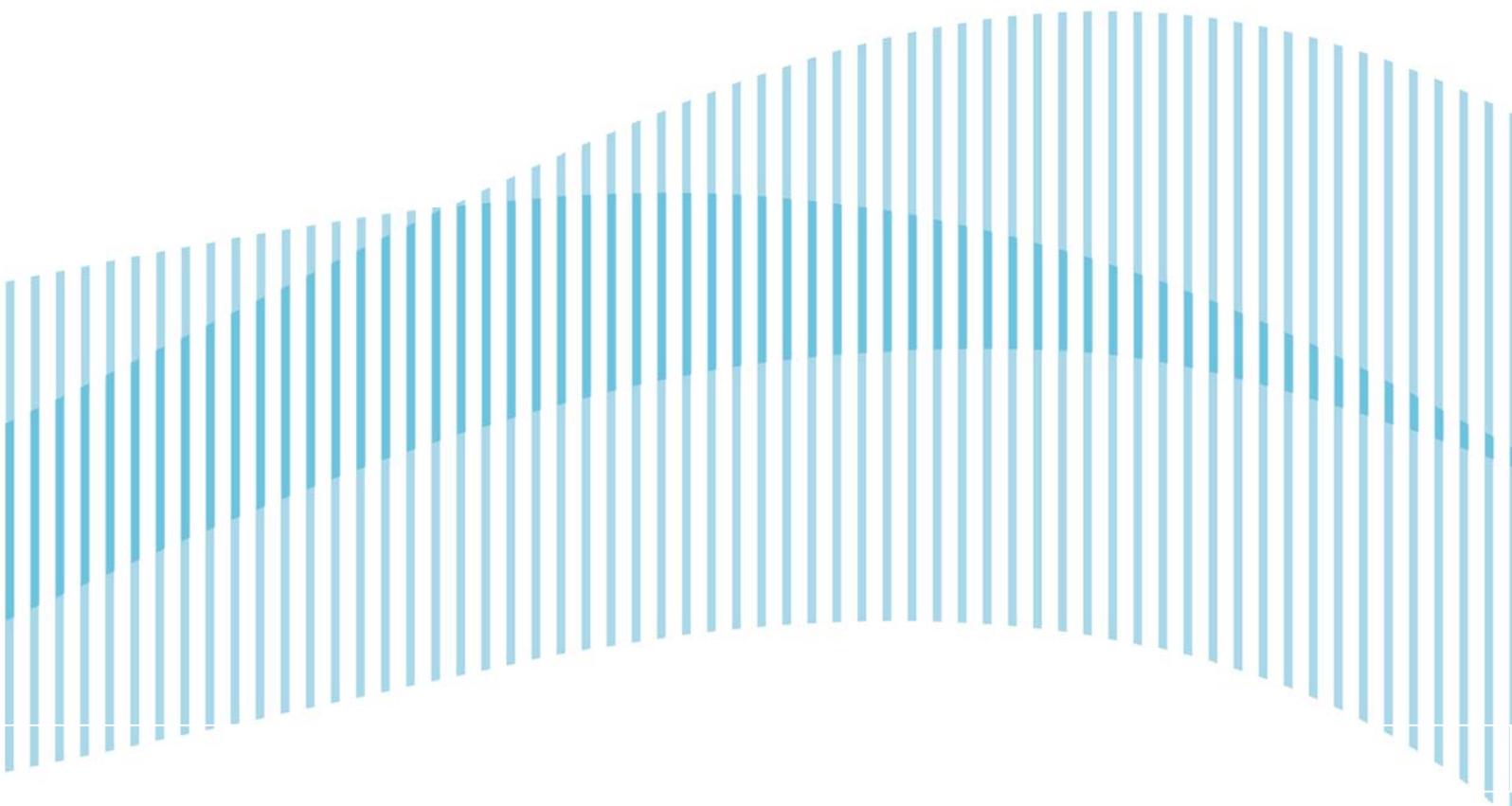




Protect

# Tackling violence and antisocial behaviour in the NHS

Joint Working Agreement between  
the Association of Chief Police Officers,  
the Crown Prosecution Service and  
NHS Protect



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# **Tackling violence and antisocial behaviour in the NHS: Joint Working Agreement between the Association of Chief Police Officers, the Crown Prosecution Service and NHS Protect**

## **Executive Summary**

The purpose of this agreement is to put in place a broad framework to assist local units of the three national organisations (the Association of Chief Police Officers, the Crown Prosecution Service and the NHS) in setting up closer working arrangements to reduce the problem of violence and anti social behaviour affecting the NHS. By setting out some areas where examples of best practice have been identified and agreed at a national level, it is hoped that local partners will have a starting point for dealing with topics requiring improved cooperation in their area.

The nature of the health service and the extensive range of locations where services are provided mean that NHS staff and premises are vulnerable to violence and anti social behaviour. These have implications not just for those directly involved, but for the public as a whole. Not only can incidents delay the provision of treatment, including life saving treatment, but they can also have a significant financial cost to health bodies, reducing the resources available for patient care.

While there are many examples where NHS staff, often in conjunction with the police, work well to prevent crime, it is impossible to eradicate it completely. It is vital then that the NHS works closely with the police and the Crown Prosecution Service (CPS) to respond to those incidents which cannot be prevented.

All of the national organisations involved in this agreement recognise that in many areas close working is already in place. By examining examples of best practice from throughout England, it is clear that joint working is at its best when it is developed and owned locally. It is also apparent that there are differing problems in different parts of the country and that the solutions cannot be imposed at a national level.

The areas identified in this agreement are those which experience at a national level has shown may require attention. Difficulties with communications and sharing of essential information needed to progress cases are areas which are regularly acknowledged as causing problems. Some solutions are identified here and reaching agreement nationally should instil some confidence that similar areas can form the basis for developing local agreements.

Incidents involving mentally disordered persons are another key area where improvements in joint working may be required. Cooperation is essential, not just to deal with the offender and support the victim, but to seek to reduce levels of violence in order that the majority of patients receiving mental health services, who are not violent or abusive, can receive care in a safe and therapeutic environment.

As is made clear in the document the content of local agreements is a matter for local negotiation. All three organisations are committed to supporting the development of local agreements at whatever level proves to be best for the parties involved.

## 1. Statement of intent

- 1.1. This agreement seeks to outline best practice for joint working between the Association of Chief Police Officers (ACPO), the Crown Prosecution Service (CPS) and NHS Protect (and, by extension, local NHS bodies), 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 best practice set out in this agreement. NHS Protect has responsibility for the NHS in England only; this agreement covers England and not Wales. However, the parties will encourage a similar approach from NHS bodies, police services and CPS areas in Wales.
- 1.2. **All parties agree that there is a strong public interest in prosecuting those who assault NHS staff or commit offences that disrupt the provision of NHS services to the public. It is recognised that NHS staff are among the most likely to face violence and abuse at work. The figures for physical assaults<sup>1</sup> on NHS staff in 2009–10 are shown in the table below.<sup>2</sup> All parties will encourage individual police services, CPS areas and NHS bodies to seek the strongest possible action in appropriate cases.**

	Total health bodies	Total assaults 2009/10	Assaults involving medical factors	Assaults NOT involving medical factors	Total staff	Assaults per 1000 staff	Reported sanctions (convictions and out of court disposals)
Acute (general hospital) trusts	168	13,219	9,144	4,075	786,673	16.8	412
Ambulance Service	11	1,262	259	1,003	38,374	32.9	288
Mental Health	73	38,959	22,624	16,335	203,220	191.7	412
Primary Care	138	3,278	2,310	968	234,544	14.0	16
Strategic Health Authorities	10	0	0	0	4251	0.0	0
Special Health Authorities	3	0	0	0	11,009	0.0	0
<b>Total</b>	<b>403</b>	<b>56,718</b>	<b>34,337</b>	<b>22,381</b>	<b>1,278,071</b>	<b>44.4</b>	<b>1,128</b>

### Previous agreements

- 1.3. **This agreement replaces the existing memorandums of understanding between the NHS Security Management Service (now renamed NHS Protect) and ACPO and between the NHS Security Management Service (now NHS Protect) and the CPS. It does not supersede existing examples of other joint working (e.g. Crime and Disorder Reduction Partnerships).**
- 1.4. While the content of local agreements should be informed by this document, local partners should not be limited to the areas included here. The basis of local agreement can include matters not covered here, e.g. theft and criminal damage, responses to incidents where vulnerable patients are missing, etc. Matters relating to fraud against the NHS are the subject of separate agreements.

<sup>1</sup> 'Physical assault' and other terms are defined in annex F.

<sup>2</sup> Further information on these figures can be found on the NHS Protect website at - [http://www.nhsbsa.nhs.uk/SecurityManagement/Documents/SecurityManagement/2009-10\\_Physical\\_Assaults\\_Against\\_NHS\\_Staff\\_FINAL\\_241110.pdf](http://www.nhsbsa.nhs.uk/SecurityManagement/Documents/SecurityManagement/2009-10_Physical_Assaults_Against_NHS_Staff_FINAL_241110.pdf)

## **2. Parties to the agreement**

### **2.1. The Association of Chief Police Officers (ACPO)**

2.2. The role of ACPO is set out in the organisation's 'Statement of Purpose':

2.3. 'The Association of Chief Police Officers (ACPO) is an independent, professionally led strategic body. In the public interest and, in equal and active partnership with Government and the Association of Police Authorities, ACPO leads and coordinates the direction and development of the police service in England, Wales and Northern Ireland. In times of national need ACPO, on behalf of all chief officers, coordinates the strategic policing response.'

### **2.4. The Crown Prosecution Service (CPS)**

2.5. The CPS 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, impartially and with integrity help to deliver justice for victims, witnesses, defendants and the public.

2.6. 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.

### **2.7. NHS Protect**

2.8. The NHS Business Services Authority (NHSBSA) is a special health authority that provides a wide range of services to support the NHS, including NHS Protect.

2.9. NHS Protect is the national body responsible for the security of NHS staff and property in England. This remit includes:

- protecting NHS staff from violence and abuse
- taking action, including criminal prosecution, against those who assault or abuse NHS staff
- helping to ensure the security of NHS property, facilities, equipment and other resources such as drugs.

## **3. Commencement, amendment and review**

3.1. **This agreement will take effect on 31.10.2011.**

3.2. This agreement can be amended as appropriate at any time if the relevant parties agree. Any amendments should be agreed in writing. However, any amendment must be consistent with the nationally agreed protocols and standards.

3.3. The parties will review this agreement every 2 years.

### **3.4. Local implementation**

3.5. This protocol should be implemented locally by a service level agreement between the parties and any other organisations or bodies that the parties think appropriate. The service level agreement should strongly reflect the national policy. The delivery of local agreements within the framework of this agreement will be consistent with the protocols and standards listed in annex A. As CPS areas/police service

boundaries will cover a number of NHS bodies, it is expected that such agreements will be coordinated by the NHS Protect Area Security Management Specialist rather than individual Local Security Management Specialists (LSMSs).

### 3.6. **Distribution and publicity**

3.7. All parties will bring this agreement to the notice of the police services, CPS Areas and NHS bodies covered by them and encourage those bodies to bring it to the attention of all relevant staff.

3.8. **This agreement and any service level agreements arising from it should be brought to the attention of existing groups (e.g. CSPs, MAPPA, child protection, etc) to ensure that there is no duplication of effort and that all those involved are aware of newly created methods of joint working.**

3.9. The press offices of all parties involved will liaise to maximise positive publicity around this new agreement.

## 4. **Contact and liaison**

4.1. Before agreeing what the expected response to incidents would be, it is important that effective channels of communication are established.

4.2. The key objectives in building a local communications network between the NHS, CPS and police are:

- to improve the protection of NHS staff
- to strengthen the investigation and prosecution process, by improving the quality of information exchanged
- to improve victim and witness care.

4.3. It is not possible at a national level to specify individuals, ranks or grades in each organisation that may be suitable as contact points. However, it is recommended that, where possible and practical, all parties should nominate a single point of contact for strategic/force/area-wide issues and a single point of contact for local service delivery. **Each police force will be responsible for ensuring that there is a clear governance and communication structure to monitor these arrangements.**

4.4. The single point of contact for the police and CPS should be invited to attend security meetings within the health body. The LSMS, CPS and police will liaise and share information on crime and crime reporting where it relates to the NHS.

4.5. **It is expected that the LSMS will be the single point of contact or lead at an operational level for violent and other security-related crime matters at a health body, both day-to-day and post-incident. If the police or CPS encounter difficulties and cannot resolve issues with the health body concerned, they should contact the NHS Protect Area Security Management Specialist (ASMS).**

4.6. Regular local liaison should also take place on more general issues, which will:

- promote a consistent approach
- encourage wider police/CPS/NHS liaison
- ensure effective contact in specific cases
- allow discussions about the levels of involvement of the organisations involved

- provide an avenue for the provision of mutual NHS, CPS and police expertise and access to effective channels of information
- enable NHS Protect to be kept informed of developments in cases being investigated by the police or prosecuted by the CPS
- encourage adherence to a national standard approach
- develop the concept of mutual support in tackling crime within the NHS.

4.7. It is expected that the LSMS will act as a liaison point for the NHS body for non-operational contact with the police and the CPS.

## 5. Incident reporting – general

5.1. The LSMS will aim to ensure that all security related crime that affects the health body is reported to the police. This can include offences involving NHS staff, patients or visitors, offences involving property or other offences committed on health body premises.

## 6. Incident reporting – assaults and ASB

6.1. NHS staff will report security related crime to the police in line with local policy and national guidance.

6.2. The LSMS will ensure that incidents are reported if staff have been unable to do so. Unless specified, the reporting of a crime by an LSMS does not always indicate that the victim wishes to pursue the matter. This issue must be clarified in all reporting.

6.3. NHS bodies, via the LSMS, are obliged to report all incidents of physical assault (i.e. where physical contact is made with the victim) against staff to the police (as well as internally). An exception to this is if the offending behaviour is directly caused by a physical or mental health condition, or an adverse reaction to prescribed medication or treatment.

6.4. **Incidents requiring an emergency response should be reported via the 999 service.**

6.5. **The LSMS and police should identify and agree a suitable route for reporting non-urgent incidents that do not require an emergency response.**

6.6. It is important that NHS staff are aware of the nature of incidents that would justify an emergency response. The LSMS and police should ensure that all staff understand when to seek an emergency or priority response. Consideration should be given to establishing a process for NHS and police control to identify such incidents.

**The LSMS should ensure that their organisation has clear 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.

6.7. The following list gives an indication of how incidents may be graded, how they should be reported and what level of response can be expected.

### **Immediate (use emergency 999 number)**

- danger to life
- use or immediate threat of violence

- serious injury to a person/serious damage to property
- a crime which is, or is likely to be, serious or in progress
- an offender has been disturbed at the scene
- an offender is detained and poses, or could pose, a risk to others

**Priority (use locally agreed police number)**

- concern for safety
- offender detained but risk posed is manageable
- a witness or other evidence is likely to be lost
- vulnerable or extremely distressed person involved
- hate crime
- local agreement that this is a priority

**Scheduled (used locally agreed means of reporting which, in some cases, will include email)**

- non-time critical (e.g. historical incident)
- all incidents other than detailed above.

## 7. Incident reporting – mentally disordered persons

- 7.1. It must be stressed that, in the majority of cases reported to the police by NHS staff working in mental health/learning disability settings, there will have been an initial assessment that the offending behaviour is not directly caused by the person's condition and that any police and CPS response should take account of this internal assessment process.
- 7.2. **The LSMS, relevant clinicians, the CPS and the police should seek agreement on the information required to enable prompt investigation and charging of mentally disordered offenders. Details of the type of information which may be required can be found in the CPS legal guidance on Mentally Disordered Offenders.<sup>3</sup>**
- 7.3. **In order to enable cases to be progressed quickly information should be provided to the police as quickly as possible. Recommended best practice would be to provide key statements within 5 working days.**
- 7.4. An example of a form for providing information relating to mentally disordered persons is provided in annex B. All involved must agree the content and use of such forms. **N.B. It is important to remember that any such forms may be disclosed to defence as part of the disclosure of unused material process.**
- 7.5. Such forms are intended only for making initial decisions on investigation/charging/diversion and will not replace the need for witness statements, psychiatric or medical reports, etc, should the matter progress to prosecution. The information that may be required by the CPS for post-charge purposes is dealt with later in this document.
- 7.6. The most senior member of staff available may complete the forms at the time and in the majority of cases; this will be a registered mental health nurse if the individual's psychiatrist is not available. It is worth noting that the Bradley Report on people with mental health problems or learning disabilities in the criminal justice system refers to a pilot scheme whereby court reports are provided by 'a community

<sup>3</sup> 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/](http://www.cps.gov.uk/legal/l_to_o/mentally_disordered_offenders/)

psychiatric nurse or mental health social worker – and by a psychiatrist only where the mental health service providers deem it appropriate (for instance where a hospital order is required)' p73.

- 7.7. While most cases involving mentally disordered offenders will relate to incidents where the assailant has the necessary mental capacity to be held responsible for their actions, there will be limited exceptions.
- 7.8. Cases involving serious or repeated violence where the offending behaviour is directly caused by a mental health condition 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.
- 7.9. 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.
- 7.10. Where 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.

## 8. Police response to incidents

### 8.1. Response to specific types of incident – police

- **Lone workers, community staff and ambulance crew**

Many NHS staff provide services in patients' homes or in public places where support from colleagues may not be available. This should be taken into account when deciding on the response required. Many but not all NHS staff who work alone or in the community may now have lone worker protection devices. These devices can assist in locating persons and can make audio recordings of incidents. (N.B. Many NHS lone worker devices are monitored by operators at a category 2 alarm receiving centre (ARC) who will listen in to the incident, assess the situation and only summon the emergency services in the case of a genuine case where a response is required.) **LSMSs should ensure that their 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 made aware of the potential additional evidence that such services can provide.**

- **Incidents in mental health/learning disability units**

It should be stressed that the majority of persons in mental health/learning disability units are not violent or abusive and many patients are there on a voluntary basis, i.e. they are not formally detained 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 directly caused by a mental disorder, the police should respond and investigate in the same way as they would had the incident taken place elsewhere.**

While this agreement does not cover offences committed against patients in such units, it is recommended that a similar approach is taken to these cases. Patients who have been the victims of offending behaviour should have an equal entitlement to justice.

- **Nuisance and disturbance – offence and removals**

The Criminal Justice and Immigration Act 2008 creates powers for authorised NHS staff and constables to remove those who commit the offence of causing a nuisance or disturbance on NHS hospital premises. Not all health bodies will have staff trained to use the power of removal and it applies only to hospital buildings and grounds. **It is recognised that the use of this power is discretionary and will be dependent on the prevailing circumstances; however it would be wise to discuss this issue at a local level to agree a local protocol.**

8.2. **Arrests on NHS premises**

8.3. The decision to arrest is ultimately a matter for the police officers in attendance. This decision will, however, be informed by any medical considerations, and staff should be prepared to disclose this information upon request.

8.4. Staff should also be prepared to disclose information to the police about any known risks that an arrested person may pose to the police or matters relating to the person's health that the police may require in order to discharge their duty of care to those involved.

## 9. Investigation

9.1. **It is the responsibility of the police to investigate criminal activity within the community. However, the LSMS, in addition to leading on and managing all security-related work in their health body, should give the required support to the police during investigations in an NHS healthcare setting.**

9.2. If an investigation requires the seizure of NHS property or the non-use of an area of NHS premises, liaison must take place between the Security Management Director or LSMS and the senior investigating officer to ensure that patient care is the priority and that evidence is protected and preserved wherever possible. If incidents happen out of hours, the Security Management Director/LSMS 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.

9.3. **NHS assistance for investigations**

Accredited LSMSs are trained investigators. Part of their role is to pursue investigations into security-related matters and incidents involving violence against NHS staff. LSMSs undertake training accredited by the University of Portsmouth. They are trained in investigation and statement taking in accordance with PACE and PEACE standards.

LSMSs have been trained in and received guidance on protecting a scene of crime. When available, they are responsible for assisting the police with this process as

required. LSMSs should make the local police (and CPS) aware of their normal working hours and of any arrangements for out of hours cover and urgent contact details.

As the LSMS may not be available at the time of an incident, other steps should be taken to assist the police in responding to incidents and collecting information. The LSMS 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 as a result, other staff may be able to assist with collecting information for the police. **The police and LSMS should agree guidance to be issued to staff detailing what information individual members of staff may be able to collect.** 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 incidents.

The LSMS will assist the police by providing details of NHS victims' and witnesses' work patterns and work contact details if direct communication may be difficult due to shift working. They may also act as a liaison point if the incident has resulted in sick leave and the member of staff may not wish to be contacted at home by the police.

#### 9.4. **Witness statements and evidence gathering**

9.5. While it is primarily the role of the police to interview witnesses, take statements and gather evidence, an accredited LSMS may assist the police by gathering additional evidence and statements.

#### 9.6. **Victim personal statement**

9.7. When relevant, the police should obtain a victim personal statement and, with the consent of the victim, check its currency with the LSMS. The prosecutor can then rely upon this statement when an offender is being sentenced and will provide the court with a full and up-to-date picture of the impact of the offence on the victim. If victims consent, the LSMS can assist in taking this statement or providing updated statements of this sort.

#### 9.8. **'Official or business victims'**

9.9. **In cases where there is no individual victim** (e.g. drug dealing on trust property, public order offences, etc) **arrangements should be made for the LSMS to take the role of 'official victim' on behalf of the NHS body affected.** See paragraph 3.7 of the Code of Practice for Victims of Crime.

9.10. **Community impact statements**

9.11. NHS Protect will encourage the LSMS to prepare a 'community impact statement' and make this available to the police at the earliest possible opportunity in all investigations. This statement 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.

9.12. Such 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.

9.13. The precise content will depend on the nature of the service provided by the NHS body (e.g. general hospital, ambulance, mental health, community-based, etc) but 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 sick 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.

9.14. **It is expected that the content and format of NHS community impact statements will be agreed between all the parties. The statement should be reviewed annually and any statistics and other information updated where possible.**

9.15. **Individual incident impact statements**

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 in question. It is not expected that such statements will be required in all cases. The LSMS or the police may obtain this statement

9.16. **All parties will seek agreement for the use of statements and other evidence obtained by LSMSs.**

9.17. **Bail conditions**

9.18. When investigating incidents on NHS premises, the police should 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 the required protection while not denying the suspect necessary access to NHS services. It is important that all parties are made aware of any bail conditions imposed by the police and that should a suspect be brought to court, the court is asked to consider imposing similar conditions where appropriate. See annex D for

generic conditions to prevent inappropriate or unnecessary attendance on NHS premises during an investigation.

## 10. Victim/witness communication

- 10.1. It is recognised that the police and CPS are bound by guidance and codes of practice on communications with victims and witnesses.
- 10.2. However, it is important to recognise that effective communication can be disrupted by operational requirements of all services (e.g. shift working, emergencies, etc). The LSMS may be able to assist in this – for example, by advising the police of when witnesses will be at work and available for statement taking, etc.
- 10.3. **If effective and timely communication may prove problematic, and if the victim has given written consent, the LSMS may receive and pass on information to and from the police and CPS about the progress of a police investigation, CPS decisions on charging or prosecution, and consideration of non-court disposals.**
- 10.4. See the section below ‘Updates on investigation and prosecution progress and outcomes’ for details of the LSMS role in monitoring investigations and prosecutions. N.B. written consent will not be required for updating the LSMS of the progress of the case; it is only required if the LSMS takes on the responsibility for updating the victim of progress.
- 10.5. **The LSMS, CPS and police should agree what format any written consent should take.** The suggested content for such a form is provided in annex C.
- 10.6. **Compensation and on conviction orders**
- 10.7. While such issues will ultimately be decided by the court, it is important that investigating officers have regard to them at an early stage and obtain the required evidence to prove the injury, loss or damage and that it resulted from the offending behaviour
- 10.8. Victims (including business ‘victims’) should always be asked if they wish to seek compensation.
- 10.9. If a prosecution does take place, the police should always 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.
- 10.10. Assistance with drafting suitable conditions for such orders, which offer protection to staff while still allowing access to healthcare, can be sought from the LSMS or NHS Protect’s Legal Protection Unit.

## 11. LSMS investigations

- 11.1. If the police do not undertake a criminal investigation, for whatever reason, and an accredited LSMS is in post, the LSMS should undertake an investigation with the full knowledge and support of the Security Management Director and the police.
- 11.2. If the LSMS investigation uncovers a criminal matter, it is recognised that policing priorities may affect the ability of the police to conduct an investigation. The LSMS, with the support of NHS Protect, will progress investigations that cannot be

investigated by the police where they consider it necessary, with the full knowledge of the police.

- 11.3. All criminal investigations undertaken by the LSMS will be carried out in compliance with the Police and Criminal Evidence Act 1984 (PACE), the Criminal Procedure and Investigations Act 1996 (CPIA), the Regulation of Investigatory Powers Act 2000 (RIPA), Secretary of State Directions and all relevant Codes of Practice.
- 11.4. Where appropriate, NHS Protect's Legal Protection Unit will support investigations conducted by LSMSs and provide legal guidance.
- 11.5. In most cases where the LSMS conducts an investigation, either the police or the CPS will have decided not to proceed with the case.
- 11.6. If the police have decided not to pursue the case and, after seeking advice from NHS Protect's Legal Protection Unit, the LSMS feels that there is sufficient or additional evidence of an offence having been committed, the case will be submitted to the police for review and, where appropriate, to be passed to the CPS for advice/progression.
- 11.7. **The parties will agree on the format that is required for cases to be submitted by the LSMS to the police for review and, where appropriate, for prosecution by the CPS.**

## 12. Consideration of method of disposal

12.1. **The parties agree that in the following cases:**

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

**the police will undertake to investigate and refer cases where there is sufficient evidence to support a prosecution to the CPS. It is important that, when dealing with cases involving NHS staff, premises or property, officers have regard to any particular aggravating factors (see annex E).**

## 13. The decision to prosecute

13.1. 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 DPP's Guidance on Charging. The Full Code Test will be applied wherever possible, other than in limited circumstances where the narrower threshold test applies.<sup>4</sup>

### **The Code for Crown Prosecutors**

#### **The full code test**

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

The full code test has two stages. The first stage is 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 does pass the evidential test, prosecutors must go on to consider whether a prosecution is required in the public interest.

### **The 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.

### **The second stage – the public interest stage**

If the case does pass the evidential stage, prosecutors must then decide whether a prosecution is needed in the public interest. A prosecution will usually take place unless the prosecutor is sure that there are public interest factors tending against prosecution which clearly outweigh those tending in favour, or unless the prosecutor is 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.

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.

In most cases of violent or threatening behaviour directed at NHS staff, one or more of the following aggravating factors would be present, along with the more widely known factor that the offence has been committed against a person serving the public.

- 13.2. **Particular aggravating factors in offences involving NHS staff or on NHS premises**
- 13.3. 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.
- 13.4. Examples of particular aggravating factors would include:
- the withdrawal from service of an emergency ambulance and the potential for harm this may cause to those in urgent need of this service
  - the withdrawal of staff from active duty in accident and emergency units and the resultant reduction in service
  - the vulnerability of staff working in the community, particularly those who work alone or in isolated locations
  - the potential impact on vulnerable patients in paediatric, mental health and learning disability units and the effects that being exposed to such behaviour may have on them.

- 13.5. Consideration should also be given to the fact that there are high levels of violence and unacceptable behaviour in the NHS 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.; or
  - 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.
- 13.6. \*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, elderly care, etc. It is wrong to assume that, due to the nature of their employment, NHS staff are not ‘members of the public’ or part of the community.

## 14. The decision to prosecute and mentally disordered offenders

- 14.1. It is recognised that the majority of 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’.
- 14.2. 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.
- 14.3. While this agreement is primarily concerned with deliberate incidents of violence, incidents where the behaviour was directly caused by a mental disorder should receive similar consideration, and prosecution should take place where the evidence and public interest supports this. It should be borne in mind that the guidance issued by NHS Protect on the reporting of assaults against NHS staff states that all cases should be reported to the police ‘except in those cases where [...] having consulted with relevant staff and obtained clinical advice, [staff have] reached the conclusion that the assault was not intentional and that the patient did not know what he was doing, or did not know what he was doing was wrong due to the nature of his medical illness, mental ill health or severe learning disability or the medication administered to treat such a condition’<sup>5</sup>. This means that cases should be reported if the staff present have formed an initial view that the offender’s behaviour has not arisen as a direct result of any condition or treatment. In effect, this means that many cases not suitable for disposal in the criminal justice system will have been filtered out by staff and not reported.
- 14.4. **Mental disorder is not an automatic bar to prosecution. It should be stressed that a diagnosis of mental disorder, or the fact that a suspect is detained under the Mental Health Act, does not mean that the person lacks mens rea or that the Full Code Test is not met.**
- 14.5. The Code for Crown Prosecutors provides important guidance to prosecutors 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 **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

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<sup>5</sup> Tackling violence against staff – explanatory notes, NHS Security Management Service, 2004

mental or physical ill health with the need to safeguard the public or those providing care services to such persons’.

- 14.6. In addition to the CPS legal guidance on Mentally Disorder 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), it states at para 4.141 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’.
- 14.7. 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 liaison officer, LSMS or NHS Protect, and asked to provide current information along with any opinion they feel appropriate.
- 14.8. 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.
- 14.9. 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 will not be the sole reason for pursuing a prosecution.
- 14.10. To review a case involving a mentally disordered suspect properly, the CPS will need information and evidence regarding the mental disorder at the earliest opportunity.
- 14.11. A prompt response will be required and the LSMS/NHS Protect should assist the police and CPS in obtaining the information from the relevant NHS body when required. The CPS should immediately notify the LSMS/NHS Protect if it is having difficulty in obtaining any information relevant to its review of the case. This will ensure that appropriate cases are properly progressed and prevent any arbitrary decisions from being taken regarding a person’s mental health or capacity without the decision-maker obtaining the fullest information.
- 14.12. The information that may be requested 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 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 and/or any medication or other treatment for his or her disorder
- evidence regarding the person's fitness to plead.

14.13. It is not always the case that prosecutors are aware – either owing to the circumstances of the incident or from the police – from the outset that an offender has a mental disorder. 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 LSMS and NHS body.**

## 15. Sentencing and ancillary orders

- 15.1. 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'.
- 15.2. 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 guidance (issued 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.
- 15.3. 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 of particular relevance when determining the appropriate sentence for offences of violence and abuse against NHS staff.

15.4. Prosecutors also have a duty to draw the court's attention to the impact of the offending on a community. Examples of the possible impacts are referred to above and reproduced in annex E – Particular aggravating factors in offences involving NHS staff or on NHS premises. The LSMS will be able to provide further information if required.

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

- **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 guilty plea.

15.6. **Compensation**

15.7. 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.

15.8. **Anti-Social Behaviour Orders (ASBOs)**

15.9. **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 anti social behaviour order (ASBO) on conviction. The LSMS 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 LSMS may assist in the collection of supporting evidence.**

15.10. There is no qualification in terms of the type of offence, but two tests must be satisfied in order to qualify:

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

- 15.11. 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 LSMS 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.
- 15.12. 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.
- 15.13. **It is important that the LSMS 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, etc. Advice on appropriate conditions may be sought from NHS Protect's Legal Protection Unit and an example of generic conditions is provided in annex D. 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.
- 15.14. 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 LSMS(s) 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 NHS Protect's Legal Protection Unit with a copy, where it is felt that wider distribution may assist in enforcement.**
- 15.15. **Where appropriate, the police may provide photographs for distribution to relevant NHS staff to assist in identification of persons subject to ASBOs.**
- 15.16. Publicity of the order within the NHS will be a matter for NHS Protect and the healthcare establishment. *The Home Office Guide to Anti-Social Behaviour Orders*<sup>6</sup> provides guidelines on the handling and appropriateness of publicity and these should be followed.
- 15.17. **Breaches and modifying conditions of ASBOs**

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<sup>6</sup> Published August 2006

- 15.18. In the event of a breach of an ASBO, the LSMS 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.
- 15.19. If the subject behaves inappropriately and in such a way as to avoid the conditions of the order, the LSMS or NHS Protect should raise this with the CPS/police, in order for consideration to be given to a review of the ASBO conditions.
- 15.20. 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.
- 15.21. **Any proceedings in relation to breach of the order, variations of the conditions or discharge of the order will be notified to the LSMS by the CPS officer with conduct of the matter.**
- 15.22. **Other orders available to restrict and protect**
- 15.23. 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.
- 15.24. 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.
- N.B. These orders are now available in appropriate cases upon conviction for any offence and not just for offences under the Protection from Harassment Act 1997.
- 15.25. As with ASBOs, details of the conditions of any community order or restraining order should be provided to the LSMS (or NHS Protect's Legal Protection Unit) 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 LSMS.

## **16. Out of court disposals**

- 16.1. It is recognised that the decision to use a non-court disposal is ultimately an operational decision for the police (or, for some disposals, the CPS) to take.
- 16.2. **In all cases of assault or violence against the person, before a non-court disposal is administered, the police will seek the views of the victim(s). The police will explain the consequences of the disposal, especially when a particular method of disposal will prevent the victim, or NHS Protect, from pursuing a criminal prosecution.**

- 16.3. NHS Protect is authorised by the Secretary of State for Health to prosecute cases of assault on NHS Staff where the police or CPS have decided not to prosecute. Where the victim or the LSMS indicates that they wish to seek advice from NHS Protect in relation to this consideration should be given to allowing time for this to be done before a final decision is made.
- 16.4. **It is expected that non-court disposals will only be used in exceptional circumstances for such cases.**
- 16.5. **Simple cautions and conditional cautions**
- 16.6. Offenders should not be considered eligible for a simple caution at the scene of the incident.
- 16.7. **A simple caution should not be given for any violent offence other than in exceptional circumstances.**
- 16.8. 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 penalty<sup>7</sup>) 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 LSMS or NHS Protect's Legal Protection Unit.
- 16.9. **Penalty notice for disorder (PND)**
- 16.10. A PND should not normally be issued if NHS staff have been assaulted or threatened with violence.
- 16.11. **Out of court disposals for mentally disordered offenders**
- 16.12. 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.
- 16.13. 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 significantly more severe to in-patients than to the majority of offenders.
- 16.14. 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.

## **17. Updates to LSMSs on investigation and prosecution progress and outcomes**

- 17.1. Health bodies, via the LSMS or Security Management Director, have a legal obligation to report assaults and other offences against NHS staff to NHS Protect. This includes an obligation to report the outcome of any police investigation or criminal prosecution.

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<sup>7</sup> N.B. Financial penalty conditions for conditional cautions may not yet be available in some areas.

**The parties agree that LSMSs have a legitimate need to access this information and that they will encourage police forces and CPS Areas to provide it.**

- 17.2. The parties agree that the relevant police service will provide the following information to the LSMS:
- 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 non-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.
- 17.3. Once a suspect has been charged, information on its progress will be sought from the Witness Care Unit (WCU) and not the police.
- 17.4. The parties agree that the WCU will provide the following information to the LSMS:
- details of all court hearings (i.e. date, time, location and purpose)
  - details of NHS witnesses required to attend and give oral evidence
  - outcome of court hearings
  - details of sentence, financial orders and any on conviction ancillary orders
  - details of any appeals.
- 17.5. **The LSMS, the CPS and the police should agree procedures for the sharing of information in individual cases. All parties must ensure that all staff are aware of this process. Once agreement has been reached and relevant staff informed, it is anticipated that the most effective route for providing updates will be by telephone or secure email.**

## **18. When the police or CPS do not prosecute**

- 18.1. 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 LSMS 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 NHS Protect's Legal Protection Unit.

## **19. NHS prosecutions and disclosure of evidence/information to LSMS/NHS Protect's Legal Protection Unit (LPU)**

- 19.1. NHS Protect has been authorised by the Secretary of State for Health to 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.

- 19.2. In such cases NHS Protect's LPU 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.
- 19.3. Requests for disclosure of evidence and other information will be made in writing, by the LPU.
- 19.4. Such requests will be addressed to the police's single point of contact with the NHS body in question. **N.B. This agreement cannot pre-authorise disclosure and such decisions must be made on a case by case basis.**
- 19.5. 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.
- 19.6. 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.
- 19.7. Consent will normally be required from witnesses for disclosure of their witness statement. Responsibility for obtaining consent will rest with the relevant police force however the LSMS may assist in obtaining consent from witnesses employed by the NHS.
- 19.8. As NHS Protect has limited access to the police national computer, information on previous convictions will not usually be requested initially by the Legal Protection Unit. Further information on the detail of specific convictions may be requested from the police if this is required to support a prosecution (e.g. for use as bad character evidence).
- 19.9. **Any information disclosed by the police to NHS Protect's LPU 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.**
- 19.10. If NHS Protect's Legal Protection Unit is considering a prosecution on behalf of the Secretary of State for Health, 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.

## 20. Data protection and confidentiality issues

- 20.1. As the disclosure of information to comply with data protection principles must be decided and justified on a case-by-case basis, the CPS, NHS Protect or ACPO cannot 'pre-authorise' disclosure.
- 20.2. 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*").
- 20.3. 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 also 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.

20.4. Medical information must only be sought and disclosed if it is directly relevant to the investigation or prosecution of offending behaviour. Disclosure must be limited to the minimum amount necessary for the purpose required. Disclosure of identity information to the police investigating an offence against NHS staff is not considered to be disclosure of confidential information.

20.5. **In general terms, the parties agree that the disclosure of information in the scenarios considered in this document will be legitimate where disclosure is necessary, proportionate and 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 advice**
- **the discharge of legal obligations placed on NHS bodies to report incidents to NHS Protect.**

20.6. If the police or CPS encounter difficulties with accessing information because NHS staff have concerns about confidentiality or data protection, they should contact the LSMS or NHS Protect for assistance.

## **21. Information sharing**

21.1. There should be 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, etc).

21.2. The parties should 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.

21.3. **Where it is established that existing arrangements are not sufficient or are not in existence, further local information sharing agreements should be based**

on or revised in accordance with the existing guidance – in particular, guidance in section 6 and appendix 3 of the document *Guidance on the Management of Police Information (2010)*. A copy of this can be found on the NPIA website at:

<http://npia.police.uk/en/6533.htm>

- 21.4. **All parties should 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 absence of agreements should never be a barrier to the timely sharing of risk information in specific cases.**

## 22. NHS security alerts

- 22.1. The NHS has existing systems for alerting staff to potential risks to the safety of NHS staff or resources, including notifications of orders such as ASBOs having been put in place. At a local level, these will be dealt with by the LSMS. If the risk may be on a regional or a national scale, NHS Protect will consider issuing alerts.
- 22.2. The content and purpose of local alerts is decided at the discretion of the NHS body involved. NHS Protect can only issue regional or national alerts if there is a direct risk to NHS staff or resources.
- 22.3. If the police or CPS consider that an NHS security alert may be appropriate, they should contact the LSMS for a local alert or NHS Protect for a regional or national alert.
- 22.4. Examples of the types of matter which may be suitable for an alert include:
- ASBOs or other court orders (including sexual offences prevention orders) which have conditions designed to protect NHS staff or resources
  - threats directed against NHS staff in general, or against specific groups of staff
  - release from custody or absconding of persons with a history of offending against NHS staff.
- 22.5. The types of information which may be required to support an alert include:
- police photographs of the subject
  - information on relevant convictions and copies of court orders
  - method of offending
  - risk assessment or intelligence demonstrating risk to NHS staff.

## SIGNATORIES TO THE AGREEMENT

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



**Chief Constable Brian Moore**  
**ACPO Lead for Violence and Public Protection**



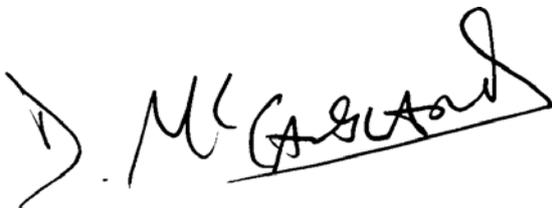
**Date: 31.10.2011**



**For the Crown Prosecution Service**  
**Keir Starmer QC**  
**Director of Public Prosecutions**



**Date: 24.10.2011**



**Dermid McCausland**  
**Managing Director, NHS Protect**



**Protect**

**Date: 27.10.2011**

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### **Nationally agreed protocols and standards**

The Code of Practice For Victims of Crime (October 2005)  
The Code for Crown Prosecutors (February 2010)  
The Director of Public Prosecutions (DPP)'s Guidance on Charging 4<sup>th</sup> Edition (Revised Arrangements) (January 2011)  
CPS Legal Guidance on Mentally Disordered Offenders  
The DPP's Guidance on Conditional Cautioning 6<sup>th</sup> Edition (January 2010)  
The 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)  
The 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)  
The Farquharson guidelines on The Roles and Responsibilities of the Prosecution Advocate  
The Bar/CPS Standard for Communication between Victim and Witnesses and the Prosecution Advocate (February 2006)  
Secretary of State Directions, November 2003 (amended 2006) and March 2004 (amended 2006) for taking forward work to tackle violence and general security management issues  
Secretary of State Directions 2006 to the NHS BSA on the functions of the NHS Security Management Service  
The NHS Business Services Authority Amendment Directions 2011  
NHS Protect's Legal Protection Unit's prosecution policy.  
The NHS Confidentiality Code of Practice  
The Information Commissioner's guidance on The Use and Disclosure of Health Data Responding to People with mental ill health or learning disabilities (NPIA 2010)

## Annex B: Information forms for mentally disordered suspects

### 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.

NHS incident reference no:	Alleged offence:
Victims name(s)	Date, location and time of incident

#### Responsible Clinician Details

Name and contact no:	Designation:
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#### SERVICE USER DETAILS

Name and date of birth:	Address if not in-patient
Detained under MHA 1983?	Service user no:

**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" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="padding: 2px 10px;">Yes</td> <td style="padding: 2px 10px;">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" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="padding: 2px 10px;">Yes</td> <td style="padding: 2px 10px;">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" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="padding: 2px 10px;">Yes</td> <td style="padding: 2px 10px;">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" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="padding: 2px 10px;">Yes</td> <td style="padding: 2px 10px;">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 LSMS.

## **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)

.....  
.....  
.....  
.....  
.....

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)

.....  
.....  
.....  
.....



Explanatory Notes for Medical Staff:

1. These notes outline why the police are requesting the information overleaf and how this information is potentially 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 of relevance 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 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 a range of related issues:
  - 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 to comment upon (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 patients in the future.
6. Whether or not a patient is attempting to comply with their management plan and co-operating with professionals is relevant. If they are absencing 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.

## Annex C: Victim Consent Form for disclosure of information

Trust/police/CPS Logo and address etc.

### Victim 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 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 LSMS and trust details] I also consent for the police and/or CPS to provide updates on the progress of the case to [LSMS] 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 LSMS 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:

## Annex D: Generic conditions for ASBOs, bail conditions, restraining orders, etc

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.

## Annex E: Particular aggravating factors in offences involving NHS staff or on NHS premises

There is a strong public interest in maintaining the effective provision of healthcare services and prosecutors should always consider whether the offending behaviour has further aggravating features relating to this.

Examples of such aggravating factors in such offences would include:

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

Consideration should also be given to the fact that there are high levels of violence and unacceptable behaviour in the NHS (see paragraph 1.2) and the following factors from the Code for Crown Prosecutors may be applicable:

- the offence was committed against a person serving the public (for example a member of the emergency services or a health worker)
- there are grounds for believing that the offence is likely to be continued or repeated, for example, by a history of recurring conduct;
- the suspect's previous convictions or previous out-of-court disposals which he or she has received are relevant to the present offence;
- the suspect is alleged to have committed the offence in breach of an order of the court;
- a prosecution would have a significant positive impact on maintaining community confidence;
- the offence involved the use of a weapon or the threat of violence.

## Definition of terms used

### **NHS body**

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

### **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.

### **Security Management Director (SMD)**

The role of the SMD is to promote and lead on security matters at NHS body board level.

### **Local Security Management Specialist (LSMS)**

The LSMS is employed or contracted by the NHS body and has responsibility for security management work locally. Some NHS bodies may directly employ one (or more LSMSs) others may share or contract the work to external organisations. In some cases, an LSMS may delegate some of the roles outlined here to another person. References to LSMSs should be read to include staff who have been deputised to carry out functions on their behalf. NHS bodies are not required to have 24/7 LSMS cover. (Note - the LSMS may be known by a different title in some health bodies).

### **Area Security Management Specialist (ASMS)**

ASMSs are directly employed by NHS Protect. Their primary function is to support the LSMS and SMD in the delivery of NHS Protect's strategy through the implementation of policy and guidance supplied by NHS Protect.

### **Legal Protection Unit (LPU)**

NHS Protect's Legal Protection Unit (LPU) provides legal services and support to LSMS and NHS bodies about security matters. The LPU is directed, by legislation, to work with healthcare bodies, the police and the Crown Prosecution Service (CPS) to increase the rate of prosecutions against individuals who are violent or verbally abusive towards NHS staff. The LPU is also authorised to conduct criminal prosecutions against those who assault or abuse NHS staff where the police or the CPS have decided not to take action.

### **'Assaults'**

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.

### **Physical assault**

A physical assault is defined as –

*The intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort.*

### **Non-physical assault**

A non-physical assault is defined as:

*The use of inappropriate words or behaviour causing distress and/or constituting harassment.*

## Annex G – Other Areas that may be suitable for local agreements

### Responses to other incidents

While not strictly within the scope of this document LSMS should consider seeking the agreement of their local police in responding to other situations, examples would include –

**Paediatric and maternity** – incidents of infant abduction and issues of child protection to be treated as a priority. Health bodies with maternity units are required to carry out abduction drills, assessing and documenting results. It is recommended that abduction drills are conducted in close liaison with the local police force(s).

**Lockdowns.** Health bodies' major incident plans should include policies to lockdown their respective site/building(s) in the event of a wide range of threats and hazards, including a terrorist incident. All trusts will need to work with their police force to determine what support can be offered when locking down.

**Anti-Social Behaviour** – standard response expected in line with individual police services' incident grading procedure. Also see above on nuisance and disturbance. Agreement should be sought on evidence gathering for possible ASBO applications.

**Burglary, theft and criminal damage.** Standard response expected in line with individual police services' incident grading procedure, where this behaviour does not significantly affect the provision of emergency health services where an enhanced response may be appropriate.

### Treatment of persons under arrest at NHS Premises

There will be occasions where persons under arrest will have to be taken to NHS premises for medical treatment. These situations will have implications for the safety of NHS staff, police officers and the public, as well as the potential for such persons to escape from custody.

#### LSMSs and the police should agree procedures for notification, reception and provision of care on NHS premises of persons still under arrest.

As many of the details of agreed procedures will be dependent on the layout of the premises involved and the type of treatment required it is impractical to go into detail in this document. It is expected however that **wherever practicable agreements should include:**

- **a named contact or direct telephone number in the health body (including out of hours provision) should be identified. Where it is not possible to provide names then an appropriate role should be identified, e.g. the Nurse in Charge or Duty Manager of the unit.**
- **The police should give prior notification of their attendance**
- **A member of NHS staff should be identified to meet and escort officers upon arrival**
- **A suitable rendezvous point should be identified, if possible at a location that would minimise contact with the public.**
- **A suitable treatment location should be identified, again with the aim of minimising contact with the public**
- **Suitable parking facilities should be identified and made available**
- **As well as relevant medical information the police should advise the NHS contact of the risk posed by the detainee as soon as possible**

- The police should be notified as soon as possible of any requirement to move the person around the site or between sites
- The police must give prior warning to NHS staff (normally the nurse in charge) where they intend to de-arrest persons on NHS premises
- When the police decide to de-arrest, e.g. because the detainee is being admitted to hospital, they must assist the person in charge of the unit in assessing the risks posed by the individual.
- Should there be disagreement over whether a continued police presence is required following de-arrest, the officers involved should remain on scene until the person in charge of the unit has had an opportunity to discuss the matter with a more senior police officer.

Where emergency situations arise it may of course not be possible to adhere to all of the points above however if all police and NHS staff are made aware of agreed arrangements it should help to minimise potential risks

## Places of Safety

As the responsibilities of parties under sections 135 or 136 of the Mental Health Act 1983 (as amended) should be the subject of separate local agreements. This is underlined in Home Office and Department of Health guidance and chapter 10 of the Mental Health Act Code of Practice gives details of what should be included in these agreements.

When health bodies, the police and other agencies are seeking agreements in relation to places of safety the LSMS should be actively involved in these discussions.

It should be stressed that not all hospitals will be suitable as places of safety for persons detained under section 136. The MHA Code of Practice states –

“It is preferable for a person thought to be suffering from a mental disorder to be detained in a hospital or other healthcare setting **where mental health services are provided** (subject, of course, to any urgent physical healthcare needs they may have). [emphasis added]

**Where appropriate places of safety have been identified and agreed NHS bodies and the police should make all staff aware of the location of appropriate places of safety.**