Mentally Disordered Offenders County Protocol

REVIEW 5
Document Summary

To ensure that practitioners within Cumbria Partnership NHS Foundation Trust and within our partner agencies are aware of their responsibilities in relation to the management and statutory arrangements when working with Mentally Disordered Offenders who may be a risk to the public and staff within our agencies.

The Policy also outlines the process and pathways through the Criminal Justice System for Mentally Disordered Offenders who are either in the community, hospital units, custody, courts or prison. The protocol will also identify alternative options and pathways to divert individuals out of the Criminal Justice process if appropriate.

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MENTALLY DISORDERED OFFENDERS PROTOCOL

The agencies represented on the County multi-agency Criminal Justice and Mental Health Steering Group is committed to working together to provide a range of services. These services are designed to improve public safety and to address the serious, and often complex, issues faced by mentally disordered offenders.

In order to facilitate this work, The Mentally Disordered Offenders Protocol has been developed as an information source for all practitioners. Understanding each others’ roles and responsibilities, and knowing the right processes to follow, are important bases for avoiding the confusions and breakdowns in communication that, so often, are found to be failings identified through inquiries following serious incidents.

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GLOSSARY OF TERMS

**ALIS** – Access and Liaison Integrated Service

**AMHP** – Approved Mental Health Professional – able to carry out duties under the Mental Health Act including assessments and compulsory admission applications

**Appropriate Adult** - The AA is there to safeguard the rights and civil liberties of the detained person who is vulnerable, and who is detained and questioned by the Police. The safeguard is there to protect vulnerable groups of people and to minimize the risk of interviews producing unreliable evidence.

**Care Co-ordinator** – Under CPA duties (see Section 9).

**CBO** – Criminal Behaviour Order

**CCG** – Clinical Commissioning Group

**CJU** – Criminal Justice Unit (Police)

**CMHART** – Community Mental Health and Recovery Team

**CPA – Care Programme Approach/Care Management** – Require Health and Social Services to conduct an assessment of need and a Multi Disciplinary Team prepare a multi-agency care plan.

**CPFT** – Cumbria Partnership NHS Foundation Trust.

**CPN** – Community Psychiatric Nurse responsible for providing mental health aftercare under the Care Programme Approach

**CTO** – Community Treatment Order

**Custody Sergeant** – police sergeant (or G4S) responsible for the care and wellbeing of detained persons in either police or G4S cells

**FHCP** – Forensic Health Care Professional – usually a nurse – old name police surgeon employed by police to (a) advise police whether a prisoner is fit to be interviewed and/or detained (b) to provide medical care to police prisoners

**Forensic Consultant Psychiatrist** – Consultant Psychiatrist who specialises in legal and criminal matters

**G4S** – Independent secure provider for detention of individuals in Police Stations and transport of same to Court and Prison

**GRIST** - Galatean Risk Screening Tool - Mental health risk assessment tool

**LDSQ** – Learning Disabilities Screening Questionnaire

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L&D – Liaison and Diversion service

MAPPA – Multi Agency Public Protection Arrangements

MARE – Multi Agency Risk Evaluation

MCA – Mental Capacity Act

MHA – Mental Health Act

MHAAM – Mental Health Act Administration Manager

MHTR – Mental Health Treatment Requirement

MDO – Mentally Disordered Offender

MDT - Multi Disciplinary Team

PACE – Police and Criminal Evidence Act

PCT – NHS Cumbria (Primary Care Trust)

PPU – Public Protection Unit (Police)

Prison Medical Officer – Doctor responsible for the healthcare (including mental health care) of prisoners

Probation Officer – Responsible for presenting reports to Courts and supervision of some court orders and prison aftercare licences

RC – Responsible Clinician under the Act responsible for the care and treatment of formally detained patients, or care of mentally disordered people in the community

Section 12 Approved Doctor – Usually, but not always, a psychiatrist – having knowledge of mental disorder and Approved within the MHA to be able to carry out specific duties under Part 2 of the Mental Health Act i.e. Medical recommendations also Part 3 of the Act i.e. Court reports

SPoC – Single Point of Contact
INTRODUCTION

This protocol is prepared by the County Criminal Justice and Mental Health Steering Group and is in accordance with the recommendations of the Reed Committee, Home Office Circulars 66/90 and 12/95 and the Bradley Review (2009). It reflects the progress that has been made in Cumbria in establishing good multi-agency practice designed to meet both the care needs of the mentally disordered person and the other issues of public safety. It should be read carefully and adhered to.

Difficulties in implementing the protocol should be referred to the Development Officer for Mentally Disordered Offenders.

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CUMBRIA CRIMINAL JUSTICE AND MENTAL HEALTH
STEERING GROUP

Terms of Reference

1. The group will have county-wide membership, be multi-agency and its aim will be to enhance inter-agency communication and working in relation to Mentally Disordered Offenders mental health and learning disability issues.

2. The group will meet quarterly.

3. Membership will consist of members from:
   - Mental health services - NHS and Adult Social Care
   - Clinical Commissioning Group
   - Courts - both Crown and Magistrates
   - Youth Offending Service
   - Probation
   - Police
   - County MDO development officer
   - Learning Disabilities
   - Secure commissioning Mental Health and Learning Disabilities
   - Crown Prosecution Service
   - Mental Health training co-ordinator
   - Prison Healthcare

4. The group will oversee management and provision of forensic services and monitor the use of the forensic care pathway.

5. The group will monitor use of multi-agency protocols and will approve changes if appropriate.

6. The group will identify training needs so that local, county and national standards can be maintained.

7. The number and types of mentally disordered offenders will be monitored, deficits in forensic services identified and where necessary information will be passed to CCG Commissioners and Trust Managers.

8. Regional and national sources of guidance on the management of Mentally Disordered Offenders will be assessed and circulated to relevant staff.

9. New legislation that affects Mentally Disordered Offenders will be assessed and circulated to relevant staff.

10. The Steering Group will support and monitor the work of local groups.
11. The Steering Group will act as an audit group in relation to MDOs and the use of section 136

12. The Steering group will set some standing agenda items and on occasions work projects for the local Criminal Justice and Mental Health sub groups

13. The minutes of the Steering Group will be forwarded to Adult and Local Services Care Governance, the CPFT Network Clinical Governance Group and the CCG Commissioners
INTERAGENCY WORKING WITH MENTALLY DISORDERED OFFENDERS IN CUMBRIA

Purpose

The purpose of this document is to clarify the expectations of all the local agencies involved in commissioning and providing services for Mentally Disordered Offenders in Cumbria.

Introduction

This Agreement is set against a background of changes that can be traced back to the Criminal Justice Act 1991 and its direct links, in terms of mentally disordered offenders, within the 1983 Mental Health Act (as amended 2007). Reference also needs to be made to government circulars and reviews which stress the importance of multi-agency co-operation in the care and treatment of mentally disordered offenders. These documents include:

- **Provision for Mentally Disordered Offenders**, HOC 66/90, which sets out specific responsibilities to be undertaken by the courts, chief constables, chief probation officers and prison medical officers.

- **Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services**, known as the Reed Report (1992) HMSO.

- **Mentally Disordered Offenders: Inter-Agency Working** HOC 12/95


- **Lord Bradley Review of people with mental health problems or learning disabilities in the Criminal Justice System – April 2009**


Definition

For the purpose of this document, the term Mentally Disordered Offender is defined as an individual with mental health needs or a learning disability or any other offender who meets the definition of mental disorder in the Mental Health Act 2007 who comes into contact with the Criminal Justice System. This will

Mentally Disordered Offenders County Protocol  Version 5
include individuals who have contact with the police, those that are suspected
or charged with offences, as well as those who are convicted offenders.

Mental Health Act 2007 definition of mental disorder

S.1 (3) Mental Disorder means any ‘disorder or disability of the mind and
mental disorder shall be construed accordingly’.

S.1 (4) Learning Disabilities means a state of arrested or incomplete
development of the mind which includes significant impairment of intelligence
and social functioning

Values

The following values underpin work with mentally disordered offenders:

- Mentally Disordered Offenders should be treated with respect and dignity
  and ensured of humane treatment, care and support to the same extent as
  any other group.

- The safety of the public should be promoted.

- Effective co-operation and co-ordination between the agencies and
  professionals involved in the management of Mentally Disordered Offenders
  should be developed and strengthened.

- Special consideration should be given to the issues of discrimination and
disadvantage arising from race, gender, disability or sexual orientation.

Guiding Principles

It is important that the development of local services for Mentally Disordered
Offenders should incorporate the five principles set out in the Reed Report. The Report recommended that Mentally Disordered Offenders who require
treatment and support because of their health care needs should be treated or
cared for:

- With regard to the quality of care and proper attention to the needs of the
  individual;

- As far as possible, in the community, rather than in institutional settings;

- Under conditions of no greater security than is justified by the degree of
danger they present to themselves or others;

- In such a way as to maximise rehabilitation and their chances of sustaining
  an independent life;

- As near as possible to their own homes or families, if they have them.
National Objectives

The Reed Report also identified five national objectives for the health of Mentally Disordered Offenders. They are:

- To improve their health and social functioning.
- To reduce their suicide rate.
- To reduce the incidence and prevalence of offending and re-offending amongst those with mental disorder.
- To develop a sensitive, flexible and, as far as possible, integrated range of health and social services, having regard to both quantity and quality, and also the preventative aspects.
- To ensure the safety of the public and that of the mentally disordered offender.

Strategic Aims

The strategy to meet these national objectives for mentally disordered offenders in Cumbria includes the following objectives:

- To ensure that mentally disordered offenders have well coordinated access to appropriate health and social care at all points in the Criminal Justice System.
- To reduce the risk of re-offending by early identification and multi-agency management of mentally disordered offenders.

These strategic aims will be achieved by:

- Developing effective collaboration between all agencies, including involvement in joint training.
- Supporting the development of local mechanisms and procedures for assessment, diversion, treatment and care of mentally disordered offenders at all levels of the Criminal Justice System.
- To review local progress in achieving these objectives.
Developing a Multi-Agency Approach

The development of initiatives and multi-agency working to meet the needs of Mentally Disordered Offenders should be co-ordinated at both a county-wide and local level.

At a county-wide level

A multi-agency Criminal Justice and Mental Health Steering Group has been operating at a county level for a number of years.

Some agencies involved in the commissioning and provision of services for Mentally Disordered Offenders have a county-wide remit, such as the Police, National Probation Service, Cumbria Partnership NHS Trust, and their policy is determined at a county level. There are also other specialist services that operate beyond localities and districts, such as prisons and secure services.

By bringing together representatives of these different bodies, the county-wide co-ordinating group will enable multi-agency support, co-ordination of local initiatives, sharing of information and positive practice. The group also enables links to be established with other bodies such as the Crown Prosecution Service, the County Drug Action Team and regional groups including the Cumbria Criminal Justice Board and the North East and North West Secure Commissioning Teams.

The county-wide steering group should include nominated representatives from the following bodies:

- Cumbria Constabulary
- County Mentally Disordered Offenders Officer
- Cumbria Clinical Commissioning Group
- Crown Prosecution Service
- Crown and Magistrates Courts Service
- Cumbria Probation Trust
- Youth Offending Service
- HM Prison Service Healthcare Haverigg
- Cumbria Partnership NHS Trust-both social work and NHS representatives
- NHS Mental Health & Learning Disabilities Commissioner
- Learning Disabilities Services
- Cumbria Adult and Local Services
- Liaison and Diversion Services
- G4S
- Unity Drug and Alcohol Recovery Service

The role of the county-wide steering group is:

- To provide a forum for chairs of local mentally disordered offender subgroup to share information, positive practice, and encourage greater consistency and joint approaches.
• To establish and maintain links with and report to regional and national bodies such as the Association of Directors of Social Services, secure services and the Criminal Justice Strategy Board and report to the latter as appropriate.

• To assist the development of an overall county-wide approach.

• To circulate information about good practice, as well as key policy documents and reports.

• To develop consistent information gathering and analysis across agencies.

• To help initiate and co-ordinate action identified by local groups and support and implement appropriate action on policy issues.

• To provide a forum to discuss ways of resolving problems identified at a local level which emerge from working practice and require resolution at a county-wide level.

• To promote the development and range of services to address the needs of Mentally Disordered Offenders.

• To facilitate and monitor the effectiveness of local multi-agency steering groups, and assist in setting standards to enable local groups to audit their local services and monitor progress.

• To identify the county wide training needs of those working with Mentally Disordered Offenders and formulate development of multi-agency training.

• To advise on the establishment and management of multi agency assessment teams

OPERATIONAL ISSUES

Points of Intervention in the System

There are a number of options for intervention in dealing with Mentally Disordered Offenders, following initial identification by the police or at various points in the Criminal Justice System.

• in the community and when individuals are at risk of further offending;

• following arrest;

• at the police station;

• at the court;
• on a community order following sentence
• in prison or hospital and at time of release/discharge;
• Following release/discharge from prison or hospital.

Options for Practice

It is acknowledged that local services will develop according to local needs. However it is important that systems are in place which enables the needs of Mentally Disordered Offenders to be addressed.

Local initiatives which have developed include the Cumbria Mentally Disordered Offenders County Protocol, Multi Agency Risk Evaluation Meetings (MARE) and the development of prison in-reach, involving operational staff from relevant local agencies. All these initiatives should ensure comprehensive, multi-disciplinary needs assessments are carried out that include risk assessments and the sharing of care plans and information, as appropriate.

These services should aim to prevent the inappropriate entry or re-entry of people into the Criminal Justice System. When Mentally Disordered Offenders are prosecuted the aim is to provide courts with high quality reports which give clear information on the assessment of an individual’s needs and provide a range of services to help meet their needs in the community, in prison or in hospital.
SECTION 1
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COMMUNITY MANAGEMENT

1. GENERAL PRINCIPLES:

COMMUNITY MENTAL HEALTH SERVICES SHOULD SEEK TO FORGE STRONG LINKS WITH NEIGHBOURHOOD POLICING TEAMS – BRADLEY REVIEW APRIL 2009

1.1.1 In certain circumstances, where a Mentally Disordered individual living in the community exhibits anti-social and/or criminal behaviour, the clinical/care team responsible for that individual’s care plan should discuss with the individual an appropriate response to such behaviour. If the individual does have capacity and is responsible for his/her actions the care plan should include this information. Where the Police request information about the individual’s capacity and responsibility for the offending behaviour, opinion will be sought from the clinical/care team as to whether the individual does have capacity and is responsible for his/her actions and can be processed through the Criminal Justice System. The Police will adopt the procedures within the Mentally Disordered Offenders Protocol (Section 2 – Upon Arrest) should an arrest/attendance be made under such circumstances.

1.1.2 The entry in the Care Plan is designed to give the mentally disordered individual an appropriate response to his/her offending or behaviour and should be proportionate to that individual’s circumstances. It would apply where it is clear that the offending or criminal behaviour is not wholly driven by the individual’s mental disorder.

1.1.3 Where it is assessed that the offending or criminal behaviour is being driven by the individual’s mental disorder the following action should be taken:

- Where an individual displays clear mental health relapse indicators, early identification of that relapse should be relayed to the clinical/care team in order that intervention can take place prior to offending or criminal behaviour taking place.
- Where identifiable relapse indicators are known and apparent, those indicators should be passed to other agencies that have close links or contact with the individual.
- It will be the individual’s care co-ordinator’s (care manager etc) responsibility in conjunction with the individual’s Responsible Clinician (RC) to ensure that the relapse indicators are relayed to appropriate Professionals. (E.g. if the individual is subject to Probation supervision it is important that the individual’s Probation Officer is aware of the relapse indicators).
- It would also be appropriate to inform the Public Protection Unit of the Police in order that that unit can make the Police Problem Solving Team responsible for policing the area where the individual lives aware of the indicators.
• In all cases where an MDO is living in the community it is strongly recommended that key agencies work collaboratively to agree appropriate care/supervision planning and effective management of any identified risks.
• It is essential that care co-ordinators/key workers/Care Managers produce robust crisis and contingency plans within individuals care plans

1.1.4 There is no prescriptive format for this and any relapse indicator information should revolve around an individual’s specific circumstances and only be relayed on a need to know basis in order to ensure early action is taken to intervene when that individual’s mental health deteriorates and prevent possible involvement with the Criminal Justice system.

1.1.5 Where recognised relapse indicators are identified by a non-health agency early contact should be made with the designated care co-ordinator or the ALIS team, who will refer to the existing contingency and/or crisis plan, this may lead to a further assessment of their mental health.

1.1.6 Some individuals may not display obvious relapse indicators when their mental health deteriorates. It will only be appropriate to pass information on relapse indicators if the indicators are apparent and will always be at the discretion of the care co-ordinator and RC.

1.2. **PEOPLE WITH LEARNING DISABILITIES**

1.2.1 If Learning Disabilities staff are concerned that a person with learning disabilities may be committing an offence(s) they should refer the matter to the police for a decision on whether or not the persons actions constitute an offence.

1.2.2 Certain categories of behaviour such as sex offending, arson, violence against another person, should always be referred.

1.2.3 If staff are aware that a person with learning disabilities is persistently behaving in such a way that it leads the staff member to believe that an offence is being committed and that the person is responsible for their actions, then the staff should contact the police.

1.2.4 If staff are concerned that a person newly in receipt of learning disability services may have a criminal background they should seek advice from the police. The police may, in order to minimise the risk of further offending, reveal details of previous convictions to staff. This should be done in line with the Information Sharing Agreement between the Police and Mental Health Services.
1.2.5 Prosecution of a person with learning disabilities who is suspected of having committed an offence can have several benefits:

A. It may act as a deterrent to further offences being committed
B. It helps build up a long term picture of the persons actions and any risks posed to others in the community,
C. Via pre-sentence reports local clinical and forensic advice can be accessed to determine if mental health intervention and/or possible placement is appropriate.
D. Subsequent DBS checks of an individual will include details of offences and avoid problems experienced in the past.

1.2.6 If a person has committed or is committing or is judged to be potentially capable of committing serious offences, but is judged to be unfit to plead by a RC and there are insufficient grounds for action under the ‘Criminal Insanity Unfitness to Plead’ legislation, following a MARE or multi-agency case conference a decision may be taken to detain the person under Section 3 of the Mental Health Act on the grounds of abnormally irresponsible or aggressive behaviour or Section 2 on the grounds of the interests of his own health or safety or with a view to the safety of others.

1.2.7 Police, staff, care providers and carers working in the field of learning disabilities can request a case conference. Normally this should be arranged by the clients Care Manager. Where there is no identified Care Manager, the Development Officer for Mentally Disordered Offenders may be contacted to arrange such a conference. Such a case conference may then look at the person’s behaviour i.e. is it challenging or criminal behaviour? Who is it affecting? What can be done about it? Resulting from such a case conference, a comprehensive care plan subject to review should be devised. Inherent in this care plan should be an ongoing process of pro-active information exchanged between the police and learning disabilities staff so that the persons actions in the community can be closely monitored and any behaviour which causes concern can be dealt with either by referring to the police for possible prosecution or by attempting to address the causes of such behaviour, e.g. is there some aspect of the persons life which is making him unhappy, is there a lack of structure and adequate supervision, are there peer group reinforcers to such behaviour etc? Where the risks of serious harm to others are present referral should be made through the MAPPA/MARE pathway in order that a Multi-Agency Risk Management assessment of the risks is instigated and an effective Risk Management Plan is put in place (see Section 7 Public Protection).

1.2.8 Following up on a multi-agency case conference decision, certain cases may be referred via the consultant psychiatrist for Learning Disabilities to the Forensic Psychiatrist at Northgate hospital, the local gatekeeping referral process (Consultant Psychiatrist, Forensic Community LD Nurse, and Consultant Clinical Psychologist) for LD
1.2.9 If a person is judged to be unfit to enter a plea but there is sufficient forensic evidence to lead police to believe that the person has committed a serious offence, it may be possible to proceed under the ‘Unfitness to Plead’ legislation. In order to assist the police and the Crown Prosecution Service in this process, learning disabilities staff should cooperate fully in giving as much information as possible which may lead to building up a comprehensive picture of the person’s actions and motivations. See ‘Unfitness to Plead’ details at Appendix F.

1.3. COMMUNITY TREATMENT ORDER (CTO)

1.3.1 The Mental Health Act 2007 (Sections 17a-17g inclusive) makes provision for Supervised Community Treatment through the introduction of Community Treatment Orders. Such Orders cannot be imposed unless certain criteria are met.

- The patient must be detained under Section 3, 37, 47 or 48 of the Mental Health Act 1983 (amended 2007).
- The Patients RC is of the opinion that certain criteria have been met.
- An AMHP states in writing that they are in agreement that criteria are met and it is appropriate to make a CTO.

1.3.2 The CTO specifies certain conditions that the Patient must comply with in the community and the standard conditions are

- The patient makes themselves available for examination by the RC when/if the RC is considering whether to remove the CTO.
- The patient makes themselves available for examination by a second opinion doctor (certain type of treatment can only be given with the agreement of a second opinion doctor).

1.3.2 The RC may impose other conditions but only if they are necessary and appropriate.

- To ensure the patient receives treatment
- To prevent the risk of harm to the patient’s health or safety
- To protect other persons

1.3.3 The discretionary conditions might be, for example, a condition that the patient resides at a certain address, agrees to take prescribed medication or agrees to provide urine samples etc.

1.3.4 There is a power of recall to hospital if the patient fails to comply with either of the two standard conditions, or if the RC is of the opinion

- That the patient needs hospital treatment AND
- There would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled.

1.3.5 The above is a brief summary in relation to CTO’s. The CPFT has in place an Operational Policy in relation to CTO’s and this, together with recall procedures in the Police Assistance Protocol should be referred to
if a more comprehensive understanding of the legislation, procedures and process is required.

1.4. **FORENSIC PATIENTS**

1.4.1 There is no dedicated forensic service in Cumbria. It will be necessary at times for the clinical/care team of a patient living in the community to refer the individual for a forensic opinion by a Forensic Consultant Psychiatrist. This may be as a result of persistent or serious criminal behaviour or an assessed risk of serious harm to others.

1.4.2 Mental Health Clinicians and Practitioners can make such referrals either through prescriptive Forensic Care Pathways, in more serious or urgent cases, or through the Forensic Clinics that operate in the County.

1.4.3 The CPFT has in place two Forensic Care Pathway processes and Forensic Clinic referral processes covering Carlisle, Eden, Allerdale and Copeland (North East Forensic Services) and South Lakes and Furness (North West Forensic Services) These documents should be referred to for more details of the procedures (see Appendix?).

1.4.4 Where there is an assessed high risk of serious harm to others consideration should be made to discussing the risks in a multi agency forum and in line with the procedures set out for Public Protection (see Section 7).

1.5 **FORENSIC PATIENTS RETURNING TO THE COMMUNITY**

1.5.1 Patients requiring a more intensive forensic intervention are provided this service through a dedicated forensic pathway. All forensic in-patient placements are outside of Cumbria County and are facilitated through dedicated Forensic Case Managers in the North West and North East Secure services networks. Some patients will be out of county for some considerable time receiving treatment through a Forensic Care Pathway, but it is inevitable that at some stage most patients will return to live in the community in Cumbria. It is of the utmost importance that where forensic patients are returning to the community the local clinical/care team must assess fully the risk profile of the patient and comply with the Public Protection procedures outline in Section 7 of this document. All proposed transfers from Forensic Services back to Cumbria should be reported to the Development Officer for Mentally Disordered Offenders (Cumbria) at the earliest possible instance.

1.5.2 When the care of patients is transferred from Forensic Services to local secondary care mental health services a transfer summary should accompany them and be copied to their GP. The summary should detail the outcome of the assessment by the Forensic Services and include, as a minimum sections on diagnosis and risk assessment. The summary
should include a crisis and contingency plan and give advice on future management. *(National recommendation from the Garry Taylor Independent Homicide Inquiry December 2007).*

1.5.3 Local mental health and learning disability services and social care staff must ensure that risk management processes outlined in Section 7 are complied with.
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SECTION 2A

2.1 UPON ARREST: (BARROW, CARLISLE and WORKINGTON)

2.1.1 Where any person commits any offence and is arrested, they will be subject to the relevant sections of the Police and Criminal Evidence Act (PACE) and its Codes of Practice. Detainees in custody of the Court are subject to detention by G4S (Independent Provider), who are also subject to the principles of PACE.

2.1.2 Upon arrival at a designated Police Station a detained person will be seen by the Custody Officer. The Custody Officer will determine whether the detained person should be admitted to the Custody Suite. They will begin the process by asking the detained person for personal details and assess whether the detained person is fit to be detained and fit to be interviewed. This will include an initial evaluation of whether the detained person is suffering from a mental disorder. A detained person’s mental disorder may be identified in a number of ways:

- Overt presentation of mental disorder through words or actions
- Information from the detained person
- Information from a legal representative
- Information from a family member or friend
- Information from Police staff who know the detained person
- Information on PNC or Police Intelligence systems etc

2.1.3 If the custody officer determines that a detained person is presenting with a mental disorder and may not be fit to be detained and/or interviewed by the police, the Forensic Health Care Professional (FHCP) should be requested to attend to assess the detained person.

2.1.4 The role of the FHCP is to determine whether the detained person is fit to be detained and/or interviewed. The FHCP must enter their assessment findings and decision of whether the detained person is fit to be detained and/or interviewed on the appropriate custody medical form:

A. If the detained person is judged to be fit to be detained and/or interviewed, normal police procedures in relation to detained persons will follow. A referral to the Liaison and Diversion Team will also be offered to explore/assess any additional support options regarding health and social needs.

B. If the detained person is assessed as not being fit to be interviewed the FHCP will contact the Liaison & Diversion (L&D) Practitioner when on duty or the ALIS team at any other time, and ask for a further assessment of the detained person’s mental health needs. The ALIS practitioner will not make any decisions without first attending the Police Station and assessing the detained person.

C. The role of the Liaison & Diversion (L&D) Practitioner or the ALIS team practitioner is exclusively around assessment of the detained persons Mental Health at that specific time and the decision to assess should not be influenced by the alleged offence or whether the detained person is fit to be detained or interviewed.
D. Following an assessment by the L&D / ALIS Practitioner, if the detained person is judged to be suffering from a mental disorder then the L&D / ALIS Practitioner should inform the Custody Sergeant of the outcome of their assessment. The Custody Sergeant will then make a decision based on the information provided by the L&D / ALIS Practitioner as to whether the detained person is not fit to be detained and/or interviewed.

E. If the Custody Sergeant makes a decision that the detained person is not fit to be detained and/or interviewed they may be offered appropriate assessment/treatment by Mental Health Services or Learning Disabilities Services in either:
   i. The community OR
   ii. by informal admission to hospital based on an assessment by either the L&D / ALIS Practitioner OR
   iii. by a formal admission to hospital following an assessment under the Mental Health Act by duty Approved Mental Health Professional (AMHP) and two Section 12 Approved Doctors. This can be arranged by contacting the duty Approved Mental Health Professional (AMHP).
   iv. where the offence is more serious, and especially where the nature of that offence will impact on the police decision to grant bail, the L&D/ALIS Practitioners should involve the local duty psychiatrist in their decision making. Where that psychiatrist believes that forensic services may need to be involved, s/he should make contact with the relevant Forensic Services (contact numbers are shown below). On-call Forensic Consultants are available 24/7 to provide guidance and advice.

It should be noted that there is no emergency pathway into Secure Services. If the offender is assessed as having mental health needs, and cannot be safely or appropriately managed in local or PICU facilities, a criminal justice pathway should be pursued through the courts to prison (hospital) services (Part 3 MHA 1983). This is the agreed pathway for offenders of this nature to access specialised Forensic Services.

For advice and support the on-call Forensic Consultants can be contacted on the following numbers

- **North Cumbria patients:**
  NTW – 0191 213 0151 (switchboard has the on-call rota)
  TEWV – 01642 837 300 (switchboard) or 01642 838 108 (control room) who have access to the Consultant on-call rotas.

- **South Cumbria patients:**
  Guild lodge – 01772 406700 (The control room has details of Consultant on-call rotas)

v. Where the assessment by the Liaison & diversion team or ALIS determines that
i. No mental health intervention is required OR
ii. Assessment /treatment can take place in the community **AND**

iii. Informal admission to hospital or assessment for formal admission to hospital is not necessary

The Custody Officer must then decide whether the detained person is fit to be detained and/or fit to be interviewed. If following the assessment the police decide to continue to interview/charge the service user, the police will inform the L&D / ALIS Practitioner prior to release from custody if further ALIS/HT input had been planned at assessment.

F. It is important that all decisions relating to this process; including whether or not it is appropriate to proceed through the Criminal Justice System, should be fully documented with the rationale for the decisions in the detained person’s custody medical record.

G. Where the above assessments have taken place the custody officer must consider whether an appropriate adult should be present for the detained person during any interview (in accordance with PACE – code C para 1, 4 and 1.7).

H. If the detained person is judged to be fit to be detained and interviewed, normal police procedures in relation to detained persons will follow. The L&D / ALIS Practitioner will follow current policy and practice of sharing relevant information with the Courts. Where the DP is sentenced to a term of imprisonment, the L&D / ALIS Practitioner/ Care Coordinator will contact the Prison Healthcare of the receiving prison and inform them of the subject’s care plan, prescribed medication and full risk profile.

NB: Before the detainee leaves the police station all parties should confirm his/her legal status. E.g. remanded; released without charge; reported for summons; cautioned or charged to Court. The L&D / ALIS Practitioner must also complete Form DP3d in relation to the assessments carried out and ensure that one copy is handed to the Commissioned Health Care professional at the Police Station and a copy is added to the Service Users file. See Appendix G for details of the DP3d form.

### 2.2 INTERVIEWS WITHOUT ARREST

2.2.1 There will be occasions where it is entirely appropriate for police officers to pursue their investigation without arresting an individual e.g. – this might be where the offence is minor, the offender is a young person, or, in some cases, where a vulnerable adult has committed minor offences on mental health wards.

2.2.2 It is imperative that the officer in the case highlights any concerns regarding mental disorder on the case file by endorsing the MG6 (confidential case file document) in order that appropriate enquiries can be made with mental health services in line with section 3 of this protocol.
2.3 **PEOPLE WITH LEARNING DISABILITIES**

2.3.1 If the Police arrest a person who they suspect may have learning disabilities they should refer to the Liaison & Diversion (L&D) Practitioner when on duty or the ALIS team at any other time, who will be able to seek information about whether the individual is known to Learning Disability (LD) services. They will also assess if there are any health and social needs which might need to be addressed. This process should confirm to the Police whether the individual is currently in receipt of services from the Learning Disabilities Teams. If there is doubt about a person’s ability to be interviewed, the Police should request the presence of an appropriate adult under the terms of PACE. If there is concern about the person’s general fitness to be detained and interviewed the police should seek the advice of the Forensic Health Care Professional (FHCP), who will use their face to face assessment as well as any relevant information gathered from the L&D practitioner to inform their decision making.

2.3.2 Where the L&D practitioner or ALIS determines that the detained person is suspected of suffering from a Learning Disability and is not known to Learning Disability or Mental Health Services the Health Professional will complete the CPFT’s accepted Learning Disability Screening Questionnaire (LDSQ) and submit the form to the Forensic Lead for Learning Disabilities for that area.

2.4 **REQUESTS FOR MENTAL HEALTH ASSESSMENTS FOR THE GATHERING OF EVIDENCE IN SERIOUS CRIMES**

2.4.1 In cases where mental disorder has not been assessed through the identified process the Senior Investigating Officer (SIO) can in certain cases (e.g. Murder, Manslaughter, Stranger rapes and other serious crime where there is extreme violence or extreme behaviour) in their determination request that the detainee is examined by a Psychiatrist. The rationale is, an early examination of the detained person can counter an examination made by a defence employed Psychiatrist employed months after the offence. It can negate a defence of “a psychotic episode” where they did not have capacity at the time, and also prove that they could comprehend the questions put to them in interview and that they were competent to give rational answers.

2.4.2 The SIO will arrange an Approved Doctor (Section 12 MHA 1983) through Cumbria Constabulary’s privately contracted arrangements to conduct an “evidential assessment”. A list of approved doctors is held on the Cumbria constabulary intranet. It can be located on the Custody Cares website, in a folder labelled Mental Health Matters and a sub folder labelled “SIO Evidential Mental Health Assessment”.
2.5 **UNFIT TO PROCEED THROUGH CRIMINAL JUSTICE SYSTEM**

2.5.1 There will be occasions where a person is unfit (by reason of their mental disorder) to proceed through the Criminal Justice System and it is not appropriate to divert, either informally or through legislation to hospital e.g. severe learning disability and dementia etc.

2.5.2 If following an assessment (Para 2.1.4 E) and where the offence is a serious offence the Police and Crown Prosecution Service will consider whether it is appropriate to proceed under “Unfitness to Plead” legislation (See Appendix F for details).

2.5.3 Where the offence is a minor offence and would not meet the criteria for “Unfitness to Plead” legislation the Police will need to ensure that there is an appropriate outcome to such cases that is fully documented and proportionate to all parties. This should include a transparent process for any victims of such offences. The Police will, if required, call a meeting with the Health Professional Lead for the individuals care, to discuss whether it is appropriate to develop a management plan in order that further offending is minimised or eliminated.

2.6. **YOUNG PERSONS IN CUSTODY (Under 18 years of age)**

2.6.1 In general the principles outlined for the screening and assessment of young persons arrested for criminal offences and taken to a designated Police Station will follow the procedures for adults.

2.6.2 The role of the FHCP is to determine whether the young person is fit to be detained and/or interviewed.

A. The FHCP must enter their assessment findings and decision whether or not the young person is fit to be detained and/or interviewed on the appropriate custody medical form:

B. If the young person is judged to be fit to be detained and/or interviewed, normal police procedures in relation to detained persons will follow.

C. If the young person is assessed as not being fit to be detained and/or interviewed the FHCP will contact the L&D and/or Child and Adolescent Mental Health Service (between 9am and 5pm) or the Access and Liaison Integrated Services (ALIS) out of hours and ask that a further assessment of the young person’s mental health should be conducted. The FCHP must give full details and information of their initial assessment to the CAMHS/L&D/ALIS. The CAMHS/L&D/ALIS will not make any decisions without first attending the Police Station and assessing the detained person.

D. If the detained person is judged to be suffering from a mental disorder and is not fit to be detained and/or interviewed and after assessment by the CAMHS/ALIS the detained person may be offered appropriate assessment/treatment by Mental Health Services or Learning Disabilities Services either:

i. In the community;
ii. By informal admission to hospital or
iii. By contacting the CAMHS duty Consultant Psychiatrist (between 9am and 5pm) or the duty AMHP (Out of Hours) to request an assessment under the Mental Health Act for formal admission to hospital under Section 2 or Section 3 of the Mental Health Act 1983 (as amended 2007). An Out of Hours assessment under such circumstances will be undertaken by the on call Adult Consultant Psychiatrist

E. Where the assessment by the CAMHS/ALIS determines that:
   I. No mental health intervention is required OR
   II. Assessment /treatment can take place in the community AND
      Informal admission to hospital or assessment for formal admission to hospital is not necessary.

F. The FHCP must decide in collaboration with the Custody Officer whether the detained person is fit to be detained and/or fit to be interviewed

G. It is important that all decisions relating to this process and whether it is appropriate or not to proceed through the Criminal Justice System should be fully documented with reasons for the decisions in the young person’s custody record medical form.

H. The custody officer must ensure that an appropriate adult is present for the young person during any interview.

NB: Before the detainee leaves the police station all parties should confirm his/her legal status. E.g. remanded; released without charge; reported for summons; cautioned or charged to Court. The ALIS/CAMHS Professional must also complete Form DP3d in relation to the assessments carried out and ensure that one copy is handed to the Commissioned Health Care Professional at the Police Station and a copy is added to the Service Users file. See Appendix G for details of the DP3d form

2.7 ADMISSION TO HOSPITAL OF YOUNG OFFENDERS

2.7.1 Where it is deemed necessary to admit a young offender into hospital because of a mental disorder the following procedure must be adopted.
   I. Where an appropriate placement is found the young person will be admitted to that placement
   II. Where there are delays in finding an appropriate bed the CPFT will provide clinical support to manage the clinical needs and manage the risks to the young person at the Police Station. This may require 1:1 observation
   III. A clinical assessment, including the GRIST Adolescent risk assessment tool must be completed
   IV. The Custody Officer will contact the CPFT on call CAMHS Service Manager (9am to 5pm) or Duty Manager (Out of Hours) and discuss and agree the most appropriate place to meet the best interests of the young person.
2.8 DIVERTED MENTALLY DISORDERED OFFENDERS

2.8.1 The Police have a specific form (Form CID 20) which should be completed by the Police when someone is diverted from a Police Station to a ward. The officer in the case will endorse the CID20 with the incident log number which refers to the specific case. The officer in the case will then use the incident log to update instructions which relate to progressing the investigation, at the time when the patient is released from hospital.

2.8.2 The CID 20 has details of the officer in the case or other relevant Police contact and should accompany the diverted individual to the ward. When the individual is subsequently discharged from the ward the Police should be informed of that discharge.

2.8.3 Form CID 20 should be used when an alleged offender, who is assessed under the MDO Protocol, is deemed not fit to be detained or interviewed and is, diverted into the care of local mental health services. The form should be completed by the Police and handed to Mental Health staff, who will ensure that the patient’s clinical team are aware that the Police need to be informed prior to the patients discharge and that the form is placed in the patient’s medical record.

2.8.4 Prior to discharge the police will be contacted on the dedicated police number of 101 (number shown on form CID20) and will quote the incident log number which will be recorded on the same form. This will allow for ready access to instructions left by the office in the case in relation to how the enquiry should be pursued. Form CID20 is at Appendix A.

2.9 MENTAL HEALTH PATIENTS SUBJECT TO DETENTION UNDER THE MENTAL HEALTH ACT 1983 (AS AMENDED 2007) IN POLICE CUSTODY

2.9.1 A dynamic risk assessment of all relevant factors needs to be undertaken where a criminal offence has been committed by someone detained under the Mental Health Act and consideration of proceeding through the Criminal Justice system is taking place. The purpose of this is to determine whether the use of the police custody suite is appropriate, or what alternative arrangements are available to allow the necessary gathering of required evidence. It is important that the proper level of care and support is maintained throughout.

2.9.2 When a person, who is subject to detention under a civil/criminal section of the Mental Health Act, is arrested for a criminal offence and taken into custody the Provider Trust or organisation responsible for that persons clinical care continues to have responsibility for the clinical management of the detainee’s mental disorder whilst that person is in custody at the Police Station.
A. The Custody Officer, in such cases should make early contact with the ALIS to establish an effective care management plan and the criteria where Mental Health staff would attend the Police Station to assist in care management.

B. On completion of the Police inquiry, if the Police are not considering a remand to prison, the Trust has a duty of care to ensure that the person is either received back into local Mental Health services or, if not appropriate, must ensure that alternative in-patient arrangements are made to a relevant and safe environment for the detainee’s health needs.

2.10  **FHCP, L&D & SPECIALIST MENTAL HEALTH TEAMS**

2.10.1 Organisational changes within agencies will inevitably occur and this sometimes leads to confusion over roles and responsibilities within Custody Suites.

2.10.2 Although the ALIS teams within the County do have a role in giving advice and management of Mentally Disordered Offenders in Police Stations the following summary should assist in establishing roles, responsibilities and demarcation lines of FHCP’s, L&D and ALIS.

- The Police and FHCP can contact L&D or ALIS and enquire whether a particular person is known to the service and seek advice about managing that individual whilst at the Police Station.
- The L&D or ALIS may also be contacted by the Custody Officer prior to a detained person being released from custody where the Custody Officer has concerns about the detained person's risk because of their mental disorder. The L&D or ALIS will determine how this will be followed up and the decision and reasons for that decision will be documented on the individual’s custody record.
- **The Custody Officer should be the only authority to determine whether someone is fit to be detained and is fit to be interviewed after discussions with health professionals**

**Annex G of Code C of PACE 1984** gives general guidance to police officers and healthcare professionals, on whether a detainee might be at risk in an interview. There are circumstances, despite a person being assessed as unfit to interview and/or unfit to be detained, where such vulnerable suspects, need to interviewed urgently at police stations. The effect of not interviewing them can have the following consequences and may lead to:

A. interference with, or harm to, evidence connected with an offence; and/or
B. interference with, or physical harm to, other people; and/or
C. serious loss of, or damage to property; and/or
D. alerting other people suspected of committing an offence but not yet arrested for it; and/or
E. hinder the recovery of property obtained in consequence of an offence.

- The safeguards that must be adhered to by Police when conducting an interview in these circumstances are contained in **PACE Code C Paragraphs 12.3; 11.18 to 11.20; 11.1 and Annex G to Code C**.
  A. If the FHCP determines that a person is not fit for detention or interview because of a suspected mental disorder then the FHCP must follow the procedures outlined in Paras 2.1.4 and 2.3.2 above
  B. The ALIS should not be asked to perform any other assessments other than those outlined in this Protocol.
  C. AMHP and Consultant Psychiatrists should not be asked to perform any other assessments other than those outlined in this Protocol.
SECTION 2B:

2.11 UPON ARREST: (KENDAL POLICE STATION)

2.11.1 Where any person commits an offence and is arrested, they will be subject to the relevant sections of the Police and Criminal Evidence Act (PACE) and its Codes of Practice. Detainees in custody of the Court are subject to detention by G4S (Independent Provider), who are also subject to the principles of PACE.

2.11.2 Upon arrival at a designated Police Station a detained person will be seen by the Custody Officer. The Custody Officer will determine whether the detained person should be admitted to the Custody Suite. They will begin the process by asking the detained person for personal details and assess whether the detained person is fit to be detained and fit to be interviewed. This will include an initial evaluation of whether the detained person is suffering from a mental disorder. A detained person’s mental disorder may be identified in a number of ways:

- Overt presentation of mental disorder through words or actions
- Information from the detained person
- Information from a legal representative
- Information from a family member or friend
- Information from Police staff who know the detained person
- Information on PNC or Police Intelligence systems etc

2.11.3 If the custody officer determines that a detained person is presenting with a mental disorder and may not be fit to be detained and/or interviewed by the police, the Forensic Health Care Professional (FHCP) should be requested to attend to assess the detained person.

2.11.4 The role of the FHCP is to determine whether the detained person is fit to be detained and/or interviewed. The FHCP must enter their assessment findings and decision of whether the detained person is fit to be detained and/or interviewed on the appropriate custody medical form:

A. If the detained person is judged to be fit to be detained and/or interviewed, normal police procedures in relation to detained persons will follow.

B. If the detained person is assessed as not being fit to be interviewed the FHCP will contact the ALIS team and ask for a further assessment of the detained person’s mental health needs. The ALIS practitioner will not make any decisions without first attending the Police Station and assessing the detained person.

C. The role of the ALIS team practitioner is exclusively around assessment of the detained persons Mental Health at that specific time and the decision to assess should not be influenced by the alleged offence or whether the detained person is fit to be detained or interviewed.

D. Following an assessment by the ALIS Practitioner, if the detained person is judged to be suffering from a mental disorder then the ALIS Practitioner should inform the Custody Sergeant of the outcome of their
assessment. The Custody Sergeant will then make a decision based on the information provided by the ALIS Practitioner as to whether the detained person is not fit to be detained and/or interviewed.

E. If the Custody Sergeant makes a decision that the detained person is not fit to be detained and/or interviewed they may be offered appropriate assessment/treatment by Mental Health Services or Learning Disabilities Services in either:

i. the community OR

ii. By informal admission to hospital based on an assessment by either the L&D / ALIS Practitioner OR

iii. By a formal admission to hospital following an assessment under the Mental Health Act by duty Approved Mental Health Professional (AMHP) and two Section 12 Approved Doctors. This can be arranged by contacting the duty Approved Mental Health Professional (AMHP).

IV. Where the offence is more serious, and especially where the nature of that offence will impact on the police decision to grant bail, the L&D/ALIS Practitioners should involve the local duty psychiatrist in their decision making. Where that psychiatrist believes that forensic services may need to be involved, s/he should make contact with the relevant Forensic Services (contact numbers are shown below). On-call Forensic Consultants are available 24/7 to provide guidance and advice.

It should be noted that there is no emergency pathway into Secure Services. If the offender is assessed as having mental health needs, and cannot be safely or appropriately managed in local or PICU facilities, a criminal justice pathway should be pursued through the courts to prison (hospital) services (Part 3 MHA 1983). This is the agreed pathway for offenders of this nature to access specialised Forensic Services.

For advice and support from the on - call Forensic Consultants can be contacted on the following numbers

- **South Cumbria patients:**
  - Guild lodge – 01772 406700 (The control room has details of Consultant on-call rota)

v. Where the assessment by the Liaison & diversion team or ALIS determines that

a) No mental health intervention is required OR

b) Assessment /treatment can take place in the community AND

c) Informal admission to hospital or assessment for formal admission to hospital is not necessary.

The Custody Officer must then decide whether the detained person is fit to be detained and/or fit to be interviewed. If following the assessment the police decide to continue to interview/charge the service user, the police will inform the ALIS Practitioner prior to release from custody if further ALIS/HT input had been planned at assessment.
F. It is important that all decisions relating to this process; including whether or not it is appropriate to proceed through the Criminal Justice System, should be fully documented with the rationale for the decisions in the detained person’s custody medical record.

G. Where the above assessments have taken place the custody officer must consider whether an appropriate adult should be present for the detained person during any interview (in accordance with PACE – code C para 1, 4 and 1.7).

H. If the detained person is judged to be fit to be detained and interviewed, normal police procedures in relation to detained persons will follow.

NB: Before the detainee leaves the police station all parties should confirm his/her legal status. E.g. remanded; released without charge; reported for summons; cautioned or charged to Court. The ALIS must also complete Form DP3d in relation to the assessments carried out and ensure that one copy is handed to the Commissioned Health Care professional at the Police Station and a copy is added to the Service Users file. See Appendix G for details of the DP3d form.

2.12 INTERVIEWS WITHOUT ARREST

2.12.1 There will be occasions where it is entirely appropriate for police officers to pursue their investigation without arresting an individual e.g. – this might be where the offence is minor, the offender is a young person, or, in some cases, where a vulnerable adult has committed minor offences on mental health wards.

2.12.2 It is imperative that the officer in the case highlights any concerns regarding mental disorder on the case file by endorsing the MG6 (confidential case file document) in order that appropriate enquiries can be made with mental health services in line with section 3 of this protocol.

2.13 PEOPLE WITH LEARNING DISABILITIES

2.13.1 If the Police arrest a person who they suspect may have learning disabilities they should seek information via Adult Social Care Customer Services within office hours and via the ALIS, or, out of hours, the out of hours team. This process should confirm to the Police whether the individual is currently in receipt of services from the Learning Disabilities Teams. If there is doubt about a person’s ability to be interviewed, the Police should request the presence of an appropriate adult under the terms of PACE. If there is concern about the person’s general fitness to be detained and interviewed the police should seek the advice of the Forensic Health Care Professional (FHCP).
2.13.2 Where the ALIS assessor or AMHP attends and it is assessed that the detained person is suspected of suffering from a Learning Disability and is not known to Mental Health Services the Health Professional will complete the CPFT’s accepted Learning Disability Screening Questionnaire (LDSQ) and submit the form to the Forensic Lead for Learning Disabilities for that area.

2.14 REQUESTS FOR MENTAL HEALTH ASSESSMENTS FOR THE GATHERING OF EVIDENCE IN SERIOUS CRIMES

2.14.1 In cases which include Murder, Manslaughter, Stranger rapes and other serious crime where there is extreme violence or extreme behaviour the Senior Investigating Officer (SIO) can request that the detainee is examined by a Psychiatrist. The rationale is, that an early examination of the detained person can counter an examination made by a defence employed Psychiatrist employed months after the offence. It can negate a defence of “a psychotic episode” where they did not have capacity at the time, and also prove that they could comprehend the questions put to them in interview and that they were competent to give rational answers.

2.14.2 The SIO will arrange an Approved Doctor (Section 12 MHA 1983) through Cumbria Constabulary’s privately contracted arrangements to conduct an “evidential assessment”. A list of approved doctors is held on the Cumbria constabulary intranet. It can be located on the Custody Cares website, in a folder labelled Mental Health Matters and a sub folder labelled “SIO Evidential Mental Health Assessment”.

2.15 UNFIT TO PROCEED THROUGH CRIMINAL JUSTICE SYSTEM

2.15.1 There will be occasions where a person is unfit (by reason of their mental disorder) to proceed through the Criminal Justice System and it is not appropriate to divert, either informally or through legislation to hospital e.g. severe learning disability and dementia etc.

2.15.2 If following an assessment (Para 2.11.4 E) and where the offence is a serious offence the Police and Crown Prosecution Service will consider whether it is appropriate to proceed under “Unfitness to Plead” legislation (See paragraph F for details).

2.15.3 Where the offence is a minor offence and would not meet the criteria for “Unfitness to Plead” legislation the Police will need to ensure that there is an appropriate outcome to such cases that is fully documented and proportionate to all parties. This should include a transparent process for any victims of such offences. The Police will, if required, call a meeting with the Health Professional Lead for the individuals care, to discuss whether it is appropriate to develop a management plan in order that further offending is minimised or eliminated.
2.16 YOUNG PERSONS IN CUSTODY (Under 18 years of age)

2.16.1 In general the principles outlined for the screening and assessment of young persons arrested for criminal offences and taken to a designated Police Station will follow the procedures for adults.

2.16.2 The role of the FHCP is to determine whether the young person is fit to be detained and/or interviewed.

A. The FHCP must enter their assessment findings and decision whether or not the young person is fit to be detained and/or interviewed on the appropriate custody medical form:

B. If the young person is judged to be fit to be detained and/or interviewed, normal police procedures in relation to detained persons will follow.

C. If the young person is assessed as not being fit to be detained and/or interviewed the FHCP will contact the L&D and/or Child and Adolescent Mental Health Service (between 9am and 5pm) or the Access and Liaison Integrated Services (ALIS) out of hours and ask that a further assessment of the young person’s mental health should be conducted. The FCHP must give full details and information of their initial assessment to the CAMHS/ALIS. The CAMHS/ALIS will not make any decisions without first attending the Police Station and assessing the detained person.

D. If the detained person is judged to be suffering from a mental disorder and is not fit to be detained and/or interviewed and after assessment by the CAMHS/ALIS the detained person may be offered appropriate assessment/treatment by Mental Health Services or Learning Disabilities Services either:
   i. In the community;
   ii. By informal admission to hospital or
   iii. By contacting the CAMHS duty Consultant Psychiatrist (between 9am and 5pm) or the duty AMHP (Out of Hours) to request an assessment under the Mental Health Act for formal admission to hospital under Section 2 or Section 3 of the Mental Health Act 1983 (as amended 2007). An Out of Hours assessment under such circumstances will be undertaken by the on call Adult Consultant Psychiatrist.

E. Where the assessment by the CAMHS/ALIS determines that:
   I. No mental health intervention is required OR
   II. Assessment/treatment can take place in the community AND
   III. Informal admission to hospital or assessment for formal admission to hospital is not necessary

F. The FHCP must decide in collaboration with the Custody Officer whether the detained person is fit to be detained and/or fit to be interviewed.

G. It is important that all decisions relating to this process and whether it is appropriate or not to proceed through the Criminal Justice System should be fully documented with reasons for the decisions in the young person’s custody record medical form.

H. The custody officer must ensure that an appropriate adult is present for the young person during any interview.
NB: Before the detainee leaves the police station all parties should confirm his/her legal status. E.g. remanded; released without charge; reported for summons; cautioned or charged to Court. The ALIS/CAMHS Professional must also complete Form DP3d in relation to the assessments carried out and ensure that one copy is handed to the Commissioned Health Care Professional at the Police Station and a copy is added to the Service Users file. See Appendix G for details of the DP3d form.

2.17 ADMISSION TO HOSPITAL OF YOUNG OFFENDERS

2.17.1 Where it is deemed necessary to admit a young offender into hospital because of a mental disorder the following procedure must be adopted. Where an appropriate placement is found the young person will be admitted to that placement.

2.17.2 Where there are delays in finding an appropriate bed the CPFT will provide clinical support to manage the clinical needs and manage the risks to the young person at the Police Station. This may require 1:1 observation.

2.17.3 A clinical assessment, including the GRIST Adolescent risk assessment tool must be completed.

2.17.4 The Custody Officer will contact the CPFT on call CAMHS Service Manager (9am to 5pm) or Duty Manager (Out of Hours) and discuss and agree the most appropriate place to meet the best interests of the young person.

2.18 DIVERTED MENTALLY DISORDERED OFFENDERS

2.18.1 The Police have a specific form (Form CID 20) which should be completed by the Police when someone is diverted from a Police Station to a ward. The officer in the case will endorse the CID20 with the incident log number which refers to the specific case. The officer in the case will then use the incident log to update instructions which relate to progressing the investigation, at the time when the patient is released from hospital.

2.18.2 The CID 20 has details of the officer in the case or other relevant Police contact and should accompany the diverted individual to the ward. When the individual is subsequently discharged from the ward the Police should be informed of that discharge.

2.18.3 Form CID 20 should be used when an alleged offender, who is assessed under the MDO Protocol, is deemed not fit to be detained or interviewed and is diverted into the care of local mental health services. The form should be completed by the Police and handed to Mental Health staff, who will ensure that the patient’s clinical team are aware that the Police need to be informed prior to the patients discharge and that the form is placed in the patient’s medical record.
2.18.4 Prior to discharge the police will be contacted on the dedicated police number of 101 (number shown on form CID20) and will quote the incident log number which will be recorded on the same form. This will allow for ready access to instructions left by the office in the case in relation to how the enquiry should be pursued. Form CID20 is at Appendix A.

2.19 MENTAL HEALTH PATIENTS SUBJECT TO DETENTION UNDER THE MENTAL HEALTH ACT 1983 (AS AMENDED 2007) IN POLICE CUSTODY

2.19.1 A dynamic risk assessment of all relevant factors needs to be undertaken where a criminal offence has been committed by someone detained under the Mental Health Act and consideration of proceeding through the Criminal Justice system is taking place. The purpose of this is to determine whether the use of the police custody suite is appropriate, or what alternative arrangements are available to allow the necessary gathering of required evidence. It is important that the proper level of care and support is maintained throughout.

2.19.2 When a person, who is subject to detention under a civil/criminal section of the Mental Health Act, is arrested for a criminal offence and taken into custody the Provider Trust or organisation responsible for that persons clinical care continues to have responsibility for the clinical management of the detainee’s mental disorder whilst that person is in custody at the Police Station.
A. The Custody Officer, in such cases should make early contact with the ALIS to establish an effective care management plan and the criteria where Mental Health staff would attend the Police Station to assist in care management.
B. On completion of the Police inquiry, if the Police are not considering a remand to prison, the Trust has a duty of care to ensure that the person is either received back into local Mental Health services or, if not appropriate, must ensure that alternative in-patient arrangements are made to a relevant and safe environment for the detainee’s health needs.

2.20 FHCP & SPECIALIST MENTAL HEALTH TEAMS

2.20.1 Organisational changes within agencies will inevitably occur and this sometimes leads to confusion over roles and responsibilities within Custody Suites.
2.20.2 Although the ALIS teams within the County do have a role in giving advice and management of Mentally Disordered Offenders in Police Stations the following summary should assist in establishing roles, responsibilities and demarcation lines of FHCP’s and ALIS.
• The Police and FHCP can contact the ALIS and enquire whether a particular person is known to the service and seek advice about managing that individual whilst at the Police Station.
• The ALIS may also be contacted by the Custody Officer prior to a detained person being released from custody where the Custody Officer has concerns about the detained person’s risk because of their mental disorder. The ALIS will determine how this will be followed up and the decision and reasons for that decision will be documented on the individual’s custody record.
• **The Custody Officer should be the only authority to determine whether someone is fit to be detained and is fit to be interviewed after discussions with health professionals**

Annex G of Code C of PACE 1984 gives general guidance to police officers and healthcare professionals, on whether a detainee might be at risk in an interview. There are circumstances, despite a person being assessed as unfit to interview and/or unfit to be detained, where such vulnerable suspects, need to interviewed urgently at police stations. The effect of not interviewing them can have the following consequences and may lead to:

A. interference with, or harm to, evidence connected with an offence; and/or
B. interference with, or physical harm to, other people; and/or
C. serious loss of, or damage to property; and/or
D. alerting other people suspected of committing an offence but not yet arrested for it; and/or
E. hinder the recovery of property obtained in consequence of an offence.

• The safeguards that must be adhered to by Police when conducting an interview in these circumstances are contained in **PACE Code C Paragraphs 12.3; 11.18 to 11.20; 11.1 and Annex G to Code C**.
• If the FHCP determines that a person is not fit for detention or interview because of a suspected mental disorder then the FHCP must follow the procedures outlined in Paras 2.11.4 and 2.13.2 above
• The ALIS should not be asked to perform any other assessments other than those outlined in this Protocol.
• AMHP and Consultant Psychiatrists should not be asked to perform any other assessments other than those outlined in this Protocol.
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PROSECUTION

3.1. EARLY INFORMATION EXCHANGE BETWEEN HEALTH, SOCIAL CARE SERVICES AND CRIMINAL JUSTICE AGENCIES

3.1.1 When a mentally vulnerable person or a person with a mental disorder is arrested and taken into custody, or, attends the police station for interview for an offence the following procedure will be adopted.

3.1.2 If the detained person is to be assessed in accordance with the MDO Protocol to ascertain fitness for interview and detention, the custody officer will ensure that the predefined detention log entry (MDO Protocol) on the custody record is endorsed

3.1.3 When an MDO has been deemed fit to be detained and in order to expedite Criminal Justice procedures and ‘fast track’ decision making in relation to whether the MDO should be prosecuted or not the following process will take place

3.1.4 The Single Point of Contact for Mental Health Services is the Development Officer for Mentally Disordered Offenders

3.1.5 Form DP (3a) includes the following questions

A. Does …………. have mental capacity and is he/she responsible for his/her actions?

B. Would a prosecution interfere with …….. treatment or rehabilitation?

C. Are there any risks to …………. or others which the Criminal Justice Agencies need to be aware of?

D. If prosecution proceeds can you recommend to the court any Mental Health support or intervention should …………. plead or be found guilty of the offence e.g.

- Hospital Order – Section 37 Mental Health Act 1983
- Interim Hospital Order – Section 38 Mental Health Act 1983
- Guardianship Order – Section 37 Mental Health Act 1983
- Community Order with Mental Health Treatment attachment –Section 207 Criminal Justice Act 2003

3.1.6 The SPOC will establish if the individual is a local Mental Health Service User and if he/she is will forward the form to the individual’s Responsible
Clinician (RC) and send a copy of the request to the individual’s care coordinator/care manager.

3.1.7 On answering the questions the RC will return the form to the SPOC who will ensure that the information is passed to the Team Leader in the CJU.

3.1.8 On receipt of the completed form the CJU Team Leader/CPS will ensure that the document is dealt with in strict confidence (contained within MG6 – Sensitive Information) and form part of the overall decision making process in determining whether prosecution proceeds.

3.1.9 The discretion to charge or report for summons lies solely with the police and CPS and there may be occasions where the individual is charged and appears in court without the relevant information being available (e.g. Serious Offences).

3.1.10 The decision whether to prosecute or not will be relayed to the SPOC by the CJU, who will relay the information to the RC and care coordinator.

3.1.11 If a decision is made to prosecute, the information on form DP (3a) will be included in the CPS papers under confidential cover MG6 (d) in order that the CPS can be made aware of decisions made.

3.1.12 The above procedures can only be adopted if the individual is in contact with or has had recent contact with the Mental Health Services at the time the offence was committed.

3.1.14 If the MDO’s RC is unwilling to pass the relevant information to the police, or it cannot be passed for other reasons, the SPOC will contact the designated director of the Trust to discuss the matter. The SPOC will inform the Decision Maker/CPS, giving reasons why the information is not available.

3.1.15 The designated director for Cumbria Partnership NHS Foundation Trust is the Clinical Director located at Voreda House, Penrith. This office covers all Cumbria Policing areas.

3.2. **CRIMINAL BEHAVIOUR ORDER (CBO) Anti-Social Behaviour, Crime and Policing Act 2014**

3.2.1 The criminal behaviour order was introduced to give agencies and communities what they need to deal with the hard-core of persistently anti-social individuals who are also engaged in criminal activity. The court may make a criminal behaviour order against the offender if two conditions are met: (i) the person has engaged in behaviour that caused or was likely to cause harassment, alarm or distress to one or more persons not of the same household as the offender; and
(ii) the court considers that making the order will help in preventing the offender from engaging in such behaviour.

3.2.2 The court may make a criminal behaviour order against the offender only if it is made in addition to
a) a sentence imposed in respect of the offence, or
b) an order discharging the offender conditionally.
If the offender is under 18, the prosecution must find out the views of the local youth offending team before applying for a criminal behaviour order.

3.2.3 A criminal behaviour order is granted for a specific period of time and if it includes a requirement must specify the person who is to be responsible for supervising compliance. It may include provision for the order (or a prohibition or requirement included in the order) to cease to have effect if the offender satisfactorily completes an approved course specified in the order. Breaching the order would have tough criminal sanctions with a maximum sentence of 5 years in prison.

3.3. GUIDANCE ON PROSECUTION AND DISCONTINUANCE

The decision to prosecute and the role of the Crown Prosecution Service and Criminal Justice Unit within the Police

3.3.1 The key documents which set out the Crown Prosecution Service’s and Criminal Justice Units Policy in dealing with cases in which the defendant is mentally disordered are:

a. The Code of Crown Prosecutors (the code)
b. The Home Office Guidelines on the provision for mentally disordered offenders set out in the Home Office circular number 66/90 (the Circular) and the Bradley Review (2009)
c. National polices from time to time in force. For the purpose of clarification the local protocol is to be read in conjunction with such national policies and if there is any conflict the national policy is to take precedence.

3.3.2 Each case that the CJU and CPS review ensures that it meets both the evidential and public interest tests the reviewing Crown Prosecutor has to be satisfied that there is sufficient evidence to provide a ‘realistic prospect of conviction’. Only if this test is passed will it be necessary to consider if a prosecution is needed in the public interest.

3.3.3 If there is significant mental ill health, a prosecution may not be appropriate unless it is needed in the public interest, for example, because of the seriousness of the offence or the likelihood of re-offending. Information about the person’s condition and the availability of any suitable alternatives to prosecution will also be relevant.
3.3.4 If proceedings have been started or are being considered and the CJU/CPS is provided with a medical report which states that the strain of criminal proceedings may lead to a considerable worsening of the accused person’s mental health, the implications of a report will be considered very carefully.

3.3.5 The report should cover the questions outlined in Section 3 para 1.8 above and also give an opinion by the Consultant Psychiatrist of the probable affect prosecution would have on the individuals mental health and whether alternative mental health interventions such as treatment or rehabilitation are in place and ongoing.

3.3.6 If the CJU/CPS is satisfied that the probable effect on the defendant's mental health outweighs the considerations in favour of a prosecution in that particular case, the proceedings should be discontinued.

3.3.7 **Remember** Even if a decision to prosecute is reached Health and Social Services still have a duty of care towards the accused and to represent his/her care needs to the Court.

3.3.8 Decisions to prosecute rest with the CJU and CPS. Information which may help this process should be discussed with the police as part of the multi agency management process.

3.3.9 Representation may be made via multi agency case discussions.

3.3.10 When time or urgency necessitates direct contact representation should be made to the Crown Prosecution Service or Criminal Justice Unit Decision Maker.

3.3.11 If new information comes to light, which if it had been available to the Court at the time of the hearing might have influenced the decision; it should be given to the CJU/CPS for action.

3.3.12 If the information about a possible new offence comes to light, that information should be given to the police for action.

3.4 **ATTENDANCE BY CROWN PROSECUTORS AT MULTI AGENCY CONFERENCES**

3.4.1 On rare occasions where the criminal case is complex or the risk of the serious harm to others is present a case conference or MARE may be called to discuss the issues. Crown Prosecution or CJU staff may attend such meetings if they believe it to be relevant and appropriate.
3.4.2 Principles

- Attendance is to facilitate better exchange of information between agencies to encourage more informed decision making
- Decisions on prosecutions will be made independently by CJU/CPS outside the conference
- The conference will not seek to take any multi agency decisions about prosecutions
- Discussions about a defendant, victim or witness medical or mental condition is to inform the independent decision making process
- Explanation of medical mental health or legal terms definitions processes etc. is appropriate
- Conference will not seek to discuss, persuade or seek justification by CJU/CPS of decisions made or to be made independently about prosecutions

3.4.3 Disclosure

- In criminal proceedings the prosecution are under a duty of disclosure to the defence of relevant used or unused information – see Criminal Procedure and Investigations Act 1996 (CPIA 1996)
- Information about criminal proceedings considered at a multi agency conference is subject to the principles set out in CPIA 1996
- Full and accurate records of any multi agency conference must be kept and are potentially disclosable during the course of criminal proceedings

3.4.4 Practice

- Where a crime has been investigated, CPS advice sought and given and it appears there is information about a defendant, victim or witnesses which needs further explanation before a final decision is made, the presence of a Crown Prosecutor could be helpful in focusing on the key issues
- When a crime has been investigated CPS advice sought and given or a prosecution already commenced and there are clear issues about the medical or mental health of the defendant, victim or witness and the prosecution consider that information beyond reports would be helpful to the prosecution the presence of a Crown Prosecutor to receive that information is appropriate

3.4.5 Procedure

- The police will undertake the lead role at conferences in communicating with the CPS
- When a conference considers there is information which ought to go to CPS or which may need further explanation the conference will be adjourned and a written note of the issues provided to the CPS with an invitation to attend a future conference

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• A Crown Prosecutor will assess the information provided and decide whether it is appropriate to attend or seek better written information.

• When a Crown Prosecutor is provided with information about medical or mental health issues in a case and a defendant, victim or witness is subject to conference this fact will be brought to the Crown Prosecutor’s attention. The Crown Prosecutor will communicate with the officer in the case and decide whether it is appropriate to attend conference.
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4.1 COURT

4.1.1 An MDO who is brought before Court should be subject to the principles set out in Part 3 of the Mental Health Act. That is, information should be given to the Court to help them decide if there are any mitigating factors to mental disorder before passing sentence. This information can be supplied to a Court by a:
A. Defence commissioned psychiatric report
B. Court commissioned psychiatric report
C. In line with Early Information Exchange between Health, Social Care and Criminal Justice Agencies in Section 3 of this protocol
D. Probation report after appropriate liaison and agreement with the Mental Health Services (see Reports to Court para 3 below)

4.1.2 Where the Court is mindful of making an order under Part 3 of the Mental Health Act either for assessment or treatment, as much advance notice as possible should be given to the relevant hospital and the agreement of the hospital, the supervising psychiatrist and the funding agency i.e. The Health Authority should be obtained. (See Services to the Court).

4.1.3 Where court officers or defence solicitors are concerned regarding a person's mental health at Court, checks should be made on custody records to ascertain if a mental assessment has been carried out whilst the person was in custody, or whether form DP (3a) is within the court papers. If this is not the case, the Court may commission a psychiatric report and adjourn the case until this is carried out.

4.2 APPEARING AT COURT

Patients detained under Mental Health legislation appearing before Court

4.2.1 Where a criminal offence has been committed by someone suffering from a mental disorder and who is detained under mental health legislation and that person has been charged the following action should take place.

A. When the detained person is kept in custody, with the intention of putting him/her before a Criminal Court to answer charges a senior member of the detained person's clinical team should always be in Court to listen to proceedings where an application for remand in custody is being made.

B. The senior member of a detained person's clinical team present in Court should be prepared to give evidence to the Magistrates and should liaise with the Crown Prosecution Service (CPS) lawyer as to the mental health status and implications of that status. They should also be prepared to advise the CPS lawyer and Court, if necessary,
whether a proposed bail address represents a risk of harm to the
detained person or others.

C. Where the Court do not remand the detained person in custody, the
responsibility for the person’s care lies with the CPFT and that Trust
should ensure that the detained person is either received back into
local Mental Health services, or, if not appropriate must ensure that
alternative in-patient arrangements are made to an appropriate and
safe environment for the detained person’s health needs. The Court
may also wish to impose conditions if the detained person is bailed.

D. The process will only be effective if there is clear and prompt
communication between the Police, Court and Mental Health
Services (see Section 2 para 7 for further details).

E. Any disputes in relation to this should be directed to each areas
Mental Health Liaison Inspectors or the on duty Manager for the
Mental Health Trust

NB. The above process only applies to those individuals who are formally
detained under a civil/criminal section of the Mental Health Act 1983 (as
amended 2007) and does not include discharged or former patients of the
Mental Health Services. The above process must also be complied with
for relevant patients appearing at Crown Court

4.3 REPORTS TO COURT

4.3.1 Duty of Courts to obtain a medical report

Before forming an opinion that a custodial sentence is justified, and if so,
what length that sentence should be, a Court faced with a defendant
who is either known to mentally disordered or appears to be so in the lay
opinion of the Court, should obtain a medical report subject to the caveat
that this can be dispensed with if the Court reaches a specific opinion
that such a report is not necessary. A medical report is defined as a
report as to an offenders mental condition made or submitted orally or in
writing by a doctor approved under the Mental Health Act 1983 section
12. If the Court fails to obtain a report without first reaching an opinion
that a report is unnecessary, any custodial sentence passed is
nevertheless valid but will clearly provide grounds for an appeal and in
the event of an appeal the higher Court will be required to obtain and
consider a report. The requirement does not apply where the custodial
sentence is fixed by law, i.e. for an offence of murder.

4.3.2 Medical reports prior to Hospital Orders

Medical evidence is usually secured via a psychiatric report and is
required before a Court may make a hospital order or interim hospital
order, guardianship order, community or supervision order with
requirement of medical treatment. Evidence is also required in
determining unfitness to plead. Reports are routinely prepared in all
cases of homicide.
4.3.3 **Assessment Reports and Fitness to Plead**

Assessment reports can be identified at the request of the defence, in very rare instances by the Crown and also by the Prison Health Care service, either in-house or from an outside psychiatrist.

4.3.4 Where the defence make representation to the court in relation to their client’s fitness to plead and fitness to understand court proceedings an assessment and report can be commissioned by the defence.

4.3.5 In the interests of the defendant and expediency for the court the assessment and report should be short and specific and need only address the issues of fitness to plead and fitness to understand court proceedings. The contents and length of the report, however, will always be at the discretion of the author and may vary depending on individual circumstances. This report will be funded by the clients defence team.

4.4 **EARLY INFORMATION EXCHANGE BETWEEN HEALTH, SOCIAL CARE AND CRIMINAL JUSTICE AGENCIES**

4.4.1 Section 3 of this Protocol outlines a process whereby early information is obtained by the Police Criminal Justice Unit and/or Crown Prosecution Service as to whether an individual with a mental disorder should proceed through the Criminal Justice system. In line with the recommendations of the Bradley report that information should follow the individual through the Criminal Justice system and be available to the Courts. The information provided may well be sufficient to inform the Court and Defence Team of the nature and severity of the individual’s mental disorder and possibly prevent the requirement for a full psychiatric assessment of the individual’s mental health. This will reduce court process time and reduce court and defence costs if more formal psychiatric assessment and reports are not required.

4.4.2 Before the Defence Team or the Court consider a request for a mental health assessment and report they should determine whether the information contained on Form DP (3a) is sufficient for
A. Court purposes before determining sentence
B. Can be used as part of the information contained within the Pre Sentence Report from the Probation Service to the Court
4.5 CRIMINAL JUSTICE ACT 2003

4.5.1 The Criminal Justice Act 2003 allows the Court to consider, when sentencing, to impose on an offender a Community Order with a number of attachments to the order, including a Mental Health Treatment Order and Supervision Order.

4.5.2 MENTAL HEALTH TREATMENT - the court must be satisfied that the mental condition of the offender is such as requires and may be susceptible to treatment. This requirement can only be given with the consent of the offender and a psychiatrist must be willing to act as the supervisor for the treatment in the community.

4.5.3 REHABILITATION ACTIVITY REQUIREMENT (RAR) - The Rehabilitation Activity Requirement (RAR) was introduced by the Offender Rehabilitation Act 2014. The Act amends the Criminal Justice Act 2003 and repeals the Supervision and Activity Requirements replacing them with a single new Requirement that gives greater flexibility for providers of probation services to determine the rehabilitative interventions.

4.5.4 The Court may also consider it appropriate to make a decision to impose a Community Order with Mental Health Treatment and Supervision Requirement together on the order, where a collaborative and multi-agency approach is required to address the mental disorder and offending behaviour.

4.5.6 Additional information in relation to the legislation for the above can be found at Appendix E.

4.6 MENTAL HEALTH TREATMENT REQUIREMENT (MHTR)

4.6.1 The MHTR was introduced as a sentencing option in April 2005, as one of the provisions of the Criminal Justice Act 2003. The Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2012 made changes to the administration of the MHTR by amending provisions linked to the Criminal Justice Act 2003 and the Mental Health Act 1983.

4.6.2 The LASPO Act sought to make it easier for courts to use the MHTR as part of a Community Order or Suspended Sentence Order by simplifying the assessment process and ensuring that those who require community based treatment receive it as early as possible. The Act removed the requirement in the Criminal Justice Act 2003 that evidence of an offender’s need for mental health treatment is given to a court by a Section 12 registered medical practitioner.

4.6.3 This change means that the courts may seek views and assessments from a broader range of suitably trained mental health professionals.
The intention is to ensure that courts receive appropriate advice and individuals’ mental health assessments quicker, thus reducing the avoidable financial and time costs of using the MHTR as part of a suspended sentence or community sentence.

4.6.4 At Court

- The Defendant pleads or is found guilty.
- A Pre-Sentence Report is requested by the court and undertaken by the National Probation Service. Court will ordinarily require completion of report within four weeks.
- A Report author, acting either at the explicit request of the court and/or, on the basis of professional judgement, assesses that the offender may benefit from the imposition of a MHTR and requests an assessment.
- Report author obtains consent of defendant to assessment and treatment; completes Referral Form (appendix 2) outlining presenting issues and/or symptoms and forwards this by secure email to Community Mental Health Assessment and Recovery Team (CMHART).

4.6.5. If the offender is known to Mental Health Services

- Report author to request any recent Health and Social Care and/or Risk Assessments, Multi-Agency Risk Evaluation (MARE) minutes (if appropriate).
- Report author to discuss with CMHART Team Manager and/or Team Leader if MHTR can be proposed as part of a Community or Suspended Sentence Order.
- If deemed suitable, CMHART to provide letter detailing support for inclusion of MHTR as part of sentence, including an outline of proposed work to be undertaken with the offender.
- Report author to recommend inclusion of MHTR as part of sentence.

4.6.6 If offender is not known to Mental Health Services

- Report author to liaise with CMHART Team Manager and/or Team Leader to discuss case / detailing offender’s suitability for MHTR.
- If an assessment is deemed appropriate, report author to complete referral document (see appendix 2) and forward to CMHART who in turn will complete their assessment within four weeks of receiving the referral.
- CMHART send out ‘opt in’ letter with appointment date/time to offender. A copy should also be sent to the report author/referrer.
- If offender opts in, assessment completed and suitability report sent to report author at relevant secure email address.
• If offender does not opt in, and / or is deemed unsuitable for whatever reason, report detailing reason(s) for unsuitability to be forwarded to report author at relevant secure email address.

4.6.7 Post Sentence

• If a MHTR is imposed, the offender management of the requirement is carried out by either the National Probation Service or Community Rehabilitation Company, depending on the offender’s assessed risk level, sentence received and outcome of the Case Allocation System (CAS) tool applied.
• It is necessary for CMHART and the probation provider to regularly discuss and share information in relation to an offender's progress on their MHTR.
• Enforcement of a MHTR by probation is concerned with breaching the conditions of the order but not the treatment itself. A MHTR is not court ordered treatment it is treatment entered into by an individual and endorsed by the court. Enforced mental health treatment may only be made under an appropriate section order of the Mental Health Act 1983, which should not be confused with the MHTR or other Community Orders.

4.6.8 Mental Health Treatment Providers (CMHART)

• The Court can sentence an offender to a Community Order with MHTR for a period of six months up to a maximum of three years; or up to a maximum of two years when attached to a Suspended Sentence Order.
• Post sentence, the Offender Manager and the Mental Health Practitioner will need to liaise closely throughout the course of the order / MHTR to enable the probation provider to actively monitor compliance and engagement.
• Mental Health Practitioners should report any of the following behaviours presented to the Offender Manager on the same working day wherever possible:
  - Non-attendance at planned appointments
  - Attending the appointments under the influence of alcohol or drugs
  - Non-compliance with treatment plan
  - Non-concordance with medication
  - Presenting at appointments in an aggressive or threatening manner
• Where an offender fails to meet the conditions of the MHTR due to their actions this may be regarded as a breach of their Order and could result in either a warning letter being issued and / or the offender’s return to court.
• If the offender is deemed to no longer require the services of the CMHART and is to be discharged from Mental Health Services, the Mental Health Practitioner will discuss this with the Offender Manager and will forward the discharge summary to the Offender Manager once completed. The Offender Manager will then apply to the court for deletion of the requirement if in advance of the expected requirement expiry date.

4.6.9 Additional information in relation to the protocol for the above can be found at Appendix ?.

4.6.10 For detailed information in relation to the Legal Framework for MHTRs, Integrated Delivery Model and the various roles of key agencies, staff should consult the National Offender Management Service Guide on ‘Mental Health Treatment Requirements – Guidance on Supporting Integrated Delivery’ which is available at:


4.7. WHERE A REPORT HAS BEEN REQUESTED BY THE COURT IN RELATION TO A POSSIBLE ADMISSION TO HOSPITAL

4.7.1 Under the Mental Health Act 1983 (as amended 2007) the doctor undertaking the report should have access to relevant pre-sentence reports, the inmates medical record (where the defendant is remanded in prison custody) and previous psychiatric treatment records as well as relevant documentation regarding the alleged offence. If the doctor is not given this information he should say so clearly in his report. (Mental Health Act code of practice)

4.7.2 Where a report has been prepared at the request of the Court for the purposes of any provision of the Mental Health Act 1983:

A. A copy of the report shall be given to the defendants counsel or solicitor
B. If the defendant is unrepresented the substance of the report shall be disclosed to him or her (or to the parent or guardian in the case of a child or young person).
C. The doctor may be required to attend to give oral evidence either at the request of the Court (unless the report relates only to arrangements for the defendants admission to hospital) or the defence (Mental Health Act 1983 section 54[2] and [3])
4.8. **REPORTS FOR MAGISTRATES COURTS AFTER CONVICTION**

4.8.1 A court has general power to adjourn after conviction prior to sentence to determine the most suitable method of dealing with the case, even in regard to non imprisonable offences. (Magistrates Court Act 1980 section 10[3]).

4.8.2 The maximum period for adjournment is four weeks at a time or three weeks if the defendant is remanded in custody. The normal period for preparation of a pre sentence report is 15 working days.

4.8.3 A Court can impose a condition of bail requiring the defendant to make himself available for the purposes of enabling enquires or reports to be made to assist the Court, if the Court has reason to believe he would not co-operate.

4.8.4 Powers of Criminal Courts (Sentencing) Act 2000, Section 11 gives Magistrates Courts flexible power to obtain a medical report in any instance where the Court determines that the defendant’s physical or mental condition should be investigated provided that the case is being dealt with by summary trial and the offence carries a sentence of imprisonment.

4.8.5 A statement of the reasons why the Court is of the opinion that an enquiry should be made into the defendant’s physical or mental condition and any information available to the Court about his or her condition should be sent to either the institution to which he or she is remanded in custody or to the institution or place to which he or she is remanded or to the doctor who is to conduct the examination.

4.9 **REMANDS TO HOSPITAL FOR A REPORT UNDER SECTION 35**

Mental Health Act 1983 (amended 2007)

4.9.1 Either Crown Court or Magistrates Courts may remand a defendant to a hospital specified by the Court for a report on their mental condition under the provision as follows:

A. Crown Courts: Where the defendant is awaiting trial for an offence carrying a sentence of imprisonment (other than murder) or has been arraigned before the Court for such an offence but has not yet been sentenced or dealt with.

B. Magistrates Courts: Where the offence is punishable summarily with imprisonment and
   (1) the defendant has been convicted of the offence or
   (2) the Court is satisfied that the defendant did the act or made the omission charged or
   (3) the defendant has consented to the Court’s exercise of this power.
4.9.2 Before remanding the Court must be satisfied on the written or oral evidence of a doctor that there is reason to suspect that the accused is suffering from a mental disorder. Also the Court must be of the opinion that it would be impracticable for a report on the defendant’s mental condition to be made if he or she were remanded on bail. Also there must be written or oral evidence from either the doctor who will prepare the report or a representative of the hospital managers that arrangements have been made for the defendant’s admission to hospital within 7 days of the remand date.

4.10 **PLACE OF SAFETY**

4.10.1 The defendant may be detained in a PLACE OF SAFETY. This is normally a prison establishment but can be a police station or another hospital pending his admission to the hospital to which he has been remanded for the preparation of a report.

4.10.2 The period of remand cannot exceed 28 days but the defendant may be re-remanded if it appears to the Court on the written or oral evidence of the doctor responsible for the report that a further remand is necessary to complete the assessment. But the total period spent on remand shall not exceed 12 weeks.

4.10.3 It is not necessary for the defendant to be present at Court for a re-remand provided that he or she is legally represented and the advocate has the opportunity to address the Court.

4.10.4 The Court may terminate the remand at any time if it appears appropriate to do so.

4.10.5 This may apply where the assessing hospital makes representations to the Court before the end of the 28 day period to the effect that it has completed its assessment or is able to provide the Court with a report.

**NB.** Section 35 MHA does not give the power to treat. The MHA CoP paragraph 22.39 states ‘The rules in part 4 of the Act about medical treatment of detained patients do not apply to patients remanded to hospital under section 35 for a report on their mental condition. As a result, treatment can be administered only with their consent, or, in the case of a person aged 16 or over who lacks capacity to consent, in accordance with the Mental Capacity Act 2005 (see chapter 13 MHA CoP). For children under the age of 16, who are not competent to consent to the proposed treatment, it may be possible for a person with parental responsibility for the child to consent on their behalf. (Further guidance on the informal treatment of children and young people, including the factors to consider in determining whether parental consent can be relied upon, are set out in chapter 19 MHA CoP)’

Paragraph 22.40 continues ‘Where a patient remanded under section 35 is thought to be in need of medical treatment for mental disorder which
cannot otherwise be given, the patient should be referred back to court by
the clinician in charge of their care as soon as possible, with an
appropriate recommendation and with an assessment of whether they are
in a fit state to attend court’.

4.10.6 Reports to Court following a Section 35 remand should contain a
statement of whether a patient is suffering from a specified form of
mental disorder, identifying its relevance to the alleged offence. The
report must not anticipate the outcome of proceedings as to whether the
defendant is guilty or innocent and it may be right to suggest that a
further report be submitted to Court between possible conviction and
sentence. Relevant social factors should also be included where and
when it should make recommendations on care or/and treatment
including where and when it should take place and who should be
responsible.

4.10.7 Section 35 subsection 8 indicates that the defendant is entitled to obtain
an independent medical report from a doctor of his own choice and at his
own expense and to apply to the Court for the remand to be terminated
on the basis of that report.

4.10.8 Section 36 of the Mental Health Act also allows the Crown Court only to
remand a defendant to hospital for treatment

4.11. TRANSPORTING PATIENTS SUBJECT TO PART 3 OF THE MHA

4.11.1 Patients who are detained under part 3 of the Act transported between
secure units, courts or prison are the responsibility of the unit or prison
sending the patient unless other arrangements negotiated. In certain
circumstances (e.g. an emergency situation) a clinical commissioning
group commissioned ambulance with appropriate escort may be
required to transport the patient. (Mental Health Act Code of Practice
paragraph 22.32). This requirement also applies to Sections 36, 37 and
38).

4.12 REPORTS OBTAINED BY THE DEFENCE

4.12.1 The defence is at liberty to obtain a medical report at any stage of the
proceedings. Mental Health Act 1983 section 54 (3), provides that the
defence may call evidence to rebut the evidence contained in any report
obtained upon the direction of the Court under the 1983 Act. If required,
the defence team will commission their own report.

4.12.2 If the defence does not feel that the report obtained is helpful to the
defence case, there is no obligation to submit it to the Court. However,
the defence does not own the expert’s opinion nor does it have a right to
veto its use.
4.12.3 Thus in Regina versus Crozier (1991 CRIMLR138) a psychiatrist commissioned by the defence to assess the defendant, learning that his report recommending the defendant’s detention in a special hospital had not been submitted to the Court, disclosed his opinion to the prosecution. The Crown passed this information to the Court. On the defence’s appeal, the Court of Appeal held that the strong public interest in disclosure of the psychiatrist’s opinion overrode his duty of confidence to the defendant.

4.13 HEALTH PROFESSIONALS WRITTEN AND VERBAL STATEMENTS TO THE COURT

4.13.1 Health Professionals giving verbal or written evidence to the Court must always state where the information has come from i.e. is it your opinion and if so what is your opinion based upon or is it information contained in the defendants medical or social work case notes.

NB. Do not make statements to the Court either orally or in writing without being able to back them up fully. Do not quote third party information such as ‘his mother informed me that he always beats his wife up’ without obtaining the permission of the third party involved, although in certain circumstances third party information may have to be disclosed without consent. When giving oral statements to the Court always address the bench.

4.14 INTER AGENCY LIAISON

4.14.1 Liaison should take place between probation and psychiatrists writing reports to ensure that the opinions and recommendations in both the probation report and the psychiatric report are complimentary.

4.14.2 Where the report writer is recommending that the Court remand the defendant to a hospital either for assessment or treatment and the relevant bed in that hospital is not in the report writer’s direct power or control, the report writer should wherever possible attempt to liaise in advance with the consultant who has control over the relevant bed to ensure that (a) he or she is made aware of the recommendation and that (b) that he or she is agreeable to a bed being offered and (c) that a bed is available within the statutory 28 days.

4.14.3 Where the report writer is concerned that the defendant is in need of mental health treatment and is not receiving such treatment they should refer the defendant to their General Practitioner to initiate treatment.
4.15. **SUGGESTED CONTENT AND FORMAT FOR COURT REPORTS**

4.15.1 For suggested content and format for Court Reports (see Appendix J)

4.15.2 When requesting a psychiatric assessment and report the court should make it clear to the psychiatrist what information they require (see Appendix L for suggested proforma).

4.16 **DUTY OF COURTS TO CONSIDER THE EFFECTS OF CUSTODY**

4.16.1 Power of Courts to order admission to a named unit introduced by the Crime (Sentences) Act 1997 to enable the Court or the Home Secretary to specify a level of security in which the patient needs to be detained. A named hospital unit can be any part of a hospital which is treated as a separate unit. It will be for the Court to define what is meant in each case where it makes use of the power. This is particularly important in cases where the Court orders admission to a specific ward within a hospital as clinicians and ward staff will then not be able to grant leave to any other part of the hospital e.g. to the hospital shop, without the permission of the Court. It is therefore advisable to request the Court to name the hospital rather than a specific unit unless security and public safety considerations dictate otherwise.

4.17 **PROCESS FOR COURTS IN RELATION TO YOUNG OFFENDERS**

4.17.1 In general the principles outlined for assessment and report of a young offender’s mental health to the court will follow the procedures for adults. The local (Cumbria) Mental Health Provider Trust has developed a Youth Justice Pathway for Young Offenders and this pathway should be followed by the court and defence team (See Appendix C)

4.18 **COMMISSIONING PSYCHIATRIC COURT REPORTS**

4.18.1 It is the respective responsibility of the Court and/or defence team to commission psychiatric reports for the defendant/Court and will normally make their own arrangements to do this. The commissioning authority will be responsible for funding the subsequent report. Where difficulties are experienced in commissioning such reports the Development Officer for Mentally Disordered Offenders must be contacted to address the deficit with the appropriate authorities through the Cumbria Criminal Justice and Mental Health Steering Group.
4.19 PSYCHIATRIC REPORTS COMMISSIONED PRIVATELY OR OUTSIDE THE LOCAL MENTAL HEALTH PROVIDER TRUST BY THE COURT OR DEFENCE TEAM

4.19.1 On occasions it will be necessary for the Court to commission a psychiatric assessment and report from a Consultant Psychiatrist from outside the local Mental Health Provider Trust. This sometimes results in recommendations to the Court that are not available or appropriate for local services. In order to ensure that the Court and defence team are receiving appropriate information on which they can act, the Court and/or defence team should request that any outside commissioned psychiatrist should liaise fully with the local Mental Health Provider Trust.

4.20 LEGISLATION

4.20.1 Further information in relation to Mental Health legislation can be found at Appendix F and further information of sentencing options for Mentally Disordered Offenders can be found at Appendix K.
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IN PRISON

5.1 INTRODUCTION

5.1.1 In April 2006 Prison Healthcare became the responsibility of the CCG covering the geographical area of the Prison’s location. The general principle of this provision is that for the duration of stay of a prisoner within a prison he will be treated as a resident of the area and the local CCG is responsible for providing that prisoners healthcare.

5.1.2 Cumbria has one prison located within its geographical boundary. Haverigg is a male prison that accommodates a maximum of 644 prisoners. Not all prisoners serving sentences at Haverigg will be Cumbrian residents, but wherever any prisoner is normally resident or registered with a GP, whilst he is a prisoner at Haverigg Prison his healthcare will be the responsibility of NHS Cumbria Clinical Commissioning Group.

5.1.3 Some Cumbrian residents will be serving terms of imprisonment in prisons throughout other parts of the country. Whilst this protocol does not have jurisdiction outside Cumbria the general principles are the same, in that prisoner’s healthcare is the responsibility of the CCG covering the prisons location.

5.1.4 NHS Cumbria commissions Greater Manchester West NHS Foundation Trust (GMW) to provide mental health care to the prison population at Haverigg.

5.1.5 Haverigg Mental Health Team have developed a Mental Health Pathway for prisoners and referral to the Mental Health Services can be made from a number of sources within the prison including

- GP
- Healthcare
- Prison
- Education
- Probation
- Drop In Clinic

(See Appendix H for pathway details)

5.1.6 Where an MDO is sent to prison either as a remand or sentenced prisoner the care co-ordinator/key worker of the mental health team should take responsibility for contacting the head of healthcare in the prison to give details of the prisoner’s mental condition, care plan, medication and appropriate community contacts.

5.1.7 Mentally disordered prisoners being discharged back in to the community are subject to CPA, and the head of healthcare in the prison or a nominated deputy should contact the nominated mental health team member to arrange joint planning for appropriate aftercare services.
5.1.8 Prisoners who are transferred to hospital under Sections 47 and 48 of the Mental Health Act are subject to Section 117 aftercare. Pre-discharge planning should take place between community mental health services and the appropriate hospital or prison and involve prison health care staff (if the prisoner has been transferred back to prison).

5.1.9 Mentally Disordered Offenders who have been detained in hospital under Section 37 of the Mental Health Act are also entitled to aftercare services under Section 117 of the Mental Health Act. Mentally Disordered Offenders detained under 37/41 upon conditional discharge are subject to the provisions of the Home Office Notes of Guidance 1987 and in their cases, again appropriate planning for a multi agency care package should take place.

5.1.10 If a Mentally Disordered Offender leaves the area, contact should be made with the appropriate Mental Health and Criminal Justice Agencies in the area to which he/she has moved. Guidance on this is contained within Section 6 of this Protocol.

5.2 INFORMATION TO BE PASSED TO PRISON HEALTHCARE

5.2.1 Sentenced and Remand Prisoners

5.2.2 When a Cumbria Partnership NHS Foundation Trust service user is sent to custody either on remand or sentenced the following information should be passed by the care co-ordinator/ALIS/key worker to prison healthcare to ensure that the individual continues to receive appropriate treatment/care for their mental disorder:

- Copy of care plan, risk assessment and medication (including compliance, motivation and level of engagement)
- Name and contact details of care co-ordinator, other professionals/agencies involved
- Legal status (subject to criminal sections under part 3 of the Mental Health Act 1983 or civil sections prior to custody)

5.2.3 Additionally for Remand Prisoners

- Consideration whether a request should be made to the healthcare staff at the receiving prison to determine
- Whether an assessment by forensic psychiatrist is deemed necessary, if so this should include an assessment of:
  - Clinical presentation and treatment recommendations
  - Whether diversion to a forensic placement is necessary
  - The level of security required
  - Any other in-patient placement or treatment is recommended
5.2.4 If a decision is made that a forensic pathway is not appropriate but the local clinical team determine the most effective response and management plan would be specialist assessment or placement outside the forensic pathway further representations should be made through the agreed CCG & CPFT funding request process.

NB - If the service user is a remand prisoner and not a sentenced prisoner it is important that full liaison with the Court is made by the care co-ordinator/ALIS to advise them of mental health concerns and suggested course of action.

5.3 CONTACT DETAILS FOR PRISON HEALTHCARE:

HMP Durham - 0191 332 3596
HMP Low Newton – 0191 376 4000 (main switchboard)
HMP Lancaster Farms – 01524 563450 (main switchboard)
HMP Preston – 01772 444550 (main switchboard)
HMP/YOI Styal – 01625 553000 (main switchboard)

5.3.1 The above are the main reception prisons for Cumbrian residents. If the whereabouts of a service user is not known the Prisoner Location Service can be contacted on 0121 626 2742.

5.4 DISCHARGE ARRANGEMENTS FOR PRISONERS

5.4.1 Discharge Arrangements and Ongoing Care for Prisoners with Mental Illness: Liaison between the NHS and the Prison Service

5.4.2 Prison service health care centres and NHS mental health services share responsibility for ensuring appropriate liaison on the care of prisoners with mental disorders. It is particularly important that effective links are made to ensure sound discharge planning when inmates are released from prison.
5.5 **ACTION**

5.5.1 Mental Health Care Co-ordinators for people in receipt of the Care Programme Approach (CPA) should:

- take steps to ensure that they remain in contact with the care and treatment of individuals receiving CPA who enter the prison system.

5.5.2 In particular Care Co-ordinators need to make sure that they are, wherever possible, aware of individuals’ location and likely release date, so that appropriate care can be planned for their release.

5.5.3 Prison Health Care Staff should:

- ensure that they comply with existing guidance on the discharge of prisoners with ongoing health needs, and specifically that they, as far as possible, communicate information to an individual’s general practitioner or to community services to ensure proper continuity of care;
- recognise the legitimate continuing interest of prisoners mental health Care Co-ordinators and, as far as possible, facilitate the provision of essential information to aid discharge planning.

NB – For prisoners serving a sentence of 12 months or more care co-ordination of that prisoners mental health needs becomes the responsibility of the Prison Mental Health Team. For prisoners serving a sentence of less than 12 months care co-ordinator responsibility remains with the local care co-ordinator, who should ensure liaison is maintained with the Prison Mental Health Team.

5.6 **CARE PROGRAMME APPROACH (CPA) AND PUBLIC PROTECTION**

5.6.1 It is important that prisoners in receipt of specialist mental health care have properly planned discharge arrangements. In particular it is important that there are properly co-ordinated arrangements for the release and ongoing health care of prisoners who, by virtue of their disorder, are thought to pose a potential risk to others or to themselves.

5.6.2 It is of paramount importance that CPA arrangements and if appropriate Public Protection arrangements are fully implemented prior to the release of a prisoner back into the community.

5.6.3 Where prisoners were cared for within the framework of the CPA immediately before they entered the prison system, appropriate links must be maintained between the patients’ mental health Care Co-ordinator and Prison Mental Health Team. It is the responsibility of the individual's Care Co-ordinator, with cooperation from the Prison Mental Health Team, to ensure that these links are in place. At the very least the Care Co-ordinator should know
where an individual patient is being held and ensure that they are aware of any likely release date so that, if there is a continuing need for care, they can co-ordinate such care on that person’s release. Prison Mental Health Team staff should afford Care Co-ordinators as much assistance as they are able, respecting individual prisoners’ wishes and legal requirements on the confidentiality of health information.

5.6.4 Many individuals being treated for severe mental disorders within prisons will not, however, have been cared for under the CPA when they entered the prison system – for example their mental illness may only have been diagnosed after they entered prison. In these circumstances Prison Mental Health Team staff should ensure that they act in accordance with their respective discharge procedures. These procedures should clearly set out a requirement that:

A. Information to ensure continuity of care is communicated, with the prisoner’s consent, to general practitioner and/or other responsible community agencies on discharge.

B. Where an individual was previously cared for under the CPA, the care plan should, with the prisoner’s consent, be formulated with the full involvement of their mental health Care Co-ordinator before release.

C. If a prisoner is judged to present, by virtue of a mental disorder, a potential risk to others or to themselves but does not consent to communication of information about their condition, Prison Mental Health staff should (on public interest grounds) release relevant information to appropriate agencies (including voluntary organisations) who are or may be involved in ongoing care.

D. Where the local Care Co-ordinator becomes aware that a prisoner due for discharge into the community is a risk of serious harm to others consideration by the local clinical team should be made whether or not to refer the case into the MAPPA/MARE Public Protection process. (See Section 7 Public Protection).

5.6.5 Referral into the MAPPA/MARE Public Protection process must allow adequate time to develop an effective Multi-Agency Risk Management plan and the first MAPPA/MARE meeting should take place at least 2 months prior to release from prison.

5.6.6 For those prisoners who develop a mental disorder whilst serving a sentence and who do not have a local care co-ordinator and will require CPA follow up when released from Prison the following process will be undertaken:

A. The Prison Mental Health Team will make a referral to the Mental Health Team covering the prisoners GP registration and copy the referral to the prisoners GP
B. For those prisoners who are not registered with a GP or who intend to be released from prison with no fixed address the Prison Mental Health Team will make a referral to the CCG where the prisoner intends to travel to on his day of release.

5.7 **REFERRALS FOR DIVERSION**

5.7.1 Where the Prison Mental Health Team assesses that a prisoner’s mental health is severe and enduring or has deteriorated to such a degree that admission to a hospital bed is appropriate, referral for a Forensic Psychiatric assessment must be made through the relevant Forensic Case Manager.

5.7.2 **Relevant Forensic Case Manager**

Forensic in-patient placement is a tertiary service and therefore referral to the relevant Forensic Case Manager means referring to the Forensic Case Manager covering the Health Authority responsible for the prisoner’s healthcare at the time he entered the prison system for his current sentence. The rules covering this are contained within the document “Establishing the Responsible Commissioner”. Responsible Commissioner rules are quite complicated, are different depending on a person’s circumstances and age and must be referred to before making a referral. Generally, for those prisoners resident in England and Wales prior to commencing their sentence the Responsible Health Commissioner is:

- The Health Authority covering the area where the prisoner was registered with a GP.
- If not registered with a GP it is the Health Authority covering the area of the usual place of residence of the prisoner
- If no GP and no usual place of residence the Responsible Commissioner will be the Health Authority where the current index offence was committed.

5.7.3 For those prisoners normally resident in Scotland the Responsible Commissioner rules are different and are generally

- Where the prisoner deems his usual place of residence to be.

5.7.4 Advice in relation to establishing the Responsible Commissioner for a prisoner can be sought from the Development Officer for Mentally Disordered Offenders.

5.7.5 The above process should only take place through referral by the Mental Health Services and after assessment by a local Consultant Psychiatrist, who agrees with the referral.
5.8 PERSONALITY DISORDER

5.8.1 In cases where the prisoner has a diagnosed Personality Disorder and the Mental Health Team are considering referral for diversion to a Forensic Personality Disorder Unit or transfer to a Prison that provides specialist personality disorder interventions the following process should be adopted

- The Prison Mental Health Team should make a clinical decision, including consultation with the local Consultant Psychiatrist that the prisoner is appropriate for referral
- The Head of Healthcare will refer into the MARE process and convene a MARE meeting in collaboration with the Development Officer for Mentally Disordered Offenders
- The MARE meeting must include the relevant agencies, parties and representation from Forensic Personality Services if possible
- The MARE meeting will decide whether referral to the Forensic Personality Disorder Service is relevant and appropriate
- Forensic Personality Disorder Services are also a tertiary service and Responsible Commissioner rules will apply

5.8.2 Funding for referrals based and decided on health grounds will be the responsibility of Health and the arrangements that Cumbria Health Commissioners or other Health Authorities (non Cumbrian prisoners) have with their respective Forensic Services.

5.9 PRISON HEALTHCARE BED

5.9.1 Haverigg Prison has no dedicated healthcare beds within the prison. However access to a prison healthcare bed can be obtained by referral to Preston Prison. This can only be accessed by direct consultation between the respective Heads of Healthcare at Haverigg and Preston Prisons. Funding for this provision is in place.

5.10 PAROLE BOARD AND PSYCHIATRIC AND PSYCHOLOGICAL REPORTS

5.10.1 On occasions the Parole Board will request that a psychiatric or psychological assessment and report is provided to them.

5.10.2 The same procedure in relation to obtaining the report will be followed as if a referral for diversion was being made and will revolve around the prisoners Responsible Commissioner area for reasons of service provision and continuity of care upon release.
5.10.3 Although Prison Mental Health staff may assist the Parole Board and Offender Management Service in identifying an appropriate Consultant Forensic Psychiatrist/Psychologist the commissioning and funding of the assessment and report will be the responsibility of the Offender Management Service (Probation).

5.10.4 Any difficulty in relation to Forensic or Parole Board referral requests should be directed to the Development Officer for Mentally Disordered Offenders who will take the issue to the Criminal Justice and Mental Health Steering Group for discussion and appropriate action.
Section 6 Index – MENTALL DISORDERED OFFENDERS WHO MOVE AREAS

| 6.1 | Mentally Disordered Offenders Who Move Areas | Page 79 |
6.1. **MENTALLY DISORDERED OFFENDERS WHO MOVE AREAS**

6.1.1 Patients subject to Sections 3, 37, 47 and 48 of the Mental Health Act 1983 (amended 2007) are entitled to receive aftercare under Section 117 of the same Act. The Act lays a statutory duty on the relevant Health and Social Services to provide such aftercare. This duty does not cease until the Health Authority and Social Services agree that it is no longer necessary.

6.1.2 The Clunis Report states that ‘Before a patient moves from the area where he is being cared for, a joint Case Conference should be held between those who are currently providing and those who will be providing this aftercare in the future, responsibility will remain with the original multi-disciplinary teams (Clunis p13).

6.1.3 Also ‘Catchment areas should never be allowed to interfere with proper care in the community’ (Clunis p110).

6.1.4 Where a patient is moving to another area, his/her care coordinator should discuss aftercare needs with the patient and arrange for appropriate aftercare services in the new area. Transfer of statutory responsibilities between authorities can take place by agreement after a period of time when it is apparent that the patient has settled in the new area. This should be carried out under Care Programme Approach Protocol for patients who move areas.

6.1.5 If a patient expresses a wish that the relevant aftercare services and, if appropriate, police in his new area are not contacted then it should be the responsibility of the care coordinator to convene a multi disciplinary case discussion to evaluate the degree of risk posed by the patient’s condition both to himself and others.

6.1.6 If the risk of not informing the new authorities is judged unacceptable by the multi disciplinary team then the patient’s wishes must be disregarded and the patient informed.

6.1.7 It is not acceptable for people suffering from mental disorder to be lost to those entrusted with their care by virtue of moving home.

6.1.8 It is important to note that the assessment of need and decisions about services to be provided are separate stages in the process. Assessments in themselves do not commit the Authority to provide or arrange service provision.
SECTION 7
## Section 7 Index – PUBLIC PROTECION

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7.1. **INTRODUCTION**

7.1.1 Risk assessment and Management in conjunction with Criminal Justice System already takes place within Mental Health Services as an integral part of the Assessment and Care Planning process.

7.1.2 The Probation Service, Police Service and Prison Service have a statutory responsibility in relation to the management of offenders who are identified as posing a danger to the community.

7.1.3 Dangerous offenders include those who have committed, are suspected of having committed, or assessed as very likely to commit, offences that would cause immediate and serious harm.

7.1.4 Where Mental Health Services or Learning Disability Services are concerned that a patient is known to be; or has the potential to be a dangerous offender they should, in the first instance, contact the single point of contact for the Trust who is the Development Officer for Mentally Disordered Offenders (for process see para 2.2 below)

7.1.5 The development of Multi Agency Public Protection Arrangements (MAPPA) has given rise to a need for clarity and consistency within the Trust in the way that MAPPA obligations for health and adult services are implemented. The process described here sets out the responsibilities and expectations of clinical staff in relation to MAPPA.

7.1.6 This section should be read in conjunction with the
- “Multi-Agency public Protection Arrangements – Cumbria – Protocol for the Sharing and Disclosure of Information”
- “Multi-Agency Public Protection Arrangements – Cumbria Memorandum of Understanding between Cumbria Responsible Authority (Probation, Police and North West Prison Service) and the “Duty to Co-operate Agencies”.

7.2 **POLICY STATEMENT**

7.2.1 MAPPA is intended to create a multi-agency framework in which rigorous risk assessment and risk management can take place, providing a foundation for defensible decision making in cases where there are public protection concerns.

7.2.2 MAPPA has a statutory basis in the Criminal Justice and Court Services Act 2000 and the Criminal Justice Act 2003. The Acts established the police, probation and prison services as leads or “Responsible Authorities” under MAPPA. The legislation comes with guidance detailing how the system is recommended to operate. (MAPPA Guidance V3.0)
7.2.3 The Criminal Justice Act (2003) also created the “Duty to Co-operate Agencies”, which include Health, Social Services, and a wide range of other agencies such as Education, Job Centre Plus, Housing, and Registered Landlords.

7.3 **MAPPA ORGANISATIONAL BODIES**

7.3.1 Strategic Management Board (SMB)  
The Strategic Management Board (SMB) is the means by which the Responsible Authority (RA) fulfils its duties under the Criminal Justice Act (2003). The legislation requires the RA to:

‘Keep the arrangements (i.e. MAPPA) under review with a view to monitoring their effectiveness and making any changes to them that appear necessary or expedient’

7.3.2 The SMB has responsibility for shaping MAPPA activity in its area. This involves agreeing the role and representation of the different agencies within the SMB and brokering the protocols and memoranda of understanding which formalise these.

7.33 **Single Point of Contact (SPOC)**

The Development Officer for Mentally Disordered Offenders acts as a single point of contact for health agencies regarding MAPPA issues, including:

- MAPPA referrals, which are processed in conjunction with the Trust’s Mental Health Act Administration Manager’s (MHAAM) office.
- Ensuring the MHAAM maintain a Database for all MAPPA cases within their areas that includes
- Identifying patients who are subject to sex offender notification requirement upon discharge from hospital
- Identifying patients who meet the criteria for MAPPA Management under Category 2 of the legislation
- Identifying patients who meet the criteria for MAPPA Management under Category 3 of the legislation

7.4 **WHO SHOULD BE INCLUDED IN MAPPA?**

7.4.1 The Pathway Policy will apply to any individual managed within the Trust’s Adult Mental Health Services. The Youth Offending Service has a MAPPA referral process for Child & Adolescent cases.

7.4.2 MAPPA referrals will apply to service users who have been convicted of a “relevant” violent or sexual offence. The offences are grouped into the following three categories;
7.4.3 **Category 1**  
*Registered Sex Offenders*  
Those sexual offenders required to register under the terms of the Sexual Offences Act 2003.

7.4.4 **Category 2**  
*Violent offenders and other sex offenders*  
Those offenders convicted of a relevant violent or sex offence (not requiring sex offender registration). To clarify, it is the following offenders who should be included in category 2:

A. Those convicted of a relevant offence (murder or any of the offences in schedule 15 to the Criminal Justice Act (2003)) who receive the following sentences:
   - Imprisonment for a term of 12 months or more (please note that this includes a sentence of an indeterminate term and cases where the sentence is suspended);
   - Detention in a Young Offenders Institution for a term of 12 months or more;
   - Detention during Her Majesty’s pleasure;
   - Detention for public protection under section 226 Criminal Justice Act (2003) (regardless of tariff);
   - Detention for a period of 12 months or more under section 91 of the Powers of Criminal Courts (Sentencing) Act (2000) (offenders aged under 18 convicted of certain serious offences);
   - Detention under section 228 Criminal Justice Act (2003);
   - A Detention and Training Order for a term of 12 months or more (regardless of the length of the custodial element) or
   - A Hospital Order (with or without restrictions) or Guardianship Order.

B. Those found not guilty of a relevant offence by reason of insanity or to be under a disability (unfit to stand trial) and to have done the act charged who receive a Hospital Order (with or without restrictions).

C. Those subject to a Disqualification Order (DO) imposed under sections 28-29A of the Criminal Justice and Court Service Act (2000) which relates to disqualifying individuals from working with children etc.

7.4.5 **Category 3**  
*Other Offences*  
Any other offenders, who, because of the offences committed by them, are considered to pose a risk of serious harm to the public which requires active interagency management.

To register a Category 3 offender, it must be:
   - Established that the person has committed an offence which indicates that they are capable of causing serious harm to the public; and
• Reasonably consider that the offender may cause serious harm to the public which requires a multi agency approach at level 2 or 3 to manage the risks

7.4.6 The person must have been convicted of an offence, or have received a formal caution or reprimand/warning (young offenders). The offence may have been committed in any geographical location, which means that offenders convicted abroad could qualify.

7.4.7 This may show, for example, a pattern of offending behaviour indicating serious harm that was not reflected in the charge on which the offender was ultimately convicted

7.5 MULTI-AGENCY RISK EVALUATION (MARE) FRAMEWORK

7.5.1 In addition to the three categories of MAPPA the Cumbria area operates a “Non-MAPPA” framework in relation to service users with a mental disorder. This only applies to those individuals who do not meet the criteria for MAPPA but are assessed as posing a risk of serious harm to the public.

7.5.2 Identification as a “MARE” case is based on a judgment of the clinical/care team that the individual represents a risk of serious harm, and that this risk is current (that is, it is not a theoretical risk in the long term). Unless a more urgent meeting is necessary a “MARE” must be held within the 20 working days after the date the clinical team made the decision to hold a “MARE”.

7.5.3 Risk assessment is an integral part of the management of Mentally Disordered Offenders both in hospital and within the community. The majority of Mentally Disordered Offenders will be subject to post-discharge supervision within the community by the health and adult social care services. In determining the risk of a Mentally Disordered Offender it is recommended that a more comprehensive risk assessment tool (e.g. HCR 20) is used in conjunction with the current generic risk assessment tool to enhance the decision making process and management action plans.

7.5.4 It is the responsibility of Development Officer for Mentally Disordered Offenders to chair all “MARE” meetings within the framework of care coordination and for the Care Coordinator/Ward Manager/ ALIS practitioner/ LD Caseworker or Social Care staff to invite to those meetings relevant other agencies who may be required to assist in managing the risk (e.g. Probation, Housing, 3rd Sector Providers etc). The team referring the individual to the MARE process will also provide a minute taker for the meeting.

7.5.5 It is the SPOC’s responsibility to inform the Police of the date of the “MARE”, when this has been decided.
7.5.6 Service users assessed as being of low or medium risk of harm to the public will continue to be managed within the normal CPA process. This does not preclude the clinical/care team from inviting other agencies to participate in case discussions as appropriate without invoking the more formal “MARE” process.

7.5.7 The following documents have been developed in order to have a consistent approach towards risk management and to assist practitioners and senior managers. Please ensure this document set is used within the MARE process.

This is the link to the MAPPA/MARE policy

- MARE and Case Conference Risk Assessment Format
- MAPPA/MARE Referral Form
- MARE Chair’s Guide
- MARE Front Sheet for Minutes
- MARE Attendance Sheet
- MARE Meeting Minutes Template

7.6 PATIENTS DETAINED UNDER PART III MENTAL HEALTH ACT 1983

7.6.1 Clinical/care teams must consider whether patients detained under Part III of the Mental Health Act 1983 (i.e. – S37, S47, S48 etc) should be referred in to the MAPPA/MARE pathway

7.6.2 The above is a brief summary of the MAPPA/MARE Pathway policy and reference to that document should be made for further details. The SPOC can be contacted for details of the document.

7.7 CONVICTED SEX OFFENDERS IN HOSPITAL

7.7.1 Part 2 Sexual Offences Act 2003 – Notification Requirements

- Affects those under sentence and those sentenced or formally cautioned after that date
- Applies to those in hospital or subject to guardianship under Part III of the 1983 Mental Health Act
- There is no statutory requirements of hospital managers or local authorities but they are: ‘expected to support effective implementation of the act’
- Requires those convicted of or cautioned for certain sexual offences to provide:
  I. Name and any other names used
  II. Main residence in UK
III. Date of birth
IV. National insurance number
V. Other addresses stayed at for more than 7 days
VI. Any changes in name or address within 3 days
VII. Travel outside of UK for more than 3 days
VIII. Must re-notify at least every 12 months

7.7.2 S 96 Sexual Offences Act 2003
Information about release or transfer of a detained person

7.7.3 This section applies to a relevant offender who is serving a sentence of imprisonment or a term of service detention, or is detained in a hospital

7.7.4 The Secretary of State may by regulations make provision requiring notice to be given by the person who is responsible for that offender to persons prescribed by the regulations, of any occasion when the offender is released or a different person becomes responsible for him

7.7.5 The regulations may make provision for determining who is to be treated for the purposes of this section as responsible for an offender

7.7.6 This section re-enacts, with amendments, Sections 5B of the Sex Offenders Act 1997. Section 96 allows the Secretary of State to make regulations requiring those who are responsible for an offender while he is in detention (as defined in subsection 1) to notify other relevant authorities of his release or transfer to another institution. The regulations may define the person responsible for the offender (for example, the chief executive of a hospital) and the person who must be informed about release and transfer. An example might be the governor of a prison being required to inform the local chief officer of police when a relevant offender is about to be released from prison.

7.7.7 The Sexual Offences Act 2003 – Guidance for Agencies
Hospitals: Mentally Disordered Offenders

7.7.8 Persons who are mentally disordered and are subject to the terms of the Act will receive a copy of a certificate of conviction and a notice explaining the registration requirement. The Court will copy both to the police and the hospital to which they are admitted or the authority responsible for their guardianship. In the case of patients transferred to hospital from prison or guardianship, a copy of the original Court notice will be passed on by the prison or local authority social work service. On receipt of the notices, hospital managers should ensure that the patient’s records are endorsed so that action may be taken as necessary, i.e.:

7.7.9 to inform the new hospital managers, prison, or criminal justice social work service if the patient is transferred to another hospital, back to prison, or guardianship; and
7.7.10 To remind the patient of his registration requirements when he leaves hospital on discharge or long-term leave (3 days or more) in the community

7.7.11 It will not be necessary to take further special action at the time of admission. But, as a matter of good practice, hospital managers may wish to ensure that any patient, who has been served with a notice to register under the 2003 Act, is given the opportunity to discuss the requirements with a member of the hospital staff.

7.7.12 The notice informs offenders of their requirement to register with the police within 3 days of discharge. Offenders are not required to register while they are detained in hospital, but if a detained sex offender is given leave of absence from hospital he should register with the police if leave is expected to last for 7 days or more.

7.7.14 Hospital managers are asked to ensure that patients subject to the provisions of the Act are reminded before their discharge from the hospital about the requirement to register. When and how this should be done is a matter for the RC. It is important that clinical teams are able to take account in planning discharge or leave in the community of what, if any, impact the need to comply with registration requirements may have on the patient. If the patient has severe learning disabilities, the clinical team should consider what help, including legal advice, the patient may need to assist him in complying with the registration requirements.

7.7.15 Hospital clinical managers should give serious consideration to notifying the police when a relevant patient is no longer detained. This should be explained to the patient and he should be asked to consent to this disclosure. If the patient refuses, clinical managers should consider whether public interest justifies overriding the refusal. In reaching a decision, all relevant circumstances should be taken into account, including the advice from the multi-disciplinary team, the need to protect the public and any rights of the patient to have confidentiality of personal information about him protected (information in the public domain or a matter of the public record is not of course subject to the duty of confidence).

7.7.16 While it is essential for each case to be decided on its own merits and no automatic decision made to notify the police, the need to protect the public means that the balance will generally be in the favour of informing the police of the discharge of a registerable sex offender. Where a decision is made to inform the police, managers should, nevertheless, ensure that they divulge only the minimum information necessary to protect the public interest. The original notice should be sent to the chief constable for the police area where the patient will be living (if known) or to the chief constable for the policing area in which the hospital is situated; a copy should be given to the patient, and a copy should be retained for the hospital records. In cases of particular complexity, managers should consider taking legal advice.
7.7.17 Hospitals and police forces are encouraged to establish good and effective working relationships to ensure that the requirements of the Act are met.

SEE APPENDIX E FOR DISCLOSURE FORM
| 8.1 | Offenders In Hospital | Page 92-94 |
8.1 OFFENDERS IN HOSPITAL

8.1.1 Ordinarily the police should not be called to assist in responding to a patient who is simply presenting management problems as opposed to having committed a criminal offence. NHS Trusts, Local Health Authorities and other health service providers have legal obligations to ensure that sufficient numbers of trained and qualified staff are available to restrain patients for medical intervention or to place them in isolation for their own, or another's safety, where this is necessary.

8.1.2 It is important that where ward staff considers a criminal offence has been committed and support a prosecution and the patient is deemed fit to be detained and interviewed the incident should be fully investigated and documented by the police.

8.1.3 Where a patient's behaviour is giving staff cause for concern, or minor offences have already been committed by the patient and not reported to the police, the patient's RC and care coordinator should be informed of the behaviour/offences. It is imperative that such behaviour is clearly and accurately recorded on the patient's notes and that the member of staff responsible for the entry or witnessing the behaviour is clearly identified.

8.1.4 If the patient has mental capacity and is responsible for his/her own actions and if arrested for a criminal offence would be fit to be detained and interviewed, the RC should inform the patient that the following action would be taken:

A. If he/she committed any criminal offences the police would be informed and told he/she had mental capacity and was responsible for his/her actions

B. The police would also be told that the patient was fit to be detained and fit to be interviewed at a police station. The RC should endorse the patient's notes with that information.

C. The RC should also endorse the patient's notes that if criminal offences are committed on the ward and are pursuing a prosecution the information at A and B above can be quoted to attending police officers and referred to in the staff members completed DP3b form provided to the Police (See para 1.18).

8.1.5 The above procedure would obviously only apply to patients who, on the assessment of their consultant, had mental capacity and were responsible for their own actions.

8.1.6 If taken to the police station the patient will be dealt with in accordance with the Mentally Disordered Offenders Protocol (Section 2 – Upon Arrest) and PACE. The custody officer may use his discretion to allow the patient to be interviewed without further medical examination at the police station, but only if the information at para 8.1.3 above is presented to him in a signed DP3b from a member of the Mental Health staff. The
custody officer should always consider whether there is a requirement for the attendance of an appropriate adult in such circumstances.

8.1.7 If a patient detained under a relevant section of the Mental Health Act 1983 is arrested and taken to the police station a Section 17 (MHA 1983) leave form should be completed by ward staff.

8.1.8 The custody officer’s discretion would prevent unnecessary use of an FHCP, L&D, ALIS, AMHP and S12 approved doctor because the patient’s fitness to be detained and interviewed would be known. The discretion would also prevent any delay in the patient’s detention at the police station.

8.1.9 It must be stipulated that where the consultant giving information under para 8.1.3 is a witness to any criminal offences on the ward and may be required to give evidence in Court then the custody officer must (to prevent conflict and in the interests of justice) revert to the Mentally Disordered Offenders Protocol (Section 2 – Upon Arrest).

8.1.10 If the patient or his/her legal representative or appropriate adult requests a current medical assessment, the custody officer would revert to the procedures in the Mentally Disordered Offenders Protocol (Section 2 – Upon Arrest) and call an FHCP.

8.1.11 The custody officer will make the FHCP aware of the medical evidence (in relation to fitness to be interviewed and detained) immediately upon the arrival of the FHCP at the police station and before the FHCP sees the patient.

8.1.12 After assessing the information and examining the patient the FHCP and/or L&D will take the lead in deciding whether a further assessment is required by an AMHP and S12 approved doctor.

8.1.13 When a patient commits a serious offence or the victim of the offence is a ward staff member, or patient, an expeditious management decision must be made whether the offender should return to the ward on completion of police enquiries. If a decision is made to discharge the patient from the ward that information must be relayed to the police officer dealing with the incident without delay.

8.1.14 When a person, who is subject to detention under a civil/criminal section of the Mental Health Act, is arrested for a criminal offence and taken into custody the Provider Trust or organisation responsible for that person’s clinical care continues to have responsibility for the clinical management of the detainee’s mental disorder whilst that person is in custody at the Police Station.

8.1.15 The Custody Officer, in such cases should make early contact with the ALIS to establish an effective care management plan and the criteria.
where Mental Health staff would attend the Police Station to assist in care management.

8.1.16 On completion of the Police inquiry, if the Police are not considering a remand to prison, the Trust has a duty of care to ensure that the person is either received back into local Mental Health services or, if not appropriate, must ensure that alternative in-patient arrangements are made to a relevant and safe environment for the detainee’s health needs.

8.1.17 Where a person with a mental disorder is a resident in a residential care home (including supported accommodation) or nursing home and has had recent contact with mental health services and that persons consultant and care co-ordinator are known, the above procedures should be adopted. In any other case where a mentally disordered resident of a residential or nursing home commits an offence, action should be taken by the police in accordance with the Mentally Disordered Offenders Protocol (Section 2 – Upon Arrest).

8.1.18 The term DP3b is a local identification for an agreed national document. The document has been developed and agreed between the Association of Chief Police Officers, The Crown Prosecution Service and the National Health Service in their published document “Tackling Violence and Anti-Social Behaviour in the NHS”

8.1.19 The DP3b form states that the 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”

8.1.20 The DP3(c) form has been developed to assist Health Staff understand what may be required in a subsequent statement and includes explanatory notes for Health Staff to understand the reasons why the information, that the Police would request in a statement, is relevant and necessary.

8.1.21 It must be emphasised that the Cumbria Partnership NHS Foundation Trust’s policy in relation to making statements to the Police must still be complied with and a copy of DP3b forms handed to the Police must be retained in the patient’s case notes.

8.1.22 The forms DP3(b) and DP3(c) can be found at appendix G of this document.
SECTION 9
| 9.1 | Care Co-ordinator Roles | Page 97 |
9.1 ROLE OF CARE CO-ORDINATOR UNDER CPA

9.1.1 To oversee and implement the key elements of the Care Programme Approach (care plan) by:
- Maintaining the mental health of the individual by regular appointments/contact and ensuring concordance with medication
- Ensuring that all professionals are clear of their roles and responsibilities in delivering the care plan
- Acting as central point of contact
- Liaising with individual and carer in order that they fully understand the care plan including crisis/contingency plan
- Ensuring that the care plan is regularly reviewed, maintained and amended in light of any changes and this is communicated to all involved
- Keeping the GP fully involved and informed of any progress or changes, especially if the individual fails to comply or loses contact. (The care co-ordinator’s supervisor should be informed if the individual refuses to comply or loses contact. Consideration to what action to be taken should be based on an assessment of risk).

9.1.2 The care co-ordinator is responsible for arranging reviews and inviting relevant people. If the individual’s mental health changes and there is an escalation of risks an urgent review should be arranged.

9.1.3 If discharge is being considered an appropriate discharge plan should be formulated including a contingency/crisis plan and this should be circulated to all involved. For enhanced level CPA/S117 decisions on discharge should be taken by the MDT.

9.1.4 Where an individual is admitted to hospital the care coordinator should provide all relevant information to the in-patient key worker, maintain contact with individual and take an active part in assessment and care planning in conjunction with the wider MDT. The care coordinator must be involved in any pre discharge decisions. These principles also apply should the individual who is subject to CPA be imprisoned. The care coordinator should contact the health care wing with appropriate information and continue to play an active part in reviews, care planning and discharge meetings (see Section 5 of this Protocol)
SECTION 10
## Section 10 Index – INFORMATION EXCHANGE

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10.1 INFORMATION SHARING AGREEMENT

10.1.1 Cumbria Constabulary, NHS Cumbria, Cumbria Partnership NHS Foundation Trust, North Cumbria University Hospitals NHS Trust, Adult and Local Services and University Hospitals of Morecambe Bay NHS Trust have developed and signed off an Information Sharing Agreement in relation to the sharing of information, under certain conditions. The agreement includes the sharing of information relating to Mentally Disordered Offenders.

10.1.2 The information Sharing Agreement is held within the respective policy documents of each partner organisation and can be referred to if required.

10.1.3 Part of the document includes the request for information on a reciprocal basis between the partner agencies (see Appendix B for details).

10.1.4 THE GENERAL PRINCIPLES IN RELATION TO DATA PROTECTION AND INFORMATION SHARING

10.1.5 Data Protection Legislation does not prohibit the sharing of information. It provides a framework to ensure that personal information about living persons is shared appropriately.

10.1.6 Safety – Children

Consider risk factors – How great is the risk? Who will be affected by the risk? Careful consideration should be given to disclosure, even about low risks to children

10.1.7 Safety – Adults

A relatively high risk is necessary before considering overriding the duty of confidentiality.

10.1.8 Consent

10.1.9 With consent you can disclose. In seeking consent be open, honest with the person (and/or their family if appropriate) about why, what, how and with whom information will, or could be shared. Seek their agreement, unless it is unsafe or inappropriate to do so.

10.1.10 Without consent – Must make a professional judgement balancing the following considerations
10.1.11 Balancing Considerations

- Have I got legal authority to disclose?
- Is it in the public interest to disclose?
- Is it in the interests of the individual or others that I disclose for reasons of safety or well being?
- Is there a prescriptive information sharing agreement in place with the partner agency I will share the information with?
- If I share information is it necessary, proportionate, relevant and accurate for the purpose it is required?
- Will the information shared be kept secure?

10.2 Make Decision

10.2.1 Decision to share information – stipulate that shared information can only be used for the purpose in which it was requested. It is only shared with those who need to have it. It is shared in a timely fashion and is kept secure.

10.2.2 Decisions not to share information - document fully reasons for not sharing information and inform other party of that decision and reasons for not disclosing.

10.2.3 Document – keep a record of disclosure or non disclosure and reasons for both. If information has been shared record what you have shared, with whom and for what purpose.
| 11.1 | Media Protocol | Page 104 |
11.1 MEDIA PROTOCOL

11.1.2 The Cumbria Criminal Justice and Mental Health Steering Group have developed arrangements for cross-agency notification of press, media, data or other information releases originating from Cumbria Criminal Justice and Mental Health Agencies.

11.1.3 The purpose of the arrangements is to:

- Keep partner agencies informed of activities and actions taking place within or relating to Mentally Disordered Offenders in Cumbria that will be intentionally publicised through the press or other media.
- Put partner agencies on notice of activities or actions taking place within or relating to the source agency that could potentially have a knock-on detrimental effect on them, particularly with regard to public perception of, and confidence in, the effectiveness of joint working, the wider Criminal Justice System and mental health systems. These activities or actions can include anything that may be placed in the public domain but which may not necessarily be intentionally publicised. Examples could include the release of reports and comparative data sets were there is clear or implied criticism of the local Criminal Justice System or the NHS
- Avoid potential conflict or unnecessary duplication in press and media engagement that relates to cross-agency or multi-agency working;
- Ensure consistency of the ‘message’ being received by the public concerning the local Criminal Justice System through the press and media.
- Where relevant and desirable, provide a mechanism for cross-agency consultation on press and media releases.

SEE APPENDIX I FOR FURTHER DETAILS
CID 20 – Mental Health Liaison Pro Forma
Appendix A

CID20 CUMBRIA CONSTABULARY
MENTAL HEALTH LIAISON PROFORMA

SUBJECT:

Name: Custody/Attendance Record No:

Address:

Date of Birth:

Incident Detail & Offence (If known):

Incident Log Reference Number;

Officer in Case: Station:

Date Transferred:

Authority Under which Detained in Psychiatric Establishment (expiry date if known):

Name/Telephone Number of Psychiatric Establishment:

Medical Officer in charge of case:

*Police enquiries are complete; there is no need for further liaison; *Police enquiries are continuing, there will be a need for further liaison prior to transfer or release  (* Delete as necessary)

At the time of transfer or release, the Cumbria Partnership NHS Foundation Trust will contact Cumbria Constabulary on 101 quoting the Incident Log Number (Shown above). It will be the responsibility of the Officer in the Case to endorse this Incident Log with instructions how the person should be dealt with at that time.

The appropriate course of action, in this regard, will depend on the circumstances of the case and should be discussed with a supervisor. Options could include arranging for the Custody Investigation Team to be involved, for the person to be bailed from Custody, or for the person to be released from hospital to be seen at their home address at a later date, when the OIC is next on duty.

Signature of Supervising Officer:

NOTE:
On occasions where police enquiries have continued, it will be the responsibility of the OIC to update the appropriate Medical Officer with any information that may affect the enquiry status, such as:

- The decision to take NFA
- Decision to Caution
- The determination of Court Proceedings
Information Exchange Documents
CUMBRIA POLICE

REQUEST FOR THE DISCLOSURE OF INFORMATION

Data Protection implications must be considered **before** information is disclosed or transferred and all requests for information must be documented.

* DENOTES ALL FIELDS MUST BE COMPLETED. IF NOT, THE FORM WILL BE SENT BACK FOR COMPLETION & RESUBMISSION

To: Cumbria Constabulary
For The Attention of: CumbriaDisclosureUnit@cumbria.pnn.police.uk

*From: ORGANISATION REQUESTING INFORMATION

<table>
<thead>
<tr>
<th>Details of Information Required (one form per person)</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Name of Person:</td>
</tr>
<tr>
<td>*Date of Birth</td>
</tr>
<tr>
<td>*Any Previous/Alias names:</td>
</tr>
<tr>
<td>*Current Address:</td>
</tr>
<tr>
<td>Previous Address (if any):</td>
</tr>
<tr>
<td>How long at current address:</td>
</tr>
<tr>
<td>*Has Person Resided Outside Cumbria If so Where:</td>
</tr>
<tr>
<td>Consent from the individual has been obtained:</td>
</tr>
</tbody>
</table>

*PNC Check (record of cautions/convictions) requested | NO |
*Relevant non conviction data requested | NO |
*PND check (to see if information is held by other forces) | NO |

Information Return Date (please specify if urgent) Reason For Urgency
*The information required and why: State below the information required & why - explain why this is necessary, proportionate and relevant for the information to be disclosed.

**IF THIS SECTION IS NOT COMPLETED DISCLOSURE WILL NOT BE MADE.**

Incident/intelligence supporting request (please complete):

Intelligence/information required (please complete):

Time scale of required (please select as appropriate): 6 MONTHS

Specify Timescale or Specific Date/Incident

I confirm that the personal or sensitive personal information is required for the following purpose and will NOT be disseminated to any other third party:

*Check This Box To Confirm:* *

*Failure to provide the information will result in:

*The legal gateways or policing purpose that you are requesting this information that apply:-*

| Legal Gateway | 
|---------------|-----------------|-----------------|-----------------|-----------------|
| Children’s Act 1989 Section 47 | ☐ | ☐ | ☐ | ☐ |
| Data Protection Act 1998 Section 29 (3) Section 35 (2) | ☐ | ☐ | ☐ | ☐ |
| Human Rights Act 1998 Article 8 | ☐ | ☐ | ☐ | ☐ |
| Other | Please State: | ☐ | ☐ | ☐ |
*Before requesting this information the following points have been considered:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the objective of the request for personal information to prevent or detect crime and/or disorder?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would failure to disclose the information prejudice the objective?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the disclosure of the information “in the public interest”?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have the 8 Data Protection Principles been referred to?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Personal data shall be processed fairly and lawfully
- Personal data shall be obtained for one or more specified and lawful purposes and shall not be further processed in any matter incompatible with that purpose or those purposes
- Personal data shall be adequate, relevant and not excessive in relation to the purpose for which they are processed
- Personal data shall be accurate and where necessary kept up to date
- Personal data processed for any purpose or purposes shall not be kept longer than is necessary for that purpose or those purposes
- Personal data shall be processed in accordance with the rights of the data subject under this Act
- Appropriate technical and organisation measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data
- Personal data shall not be transferred to a country or territory outside the European Economic Area, unless rights and freedoms are protected.

**Person requesting information:** (This is the named individual requesting the information who has the responsibility for using the information received in accordance with the Information Sharing Agreement)

**Print Name:** Applicants Name  Position:  
Secure Email:  Date:  
(e.g. .gsi .cjsm or similar)  
Contact Telephone Number:  
Authorised By:  Line Manager Details  
(Line Manager)
<table>
<thead>
<tr>
<th>Information Disclosed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Trace On Details Supplied</td>
</tr>
<tr>
<td>Appears Identical to person whose PNC record is attached</td>
</tr>
<tr>
<td>No Intelligence is held on Cumbria Constabulary Database</td>
</tr>
</tbody>
</table>

Our records indicate further information is held by other Police Forces as listed below:

**Details of individual disclosing information:** (This is the named individual who is authorised to disclose the information in accordance with the stated purpose and with due regard to the Data Protection Principles)

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position:</td>
</tr>
<tr>
<td>Contact Tel No:</td>
</tr>
<tr>
<td>Email:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>
REQUEST FOR DISCLOSURE OF PERSONAL DATA
SECTION 29(3) DATA PROTECTION ACT 1998

I am making enquiries which are concerned with:

(a) the prevention or detection of crime
(b) the apprehension or prosecution of offenders

Please provide information in relation to:

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

Section 29(3) of the Data Protection Act 1998 allows personal data to be supplied in relation to (a) and/or (b) above and failure to provide the information will, in my view, be likely to prejudice those matters.

It will not be used in any way incompatible with the purpose for which it is being disclosed.

I understand that if I procure information which is not in connection with (a) and/or (b), I may be committing an offence under Section 55 of the Data Protection Act 1998.

Officer making request:

Signed: .................................................. Date: .................................
Station: .................................................................

Officer authorising:

Signed: ............................................. Date: .................................
Youth Justice Pathway
Appendix C
YOUTH JUSTICE PATHWAYS

OFFENCE

CHARGED

COURT APPEARANCE

Referred to YOS for a pre-sentence report (PSR)

YOS Care Manager (PSR Author) allocated

YOS Health Practitioner involved if Custody being considered

Check if known to NHS services and complete Health Profile and provide brief summary for YOS Case Manager to put into court report

Custody

Allocated YOS officer to monitor and review

Referred to YOS Health Practitioner IF Health Concerns evident

Attendance centre order

No YOS Health Practitioner involvement

Dismissed / revoked

No YOS Health Practitioner involvement
Sex Offenders Notification Document
Appendix D

SEXUAL OFFENCES ACT 2003

SEX OFFENDERS WHO NEED TO REGISTER WITH THE POLICE

Notification to the police & probation officer of patient subject to part 2 of the Sexual Offences Act 2003 (The Sex Offender Register).

To the Chief Constable/To the patient’s Probation Officer

SEXUAL OFFENCES ACT 2003 (PART 2 – THE SEX OFFENDERS REGISTER)

I write to inform you that the patient named below will be discharged on

………..

NAME:
DoB:
ADDRESS:

SIGNED: (Ward Manager) .................................................................

YOU SHOULD NOTE THAT IF YOU WERE CONVICTED OR RECEIVED A HOSPITAL ORDER PRIOR TO THE 1ST MAY 2004, THE BELOW REQUIREMENTS MAY NOT HAVE BEEN CONTAINED WITHIN THE CERTIFICATE GIVEN TO YOU AT THE TIME OF YOUR CONVICTION/ORDER. YOU MUST ENSURE THAT YOU NOTE ALL OF THESE AMENDMENTS WHICH WERE INTRODUCED WITHIN THE SEXUAL OFFENCES ACT 2003 (PART 2).

This notice has guidance in it about what you must do to register as a sex offender. It applies to patients who have been convicted or received a hospital order on or after 1st September 1997 of a sexual offence contained within Schedule One of the Sex Offenders Act 1997, or Schedule 3 of the Sexual Offences Act 2003 (Implemented 1st May 2004). The requirements also apply to offenders who were serving a sentence/order for a like offence on the 1st September 1997. It is not a complete statement of the law. If you want more information, or if you do not fully understand what you have to do, please consult your legal advisor or read Part 2 of the Sexual Offences Act 2003.

What you must do now:

1. Within 3 days of your release from prison, you must go in person to a police station in the area where you live, and register as a sex offender. You will need to tell them your name, any other names you use, your date of birth, and you home address. If you have no home, you must give the address of the place where you are staying or, if you are of no
fixed abode, any premises you regularly visit. **You must also provide the Police with your National Insurance Number.**

If the Police want to take your photograph or fingerprints, you must let them.

2. If you then change your name or address, you must then notify the police of the new details **within 3 days.** You must do this **in person.**

3. If you go to stay at another address for **7 days or longer within any twelve months,** you must let the police know about it **within 3 days. You must do this in person.** This counts whether you stay at the address for 7 days together, or find you have spent any 7 days there in the last twelve months.

4. If you intend to go abroad for **over 3 days,** **you must notify the police.** They will tell you the precise requirements when you register with them on release.

**Penalties:**

If you fail to adhere to any of the requirements set out above, you will be committing an offence. The punishments for this are:

1. On conviction on indictment (in the Crown Court), imprisonment, or a fine, or both.
2. On summary conviction (in a Magistrates’ Court) imprisonment, or a fine, or both.

**I have received the notice outlining my responsibilities under Part 2 of the Sexual Offences Act 2003.**

SIGNED: (Patient)

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

DATE:
Relevant Legislation and Home Office Circulars
Appendix E

PART THREE OF THE MENTAL HEALTH ACT

SECTION 35 – REMAND TO HOSPITAL FOR REPORT

- Available to a Magistrates or Crown Court
  [S 35(1)]
- Applies to those awaiting trial or sentence in Crown Court or those convicted or charged in Magistrates Court and the offence in question is punishable by imprisonment
  [S 35(2)]
- Requires the written or oral evidence of a S12(2) approved doctor that “there is reason to suspect that the accused is suffering from mental disorder”
  [S 35 (3) (a)]
- Court must be of the opinion that a report on the accused’s mental condition would not be practicable if they were remanded on bail
  [S 35(3) (b)]
- Court must have written or oral evidence (from the potential RC or a representative of the hospital managers) that hospital admission can take place within seven days.
  [S 35(4)]
- Remand is initially for up to 28 days and thereafter for up to 28 days at a time up to a maximum of 12 weeks
  [S 35(7)]
- If the accused is legally represented further remands can occur in their absence
  [S 35(6)]
- Consent to treatment provisions do not apply
  [S 56(1) (b)]
- Sometimes combined with S 2 or S 3 to permit treatment
  [Cofp 17.3]
- Accused cannot be granted leave, discharge from hospital or apply to a MHRT

SECTION 36 – REMAND TO HOSPITAL FOR TREATMENT

- Only available to the Crown Court
  [S 36(1)]
- Accused must be in custody awaiting trial for an imprisonable offence other than murder
  [S 36(2)]
• Requires written or oral evidence of two doctors (one must be Section 12(2) approved) that the accused is suffering from: mental disorder' of a nature or degree which makes it appropriate for him/her to be detained in hospital for medical treatment"
[S 36(1)]
• Court must have written or oral evidence (from the potential RC or a representative of the hospital managers) that hospital admission can take place within seven days
[S 36(3)]
• Remands are for up to 28 days initially and for further periods of up to 28 days up to 12 weeks in total
[S 36(5) (6)]
• If accused is legally represented further remands can occur in their absence
[S 36(5)]
• Accused cannot be granted leave, discharged for hospital or apply to a MHRT
• Consent to treatment provisions apply
[S 56]

SECTION 37 – HOSPITAL AND GUARDIANSHIP ORDERS

• Available to Magistrates or Crown Court as an alternative to penal disposal except where the sentence is fixed by law

• a. Offender must be suffering from a mental disorder
   and
   o Mental disorder is of a nature or degree which makes it appropriate for him/her to be detained in hospital for treatment (Hospital Order)
   or
   o Has attained the age of 16 and the mental disorder is of a nature or degree which warrants reception into guardianship (Guardianship Order)
   and
   o b. The Court is of the opinion that an order under this section is the most suitable method of disposal having taken into account the nature of the offence and the character and antecedents of the offender

• Two doctors must give written or oral evidence of (a) above
• At least one doctor must be S 12(2) approved
[S 54(1)]
• In the case of a Hospital Order the written or oral evidence of the offender’s proposed RC or a representative of the hospital managers that admission to hospital can take place within 28 days is required before the order can be made
(Offender can be held in a place of safety for up to 28 days between making the Hospital Order and admission to hospital)

- In the case of Guardianship Order the Court must be satisfied that the guardian is willing to receive the offender into guardianship
  [S 37(6)]

(The local authority is not required to accept the Guardianship Order on behalf of a private guardian)

Other Points
- An order under S 37 cancels any previous order or application
  [S 40(5)]
- A Magistrates Court may make a Hospital or Guardianship Order **without conviction** where:
  i. The accused has been charged with an offence for which a Magistrates Court can convict
  ii. The Court is satisfied that the accused ‘did the act or made the omission charged’

SECTION 38 – INTERIM HOSPITAL ORDERS

Allows a Magistrate or Crown Court to send a convicted offender to hospital for up to 12 months to allow assessment of the appropriateness of making a hospital order

Grounds
- Requires the written or oral evidence of two doctors (one must be S 12(2) approved that the offender is suffering from a mental disorder and there is reason to suppose that it may be appropriate to make a Hospital Order
  [S 38(1)]
- One of the two doctors must be employed at the admitting hospital
  [S 38(3)]

Evidence
- Written or oral evidence is required (from the potential RC or a representative of the hospital managers) that hospital admission can take place with 28 days

Other Points
- Order lasts initially for 12 weeks but can be renewed (in the accused’s absence) for 28 days at a time for up to a maximum of 12 months
  [S 38(5)]
- A Hospital Order can be made in the accused’s absence if they are legally represented
Accused cannot be granted leave, discharged from hospital or apply to a MHRT

Consent to treatment provisions apply

[S 56]

SECTION 41 – RESTRICTION ORDERS

1. Available where a Crown Court has already made a Hospital Order as a further order restricting discharge where:

“…it appears to the Court, having regard to the nature of the offence, the antecedents of the offender and the risk of his/her committing further offences if set at large, that it is necessary for the protection of the public from serious harm to do so…”

9. At least one of the two doctors must have given evidence orally before the Court

10. The ‘restriction order’ can be made with or without limit of time

11. A Magistrates Court can commit an offender to the Crown Court for sentencing if it is satisfied that the conditions exist to make a restriction order (the Crown Court is not obliged to make the order)

12. There does not have to be a direct link between the ‘nature of the offence’ and ‘protection of the public from serious harm’

Effect of Restriction Orders:

- Patient can only be discharged by a MHRT, the Secretary of State or the RC with the consent of the Secretary of State
  [S 23, 41 (3) (b), 73]
- Patient can only be transferred to another hospital (S 19) or granted leave (S 17) with the consent of the Secretary of State
- The Hospital Order does not require renewal while the restriction order remains in force
  [S 41(3) (b)]
- RC must examine the patient and report to the Secretary of State at least yearly
  [S 41(6)]
- Discharge can be absolute or conditional
  [S 42(2), 73]
- Patient can apply to a MHRT between 6 and 12 months after the order and during each subsequent 12 month period.
  [S 70]
• Secretary of State must refer the patient to a MHRT where there has been no tribunal for three years
  [S 71(2)]
• Secretary of State may lift the restriction leaving the hospital order in place
  [S 41(1)]

**Discharge and Recall:**

• Absolute discharge removes both the restrictions **and** the original hospital order
  [S 42(2)]
• Any conditions can be imposed (usually conditions relate to place of residence, attendance for treatment or supervision)
• Supervision is by a probation officer or a social worker
• Conditionally discharged patients remain ‘liable to be detained’ and may be recalled by warrant to any specified hospital by the Secretary of State
  [S 42(3)]
• Secretary of State **must** refer a recalled patient to a MHRT within one month of recall
  [S 75(1)]
• Average length of stay for recalled hospital patients is over two years
• Part II of the Act may be used for the compulsory treatment of conditionally discharged patients (R v N London Mental Health NHS Trust ex parte Stewart)

**SECTION 47 – REMOVAL TO HOSPITAL OF SENTENCED PRISONERS**

Based on reports from two doctors (one must be S12 (2) approved). The Secretary of State **may** transfer a sentenced prisoner to hospital (not a mental nursing home) if:

A  They are suffering from a mental disorder

**And**

B  The mental disorder is of a nature or degree which makes it appropriate for him/her to be detained in hospital for treatment
  [S 47(1)]

• Known as a ‘transfer direction’
• Prisoners must be transferred within 14 days of the transfer direction
  [S 47(2)]
• A transfer direction has the same effect as a hospital order under S 37
  [S 47 (3)]
• Transfer directions are almost always subject to a ‘restriction direction’ under S 49 (except where the prisoner is very close to their earliest release date)
SECTIONS 48 – REMOVAL TO HOSPITAL OF OTHER PRISONERS

- Process as for S47 transfer direction but only applies to prisoners suffering from a mental disorder [S 48(1)]
- Applies to remand prisoners, civil prisoners, and persons detained under the 1971 Immigration Act [S 48(2)]
- Remand prisoners must be subject to a restriction direction under S49 [S 49(2)]
- Patient may appeal to a MHRT but a recommendation for discharge will not result in release [S 74(4)]
- A Hospital Order can be made without them being brought before the Court and without their being convicted [S 51 (5)]

SECTION 49 – RESTRICTION DIRECTIONS

Same effect as a restriction order under S 41 except:

- MHRT can only recommend discharge to the Secretary of State [S 74]
- Secretary of State on the recommendation of a MHRT, the RC, or any other doctor that the patient no longer requires treatment for mental disorder may return the patient to prison or release him/her on licence or under supervision [S 50(1)]
- Restriction direction ceases on the expiry of the original prison sentence (including remission and adding periods AWOL) [S 50(2) (3) (4)]
- No casual relationship need exist between the offender’s mental disorder and the offence(s)
- Unlike S 3 detention in hospital and treatment do not need to be necessary for the health or safety of the offender or for the protection of other persons
- If the patient cannot be admitted to the specified hospital within 28 days the Secretary of State may direct admission to another hospital [S 37(5)]
Effect of Hospital and Guardianship Orders:

Hospital Orders: as for admission under Section 3 except: (see Section 3 of Mental Health Act Practice Guidelines)

- Patient cannot appeal to a MHRT during first six months  
  [Sch1 pt i para9]  
  Nearest relative cannot apply to discharge the order  
  [Sch1 pt i para8]

- Nearest relative has a right of appeal to a MHRT between 6 and 12 months of the order and in each subsequent 12 month period  
  [S 69(1) (d)]

Guardianship Orders: as for reception into guardianship under Section 7 (see Section 7 of Mental Health Act Practice Guidelines) except

- Nearest relative cannot apply to discharge the order  
  [Sch1 pt i para8]

- Nearest relative can apply to a MHRT within 12 months of the order and during each subsequent 12 month period  
  [S 69(1) (b)]

Exceptions

A person cannot be treated as being mentally disordered for any purposes of the Act solely on the grounds that he/she: ‘is suffering from a mental disorder…. by reason only of dependence on alcohol or drugs’  
[S 1 (3)]

Information

SECTION 39

Where a Court is considering making a Hospital Order it may ask the appropriate Health Authority to provide information as to the availability of hospital places.

- There is no obligation on the authority to supply a bed
- Health Authorities should appoint a named person to respond to these requests for information  
  [Cofp 33.6]

SECTION 39a (inserted by Criminal Justice Act 1991)

Where a Court is considering making a Guardianship Order it may ask the appropriate local social services authority to provide information as to whether it, or someone approved by it, is willing to receive the offender into guardianship and give information as to how the authority or person might exercise their guardianship powers
- The local authority or private person are not obliged to accept the offender into their guardianship
- Local Authorities should appoint a named person to respond to these requests
  [Cofp 33.7]

**SECTION 45A inserted by S.46 CRIME (SENTENCES) ACT 1997
ALSO KNOWN AS HYBRID SENTENCE**

Sections 45A and 45B to the Mental Health Act allows the Court to make a hospital direction that instead of being removed to and detained in prison, the offender be removed to and detained in such hospital as may be specified in the direction
[S 45 45A (3) (a)]

- Has the same effect as a transfer direction under Section 47
  [45B (2) (a)]
- It empowers the Crown Court when imposing a prison sentence to give a direction for immediate admission to and detention in a specified hospital
- A Hospital Order must have been considered before imposing this direction
- Court must also make a 'limitation direction' which has the same effect as a restriction direction under Section 41
  [S 45A (3) (b), S 45B (2) (b)]
- Cannot be made where sentence is fixed by law (e.g. Murder)
- Medical evidence as for section 41
- RC has the option of seeking the patient's transfer to prison at any time before his release date if no further treatment is necessary, or is likely to be beneficial

**Specifying Hospital Units (Crime Sentences Act S. 47)**

Home Secretary’s consent required for leave or transfer from the specified unit (even within the same hospital)

**Private Nursing Homes**

Prisoners transferred from prison to hospital (Section 47) or directed to hospital by the Courts (Section 45a) can now go **direct** to private nursing homes

(Previously prisoners had to be admitted to NHS hospital and transferred to private nursing homes under Section 19)
CRIMINAL RESPONSIBILITY – SPECIAL CIRCUMSTANCES

Infanticide (Infanticide Act 1938)

Applies to women who wilfully cause death of her child under the age of 12 months if:

‘at the time of the act or commission the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent to the birth of the child…’

- Punishable as if guilty of manslaughter
- Only applies if the child is killed, not injured
- Only applies when the child killed is under 12 months of age
- Does not apply where the mother has recently given birth and kills an older child
- Rarely used since the plea of diminished responsibility became available

Diminished Responsibility

Introduced by the 1957 Homicide Act as a method of circumventing the mandatory sentence for murder

If the defendant can prove that he/she was suffering, at the time of the unlawful killing from an abnormality of the mind that subsequently impaired his/her mental responsibility, he/she will be convicted of manslaughter instead of murder

- Gives the judge full discretion as to the sentence
- Only applies to the offence of unlawful killing
- ‘Abnormality of mind’ does not include self-induced intoxication or other external causes such as jealousy, anger or greed
- ‘Winning’ on a plea of diminished responsibility does not guarantee a ‘therapeutic’ disposal or a less severe sentence (Judge retains discretion to give a life sentence)

Not Guilty by Reason of Insanity

‘The special verdict’ (Trial of Lunatics Act 1883)

Test of ‘insanity’ – McNaghten Rules 1843

To establish a defence of insanity it must be clearly proved that at the time of committing the act the party accused was labouring under such a defect of reason from disease of mind:

1. As not to know the nature or quality of the act he/she was doing (e.g. he/she did not know what they were doing)
2. That he/she did not know that what they were doing was wrong (contrary to law)

a. Concerned mainly with ability to reason
b. Very restrictive. Unlikely to apply to most mentally disordered persons
c. Applies to all criminal acts

**1991 Act – Changes:**

- ‘not guilty by reason of insanity’ requires the written or oral evidence of two doctors (one of which is S12(2) approved)
- Fitness to be tried is determined by a jury on the written or oral evidence of two doctors (one of which is S12(2) approved)
- Where the accused is fit to be tried the subsequent trial must be by another jury
- Where the accused is unfit to be tried a ‘trial of the facts’ takes place (usually by a second jury)
- The ‘trial of the facts’ is to determine whether the accused ‘did the act or made the omission charged against him/her’
- The accused is acquitted if the trial of the facts does not conclude (beyond reasonable doubt) that the accused did the act or made the omission charged
- If the accused is not guilty by reason of insanity or is unfit to plead and did the act or made the omission charged a new range of disposals are available

**Criminal Procedure (Insanity and Unfitness to Plead) Act 1991**

**Disposals:**

1. **Hospital Order** with or without a Restriction Order (the restriction order may be with or without limit of time unless the offence charged is murder)

2. **A Guardianship Order**

3. **A Supervision and Treatment Order** requiring the accused to co-operate with supervision by a social worker or probation officer for up to 2 years and with medical treatment by a doctor for all or part of that time
   - Treatment can be specified as a hospital in or outpatient or otherwise under a doctor’s direction
   - Magistrates can revoke or vary the order
   - Agreement of the supervisor is required before the order can be made
   - The accused’s consent to the order is not required
   - No sanctions exist with regard to non-compliance

4. **Absolute Discharge**
1. This circular sets out changes to the arrangements for defendants found unfit to plead or not guilty by reason of insanity.

2. The Domestic Violence, Crime and Victims Act 2004 ("the 2004 Act") makes a number of amendments to legislation governing unfitness to plead and insanity. In particular, it amends the Criminal Procedure (Insanity) Act 1964 ("the 1964 Act") as amended by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 ("the 1991 Act"). It applies only to the higher courts (i.e. not magistrates' courts) although magistrates' courts do have a role in reviewing, revoking or amending supervision orders made under the 2004 Act (Parts 2 and 3 of Schedule 2).

3. This circular sets out the principal changes and offers guidance on the operation of the revised procedures. The amendments introduced by the 2004 Act are procedural; no changes have been made to the substantive law on the defence of insanity or the rules determining when a person is unfit to be tried.

4. The new provisions will come into force on 31 March 2005. Where a person is arraigned in (or, in the case of a person said to be unfit to plead, committed or sent to) the Crown Court before that date or where the hearing of an appeal in the Court of Appeal began before that date, the 1964 Act (as amended by the 1991 Act) applies. Arrangements remain as set out in Home Office Circular 93/1991. This is available on the Home Office website at http://www.circulars.homeoffice.gov.uk.

5. Where a person is arraigned on or after 31 March 2005, the changes introduced by the 2004 Act apply. In cases where a person is said to be unfit to plead and so cannot be arraigned, the 2004 Act will apply if the person is committed or sent to the Crown Court on or after 31 March 2005.

**Principal changes**

6. The main changes introduced by the 2004 Act are as follows:
• The judge, rather than the jury, will determine the issue of whether a defendant is fit to plead.
• The Secretary of State will no longer have a role in deciding whether or not the defendant is admitted to hospital; this will be a matter for the court.
• The court will have a new range of disposals when it has made a finding of unfitness to plead and that the defendant did the act charged or has found the defendant not guilty by reason of insanity under the 1964 Act. They allow for the defendant to receive treatment and support if the court thinks that this is appropriate.
• A court will no longer be able to order the defendant’s admission to a psychiatric hospital without medical evidence that justifies his detention on grounds of his mental state.
• Where the Court wishes to make an order for admission to hospital, it must apply the provisions of section 37 of the Mental Health Act 1983 (“the 1983 Act”), including the requirements for medical evidence. The Hospital Order (which is normally given after conviction of an offence) will apply equally following a finding of unfitness or insanity. The one difference is that a court will be able to require a hospital to admit a person found unfit to plead or not guilty by reason of insanity, whereas it has no such power in respect of those convicted of an offence.

Further details are set out below.

**Determination of fitness to plead by judges**

7. Section 22 of the 2004 Act amends the 1964 Act so that the question of a defendant’s fitness to be tried shall be determined by the court without a jury. Where it is decided that the accused is unfit to be tried, the question of whether he did the act or omission charged against him (the “trial of the facts”) will still be determined by the jury.

**Disposal options**

8. Section 24 of the 2004 Act replaces section 5 of the 1964 Act with new sections 5 and 5A. New section 5 sets out new disposal options for the court to deal with persons found not guilty by reason of insanity or unfit to plead; section 5A sets out further provisions in respect of these options.

9. The court has three options:

- to make a Hospital Order under section 37 of the 1983 Act, which can also be accompanied by a Restriction Order under section 41 of that Act;
- to make a Supervision Order; or
- to order the absolute discharge of the accused.
Hospital order

10. The power of the court to make a Hospital Order and a Restriction Order under the 1983 Act represents a change from the previous position, whereby the court made an order for the defendant’s admission to hospital under Schedule 1 to the 1991 Act, without having to be satisfied that the 1983 Act conditions were met, and specified whether it thought restrictions were appropriate. The two principal differences under the new system are that the Secretary of State no longer has a role in deciding whether or not the defendant is admitted to hospital, and that a court can no longer order the defendant’s admission to hospital without appropriate medical evidence.

11. If the court wishes the defendant to be detained in hospital, the Hospital Order will be the appropriate order. To make a Hospital Order, the court must have the evidence required by section 37 of the 1983 Act that the defendant is mentally disordered and requires specialist medical treatment. This means that there must be medical evidence that justifies his detention on grounds of his mental state. The making of a Restriction Order alongside a Hospital Order gives the Secretary of State certain powers in relation to the management of the defendant in hospital, such as the requirement that the Secretary of State consent to the defendant being given leave or discharged. Restriction Orders are made in cases where the defendant poses a significant risk to the public (see section 41(1) of the 1983 Act).

12. Provision in section 5(3) of the 1964 Act and paragraph 2(2) of Schedule 1 to the 1991 Act required the court to order admission of the defendant to hospital subject to restrictions where he was charged with an offence for which the sentence is fixed by law (i.e. murder). The new section 5(3) has similar effect but the court is only obliged to make a Hospital Order with an Order on a charge of murder if the conditions for making a Hospital Order are met. If the conditions are not met, for example if the reason for the finding of unfitness to plead relate to a physical disorder, the court’s options are limited to a Supervision Order or Absolute Discharge.

13. The new section 5A makes provision about the detail of these orders. Subsections (1) and (3) modify the 1983 Act so that the provisions on Hospital Orders (which are normally given after conviction of an offence) apply equally to making a Hospital Order following a finding of unfitness or insanity. The one difference is that a court will be able to require a hospital to admit a person found unfit to plead or not guilty by reason of insanity, whereas it has no such power in respect of those convicted of an offence. This reflects the fact that the Court has the option of a criminal justice disposal following conviction: but has no such option following a finding of unfitness or insanity. Medical professionals should bear in mind that the court has this power.

14. Subsection (2) of new section 5A extends the powers under the 1983 Act to remand an accused person to hospital for a report or treatment and to make an
Interim Hospital Order. This is so that the court can exercise these powers where a person has been found unfit to plead or not guilty by reason of insanity and the court is considering which disposal would be appropriate.

15. Subsection (4) of new section 5A replicates existing provision in paragraph 4 of Schedule 1 to the 1991 Act and allows the Secretary of State to remit for trial a person who was found unfit to plead, while he remains detained in hospital under a Hospital Order with a Restriction Order. As now, the Secretary of State must consult with the responsible medical officer and will seek his or her opinion as to whether the person can properly be tried. The Hospital and Restriction Orders lapse on the person’s arrival at court or prison.

**Supervision order**

16. The Supervision Order replaces the existing Supervision and Treatment Order (see Schedule 2 to the 1991 Act). The new Supervision Order differs from the old Supervision and Treatment Order in that it enables treatment to be given under supervision for physical as well as mental disorder and it cannot include a requirement for a person to receive treatment as an in-patient without his consent. It is designed to enable support and treatment to be given to the defendant to prevent recurrence of the problem which led to the offending. There is no sanction for breach of the Supervision Order. Like the Supervision and Treatment Order it is non-punitive and intended solely to provide a framework for treatment. For this reason it will usually be appropriate for an approved social worker to act as the supervising officer. The court will give copies of the order to the probation officer assigned to the court but these should be immediately passed on to the supervising officer and supervised person.

17. The Supervision Order is described in detail in Schedule 2 to the 2004 Act, which introduces a new Schedule 1A to the 1964 Act.

**Absolute discharge**

18. The 2004 Act applies the provision on Absolute Discharge in section 12 of the Powers of Criminal Courts (Sentencing) Act 2000 to the case where a defendant is given an Absolute Discharge following a finding of unfitness or insanity. This might be considered, for example, where the alleged offence was trivial and the accused does not require treatment and supervision in the community.

19. Details are at section 24(1) of the 2004 Act; subsection (6) of section 5A refers.

**Appeals**

20. Corresponding changes are made to the disposals available to the Court of Appeal when substituting a finding of insanity or unfitness to plead for another finding. The new arrangements align the powers of the Court of Appeal with
those of the Crown Court in terms of the orders it may make, and removes the Court of Appeal power to order admission to hospital where it substitutes a verdict of acquittal for a verdict of not guilty by reason of insanity and there is medical evidence that the person is mentally disordered. It will still be possible to admit such a person to hospital under the civil powers in the 1983 Act. Details are at section 24(3) and (4) of the 2004 Act.

21. Section 25 of the 2004 Act inserts new sections 16A and 16B into the Criminal Appeal Act 1968. New section 16A provides a right of appeal to the Court of Appeal against a supervision order or hospital order made by virtue of section 24. New section 16B enables the Court of Appeal to quash those orders and substitute or amend them in any way available to the court below.
Criminal Justice Act 2003

Section 157 Additional requirements in case of Mentally Disordered Offender

(1) Subject to subsection (2), in any case where the offender is or appears to be mentally disordered, the Court must obtain and consider a medical report before passing a custodial sentence other than one fixed by law.

(2) Subsection (1) does not apply if, in the circumstances of the case, the Court is of the opinion that it is unnecessary to obtain a medical report.

(3) Before passing a custodial sentence other than one fixed by law on an offender who is or appears to be mentally disordered, a Court must consider-

(a) any information before it which relates to his mental condition (whether given in a medical report, a pre-sentence report or otherwise), and
(b) the likely effect of such a sentence on that condition and on any treatment which may be available for it.

(4) No custodial sentence which is passed in a case to which subsection (1) applies is invalidated by the failure of a Court to comply with that subsection, but any court on an appeal against such a sentence-

(a) must obtain a medical report if none was obtained by the Court below, and
(b) must consider any such report obtained by it or by that Court.

(5) In this section "mentally disordered", in relation to any person, means suffering from a mental disorder within the meaning of the Mental Health Act 1983 (c. 20).

(6) In this section "medical report" means a report as to an offender's mental condition made or submitted orally or in writing by a registered medical practitioner who is approved for the purposes of section 12 of the Mental Health Act 1983 by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder.

(7) Nothing in this section is to be taken to limit the generality of section 156.
Section 207

Mental health treatment requirement

(1) In this Part, "mental health treatment requirement", in relation to a Community Order or Suspended Sentence Order, means a requirement that the offender must submit, during a period or periods specified in the order, to treatment by or under the direction of a registered medical practitioner or a chartered psychologist (or both, for different periods) with a view to the improvement of the offender's mental condition.

(2) The treatment required must be such one of the following kinds of treatment as may be specified in the relevant order-

(a) treatment as a resident patient in an independent hospital or care home within the meaning of the Care Standards Act 2000 (c. 14) or a hospital within the meaning of the Mental Health Act 1983 (c. 20), but not in hospital premises where high security psychiatric services within the meaning of that Act are provided;
(b) treatment as a non-resident patient at such institution or place as may be specified in the order;
(c) treatment by or under the direction of such registered medical practitioner or chartered psychologist (or both) as may be so specified; but the nature of the treatment is not to be specified in the order except as mentioned in paragraph (a), (b) or (c).

(3) A Court may not by virtue of this section include a mental health treatment requirement in a relevant order unless-

(a) the Court is satisfied, on the evidence of a registered medical practitioner approved for the purposes of section 12 of the Mental Health Act 1983, that the mental condition of the offender-
   (i) is such as requires and may be susceptible to treatment, but
   (ii) is not such as to warrant the making of a hospital order or Guardianship Order within the meaning of that Act;
(b) the Court is also satisfied that arrangements have been or can be made for the treatment intended to be specified in the order (including arrangements for the reception of the offender where he is to be required to submit to treatment as a resident patient); and
(c) the offender has expressed his willingness to comply with such a requirement.

(4) While the offender is under treatment as a resident patient in pursuance of a mental health requirement of a relevant order, his responsible officer shall carry out the supervision of the offender to such extent only as may be necessary for the purpose of the revocation or amendment of the order.
(5) Subsections (2) and (3) of section 54 of the Mental Health Act 1983 (c. 20) have effect with respect to proof for the purposes of subsection (3)(a) of an offender's mental condition as they have effect with respect to proof of an offender's mental condition for the purposes of section 37(2)(a) of that Act.

(6) In this section and section 208, "chartered psychologist" means a person for the time being listed in the British Psychological Society's Register of Chartered Psychologists.

Section 208

Mental health treatment at place other than that specified in order

(1) Where the medical practitioner or chartered psychologist by whom or under whose direction an offender is being treated for his mental condition in pursuance of a mental health treatment requirement is of the opinion that part of the treatment can be better or more conveniently given in or at an institution or place which-

(a) is not specified in the relevant order, and
(b) is one in or at which the treatment of the offender will be given by or under the direction of a registered medical practitioner or chartered psychologist,

he may, with the consent of the offender, make arrangements for him to be treated accordingly.

(2) Such arrangements as are mentioned in subsection (1) may provide for the offender to receive part of his treatment as a resident patient in an institution or place notwithstanding that the institution or place is not one which could have been specified for that purpose in the relevant order.

(3) Where any such arrangements as are mentioned in subsection (1) are made for the treatment of an offender-

(a) the medical practitioner or chartered psychologist by whom the arrangements are made shall give notice in writing to the offender's responsible officer, specifying the institution or place in or at which the treatment is to be carried out; and
(b) the treatment provided for by the arrangements shall be deemed to be treatment to which he is required to submit in pursuance of the relevant order.
Mental Capacity Act 2005

PURPOSE

The Mental Capacity Act (MCA) 2005 gives a legal basis for providing care and treatment for people aged 16 years and over who lack the mental capacity to give their consent to such care and treatment. The Act protects decision makers where they take reasonable steps to assess someone’s capacity and then act in the reasonable belief that the person lacks capacity and that such action is in their best interests.

Although the MCA is primarily aimed at health and social care professionals and carers when making decisions about a person’s welfare, it will in some circumstances be applicable to police officers. In such cases officers will usually need to make immediate decisions while awaiting further input or direction from a heath or social care professional. This briefing note will help police officers and staff when making those decisions.

POLICE USE OF THE MCA 2005

In non-emergency situations involving a possible lack of mental capacity, such as a pre-planned mental health assessment, it may be more appropriate for officers to use other powers and tactical approaches than those involving the MCA 2005.

The MCA is most likely to be necessary in emergency situations when officers are faced with someone whose life may be at risk or who may suffer harm if action is not taken. Examples include people attempting and threatening suicide, victims of serious assaults, casualties of major incidents, and individuals with serious injuries who decline medical aid, any sort of treatment or help. In many such situations officers will not have time to discuss, negotiate or explain their actions. The following steps provide guidance to help in making decisions about a person’s mental capacity.

1. Determining someone’s mental capacity

   Everyone is presumed to have capacity, unless there is evidence that they cannot make a decision because of an impairment or disturbance in the functioning of their mind or brain because of: mental ill health; significant learning disabilities; dementia; brain damage; physical or mental conditions that cause confusion, drowsiness or loss of consciousness; delirium; concussion following a head injury; or the symptoms of alcohol or drug use.

   People are unable to make a particular decision if they cannot do one or more of the following four things:

   • Understand information given to them about the decision to be made;

   • Retain that information long enough to be able to make the decision;
• Use or weigh up that information as part of the decision making process;
• Communicate their decision.

Questioning along the lines of “Do you realise you have an injury?” and “Do you realise how serious it is?” and noting responses will help officers decide if the person concerned has capacity to make decisions at that time about their need for emergency treatment. In addition, such questions will help officers benefit from the safeguards provided within the Act against allegations of unlawful restraint or assault.

2. Determining what is in someone’s best interests

The MCA Code of Practice provides that ‘In an emergency, saving life or preventing someone suffering serious harm will almost always be in the person’s best interests and treatment should be given without delay’ (paragraph 5.61). Where a person who is threatening suicide appears to know exactly what they are doing and why, others may be reluctant to conclude they lack capacity – basing this judgement on principle 3 (i.e. ‘a person is not to be treated as unable to make a decision merely because he makes an unwise decision’). However, it is not the decision to take their own life that necessarily evidences lack of mental capacity, but rather their inability or refusal to consider or fully think through alternative options such as counselling, medical assistance or help from statutory or voluntary agencies.

3. Restraint

In situations where someone is reasonably believed to lack capacity it is lawful to restrain them. Before using restraint, however, officers must:

(a) reasonably believe restraint is necessary to prevent harm to the person who lacks capacity; and

(b) ensure the amount and type of restraint used and the amount of time it lasts is a proportionate response to the likelihood and seriousness of harm. Officers should also consider the risks of aggravating the individual’s condition, especially if forcing help on an unwilling person.

4. Recording decisions about mental capacity

Having assessed someone as not having mental capacity, and taking action in their best interests, officers should supply a rationale for their decisions. The record should include:

• the information used to decide the person lacked capacity including questions asked and the person’s replies;
• What options were considered (including each one’s potential benefits and harms, and whether each one was lawful, necessary, proportionate);
• Any other factors taken into account (e.g. powers and policies);
• What action was taken?
• The effect of the action taken.

PUBLIC AND PRIVATE LOCATIONS

If a person is attempting or threatening suicide in a public place it may be more appropriate to use section 136 MHA as a means of preventing harm and ensuring prompt mental health assessment at a place of safety than to rely on the MCA. In relation, however, to incidents in a public place involving people who are clearly seriously injured (e.g. victims of serious assaults or casualties of major incidents) but who decline medical aid, it would be more appropriate to use the MCA. While section 136 is a route to a place of safety, the mental capacity legislation is simply a way of allowing the police to take decisions in connection with the care and treatment of someone who the police reasonably believe is not currently able to make such a decision in their best interests due to their - in most cases - temporary lack of capacity.

When an incident involving an immediate threat to life occurs in a private place, it is appropriate to use section 17 PACE to enter the premises to save life or limb, and then consider relying upon the MCA where appropriate (e.g. where it is necessary to restrain an individual due to their lack of mental capacity). If the MCA is used, officers should ensure they record the steps they took to establish that the person lacked capacity.

SUPPORTING SOMEONE WHO MAY LACK MENTAL CAPACITY

People should be supported as much as possible to make their own decisions before officers conclude that they lack capacity. For example, consideration should be given to:

• Consulting relatives, partners, friends, or anyone else the person wants contacted;
• Offering assistance to the person to ease any practical concerns they have, e.g., about childcare or the welfare of their pets, or that their property is secure;
• Using an independent advocate to help with communication, or using different communication aids, such as pictures, signs, audiotapes or easy-to-read material.

POINTS TO NOTE

• Sections 5 and 6 MCA 2005 work together to provide protection from criminal and civil liability for acts done in connection with care or treatment which can, in limited circumstances, include restraint.

• Every effort should be made to encourage and enable the person who lacks capacity to take part in making decisions that concern them.
• If there is a chance that the person may regain capacity to make a particular decision, and the matter is not urgent, then the decision should be delayed until later.

• In situations where health or social care professionals are on the scene, police should defer to their expertise and provide support as appropriate and in accordance with local protocols.

• The power to restrain a person under the MCA does not interfere with existing powers of arrest for criminal offences or detention under section 136 of the MHA.
Human Rights Act 2000

Summary

Human Rights Legislation exists to safeguard our rights in the UK and expand our awareness of the basic values and standards we share. Anyone in the UK for any reason has fundamental rights which government and public authorities are legally bound to respect.

The Convention is made up of a series of short Articles; each Article is a short statement defining a right or freedom, together with any exceptions. These Rights affect matters of life and death, such as freedom from torture as well as rights which exist in everyday life. The Human Rights Act came into effect in the UK in October 2000. The Act enabled people in the UK to take human rights cases to court in the UK, whereas before they had to be taken to Strasbourg.

There are 16 basic rights in the Human Rights Act, all taken from the European Convention on Human Rights.

Articles which make up the Human Rights Act:

• Article 1: This article is introductory and not included in the Human Rights Act
• Article 2: Right to life
• Article 3: Prohibition of torture
• Article 4: Prohibition of slavery and forced labour
• Article 5: Right to liberty and security
• Article 6: Right to a fair trial
• Article 7: No punishment without law
• Article 8: Right to respect for private and family life
• Article 9: Freedom of thought, conscience and religion
• Article 10: Freedom of expression
• Article 11: Freedom of assembly and association
• Article 12: Right to marry
• Article 13: This is not included in the Human Rights Act
• Article 14: Prohibition of discrimination
• Article 1 of protocol 1 (A protocol is a later addition to the Convention): Protection of property
• Article 2 of Protocol 1: Right to education
• Article 3 of Protocol 1: Right to free elections
• Article 1 of Protocol 13: Abolition of the death penalty

A more detailed explanation of these Rights is available on the website below: http://www.direct.gov.uk/en/Governmentcitizensandrights/Yourrightsandresponsibilities/DG_4002951

However, the information below explains in more detail Rights that are relevant to people working in public authorities.

Public authorities have a duty to treat people in accordance with their Convention (law or standard) Rights and must not breach the Right’s below unless there is a legitimate reason:
**Article 8: Right to respect for private and family life**
This Right states that everyone has a right to respect for their private and family life, their home and correspondence. People have the right to live their own life and have personal privacy.

**Article 9: Freedom of thought, conscience and religion**
This Right protects people's rights in relation to their thoughts and beliefs. The State is not permitted to interfere with a person's right to hold a particular belief.

**Article 10: Freedom of Expression**
This Right states that everyone has the right to express their views and receive opinions without interference from a public authority.

**Article 14: Prohibition of discrimination**
This Right states that discrimination cannot occur on the grounds of particular attributes such as a person's sex, race, or religion. It also protects people from discrimination on the grounds of, for example, disability or marital status. A public authority should ensure policies and decisions do not involve any form of discrimination on any ground.

**Protocol 1, Article 1: Protection of property**
This article has three elements to it: a person has the right to a peaceful enjoyment of their property; a public authority cannot take away what someone owns and cannot impose restrictions on a person's use of their property. This article refers to possessions such as land, houses, leases and money.

**Protocol 1, Article 3: Right to free elections**
This Right means that people are entitled to free elections, which must be held at reasonable intervals and conducted by secret ballot. A public authority must respect the rights of voting individuals and ensure elections are conducted freely and fairly.

A public authority must always be alert to policies or actions that might interfere with these Rights. Any interference with someone's Rights must be justified and pursue one of the legitimate aims, which vary according to the Right and must be proportionate to that aim.

More information:
http://www.equalityhumanrights.com/
Early Information Exchange between Health, Social Care Services and Criminal Justice Agencies
REQUEST FOR DISCLOSURE OF PERSONAL DATA
SECTION 29(3) DATA PROTECTION ACT 1998

I am making enquiries which are concerned with:
(a) the prevention or detection of crime
(b) the apprehension or prosecution of offenders

Please provide information in relation to:

Name .................................................................

Born .................................................................

Address ................................................................

Charged with ......................................................

Brief details of offence(s) (Please attach MG5 Form if available)
...........................................................................

A. Did (Name) ....................... have mental capacity at the time of the offence and is he/she responsible for his/her actions? Yes/No/Don’t Know?

B. Would a prosecution interfere with (Name) ................. treatment or rehabilitation? Yes/No/Don’t Know?

C. Are there any risks to (Name) ....................... or others which the Criminal Justice Agencies need to be aware of? Yes/No/Don’t Know?

D. If prosecution proceeds can you recommend to the court any Mental Health support or intervention should (Name) .................. plead or be found guilty of the offence Yes/No/Don’t Know?
   e.g.
   • Hospital Order – Section 37 Mental Health Act 1983
   • Interim Hospital Order – Section 38 Mental Health Act 1983
• Guardianship Order – Section 37 Mental Health Act 1983
• Community Order with Mental Health Treatment attachment – Section 207 Criminal Justice Act 2003
• Mental Health Treatment Requirement - Criminal Justice Act 2003 (Amended by The Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2012

Any additional information:
(If you have answered ‘yes’ to questions A,B,C or D please explain your response in the additional information box below)

N.B. This procedure will assist the decision making process to determine whether an MDO should continue through the Criminal Justice process or not. It will allow those MDOs who should not face prosecution, because of their disorder, to be identified quickly and prevent or alleviate an unnecessary, sometimes protracted journey through the Court system (Bradley Report Recommendation)

Section 29(3) of the Data Protection Act 1998 allows personal data to be supplied in relation to (a) and/or (b) above and failure to provide the information will, in my view, be likely to prejudice those matters.

It will not be used in any way incompatible with the purpose for which it is being disclosed.

I understand that if I procure information which is not in connection with (a) and/or (b), I may be committing an offence under Section 55 of the Data Protection Act 1998.

Officer making request…
Signed: ................................................................. Date: .........................

Police Station: .....................................................

Officer authorising: ..........................................................
Signed: ..........................................................

Responsible Clinician/Care Coordinator/Practitioner providing information:

Name: ...............................................................................................................

Signed: ..........................................................................................

Date:.................................

Return E-mail – cpt.mdo@nhs.net
# DP3b - 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.

<table>
<thead>
<tr>
<th>NHS incident reference no:</th>
<th>Alleged offence:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Victims name(s)</th>
<th>Date, location and time of incident</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Responsible Clinician Details

<table>
<thead>
<tr>
<th>Name and contact no:</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Service User Details

<table>
<thead>
<tr>
<th>Name and date of birth</th>
<th>Address if not in-patient</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Detained under MHA 1983?</th>
<th>Service user no:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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

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

Signed:                                      Print name:  
Job title:                                   Date:  


Please ensure that this form is handed to the police when they attend and that a copy is kept on the patient's file

DP3c Health Practitioners Information
Mentally Disordered Offenders

Police request for information from the Health Service

In order to make a full assessment of whether an 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)

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

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

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

……………………………………………………………………………………………
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This information is sought in accordance with the Data Protection Act 1998. Section 29 permits disclosure for the purposes of the prevention and detection of crime and the apprehension and prosecution of offenders. Section 35 permits disclosure for the purpose of legal proceedings or obtaining legal advice. Disclosure may also be justified where the information is relevant to protecting the health and safety of all concerned.
No presumptions are made about whether it is in the public interest to prosecute offenders where sufficient evidence exists. Each case is considered on its merits, in light of the evidence and other information available at the time, to support a criminal charge.

Reference No. (custody/crime):…………………………
Officer’s signature:………………………………………..

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

Reference No. (Custody/crime):…………………………
Officer’s signature:………………………………………..

Notes in response to above request:
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 absenting themselves (repeatedly) from hospital, the confidence with which a non-formal sanction would be sought is diminished.

7. If someone is currently allowed periods of leave under s17 MHA and if that offender is returning on time and managing to look after their own welfare while on leave, it gives a clear indication that they have sufficient wherewithal to look after themselves – albeit for short periods of time or under supervision sufficiently to be able to think about the consequences of their actions and to assume a level of responsibility. This increases the likelihood that mens rea can be proved.

8. Information about care plan compliance is relevant to risk assessment decisions around prosecution and/or whether to grant bail or impose conditions on bail if charged. There is less benefit in diversionary management of offending if it is unlikely to be successful.

9. An ability to demonstrate the likelihood to further offending is relevant to risk assessment and bail decisions and would influence the likelihood of a prosecution. If threats were made towards victims, witnesses or other professional staff in order to prevent the reporting or investigation of an offence, the police custody officer may use that information to deny bail and achieve an earlier prosecution.

10. An ability to demonstrate that the staff and/or other patients within a psychiatric or other health facility are at risk without a prosecution would influence charge decisions as per point 8.
### DP3d - Information forms for mentally disordered suspects

**Strictly Confidential - medical report**

This form is for use by the ALIS health practitioner to outline the completed assessment findings of detained person in custody (Section 2 of the Cumbria Mentally Disordered Offenders County Protocol)

#### Detained Person’s Details

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Police Station</th>
<th>Custody Record No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time &amp; date Referral Received</th>
<th>Time &amp; date Assessment completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Detained Person’s MENTAL DISORDER ASSESSMENT: please use your professional judgement and opinion to answer all the questions below relating to the above detained person.

<table>
<thead>
<tr>
<th>Is there evidence of a Mental Disorder that requires Secondary Mental Health Services intervention?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment /treatment/management of the disorder can take place in the community after completion of custody procedures:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Informal admission to hospital for assessment is necessary</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A Mental Health Act Assessment is required</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If Mental Health Act Assessment requested</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time/date requested</th>
<th>Time/date commenced</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Assessment Information

Signed:  
Job title:  
Print name:  
Date:  

Please ensure that this form is handed to the Commissioned Health Care Professional at the Police Station and that a copy is kept on the patient’s file
Prison Mental Health Care Pathway
Haverigg
Appendix G

MENTAL HEALTH CARE PATHWAY HAVERIGG

Referral to Mental Health Team from GP/Healthcare/Prison/Education/Probation/Drop in Clinic

Single Point of Access for routine referrals
- Team review referral information daily, seek further information if required and/or allocate

By Team Admin
- Patient registered on iPM
- Request clinical record file from medical records

For assessment by Primary Mental Health Worker (6-8 sessions)

Step 2
- Guided self help
- Well read
- Psycho-education
- Problem solving
- Medication Management
- Listeners System
- Samaritan phone
- Mental Health Drop In Clinic

Step up to step 3 if
- Risk increases
- Needs more/higher level of intervention

For assessment by Primary Mental Health Worker

Step 3
- CBT
- Counselling
- Solution focused
- Medication Management

Step up to Specialist Mental Health Services if
- Risk increases
- Treatment resistive
- Had full course of 20 sessions but clinical need remains

For urgent assessment, SMI/CPA/Dual Diagnosis, ACCT or change in status assessments and crisis work within hours of service by RMN and /or Psychiatry

Step 4
- Psychological interventions
- Medication management
- Clinical risk
- CPA

Step up to Specialist Mental Health Services if
- Risk to life
- Combined treatment

EIP
CMHS Psychology
Learning Disabilities
Substance Misuse/IDTS

CMHS Older Adults
ALIS
Forensic
Notification of Press and Media Releases
Appendix H

CUMBRIA CRIMINAL JUSTICE AND MENTAL HEALTH STEERING GROUP

SIMPLE PROTOCOL FOR NOTIFICATION OF PRESS AND MEDIA RELEASES SEPTEMBER 2010

1. Introduction

This document outlines the arrangements for cross-agency notification of press, media, data or other information releases originating from Cumbria criminal justice and mental health agencies.

The purpose of the arrangements is to:

- Keep partner agencies informed of activities and actions taking place within or relating to Mentally Disordered Offenders in Cumbria that will be intentionally publicised through the press or other media.
- Put partner agencies on notice of activities or actions taking place within or relating to the source agency that could potentially have a knock-on detrimental effect on them, particularly with regard to public perception of, and confidence in, the effectiveness of joint working, the wider criminal justice system and mental health systems. These activities or actions can include anything that may be placed in the public domain but which may not necessarily be intentionally publicised. Examples could include the release of reports and comparative data sets were there is clear or implied criticism of the local criminal justice system or the NHS.
- Avoid potential conflict or unnecessary duplication in press and media engagement that relates to cross-agency or multi-agency working;
- Ensure consistency of the ‘message’ being received by the public concerning the local criminal justice system through the press and media.
- Where relevant and desirable, provide a mechanism for cross-agency consultation on press and media releases.
2. List of relevant agencies and contacts

<table>
<thead>
<tr>
<th>Agency</th>
<th>Nominated local contact (provisional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crown Prosecution Service – Cumbria</td>
<td>John Pears</td>
</tr>
<tr>
<td>Cumbria Constabulary</td>
<td>Helen Lacey</td>
</tr>
<tr>
<td>Cumbria Youth Offending Service</td>
<td>Liz Anderton</td>
</tr>
<tr>
<td>Her Majesty’s Courts Service – Cumbria</td>
<td>Steve Harris</td>
</tr>
<tr>
<td>Her Majesty’s Prison Service – HMP</td>
<td>Bronya Cooper</td>
</tr>
<tr>
<td>Haverigg</td>
<td></td>
</tr>
<tr>
<td>Legal Services Commission – NW Region</td>
<td>Karen Mychajlyshyn</td>
</tr>
<tr>
<td>National Probation Service – Cumbria</td>
<td>Sara Walker</td>
</tr>
<tr>
<td>Victim Support Cumbria</td>
<td>Kerry Kosak</td>
</tr>
<tr>
<td>Cumbria Criminal Justice Board</td>
<td>Mike Holme</td>
</tr>
<tr>
<td>Cumbria PCT</td>
<td>Mark Graham/Ann Marie</td>
</tr>
<tr>
<td>Cumbria Partnership Trust</td>
<td>Palmer</td>
</tr>
<tr>
<td>North West Specialised Commissioning Team</td>
<td>Deborah Prince/Kath Hughes</td>
</tr>
<tr>
<td></td>
<td>Jo Stringer</td>
</tr>
</tbody>
</table>

3. Relevant material

The emphasis of this protocol is on simplicity, the avoidance of bureaucracy, and action by mutual agreement. The identification and selection of material that may be appropriate for inclusion within this protocol rests with the individual agency.

It is noted that not all of the listed agencies have personnel locally that are specifically dedicated to generating material for submission to the press and media or for monitoring activities and actions that may result in press and media interest. However, it is anticipated that all nominated contacts are in a position that enables them to be aware of key issues, activities and actions involving their respective agency.

Questions that might help to identify relevant material include:

- What is the key issue that the material relates to? [For example, performance, case outcome, inspection report, etc]
- How might it impact on partner agencies? [For example, is it related to cross-agency systems and processes, is it explicitly or implicitly critical of partners, does it reflect good working practices, etc.]
- Is it positive or negative in the context of the local criminal justice system or the NHS?
- Is it intended to be placed directly in the hands of the press and media?
• If not intended, is it likely to reach the press and media by some means? [This can happen in various ways. For example, casual conversation, 'leaking' via staff or by press/media searching a website.]
• Is it urgent or imminent or does it require planning? What is the timescale for reaching the press and media?
• Is it suitable for consultation between other agencies?
• What is the format and how easily can it be shared?

4. Process

When material is identified as being appropriate for inclusion within this protocol, the following steps should be undertaken. Note that not all will necessarily apply in every case.

• Identify who needs to know
• Use telephone or e-mail to make contact depending on urgency
• Copy and circulate relevant material, when appropriate
• If response is needed from other agencies, specify timescale
• Collate and consider any responses
• Proceed with press and media contact
• Monitor outcome(s) and, if possible, retain copies of press and media coverage

5. Feedback

Concerns or other feedback about the workings of this protocol should be channelled through the respective agency contact (see list above).
Suggested Content and Format for Psychiatric Reports for Court
Criminal Procedure Rules, Part 33: Expert Evidence. Part 33.3: Content of expert’s report

All psychiatric reports must cover every aspect of the statutory criteria as per Part 33 Criminal Procedure Rules

(1) An expert’s report must:

(a) give details of the expert’s qualifications, relevant experience and accreditation;

(b) give details of any literature or other information which the expert has relied on in making the report;

(c) contain a statement setting out the substance of all facts given to the expert which are material to the opinions expressed in the report or upon which those opinions are based;

(d) make clear which of the facts stated in the report are within the expert’s own knowledge;

(e) say who carried out any examination, measurement, test or experiment which the expert has used for the report and –

(i) give the qualifications, relevant experience and accreditation of that person;

(ii) say whether or not the examination, measurement, test or experiment was carried out under the expert’s supervision; and

(iii) summarise the findings on which the expert relies.

(f) where there is a range of opinion on the matters dealt with in the report – (i) summarise the range of opinion, and
(ii) give reasons for his/her own opinion.

(g) if the expert is not able to give his/her opinion without qualification, state the qualification;

(h) contain a summary of the conclusions reached;

(i) contain a statement that the expert understands his duty to the court, and has complied and will continue to comply with that duty; and

(j) contain the same declaration of truth as a witness statement.
SUGGESTED FORMAT FOR COURT REPORTS

14.1 Introductory paragraph indicating that the report has been prepared at the request of the Court in relation to the alleged offence.

14.2 Statement of the report writers qualifications and experience.

14.3 The information upon which the report is based i.e. who the report writer interviewed, what documents the report writer consulted.

14.4 Family and personal history. This should be kept brief and contain information that is relevant to the defendant’s mental health, i.e. significant traumas in childhood, illness in childhood, loss of parents etc.

14.5 History of involvement with mental health services including first contacts, reason for referral, diagnosis, treatment in care plans, significant admissions including detentions under the Mental Health Act.

14.6 Criminal history where known and any previous relationship between criminal history and mental health history including previous remands under Part 3 of the Mental Health Act, periods of care in hospital following convictions and any joint management plans ‘agreed’ with the police. Any history of psychiatric assessments and treatment whilst in custody should also be included.

14.7 Details of the index offence including defendant’s explanation of the offence plus relevant mental health circumstances i.e. mental disorders which might have a direct casual effect on the offence.

NB. Psychiatrists preparing Court Reports should have full access to the depositions which contain information on the circumstances of the offence including witness statements. A full and clear understanding of the circumstances of the offence will help the report writer make any relevant connections between the offence and mental disorder.

14.8 Current mental state and current care and treatment plans should be described including any care and treatment plans which have an effect upon behaviour including possibly offending behaviour.

14.9 Opinion, i.e. opinion on what form, if any, of mental disorder(s) the defendant is suffering from and any relationship between this mental disorder and the alleged offence.

14.10 Recommendations. This should be based upon what is realistically achievable in law and in medicine. The report should include recommendations of whether one of the following is appropriate for the court to consider and whether the recommendation is available locally.

- Community Order with Mental Health Treatment attachment
- Hospital Order – S. 37 Mental Health Act 1983
- Interim Hospital Order – S.38 Mental Health Act 1983
- Guardianship Order
Overview of Sentencing Options for MDO’s
Appendix J

Sentencing options using psychiatric reports for Mentally Disordered Offenders

The Courts have powers to:

- inform their sentencing decision by remanding in hospital for a medical report or treatment, or making an Interim Hospital Order;
- order detention for treatment in hospital in lieu of prison; or
- combine hospital treatment with a prison sentence, by making a hospital direction.

Custodial Sentences

Section 157 of the Criminal Justice Act 2003 requires the Court to obtain and consider a medical report before passing any custodial sentence on a person who is, or appears to be, ‘mentally disordered’. The report must be made by a registered medical practitioner who is approved for the purposes of Section 12 of the Mental Health Act 1983. It also requires the Court to consider any other information on the offender’s mental disorder, and the likely effect of a custodial sentence on that disorder and on any possible treatment for it.

Disposals under Part III of the Mental Health Act 1983

To detain any person under the Act for treatment, the decision maker must be satisfied that medical treatment is available to that person, which is not only clinically appropriate to his/her condition but also to his/her personal circumstances. To make a psychiatric disposal with a Hospital Order, the Court must have evidence from two medical practitioners, one of whom is Section 12 approved; including confirmation that a hospital bed and a package of care appropriate to that individual is available.

Remand powers

Section 35 Remand for a Report:

The Crown Court may remand an accused person to hospital for a report on his/her medical condition, if he/she is charged with, but not yet sentenced for, an offence punishable with imprisonment, except where the penalty is fixed by law. The power is similarly available to Magistrates for a defendant convicted of an offence punishable on summary conviction with imprisonment, or who has been charged with such an offence if the Court is satisfied that he/she did the act or made the omission charged or who consents to the order. This requires a single medical opinion from a medical practitioner, approved under Section 12 of the 1983 Act, that the defendant is ‘mentally disordered’ and that it would be impracticable for such a report to be made if he/she were remanded on bail. The approved clinician who would be responsible for making the report or some other person representing the managers of the hospital must provide evidence that arrangements have been made for his/her admission to that hospital within seven days. The maximum duration of the remand is for 12 weeks, with renewal required by...
the Court every 28 days. Renewal can be ordered without the defendant being produced in Court, if he/she is represented by counsel or a solicitor with rights of audience.

Section 36 Remand for Treatment: The Crown Court may remand an accused person to detention in hospital for treatment, if satisfied on the written or oral evidence of two medical practitioners that he/she is suffering from a mental disorder of a nature or degree which makes it appropriate for him/her to be detained in hospital for medical treatment, and appropriate medical treatment is available. One of the medical practitioners must be approved under Section 12 of the Mental Health Act 1983, the approved clinician being treated as so approved. The duration of remand for treatment is a maximum of 12 weeks, as Section 35 above, with the same conditions for renewal attached.

Section 38 Interim Hospital Order: If the Court is unsure whether a Hospital Order is the appropriate disposal, they may make an Interim Hospital Order under Section 38 of the Act for assessment and compulsory treatment. The initial order may not exceed 12 weeks, but is renewable by the Court for periods of up to 28 days at time, up to the maximum of twelve months. This requires two medical reports as above, and evidence of arrangements for the offender’s admission into hospital within 28 days, as above.

Section 37 Hospital Order: The Hospital Order is an alternative to a prison sentence, including sentences for public protection under Part 12 of the Criminal Justice Act 2003. It diverts the Mentally Disordered Offender from punishment in the Criminal Justice System to care and treatment at the discretion of mental health professionals. Section 37(2) (b) provides that the Court has to be of the opinion that the Hospital Order is ‘the most suitable method of disposing of the case’. This requires written evidence from two registered medical practitioners, one of whom is approved under Section 12 of the Mental Health Act 1983, that the offender is suffering from mental disorder of a nature or degree which makes it appropriate for him/her to be detained in hospital for treatment and appropriate treatment is available for him/her. The Court is further required to be satisfied on the evidence, oral or written, of the approved clinician or hospital manager with overall responsibility for the offender’s case that arrangements are in place for admission to hospital within 28 days of the order, pending which the offender may be admitted to a place of safety. It is not an alternative to a life sentence, where this is fixed by law. These disposals are time-limited in the first instance to six months, but can be renewed.

Section 41 Restriction Orders: The Crown Court may add a Restriction Order to a Hospital Order where it considers ‘having regard to the nature of the offence, the antecedents of the offender, and the risk of his committing further offences if set at large, that it is necessary for the protection of the public from serious harm to do so’. If, following conviction, the Magistrates’ Court is satisfied that the conditions for making a Hospital Order under
Section 37 are satisfied and that there is a risk of further offending so that, if a Hospital Order were made, a Restriction Order should also be made, the case may be committed to the Crown Court under Section 43. The Crown Court may then either make a Hospital Order with or without a Restriction Order or deal with the case in any manner in which the Magistrates’ Court could have done. If the Magistrates’ Court considers that unless a Hospital Order with a Restriction Order were made, the powers of punishment should be greater than it could impose, it may commit the defendant for sentence under Section 3 of the Powers of Criminal Courts (Sentencing) Act 2000. The effect is to increase the power of imprisonment if the Crown Court does not make a Hospital Order.

The effect of a Restriction Order is to convert the Hospital Order into an indefinite order for detention. It also limits the discretion of the doctor in charge, the responsible clinician, to allow the offender access to the community without the prior consent of the Secretary of State. Discharge of the offender from hospital can only occur with the consent of the Secretary of State for Justice, or by order of the independent First-tier Tribunal (Mental Health). Discharge is also likely to be subject to conditions and to the power of the Secretary of State to recall to hospital in the event of a breach of such conditions or further dangerous behaviour arising from the mental disorder. To make a Restriction Order, the Court must hear oral evidence from one of the doctors providing medical evidence which justifies the Hospital Order, but the addition of restrictions is at the discretion of the Court.

**Prison Sentences with Hospital Direction**

**Section 45A Hospital Direction:** The Court can add a Hospital Direction to a prison sentence for any Mentally Disordered Offender, provided all conditions in section 45A are met. To add a Hospital Direction, the Court should first have considered making a Hospital Order, and have evidence which would justify a Hospital Order, but concluded that a prison sentence is necessary. The Hospital Direction is not available for sentences fixed by law.

**Guardianship Orders:** The Court may impose a Guardianship Order under Section 37. The offender is received into the guardianship of the local Social Services Department or a person (usually a relative) whom the Department is willing to accept as a guardian. This imposes an ‘authoritative framework’ for working with the patient, with compulsory powers to impose care in the community as part of an overall care and treatment plan. It depends upon Social Services’ agreement for taking on arrangements for provision.

**Community Orders and Suspended Sentences**

A Community Order or a Suspended Sentence of Imprisonment must include one or more of the requirements specified in section 177 or section 190 Criminal Justice Act 2003 respectively. This may include a Mental Health Treatment requirement for which the consent of the offender must be obtained. Mental Health Services may be able to advise the Court on the mental health treatment needs of the offender. However, a report by a psychiatrist or chartered psychologist who is approved under Section 12 of the
Mental Health Act 1983 is also needed. Treatment may be in the community or as an in-patient and, in the case of the latter the place may or may not be specified in the Order.

Where a Mental Health Treatment Requirement is not appropriate, Mental Health Services may be prepared to provide guidance in writing or give oral evidence in Court to provide information on voluntary mental health schemes within the community, and, a supervision or specified activity requirement may be appropriate.

**Diversion Sentences**

Where the Court has decided it is inappropriate to continue proceedings, a civil section may be used to divert the offender to treatment in hospital. These will usually be under Section 2 or Section 3 of the Mental Health Act 1983.
<table>
<thead>
<tr>
<th>Remand and sentencing options</th>
<th>Court sentence available at</th>
<th>Description of sentence</th>
<th>Where sentence should be considered</th>
<th>Information required in order to sentence</th>
<th>Appropriate psychiatrist</th>
</tr>
</thead>
</table>
| Community order/ Suspended Sentence Order with mental health treatment | Magistrates’ and Crown Court | Court directs the offender to undergo treatment, by/under direction of a medical practitioner or psychologist | Mental state of offender is such that it requires treatment but not such as to warrant the making of a hospital or guardianship order | ● Suitability of treatment Treatment available  
● Provision of detailed treatment plans, so that probation and court staff have sufficient information about what is required of them.  
● Named supervisor and location to provide treatment | ● Community consultant psychiatrist approved for the purposes of Section 12 |
| Guardianship Order | Magistrates’ and Crown Court | Offender placed under guardianship of the local Social Services authority for six months, renewable every six months | Evidence the offender has a mental disorder which requires enforceable support for their own protection and for the protection of other people | ● Psychiatric report  
● Confirmation of Social Services’ acceptance of the service user  
● Arrangements for provision of a guardian | ● Specialised community consultant psychiatrist, e.g. consultant in learning disability psychiatry  
● Include two medical recommendations at least one of whom is approved for the purposes of Section 12 |
<p>| Custodial Sentence | Magistrates’ and Crown Court | No specific treatment arrangements, though any reports may be of use to in-reach prison psychiatrists to provide voluntary treatment | Mental state of offender does not merit treatment as an enforceable component of sentencing | ● No treatment appropriate | Medical practitioner |</p>
<table>
<thead>
<tr>
<th>Remand and sentencing options</th>
<th>Court sentence available at</th>
<th>Description of sentence</th>
<th>Where sentence should be considered</th>
<th>Information required in order to sentence</th>
<th>Appropriate psychiatrist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imprisonment for Public Protection (IPP)</td>
<td>Crown Court</td>
<td>Indeterminate sentence. Offender to serve tariff</td>
<td>Offender considered to pose a risk of serious harm to the public. Not available for a murder charge. If there is an argument that the offender does not require an IPP, may be important to get psychiatric report If court wants advice on link between dangerousness and mental disorder so judge can decide if IPP appropriate</td>
<td>● Full psychiatric report</td>
<td></td>
</tr>
<tr>
<td>Section 35 Remand for Report</td>
<td>Magistrates’ and Crown Court</td>
<td>Remand to hospital for full assessment and report, up to 12 weeks</td>
<td>Evidence offender may be suffering from a mental disorder. Not available for a murder charge</td>
<td>● Full psychiatric report ● Evidence of arrangements for admission to hospital within seven days ● Section 12 approved medical practitioners’ recommendation</td>
<td>● Section 12 registered medical practitioner, care provider. (But the care provider may also be the section registered medical practitioner)</td>
</tr>
<tr>
<td>Remand and sentencing options</td>
<td>Court sentence available at</td>
<td>Description of sentence</td>
<td>Where sentence should be considered</td>
<td>Information required in order to sentence</td>
<td>Appropriate psychiatrist</td>
</tr>
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</tbody>
</table>
| Section 36 Remand for Treatment | Crown Court | Remand to hospital for treatment, renewable at 28 day intervals, up to 12 weeks | Evidence offender is suffering from a mental disorder. Not available for a murder charge | • Evidence of arrangements for admission to hospital within seven days  
• Evidence appropriate medical treatment is available | • Two registered medical practitioners one of whom is approved for the purposes of Section 12; the care provider may also be the registered medical practitioner approved under Section 12 |
| Section 37 Hospital Order | Magistrates’ and Crown Court | Admission to a consenting hospital for 6 months, renewal for a further 6 months, at medical discretion | Evidence offender requires hospital treatment under Sec. 37 MHA | • Full psychiatric report  
• Confirmation of admission within 28 days | • Two registered medical practitioners one of whom is approved for the purposes of Section 12  
• Admission panel of secure unit to agree Provision |
| Section 38 Interim Hospital Order | Magistrates’ and Crown Court | Initial order of 12 weeks, renewable by the courts for 28 days at a time for a maximum of 12 months Where later treatment undecided, may be a trial to determine cooperation with | Evidence offender requires treatment under Sec. 37 MHA  
Gives time to develop therapeutic rapport and provide a longitudinal assessment. E.g. trial of therapy, to test outcome. | • Full psychiatric report  
• Evidence of arrangements for admission to hospital within 28 days | • Two registered medical practitioners one of whom is approved for the purposes of Section 12  
• Security level of unit determined by nature of risk posed to the public. |
<table>
<thead>
<tr>
<th>Remand and sentencing options</th>
<th>Court sentence available at</th>
<th>Description of sentence</th>
<th>Where sentence should be considered</th>
<th>Information required in order to sentence</th>
<th>Appropriate psychiatrist</th>
</tr>
</thead>
</table>
| Section 41 Restriction Order  | Crown Court               | Restrictions on discharge from the Sec. 37 order | A hospital order is made and the court considers the offender would pose a risk of serious harm to others if prematurely at large | • Full psychiatric report  
• Restriction on ability of clinician to discharge the patient.  
• The mental health equivalent of a life sentence.  
• Evidence of dangerousness: that it is necessary for the protection of the public from serious harm to make a restriction order on the offender. | Two registered medical practitioners one of whom is approved for the purposes of Section 12  
Oral evidence to the court on dangerousness criterion also required |
| Section 45A Hospital Direction | Crown Court               | Addition of a hospital order to a prison sentence | Evidence offender requires hospital treatment under Section 37 | • Evidence arrangements have been made for admission to hospital within 28 days  
• 2 medical reports confirming the offender is mentally disordered | Two registered medical practitioners one of whom is approved for the purposes of Section 12, ideally including the care provider |
Suggested Pro Formas for Request:
Magistrates’ Court, Crown Court, Letter of Instruction, Report Template
### Appendix K  Pro Forma Request: Magistrates’/Crown Court

<table>
<thead>
<tr>
<th>Purpose of report</th>
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<tbody>
<tr>
<td>Approved medical practitioner opinion</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Report should address</th>
<th>Tick one or more boxes</th>
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<tbody>
<tr>
<td>Community order</td>
<td></td>
</tr>
<tr>
<td>Hospital order: Section 37</td>
<td></td>
</tr>
<tr>
<td>Interim hospital order: Section 38</td>
<td></td>
</tr>
<tr>
<td>Guardianship order</td>
<td></td>
</tr>
<tr>
<td>Custodial sentence</td>
<td></td>
</tr>
<tr>
<td>Current mental state</td>
<td></td>
</tr>
<tr>
<td>Relationship of mental state to reoffending</td>
<td></td>
</tr>
<tr>
<td>Risk assessment</td>
<td></td>
</tr>
<tr>
<td>Dangerousness (Criminal Justice Act 2003 criterion)</td>
<td></td>
</tr>
<tr>
<td>Suitability of treatment</td>
<td></td>
</tr>
<tr>
<td>Availability of treatment</td>
<td></td>
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<tr>
<td>Consent to treatment</td>
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<tr>
<td>Other (please specify)</td>
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<table>
<thead>
<tr>
<th>Preferred length</th>
<th>Tick one box only</th>
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<tbody>
<tr>
<td>Community order</td>
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<tr>
<td>Hospital order: Section 37</td>
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<tr>
<td>Availability of treatment</td>
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<tr>
<td>Consent to treatment</td>
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<tr>
<td>Other (please specify)</td>
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<table>
<thead>
<tr>
<th>Preferred length</th>
<th>Tick one box only</th>
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<tbody>
<tr>
<td>Summary report (e.g. two to four pages)</td>
<td></td>
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<tr>
<td>Full report (e.g. up to eight pages)</td>
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</tbody>
</table>
### Pro Forma for Letter of Instruction

<table>
<thead>
<tr>
<th>Details of offender and offence</th>
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</thead>
<tbody>
<tr>
<td>Offender</td>
</tr>
</tbody>
</table>

| Offence                        |

<table>
<thead>
<tr>
<th>Particulars of circumstances of offence (including if the offender is of no fixed abode), the place where it was committed, if known</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Section under which remand is ordered</th>
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<table>
<thead>
<tr>
<th>Reasons which led the court/defence to request the report</th>
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<table>
<thead>
<tr>
<th>Address and home circumstances of offender</th>
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<table>
<thead>
<tr>
<th>Current contact address information of offender</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Previous medical history of offender and family history, so far as known</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Previous conduct, including previous convictions, if known</th>
</tr>
</thead>
</table>
### Others involved with the case

<table>
<thead>
<tr>
<th>Name &amp; contact details of solicitor</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Name &amp; contact details of any probation officer appointed to, or having knowledge of the case</td>
<td></td>
</tr>
<tr>
<td>Name and station of police officer concerned with the case</td>
<td></td>
</tr>
<tr>
<td>A request for a second report has been made to</td>
<td></td>
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</tbody>
</table>

### Report should address

<table>
<thead>
<tr>
<th>Current mental state</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Relationship of mental state to reoffending</td>
<td></td>
</tr>
<tr>
<td>Risk assessment</td>
<td></td>
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<tr>
<td>Dangerousness (Criminal Justice Act 2003 criterion)</td>
<td></td>
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<tr>
<td>Suitability of treatment</td>
<td></td>
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<tr>
<td>Availability of treatment</td>
<td></td>
</tr>
<tr>
<td>Consent to treatment</td>
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</tr>
<tr>
<td>Other (please specify)</td>
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</table>

### Date for return
## Pro Forma Report Template

### Details of offender and offence

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</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Offence</td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

### Details of psychiatrist

To cover:
- name and contact details, including telephone number
- qualification (in particular that psychiatrist is a Section 12 approved doctor)
- previous contact with offender

### Sources on information

To cover: documentation and appointments

### Areas of concern

To cover: questions for address in letter of instructions
### Personal background
To cover brief summary of the offender

### Index offence
To cover brief summary of psychiatrist’s understanding of events

### Psychiatric history
To cover:
- relevant psychiatric history
- relevant family history
- diagnosis of mental health at current time

### Risk assessment
To cover:
- risk of harm to self or others
- risk of re-offending (including relationships between current mental disorder and re-offending)
## Treatment options

To cover whether treatment is appropriate
- what the treatment will involve
- what the components of the treatment are
- how long treatment should continue
- whether treatment is available
- where the suggested treatment would take place
- confirmation that offender is willing to comply with treatment

## Practical details

Where psychiatrist is the treatment provider:
- details of practitioner for treatment (and frequency of appointments)
- arrangements for liaison with probation

Where psychiatrist is not the treatment provider:
- details of treatment provider to be provided

## Medical recommendations
Lancashire and South Cumbria Regional Secure Services External Referral Form
HOW TO MAKE A REFERRAL - FLOWCHART

COMMUNITY
The FCC referral offers:
Co-ordination and delivery of a multi-disciplinary risk assessment and risk management consultation to referring agencies, with the prime purpose of managing and maintaining service users within a community setting within LCFT and South Cumbria.
FCC Process: - Schedule case for FCC date and send out invitations including patient’s Community Psychiatrist. Commence time line and information gathering in order to populate the most appropriate risk assessment tool. Arrange to meet with the referrer and service user. Attend pre-FCC meetings to discuss information and finalise FCC agenda. Deliver FCC and send out report within 2 weeks.

The CFPS referral offers: face to face direct MDT assessment of a time limited nature. This involves collaborative sessions with the service user and care co-ordinator in order to gain a detailed understanding of the service user’s risks and needs via a psychological formulation which will inform risk management in the community setting.

IN PATIENT WARD S
The IST referral offers: Direct comprehensive in patient support for patients at risk of admission to Secure Services. Offer time-limited engagement with risk management advice to include specialist risk assessments, formulation and recommendations for interventions to the referring agencies within LCFT and South Cumbria.
IST Process: - Identified professional makes contact with referrer and gains further understanding of case. Meet with ward team/patient as appropriate Re-present case the following week at FIT case discussion to agree the plan Develop psychosocial history and populate risk assessment tool if appropriate Attend MDT meetings and offer consultation around risk management/consider care pathway Direct service user feedback and evaluation from individual client/referring agency

The electronic referral form is available on Trust Intranet or email: deborah.wolstenholme@lancashirecare.nhs.uk for a form or Telephone: 01772 401038 and ask for a form

The completed referral form should be emailed by the referrer to the Single Point of Access at GuildLodge.Referrals@lancashirecare.nhs.uk
Further Information: jade.steel@lancashirecare.nhs.uk Telephone: 01772 406619 Fax: 01772 860428

Single Point of Access will forward the referral to the Forensic In reach Team Referral will then be allocated to a FIT Team Practitioner
Specialist Services Secure Mental Health Business Unit (SMHBU)

Guild Lodge Referral Document

Information required regarding referrals for Specialist Services SMBHU

Guild Lodge

The following information is required to be provided by referrers prior to the referral being accepted by Specialist Services SMHBU. This is based on information requirements stipulated by NHS England. (NHS England – Cheshire, Warrington and Wirral Area Team Secure and Specialised Mental Health Services, Management of the Patient Pathway Protocol – 01 April 2014)

The completed form should be returned to the Flow and Capacity Manager at GuildLodge.Referrals@lancashirecare.nhs.uk and a Referral made to the SS Flow and Capacity Team on NCRS. Please direct any queries regarding referrals to the Flow and Capacity Manager on 01772 406619, Fax 01772 860428.

If the Referral is an Emergency please complete the Emergency Referral Checklist below and contact the Flow and Capacity Manager (details above) to discuss.

### Emergency Referral Checklist

Please tick the statements that have occurred in the last 48 hours

1) Unmanageable in a PICU or equivalent setting for clinical or legal reasons with either a) or b) below
   a) Serious and sustained violence to others
   b) Continuous use of Control and Restraint

2) A mutually agreed emergency following discussion with Specialist Services Guild Lodge

<table>
<thead>
<tr>
<th>Name (including any aliases)</th>
<th>Date of Birth and Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>NHS Number</td>
</tr>
<tr>
<td>GP Name and Address</td>
<td>Referral made on NCRS to Flow and Capacity Team</td>
</tr>
<tr>
<td>CCG Contact (including address and contact details)</td>
<td>Local Care Coordinator (Including email address, address and telephone contact details)</td>
</tr>
<tr>
<td>Last Known Address</td>
<td>Current Placement (include date of this admission where relevant)</td>
</tr>
<tr>
<td>Diagnosis (ICD-10)</td>
<td>MHA Section or other Detention Order</td>
</tr>
<tr>
<td>MAPPA Level</td>
<td>Timescales of note e.g. EDR, MAPPA Meetings, Court Dates, MHRT, CPA Review,</td>
</tr>
</tbody>
</table>

182
<table>
<thead>
<tr>
<th>Approved Responsible Clinician</th>
<th>MARAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have they agreed to the referral?</td>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Assessment for Admission (Mental Illness; Personality Disorder; Autistic Spectrum Conditions)</td>
</tr>
<tr>
<td>☐ Acquired Brain Injury (If yes, please complete additional ABI section of Referral Form)</td>
</tr>
<tr>
<td>☐ Risk Management advice (including services offered by the Forensic In-reach Team)</td>
</tr>
</tbody>
</table>

For further information on the services available please visit website: [www.lancashirecare.nhs.uk/Services/Specialist/Secure-Mental-Health.php](http://www.lancashirecare.nhs.uk/Services/Specialist/Secure-Mental-Health.php)

<table>
<thead>
<tr>
<th>Detail reason for Referral/ Presenting Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offending and Forensic History (Including victim issues)</td>
</tr>
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<table>
<thead>
<tr>
<th>Current Treatment and Management Strategies (Including medication)</th>
</tr>
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<table>
<thead>
<tr>
<th>Risk Issues (Including behaviours and triggers)</th>
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<tr>
<th>Any other relevant information</th>
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<table>
<thead>
<tr>
<th>Please attach a copy of the most recent Risk Assessment</th>
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<tr>
<th>If available, please attach the following documentation</th>
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</thead>
<tbody>
<tr>
<td>• CPA Reviews or reports</td>
</tr>
<tr>
<td>• Social Work reports</td>
</tr>
<tr>
<td>• Mental Health Tribunal reports</td>
</tr>
<tr>
<td>• PNC Records</td>
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</table>
- Probation Reports
- Prison Mental Health Records
- Any other significant documents

<table>
<thead>
<tr>
<th>Name/Designation of person completing this form</th>
<th>Date</th>
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</table>

- If clinical presentation/needs change after the Referral has been made, please inform the Flow and Capacity Manager immediately clearly outlining if Referral is still required

### Referrals to the Acquired Brain Injury Service

<table>
<thead>
<tr>
<th>History of Acquired Brain Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detail evidence of Brain Injury</td>
</tr>
<tr>
<td>(Findings from previous CT scans or MRI scans of the brain, Functional Imaging of the brain such as SPECT or PET, EEG, Neuropsychological assessments)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of onset of the Brain injury</th>
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<table>
<thead>
<tr>
<th>Physical/Neurological disabilities/impairments related to (or as a result of) the Brain injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>(mobility, vision, speech, paralysis, epilepsy, neurological deficits; incontinence; swallowing difficulties)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cognitive impairments related to (or as a result of) the Brain injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>(attention, concentration, memory, executive functioning - evidence of use of compensatory tools)</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Functional impairments related to (or as a result of) the Brain injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>(daily living skills, personal care evidence of use of compensatory tools)</td>
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</table>

<table>
<thead>
<tr>
<th>Interpersonal impairments related to (or as a result of) the Brain injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>(communication, receptive/expressive difficulties, social skills, evidence of use of)</td>
</tr>
<tr>
<td>Compensatory tools</td>
</tr>
<tr>
<td>--------------------</td>
</tr>
<tr>
<td>Behavioural impairments related to (or as a result of) the Brain injury (impulsivity, disinhibition, emotional dyscontrol, sexually inappropriate behaviour-including verbal, evidence of use of compensatory tools)</td>
</tr>
<tr>
<td>Psychiatric symptoms related to (or as a result of) the Brain injury (psychosis, depression, organic mania, personality change, substance misuse):</td>
</tr>
<tr>
<td>Detail any previous admissions to Acquired Brain Injury Services</td>
</tr>
<tr>
<td>Any other relevant information</td>
</tr>
</tbody>
</table>
| If available, please attach the following documentation | • Investigations  
• Occupational Therapy Reports  
• Psychology Assessments / Reports |

Date of referral: 
Signed:
North East Regional Secure Services
External Referral Form (Newcastle, Tyne and Wear NTW and Tees, ESK & Wear Valley TEWV)
Thank you for your enquiry. The Regional Specialist Secure Services require information in order to proceed with referrals. This is an agreed regional standard format for NHS England.

While it is accepted that information may be provided in appended reports, please note that ALL fields (where applicable) on this form are mandatory and require an up to date clinical summary rather than referral to supplementary document(s).

On completion please return to the following:

For NTW inpatient referrals please forward completed referral forms to:

NTAWNT.FORENSIC@NHS.NET

Contact Susan Forbister or Julie Wilson, Administrator on 0191 245 6789 (internal extension 56789)

For TEWV referrals please forward completed referral forms to:

dawnwoods@nhs.net

Contact Dawn Woods, Medical Secretary on 01642 837512
### INPATIENT REFERRAL FORM
#### FORENSIC SECURE SERVICES

**All sections must be completed**

<table>
<thead>
<tr>
<th><strong>Urgent/Non Urgent</strong></th>
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<table>
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<th><strong>Date Referral Sent</strong></th>
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</table>

<table>
<thead>
<tr>
<th><strong>Name including any aliases</strong></th>
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<table>
<thead>
<tr>
<th><strong>Date of Birth</strong></th>
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<th><strong>GP</strong></th>
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<tr>
<th><strong>CCG/GP Consortia Contact</strong></th>
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<th><strong>Diagnosis</strong></th>
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<thead>
<tr>
<th><strong>MHA section or other Detention Order</strong></th>
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<table>
<thead>
<tr>
<th><strong>Timescales of note e.g. expected date of release</strong></th>
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<table>
<thead>
<tr>
<th><strong>Legal Status</strong></th>
<th>Remand or sentenced?</th>
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<tbody>
<tr>
<td></td>
<td>Prospective release date</td>
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<tr>
<td></td>
<td>Current charge or offence</td>
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<thead>
<tr>
<th><strong>Last address including Postcode</strong></th>
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<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Referrer’s Details</td>
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<tr>
<td>--------------------</td>
</tr>
<tr>
<td>Referrer’s Details</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Responsible Local Authority (S117)</th>
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<thead>
<tr>
<th>Are the relevant NHS England commissioners aware of the referral?</th>
<th></th>
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<table>
<thead>
<tr>
<th>Local Care Coordinator (name, address, telephone number, designation, email)</th>
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</table>

<table>
<thead>
<tr>
<th>Consultant Psychiatrist/Responsible Clinician (name, address, telephone number, email)</th>
<th></th>
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<thead>
<tr>
<th>Next of Kin/Nearest Relative (name, address, telephone number)</th>
<th></th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Other People and Agencies Involved (Nursing, Psychology, Social Work, OT, Speech &amp; Language, Ministry of Justice Case Worker, Probation Officer, Solicitor)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>REASON FOR REFERRAL/PRESENTING PROBLEM (RECENT HISTORY)</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
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<table>
<thead>
<tr>
<th>ANY OTHER REFERRALS PAST OR PENDING</th>
</tr>
</thead>
<tbody>
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<td></td>
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<table>
<thead>
<tr>
<th>OFFENCES INVOLVING CRIMINAL PROCEEDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>OFFENDING OR BEHAVIOURS NOT INVOLVING CRIMINAL PROCEEDINGS</th>
</tr>
</thead>
<tbody>
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<td></td>
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<table>
<thead>
<tr>
<th>IMPULSIVE BEHAVIOURS (e.g. alcohol/substance misuse, self-harm)</th>
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<tbody>
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<thead>
<tr>
<th>RELEVANT PAST PSYCHIATRIC HISTORY AND MEDICAL HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>DRUG AND ALCOHOL HISTORY</td>
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<table>
<thead>
<tr>
<th>RISK HISTORY</th>
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<table>
<thead>
<tr>
<th>PERSONAL HISTORY AND FAMILY HISTORY</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>VULNERABLE ADULT ISSUES</th>
<th>Yes/No</th>
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</table>

<table>
<thead>
<tr>
<th>CHILD PROTECTION ISSUES</th>
<th>Yes/No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>OTHER SAFEGUARDING ISSUES</th>
<th>Yes/No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MAPPA INVOLVEMENT</th>
<th>Yes/No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>VICTIM ISSUES</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>CURRENT MEDICATION</td>
<td></td>
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<table>
<thead>
<tr>
<th>CURRENT MENTAL STATE</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>EXPLANATION OF URGENCY OF REFERRAL</th>
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<table>
<thead>
<tr>
<th>URGENCY OF ADMISSION</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>FORENSIC CASE MANAGEMENT ISSUES</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the evidence of need for security?</td>
</tr>
<tr>
<td>How has the patient responded to any period of supervision or increased security?</td>
</tr>
<tr>
<td>Question</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>What is the patient’s understanding of the risk issues?</td>
</tr>
<tr>
<td>Please detail any recent use of restrictive interventions i.e. seclusion, rapid tranquilisation or physical interventions</td>
</tr>
<tr>
<td>Is the patient aware of this referral?</td>
</tr>
<tr>
<td>Does the patient want carer/family involvement in assessment/care? Please identify carer/family member(s)</td>
</tr>
<tr>
<td><strong>RISK TO ASSESSING TEAM</strong></td>
</tr>
<tr>
<td>Are there any specific factors not mentioned that the referral team should consider if meeting with the person referred (e.g. location, racism, litigious behaviour, unsubstantiated allegations)?</td>
</tr>
</tbody>
</table>
Please complete the following where applicable

**FOR PATIENTS WITH SUSPECTED OR CONFIRMED LEARNING DISABILITY OR DEVELOPMENTAL DISORDER / AUTISM / ASPERGER’S PLEASE SUPPLY EVIDENCE**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the evidence of intellectual impairment? (e.g. psychometric assessment)</td>
<td></td>
</tr>
<tr>
<td>Please note that any assessment should be appended to this referral</td>
<td></td>
</tr>
<tr>
<td>What is the evidence of deficit of adaptive functioning? (e.g. disability living allowance, recent work history, type of residential setting etc)</td>
<td></td>
</tr>
<tr>
<td>Please note that any assessment should be appended to this referral</td>
<td></td>
</tr>
<tr>
<td>What is the evidence of developmental onset (e.g. delayed developmental milestones, special school)</td>
<td></td>
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</tbody>
</table>

**FOR PATIENTS WITH SUSPECTED OR CONFIRMED PERSONALITY DISORDER PLEASE SUPPLY EVIDENCE**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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</thead>
<tbody>
<tr>
<td>Where is the evidence of disorder?</td>
<td></td>
</tr>
<tr>
<td>Please note that any assessment should be appended to this referral</td>
<td></td>
</tr>
</tbody>
</table>
Summary of Police Powers
Mental Health Act 1983
<table>
<thead>
<tr>
<th>MHA Codes of Practice Reference</th>
<th>Police Powers within MHA 1983</th>
<th>Police Powers to Detain</th>
<th>Police Powers to Convey</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.5, 17.6 &amp; 17.12 – 17.16 Pages 153, 154 &amp; 155</td>
<td>Section 6 MHA Conveyance of patients to hospital to be detained for assessment or treatment</td>
<td>Yes – A properly completed Application for detention under the MHA 1983 with the required Medical Recommendations MHA 1983 gives the applicant (AMHP or Nearest Relative) the authority and legal power to transport patients against their will.</td>
<td>Yes – Ambulance as first consideration but subject to risk assessment and written authority of AMHP police may be requested to convey</td>
</tr>
<tr>
<td>17.30, 17.31 &amp; 17.32 - pages 157 &amp; 158 17.5, 17.33, 17.34, 17.35 page 158 28.3 – 28.23 pages 324 - 327 29.58 - page 338</td>
<td>Section 17 &amp; 18 (1-3 &amp; 7) MHA Patients are considered to be Absent Without Leave (AWOL) when they: have left the hospital in which they are detained without leave being agreed • have failed to return to the hospital at the time required • are absent without permission from a place where they are required to reside • have failed to return to hospital if their leave has been revoked • are guardianship patients who are absent without permission from the place where they are required to live by their Guardian. • are Supervised Community</td>
<td>Yes - Detained patients who are AWOL may be taken into custody and returned by an Approved Mental Health Professional (AMHP), any member of the hospital staff, any police officer, or anyone authorised in writing by the hospital managers</td>
<td>Yes – return to the hospital to which they have been recalled. The police should be asked to assist in returning a patient to hospital only if necessary. If the patient’s location is known, the role of the police should, wherever possible, be only to assist a suitably qualified and experienced mental health professional in</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
<td>Yes</td>
<td>No</td>
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<td>---------</td>
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<tr>
<td><strong>17.30, 17.31 &amp; 17.32 - pages 157 &amp; 158</strong></td>
<td>Treatment (SCT) patients who have failed to attend hospital when recalled&lt;br&gt;• are SCT patients who have absconded from hospital after being recalled there.&lt;br&gt;• are conditionally discharged restricted patients whom the Secretary of State for Justice has recalled to hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>17.5, 17.33, 17.34, 17.35 page 158 28.3 – 28.23 pages 324 - 327 29.58 - page 338</strong></td>
<td>Section 18 (1 – 3) MHA -&lt;br&gt;Patients are considered to be Absent Without Leave (AWOL) when they&lt;br&gt;• have left the hospital in which they are being detained without their absence being agreed (under section 17 of the act) by their responsible clinician&lt;br&gt;• have failed to return to the hospital at the time required to do so by the conditions of leave under section 17&lt;br&gt;• are absent without permission from a place where they are required to reside as a condition of leave under section 17&lt;br&gt;• have failed to return to the hospital when their leave under section 17 has been revoked.</td>
<td>Yes - Detained patients who are AWOL may be taken into custody and returned by an Approved Mental Health Professional (AMHP), any member of the hospital staff, any police officer, or anyone authorised in writing by the hospital managers</td>
<td>Yes – return to hospital&lt;br&gt;The police should be asked to assist in returning a patient to hospital only if necessary. If the patient’s location is known, the role of the police should, wherever possible, be only to assist a suitably qualified and experienced mental health professional in returning the patient to hospital. (C.O.P 22.13)</td>
</tr>
<tr>
<td><strong>17.5 &amp; 17.29 - pages 153 &amp; 157</strong></td>
<td>Section 19 (1-4) &amp; Paragraph 11.26 &amp; 30.13 A MHA - Transfer of an unrestricted patient to another hospital</td>
<td>Yes – Patient is already compulsory detained under Sections 2 or 3 of MHA</td>
<td>Yes – Hospital managers responsibility to authorise transfer – Ambulance as first</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td><strong>30.24 – 30.25</strong></td>
<td><strong>Section 19 MHA</strong> - Transfer of a patient to another hospital or into Guardianship of the Local Authority or the Transfer of patient to hospital who is under the Guardianship of the Local Authority</td>
<td>Patient is already detained compulsory under Section 7 of MHA</td>
<td>Hospital manager/Guardian responsibility to authorise transfer</td>
</tr>
<tr>
<td><strong>17.5, 17.30, 17.31 &amp; 17.32 - pages 157 &amp; 158 28.3 - page 324</strong></td>
<td><strong>Sections 37 (1 &amp; 2) &amp; 42 (3 &amp; 6) MHA</strong> - Patients are considered to be Absent Without Leave (AWOL) when they are Conditionally discharged restricted patient whom the Secretary of State for Justice has recalled to hospital or directed their attendance at any place in Great Britain in the interests of justice</td>
<td>Detained patients who are AWOL may be kept in custody and returned by an Approved Mental Health Professional (AMHP), any member of the hospital staff, any police officer, or anyone authorised in writing by the hospital managers</td>
<td>return to the hospital to which they have been recalled or any place stated on the Warrant by the Ministry of Justice (MoJ). A constable or any other person required or authorised to take the person into custody, or</td>
</tr>
</tbody>
</table>
16.7 - page 140
Sec 135 MHA (1) -
A police officer may use Powers of entry under section 135(1) of the Act when it is necessary to gain access to premises to remove a person who is believed to have a mental disorder and is not receiving proper care and remove patient to a Place of Safety for further assessment within MHA 1983.

Yes – The warrant gives any police officer the right to enter the premises, by force if necessary. The police officer may then remove the person to a place of safety, where they can be detained for up to 72 hours from the time of their arrival.

Yes – Ambulance as first consideration but subject to risk assessment and written authority of AMHP may be Police.

This requires a magistrate’s warrant. A magistrate may issue a warrant under section 135(1) in response to an application from an Approved Mental Health Professional (AMHP). See s135 & s136 Policy and Procedures for further Information.

16.16 – page 141
Sec 135 MHA (2) -
Section 135(2) provides for the issue of a warrant by a magistrate authorising entry by the police to remove a patient who is liable to be taken or returned to hospital or any other place or into custody under the Act Warrant to search for and remove patient

Yes – It enables a police officer to enter the premises and remove the patient so that they can be taken or returned to where they ought to be

This requires a magistrate’s warrant. A magistrate may issue a warrant under section 135(2) in response to
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Yes/No</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.41 - page 147</td>
<td>Sec 136 MHA - removal to a place of safety of any person found in a place to which the public have access who appears to a police officer to be suffering from mental disorder and to be in immediate need of care or control.</td>
<td>Yes</td>
<td>Removal to a place of safety may take place if the police officer believes it necessary in the interests of that person, or for the protection of Others.</td>
</tr>
<tr>
<td>16.53 - 16.58 pages 149 &amp; 150</td>
<td>S136 MHA - Transfers between Places of Safety (Police Station, Mental Health Unit or Accident and Emergency Unit)</td>
<td>Yes</td>
<td>Detained person already detained on s136 MHA</td>
</tr>
<tr>
<td>28.9 &amp; 28.10 page 325</td>
<td>Section 138 MHA (1) (4,5 &amp; 6) – Retaking of persons who have escaped from legal custody i.e. Detained under MHA</td>
<td>Yes</td>
<td>Detained patients who are AWOL may be taken into custody and returned by an Approved Mental Health Professional (AMHP), any member of the hospital staff, any police officer, or anyone authorised in writing by the hospital managers</td>
</tr>
</tbody>
</table>

See Policy link (4)
FACTORS TO BE CONSIDERED BY CUMBRIA APPROVED MENTAL HEALTH PROFESSIONALS, CUMBRIA POLICE, CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST STAFF & NORTH WEST AMBULANCE SERVICE

When deciding on the most appropriate method for conveying a patient, factors to be taken into account include:
• The availability of different transport options;
• The distance to be travelled;
• The wishes and views of the patient, including any relevant statement of those views or wishes made in advance;
• The patient’s age;
• Any physical disability the patient has;
• Any risks to the health and safety of the patient and any need for support, supervision and clinical care or monitoring during the journey. This is particularly important where sedation has been, or may be, used;
• The nature of the patient’s mental disorder and their current state of mind;
• The likelihood of the patient behaving in a violent or dangerous manner;
• The health and safety of the people conveying the patient and anyone else accompanying them;
• The likelihood that the patient may attempt to abscond and the risk of harm to the patient or other people were that to happen;
• The impact that any particular method of conveying the patient will have on the patient’s relationship with the community to which they will return;
• The effect on the patient of who accompanies them, for example, whether the presence of the approved mental health professional (AMHP) or one of the doctors involved in the decision to detain them may have a detrimental effect; and
• The availability of transport to return those who accompany the patient. (MHA CoP 11.4)

Patients who have been sedated before being conveyed should always be accompanied by a health professional that is knowledgeable in the care of such patients, is able to identify and respond to any physical distress which may occur and has access to the necessary emergency equipment to do so (MHA CoP 11.5).

LINKS TO POLICIES
1) Regional Policy and Guidance for Conveying Mental Health Patients

2) Policy for the Management of Service users Missing or Absent Without Official Leave

3) Use of Supervised Community Treatment - MHA Section 17(a)

4) Mentally Disordered People Found In Public Places (Section 136 Mental Health Act 1983)
Cumbria Liaison and Diversion Scheme
Cumbria Liaison and Diversion Scheme
(Delivered by Lancashire Care NHS Foundation Trust Criminal Justice Liaison and Diversion Services)

Liaison & Diversion services operate within police custody suites and magistrates courts to ensure that those with mental health conditions, learning disabilities or other vulnerabilities can access specialist support when in contact with the criminal justice system. This may include an assessment of need, referral on to other services and support agencies, access to health care or general advice about health and wellbeing.

From the 1st September 2015, a Liaison and Diversion Practitioner has been present in the Carlisle custody suite. A further two Practitioners have been appointed, meaning that following an induction period, staff will be present in Carlisle custody between 8am and 4pm 7 days a week.

The Liaison and Diversion Practitioners will provide an all-age service, inclusive of adults, older adults, children and young people and will act as mental health / vulnerabilities advisors to custody Sergeants, legal advisors, court Staff, Detention Officers and investigating officers. The Liaison and Diversion Practitioners will have access to NHS records so that they are well placed to make informed decisions about the care of detainees.

Liaison and Diversion Assessments will be offered to individuals at the earliest opportunity if any of the following vulnerabilities are identified:
- Mental health
- Learning disabilities
- Autistic spectrum
- Substance misuse
- Physical health
- Personality disorder
- Acquired brain injury
- Speech, language and communication needs
- Attention deficit hyperactivity disorder
- Learning difficulties
- Safeguarding issues/child protection issues

The Liaison and Diversion Practitioners will work in collaboration with Cumbria Partnership Trust professionals and other agencies already involved with the service user and discuss options if further support is needed.

If appropriate, after gaining patient consent, a report can be provided to the court following assessment, detailing the relevant support plan in place, past engagement with health and social services, relevant health and social circumstances of the individual at that time, present mental state examination and any recommendations for further support.
A mobile number will be provided to relevant North Cumbria agencies in the coming weeks to enable you to contact the L&D team within Police Custody. If you have any queries regarding this service or would like to meet to discuss Liaison and Diversion you can contact Gemma Richardson Senior Liaison and Diversion Practitioner on 07939981632 or gemma.richardson@lancashirecare.nhs.uk