



**PROTECTING NHS STAFF AGAINST
VIOLENCE AND AGGRESSION**

MEMORANDUM OF UNDERSTANDING

BETWEEN

**ACPO CYMRU/WALES
NHS WALES
CROWN PROSECUTION SERVICES**

February 2013

Contents

Page

	Purpose and Structure of Document	4
1	Statement of Intent	5
2	Parties to the Agreement	5
3	Implementation & Review	6
4	Effective Communication	6
5	Liaison	7
6	Incident reporting	9
7	Police Response	11
8	Investigation	13
9	Decision on Prosecution	15
10	Sentencing	21
11	Out of court disposals	24
12	Updates to NHS Case Manager on progress	25
13	Victim/witness support	26
14	Data Protection & confidentiality issues	28
15	Information Sharing	29
16	Management and development of this agreement	31
17	Signatories to the agreement	32

Annexures

- A Tri-Partite Group – details and membership
- B Nationally agreed protocols and standards
- C Information forms suspects with mental disorder and/or learning disability
- D Victim consent form for disclosure of information
- E Generic conditions for ASBOs, bail conditions, restraining orders
- F Glossary

PROTECTING NHS STAFF AGAINST VIOLENCE & AGGRESSION

PURPOSE

This Memorandum of Understanding (MoU) sets out the responsibilities of the partners when dealing with violent or aggressive incidents relating to NHS staff. Its focus is on those incidents which need to be addressed by the criminal justice system. It builds on two previous agreements in Wales.¹ Also, it has been informed by: *Tackling Violence and Antisocial Behaviour in the NHS*, an agreement made in October 2011 between the relevant partner organisations in England.

The Agreement is between the four Police services in Wales, the Crown Prosecution Service and NHS in Wales and seeks to achieve:

- effective and efficient communication across partners, including the exchange of information at all levels;
- a clear understanding of the respective roles, responsibilities, processes and legal constraints; and a
- clear statement on prosecution policy which will help NHS staff to understand the criminal justice system and have confidence in it.

STRUCTURE OF AGREEMENT

This Agreement is set out as follows:

Sections 1-3: Introduction

This provides information on the aim of the MoU, the partners to the agreement and how it will be monitored.

Sections 4 & 5: Key Principles

This covers a range of underpinning operating principles around communication and liaison.

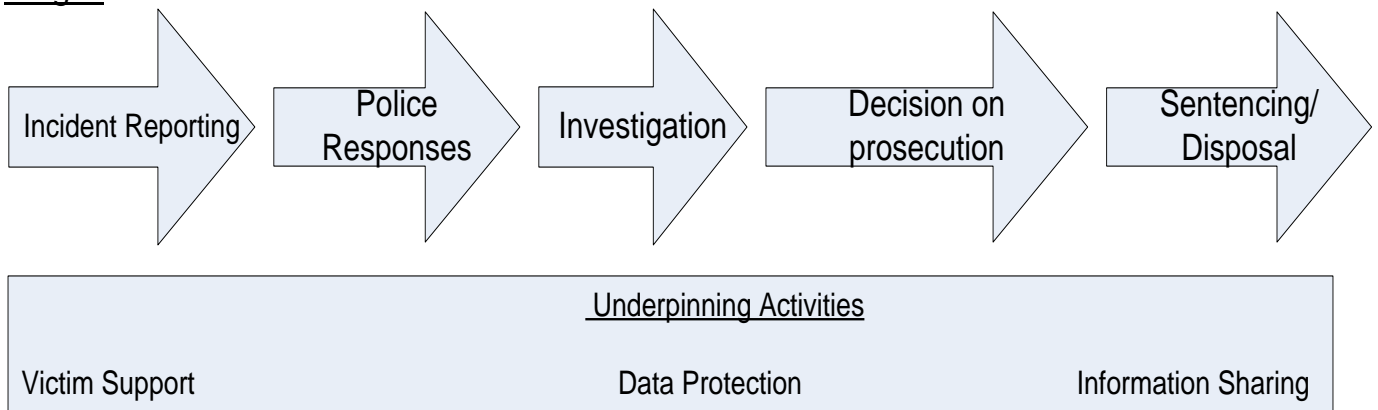
Sections 6-11: Guidance

This summarises the sequential phases following an incident and the roles and responsibilities of each party during each phase. The MoU includes guidance on how each phase should operate, though there will be scope for local interpretation which is agreed by all parties.

This is illustrated in the diagram overleaf.

¹ This MoU replaces two previous agreements: one signed on 22 March 2007 between the Welsh Government and the Crown Prosecution Services and a second one on 14 September 2009, between the Welsh Government and the Chief Constables of South Wales, North Wales, Dyfed Powys and Gwent Police.

Stages



Sections 12-16 Underpinning Support

Sets out the expectations in terms of the underpinning activities which are relevant at all stages (see above diagram).

Appendices

Provides a range of detailed guidance, examples and suggestions, including suggested pro forma.

1 STATEMENT OF INTENT

It is recognised that NHS staff are among those most likely to face violence and abuse at work. There is a strong public interest in prosecuting those who assault NHS staff deliberately, or those who commit offences that disrupt the provision of NHS services to the public. All parties to this Agreement will encourage individual Police services, Crown Prosecution Service areas and NHS bodies to seek the strongest possible action in appropriate cases.

This MoU also incorporates good practice to support joint working between the partners in Wales and to provide a basis for local agreements. While the parties to the agreement cannot enforce measures locally, they will endeavour to promote, encourage and support local agreements and the implementation of the good practice set out in this agreement.

2 PARTIES TO THE AGREEMENT

Association of Chief Police Officers CYMRU/Wales (hereafter, ACPO CYMRU/Wales)

Taken from its Statement of Purpose, ACPO is an independent, professionally-led strategic body. In the public interest, and, in partnership with government and the Association of Police authorities, ACPO leads and coordinates the direction and the development of the Police service in England, Wales and Northern Ireland.

Crown Prosecution Service (hereafter, the CPS)

The CPS, including the RCPO, is the principal public prosecution service for England and Wales. Although the prosecution service works closely with the Police and other investigators, it is independent of them. Casework decisions are taken fairly and with integrity to help deliver justice for victims, witnesses, defendants and the public.

NHS Health Boards and Trusts (hereafter NHS Wales)

NHS Wales comprises ten health bodies: seven health boards which provide health and healthcare services across defined geographical areas across Wales. There are three NHS Trusts which provide all-Wales services, including public health and ambulance services.

3 IMPLEMENTATION & REVIEW

Supporting this Agreement on a day to day basis is a group of senior representatives drawn from the above parties. This Tri-Partite Group is responsible for the implementation and monitoring of the MoU and its ongoing development. It will also oversee a review of the MoU in 2015. Details of the Tri-Partite Group are at Annex A.

Specifically in terms of variations and amendment, the MoU can be amended at any time by the Parties to the MoU if the relevant parties agree. Any amendments should be agreed in writing by the Parties and must be consistent with the nationally agreed protocols and standards.

Implementation

While national agreement between the parties is a pre-requisite, it is recognised that its benefits will be realised if the parties prioritise implementation at the local level. Each party agrees to ensure that effective communication arrangements will be in place to raise awareness of the MoU at the operational level, thereby bringing it to the attention of all relevant staff.

Commencement

This agreement will take effect on 1 March 2013.

4 EFFECTIVE COMMUNICATION

Effective communication is pivotal to the success of this Agreement and the parties recognise that this is essential in order to:

- improve the protection of NHS staff;
- strengthen the investigation and prosecution process, by improving the quality and timeliness of shared information;
- improve victim and witness care; and to
- raise the public's awareness of the issues of violence and aggression as well as the action that will be taken by all parties.

The parties agree that, where possible and practical, single points of contact (SPOC) will be identified and that to be effective, SPOCs may be needed at the strategic and operational levels.

Single Points of Contact

NHS – SPOC

All health bodies in Wales have a board-level violence and aggression lead.

In addition, to support staff who have been victims of violent or aggressive incidents, all Health Boards and NHS Trusts have SPOCs at the operational level, namely: an identified Case Manager who provides support to the victim as well as guiding them through the criminal justice system if required. The Case Manager is the SPOC. (It is recognised that case management may be provided differently in the ten NHS organisations, for example some health bodies have more than one case manager who will also have other duties. Throughout this Agreement, the term case manager will be used to denote the person or persons who fulfil the role described above).

Police - SPOC

The relevant Chief Constable will ensure that a SPOC is designated at strategic and operational levels.

The names and contact details for the SPOC at each level will be made available to the parties and updated on a regular basis as required and at least on an annual basis.

CPS – SPOC

District Crown Prosecutors will act as SPOCs for the CPS at an operational level. Police and Case Managers should contact the District Crown Prosecutors for the relevant geographical area where the alleged criminal activity has taken place.

A secure web portal, accessible by the partners, will be the repository for these details and will be kept up to date (see page 30 for more details).

5 LIAISON

All parties are committed to encouraging regular, local liaison which is expected to:

- promote a consistent approach;
- encourage wider Police/CPS/NHS liaison;
- ensure effective contact and sharing of timely information in specific cases;
- provide an avenue for the development of mutual NHS, CPS and Police expertise and access to effective channels of information;
- enable Legal & Risk Services to be kept informed of developments in cases being investigated by the Police or prosecuted by the CPS;
- inform that development of of a national standard approach; and
- embed the concept of mutual support in tackling crime within the NHS.

Escalation

Where a violent or aggressive incident in the NHS occurs or is reported, it is expected that the NHS Case Manager will be the SPOC at the operational level for violent and other violence and aggression crime matters at a health body. If a matter cannot be resolved, with the health body concerned, the NHS board level lead for violence and aggression should be contacted.

For non operational matters, the Legal & Risk Services of the NHS Wales Shared Services Partnership and/or the NHS body's Lead Director for violence and aggression will act as a liaison point for contact with the Police and the CPS.

Established Networks

Between 2009-12 the Welsh Government undertook a programme to address violence and aggression against NHS staff and the parties to this MoU were active participants. Three important networks arose from that work and it has been agreed that they should continue to add value, as follows:

Tri-partite Group – a group of senior managers from the NHS, CPS and Police has been instrumental in building relationships across the partners and steering the on-going development of joint working and training (see Annex A).

All Wales NHS Case Managers Network – SPOCs from the Police, CPS and the NHS are invited to attend these meetings which occur on a bi-monthly basis and include dedicated learning events.

All Wales NHS Security Managers' Group – share information on crime and crime reporting where it relates to the NHS. Joint training events with the Case Managers to share learning.

All Wales Violence & Aggression Advisory Group – was established in 2001 as a sub group of the Health and Safety Advisors' Forum. Its objective is to develop policies and procedures to enable NHS employers to identify and manage the risk of violence and aggression against staff working across the NHS.

Contact details for the above groups are available on:

www.WalesViolenceandAggression.com



6. INCIDENT REPORTING

The Case Manager will aim to ensure that all incidents involving violence and aggression against NHS Staff are reported to the Police.

NHS staff will report violent and aggressive crime to the Police in line with local policy and national guidance, ensuring that incidents are reported if staff have been unable to do so at the time of the incident.

Alongside internal processes within each health body, the NHS bodies, via the Case Manager, are obliged to report to the Police all incidents of physical assault against staff (i.e. where physical contact is made with the victim). An exception is where the offending behaviour is caused directly by a person's physical or mental health condition, or learning disability, or an adverse reaction to prescribed medication or treatment. These types of incidents are non-intentional or non-gratuitous violence.

Incidents requiring an emergency response should be reported via the 999 service. The Case Manager (or named appropriate person) and Police should identify and agree a suitable route for reporting non-urgent incidents. The Case Managers should ensure that there are instructions for staff on when staff should seek an emergency response from the Police and when non-emergency reporting will be appropriate. The Police should assist by providing relevant contact details and other information.

Police Grading of Responses

Police services will grade reported incidents on a case by case basis, dependent on information provided by the caller.

The Case Manager or nominated appropriate person will ensure that, where there is an assault upon a member of NHS staff, the Police are able to take a victim's complaint statement within 24 hours. The staff member will also be encouraged to make a Victim Personal Statement (VPS) to indicate, if appropriate, the impact on them and their colleagues. If this is not achievable, the Case Manager will liaise with Police for the VPS statement to be taken as soon as possible.

The Police divisional SPOC and/or Investigating Officer will take responsibility to notify the NHS Board level lead or the Case Manager of the progress and outcome of all investigations involving the NHS.

Incident Reporting – people with mental disorder and/or learning disability

All cases should be reported to the Police except where, having consulted with relevant staff and obtained clinical advice, it has been concluded that the assault was not intentional and the patient did not know what s/he was doing; or did not know what s/he was doing was wrong owing to the nature of his medical illness, mental ill health or learning disability or the medication administered to treat such a condition.

Whether or not the behaviour is referred to the Police, there is an obligation to report internally.

In cases reported to the Police by staff working in mental health/learning disability settings, there is likely to have been an initial assessment about whether the offending was caused directly by the person's condition. Any Police and CPS response should take account of this initial assessment. The response should also take into account information obtained about the capacity of the alleged offender.

NHS Case Managers, relevant clinicians, the CPS and the Police should seek agreement on the information required to enable prompt investigation and charging of people with a mental disorder and/or learning disability where appropriate. Details of the type of information which may be required can be found in the CPS legal guidance on Mentally Disordered Offenders.²

In order to progress cases effectively, information should be provided to the Police as quickly as possible. The police are responsible for obtaining statements and recommended best practice is for key statements to be available within 2 working days. Where the suspects are in custody, key statements should be available within 6 hours to enable them to be bailed where appropriate.

An example of a form for providing information relating to people with mental disorder and/or learning disability is provided in **Annex C**. All involved must agree the content and use of such forms and be aware that they may be disclosed to the defence as part of the disclosure of unused material process.

Such forms are intended only for making initial decisions on investigations/charging/diversion. Should the matter progress to prosecution, they will not replace the need for witness statements, psychiatric or medical reports.

While a number of cases involving people with mental disorder and/or learning disability will relate to incidents where the assailant has the necessary mental capacity to be held responsible for their actions, there will be some exceptions. Cases involving serious or repeated violence, where the offending behaviour is directly caused by a mental disorder and/or learning disability, may be reported. This will usually occur where it is felt that intervention by the criminal justice system should be considered to protect NHS staff and/or the wider public.

In other cases where the assailant lacks capacity and the victim has suffered serious injury, a report to the Police may be required in order to seek compensation from the Criminal Injuries Compensation Scheme.

If NHS staff report incidents where the assailant lacked capacity at the time of the incident, this should be clearly stated along with the reason for reporting.

² The CPS guidance on Mentally Disordered Offenders can be found on their website at - http://www.cps.gov.uk/legal/l_to_o/mentally_disordered_offenders/



7. POLICE RESPONSE

Lone workers, community staff and ambulance crews

NHS staff often provide care in a patient's home or in public places where support from colleagues may not be available. This will be taken into account when deciding on the response required.

Health bodies take measures to prevent risks to lone workers and many NHS staff who work alone or in the community, have a lone worker protection device which can assist in locating the user and can make audio recordings of incidents. (Many NHS lone worker devices are monitored by operators at a category 2 alarm receiving centre who will listen in to the incident, assess the situation, and summon the emergency services if required).

NHS Case Managers will ensure that local Police are aware of any lone worker device services in operation in their area and how the response to lone worker services is managed. Both the Police and CPS should be familiar with the potential additional evidence that such services can provide.

Incidents in mental health/learning disability units

It should be emphasised that the majority of people receiving treatment from mental health or learning disability services are not violent or abusive. Many are there on a voluntary basis – they are not detained formally under mental health legislation. They, and all the staff who provide services for them, should be able to receive and provide services in a therapeutic and non-threatening environment.

The National Policing Improvement Agency's guidance *Responding to people with mental ill health or learning disabilities* states that 'the basic elements of the criminal justice response (for example, arrest caution, detention, legal rights and interviewing) are the same whether or not a suspect has mental ill health or learning disabilities'.

Unless there is clear and reliable information stating that offending behaviour has been caused directly by a mental disorder and /or learning disability, the Police should respond and investigate in the same way as they would had the incident taken place elsewhere.

Arrests on NHS premises

The decision to arrest is a matter for the Police officers in attendance. It will be informed by any medical considerations and NHS staff should be prepared to disclose this information upon request. This will include any known risks that an arrested person may pose to the Police and must disclose any information relating to the person's health that the Police may require in order to discharge their duty of care to those involved. It is the responsibility of the NHS to ensure that staff are aware of their

responsibilities and the policy framework regarding the disclosure of information. Section 14 of this MoU provides guidance in this respect.

It is the responsibility of the Police to investigate criminal activity within the community. However, the Case Manager should give the appropriate support to the Police during investigations in an NHS healthcare setting.

If an investigation requires the seizure of NHS property or the need to restrict the non-use of an area of NHS premises, liaison must take place between the NHS Lead Director for violence and aggression and the senior investigating officer to ensure that evidence is protected and preserved wherever possible. If incidents occur out of hours, the Security Management Director/Case Manager should ensure that appropriate staff have been nominated to decide on these matters and that all such persons are made aware of each other's responsibilities.

8. INVESTIGATION

NHS assistance for investigations

The Case Manager should identify the staff in charge of each unit within their health body and provide them with basic information on collecting information and preventing disturbance to scenes of crime.

Where possible, and where safety or patient care will not be compromised, other staff may be able to assist with collecting information for the Police. The Police and Case Manager will issue guidance, this may include:

- a description of a suspect who has left the scene before the Police have arrived
- details of previous incidents and Police attendances involving the same individual(s)
- retention of any weapons used
- photographs or reports of injuries suffered
- seizure and preservation of CCTV footage
- initial information on mental disorder issues
- swabs of saliva in spitting and biting incidents.

The Case Manager will assist the Police by providing details of work patterns and work contact details, if direct communication is difficult owing to shift working. They may also act as a liaison point if the incident has resulted in sickness absence and the member of staff may not wish to be contacted at home by the Police.

Witness statements and evidence gathering

It is the role of the Police to interview witnesses, take statements and gather evidence.

Victim Personal Statement

The Police will obtain a victim personal statement with the consent of the victim. The prosecutor can then rely upon this statement when an offender is being sentenced to provide the court with a full and up-to-date picture of the impact of the offence on the victim. With the victim's consent, the Case Manager (or named appropriate person) can assist in taking this statement or providing updated statements of this sort.

'Official or business victims'

In cases where there is no individual victim (e.g. where criminal damage to property was resulted from an assault against NHS Staff) arrangements should be made for the Case Manager (or named appropriate person) to act as the single point of contact for the NHS body affected.

The Case Manager should obtain any impact statements from the 'business' and supply them to the Police.

Community Impact Statements

Case Managers will ensure that a 'community impact statement' is prepared and make this available to the Police at the earliest possible opportunity in all investigations. This statement provides details of the impact that such incidents have had on the hospital, staff and patient care and can refer to past incidents. It is intended to assist the Police in making decisions on disposals by highlighting the effect that the particular type of offending behaviour has on the NHS body involved.

If a particular incident has had a significant effect on the health body or on the provision of NHS services, consideration should be given to obtaining a statement containing similar information to that outlined above, but with details that reflect the impact of the incident. Such statements will not be required in all cases.

These statements may also assist the CPS decision on appropriate disposal and the court in determining the correct sentence for offences by putting such behaviour in context. The content will depend on the nature of the service provided by the NHS body (e.g. general hospital, ambulance, mental health, community-based) and the following information might be useful:

- details of the impact of such incidents on the provision of service
- the number of assaults (physical and non-physical) in the last year for which statistics are available, both for the body concerned and nationally
- the number of days of sick leave taken by staff who have been subject to violent or abusive behaviour
- the cost of sickness absence leave and replacement staff
- if possible, the cost of security staff and equipment to prevent/respond to such incidents
- the impact on staff and patients (or other visitors)
- details of impact on patient waiting times (or rescheduling of appointments)
- details of loss of emergency ambulance or other emergency service.

Bail conditions

When investigating incidents on NHS premises, the Police will ascertain whether there is any information to suggest that a suspect may pose an ongoing threat to NHS staff or services. In such cases, consideration should be given to imposing bail conditions. Consultation will be required to ensure that such conditions offer protection; while not denying the suspect access to NHS services. NHS staff should also make it clear if they feel that this is the case.

It is important that all parties are made aware of any bail conditions; should a suspect be brought to court, the court is asked to consider imposing similar conditions where appropriate. See Annex E for generic conditions to prevent inappropriate or unnecessary attendance on NHS premises during an investigation.

9. DECISION ON PROSECUTION

The parties agree that the Police will undertake to investigate and refer cases to the CPS where there is sufficient evidence to support a prosecution

Such cases would be where:

- violence has been used against NHS staff;
- NHS staff have suffered injury;
- there has been serious disorder on NHS premises;
- there has been an inability to provide a service
- an emergency ambulance crew/vehicle or emergency care location has been taken out of service;

It is important that, when dealing with cases involving NHS staff, premises or property, officers have regard to any particular aggravating factors (see next page).

Decision to prosecute

It is the duty of prosecutors to review, advise on and prosecute cases and ensure that the law is properly applied in accordance with the principles set out in the Code for Crown Prosecutors. A prosecution can only start or continue when the case has passed both stages of the Full Code Test. Prosecutors make charging decisions in accordance with this code and the Director of Public Prosecutions Guidance on Charging. The Full Code Test will be applied wherever possible, other than in limited circumstances where the narrower threshold test applies.³

Full Code Test

The full code test has two stages; the first being consideration of the evidence. A case which does not pass the evidential stage must not proceed, no matter how serious or sensitive it may be. If the case passes the evidential test, prosecutors must go on to a second stage: to consider whether a prosecution is required in the public interest.

First stage – the evidential stage

Prosecutors must be satisfied that there is sufficient evidence to provide a realistic prospect of conviction against each suspect on each charge. This means that an objective, impartial and reasonable jury, a bench of magistrates or a judge hearing the case alone and acting in accordance with the law, is more likely than not to convict the defendant of the charge alleged.

³ The parties are aware of the changing responsibilities for charging as set out in The Director of Public Prosecutions (DPP)'s Guidance on Charging 4th Edition (Revised Arrangements) (January 2011)

Second stage – the public interest stage

If the case passes the evidential stage, prosecutors must decide whether a prosecution is in the public interest. Usually a prosecution will follow unless the prosecutor is sure that there are public interest factors against prosecution which clearly outweigh those in favour. The prosecutor may be satisfied that the public interest may be properly served, in the first instance, by offering the offender the opportunity to have the matter dealt with by an out-of-court disposal. An example of an out-of-court disposal is included in Section 11.

This agreement does not remove the need for each case to be considered on its own merits or restrict the discretion to prosecute the most appropriate offence depending on the facts of the case.⁴

Aggravating factors in offences involving NHS staff or on NHS premises

In all cases, the fact that an offence has been committed against a person serving the public will be considered an aggravating factor. There is a strong public interest in maintaining the effective provision of healthcare services and the CPS should always consider whether the individual incident has further aggravating features that may influence a decision on disposal.

Examples of particular aggravating factors would include:

- withdrawal from service of an emergency ambulance and the potential for harm this may cause to those in urgent need of this service;
- withdrawal of staff from active duty in accident and emergency units and the resultant reduction in service;
- vulnerability of staff working in the community, particularly those who work alone or in isolated locations; or the
- potential impact on vulnerable patients and the effects that being exposed to such behaviour may have on them.

Consideration should also be given to the high levels of violence and unacceptable behaviour against NHS staff and the following factors from the Code for Crown Prosecutors may be applicable:

- there are grounds for believing that the offence is likely to be continued or repeated – for example, by a history of recurring conduct;
- the offence, although not serious in itself, is widespread in the area where it was committed;
- a prosecution would have a significant positive impact on maintaining community confidence; or
- the offence involved the use of a weapon or a threat of violence.

In this context, 'community' should also be taken to mean the staff and patients of a hospital, particularly where patients spend lengthy periods there, e.g. mental health,

⁴ Paragraph 4.12 of the Revised Code for Crown Prosecutors (January 2013) provides details of the questions to be asked by Crown Prosecutors in considering the public interest
<http://www.cps.gov.uk/publications/docs/code2013english.pdf>

elderly care. It is wrong to assume that, owing to the nature of their employment, NHS staff are not 'members of the public' or part of the community.

Prosecution of people with mental disorder and/or learning disability

Many reported acts of violence, abuse and threats of violence against NHS staff are committed by those who may be suffering from a mental disorder. 'Mental disorder' is defined in the Mental Health Act 1983 (as amended by the 2007 Act) as 'any disorder or disability of the mind'. Within the Act people with learning disability are not considered to be suffering from a mental disorder unless the disability is 'associated with abnormally aggressive or seriously irresponsible conduct'.

The CPS, where necessary, applies Home Office guidelines on how to deal with mentally disordered offenders and follows the Code for Crown Prosecutors and the CPS Legal Guidance on Mentally Disordered Offenders.

While this Agreement is concerned primarily with deliberate incidents of violence, incidents where the behaviour was directly caused by a mental disorder or learning disability should receive similar consideration, and prosecution should take place where the evidence and public interest supports this.

Mental disorder and/or learning disability is not an automatic bar to prosecution. It should be emphasised that a diagnosis of mental disorder and/or learning disability, or the fact that a suspect is detained under the Mental Health Act, does not mean that the person lacks *mens rea* – the necessary intention to commit a crime - or that the Full Code Test may not be met.

The Code for Crown Prosecutors provides important guidance when applying the public interest test in cases involving a mentally disordered offender. There is a factor against prosecution if a defendant, *at the time of the offence*, was suffering from significant mental or physical ill health and/or learning disability unless the offence is serious, and/or there is a real possibility that it may be repeated, or there is need to protect staff or the wider public. This factor also obliges prosecutors to 'balance a suspect's mental or physical ill health with the need to safeguard the public or those providing care services to such persons'.

In addition to the CPS legal guidance on Mentally Disordered Offenders and the additional public interest factors set out therein, prosecutors should also consider whether a prosecution might help a defendant take responsibility for his or her actions. In the Mental Health Act Commission's report *In Place of Fear* (2005; p 4.141), it stated that that:

'it may also be the case that excusing offending may not be in the patient's interests: the legal process itself may be useful for a patient's reality testing, and a presumption that prosecution of violent behaviour is routine rather than exceptional may help patients take responsibility for their behaviour and instil a sense of justice amongst patients and staff. In cases of serious allegations, where the allegation may colour future care planning or even instigate a move to higher security care, the criminal justice system provides an opportunity for justice for the accused offender, including testing of the allegation and culpability for the actions constituting the alleged offence'.

The views of the alleged offender's responsible clinician must be sought and considered. If treatment is likely to be an important factor in the decision to prosecute, the relevant NHS body should be contacted, through the Case Manager and asked to provide current information along with any opinion they feel appropriate.

The existence and treatment of a mental disorder is only one of the factors to be taken into account when deciding whether the public interest requires a prosecution. Importantly, the views of the victim and the offender's responsible clinician at the health body must also be considered.

It is important to understand that the decision to prosecute must be determined on the relevant public interest factors, once the test for evidential sufficiency has been met. The perceived need for the treatment and management of a mental disorder and/or learning disability will not be the sole reason for not pursuing a prosecution.

To review a case involving a suspect with mental disorder and/or learning disability properly, the CPS will need information and evidence regarding the mental disorder/learning disability at the earliest opportunity.

A prompt response will be required and the Case Manager should help the Police and CPS in obtaining the relevant information which includes (but is not limited to):

- medical reports from the appropriate clinician or responsible medical officers to explain the nature and degree of the disorder/disability and the treatment and behaviour of the patient;
- any other relevant information from other hospital staff about the treatment and behaviour of the patient, including the treatment regime, history of similar and recent violent or otherwise offending behaviour;
- information about an offender's status in hospital – whether voluntary or detained under section 2 or section 3 (civil procedures) or under section 37 (Court Hospital Order) and whether there is a restriction order under section 41 attached to the section 37 order, or whether s37/41 orders should be sought;
- if the Police or Social Services have used their powers under sections 135 or 136 Mental Health Act 1983;
- if the defendant is receiving supervised community treatment under a Community Treatment Order made under section 17A Mental Health Act 1983;
- if the offender has been admitted to hospital as an informal patient under section 131 Mental Health Act 1983 or if an order for guardianship under section 7 Mental Health Act 1983 has been made;
- evidence from a suitably qualified clinician about the offender's state of mind at the time of the incident, including whether the patient knew what he or she was doing, whether the patient knew that what he or she was doing was wrong and, if not, whether the lack of knowledge was attributable to his or her disorder/disability and/or any medication or other treatment for his or her disorder/disability;
- evidence regarding the person's fitness to plead.

The CPS should notify the Case Manager if there are problems in obtaining information relevant to the case. This will ensure that appropriate cases are progressed properly and prevent any arbitrary decisions being taken about a person's mental health or capacity, without the decision-maker obtaining full information.

It is not always the case that prosecutors are aware from the outset that a suspect has a mental disorder or learning disability. The information may come instead from defence representatives, court staff or any other person who has had dealings with the suspect. In many cases involving mentally disordered persons, there may be an urgent need for medical reports and other information to clarify the nature and degree of the mental disorder. These requests should be treated as a priority by the NHS.

When the Police or CPS do not prosecute

There will be cases where, for a variety of reasons, the Police or CPS decide not to proceed with a case, or where the victim or health body is unhappy with the response. In such circumstances, the Case Manager, in conjunction with Legal & Risk Services, may launch an investigation. This may result in the matter being submitted to the Police or CPS for a review of their original decision, or a prosecution by Legal & Risk Services.

Legal & Risk Services is part of the NHS Shared Services Partnership and can conduct criminal prosecutions in cases where NHS staff have been subjected to assaults and either the Police or the CPS have decided not to prosecute. In such cases Legal & Risk Services will need access to evidence held by the Police in order to make a properly informed decision on whether an NHS prosecution should take place.

Requests for disclosure of evidence and other information will be made in writing by Legal & Risk Services and will be addressed to the Police SPOC. This Agreement cannot pre-authorise disclosure and decisions will be made on a case by case basis.

The Police agree to deal with all requests promptly, acknowledging that the interests of justice require prosecutions to be brought as soon as possible after a crime has been committed. Requests will usually seek disclosure of the following information:

- the alleged assailant's personal details (i.e. name, date of birth and address (if not already known))
- witness statements
- officer's pocket book entries
- copy of the recording and transcript of any interview under caution
- any other relevant evidence
- charging decision documents

In some cases, particularly if there may be issues concerning the alleged assailant's mental or physical health, disclosure of the custody record may be appropriate.

Consent will normally be required from witnesses for disclosure of their witness statement. Responsibility for obtaining consent will rest with the relevant Police Service however the Case Manager may assist in obtaining consent from witnesses employed by the NHS.

Any information disclosed by the Police to Legal & Risk Services for potential criminal prosecutions will be used only for this purpose. Any disclosure to any party not connected with criminal proceedings will not be permitted.

If Legal & Risk Services are considering a prosecution, the CPS Crown Prosecutor should, when requested, consider providing a full explanation of their decision not to prosecute, or of why the offender was given an out of court disposal.

10. SENTENCING

Section 143(1) of the Criminal Justice Act 2003 provides: *'In considering the seriousness of any offence, the court must consider the offender's culpability in committing the offence and any harm which the offence caused, was intended to cause or might foreseeably have caused'*.

Sentencing guidelines for a particular offence will normally include a list of aggravating features, which, if present in an individual instance of the offence and relevant, should be taken into account.

The Sentencing Guideline Council issued guidance in December 2004: [Overarching Principles: Seriousness](#) advises that the fact that an offence was committed against those providing a service to the public is identified as a 'serious aggravating factor'. Other factors that have been identified in this guidance that may be relevant in this context are evidence of offenders acting as part of a group or a gang, and any evidence of planning or pre-meditation. If any of these factors are present in a particular case, this must be drawn to the attention of the court.

Among the factors indicating higher culpability is the commission of an offence while under the influence of alcohol or drugs. Among the factors indicating a more serious than usual degree of harm, is the fact that an offence is committed against those working in the public sector or providing a service to the public. Both of these may be relevant when determining the appropriate sentence for offences against NHS staff.

Prosecutors also have a duty to draw the court's attention to the impact of the offending behaviour on a community.

Previously the Court of Appeal has upheld lengthy custodial sentences for assaults on NHS Staff, for example:

- **R v McNally** [2000] 1 Cr. App. R (S) 533 – the appellant was attending a hospital with his son when he became involved in an argument with a doctor and assaulted him with one punch. He had no previous convictions and was charged with 'ABH'. The Court of Appeal held that 6 months imprisonment was the appropriate sentence, and reiterated that such circumstances seriously aggravated the offence.
- **R V Eastwood** [2002] 2 Cr. App. R. (S) 72 (at 318) – the appellant was drunk and in A&E when he assaulted a nurse during the course of an X-ray. The nurse suffered torn ligaments in her hand, and he was charged with 'ABH'. The Court found that in such circumstances, the starting point after trial was between 21 - 24 months imprisonment with a sentence of 15 months imprisonment suitable after a guilty plea.

Compensation

When the victim has been injured or has suffered financially, or the relevant NHS body has suffered financial loss or damage, the CPS will:

- ensure that the information provided by the Police on compensation claims is sufficient for the court to make a compensation order if it wishes
- remind the court of its power to award compensation in cases where there is no financial loss (e.g. personal injuries sustained)
- remind the court that it must give reasons if a compensation order is not made if the case is one in which an order may have been possible.

Anti-Social Behaviour Orders (ASBOs)

When reviewing a case involving an NHS staff member who has been assaulted, threatened or abused, prosecutors should always consider whether it may be appropriate to apply for an ASBO on conviction. The Case Manager should ensure that any request for consideration of an ASBO on conviction is passed to the CPS as soon as possible in the case. The Case Manager may assist in the collection of supporting evidence.

ASBOs are not suitable as disposals for violent behaviour.

There is no qualification in terms of the type of offence, but two tests must be satisfied:

- the individual has committed an act of antisocial behaviour; and
- an order is necessary to protect members of NHS staff or the wider public.

A number of different public bodies may apply for ASBOs, in addition to the CPS prosecutor's power to apply for an ASBO on conviction. It is advisable that the Case Manager will consult with relevant agencies in the area before an ASBO application is forwarded to the CPS to ensure that there is a coordinated approach to applications and that all relevant evidence is put forward with the application.

In cases where the CPS applies for a post-conviction ASBO, it is important that appropriate evidence is obtained at the earliest opportunity. The defence must be served with a copy of the papers and notified that an application is pending. Appropriate evidence will include:

- statements from witnesses to the incident
- CCTV imagery
- medical records
- impact of the behaviour on those NHS staff who were subjected to it
- impact of the behaviour on NHS service provision
- incident reports or other evidence of previous antisocial behaviour
- information on any steps taken by the NHS to address the behaviour (e.g. warning letters, exclusion from premises notifications, behaviour agreements, additional security measures, etc)
- location maps of premises where attendance is prohibited or restricted, including details of specific entry/exit points.

It is important that the Case Manager works closely with the Police and CPS to assist their drafting of appropriate conditions to be attached to the ASBO. The full extent of the antisocial behaviour must be covered in draft orders e.g. harassment, phone calls, threatening behaviour. An example of generic conditions is provided in Annex E.

Special consideration should be given to seeking ASBOs and other restrictive orders for offenders who have mental health conditions or learning disabilities. Advice should be sought from staff caring for such individuals when drafting conditions to ensure that they can be understood and that any medical condition will not result in non-compliance with the order.

After a post-conviction order has been served on a defendant, it will be recorded on the Police national computer and Police national database. The relevant Case Manager (or named appropriate person) should be provided with a copy of the order so that they can circulate this information to the relevant health body. Where any conditions that relate to the NHS have a regional or national application, consideration should be given to providing Legal & Risk Services with a copy, where it is felt that wider distribution may assist in enforcement.

Where appropriate, the Police may provide photographs for distribution to relevant NHS staff to assist in identification of persons subject to ASBOs.

Publicity of the order within the NHS will be a matter for the health body. *The Home Office Guide to Anti-Social Behaviour Orders (2006)* provides guidelines on the handling and appropriateness of publicity and these should be followed.

Breaches and modifying conditions of ASBOs

In the event of a breach of an ASBO, the Case Manager will assist in providing evidence to the Police about the behaviour that caused the breach. It will be referred to the CPS for consideration of charge.

If the subject behaves inappropriately and in such a way as to breach the conditions of the order, the Case Manager (or named appropriate person) should raise this with the CPS/Police, in order for consideration to be given to a review of the ASBO conditions.

If circumstances change and there is a need to discharge the ASBO, the CPS will apply to the court, if there is evidence to support the application, it is appropriate to do so and all the parties have been consulted and have consented.

Any proceedings in relation to breach of the order, variations of the conditions or discharge of the order will be notified to the Case Manager by the CPS officer with conduct of the matter.

Other orders available to restrict and protect

In some cases, because of either the particular nature of the offending or a focus on a particular individual or organisation, an ASBO will not be appropriate. In such cases, consideration should be given to reminding the court of other avenues available to restrict the offender's future conduct and offer protection to victims.

There is a wide range of ancillary orders and other types of order that can be used by both prosecutors and investigators at different stages of the investigation or prosecution process. The *CPS Ancillary Orders Toolkit* for prosecutors sets out all orders available to address harm caused by offenders and includes information on when and how to use the orders, including:

Criminal Justice Act 2003
Section 203 Prohibited Activity Requirement
Section 205 Exclusion Requirement

Protection from Harassment Act 1997
Section 5 Restraining Order

These orders are now available in appropriate cases upon conviction for any offence and not only for offences under the Protection from Harassment Act 1997. As with ASBOs, details of the conditions of any community order or restraining order should be provided to the Case Manager in order that relevant staff can be notified and so assist in identifying any breaches. Any proceedings resulting from breaches or variation/discharge of such orders should also be relayed to the Case Manager.

11. OUT OF COURT DISPOSALS

It is recognised that the decision to use an out of court disposal is ultimately an operational decision for the Police to take (for some disposals it is the CPS).

Simple cautions and conditional cautions

Offenders should not be considered eligible for a simple caution at the scene of the incident. A simple caution should not be given for any violent offence other than in exceptional circumstances.

The Police will not caution without obtaining the views of the victim(s) and/or the Case Manager as appropriate.

Conditional cautions should be considered where there might be a need to prevent further contact with a victim or attendance on NHS premises. Conditional cautions with a financial condition (i.e. compensation or a financial penalty⁵) may also be suitable for cases where imprisonment or a community sentence may not be available. Advice on suitable conditions that would achieve this purpose, while still allowing access to essential healthcare, can be provided by the Case Manager.

Penalty notice for disorder

Normally a penalty notice disorder should not be issued if NHS staff have been assaulted or threatened with violence.

Out of court disposals for offenders with mental disorder and/or learning disability

When considering the public interest in relation to disposal of a case, the question of the severity, or otherwise, of the possible sentence may be taken into account. The fact that a sentence of imprisonment or community sentence may not be available to the courts for detained patients should not prevent prosecution.

⁵ N.B. Financial penalty conditions form conditional cautions may not yet be available in some areas

In such cases, consideration should be given to the fact that a financial penalty (fine, compensation or similar conditions on a conditional caution) may be viewed as more severe to in-patients than to the majority of offenders.

It should also be considered that a prosecution would enable the court to use its powers, under mental health legislation, to enhance the safety of NHS staff and the public (e.g. by imposing a hospital or restriction order), although cases should not be prosecuted solely for this purpose.

Views of Victim

In all cases of assault or violence against the person, before an out of court disposal is administered, the Police will seek the views of the victim(s). The Police will explain the consequences of the disposal, for example, where a particular disposal may prevent the victim, or Legal & Risk Services, from pursuing a criminal prosecution.

Legal & Risk Services is authorised to prosecute cases of assault on NHS staff where the Police or CPS have decided not to prosecute. Where the victim or the Case Manager indicates that they wish to seek advice from Legal & Risk Services in relation to this, consideration should be given to allowing time for this to take place before a final decision is made.

It is expected that out of court disposals will only be used in exceptional circumstances for such cases.

12. UPDATES TO NHS CASE MANAGER ON PROGRESS

The parties agree that the Case Manager has a legitimate need to access this information and that they will encourage Police Services and CPS areas to provide it.

The parties agree that the relevant Police service will provide the following information to the Case Manager:

- details of any person arrested (i.e. name, date of birth and address)
- details of any bail conditions imposed which relate to the protection of NHS victims or witnesses or restrictions on attending NHS premises
- details of any out of court disposal imposed or cases where no further action is to be taken
- details where any person is charged or summonsed
- details of the initial court hearing.

Once a suspect has been charged, information on the progress of a case will be sought from the Witness Care Unit (WCU). The WCU will provide the following information to the Case Manager:

- outcome of the first court hearing and what will happen next
- if applicable the date of the trial, the location and the details of NHS witnesses required to attend to give oral evidence
- outcome of court hearings
- final result and sentence if appropriate

- details of sentence, financial orders and any conviction ancillary orders
- details of any appeals

The NHS Bodies, the CPS and the Police will agree procedures for sharing information on cases. All parties will ensure that all staff are aware of this process. Once agreement has been reached and relevant staff informed, it is expected that the provision of updates will be by telephone or secure email.

13. VICTIM/ WITNESS SUPPORT

Victim/witness communication

The Police and CPS are bound by guidance and codes of practice on communications with victims and witnesses. It is recognised that communication can be disrupted by operational requirements of services (e.g. shift working, emergencies). NHS Case Managers can assist by advising the Police about the availability of staff witnesses e.g. for statements.

If effective and timely communication proves problematic (and if the victim and witnesses have given written consent) the Case Manager may receive and pass on information about: the progress of a Police investigation; about CPS decisions on charging or prosecution, and about the consideration of non-court disposals.

The Case Manager has a role in monitoring investigations and prosecutions. Written consent will not be required for updating the Case Managers on the progress of the case; it is only required if the Case Manager takes on the responsibility for updating the victim of progress.

Case Managers, the CPS and the Police should agree what format any written consent should take. Where appropriate, the Case Manager will endeavour to obtain this consent form and provide it to the Police and the CPS at the earliest opportunity.

Suggested content for a consent form is at **Annex D**

If, after a suspect has been charged, the CPS takes a decision to alter or drop any charge the CPS will notify the victim; in serious cases, this may involve a meeting with the victim.

When a plea of guilty is offered to the CPS at court or otherwise, the prosecution will speak to the victim or victim's family to ensure that any views expressed are taken into account when considering the acceptability of the plea. This may require the prosecution to seek an adjournment.

Witness Care Units

Joint Police and CPS Witness Care Units (WCUs) are responsible for supporting victims and witnesses and keeping them informed about progress of their case. A Witness Care Officer will:

- discuss and agree with victims the level of contact/support they would like during the life of the case and these requirements will be met;

- explain to victims the purpose of the detailed needs assessment and give them the opportunity to complete one;
- contact victims and witnesses who have been identified as vulnerable or intimidated, or as having particular support needs, to discuss what support they may need.

In addition, the Witness Care Officer will inform all victims and witnesses required to attend court of:

- the trial date, the location of the court and discuss any concerns about attending court;
- any relevant changes to the defendant's custody status or bail conditions;
- the outcome of special measures applications that relate to them; and also
- if the case is discontinued.

At the end of the case, the Witness Care Officer will inform all victims and witnesses of the final result and the sentence if appropriate.

Victim care during progress of a case

The prosecutor will always address the specific needs of a victim or witness. Before every trial, prosecutors will consider whether it is absolutely necessary to require the attendance of a witness.

Where possible, the CPS will seek to agree evidence, although it is a matter for the defence whether they wish to agree any evidence or not. Ultimately, the success of a prosecution must not be jeopardised by the prosecutor dispensing with a witness's attendance for reasons of convenience.

The service of copied originals of the medical notes, which can be attached to the relevant statement, may avoid the need to call a member of NHS staff as a witness.

When NHS staff are required to attend court to give evidence and support a prosecution, the CPS will seek to minimise the impact by using standby arrangements. Where the distance from the hospital or place of employment to the court makes it a practical option, such arrangements will be offered.

The CPS will consult the court to determine whether agreement to the terms of the standby arrangements can be obtained and will inform the Police of the agreed arrangements. Full use should be made of pager/bleeps and mobile telephones.

Special Measures

Where a victim, who is to be called as a witness in criminal proceedings, has been identified as potentially vulnerable or intimidated, Special Measures may be applied for to assist them in giving evidence at court. These may include giving evidence behind a screen or via a TV link. The availability of Special Measures will depend on whether the witness is vulnerable or intimidated.

It is the role of investigators to establish at an early stage whether a witness is likely to qualify for a Special Measures Direction and, if so, which particular measures will

assist. The views of the victim will be important and will be considered carefully. The responsibility for considering the application for Special Measures rests with the CPS.

The WCU will ensure that any change of circumstances that may affect the victim's decision on Special Measures is communicated to that person and, likewise, communicate back to the Police and CPS any change of views/circumstances that the witness may have experienced. NHS Case Managers will help to identify when Special Measures need to be considered. However, it should be noted that such measures are rarely considered necessary and must be approved by the judge or magistrates.

Compensation on conviction orders

While such issues will ultimately be decided by the court, it is important that investigating officers consider them at an early stage and obtain the evidence to prove that the injury, loss or damage was caused by the offending behaviour.

Victims (including 'office or business victims') should always be asked if they wish to seek compensation.

If a prosecution does take place, the Police will consider whether there is a need to seek an antisocial behaviour order, a restraining order under the Protection from Harassment Act 1997, or similar conditions on a community order so that NHS staff can be protected from further offending behaviour. For a number of these orders, a Victim Personal Statement will be needed.

14. DATA PROTECTION AND CONFIDENTIALITY ISSUES

As the disclosure of information must comply with data protection principles and must be decided and justified on a case-by-case basis, the CPS, NHS Bodies or ACPO Cymru/Wales cannot 'pre-authorise' disclosure.

The Information Commissioner has identified that disclosures of relevant information to the Police in connection with assaults on staff would, in general, be in accordance with the Data Protection Act (see Information Commissioner's guidance "*The Use and Disclosure of Health Data*").

As with data protection issues, no blanket authority for disclosures that may breach a duty of confidentiality can be given by national bodies, as each disclosure will have to be considered individually. It is accepted that certain professions have to abide not only by national guidance but also by that of their regulatory or professional bodies.

It is acceptable to breach confidentiality if doing so can be justified as being in the public interest. Assaults on NHS staff affect not only those who are victims, but also those staff and patients who witness such violence and the wider public, whose access to services may be severely disrupted in some circumstances, with life threatening results.

It is the view of the parties to this agreement that disclosure of relevant information to those investigating or prosecuting such incidents is generally a legitimate breach of any duty of confidentiality.

Medical information must only be sought and disclosed if it is relevant to the investigation or prosecution of offending behaviour. Disclosure may be permitted with the victim's consent. Disclosure of identity information to the Police investigating an offence against NHS staff is not considered to be disclosure of confidential information.

In general, the parties agree that the disclosure of information in the scenarios considered in this document will be legitimate. Where disclosure is necessary and proportionate and may be obtained without the victim's consent for one or more of the following purposes:

- the prevention and detection of crime
- the apprehension and prosecution of offenders
- the early identification of cases which would be suitable for diversion from the criminal justice system
- the assessment of risk to inform action to protect the health and safety of NHS staff, patients, visitors, Police officers and other Police, CPS and court staff
- disclosures in connection with legal proceedings or seeking legal advice⁶

If the Police or CPS encounter difficulties in with accessing information because NHS staff have concerns about confidentiality or data protection, they should contact the Case Manager or Legal & Risk Services.

15. INFORMATION SHARING

There are existing avenues for the routine information sharing of intelligence, risk information and statistics, some of which will be on a statutory basis (e.g. Community Safety Partnerships, Local Safeguarding Children Boards).

The parties will examine where existing information sharing agreements may be deficient, particularly where they may not adequately address individual or urgent cases – for example:

- provision of information in relation to missing persons and absconded detained patients and response to incidents
- details of persons who may pose a particular risk to NHS staff or Police
- arrangements for the transfer of persons to and from NHS premises and Police stations or court premises.

WASPI – The Wales Accord on the Sharing of Personal Information

Where there is a regular exchange of information the parties will utilise the WASPI framework to create Information Sharing Protocols.

All parties will take a proactive approach to information sharing where they have identified a potential threat to the safety of staff, the public or specific individuals. The

⁶ Section 115 Crime and Disorder Act 1998

absence of agreements should never be a barrier to the timely sharing of risk information in specific cases.

Sharing and Spreading Good Practice Across Wales

A secure web portal has been developed for use by the partners as a repository for of key guidance and other useful materials. It will be monitored and developed by the Tripartite Group in conjunction with the NHS Case Manager (or named appropriate person)'s group.

It can be accessed only by staff of the Police, NHS in Wales and the CPS via: www.WalesViolenceandAggression.com



Continuous Improvement

It is the aim of the partners to improve how NHS staff are protected from violence and aggression. When an incident occurs, the partners will support the victim and deal with the alleged offender using the full extent of the law. These arrangements are recognised throughout Wales as the benchmark and is kept under regular review to seek improvements.

Timely Receipt of A&E Records for All Assaults

An important component is the Tri-Partite Group comprising senior officials from the NHS, CPS and the Police. This group will be responsible for oversight of this MoU including its implementation across Wales.

As part of its work on continuous improvement, the Tri-Partite Group has developed standards and processes to improve and expedite the availability clinical notes from Accident & Emergency Units to support timely and appropriate charging decisions in all cases of assault.

Since 1 April 2012, where an assault has taken place and the victim has attended the Accident & Emergency Unit, the A&E record will be provided to the Police (subject to consent) as follows:

- within 6 hours if the perpetrator was in custody
- within 48 hours if the perpetrator was on bail

NO FEES will be charged by the NHS.

Work is underway to streamline the transfer of the consent form and the A&E record using a secure web application.

16. MANAGEMENT & DEVELOPMENT OF THIS AGREEMENT

Dispute Resolution

Any disagreement will normally be resolved at local level. This is expected to be at the post-incident stage where an incident review will cover all the relevant issues. Where resolution is not possible locally, the matter can be referred to the Tripartite Group which will seek comments from the relevant parties and make recommendations on a way forward. Details of the Tripartite Group will be on the website.

Monitor and Review

The Tripartite Group will monitor annually the workings of this agreement with a view to improving the efficiency and effectiveness of local professional working arrangements.

Further copies of this MoU can be obtained from:

Catherine Thomas
Catherine.Thomas28@Wales.NHS.UK
01443 233333

Queries about the Agreement can be sent to:
Sally Attwood
Sally.Attwood@Wales.NHS.UK
01443 233333

17. SIGNATORIES TO THE AGREEMENT

The signatories agree to implement the provisions of this memorandum and any arrangements set out in the attached documents.

Mark Polin
Chief Constable North Wales Police
ACPO Cymru/Wales Lead on Violent Crime



Date:

Mr Ed Beltrami
Chief Crown Prosecutor
Crown Prosecution Service



Date:

Mary Burrows
Chief Executive, Betsi Cadwaladr University Health Board
(on behalf of NHS Wales)



Date:

Tri-Partite Membership

Sally Attwood, All Wales Violence and Aggression Co-ordinator, NLIAH
Leanne Coburn, External Communications and Events, Cardiff & Vale Health Board
Jeff Cooksley, Strategy and Operations, South Wales Police
Catrin Evans, Head of Complex Casework Unit, CPS
Andrew Hynes, Solicitor NWSSP Legal and Risk Services
Gaynor Kynaston, Solicitor NWSSP Legal and Risk Services
Sarah Lawton, Chief Inspector, Territorial Police, South Wales Police
Catherine Thomas, All Wales Violence and Aggression Support, NLIAH
Peter Welsh, Hospital General Manager, Cardiff and Vale University Hospital

All Wales Case Managers Group

Chair – Peter Welsh, Hospital General Manager, Cardiff and Vale University Health Board

All Wales Security Managers Group

Chair – Lee Garner Security Manager, Betsi Cadwaladr Health Board

All Wales Violence & Aggression Advisory Group

Chair - Frank Stagg, Health, Safety and Fire Advisor ABMu Health Board

Contact details are updated:

www.violenceandaggression.com

Nationally agreed protocols and standards

Code of Practice For Victims of Crime (October 2005)

Code for Crown Prosecutors (February 2010)

Director of Public Prosecutions Guidance on Charging 4th Edition (Revised Arrangements) (January 2011)

CPS Legal Guidance on Mentally Disordered Offenders

DPP's Guidance on Conditional Cautioning 6th Edition (January 2010)

DPP's Guidance on Youth Conditional Cautioning (pilot sites only) (January 2010)

Charging standards for relevant offences

CPS policy statements, including the statement on racially and religiously aggravated crime and homophobic crime (July 2003)

Crown Prosecution Service's Anti-Social Behaviour Guidance (August 2006)

Attorney General's Guidelines on the Acceptance of Pleas and the Prosecutor's Role in Sentencing 2009

CPS Public Policy Statement on the Delivery of Service to Victims (April 2010)

Farquharson guidelines on The Roles and Responsibilities of the Prosecution Advocate

Bar/CPS Standard for Communication between Victim and Witnesses and the Prosecution Advocate (February 2006)

NHS Confidentiality Code of Practice

Information Commissioner's guidance on The Use and Disclosure of Health Data

Responding to People with Mental Ill Health or Learning Disabilities (NPIA 2010)

The Welsh Accord on the Sharing of Personal Information (WASPI)

**Information forms for suspects with mental disorder and/or learning disability.
For completion by the Case Manager or appropriate person**

NHS incident reference no:

Alleged offence:

Victims name(s)

Date, location and time
of incident

Responsible Clinician Details

Name and contact no:

Designation:

SERVICE USER DETAILS

Name and date of birth:

Address if not in-
patient

Detained under MHA 1983?

Service user no:

Strictly Confidential – incident medical report

This form is for use by the Police/CPS in making initial investigation/prosecution decisions and is not intended to replace the need for witness statements and reports should the matter proceed to court.

SERVICE USER'S MENTAL STATE: please use your professional judgement and opinion to answer the questions below related to the service user above.

Would you consider the service user at the time of the alleged offence was capable of understanding his/her actions? Comment:	<table border="1"><tr><td>Yes</td><td>No</td></tr></table>	Yes	No
Yes	No		
Would you consider the service user at the time of the alleged offence was capable of controlling his/her actions? Comment:	<table border="1"><tr><td>Yes</td><td>No</td></tr></table>	Yes	No
Yes	No		
Would you consider the service user is capable of understanding the legal process is a prosecution is sought? Comment:	<table border="1"><tr><td>Yes</td><td>No</td></tr></table>	Yes	No
Yes	No		
Would you consider that a prosecution of the service user would be detrimental to his/her care plan? Comment:	<table border="1"><tr><td>Yes</td><td>No</td></tr></table>	Yes	No
Yes	No		

Signed:
Job title:

Print name:
Date:

Please ensure that this form is handed to the Police when they attend and that a copy is kept and passed to the Case Manager

Mentally Vulnerable Offenders
Police request for information from the health service

In order to make a full assessment of whether and individual accused of offending should be arrested, charge or diverted from the criminal justice system, the following information is sought by the Police where available from the NHS (or other healthcare provider):

[insert details of alleged offender and incident]

(Investigating/Custody Officers should delete, if appropriate to the investigation)

- a headline of the psychiatric condition, if known
- what is the RMO's/RC's opinion on prosecution Are there any clinical barriers to it
- an outline of the care management plan should a prosecution not occur
- any known previously unreported offending, relevant to the current investigation
- any previous history of absconding from psychiatric care
- any known failure to return from s17 MHA leave
- any known relevant failure to comply with care plans, including any medication programme
- is there any information concerning any intended criminal offending
- is there any information concerning any continued threats to the health and safety of any person
- what is the person's legal status under the Mental Health Act 1983

This information is requested in furtherance of a criminal investigation into an offence of[please state]. This information is directly relevant to whether or not criminal charges are brought and/or whether bail is appropriate; decisions which are required of [insert name of Police force] by the Police and Criminal Evidence Act 1984.

(any additional relevant information/reasons, including confirmation of why disclosure is required now)

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This information is sought in accordance with the Data Protection Act 1998. Section 29 permits disclosure for the purposes of the prevention and detection of crime and the apprehension and prosecution of offenders. Section 35 permits disclosure for the purpose of legal proceedings or obtaining legal advice. Disclosure may also be justified where the information is relevant to protecting the health and safety of all concerned.

No presumptions are made about whether it is in the public interest to prosecute offenders where sufficient evidence exists. Each case is considered on its merits, in light of the evidence and other information available at the time, to support a criminal charge.

Reference No. (custody/crime).....

Officer's signature.....

Further notes in support of the request (investigating/custody officer)

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Reference No. (Custody/crime):.....

Officer's signature:.....

Notes in response to above request:

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Signature:..... Time/date:.....
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Name:.....

Professional Position:.....

Explanatory Notes for Medical Staff:

1. These notes outline why the Police are requesting the information overleaf and how this information is relevant to the consideration of whether to arrest and/or prosecute a mentally vulnerable offender.
2. Whether or not a formal diagnosis has been reached is relevant to determining whether a prosecution occurs. If the CPS lawyer knows that a formal diagnosis has been reached, which may satisfy the criteria for various sections of Part III of the Mental Health Act 1983 then they may consider those Part III outcomes in considering the benefits of a prosecution. This may not be possible if the diagnosis was unclear.
3. The opinion of the Responsible Clinician (RC) is vital, not only because legal decisions to prosecute should include consideration of the impact of a prosecution on the offender's mental health, but also because it may be relevant to consider the RC's opinion on:
 - The context of the offence
 - Impact on the ward/hospital
 - Impact on other patients
 - Relevance of previous non-prosecution based attempts to manage behaviour
 - Relevance of any previous similar incidents
 - Any escalation in seriousness of behaviour
 - Whether or not the RC views the offending as related to or caused by the mental disorder or co-incidental to it
 - The presence of any clinical barrier to criminal prosecution; e.g. medication.

Any clinical barriers to prosecution are matters for the relevant psychiatrist (i.e. high levels of medication that would affect the ability to foresee consequences of actions or particularly acute psychotic states that would affect the ability to prove mens rea.)

4. A prosecution decision is the careful balancing of many potentially complex factors. This must by law, include consideration of whether it is in the public interest to prosecute. The public interest test is affected by the psychiatric management plan for that offender and any alternatives to prosecution that may be available at that time.
5. If an offender is being investigated now for assaulting staff having previously done so (whether or not reported/prosecuted), such information is *directly* relevant to the prosecution decision. If for example, it has occurred before it is easier to demonstrate that a prosecution is required to prevent further offending and risk to staff and patient.
6. Whether or not a patient is attempting to comply with their management plan and co-operating with professionals is relevant. If they are absenting themselves (repeatedly) from hospital, the confidence with which a non-formal sanction would be sought is diminished.
7. If someone is currently allowed periods of leave under s17 MHA and if that offender is returning on time and managing to look after their own welfare while on leave, it gives a clear indication that they have sufficient wherewithal to look after themselves – albeit for short periods of time or under supervision sufficiently to be able to think about the consequences of their actions and to assume a level of responsibility. This increases the likelihood that mens rea can be proved.
8. Information about care plan compliance is relevant to risk assessment decisions around prosecution and/or whether to grant bail or impose conditions on bail if charged. There is less benefit in diversionary management of offending if it is unlikely to be successful.
9. An ability to demonstrate the likelihood to further offending is relevant to risk assessment and bail decisions and would influence the likelihood of a prosecution. If threats were made towards

victims, witnesses or other professional staff in order to prevent the reporting or investigation of an offence, the Police custody officer may use that information to deny bail and achieve an earlier prosecution.

10. An ability to demonstrate that the staff and/or other patients within a psychiatric or other health facility are at risk without a prosecution would influence charge decisions as per point 8.

Victim Consent Form for disclosure of information

Annex D

Health Board / Trust/Police/CPS Logo and address

Victim/ Witness Consent Form for disclosure of information

Alleged Offender details (if known):

Date and time of Incident:

Location:

Police log and/or Crime Reference no.:

Officer details if known:

I, [insert name and date of birth of victim] am the victim/witness of the above incident. I give my consent for [insert name of Police service/CPS office] to provide information relating to the above incident directly to [insert details of the Case Manager (or named appropriate person) of health board/trust]. I also consent for the Police and/or CPS to provide updates on the progress of the case to [the Case Manager (or named appropriate person) if they are unable to contact me directly.

I have been made aware of the duties of the Police/CPS to provide information and I understand that by agreeing to this arrangement the Police/CPS will have fulfilled their duties to notify me of developments.

Signed:

Date:

I, [insert Case Manager (or named appropriate person) name] agree to receive information on behalf of the above and accept responsibility for passing this information on promptly.

Signed:

Date:

Date received and logged on Police record:

Officer signature:

It is ordered that the defendant:

1. be prohibited, without having first notified the relevant establishment of his true name, and that he is the subject of this order, from entering in person any premises or grounds, belonging to, or under the control of any NHS body, or any premises where NHS services are provided except in the following circumstances –
 - a) where he or a member of his immediate family require urgent or emergency medical treatment,
 - b) to attend himself, or to accompany a member of his immediate family, at a pre-arranged appointment,
 - c) to attend himself as an in-patient or to visit a member of his immediate family who is an in-patient,
 - d) to attend for non-medical purposes any meeting previously arranged in writing;
2. be prohibited from entering any part of the premises described in (1) above, which is not open to the public for the purposes of accessing NHS services, except by invitation;
3. must not refuse to comply with any instruction to remain in, or to remove himself from any area of the premises described in (1) above;
4. be prohibited from remaining on any premises (including its grounds) described in (1) above when asked to leave;
5. be prohibited from removing any object, article or other thing from the premises described in (1) above which he is not authorised to remove.

Glossary

Assault

The NHS reporting system uses two nationally agreed definitions for incidents of violent, threatening or abusive behaviour against staff. These do not directly replicate legal definitions used in describing specific offences and have been created solely in order to assist NHS staff in reporting incidents. They do not indicate any assessment of seriousness other than that physical contact has taken place. The definitions in most cases will reflect offending behaviour typical of the following offences:

- Common Assault
- Offences Against the Person Act 1861 (e.g. ABH, GBH etc.)
- Public Order Act 1986 (up to and including affray)
- Protection from Harassment Act 1997 (Sections 2 and 4)
- Nuisance and Disturbance Behaviour against NHS Staff (section 119 of the Criminal Justice and Immigration Act 2006)
- Emergency Workers (Obstruction) Act 2006 (obstructing or hindering an emergency worker)
- Drunk and Disorderly
- Malicious Communications Act 1988 and Communications Act 2003 offences.

Case Manager (or named appropriate person)

Each NHS body (as set out above) operates a case management service has a Case Manager (or named appropriate person) appointed to deal with violence and aggression at an operational level.

A list of these individuals will be made available on the web portal for violence and aggression.

Criminal Injuries Compensation Scheme

The Scheme began in 1996 with the enactment of the Criminal Injuries Compensation Act (1995). The concept of statutory compensation for criminal injuries reaches as far back as 1964. From that year until the establishment of the Criminal Injuries Compensation Authority (CICA), which is responsible for running the scheme that has been in place (with minor revisions) since 1996, the Criminal Injuries Compensation Board dealt with similar claims.

Legal & Risk Services (L&RS)

L&RS was formerly known as 'Welsh Health Legal Services'. In April 2011 it formally became part of the NHS Wales Shared Services Partnership which provides common services to support NHS Wales in delivering frontline healthcare.

L&RS is a unit of 27 solicitors providing a range of legal advice and representations exclusively to NHS Wales. L&RS has agreed to work with healthcare bodies, the Police and CPS in order to increase the number of prosecutions (that are legally robust) and to provide cost-effective advice on available sanctions against individuals who are violent or verbally abusive towards NHS staff and professionals. L&RS, with the permission of the

NHS body may lawfully pursue private criminal prosecutions. This power stems from directions issued by the Secretary of State under the NHS Act 1977.

NHS Board Level Lead for Violence and Aggression

NHS Wales is managed with different Health Boards and Trusts.

They are Abertawe Bro Morgannwg University Local Health Board, Betsi Cadwaladr University Local Health Board, Powys Teaching Local Health Board, Cardiff and Vale University Local Health Board, Hywel Dda Local Health Board, Cwm Taf Local Health Board, Aneurin Bevan Local Health Board, Velindre NHS Trust, Welsh Ambulance Services NHS Trust, Public Health Wales.

Each of these bodies has a designated lead for violence and aggression at Director level, who will oversee the management of violence and aggression in that organisation.

A list of these Lead Directors will be made available on the “web portal” for violence and aggression. www.WalesViolenceandAggression.com

NHS body

This means any Health Board, NHS Trust, NHS Foundation Trust, NHS Primary Care Trust, NHS Ambulance Trust, Strategic Health Authority or Special Health Authority in Wales.

NHS staff

NHS staff means any person employed by or engaged to provide services to an NHS body. Many staff included under this definition will not be directly employed by the NHS but contracted to provide NHS services such as General Practitioners and their surgery staff etc. The definition also includes those providing services to an NHS body on a voluntary basis.

This also includes the definition of “NHS staff” under the National Health Service Act 1977 as “any person who is employed by or engaged to provide services to an NHS body”.

Tripartite Group

The Tripartite Group consists of senior representatives from NHS Wales, Legal & Risk Services, the CPS in Wales and ACPO Cymru. It is a forum for overseeing the operation and revision of the MOU.

WASPI

The Wales Accord on the Sharing of Personal information - where there is a regular exchange of information the parties will utilise the WASPI framework to create Information Sharing Protocols