SDU Case Studies

There have been several cases in which SDU personnel have strongly resisted managerial intervention or direction pertaining to the registration, de-registration of handling of CHIS over the past two and a half years. The predominate attitude by the controllers [redacted] and long serving handlers [redacted] is that as management are not trained to [redacted] Human Source standard and that they can not make decision pertaining to the risk presented.

What these SDU staff failed to understand is that management act as governance across the deployment of high risk human sources to ensure that the community, the organisation, the members and the human source are not placed at a unacceptable level of risk. This has developed over the past five to eight years due to a culture of risk taking, based on ego rather than *risk versus reward*.

In May 2010 a CMRD Audit of Human Sources was conducted across the organisation including the SDU. The Controllers at the unit resisted this believing that CMRD has no right to audit the handling of high risk human sources within the SDU. They were directed by the OIC to comply with the requests of CMRD Audit Team.

In January 2011 CAMDOC removed the Controlled Operations Authority given to a long term CHIS due to the overwhelming risk posed by the continued deployment of the individual. Several staff at the unit, including both controllers were not accepting of this decision believing that they could manage the risk. They believed that the members of CAMDOC were risk adverse and had no knowledge in regards to managing CHIS and risk.

NSW Matter – Op [redacted] In [redacted] 2011 as a result of the NSW Pol and VicPol internal enquiries, the controllers were advised that deployments interstate particularly in NSW the OIC of the SDU may travel with staff when deploying. The controllers were extremely resistant to having an officer travel with them as they were experts in human source management and the OIC was not [redacted] qualified.

Echo TF - early 2011 – LSR assessed that the CHIS was not suited to be deployed into the [redacted] environment and due to [redacted] may [redacted] under pressure which would precipitate significant risk of harm. Attempts made by controller to circumvent decision by attempting to go through Crime Dept management re have decision reviewed.

In mid 2011 one of the controllers at an operations meeting sought feedback from staff as to notifying a long term human source that search warrants were about to be executed on associates addresses. The OIC stopped this immediately and spoke with the controller who thought that it was not an unreasonable suggestion.

At a training day in late 2011 several staff expressed that in their role as human source handlers their first loyalty was to the high risk human source and not the Victoria Community and the Victoria Police Force. When the OIC explained to them that their loyalty should be to the Victorian Community, the people that they had sworn to protect, they still believed that "they should look after the source first." This clearly demonstrates that they have lost connection with the organisations philosophies.

Op Miko Trial (AFP) - In early 2012 a trial involving the largest seizure of ecstasy in Australia was underway. There were several defendants in the matter including some well known importers and traffickers of drugs. One of the controllers at the unit wanted to try and get two of the defendants to become human sources. The controller wanted to approach the potential human sources in the grounds of the court. When the OIC of the unit did not allow this, the controller struggled to understand that his actions if allowed to continue had the potential to have a lengthy Supreme Court trial being aborted and bring adverse publicity to Victoria Police. The controller failed to understand the 'risk versus reward' in source management and allowed his professional ego get in the way of making a sound judgement in this matter.

In [redacted] 2012 – [redacted] matter – D/Insp and LSR assessment that CHIS was not a fit and proper person to be deployed by SDU. Intense resistance and inappropriate comments to RFA and others from controller / handler in regards to this decision.

In [redacted] 2012 – [redacted] – CHIS had been identified through other intelligence sources to be actively involved in planning a [redacted] following the [redacted] SDU personnel did not accept the risk assessment of management and argued to continue deployment in face of strong evidence that deployment would/would be used by CHIS as a likely defence if apprehended [redacted] against the person.

In [redacted] 2012 a shooting occurred in [redacted]. A CHIS had passed on information within hours of it occurring that was critical for the investigation. The [redacted] of the victim was not known and the victim's [redacted] nearby. The SDU controller and handler were concerned that by passing on single source information it may expose the source to risk. The OIC had to direct then controller to pass on the information immediately as it was not known if the victim was [redacted] The controller and handler were concerned that the sources welfare had to be look after, even though it was unknown if the victim was alive or dead. Fortunately the victim was [redacted] several days later by investigators. This example again highlights the cultural attitude within the unit that the priority is the source and not the Victorian Community.

In [redacted] 2012 – [redacted] – CHIS under investigation and being [redacted] SDU personnel desirous of [redacted] CHIS with [redacted] to enable deployment to be free from [redacted] D/Insp / LSR did not allow this to occur. SDU personnel unable to see that this action it allowed to occur would alert the CHIS that he was under investigation and effectively have the unit working against the investigating unit.

In [redacted] 2012 a controller refused to make an approach to a potential human source / witness, who was [redacted] stating that the risk was extreme. After circumstances changed the controller was still extremely reluctant to make an approach. A decision was made for the OIC to make the approach with an investigator. The day before the OIC and investigator went [redacted] the controller forwarded an IR to the [redacted] that provided information that would have assisted in the approach. The controller failed to pass this onto the OIC, knowing this was of importance.

In [redacted] 2012 – Op [redacted] – controller / handlers desirous of facilitating the commission of [redacted] utilising a CHIS to assist investigators. Terminated on the basis that police would cause the commission of the offence which without the involvement of the CHIS would not occur.