



NOTTINGHAMSHIRE  
**POLICE**  
PROUD TO SERVE

**PD 620** **Dealing with Persons with Mental Health (Consolidated Procedures)**

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**SECTION 1 VERSION CONTROL**

Version No.	Date	Post Holder / Author	Post	Reason for Issue
1.0	April 2013	Paul Saint / Andy Rourke	Head of Custody	Consolidation of procedures
1.1	July 2014	Neil Fletcher	Policy & Change Officer	Review of procedure – no changes required

## **SECTION 2 AIMS / OBJECTIVES**

In any given year at least 1 in 4 adults in the UK will experience some form of mental ill health. Whether mental disorder is short or long term, its effect on those suffering from it, their family, friends and general community can be significant.

People with mental ill health or learning disabilities often suffer discrimination and stigma because of their condition – from low-level harassment to serious violence and murder.

Whilst the vast majority of persons with mental disorder never come to the attention of the police there will be many occasions on which the police become involved with persons with mental ill health who may be victims, witnesses, suspects, missing or a risk to either themselves or others.

This document is intended as a consolidated guide to the powers and procedures in place to assist in dealing with persons with mental ill health or learning difficulties.

## SECTION 3 DETAILS

### DEFINITIONS OF MENTAL ILL HEALTH AND LEARNING DISORDER

Terminology relating to mental ill health and learning disability can be complex and changes over time. The term mental ill health is used in this document to include mental disorder, mental illness and mental health needs, together with those suffering mental distress at the time of contact with the police, whether or not formally diagnosed as or accessing mental health services.

Mental ill health can therefore include severe and enduring conditions (e.g. schizophrenia, bipolar affective disorder etc.), and more common problems including depression, phobias, and self harm (including vulnerability to suicide). It includes 'mental disorder' as defined in Section 1(2) Mental Health Act 1983, which states:

*'Mental disorder'* means any disorder or disability of the mind; and *'mentally disordered'* shall be construed accordingly. The condition may be either permanent or temporary.

Learning disability, sometimes referred to as learning difficulty or intellectual disability, is defined by Section 1(40) of the Mental Health Act 1983 as:

***'A state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning.'***

There are many types of learning disability, ranging from mild to severe. Persons with learning disability may be extremely vulnerable and suggestible, although their condition may not be immediately or readily apparent.

For the purpose of this document the term 'mental disorder' includes both mental ill health and learning difficulty and is interchangeable with them unless specifically stated.

### MENTALLY DISORDERED PERSONS IN A PUBLIC PLACE (SECTION 136 MHA)

Section 136(1) states that:

***"If a constable finds in a place to which the public have access a person who appears to him/her to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if s/he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety..."***

A person may be detained for a maximum of 72 hours but should be seen as soon as is practicable.

The power can only be exercised in a public place, and is available whether or not the person has committed an offence. However when a substantive offence may have been committed the person it is generally more appropriate to arrest for the offence and convey to a custody suite, rather than detain under Section 136. In such circumstances a mental health assessment can be conducted in custody if required.

As a general rule arrest for an offence should be considered when the offence is recordable and/or when previous attempts at diversion outside the criminal justice system have been ineffective. Detention under Section 136 should be used where there are no offences, or where any offences are of a minor nature and do not warrant action within the criminal justice system.

A person detained under Section 136 may later be arrested for an offence but once arrested for an offence cannot then be detained under Section 136.

#### **4.1.1 Deciding to use Section 136(1)**

Either finding or being directed towards a person with mental disorder in a public place is not enough in itself to detain under section 136. The power to remove requires 4 conditions to be fulfilled before police act.

- The person must be found in a public place\*
- The person must appear to the officer to be suffering from mental disorder
- They must appear to the officer be in immediate need of care or control
- The officer must think they need removing in their own interests or for the protection of others

The clear implication is that the officer must believe the person or someone else will suffer some kind of harm if they do not take action to remove them. Simply behaving in an odd or unusual way does not necessarily mean they should be removed. The power to remove under section 136 does not require police officers to make a diagnosis of someone's mental state, but encourages officers, who believe in good faith that someone is mentally ill and requires immediate care and control, to remove them to a place of safety. It is also important to recognise that people who are deaf or who have other disabilities may act in ways that may give the impression they are mentally ill.

***\*A person must not be persuaded to leave a private place and enter a public place simply to enable use of this power***

#### **4.1.2 Guidance to determine if the threshold for Section 136 has been reached**

Simply acting in a way that is different from what might be considered to be normal is not in itself a reason to interfere with a person's freedom to go about their lawful business in a public place. The following considerations will aid decisions about using section 136 to detain an individual who appears to have mental illness in a public place. These describe some of the behaviour that might accompany mental illness but might not, on their own, justify immediate removal using Section 136.

- The person is engaging in irrational, inappropriate or bizarre conversation or behaviour. (Be aware and consider that certain behaviours are normal within the context of that persons culture for example praying out loud in public is a normal accepted occurrence in some religious groups).
- They are talking about seeing things or hearing voices which you cannot see or hear.
- They are putting themselves in danger, for example walking into the path of moving traffic or on railway lines.
- They are engaged in threatening behaviour towards others for no obvious reason.
- They have been asking for help with their mental condition.

- They are threatening or engaged in self-harm or suicide.
- Paranoid beliefs or delusions
- The person is removing clothing for no apparent reason.
- The person is confused, disorientated or agitated or unresponsive.
- Extreme volatility
- Hyperventilation
- Tripping, falling over, bumping into things
- Physical signs of severe malnourishment and self neglect
- There is an immediate risk of harm through perhaps assaults on others

Ask yourself:

- What is the degree of threat to themselves or others?
- Based upon their current behaviour and what you know about them, what do you believe will happen if you walk away and don't detain them?

In some circumstances the behaviour of the person may demand immediate action but where time permits the following information sources can help to assess the need for detention using the power.

- Information from police databases (PNC, intelligence etc.)
- Friends, relatives, neighbours, professionals with previous knowledge.

#### 4.1.3 Place of Safety

It is recognized that the preferred Place of Safety as outlined in the Code of Practice should be a designated 136 suite in a hospital:

- For Ashfield, Mansfield, Newark and Bassetlaw this is at Kings Mill Hospital

**The Lucy Wade Unit, 01623 785743**

- For Nottingham City, Gedling, Broxtowe and Rushcliffe this is at QMC

**Cassidy Unit, 07827833720**

The Section 136 Suite will always be the Place of Safety other than:

- When the person has urgent medical needs, in which case it should be the nearest Emergency Department
- In exceptional circumstances when the person presents an unmanageable risk to self or others which can only be dealt with in a police custody environment, for example where a person is presenting as aggressive / violent.
- When other Places of Safety, including friends' and relative's home and care homes may be more appropriate. E.g. this should be considered in relation to elderly persons who could be detained at a Day Centre, Care Home or home of a relative or friend.

NB Police stations should only be used as a place of safety in exceptional circumstances where detention elsewhere would present an unmanageable risk to the detainee, staff or other persons.

Violent behaviour may be connected to certain mental health conditions and should not prevent acceptance at a Section 136 unit unless unmanageable.

Intoxication, whether through drink or drugs, does not in itself present an unmanageable risk and does not preclude acceptance at a dedicated Section 136 suite unless the degree of intoxication etc. is so acute as to require urgent treatment in a hospital Emergency Department.

#### **4.1.4 Procedures under S136**

A police officer who is considering use of Section 136 in a public place as defined by the Public Order Act and the Crime and Disorder Act 1998 will have a number of options available:

- Wherever possible the police officer should seek to assist the person by obtaining their consent to any action and should avoid using the power to detain under Section 136
- With the person's agreement, to return them home or to their place of residence (which may be a hospital or Care Home). When the person is dealt with in this way, the police officer should be satisfied that appropriate care and support is available at their place of residence.
- If the person is already subject to detention in hospital under the Mental Health Act 1983, then they may be returned directly to the appropriate psychiatric in-patient facility. In these circumstances the police officer should make contact with the appropriate hospital to check that they have the legal authority to return the person and that it is appropriate to do so (see also separate protocol regarding missing persons and absconders from Mental Health Services)
- Children and young persons under 18 should only be considered for section 136 when other alternatives (including safeguarding powers if appropriate) have been considered. To assist this, if practicable, the police officer should liaise with the Children's Department of the relevant Local Authority or outside Monday-Friday 9-5, the relevant Emergency Duty Team
- Detention under S136 is an arrest. The detained person must be informed at the time of arrest that he/she has been detained under S136 of the mental Health Act to be taken to a place of safety for their own care and protection. A person so arrested may be subject to search and physical restraint if appropriate.
- If the person appears to be physically ill or is suspected of having taken an overdose and is in need of urgent medical attention then they should be taken to the nearest Emergency Department. If the person lacks the capacity to make this decision and it's an urgent situation, the police must make this decision based on their assessment of the person's best interests. Ambulance staff may be consulted in making that decision. This could be an alternative to or in addition to use of Section 136
- Other than in such (physical) medical emergencies, the local Section 136 duty nurse should be contacted immediately – to discuss the most appropriate Place of Safety, which would only exceptionally be the Police Station. The decision would be based on the police risk assessment at that point in time. The journey to the suite must not commence until the authorisation is given by Section 136 duty nurse

- The principle of respect as well as risk assessment of health and safety to all concerned should be considered in relation to conveyance. If at all possible an ambulance should be the first choice in recognition that the person has not committed a criminal offence. It may occasionally confer more dignity to remove the person from a public place in a police vehicle if the ambulance is likely to be delayed
- Police officers have the power to search a person as they would a person arrested for an offence including those who are taken to the Place of Safety suite.
- Any Place of Safety, whether hospital or police station, may not accept a person whose detention was unlawful (for instance a S136 'detention' on private property). In such circumstances it is the responsibility of the arresting/escorting officer to consider the use of alternative powers of arrest (if appropriate) and the need to protect the detainee, public and staff.

#### **4.1.5 Police support in Section 136 Suites:**

- Escorting officers must remain with the detainee until the Suite Staff are satisfied that the detainee can be managed safely.
- Escorting officers must inform Suite Staff of the circumstances and grounds for the detention and any other relevant information, including concerns regarding physical health, any suggestion of drink or drugs consumption, any use of force or restraint and any information concerning risks or threats to or from the detained person. A PNC check must be completed by the police and healthcare staff informed of any relevant warning markers.
- From time of detention until examination and assessment are completed, the person is deemed to be in lawful custody and can be detained and restrained at the place of safety by police and/or members of health staff.
- Escorting officers must complete part 1 of the Section 136 monitoring form, a copy of which must be retained by them and forwarded to CJ development.

#### **4.1.6 Police support in acute care (medical) hospitals:**

Physical health needs must always be prioritised over mental health assessment needs. In a physical medical emergency the person must be conveyed directly to the nearest appropriate hospital emergency department irrespective of any mental ill health issues.

- Escorting officers must remain with the detainee until hospital staff are satisfied that the detainee can be managed safely and/or a mental health assessment has been completed. All practical steps possible should be taken to ensure the earliest release of police officers from such duties. This includes having a mental health professional in attendance. If there is a disagreement about the release of police officers this should be decided between the Emergency Department Senior Clinician and the Duty Inspector for the escorting police and the Section 136 duty nurse.
- From time of detention until examination and assessment are completed, the person is deemed to be in lawful custody and can be detained and restrained at the place of safety by police and/or members of health staff.



- Escorting officers inform hospital staff of the circumstances and grounds for the detention and any other relevant information, including concerns regarding physical health, any suggestion of drink or drugs consumption, any use of force or restraint and any information concerning risks or threats to or from the detained person. A PNC check must be completed by the police and healthcare staff informed of any relevant warning markers
- Escorting officers must complete part 1 of the Section 136 monitoring form, a copy of which must be retained by them and forwarded to CJ development.
- In order to preserve the dignity of the person detained, and minimise risks to the detainee, public, hospital staff and escorting officers, it is good practice for hospitals to provide a room isolated from the public in which the detainee and escorting officers can wait pending assessment and/or treatment. Escorting officers should request the use of such a room on arrival at hospital.

#### 4.1.7 Police Station as a Place of Safety

(In the **exceptional event** that a person detained under Section 136 is taken to a police station):

##### Role of Custody Sergeant

- Ascertain reason and grounds for arrest and authorise detention (if appropriate).
- Ensure risk assessment conducted and detention managed in accordance with force 'Safer Detention' procedures.
- Ensure relevant S136 nurse notified and agree with him/her if/when it is possible to transfer to a dedicated S136 facility or whether assessment at police station is necessary.
- Act in accordance with PACE guidelines. This confers the power to ascertain what items the person has on them, remove items if permitted and to search the person as necessary for this
- Obtain and record as much detail about the detainee as possible including the name of the person's GP, family contacts, the reason for detention and any involvement with the mental health services. **The detaining Police Officers' concerns about risk issues must be passed on to the FME, 136 Duty Nurse and AMHP**
- Request attendance of the FME to assess if the person is 'fit to detain'.
- In the event assessment at the police station is necessary immediately notify and request the attendance of the relevant AMHP and FME
- Give AMHP/FME each other's contact details so that they can liaise to plan the assessment.
- A mental health assessment may not be possible while a person is under the influence of drink/drugs. This applies only when the person is not fit to be interviewed and would not apply to mild intoxication. In such circumstances the AMHP should be informed and be readily available but may not attend until an FME has confirmed fitness for assessment. If a detainee's intoxication is such as to warrant deferred

assessment he/she must be seen by the FME to consider fitness to detain.

- Ensure request and attendance times are entered into custody record.
- Ensure a rights leaflet is given and verbally explained to the person, ensuring that the person understands their right to have a solicitor present and request contact with a friend, relative or advocate. They should be available electronically in several languages.
- Consider whether an appropriate adult should be involved.
- Ensure the arresting escorting officers complete part 1 of the monitoring form on arrival, and that the AMHP completes part 2 before departure.

### **Role of Forensic Medical Examiner (FME) for Section 136 detentions**

The FME should ideally be Section 12 approved, in line with the recommendations in 10.27 of the Code of Practice and:

- Attend as soon as practicable and in any case **within 1 hour** of being requested and assess fitness to detain
- Provide an initial mental health screening including assessment of fitness for assessment. NB. Mild intoxication should not necessarily prevent mental health assessment
- Liaise appropriately with other professionals particularly recognizing that it is best practice to wait for the AMHP to jointly conduct the full mental health assessment
- Document the assessment and communicate this to the relevant mental health services.

#### **4.2.1 Mentally disordered Persons in a Private Place**

Section 136 cannot and must not be used on private property. A number of other powers can, however, be considered depending on the risks and urgency of the situation. As with S136 it must be emphasised that if a substantive criminal offence is suspected the person should be arrested for the criminal offence and taken to a custody suite, where a mental health assessment can then be conducted if appropriate.

#### **4.2.2 None urgent**

Officers and staff may attend incidents or come into contact with persons who, whilst not presenting an immediate risk to themselves or others, are nevertheless believed to be in need of care or support. In such circumstances details of the person, together with the grounds for concern, should be passed on to the local Social Services department. The consent of the person concerned should be obtained before such information is passed on to other agencies unless the circumstances are such that this may not be practicable (for example if concerns relate to level of care and support provided by a 'carer' who is present at that time).

### 4.2.3 Urgent

If an officer or member of staff is dealing with a person on private premises, and that person is believed to be suffering from a mental disorder that requires urgent but not immediate assessment, care and control, the persons G.P. service should be contacted with a view to arranging an assessment under S4 of the MHA. If a relative or other responsible person is present or can be arranged it would not usually be necessary for the officer/staff member to remain with the person pending doctors attendance/assessment unless there was a risk of serious harm to the patient and/or others.

If a person refuses to cooperate with attending officers/ambulance staff etc and there are no powers in place (MHA warrants) to convey the person to a place of safety, then the officer should consider alternative powers e.g. arrest to prevent a breach of the peace (if the criteria are met lawfully).

The provisions of the Mental Health Act and Mental Capacity Act cannot be used to detain persons who may be at risk from physical injury, including overdose, who are able to make their own decisions regarding treatment etc. In such circumstances it is suggested that the consequences' of the persons actions are explained to them and they are requested to sign a pocket book entry to the effect they are refusing treatment/help. A suggested entry is:-

You have been examined/it is felt that you should attend hospital for a period of assessment and treatment if required; the possible consequences of not taking the advice may result in serious illness or death. Please sign the below declaration.

***“The consequences of my refusal to accept medical advice have been explained to me, I am refusing to consent to medical help at this time”.***

Officers attending incidents whereby someone clearly has mental health issues and is refusing treatment do not have powers delegated to them (MHA/MCA) to transport/restrain the person. Police officers may use Common Law powers to assist the ambulance staff, but cannot assume their role.

Notwithstanding the above, Police officers have a basic duty of care around the *“Preservation of life and property”*. When an officer is confronted with a situation whereby they have no powers under the Mental Health Act then they need to consider and use their Common Law powers and basic Duty as a Constable. If a Health Care Professional (Doctor) details how serious the situation has become then a Police Officer can and should use their Duty of Care/Common Law powers to assist the Health Care Professional, this may involve control and restraint if necessary to gain compliance.

The officers need to have a real and genuinely held belief that their actions are justifiable/necessary to *“save life/prevent serious injury”* in order to intervene. If a Health Care Professional or evidence at the scene heightens an officers belief that they need to act to save life, their common law powers are sufficient

Examples - Officers attend and address whereby a Doctor has asked for Police assistance because a subject/patient claims to have taken a large drug overdose (as a means to ending their life) and the Doctor details how serious the consequences are, then the information from the doctor is sufficient to enable a Constable to use their Common Law power.

Legal advice is that if a Police officer is in such a situation (i.e. someone with mental health issues threatening suicide etc) and they have an honest held belief that it is justifiable and necessary to use force to restrain and detain the subject, and then their common law powers are sufficient to do so. The belief must be based on something tangible, which could be information provided by a Health Care Professional or physical items at the scene e.g. empty drugs bottles etc.).

#### **4.2.4 Emergency (Mental Capacity Act 2005)**

The case of *Sessay v South London & Maudsley NHS Trust*, (decided in the High Court in October 2011) is the authority for the principle that sections 5 and 6 of the Mental Capacity Act DO NOT confer on Police Officers authority to remove persons to hospital or other

Places of safety for the purposes set out in sections 135 and 136 of the Mental Health Act. In cases of genuine concern for life Common Law powers (as outlined above) should be considered.

#### **4.3.1 Pre-planned Mental Health Act Assessments**

Most Mental Health Act assessments do not require the involvement of the police. On occasion however it may be necessary for healthcare colleagues to request assistance of the police when undertaking an assessment in the community. This could arise either spontaneously, for example where a doctor and/or AMHP is already undertaking an assessment and the patient has become violent, or where an assessment is planned and risk assessments identify a likelihood of violence.

In the event entry is required by health services to undertake an assessment, and it is believed likely that such entry may be refused, an APHM may also obtain a warrant to enter under Section 135 of the MHA. In such cases police assistance will be required irrespective of the threat level as only a police officer may lawfully execute such a warrant.

In line with the above there are two standards for referral to the police:

- i) Requests for assistance at planned assessments where health services have identified a credible risk and or execution of a S135 warrant is required. (In the case of risks the AMHP will be expected to identify the risks when contacting the police control room, but not to evidence/justify that assessment).
- ii) Urgent requests where health services are already on site and urgent assistance is required.

The duties of the police when assisting with pre-planned (community) assessments are:

- Keep the peace and protect persons/property
- Execute S135 warrant (if applicable)
- Assist in escort of person detained under MHA if necessary to prevent harm, injury, escape
- Use of restraint if necessary

It is the responsibility of the AMHP to arrange transport of persons detained under these provisions, including the use of an ambulance if appropriate. Police transport must not be used unless the person to be conveyed is so violent that alternative transport is unsafe.

#### **4.3.2 Risk Assessments**

When requests are received in advance to assist at planned assessments the police should conduct their own risk assessment taking account of information provided by the AMHP. This is necessary to determine the appropriate resources and equipment required. It is good practice for the police to satisfy themselves that the AMHP has made advance provision for transport etc. in the event that the patient is uncooperative etc.

#### **4.3.3 Missing Persons**

Persons with mental disorder who are reported missing must be dealt with in accordance with the generic force MFH policy: [PD361 Missing Persons Recording and Investigation](#)

OR

The [Joint Protocol for Service Users Missing from Hospital or Other Healthcare Setting](#) as appropriate.

In the event mental health service users are reported 'missing' by hospital staff, but there whereabouts are known, it should be remembered that the power to detain persons who are AWOL and return them to hospital is held by AMHP's and hospital staff as well as police officers and that primary responsibility lies with the healthcare agency responsible for the patient. Arrangements for routine collection, and return, including transport, should usually be made by the hospital, with the police only being called on to assist in emergency/high risk cases.

When necessary, Section 18 MHA provides powers to detain and return persons lawfully detained under Act, although it does not provide a power of entry to detain. If lawful entry cannot be gained by other means consideration should be given to application for a warrant of entry under Section 135(3) MHA. It should be noted that whilst a warrant for entry and assessment under section 135(1) can only be applied for by an AMHP, a warrant to enter to 'retake' a person already 'sectioned', a section 135 (2) can be applied for by either an AMHP or the police.

#### **4.3.4 Conveyance**

National guidance and Codes of Practice dictate that all persons detained under either the MHA or MCA should be conveyed to or between places of safety, hospitals etc by ambulance.

In the event the police detain a person under either MHA or MCA attempts must be made to secure the attendance of an ambulance to convey that person. Only in the event that an ambulance cannot attend within a reasonable period of time, or risk assessment dictates the use of an ambulance would be unsafe due to the demeanour etc of the detainee, should police transport be used.

If/when an ambulance is used the detainee remains in police custody until handed over to

the place of safety and should be escorted by the police.

Responsibility for transferring a patient from a place of safety to place of treatment etc. (post assessment) lies with the relevant Social Services Department. The police should not undertake such transport unless the use of non-police transport presents unacceptable risks or delay.

Request for the police to undertake 'out of county transport' should only be considered in the event the relevant authority agrees to meet the costs of such, including overtime etc. for officers if necessary.

The police have no responsibility for the transportation of 'in patients' to/from or between mental health facilities, but may (rarely) be asked to assist in unforeseen emergency situations where it is necessary to protect life or serious injury.

#### **4.3.5 Inpatients – Requests for Police Assistance**

Ordinarily the police should not be called upon to assist healthcare staff in the management, including transfer, of a patient presenting a 'management problem'. The NHS Trust and other healthcare agencies have a legal obligation to ensure sufficient trained staff and adequate resources/facilities exist to restrain patients and/or place in isolation.

In the event that healthcare staff are, for whatever reason, unable to manage a situation general police duties and powers in respect of preserving order, preventing harm etc. apply. It should be noted however that hospital staff powers to control, restrain and transport patients cannot be delegated to or exercised by the police. Police may use Common Law powers to 'assist' hospital staff, but cannot assume their role. If necessary and appropriate to arrest the patient for a criminal offence normal police powers then apply.

#### **4.4.1 Victims and Witnesses**

All victims and witnesses, including those with mental ill health or learning disabilities, are entitled to an equitable quality of service in accordance with the Witness Charter and Codes of Practice for Victims of Crime.

People with mental ill health or learning difficulties are often particularly vulnerable to victimisation or exploitation relating to their condition. This can range from low-level anti-social behaviour and harassment to more serious crime including murder. All such incidents create alarm and fear and can undermine the confidence in the police and justice system.

Offences motivated by, or showing evidence of hostility based on disability, are classified as 'Hate crime under section 146 of the Criminal Justice Act 2003. Mental ill health and learning difficulties are disabilities within the meaning of that Act.

Research and statistics show that disability hate crime is significantly under-reported and under-identified by the police.

If there is evidence of a disability hate crime or incident it must be identified as such on the incident log and crime report. Consideration should be given to an 'Achieving Best evidence Interview' of the victim at an early stage. It should also be brought to the attention of the CPS as a factor to be considered in charging decisions. In addition it should be

highlighted on any prosecution file to allow it to be dealt with as an aggravating factor when considering sentence.

#### 4.4.2 Credibility

It must not be assumed that simply because someone has mental ill health or learning disabilities they are not or cannot be a reliable witness or may not be able to cope with the prosecution and court process. In most cases, mental ill health or learning disability does not mean mental incapacity. As with suspects, there is a presumption of mental capacity unless proved otherwise. Perceptions about the mental capacity of persons with mental ill; health or learning difficulties are therefore unfair and inaccurate. They have served to undermine the service and treatment of persons with mental ill health and, in some cases, made them more vulnerable and prone to repeat victimisation and harassment when offenders perceive that the victim will not be believed.

#### 4.4.3 Interviewing Vulnerable Witnesses and Victims

The quality of a vulnerable witness' evidence is less a function of the witness than of the interviewer. Research has consistently shown that the evidential value of vulnerable witness' testimony is dependent on the techniques and skills of the interviewer.

It is the case however that care must be taken to establish and deal with any indicators of mental ill health at the earliest opportunity. This is necessary not just because such persons may be vulnerable to intimidation, but as their condition may make them more suggestible and/or they may require assistance or support, including in certain circumstances 'special measures'. Indicators of concern about victims and witnesses include:

- High suggestibility
- Eagerness to please
- Giving answers that they see as wanted
- Confusion over source of memory
- Easily distracted
- Difficulty with concepts of time and quantity

Best practice is to complete the 'initial needs assessment' on the reverse of the MG11 Witness Statement to assist in early identification of any relevant issues.

Whilst it may be necessary, in some cases, to secure the assistance of a 'responsible adult' when interviewing or taking statements from persons with mental disability, care must be taken to treat all victims and witnesses with dignity and compassion, not undermine them and to involve them in any decision making process to whatever extent is permitted by their condition.

In certain circumstances it may be necessary to obtain medical advice regarding the capacity to understand/remember what has happened and mental capacity to understand the rules of evidence, implications of prosecution etc.

Further advice and guidance on dealing with persons with mental ill health or learning difficulty can be found in **Achieving Best evidence in Criminal Proceedings: Guidance on Interviewing Victims and Witnesses, and Using Special Measures.**

#### **4.5.1 Mentally disordered Suspects**

The fact that a suspect is believed to have mental ill health or learning difficulties must not preclude full investigation of an offence and should only rarely prevent arrest and interview of a suspect.

A healthcare response to such suspects should not be seen as an alternative to criminal investigation or vice versa. In many cases there may be a need for both responses to take place alongside each other.

There is a misconception that arrest, interview and prosecution of persons with mental disorder should not be considered due to 'mental capacity' issues and/or the public interest. In reality there is a presumption that, unless the suspect is already detained as an involuntary patient in a psychiatric facility, he/she has the mental capacity to be detained, interviewed and prosecuted.

In some cases prosecution may be in the public interest, even for persons already in secure mental health facilities, as it may enable the use by courts of additional terms and conditions, be admissible in applications for release, and to prevent development of a culture whereby it is seen as acceptable, with no realistic sanctions, to behaviour to assault staff, damage property etc.

The presumption of capacity does not preclude use of alternative disposals ('diversion' from or within the criminal justice system) where there is sufficient evidence. Care must however be taken in ensuring that sufficient capacity exists to understand the terms and implications of any diversion (be it caution, PND, conditional caution etc) or prevent completion of any terms (in case of conditional cautions, payment of PND etc.). For these reasons the advice of a mental health professional should always be sought when considering out of court disposals

In situations where officers might consider the use of powers under S136 MHA or the MCA the person must always be arrested for any substantive offence where there is evidence of such.

#### **4.5.2 Procedures for dealing with mentally disordered suspects**

##### **Inpatient – Detained**

(This procedure applies to non-voluntary in patients in psychiatric facilities)

Wherever practical the police and Trust representatives should liaise and discuss options for investigation of allegations and the most appropriate means of dealing.

If a Trust clinician advises that the suspect does not and will not have the mental capacity to be interviewed it may be appropriate to consider no further action. If it is determined that no offence could have been committed as the suspect could not have formed the necessary 'mens rea' at the time of the incident the force Crime Registrar should be consulted with a view to 'no-criming' the incident.

If the clinician determines that the suspect has the capacity and is fit for interview, but not arrest and detention at a police station, arrangements should be made to interview/RFS the suspect on Trust premises. The clinician will provide a signed declaration of the suspect's fitness for interview. NB an appropriate adult will be required.



In the event a patient is deemed both fit for interview and detention a signed declaration will be provided to that effect by a (Trust) s12 approved clinician. Consideration should still be given to the necessity for arrest and, where appropriate, arrangements made to interview the suspect on Trust premises.

In the event an arrest and conveyance to police station is deemed necessary the Trust will provide a qualified member of staff to accompany the suspect in the capacity of 'responsible adult'. This person will assist and advise police officers in the treatment of the suspect and continually assess/review and advise on the mental capacity, welfare and (mental) fitness of the suspect. This person will not act in the legal capacity of appropriate adult; this service will be provided by TAS on behalf of the local authority.

Provided the relevant declaration and responsible adult is provided there will be no need for the suspect to be seen by an FME/HCP on arrival or prior to interview at the police station.

The doctor providing the declaration of capacity, and the responsible adult accompanying will be specialists in their field and fully aware of the mental capacity and limitations of the suspect. If for any reason there are concerns about the mental capacity/fitness to detain/interview whilst at the police station reference should initially be made to the Responsible Adult. If the responsible adult is unable to address any concerns to the satisfaction of the custody officer the FME should be contacted. The FME will liaise with the Responsible adult and, if necessary, the Trust clinician before diagnosing the suspect. The FME may over ride the advice of the Responsible adult/Trust clinician, but must fully record their ground for going against the advice of specialist advisor with an in depth knowledge of the patient.

In the event a suspect needs to be arrested and physically removed as a matter of urgency (for example due to the serious nature of the allegation and/or risks to other patients/staff) the procedures above will apply, but the arrest and transfer of the suspect should not be delayed pending availability of the clinician's declaration and/or Responsible Adult, which will be sent directly to the police station ASAP by the Trust. In such circumstances, unless the arrival of the declaration/Responsible Adult is imminent, an FME should be contacted to make an initial assessment of fitness to detain/fitness to interview.

### **Inpatient – voluntary patient**

(Applicable to persons staying in a psychiatric facility on a voluntary basis)

Such patients differ from those detained under the Mental Health Act in that they are free to leave Trust premises and are not already in lawful detention. There is a presumption that, if the person has not required detention under the act, he/she will be (mentally) fit for detention and interview by the police.

Procedures for dealing with voluntary patients are, however, identical to those for MHA detained patients with the sole exception that the Trust will not provide a responsible adult to accompany the suspect should arrest be necessary.

Provided the appropriate declaration has been supplied by a Trust clinician, further reference to an FME on arrival at the police station is unnecessary other than in circumstances outlined above.

In all cases involving a MH inpatient, use should be made of an Appropriate Adult

### **MH Service User – Outpatient**

(Applicable to persons receiving mental health treatment but not staying in a psychiatric facility)

As with voluntary inpatients (above) there is a presumption that such persons have the mental capacity for interview and are fit for detention.

If an arrest is planned and the suspect is known or believed to be a mental health service user and the suspects clinician and/or place of treatment is known it is best practice for the OIC to liaise with the Trust prior to arrest in order to determine any known requirements and risks.

If an arrest is necessary and the suspect is known or believed to be a service user then an HCP (doctor or qualified nurse) should be requested to assess fitness for detention / interview. This is irrespective of the presumption of capacity/fitness irrespective of the presumption of capacity and acts as a safeguard to both suspect and police in event of deterioration of the suspect's condition since last seen by Trust personnel. The HCP's diagnosis should be made in consultation with Trust personnel, who will advise on their understanding of the capacities and competencies of the suspect. Being a MH service user does not preclude a person from being fit for interview/detention per se. There should be a presumption that a (none-MHA detained) suspect is both fit for detention and interview unless there are specific grounds for believing otherwise.

The fact that a person arrested for an offence may, at that time, be unfit for interview/detention and/or require detention under the MHA, does not mean that they will not be fit for interview etc. at a later date. In many cases a MHA detention and/or temporary unfitness will not preclude interview/investigation at a later date. Criminal investigations should not automatically be dropped simply because a person is detained under the MHA. Advice of a Trust clinician should be obtained as to the medium to long-term fitness of the suspect

The HCP, in consultation with a Trust clinician, should advise on the need (or otherwise) for an Appropriate Adult.

### **None (MH) Service Users**

(Applicable to persons not currently known psychiatric services or receiving treatment in respect of a mental disorder, but whom the police believe may have a mental disorder). In the event a person is arrested for an offence, and is believed or suspected to be suffering from mental illness or have mental health issues, an HCP must be called to assess his/her (mental) fitness to detain/interview. The principles outlined above apply in respect of presumption of capacity/fitness, appropriate adults and suspension of investigations.

See [The role of Nottinghamshire Community Forensic Teams in Custody Suites](#) for guidance of the role of such teams in advising on diversion opportunities and options for some offenders with Mental Ill Health.

## **CPS Liaison**

In any case where the charging of a person known or believed to be subject of a mental ill health or learning disorder is being considered the matter must be referred to CPS. The CPS will require evidence of the suspect's mental capacity at the time of the alleged offence, at the time of interview, and fitness for prosecution.

The CPS must also be made aware of any victim or witness believed to have mental ill health or learning difficulties

## **Public interest issues**

When a person experiencing a mental disorder commits an offence, it is sometimes presumed that the offence is linked to the mental disorder. This is often not the case and the mentally disordered offender may then proceed through the Criminal Justice System. It is no more helpful or fair for persons with mental ill health or learning difficulty to be 'labelled' as unfit to prosecute than it is to assume they are not fit or competent to access the criminal justice system as victims or witnesses.

Advice can be sought from Mental Health Services in the decision making process around prosecution and of potential disposal options. Mental Health Services will support a Mentally Disordered Offender (MDO) through the Criminal Justice process. Continuation of due process can be helpful in issues of personal responsibility for the MDO, and there are ethical reasons for MDO's having access to the right to justice in a court.

Under certain circumstances it may be necessary to prosecute an offender to allow Mental Health Treatment orders and/or other statutory support.

## APPENDIX

### A) GLOSSARY OF ACRONYMS

<b>ACPO</b>	Association of Chief Police Officers
<b>AMHP</b>	Approved Mental Health Professional
<b>ASW</b>	Approved Social Worker
<b>BME</b>	Black and Minority Ethnic Group
<b>CAMHS</b>	Child and Adolescent Mental Health Services
<b>CPS</b>	Crown Prosecution Service
<b>DSPD</b>	Dangerous and Severe Personality Disorder
<b>FME</b>	Forensic Medical Examiner
<b>HCP</b>	Health Care Professional
<b>IPPC</b>	Independent Police Complaints Commission
<b>MDO</b>	Mentally Disordered Offender
<b>MHTR</b>	Mental Health Treatment Required
<b>NHS</b>	National Health Service
<b>NPIA</b>	National Police Improvement Agency
<b>PACE</b>	Police and Criminal Evidence Act
<b>PCT</b>	Primary Care Trust
<b>PER</b>	Prisoner Escort Record
<b>PSA</b>	Public Service Agreement
<b>SMI</b>	Severe and Enduring Mental Illness

### B) COPY OF S136 FORM

A copy of the S136 MHA monitoring form **must** be completed by the **arresting officer** in all cases where a person has been detained under S136 MHA and taken to police custody suite as a place of safety. The completed S136 MHA monitoring form **must** be left with the custody sergeant at the custody suite, the custody sergeant will retain the monitoring form for distribution to HQ CJ Policy & Mental Health Liaison on a monthly basis.

NB: If the patient is transferred to a mental health unit before the assessment has been conducted it is important that the S136 MHA monitoring form is left with the custody sergeant at the custody suite and a copy taken for transfer with the patient to the relevant mental health unit.

**Section 136 MHA Communication & Monitoring Information**

**Form 1 Completed by police (for police, patient notes & monitoring)**

Station code  
 Custody number (if applicable)  
 Police reference number

Please fill in the required sections and, where there is a text box (  ), put a Y (yes) or N (no) in the box.

Person detained – Surname:		Forename(s):	
Address:			
Place of birth:	Date of birth:		(DD/MM/YYYY)
Gender:	ID code:	Self-defined ethnicity code:	
PNC & local check done? Yes <input type="checkbox"/> No <input type="checkbox"/>		PNC outcome:	
Date of detention:	(DD/MM/YYYY)	Time of detention:	(xx:xx hrs)
Place of detention:			
Since detention, has the person received any medical attention prior to arrival at a place of safety?			
Yes <input type="checkbox"/> No <input type="checkbox"/> If 'Yes', please describe <input type="text"/>			
Risk factors the place of safety or assessment staff should be aware of? (Consider self-harm, suicide, physical aggression, impaired judgment, self-neglect, absconding, etc)			
Has the person been restrained? Yes <input type="checkbox"/> No <input type="checkbox"/>		If 'Yes', how and for how long? <input type="text"/>	
Is the person suffering from the effects of drink or illicit drugs? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>			
Initial Place of Safety used: S136 suite <input type="checkbox"/> emergency department <input type="checkbox"/> police station <input type="checkbox"/>			
other (describe) <input type="text"/>			
If not S136 suite, explain: no S136 suite locally <input type="checkbox"/> S136 suite full <input type="checkbox"/> physically unwell <input type="checkbox"/>			
too disturbed <input type="checkbox"/> other (state) <input type="text"/>			
Ambulance requested at:	Date:	(DD/MM/YYYY)	Time: (xx:xx hrs)
Conveyance to Place of Safety: ambulance <input type="checkbox"/> police vehicle <input type="checkbox"/> other (describe) <input type="text"/>			
If not ambulance vehicle, explain: person too disturbed <input type="checkbox"/> patient too distressed <input type="checkbox"/>			
would take too long <input type="checkbox"/> other (describe) <input type="text"/>			
Arrival at Place of Safety:	Date:	(DD/MM/YYYY)	Time: (xx:xx hrs)
Has the person been searched? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Time of departure (police):	(xx:xx hrs)	Received by:	<input type="text"/>
Officer reporting (signature):	<input type="text"/>	Wt. no.:	<input type="text"/>

**Section 136 MHA Communication and Monitoring Information**

**Form 2 For patient notes & monitoring**

<b>Person detained – Surname:</b>				<b>Forename(s):</b>			
<b>Rights leaflet was given and rights read at:</b>		<b>Date:</b>	(DD/MM/YYYY)		<b>Time:</b>	(xx:xx hrs)	
<b>Professional</b>		<b>Contacted at:</b>			<b>Arrived at:</b>		
		<b>Date (DD/MM/YYYY)</b>	<b>Time hrs</b>	<b>(xx:xx)</b>	<b>Date (DD/MM/YYYY)</b>	<b>Time hrs</b>	<b>(xx:xx)</b>
<b>AMHP</b>							
<b>First Doctor</b>							
<b>Second Doctor</b>							
<b>If there were any delays, please state the reason on the next page.</b>							
<b>Details of relative or friend</b>							
<b>Name:</b>							
<b>Address:</b>							
<b>Tel no.:</b>				<b>Informed? Yes <input type="checkbox"/> No <input type="checkbox"/></b>			
<b>Assessment completed at:</b>		<b>Date:</b>	(DD/MM/YYYY)		<b>Time:</b>	(xx:xx hrs)	
<b>Patient discharged from Place of Safety at:</b>		<b>Date:</b>	(DD/MM/YYYY)		<b>Time:</b>	(xx:xx hrs)	
Was the first doctor approved under Section 12 MHA?    Yes    No							
Is the person on medication?    Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>							
Any Serious Untoward Incident following detention including in place of safety?    Yes <input type="checkbox"/> No <input type="checkbox"/>							
If Yes, please complete one of boxes and give details:							
Minor self harm <input type="checkbox"/> self harm requiring medical attention <input type="checkbox"/> assault <input type="checkbox"/> absconson <input type="checkbox"/>							
Other (please state) <input type="checkbox"/> .....							
<b>Details:</b>							
<b>Transfer from one Place of Safety to another Place of Safety prior to S136 assessment being completed</b>							
Yes <input type="checkbox"/> No <input type="checkbox"/>							
<b>Name of unit:</b>							
<b>Arrival at second place of safety:</b>		<b>Date:</b>	(DD/MM/YYYY)		<b>Time:</b>	(xx:xx hrs)	
<b>Reason for transfer:</b>							
Was there a further transfer?    Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, record above information on back of form.							
<b>Arrangements made after initial assessment</b>							
Was not suffering from mental disorder and was discharged <input type="checkbox"/>							
Was suffering from mental disorder and was discharged but:							
a) no follow up was required <input type="checkbox"/>							
b) follow up was arranged <input type="checkbox"/>							
Was admitted or transferred on an informal basis <input type="checkbox"/>							
or under MHA section 2 <input type="checkbox"/> 3 <input type="checkbox"/> other <input type="checkbox"/> (please state)							
<b>To:</b>	<b>Ward:</b>					<b>Hospital:</b>	
<b>Arrival on ward:</b>		<b>Date:</b>	(DD/MM/YYYY)		<b>Time:</b>	(xx:xx hrs)	
<b>Signed:</b> (person completing form)						<b>Print name:</b>	
<b>Date:</b>		(DD/MM/YYYY)		<b>Time:</b>		(xx:xx hrs)	



**Full list of all police and private witnesses who can provide evidence**

**Witness 1**

Name (Mr, Mrs, Miss, Ms): .....

Address (Business or Private): .....

.....

Tel. No.: ..... Mobile: .....

**Witness 2**

Name (Mr, Mrs, Miss, Ms): .....

Address (Business or Private): .....

.....

Tel. No.: ..... Mobile: .....

**Notes made at scene**

Time notes started: ..... (xx: xx hrs) Time notes completed ..... (xx: xx hrs)

Location notes made: .....

Persons Present: .....

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**GP details**

.....

From front sheet:

Print name: .....

Rank/Div. no.: .....

Station: .....

Supervised by: ..... Rank/Div. no.: .....



**1) Section to be completed by person who detained the person on a S136**

Area of work: Nottinghamshire  Oxfordshire  Redbridge

Was the form easy to use? Yes  No

How long did it take to complete your section of the monitoring form? (In minutes) .....

Did you have any problems with the form? Please give details .....

.....  
.....

Are there any other questions that you think that should be included on the form? Please list suggestions below .....

.....  
.....

How could the form be improved? Please give details .....

.....  
.....

Any other comments

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

**2) Section to be completed by the staff member in the place of safety (duty S136 nurse or custody sergeant)**

Job title of person completing this form .....

Place of safety used on this occasion .....

Was the form easy to use? Yes  No

How long did it take to complete your section of the monitoring form? (in minutes) .....

Did you have any problems with the form? Please give details .....

.....  
.....

Are there any other questions that you think that should be included on the form? Please list suggestions below .....

.....  
.....

How could the form be improved? Please give details .....

.....  
.....

Any other comments

C) RMO STATEMENT

Procedure for communicating with CPS

Agreed version

**WITNESS STATEMENT**

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

Statement of: \_\_\_\_\_

Age if under 18: \_\_\_\_\_ (if over 18 insert 'over 18') Occupation \_\_\_\_\_

This statement (consisting of **one** page signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I am the Responsible Clinician (approved under Section 12(2) of the Mental Health Act 1983) for Patient .....

OR

On(date).....I was the Responsible Clinician (approved under Section 12(2) of the Mental Health Act) for Patient.....

Tick as appropriate

The patient, at the time I make this statement, is fit for interview.

There are no clinical reasons now, nor were there any clinical reasons at the time of the alleged offence, why consideration should not be given to prosecution in this case.

Signature: \_\_\_\_\_ Signature witnessed by: \_\_\_\_\_

## D) THE ROLE OF NOTTINGHAMSHIRE COMMUNITY FORENSIC TEAMS IN CUSTODY SUITES

This NHS Trust Liaison and Diversion service operates in the County only, currently in Mansfield Police Station. The service may expand to cover all police custody suites in County and City, in due course.

The purpose of this service is to screen the profiles of all detainees, to identify those with Mental Health issues and to carry out Mental Health assessments, provide advice to Police and to the Court of appropriate and to signpost and facilitate onward referral and Police/Court disposal.

The service operates in line with Home Office recommendations (Reed 1992) to intervene at the point in the Criminal Justice System closest to arrest, i.e. at Police stations, to divert Mentally Disordered offenders from the Criminal Justice System, into Health and Social Care, or to enable progression through the criminal justice process, with access to Health and Social Care.

Assessments are likely to be carried out on detainees meeting the following criteria (recommended by Reed 1992)

1. Those known to have a history of mental health problems.
2. Those presenting as mentally disordered at arrest or during detention and causing some concern to custody staff and for arresting offices.
3. Detainees expressing ideas of self harm / suicide and/or ideas to harm others.
4. Those having committed serious offences: - Murder, Arson, Grievous Bodily Harm/ S18 wounding etc.
5. Those arrested on suspicion of having committed Sexual Offences.

There is a misperception that the service exists to deal with S136 Adult Mental Health Act which is incorrect. The service can sometimes help with S136 by facilitating/ expediting the process. However on occasions where the Approved Mental Health Practitioner / FME / Psychiatrist are already aware of the case and on their way to the Police Station, the Nottinghamshire County Community Forensic Team will not become involved. This is because to do so can complicate the process and duplicate assessments for the detainee.

The role of the Medacs FME is to determine the detainee's fitness to be detained and interviewed. This is not a role of the mental health staff in the custody suite, although the team may offer an opinion around the necessity for Appropriate Adult presence.

The FME and Medacs nursing staff are not specialists in Mental Health. A Protocol exists between Medacs and the Police whereby the FME is called whenever any health issues are identified.

Medacs are always contacted to attend the suites when a detained person is arrested under the MHA or an assessment is required. However, the Community Forensic Team staff who work in custody suites are specialists in Mental Health and should always be consulted where there is a concern around mental health (exception is S136 MHA) during the teams operational hours.

A Protocol is in existence detailing the operational procedure for the service.

## **SECTION 4 LEGISLATIVE COMPLIANCE**

This document has been drafted to comply with the general and specific duties in the Equality Act 2010; Data Protection Act; Freedom of Information Act; European Convention on Human Rights; Employment Act 2002; Employment Relations Act 1999, and other legislation relevant to policing.