Investigation of Offences

Strategic Intention:

- Ensure the safety, the dignity and the rights of the public are placed at forefront of all WMP decisions on policing and mental health.
- Ensure the effective, proportionate investigation of criminal allegations.
- Ensure that any decision to divert vulnerable suspects away from the criminal justice systems is in the public interest
- Ensure that vulnerable victims and witnesses are supported in raising complaints and / or giving evidence.
- Ensure WMP fulfils its responsibilities under the Equality Act 2010.
- Ensure WMP officers are operating with supported guidance.

It is generally recognised that one area of national police practice which has historically been inconsistent is in the investigation of offences involving vulnerable victims, witness or suspects – and in particular, where this has involved allegations by health or social care staff that they have been assaulted in the course of their work. It has also been observed that discussion within the NHS about whether 'medical factors' affect a recorded assault against NHS staff was also inconsistently applied and sometimes undermined investigations.

The more serious the offence or the risk to the public, the more likely it will be that a prosecution should take place and the less relevant someone's condition will be to that decision. However, any decision not to prosecute someone after an allegation is made is likely to be because a) there is insufficient evidence to prove the offence; OR b) it is not in the public interest to prosecute them having considered the evidence, their mental health and the alternatives available to ensure they get proper health and social support. This approach is governed by national criminal justice policy, inc Home Office Circular 66/90, the Code for Crown Prosecutors and CPS Guidance.

Where allegations of crime are made by or against medical professional or care staff, WMP has a duty to consider *all allegations*, to record crimes in accordance with National Crime Recording Standards and to undertake a *proportionate* investigation. The National Crime Recording Standard (NCRS) states allegations should be recorded regardless of the mental state of those involved. Police officers are trained and have the lawful authority to secure evidence in respect of allegations through a range of techniques and investigative powers. However they will often require cooperation and support from NHS staff to take account of the public interest test as this involves consideration of a patient's circumstances and background, whether they are a victim, a witness or a suspect in the allegation.

Where a vulnerable person is a suspect, it will not be relevant or appropriate to discuss whether or not they "have capacity to commit the offence" or to "know what they are doing". The law presumes that all people over the age of criminal responsibility know what they are doing and will be held to account for their actions. It is for the person themselves to argue the contrary. 'Capacity' is not a concept in criminal law, despite the term's common usage. Investigations focus firstly on whether or not the allegation made would amount to a criminal offence, if proved. Officers need to establish first what evidence exists of the actions alleged. Can officers prove that someone punched a victim, for example (through witness evidence, CCTV, etc.); and then, can we prove they were aware it might hurt or injure; or that they were intending to seriously hurt or injure someone, or were reckless? It may be officers need an informal indication early on about the implications of someone's condition on these matters.

There is no requirement in law for 'capacity statements' in criminal investigations – the Crown Prosecution Service guidance and the Code for Crown Prosecutors do not require it. However, any information or professional opinion about the suspect's mental health and its potential relationship to their behaviour would always help consideration of the relevant legal issues, where available.

Where orders under Part III MHA are necessary, prosecution and the criminal justice is the only route. **Effective communication and cooperation between health and justice agencies is essential** to minimise risk and maximise safety of those involved, including the broader public.

The fact a policing incident may be affected by the mental health of a victim, witness or suspect does not prevent a criminal investigation leading to the arrest, prosecution and conviction of the defendant.

Mental 'capacity' is not a strict concept in criminal law - and we should not refer to those involved in criminal allegations as being someone who "does not have capacity". A prosecution could occur even if a victim is so affected by their condition they are unable to give any evidence at all –

- Recent events (Winterbourne View, Bristol, 2011; Whorlton Hall, Durham, 2018) have shown that the police service can be far too quick to dismiss allegations made by vulnerable people; especially where those allegations are made by patients detained under the Mental Health Act and are allegations against professional staff responsible for their care.

- Equally, the police service has on occasion not been consistent in how it handles allegations of crime made by NHS staff where they have, for example, been assaulted by patients in the course of their work. It is too quickly assumed those patients with serious mental health problems must, by definition 'lack capacity' (see above) and this would not necessarily be true, even if 'capacity' was a concept in criminal law. Even patients detained in hospital under the MHA could, in theory, be prosecuted for offences and taken to court.

  The key point is: all cases turn on their *individual* merits – at least some level of proportionate investigation may be required to establish the precise nature of allegations, the nature of supporting evidence and the context and background to the allegation.

- History also shows that suspects, including those with serious mental health problems are often able to be held responsible for their actions, and criminal offences proved. Even where someone is so unwell that they could put forward an 'insanity' defence or be found unfit to plead in court, it may still be necessary to investigate an incident in order that a formal decision can be made with regard to how the case should progress including seeking advice from the CPS.

RECEIPT OF ALLEGATIONS

In the first instance, the WMP response to any allegation of a crime will be no different to any other allegation of crime –

- Prioritise the call received in the normal way in terms of THRIVE+ assessment.

- Despatch resources in the normal way, especially where urgently required for on-going disorder.

- Officers and staff must record offences in accordance with Home Office counting rules, notwithstanding the mental state of those involved.

- Ensure the necessary steps to preserve reserve evidence and to understand the overall context of the incident and any relevant medical or psychiatric background.

- **Drug seizures:** it is agreed policy that NHS staff dispose of unlawful substances where quantities are consistent with 'personal possession' – officers should be deployed only where quantities involved exceed this level or where patients refuse to surrender the substances.

Regardless of whether the allegation under consideration involves a vulnerable witness (this includes the victim being vulnerable) or a vulnerable suspect: the principles remain the same as for *all* other criminal investigations. Witness evidence is *not automatically unreliable* because someone lives with a mental disorder and in any event, there may be corroboration of any allegation made.

Mental 'capacity' is not a strict concept in criminal law – and therefore all allegations should be considered and take account of the following –

- **Actus reus** – is there available evidence to identify the actus reus of this allegation? Is there some evidence that the suspect punched the victim, damaged that property, steal that item, etc.? If not, there will be no possibility of proving the offence, regardless of anything else, including someone's mental state.
- **Mens rea** – the 'mental' element of any offence will be of particular concern regarding a vulnerable suspect. Mens rea can be established by various means (intent, recklessness and omission) and taking account of other considerations (eg, subjective or objective recklessness; basic, simple or specific intent, etc.). For example, can you prove that when that suspect punched that victim they were aware it might hurt or injure? Can you prove they were trying to seriously injure someone, or objectively reckless about whether damage would be caused?
- **Public Interest** – this is the most relevant point to consider serious mental ill health because even if someone is so ill that they lacked all insight in to their actions, it may STILL be appropriate to prosecute them. Conversely, even if you can prove that a seriously unwell person stole food from a shop whilst sleeping rough, in crisis, this does not mean you must prosecute them. The offence, its context and the health of the suspect should be considered including alternatives to prosecution and an appropriate outcome identified.

Only the criminal courts in the England & Wales have the authority to impose certain orders under the Mental Health Act 1983 and only they can request full psychiatric reports in consideration of appropriate criminal justice outcomes. It therefore follows that where an offence or its background is more serious, prosecution may be more likely in the public interest to allow the courts to fully understand matters which may not be available to the police. For lower level offences or offending where the evidence would not be admissible in court, diversion from justice can and should occur after consultation with Liaison and Diversion professionals in custody, where appropriate.

As a general rule: the more serious the offence or the risk to the public, the more likely it will be that prosecution is required and the less relevant someone's condition will be to this decisions. But any decision not to prosecute someone after an allegation will usually be because a) there is insufficient evidence to prove the offence; OR b) it is not in the public interest to prosecute them having considered the evidence, their mental health and the alternatives available to ensure they get proper health and social support.

See the Offer on Inpatient Units

Also see *the Code for Crown Prosecutors* (2018) and the CPS *Guidance on the Prosecution of Mentally Disordered Offenders* (under review, forthcoming autumn 2019).

The majority of individuals whose custody detention is affected by their mental health will not be so acutely ill as to require admission to hospital or detention under the Mental Health Act 1983. There is no legal reason why someone with a mental illness, including a serious mental illness that would justify their detention in hospital under the MHA, cannot be prosecuted if the circumstances justify it. Typically, the more serious the offence someone is alleged to have committed, the more necessary it may be in the public interest to investigate and prosecute them. This is, of course, always subject to their fitness for detention and the evidential tests being satisfied.

- The law presumes that everyone is capable of being held criminally responsible for their actions.
- **Mental 'capacity' is not a strict concept in criminal law** – in the context of criminal law it is an informal, imprecise term only. The questions for all investigations, including whilst someone is detained under arrest is whether investigating officers can prove the *actus reus* of the offence and the *mens rea*.
- **Mental illness is no automatic barrier to proving *mens rea*** – the *mens rea* for assault is whether we can prove the accused person was aware their punch may hurt or injure the person; or whether they intended to seriously hurt or injure, or were reckless. Intent is not the only form of *mens rea*: criminal damage may involve consideration of recklessness, for example.
- Only criminal courts can order psychiatric reports on someone's mental health and its relationship to the offence alleged; only the criminal courts can impose certain orders under (Part III) MHA to ensure the patient's right to treatment and care is balanced against the need for public protection during detention and after discharge from hospital.
- **There is no authority under PACE to detain someone for the purposes of a MHA assessment; OR to detain someone pending the identification of an inpatient hospital for admission.**

LIAISON AND DIVERSION

It is more often the challenge during investigations to weigh the public interest test than to address the evidential test because it would be very rare for a psychiatric patient to have absolutely no insight in to the actions during an offence. The *Code for Crown Prosecutors* (2018) and the CPS Guidelines on the Investigation and Prosecution of Mentally Disordered Offenders both stress the importance of considering a suspect's mental health and obtaining relevant background information. In custody, Liaison and Diversion services are available to share relevant information.

USE OF SECTION 136 IN CUSTODY

If someone arrested for offence is mentally unwell and in need of MHA assessment or admission to hospital, their detention is governed by PACE unless they are 'sectioned' after an MHA application **has been made**. The person must be released (NFA / bail / RPI) if grounds for PACE detention cease to apply unless an applications has been made. There is no authority to detain someone for the purpose of MHA assessment or admission. If release from custody poses a risk to safety, officers should consider using s136 for removal to a Place of Safety and completion of MHA processes. Consultation with a healthcare professional should occur prior to this decision, where practicable.