AVON & SOMERSET POLICE & CRIME COMMISSIONER

Independent Scrutiny of Police Complaints Panel

September 2024

Contents

Purpose of the Independent Scrutiny of Police Complaints Panel

The Independent Scrutiny of Police Complaints Panel (ISPCP) consists of 11 independent panel members, as pictured below, who are all volunteers representing the communities of Avon and Somerset. Their aim is:

'To act as a 'critical friend' to the Police and Crime Commissioner (PCC) and to Avon and Somerset Constabulary by providing feedback on completed complaint files to the office of the PCC and to the Constabulary's Professional Standards Department (PSD). The Independent Scrutiny of Police Complaints Panel (ISPCP) will review complaints against the police from a local citizen's viewpoint.'

Further information can be found on our website.

Figure 1 - Independent Scrutiny of Police Complaints Panel

STRUCTURE OF THE SESSION

6 panel members attended this quarter, and each panel member worked independently to scrutinise their own complaint cases. A total number of 24 completed complaint files were reviewed in detail by the panel prior to the meeting. The Panel opted to focus their meeting on the theme of complaints relating to Mental Health.

The cases scrutinised were discussed in depth verbally with Chief Inspector William Barlow and Inspector Louise Pressly from Avon and Somerset Constabulary's PSD. The panel welcomed a presentation from Chief Inspector George Headley regarding 'Right Care Right Person'.

Panel Attendees – (in-person) KS, PR, JB, BK, (virtually) JS-G, AD.

Right Care Right Person

launches in ASC -

Chief Inspector George Headley

On Monday 17th June 2024, Avon and Somerset Constabulary went live with the first phase of the Right Care Right Person initiative.

For over 12 months the Constabulary have been working closely with their partners to make the necessary changes to service provisions, to ensure that people will get help from the most appropriate agency.

Phase One – Concerns for Safety - the first phase will see changes as to when the police are asked to attend incidents involving a concern for the safety of a person. This will include when the police are requested to make contact with someone who is believed to be vulnerable or at risk, to check they are safe and well. Currently a lot of these calls come through to the police service, with officers responding on a large number of occasions. The new agreed policy with partners is aimed to align the responsibility of safety checks to agencies who have the specialist knowledge, skills and who are already engaged with the individuals or their families.

Partnership working - the success of Right Care Right Person relies on multiple parts of the NHS, including South Western Ambulance Service Foundation Trust (SWASFT), Avon and Somerset Police, and adult social care to come together. There is an agreed Memorandum of Understanding with SWASFT that is now in place to ensure there are no service gaps between emergency services, and that all agencies are aligned on decision-making when responding to these incidents (see the diagram below).

The police will still be there when needed; to deter, prevent and tackle crime, or when there's a threat to life. It is hoped that this approach will not only ensure people receive the right care, but it will also help free police resources to tackle crime and make a bigger positive difference to our communities.

		Known and Static Incident Location		Unknown location
		Emergency Response Within 4 hours	Non-emergency Response Over 4 hours	Emergency Response
Incident Type	Ongoing or continuing actions endangering life	ASC	N/A	ASC
	Ongoing or continuing actions involving serious harm	ASC	N/A	ASC
	Ongoing or continuing actions involving significant harm to a child	ASC	N/A	ASC
	Suicidal ideation	SWASFT	NHS 111*	ASC
	Self-harm	SWASFT	NHS 111*	ASC
	Behaviour associated with perceptual or thought disturbance or impaired impulse control such as Delirium, Dementia	SWASFT	NHS 111*	ASC
	Symptoms of psychosis and / or severe mood disorder	SWASFT	NHS 111*	ASC
	Reported overdose	SWASFT	NHS 111*	ASC
	Non-specific mental health concern	SWASFT	NHS 111*	ASC

*This response may vary depending on local commissioning arrangements for access to mental health services

PROFESSIONAL STANDARDS DEPARTMENT (PSD) UPDATE

Chief Inspector William Barlow & Acting Superintendent Sharon Baker

PSD STAFFING UPDATE

Since the last ISPCP Supt Mark Edgington has been promoted to Chief Supt and has now left PSD. Chief Inspector Sharon Baker is acting up as Temporary Head of PSD in the interim until a permanent replacement is found. The panel welcomed Chief Inspector Will Barlow who will attend future meetings supported by Inspector Louise Pressly.

Comments from Acting Superintendent Sharon Baker: *I am sure you will all join me in congratulating Superintendent Mark Edgington in achieving promotion to Chief Superintendent, due to pressing organisational need he moved very quickly to his new role in heading up our Criminal Justice, Intelligence and Operational Support departments. I know Mark will say the experience he gained from leading PSD has equipped him to lead the organisation in a more senior role. That of course leaves big shoes to fill, the process to fill the vacancy of Head of PSD has already commenced, by the Autumn we will know who will be leading the department more permanently, in the meantime I have been given the opportunity to cover temporarily, with nearly 3 years in PSD as Chief Inspector I hope I can help make this short transition period as seamless as possible for everyone.*

We have seen enormous challenge in policing over the last few weeks and months, the disorder on our streets called for a significant policing response and co-ordination across our force area. I am pleased to say we received only a handful of complaints that related to the policing response, this demonstrates the tone and proportionality of our response matched the threat posed.

As an organisation we all stepped up to help those front-line colleagues had to work their days off and placed themselves in danger to protect our communities. PSD teams played their part, we took on additional responsibility over that period taking complaint calls from the public and dealing with over 40 OTBI's ordinarily allocated to front line supervisors. We were only able to do so because our staff all voluntarily worked additional hours to help the front line.

Our work to improve the quality of complaints handled outside of PSD continues, Insp Pressly and I have delivered workshops throughout the year, and whilst we paused these in the peak demand period, we will re-commence from September. Combined with the introduction of our new way of providing your feedback to complaint handlers and recording themes we are confident that we have a structure of improvement.

We rely on all your support in helping us provide a transparent, high quality complaint process, the key to maintaining the confidence of our communities, and remain grateful for all your time and effort in helping us achieve that.

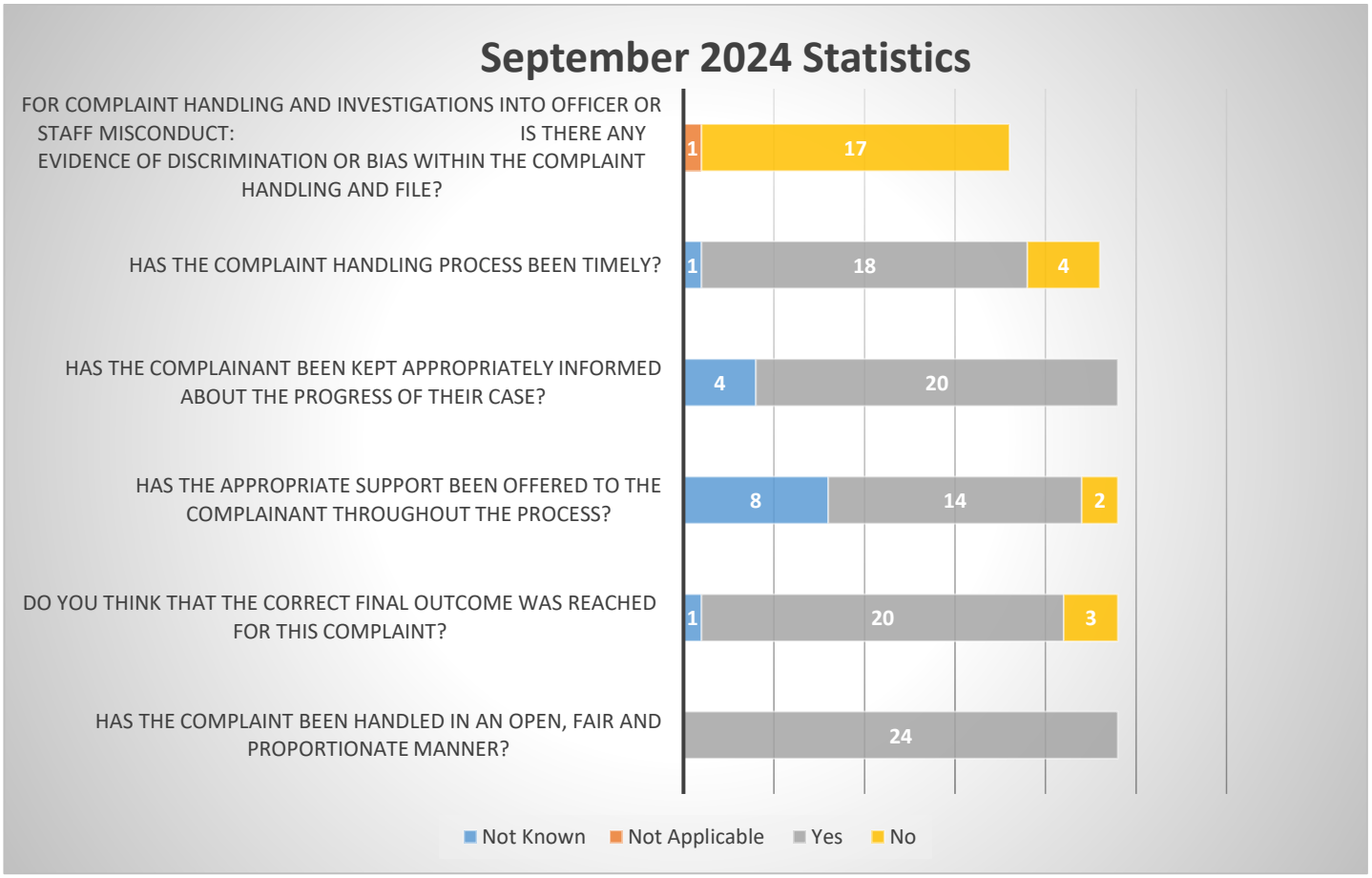
ACTIONS

This section logs ongoing actions requested by the Panel and forms part of their ongoing work to scrutinise police complaint handling.

No	Date	Action (OPCC, ASC, Panel)	Progress update	Completed Ongoing/KIV
1	Sept 2022	PSD to update the panel following Learning Meetings & provide a briefing on any recent complaint statistics of interest including the IOPC quarterly bulletins and annual complaints report. (ASC)	Sept 24 – C/I Barlow stated that recently these meetings have regrettably been superseded by other priorities. Will seek an update for the panel regarding the future of these meetings.	PSD to update Dec 24
2	Feb 23	Schedule 3 advice issue to be monitored. (Panel)	Complainants can request that their complaint is recorded under Schedule 3. KIV the wording in the finalisation documents, whilst the Complainant has the option of having the complaint formally recorded under Schedule 3 of the Police Report Act 2003, the 'outcome will remain the same'. Agreed this statement should be avoided as complainants could be dissuaded from exercising their right to have their complaint recorded.	KIV
3	Mar 24	Identifying Disproportionality in the Criminal Justice system. Recommendation 9 – examination of all Stop & Search Complaints to be examined. (Panel)	Sept 24 – ISPCP Chair confirms happy to take forward in 2025. OPCC to facilitate a meeting between the ISoPPP chair & ISPCP chair to discuss how this case scrutiny will interlink effectively between the two panels.	OPCC to facilitate meeting (DD OPCC)
4	Jun 24	Individual Learning Tracker created. New feedback system introduced: panel issues identified with grammar, spelling & tone of correspondence being sent out by PSD to complainants to be fed back directly to relevant individuals, this will also include positive feedback.	System is up and running, PSD to update on how the feedback is being received to relevant individuals.	Ongoing

No	Date	Action (OPCC, ASC, Panel)	Progress update	Completed Ongoing/KIV
5	Sept 24	IOPC Youth Panel National Survey Report - Youth-Panel-National-Survey-2024.pdf. ISPCP Chair requests an update from PSD on what they are doing to take account of the key recommendations contained in the report?	C/I Barlow will seek an update on this. It is acknowledged that increasing young people's trust in policing and police complaints and in their overall engagement is an important area.	PSD to update Dec 24
6	Sept 24	Otherwise Than By Investigation Workshops – update sought	PSD – workshops paused over summer, being rolled out in Sept (x1) & Oct (x3) to Patrol & CID	Ongoing

STATISTICAL ANALYSIS



This chart related to the six questions in the feedback form, 34 cases were sampled. Panel members record 'not known' when the case file does not give sufficient detail to allow a categorical yes or no answer

EXAMPLES OF POSITIVE FEEDBACK

Positive remarks regarding the summary of Complaint Letter – *"I'm sorry that it has been necessary for you to make a complaint. Your complaint has been carefully read to understand the concerns you are raising." This is very well worded.'*

'Response letter is good - full explanations given and clearly written. It refers back to the phone conversation with the complainant, where the Investigating Officer ascertains the Complainant's main concerns and desired outcomes. An additional concern was raised, that the complainant had requested an Appropriate Adult, but this had not been provided. This was addressed in the final letter- it was raised with the Custody Sergeant who had no recollection of this but offered an apology. Treated as a separate allegation Service provided was not acceptable, words of advice given.'

'Information sharing between the complainant and the leading investigation officer was carried out in a timely fashion and written in a comprehensive but simplistic manner. The final letter to the complainant identified that the service level was not acceptable and an apology was offered. The inclusion of the investigation report evidenced that the complaint had being treated with the level of seriousness that was deserved.'

HIGHLIGHTS OF CONCERNS, QUESTIONS OR ISSUES RAISED BY THE PANEL

Panel Member Feedback	PSD Response
BK/1 - Complaint Summary (Mental Health) Use of force. Complaint received from nurse at place of safety on behalf of complainant. Complainant alleges officer(s) used excessive and unnecessary force on them. ***Panel Member Feedback*** ***1.) Is there any guidance in relation to the length of time to wait for an ambulance before using police vehicles to transport Mental Health patients?*** ***2.) Is an ambulance the preferred method of transport for these situations?***	*Answer to Qu.1 and 2.* *There is no specific time limit, each case should be treated on its individual merits. Generally held that it should be at least 30 minutes unless circumstances dictate otherwise. Authority from an Inspector is normally sought prior to using police vehicle over an ambulance.* *Below is extract from Avon and Somerset Constabulary Mental Health (Operational Policing) Procedural Guidance:* *25.1 - Ambulance is the preferred mode of transport to convey an individual to a place of safety or hospital. They should be contacted and requested in every case. In addition to transport, we are seeking a clinical assessment of the person detained for any urgent or over-riding medical needs which police officers, with*

Panel Member Feedback	PSD Response
	minimal first-aid training and equipment, may not recognise or see. *25.2 - In cases where a risk assessment then dictates that a wait or delay would create unacceptable risk or unnecessary distress then the most suitable police vehicle available may be used.* *25.3 - Officers are reminded that the security of the detained person within the ambulance remains THEIR responsibility.* *25.4 - The risk assessment may also determine that a police officer accompanies the person in the rear of the ambulance or even that a paramedic travel with officers in a police vehicle.* *25.5 - As a minimum, police officers should follow the ambulance to the place of safety in every case where they have used their powers under S.136 or executed a S.135 warrant to ensure that the handover process is complete on arrival.* *25.6 - Whichever method of transport is used, officers should convey the person DIRECTLY to the identified Place of Safety (e.g., should not divert to home address to collect personal items.) A diversion to ED for clinical reasons is acceptable.*
3.) Do either of the PCs have previous Use of Force complaints?	*During the assessment of all reports to PSD we look at an officers' complaints history to see if it is relevant, and if there is a pattern we would pick it up and address it. We are currently working on our Qlik app, which collates data, to take this to the next step. The App will work pro-actively with other information from intel, highlight issues and help us address patterns or risky individuals.*
KS/1- Complaint Summary (Mental Health) Complainant alleges 1. that when in custody he was not given his medication despite telling officers at 9.15 that he would need to take his MH meds between 1 and 2 pm. 2.Complainant told officer that he could not attend court, officer said they would put a note	

Panel Member Feedback	PSD Response
to that effect, but this was not done so C had to attend court. 3. Police discriminated against his MH because he was only given 2 weeks' notice of the need to attend court, which has increased his anxiety to an all-time high. 4. Only offered a drink, no food. Asked to see nurse on arrival at 9.15, was not seen until 3.15	
<u>Panel Member Feedback:</u> ***1. Complainant was not given his MH medication at all, meaning that he had to undertake his interview without, adding to his anxiety. I understand the reason for this, and also the explanation for the delay in seeing the nurse. However, this does not mean that the service provided was acceptable. He was reassured that had it been "relating to a serious health condition" the nurse would've attended. However, it is equally important for MH medication to be given as prescribed as it is for physical health medication. It may not have been within the gift of the custody officer to resolve the problem given the medication protocols, but to this panel member this doesn't mean that the service provided was acceptable, merely that it was within policy/protocol.*** ***Q: Given the frequency whereby this situation is likely to arise, is it monitored and discussed with the Healthcare Provider to find ways to minimise the occasions whereby detainees are deprived of their medication at the point when it is due?*** ***2. Providing refreshments and responding to requests for Appropriate Adults (AA) are both routine tasks for custody suites, and presumably part of a checklist, so it is concerning that both were omitted for the complainant.*** ***Q: Please could PSD confirm whether*** ***a) the officer's supervisor would be made aware of the need for words of advice and***	*The issue over not being able to give meds that are unboxed is an accepted medical protocol. The Health Care Professional (HCP) will often try and resolve the issue, for example some can access patient records and if they can see a current prescription for the medication and can identify it as the prescribed meds they will dispense.* *In relation to delays in seeing HCP, there is one HCP contracted to a custody unit and it depends how busy they are. They will prioritise detainees most at risk and medical needs. If they weren't able to see a detainee due to demand and that put a detainee at risk we would take them to hospital.* *There are contingency plans in place when an HCP can't see a detainee, options such as calling the duty Force Medical Officer or requesting cover from another unit. If the HCP provider fails to meet their contractual commitments (for example can't provide HCP cover for a unit) then ASC does raise this and addresses the contract at a senior level.*

Panel Member Feedback	PSD Response
closer supervision to ensure that the advice was taken on board. ***b) appropriate checks would be made (e.g. records, ICV reports) to ascertain whether this was indicative of a wider problem, either with this officer, or within this custody suite. (AA were flagged as an area for improvement in the recent Report on an inspection visit to police custody suites in A&S by HMICFRS and CQC)***	*a) The complaint handler was the officer's line manager and has stated words of advice given as an outcome.* *b) These are performance issues rather than misconduct issues, therefore responsibility of custody SLT to monitor and seek improvements. An OTBI is handled at manager level within that department, and they should be addressing any wider performance concerns as part of their management role. PSD do not have capacity to monitor performance issues raised out of an OTBI. We do identify organisational learning, and this has a process for informing managers.*
3. Comment: For allegation 4 the initial Case assessment conflates 2 issues (refreshments & delay seeing nurse). An additional allegation 5 should have been created to address the delay in seeing the nurse. In the response letter the delay seeing nurse is linked to the medication delay in allegation 1, which makes more sense, but means that the allegations section of the letter and the response section do not tie up.	*Agreed, the assessment confused matters. Can provide feedback to assessors.*
The final letter clearly addresses an additional concern subsequently raised in the phone conversation. Allegation 3 (discrimination) receives an explanation about how court dates are set but does reach not a conclusion as to whether the service provided was acceptable or not (as required). Better presentation of the final letter would have ensured that the initial allegations and the issues raised in final letter matched. The additional concerns from the phone call could then have been tacked on. ***Should PSD have picked this up? The letter had already been returned to IO once for amendment.***	*They were on the final letter:* *'Court date – this is an automatic date allocated. You have attended court and whilst I understand this was uncomfortable and you felt you should have had a longer court date, you understood how this processed worked and how court date/times are provided – The service provided was acceptable.'* *Unless I've misunderstood, I think this was picked up and covered in second version of the final letter. The reference to the court date was included on the 2nd version as copied in above.*
JB/1 - Complaint Summary (Mental Health) The complainant alleges, the action of the police wrongly arresting her son has caused him to self-harm and caused him anxiety and his mental health to decline.	

Panel Member Feedback	PSD Response
Panel Member Feedback: ***The final letter to the complainant, whilst acknowledging that the service level was not acceptable, did not provide an assurance for the current ways of working to be reviewed. In that no learning outcomes for both personnel/systems were identified that could minimise the risk of a re-occurrence other than to state 'further checks could have been completed to corroborate ******* possible addresses'.***	*Agree that learning could have been identified for officers in the circumstances, for example they could have delved deeper into the name and address checks on niche. There was an opportunity for reflective practice at the time. We have considered the worth in now referring the case for Reflective Practice, however, due to being over 12 months old, this conflicts with the requirement for learning to be timely and can devalue the process. The Inspector who could have identified the learning and referred to reflective practice has retired.* *Our workshop on OTBI and RPRP does inform supervisors they are empowered to identify learning opportunities and to act on them.*
The final letter also contained 2 sets of abbreviations 'IO' and 'IOPC' without any clarification of their meaning.	*The final letter was from Inspector Kerry Brickwood – who has since retired so cannot feedback. We emphasise in our OTBI workshops running this year to either not use or explain police abbreviations.*
LC-2 – Complaint Summary (Mental Health) Officer attended her property for a welfare check and changed the code on her key safe; he wrote the new code down in his notebook. Member of the public has contacted 101 3 or 4 times in the months from Jan to Sept – requesting the officer check his notebook for the code. **Panel Member Feedback:** ***Regarding the initial need to contact A&S, not the complaint handling – member of the public spoke with 101 3 or 4 times and each time the call handlers have requested the officer checks his notebook for the missing code. I can understand the frustration from this person, and wonder if the call handlers could see that the officer was not responding (albeit not able to due to other events) and maybe they could***	*Response from Mike Blinco Comms department complaint handler:* *'This is one of those things where there is no set policy and is very much experience and workload dependant. I would expect a switchboard operator to make a quick check on GRS to see if the OIC is about or when she/he is next on duty and provide a quick update but apart from that, put the call through to a call-handler (secondary queue). Depending on what*

Panel Member Feedback	PSD Response
have escalated to a supervisor? Nine months is a long time to not have access to a keysafe!.	*they were told (again I don't know the specifics here) I would imagine a more experienced person would at that stage send a message to the team mailbox of the OIC concerned. An inexperienced member of staff would probably seek the advice of a supervisor and be told to escalate it.'*
PR-1 - Summary of Complaint (Mental Health) Daughter arrested at parents' home, five officers in attendance and complainant alleges unnecessary heavy-handed police tactics, glib attitude of officers who are accused of laughing and smiling during daughters' arrest process. One officer singled out by complainants as having an attitude problem towards their daughter. Both parents complained separately to police authority but the nature of the complaints identical to one another and so investigated as a single complaint. **Panel Member Feedback:** ***Failure to conclude investigation within usual time constraints. 24/07/23 date of decision but not signed off till 9/05/24*** ***Would it not have been an option for the daughter for the police to have phoned the daughter and ask for her to voluntarily present herself at the police station?***	*Looking at final letter, the investigation itself was conducted in a timely manner but unfortunately due to an admin error it was not signed off at the time.* *'I would like to apologise for the delay in completing this complaint. The IO, Chief Inspector McGowan, left the organisation at the end of last year and some of the complaints that he was dealing with, were incorrectly finalised prior to them being signed off. I apologise on behalf of the organisation for this oversight and hope that the complaint has been answered to your satisfaction.'* *Looking at the niche entry I can see that the officers were planning on seeking a remand in custody. They can only do this if someone is under arrest, so they needed to arrest the female. PACE states if you invite someone to a police station for a voluntary interview you cannot then arrest them unless the circumstances have changed. In other words, you can't arrange a voluntary attendance under false pretences. You can ask someone to come to the police station in order to be arrested and*

Panel Member Feedback	PSD Response
	some people who are wanted are happy to be arrested by arrangement, but there are obvious risks with this, and officers would have to have considered her flight risk and safeguarding.
PR-3 - Summary of Complaint (Discrimination) Complaint raised by mother and son relating to a phone conversation with police officers investigating allegations made against them. Complainants unhappy with investigating officers' attitude, patronising in tone, and accuses him of not listening to them. Also complains about insensitivity by ringing on Mother's Day and of being sexist. A date and time were arranged for an interview but subsequently cancelled at short notice and no further contact was made by that officer **Feedback Panel Member 1:** ***The mother claims the officer was sexist in attitude and I feel this should have been pursued more thoroughly by IO asking for specific examples of this, and to why she thought he was being sexist. This bit of the complaint seems to have been lost in the mix. Does the complaint of sexism rest solely on the fact that the officer phoned on Mother's Day?*** ***Why was a voluntary interview arranged and then cancelled at short notice? Could not***	*I understand your point. This complaint was handled by a district inspector not an IO, they were unable to speak with complainant on phone and only communicated via email (at complainant's request) which can reduce level and detail of information/conversation. The Inspector does not appear to have delved any deeper into the issue. This was prior to running our workshops to improve quality of OTBIs on district.* *We can provide feedback to the inspector.* *We have introduced a process whereby the feedback from the panel is recorded and then sent out to the individual it concerns. We will have a record to refer to for those who may have reoccurring issues, so these can be picked up on and provided with training.*

Panel Member Feedback	PSD Response
another officer have stepped in sooner as ultimately the investigation was progressed by some other officer?	*Due to officers carrying multiple investigations, there is generally no scope to re-allocate to another officer in their absence, unless the risk is considered high. The risk would not normally be high for a voluntary interview. With high-risk cases the suspect would normally be arrested and dealt with in custody. Cancellation at short notice is far from ideal but not uncommon when we have response officers responding to 999 calls while also trying to progress investigations. Supervisors will try to protect staff's time if they have appointments with the public, but there are times it is just unavoidable when managing operational demand with limited resources.* *It is generally considered better to delay an interview to ensure it is conducted by the officer with the most knowledge of the case, rather than ask another officer to acquaint themselves with the details at short notice and expect a quality interview.*
SB-3 - Summary of Complaint (Discrimination) Complainant complains that she reported an assault on her child and there was a delay in progressing the case which meant that an aspect of it (an assault) may be outside the statutory time limit, and she was not updated every 28 days. Complainant alleges that OIC was rude to her SARI worker. Complainant complains this was all due to racial discrimination. The SARI worker was spoken to – they said that the OIC was not rude but that there may have been unconscious bias which hindered the investigation. All aspects of the complaint were upheld. Conclusion is that the delays were due to backlogs in the Criminal Justice Unit rather than race. Also apologises for the lack of updates every 28 days. **Feedback Panel Member 1:** **There are aspects of the final letter which I think a member of the public might struggle to**	*We cover in the OTBI workshops the importance of explaining police terms and have provided a*

Panel Member Feedback	PSD Response
understand i.e. references to Niche and CJU. I also think it is unnecessary to repeat the complaints in full in the Conclusion and Rationale section as this makes the letter longer than it needs to be – I suggest a summary here as it has already been set out in full above.	*link to police term definitions they can use to explain to members of the public.* *There was no further response or appeal by the complainant after the final letter.*
****RE-REVIEW OF COMPLAINT REQUESTED** - Please would PSD review this file because the allegation was racial discrimination and the SARI worker's impression was that unconscious bias may have been a factor. Because it is difficult to identify unconscious bias, I think this is a case which would benefit from some scrutiny by PSD, even if it is just to identify any learning. I would also be interested to know if there was any response to the final letter from C?**	*PSD can't review or change an outcome, as this would be outside of the Police Regs. The review body is stipulated and is either the OPCC or the IOPC. However, we can look at something for areas of learning.* *I have gone over the available material and viewed the Niche:* *The offence reported was correctly identified from the start as racially aggravated. The safeguarding referrals were completed early, and the need for urgency identified.* *Unfortunately, there were significant delays due to a number of factors, these were in line with the delays seen in many investigations at the time. There is no indication that discrimination or unconscious bias was a factor.* *On 30/11/22 the investigation was reviewed by Chief Inspector Ronnie Lungu (Trust and Confidence lead) as a result of the complaint of race discrimination. Ronnie did not identify any concerns.* *What is not clear, as the complaint handler does not elaborate, is what was said by the SARI worker and how the misunderstanding came about with regards being rude, or if the comment around unconscious bias was explored further. Nor does it appear that the complaint handler probed further, beyond the delays in the investigation, as to why the complainant felt race discrimination was a factor.* *There is some learning here for the complaint handler with regards to handling complaints of discrimination, and it is unlikely they have*

Panel Member Feedback	PSD Response
	referred to the IOPC guidance. This will be fed back to the complaint handler. *The IOPC provide guidance on handling discrimination cases. I have provided the link below to a summary of that guidance:* IPCC guidelines for handling allegations of discrimination – Summary guide (policeconduct.gov.uk)

Further information about the Independent Scrutiny of Police Complaints Panel (ISPCP)

Further information about the ISPCP can be viewed through the following link:

Independent Scrutiny of Police Complaints Panel | OPCC for Avon and Somerset (avonandsomerset-pcc.gov.uk)

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