Diabetes and the Police Officer

A Survey Report

Led by Diabetes UK
In collaboration with the Disability Rights Commission, the National Police Diabetic Association and the National Disabled Police Association

“In safety-critical roles, the question is NOT whether insulin is used, but whether there is good control of the disease, lack of significant complications of the disease and good knowledge of the disease”

Sussex Police Force

Contents

Executive summary	**6**
1 Introduction	**8**
1.1 Background	8
1.2 Aim of the project	8
1.3 Scope of the report	9
1.4 Confidentiality	9
1.5 Acknowledgements	9
2 About diabetes	**10**
2.1 What is diabetes?	10
2.2 Type 1 and Type 2 diabetes	10
2.3 Aim of treatment	11
2.4 Who has diabetes?	11
2.5 Diabetes and pregnancy	11
2.6 Implications for police officers	11
3 Methodology	**12**
3.1 Research amongst police officers	12
3.2 Research amongst police forces	12
4 Analysis of police officers' survey	**13**
4.1 Level of response	13
4.2 About the respondents	13
4.3 About their experiences	14
5 Analysis of police forces' survey	**31**
5.1 Level of response	31
5.2 Number of officers with diabetes	31
5.3 Positive treatment	31
5.4 Recruitment policy	31
5.5 Retention policy	32
5.6 Restrictions on duties	32
5.7 Individual assessment	33
5.8 Adjustments made by police forces	33
5.9 Equal treatment	34
5.10 DDA extension	34
5.11 Setting a good example	34
6 Policies on diabetes	**35**
6.1 What the officers told us	35
6.2 Force policies on diabetes	35
6.3 Recommendation	38
7 Conclusions & recommendations	**39**
7.1 Overview	39
7.2 Recruitment	40
7.3 Disclosure and confidentiality	40
7.4 Discrimination	41
7.5 Individual medical assessment and case evaluation	42
7.6 Policies on diabetes	43
Appendices	
Appendix 1: About the partners	44
Appendix 2: Glossary	48

Executive summary

In October 2004 the Disability Discrimination Act (DDA) was extended to cover police officers. This meant that the question can no longer be about whether an individual has diabetes or uses insulin but whether their diabetes might impact on their job and if it does what can be done to overcome that. Diabetes UK, the National Disabled Police Association, the National Police Diabetic Association and the Disability Rights Commission have joined together to assess progress in eliminating discrimination.

People with diabetes are all different and they manage the condition differently. It will not be appropriate for all people to do all the activities associated with being a police officer and in some cases exclusions may be necessary. However, this should be decided on a case by case basis with the ability of the individual being the deciding factor.

What officers say

Nearly half of all respondents felt they had been treated positively by their force. There were many examples of good practice, with officers assessed individually. In some cases officers on insulin have been properly assessed and continue to fulfil their full potential in roles that include driving, firearms and public order.

Sadly these cases of good practice provide a stark contrast to the experience of other officers. This is particularly true of people who use insulin injections, many of whom have found themselves banned from undertaking some duties, without any assessment of their individual case. In some cases the discrimination has been bad enough to cause officers to leave the profession.

Much of the discrimination appears to be based on a lack of knowledge and understanding of the condition. There have been cases where the officer is not listened to, where no expert advice has been sought, where expert advice has been ignored and where advice has been sought from those with little or no real knowledge of diabetes.

The survey has also highlighted a lack of consistency in how individuals are treated. Even within forces the experience of officers can vary greatly.

What forces say

Forces appear to be aware of the need to tackle the issue of discrimination against people both within their ranks and those seeking to join. There is a reasonable level of recognition of the need to look at each case on its individual merits but, over 18 months after the DDA extension, that need should be formally recognised by all forces.

On recruitment, most forces refer to Home Office guidance which until May 2006 continued to carry the illegal advice that insulin users were banned. Following our intervention, this has now been corrected but some forces continue to act illegally in that regard.

The vast majority of forces have made adjustments to accommodate individual officers and most feel they treat people with diabetes equally. In most cases forces apply general disability policies when dealing with diabetes.

Conclusions

The results of both surveys show many examples of good practice around the UK. In these cases individual officers, including those on insulin, are fulfilling their potential, including some undertaking duties such as advanced driving, firearms and public order. These cases offer a way forward for all forces.

Despite some forces leading the way, there remain many cases where unlawful discrimination is still in operation. The survey has also highlighted a real problem with consistency, both within forces and between them.

It is hoped that this report and the associated Guidance on the recruitment and employment of police officers with diabetes will shine a light on the examples of discrimination and offer a way forward for all forces to treat all individuals in a fair manner. This will not only benefit the individuals but will allow forces to make the most of their most important resource, their officers.

1 Introduction

1.1 Background

Diabetes UK has a history of campaigning against discrimination in employment, especially in the emergency services. The organisation played a key role in securing an extension of the Disability Discrimination Act (DDA) in October 2004 to cover the fire, police and prison services. Like all employers, they are now required to ensure that people with diabetes are individually assessed as to their fitness for work and that reasonable adjustments are made to their working conditions in order to accommodate their requirements.

1.2 Aim of the project

In Autumn 2005, 12 months after the DDA extension came into force, Diabetes UK joined forces with the Disability Rights Commission (DRC) on a series of surveys to examine how the emergency services are meeting their new obligations. This is the report of the first element of that research – a survey of police officers and police forces. It will be followed by a report of similar research with the Fire and Rescue Service later this year.

This project has been led by Diabetes UK with support from the DRC, the National Police Diabetic Association (NPDA) and the National Disabled Police Association (NDPA). The aim was to find out how police forces are responding to the requirements of officers with diabetes and to identify and share best practice across police forces in the UK.

It was also envisaged that the findings would provide forces with valuable information about how well they currently meet their obligations to people with disabilities in general, as well as to officers with diabetes, as they prepare for the introduction of the Disability Equality Duty (DED).[1]

1.3 Scope of the report

The project involved two strands of research: a survey of police officers with diabetes to find out about their experience; followed by a survey of police forces to find out about their policies. This report sets out the results of both surveys, with conclusions and recommendations based on our findings. Working guidance for forces and officers on how to individually assess police officers and recruits with diabetes in line with the DDA, has also been published and is based on the results of the survey.

1.4 Confidentiality

The information provided by individual police officers is confidential. Individuals have not been named but agreement to quote them and cite their position and force has been obtained. However, some respondents did not provide any contact details and we were therefore unable to gain approval for their quotes. We have marked these cases 'anonymous'.

1.5 Acknowledgements

Our thanks to our partners and to all those working in the Police Service who took the time and trouble to respond to our questionnaire. Without them this research would not have been possible.

For information about the partners see Appendix 1.

[1] From December 2006 all public authorities, including police forces, will be required to actively promote equality for disabled people and to produce a disability equality scheme which has been developed through the involvement of disabled people. This is known as the Disability Equality Duty (DED). The DED requires all public authorities to have due regard to:
- Promote equality of opportunity between disabled people and others.
- Eliminate discrimination that is unlawful under the DDA.
- Eliminate harassment of disabled people that is related to their disability.
- Promote positive attitudes towards disabled people.
- Encourage participation by disabled people in public life.
- Take steps to meet the needs of disabled people even if this requires more favourable treatment (Source: DRC).

2 About diabetes

2.1 What is diabetes?

Diabetes mellitus is a condition in which the amount of glucose (sugar) in the blood is too high because the body cannot use it properly. Glucose comes from the digestion of starchy foods such as bread, rice, potatoes, chapatis, yams and plantain, from sugar and other sweet foods, and from the liver, which makes glucose.

Insulin is vital for life. It is a hormone produced by the pancreas that helps the glucose to enter the cells where it is used as fuel by the body.

The main symptoms of untreated diabetes are increased thirst, going to the loo all the time - especially at night, extreme tiredness, weight loss, genital itching or regular episodes of thrush, and blurred vision.

2.2 Type 1 and Type 2 diabetes

Type 1 diabetes develops if the body is unable to produce any insulin. It usually appears before the age of 40. Type 1 is treated by insulin injections and diet, and regular physical activity is recommended.

Type 2 diabetes develops when the body can still make some insulin, but not enough, or when the insulin that is produced does not work properly (known as insulin resistance). In most cases this is linked with being overweight. Type 2 diabetes usually appears in people over the age of 40, although in Asian and African-Caribbean people it often appears after the age of 25. Recently, more children are being diagnosed with the condition, some as young as seven.

Type 2 diabetes is treated with lifestyle changes such as a healthier diet, weight loss and increased physical activity. Tablets and/or insulin may also be required to achieve normal blood glucose levels.

2.3 Aim of treatment

The main aim of treatment of both types of diabetes is to achieve blood glucose, blood pressure and cholesterol levels as near to normal as possible. This, together with a healthy lifestyle, will help to improve wellbeing and protect against long-term damage to the eyes, kidneys, nerves, heart and major arteries.

2.4 Who has diabetes?

The total number of people in the UK with diabetes is now over two million representing over 3 per cent of the population. Of this, close to 250,000 people have Type 1 diabetes and over 1.8 million have Type 2 diabetes. Figures for the number of people thought to have undiagnosed Type 2 diabetes are estimated to be up to 750,000.

The prevalence of diabetes is up to six times higher amongst people from an African-Carbbean or Asian background in the UK.

2.5 Diabetes and pregnancy

Gestational diabetes mellitus (GDM) is a type of diabetes that arises during pregnancy (usually during the second or third trimester). This usually goes away postnatally. However, women who have had GDM are at an increased risk of developing Type 2 diabetes later in life.
Pregnancy affects blood glucose levels in all women (even those without diabetes), so for women with diabetes it is a particularly trying time which requires a lot of work and dedication.

2.6 Implications for police officers

A police officer with diabetes that is well managed should be able to perform his or her duties in the same way as anyone else, but everyone's experience of diabetes is different. It is crucial, therefore, that every officer with diabetes is assessed individually in order to determine whether and, how, their diabetes impacts on their ability to do their job.

(For more information about diabetes see www.diabetes.org.uk)

3 Methodology

3.1 Research amongst police officers

At the beginning of December 2005 we sent a short questionnaire[2] to every member of the National Police Diabetic Association (NPDA) – a total of over 120 police officers with diabetes. At the same time, we wrote to 60 representatives of the National Disabled Police Association (NDPA) asking them to publicise the survey and to forward the questionnaire to any of their members known to have diabetes. They used a variety of methods including the intranet and payslip attachments.

In addition, Diabetes UK issued a press release to a number of relevant publications and the DRC publicised the survey through their email bulletin.

3.2 Research amongst police forces

At the beginning of March 2006 we sent a similar questionnaire[3] to both human resources managers and occupational health advisers in all 57 forces across the UK.

[2]For a copy of the questionnaire contact Diabetes UK or see www.diabetes.org.uk
[3]For a copy of the questionnaire contact Diabetes UK or see www.diabetes.org.uk

4 Analysis of police officer's survey

4.1 Level of response

A total of 102 officers from forces across the whole of the UK responded to the survey[4]. The findings are a reflection of their experience.

4.2 About the respondents

Respondents were asked to provide background information both about themselves and their diabetes, and about their service in the police force. The key findings are summarised below. (Frequency tables are available on request.)

Length of service
The majority of respondents (84 per cent) had been in the police service for over 10 years. Only two had been in the service for two years or less.

Age and gender
Most (75per cent) were aged 41 or over and the vast majority (92 per cent) were men.

Force and position
Responses were received from officers in 30 forces. Half (50 per cent) were in the Metropolitan Police Service (MPS), with the remainder spread throughout the rest of the UK[5].

In terms of the positions held by respondents, the largest group were constables (43), followed by sergeants (19) and senior staff (9) including three chief inspectors[6].

[4]As with all disabilities, the precise number of police officers with diabetes is unknown. It is therefore not possible to say what proportion of police officers with diabetes this represents.

[5]There are 43 forces in England and Wales; the MPS is the largest with over 31,000 officers, equivalent to 22 per cent of the total. (Source: Home Office Statistical Bulletin: Police Service Strength, England and Wales, 31 March 2005, published 25 July 2005.)

[6]As at 31 March 2005 there were approximately 141,000 police officers in England and Wales, of whom 78 per cent were constables, 14 per cent were sergeants, and 1.5 per cent were chief inspectors. (Source: Home Office Statistical Bulletin: Police Service Strength, England and Wales, 31 March 2005, published 25 July 2005.)

When diagnosed
Roughly one third of respondents (33) had been diagnosed within the last two years; of those, nine were diagnosed after the extension of the DDA.

Type of diabetes and method of control
Slightly more respondents had Type 2 diabetes (56%) than Type 1 diabetes (43%) and just over half (51%) were using insulin injections.

4.3 About their experience

Informing the force
The vast majority (92%) of respondents had informed the force about their diabetes, but a small number had not. Those who had not all had Type 2 diabetes and were not using insulin. By contrast, all insulin users had informed their force.

Case 47 is a staff member from Essex Police Force. She said:

‘I was informed when I applied to the job that Essex Police did not discriminate as far as disability was concerned, so I did not feel uncomfortable telling them that I was diabetic.’

Positive treatment
Almost half of all respondents (44%) felt they had been treated positively by their force but over a third (37%) did not. Insulin users were more likely than non-insulin users to say they did not feel their force had treated them positively.

Those diagnosed more recently were more likely to feel their force had treated them positively. For example, Case 82 works in the Corporate Support Department in Essex. He was diagnosed less than 12 months ago with Type 2 diabetes and does not inject insulin. He feels very positive about his treatment by the force and said:

‘The force has supported me by providing work time and financial support for me to go to counselling and to see a nutritionist. The reaction to my diabetes and level of support for me personally has been overwhelming.’

Case 15 (anonymous) is an officer in Merseyside. He is also very positive about the way his force has responded to his diabetes. He was diagnosed three to five years ago, is Type 2 and does not use insulin. He said:

‘Merseyside Police asked if I considered myself disabled under the DDA. I now receive regular updates and am part of the Disabled Staff Support Network.’

Conversely, Case 89 is a member of the Kent Police Force. He was diagnosed fairly recently with Type 1 diabetes. He does not feel he has been treated positively and says ignorance about diabetes is largely to blame:

‘It took too long for my force to make a decision as to what to do with me…. I have not been treated equally, my privacy has been breached. The force is ignorant to my disease.’

Individual Medical Assessment (IMA)
Only one third of respondents (35%) had undergone an IMA by a consultant diabetologist, occupational health doctor or other medical practitioner at the request of the force. The remaining two thirds (61%) had not.

IMA refused
A number of respondents had requested an IMA, often several times, and been refused. Case 30 is a typical example. He holds a senior role in the MPS and has been in the service over 10 years. He was diagnosed three to five years ago with Type 2 diabetes and does not use insulin. He is a response driver, subject to yearly reviews. He said:

‘I have never been offered individual assessment even though I requested it. My firearms authorisation was revoked permanently, despite a glowing report from my GP. I was never given the option of an individual assessment.’

Some officers have persisted and eventually succeeded in getting an individual assessment, often after several years. For example, Case 46 is a PC in the MPS with Type 1 diabetes. He has been prevented from undertaking response and advanced driving and firearms duties, without IMA. He feels he has been discriminated against but says there has been an improvement since the DDA. He was eventually granted an individual assessment:

'In November 2005 – after 18 years of trying.'

He was not alone. An officer in Northern Ireland was finally allowed to drive and ride motorbikes after 18 years.

IMA conducted

IMA was more common amongst Type 1s and insulin users. Those who had undergone an IMA were more likely to feel negative about the way they had been treated by their force – 58 per cent of those undergoing IMA compared with 27 per cent of those who had not undergone IMA.

Disagreements often occur between the diabetologists conducting the medical assessment and those making the final decision, as demonstrated by Case 34, an officer from Avon & Somerset. He was recently diagnosed with Type 1 diabetes. He is banned from response driving on the basis of IMA and feels discriminated against. He said:

'Even though my condition is well managed and I am supported by the diabetic consultant, the force medical officer (FMO) will not authorise driving authorities as she stated she "would be sued if I had an accident". Although I agree that the force should be able to refer individuals to independent consultants, the force should then act on their recommendation - unlike Avon & Somerset where the FMO appears to have little understanding of diabetes.'

Many officers simply disagreed with the decision on the basis that they are fit and their diabetes is well managed. For example, Case 49 is a police sergeant in the MPS. He was diagnosed over five years ago with Type 2 diabetes and injects insulin. He does not feel positive about his treatment by the force, having been removed from firearms duties and advanced driving on the basis of assessment by the chief medical officer (CMO). He said:

'I cannot understand the view that a diabetic cannot be authorised for firearms duties. I am fitter than the average officer. Also as a supervisor I only booked a firearm out about 15 per cent of my duty time. A sledgehammer to crack a nut comes to mind.'

Restrictions on duties

Anecdotal evidence suggests that many police officers have had their duties changed or restricted as a direct result of their diabetes, without individual assessment. Driving response vehicles, firearms and public order duties were known to be contentious and force policies appeared to be inconsistent. This picture of inconsistency was borne out by the research as respondents reported wide variations in practice.

Many police officers with both Type 1 and Type 2 diabetes told us they were driving response vehicles (23), undertaking advanced driving duties (14), carrying firearms (3) and undertaking public order duties (12). Many of them said they had not been medically assessed before being allowed to do so. However, almost half (43%) reported that they had been prevented from undertaking these duties because of their diabetes.

- Over a quarter of respondents had been prevented from undertaking advanced driving.
- A similar number had been excluded from response driving.
- Just under a fifth had been excluded from firearms duty.
- Around one in twenty had been excluded from some form of public order duties.

And, contrary to best practice, two-thirds (28 out of 44) of those who had been prevented from undertaking these duties said that the refusal was not based on an IMA.

Case 97 (anonymous) is an officer from Wales. He was diagnosed over five years ago and is on insulin. He has been prevented from undertaking

advanced driving and firearms duties without individual assessment and feels discriminated against:

'Despite maintaining a healthy lifestyle with strict control of my diabetes, the Occupational Health Unit (OHU) has prevented me from applying to become an advanced driver. The decision was made based on guidelines with no consideration given to my individual case and how I look after my health.'

Case 102 is a road policing officer in Northern Ireland. He was diagnosed with Type 1 diabetes over five years ago. He currently undertakes non-response driving and firearms on the basis of IMA but was refused response and advanced driving without IMA. He feels he has been discriminated against and said:

'Initially I was removed from driving duties by OHU but this was not supported by my authorities. After seven years I negotiated to have my driving duties provided I did not get involved in high speed driving. Eleven years later I managed to negotiate non-operational motorcycle duties.'

However, IMA seems to have had a positive impact in some respects. For example, a third (12) of those undergoing IMA were driving response vehicles compared with less than a fifth (10) of those who had not undergone IMA. And the three respondents who were using firearms had been medically assessed before being allowed to do so – all examples of good practice.

Looking at the experience of different groups:

- Many more Type 1s than Type 2s had been prevented from undertaking certain duties because of their diabetes.
- Type 1s were far more likely than Type 2s to say that refusal to undertake those duties was not based on an IMA.
- The majority of those who did undergo an IMA were insulin users.
- Those diagnosed over five years ago were slightly more likely to have been prevented from undertaking certain duties than those diagnosed more recently and this was least likely to have been based on an IMA.

Driving

DVLA guidance states that 'drivers with insulin-treated diabetes should not drive emergency vehicles'. However, this does come with a qualification saying that 'it is for others to decide whether or how those recommendations should be interpreted for their own areas of interest, in knowledge of their specific circumstances.' Whilst this does allow forces to decide for themselves whether to follow the DVLA guidance, many err on the side of caution and operate what is, in effect, a blanket ban without taking full account of the individual's circumstances.

Case 13 is just one example of those who have had to give up driving without an IMA. Now working as a Neighbourhood Beat Manager/ Response Officer in Devon and Cornwall, he was diagnosed over five years ago with Type 1 diabetes. He told us:

'I have had a change in career FORCED on me due to the force's lack of foresight or apparent understanding of the condition. I was an advanced driver on traffic and over the years have been stripped of my driving authorisation to the point of being non-response. No account has been taken of my ability to control the condition and I have now been forced into a job role that fits what the force allows me to do.'

Case 68 (anonymous) is a senior officer in the Met. He was diagnosed three to five years ago with Type 2 diabetes but does not use insulin. He feels positive about the way he has been treated by the force but criticised the confusion over driving:

'There appears to be confusion over driving issues with no definitive answer. There also appears to be confusion over who, if anyone, you should tell and what then should happen. You get different answers from people of the same rank/band.'

Some of these anomalies are illustrated by Case 20 who is from Cheshire and was diagnosed over five years ago with Type 1 diabetes. When he informed the force about his diabetes he was a collision investigator. He was then taken off response and advanced driving duties but was not assessed. He said:

'Eventually I was allowed to use a 1.8 tonnes Ford Transit van and work shifts that were 7am – 3pm and/or 12 noon – 8pm. I was also on a county-wide call out rota. Ironically I couldn't use a traffic car for skid testing but could use the incident car, even if it was more powerful in engine capacity than a police vehicle. I could even work in excess of 16 hours a day and then drive home in the early hours with no consideration to fatigue by the force.'

However, according to Case 95 who is the head of the MPS driving school, a detective chief inspector with Type 2 diabetes, things are improving:

'I have just trained the first Type 1 diabetic police officer to drive in response mode. One other Type 1 diabetic has returned to full driving duties following an assessment of both his diabetic management and driving skills. The MPS remains at the forefront of driver training for Type 1 diabetics.'

Promotion and other issues

Only two respondents said they had been discouraged from seeking promotion because of their diabetes and they were both Type 2s who had been recruited in the last two years and had undergone IMA. No-one reported actually being turned down for promotion because of their condition, although some didn't know. However, almost a quarter of respondents (24), most of them (17) insulin users, told us that diabetes had affected their treatment by the service in some other way and a number are actively pursuing a career elsewhere.

For example, Case 21 is a PC in the MPS. He has Type 1 diabetes and was diagnosed three to five years ago. He has been prevented from undertaking response and advanced driving, firearms and dog handling, without IMA. He is very negative about his treatment by the force and is now looking outside the service for a job:

'Although I am now aware that the blanket ban in relation to response driving has been lifted, in practice it still remains. Courses for response driving are allocated to teams with a cut off period for applications in a few weeks time. As the Met wants each diabetic officer to be individually assessed by an occupational health doctor before they lift the ban on that person, you have to request an occupational health appointment. This takes months, by which time the courses have been allocated and no other courses are available. So the diabetic officer misses out due to the ineptitude of the occupational health department.

This has serious repercussions for career progression and means you are effectively shelved in the role you are already in. I am actively seeking employment outside of the Met so that I can compete on a level playing field again.

I have always wanted to be a copper but now I wish they would just medically discharge me.'

Adjustments by employers

Roughly a quarter (26) of respondents reported that adjustments had been made by their employer in response to their diabetes and the majority (19) were insulin users.

Case 26 was diagnosed over five years ago with Type 2 diabetes and uses insulin injections. He is a constable in the MPS. He feels positive about his treatment by the force and feels they treat people equally. He said:

'They offered me a room to administer insulin. I have been posted to the Divisional Intelligence Unit (DIU) as this rarely involves shift work, which helps me control my eating habits and times, and therefore helps control my diabetes.'

Case 78 is a constable in the MPS. She is generally positive about her employer:

'I have negotiated a working conditions package with the occupational health adviser and the package is respected by my borough. Generally line managers have been accommodating to my welfare throughout.'

Case 47 is a member of police staff at Essex Police Force. She is also positive about her employer:

‘I am allowed to eat at my desk to prevent hypos and there is never any question about time off for doctor/hospital appointments. I am allowed to manage my condition in my own way and I am given an early lunch hour to allow me to eat when I need to.’

In many cases, however, no attempt had been made to make reasonable adjustments. For example, Case 3 (anonymous) was diagnosed over five years ago with Type 1 diabetes. He said:

‘My line manager told me that the organisation could not give me special consideration and I was to be treated like all officers. If I required a meal break I was to approach one of the three patrol sergeants on duty and make my own arrangements with them to cover. I indicated that this was impractical and pursued the idea of a role away from custody. He said there wasn’t one available that would take into consideration my condition and that I would have to get the formal backing of my doctor to encourage the organisation to find one elsewhere.’

Moving to another position would have meant much more travelling so he has decided to retire early.

Case 79 is a WPC in the MPS. She was diagnosed three to five years ago with Type 1 diabetes. No allowances were made for her when she was pregnant with her first child and despite the extension to the DDA she feels that little has changed since:

‘When I was pregnant with my first child no allowances were made for the fact that my diabetes was unstable. I still worked full time, long hours and basically I was not risk assessed. I am currently pregnant and after some initial ignorance they realised that my pregnancy did actually affect my diabetes. I felt as though I was not believed.

As I write, I have nowhere private or CLEAN to inject (I inject five times a day). I refuse to go to the toilet to inject so I do it through my trousers! I have nowhere to store insulin or hypostop apart from in the knackered office fridge in my own box. I was also told to take my needles home as they won’t give me a sharps box! (Not good when you have a two-year-old rummaging through your bag.)’

Equal treatment

Less than a third (30%) of respondents felt that they were treated equally by their force, regardless of their diabetes; a similar proportion felt the opposite and the remainder were unsure.

‘My force treats people equally, regardless of their diabetes.’

Strongly agree	**13 %**
Agree	**18 %**
Neither agree nor disagree	**36 %**
Disagree	**16 %**
Strongly disagree	**15 %**
No reply	**3 %**

These results are comparable to those of the Morris Inquiry[7] which found that 46 per cent of respondents overall agree that the MPS treats people equally regardless of their disability. The figure fell to 32 per cent for those respondents with disabilities.

However, the comments reveal wide variations in interpretation of the meaning of ‘equal treatment’. For example, Case 32 (anonymous) is a sergeant in Grampian. He was diagnosed one to two years ago, has Type 2 diabetes and does not inject insulin. He said:

‘In my force I would have to say that you are not treated differently or ostracised. Whilst it is evident that some are aware of my condition they do not treat me as inferior or less able.’

Case 91 is a PC with Thames Valley. He was diagnosed over five years ago with Type 2 diabetes and does not inject insulin. He feels positive about his treatment, has been continually supervised by occupational health (OH), has undergone IMA, has been prevented from undertaking a range of duties on the basis of IMA and no longer works shifts or overtime. He said:

[7]Report of the Morris Inquiry ‘The Case for Change: People in the Metropolitan Police Service’, 2004.

‘I have been positively discriminated to the disadvantage of workmates. They seem to treat officers with diabetes as special cases…This does cause resentment amongst able-bodied officers. This is positive discrimination. I am not complaining. I was due to retire but have stayed on because of how well I have been treated.’

The sort of resentment cited by this PC shows that education about diabetes in particular, and possibly about disability in general, is badly needed.

But Case 11 (anonymous) is an officer in the MPS who was diagnosed very recently and already feels very strongly that the force does not treat people equally. He is Type 2 and not on insulin. He’s waiting to be seen by the chief medical officer. He said:

‘I don’t trust my force at all.’

DDA extension

Evidence from the partners in this project suggests that there have been some improvements since the extension of the DDA to cover police officers in October 2004.

Case 78 is a WPC in the MPS. She was diagnosed over five years ago with Type 1 diabetes. More recently she feels she has been treated positively and is now treated equally. She said:

‘My condition has been discussed and the CMO has implemented an individual care plan. Not so in earlier years – my driving classification was removed circa 1998. I was a van driver/standard – now – basic!’

Case 28 is a sergeant with Type 1 diabetes who was working for Sussex police and transferred to the MPS:

‘For some time I was barred from making a transfer but the Met obviously embraced the DDA and took me on. They made the minimum of fuss and I received personal contact from the Met medical officer. The process was very easy and was dealt with via a letter from my GP, a couple of phone calls and emails.’

However, only one in ten (11 per cent) respondents said they had noticed a difference in the way their force responded to their diabetes after the DDA extension.

Sometimes officers in the same force reported different attitudes. This female member of staff also works in the Met but her recent experience was quite different:

Case 19 is a female Computer Aided Despatch (CAD) controller who applied to become a PC in the MPS in February 2005. She was diagnosed over five years ago with Type 1 diabetes. She said:

‘I applied for a role as PC in February 2005, four months after the changes to the DDA, and was sent home from my medical after being told, “Sorry, we don’t take diabetics” even though I advised them this was incorrect due to the new DDA. The recruitment nurse was not aware the Act had changed. I have now withdrawn my application due the treatment I received from medical branch. As a member of police staff I was never treated any differently. It was only on applying to join the service as a uniformed constable that I had any discrimination or adverse treatment.’

Discrimination

Almost a third of respondents (29 per cent) said they felt they had been discriminated against by their force because of their diabetes.

- Type 1s were much more likely than Type 2s to feel they had been discriminated against.
- Insulin users were much more likely than others to feel they had been discriminated against – three-quarters (24) of those who answered ‘yes’ were on insulin.
- Those diagnosed over five years ago were more likely than those diagnosed more recently to feel they had been discriminated against. As were those who had undergone IMA or been prevented from undertaking certain duties.

Case 37 is a constable in the MPS and for him the DDA has come too late. He was diagnosed over five years ago, is Type 2 and uses insulin. He feels discriminated against by his force. He said:

'The only time I have had any consultation with the MPS is since the DDA was implemented…The last 16 years of my service has, in effect, been wasted because of the MPS's attitude towards diabetes and my career options have been ruined. What can be done to compensate me for the last 16 years of discrimination?'

Case 59 (anonymous) is an officer who feels equally strongly. He was diagnosed around five years ago with Type 1 diabetes. He was taken off response driving on diagnosis and feels discriminated against. He was forced to submit a grievance which was initially ignored. The force then said they refused to look at his case on an individual basis and the whole process has understandably caused him a lot of stress and anguish.

Setting a good example

Less than a third (29 per cent) felt their force was a good example for others to follow.

Insulin users and those who had undergone IMA were more likely to say that their force was not a good example for others to follow, but those diagnosed most recently were more likely to feel their force was.

Case 18 is a PC in Essex. He was diagnosed one to two years ago, is Type 2 and does not use insulin. He is an advanced driver but has not been individually assessed. He is very positive about the way he has been treated and considers his force a good example for others. However, he highlights ignorance within human resources departments:

'I am very fortunate to have a unit commander who understands this issue and adjusts my duties accordingly. However, I'm not convinced that my divisional personnel managers understand the problems that diabetes can cause. I think they could do a lot more to assist and to understand the health and welfare issues.'

Lack of awareness and understanding of diabetes

Lack of understanding of diabetes amongst occupational health staff, managers and others was mentioned by numerous respondents, even those who felt positive about their treatment by the force. For example:

Case 12 is a sergeant from Essex who has been seconded to Centrex – the police training organisation. He was diagnosed three to five years ago with Type 1 diabetes. He feels he has been treated positively and that the force treats people with diabetes equally. He still does response and advanced driving but has never undergone an IMA other than regular checks with his force medical officer. And despite adjustments in shift patterns – regular meal breaks etc – by his force, he has come across ignorance within Centrex. He said:

'A senior manager within Centrex tried to prevent me injecting insulin in the staff canteen.'

For many others ignorance was cited as a key factor in discrimination:

Case 94 is from Surrey. He was diagnosed over five years ago with Type 2 diabetes and is due to move onto insulin injections. He feels he has been discriminated against and said:

'My force have reluctantly complied with the DDA restrictions, however, they have made it very difficult for diabetics to join the service… At times I am made to feel like a burden. I am constantly challenged about what I can do and what I can't do. This comes from a lack of training of police supervisors and managers. There is a clear lack of understanding of the effect diabetes has on people.'

And even those diagnosed more recently cite similar attitudes and lack of understanding about the condition:

Case 88 is a PC in the Met. He was diagnosed less than 12 months ago with Type 2 diabetes and does not inject insulin. He feels he has been discriminated against and that this is largely due to ignorance:

'I believe many problems are caused because of ignorance connected with the condition. Managers do not understand the condition and the consequences of it. This is increased when dealing with Type 2 diabetics.

Problems arise when I am expected to stay at work without any notice. I get the impression that managers believe I am being obstructive when I say that I must eat a main meal and accompany that meal with medication which I may not have with me. They can get stroppy when I say I'm sorry but my condition needs to be taken into consideration…'

Attitudes to insulin users

There is strong evidence throughout our research that insulin users are discriminated against. This case demonstrates quite clearly the difference that insulin injections can make:

Case 76 is a PC in the Met. He was diagnosed over five years ago with Type 2 diabetes and now injects insulin. He does not feel positive about his treatment by the force and feels he has been discriminated against because of his use of insulin. He said:

'As soon as my treatment was changed to insulin, attitude changed totally and all my qualifications were suspended, my role/job within the service changed.'

Case 90 is a PC in Devon & Cornwall. He was diagnosed over five years ago with Type 1 diabetes. He does not feel he has been treated positively by his force and feels he has been discriminated against. He said:

'I was immediately removed from my duties (driving and firearms) and treated like a leper. From highly qualified ARV protection duties I was removed to foot patrol.

… Several times over the past five years I have honestly believed that I was being pushed towards resignation as an easy alternative to the problem faced by the constabulary. Immediately following diagnosis I was offered no support even though my whole career was in tatters. I was moved to an outback station with no supervision and had all of my specialisations removed. The constabulary continually followed poor advice from the FMO until suggestions of the DDA were raised approximately two years ago… My treatment by the constabulary has been far worse than unsatisfactory.'

Experience of senior staff

The majority of respondents in senior positions, both Type 1 and Type 2, commented positively on their treatment, or said they had not been treated any differently. Only one said he had not been treated positively.

Case 100 is a detective inspector in Essex. He has Type 1 diabetes and was diagnosed over five years ago. He undertakes response and advanced driving and public order level two:

'I have managed to enter into the areas I have been interested in eg traffic, public order and now crime. However, I did not declare my diabetes in the application process because I was never asked!…I have in the past tried to gather information on all those with diabetes within Essex. OH won't tell me and it seems to me that people are still reluctant to make themselves known. Why is that? Because they didn't trust the organisation to do the right thing.'

Case 84 is a senior member of staff. He was diagnosed three to five years ago with Type 1 diabetes and is on insulin. He said:

'I've not been treated in any way, nobody is particularly interested…I do think that disability at senior level is simply not acknowledged and to mention it is seen to be a weakness or somewhere we simply do not go.'

Experience of officers diagnosed recently

We looked closely at the experience of those respondents who had been diagnosed within the last 12 months to assess whether there had been any improvements since the extension of the DDA in October 2004. We also looked at the experience of those diagnosed one to two years ago.

Five of the nine respondents who had been diagnosed in the last 12 months felt positive about the way they had been treated by their force and considered their force a good example to follow. They were all Type 2 and did not use insulin. Forces represented were: Leicestershire, Essex, Hampshire and the Met.

Only one respondent in this category felt he had not been treated positively; he has Type 1 diabetes and works in Kent as a weapons instructor (see Case 89, page 15).

Ten of the 24 respondents who had been diagnosed within the last one or two years felt they had been treated positively and that their force was a good example to follow. The majority (eight) were Type 2 and non-insulin users. They came from Hampshire, Cleveland, Essex, Greater Manchester, Avon and Somerset, Grampian, the Met, Norfolk and Devon and Cornwall.

A further seven respondents in this category felt negative about their treatment. Again, the majority (five) were Type 2, non-insulin users. Forces represented were: Fife, Greater Manchester, West Midlands, the Met, Norfolk and Avon and Somerset.

5 Analysis of police forces' survey

5.1 Level of response

There were 25 responses to the survey from 23 forces across the UK.

5.2 Number of officers with diabetes

Over half of all respondents don't know how many officers have diabetes . In most cases where numbers were known they were fairly small. Although one respondent from a large regional force said they were aware of 20 non-insulin users within their force.

5.3 Positive treatment

The vast majority of respondents felt that officers with diabetes were treated positively within their force.

5.4 Recruitment policy

The majority of forces said they did not have a policy for the recruitment of people with diabetes. Many said they applied Home Office guidance[8] – a general disability policy which does not refer specifically to diabetes, but does promote individual assessment. A small number specifically said they individually assess each case.

> 'They are subject to individual risk assessment…Policies are no longer lawful for specific groups like diabetics. No specific policy for diabetics. Deployment is subject to risk assessment with redeployment or restricted duties as necessary.' (Northumbria)

However, there were considerable variations in the perceptions of what constitutes a policy:

- Some forces said they didn't have a policy but they appear to adopt good practice.

[8]Home Office Circular 59/2004, Isobel Rowlands.

- Others said they do have a policy but closer inspection showed these were general disability policies with no mention of diabetes.
- Some said they refer to DVLA guidance for driving duties.

It is clear that there is no standard policy in use across all forces for the recruitment of officers with diabetes.

5.5 Retention policy

Four respondents said their force had a policy on the retention of officers with diabetes but all were referring to Home Office guidance or general disability policies.

5.6 Restrictions on duties

Many forces apply restrictions to certain duties, particularly advanced driving and firearms (see page 19 above for more on driving). More restrictions are placed on people who use insulin to control their diabetes. One force admitted to operating a blanket ban on people with Type 1 diabetes driving response vehicles:

> 'We don't allow people with Type 1 diabetes to drive response vehicles.' (Northants)

Comments on why they prevented officers with diabetes from undertaking certain duties included:

> 'Where occurrence of hypoglycaemia risks the officer or operational capability or risks general public.' (Northern)

> 'Generally any condition that can result in sudden, unexpected incapacitation eg, hypos in safety critical roles. However, once the condition is well controlled then the restriction can be withdrawn.' (Central Scotland)

Just less than half of respondents said they apply restrictions in other areas, again particularly for insulin users.

> 'Shift restrictions – regular 7am – 7pm shifts with time for meals.' (Norfolk)

A number of forces said they referred to DVLA guidance when restricting driving duties.

5.7 Individual assessment

Around half of respondents said their force requires officers with diabetes to undergo an individual assessment by a consultant diabetologist, occupational health doctor or other medical practitioner for driving and firearm duties and fewer for public order duties. In some cases this was only for insulin users.

Respondents expressed great variation in who they said carried out the assessment within their force. Decision makers in this process included the occupational health physician, force medical officer, independent diabetologist, or managers and supervisors.

> 'All officers/staff are required to attend force medical adviser or nurse annually to ensure good control and the best possible medical advice.' (Northants)

Some respondents seemed to have a good understanding of individual assessment:

> 'In safety critical roles, the question is NOT whether insulin is used, but whether there is good control of the disease, lack of significant complications of the disease and good knowledge of the disease.' (Sussex)

5.8 Adjustments made by police forces

The vast majority of respondents said their force made adjustments to allow officers with diabetes to manage their condition effectively. However, it is unclear whether there are formal processes in place for adjustments to be decided openly and reviewed on a regular basis.

'We would look at shift patterns, particularly in areas where meal breaks may not be taken normally due to operational needs.'
(Avon and Somerset)

'Sometimes an officer's role may be changed either on a temporary or permanent basis to allow the condition to 'settle' after diagnosis – some people need time to come to terms with the condition and to get medication levels right.' (Dorset)

'Redeployment into non-operational office-based role without shifts.'
(Northern)

5.9 Equal treatment

Eighteen out of 25 (74 per cent) respondents felt their force treats people equally, regardless of their diabetes. This far exceeds the equivalent figure for police officers, which was 30 per cent.

5.10 DDA extension

About a third of respondents said their force changed their policies after the DDA was extended.

5.11 Setting a good example

Over half of respondents felt their force was a good example to follow. This is comparable to the equivalent figure for police officers (65 per cent).

6 Policies and diabetes

6.1 What the officers told us

There are clearly inconsistencies in the way officers with diabetes are treated across forces in the UK. Many respondents who felt they had been treated positively knew of others with diabetes whose experiences hadn't been so positive.

Case 83 is an officer from Devon and Cornwall with Type 1 diabetes, who was diagnosed recently. He said:

'I think the support I was offered was mainly due to individuals and not necessarily the force policy. Also, one of my colleagues was diagnosed with Type 1 diabetes about four years ago and his experience was completely different to mine. He has had to fight for many things to be changed within the force.'

Case 91 is an officer for Thames Valley. He was diagnosed with Type 2 diabetes and feels positive because his force made adjustments to allow him to continue working, but thinks there still needs to be improvements:

'I was lucky that I was dealt with by one particular occupational health doctor. There were three employed at that time. Other officers who went to the other two doctors received widely differing outcomes from mine. An improvement would be to standardise how officers are dealt with. It is a matter of pot luck who you see and how they deal with the health problem.'

6.2 Force policies on diabetes

Only one of the respondents to the forces' survey provided us with a copy of their policy and this was a general disability policy with no mention of diabetes. Following the survey we conducted a trawl of force policies through their websites.

Poor practice

The results show that of the 43 forces in England and Wales, the majority refer to the Home Office recruitment website, 'police – could you?' (www.policecouldyou.co.uk), which until we contacted them in May 2006 stated that applicants with diabetes would be rejected. Following our intervention the text was amended and the site is now correct.

This is not the only example of poor practice. Several forces have their own guidelines which, at the time of our survey, included illegal blanket bans. And one force, Cheshire, had three conflicting policies, none of which were dated.

One stated that:
'The procedures laid down in this policy apply equally to members of staff joining the constabulary with disabilities, as well as existing employees who become disabled during the course of their career. Police officers are excluded from these provisions as by law they would be required to resign if they became disabled.'

The second stated:
'The procedures laid down in this policy apply equally to members of staff joining the Constabulary with disabilities, as well as existing employees who become disabled during the course of their career. The Constabulary will offer every assistance and support to any disabled police officer in the recruitment process.'

The third expanded on the second covering how the procedure side would be implemented.

The forces concerned were alerted to the problems immediately and most policies, including Cheshire's, have now been removed or amended by their respective hosts. However, some, such as Bedforshire, have yet to take action, and, at the time of writing, their policy still states that applicants with diabetes will be rejected.

The City of London force has a blanket ban on several conditions, including diabetes, although this conflicts with the Home Office 'could you' site which is also featured.

We were unable to find any clear disability policies on the websites of forces in Scotland. Most told applicants with a disability to contact the recruitment section for a copy of the medical criteria but these were not available on the site.

The majority of force websites right across the UK had very little information about disability or about medical standards. Most featured a self-selection questionnaire which asked: 'Do you have any medical conditions that could prevent you from becoming a police officer? (Yes or No.)' Those answering 'yes' were instructed to contact the force.

Good practice

Examples of forces who had processes in place to meet the DDA were rare. However, two worthy of note were Northumbria and Northern Ireland:

'You will be required to complete a medical questionnaire and to undertake a medical examination as part of the recruitment and selection process.

From 1st October 2004, police officers are covered by the Disability Discrimination Act. If you have a disability, we will make reasonable adjustments where it is reasonable to do so. Please provide any relevant information about your disability and details of any reasonable adjustment you think you will need to undertake the assessment process and the role of a police officer.' (Northumbria)

'Any applicant with a disability will be considered individually on their merit.' (PSNI)

Clearly, in terms of their written policies, many forces have not responded appropriately to the requirements of people with diabetes. And although some do actually operate according to best practice, this is not reflected in the documentation.

6.3 Recommendation

Forces may choose to have a separate policy on individuals with diabetes, whether applicants or existing officers, and this would not be in breach of the DDA. Forces must have a publicly available policy on making adjustments for individuals who have diabetes. These should be based on an assessment of their individual case and should follow the principles outlined in *Guidance on the recruitment and employment of police officers with diabetes.*

7 Conclusions and recommendations

7.1 Overview

The results of both surveys show that there are many examples of good practice around the UK with individuals fulfilling their full potential. This benefits both the individuals and the forces who are getting the most out of their officers. However, the results also highlight how far there is still to go, with many forces failing to deliver on the DDA. This leaves a number of forces not only potentially breaking the law but also failing to make the most of their most valuable resources, their police officers.

It was also clear from the survey that there is some confusion about assessments – what they are, who should do them and how they should be done. In order to clarify the situation we recommend the use of two terms:

Individual Medical Assessment (IMA) – a formal medical review of an individual's diabetes and how it affects them, carried out by diabetes specialists.

Case Evaluation (CE) – using information, which could include medical or other specialist sources, to understand what effect the individual's diabetes has on their ability to do their job and to decide what reasonable adjustments can be made.

All decisions regarding people with diabetes must be based on the ability of individuals to carry out their duties to the required standard and the needs of dealing with their condition. This report offers examples of good practice which all forces should look to deliver. It also offers recommendations and guidance which will provide forces with a way forward in fulfilling their duty to their officers and to the wider public.

The danger of not acting is highlighted in the cases of officers who feel they are being treated unfairly and in some cases even forced out of the job. It is worrying that less than a third of the officers who responded felt that their force set a good example for others to follow.

When should an IMA, CE and reasonable adjustment review be made?

- CEs and IMAs must only be made when an individual's diabetes is likely to affect their ability to do their job.
- Reasonable adjustment reviews should be done annually or when the officer's job changes. This should apply even if no reasonable adjustments were needed initially.
- Anyone undertaking a specialist role should undergo an Individual Medical Assessment. The individual officer should then have their condition reviewed on an annual basis using details requested from their diabetes annual review[9]. A further IMA should only take place if there is a change in role or in condition.
- A CE should be made when an officer's role changes, or there is a change in their medical condition.

7.2 Recruitment

Findings

While there is a lack of evidence in this area there appear to be wide variations in approaches to the recruitment of people with diabetes. While some forces are recruiting insulin users there are others who appear to be breaking the law by continuing to operate de facto blanket bans.

Recommendations

- **All forces should base recruitment decisions on the ability of the individual to do the job.**
- **Where an individual applicant has diabetes a CE should be conducted so that forces can make reasonable adjustments.**

7.3 Disclosure and confidentiality

Findings

Disclosure of diabetes did not seem to be an issue, with most officers saying they had informed their force about their condition.

[9]All people with diabetes should have a series of checks at least once a year. These checks include blood glucose control, HbA_{1c} blood test, kidney function, blood fats, weight, legs and feet, blood pressure, eyes, injection sites and a review of lifestyle issues.

Recommendations

- **All officers should be encouraged to tell their force about their diabetes. Without disclosure forces cannot make reasonable adjustments nor are they under any obligation to do so.**
- **Forces should reassure officers that if they do disclose their condition, they will receive a CE and IMA if appropriate.**

7.4 Discrimination

Findings

People with diabetes are all different and they manage their condition differently. It is not appropriate for all people to do all activities associated with being a police officer and in some cases exclusions may be necessary. However, this should be decided on a case by case basis with the ability of the individual being the deciding factor.

It cannot be assumed that because an officer has diabetes or a certain type of diabetes, that they will be a risk to themselves, fellow officers or members of the public.

Nearly half of respondents felt they had been treated positively by their force and the majority did not feel that they had been discouraged from seeking promotion because of their diabetes. However, too many officers with diabetes feel discriminated against.

Discrimination was a particular problem for insulin users who have a far less favourable experience than others. The survey showed that many people using insulin were discriminated against, often without an individual assessment.

A recurring theme in the survey results is that much of the discrimination is based on a lack of knowledge and understanding of what diabetes is and what it means to individuals. Where it arises, this often appears to be an institutional problem as well as relating to individuals dealing with particular cases.

We found that many forces have done and continue to place restrictions on the duties undertaken by police officers with diabetes, particularly in

relation to driving, firearms and public order. The survey shows that many police officers with diabetes are successfully undertaking these duties to the benefit of themselves and their forces. However, many officers are still being excluded, often without an individual assessment. There also appear to be problems in some areas with how individual assessment is carried out.

Recommendations

- **Assumptions should not be made about what duties officers with diabetes can or cannot undertake.**
- **There should be an appeals process for officers to use if they feel that an unfair IMA or CE has been made.**
- **Any officer with diabetes should undergo an annual reasonable adjustment review which is separate from a performance review.**

7.5 Individual Medical Assessment and Case Evaluation

Findings

The approach to individual assessment varies considerably, not only in terms of when to undertake it but also in terms of what it involves and how and what decisions are made. This is the case at all levels, from decisions on what duties an officer can undertake through to reasonable adjustments in shift patterns and facilities being provided to officers to allow them to cope with their condition.

Some forces have officers undertaking a full range of duties, including response vehicle driving and firearms duties, based on individual assessment of their management of the condition. Unfortunately, many officers said they had requested an individual assessment after being refused promotion or access to duties because of their diabetes, but were continuously refused.

Those diagnosed more recently didn't seem to have better experiences than those diagnosed before the extension of the DDA. Many of the officers who had undergone IMA felt very negative about the experience for various reasons, suggesting problems with the operation of the system.

Recommendations

- **All officers with diabetes should be offered a CE based on open discussion and should be informed about the merits of having regular IMA.**
- **A policy procedure should be put in place detailing the steps that need to be taken to make reasonable adjustments.**
- **No officer should be prevented from carrying out a duty/getting a job because they have diabetes without an IMA and a CE.**
- **Forces might also offer psychological support to enable the officer to come to terms with the condition, but this all depends on individual circumstances.**
- **CE, whether or not it includes an IMA, must not inhibit or delay promotion or specialisations. Time must be allowed for these to take place before job application deadlines pass.**
- **Specialisms and hazardous aspects of the job should be considered at CE and at IMA if appropriate.**
- **There should be an appeals process for officers to use if they feel that an unfair decision has been made.**

7.6 Policies on diabetes

Findings

A small number of forces seem to operate according to best practice but very few forces have written policies that reflect this. In relation to recruitment, the majority of forces refer to Home Office guidance which, until our intervention, stated that applicants with diabetes would be rejected.

Recommendations

- **The Home Office should provide a clear policy statement reminding forces of their duty under the DDA. This should deal with all elements of the recruitment and retention of people with diabetes, along with other disabilities, on an individual basis and on the merits of each case.**
- **The statement should refer to the guidance produced as a result of this report, Guidance on the recruitment and employment of police officers with diabetes.**
- **Every force should adopt the above guidance and include it on their force website.**

Appendix 1 – About the partners

1 Diabetes UK

Diabetes UK is the charity for people with diabetes. We stand up for the interests of people with diabetes by campaigning for better standards of care. We also fund research to improve the treatment of diabetes and to find a cure, and we provide practical information and support services to help people manage their diabetes better. We have over 170,000 members and a network of offices across the UK. We are one of the largest patient organisations in Europe.

Diabetes UK works for people with diabetes, their carers, family and friends. We represent the interests of people with diabetes by lobbying the government for better standards of care and the best quality of life. Diabetes UK spends £6 million on research every year to improve the treatment of diabetes and we hope our research will ultimately lead to finding a cure for diabetes.

Diabetes UK's mission is 'to improve the lives of people with diabetes and to work towards a future without diabetes'.

Specifically we want to:

- set people free from the restrictions of diabetes
- ensure the highest quality care and information for all
- end discrimination and ignorance
- ensure universal understanding of diabetes and Diabetes UK
- achieve a world without diabetes.

For more information about Diabetes UK visit our website at www.diabetes.org.uk or phone us on 020 7424 1000.

2 The Disability Rights Commission

The Disability Rights Commission (DRC) is an independent body, established by Act of Parliament. We enforce the Disability Discrimination Act 1995 and 2005 (DDA), tackle discrimination and promote the benefits of an inclusive society.

What the DRC does

- Supports disabled people in securing their rights under the DDA.
- Solves problems by achieving solutions, often without going to a court or employment tribunal.
- Supports legal cases to set new precedents and test the limits of the law.
- Works to change organisations and sectors through formal investigations and good practice development.
- Provides an independent Disability Conciliation Service for disabled people and service providers through Mediation UK.
- Works to strengthen the law so that it protects more disabled people.
- Organises campaigns to shift attitudes and to change policy and practice.
- Produces information on rights for disabled people, good practice for employers and service providers and research reports on disability rights.
- Holds events and conferences to build business networks and raise awareness of disability issues.
- Creates networks with other organisations to increase the profile of disability rights.

What the DRC does not do

The DRC does not give advice or information on any of these areas, except when relating to discrimination on the grounds of disability:

- benefits
- community care
- equipment for disabled people
- housing
- medical treatment
- human rights (no power to act).

You can contact the DRC Helpline by voice, text, fax, post or by email via the website. You can speak to an operator at any time between 08:00 and 20:00, Monday to Friday.

Telephone: 08457 622 633
Textphone: 08457 622 644
Fax: 08457 778 878
Website: www.drc-gb.org
Post: DRC Helpline, FREEPOST, MID 02164, Stratford upon Avon, CV37 9BR

3 National Disabled Police Association (NDPA)

The National Disabled Police Association (NDPA) is a national organisation formed to promote and support all members of the police family with an interest in disability across the UK. The NDPA aims to raise disability awareness and to promote a positive image of people with disabilities. It will encourage people to see beyond the disability and see the potential held within each individual.

About Us

Although the Disability Discrimination Act has been with us and applicable to police staff since 1996 it was not until the 2004 update, which saw the inclusion of police officers and for buildings to be fully accessible, that disability issues began to be addressed.

The NDPA was launched on the 6 September 2004 at New Scotland Yard in London. The launch was hosted by the Metropolitan Police's Disabled Staff Association as the result of a recognised need to bring together and co-ordinate efforts to ensure disabled police officers and police staff are treated fairly and consistently throughout the country. Our mission is to be a support organisation and pressure group to ensure that:

- The DDA is applied and adhered to.
- Best practice is shared between forces and constabularies.
- Instances of poor management are identified and rectified.
- Legislation is current and relevant.
- To mediate between employer and employee.
- To be a source of knowledge and experience to be used in education and training.
- To be a link and forum for all individual staff associations.

What We Do

The National Disabled Police Association will assist with training, educating and developing management personnel in a uniform way. Whereby a disabled person could feel that should they transfer to another force within the UK the policies and management have parity. This will ensure less pressure and stress for staff, and make it easier for the various Police forces to limit their potential legal liabilities.

The National Disabled Police Association will strive to achieve this by working closely with stakeholders and sitting on various forums to represent the views of its members.

Further details can be obtained from our website: www.ndpa.info or email secretary@ndpa.info

4 National Police Diabetic Association (NPDA)

The NPDA was one of the first police staff associations to be founded. It was formed in 1993 by Tim Savage and now has over 120 members.

The association provides specialist advice to members, employers and the public on the best management of diabetes within a policing environment.

The National Police Diabetic Association (NPDA) was formed to dispel unfounded assumptions made about people with this condition and to promote the status of the individual behind the diabetic label.

The first official meeting was held on 7 June 2005 at New Scotland Yard in London. John Grieve, the President of the NPDA, chaired the launch. The Chair of the NPDA is Borough Commander of Greenwich, Chief Supt Peter Lowton.

The NPDA campaigns to end discrimination and restrictions against police officers with diabetes.

For further details please contact:

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Tel: 01959 571 174.

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Chair: Chief Supt Peter Lowton, Borough Commander of Greenwich

0208 855 1212.

Appendix 2 – Glossary

ARV	Armed Response Vehicle
CAD	Computer Aided Despatch
CE	Case Evaluation
CMO	Chief medical officer
DDA	Disability Discrimination Act
DED	Disability Equality Duty
DIU	Divisional Intelligence Unit
DRC	Disability Rights Commission
FMO	Force medical officer
GDM	Gestational diabetes mellitus
IMA	Individual Medical Assessment
MPS	Metropolitan Police Service
OH	Occupational health
OHU	Occupational Health Unit
NDPA	National Disabled Police Association
NPDA	National Police Diabetic Association

Registered charity no. 215199