the in-house provision. The review found that the resilience and commitment of those appointed as welfare leads was undiminished throughout the period of demand. However, the requirement for a particular set of skills and experience left some welfare leads feeling ill-equipped for the demands they faced.

4.4.12 The experience of many involved was that welfare provision involved no element of self-selection and was not tailored to meet their needs. In some cases, individuals were allocated a welfare lead who they felt was unsuitable. Requests to make alternative welfare leads available were

refused. Concerns were expressed by some participants about confidentiality, given the size and culture of the force. As events unfolded, a more personal approach could have been put in place. This would have assisted the organisation in understanding the size and complexity of the demands and their planning and delivery of welfare provision.

4.4.13 The alternative approach adopted in relation to the provision of family liaison services assessed need at the outset on an individual basis and provided an appropriate response to the demands identified. This produced a situation where the system for support was more effective and efficient both for those providing and those receiving it. The dedication and independence of external resource addressed the need for confidentiality.

4.4.14 In accordance with best practice, the welfare provision for the family was addressed by family liaison officers. Due to the circumstances of the case, this was provided from outside Wiltshire Police.

4.4.15 Given the length of the investigation, some participants left the organisation before it was completed. In these circumstances their experience of welfare provision was varied. Some reportedly received no support.

4.4.16 At the outset of the formal investigation, Mr Ainsworth's welfare needs were considered and a welfare lead was appointed in consultation with him. Although some participants reported some concern about the level of support offered to Mr Ainsworth, a review of the documents shows that a range of external and internal support was available to him. Much of the support that was taken up (including an ACPO 'friend') was initiated by him according to his perceived needs on the basis of information available to him at that time.

4.4.17 There was an apparent lack of coordination of Mr Ainsworth's welfare support by the Force or Police Authority. It was not clear who was responsible for his welfare. The Police Authority understood that the provision of welfare was designed around the location from which Mr Ainsworth was working at any particular time.

4.4.18 Organisational responsibility for Mr Ainsworth's welfare should have been clear from the outset of the misconduct investigation. Whilst there was a lack of structure and coordination between those providing welfare assistance to Mr Ainsworth, it is acknowledged that confidentiality arrangements made it extremely difficult to share information.

4.4.19 There is an absence of any formal structure in place for ACPO ranks to consider and assess welfare needs for chief officers.

**Key learning points:**

- **Welfare provision should be tailored to individual needs.**
- **When complex welfare needs arise, consideration should be given to independent professional intervention to coordinate and assess ongoing welfare needs within and outside the force.**
- **ACPO should consider reviewing welfare arrangements for chief officers to bring greater clarity over the responsibility for chief officers' welfare.**

**Complaint investigation within Wiltshire Police**

4.4.20 The review found that the Chief Constable and Police Authority were met with an exceptional situation for which they were understandably ill-prepared.

4.4.21 Misconduct proceedings in relation to Mr Ainsworth ended with his death, as did any opportunity to conclude on these matters. This is an unsatisfactory situation for all parties.

4.4.22 At the time matters were brought to the attention of the Chief Constable in 2009 and 2010, police regulations meant that he had to refer the issue to the Police Authority to determine whether or not a conduct investigation was appropriate. Some of those involved suggested that the Force or Police Authority should have dealt with the issues more quickly and decisively. The review found that individual issues were dealt with in a timely way in accordance with the existing guidance, and it was only when a further complaint was reported to the Police Authority that a formal investigation was initiated.

4.4.23 Several participants expressed concern over the length of the investigation as a whole. It is difficult to see how this situation could have been reasonably anticipated at the outset, given the new evidence that emerged during the investigation and the impact this had on the scale of the investigation.

4.4.24 South Wales Police were asked to conduct a misconduct investigation into the deputy chief constable. It would have been clear to the investigators at the outset that this investigation was likely to lead to a misconduct or gross misconduct hearing. It is inconceivable that the investigators would conduct anything other than a full and thorough investigation. This would include following all lines of enquiry made available to the investigative team. The investigation was reviewed by Chief Constable Cunningham of Staffordshire Police, who was satisfied that the investigation was proportionate and timely. This was further supported by HM Coroner who stated that he was not surprised at the length of time the South Wales Police investigation had taken.

4.4.25 Taking into account the need for confidentiality, some of the dissatisfaction expressed could have been avoided by an earlier communication explaining the misconduct investigation process and giving timescales. Managing expectations was raised as an issue, particularly by some family members, who were initially given unrealistic timeframes for the conclusion of the investigation. There was a

perception that the Police Authority and investigation team allowed an organic timeline to develop, which caused uncertainty and a lack of clarity for all parties.

4.4.26 A small number of participants experienced a conflict of interest in the multiple roles they found themselves in within the investigation. This issue deserved explicit recognition and for a risk assessment to be undertaken, with a view to identifying and managing contingencies. This approach would protect the investigation and those involved as witnesses, safeguard the reputation of the force and allow for the maintenance of day-to-day business.

4.4.27 A number of participants were unclear about their status in the investigation. Some felt that they had been wrongly categorised as complainants when they did not wish to make a complaint, which has caused significant distress to some individuals. Future investigations should consider explicitly informing parties of their status, since this also impacts on their welfare and communication needs.

**Key learning point:**

- **Although difficult to achieve in all cases, greater clarity about the investigation process and timescales would have assisted some of those involved.**

## **4.5 People and skills**

4.5.1 In examining the availability and deployment of resources, the review considered the question of resources in the widest sense, including availability, resilience, and whether their deployment was efficient, effective and timely. In doing so, the review recognised the current fiscal constraints placed upon the force in view of the comprehensive spending review.

- 4.5.2 There was evident commitment from all bodies involved to allocate appropriate resources, for example through the formation of the welfare co-ordination group and the provision of trauma risk management (TRiM) services. The gold group conducted an ongoing re-examination of resource needs, a process that was adequately documented.
- 4.5.3 In terms of the provision of welfare to employees, the majority was provided in house. This inevitably placed strain upon individuals, and in particular on their ability to fulfil their day-to-day duties, a position which was further exacerbated by a lack of training and experience in providing welfare support. There was an identified demand for independent resourcing of welfare, and the positive experience in relation to external family liaison provision supports this perspective.
- 4.5.4 Participants raised the lack of ongoing training on force policies as an issue, particularly around equality and diversity. Provision of training would help the organisation be better prepared for approaching and managing work-based issues in a more effective way. The issue of the specific training needs of individuals providing either welfare support or backfilling posts to increase resilience requires consideration.
- 4.5.5 There were concerns in relation to the timeliness of resource allocation and the resilience of the organisation to respond to competing business needs. To support chief officer team resilience, the Chief Constable requested a replacement deputy chief constable. For legal reasons, the Police Authority felt that this was inappropriate and they instead offered the support of an additional assistant chief constable. This offer was declined by the Chief Constable.
- 4.5.6 The provision of external advice and mutual aid to the Chief Constable in managing the situation should have been explored to ensure best practice was followed, resilience maintained and risk reduced. The resourcing strategy should include provision for appropriate legal advice

to both the Force and the Police Authority, with due regard to its timeliness, relevance and potential impact.

**Key learning points:**

- **Further training in relation to force policy, particularly around equality, diversity and staff welfare, would be helpful.**
- **The Force and Police Authority would have benefitted from seeking external professional assistance at an early stage.**

## **4.6 Audits and performance**

4.6.1 Beyond issues of leadership and governance, reviewing the audit and performance arrangements around the management of events enables some reflective observations to be made on strategy, structure and risk management.

4.6.2 An internal gold group was established within the Force following the death of Mr Ainsworth. Membership was broad and inclusive, and the group met regularly to manage the welfare needs of staff, coordinate communications and identify learning. The Chief Constable and the gold group documented their decisions in a format capable of being audited.

4.6.3 The gold group gave structure to the management of events following the death of Mr Ainsworth.

4.6.4 The review found limited evidence of an overarching strategy to determine and devolve roles and responsibilities within the gold group structure. The scope of the group swiftly and necessarily evolved in response to changing circumstances – yet traditional sub-groups or delegated functions did not apparently feature in arrangements. Some participants described the gold group operating in an attempt to ‘be all things to all people’. As a result, the Group concurrently acted as the tactical implementation arm of the strategic decision-making body.

- 4.6.5 It is unsurprising that the Chief Constable took responsibility for the management of all aspects of the events; however, both he and the organisation would have benefitted from a formalised process of delegation and tasking. This would have given greater opportunity for structured accountability, resilience and objective review.
- 4.6.6 It is accepted that risk was given due consideration throughout the operation of the gold group and regularly featured in discussion. This process would have benefitted from a more formalised approach to record, action and review risk in the form of a risk register, available for scrutiny and reflection throughout and beyond the scope of activity.
- 4.6.7 The challenge for the Force and Police Authority is to draw governance arrangements to a close in a way that facilitates the organisation in moving forward. The terms of reference of any governance structure should be regularly reviewed to ensure that they are specific, achievable and time limited. Consideration should be given to including external and independent scrutiny to safeguard the integrity of the process, both for participants and the wider audience. An enquiry of this nature and scale would benefit from a full and structured debrief process.



**Key learning points:**

- **Establishing the gold group was good practice and enabled key decisions to be recorded.**
- **A gold group strategy in these circumstances would have been more effective if there was greater clarity about:**
  - **delegated lines of responsibility;**
  - **decision taking;**
  - **the management of risks; and**
  - **review periods.**
- **A structured de-briefing arrangement now needs to take place to promote a lessons learned approach.**

## 5. Lessons to be learned

The report is set against six key themes: organisational culture; leadership and governance; policies; systems and processes; people and skills; and audit and performance. We have drawn out the key learning points for each of these sections below. These are based upon the facts as we understand them, actions of parties involved and a review of available established practice.

### Key learning points

#### Organisational culture

- Organisational staff surveys are good practice and should be continued so as to benchmark progress.

#### Leadership and governance

- When dealing with complex welfare issues, the strategic governance and leadership role of the Police Authority should be clarified at the earliest opportunity.
- Although a detailed understanding of the relevant legal framework is necessary, the Police Authority should adopt a people-orientated approach by recognising the distress that an incident of this nature causes to those inside and outside the Force.

#### Policies

- A dedicated 'whistle-blowing' policy should be developed.
- A distinctive and practical delivery plan addressing equality and diversity issues across the force would promote trust and confidence.
- ACPO should consider developing guidance on the welfare arrangements for chief officers.
- Force vetting procedures should be reviewed.
- ACPO should consider reviewing national chief officer vetting policy and procedures, and how they are applied.

- A clear, structured and timely review process of temporary redeployment as an alternative to suspension assists in the management of deployment, and brings clarity for those deployed from normal duty and for those members of staff who are affected by that arrangement.

## **Systems and processes**

### ***Communication***

- A communication strategy is required when dealing with situations of this kind. It must be sufficiently flexible to accommodate individual need within and outside the Force.
- The use of external family liaison support represents good practice.

### ***Welfare***

- Welfare provision should be tailored to individual needs.
- When complex welfare needs arise, consideration should be given to independent professional intervention to coordinate and assess ongoing welfare needs within and outside the force.
- ACPO should consider reviewing welfare arrangements for chief officers to bring greater clarity over the responsibility for chief officers' welfare.

### ***Complaint investigation***

- Although difficult to achieve in all cases, greater clarity about the investigation process and timescales would have assisted some of those involved.

## **People and skills**

- Further training in relation to force policy, particularly around equality, diversity and staff welfare would be helpful.
- The Force and Police Authority would have benefitted from seeking external professional assistance at an early stage.

### **Audits and performance**

- Establishing the gold group was good practice and enabled key decisions to be recorded.
- A gold group strategy in these circumstances would have been more effective if there was greater clarity about:
  - delegated lines of responsibility;
  - decision taking;
  - the management of risks; and
  - review periods
- A structured de-briefing arrangement now needs to take place to promote a lessons learned approach.

## 6. Next steps

- 6.1 The Force and Police Authority are in the midst of a major and comprehensive restructuring programme to reposition the way they deliver policing services within a reduced budget over the next three years.
- 6.2 There have also been changes in senior personnel - Chief Constable Moore has left the Force and has been replaced by temporary Chief Constable Geenty.
- 6.3 It is to the credit of the Force and Police Authority that they commissioned and engaged fully in this review process. A genuine commitment has been shown to learn from the management of these events, and they now need to consider the findings of the review. It should be accepted that the circumstances the force found itself in are unlikely to be repeated and therefore priority should be given to key learning points and their continuing relevance.
- 6.4 The review team suggest that all those involved study the lessons learned and reflect on their personal involvement. An understanding and acceptance of personal responsibility will enable the force to reconcile differences and establish a foundation that enables them to move forward positively.
- 6.5 The lessons identified will assist this process and provide opportunities for a wider audience to review current practice and policy and to inform strategies for the management of events in the future.

## Appendix A: Chronology of significant events

28/07/2008	Appointment of DCC Ainsworth confirmed by letter.
17/02/2009	Confirmation that DCC Ainsworth was medically cleared for appointment.
Oct 2009	First grievance raised against DCC Ainsworth, investigated by Warwickshire Police.
Nov 2009	First grievance resolved, resulting in management action plan for DCC Ainsworth.
Aug 2010	Second grievance raised against DCC Ainsworth.
23/08/2010	UNISON letter to Chief Constable Moore details concerns regarding the behaviour of DCC Ainsworth in the workplace.
27/08/2010	Resolution of second grievance against DCC Ainsworth. Personal development action is identified.
27/08/2010	Chief Constable Moore submits report to the Police Authority regarding DCC Ainsworth.
02/09/2010	Police Authority misconduct panel confirms that the further matters raised are prima facie evidence of misconduct and that the allegation will be recorded and investigated.
08/09/2010	Chief Constable Moore addresses the deployment of DCC Ainsworth.
10/09/2010	DCC Ainsworth informed of the nature of the allegations against him.
14/09/2010	DCC Ainsworth is appointed a welfare officer.
16/09/2010	The Police Authority appoints South Wales Police to investigate allegations of misconduct against DCC Ainsworth.
17/09/2010	Draft terms of reference for complaint investigation agreed between South Wales Police and the Police Authority.
28/09/2010	South Wales Police agree that Wiltshire Police should take responsibility for staff welfare issues.
28/09/2010	Letter to the Police Authority expresses concern about operational restrictions placed upon DCC Ainsworth.
19/10/2010	First Regulation 15 notice served on DCC Ainsworth regarding alleged inappropriate behaviour.
29/10/2010	Chief Constable Moore writes to DCC Ainsworth regarding deployment, informing him that the South Wales Police investigation is ongoing and deployment remains the same.
03/11/2010	UNISON writes to the Police Authority expressing concern that DCC Ainsworth has not been suspended.
15/11/2010	Chief Constable Moore writes to DCC Ainsworth regarding deployment, informing him that the South Wales Police investigation is ongoing and his current deployment will remain.
25/11/2010	All witnesses updated by letter from South Wales Police regarding process of the investigation.
10/12/2010	South Wales Police investigation review.
15/12/2010	Chief Constable Moore, DCC Ainsworth and his welfare officer discuss the appointment of a temporary DCC and another role for DCC Ainsworth.
16/12/2010	Second Regulation 15 notice served on DCC Ainsworth.
11/01/2011	Independent welfare status check of Operation Yellowstone.

24/01/2011	Chief Constable Moore makes arrangements for the secondment of DCC Ainsworth to the Forensic Science Service.
25/01/2011- 26/01/2011	Chief Constable Moore and the Police Authority clarify respective roles and this is communicated by the Chief Constable to those involved in Operation Yellowstone.
08/02/2011	The Police Authority reviews the suspension decision at meeting of the professional standards committee.
16/02/2011	UNISON letter to Chief Constable Moore raises concern about the length of the investigation and presence of DCC Ainsworth on police premises.
17/02/2011	Letter from Chief Constable Moore to UNISON addresses issues of expeditious investigation and review of suspension.
18/02/2011 – 19/02/2011	DCC Ainsworth receives bundles of disclosure statements.
10/03/2011	DCC Ainsworth signed off as unfit to work.
22/03/2011	Death of DCC Ainsworth.
29/03/2011	The Police Authority formally closes the South Wales Police investigation following the death of DCC Ainsworth.
20/07/2011	Wiltshire Police Authority invites HMIC to conduct a lessons learned review.