



A joint inspection of the treatment of offenders with learning disabilities within the criminal justice system - *phase 1* from arrest to sentence

*A Joint Inspection by HMI Probation,
HMI Constabulary, HM Crown Prosecution
Inspectorate and the Care Quality Commission*

January 2014

This page is intentionally left blank

Acknowledgements

We would like to express our thanks to Jenny Talbot, Prison Reform Trust, Richard Mills, Research Autism, Mencap and the National Autistic Society (NAS) for their assistance prior to the inspection field work.

Thanks are also due to the Probation Trust staff and managers, the Crown Prosecution Service (CPS), health, police and Crown Prosecution Service officers and staff in the areas which participated in the inspection; these were Gloucestershire, Leicestershire & Rutland, Lincolnshire, London, Thames Valley and Wales.

In addition, we would like to thank the Chief Executive Officer, managers and staff of Greater Manchester Probation Trust, where we piloted the methodology for this inspection.

Lead Inspector	Les Smith, <i>HMI Probation</i>
HMI Probation Inspector	Yvonne McGuckian
HMI Probation Assistant Inspector	Helen Morton
HMI Constabulary Inspectors	Rob Bowles; Paul Eveleigh
HM Crown Prosecution Service Inspectorate Legal Inspectors	Hilary Reeve; Katey Rushmore
Care Quality Commission Inspector	Michelle Fordham
Inspection Support	Joanna Hewitt, <i>HMI Probation</i>
HMI Probation Publications	Alex Pentecost, Christopher Reeves (<i>Proof reader</i>)
Editor	Andy Smith, <i>HMI Probation</i>

Foreword

People with learning disabilities have contact with criminal justice services at every point of the criminal justice system - police, prosecution, courts, probation and prison; this report deals with the first phase of contact, focusing specifically on the period from arrest to conviction and sentence.

No clear definition or agreement exists across criminal justice and health organisations about what constitutes learning difficulties or disabilities. Although believed to be a sizeable minority, possibly as high as 30%, we have no way of knowing the number of people with such conditions within the criminal justice system. Adequate provision is, consequently, not always made by the agencies involved to cater for their specific needs which, as we found in this report, often appear to go unnoticed. Given the recent changes in the commissioning of health services, it is now increasingly important that the specific needs of this group of offenders are both recognised and addressed.

In his review of people with mental health problems or learning disabilities in the criminal justice system, published in 2009¹, Lord Bradley suggested that *'that the police stage in the offender pathway provides the greatest opportunity to effect change'*. It was, therefore, disappointing to find that little had changed by way of effective screening of detainees with a learning disability at the police arrest stage. We were also disappointed to find few medical or psychiatric professionals specifically trained to work with people with learning disabilities available in police custody suites. We believe that this was a missed opportunity to divert many offenders with learning disabilities to more appropriate services, or at least to ensure that they are dealt with effectively by criminal justice agencies. However, the recent government announcement confirming the decision to extend the provision of mental health and learning disability nurses to police stations and courts in ten pilot areas is a positive development².

We found unwieldy processes, the absence of services or a simple lack of knowledge and training led to offenders with a learning disability being perceived as a problem to be processed, rather than an individual with particular needs requiring individual help. Far too often offenders with learning disabilities were not receiving the support they required to address their social care needs, or to reduce their risk of harm to others and their likelihood of reoffending.

Although we found some excellent examples of professionals going the extra mile to ensure that individual offenders with learning disabilities received appropriate support they required, such instances were exceptional and these deficits were mirrored across the criminal justice system.

If offender engagement is to have any real meaning it has to start with an understanding of the offender's learning ability and style based on an effective screening of all offenders. For those with a learning disability this is even more important as failure to identify and address their needs denies them their right to access services both inside and outside the criminal justice system. This report aims both to draw attention to the current situation and to highlight best practice so it may be shared throughout those agencies working with this group of offenders.

Liz Calderbank
HM Chief Inspector of Probation

David Behan
Chief Executive, Care Quality Commission

Michael Fuller
HM Chief Inspector of the Crown Prosecution Service

Tom Winsor
HM Chief Inspector of Constabulary

January 2014

Contents

Acknowledgements	1
Foreword	2
Summary of Findings	4
Recommendations	7
1. Structure of the inspection	10
2. Context and definitions of learning disability	14
3. Police detention	17
4. Before court: the decision to prosecute	24
5. The court process	28
6. Advising the court and preparing for sentence	32
Appendix 1: Glossary	38
Appendix 2: Role of the inspectorates and code of practice	40
Appendix 3: References	41

Summary of Findings

The inspection

As the first of two inspections about the treatment of offenders with learning disabilities within the criminal justice system, we focused specifically on the period from arrest to conviction and sentence. The inspection covered activity at police stations, the prosecution and court process, pre-sentence report preparation and the assessment and planning undertaken at the start of the community order.

The scope of the inspection covered adult offenders and included both magistrates' court and Crown Court cases. It included cases that had proceeded to sentence and also those formally or informally diverted from prosecution. We aimed to examine the decision-making processes and the quality of the supporting information that resulted in the decision to charge or not.

Overall findings

An accurate estimate of the number of people with learning disabilities within the criminal justice system is impossible because of poor interpretations, about what constitutes a learning disability and a failure to properly identify and record this issue by all the key agencies at all points in the criminal justice process. The specific findings of this inspection are to a great extent a manifestation of these problems of definition and identification. As a result, the needs of offenders with learning disabilities are often overlooked and, although there were some pockets of good practice and examples of practitioners 'going the extra mile' to ensure that these offenders received the support and treatment they needed, examples of good practice were the exception rather than the norm.

Offenders with learning disabilities were not always afforded the level of service appropriate to the risk of harm they presented or their needs. Problems included a failure to recognise a learning disability, and failure to refer the offender to specialist services for assessment. We regularly found an absence of access to specialist support that would address their offending behaviour and manage the risk of harm posed to the public.

We were particularly concerned to find that the processes, absence of services or a simple lack of knowledge and training often led to offenders with a learning disability being perceived as a problem to be processed, rather than an individual with particular needs requiring individual treatment.

Specific findings

Police custody

Contact with the police is the first stage in the criminal justice system and for the majority of offenders with learning difficulties provides the first opportunity to assess their needs.

Identification of learning disabilities by police custody staff is based on a combination of judgement drawn from experience, a risk assessment that does not specifically examine learning disabilities and the availability of historical information held on police systems. Risk assessment processes normally consisted of asking the detainee a series of set questions on arrival in custody. Questions regarding learning disabilities were usually general about whether the detainee had any problems with reading or writing or any mental health problems.

Problems identifying learning disabilities were compounded by the physical layout of custody units. The custody facilities we saw were mainly open plan units, which afforded little privacy for detainees and reduced the likelihood of them disclosing a learning disability.

We found a variety of Appropriate Adult schemes in the police forces visited; some were run by charities

whilst others relied on adult social care services or commercial provision. Police forces are individually responsible for the arrangement of Appropriate Adult services, with no statutory obligation on any agency to provide them. In some areas custody sergeants said Appropriate Adults were not always available to assist with cases.

Only one of the police forces we visited had a mechanism to divert offenders from custody before arrest on the grounds of identified mental health problems or a learning disability. A Community Psychiatric Nurse worked alongside officers responding to reported incidents involving people with mental health or learning difficulties, and could access medical histories and services to divert suspects away from arrest where this was appropriate. In the other areas, diversion schemes were implemented within the court building rather than before or at arrest. Earlier interventions might have avoided the need for a costly and stressful court process in some cases.

Health interventions: custody suites

The availability of specialist mental health practitioners within custody suites can assist police in the timely identification and assessment of detainees with specific mental health needs.

In some instances health professionals had been invited to provide input to police custody training but this was inconsistent across the forces inspected. There is no national requirement for custody sergeants to receive training on learning disabilities and how they should inform risk assessments and the management of detainees. We found a general lack of understanding among police officers of the difference between mental capacity and mental health needs leading to confusion over whether a detainee had a mental illness or learning disability.

Where general health personnel were present in custody suites and had access to the NHS patient database there was also good, timely and accurate information sharing between agencies to safeguard the detainee's health needs. However, health workers without access to the NHS database were reliant on disclosures made by those detainees who consented to see the medical staff; the accounts of police and witnesses; and their experience and professional judgement to inform their assessments of the detainee's fitness to be interviewed.

Force Medical Examiners play a lead role in examining and treating detainees in police custody. Unfortunately many Force Medical Examiners have no specific training in the screening and support of people with learning disabilities. As a result, many detainees with learning disabilities, even when seen by the Force Medical Examiner, were not offered the support they needed. Even in cases where the Force Medical Examiner had recognised that the detainee had a learning disability, they often failed to understand the requirement, under the Police and Criminal Evidence Act 1984 that vulnerable suspects needed an appropriate adult.

Prosecution and sentence

In two-thirds of the cases inspected we found that the Crown Prosecution Service was not provided with information regarding the offender's learning disability at either the charging stage or on receipt of the file in police charged cases. In the majority of the cases this information was recorded on the police system but was not made available to the Crown Prosecution Service. This was a matter for concern as it meant that people with learning disabilities were disadvantaged in that the full details of their background were not always taken into account at a crucial point in the criminal justice process.

At court

For someone with a learning disability, the court environment and process is confusing and possibly frightening. The court environment could very easily, and with little extra cost, be made less intimidating

for people with learning disabilities. We found, however, that little attention had been paid to the needs of those with learning disabilities, for example through the availability of 'easy read' posters and leaflets to explain the court process.

We also found that trained Intermediaries were rarely used to support defendants through the court hearing. Community Psychiatric Nurses provided a good service to courts where they were deployed, but their primary focus appeared to be with defendants who had a mental health condition rather than a learning disability. Many staff working in court also reported that it was difficult and confusing to make referrals to health services.

Court reports, assessment and planning

A significant minority of reports on people with learning disabilities were prepared on the day of sentence and this meant that their needs were not always given sufficient consideration. In addition, reports were not always based on an appropriate risk/needs assessment. In the majority of those cases, the assessment emphasised the offender's need rather than any risk they may have posed to the public. As a result, these offenders were sometimes denied access to interventions to address their offending.

Less than half of the pre-sentence reports took relevant learning disability issues into account as part of the offence analysis. Those reports that failed to adequately address offenders' needs, often cited the 'difficulties' in managing such needs within a community order. Most initial assessments included information relating to the offender's learning disability. However, the learning disability needs were assessed correctly, in that they understood the nature and potential impact of the disability on their ability to fully engage, in just over one-third of the cases inspected.

People with learning disabilities have different learning and support needs from the general population. The failure to address this issue in reports and assessments had the potential to reduce the chances of the offender successfully engaging in activities aimed at reducing the likelihood of reoffending and/or risk of harm.

Conclusion

A balance needs to be struck between the support needs of those with learning disabilities and the need to hold them to account, where appropriate, for their offending. At all points in the criminal justice process, up to and including the point of sentence the treatment of people with learning difficulties could be significantly improved. Without the ability to correctly identify and assess the detainee's learning disability, at the arrest and charge stages, there is a greatly reduced chance of them receiving the support they need or the access to services to help them understand what is happening as they go through the system and the consequences/implications of decisions made.

Even when an offender's learning disability is correctly assessed, at arrest, that information is not always recorded or communicated to the Crown Prosecution Service who need that information to inform their charging and decisions on how to proceed with the case. The lack of information sharing can then affect the ability of probation staff preparing reports for court, to correctly assess both the offender's needs, and leading to an incorrect assessment of the most suitable court order to reduce the likelihood of reoffending.

Following conviction, probation staff, preparing reports to court, often fail to either recognise or understand the nature and affect the offender's learning disability may have had, on their offending. This failure can mean that they do not provide the court with all the relevant information they need to sentence the offender and can impact on the quality of any supervision post-sentence.

Recommendations

All criminal justices agencies should:

- jointly adopt a definition of learning disability.

Police forces and the Crown Prosecution Service should:

- ensure that Police decision-makers and Crown Prosecution Service lawyers are provided with information about learning disability when making decisions about charging and prosecution;
- ensure that a defendant's learning disability is considered fully when making decisions on charging and prosecution.

Police forces should:

- make effective screening tools available in all custody suites, to assist custody staff in identifying detainees with learning disabilities;
- ensure that the rights and interests of people with learning disabilities in police custody are safeguarded through the provision of good quality Appropriate Adult schemes that are available both during and outside normal working hours;
- ensure that, at the design stage, new and refurbished custody suites consider screened booking-in areas where potentially vulnerable detainees can be interviewed in privacy so that an assessment of a detainee's learning disability is more likely;
- ensure that custody staff are sufficiently aware of a range of learning disabilities and the requirements of the Codes of Practice so that detainees with learning disabilities are treated as 'vulnerable persons'.

The Department of Health and NHS England (Health and Justice) should:

- ensure that custody suites and courts have access to specialist learning disability staff to support assessments and the signposting of offenders with learning disability needs into appropriate services;
- ensure that Force Medical Examiners are fully trained to assess and treat detainees with learning disabilities, and all medical staff are made aware of the exact requirements of the Codes of Practice in relation to the need for appropriate adults.

HM Courts and Tribunals Service should:

- ensure that all possible steps are taken to assist vulnerable defendants to understand and participate in court proceedings in line with the Consolidated Criminal Practice Direction, 2011: treatment of vulnerable defendants³.

Probation Trusts should¹:

- ensure that reports and assessments take full account of the risk of harm and likelihood of reoffending as well as the support needs of offenders with a learning disability to reduce the risk and likelihood of reoffending of offenders with learning difficulties.

¹ Under the government's Transforming Rehabilitation strategy, Probation Trusts are scheduled to be replaced by the National Probation Service. Recommendations addressed to Probation Trusts should be followed up by whoever delivers probation services in the future, including both the National Probation Service and private providers.

The Ministry of Justice should:

- implement the provisions of Section 104 of the Coroners and Justice Act 2009 which provides a statutory framework for the provision of registered intermediaries for vulnerable defendants.

All agencies should:

- ensure that all relevant staff understand the offending and support-related needs of offenders with learning disabilities.

Structure of Inspection

1

1. Structure of the inspection

Summary

This chapter outlines the terms of reference and methodology of the inspection.

Key facts

- Most offenders in the inspection sample were male and the cases inspected covered most types of offences including violent and sexual offences
- All agencies had difficulty identifying cases due to the limitations of their recording and IT systems.

Terms of reference

- 1.1. The Criminal Justice Chief Inspectors' Group commissioned the inspection, incorporating it into their *Joint Inspection Business Plan 2012-2014*⁴. This is the first of two inspections into the treatment of offenders with learning disabilities. The second inspection, which will focus on the delivery of interventions in the community and prison and fieldwork, is planned to start early 2014.
- 1.2. Following the publication of Lord Bradley's report *The Bradley Report: Lord Bradley's review of people with mental health conditions or learning disabilities in the criminal justice system* (April 2009), a good deal of work has been done by the Department of Health (DoH) Offender Health Unit, and a number of voluntary organisations, in particular the National Autistic Society (NAS) and the Prison Reform Trust, to raise awareness of the needs of offenders with a learning disability, and promote best practice among criminal justice staff.
- 1.3. The inspection was led by HMI Probation with support from HMI Constabulary, HM Crown Prosecution Service Inspectorate and the Care Quality Commission (CQC). A previous joint thematic inspection on the topic of; work prior to sentence with offenders with mental disorders was undertaken in 2009⁵. This inspection, sought to focus more specifically on the treatment of offenders with a learning disability, as our scoping had indicated that despite some progress in relation to mentally disordered offenders following the publication of the previous inspection findings and the Bradley Report (2009) little progress had been made with this group of vulnerable offenders.
- 1.4. The inspection's terms of reference were to: assess the quality and effectiveness of information exchange between criminal justice agencies in dealing with offenders with a learning disability, to ensure appropriate services and support both within and outside the criminal justice system and, where appropriate, to facilitate their diversion from prosecution or custody, covering the period from arrest (or detention) to sentence.
- 1.5. Criteria were drawn up for the inspection based on good practice guidance and instructions that had been issued to the agencies dealing with offenders with learning disabilities in the criminal justice system. We wanted to know whether:
 - staff in criminal justice agencies, were aware of learning disabilities and associated needs
 - information had been recorded in appropriate cases
 - information was exchanged correctly with other agencies.

We also wanted to examine the level to which staff were trained to deal with offenders with learning disabilities and the circumstances whereby cases might be diverted away from the formal criminal justice system.

What we were inspecting

- 1.6. The inspection examined four specific stages of the criminal justice system with which an offender with learning disabilities may come into contact. We looked at: the role of the police and in particular activity in police custody suites; the role of the Crown Prosecution Service (CPS) and the prosecution process; the court experience and finally the work of Probation Trusts in advising courts on sentence through pre-sentence reports (PSRs).
- 1.7. The cases we inspected included most types of offences including violence and sexual offences ranging from rape to indecent exposure. The individuals displayed the following characteristics:
 - 84% were male.
 - 92% were White British.

Inspection methodology

- 1.8. Fieldwork for the inspection took place during February and March 2013 and incorporated visits to police forces and Probation Trusts. This enabled us to judge the quality of practice through meetings with police and probation managers and staff, and by examining case records. We also interviewed liaison and diversion workers, police Force Medical Examiners (FMEs) who assess offenders with learning disabilities and interrogated CPS records.
- 1.9. Inspectors visited six areas: Cardiff, Gloucester, Harrow and Hillingdon, Leicester, Lincoln and Oxford.
- 1.10. HMI Constabulary examined the detention and charging processes and procedures, at police custody suites, including the recognition of the offender's learning disability and the use of Appropriate Adults in Police And Criminal Evidence Act 1984 (PACE) interviews. They also inspected the extent to which professional assessments were used during detention to ensure rights were safeguarded and the most appropriate charging decision.
- 1.11. HM Crown Prosecution Service Inspectorate assessed CPS charging decisions and case reviews to ensure that decisions to prosecute or not were made on the basis of accurate and timely information, including assessments of the offender's learning disability. They also visited courts and spoke to court users about their experience of dealing with offenders with a learning disability.
- 1.12. HMI Probation assessed the quality of PSRs to ensure that they contained relevant information on the offender's learning disability to assist sentencers, that initial assessments took account of the offender's needs and that sentence plans included objectives aimed at reducing the offender's likelihood of reoffending, risk of harm to others and their own vulnerability.
- 1.13. The CQC interviewed police FMEs and liaison and diversion staff involved in the assessment of offenders with a learning disability in both custody suites and courts.

Inspection sample

- 1.14. In each police force we inspected ten cases involving detainees with a learning disability. Due to the restrictions on searching IT systems, some forces could only identify cases involving learning disabilities by retrieving cases where an Appropriate Adult had been provided because they had been assessed as vulnerable. This gave us limited ability to identify and assess cases where learning disabilities had not been recognised. Consequently, HMI Constabulary inspectors also reviewed six cases in each police force, identified by HMI Probation inspectors from a list provided by individual Probation Trusts, giving a total of 96 cases. This enabled us to assess whether the individual had been identified as having a learning disability at arrest and whether their rights and interests had been protected during their involvement with the police.

- 1.15. Inspectors from HMI Probation assessed ten cases managed in the community, from each of the six Probation Trusts. Of the 60 cases, 36 were selected from cases identified by Probations Trusts of offenders with learning disabilities. This was not an easy task as the majority of Probation Trusts either did not have a system for identifying such cases, or listed offenders with autism, low IQ and dyslexia under a single learning disability indicator. HMI Probation inspectors also inspected 24 cases identified during the inspection of police custody suite cases that were also known to the Probation Trusts.
- 1.16. All of the cases identified by inspectors on both police and probation recording systems were followed up on the CPS system to identify their progress through the court system, and to examine the quality of information relating to the offender's learning disability and the appropriateness of decisions to progress to charge or not. In all, there were records of 44 cases which had been referred to the CPS for prosecution.
- 1.17. During the inspection we also interviewed police officers, police and probation managers, staff and others involved in dealing with learning disability, including FMEs and Community Psychiatric Nurses (CPNs) in order to put our case sample findings into context.

Context and definitions of learning disability

2

2. Context and definitions of learning disability

Summary

In this chapter we look at the context within which the inspection took place and describe the range of definitions applied to offenders with learning disabilities. It also comments on the estimated numbers of offenders with a learning disability in the criminal justice system.

Key Findings

- The lack of a clear agreed definition of learning disability meant that there were wide variations in the estimated numbers of offenders with a learning disability.
- Little progress had been made in response to the findings of the Bradley report, in relation to offenders with a learning disability.

Definitions

- 2.1. The World Health Organisation (WHO) defines learning disabilities as '*a state of arrested or incomplete development of mind*'. Someone with a learning disability also has '*significant impairment of intellectual functioning*' and '*significant impairment of adaptive/social functioning*'⁶. This means that the person will have difficulties understanding, learning and remembering new things, and in generalising any learning to new situations. Because of these difficulties with learning, the person may also have difficulties with a number of social tasks, for example communication, self-support, awareness of health and safety.
- 2.2. A final dimension to the definition, of a learning disability, is that these impairments are present from childhood, not acquired as a result of accident or following the onset of adult illness or accident. There is still a good deal of debate about the best way to measure 'significant' impairment, and the impact of impairments of social functioning.
- 2.3. Although there had been an increase in the number of liaison and diversion schemes across England and Wales, the vast majority of these were based in courts rather than police custody suites.
- 2.4. This report uses the term 'learning disability' throughout. We have used this term to cover those people who have an IQ measured below 70, and those between 70 and 80, who are normally assessed as unsuitable to attend community and prison based accredited programmes. This group of people is sometimes referred to as having an intellectual and developmental disability (IDD). We have also used the term 'learning disability' to include people with an Autism Spectrum Disorder (ASD). We have not included people with a sole assessment of dyslexia.

Context

- 2.5. Lord Bradley's review of people with mental health problems and learning disabilities in the criminal justice system was commissioned in 2007 by the Government and published in April 2009. Although the review addressed both mental health and learning disabilities, it is generally recognised that the response to the review centred on mental health rather than learning disabilities. Lord Bradley argued that, '*learning disabilities must be looked at as separate from mental health problems. Even when talking to professionals in this field, I found that there was a lack of consensus in defining the boundaries between learning disability, borderline learning disability and learning difficulty. The problems with definition are due, in part, to the lack of agreement on the most effective methods of identification and assessment*'.

- 2.6. Given the lack of attention to the needs of offenders with learning disabilities highlighted in the Bradley Report there is clearly the potential for this group of offenders to be treated unfairly. In their 2008 report⁷ into the lives of people with learning disabilities, the Joint Committee on Human Rights said: *'We are concerned that the problems highlighted by this evidence could have potentially very serious implications for the rights of people with learning disabilities to a fair hearing, as protected by the common law and by Article 6 ECHR. Some of this evidence also suggests that there are serious failings in the criminal justice system, which gives rise to the discriminatory treatment of people with learning disabilities'* (paragraph 212, March 2008).
- 2.7. Estimates of the numbers of adult offenders with a learning disability vary widely. However, exact numbers are unknown as no accurate records are kept and there is a lack of clear definition of what a learning disability is. With some agencies including only those offenders with a recorded IQ under 70, and others covering all offenders with a specific learning disability including those with an IQ of under 80, ASD, and those with speech language and communication skills which make up to 50% of adults offenders within the criminal justice system.
- 2.8. The average IQ score of the general population, in the UK, is 100. A significant number of offenders have an IQ below the national average (a recent study found that 7% of adult prisoners have a learning disability demonstrated by an IQ score of less than 70 and a further 25% with a borderline learning disability with an IQ of under 80 (Mottram, 2007⁸) and would therefore benefit, from a greater understanding of their needs. Although we did not look specifically at the problems of offenders with dyslexia, it is worth noting that it is three to four times more common amongst offenders than in the general population.
- 2.9. Recent changes in the commissioning of health services, brought in through the Health and Social Care Act 2012, came into force in 2013. From April 2013, Health and Well-being Boards assumed strategic oversight of the commissioning of health and social care services, with Clinical Commissioning Groups and local authority Public Health teams leading on the commissioning of services locally. Separate arrangements have been introduced for the commissioning of some specialist groups, including the commissioning of health and substance misuse services for vulnerable suspects and defendants within custodial settings. Changes to commissioning arrangements have also set up regional offender health and justice commissioners who now have responsibility for health and justice commissioning. Although these commissioners are mainly responsible for prison health care provision it is vital for probation trusts and other providers, established through the *Transforming Rehabilitation* arrangements, to engage with both the offender commissioners and the Health and Well-being Boards to ensure that vulnerable offenders are not forgotten when services are commissioned.

Conclusion

Despite the recommendations in Lord Bradley's report, that learning disabilities be considered as separate to mental health problems, no clear definition of learning disability exists. As a result, there are considerable variations in the estimated numbers of adult offenders with learning disabilities. Given the recent changes in the commissioning of health services with the introduction of separate arrangements for some specialist groups, it will be important that the specific needs of this group of offenders are properly identified and catered for. The new *Transforming Rehabilitation* arrangements give an opportunity to help ensure that these needs are met.

Police detention

3

3. Police detention

Summary

In this chapter we analyse the treatment of offenders following arrest, including the appropriate use of specialist medical and mental health professionals and the use of Appropriate Adults in PACE interviews.

Key findings

- Many detainees' learning disabilities were not adequately assessed or recorded.
- Police custody suites were often unsuitable environments within which to make assessments of the needs and/or the risks posed by detainees with learning disabilities.
- Appropriate Adults were not always called, even when it was recorded that the detainee had a learning disability; Appropriate Adults are not trained sufficiently to support this client group.
- Referrals were not always made to relevant adult care services, leaving adults with learning disabilities vulnerable when released from custody.

Identification and assessment of learning disability

- 3.1. For the majority of offenders, including those with learning disabilities, contact with the police is the first stage of their involvement in the criminal justice system. PACE places a legal obligation on police forces to ensure that a 'mentally vulnerable' person's rights and interests are safeguarded through the provision of an Appropriate Adult. PACE defines mentally vulnerable as: *'any detainee who, because of their mental state or capacity, may not understand the significance of what is said, of questions or of their replies'*. Detainees with a learning disability clearly fit this definition. Contact with the police presents an early opportunity, through intervention and liaison, to engage appropriate services and potentially avoid future offending by those with learning difficulties.
- 3.2. In his report, Lord Bradley concluded that the police stage in the offender pathway provides the greatest opportunity to effect change. Through: *'improving access to services for offenders and potential offenders, improving safety for individuals and the public, supporting the police to fulfil their responsibilities and providing valuable information to agencies at the later stages of the criminal justice system'*.
- 3.3. Different police forces ascribed different meanings to the terms 'identification' or 'screening' of learning disabilities, and 'assessment' and referral to liaison and diversion agencies. For the purpose of this report, 'identification' is referred to as the screening process for learning disabilities at the point of entry to the custody unit; 'assessment' is any subsequent process involving trained professional assessment.
- 3.4. The identification, assessment, referral and diversion of offenders with learning disabilities, and the provision of Appropriate Adults, depend on the ability of police officers and other custody staff to recognise learning disability. This is, in part, dependent on the level of training provided to officers and other staff.
- 3.5. Inadequate training in mental health and learning disability was identified in the Bradley report. While custody sergeants in all of the forces we visited received training on vulnerability, none of the forces provided specialist training to police officers in custody suites on how to identify or deal with detainees with learning disabilities.

- 3.6. However, training on learning disabilities had recently been provided to Custody Detention Officers in one of the forces visited. This training provided practical guidance on the definition and identification of a learning disability, as well as the potential impact of the criminal justice system on a person with a learning disability.
- 3.7. In all of the forces visited, custody staff stated that they used historical information about a detainee from police computer records when booking them into custody. These records were commonly used to determine whether the detainee had any mental health problems, and to assist in assessing the level of risk they presented, to themselves and others whilst in custody. To a lesser extent, these systems were used to identify previous learning disability issues, and to establish whether the detainee would need an Appropriate Adult. Staff also frequently used prior personal knowledge of the detainee to identify learning disabilities.
- 3.8. Custody staff told us that, in the majority of cases, they relied on their judgement and experience in identifying learning disabilities, with one custody police inspector stating that identification can be "*subjective and contextual*". A common theme among custody sergeants was that identifying learning disabilities was generally only possible by reading cues from the detainees' responses to questions on risk assessment; it was often more about what they did not say than the answers themselves. Correctly reading the cues prompted the custody sergeant to ask further questions to identify whether the detainee had a learning disability.
- 3.9. In all forces, the principal risk assessment process involved asking the detainee a series of set questions on arrival in custody. In all but one force, these questions were in the form of a template on the computer system. The other force used a paper-based custody record system. In all forces the questions regarding learning disabilities were general and involved asking whether the detainee had any problems with reading or writing, or whether they had any mental health problems. There was no specific question in any of the risk assessments that asked detainees whether they had a learning difficulty or disability.
- 3.10. Detainees frequently reported poor reading and writing skills; some reported that they attended specialist education services. Such indicators were not consistently recognised by police as potential indicators of learning disabilities, and that this could mean that the person could benefit from the additional support of an Appropriate Adult.
- 3.11. Problems with identification were illustrated during the inspection in the findings from the inspection case reviews. Of the 36 cases identified by HMI Probation as involving offenders with learning disabilities, 15 were identified by the police as such; it follows that 58% of 36 detainees with learning disabilities had not been identified at the initial point of contact.
- 3.12. In three of the forces visited the assessment of mental health and learning disabilities was frequently undertaken by specialist nurses with differing levels of expertise in relation to learning disabilities. Some had little or no training in matters relating to detainees with learning difficulties, such as access to Appropriate Adults and CPNs.

Practice Example

Michael was arrested for indecent assaults, by touching women in a shopping centre. He was interviewed with an Appropriate Adult present and the interview records show that the Appropriate Adult intervened when the police tried to test Michael's understanding about being arrested. Although Michael knew he had been arrested he did not understand why or what it meant. The Appropriate Adult advised Michael and the police that he should be fully assessed by a CPN before being further interviewed. This helped with subsequent interviews as Michael had a better understanding of what he was being asked.

- 3.13. In one police force area, a CPN not only assessed vulnerability, but also directed detainees to other relevant services and helped with access to an appropriate adult. The CPN ensured that detainees' needs were met by accessing their NHS mental health records to identify the nature of their need and the current support provided. In one instance during the inspection, the CPN was able to request that the detainee's outreach worker attend the custody suite.
- 3.14. Another force used Custody Intervention Programme workers to screen for learning disability. Workers used a scored questionnaire to indicate whether the detainee had learning disabilities. Where appropriate, referrals were made to agencies that could help to address specific needs. However, with one exception, this approach was limited to detainees who had been referred for drug and alcohol screening. Although this was a valuable service, and a clear improvement on what was available in other forces, it was of limited use and should not be regarded as an alternative to the availability of effective screening and assessment for all detainees.
- 3.15. Custody facilities used by the forces inspected were mainly open plan units, which afforded little privacy for detainees. This may reduce the likelihood of them disclosing information about a learning disability. Custody staff also told us that they were under pressure to process detainees quickly, in order to release arresting officers back onto the street. They sometimes felt that this was at the expense of a thorough risk assessment.

Practice Example

Cleo was a 30 year old woman with learning disabilities and depression. Cleo was arrested for three offences of making nuisance calls to the emergency service, specifically the police, and then writing threatening letters to the arresting police officer. There was no record on police or CPS case papers of Cleo's learning disability, although there was reference to her behaviour at the custody suite that should have indicated that there were possible mental health or learning disability issues.

Appropriate Adults

- 3.16. The Appropriate Adult role was created under PACE, and is a requirement for the 'mentally vulnerable' and juveniles. The Appropriate Adult is required to be present at a number of points, for example when the child or young person or vulnerable adult is told their rights and entitlements; when they are interviewed; and, if already at the police station, when the child or young person or vulnerable adult is charged.
- 3.17. As well as ensuring the welfare of vulnerable detainees, Section 77 of PACE includes provisions for a judge to exclude evidence, such as confessions, where there has been a failure to provide an Appropriate Adult during police detention. This can impact on the outcome of a trial.
- 3.18. In one force we visited none of the ten detainees with learning disabilities in cases we looked at had received an Appropriate Adult, even though many had been medically assessed. Some FMEs did not always recognise the need for an Appropriate Adult to be called. In one case where an FME had recorded that the detainee had: '*Complex problems including; Aspergers, anger management problems, suicide attempts and thoughts, self-harmer, self-inflicted head injury*', the FME concluded that an Appropriate Adult was not required. This was a disturbing finding and calls into question the training, management and capability of FMEs to recognise when an appropriate adult is required.
- 3.19. Where a learning disability had been identified in police detention, an Appropriate Adult was used in 63% of cases. This was a disappointing finding. Custody records made it clear that a learning difficulty existed, yet there was little acknowledgement that this meant that the custody officer should treat the detainee as 'mentally vulnerable'.
- 3.20. We identified a wide variety of Appropriate Adult schemes; some schemes were run by charities while others relied upon social services or private sector provision. Police forces are responsible for

ensuring the attendance of Appropriate Adults when they are required for detainees in police custody, but there is no statutory obligation placed on any agency to provide them. Schemes varied, even within the same force area, with some custody suites getting a good service and others receiving a poor one. In this respect, our findings in this inspection mirror those of the Joint Criminal Justice inspection report of Appropriate Adults: *Who's looking out for the children? A joint inspection of Appropriate Adult provision and children in detention after charge*⁹.

Good practice example

South Wales Police employed a local charity (HAFAL) to provide the Appropriate Adult service using staff trained to work with people with learning disabilities. This ensured the service provided met the particular needs of detainees with learning disabilities. It was also recognised by police custody officers as a real improvement on the previous arrangements.

- 3.21. Two of the six forces (South Wales and Leicestershire) reported that they had Appropriate Adults available day or night. In another force, where the police relied on the social services emergency duty team to provide Appropriate Adults, one of the cases we looked at demonstrated that lack of availability of Appropriate Adults affected operational decisions.

Practice Example

The custody sergeant contacted the Emergency Duty Team (EDT) to request an Appropriate Adult at 21:55 but was told no one was available until the morning. Despite strong representations from the duty solicitor, the custody officer was faced with the decision to bail a vulnerable adult who had no support mechanism, or detain him overnight unnecessarily. He opted to detain overnight.

- 3.22. Custody staff told us that this problem was compounded by the perception, within local authority adult social care services, that a detainee in custody was safe from harm, and therefore not their highest priority. Some forces cited problems with local authority provision, in that Appropriate Adults would not attend unless the detainee had also requested a solicitor. During unsociable hours there was often no cover for providing the Appropriate Adult role, or cover was provided by the emergency social worker.
- 3.23. It was apparent from reading probation case files that, in a small number of cases, parent/ carers and other family members had been used as Appropriate Adults for adult offenders with a learning disability. While this might be satisfactory in many cases, there were concerns in some instances this could lead to problems, such as where the allegations concerned sexual offences or allegations against other members of the same family. South Wales Police had Appropriate Adults who specialised in working with adults with learning disabilities. Inspectors viewed this as effective practice. If the Appropriate Adult system is to be fit for purpose, it must be staffed by workers/ volunteers who have received appropriate training in supporting people with a learning disability.

Pre-release risk assessment and referral

- 3.24. The pre-release risk assessment process was the mechanism used to ensure that vulnerable detainees were released with enough support to ensure their welfare.
- 3.25. In all of the forces visited there were problems with the pre-release risk assessment process, with little consideration beyond ensuring the detainees' safe return home. There was scant evidence in

the case reviews conducted of any wider consideration of the risks facing the detainee or the public. In one case a detainee who had been assessed as a suicide risk whilst in custody, with a propensity for running into the road, was given a lift home; we found no written evidence of any consideration of onward support.

- 3.26. There was no written evidence in any of the forces visited that referrals to relevant agencies were being made as a result of the identification of learning disabilities while detainees were in custody.

Health provision

- 3.27. To complement training on vulnerability, some forces had invited medical staff to deliver presentations on mental health issues and learning disabilities on custody sergeants' training courses or training days. Although this practice was not fully embedded or consistent across forces, we regard it as a positive development.
- 3.28. Where health personnel were present in police custody suites, and had direct access to the NHS patient database, there was good, timely and accurate information sharing between agencies to safeguard detainees' health needs. Health staff could identify, confirm and alert custody staff to known health needs of detained persons. This could influence both the management and support of the detainee and/or the potential risks they could present to themselves and to others.
- 3.29. We found a general lack of understanding among police officers about the difference between learning disabilities and mental health needs. This was unsurprising given the scope of their role and the absence of specific training to enable them to distinguish between the two. However, the creation of partnership forums in some areas, involving health professionals and the police, had assisted decision-making in cases where detainees had mental health needs or learning difficulties. In some instances, detainees were bailed to enable them to access specialist support.

Good practice example

A South Wales police custody suite has a full-time mental health nurse whose role is to review all detainees, identify the mentally vulnerable and ensure that they receive appropriate support whilst in custody.

- 3.30. In two out of the six forces inspected, community health records were fully accessible to medical staff in police custody suites. Medical staff without access to the NHS database relied on disclosures made by those detainees who consented to see them; the accounts of police and witnesses; and their experience and professional judgement, to inform their assessments of the detainee's fitness to be interviewed.

Diversion from the criminal justice system and/or from prosecution

- 3.31. The Bradley report clearly stated the importance at the police stage of the offender pathway referring those with mental health needs away from a criminal justice outcome. Bradley stated: *'If a mental health need is identified, the challenge for the police is to decide whether or not a criminal justice outcome should be pursued, and if diversion to health and social services is more appropriate'*. Evidence of links between learning disability, offending behaviour and reoffending indicates that the same principle should be applied to persons with learning disabilities
- 3.32. In the joint criminal justice inspection report on work with offenders with a mental disorder, published in 2009, inspectors said: *'We found, perhaps surprisingly, that there was not a clamour from either criminal justice or health professionals for diverting an increased number of offenders from prosecution'*. This was also the case with offenders with a learning disability.

3.33. We were impressed that one of the forces we visited had a process to divert people from custody before arrest, on the grounds of identified mental health problems or a learning disability. Leicestershire police operated a 'triage car' which could be requested by police officers who identified concerns when attending incidents. The car was staffed by a police officer and a CPN provided by Leicestershire partnership NHS trusts. The CPN provided expert advice in dealing with possible mental health and learning disability issues, and could access medical histories and services to divert suspects away from custody. This was the only force to have a bespoke diversion scheme in place at the pre-custody stage. As a result, in other force areas, opportunities were missed to divert this group of offenders into more appropriate services.

Conclusion

Although the police service is under a statutory obligation to safeguard the rights and interests of 'mentally vulnerable persons', the forces we visited did not always have a systematic approach to identifying people with learning disabilities and assessing their needs. Custody facilities are not always conducive to disclosure, by detainees, of their learning disabilities; specialist clinical support is inconsistent; and Appropriate Adult services are not always accessed or available, even where learning disabilities have been identified and recorded. Failures to identify detainees with learning difficulties can mean that relevant information is not always passed on to the CPS, courts and probation staff and, in some cases, referrals are not made to specialist services in the community.

Before court: the decision to prosecute

4

4. Before court: the decision to prosecute

Summary

In this chapter we look at how well information regarding the offender's learning disability is shared between the police and CPS, and taken into account when making decisions about prosecution and diversion.

Key findings

- Police information about an offender's learning disabilities is not routinely passed to the CPS.
- When the CPS receives this information it is generally considered properly by CPS lawyers when it is relevant.

The role of police and the CPS when charging

- 4.1. The decision whether to charge will be taken by the police except in more serious cases when the case is referred to a CPS lawyer. All decisions whether to charge, whether by the police or the CPS, must be made in accordance with the test set out in *The Code for Crown Prosecutors*¹⁰ (the Full Code Test). The Full Code Test has two stages¹: the first is the evidential stage and the decision-maker must be satisfied that there is a realistic prospect of conviction given the evidence available. If the decision-maker is satisfied that there is sufficient evidence to justify a prosecution they must then consider the second stage, which is whether a prosecution is required in the public interest.
- 4.2. The Full Code Test is applied by the Police as well as CPS prosecutors when making charging decisions and applies to decisions made throughout the life of a prosecution case. Information that a defendant may have a learning disability is provided by police and will be taken into account by the crown prosecutor where relevant.
- 4.3. The CPS guidance on mentally disordered offenders is used in conjunction with the *Code for Crown Prosecutors* when dealing with cases involving defendants/suspects with a learning disability. The mental ability of a suspect may be relevant to the decision as to whether there is enough evidence to prosecute.
- 4.4. When considering the public interest stage, the prosecutor examines all available information include the seriousness of the offence, the circumstances of, and the harm caused, to a victim and the level of culpability of the suspect, including information about the disorder provided by the police or defence. In some circumstances these factors may mean it is less likely that a prosecution is required. This needs to be balanced with the other public interest factors including the need to safeguard the public and those caring for such persons.
- 4.5. Where the police make the decision to charge, the case should be reviewed by the CPS before the first hearing at court. Furthermore, all cases should be kept under review as they progress through the court system.
- 4.6. In cases where the CPS was aware that the defendant had a learning disability, we expected to see information relating to this in the file including in CPS review notes. We were concerned to find that, overall, the CPS was not provided with adequate information from the police in two-thirds of 70 cases.

¹ There is an exception where the pre-charge "Threshold Test" is applied (defined in the Code for Crown Prosecutors) This test is used in serious cases where key evidence is not yet available and where the prosecution want to apply to keep the defendant in custody to protect the public from offending and/or to secure the attendance of a defendant for trial.

Practice Examples

The case of an offender who had sexually assaulted another resident in a care home was reviewed by the CPS. The information about his learning disability was discussed and taken into account by the charging lawyer. Although the case proceeded to court, it was done so on the basis of full knowledge of the offender's disability which was then made available to the judge and jury.

An offender with autism was arrested for burglary. He told police in an interview that he had followed instructions from another offender and he did not realise his actions were wrong. The CPS charging lawyer was told about the autism but not the detail of what had been said in the interview, although this would not have altered the charge decision, it might have saved some time. The information was supplied later but was not considered by CPS. The defence later requested an assessment about the defendant's mental capacity leading eventually to a guilty plea.

- 4.7. We examined the decision-making in the 70 cases that were referred to the CPS for prosecution. Twenty-six of these cases had been charged by the police and a further 42 were charged by the CPS (in two other cases the CPS decided not to charge for reasons unconnected to the defendant's learning disability). The cases included a variety of offences ranging from rape and serious arson to relatively minor thefts, assaults and public order incidents. All of the pre-charge decisions made by the CPS complied with the *Code for Crown Prosecutors*.
- 4.8. In nine of the 42 CPS charging decisions, we considered that the information relating to the offender's learning disability was potentially significant because it was required to inform the decision making process. However, in the specific cases we judged that the same decision would have been taken even if the prosecutor had been aware of the learning disability.
- 4.9. In three of the nine cases, the CPS was not given sufficient information to make a fully informed decision. In two cases the information was given to the CPS but not considered properly and in four cases the information was supplied and was properly considered before charge.
- 4.10. Once in court, we considered that 12 of the cases had significance for the application of the Code test. In three, the police did not supply the information at all; in five, the information was available but not properly considered by the CPS; and in the other cases the information was supplied and properly considered. All, except one, of the post-charge decisions made by the CPS complied with the *Code for Crown Prosecutors* in that there appeared to be a realistic prospect of a conviction and the prosecution was in the public interest.

Practice Examples

In an arson case, information about the defendant's learning disability had been supplied and considered by the charging lawyer; this consideration was reflected in the choice of charge and venue. For unrecorded reasons a much more serious charge was added meaning the case went to the Crown Court. We considered that this decision to add the serious charge was not in compliance with the Code for Crown Prosecutors as there was insufficient evidence to prove the intent. A later review supported our judgement and the case was dropped.

- 4.11. On occasion, after a case has entered the court system, it was the defence solicitor who told the CPS about the learning disability. There were four cases where, except for the defence information, the CPS would have been unaware of offender's learning disability.

Conclusion

The decision to prosecute a person should always be taken with as much relevant information as possible about the offence and the offender. CPS lawyers are not getting the right, or sufficient, information from the police, even in cases where police staff or the FME had recorded that the person had a learning disability. The type of information that the police should be passing on to the CPS in such cases needs to be made a much more explicit requirement.

It is a matter for serious concern that in two-thirds of cases the CPS lawyer was not provided with information about a learning disability; it would also appear that the CPS lawyers are not always sufficiently alert to the issues of learning disability. Prosecutors should also be more alert, when material or evidence suggests there may be a learning difficulty, to requesting clarification from the police.

The court process

5

5. The court process

Summary

In this chapter we look at how well offenders' learning disabilities are taken into account when defendants attend court.

Key findings

- There was a lack of 'easy read' leaflets for people with learning disabilities in court waiting areas.
- Specialist training, for court based liaison and diversion workers to ensure defendants with learning disability are supported appropriately at court, was needed.
- Accredited and registered intermediaries were not always available to support vulnerable defendants with learning disabilities during the trial process.
- There were some significant delays in progressing cases particularly when specialist assessments and reports were ordered.

Advice and support at court

- 5.1. During the inspection fieldwork we visited courts in all six areas. When visiting the courts we were looking at whether there was help for people with learning disabilities, for example easy read leaflets or posters. Unfortunately, we saw no easy read leaflets and posters readily available. In one court waiting area, there was a notice informing court users that 'leaflets were available in other languages including an 'easy read' format' but these had to be specially requested from busy court staff.
- 5.2. For anyone entering a criminal court for the first time, the environment and process is confusing and possibly frightening and this is especially so for someone with a learning disability. The availability of 'easy read' posters and leaflets is the very least that should be available to help someone feel less intimidated.
- 5.3. Court staff do not receive any special training on how to recognise or deal with vulnerable defendants, including those with a learning disability. It is desirable that court staff, who often have the first contact with a defendant, should be able to recognise signs and symptoms of learning disabilities. They should also be aware of any liaison and diversion arrangements available at the court in case specialist advice is needed.
- 5.4. Once a person has been charged there are opportunities to provide health-related support to vulnerable offenders during the court process. In all but one of the areas we visited, there were schemes in operation within the magistrates' court building. There are currently over 100 of these Criminal Justice Liaison and Diversion schemes across England and Wales. The majority specialise in mental health issues, with very few having any specialist knowledge of learning disabilities.
- 5.5. From observations and information from court staff and advocates it was apparent that the presence of CPNs at court was considered an asset. They were valued as a source of information about a defendant's background, especially where the defendant was previously known, and gave courts guidance on the availability of specialist accommodation and suitability and availability of support options. Connections with the health system also meant that courts could avoid lengthy delays obtaining reports.
- 5.6. Most mental health professionals interviewed within Liaison and Diversion schemes had some

training in assessing people with a learning disability, and in all but one area there was an assessment tool available for them to use. However, the majority of mental health workers felt that they had limited skills in working with this client group. Across all areas inspected we found that even where there were formal referral processes with local adult services, it was hard to get referrals accepted and services were limited. This was a particular problem for offenders with an ASD, despite the Autism Act 2009, which places a duty on local authorities produce an autism strategy.

- 5.7. Court-based probation staff interviewed during the inspection described a mixed picture in relation to liaison and diversion schemes at court. Although most courts had mental health professionals available, they believed the main focus of their work was defendants who appeared to have a mental health disorder rather than a learning disability.
- 5.8. Mental health professionals told us of the difficulty they had making referrals and getting information about offenders who might have a learning disability. Often such offenders were identified when they arrived in the court cells, as there was usually a close working relationship with security staff. However, this is clearly not an alternative to effective information sharing protocols and arrangements between the police, custody suite CPNs and court CPNs. A number of programmes of work, including the transfer of commissioning of health services in police custody from individual forces to the NHS, and the national roll out of liaison and diversion services are planned under the restructuring of NHS commissioning.

Good practice example

Melanie was arrested for an assault on a neighbour. The CPN at the initial court hearing recognised that she had a learning disability. The CPN made further enquires and discovered that Melanie was known to adult social care services. She also discovered that Melanie had a two year old child and her parenting had caused Children's Services concern. The CPN made contact with Melanie's social worker, who checked that the child was safe and made provision for the child if Melanie was remanded in custody.

The trial process

- 5.9. Since 2011, trained and accredited intermediaries have been available to support vulnerable witnesses, including those with a learning disability. These intermediaries are covered by a statutory registration scheme. The provisions for intermediaries are under the Coroners and Justice Act 2009, which also included a provision under Section 104 to support similarly vulnerable defendants, however this provision has not yet been implemented. Intermediaries for defendants are not, therefore, routinely available, although their use has been developed through the courts' inherent powers¹. The use of an intermediary for a vulnerable defendant can be used to assist understanding and so avoid a Mental Health Act finding of unfit to plead. Such a finding can have significant consequences for a defendant (in terms of detention) as well as for a victim.
- 5.10. Because there is no statutory provision, intermediaries for defendants are not routinely available and are rarely registered or accredited. Although we were told by CPS prosecutors and court users that their experiences with intermediaries were largely positive, we did not see their use because none of the cases warranted such a measure. Inspectors spoke to care workers and court-based mental health staff who had accompanied or assisted defendants at court in a small number of cases. Although the involvement of mental health and care professionals appeared to be positive, they should not be seen as an alternative to registered and accredited intermediaries.
- 5.11. From the cases inspected there was evidence of a wide variation in the time it took for offenders with a learning disability (whether formally diagnosed or not) to progress through the criminal

¹ *R v. GP and 4 others*, Leeds Crown Court, 20 July 2012: a judgment by His Honour Judge Peter Collier QC that summarises the current practice and guidance on the use of defendant intermediaries.

justice system. Delays were caused by a variety of reasons, particularly the funding of specialist assessments and reports. We also found that many of the reports, prepared by psychiatrists and psychologists who did not specialise in learning disabilities, added little to the courts understanding and reports often concluded that a more specialist report was required. Delays could be reduced if specialist learning disability professionals were available at court to provide speedy quality assessments and reports.

- 5.12. In most of the courts we visited, probation staff were using a PSR referral form containing a diversity checklist including dyslexia, literacy and learning disabilities. However, we found very few fully completed forms in cases where the offender was recorded as having a learning disability. We felt this was an opportunity to share information between all professionals at an early stage, which unfortunately appeared to have been missed.

Conclusion

The lack of information about the number of defendants with learning disabilities going through the courts means that the entrenched problems in taking them through the criminal justice system are going unaddressed. The court environment could very easily, and with little extra cost, be made less intimidating for defendants (and witnesses) with learning disabilities by the provision of information displays, easy read documents and awareness training for court staff – including ushers.

The importance of the potential role played by intermediaries has been underestimated and the introduction of a statutory role for intermediaries, supported by an effective registration system, could make a significant difference to the outcomes for those with learning disabilities going through the courts. Similarly, CPNs working in courts clearly provided a valuable service; however, their potential could, and should, be maximised with more attention given to working with people with learning disabilities and the recruitment of more specialist learning disabilities workers within the criminal justice system.

An opportunity now exists and should be taken to address problems in communication between the different disciplines operating within the court setting through the changes to commissioning arrangements brought about by the Health and Social Care Act 2012.

Advising the court and preparing the sentence

6

6. Advising the court and preparing for sentence

Summary

This chapter looks at how aware offender managers are of the offender's learning disability when preparing pre-sentence reports and initial assessments

Key findings

- The majority of reports and assessments were timely and of an appropriate type to assess the offender's needs and provide useful information to the court.
- The offence analysis, contained in reports and the initial assessment, failed to take account of the offender's learning disability either as a mitigating or risk factor.
- Reports often confused the offender's learning disability and the risk of harm they posed to others.
- Reports and assessments failed to take account of the likely impact of the offender's learning disability on their ability to engage with their order.
- Offender managers gave too much weight to the offender's needs at the expense of possible risk of harm factors.
- Training of probation staff was mixed, with some offender managers reporting excellent training and others reporting none.

Pre-Sentence reports

- 6.1. The role of Probation Trusts is to provide PSRs to court to assist magistrates or judges with sentencing. Reports should contain an analysis of the offence, assessment of those factors that contributed to the offence and what work needed to be done to reduce the likelihood of reoffending. Reports can be produced on the day of the court hearing or following a short adjournment period. Complex cases, including those where the defendant has a learning disability, would normally require a longer period adjournment for a full assessment.
- 6.2. The *Probation Circular 18/2005 Criminal Justice Act 2003 - New Sentences and the New Report Framework*¹¹ states that the report writer should: 'consider requesting an adjournment to complete a standard delivery report 'where any factor comes to their attention that suggests a full OASys assessment and an adjournment is required'.
- 6.3. The majority of reports we saw were prepared following an adjournment. We were concerned, however, to see a number of reports (8 out of 60) produced on the day of the court hearing which did not contain sufficient information. These reports did not allow sufficient time to investigate the offender's learning disability and, therefore, to provide the court with appropriate sentencing options. Some probation staff interviewed during the inspection told us that they had only 20 minutes to interview offenders for reports prepared at court; this is clearly insufficient when reporting on a vulnerable offender.
- 6.4. It is vital that the report writer takes account of how the court viewed the offence and any likely sentence. In all but 2 out of 37 relevant cases, the report took into account the seriousness level as indicated by the court.
- 6.5. Although there was evidence in all but five reports that the author was aware that the offender had a learning disability, the offence analysis took into account relevant learning disability issues in only 40% of the reports. We saw examples of reports that despite evidence of a direct links between

the offence and the learning disability, in witness statements those links were not included in the offence analysis. We considered this limited the value of the reports in ensuring that the offender was sentenced to an order that would help them stop offending.

Good practice example

In South Wales, a CPN with specialist knowledge of learning disabilities provided advice to offender managers preparing reports on offender with a learning disability; this helped the report writer address the offender's learning disability in reports better.

Good practice example

Matt was a 24 year old man with a number of convictions, including assault, domestic violence and burglaries. During the PSR interview at court, Matt disclosed that he had Aspergers Syndrome. The offender manager interviewing Matt made a good link between Matt's offending and his Aspergers. The report recommend a three week adjournment for a full report. The offender manager used the adjournment to arrange for Matt to be assessed by a CPN, experienced in dealing with learning disabilities. The final report included the CPN's assessment of how Matt's Aspergers affected his thinking, and proposed a community order with a plan of work developed to meet Matt's specific needs. The court agreed with the report and made a community order.

- 6.6. Half of all reports failed to clearly document any pattern of offending behaviour including reference to previous convictions as well as police warnings and cautions that were linked to the offender's learning disability. This included a case where a man had a number of police warnings and cautions for inappropriately touching women in public, but this information was not later included in a PSR for a much more serious sexual offence.
- 6.7. The risk of harm posed by offenders with a learning disability was often under-reported or confused with their learning disability. As a result, in over one-third of cases the PSR failed to include a clear assessment that differentiated between offending behaviour and the impact of that behaviour on the victim. An example was an offender whose behaviour was deemed antisocial; the report overlooked the risk of harm element, despite the offence being assaults on a member of the public and a police officer.

Practice Examples

Frank was a 24 year old man diagnosed as having ASD. He was convicted of harassment of his ex-partner and her children. Frank had three previous recorded police warnings and cautions for harassment of other ex-partners. The PSR proposed a community order with only unpaid work, as he was assessed as unsuitable for any accredited programmes, and the court agreed with this proposal. Frank completed his unpaid work but was arrested again outside his ex-partners house. The offender manager reduced the assessed risk of harm to low and a further PSR recommended another unpaid work order.

- 6.8. Only half of the reports inspected assessed risk of harm to others, taking into account the offender's learning disability. We judged that the offender's learning disability was accurately assessed in less than one-third of reports that contained an assessment of the offender's risk of harm to others. This was mainly due to the report writer either not understanding the potential link between the offender's disability and the risk of harm they posed, or simply not understand the nature of the

learning disability. One report writer told us; *"A lot of offenders with a learning disability have very complex needs and I often feel unable to propose a probation-based sentence"*.

- 6.9. We were particularly concerned by the PSR writers' lack of understanding or awareness of offenders' learning disability needs. Reports either failed to address needs or cited the 'difficulties' in managing such needs within a community order. We saw a number of reports where the writer struggled to recommend a community-based intervention and recommended fines, conditional discharge, standalone curfews with electronic monitoring or even, in one case, a short period of custody. Offender managers constantly told us they lacked confidence to deal with such cases or felt that other agencies should take responsibility for the offender.
- 6.10. In 18 of the 60 cases inspected a specialist psychiatric or psychologist report was available to the court. The vast majority of these reports were prepared by professionals with a mental health rather than a learning disability background. We found many reports that were unclear on either the diagnosis or the most appropriate sentence, often recommending a further report to assess the offender's learning disability.

Practice Examples

Anne was convicted of arson at the home of her partner and his children. There was a psychiatric report to court; however, this only mentioned her learning disability in relation to her low IQ. Neither the specialist report nor the PSR included an assessment of what Anne's learning disability meant to her understanding of the risk of harm her action posed or the likelihood of Anne reoffending.

- 6.11. It is vital that sufficient time and resources are made available to offender managers preparing PSRs on offenders with learning disabilities. In Wales and Thames Valley we found evidence of report writers consulting CPNs and learning disability specialists prior to preparing their reports. In London we also found that a learning disability specialist was available in court to advise on appropriate interventions, and possible diversion programmes. However, these resources were few and far between and the norm was for PSR authors to write reports without any advice.
- 6.12. Omissions in PSRs were also reflected in the outline sentence plans contained within the reports. In a number of cases inspected we found that offender managers were unaware of the offender's disability and failed to address diversity issues linked to the offender's learning disability at the start of their supervision

Good practice example

Following a first interview with Stephanie in court, the report writer was concerned that she might have a learning disability. Although the court had only adjourned the case for a week for a short format report, the probation officer was able to ask the court for a full three week adjournment. During that time a full assessment was undertaken by a learning disability worker attached to the court and the report contained an appropriate proposal to address both the offender's needs and their offending behaviour. As a result, by the time Stephanie was sentenced to a community order, support services were in place that enabled her to get the most out of the order and support the supervising offender manager in their work with Stephanie.

Initial assessment and sentence planning

- 6.13. In 47 of the 60 cases inspected, the initial assessment included information relating to the offender's learning disability. The most common problem with assessments was inaccurately describing the nature of the disability, for example recording that the offender may have '*grown out*' of Attention Deficit Hyperactivity Disorder (ADHD).
- 6.14. Given that the majority of PSRs failed to recognise or report on how best to address the link between the offender's learning disability and their offending, it is not surprising that the supervising offender manager also failed to recognise these factors in their OASys initial assessment in less than half of cases.
- 6.15. In the vast majority of cases there was a timely initial sentence plan. Unfortunately, fewer than one-third of the sentence plans contained an objective to address the offender's learning disability or how and by who, their related needs would be met.

Practice Examples

A Carl, a 19 year old man with a long history of petty offending, antisocial behaviour and breaching court orders was sentenced to a short prison sentence for breach of an antisocial behaviour order and community order. Carl was due to be released from custody within a few weeks. An OASys assessment still simply recorded "ADHD and depression." No consideration was given to either how his disorder may affect his behaviour or what work was needed to help him better comply with his Young Offenders Licence when he is released.

- 6.16. In a number of cases the assessment of risk of harm to others was underestimated due to the offender's learning disability. We were very concerned that in one case involving an offender who had committed sexual offences against a child, the initial assessment stated that the offender had "*difficulty in forming relationships and that the sexual offence was not committed through malice or harmful intent*". The perceived intent and the impact had become confused in the mind of the offender manager and they assessed the risk of harm to others as low on that basis. In cases where the offender was known to the local authority adult services prior to the offence, offender managers were often confused over who was responsible for the offender. In two cases where offenders had committed sexual offences while living in supported accommodation, including one of rape of a 13-year-old girl, the offender manager reduced the level of risk of harm. They believed the offender would be getting the required support from social care staff in the supported accommodation, despite clear evidence that the initial offence had taken place while the offender was living in exactly the same circumstances.

Training

- 6.17. Across the six Probation Trusts inspected we saw a mixed picture in relation to both the training of staff to work with offenders with a learning disability and the level of professional support and advice available to offender managers. In Thames Valley there was a comprehensive training package available which all staff were expected to attend. The Trust also had a learning disability section on its intranet, which included links to guidance such as the DoH offender health guide *Positive Practice, Positive Outcomes: A Handbook for Professionals in the Criminal Justice System working with Offenders with Learning Difficulties*¹² and simple assessment tools for use with offenders who presented as having a learning disability. Offender managers across Oxfordshire and Buckinghamshire also had access to a full-time forensic psychologist who could offer advice as well as undertaking more in-depth assessments. In other Probation Trusts we found a less formal

structure of training and support, with most offender managers reporting having to search the internet for guidance and CPNs and psychologists offering support and advice on a more ad hoc basis.

Good practice example

Thames Valley Probation Trust have produced a learning and support pack for staff available as a one day training programme and via an online resource on the intranet, giving staff an understanding of learning disability issues and access to information as they managed cases. These had given offender managers more confidence in assessing offenders with learning disabilities and were seen by Thames Valley staff as vital tools.

Conclusion

The practice of using PSRs prepared on the day of sentence for offenders with learning disabilities is inappropriate because these offenders have complex needs that require a full and detailed report to assist the court with sentencing. In far too many cases we found reports and initial assessments that failed to correctly assess the offender's learning disability or confused the offender's needs with their risk of reoffending or harm. The poor quality of court reports and assessments prepared on those with learning disabilities also raises questions about the quality of training given to probation staff in such issues; this will have implications for the *Transforming Rehabilitation* arrangements as it is anticipated that although the National Probation Service will prepare court reports the majority of such cases will be passed over to private or voluntary sector providers.

People with a learning disability have very different learning needs from the majority of the population. The failure to properly consider the implications of an offender's learning disability in PSRs and initial assessments meant that there was less chance of the offender successfully engaging in activities designed to reduce the likelihood of reoffending or reduce their risk of harm.

Appendices

Appendix 1: Glossary

ADHD	Attention Deficit Hyperactive Disorder: a condition within the autism spectrum
Appropriate Adults	Appropriate Adults: support children and young people and vulnerable adults in police custody in particular sitting in on Police And Criminal Evidence Act 1984 interviews
ASD	Autism Spectrum Disorder: covers all autism conditions including Aspergers syndrome and dyspraxia
CPN	Community Psychiatric Nurse: provides assessments and support of adults with mental health or learning disabilities who have offended or are at risk of offending
CPS	Crown Prosecution Service
DoH	Department of Health
EDT	Emergency Duty Team: local authority team who provide out of hours social workers, including acting as Appropriate Adults for children and vulnerable adults in police custody
ETE	Education, training and employment: work to improve an individual's learning, and to increase their employment prospects
FME	Force Medical Examiner: qualified medical doctor who attends police custody suites to asses and treat detainees including those with mental health and learning disabilities. This is often also referred to as a Forensic Medical Examiner
HAFAL	Welsh voluntary sector organisation contracted to provide Appropriate Adults to detainees in custody in Wales
HIW	Healthcare Inspectorate Wales
HM	Her Majesty's
HMI Probation	HM Inspectorate of Probation
HMCPPI	HM Crown Prosecution Service Inspectorate
HMI Constabulary	HM Inspectorate of Constabulary
	HM Inspectorate of Prisons
HMI Probation	HM Inspectorate of Probation
Interventions; constructive and restructive interventions	<p>Work with an individual that is designed to change their offending behaviour and/or to support public protection.</p> <p>A constructive intervention is where the primary purpose is to reduce likelihood of reoffending.</p> <p>A restrictive intervention is where the primary purpose is to keep to a minimum the individual's risk of harm to others.</p> <p>Example: with a sex offender, a constructive intervention might be to put them through an accredited sex offender programme; a restrictive intervention (to minimise their risk of harm) might be to monitor regularly and meticulously their accommodation, their employment and the places they frequent, imposing and enforcing clear restrictions as appropriate to each case.</p> <p>NB. Both types of intervention are important</p>
LSAB	Local Safeguarding Adult Board: set up in each local authority to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of vulnerable adults in that locality

MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher risk of harm to others
NAS	National Autistic Society. A voluntary sector organisation that supports people with autism, their families and friends and those who work with them
OASys/eOASys	Offender Assessment System/electronic Offender Assessment System
Prison Reform Trust	The Prison Reform Trust aims to create a just, humane and effective penal system. They have undertaken research on offenders with learning disabilities, and have published a number of reports see www.prisonreformtrust.org.uk/nok
PACE	Police and Criminal Evidence Act 1984: instituted a legal framework, supported by Codes of Practice, for the exercise of police powers in combating crime across England and Wales
PSR	Pre-sentence report: for a court
Risk of harm to others	This is the term generally used by HMI Probation to describe work to protect the public, primarily using restrictive interventions, to keep to a minimum the individual's opportunity to behave in a way that is a risk of harm to others
Safeguarding	The ability to demonstrate that all reasonable action has been taken to keep to a minimum the risk of a child or young person coming to harm

Appendix 2: Role of the inspectorates and code of practice

HMI Probation

Information on the Role of HMI Probation and Code of Practice can be found on our website:

<http://www.justice.gov.uk/about/hmi-probation>

The Inspectorate is a public body. Anyone wishing to comment on an inspection, a report or any other matter falling within its remit should write to:

HM Chief Inspector of Probation
1st Floor, Manchester Civil Justice Centre
1 Bridge Street West
Manchester, M3 3FX

Care Quality Commission

Information on the Role of the Care Quality Commission and Code of Practice can be found on our website:

<http://www.cqc.org.uk/>

The Inspectorate is a public body. Anyone wishing to comment on an inspection, a report or any other matter falling within its remit should write to:

Chief Executive, Care Quality Commission
Finsbury Tower, 103-105 Bunhill Row
London, EC1Y 8TG

HM Crown Prosecution Service Inspectorate

Information on the Role of HM Crown Prosecution Service Inspectorate and Code of Practice can be found on our website:

<http://www.hmcpsi.gov.uk/>

The Inspectorate is a public body. Anyone wishing to comment on an inspection, a report or any other matter falling within its remit should write to:

HM Chief Inspector of the Crown Prosecution Service
One Kemble Street
London, WC2B 4TS

HMI Constabulary

Information on the Role of HMI Constabulary and Code of Practice can be found on our website:

<http://www.hmic.gov.uk/>

The Inspectorate is a public body. Anyone wishing to comment on an inspection, a report or any other matter falling within its remit should write to:

HM Chief Inspector of Constabulary
6th Floor, Globe House, 89 Eccleston Square
London, SW1V 1PN

Appendix 3: References

- ¹ Bradley, Lord Keith, (April 2009), *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*, Department of Health, London
- ² Department of Health and HMI Constabulary, (January 2014), *Extra funding for mental health nurses to be based at police stations and courts across the country*, <http://dhmediacentre.tumblr.com/post/:id/:summary> (accessed 06 January 2014)
- ³ *Consolidated Practice Directions* [2013] EWCA Crim 1631
- ⁴ Criminal Justice Joint Inspectors Group, (2012), *Joint Inspection Business Plan 2012-14*, HM Crown Prosecution Service Inspectorate, et al, London
- ⁵ HMI Probation, et al, (December 2009), *A joint inspection on work prior to sentence with offenders with mental disorders*, HMI Probation, Manchester
- ⁶ World Health Organisation (WHO) (2010 version), International Classification of Diseases, <http://apps.who.int/classifications/icd10/browse/2010/en> (accessed 06 January 2014)
- ⁷ Joint Committee on Human Rights, (March 2008), *A life like any other?: Human Rights and Adults with Learning Disabilities*, The Stationery Office, London
- ⁸ Mottram, P, et al, (September 2007), "The prevalence of intellectual disability in a major UK prison", *British Journal of Learning Disabilities*, Vol. 35 Iss. 3, pp. 162-167
- ⁹ HMI Probation, et al, (December 2011), *Who's looking out for the children?: A joint inspection of appropriate adult provision and children in detention after charge*, HMI Probation, Manchester
- ¹⁰ Crown Prosecution Service, Seventh Edition (January 2013), *The Code for Crown Prosecutors*, Crown Prosecution Service, London
- ¹¹ National Probation Service for England and Wales, (March 2005), *Probation Circular 18/2005 Criminal Justice Act 2003 - New sentences and the New Report Framework*, Home Office, London
- ¹² Department of Health, (2011), *Positive Practice, Positive Outcomes: A Handbook for Professionals in the Criminal Justice System working with Offenders with Learning Difficulties*, Department of Health, London



Arolygiad ar y Cyd Cyfiawnder Troseddol

ISBN: 978-1-84099-626-5