	PART TWO **Operational Guidance – Available at** http://www.nwssp.wales.nhs.uk/page/97264	
12	Incident reporting	
13	Police Response	
14	Investigation	
15	Decision on Prosecution	
16	Out of court disposals	
17	Updates to NHS Case Manager on progress	
18	Victim/witness support	
19	Data Protection & confidentiality issues	
20	Information Sharing	
21	Management and Development of this agreement	

PART TWO **OPERATIONAL GUIDANCE**

12. INCIDENT REPORTING

The NHS Case Manager, Health and Safety team and Managers will aim to ensure that all incidents involving violence and aggression against NHS Staff are investigated promptly and reported to the Police where appropriate.

Internal incident reporting via Datix must be promoted.

This is fundamental to the success of the agreement; although practical difficulties will arise, staff should be encouraged, supported and empowered to report these incidents.

NHS staff can always report violent and aggressive crime to the Police using 999 (urgent) and 101 (non urgent) or 'online reporting'.

NHS bodies, via the Case Manager, are obliged to report to the Police all incidents of physical assault against staff An exception is where the offending behaviour is caused directly by a person's physical or mental health condition, or learning disability, or an adverse reaction to prescribed medication or treatment.

The Case Managers should ensure that there are instructions for staff as to when staff should seek an emergency response from the Police, and when non-emergency reporting will be appropriate. The NHS recognises that whether or not behaviour is referred to the Police, there is an obligation to report internally.

Staff should be encouraged to report using the Datix system and all incidents of violent conduct by patients. A proforma for multiple incidents by the same

perpetrator is contained at **Appendix (F)**

All Datix forms involving violence upon staff should be reviewed by the Health Board in order to inform improvement in risk management initiatives and to reassure staff that reports are reviewed and considered worthwhile to complete.

Staff need to believe that reporting has a real purpose.

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

All cases should be reported to the Police except where, having consulted with relevant staff and obtained clinical advice, it has been concluded that the assault was not intentional and was secondary to a clinically recognised condition. Outline reports may be submitted for accurate crime recording purposes.

The response should also take into account information obtained about whether the perpetrator had a medical condition relevant to the concept of criminal intent of the alleged offender.

13. POLICE RESPONSES

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

The Case Manager or nominated appropriate person will try to ensure that, where there is an assault upon a member of NHS staff, the Police are able to take a victim's complaint statement within 24 hours. The staff member will also be encouraged to make a Victim Personal Statement (VPS) to indicate, if appropriate, the impact on them and their colleagues.

The Police Investigating Officer or S.P.O.C in the sector or hub will notify the Case Manager and / or the victim of the progress and outcome of their investigation. Once a charge has been made the witness care unit will take over this role

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

INVESTIGATING CRIMES WHERE A SUSPECT HAS A CLINICAL CONDITION RELEVANT TO THE CONCEPT OF CRIMINAL INTENT

The legal issues before the police as investigating officers are, firstly, to determine whether there is evidence of an offence and then, to determine whether or not it is in the public interest to prosecute. This is known as 'the evidential test' (evidence to charge) and 'the public interest test' (whether a prosecution should be brought).

Mental "capacity", strictly speaking, is not a relevant legal issue in criminal law and where it is necessary in the public interest to do so, any offender who 'lacks capacity' can still be prosecuted in order to ensure criminal courts can consider whether orders to protect the public are necessary, whether the defendant has been convicted, found unfit to plead or found insane. Equally, the fact that an offender 'has capacity' is not, of itself, sufficient to demand a prosecution. The mental state of an accused patient is just one thing to consider and any decision-making process which over-focuses on so-called 'capacity' is prone to reach inappropriate conclusions which prevent the prosecution of serious, dangerous offenders or which over-prosecute vulnerable people whose needs should be addressed by diversion from justice.

The starting point for all criminal investigations is a neutral one.

Police officers must determine whether or not they can prove –

- the *actus reus* of the alleged offence
- the *mens rea*, associated with that offence.

Actus reus is the 'act done' – whether someone punched a victim, whether they kicked a window, breaking it, etc..

Mens rea is not the same thing as 'capacity' and each case turns on its merits. Offences may involve the need to prove intent, recklessness or omission, amongst other things – there are various kinds of intent and recklessness in law. Careful consideration needs to be given by investigators to what, in fact, must be proved in order to substantiate any particular allegation and all involved must consider how clinical information or opinion from NHS staff may help determine whether thresholds are met to give sufficient evidence to charge. It may be necessary in each area to establish an information sharing mechanism for the exchange of this information in accordance with the General Data Protection Regulation 2017.

The public interest test for any prosecution only becomes relevant once it is determined that there is evidence to charge someone with an offence. The Code for Crown Prosecutors outlines how police investigators and prosecutors should approach this question and the beginning point is that there is no presumption either way on whether or not someone should be brought before a court. As part of considering the response to a particular offence, consideration should also be given to the appropriateness of out-of-court disposals, such as fixed penalty tickets, cautions or conditional cautions, as well as other approaches such as restorative justice. Guidelines on the prosecution of mentally disordered offenders is also available on the CPS website.

Public policy on the prosecution of mentally disordered offenders, contained in Home Office circular 66/1990 is, in summary: the more serious an offence committed and the greater risk that accused person poses to public safety, the less relevant their illness is to a **police** or **CPS** decision to prosecute. Serious crimes, regardless of mental state, may still require the consideration of a court even if it is thought possible or likely that a defendant's mental state may preclude a conviction. This could be because of the need for a full psychiatric report to influence a legal hearing which seeks to determine issues such as fitness to plead or for juries to consider as part of a trial any defence or partial defence put forward, such as insanity or diminished responsibility.

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

An example of a form for providing information relating to people with mental disorder and/or learning disability is provided in **Annex G.** Such forms may be disclosed to the defence as part of the disclosure of unused material process.

Such forms are intended to inform initial decisions on investigations/charging/

diversion.

Indications about whether a patient had acted with criminal intent can be taken from registered nurses as well as or in conjunction with doctors.

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

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

The NHS undertake to collate, review and analyse the body of incident reports relating to violence against staff in order to prevent violence occurring in the first instance. #EmpowermentThroughPrevention

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

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

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

The College of Policing Authorised Professional Practice (APP) provides 'Suspects with mental ill health and vulnerabilities,' and states that Investigating Officers should recognise that the law presumes all suspects ***to be legally accountable for their actions unless the contrary is proved in Court'*** (e.g. arrest, detention, legal rights and interviewing are the same whether or not a suspect has mental health or learning disabilities). Appropriate assessment and support will be provided by Police.

The Police should respond and investigate in the same way as they would had the incident taken place elsewhere.

Arrests on NHS premises
The decision to arrest is a matter for the Police officers in attendance. It will be informed by any medical considerations and NHS staff should be prepared to disclose this information upon request. This will include any known risks that an arrested person may pose to the Police, and must disclose any information relating to the person's health that the Police may require in order to discharge their duty of care to those involved. It is the responsibility of the NHS to ensure that staff are aware of their responsibilities and the policy framework regarding the disclosure of information. Section 14 of this MoU provides guidance in this respect.

The Case Manager should give the appropriate support to the Police during investigations in an NHS healthcare setting.

If an investigation requires the seizure of NHS property or the need to restrict the non-use of an area of NHS premises, liaison must take place between the NHS Lead Director for violence and aggression and the investigating officer to ensure that evidence is protected and preserved wherever possible.

Training in this area is proposed for Case Managers.

If incidents occur out of hours, the Security Management Director/Case Manager should ensure that appropriate staff have been nominated to decide on these

matters and that all such persons are made aware of each other's responsibilities.

As an example

NB – Senior Nurse Practitioners who are on call.

14. INVESTIGATION

NHS assistance for investigations

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

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

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

The Case Manager will assist the Police by providing details of work patterns and work contact details of witnesses.

Training in appropriately obtaining this information will be provided to Case Managers.

Witness statements and evidence gathering

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

Victim Personal Statement

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

Service Impact Statements

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

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

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

A Director or CEO will sign the service impact statement. An example of a service impact statement is provided at **Annex (H)**

Bail conditions

When investigating incidents on NHS premises, the Police will ascertain whether there is any information to suggest that a suspect may pose an ongoing threat to NHS staff or services. In such cases, consideration should be given to imposing bail conditions.

It is important that all parties are made aware of any bail conditions; See **Annex I** for suggested bail conditions to prevent inappropriate or unnecessary attendance on NHS premises during an investigation.

15. DECISION ON PROSECUTION

The parties agree that the Police will undertake to investigate and refer cases involving violence and aggression towards NHS staff or violent incidents that take place in NHS environments to the CPS, where there is sufficient evidence to support a criminal prosecution.

It is important that, when dealing with cases involving NHS staff, premises or property, officers have regard to any particular aggravating factors such as hate crime.

Legitimate Alternatives to Prosecution – Restorative Justice
It is important that the NHS make staff aware that the Police have a range of measures available to them other than traditional prosecution, these are set out in Part 3 Annex (M)

Decision to prosecute

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

Full Code Test
The full code test has two stages; (i) the evidential stage; followed by (ii) the public interest stage.
The Full Code Test should be applied:
a) when all outstanding reasonable lines of inquiry have been pursued; or
b) prior to the investigation being completed, if the prosecutor is satisfied that any further evidence or material is unlikely to affect the application of the Full Code Test, whether in favour of or against a prosecution.

In most cases prosecutors should only consider whether a prosecution is in the public interest after considering whether there is sufficient evidence to prosecute. However, there will be cases where it is clear, prior to reviewing all the evidence, that the public interest does not require a prosecution. In these instances, prosecutors may decide that the case should not proceed further.

Prosecutors should only take such a decision when they are satisfied that the broad extent of the criminality has been determined and that they are able to make a fully informed assessment of the public interest. If prosecutors do not have sufficient information to take such a decision, the investigation should continue and a decision taken later in accordance with the Full Code Test set out in this section.

The Evidential Stage

Prosecutors must be satisfied that there is sufficient evidence to provide a realistic prospect of conviction against each suspect on each charge*. They must consider what the defence case may be, and how it is likely to affect the prospects of conviction. A case which does not pass the evidential stage must not proceed, no matter how serious or sensitive it may be.

The finding that there is a realistic prospect of conviction is based on the prosecutor's objective assessment of the evidence, including the impact of any defence and any other information that the suspect has put forward or on which they might rely. It means that an objective, impartial and reasonable jury or bench of magistrates or judge hearing a case alone, properly directed and acting in accordance with the law, is more likely than not to convict the defendant of the charge alleged. This is a different test from the one that the criminal courts themselves must apply. A court may only convict if it is sure that the defendant is guilty.

The Public Interest Stage

In every case where there is sufficient evidence to justify a prosecution or to offer an out-of-court disposal, prosecutors must go on to consider whether a prosecution is required in the public interest.

It has never been the rule that a prosecution will automatically take place once the evidential stage is met. A prosecution will usually take place unless the prosecutor is satisfied that there are public interest factors tending against prosecution which outweigh those tending in favour. In some cases the prosecutor may be satisfied that the public interest can be properly served by offering the offender the opportunity to have the matter dealt with by an out-of-court disposal rather than bringing a prosecution.

When deciding the public interest, prosecutors should consider each of the questions set out in paragraphs 4.14 a) to g) of the Code for Crown Prosecutors so as to identify and determine the relevant public interest factors tending for and against prosecution. These factors, together with any public interest factors set out in relevant guidance or policy issued by the DPP, should enable prosecutors to form an overall assessment of the public interest.

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[3] The parties are aware of the changing responsibilities for charging as set out in The Director of Public Prosecutions (DPP)"s Guidance on Charging 5th Edition (Revised Arrangements) (May 2013)

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

The Code for Crown Prosecutors is provided in Part 3 Annex (F)

Aggravating factors in offences involving NHS staff or on NHS premises

The fact that an offence has been committed against a person serving the public will be considered an aggravating factor. There is a strong public interest in maintaining the effective provision of healthcare services.

Examples of particular aggravating factors would include:

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

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

- there are grounds for believing that the offence is likely to be continued , repeated or escalated – for example, by a history of recurring conduct;
- the offence was motivated by any form of prejudice against the victim's actual or presumed ethnic or national origin, gender, disability, age, religion or belief, sexual orientation or gender identity; or if the suspect targeted or exploited the victim, or demonstrated hostility towards the victim, based on any of those characteristics; and
- The greater the impact of the offending on the community, the more likely it is that a prosecution is required. In considering this question, prosecutors should have regard to how community is an inclusive term and is not restricted to communities defined by location.

In this context, 'community' should for example also be taken to mean the staff and patients of a hospital.

[4] Paragraph 4.14.of the Revised Code for Crown Prosecutors (October 2018) provides detail s of the questions to be asked by Crown Prosecutors in considering the public interest

Prosecution of people with mental disorder and/or learning disability

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

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

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

Mental disorder and/or learning disability is not an automatic bar to prosecution. It should be emphasised that a diagnosis of mental disorder and/or learning disability, or the fact that a suspect is detained under the Mental Health Act, does not mean that the person lacks *mens rea* – the necessary intention to commit a crime - or that the Full Code Test may not be met. Each case must be considered on its merits, taking into account all available information about any mental health problem, and its relevance to the offence, in addition to the principles set out in the Code for Crown Prosecutors. The Code explains that there is a balance to be struck between the public interest in diverting a defendant with significant mental illness from the criminal justice system and other public interest factors in favour of prosecution including the need to safeguard the public.

The Code for Crown Prosecutors provides important guidance when applying the public interest test in cases involving a mentally disordered offender. It states that, "Prosecutors should also have regard when considering culpability as to whether the suspect is, or was at the time of the offence, suffering from any significant mental or physical ill health as in some circumstances this may mean that it is less likely that a prosecution is required. However, prosecutors will also need to consider how serious the offence was, whether it is likely to be repeated and the need to safeguard the public or those providing care to such persons.

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

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

provides an opportunity for justice for the accused offender, including testing of the allegation and culpability for the actions constituting the alleged offence'.

When there is a question about an alleged offender's criminal intent, prosecutors should seek reliable information to enable them to make an informed decision. A recent report from a psychiatrist, community psychiatric nurse or social worker may provide sufficient information about the offender's mental disorder to allow the prosecutor to decide whether a prosecution is in the public interest.

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

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

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

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

- medical reports from the appropriate clinician or responsible medical officers to explain the nature and degree of the disorder/disability and the treatment and behaviour of the patient;
- any other relevant information from other hospital staff about the treatment and behaviour of the patient, including the treatment regime, history of similar and recent violent or otherwise offending behaviour;
- information about an offender's status in hospital – whether voluntary or detained under section 2 or section 3 (civil procedures) or under section 37 (Court Hospital Order) and whether there is a restriction order under section 41 attached to the section 37 order, or whether s37/41 orders should be sought;
- if the Police or Social Services have used their powers under sections 135 or 136 Mental Health Act 2007;
- if the defendant is receiving supervised community treatment under a Community Treatment Order made under section 17A Mental Health Act 2007;
- if the offender has been admitted to hospital as an informal patient under section 131 Mental Health Act 2007 or if an order for guardianship under section 7 Mental Health Act 2007 has been made;
- evidence from a suitably qualified clinician about the offender's state of mind at the time of the incident, including whether the patient knew what he or she was doing, whether the patient knew that what he or she was doing was wrong and, if not, whether the lack of knowledge was attributable to his or her disorder/disability and/or any medication or other treatment for his or her disorder/disability; and
- evidence regarding the person's fitness to plead.

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

Information about the offender may come from a variety of sources and not just from the police. Information from some sources such as a relative, friend or gaoler may give rise to concerns that should prompt further investigation. In many cases involving mentally disordered persons, there may be an urgent need for medical reports and other information to clarify the nature and degree of the mental disorder. These requests should be treated as a priority by the NHS.

When the Police or CPS do not prosecute

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

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

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

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

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

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

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

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

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

Compensation

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

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

Injunction to Prevent Nuisance and Annoyance (IPNA)
Criminal Behaviour Orders (CBOs)

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

The CBO is available on conviction for any criminal offence in any criminal court. The order is aimed at tackling the most serious and persistent offenders where their behaviour has brought them before a criminal court.

CBOs include prohibitions to stop the anti-social behaviour, and may also include requirements to address the underlying causes of the offender's behaviour.

The court may make a CBO against an offender only on the application of the prosecution. For a CBO to be made:

•The court must be satisfied, beyond reasonable doubt, that the offender has engaged in behaviour that caused, or was likely to cause, harassment, alarm or distress to any person; and

•That the court considers making the order will help in preventing the offender from engaging in such behaviour.

An application for an order on conviction may be supported by:

•The facts of the offence for which the defendant has just been convicted;

•The facts of the defendant's previous convictions; and

•The facts of other behaviour (causing harassment, alarm or distress) by the defendant which did not lead to a conviction.

The court may consider evidence led by the prosecution and evidence led by the

offender. It does not matter whether the evidence would have been admissible in the proceedings in which the offender was convicted.

The standard of proof to show that the offender has engaged in behaviour that caused or was likely to cause harassment, alarm or distress, is to the criminal standard.

IPNAs are not suitable as disposals for violent behaviour.

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

- the individual has acted or threatened to act in an anti-social manner.
- an order is necessary to protect members of NHS staff or the wider public.
- The injunction is a just and convenient mechanism for preventing the person behaving in this manner in the future

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

It is noted that the Case Manager should take the lead in pursuing such injunctions and orders.

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

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

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

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

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

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

Breaches and modifying conditions of CBOs

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

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

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

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

Other orders available to restrict and protect

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

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

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

Protection from Harassment Act 1997
Section 5 Restraining Order

These orders are now available in appropriate cases upon conviction for any offence. The guiding principle is that there must be a need for the order to protect a person or persons from harassment, stalking or conduct that will put them in fear of violence. Restraining orders are therefore likely to be appropriate in cases where the defendant and the victim are known to each other and where there is a continuing risk to the victim of harassment or violence after the date of conviction.

A restraining order made under section 5 or 5A of the PHA 1997 may have effect for a specified period or until further order. Details of the conditions of any community order or restraining order should be provided to the Case Manager in order that relevant staff can be notified and so assist in identifying any breaches. Any proceedings resulting from breaches or variation/discharge of such orders should also be relayed to the Case Manager.

16. OUT OF COURT DISPOSALS

Section 7 of The Code for Crown Prosecutors directs that an out-of-court disposal may take the place of a prosecution in Court if it is an appropriate response to the offender and/or the seriousness and consequences of the offending. It is recognised that the decision to use an out of court disposal is ultimately an operational decision for the Police to take (for some disposals it is the CPS) .

Simple cautions and conditional cautions
A simple caution (once known as a formal or police caution) is a formal warning that may be given by the police to persons aged 18 or over who admit to committing an offence.

The simple caution scheme is designed to provide a means of dealing with low-level, mainly first-time, offending without a prosecution. A simple caution should not be given for any violent offence other than in exceptional circumstances.

Offenders should not be considered eligible for a simple caution at the scene of the incident.

A simple caution should not be given for any violent offence other than in exceptional circumstances.

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

Conditional cautions should be considered where there might be a need to prevent further contact with a victim or attendance on NHS premises. Conditional cautions with a financial condition (i.e. compensation or a financial penalty[5]) may also be suitable for cases where imprisonment or a community sentence may not be available. Advice on suitable conditions that would achieve this purpose, while still allowing access to essential healthcare, can be provided by the Case Manager.

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

Penalty notice for disorder

A Penalty Notice for Disorder (PND) is a statutory disposal introduced by the Criminal Justice and Police Act 2001 (sections 1-11). A PND is a type of fixed penalty notice for a specified range of low level offences and attract penalties of £60 and £90 respectively. Where the PND is paid in full that discharges any liability to be convicted of the penalty offence. Normally a penalty notice disorder should not be issued if NHS staff have been assaulted or threatened with violence.

Out of court disposals for offenders with mental disorder and/or learning disability When considering the public interest in relation to disposal of a case, the question of the severity, or otherwise, of the possible sentence may be taken into account. The fact that a sentence of imprisonment or community sentence may not be available to the courts for detained patients should not prevent prosecution.

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

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

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

Views of Victim

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

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

17. UPDATES TO NHS CASE MANAGER ON PROGRESS

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

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

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

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

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

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

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

18. VICTIM/ WITNESS SUPPORT

Victim/witness communication

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

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

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

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

Suggested content for a consent form is at **Annex E (ii)**

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

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

Witness Care Units

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

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

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

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

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

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

Victim care during progress of a case

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

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

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

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

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

Special Measures

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

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

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

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

Compensation on conviction orders

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

Victims should always be asked if they wish to seek compensation.

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

19. DATA PROTECTION AND CONFIDENTIALITY ISSUES

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

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

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

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

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

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

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

- the prevention and detection of crime
- the apprehension and prosecution of offenders
- the early identification of cases which would be suitable for diversion from the criminal justice system
- the assessment of risk to inform action to protect the health and safety of NHS staff, patients, visitors, Police officers and other Police, CPS and court
- staff disclosures in connection with legal proceedings or seeking legal advice[6]

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

20. INFORMATION SHARING

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

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

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

WASPI – The Wales Accord on the Sharing of Personal Information

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

All parties will take a proactive approach to information sharing where they have identified a potential threat to the safety of staff, the public or specific individuals. Formal information sharing agreements are to be encouraged and consideration given to allowing case managers access to Police 'Niche' system.

[6] Section 115 Crime and Disorder Act 1998

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

Timely Receipt of A&E Records for All Assaults

An important component is the Anti-Violence Collaborative (AVC)comprising senior officials from the NHS, CPS and the Police. This group will be responsible for oversight of this MoU including its implementation across Wales.

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

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

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

NO FEES will be charged by the NHS. An agreed format for provision of medical evidence is contained in **Annex (K)**

21. MANAGEMENT & DEVELOPMENT OF THIS AGREEMENT

Dispute Resolution

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

Monitor and Review

The NHS Anti-Violence Collaborative will monitor annually the workings of this agreement with a view to improving the efficiency and effectiveness of local professional working arrangements.

Appendix A

Help for Victims

The victims of assaults covered by this agreement are all NHS Staff and staff similar, but not limited to the illustrations provided as follows;

i. Hospital staff
   - Doctors; Surgeons; Nurses; Midwives; Therapists; Pharmacists; Dieticians; Podiatrists; Dentists; Speech pathologists; Clerks; Porters; Technicians; Managers, Support staff; Domestics; Catering; Maintenance staff (Work & Estates); Security; Volunteers

ii. Ambulance staff
   - Paramedics; Technicians; Patient Transport Service drivers; Call handlers / emergency medical dispatchers, Managers and office workers

iii. Community staff
   - Nurses; Support staff; Therapists; Midwives; Social workers, Managers Receptionists

iv. Primary Care staff
   - General practitioners; Pharmacists; Dentists; Opticians; Support Workers working within those environments

If you are a victim of assault falling under one of these categories then you should be aware of the following information which outlines what you can expect as a result of this agreement:

This is how we try to keep you safe
When NHS staff report incidents involving violence and aggression, we can identify repeated problems and use this information to manage risks and prevent further assaults. This is why it is so important that you report an incident if you are a victim and/or witness of an assault in work. We provide the relevant training to staff that we feel are a risk of being victim to violence and aggression with the aim of better equipping you for such a situation. The people involved in putting this agreement into practice will meet every six months to review its effectiveness and ensure that it is working to keep you safe.

This is what to do if you're a victim and/or witness of an assault in work
You should report the incident as soon as possible using the Datix system and by speaking to your Line Manager and/or Supervisor. There is an obligation on you to report an incident of this nature internally to your employer. If the incident is violent and aggressive and you believe that Police assistance is required then you can also report to the Police by calling 999 (urgent matters) and 101 (non-urgent matters) or using online reporting.

This is what your manager should do to assist you
Once you have reported the incident to your Line Manager, they should ensure that a Datix report has been completed and help you to do this if you haven't already. They should then liaise with the Health Board's Case Manager (**Appendix D** Contains identity and contact for

each Case Manager) and assist where possible in collecting information and evidence of what happened for the Police. They should also refer you to any available support services if you feel that you need talk to someone about what happened.

This is what the Police will do as part of their role
Once an incident has been reported to the Police, they will try to ensure that your statement is taken within 24 hours. Having received an accurate account of what happened they will investigate the incident and then decide what type of disposal would be the most appropriate. The Police will keep the Health Board's Case Manager updated on what they're doing throughout the process. If the Police investigation results in enough evidence to support a criminal prosecution then they will refer the matter to the CPS to proceed.

This is what the CPS will do as part of their role
If the matter is referred to the CPS, they will consider whether to move forward with a criminal prosecution. They will look at the evidence gathered in the Police investigation and decide whether there is enough in existence to prove that the offender could be convicted. If there is, they will then decide whether a criminal prosecution would be in the interest of the wider public. If they believe that it is, they will proceed with the criminal prosecution against the offender. The CPS makes these decisions in accordance with official codes and guidance.

This is why not every case will end up in Court
Sometimes, the CPS may feel that the public interest could be properly served by instead offering the offender the opportunity to have the matter dealt with out of Court. The seriousness and consequences of the crime will be considered when making this decision. The offender will still receive a sanction, but it may be in the form of early intervention or a caution. These alternatives are used as they have been shown to prevent re-offending and may be more appropriate in crimes involving mental health or dependencies. If you are unhappy with this outcome then there may be an investigation into the reasons why the decision was made not to proceed with the case.

This is why not every case will be a Police matter
There are many occasions where an assault at work is carried out by someone who may be suffering from a mental disorder. This is anyone who has 'any disorder or disability of the mind.' If the offender has a mental disorder then this does not automatically mean that there won't be a prosecution, although there is more detailed guidance to be followed. If clinical advice is given which confirms that the assault was not intentional then sometimes the Police will not become involved. However, this should not discourage you from reporting an assault carried out by someone suffering from a mental disorder, especially if the offence is serious enough and is likely to be repeated. If it is felt that intervention by the criminal justice system would protect NHS staff and/or the wider public then the Police and CPS may still pursue a case dependent on its facts.

Can I Request a Review?
Victims have the right to request a review of the decision of the Police not to prosecute and a review may mean that a decision is changed.

Victims also have the right to request a review of CPS decisions not to proceed with a case.

This is the support that is available to you
There are lots of services and organisations that want to help you if you need it. The following are available to you as a staff member of the NHS who has been a victim of crime in work:

- NHS Counselling Services
- NHS Direct Wales' Health, Wellbeing and Support groups
- Occupational Health
- The Ambulance Charity
- Trade Unions

This is how the agreement will support you through the prosecution process

The agreement will support you by appointing a Health Board Case Manager who will monitor the process and can act as a point of contact between you and the Police and CPS. It sets out an obligation on the CPS to speak to you throughout the process to ensure that your views are taken into account and your specific needs addressed.

Annex B

PUBLICITY MATERIALS AND POSTERS

PATIENTS ARE NOT IMMUNE FROM PROSECUTION

Report all incidents of violence towards NHS staff to:

Your Manager /.....

Your NHS V&A Case Manager /.....

The Police / Call 999 for an emergency or 101 for a non emergency

Scan the QR code to find out more

IF YOU ASSAULT A NURSE OR DOCTOR TODAY

WHO WILL TREAT YOUR LOVED ONES TOMORROW?

@NHSantiviolence
#EmpowermentThroughPrevention

Scan the QR code
to find out more

IF YOU SEE A COLLEAGUE BEING ASSAULTED REPORT IT!

@NHSantiviolence
#EmpowermentThroughPrevention

Scan the QR code to find out more

Report all incidents of violence towards NHS staff to:

Your Manager /.....

Your NHS V&A Case Manager /.....

The Police / Call 999 for an emergency or 101 for a non emergency

GIG CYMRU NHS WALES

CPS

IT'S A CRIME.

Scan the QR code to find out more

Report all incidents of violence towards NHS staff to:

Your Manager /.....

Your NHS V&A Case Manager /.....

The Police / Call 999 for an emergency or 101 for a non emergency

GIG CYMRU NHS WALES

CPS

THERE IS SUPPORT AVAILABLE TO ALL NHS EMPLOYEES IF

YOU HAVE BEEN A VICTIM OF VIOLENCE

Report all incidents of violence towards NHS staff to:

Your Manager / .....

Your NHS V&A Case Manager / .....

The Police / Call 999 for an emergency or 101 for a non emergency

Scan the QR code to find out more

IF YOU DON'T REPORT IT,

WHO WILL BE NEXT TO SUFFER VIOLENCE?

Scan the QR code to find out more

@NHSantiviolence
#EmpowermentThroughPrevention

WE NEED TO DETER ABUSIVE PATIENTS AND MAKE THEM TAKE RESPONSIBILITY FOR THEIR ACTIONS

Scan the QR code to find out more

Report all incidents of violence towards NHS staff to:

Your Manager /.....

Your NHS V&A Case Manager /.....

The Police / Call 999 for an emergency or 101 for a non emergency

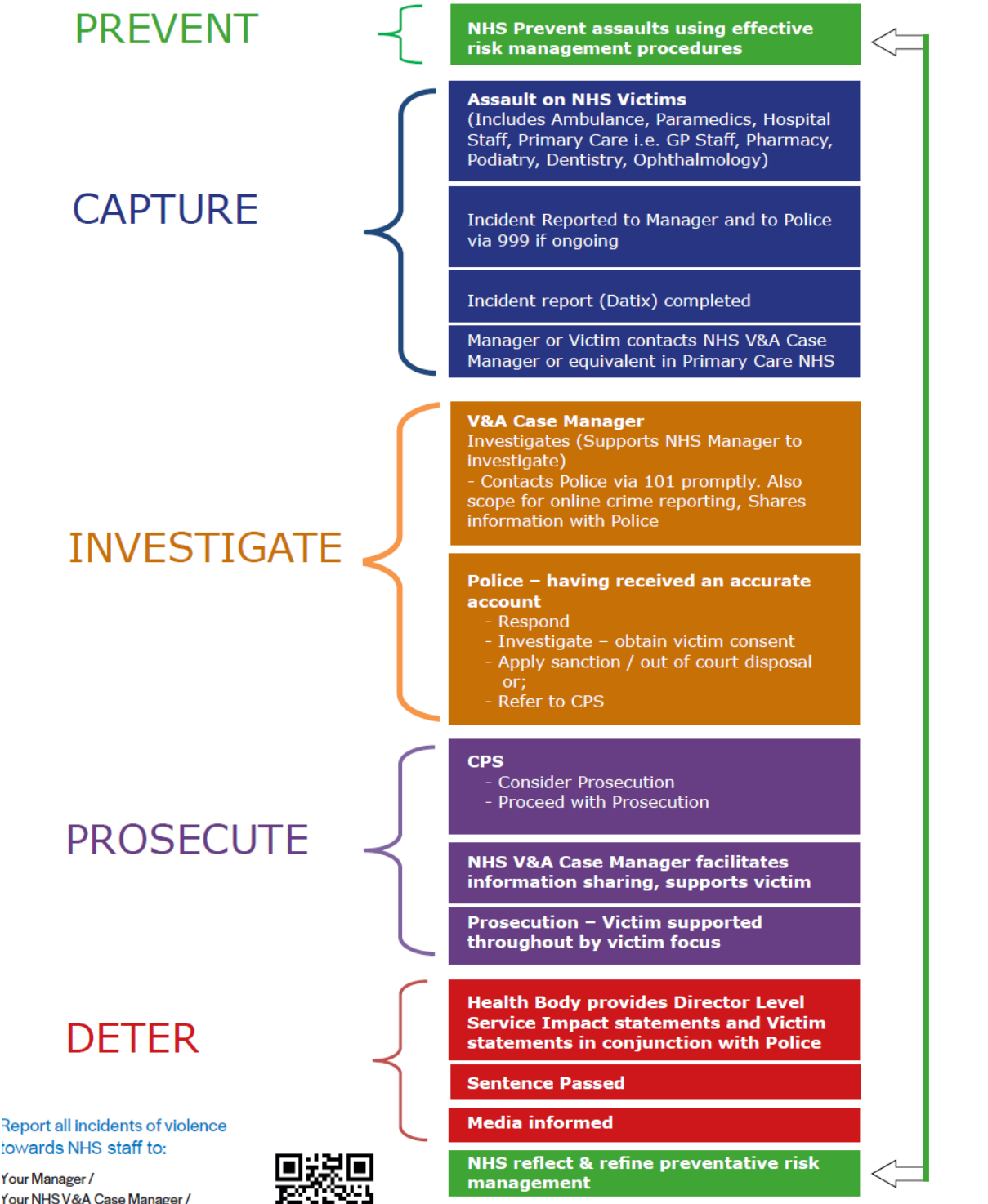
GIG CYMRU NHS WALES

CPS

OBLIGATORY RESPONSES TO VIOLENCE IN HEALTHCARE

Simplified Process

@NHSantiviolence #EmpowermentThroughPreventior



Report all incidents of violence towards NHS staff to:

Your Manager /
Your NHS V&A Case Manager /
The Police / Call 999 for an emergency or 101 for a non emergency

Scan the QR code to find out more

"WE ARE HERE TO HELP, NOT TO BE THREATENED"

- Emergency Medical Services Call Taker

Scan the QR code to find out more

Report all incidents of violence towards NHS staff to:

Your Manager /.....

Your NHS V&A Case Manager /.....

The Police / Call 999 for an emergency or 101 for a non emergency

VERBAL ABUSE IS ABUSE DON'T JUST ACCEPT IT REPORT IT

Scan the QR code to find out more

Report all incidents of violence towards NHS staff to:

Your Manager /.....

Your NHS V&A Case Manager /.....

The Police / Call 999 for an emergency or 101 for a non emergency

TAKING CARE OF THOSE THAT CARE

Obligatory Responses to Violence in Healthcare

Signed on 21st November 2018

GIG CYMRU NHS WALES

CPS

Llywodraeth Cymru
Welsh Government

Comisiynydd yr Heddlu a Throseddu
Police and Crime Commissioner

TAKING CARE OF THOSE THAT CARE

NHS Anti-Violence Collaborative
Obligatory Response to Violence in Healthcare Settings
November 2018

WHAT IS IT?

- A signed protocol between the NHS, CPS and Welsh Police Forces
- Previous MOU in existence since 2012 which has been refreshed
- New protocol due to be launched on 21st November 2018 at Llandrindod Wells
- Launch is Welsh Government sponsored / funded and CC Jukes is one of the key speakers
- Two important agreements in one document
- Supports the Assaults on Emergency Workers (Offences) Act 2018
- PSC 'wrap up codes' for all NHS Violence reports for monitoring purposes

WHY DO WE NEED THIS PROTOCOL?

- Assaults are an everyday occurrence for many emergency workers
- Nurses, Paramedics and Medical Staff have no PPE
- Violence is hugely under reported by NHS staff
- Assaults on Emergency Workers (Offences) Act 2018 received Royal Assent on 13th September 2018 and is now Law
- This Law applies to all emergency workers including Police
- Increase public confidence in the Police if we take positive action
- Good partnership working leads to the benefits of reciprocal arrangements
- These are our emergency service colleagues – it's the right thing to do!

KEY POINTS OF THE PROTOCOL

- Take Positive Action following all reports of violence or aggression towards NHS staff - BAU
- Designated SPOC for each Health Board (Case Manager) – regular liaison with Hub SPOC
- Statement from NHS victim within 24 hours, including VPS
- Service Impact Statements will be provided by Chief Executives
- Key S9 statements provided within 2 working days or within 6 hours if suspect in custody
- Access to CCTV, details of victims / witnesses etc to assist investigation
- Contact details and shift availability of victim and witnesses through Case Manager

RECIPROCAL ARRANGEMENTS SECOND AGREEMENT

- Provide medical evidence required for urgent Charging Decisions within 6 hours if suspect is in custody and within 48 hours if bailed / RUI
- Proforma included in Protocol- Agreed with CPS and already being used in Bridgend PoW
- No charges will apply
- Case Managers will collate monthly statistics for review by the AVC
- Police will produce a 6 monthly report for the AVC
- Further reciprocal arrangements for discussion post launch

MENTAL HEALTH

- College of Policing Authorised Professional Practice (APP)
- Law presumes all suspects to have capacity unless the contrary is proved at Court
- Mental Health Locations
- Respond and investigate in the same way as if taken place elsewhere
- If Police have been contacted, take positive action

CUSTODY

- Fit to detain?
- NB - Different to S136 ie a criminal investigation
- Consider Public Interest Test re OOCD
- Consider Aggravating Factors re new legislation
- Consider Safeguarding / Bail conditions
- Remember victim updates

Annex D

Single Points of Contact

As referenced in Part 1 (5) of the agreement the S.P.O.C's for each organisation are as follows:

i. NHS EXECUTIVE VIOLENCE AND AGGRESSION LEADS

Name	Organisation	Role	Contact Details
Julie Rowles	Powys Teaching Health Board	Director of Workforce and OD	Julie.Rowles@wales.nhs.uk
Nick Wood	Aneurin Bevan UHB	Chief Operating Officer	Nick.Wood@wales.nhs.uk PA – Linda.Barrett@wales.nhs.uk
Deborah Carter	Betsi Cadwaladr University Health Board	Associate Director of Quality Assurance	Deborah.Carter2@wales.nhs.uk
Mandy Rayani	Hywel Dda UHB	Director of Nursing, Quality and Patient Experience	Mandy.Rayani@wales.nhs.uk
Phil Bushby	Public Health Wales	Director of People and Organisational Development	Phil.Bushby@wales.nhs.uk
Peter Welsh	Cardiff and Vale University Health Board	Director of Corporate Governance/Hospital General Manager UHL	Peter.Welsh@wales.nhs.uk
Claire Vaughan	WAST	Director of Workforce and OD	Claire.Vaughan@wales.nhs.uk
Lee-Anne Leyshon	WAST	Head of Communications	Lee-Anne.Leyshon@wales.nhs.uk
Robert Williams	Cwm Taf	Executive Directorate	Robert.Williams@wales.nhs.uk
Sian Harrop-Griffiths	Abertawe Bro Morgannwg University Health Board	Director of Strategy	Sian.Harrop-Griffiths@wales.nhs.uk PA – Paula.Picton@wales.nhs.uk
Professor Susan Morgan	Velindre University NHS Trust	Executive Director Nursing & Service Improvement	Susan.Morgan5@wales.nhs.uk

ii. NHS CASE MANAGERS

Name	Organisation	Role	Contact Details
Chris Wilson	Abertawe Bro Morgannwg University Health Board	Personal Safety Advisor	Chris.Wilson2@wales.nhs.uk DD: 01656 753940
Frank Stagg	Abertawe Bro Morgannwg University Health Board	Health Safety and Fire Adviser	Frank.Stagg@wales.nhs.uk
Mark Parsons	Public Health Wales	Head of Estates and Health and Safety	Mark.Parsons@wales.nhs.uk DD 02921 674954
Chris Beadle	Cwm Taf UHB	Head of Health and Safety	Chris.beadle@wales.nhs.uk DD 01443 443443 Ext 5385
Dave Baker	Betsi Cadwaladr UHB	Violence And Aggression Case Manager	David.Baker2@wales.nhs.uk DD 01248 682665
Carl Ball	Cardiff and Vale UHB	Personal Safety Advisor	Carl.Ball@wales.nhs.uk DD 02920746434
Charles Dalton	Cardiff and Vale UHB	Head of Health and Safety	Charles.Dalton@wales.nhs.uk DD 029 2074 3751
Emma Foley	Cardiff and Vale UHB	Case Management Officer	Emma.Foley@wales.nhs.uk DD 02920742671
Catherine Lang	Cardiff and Vale UHB	Case Management Officer	Catherine.Lang@wales.nhs.uk
Scott Taylor	Aneurin Bevan UHB	Head of Health and Safety	Scott.Taylor@wales.nhs.uk DD 01633 431819 Ext 51819
Phil Lloyd	Hywel Dda UHB	Security and Case Manager	Phil.Lloyd@wales.nhs.uk DD: 01554 899048
Robert Mason	WAST	Head of Risk and Health + Safety	Robert.Mason3@wales.nhs.uk DD: 01745 532917
Dawn Rogers	WAST	Regional Health and Safety Manager	Dawn.C.Rogers@wales.nhs.uk
David Freckleton	WAST	Regional Health & Safety Manager	David.Freckleton@wales.nhs.uk DD: 01745 532996
Malcolm Lilburn	WAST	Health, Safety & Welfare Manager	Malcolm.Lilburn@wales.nhs.uk DD: 01633 471167

iii. POLICE FORCES

Name	Organisation	Role	Contact Details
Jolene Mann	Dyfed Powys Police (link with Hywel Dda Health Board)	Chief Inspector	Jolene.Mann@dyfed-powys.pnn.police.uk
Andrew Pitt	Dyfed Powys Police (link with Powys Teaching Health Board)	Chief Inspector	Andrew.Pitt@dyfed-powys.pnn.police.uk

Wayne Jones	North Wales Police	Chief Superintendent	Wayne.Jones@nthwales.pnn.police.uk
Ian Roberts	Gwent Police	Superintendent	Ian.W.Roberts@gwent.pnn.police.uk
Claire Evans	South Wales Police	Superintendent	Claire.Evans5@south-wales.pnn.police.uk

iv. CPS – CROWN PROSECUTION SERVICE

Name	Organisation	Role	Health Board	Contact Details
Tony Dicken	CPS	Head of Cymru-Wales Fraud Centre	Not a specific SPOC but the overall CPS Cymru-Wales liaison point for NHS Wales and general matters	Tony.Dicken@cps.gov.uk
John Lloyd	CPS	District Crown Prosecutor	Abertawe Bro Morgannwg and Hywel Dda	John.Lloyd@cps.gov.uk
Susan Duncombe	CPS	District Crown Prosecutor	Powys Teaching Health Board and Betsi Cadwaladr	Susan.Duncombe@cps.gov.uk
Ian Kolvin	CPS	District Crown Prosecutor	Aneurin Bevan UHB and Cwm Taf	Ian.Kolvin@cps.gov.uk
Nicola-Jane Powell	CPS	District Crown Prosecutor	Cardiff and Vale University Health Board	Nicola-Jane.Powell@cps.gov.uk

Role of Case Manager

Cardiff and Vale University Health Board

Royal College of Nursing Stakeholder Event - *Assaults on Emergency Workers Offences Act*

Violence and Aggression Case Management

Carl Ball & Emma Foley

GOFALU AM BOBL, CADW POBL YN IACH
CARING FOR PEOPLE, KEEPING PEOPLE WELL

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board

Reason/Background for Implementation of Violence and Aggression Case Management

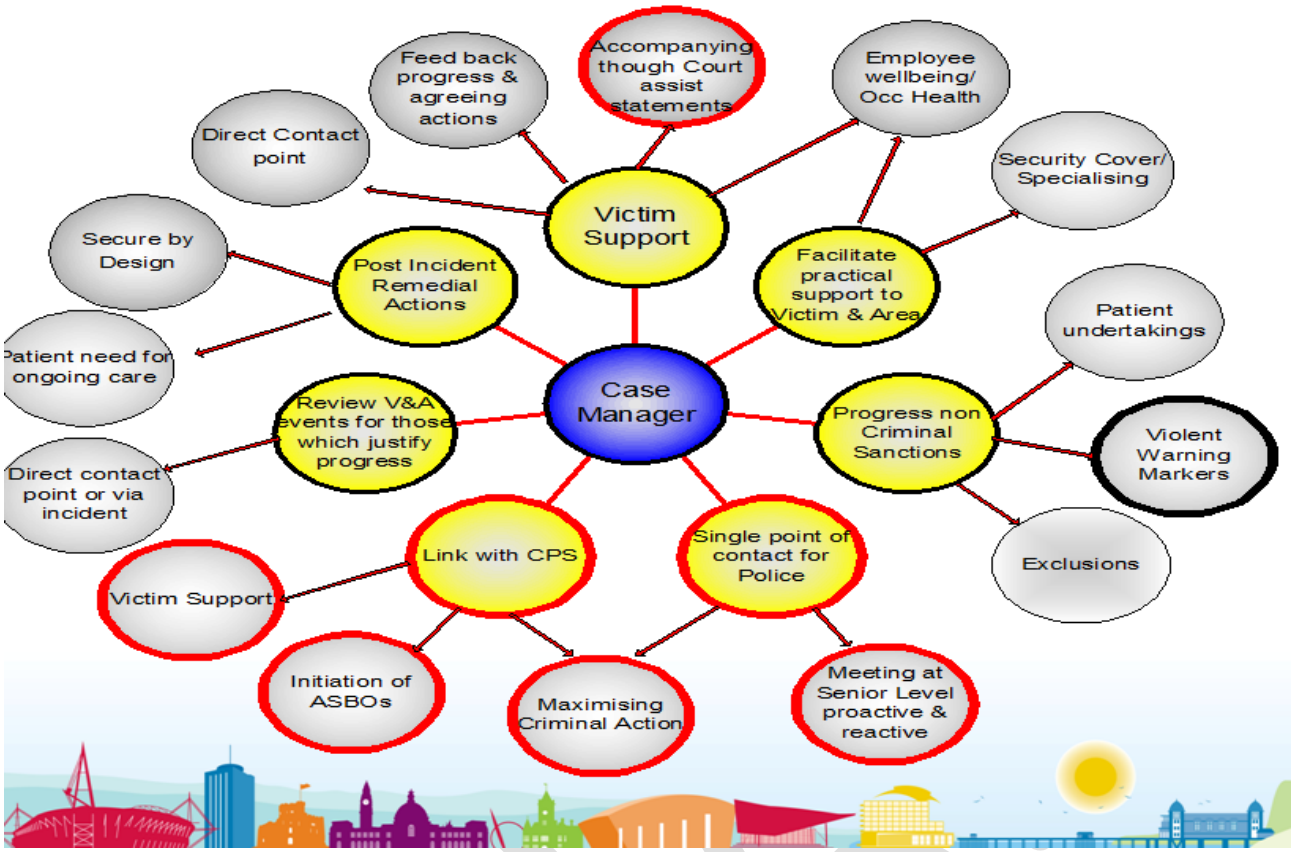
- Lack of Staff Support
- No Partnership Working
- Prosecution rate very low (7 in a Two Year Period - ALL WALES)
- No Internal Sanctions

Established Links

- South Wales Police
- NHS Wales Shared Services Partnership - Legal and Risk Services
- Crown Prosecution Service
- Court Services
- All Wales Case Management Network

Cardiff and Vale UHB
V&A Case Management Priorities

Case Management Work Stream



Case Management- Criminal Sanctions Victim Support

- **Support given includes**
  - Meetings staff/managers within 48 Hours, to provide ongoing support
    - Immediate protection i.e. security/police
    - Re assurance (victim support)
    - Body Cams Issued to Security Staff (Evidential Purposes)
  - Single Point of Contact
  - Witness Support
  - Court Familiarisation, accompany/support day of court case
  - Assistance with Post Incident Support
    - Wellbeing Service,
    - Occupational Health
    - (Counselling/Criminal Injuries Compensation Scheme, Small Claims).

Case Management- Internal Sanctions Victim Support

63% of Assaults are from persons with related medical conditions.

In a significant number of Incidents the Severity does not justify police involvement but will have an ongoing care need

Highlight Case

- Community incident (Rover Way)
- **Support given includes**
  - Meetings staff/managers within 48 Hours, ongoing support
    - Signposting to relevant service
    - Re-assurance
    - Internal sanctions Issuing (Warning Letters) (Banning Orders) (Behavioural contract issued UHB wide)
    - Violent Warning Markers
    - Assistance with Post Incident Support/Wellbeing Service, Occupational Health).

Risk Assessments/Management Plans

- Work with ward/community Managers for assistance in completing above

Proactive & Reactive Interventions

- **Support for staff involved in Domestic violence (signposting)**
- **GP Surgeries/Safe Haven Partnership Working**
- **Issuing of Violent Warning Markers on Patients notes**
- **Lone Working advice**
- **Risk Assessments/Management Plans**
- **Case Management Team visit wards to advise staff on specialist advice and V&A Training techniques**
- **Policies and Procedures**

Proactive & Reactive Interventions

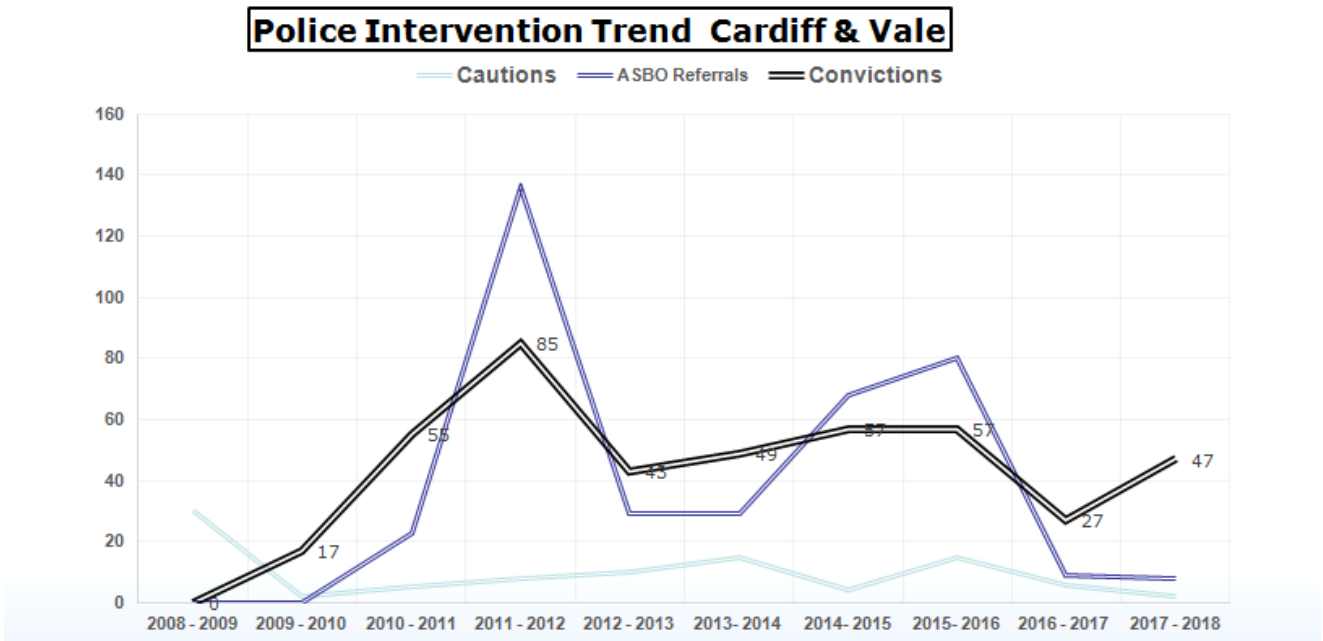
- Support for staff involved in Domestic violence (signposting)
- GP Surgeries/Safe Haven Partnership Working
- Issuing of Violent Warning Markers on Patients notes
- Lone Working advice
- Risk Assessments/Management Plans
- Case Management Team visit wards to advise staff on specialist advice and V&A Training techniques
- Policies and Procedures

Lone Worker Device Protection Previous Serious Events

- Pre Device - Community Nurse visits a patient home to administer medication
  - The patient threatened the nurse and would not let her leave (he was a drug user and had been attacked earlier)
  - She had no alarm and could not use her phone (in her bag)
  - Fortunately a person had heard the earlier assault and called the police-The nurse escaped when the patient was distracted by the police
- Post Device- A CMH Nurse visited a clients home in Cardiff 2014/15.

  He threatened the nurse with a wooden shaft and would not let him leave.
  - The nurse activated the red alert on their device
  - The ARC operator heard the nurse say they were sca
  - ARC -Police called, who responded and attended
  - Nurse got out safely
  - Client not charged but Sectioned under the MH Act

Case Management- Criminal Sanctions Police Interventions



Year	Cautions	ASBO Referrals	PNC	Convictions	Restraining Orders	Total Police actions/Occurrences
09/10	2	0	2	17	0	21
10/11	5	23	2	55	1	86
11/12	8	136	6	85	1	306
12/13	10	29	8	43	2	90
13/14	15	29	11	49	0	104
14/15	4	68	3	57	4	132
15/16	11	80	7	57	2	171
16/17	6	9	1	27	0	94
17/18	2	8	0	50	1	153
Totals	63	382	40	440	11	1156

Victim My Story - Senior Nurse EAU
Summary of Presentation given to The Chief Executive of NHS Wales , Welsh Assembly, CPS and Police - December2017

- My career in emergency care began in 1977, in casualty, at Cardiff Royal Infirmary
- I love my job, but one of the hardest parts is having to deal with the violence and aggression
- For a huge proportion of my career it was normal for me to experience verbal aggression on every single shift .
- I've been a victim of physical violence several times and witnessed violence against my NHS colleagues on many occasions.
- In my early career it was rare that anyone was convicted of a public order offence
- At the time, I was expected to 'man up', have a cup of coffee and continue as normal – which is what I did.

Victim– My Experience in A&E

- I've been
  - spat at,
  - threatened with weapons,
  - had equipment thrown at me,
  - grabbed, shoved and pushed over,
  - had blood deliberately flicked over me,
  - received death threats & a victim of stalking.
- I've been a victim of physical violence several times e.g.
  - A regular attendee sneaked up behind me,
  - He grabbed me, pushed me up a against a wall and held a heavy metal meat hook to my face.
  - he wanted drugs

- I've witnessed colleagues
  - being punched and knocked out,
  - stubbed several times with a lit cigarette

Senior Nurse– "How things changed"

- Memorandum of Understanding
- Carl Ball was the first Case Manager in Cardiff and Vale/Wales, and he made such a difference to the experience that employees received following a violent and aggressive act.
- Staff were encouraged to report verbal as well as physical abuse and were supported both practically and emotionally up to a positive outcome.
- Antisocial behavioural orders were introduced and when a high profile VIP verbally and physically assaulted nurses, staff were supported by Carl and the legal team at UHW in order to secure a highly publicised conviction.
- Violence and aggression will always be a part of emergency nursing. Patients with dementia can't help their behaviour and would probably be mortified if they knew what they were doing.
- Nurses need to be empowered to refuse treatment and encouraged to report anti-social behaviour.

Violence & Abuse we don't have to take it

Over 3000 V&A incidents

Recent Cases

- Conviction against a person who threatened a receptionist with knife – 18 month sentence and deportation once sentence complete
- 4 year custodial sentence with an indefinite restraining order for Common Assault, Racially aggravated common assault, Affray and making a threat to kill.
- 15 month custodial sentence against a person who assaulted and spat at security and also broke their restraining order not to attend UHW unless a genuine emergency.


@NHSAntiViolence
Empowerment through prevention
GIG CYMRU NHS WALES
NHS Anti-Violence Collaborative
CPS
OBLIGATORY RESPONSES TO VIOLENCE IN HEALTHCARE
The NHS undertake to collate, review and analyse the body of incident reports relating to violence against staff in order to prevent violence occurring in the first instance.
#EmpowermentThroughPrevention
Llywodraeth Cymru
Welsh Government
GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Cyfreithiol a Risg
Shared Services Partnership
Legal and Risk Services
GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership


Empowerment Through Prevention
PREVENT
NHS Prevent assaults using effective risk management procedures
CAPTURE
Assault on NHS Victims
(Includes Ambulance, Paramedics, Hospital Staff, Primary Care i.e.
GP Staff , Pharmacy, Podiatry, Dentistry, Opthamology
Incident reported to Manager and Police via 999 if ongoing
Incident reported DATIX completed
Manager or Victim contacts NHS Case Manager or equivalent in Primary Care
INVESTIGATE
NHS CASE MANAGER
Investigates(Supports NHS Manager to Investigate)
- Contacts Police via 101 promptly. Also scope for outline crime reporting.
Shares information with police
Police - Having Received an accurate account
-Respond
-Investigate – obtain victim consent
-- apply sanctions / out of court disposals or
-- Refer to CPS
PROSECUTE
CPS
-Consider Prosecution
-- Proceed with Prosecution
Prosecution – Victim supported throughout by victim focus
Prosecution – Victim supported throughout by CMT
DETER
Health body provides Director Level Service Impact Statements and Victim statements in conjunction with Police
Sentence Passed
Media Informed
NHS Reflect & Refine preventative risk management

To End

- Provide Victim Support to UHB staff
- Progress internal and external Sanctions against perpetrators of violence and aggression
- Established Communication with Police and CPS
- Established Communication Links with GP Surgeries/Primary Care

Victim Consent Form for Disclosure of Information **Annex E (ii)**

Health Board / Trust/Police/CPS Logo and address

Victim/ Witness Consent Form for disclosure of information

Alleged Offender details (if known):
Date and time of Incident:
Location:
Police log and/or Crime Reference no.:
Officer details if known:

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

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

Signed: Date:

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

Signed: Date:

Date received and logged on Police record:
Officer signature:

CODE FOR CROWN PROSECUTORS

Available in secure portal link at http://www.nwssp.wales.nhs.uk/page/97264

Annex F - Code for Crown Prosecutors - C

Annex (G)

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

NHS incident reference no:

Alleged offence:

Victims name(s)

Date, location and time of incident

Healthcare Professional
Name and contact no:

Designation:

SERVICE USER DETAILS

Name and date of birth:

Address if not in-patient

Detained under MHA 1983?

Service user no:

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

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

Would you consider the service user at the time of the alleged offence was capable of understanding his/her actions? Comment:	Yes	No
Would you consider the service user at the time of the alleged offence was capable of controlling his/her actions? Comment:	Yes	No
Would you consider the service user is capable of understanding the legal process is a prosecution is sought? Comment:	Yes	No

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 and passed to the Case Manager

(G)

Mentally Vulnerable Offenders
Police request for information from the health service

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

[insert details of alleged offender and incident]

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

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

This information is requested in furtherance of a criminal investigation into an offence of ……[please state]. This information is directly relevant to whether or not criminal charges are brought and/or whether bail is appropriate; decisions which are required of [insert name of Police force] by the Police and Criminal Evidence Act 1984.
(any additional relevant information/reasons, including confirmation of why disclosure is required now)
……
……
……
……
……
……
……

This information is sought in accordance with the Data Protection Act 2018. Section 29 permits disclosure for the purposes of the prevention and detection of crime and the apprehension and prosecution of offenders. Section 35 permits disclosure for the purpose of legal proceedings or obtaining legal advice. Disclosure may also be justified where the information is relevant to protecting the health and safety of all concerned.
No presumptions are made about whether it is in the public interest to prosecute offenders where sufficient evidence exists. Each case is considered on its merits, in light of the evidence and other information available at the time, to support a criminal charge.

Reference No. (custody/crime)……

Officer's signature…….
Further notes in support of the request (investigating/custody officer)
……
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Reference No. (Custody/crime):……

Officer's signature:……..

Notes in response to above request:
……
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……
……
……
……...

Signature:……Time/date:……
……...

Name:…….
Professional Position:……..

Explanatory Notes for Medical Staff:

1. These notes outline why the Police are requesting the information overleaf and how this information is relevant to the consideration of whether to arrest and/or prosecute a mentally vulnerable offender.

2. Whether or not a formal diagnosis has been reached is relevant to determining whether a prosecution occurs. If the CPS lawyer knows that a formal diagnosis has been reached, which may satisfy the criteria for various sections of Part III of the Mental Health Act 1983 then they may consider those Part III outcomes in considering the benefits of a prosecution. This may not be possible if the diagnosis was unclear.

3. The opinion of the Responsible Clinician (RC) is vital, not only because legal decisions to prosecute should include consideration of the impact of a prosecution on the offender's mental health, but also because it may be relevant to consider the RC"s opinion on:

    - The context of the offence
    - Impact on the ward/hospital
    - Impact on other patients
    - Relevance of previous non-prosecution based attempts to manage behaviour
    - Relevance of any previous similar incidents
    - Any escalation in seriousness of behaviour
    - Whether or not the RC views the offending as related to or caused by the mental disorder or co-incidental to it
    - The presence of any clinical barrier to criminal prosecution; e.g. medication.

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

4. A prosecution decision is the careful balancing of many potentially complex factors. This must by law, include consideration of whether it is in the public interest to prosecute. The public interest test is affected by the psychiatric management plan for that offender and any alternatives to prosecution that may be available at that time.

5. If an offender is being investigated now for assaulting staff having previously done so (whether or not reported/prosecuted), such information is *directly* relevant to the prosecution decision. If for example, it has occurred before it is easier to demonstrate that a prosecution is required to prevent further offending and risk to staff and patient.

6. Whether or not a patient is attempting to comply with their management plan and co-operating with professionals is relevant. If they are absenting themselves (repeatedly) from hospital, the confidence with which a non-formal sanction would be sought is diminished.

7. If someone is currently allowed periods of leave under s17 MHA and if that offender is returning on time and managing to look after their own welfare while on leave, it gives a clear indication that they have sufficient wherewithal to look after themselves – albeit for short periods of time or under supervision 0 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.

EXAMPLE – SERVICE IMPACT STATEMENT

WITNESS STATEMENT

Criminal Procedure Rules, r 27. 2; Criminal Justice Act 1967, s. 9; Magistrates' Courts Act 1980, s.5B

URN				

Statement of:			
Age if under 18:		Occupation:	

Which language would you prefer to give your evidence in: ENGLISH

Which language would you prefer to give your oath in: ENGLISH

This statement (consisting of 2 page(s) each 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 in it, anything which I know to be false, or do not believe to be true.

Signature:		Date:	

Tick if witness evidence is visually recorded ☐ (supply witness details on rear)

I am the Chief Executive Officer and have responsibility for the delivery of National Health Services (N.H.S) activity across the area. In order to execute my duty I must rely upon the actions of a large number of N.H.S staff members, contractors and volunteers who provide care and treatment for all members of the community and also to visitors of the area. They do so in order to make a Healthier Place through caring for communities and delivering excellent care.

In providing this statement I hope that it will assist in my duty to protect the members of the organisation that provide the public with essential healthcare services.

All too often N.H.S staff are subjected to assaults and threats. While the severity of such attacks changes, the impact upon society does not. It is never acceptable to assume that assaults upon N.H.S staff should be in any way tolerated; such attacks are not simply 'part of the job'. While it is clear that the nature of healthcare requires members of the organisation to handle difficult and hostile situations, assaults and abuse directed upon them are serious and unacceptable. The sentencing guidelines reflect this fact and highlight that assaults on public officials performing their duty are an aggravating feature. There are many ways in which assaults against public servants impact upon society. Each time N.H.S staff are assaulted and abused there are potential sickness absences implications and the halting of service delivery through damage and disruption caused to clinical and non clinical areas. These absences and disturbances impact acutely upon resourcing and the ability of the N.H.S to deliver "quality services & treatment" which could have catastrophic consequences for

URN				

Statement of:	

the most vulnerable members of the community. They also place additional strain on other members of the organisation due to the transfer of work to others, which can have significant impact on the wellbeing of N.H.S staff.

We continue to see an increase in the number of assaults on N.H.S staff and recently recorded XXXX incidents which affected staff.

Not only do assaults and abuse upon NHS staff have a negative impact on the community but also internally to the organisation. On a personal basis, staff suffer not just physical injuries, but also the psychological effects. Many find the return to frontline duties after being assaulted and abused especially challenging or traumatic. On a wider scale, morale is significantly impacted when N.H.S staff see their friends and colleagues being assaulted and abused. This, in turn, can damage the ability of the NHS to recruit new people into the organisation.

The public call upon the NHS to help them when they are most in need. We have a duty to protect the public but we are all too often prevented from doing so due to violent individuals who choose to attack those who are there to help them.

Most importantly it should be remembered that NHS staff are people, they are fathers, mothers, sons and daughters. When they are attacked they become victims just like any other.

This case relates to the assault of (insert employee details here) who was assaulted during the execution of their duty.

Generic conditions for CBOs, bail conditions, restraining orders **Annex I**

It is ordered that the defendant:

1. be prohibited, without having first notified the relevant establishment of his true name, and that he is the subject of this order, from entering in person any premises or grounds, belonging to, or under the control of any NHS body, or any premises where NHS services are provided except in the following circumstances –

    a) where he or a member of his immediate family require urgent or emergency medical treatment,
    b) to attend himself, or to accompany a member of his immediate family, at a pre-arranged appointment,
    c) to attend himself as an in-patient or to visit a member of his immediate family who is an in-patient,
    d) to attend for non-medical purposes any meeting previously arranged in writing;

2. be prohibited from entering any part of the premises described in (1) above, which is not open to the public for the purposes of accessing NHS services, except by invitation;

3. must not refuse to comply with any instruction to remain in, or to remove himself from any area of the premises described in (1) above;

4. be prohibited from remaining on any premises (including its grounds) described in (1) above when asked to leave;

5. be prohibited from removing any object, article or other thing from the premises described in (1) above which he is not authorised to remove.

Annex J

Possible Disposals including Out of Court Disposals

Court Disposals

There are four main types of disposals that may be used by the Court for sentencing if a prosecution is achieved. These are as follows:

- A prison sentence
- A community sentence
- A financial penalty (a fine)
- Discharge

Out of Court Disposals

There are several Out of Court disposals available to the Police and Crown Prosecution Service. These are a valuable tool in cases which could more appropriately be resolved without a prosecution at Court. They are as follows:

- Community resolutions – adults (18+) and youths (10-17)
- Penalty Notices for Disorder – adults (18+) and youths (10-17)
- Youth Cautions (10-17)
- Simple Cautions – adults (18+)
- Conditional Cautions – adults (18+) and youths (10-17)
- Restorative Justice in conjunction

Why?

Out of Court disposals have been shown to tackle low-level crime and can represent a proportionate and effective response to offending that can focus on the needs of the victim. They mean that:

- More time can be spend on frontline duties and tackling serious crime;
- There is a means of providing reparation and a prompt resolution for victims;
- There is opportunity for offenders to be directed into rehabilitative or educational services to tackle the causes of offending behaviour reducing the likelihood of re-offending;
- An offender can be punished by means of a financial penalty or unpaid work.

When are they appropriate?

Out of Court disposals are often used for low-level and first time offending. They are not intended for serious, persistent or contested cases where Court would be the right forum for deliberation and adjudication. However, there will be some rare occasions when it will not be in the public interest to prosecute an offender for what appears to be a serious or persistent offence and an Out of Court disposal may be considered on the facts of the case.

Annex K

Protocol for Timely Provision of A&E Records for all Assaults

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

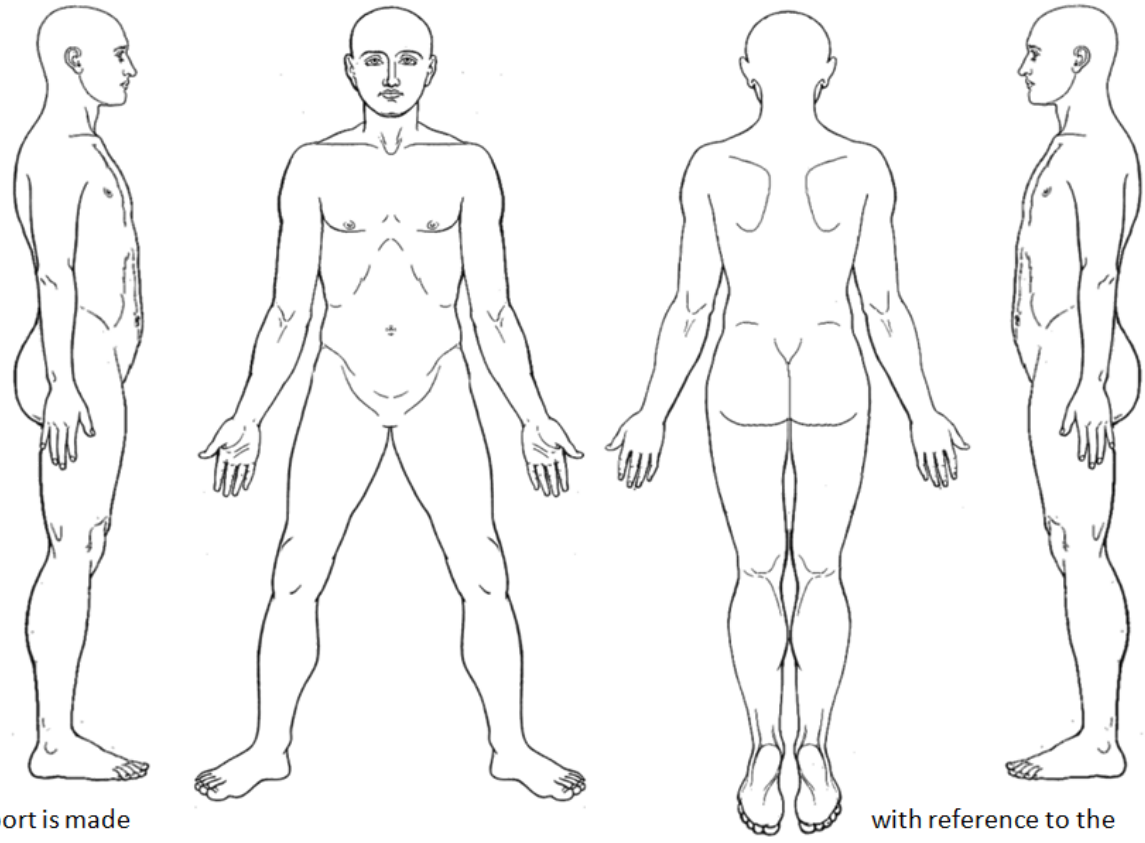
Patient surname, first name, dob

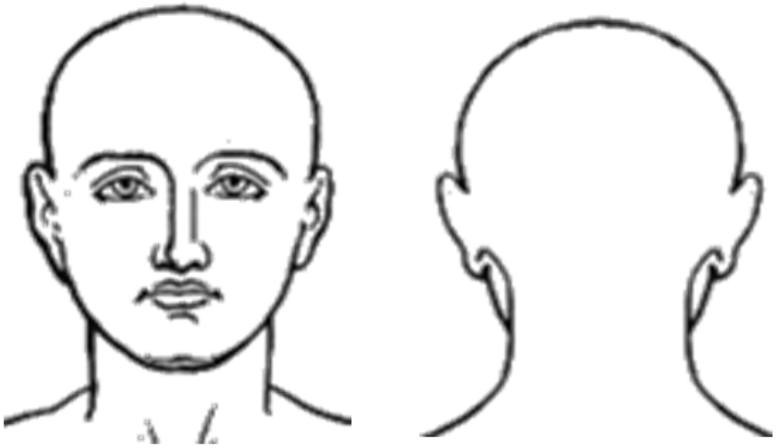
ED No:

Report of injuries

Date: Time:

This report is made with reference to the clinical record made at the time of the patient's attendance. The purpose is to provide the police (bearing appropriate consent) with relevant documentation of the **INJURIES** sustained by the patient. Document reported examination findings, **not history**.





GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Patient surname, first name, dob

ED No: .....

Report of injuries

Date: ..... **Time:** .....

This report is made with reference to the clinical record made at the time of the patient's attendance. The purpose is to provide the police (bearing appropriate consent) with relevant documentation of the **INJURIES** sustained by the patient. Document reported examination findings, **not history**.

Description of injuries – eg abrasion, wound, discolouration, swellings

X-ray/CT findings – layman's terms

Diagnosis, treatment, outcome

Name: ..... **Signature:** ..... **Date:** .....

Annex L

Glossary

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

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

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

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

L&RS is a unit of 5 7 solicitors providing a range of legal advice and representations exclusively to NHS Wales. L&RS has agreed to work with healthcare bodies, the Police and CPS in order to increase the number of prosecutions (that are legally robust) and to provide cost-effective advice on available sanctions against individuals who are violent or verbally abusive towards NHS staff and professionals. L&RS, with the permission of the

NHS body may lawfully pursue private criminal prosecutions. This power stems from directions issued by the Secretary of State under the NHS Act 1977. Such prosecutions will require authorisation from the Board of the relevant Health Body.

NHS Board Level Lead for Violence and Aggression
NHS Wales is managed with different Health Boards and Trusts.

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

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

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

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

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

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

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

Established Networks

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

NHS Anti-Violence Collaborative – eminent practitioners from partner organizations formed this group to oversee the revision of this agreement in 2017.
Contact Email: Andrew.Hynes@wales.nhs.uk

All Wales NHS Case Managers Network – SPOCs from the Police, CPS and the NHS are invited to attend these meetings which occur on a quarterly basis and include dedicated learning events.
Contact Email: Peter.Welsh@wales.nhs.uk

All Wales Violence & Aggression Advisory Group **–** was established in 2001 as a sub group of the Health and Safety Advisors‟ Forum. Its objective is to develop policies and procedures to enable NHS employers to identify and manage the risk of violence and aggression against staff working across the NHS.
Contact Email: Emyr.W.Jones@wales.nhs.uk

All Wales Health and Safety Managers Group.
The principle NHS Group overseeing Health and Safety within NHS Wales.
Contact Email: Tim.Harrison@wales.nhs.uk

Nationally agreed protocols and standards

Code of Practice For Victims of Crime (October 2015)

Code for Crown Prosecutors (January 2013)

Director of Public Prosecutions Guidance on Charging 5th Edition (Revised Arrangements) (May 2013)

CPS Legal Guidance on Mentally Disordered Offenders

DPP"s Guidance on Conditional Cautioning 7th Edition (April 2013)

DPP"s Guidance on Youth Conditional Cautioning (pilot sites only) (January 2015)

Charging standards for relevant offences

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

CPS Legal Guidance on Criminal Behaviour Orders

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

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

Farquharson guidelines on The Roles and Responsibilities of the Prosecution Advocate

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

NHS Confidentiality Code of Practice

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

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

Welsh Accord on the Sharing of Personal Information (WASPI)