The use of the appropriate adult for mentally disordered suspects in the police station

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‘The Use of the Appropriate Adult for Mentally Disordered Suspects in the Police Station’.

By
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A Thesis in fulfilment of the Regulations governing Higher Degrees by Research of Loughborough University.

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ABSTRACT

The research discussed in this thesis was the first to analyse the use of the Appropriate Adult for mentally disordered adult suspects in the police station. The role of the Appropriate Adult raises questions about how, and under what circumstances should mentally disordered suspects be detained and interviewed in the police station? The Appropriate Adult is the only special protection provided for mentally disordered suspects during their detention and interrogation. The Appropriate Adult's role and function is defined in Code C of the Police and Criminal Evidence Act 1984. The role of the Appropriate Adult is to ensure that the suspect's rights are respected, the suspect understands the procedures involved and that the police adhere to the Code, thereby minimising the risk of the police obtaining unreliable evidence from the suspect e.g. false confessions. The data in this thesis shows that the use of the Appropriate Adult is rarely used.

Out of the study of 20,805 custody records in four police stations in three police areas during 1992, it was found that an Appropriate Adult was used for only 38 mentally disordered adult suspects. The research also showed that at least a further 448 mentally vulnerable suspects should have had an Appropriate Adult called for them. Some of the reasons why the Appropriate Adult protection is neglected are examined and in so doing many socio/legal questions are raised such as: false confessions, miscarriages of justice, the amendment to the 'right to silence,' confidentiality, the roles of the custody officer, solicitors and police surgeons, and last but not least, the role and function of the Appropriate Adult. While there is growing concern about the ability of persons asked to act as Appropriate Adults the thesis includes a case study of a volunteer Appropriate Adult Scheme that provides some answers to the many issues raised and points the way to future development of those suspects detained and interviewed in the police station.
Acknowledgements.

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For my son,

Luke
"...illness of any sort was considered in Erewhon to be highly criminal and immoral."

Samuel Butler

*Erewhon* 1872
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CHAPTER 1
THE APPROPRIATE ADULT: AN INTRODUCTION

The Problem Stated.

The main aim in this research is to determine how and under what circumstances are people suffering from mental disorder and/or learning difficulties interviewed in a formal setting, with the assistance of an Appropriate Adult. A formal setting for the purposes of this thesis means a police station.

There are other formal settings where such interviews might take place, for example, in Special Hospitals when patients claim assault by a member of staff or another patient, or even an interview by a psychiatrist for the purpose of preparing a report to the Court. However, one of the most formal and potentially life changing contexts is an interview by the police in the police station, an environment which is intimidating and controlling; both of which are essential features of the police station itself. The formal police interview deliberately emphasises the unequal status between the police and the suspect - the power lies with the police. (McConville et al 1991).

Clearly, the problem is a large one; in terms of the numbers of mentally disordered it is estimated that 7% of all suspects who pass through a police station are mentally ill, 3% are mentally handicapped, and 1 or 2% are suffering from brain damage (Gudjonsson G. et al 1993). Gudjonsson et al (ibid) estimated that between 15 - 20% of suspects were what they call 'disadvantaged', and what are referred to in this thesis as 'vulnerable'. The question to be asked is what protection can be provided for these vulnerable suspects and how effective is it? One solution provided in England and Wales is for an Appropriate Adult (or AA from now on) to be present
during police interviews. It will be the purpose of this thesis to ask what extent is that protection used, is it adequate, and if not how can it be improved?

**A Legal Overview.**

There is no clear or accepted definition of the Appropriate Adult except that which is defined in law. One approach is by way of an analogy when issues are raised about consent in the Mental Health Act 1983 (MHA 1983). What does consent in this instance mean? Philip Bean states that - "The principle (of consent) is aimed at assisting the patient to come to a considered decision, not about protecting the medical practitioner." (Bean, 1986 p:136).

Just as the concept of informed consent is recognised in law, so a formal interview of a person (suspect) who is recognised as suffering from some incapacity or vulnerability, is recognised as needing the assistance of an Appropriate Adult i.e. to arrive at considered decisions or answers to questions which in this case means about police interviews. To continue with the analogy Philip Bean declares regarding the concept of consent -

"...consent is about a moral commitment on behalf of the informer to provide information upon which the decision can be made." (Bean, p.136, op.cit.).

It is here that the analogy becomes apparent. Just as the concept of consent as defined in the 1983 MHA, as a moral issue, so the protection by the Appropriate Adult was created to fill a moral vacuum. The formal police interviews of vulnerable people is also a moral issue and so too are issues about what the Appropriate Adult should, or should not do. The AA procedures have brought sharply into focus how vulnerable people are, or should be treated, whenever they are interviewed formally.
The legal definition of the AA can be found in Code C of the Codes of Practice which accompany the Police and Criminal Evidence Act 1984 (PACE) (Home Office 1985). There are five Codes which were revised in 1991 (Home Office 1991) and 1995 (Home Office 1995), and provide for the practical day to day operation of the PACE Act. Code C which is the most relevant is concerned with the detention treatment and questioning of suspects. The Codes of Practice, unlike the PACE Act, are not statutory instruments in the formal sense. However, failure by the police to implement the Code is subject to disciplinary action and is nevertheless a moral commitment on their behalf to ensure that advice and assistance is provided in respect of a suspect's capacity to understand and to make him or herself understood during a formal interview. This protection should be provided by an Appropriate Adult.

On the face of it then the use of an Appropriate Adult seems fairly straightforward, although as will be shown throughout this thesis it turns out to be immensely complex. If an Appropriate Adult was introduced initially to fill a moral vacuum the question remains - how and under what circumstances should that moral vacuum be filled? That is to say how should people who are suffering from mental disorder be interviewed in a formal setting? These questions have rarely been fully explored and defined, especially by those whose task it is to implement policy. For while the moral dimensions surrounding the mentally disordered or vulnerable suspect remain clear, the substance i.e. what the Appropriate Adult does or not do has never been debated.

**Why Is The Appropriate Adult Topical?**

The Appropriate Adult is of contemporary relevance for a number of reasons. First, because of the way it connects to other changes taking place in the criminal justice
system and related areas, some of which are legal, others of a wider social
movement. So for example, it is related to the conclusions of the Royal
Commission on Criminal Justice 1993 (RCCJ 1993) in as much as the Royal
Commission was seen to be about police procedures and miscarriages of justice.
Following a series of miscarriages of justice in the 1980's the Royal Commission
was established under the Chairmanship of Lord Runciman. Its remit was to -

"...examine the effectiveness of the criminal justice system in England and
and Wales in securing the conviction of those guilty of criminal offences and
and the acquittal of those who are innocent, having regard to the efficient use
of resources". (RCCJ 1993).

The Royal Commission's remit was wide ranging. As part of that remit however, a
number of research studies that were commissioned by the RCCJ (1993) are
relevant to this thesis, in as much as they were concerned with the treatment of
mentally handicapped and mentally disordered suspects. As a result of that
research the RCCJ (1993) recognised many problems associated with the AA
procedures and called for a working party to be established by the Home Office to
carry out a comprehensive review of -

"the role, functions, qualifications, training and availability of
appropriate adults". (RCCJ 1993 p.44)

Second, the Appropriate Adult is topical because, as stated above, there are already
legal procedures outlining the role and function of the AA in Code C of the PACE
Act 1984, and the question is being asked in numerous circles, including that of
policy makers and the Judiciary, to what extent are they being implemented.

Briefly, the main legal procedures state that -

"If an officer has any suspicion or is told in good faith that a person of any age, may be mentally disordered or mentally handicapped, or mentally incapable of understanding the significance of questions put to him or his replies, then that person shall be treated as a mentally disordered or mentally handicapped person for the purposes of this code." (C 1.4 Revised Code of Practice 1995)

(The original Code C 1.4 approximated to the above, the Revised 1991 Code C 1.4 is the same as the above).

It is worth noting here that Code C’s, Notes for Guidance 1H (Revised Codes 1995) states that the generic term mental disorder is used throughout the Code and reproduces the definition of mental disorder found in the Mental Health Act 1983 s1(2)(MHA 1983) as -

“...mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind.” (Notes for Guidance 1H)

This Note for Guidance states that the generic term mental disorder is different to mental handicap but for the purposes of the Code they are treated the same. Until a meaningful definition of mental illness, mental disorder or indeed psychopathic disorder is produced, the Mental Health Act 1983 and the PACE Act 1984 Codes of Practice that relate to mentally vulnerable suspects remains confused. However, Note for Guidance 1H 1995 unlike Note for Guidance 1G in the 1991 Revised Codes, includes an extra sentence, probably in recognition of the confused state of the formal definitions of mental disorder outlined above. Note 1H goes on to state that -

“Where the custody officer has any doubt as to the mental state or capacity of a person detained an appropriate adult should be called.” (Note 1H, 1995).
The inclusion of this extra sentence is important, in that it helps police officers and others who are not medically trained in identifying or defining someone who is mentally disordered. As such it indicates that the decision to call an AA may in the first instance be based on the subjective opinion of the custody officer. (In Scotland a Circular (NO 2/1990) the 'Interviewing of Mentally Handicapped or Mentally ill Persons'. was issued in 1990 by the Scottish Home and Health Department to the police. The main provision in the Circular, which is drawn directly from the PACE Act Code of Practice, is that interviews with mentally disordered people should be carried out in the presence of an Appropriate Adult).

Third, the Appropriate Adult is topical because it is linked to the 'decarceration' movement which has thrust forward the problem of mentally disordered suspects in ways perhaps less obvious than ten years ago. One outcome of this decarceration movement is that an increasing number of mentally disordered persons are prosecuted and imprisoned. (Coid J. 1988; Gunn J. et.al. 1991) Another, is that the police become important agents and key figures in the promotion of primary mental health care. (Bean P. et al. 1991). Consequently, the police station has become the place where decisions are made about the treatment or punishment of mentally vulnerable suspects; the AA role and function is part of those decisions making procedures.

Fourthly, the recent amendment to the 'right of silence' rule is of contemporary interest and relates to the role of the AA. The new police caution (was planned to be 60 words long) but has been reduced to 37 words, replaces the old caution which was 22 words long. Without going into too much detail the planned new caution was to read-

"You do not have to say anything. But if you do not mention now something which you later use in your defence the court may decide that your failure to mention it now strengthens the case against you. A record will be made
of anything you say and it may be given in evidence if you are brought to trial."
However, after much discussion the new caution now reads -
"You do not have to say anything. But it may harm your defence if you do not mention when questioned something which you later rely on in court. Anything you do say may be given in evidence."
Although not directly connected to the main thrust of this thesis it is worth noting that research conducted for the 'Royal Commission on Criminal Justice' (RCCJ 1993) found that large numbers of suspects did not understand the original caution! (Clare and Gudjonsson 1993). The proposed new police caution was criticised for being largely unintelligible for people of average intelligence. The revised new caution, although somewhat improved, remains ambiguous for most people who have no experience of the criminal justice system. In this respect it is relevant to the role of the AA, as needless to say, vulnerable suspects will remain at a disadvantage regarding the new caution, as they did with the old one.

Finally, it is topical by default. By that is meant that linked to the role of the AA are questions about diversion of the mentally disordered from the criminal justice system. It is generally accepted as official policy that wherever possible, mentally disordered offenders should be diverted from the criminal justice system and dealt with instead by the health and social services. (Home Office Circular 66/90; and the Reed Reports, Home Office and Department of Health 1991). Clearly, many agencies, wrongly it seems, view the Appropriate Adult as being an integral part of any diversion scheme. (NACRO, 1993). Yet to include it within a diversion strategy not only widens the definition of the AA as it is now defined in the Code of Practice, but suggests that the duties of the AA should include advice or imparting information about suspects to other agencies. Questions relating to diversion will be discussed further. At this stage the point is made only in terms of the way the AA and diversion schemes have become linked where the AA is seen wrongly as a means of diverting the mentally disordered suspect out of police stations. It should
of course be seen in ways more akin to that of an interpreter rather than as a procedure promoting treatment.

In order to open out the discussion and to determine further the nature of the problem, that is, how and under what circumstances should vulnerable suspects be interviewed in formal settings, an outline of the legislation as defined in Code C of the PACE Act Codes of Practice and the background that led up to this legislation is provided.

**Legal Background.**

Modern lawyers have inherited from the neo-classicists the basic premise that where a person caused an *actus reus* and had the appropriate *mens rea* he will be held liable. There are exceptions such as for those offenders not regarded as being fully responsible for their actions. Two groups are identified, the mentally disordered and children, both of whom have been granted special legal provisions whether at the trial stage or at the post sentence stage. The AA fits into this neo-classical scheme of things: the task of the AA is to protect those not fully responsible whilst being interviewed i.e. the mentally disordered and children. Protection in this context means *inter alia* the rights of those special groups to be protected from unfair questioning, to be informed and understand the position in which they find themselves, and to have the right to determine whether any admission of guilt in whatever form that may take including a confession is not produced under duress.

On the face of it the need for someone to protect and assist such suspects is both clear and necessary, not the least because some, especially those with learning difficulties in their eagerness to please, may confess to crimes they could not possibly have committed. In legal terms such provisions are merely an extension of
the necessary legal rules which apply when those not held fully responsible face trial and are sentenced. Protection for these groups is an obvious extension of procedures and are additions to that large number of legal provisions which range from the Insanity Defence to the development of the Juvenile Court.

The Law has traditionally linked the mentally disordered and children because they are seen to lack full responsibility. Without entering that debate on the nature of responsibility it is clear that when full responsibility is lacking, similar legal provisions are likely to exist. And indeed this is what has happened as far as the AA is concerned; the AA has been used for both children and the mentally disordered. Except that for reasons which still remain unclear the provisions for children have become more widely known and accepted than for the mentally disordered. So much so, that the police routinely call an AA whenever a child is in the police station, a recurring theme throughout this thesis, but too often they seem unaware that the same provisions exist for the mentally disordered. This thesis is not concerned with the AA procedure for children. It is concerned with the mentally disordered adult and even then the categories have been widened to include others who are physically vulnerable i.e. the visually and hearing impaired. The AA fits into the legal traditions of England and Wales, that is to say within those special defences mentioned earlier. (Bean P.T. and Nemitz T. 1998, forthcoming).

The contemporary Appropriate Adult owes its inception in part, to the aftermath of the murder in 1972 of Maxwell Confait. Three youths were charged and convicted of the murder, two of whom were diagnosed as mentally disordered, in their particular cases as mentally handicapped. One of the accused youth, aged eighteen, had a mental age of an eight year old. He was described by a psychiatrist as - "...very markedly suggestible so that the slightest indication of the expected answer will produce it" (Price and Caplan, 1977).
Another of the youths, aged 15 at the time of the murder, was described as 'borderline intelligence'. The third boy, although described as being of 'reasonable intelligence', had only just turned 14. All three youths confessed to the murder after interrogation by the police. Their conviction was based primarily on the first confession. (Irving and McKenzie, 1989). One youth (the eighteen year old) was found guilty of manslaughter by reason of diminished responsibility and was detained under Sections 60 and 65 of the Mental Health Act 1959 without limit of time and was sent to Rampton Special Hospital. The other youth was found guilty of murder and was sent to Aylesbury Prison. The 14 year old boy was sentenced under the 'Children and Young Person's Act' to four years' detention at the Royal Philanthropic School at Redhill in Surrey. (Price and Caplan, 1977)

A campaign for a review of their case was led by a Member of Parliament and their Appeal was upheld after three years. The subsequent Fisher Inquiry Report (Fisher, 1977) revealed that the police had broken the Judges' Rules and Administrative Directions to the Police, which were designed to govern the way the police interview suspects and the taking of statements. (The Judges' Rules are thought to have originated in 1906; they have now been replaced by the PACE Act Codes of Practice 1984). The Judges' Rules only referred to mentally handicapped people, but the Codes of Practice use the generic term mental disorder which includes the mentally ill). (Thomas T. 1994)

The two younger boys involved in the Confait case, were not interviewed in the presence of their parents or other responsible adult, which was a requirement of the Judges' Rules. All the parents did eventually attend the police station and the 14 year old boy was ultimately interviewed in the presence of his mother. However, this boy's mother needed an interpreter because she could not understand the English language. Apparently no one thought to include the presence of a solicitor during the interviews. The other boys' parents signed statements declaring that they
were satisfied with the conduct of the interviews, and countersigned the inaccurate confessions - despite not being present. An indication of the intimidation those parents must have experienced was expressed by Mrs Leighton (the mother of the 18 year old youth who was defined as 'very markedly suggestible') when she explained -

"...when you've got a room full of detectives and....they look at you and say "sign", you naturally sign. I mean I was just as scared as what Ronnie was...". (quoted by Dixon D. et al 1990, p.119).

Irving and McKenzie (1989) explain the parent's deference towards the police in social class terms -

"None of the three parents challenged the account given either by the police or the boys and given the circumstances there was no reason why these particular individuals with their working class background should have attempted to challenge a murder squad in full cry."

(Irving and McKenzie, 1989, p.224)

Moreover, the Fisher Report criticised the way the police conducted the investigation, in particular failing to pursue leads which would have vindicated the youths:

"The evidence which I have heard suggests that the police do not at present see it as their duty to initiate enquiries which might point to the fact that they had got the wrong man, or that for some other reason the prosecution should fail. And there is nobody outside the police who regards it as his duty to spur the police on to question the case and to follow lines of enquiry which might be inconsistent with it. (Fisher, 1977, para,2.30)".
Price and Caplan (op. cit) give detailed descriptions of how the prosecution glossed over the discrepancies between the forensic evidence and the confessions. The defence council was also criticised for conducting an inadequate defence it must be said ironically, that this defence lawyer later became a Home Secretary. Yet, despite the overwhelming evidence that the youths could not have committed the murder, and the subsequent quashing of the conviction by the Court of Appeal, Fisher remained sceptical of the boys' innocence and the probability of 'false confessions' - which remains an area of controversy today.

"While the story told in the confessions may be difficult to believe, I find it (as I have said) impossible to believe that the confessions could have been made as they were unless at least one of the boys was involved in the killing."

(Fisher, 1977, para.9)

What Sir Henry Fisher was alluding to were the complex details about the murder that appeared in the boys' confessions (especially the first confession upon which the boys were convicted) that he assumed only the murderer(s) could have known about. What he failed to take into account is how those details could have been revealed by the police during the period of detention and interrogations. Because no formal record keeping i.e. custody records existed at that time, Irving and McKenzie describe what probably happened thus -

"Because the confessions were linked and detailed and the first confession was the one which later appeared to be untrue, the question arose, how did the various details of the murder which appeared in the confession material come to be there? Was it because interviewing officers in fact went backwards and forwards between suspects, even perhaps talking among themselves in the hearing of the suspects?

(Irving and McKenzie 1989, p.221)
The Confait case is often cited as the foremost example of wrongful convictions based on false confessions brought about by oppressive police interviewing techniques, failure to comply with the rules and faulty forensic evidence. Moreover, Irving and McKenzie (1989) point out that the Confait case also contained other ingredients that probably ensured its notoriety -

"The 'three persons' were variously juvenile, mentally handicapped, emotionally disturbed, or spoke English only as a second language. One of the interrogating officers had been involved in a previous case which might have led some observers to class him as a 'black sheep'....". (p.219)

Since then, many more 'miscarriages of justice' have occurred when convictions were based on false confessions obtained without the presence of an Appropriate Adult, a solicitor and/or unsafe expert evidence. (JUSTICE, 1994)

The Legal Requirements: The 'Role and Function' of the Appropriate Adult.

After the Fisher Inquiry Report the Royal Commission on Criminal Procedure (1981) was set up which led to the Police and Criminal Evidence Act 1984 (PACE). The PACE Act Codes of Practice are the successors to the Judges' Rules. The PACE Act Code C and now including the 1991 and 1995 Revised Codes of Practice, outlines the rules and guidelines concerning 'The detention, treatment and questioning of persons by police officers' (which includes juveniles and mentally disordered suspects as the following states).

"If an officer has any suspicion, or is told in good faith that a person of any age may be mentally incapable of understanding the significance of questions put to him or his replies, then that person shall be treated as a mentally disordered or mentally handicapped person for the purposes of this Code". (C 1.4 Codes of Practice)
Being treated as such, means *inter alia*, that an Appropriate Adult be informed of
the person's detention and asked to attend the police station. The Codes of Practice
are not statutory instruments, however police officers are liable to disciplinary
proceedings for any failure to comply with the Codes. Moreover, the Court may
consider breaches of the Code when determining the admissibility of evidence.

The Appropriate Adult, who may be a relative or guardian, or someone experienced
in dealing with the mentally disordered or handicapped (the Revised Code C 1995
advises that such a person is likely to be an approved social worker as defined by
the Mental Health Act 1983, or a specialist social worker) or some other responsible
adult (C 1.7). The Police Surgeon must also be called for anyone who appears to
be suffering from a mental disorder (C.9.2).

Other than in exceptional urgent situations, interviews with mentally ill or
handicapped suspects must take place in the presence of the Appropriate Adult
(C.11.14). The Code's Guidance Notes state that due to the potential unreliability
of this "particularly vulnerable" group the provision should be applied in
exceptional cases only. (see C 11.1). The Code describes the duties of the AA thus-

"Where the appropriate adult is present at an interview, he shall be informed
that he is not expected to act simply as an observer; and also that the purposes
of his presence are, first, to advise the person being questioned and to observe
whether or not the interview is being conducted properly and fairly, and
secondly, to facilitate communication with the person being interviewed."

(C 11.16)

Clearly, the expectation is that the Appropriate Adult will challenge inappropriate
questioning strategies that seem unfair. This means that the Appropriate Adult may
properly interrupt the police interview, perhaps even interpreting each question and answer where the suspect is unable to understand what is being asked.

The Guidance Notes go on to state that -

"It is important to bear in mind that, although juveniles or persons who are mentally disordered or mentally handicapped are often capable of providing reliable evidence, they may, without knowing or wishing to do so, be particularly prone in certain circumstances to provide information which is unreliable, misleading or self-incriminating. Special care should therefore always be exercised in questioning such a person, and the appropriate adult should be involved, if there is any doubt about a person's age, mental state or capacity. Because of the risk of unreliable evidence it is also important to obtain corroboration of any facts admitted whenever possible. (Code C. Note for Guidance 11B)

Clearly the task of the Appropriate Adult is onerous. The AA must ensure that the rights of the detained person are respected, while helping to assist with communication between the interviewing officers and the suspect. In order to ensure the protection of the vulnerable suspect's rights, the AA must be present during every stage of the detention. If the suspect has been told of his or her rights or cautioned in the absence of the AA, then they must be repeated in the presence of the AA (C3.11); if the AA considers that legal advice is required then the AA can request a solicitor (C 3.13); moreover, even if the police have reasons for delaying the suspect's right to inform someone of his/her arrest the AA must still be informed. (C Annex B.B1)

As already mentioned, one duty of the AA is to inform the suspect of his/her right to silence although paradoxically this advice would be in conflict with the AA's duty to assist with communication. However, some commentators argue that a mentally
disordered suspect's silence is more likely due to his/her condition, rather than any attempt to hide guilt. (Zuckerman, 1989, Gudjonsson et al 1993). Whether so or not, now that the right of silence is amended in the new Criminal Justice Bill, the need for the presence of the AA for the protection of the vulnerable suspect becomes even more crucial, especially as this research study shows that protection by the Appropriate Adult is not always implemented.

The PACE Act Code C of the Codes of Practice outlined above (albeit ambiguous and confused) sets out the role of the Appropriate Adult. Thus, the responsibilities of the Appropriate Adult are not only to protect the rights of the vulnerable suspect, but further - to ensure that the testimony is reliable.

But the presence of the Appropriate Adult is surely more than ensuring that PACE requirements are complied with, and to see that testimony is reliable in order to prevent wrongful convictions. The AA’s role is also to protect the vulnerable suspect from the special disadvantages they face when being required to participate in detention and questioning in order to protect the non-discrimination principle, and to avoid for them unnecessary stress and anxiety. In essence the Appropriate Adult is the detainee's mentor, not just in the limited forensic sense, but as a supporter of the vulnerable suspect when facing interrogation and detention for unknown periods of time.

**Key Figures in the Process.**

The role of the AA outlined above in the Codes of Practice sets out the legal requirements. But the effectiveness of the special protection of the AA depends on more than this; it depends on how key figures especially the police accept their responsibility. The major part of that responsibility falls upon the custody officer.
However, as this research will reveal, there is confusion about where the overall responsibility lies. Yet the PACE Act Codes of Practice are clear; they state that the police, in this case the custody officers, have a duty to call the Appropriate Adult as well as to call the police surgeon, but the latter is a less important figure. There is no guidance in the Codes that the police should ask the police surgeon to assess the suspect's need for an Appropriate Adult. The implication of this is important: the special protection of the Appropriate Adult is not a medical decision.

Interestingly, the reverse is the case in Northern Ireland for detainees arrested under 'The Prevention of Terrorism Act' and confined in the Holding Centres. There the medical examination of every detainee is automatic, that is, the presence of a medical examiner does not depend upon the police, and the decision to call an AA is influenced by the medical examiner's psychiatric assessment. The requirement to call an AA for vulnerable suspects detained in the Holding Centres in Northern Ireland, only came into force on 1st January 1994 and is now included in the 'Code of Practice on Detention, Treatment and Questioning'. A discussion of the practices relating to the AA in Northern Ireland is discussed further in the study.

Suffice to state here, that the special circumstances of suspected terrorists in Northern Ireland's Holding Centres, who are seen to be vulnerable - the definition of 'vulnerability' is likely to be adopted as the criterion for the attendance of an AA will ultimately be decided by a senior police officer, "who will not be bound by the medical officer's decision". (Blom-Cooper L. 1994, personal correspondence). Thus, although the medical diagnosis is likely to affect the decision to call an AA, the ultimate responsibility lies with the police regardless of the medical diagnoses.

However, in England and Wales the problem of recognising mental disorder and/or vulnerability in the ordinary suspect lies with the arresting officers and the custody officer (often members of the public or relatives will inform the police about the
suspect's mental health, or the suspect will volunteer the information themselves, the case histories recorded in this research shows many instances where the detainees inform the custody officer about their psychiatric problems). Only then do other professionals play a part in the procedures namely: the police surgeon, social workers, psychiatrists, solicitors etc. The role of the police and other professionals will be discussed in detail later; the point to be made here is that the ability of the Appropriate Adult to perform the required role, as stated in the Codes of Practice, necessitates knowledge of police practice and procedure, together with experience in dealing with a wide range of vulnerability.

The Code states that the Appropriate Adult may be:

"A relative, guardian or other person responsible for the person's care or custody. Or someone with experience of dealing with mentally disordered or mentally handicapped persons." The Revised 1995 Code recommends an approved social worker as defined by the Mental Health Act 1983 or a specialist social worker. Or failing either, some other responsible person aged 18 or over. A police officer or someone employed by the police may not act as the Appropriate Adult. (C 1.7)

The 1991 Revised Code prohibited solicitors from acting simultaneously as legal advisor and Appropriate Adult. However while the Code gives primacy to the person who is responsible for the care of the mentally disordered suspect to act as the AA, the Notes for Guidance indicates that a 'better qualified stranger' i.e. an approved social worker would be preferable. As will be shown in this study a wide range of people act as AA's suggesting perhaps that the police should be made aware of who is appropriate.
Legislative Problems

Many of the questions relating to the ambiguities of the role and function of the AA can be traced to the legislation itself. The Code continues to promote problems. For example, what should the AA advise the suspect about? Should he/she advise the suspect not to answer a question thought to be unfair? In effect what does ‘facilitating communication’ mean? Can the AA be a referee in the investigatory process and be a friend or mentor, interpreter, protector and independent adviser all without having the legal privilege of confidentiality that legal advisers enjoy. The Home Office Appropriate Adult Working Group (Home Office 1994) recognised that there was a conflict between the vulnerable suspect and the role of the AA and the proviso that they should not discuss the alleged offence. The Home Office Appropriate Adult Working Group (ibid) suggested many amendments to the Codes of Practice, including recommending that the Codes should contain a clear definition of the role of the AA. (Home Office 1994, para 11).

A further area of criticism centres around the 1983 Mental Health Act and other statutory provisions and case law. The language used to describe mentally vulnerable people hardly makes things easier. Difficulties about the definition of mental illness/mental disorder currently used in the Codes and the MHA 1983 were taken up by the Home Office AA Working Group (ibid) which suggested that -

"Terminology about the mentally vulnerable suspect needs to be modernised, and should reflect the needs of those with learning difficulties. (para 9.)

For example the term mental handicap is still used in the Codes of Practice and the 1983 MHA and the Revised 1995 Codes of Practice do not attempt to clarify the definition of mental handicap or indeed mental disorder. It is perhaps unrealistic to expect bodies such as the Home Office AA Working Group to take the lead here, when it seems that they could not define clearly what they meant by 'terminology
that should reflect the needs of those with learning difficulties'. However, recently completed research by Sanders et al 1996, could be used to provide clearer definitions of some of the terms including that of 'learning difficulties'. They state that the term learning disabilities covers a wide range of abilities and disabilities and that -

"Problems at different stages in the criminal justice process can develop through learning disabilities affecting three main areas: memory, communication skills and response to perceived aggression". (Sanders et al 1996, p:2).

Perhaps it will be necessary to wait until the 1983 MHA is revised before the terms are amended, certainly a review of the 1983 MHA is overdue. At the very least the Codes should give a clear definition of the role of the Appropriate adult, paying particular attention to the conflicts inherent in the role for example, problems relating to facilitating communication between the person and the police, and about having to advise the suspect about rights of silence etc. One looks in vain for assistance from other quarters. Thomas (1994) points out that The Royal Commission on Criminal Procedure 1981 advised only that -

"'Appropriate Adults' are not legal advisers but should be clear about 'the nature of their role, responsibilities and duties'. The Royal Commission offered little to clarify what that role was, other than saying they should ensure that the person being interviewed 'understands the questions that are being put to him' (Philips Report, 1981, para.4.108).".

(Thomas T. 1994, p.48).

As will be shown throughout although language, terminology and concepts are important, their interpretation and the effectiveness of the guidelines is more important still. That depends upon the training of the custody officers and the
Appropriate Adults - but essentially the protection of the mentally vulnerable suspect in the police interview will depend upon the moral commitment of all the actors.

The following statement by Irving and McKenzie (1989) encapsulates many of the issues discussed above, and moreover, reveals why the problems of the mentally disordered offender remains largely unresolved -

"The mentally abnormal by the very nature of their handicap tend to break social norms frequently. If as is now the case more of the handicapped population are living in society rather than removed from it that will increase the prevalence of cases involving mental abnormality being dealt with by the police. The Commission's intentions to strengthen the protection of this class of vulnerable suspects were well intentioned but the problem is as they judged it to be: The mentally handicapped present a problem to which we see no ready solution (RCCP 4.106). The fail-safe provisions of the codes have sufficiently alerted police officers to the danger but there is scant provision for providing adequate round-the-clock expert advice and help once the possibility of mental handicap in the suspect has been recognised. Apart from these practical difficulties, the dilemma of how to deal with mentally abnormal behaviour in a legal framework persists.”. (Irving and McKenzie 1989, p.204)

What Irving and McKenzie refer to above as ‘the dilemma’ of how to deal with mentally disordered offenders within a legal framework lies at the heart of the matter, at the centre of which, at least in the police station, is the Appropriate Adult. It may well be, if the role and function of the AA is resolved and formalised, a major improvement in how mentally vulnerable suspects are detained and interviewed will be achieved.
CHAPTER 2

A Review of the Literature

The research undertaken for this thesis was the first to look specifically at the use of the Appropriate Adult for mentally vulnerable adult suspects in the police station. The empirical data collection began in October 1992 and lasted for approximately two years. Therefore the literature relevant to the role of the Appropriate Adult (AA) is somewhat restricted, although there has been a growing interest since the publication of research undertaken by The Royal Commission on Criminal Justice 1993. Following the research for this thesis a study undertaken by Evans and Rawstorne (1995) also concentrated on the way the AA provision operated as a means of providing protection for vulnerable suspects in England and Wales. They completed their research on the AA procedures for adults and juveniles for the Home Office in April 1995, this study will be discussed further in this chapter. More recently two important research studies have contributed to our understanding of the use of AA’s (Robertson, Pearson and Gibb 1995, and Palmer and Hart 1996), these studies also will be discussed further in this chapter.

Other research has looked at the working of the AA role as an adjunct to the main aims of the research (Robertson 1993; Gudjonsson 1992; Gudjonsson et al 1993; Clare and Gudjonsson 1993; Brown 1989; Brown et al 1992; Williamson 1990; Evans 1993 (here Evans looked at the AA protection for juveniles only); Irving 1980; Irving and McKenzie 1989; McConville et al 1991; McConville and Hodgson 1993; Thomas 1994, 1995; and Baldwin 1993(a)(b)). Broadly speaking, the literature that mentions the Appropriate Adult, or if not directly referring to the AA then refers to suspects’ rights and police powers in the police station, and particularly police compliance with the Police and Criminal Evidence Act 1984
PACE) and the accompanying Codes of Practice can be divided into three or possibly four areas:

(a) observational, sociological or psychological studies of police interrogation in police stations with special emphasis on justice;
(b) observational psychometric studies of detained suspects in police stations;
(c) other related research which includes studies looking at the role of police surgeons and solicitors who attend police stations.

The research categories listed above are not mutually exclusive as most of the literature discussed in this chapter also emphasises sociological, criminological and psychological explanations. Classifications are difficult enough normally but much more so when the research tends to be in its early stages when looking at a new topic. Then the questions tend to be of a general nature and the research methodologies similarly general. That means there is likely to be considerable research overlap in the research studies concerned, unlike say when the questions are more specific and the methodologies equally specific. Then it is possible to produce more discrete classifications. Accordingly, the areas selected here are not discrete, nor can they ever be given the relatively few studies concerned with the AA at this point in time. However, what these research studies listed below have in common is that all or part of the research was conducted in police stations, and then usually a combination of methods was used; for example: data was taken from custody records compiled when a detainee was brought to the police station, or was from assessments of tape recordings made during police interviews. Other researchers also conducted psychological and/or psychiatric assessments of selected suspects and/or carried out observational studies of police decision making and interrogation.

The research discussed here, generally speaking, has been restricted to one or two areas, those concerning the rights and protections of suspects defined in the PACE
Act Code C of the Codes of Practice, that is: "The detention, treatment and questioning of persons by police officers". (PACE 1984) Or, research that looks at key figures in this, the important stage in the criminal justice process; for example, the role of the solicitor, or that of the custody sergeant, or that of the police surgeon and of course, the Appropriate Adult. There are only a small number of research studies that looks at the use of the AA by the police.

How the police comply with the Codes of Practice crucially determines the fate of suspects as they are processed into the criminal justice system. Therefore, as the use of an Appropriate Adult is a requirement of the PACE Act Codes of Practice - and further, is the only extra protection for vulnerable suspects, a study of the research that looks at how the police and other key figures comply with the Codes of Practice in the police station, is central to this review.

(a) Observational, Sociological and/or Psychological Studies of Police Interrogation in Police Stations, with a special emphasis on Justice.

Studies carried out in police stations pre and post the implementation of the PACE Act and the Codes of Practice, looked at the detention procedures and the questioning of suspects. Sometimes the mental state of the suspects' as well as the interrogation processes were observed (Irving 1980, Irving and McKenzie, 1989), but basically their research carried out in police stations covers police powers and suspects' rights. Studies conducted post the PACE Act have tended to concentrate on the effectiveness of the PACE Act and the corresponding Codes of Practice and their effects on police tactics during the interrogation, thereby ensuring that suspects' rights, as defined in the Codes of Practice, are adhered to. The role and function of custody officers, solicitors and police surgeons are also scrutinised in these studies, including the role and function of the AA.
Some of the most cited pre and post PACE studies on police interrogation are those that were carried out by Irving (1980) and Irving and McKenzie (1989). Irving’s 1980 study was replicated twice by Irving and McKenzie in 1986 and 1987. Irving's study (1980) was conducted during 1979, and was commissioned by the Royal Commission on Criminal Procedure 1981 (RCCP) which was set up in 1978 following the Fisher Report (Fisher 1977). The RCCP was concerned about how the police conducted the detention and interrogation of suspects in relation to the Judges’ Rules and the Administrative Directions to the Police. In effect, they were concerned with the question, what were the conditions that might produce false confessions? Irving’s 1980 study is generally seen as path breaking and the research most responsible for influencing the Royal Commission’s recommendations which eventually led to the implementation of the PACE Act 1984 and the accompanying Codes of Practice.

Irving's (1980) study was carried out in a Brighton police station. The aim was to look at police interviewing tactics and techniques when detained suspects were interrogated in the police station. It is important to note that at the time the RCCP was set up there was no body of research available on police interrogation (Irving and McKenzie 1989). Irving states that because of his experience in the Confait inquiry (Fisher, 1977) and in other cases where false confessions had likely taken place he believed that -

"...it would be necessary to engage in a different kind of study to that proposed by the Home Office if police interrogation tactics were to be accurately described and their effects properly understood....how - what methods - what is the system like - what are its critical elements - who is at risk - what are the safeguards - do they work? I felt that, unless we could answer some of these questions...., then policy makers faced with a Police Bill to design could not possibly control the problem.

Initially, Irving carried out a literature review of psychological explanations of police interrogation practice (Irving and Hilgendorf, 1980). From this study the authors devised the first psychological and theoretical model of police interrogation. Thus, armed with an understanding of the theory and method of the interrogation process, Irving then conducted his important observational study in a police station in Brighton in 1980. In many ways Irving’s 1980 study remains a benchmark from which other studies - including Irving and McKenzie's follow up studies in 1986 and 1987, were and are evaluated today. But for these purposes this is the first comprehensive study which looked at the role of the AA.

Irving’s method in the 1980 study and subsequently replicated in the 1986 and 1987 studies, included observation of 60 interviews in 1980, and observation of 68 interviews in both the follow up studies. These interviews were chosen by the researchers for observation because they presented certain complications and it was felt therefore that they would provide the interviewing officers with opportunities for demonstrating their interviewing techniques. In order to compensate for the bias in these selected observational interviews, the researchers included in the method the observation of a random sample of a further 100 suspects, and quantitative data was taken from arrest records of suspects over a one month period from a random point of entry.

Some of the main findings of Irving's (1980) and Irving and McKenzie's follow up studies are relevant to this thesis. In the 1980 observational study of 60 chosen interviews Irving found that 5 suspects (8 per cent) were mentally ill, 1 suspect (2 per cent) was identified as mentally handicapped, 8 suspects (13 per cent) described as frightened and 11 suspects (18 per cent) were intoxicated or withdrawing from drugs immediately before the interview. Other descriptions of the observed suspects' mental state at the time of the interview were variously described as: withdrawn or uncooperative, aggressive, and friendly. Overall, Irving noted that -
"...Nearly half the suspects he observed (41%) were in some kind of
abnormal state. In 28% of the 1979 sample there was identifiable
mental abnormality; a further 13% were frightened enough to show
visible symptoms (trembling, shivering, sweating, yawning, hyper-ventilation,
incoherence.)." (Irving, 1989, p:71)

In the follow up study in 1986 the researchers found a decrease in the mental
vulnerability of the 68 observed suspects, except, that, is those defined as
frightened. The number of suspects in this category was 15 (22 per cent). Only 3
(4 per cent) of the suspects were identified as mentally ill, and none was seen as
mentally handicapped. However, the biggest decrease was seen in suspects who
were intoxicated or withdrawing from drugs. Irving and McKenzie noted that -
"...only 30% of the sample fell into this ‘abnormal state’ category.
The figure is clearly affected by the fall in interviews with those
who were intoxicated, etc. and those who were mentally ill. It
should be noted however that there was an increase in those defined
as frightened". (ibid).

The 1987 study showed a further decrease in the sample of 68 observed suspects
defined as being in an ‘abnormal mental state’. Only one suspect was defined as
mentally ill, none were mentally handicapped, seven described as frightened and
only one suspect was interviewed while being intoxicated or under the influence of
drugs. The researchers stated that the decrease in ‘abnormal mental states’ amongst
the observed sample of interviews was “statistically significant overall” (Irving and

What did the studies record about Appropriate Adults? The 1980 study was
conducted while the Judges’ Rules and the Administrative Directions to the Police
were the only guides to best practice when detaining and interviewing vulnerable
people in the police station. Whenever, Irving (1980) and Irving and McKenzie 1989 discuss the role of the AA they do so under the heading of 'Independent Third Parties' or 'other third parties'. They include under these headings solicitors, social workers and parents. The term AA is used in the follow up studies but still under the heading of 'other third parties'. It will be remembered that the term Appropriate Adult was created and defined in the PACE Act and the Codes of Practice.

Irving’s 1980 study referred to the presence of third parties (solicitors, social workers and parents) as -

"...dramatically changing the nature of the social interaction. Parents and social workers tend to get involved so that the interaction becomes a three way process. Solicitors on the other hand, act solely in a supervisory capacity, challenging questions put by the interviewing officer, advising their clients on replying and making notes of their questions and answers. While solicitors and to some extent experienced social workers place considerable constraints on the behaviour of the interviewer, parents, relatives and inexperienced social workers can be swept into the interview in such a way that their presence actually aids the interviewing officer in his task.

(Irving and McKenzie 1989, p. 53)

Thus, Irving and McKenzie (1989) were the first researchers who observed the possible unintended consequences of using inexperienced or untrained AA’s. Moreover, by 1986 the researchers recorded that the presence of third parties during the interview did not have the same dramatic effect as described above. The authors do not explain the perceived changes in the social interaction of the interviews produced by the presence of other third parties, other than accounts of the strained relationship between the police and solicitors.
Out of the three suspects identified as mentally ill in the 1986 study, a mental health social worker was called for only one suspect (described as having simple schizophrenia). The authors do not describe the social worker as an AA however, the social worker was described as fulfilling the role anticipated in the Code of Practice. The second mentally ill suspect, described as suffering from paranoid schizophrenia, was detained in a cell overnight because the solicitor declined to attend at night. The authors were critical of the way the interviewing officers and the solicitor acted during the interview. Irving put their behaviour and attitudes down to their anxiety and ignorance about mental illness. The third suspect who had himself informed the police that he was a manic depressive had no AA or solicitor called.

The authors criticise the failure of the police to implement the Codes of Practice in relation to the two cases described above. They reproduce what the Code states about calling an AA for vulnerable suspects, which declares first and foremost that if there is-

"...any suspicion that a person is mentally ill, mentally handicapped,...the person is to be treated as Such (para 1.4)". (Irving and McKenzie 1989, p:72).

The authors were in no doubt that the police officers were well aware that these suspects were mentally disordered (the officers referred to these suspects as ‘nutters’, language that has still not declined in police stations). The authors conclude -

"While this may have been an isolated incident, it bears witness to the fact that no legislation can ensure proper treatment for the mentally ill. That will continue to depend on the empathy and understanding of those who deal with them. Proper attitudes are endangered by ignorance and
anxiety which can only be combated by training which must include exposure to the more florid psychiatric conditions”.


The above statement is depressing because the findings of many other studies since then have confirmed Irving and McKenzie’s views about the treatment of vulnerable people in police stations. However, Irving and McKenzie also criticise the actions of others besides the police. They particularly question the appropriateness of those who act as AA’s, particularly parents who do not always act in the best interests of their children. The authors state that the quality of advice and help of social workers who act in the ‘mentor’ role depends on whether they have received any training. Parents and others called to act as the AA are unlikely to know what is required of them. The authors stated that only solicitors, even given their variable services, were seen to carry out the ‘mentor’ role in a competent manner. A further difficult case observed in the 1987 study showed how psychiatrists confuse their role. In this case the custody officer called a psychiatrist and a social worker to see a man who had been arrested for a serious offence. The interviewing officers decided very early in the interview that the suspect was mentally disordered. However, the psychiatrist found no ‘identifiable clinical syndrome’ but that the suspect was experiencing the effects of the long-term use of cannabis, and declared the suspect fit to be detained and interviewed.

Notwithstanding the clinical diagnosis of the psychiatrist, which is nothing unusual as many subsequent studies of psychiatric and police surgeons assessments confirm, (see Bean, 1983,1986, Bean and Mounser, 1993, Roberston 1993) Irving and McKenzie (ibid) point out that if the psychiatrist and the social worker had understood the requirements of the PACE Act and the Codes they should have assured protection for the suspect. To this end senior police officers, while not fully understanding the nature of the suspect’s vulnerability, nevertheless decided to
abide by the wording in the Codes which states (as outlined above) that all safeguards should be put in place for the mentally vulnerable if there is any suspicion of mental disorder, and an AA should have been called.

Irving and McKenzie discuss in great detail the problems the police, lay persons, social workers and medical practitioners have in being able to diagnose mental disorders and learning difficulties - the latter may be varied and complex. These problems remain relevant today. Irving and McKenzie (ibid) were able to declare with some confidence, probably based on the outcome of the case history outlined above, that -

"We believe this fail-safe provision is working as well as the exigencies of the problem allow, but if it is impracticable to improve the diagnostic ability of the police, then the role of medical and social work advisers becomes crucial".

(Irving and McKenzie 1989, p.203)

Yet despite the improvements in the treatment of mentally vulnerable suspects in the police station that Irving and McKenzie describe after the implementation of the PACE Act, they were well aware that the problem of dealing with those suspects were far more complex. So much so, that they proposed the following in what can only be called unambiguous terms -

"In practical terms and however one chooses to analyse success and failure, this legislation has vaulted over a dishonourable pile of criminal justice problems. In the breathing space this has created why not attend now and in greater detail to the very special needs of the most powerless participants in the criminal justice system?".

(Irving and McKenzie 1989, p.234)
It would be fair to say that Irving and McKenzie’s proposal has not been entirely ignored when considering the enormous scholarship that has grown up over the intervening years, not least in the Reed Reports (e.g. Reed Report 1992) on the mentally abnormal offender. Yet it is remarkable that confusion and ignorance surrounding the medical and psychiatric assessments of mentally vulnerable suspects in the police station, and the safeguards contained in the Codes of Practice, remain still, ten years after the implementation of the PACE Act.

It is worth mentioning here that (i) that Gudjonsson’s (1993) study found similar numbers of suspects to be mentally ill, and (ii) that according to Robertson's 1993 study on police surgeons (see below) the aim of the majority of police surgeons' work in police stations is to determine whether intoxicated suspects (alcohol and/or drugs) are fit to be interviewed - probably a direct consequence of Irving's 1980 study and the follow up studies which criticised the police for interviewing suspects while still under the influence of alcohol or drugs. Added to the above, Irving (1980) found that about half the suspects were in an abnormal mental state due to the distress and anxiety they experienced by being in a police station, and fear of the police interrogation.

Irving (1980) concluded that the interviewing officers used manipulative interrogation techniques that were effective in gaining confessions (58% of the 60 suspects observed by Irving confessed during the interview). The police viewed the interview as central to gaining a confession, even when other evidence was available. Moreover, the interview was also used to gain admissions about other crimes (to be taken into consideration or TIC's as they are commonly called) - which helped the clear up rate considerably, (see also Softley, 1980 and McConville et. al (1991) for a discussion of bargaining techniques that McConville et. al. assert is endemic to police work).
It is also worth discussing other findings of Irving’s 1980 study, and the follow up studies, as they bear directly on how vulnerable, and indeed all suspects are dealt with in a police station. As previously stated, Irving's 1980 study was replicated twice at the Brighton police station, once in 1986 a few months after the implementation of PACE, and again in 1987 (Irving and McKenzie 1989). Both studies observed the interviews of 68 suspects (see above for a full description of the method). In the 1986 study Irving and McKenzie found a decrease in the number of tactics used by the police during the interviews (from 165 to 42). The authors stated that the decrease in these tactics was largely due to the requirement to take contemporaneous notes. That means recording by hand verbatim what is said by the interviewing officers and the suspect during the police interview, or indeed outside the police station.

Moreover, the 1987 study showed an increase in manipulative tactics during the interview, from 42 to 88. Manipulative tactics are variously described, such as when interviewing officers try to get the ‘story to fit the facts’ by using such methods ranging from making suggestions or leading questions, or changing information to make it into outright confabulation or using blatant psychological manipulation. The authors stated that the increase in manipulative tactics in 1987 could have been due to a relaxation of procedures after the formal introduction of the PACE Act and Codes - which was after all, the first Act and Codes of Practice designed to control police powers and practices.

Irving and McKenzie (1989) concluded that overall the introduction of the PACE Act and the Codes of Practice had made a significant difference in how the police conduct interrogations and the procedures designed to protect vulnerable suspects.
"The effect of the PACE Act, as we have shown, was to produce at first a major reduction in the use of interrogation tactics, followed by a partial reversion to former practice. The Act also produced a marked change in the level of support available for the suspect in police custody."

(Irving and McKenzie 1989, p.237)

Irving and McKenzie's follow up studies are sometimes criticised for being too optimistic in their interpretations of the changes in police interrogation practices (McConville et al 1991, Brown et al 1992, Dixon et al 1990). It seems that Irving and McKenzie expected this criticism and defend their findings thus:

"It might be argued that if Irving was prone to the effects of the police culture in 1979, McKenzie would be extremely so in 1986. The experience of the authors in this matter has been interesting. McKenzie has a publication record which belies any tendency to accept police norms blindly. Indeed his work before his retirement from the police service was focused on producing training packages to try and mitigate the effects of police culture on recruits - an assignment which positively encouraged a critical and analytic stance. Moreover, Irving found that McKenzie's detailed knowledge of police procedure, precedent and practical law made critical analysis of observational data more thorough than had been the case in the original study. It is hoped that the scope of this report attests to that conclusion."

(Irving and McKenzie 1989, p.29)

More recently, Irving stated that with the advantage of hindsight, the follow up studies in 1986 and 1987 were carried out too early after the implementation of the PACE Act to gain a proper judgement of changes in police practice.
"I think with the advantage of hindsight that my conclusions at that time were over-optimistic... In that follow-up research evidence of the protection afforded by third parties was very thin. The availability of effective legal advice was questionable and parents and social workers were never really observed performing an effective proactive mentor service."

(Irving, 1995)

To be fair to Irving it is hardly surprising that he and McKenzie found some improvement in the Brighton police station procedures from that which was before PACE, where at the very least, fewer intoxicated suspects were being interviewed. After all, the PACE Act and the Codes of Practice was the first comprehensive legislation concerned with police procedures and practices and the rights of individuals detained in the police station. Moreover, Irving and McKenzie (1989) make the following proviso about the working of the PACE Act legislation and future development which is relevant to the findings of this research.

".....the Police and Criminal Evidence Act seems to have produced examples of good design and potentially effective sanctions. However the potential for further development in response to the emergence of specific problems should not be dissipated."

(Irving and McKenzie 1989, p:246)

The specific problems that the above quotation refers to have emerged, particularly the research carried out for the RCCJ 1993 which suggests that the police and other professionals cannot be relied upon to protect the rights of detained suspects, especially the vulnerable. Clearly, Irving and McKenzie were aware that revisions to the Codes of Practice would be needed, which is a relatively simple procedure, and quite different from re-designing new legislation. Moreover, Irving viewed the
findings of this research, as revealing 'a piece of legislation that is not working'.
(1996 personal communication).

However, it is probably naive to expect that revisions to the Codes of Practice would deal with all the problems as they arose. The 1995 Revised Code does not include any recommendations put forward by the Appropriate Adult Working Group (Home Office 1994) that was set up to review the 'role, function and availability of the appropriate adult', as recommended by the Royal Commission on Criminal Justice (RCCJ 1993). This Working Group will be discussed further in the study. It seems that Irving and McKenzie's (1989) statement outlined above, was again optimistic when they declared that, while the PACE Act and the Codes provide potentially effective safeguards, nevertheless the legislation should be able to respond to 'specific problems'(Irving and McKenzie (ibid). The 1995 Revised Codes of Practice failed to take the opportunity to respond to the recommendations concerning the role of AA, which might have helped clear up some of the anomalies and definition of the AA procedure.(Home Office 1995).

Other groups, such as civil rights organisations have reviewed research on the detention and interviewing of suspects in police stations, with particular reference to the miscarriages of justice that have taken place since the implementation of the PACE Act and the Codes of Practice. Their views are relevant to this study because they state that what happens to suspects, particularly vulnerable suspects in the police station, has a direct bearing on the outcome for vulnerable people generally, especially where there is a possibility of a miscarriage of justice taking place.

Certainly, civil rights organisations such as 'JUSTICE' (1994) - ("the broadly-based and influential lawyers' group", Rozenberg 1994) - do not view too optimistically changes in police tactics and interviewing techniques, post the PACE Act. While
admitting that the PACE Act and the Codes of Practice procedures and safeguards
has led to a decrease in some of the most blatant practices of abuse and fabrication
of evidence, nevertheless 'JUSTICE' (ibid) presents evidence of miscarriages of
justice still occurring since the implementation of the PACE Act. Their research
reveals that some police officers still exploit gaps in the Codes of Practice
protections such as: tactics delaying the presence of solicitors during interviews,
informal conversations in police cars or in the cells, threats or inducements to
confess, and solicitors, often unqualified, and unable or unwilling to protect
suspects' rights. ('JUSTICE' 1994). Moreover, 'JUSTICE' (ibid) have identified 89
miscarriages of justice (i.e. cases of disputed confessions) 72 of them since 1986.
The 'JUSTICE' organisation receives over 600 allegations of miscarriages of justice
every year.

Several research studies carried out for the Royal Commission on Criminal Justice
(RCCJ, 1993) confirmed many of the criticisms stated above about police tactics,
and solicitors neglect of their client's rights, during PACE interviews. (Baldwin J.
16; Moston S. and Stephenson G. (1993) Research Study no. 22). (These studies
will be discussed later in this chapter).

Gudjonsson (1992) discusses research by Williamson (1990) (an unpublished Ph.D.
thesis) on the implementation of the PACE Act and the Codes of Practice.
Williamson found improvements in police procedures and concluded that the PACE
Act and the Codes were effective in protecting suspects' rights, in that the
questioning of suspects was less coercive, produced better recording of information,
had fewer repeated interviews and more suspects consulted a solicitor before the
interview. These findings were in accord with Irving and McKenzie (1989).
However, what is most relevant to this discussion, is information concerning the Appropriate Adult taken from Gudjonsson who records what Williamson, 1990 (ibid) observed-

"...it is evident from Williamson's (1990) study that: (a) the "appropriate adult" is extremely infrequently used (i.e. in only five out of 1627 cases); and (b) English police officers are generally reluctant to accept that suspects can and do sometimes make false confessions and they often fail to appreciate the potentially deleterious effects of psychological vulnerabilities (e.g. mental handicap and mental illness) on the reliability of evidence. Furthermore, many police officers do not appear to know the difference between mental illness and mental handicap". (Gudjonsson G. 1992, p:46).

Williamson's (1990) study along with Irving and McKenzie's (1989) post PACE research, is also criticised for being too optimistic by Brown et.al (1992); Brown states that Williamson's research was affected by his position as a police superintendent. Whether so or not, Williamson's status did not prevent him from criticising the failure to use Appropriate Adults and police officers' apparent ambivalence towards mentally vulnerable suspects. (See above Irving and McKenzie's defence of their methodology and observer bias, which is relevant here).

The Irving (1980) and Irving and McKenzie (1989) studies have been discussed at length because they provide an understanding about police procedures and practices pre and post the implementation of the PACE Act and the Codes of Practice. The studies are central to this thesis because they reveal the problems about how and under what circumstances vulnerable suspects were treated in the police stations, and as such provide a benchmark by which success can be measured alongside failure or changes in police practices, particularly relating to the role and function of the AA.
(b) Observational, Psychometric Studies of Detained Suspects in Police Stations

The following research, described here as observational, also includes retrospective data collection and analysis from custody records and interviews with suspects. As stated above, the majority of the research relies on several research methods making it difficult to place studies under one methodological heading. So, for example, studies carried out in police stations by Brown (1989) and Brown et al (1992) are included under this heading because in the Brown et al (1992) study the authors emphasised the importance of the researchers' observations in the police stations. The earlier Brown (1989) study did however use rather less observation as a method, and rather more quantitative data analysis of the police custody records. Even so, this has been included as an observational study. The aims and purposes of both studies were similar, in that they looked at the implementation and the effectiveness of the PACE Act 1984 and the Codes of Practice. The 1989 study was seen by Brown as providing a "baseline on the operation of PACE to inform policy-makers, police and others" (Brown 1989:7). In contrast the 1992 study looked at the effectiveness of the 1991 Revised Codes of Practice.

To provide continuity Brown’s 1989 study is discussed first. This research was carried out in ten police forces covering 32 police stations, the forces included metropolitan and rural areas. The method used was to extract quota samples of custody records from the 32 police stations. The quota sample of custody records was chosen to reflect the workload of the particular police force. A total of 5,500 custody records was gathered for the month of March 1987, by then the PACE Act and the Codes of Practice had been in operation from January 1986. This study was not then able to include a random sample of custody records.

Brown (1989) states that the principal aim of the study was to compile a database of the operation of PACE in the police station. The study includes information on the
operation of procedures during the detention of suspects. These include the reasons
for detention, the length and outcome of the detention, and the use of solicitors
during the interview. However, for these purposes the main area of interest is the
treatment of “juvenile and sick prisoners” (p,7).

Brown (1989) reproduces in chapter 4 of the study the procedures relating to the
requirement to call an AA for juveniles and mentally ill or mentally handicapped
suspects. However, the author emphasises the demands juveniles place on the
custody officer, especially relating to AA’s. This is understandable because the
number of juveniles detained in some police stations were well above average, while
the number of mentally ill or mentally handicapped suspects only accounted for 1%
of the quota samples. Thus out of the 5,519 sample of custody records only 54
suspects (1 per cent) were identified as mentally ill/handicapped.

Brown (1989) states that the police called an AA for 95% of those who required
one. Unfortunately Brown (ibid) does not distinguish between the juveniles and the
mentally disordered within the 95% who received an AA. Or to put it another way,
the author does not state how many of the mentally disordered suspects were
included in the 5% of cases when the police failed to call an AA. Brown states that
the reason for the failure to call an AA was because contact was not made, or that
vital information was missing from the custody record.

However, Brown points out that 43% of the mentally ill/handicapped in their quota
sample were not arrested on suspicion of crime, but were described as missing
persons. Thus, only just over half of the 54 people defined as mentally disordered
were arrested for suspected offences and would have been required to take part in an
interview. As said above it would have been interesting to know if the AA attended
the interview with those 30 or so mentally disordered suspects. But unaccountably
Brown did not differentiate between those mentally disordered suspects and the
juveniles, except to say that in three quarters of juvenile cases the AA was a parent or relative and a social worker attended in 17% of the cases. Moreover, Brown (ibid) does not include information specifically relating to these mentally disordered suspects, for example, whether they were seen by a police surgeon, or if a solicitor was called for them.

Brown (1989) expected the findings of this study to be of value to policy makers and the police, and indeed the vast amount of data collated could have provided much information about police procedures in the station post PACE. However, for the purposes of this thesis Brown's 1989 study is disappointing. Although Brown (ibid) discusses the AA, he does so primarily in relation to juveniles. It is likely that because of the large proportion of juveniles found in the quota samples, Brown emphasised the problems associated with their detention and the manner in which the AA's were called for them.

The low number of mentally disordered suspects found in the quota samples, could be explained by the methods used. Quota samples, although taken from 32 police stations, covered only a one month period. It may be the case that quantitative data gathering from custody records needs to be collated over a longer time period, in order to gain a more accurate picture of the numbers of suspects identified by the police as mentally disordered. Brown suggests that further studies in police stations should include such qualitative methods as observation and interviews. Brown (1989) hoped that such qualitative methods would help account for the wide variations he found in, for example, the take up of legal advice, the proportion of suspects charged and length of time spent in detention. Brown (ibid) did not include mentally disordered suspects and the AA procedure in his list of priorities for further research or interest. However, Brown's observational study he and others conducted in 1992 looked at the impact of the revisions to the Codes of Practice which came into effect on April 1st 1991 (Home Office 1991). The only
relevant change to the revised Code C for the purposes of this discussion, is that which defined more closely who was suitable to act as an AA (the Code suggests that someone with experience of or training in mental health care may be better qualified to act as the AA, but relatives were not excluded). The study relied on observational data and interviews with suspects, but the researchers also looked at custody records. The researchers were able to compare data pre and post the revised Code C. The study was conducted in twelve police stations in six police forces which included the metropolitan.

Brown et al (1992) state that their sample of 10,167 custody records (consisting of 5,042 from 1990 and 5,125 from 1991 i.e. pre and post revised Code) is a representative sample, although it is not clear why this should be so. Nevertheless, their results show that pre and post PACE, only 106 cases were identified from the records as offenders who were regarded as mentally disordered or handicapped (i.e. 60 pre PACE and 46 post PACE). Moreover their research findings show that over half of these suspects were initially detained at the police station under s.136 of the Mental Health Act 1983 (i.e. that section of the 1983 Mental Health Act which allows police to detain a person suspected of being mentally disordered in a public place).

Perhaps the low number of mentally disordered detainees (1% of the sample) found in the above study may be due to the methodology used i.e. samples of custody records were taken from the twelve police stations for two periods of two weeks prior to and after the introduction of the revised Codes (note that this was a similar time scale as the 1989 study). Although 10,167 custody records seems a sufficient representative population, together with the observational studies and interviews carried out by the researchers within the twelve police stations, nevertheless, the research failed to produce the expected numbers of mentally disordered or vulnerable suspects that Irving (1980) and Gudjonsson (1993) found (see below).
Clearly, the study was successful in that the authors could conclude, with some reservations, that there had been a measure of improvement in police compliance with PACE requirements - probably as a result of the revised Code C (i.e. the detention, treatment and questioning of persons by police officers) However, their research failed to identify the expected numbers of mentally disordered suspects; the likely reason for this is that the research methodology really only revealed a snapshot of police practices and procedures. Overall the methodology employed by Brown et al (ibid) certainly gave an impression of changes in police practices but little more. Clearly this methodology, that is, using a sample of custody records covering a two week period only, is not a sufficient time interval for determining how many detainees are identified as mentally disordered by the police or other key figures in the police station, nor how vulnerable suspects are treated in the police station. Thus it may be argued that if the study of custody records is the chosen method in order to identify a representative sample of vulnerable suspects detained in police stations, which was the method used in this thesis, then the records studied should cover a longer time interval than only two weeks.

The observational part of the Brown et al 1992 study identified only 10 detainees thought to be suffering from mental disorder. Again, as above, the likely reason for this low number of identified vulnerable suspects was because the observers were only present in the police stations one week prior to and one week after the introduction of the revised Codes. The research states that Appropriate Adults were called for only 3 out of the 10 detainees thought to be mentally disordered, as the following quotation reveals.

"The observational study included only ten cases in which observers considered that suspects were mentally disordered or handicapped. Appropriate adults were summoned in only three of these. However, only a minority of cases involving these groups were included in this
part of the study because mentally disordered or handicapped detainees were often not suspected of crime but detained as a place of safety.

The observational study gave priority to criminal cases.

(Brown et.al 1992, p:78)

The above quotation is unclear. For example, were the ten detainees identified as mentally disordered by the observers only, or was the custody officer involved in the identification? The observers were described only as Home Office researchers, not trained psychologists. Moreover, were those suspects detained on s.136's, the so-called place of safety order, or were they arrested for an offence as well? Place of safety detentions are rarely so clear cut. It is interesting to note that during the course of the empirical study reported here it was noted that custody records often listed an offence and a 'place of safety' as the so called 'Reason for Detention' (see Bean et. al 1991, see also a later discussion on s136. Brown et al (1992) did not mention what happened to their so-called place of safety detentions, especially those suspects assessed as 'not sectionable'. It is likely that some may have been interviewed under PACE for a suspected offence without an AA being called.

Although Brown et.al (1992) state that they gave priority to criminal cases, nevertheless, the aims of their research was to evaluate the impact of the revised Code C of the PACE Act, which presumably should include all those who are detained at a police station. Moreover, persons detained at the police station on a 'place of safety' (s.136) are also entitled to the rights and protection of PACE Code C, as the following makes clear -

Code C. para. 1.10 "applies to persons who are in custody at police stations whether or not they have been arrested for an offence and to those who have been removed to a police station as a place of safety under s.135 and s.136 of the Mental Health Act 1983". (Code c para.1.10).
The above implies that the Appropriate Adult should be called for detainees brought to the police station on a Place of Safety Order. (Fennell (1993); Mental Health Act Commission (MHAC) 1991-1993). There is certainly a need for an Appropriate Adult when the person is detained on s.136 and an offence, because if the suspect/client is assessed as 'not sectionable', a PACE interview may then be carried out - and then Code C. applies and the requirement to call an Appropriate Adult should be implemented. This argument will be developed later in this study; suffice to state here that the role of the Appropriate Adult is already complicated and ambiguous, and that the introduction of an AA during a s.136 assessment - which is often 'more honoured in the breach' anyway would only add to the general confusion. Such arguments indicate the urgent need for the role and function of the Appropriate Adult to be clearly defined.

Finally, to end the discussion of the Brown et al (1992) research, there is little debate about mentally disordered suspects. What the authors say about the AA for mentally disordered adults is interesting in itself.

"Adults were not summoned by the police in all cases in which the suspect was suspected to be mentally disordered or handicapped. The reasons for not doing so are unclear from the custody record data, but it is possible that custody officers may not always have considered the suspect's mental condition serious enough to warrant calling an appropriate adult or that initial concerns may subsequently have been felt to have been exaggerated.". (Brown et.al 1992, p:78)

An overall assessment of the Brown et. al. research is that it fails to include certain key features. For example it does not show:
(a) how many mentally disordered suspects were denied the protection of an AA?
The research identified 106 cases from custody records and 10 from the
observational study as suffering from mental disorder and/or mental handicap? and;
(b) whether those suspects denied an AA underwent an examination by the police
surgeon in order to determine if they were fit to be detained and interviewed? If
these suspects were assessed by the police surgeon as fit for detention and interview,
why was the AA not called as well?

Such information, if it were available, would show or perhaps indicate some of the
reasons why an Appropriate Adult was not called. However, Brown et al (1992)
qualify their inability to account for the custody officers' apparent failure to call
AA's for mentally disordered adults, accordingly;

"The wording of Code C does, however, point to the need for custody officers
to err on the side of safety (C.14). The data indeed suggests that there
has been some increase in caution, with appropriate adults attending in around
80 per cent of cases in phase two compared with half in phase one".


Again, this quotation is confusing. The first sentence refers to the fact that
although custody officers might not be calling an AA for all suspects identified as
mentally disordered - nevertheless, they should, as Code C states, 'err on the side of caution'. The authors insist that despite everything their data shows an 80 per cent increase in calling AA's - but who for? - this is not clear. As the only data about the attendance of AA's, is revealed in Table 5.1 on page71 of the Brown et al research, and this refers only to juveniles, it seems reasonable to assume that the authors are only referring to the implementation of the AA protection for juveniles.
Although, to be fair to Brown et al (ibid), their study was concerned only with the impact of revised Code C, as far as the mentally disordered offender was concerned and the role of the Appropriate Adult, the revised Code did not alter the basic provisions regarding the mentally disordered and the requirement to call an AA. The revised Code, as previously stated, defined who was 'appropriate' to act as an AA, and that the AA should understand their role.

Brown et al (1992) interestingly found some changes in the personnel who were being called to act as the AA. In the second phase of the research the data shows parents were called on fewer occasions for mentally disordered adults, (after the Revised Codes) and more specialist and psychiatric workers were increasingly involved as AA's (p.78). These changes suggest that notice was being taken of the Revised Codes of Practice which defined more clearly who should be the AA. Irving and McKenzie (1989) asserted that parents may not always act in the best interests of their children or indeed for adult mentally vulnerable relatives. However, the Brown et al (1992) research states that it was not always clear from the custody records who was the AA and who was not. What this probably means is that sometimes when the custody record indicates that a social worker had been called, it was not always clear whether the social worker was called to conduct a mental health assessment, act as the AA, or indeed perform both roles. Thus, custody records often fail to indicate who was acting formally in the role of the AA.

Aside from the Brown et al (1992) research and despite problems associated with using custody records, other research in police stations reveals a number of interesting points:

(a) that the use of psychological tactics by interviewing officers designed to manipulate suspects into making confessions against their will or inclination (whether these tactics have declined or not since the implementation of the PACE
Act) combined with the intimidating environment of the police station, place mentally vulnerable suspects particularly, at risk of involuntarily making false confessions (Gudjonsson, 1993);

(b) that the police place great importance on confessions (McConville et al 1991, see also socio/legal chapter);

(c) that despite the introduction of the PACE Act and the Codes of Practice, there remains some disagreement about how much improvement in police practices has occurred in the detention and questioning of suspects in the police station; and

(d) the obvious need for the Codes of Practice protections for everyone who is detained in a police station - most of all for the mentally disordered and vulnerable suspect; and

(e) that questions must ask whether it is realistic to expect legislation such as the PACE Act to be complied with even within the spirit of the Codes of Practice? - and;

(f) there are important implications in relation to the role and function of the Appropriate Adult?

One of the most important criminological/sociological studies - albeit, still within the category of observations within police stations that exemplifies many of the issues outlined above, especially relating to (e) - which particularly reveals insights into police culture and the workings of the criminal justice system - is that of McConville et al (1991). McConville et al's research (including Irving and McKenzie, 1989 study) have had the greatest influence on this thesis and promoted many ideas which have been included throughout.
McConville et al (ibid) present a view of police practices in particular, and the
criminal justice system in general, as an exercise in what they call 'case
construction'. That is, to ask questions about whether this or that piece of
legislation is being implemented or not, or if police practices have improved or not,
is to miss the point of the exercise. The authors record case histories that reveal -

"...that there is no single reality but rather competing versions of reality
and this may be so even within the official records or the police organisation
itself......for official purposes, the police have a pivotal role in deciding
which reality will be accorded dominance and, in this way, are central
'definers of reality'." (McConville et al 1991:9-10)

The above observation and indeed the whole of the McConville et al study reveals
important insights into police culture and practices. Irving and McKenzie make
the same point, in less elegant language perhaps, yet reveal a pragmatism that is
perhaps more plausible -

"...we prefer an ergonomic approach to law and rule systems which recognises
the complex heterogeneity of the police work-group especially with respect to
attitudes to the law and ethics. Given that police work will continue to
embrace diverse roles the idea of grass roots deviance in policing begins to
look naive. It also seems naive under current conditions to expect this
heterogeneity to decline markedly."

(Irving and McKenzie 1989, p.246)
(The above quotation is reproduced in full in chapter 3)

Although McConville et al’s research does not refer specifically to the Appropriate
Adult, nevertheless, the research reveals how vulnerable all suspects are who are
detained in police stations. There the police are in control. Even personal matters
such as access to the lavatory, food and water are all dependent upon the whim or
gift of the custody officer. McConville et al show how the police station is an
intimidating and daunting place for anyone, especially those not privy to the police
language and culture. Traditionally, the police view others such as solicitors and
social workers who enter their domain, with suspicion. While the PACE Act and
the Codes of Practice provides rights to the detainee and places obligations upon the
custody officer, McConville et al rightly point out that legislation cannot change the
intimidating atmosphere within which interrogations take place. (Interestingly,
during the course of the research for this thesis, several police officers confessed
that even they found the custody area intimidating!).

One further study that should be mentioned within this category of research, is that
of Dixon et al (1990). The findings of this study were based on two previous
research studies, the first study was conducted by Dixon and Wall and the second
larger study by Dixon et al - a total of 5 researchers were used. The methods used
involved a study of custody records but with a mixture of interviews and
observational data. In all, 2,844 custody records covering a four year period before
and after PACE were analysed, plus formal interviews with 160 officers, and 870
hours of observation. The first smaller study consisted of 35 interviews with legal
advisers. The purpose of the research was to - "...assesses the PACE safeguards on
the rights of suspects in police custody who have not been charged". (p.115).
Consequently, the aims of the research did not specifically include the mentally
disordered suspect. Even so, the Dixon et al research presents a comprehensive
review of previous research carried out in police stations. They also make
reference to the role of the Appropriate Adult, recounting many of the problems
outlined above, for example: the difficulties police officers have recognising
mentally disordered people, how other research such as Brown 1989 (see above)
failed to find the expected number of mentally disordered or handicapped in their
research, and the need for more training of police officers in identifying vulnerable suspects.

Dixon et al's study is important because the authors analyse and discuss a wide range of procedures and practices by the police, legal advisors and social workers, at the police station. However, apart from reproducing the PACE Codes of Practice's definition and role of the AA, they declare that because other research has not recorded the expected number of mentally disordered detainees consequently - "....some mentally ill or handicapped people are presumably being detained and questioned without the benefit of the legal protections provided for them..". (Dixon et al 1990, p.119)

It is important to note that Dixon et al (ibid) do not include evidence from their own research in the above warning. They do not mention the number of mentally disordered suspects found, and we have no way of knowing if they recorded any mentally disordered detainees at all. The authors go on to state that -

"The majority of suspects requiring attendance by an appropriate adult will continue to be juveniles: they made up one in seven of prisoners in our sample and 18 per cent in Brown's (1989, 38). Consequently, the rest of this discussion will largely concern the role of appropriate adults in the detention and questioning of juveniles.". (Dixon et al 1990, p.119)

Clearly, Dixon et al's research along with Brown's 1989 and 1992 studies (ibid) suffers from the same shortcomings, that is they fail to find qualitative information about the use or non use of the appropriate adult for mentally disordered adults.

The larger study of Dixon et al's (ibid) upon which the findings were based was carried out by 5 researchers which included many hours of observation and
apparently a large number of interviews in police stations, yet again, only a relatively small number of custody records were analysed. As already noted above (see the discussion of Brown's 1989 and Brown et al 1992 study above) this method would only give a snapshot view of the kind of data available from custody records. Thus Dixon’s research is also disappointing as far as discovering the number of mentally disordered people who go through police stations is concerned.

Moreover, the following observation by Dixon et al (ibid) reveals more than the authors’ assumptions regarding mentally disordered suspects. It perhaps provides a clue as to why vulnerable suspects are missing from their research -

"We are concerned here with people brought to police stations under arrest for suspected crime. Others (some juveniles and mentally disordered people) will be detained under powers intended to protect a person’s welfare."

(Dixon et al 1990, p.116)

May it not be that Dixon et al, along with other research studies discussed so far, including the police, view the mentally disordered suspect primarily as a medical and/or welfare problem? If so, then when researchers have not found the expected number of mentally disordered adults in their data sample, they assume like Dixon et al, that vulnerable adults have been detained as a ‘place of safety’ and diverted into the mental health system. It seems that only the analysis of a large number of custody records, will reveal the numbers of mentally disordered and vulnerable people who pass through the police stations. But more importantly, if the research method they used is the only method available, then it seems that in order to determine the likely proportion of mentally disordered suspects who pass through police stations and how they are treated, then the base number from which such information is drawn needs to be large. Thus the study of one year’s custody records in several police stations (conducted for this thesis) seems to be the one more likely to show the proportion of mentally vulnerable suspects, and present a
greater understanding of contributing factors such as the link between the police surgeon's assessment, and the use or not of the Appropriate Adult.

Thus, although the studies concerned with the interactions between the detainee, police and other key figures in police stations are generally disappointing in terms of information about the role of the Appropriate Adult, and mentally disordered suspects are concerned, they reveal insights into how suspects are treated in the police station and especially during interrogations. If the research discussed in this chapter gives insights into how such suspects may be treated then what do these mean for the mentally disordered or vulnerable suspect, and the role of the Appropriate Adult?

(c) Other Related Research Which Includes Studies Looking at the Role of Police Surgeons and Solicitors Who Attend Police Stations.

The most useful research published so far (apart from those outlined above) at least as far as this literature review is concerned, is that by the Royal Commission on Criminal Justice 1993 (RCCJ, 1993). Several studies commissioned by the RCCJ 1993 cover all the classifications of methodologies outlined at the beginning of this chapter. The Royal Commission on Criminal Justice (RCCJ 1993) is included here because the Commission appointed several important studies that are relevant to the role of the AA. The RCCJ 1993 itself, that is, a committee chaired by Viscount Runciman, has been classified with the 'Other Related Research Category' as outlined at the beginning of this chapter. The Royal Commission on Criminal Justice devoted less than two pages to issues concerning the Appropriate Adult, but what the Report did conclude about the protections of the Appropriate Adult was important. It said,
"We cannot say that we are fully satisfied with the present rules and practical arrangements for providing necessary advice and protection for those who are likely to be particularly vulnerable to pressure while in police custody. ....It seems to us that a more systematic approach is needed to the question of which people are suitable for being called upon to serve as Appropriate Adults and the training that they should receive.".

(RCCJ 1993 p.44)

What brought the RCCJ to this conclusion was the findings of the research conducted for the Commission. That research suggested a significant degree of failure by the police to identify vulnerable suspects and their need for an Appropriate Adult. The Commission’s research studies also suggested failure by other professionals, namely solicitors who seemingly had an inability to act in the best interests of the suspect. That research also looked at the role of the police surgeon. Yet all the Royal Commission offered concerning the Appropriate Adult was a recommendation:

"...for a comprehensive review of the role, functions, qualifications, training and availability of Appropriate Adults.". (RCCJ 1993, p.44)

Clearly, the recommendation is fundamental because it calls into question the adequacy of the Appropriate Adult protection. But the RCCJ could have been more critical of the police in their failure to use the AA for many mentally disordered suspects. Moreover, the RCCJ could have endorsed the importance of the AA procedure, and affirmed the AA role as the only extra protection for mentally vulnerable adults.

Probably the most influential research that informed the RCCJ was conducted by Gudjonsson et al 1993; together with the study conducted by Clare and Gudjonsson,
Gudjonsson et al (1993) investigated the psychological characteristics of adult suspects prior to being interviewed by the police, in order to identify those who might be vulnerable.

"The characteristics studied are those that are considered relevant to the potential vulnerabilities of suspects to giving erroneous or misleading information to the police during interviewing...". (Gudjonsson et al 1993, p:23)

The characteristics Gudjonsson considered relevant were:

"...their current mental state, their intellectual functioning, reading ability, state and trait anxiety and interrogative suggestibility. ...The suspects' understanding of their legal rights was also investigation". (ibid p:23).

Three clinical psychologists carried out the research in two police stations in the London area, over a three month period. In total the psychologists assessed 156 detainees who had been selected by the custody officers; there was no evidence that this selection was biased. Out of the 156 assessments they considered a total of 25 (15%) suspects being in need of an Appropriate Adult. Gudjonsson’s criteria for assessment rests on the theory that personality traits, particularly suggestibility, determines the behaviour of these suspects during interrogation and therefore places such people at risk of making false confessions. The researchers considered that 7 per cent of suspects were suffering from mental illness, 3 per cent from mental handicap, 3 per cent were illiterate and 2 per cent had language problems. The research states that they considered between 15 and 20 per cent of the cases assessed were in need of an Appropriate Adult, but the police called an Appropriate Adult in only 4 per cent of cases (a total of 7 suspects). It appeared that the police only called an AA in 'exceptional circumstances', in that they were able to detect the
"most disabled and vulnerable detainees and take the necessary action to call in an appropriate Adult". (ibid. p.16).

This study mentioned the use of police surgeons in London, or forensic medical examiners as they are often called, but will be referred throughout this thesis as police surgeons. There the police surgeon was called for 26 detainees, but it is not clear from the report if this number included any or all of the 25 suspects the psychologists identified as mentally disordered or vulnerable and in need of an AA. In other words, did the police surgeon assess the same detainees that the psychologists assessed? The report states that the police surgeon was 'typically' called for suspects suffering from physical injuries or pain and drink/drug problems. This implies that the police surgeon did not assess the same suspects as the psychologists, although information about the police surgeon's assessments is included in the same Table of results that shows the psychologists' assessments. (see Table 6, p.16 ibid.).

This would seem to indicate that the police usually call the police surgeon for physical problems or drink/drugs matters. Gudjonsson et al (ibid) make the point that the police only called an AA for 4 out of the 12 suspects they (the psychologists) identified as suffering from mental illness - they classified those 12 as having severe depression or schizophrenia. Of these 12, the police apparently identified only those suffering from schizophrenia and failed to recognise those suffering from severe depression (p.26). But were the police the only ones who failed to recognise those suffering from this condition? Did the police surgeon also declare those suspects as 'fit to be detained and interviewed'? Obviously, without knowing whether the police surgeon attended the same detainees who were assessed by the psychologists, any assumptions about the influence the police surgeon's assessments might have had on the custody officers' decisions about calling an AA, must remain conjecture.
This does not imply a major criticism of the Gudjonsson et al study, only to say that their aims and methodology unaccountably did not include information about the police surgeon's assessments. But if the police surgeon was called for the same suspects that the psychologists assessed as needing an AA, then an important variable in the implementation of the AA protection has been overlooked. That is, were the police using the police surgeon's assessment of fitness for detention and interview but then neglecting to call an AA? The psychologists identified 25 suspects needing an AA, the police called the police surgeon for 26 suspects prior to the interview - were any, or all of them the same suspects? It is unclear whether the psychologists or the police surgeon assessed the 7 suspects who had an AA called for them. At the Association of Police Surgeons Conference in 1997 Gudjonsson said that he would have to re-analyse the data before being able to state with certainty that the police surgeons had also assessed their sample (personal communication).

Custody officers' reasons for calling a police surgeon are often complex, but mainly it seems to determine if the suspect is 'fit to be detained'. This surely indicates a custody officer's suspicion that the suspect is vulnerable in some way. However, the Code of Practice is clear; if the custody officer has any suspicion that a suspect may be mentally disordered then an AA must be called - as well of course as the police surgeon. Gudjonsson et al (ibid) fail to associate the police surgeon being called to assess the suspect and the failure by the custody officer to call the AA.

Despite some weaknesses outlined above, the Gudjonsson et al research is the most useful as far as this study is concerned, because the research discusses some of the major issues surrounding the use of the Appropriate Adult. But more importantly it was the first research to reveal the neglect by the police to call Appropriate Adults for many mentally vulnerable suspects. Moreover, Gudjonsson's study clearly influenced and informed the RCCJ 1993 concerning the role of the AA.
Gudjonsson et al's (ibid) conclusions was that the identification of vulnerable suspects is extremely difficult for the police, although the police are good at identifying the most disturbed offenders (Bean et al 1991). But for the majority of vulnerable suspects, which include the mildly mentally handicapped, the task of identification is difficult even for trained clinicians (Gudjonsson et al 1993, p:26). Gudjonsson et al (ibid) conclude that -

"not every suspect who was in an abnormal mental state required the presence of an appropriate adult in accordance with PACE". (ibid. p:25)

They admit that the criteria for the presence of an AA in the Codes of Practice are 'poorly defined operationally', and theirs is a 'conservative estimate' of those who needed an AA. Yet, although the wording in the Codes of Practice as they relate to the AA may be 'poorly defined operationally', nevertheless the Codes state that an AA must be called if the custody officer has 'any suspicion' that a suspect may be vulnerable in some way.

It would have been helpful to know what 'an abnormal mental state' means and why those so identified would not have needed an AA. Would those psychologists have agreed with the police surgeons' assessments above, that those detainees were 'fit to be interviewed' and even 'fit to be charged'. Gudjonsson et al (ibid) ends the study with several recommendations which included inter alia:

(a) "an operational definition of mental disorder and vulnerability;
(b) clearer guidelines for the police on the use of the Appropriate Adult;
(c) basic training for officers in identifying vulnerable and mentally ill suspects;
(d) a comprehensive review of the role, function, qualification, training and availability of persons acting as an appropriate adult is urgently needed;
(e) (and interestingly Gudjonsson recommends that) part of the onus of identification of vulnerable individuals should be placed on the detainee. This would involve a simple enquiry as to whether they qualify for special help." (Gudjonsson et al (op.cit)).

Gudjonsson et al's recommendations outlined above are important and similar recommendations have been put forward in other studies (Palmer and Hart, 1996). However the first recommendation (a) remains difficult to define let alone operationalise because clinical assessments of mental disorder are arbitrary given the fragile nature of psychiatry (Bean 1980). Moreover, the RCCJ 1993 did include recommendation (d) in their report. As to (e) above, the study conducted by Clare and Gudjonsson (1993) tested this recommendation. The main purpose of that research was to devise an experimental 'Notice to Detained Persons'. That 'Notice to Detained Persons' provides information to the detainee about the importance of the caution and the rights of suspects while detained in the police station. The experimental notice that Clare and Gudjonsson (ibid) devised was designed to be easier to understand and assist persons with reading or intellectual difficulties or mental health problems to make their difficulties known to the police.

Clare and Gudjonsson (ibid) reported impressive success with their experimental version of the Notice to Detained Persons. That version used more simple language and required the custody officer to tell detained suspects about their rights. The authors state that all persons in the experimental group who were significantly intellectually impaired understood their right to legal advice, compared with 70% of those who were given the current version. Moreover, and particularly relevant to this study was that 80% of suspects known to be unable to read or to have learning disabilities identified themselves as needing an Appropriate Adult in response to direct questions put to them, e.g. is the suspect taking any medication for mental health problems, or is the suspect attending a psychiatric clinic? The authors
recommended that direct questions should be developed in order to establish the
detainee's need for an Appropriate Adult.

However, many people with learning difficulties have been able to disguise their
disabilities and cope very well in the community. Gudjonsson et al (1993) himself
points out:

"...some persons with a mental handicap see their handicap as a private
matter, would not tell the police about it and may even deliberately
disguise it as far as they are able to."

(Gudjonsson et al 1993, p:26)

Clearly, a Notice containing simple language will be an improvement and most of
all for those who are vulnerable. But for the reasons mentioned above, Gudjonsson
is probably right when he stated that:

"...it is unlikely that the identification of vulnerable suspects can be made
error-free."

(Gudjonsson et al, ibid. p:26)

A study commissioned by the RCCJ 1993 by Robertson (1993) was the first to look
at the role and function of police surgeons in police stations. This study comes
under the classification outlined above as 'Other Related Research' not just because
of its methodology which includes a study of records, and interviews with custody
officers, but because of the central interest in police surgeons. As will be shown
later in this thesis police surgeons are central figures surrounding the AA - more so
than is apparent from most research studies.

The role of the police surgeon in the police station has evolved since the start of the
National Health Service in 1948. Prior to 1948 the police surgeon looked after the
health of police personnel only. Once the NHS was in place the police doctor as
he/she was then called, was paid to attend the police station and examine suspects, victims and witnesses. Robertson describes the transfer of the police surgeon's work into the police station as historical - that is, a natural transition, once health care was free at the point of need. (Robertson, 1993). The appropriateness of the police doctor taking on the care of suspects in the police station was apparently never questioned.

The aims of Robertson's study 'The Role of Police Surgeons' (ibid) were to describe and assess the role of doctors employed as police surgeons, including that of assessing suspects' fitness to be detained or interviewed, and to identify areas of concern about the way the system operates and make suggestions for improvements.

The method Robertson used was to study 2987 police surgeon claim forms and the accompanying doctors entries on the custody records. This data was gathered at 15 police stations from eight police forces throughout the country. A small number of interviews were carried out with custody officers and police surgeons.

Robertson found 181 detainees were referred to police surgeons by custody officers because of concern for the detainee's mental health. Out of the 181 suspects, 68 were defined by the police surgeon as 'definitely abnormal', but an AA was indicated for only 8 of these. A further 33 suspects were described as 'possibly abnormal', but again only 7 AAs were indicated. It should be noted that Robertson is only stating that the police surgeon is suggesting that an Appropriate Adult was to be called, he does not state whether the recommendation was actioned upon by the police.
Out of the 17 Appropriate Adults called 16 were recommended by police surgeons in the London police stations, only 1 Appropriate Adult was recommended by a police surgeon outside London. As Robertson states -

"What is clear, is that advise (sic) about appropriate adults was rarely given in the provincial Forces which were visited". (Robertson, 1993 p:24)

Robertson seems to indicate that the AA should be recommended by the police surgeon, or implies that the police surgeon's advice was instrumental in implementing the AA procedures. Robertson goes on to state that,

"Decisions regarding the need for appropriate adults are ultimately matters for the police to decide upon, but medical advice of this type would always be followed". (Robertson, ibid. p:39)

Interestingly, the Independent Commissioner for the Holding Centres in Northern Ireland makes a similar point. (The Appropriate Adult protection has been in place in the Holding Centres since January 1994, see Northern Ireland (Emergency Provisions) Act 1991 Codes of Practice paras 10.9.,11.10, 11.12., 11.13. 11.A.). But, as said earlier, the routine in the Holding Centres is different, in that a medical officer attends suspects automatically, at regular intervals, with or without requests from the police or the suspect, as the following shows -

"This initial medical examination is very important providing as it does an opportunity for the medical officer to detect mental disorder or mental handicaps which might exist, and allow the appropriate adult scheme to be activated. If the Medical Officer detects mental illness, learning disability or incapacity of understanding of questioning and answering in the interview, the custody officer is bound to appoint a
appropriate adult. Hence everything depends on the Medical Officer's assessment during the short time - usually in practice 15-20 minutes - of the initial medical examination, although the decision is theoretically an administrative one, performed by police officers, the medical opinion will in practice almost invariably dictate the decision. (The reverse, interestingly, is probably the case under PACE in both Northern Ireland and England & Wales, where criminal suspects held in custody in ordinary police stations are not routinely subjected to medical examination and where the Custody Officer is the person designated initially to decide on the suspect's mental condition and, if required, to appoint the appropriate adult)."


The above has been reproduced in full because it encapsulates an important area of confusion surrounding the Appropriate Adult procedures. Similar confusion seems to exist amongst police officers and police surgeons as was clear at a conference held at Guy's Hospital in January 1995, about whose responsibility it is to initiate the Appropriate Adult procedures.(Joint Meeting of The Royal Society of Medicine and The Metropolitan and City Group of the Association of Police Surgeons, 1995). Yet, the PACE Act Codes of Practice clearly state that the responsibility lies with the custody officer. One further point to note: police surgeons' average length of time taken for assessments in the police stations is usually 3-4 minutes (Robertson op.cit. and this research) unlike the medical officers in the Holding Centres who obviously conduct a more extensive examination of the suspects.

Robertson (ibid) records that when police surgeons were asked about matters concerning the Appropriate Adult in forces outside London, they said they regarded that decision to be the responsibility of the police. This means that Robertson’s
study points to differences in perceptions between police surgeons in London and elsewhere, about issues concerning the AA.

Robertson (ibid) confines his discussion about Appropriate Adults to the debate about the police surgeon's assessment of 'fitness for interview'. That is, he does not discuss the role of the AA separate from the assessment for detention and interview. Robertson (ibid) found that the police surgeons' criteria used to assess fitness for interview varied, although the basis for most decisions was the detainee's orientation in time and place, and capacity to understand questions and produce rational answers. Generally, a suspect's emotional state, as distinct from his or her orientation, was not a factor that was taken into account in relation to fitness to be interviewed. (Robertson, 1993)

Robertson (ibid) states, that anxiety is to be expected in someone being interviewed by the police, and asks the question - "When does that anxiety become debilitating?". He concludes that despite the criteria for fitness for interview is basic it nevertheless is "adequate". Robertson (ibid) seems to suggest that while police surgeons' assessments for fitness for interview is inconsistent and arbitrary, nevertheless, mentally vulnerable suspects are probably protected adequately. Yet the Notes for Guidance in the PACE Act Codes of Practice state that the custody officer should err on the side of caution when deciding about the need for an Appropriate Adult. The Revised Codes of Practice 1991 and 1995, states that the special provision of the AA for potentially vulnerable suspects during police interrogation is because -

"It is important to bear in mind that although mentally disordered or mentally handicapped are people often capable of providing reliable evidence, they may, without knowing or wishing to do so, be particularly prone in certain circumstances to provide information which is
unreliable, misleading or self-incriminating. Special care should therefore always be exercised in questioning such a person and the appropriate adult involved, if there is any doubt about a person's mental state or capacity. Because of the risk of unreliable evidence, it is important to obtain corroboration of any facts admitted whenever possible."


Sir Louis Blom-Cooper views the criteria for calling an Appropriate Adult thus:

"Our suggestion is that the criteria for the appointment of an appropriate adult ought to focus on vulnerability. Vulnerability, in the sense of ability to cope with sustained questioning periodically over two or more days; whereas a less vulnerable person is able to protect himself/herself without assistance. While we think that the assessment of vulnerability must initially depend largely on the Medical Officer's opinion about the individual's mental state (including learning disability and capacity for understanding the questions and answers in the interview process) we think that consideration should be given to whether the ultimate decision to activate the appropriate adult scheme should be made by an officer not below the rank of Chief Inspector."

(Sir Louis Blom-Cooper, 1995, p.21)

Although Sir Louis is referring primarily to the special conditions relating to the Holding Centres, where suspects may be held for up to 7 days under the Prevention of Terrorism Act (in practice suspects are rarely held for more than 2 days) it is suggested that his criteria of vulnerability should apply to all suspects detained for questioning in police stations. Again, the available research indicates that it is rare
for suspects to be held for questioning for more than 4 hours, most interviews last less than 1 hour.

What Robertson (op. cit) fails to discuss in his research is the huge number of suspects who were referred for a mental health assessment, but were consequently declared 'fit to be interviewed' by the police surgeon. Out of his sample of 181 detainees referred to the police surgeon because of concern for the suspects’ mental health, 53 suspects or (76%) of the sample of 70 detainees' in London were recorded as 'fit for interview', or nothing further was recorded by the police surgeon. In the other Forces 97 suspects or 87% of the sample of 111 detainees were declared 'fit' for interview, or nothing was recorded.

It can only be assumed that 150 out of the 181 detainees referred to the police surgeon were subsequently interviewed without an Appropriate Adult. Robertson does not mention the implications of this and of so many suspects who were thought to be vulnerable yet who were denied the protection of an AA. In the light of the above Code of Practice (Guidance notes) that urges the custody officer to err on the side of caution when interviewing potentially vulnerable people, Robertson’s conclusions seem to be particularly worrying. (see above)

It must be remembered however that the aims of Robertson's study were to assess the role of police surgeons not to determine whether the Appropriate Adult was used. Even so, the police surgeons' assessments are crucial to decisions about the Appropriate Adult. After all the police surgeon is understandably not without influence on police practices.

Robertson (op. cit) shows that in the London police stations, 16 or 23% of his sample were recommended for an AA. This seems to indicate that police surgeons in London operate slightly differently from the provinces, or at least use different
diagnoses. Or it might mean that police surgeons in London are more conversant with the PACE Act requirements. Even so, Robertson concluded that there is no consistency in the criteria used by police surgeons to assess prisoners' fitness for interview.

The variability that Robertson (ibid) found in police surgeons' practices reveals a measure of inconsistency. It is this variability and inconsistency in police surgeons' assessments that is probably the most important finding about the role of police surgeons in the police station in his research. It should be noted that Robertson’s assessments were of all suspects, not only those who might be considered mentally disordered.

Robertson's study (ibid) raises further issues about the doctor/patient relationship, and its meaning in respect of confidentiality. Robertson's study (ibid) shows that sometimes during the medical examination the suspect had 'confessed' the offence to the police surgeon. Clearly, the suspect/patient needs to be cautioned before a police surgeon examination - in that anything he or she says might be given in evidence against him or her. Robertson (ibid) found that few police surgeons informed the suspect that any information about the offence could be used as evidence. Clearly there are issues here about confidentiality, and indeed about the doctor/patient relationship. Robertson (ibid.) is in no doubt that the normal doctor/patient relationship should prevail in the police station.

Interestingly, it is argued, that the normal doctor/patient relationship is said not to apply in the Holding Centres in Northern Ireland. (Sir Louis Blom-Cooper, 1995) The medical examination in the Holding Centres is automatic; that means that the presence of the medical examiner does not depend upon the custody officer, nor on the request of the detainee. It is argued then, that if the medical examination is not refused by the detainee - then this is:
"...not a health care situation. While it is true that the detainee may choose to be medically examined, by not opting out of the process, he nevertheless is not seeking a consultation with the doctor because of some ailment or medical problem. The detainee's submission to medical examination is simply acceptance that the health, both physical and mental, of the detainee is an important aspect of the detainee's detention in police custody for concentrated interrogation over a period of at least 48 hours. The medical examination covers a dual purpose of protecting the detainee from infringement of civil rights and for safeguarding the police from false allegations. The doctor is exercising a professional service in the field of public administration. The information imparted to him or her by the patient does not belong to the detainee but is the property of the Police Authority for Northern Ireland for whom the doctor is contracted to supply the service. What is important is the relationship of the doctor to the interrogating officers."

(Sir Louis Blom-Cooper, 1995 and personal correspondence)

While Sir Louis's argument above would be the accepted test in law, it is debatable whether any doctor who attends the Holding Centres would agree with the above statement. During a seminar held in Belfast recently (Sir Louis Blom-Cooper 1995 and personal communication) several doctors who attend the Holding Centres, insisted that their relationship with the suspect was definitely the normal doctor/patient relationship.

Moreover, the doctors who attend the Holding Centres believe that an Appropriate Adult was needed for detained persons, and moreover, the AA was seen as providing valuable support to them in their diagnosis. For despite these doctors' long experience in assessing suspects in the Holding Centres, (one doctor had attended the Holding Centres for 25 years) they expressed uncertainty about being able to diagnose mental disorder.
It is ironical then that the medical examiners in Northern Ireland's Holding Centres insist that the normal doctor/patient relationship applies for suspects detained under the Prevention of Terrorism Act, (Sir Louis Blom-Cooper 1995 and personal communication). On the other hand, and paradoxically, it seems that in England and Wales many police surgeons do not consider suspects detained under the Police and Criminal Evidence Act 1984, in quite the same light.

The RCCJ 1993, recommended that a working party look at the work of police surgeons or forensic medical examiners. Robertson (ibid) found that only 2% of police surgeons in the country had undertaken any forensic training. There are even fewer police surgeons who are Section 12 Approved Doctors under the Mental Health Act 1983. All police surgeons who attended the police stations in this study were local General Practitioners (GP's), who were paid a fixed fee for every call out plus an honorarium. Robertson (ibid) found that some police surgeons in the London area had given up their practice and become full time police surgeons earning in excess of £100,000 a year.

However, probably as a reaction to the Robertson study and subsequent criticisms about their quality of service and high remuneration, police surgeons themselves are now beginning to question what they mean by 'fit to be detained and fit to be interviewed'. This was demonstrated during a recent conference attended by the Metropolitan and City Group of The Association of Police Surgeons and the Royal Society of Medicine. It was also obvious during this conference, judging by the questions asked, that many doctors confessed to the difficulty in identifying vulnerable suspects. The evidence so far suggests that -

"The police surgeon is not necessarily the best source of advice, since many doctors have no special expertise in mental illness or mental handicap.". (McKay C. 1992, pp:182-184).
It was also clear that many police surgeons were not aware of the role of the Appropriate Adult. Interestingly, and sadly, several police surgeons asked, what use are Appropriate Adults anyway?

Issues about confidentiality are of course relevant to the role of social workers who act as AA's and indeed to all others who act in the role of the Appropriate Adult. This is discussed further in the chapter on socio/legal issues. But for the purposes of this discussion on the relevant literature the research carried out by Gudjonsson et al (1993), Clare and Gudjonsson (1993) and Robertson (1993) outlined above are probably the most relevant.

Other research commissioned by the RCCJ 1993 looked at the role of solicitors in the police station and during the interrogation (Baldwin 1993, and McConville and Hodgson, 1993). The position of solicitors or legal representatives in the police station is relevant to the study of the Appropriate Adult in so far as they are requested by the police or the suspect to advise on matters of law during the interrogation, that is, instead of or as well as the AA. There is of course a wider question about the quality of the service they provide in relation to the AA and of course in relation to the suspect. In other words, is the protection solicitors are said to provide or the right to have a solicitor or legal representative present during a PACE interview, always likely to protect the suspect's rights? If not, what are the implications for this for mentally disordered suspects, especially if they are also denied the protection of the Appropriate Adult?

Baldwin (1993, and personal communication) and McConville and Hodgson (1993) do not make specific reference to mentally disordered suspects in their research. Their aims were rather different. Even so, Balwin's research (1993) was concerned with the role solicitors played during interrogation, specifically the extent of intervention in their clients' interests, and McConville and Hodgson (1993)
examined the circumstances in which solicitors or legal representatives advise suspects during the interrogation of their right to remain silent. Both are of direct relevance here.

The findings of both Baldwin, and McConville and Hodgson's research suggested significant shortcomings in the quality of advice and service by solicitors and legal representatives to suspects during detention in the police station. Both Baldwin and McConville and Hodgson state that by and large, solicitors do not intervene during the interview - their role is 'primarily a passive one' and 'at best carry out a watching brief over police interviews and undertake little in the way of advocacy'. (Baldwin 1993, McConville and Hodgson 1993). These studies are mentioned here because they raise important questions about false confessions and miscarriages of justice. What seems clear from their research is that vulnerable suspects are at risk if they are denied the presence of an Appropriate Adult. Nor does it seem as if solicitors provide much protection which must be a matter of great concern.

The following studies discussed below are also included under classification (c) outlined above. The studies conducted by Evans and Rawstorne 1995, Palmer and Hart 1996 and Robertson, Pearson and Gibb 1995, provide the most recent up to date findings on issues relating to the Appropriate Adult. The final research study to be examined comes from Western Australia also included under category C. (Underwood R. et al 1993). The views from Western Australia are interesting because the arguments raise issues about the mentally disordered offender which are similar to the debate in this country, yet the conclusions are widely different.

The research conducted by Evans and Rawstorne (1995) was submitted to the Home Office Research and Planning Unit (HORPU) in April 1995. This research (including the Palmer and Hart and Robertson et al studies ibid) were commissioned by the Home Office for the 'Appropriate Adults Review Group'. This was set up in
1994 to consider the RCCJ 1993 recommendation on the 'role, functions, qualifications and training of Appropriate Adult'. A report was also commissioned by the HORPU for the Appropriate Adults Review Group from Bean and Nemitz (1994) which drew on some of the findings of this thesis. The aims of the study carried out by Evans and Rawstorne (1995) were -

"...concerned with the role, functions, qualifications training and availability of appropriate adults with vulnerable adult suspects and with juveniles."

(Evans and Rawstorne 1995, p:17)

It should be noted that Evans and Rawstorne (ibid) include juveniles in their research. This is not surprising for Evans (1993) himself had earlier conducted research for the RCCJ 1993 on the way juveniles were interviewed by the police. The method used by Evans and Rawstorne (op.cit) was in two stages. Stage 1 was a "brief exploratory survey" of 18 Local Authority Social Service Department's Emergency Duty Teams (EDT). The authors state that they decided to use the EDT network as they are, "..significant providers of appropriate adults for mentally disordered adults and juveniles particularly out of normal office hours". (p:17) The intention during Stage 1 was to -

"Provide an overview of policies and procedures governing the training and supply of appropriate adults amongst the eighteen Social Services Departments. (and)... To identify models of good practice.". (Evans and Rawstorne 1995, p:18)

Stage 2 of the research consisted of interviewing custody officers, interviewing officers and social workers who had experience acting as AA's. The interviews were confined to three Social Services and Police Forces: Liverpool Social Services and Merseyside police, Sefton Social Services (inner city) and Merseyside police and Lancashire Social Services and Lancashire police. The authors also discuss agencies' views about how they obtain AA's. The training given to police officers and social workers was also included. Altogether the authors conducted 78
interviews with police officers which included 28 custody officers and 50 interviewing officers and 62 interviews with social workers. The authors point out that -

"Given the limited time and resources available for this project it is inevitably an exploratory study."

(Evans and Rawstorne 1995, p.20)

The research was conducted over a 1 year period, from March 1993 to April 1994. Evans and Rawstorne (ibid) found, inter alia, that custody officers used an Appropriate Adult rarely for mentally disordered adults. The authors state that most custody officers recall only calling 3 AA's in the past year. In order to calculate the number of times an AA was called by the police, they extrapolated from this finding to arrive at a likely percentage of the use of AA's thus -

"The estimate is arrived at by assuming that all the active custody officers in the station dealt with three such cases and dividing this by the total number of adult cases dealt with. The percentage of for Liverpool (sic) is 3.3%; for Sefton 1.7%; and that for Blackburn 1.5%. The corresponding percentage from the RCCJ research is 4.0%.

(Evans and Rawstorne 1995, p.26).

The RCCJ research of 4% that Evans and Rawstorne (ibid) refer to is the Gudjonsson et al study 1993. The above method of calculating the probable number of times an AA was called by the police is clearly unsatisfactory. Rawstorne, (personal communication 1996) stated that she was unable to gain permission from the Chief Constable of Merseyside to analyse custody records. Consequently, the researchers have had to rely on the memory of the 28 custody officers they interviewed, and then devised the above calculation in order to estimate the average number of times an AA was called.
However, despite the problems, it remains likely that the use of the Appropriate Adult in the North West Region of the country is similar to that found elsewhere. In addition the Evans and Rawstorne research (ibid) reveals some interesting contradictions. On the one hand, two local authorities were able to show that there had been a significant demand for Appropriate Adults for vulnerable adults, which was assumed to be caused by the so called care in the community policies. However, this significant demand does not correspond with what the police were saying, as the following suggests -

"It was rare for custody officers to identify adults as vulnerable and they were only likely to do so when there were the most obvious indicators of mental disorder or learning difficulties.".

(Evans and Rawstorne, 1995, p.3)

The likely explanation for these apparent contradictions or difference in perceptions between the police and social workers in the use of the AA, is probably caused by the confusion arising when the police request the Emergency Duty Team (EDT) or any social worker to attend the police station for mentally disordered adults. Confusion arises about whether the social worker is there to make a mental health assessment and/or to act in the role of an Appropriate Adult. This assumption is borne out by the following.

"The custody officers themselves seemed confused between suspects with mental disorders arrested for criminal offences and those brought to the station under Section 136.". (Evans and Rawstorne (ibid.) p:28)

However, Evans and Rawstorne (op.cit) record the following finding, which is one of the most important observations for the purposes of this study.
"When custody officers suspected that an adult might be vulnerable they invariably called the police surgeon. In the majority of cases the surgeon confirmed the custody officer's initial assessment and passed the suspect fit for interview.". (ibid p:28)

The authors do not say however, that an Appropriate Adult was, or was not called in addition to the police surgeon. But it is safe to assume that what they mean is that only the police surgeon was called and who incidentally invariably declared the suspect 'fit to be detained and fit to be interviewed'. Indeed, Rawstorne, (personal communication 1996) confirmed that the police surgeon was the only person called by the police when the police suspected a detainee was vulnerable in some way.

The Evans and Rawstorne study (1995) is not the only research that has confirmed that the Appropriate Adult is rarely called for mentally disordered or vulnerable suspects - but it is the only research that records the police surgeon being called to assess detainees whom the police suspect are vulnerable in some way. However, the main thrust of the arguments presented in the Evans and Rawstorne research (op.cit) concerned the issues of welfare v justice, particularly in relation to juveniles.

The study conducted by Palmer and Hart (1996) claimed to be the first qualitative research to look at the PACE safeguards for mentally disordered and mentally handicapped suspects. Palmer and Hart (ibid) unaccountably do not refer to Evans and Rawstorne's research (ibid) whose method was also primarily qualitative. The Palmer and Hart study included interviews with custody officers, solicitors, police surgeons and interviews with members of the Crown Prosecution Service and court diversion schemes. The study took place in South Yorkshire. The authors state that their research was from a 'legal standpoint'.
Palmer and Hart’s study is interesting and different from research already discussed here, because of the legal slant given to their conclusions, derived as they were from an analysis of interviews with various criminal justice personnel. The research also includes a critique of research already conducted in police stations concerning mentally vulnerable adults and a review of case law relevant to the effectiveness of the PACE Act and the Codes including the effectiveness of AA’s. In effect, the study reads more like a literature review of what was already known about the treatment of mentally vulnerable suspects in police stations, including the AA procedure, than a qualitative research study, but with the added dimension of a critique of the legal provisions contained in the PACE Act. The authors discuss case law relevant to issues about the role of the AA, and in many ways brings the debate about how mentally vulnerable suspects are treated in the police station up to date. Palmer and Hart (ibid) present examples of Court of Appeal cases where it was argued that the absence of the AA, or the failure of the solicitor to protect the client, or other breaches of the Codes of Practice by the police made the evidence unreliable and unsafe.

Palmer and Hart state, somewhat obviously, that the use of inappropriate or inept AA’s do not protect vulnerable suspects, but as yet the Court of Appeal has not questioned the effectiveness of AA’s. However, the authors point out that most of the Court of Appeal cases so far, have been for juveniles. Palmer and Hart are concerned that the use of inept AA’s will be overlooked by the Courts of Appeal. However, a recent Court of Appeal judgement (R v Howard James Law-Thompson (1997)) casts some doubt upon Palmer and Hart’s concerns. This Appeal was brought because an AA was not present for an eighteen year old man assessed as suffering from Asperger’s Syndrome, he was convicted of attempted murder and sentenced to life imprisonment.
The Court of Appeal found that the absence of an AA in this case, did not make the evidence unreliable, or unsafe. Palmer and Hart’s concerns about inappropriate or inept AA’s lending too much credibility to evidence may well be unfounded, if, as this judgement shows, the Court of Appeal may not place too much importance upon the AA protection, but prefers instead to consider other variables when judging the reliability of evidence. Clearly, the Court of Appeal must take into consideration all relevant information when determining the reliability of evidence, yet the fact remains that the AA procedure is the only extra protection for mentally vulnerable suspects who are detained and interviewed in police stations. The above judgement questions the relevance of the AA role and function at a time when research shows that AA protection is not always implemented for many vulnerable suspects.

However, what makes the Palmer and Hart study relevant is the interesting observations and conclusions the authors make about the effectiveness of AA’s. They look at the AA within a legal framework and consider the effectiveness of key personnel such as custody officers, solicitors and police surgeons. Although the authors discuss many of the problems associated with the use of the AA, for example, how difficult it is for the police to identify vulnerable suspects particularly people with borderline mental vulnerabilities, followed by the police’s decisions that affect the implementation of the Codes, the authors then criticise the effectiveness of the safeguards defined in the Codes of Practice. Their study is wide ranging. It is concerned on the one hand with the PACE safeguards for mentally vulnerable suspects, and on the other with providing a critique about the effectiveness of those safeguards.

It is clearly important to examine the weaknesses of the PACE Act safeguards for vulnerable suspects, particularly when those weaknesses affect the role of the AA. For example, the authors discuss the lack of confidentiality between the suspect and
the AA in relation to the offence. That is, the AA does not have legal privilege and for that reason could be called to give evidence for the prosecution if required. They cite the case of the AA who gave evidence in the Rosemary West trial as an example of what this means (see Palmer 1996, and Pearse & Gudjonsson 1996). They show that the person who acted as an AA for Frederick West, did not understand the implications of the role and did not appreciate the importance of that position in terms of a lack of legal privilege. Neither it seems did the police, whose duty it is to inform the AA about the role.

Palmer and Hart (1996) reproduce contents of interviews with police officers, solicitors and members of the crown prosecution service which reveal their views about AA’s. The views these personnel express were based on their experiences or on anecdotes given to them by others about AA’s; sadly their views are generally contemptuous. They record accounts of AA’s advising suspects to confess, or express doubts about the confidence of AA’s to interrupt interviews and in general question the AA’s ability to act in the best interests of the suspect. The impression the authors portray of the role of the AA is generally negative.

Although Palmer and Hart point out that the AA is rarely used they fail to distinguish whether the views they recorded refer to AA’s acting for juveniles or adults. Perhaps the many criticisms Palmer and Hart make about the ability of AA’s to act correctly in the role can be remedied by training, and indeed the authors recommend the setting up of AA training schemes. The authors also recommend improved training for the police, legal advisers and police surgeons in identifying vulnerable suspects, and particularly for police surgeons when assessing and defining fitness for detention and interview. Further, regarding police surgeons the authors point out that -
"The situation where some police surgeons voluntarily advise on the need for an appropriate adult and others do not is dangerously inconsistent. It gives rise to the possibility that some custody officers may believe that if the police surgeon assesses a suspect as fit for interview, it means that they can be interviewed alone although they may in fact be fit, but nevertheless require an appropriate adult. Also the custody officer may ask advice from someone who knows less about the need for, or role of, an appropriate adult than he or she does.....custody officers must be reminded that there will be situations where a police surgeon may not be called, but there will still be a need for an appropriate adult, particularly where the suspect has learning difficulties (where a police surgeon is not required).” (Palmer and Hart, 1996 p:62)

The above passage calls into question the possible influence police surgeons have on custody officers decisions about calling an AA. Palmer and Hart’s conclusions correspond with much that Robertson (ibid) and Evans and Rawstorne (ibid) say about the importance of the association between the AA and the police surgeon. That is, when the police surgeon is called, the police rarely call an AA as well.

The Palmer and Hart research is also important because it provides a comprehensive study taking in the breadth and depth of the many complex problems surrounding the treatment of mentally vulnerable suspects in police stations. Although at one level the study confirms much of what is already known about the treatment of vulnerable suspects in police stations, at another level Palmer and Hart ask questions about the effectiveness of the AA and their ability to provide the right sort of protection. While their criticisms, based as they are upon interviews with various criminal justice personnel is important, perhaps they are premature. After all AA protection for many vulnerable adults is still rarely implemented. It is possible, that much of the criticisms Palmer and Hart record belong to those who act as AA’s for juveniles - it will be remembered that the AA procedure is commonly
used for children. It is interesting to note that the following research by Robertson G. *et al* (1996) asks similar questions about the effectiveness of AA’s, but their research method was, however, different.

Robertson, Pearson, and Gibb (1996) conducted an observational study for a period of 21 days in 7 police stations in London. Pearson and Gibb are forensic psychiatrists and Robertson is a psychologist (Robertson conducted the research on police surgeons for the RCCJ 1993, ibid). Robertson *et al* (1996) also collected information about the suspects they observed. This included their perception of suspects’ mental state (assessed by observation of their behaviour) the police perception of suspects’ mental state, the involvement of solicitors, AA’s, police surgeons, psychiatrists, and the outcome of the detentions. Robertson *et al* (ibid) state that the main purpose of their research was -

"...an investigation of the means by which mentally ill (mainly psychotic) people entered the criminal justice system beyond the level of the police station.

(Robertson *et al* 1996, p.289)

The Robertson *et al* study collated information on all procedures, from reception at the police station, to the charge and outcome for the detainee. The authors found that during their observation period, 902 suspects were interviewed (out of a total of 2,947 people detained at these police stations) of these, 131 suspects had an AA called. However, 85% (110) of the 131 suspects who had an AA called, were juveniles. A further 8 suspects who were aged between 17-18 years had a parent called who were allowed to sit in on the interview. The authors state that in these cases the parents were not acting formally as AA’s as defined in PACE. This is because the PACE Act defines juveniles as under the age of 17, but, to complicate matters the Children Act includes juveniles up to 18 years. Moreover, the 17-18
age group are brought before Youth Courts. The point about this is that the 17 - 18 year age group is often neglected, and denied the protection an AA.

As far as adult suspects were concerned, out of a total of 752 adults interviewed, only 13(2%) suspects were identified by the police as mentally vulnerable and were interviewed with an AA in attendance. The authors state that this number represented only -

"...0.4% of the total detainee population; less than one such case per week in the 18-week period of observation." (Robertson et al 1996:301)

The Robertson et al study showed that out of the 13 suspects who had an AA in attendance 8 were seen by a police surgeon -

"Of the 8 cases which involved a doctor, an appropriate adult (social worker) had been called before the doctor arrived at the station in three instances (2 of these cases involved mentally handicapped people). In 4 cases the appropriate adult was called following examination by the doctor and in one case the doctor said the person was fit to be interviewed without an appropriate adult but the custody sergeant obtained one anyway." (p:302)

However, in contrast to the above when an AA was called, despite the police surgeon’s assessment, the authors reveal other incidents when the AA’s were not called. These occurred after the police surgeon had declared the suspect fit for interview. Here we find similar inconsistencies to those found by Palmer and Hart (1996) which show how police surgeons make assessments for fitness for interview, and then take responsibility in matters as to whether an AA should be called.
The number and percentage of mentally disordered suspects appearing in the police station recorded by Robertson et al (1996) is in accord with other research discussed here - with the exception of that by Gudjonsson et al (op.cit). However, the authors observed a further 37 suspects as "definitely or probably ill", but only 2 of these were interviewed by the police. One of these suspects had an AA present during the interview but the other did not - in the latter case the suspect was seen by the police surgeon who declared her fit for interview. The authors state -

"In other circumstances (i.e. had a different custody sergeant been on duty), an appropriate adult might have been called to attend, regardless of the doctor's view. We thought that her condition merited the label 'vulnerable' and that PACE guidelines should have been implemented."

(Robertson et al 1996:302)

The authors point out that, if the police are later criticised for not calling an AA, they could fall back on the police surgeon's assessment. In this way they can exonerate themselves. However, Robertson et al argue that in spite of what is said above, the seriousness of the offence often determined the attendance of an AA. Even when, in the opinion of the authors, who claim expertise in this field, an AA was not needed. In such cases the police are clearly adopting, as the authors describe, a 'belt and braces approach'(Robertson et al (ibid), that is, they comply with the letter and spirit of the Act when they think it important to do so.

In addition to the 37 suspects Robertson et al regarded as 'probably mentally ill', the authors observed a further 16 suspects who had a psychiatric history, but were judged not to be ill by the researchers. Out of these 16 suspects 8 were interviewed by the police but only 4 had an AA called. The authors record a further 3 suspects they defined as being of "uncertain" mental vulnerability, 2 were seen by the police surgeon and passed as fit for interview unconditionally. Clearly, Roberston et al's
study (ibid) shows inconsistency and confusion by the police in their decisions about calling an AA for vulnerable suspects.

The Robertson et al study also confirms much that has already been discussed so far in this chapter particularly relating to the implementation of the PACE Act Codes of Practice for those suspects the police identify as mentally vulnerable. In addition to their comments regarding the contribution made by police surgeons, the authors make some interesting observations concerning the role and effectiveness of AA’s. Robertson et al argue that much confusion arises about the role and function of the AA because the term ‘appropriate adult’ and the role and function of the AA as it is defined in the Codes, was initially created and intended for juveniles. Thus a different approach is needed for mentally disordered adults. No doubt the authors are right to criticise the legislation which incorporates both children and mentally disordered adults, indeed other studies discussed in this chapter refer also to this anomaly. However, in law, our legislation recognises that there are special groups, children and mentally disordered adults, who are not regarded as being fully responsible for their actions.

This basic premise determines why juveniles and mentally disordered adults are treated alike in law. The authors suggest that the AA, when used for vulnerable adults, should be called the ‘independent third person’, and moreover, their role should be limited to that of a ‘friend’ concerned only with the suspect’s welfare during the detention and interrogation. What is perhaps more important at this stage than suggesting changes to the title, role and function of the AA, is to find out how to implement the Codes of Practice. The Robertson et al (ibid) study and others discussed in this chapter reveals inconsistencies and contradictions that surround the role of the AA, but it is suggested that many could be remedied by providing training for custody officers and for those willing to act as AA’s.
One final point about the Robertson et al study; the three researchers acted as AA’s on a few occasions during their time in the police stations. The authors explain that they did so in order to prevent further delay for the suspects. Although the researchers acknowledge that their presence in the police station probably affected the number of AA’s that might have been called, they do not concede that their participation when acting as AA’s may have produced a bias into the validity of their findings or influenced their criticism and suggestions about the AA role. This seems hardly credible but is one of their claims nevertheless.

Finally, research from Western Australia is interesting and relevant to this study. Professor Rod Underwood et al (1993) of the Edith Cowan University in Perth WA, conducted research which was aimed at examining the attitudes, beliefs and procedures of the police, judges or magistrates, prison officers and community correction officers - towards people who are intellectually disabled. The research seems to be concerned only with people with an intellectual disability, the authors do not refer to mental illness.

Community correction officers are not the same as probation officers in this country, whose roots stem from the social reformers of the 19th Century. Australia’s community correction officers are more closely allied to the prison service. However, the research method included what the authors describe as 'service workers', which includes social workers, clinical psychologists, hostel managers, employment supervisors and a community education officer - and lawyers.

The purpose of the study was concerned with the apparent over-representation (compared to their proportion in the general population) of people who are intellectually disadvantaged, who enter the penal system. The authors partly define intellectual disability in terms of an IQ below 70. The authors argued the case for
the apparent over-representation of this disadvantaged group in penal system, mainly with evidence from the USA and Australia.

They conclude that the usual explanations found in the literature suggests that people who are intellectually disadvantaged are more likely to enter prison because of a variety of factors which includes:

"...impulsivity, suggestibility, exploitability and desire to please lead to an increased frequency of offences. Others suggest a greater likelihood of detection due to an inability to conceal actions, less likelihood of ready access to legal counsel, desire to please and poor resilience.....impulsivity and the need for immediate gratification....(or) to be more likely to be led into petty crime, to be exploited and to be cajoled into taking the most risky role...less successful at concealing his actions or getting away.... the likelihood of confession increases where there is no access to legal advice. ....... Overall then, these authors attribute certain negative characteristics or inadequacies to people with an intellectual disability to explain their over-representation in the prisons.".

(Underwood et al 1993, pp:3-4)

Surprisingly, Underwood et al (ibid) do not include Gudjonsson’s work in their literature review about intellectually disadvantaged prisoners/suspects. Gudjonsson discusses at length suggestibility, and the desire to please as part of the explanations accounting for false confessions. (see chapter on socio/legal issues and Gudjonsson 1992). Neither do the researchers include Gunn et al’s (1991) research on mentally disordered prisoners.

Interestingly, many of the explanations outlined in the above quotation, were confirmed by the medical officers who attend the Holding Centres in Northern
Ireland; particularly the likelihood of these people being exploited and led into risky criminal acts. (Conference chaired by Sir Louis Blom-Cooper in Belfast in 1995, on the treatment of suspects in the Holding Centres).

Further, Underwood et al (1993) argue that besides the explanations outlined above, intellectually disabled people are treated differently when they come into contact with the criminal justice system.

"For example, they may be coerced to confess to a crime they have not committed and not have their rights explained in a manner which they would understand; they may have a greater rate of refusal of bail, perhaps as a result of previous breaches of bail conditions, or lack of supports and resources enabling them to obtain bail; and they may receive more custodial sentences, either because of the nature of the offence or their presentation in court.". (Underwood et al. 1993. p:4)

Therefore, the aims of the Underwood et al (ibid) research was to -

"...relate the beliefs of each of the groups to the theories of over-representation to determine if there is support for one or more of the alternative explanations.". (Underwood et al (cf) p.3)

Thus, the researchers wanted to test the hypothesis that the negative stereotypical assumptions of intellectually disabled people discussed in the literature, if held by influential criminal justice personnel, would determine the differential treatment of these disadvantaged people and in turn lead to their over-representation in prisons. The method the researchers used was to conduct structured interviews followed by a 55 item Likert-style questionnaire based on the interview responses. The authors note that the research design used a combination of both qualitative and quantitative
data. Regression analysis showed significant correlation's between groups and a lack of significant differences which the researchers state shows -

"...considerable agreement between the experts in the field, even though they come from very different work backgrounds and service culture.".  
(Underwood et al 1993, p:6)

The Underwood et al (ibid) research reveals many important findings. For example, on the one hand there was general agreement amongst all these professionals that intellectually disabled people committed offences because of lack of supervision or were "led astray", in other words, blame does not entirely lie with the defendants themselves. More important though were the other attributed characteristics the experts agreed on, for example: that people with an intellectual disability were less likely to be aware of the need to remain silent, were more susceptible to leading questions, and have different needs to other groups or suspects. In effect, the Underwood et al research findings confirm many of the arguments presented in this chapter, the most important being that vulnerable people are at risk when they come into contact with the criminal justice system, if they are not afforded extra protection.

"...that a person with an intellectual disability would be severely disadvantaged when coming into contact with the police and judicial system. In social justice terms some compensatory mechanisms clearly need to be installed if the rights of the people are to be protected.".  
(Underwood et al (ibid) p:7)

What were the "compensatory mechanisms" that the authors recommended?

"...that people with an intellectual disability should be interviewed in the presence of a supporting adult; and that they are not treated the same as other people.".  
(Underwood et al (ibid) p:7)
It is ironic, that the Australian researchers recommend the PACE Act Code of Practice Appropriate Adult requirement, as being in the vanguard of protecting the rights of vulnerable people. Clearly, it seems that they, like many others assume that if legislation is in place then it will be implemented.

The implications of the Underwood et al research is important and lies at the heart of the arguments discussed further in the chapter on socio/legal issues. It is interesting that the Australian research, brings the argument around full circle - that, as stated at the beginning, mentally disordered people who come into contact with the criminal justice system are severely disadvantaged. The Appropriate Adult protection was expected to counterbalance their disadvantage. But, the question that remains to be answered is - how appropriate is the Appropriate Adult?

Summary and Conclusions.

This literature review has shown that there is an increasing interest in the way the AA is used and has drawn attention to the variations in its use. At present, 1997, the relevant research is somewhat widely dispersed and concerned with asking rather basic questions about the way the AA operates. There is little that goes beyond this, and rarely if at all has the research placed the debate within a wider socio-legal context. Perhaps this is to be expected given the way interest in the AA has only recently began to develop.

Placing the research conducted for this study and to be reported in Chapters 5 and 6 within the context of the literature review, shows that there is nothing so far which comes near the extensive empirical study conducted here, nor placed that empirical study within the framework in which the custody officers or others make their decisions about the AA. In this sense the empirical study for this research will show that the argument is taken forward.
CHAPTER 3

SOCIO/LEGAL QUESTIONS

In this chapter the aim is to place the Appropriate Adult and the associated procedures within a specific socio-legal context. The discussion that follows explores some of the implications arising when an AA is required to act for a vulnerable suspect insofar as they relate to the legal requirements of Statute and Case Law. The socio/legal questions discussed in this chapter need to be addressed, whenever and wherever there are debates about the Appropriate Adult.

It was said in Chapter 1 that the definition of the AA and what the AA does is straightforward enough, but a closer examination shows it is complex and involves many inherent contradictions. A great deal of the existing research has tended to avoid the more difficult issues, and as will be shown in this Chapter it is perhaps easy to see why this is so. The socio/legal questions raised here, concern the ways in which the legal requirements of the AA touch upon other legal matters especially false confessions, and oppressive interviewing, all related to miscarriages of justice, Court of Appeal judgements, amendment to the right of silence, and confidentiality etc. It is one of the central tasks of the AA to interrupt interviews that he or she sees as unfair or oppressive.

The PACE Act, The Suspect in Police Station and Mental Disorder.

It was said in Chapter 1 that the AA grew out of the special legal defences with mental disorder. Accordingly, it would be reasonable to expect the legislation, that is the PACE Act's associated Codes of Practice, to deal specifically with these matters. What one finds however is that the legislation is full of omissions and
defects, making it difficult to see how it becomes possible to operate the procedures in a strict legal sense. That is to say mental disorder is neither defined in the relevant legislation, nor is it often referred to. Moreover, as is shown in this Chapter the Court of Appeal decisions which forms the basis of important Case Law is little better. What exists then is a set of procedures based on a special defence of mental disorder where the mental disorder itself is either poorly defined or only obliquely referred to.

The impact of the Police and Criminal Evidence Act 1984 (PACE) has created controversy amongst academics, professionals and, of course, the police. Civil libertarians argue that PACE has granted the police extensive powers, while others, declare that the police are unnecessarily constrained in their attempts to enforce law and order (see Reiner 1992, Zander 1990). Many police officers complained during the course of this study that they were burdened and hampered by the requirements of PACE, indeed some officers stated that the PACE Act was only brought in because of the past misdeeds in one or two police areas. In saying this, of course they conveniently forgot other numerous serious miscarriages of justice which have occurred since 1990. The powers conferred on the police to deal with the suspect at the police station have been the subject of much debate both pre and post the PACE Act (see Chapter 2). Research carried out in police stations brings sharply into focus the implications for all people who are detained, the most obvious issues concern an individual's right to liberty, and the undoubted distress and anxiety experienced by many detainees (Irving and McKenzie 1989, Gudjonsson, 1992/93, Hayes and Hayes, 1989). It is within the confines of the police station that the process begins, a process that has a direct bearing on the outcome for the suspect -
"The importance of the Defendant’s encounter with the police can scarcely be overstated for, in the great majority of cases, what takes place at that stage can critically influence what happens at a later stage of the criminal process".  

(Baldwin J. and McConville M. 1977, p:105).

Indeed many argue that the police interrogation is crucial to the police investigative procedure (McConville et al 1991, Baldwin and McConville 1981, Irving and McKenzie 1989). Interestingly, according to Robertson et al (1996) they found the police operating a different criteria for interviewing -

"The purpose of interviewing was often to provide detainees with an opportunity to give their account of an incident rather than to acquire information which would be of evidential value in the prosecution case. This was particularly true, for example, in the case of shop theft". (ibid. p:299).

It is unclear whether the above statement was the researchers' opinion gleaned from their observational studies, or acknowledged by the police about their change in police policy and practice. However, during the course of this study there was no indication that the police were operating a criteria for interrogation that Robertson et al (op.cit) recount. Usually the reason given for interviewing suspects was described as ‘getting to the truth’ and ‘gaining evidence by questioning’, i.e. meaning a confession. Indeed the role of the police in preparing a case for the prosecution requires that they glean sufficient evidence for that process (McConville et al, 1991).

Although a confession is not essential in securing a conviction, the confession is useful to the prosecution because of the difficulty the defendant has retracting it
(Baldwin and McConville, 1977). Moreover, a confession precludes the need to gain further evidence and thus saves time and police resources (Brown 1989). Robertson et al (op.cit) seem to agree with the police’s view about interrogation: that it is the objective search for the truth. But the police are not neutral, they must prove legal points, or at least they must provide the Crown Prosecution Service (CPS) with legal points of evidence (Baldwin 1993). What seems curious is that only recently has it been agreed that the police should tape interviews and then only after lengthy public debates, but no-one seems to use them. Transcripts of the interviews are rarely asked for, the courts appear to rely on summaries of interviews i.e. the police interviewer’s version of the tapes, which are generally poor and confusing, with a strong prosecution bias (Baldwin 1993(a)). The importance the police attach to the interrogation has caused others to declare that -

“....the attachment the police have to interrogation will lead them to violate the rights of the persons in custody, even where the enforcement of those rights would not thwart investigations”. (Baldwin and McConville, 1981, p:158).

Indeed, there is expressed concern about police powers generally, and the inbuilt bias the police enjoy, particularly in the police station (see Irving and McKenzie 1989, Brown 1989). The PACE Act was intended to provide a balance between police powers and the need to bring the guilty offender to justice. The safeguards provided by the PACE Act are found in Part IV and V of the Act which gives statutory rights to all suspects who are arrested and detained in police stations. They include the right to receive legal advice (under s.58), the right to have someone informed about the arrest (under s.56), the right to have regular reviews of the detainee’s detention (under s.40), the right that limits the length of time a suspect spends in detention without charge (under s.41). The PACE Act legislation
includes Codes of Practice (A, B, C, D, & E). Code C. ‘The detention, treatment and questioning of persons by police officers’, provides guidelines concerning all suspects detained in police stations, including the mentally handicapped and mentally disordered suspects.

The Royal Commission on Criminal Procedure 1981 sought to safeguard vulnerable detainees, recognising two classes of vulnerability: “..juveniles...and the mentally handicapped and ill...” (Irving and McKenzie 1989 :201). The Royal Commission on Criminal Procedure 1981 (RCCP) accepted the evidence of their own research (for example: Irving 1980, Softley et al 1980) and that of the Fisher Report (Fisher, 1977) that previous safeguards for the vulnerable suspect during detention and interrogation, contained in the Judges’ Rules and Administrative Directions, were ineffectual. Irving was confident that -

“An important step in improving the design of safeguards was the rejection of the voluntariness principle in favour of the principle of reliability of confessions (RCCP 4.68-4.75). The young and the mentally handicapped regularly present the police with entirely voluntary (in legal terms) admission which are nevertheless extremely unreliable. The sources of this unreliability, as the Commission acknowledged, are multiple. The young of normal IQ and emotional development can easily misunderstand and misconstrue social situations; the mentally and emotionally handicapped and ill in addition fabricate, confabulate and sometimes act suggestively to an extreme degree. If safeguards are to be applied, diagnosis becomes an important issue and, as the Commission underlined, this can create insuperable problems for the police (RCCP 4.106). The Commission’s report deals with two general classes of vulnerability: juveniles...and the mentally
handicapped and ill.... The intention of these paragraphs is to gather in the safeguards contained in the old Judges' Rules and Administrative Directions and reinforce them by surrounding them with the unreliability principle... and setting them out in a general code of conduct to regulate interrogation. The main safeguard offered to juveniles is the presence at interview of a parent or guardian, social worker or other appropriate adult. Similarly the mentally handicapped are protected by providing preferably expert mentors to oversee their interrogation.”.

(Irving and McKenzie 1989, p:201)

If the mentally disordered suspect is to be seen as a major vulnerable group it is both interesting and astonishing that the PACE Act does not make any specific reference to mentally disordered suspects, except that is in s.77 where provision is made for people described as mentally handicapped. Indeed the Royal Commission on Criminal Justice 1993, (RCCJ) noted the omission of mental disorder in s77 and recommended consistency between the PACE Act and the Codes of Practice in this matter. (Palmer and Hart, 1996) Section 77 requires that the judge should warn the jury of the need for caution when considering a conviction for a mentally handicapped person when the evidence is based wholly, or in part, on a confession obtained in the absence of an AA. The inclusion of only the mentally handicapped in the PACE Act may be related to the defendants in the Confait case. (Gudjonsson 1992). However, while the PACE Act legislation does not refer to the mentally disordered, as mentioned above, Code C 1.4 of the Codes of Practice does -

“If an officer has any suspicion, or is told in good faith, that a person of any age may be mentally disordered or mentally handicapped, or mentally incapable of understanding the significance of questions put to him or his replies, then that
person shall be treated as a mentally disordered or mentally handicapped person for the purposes of the Code”.

But what seems to have happened is that definitions of mental disorder and mental handicap become confused in the Act and in Code C. The definition of mental disorder found in the Code’s Notes for Guidance 1G, reproduces the definition contained in s1(2) of the Mental Health Act 1983 which states that “mental disorder”-

“... means mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind...”.

The definition of mental handicap is found in s77(3) of the PACE Act states that - “Mentally handicapped’, in relation to a person, means that he is in a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning;...”.

The definition of mental disorder found in the Notes for Guidance 1G (ibid) seems to indicate that mental disorder includes mental handicap (Palmer and Hart 1996) - which is exactly what the Mental Health Act 1983 does, that is, the Act combines the two conditions. However, Notes for Guidance 1G goes onto state that -

“...It should be noted that ‘mental disorder’ is different from ‘mental handicap’ although the two are dealt with similarly throughout this code. Where the custody officer has any doubt as to the mental state or capacity of a person detained an appropriate adult should be called”.

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It seems that legislation has not advanced much since the middle of the last century when medical diagnosis did not differentiate between mental illness and mental handicap, presumably because there was no specific treatment for either condition (Hayes and Hayes, 1984). Of course, some critics of the mental health treatment services might say that the reason the legislation is confused is because it reflects modern medical diagnosis and treatment. (see Bean, 1983 and 1986).

However, the obvious confusion or lack of clarity in the terminology of these conditions could have been dealt with in the 1995 Revised Codes of Practice (Appropriate Adults Review Group 1995). Custody officers particularly would benefit from clearer guidelines. For example, how does the custody officer deal with the generic term “mental state or incapacity”? It is they who are responsible for calling the AA and the police surgeon. All we find in the 1995 Revised Code C is an insertion in paragraph 3.9 which may, or may not help custody sergeants recognise mentally disordered suspects. The crucial phrase is -

“appears to be suffering from a mental disorder”.

“If the person is a juvenile, is mentally handicapped or appears to be suffering from a mental disorder, then the custody officer must, as soon as practicable, inform the appropriate adult.......”.

Thus, while the PACE Act itself only refers to the mentally handicapped, it is Code C where we find references to the mentally disordered and the procedures to be followed during their detention and interrogation. However, to repeat a point, the Codes of Practice are not statutory instruments (Brown 1989), but -
failure to follow those procedures does not automatically mean that the evidence so obtained is inadmissible, but can be argued to amount to 'unfairness' under s.78". (Justice, 1995 p:5)

What all this shows is that there is a seemingly reluctance or inability to define mental disorder that would help those who must operationalise the legislation.

Case Law relating to the Legislation, with special reference to Confessions.

There is a growing body of Case Law that has dealt with breaches of the Codes (see Justice 1995, Sheppard 1995, Palmer and Hart 1996, Rozenberg 1994, Gudjonsson 1992). For the purposes here a discussion of some of these Court of Appeal decisions is relevant, in order to determine how the safeguards, particularly those that refer to the AA, contained in the PACE Act and Codes have been dealt with by the Courts. It should be borne in mind that by the time a case arrives at the Court of Appeal several years may have elapsed. In the cases outlined below the defendants were acknowledged to be mentally vulnerable, yet judges have allowed the admission of evidence, sometimes based wholly on a confession, in the absence of an AA and/or a solicitor, that is, when clear breaches of the PACE Act and the Codes of Practice have taken place. In the meantime these mentally vulnerable defendants have suffered imprisonment, sometimes for many years. Reports by the Inspector of Prisons, whose frequent criticisms of degrading and neglectful conditions in prisons are a reminder that the mentally vulnerable prisoner will probably suffer more from degradation, humiliation and exploitation, than perhaps his fellow inmates.
It will be remembered that confessions, or rather false confessions, especially the Confait case provided the major impetus for changes to the Judges’ Rules, and by implication providing the change that brought about the modern equivalent of the AA. Accordingly a more detailed examination of confessions and confessional evidence is required in order to show how the AA is expected to operate within PACE; that is to say *inter alia* to reduce false confession and thereby reduce miscarriages of justice.

A brief description follows of the legislation found in Sections 76, 77, 78 and 82(3) in the PACE Act, that deals with confessions especially the admissibility, reliability and exclusion of confession evidence, and whether such evidence was obtained unfairly, by oppression or in the absence of the AA. Some extracts from Court of Appeal judgements are included where relevant.

(i) **The Confession - (false confessions) with or without Corroboration?**

Before a review of the Case Law relevant to the mentally vulnerable suspect is discussed a brief examination of the concept of false confessions is needed (see Gudjonsson 1992). There is grudging recognition by the police, and perhaps the Court of Appeal that confessions are sometimes falsely made. The high profile miscarriages of justice support this. (see Gudjonsson 1992/1993, Gudjonsson and MacKeith 1994, McConville et al 1991, Irving and McKenzie 1989, Rozenberg 1994). Indeed the PACE Act’s Code C. outlines the reasoning behind the recognition that mentally vulnerable suspects are at risk in the police station during booking in procedures and when interviewed and warns the police accordingly -
"...that, although juveniles or people who are mentally disordered or mentally handicapped are often capable of providing reliable evidence, they may, without knowing or wishing to do so, be particularly prone in certain circumstances to provide information which is unreliable, misleading or self-incriminating. Special care should therefore always be exercised in questioning such a person, and the appropriate adult should be involved, if there is any doubt about a person's age, mental state or capacity. Because of the risk of unreliable evidence it is also important to obtain corroboration of any facts admitted whenever possible." (Note for Guidance 11B)

The above extract from Code C makes clear a number of important points: firstly, the recognition that some mentally vulnerable suspects may be at risk of making a false confession, and of course when that occurs the police if they accept a false confession (with or without corroboration) use unreliable evidence. Secondly, that an AA should be always be called if there is any doubt about a suspect's mental vulnerability, and thirdly that corroboration of any facts is a necessary pre-requisite when dealing with a mentally disordered suspect.

Gudjonsson (1992) suggests three types of false confessors, they are voluntary, coerced-compliant and coerced-internalised. Gudjonsson describes the voluntary confessor as someone who confesses to crime without coercion by the police. The reasons for such confessions include the desire to protect someone else, feelings of guilt for a real or imagined crime, or the inability on the part of the suspect to distinguish fact from fantasy, Gudjonsson gives the case of McKenzie as an example of such a voluntary confessor (Gudjonsson 1992, pp:243-7). (The McKenzie case is discussed below).
Next, the coerced-compliant confessor: these are people who have made confessions under police pressure during the interrogation. The coerced-internalised confessor is someone who has doubts about the accuracy of his/her memory and accordingly agrees with the interrogator’s view of the events. Gudjonsson uses a Suggestibility Scale in order to assess an individual’s reactions to differing types of police interview techniques, such as negative feedback’ or ‘leading questions’ (Gudjonsson 1992). However, McConville et al (1992) indicates that from their research there is a third type of false confessor:

"..the coerced-passive confession’. Confessions of this kind occur when the process of questioning induces suspects to adopt the confession form without necessarily adopting or even understanding the substance of what has been accepted or adopted. In this situation, suspects may internalize the confession by taking on trust the police assertion that they have committed a crime, but equally they may simply adopt words which amount to a confession without even appreciating that they have made an admission.”

(McConville et al 1992, p:68, italics in the original)

It seems that Gudjonsson’s theories have been accepted at least by certain Courts when assessing the reliability of confessions (Gudjonsson 1992 and 1994 and see transcript of R v McKenzie). As the law stands at present in England and Wales any individual can be convicted on her/his confession alone. This remains so even after examination of the question by two Royal Commissions (RCCP 1981, RCCJ 1993) and numerous judicial inquiries, set up following miscarriages of justice. The Fisher Inquiry (Fisher 1977) (set up following the Confait Case, see Chapter 1) which is generally acknowledged as being the spur to the RCCP and the PACE Act (Brown 1989) recommended however that supporting evidence be obtained. This
was of course ignored. The RCCJ 1993 set up in the aftermath of more notorious miscarriages of justice, acknowledged that people confess to crimes they have not committed, said -

"The legal system has always allowed in evidence statements that are made against the interests of the maker in the belief that individuals will not make false statements against themselves. This belief can no longer be sustained. Research has conclusively demonstrated that under certain circumstances individual may confess to crimes they have not committed and that it is more likely that they will do so in interviews conducted in police custody even when proper safeguards apply. (RCCJ 1993, para. 66, quoted in Rozenberg 1991 p:334).

However, despite the concession to the possibility of false confessions (no doubt influenced by Gudjonsson’s research (ibid)) the RCCJ failed also to insist upon corroborative evidence. Rozenberg points out that -

"The main argument against insisting on corroboration is, of course, that it would allow a number of guilty people to walk free". (Rozenberg 1994, p:334).

However, it should be remembered that corroborative evidence was given in the Confait case (Price and Caplan 1977) and in the case of Stefan Kiszko (Kiszko 1992). These two cases alone, are examples of wrongful convictions based partly on false confessions and corroborated by, what later turned out to be faulty forensic evidence. Apparently three (unnamed) Royal Commissioners concluded that a defendant should never be convicted only on a confession. However, Rozenberg (1991) maintains that the RCCJ (1993) clearly saw the term ‘miscarriages of justice’
to include wrongful acquittals as well as wrongful convictions, and quotes another extract from the RCCJ’s opening chapter which reveals the Commission’s priorities-

“It is widely assumed - and we are in no position to contradict it - that the guilty are more often acquitted then the innocent convicted. To some extent, an inevitable and appropriate consequence of the prosecution being required to prove its case beyond reasonable doubt must be that not every guilty person is convicted. But there is only a handful of cases in which it is possible to be certain, with hindsight, that the jury’s verdict was mistaken. We have simply to acknowledge that mistaken verdicts can and do sometimes occur and that our task is to recommend changes to our system of criminal justice which will make them less likely in the future”. (quoted by Rozenberg 1994, p:335)

Rozenberg (ibid) and many others have criticised the failure of the RCCJ to tackle and answer fundamental questions within the criminal justice system - not least the amendment to the right of silence (this is discussed further in this chapter). Moreover, Justice (1995) and other civil libertarian organisations disagree that there are only a handful of wrongful convictions judging by the substantial number they record. Indeed, the newly appointed Criminal Cases Review Authority, recently stated that they are unable to cope with the number of alleged miscarriages of justice cases they are asked to review (Independent, April 8th. 1997). However, despite examples of miscarriages of justice such as the Confait Case (referred to in Chapter 1, see also the Fisher Report 1977) the only provision in the PACE Act that provides special treatment for the mentally vulnerable person’s confession (and then only the mentally handicapped) is found in s77.
(ii) Section 77 of the PACE Act: Confessions by Mentally Handicapped Persons

The provision in the PACE Act that provides special treatment for the mentally vulnerable (mentally handicapped) person's confession is outlined in the following - "77. (1) Without prejudice to the general duty of the court at a trial on indictment to direct the jury on any matter on which it appears to the court appropriate to do so, where at such a trial - (a) the case against the accused depends wholly or substantially on a confession by him; and (b) the court is satisfied - (i) that he is mentally handicapped; and (ii) That the confession was not made in the presence of an independent person.

the court shall warn the jury that there is special need for caution before convicting the accused in reliance on the confession, and shall explain that the need arises because of the circumstances mentioned in paragraphs (a) and (b) above. .......". (s77)

There is little Case Law or commentary on the use of s77 and what there is does not give an entirely clear view as the following Court of Appeal extracts shows. Indeed, as will be shown throughout, the Court of Appeal judgements have rather than clarified matters, tended to make them less clear.

One of the most important is R v Lamont Court of Appeal, 30th. June 1989, (Crim. L.R. 813). Here the defendant, aged 23, had an IQ of 73. His ability to read and write and understand was comparable to that of an eight year old. While on holiday
with his wife and seven month old baby, the baby suffered injuries. The medical evidence concluded that the marks on the baby’s neck suggested “an impulsive, uncertain action, rather than a resolute one.” There was evidence that the defendant had visited the baby’s room shortly before the injuries were discovered. The only evidence of intent was a confession in an interview. The objection to the confession had been based on ss.76, 77 and 78 and certain provisions of Code C. principally para. 13(1). The Appeal was upheld.

The Court of Appeal was surprised that the defence objection to the confession evidence had failed on all grounds. Relevant factors before the trial judge had included the expert evidence of the defendant’s handicap. There was a delay of 18 hours in interviewing the defendant during which time he had refused all food, and was in a tearful and highly emotional state when he had been taken from the cell to be interviewed. He cried in the interview, there was no adult person present (sometimes the Court of Appeal refers to the AA, as in this case, as ‘an adult person’ in others AA’s are described as an ‘independent person’) during the interview, the defendant was not shown the note of those 15 minutes, the defendant had difficulty in following the note of the interview when it was read over to him, and expert evidence said that the defendant would be prone to suggestibility. But the Court did not need to decide the case on the question of admissibility. It quashed the conviction because the trial judge had failed to warn the jury in accordance with s77. The trial judge had taken the view, wrongly, that on the facts of the case no warning had been required under s77, but had decided nevertheless, and told counsel, that it was prudent for him to give a warning in any event. However, the trial judge failed to give any warning in his summing up. Accordingly the conviction was unsafe and unsatisfactory. The conviction for
attempted murder was quashed and a conviction for assault occasioning actual bodily harm was substituted.

The Court of Appeal judgement in the Lamont case emphasises the "special need for caution" contained in s77 which was seen as an essential part of the Judge's summing up (Birch, 1989). Apparently that was all the Court of Appeal decided was wrong in this case; the fact that there was no AA which meant a breach of Code C was not, it seems, regarded as important. Moreover, the following Court of Appeal judgement confirms that s77 is only relevant when the prosecution evidence depends "wholly or substantially" on a confession. Again, it should be noted the AA is not referred to in this judgement.

R v Campbell Court of Appeal, 30th. June 1994, (Times Law Report 13th. July, (1994) Independent Law Report 29th. August, (1995) Crim. L.R. 157, (1995) I Cr. App.R. 522). A man was shot dead during the course of an attempted robbery by two men at an off-licence. There was some identification evidence against Campbell, albeit at trial the judge told the jury he would have withdrawn the case from them had that been the only evidence, and there were links between Campbell and an unusual baseball cap worn by one of the robbers and found at the scene. Campbell was examined by a doctor, who told the police that he was mentally handicapped (at trial it was agreed that his IQ was such as to make him "borderline defective"). There followed a series of interviews in the presence of a solicitor and an Appropriate Adult, although one interview was in a police car without the Appropriate Adult present and no record was made until after the formal interview, at which point a pooled recollection of the officers present was written up.
All the confessions Campbell made were without a solicitor present, or in informal exchanges with police. An Appropriate Adult or a solicitor was present during the first taped interview. Campbell was seen by a police surgeon in another police station several hours after the first taped interview, when he was assessed as suffering from “significant mental handicap” (see page 6 transcript). However, the AA who was present during Campbell’s first taped confession claimed that she had not been told of the seriousness of the charges, had no time properly to consult with the suspect before the interview, and had thought the police were making enquiries about a hat. Following his arrest, his co-accused told police that he could not believe it when Campbell shot the victim and he had not known that Campbell had a gun. Campbell was convicted of conspiracy to rob and murder. His co-accused pleaded guilty to the conspiracy and was acquitted of murder. In a voir dire, the Judge ruled all interviews admissible. The Appeal was unsuccessful.

The above case shows that a clear breach of the Codes existed in that an AA was not present during the interviews. Again, it seems this did not result in a successful appeal. The Judges in this case argued that although Campbell’s confession was obtained without the presence of an AA, the case against him would have been enough to convict him anyway, and therefore the trial judge was not obliged to give the special need for warning under s77. That Campbell was mentally vulnerable and denied the protection of an AA does not, it is suggested, disappear or cease to matter even if other evidence besides the confession was available. The Law Report printed in The Times (July 13th, 1994) would appear to agree. It maintains that the special need for caution should have been explained to the jury because the suspect was mentally vulnerable -
"However, in a case where the judge was obliged to give the warning, although he did not have to follow any specific wording, he would be wise to use the phrase “special need for caution”. He should also explain why a confession from a mentally handicapped person might be unreliable. The explanation should be tailored to the particular evidence in the case, for example if there was evidence that the accused was particularly suggestible, or prone to acquiesce, comply, or give in to pressure. The judge should go on to explain that the function of the appropriate adult was designed to minimise the risk of the accused giving unreliable information by seeing that the interview was facilitating, if need be, communication between the police and the suspect”.

If the Court of Appeal had adopted the argument outlined above, then the role and function of the AA could have been brought more to public attention and been publicly and legally discussed. Those discussions should have included the part the police have to play in this whole matter and to inform the AA of his duties. This case highlights one of the major problems concerning the AA role i.e. in order to act in the best interests of a vulnerable suspect, the AA needs to undertake an extensive training programme covering all requirements of the role, not least that which concerns the presence of a solicitor.

The above are two examples when the Court of Appeal Judgements indicate that mentally vulnerable suspects under s77 are offered scant protection, or at best, are provided with a test that is unclear and depends too much on individual judges’ interpretation. The judgements are ambiguous as to the effect such a warning from the judge may have on a jury. Indeed, as things stand it is perhaps better for mentally vulnerable defendants to rely on the PACE Act’s provisions, and safeguards that are available to everyone under Sections 76 and 78 than to rely on...
the uncertainties of Case Law. Indeed it is recognised that Sections 76 and 78 are the two most important Sections involving the exclusion of confession evidence (Gudjonsson 1992). There are of course differences between these two Sections, for s78 gives additional discretionary powers to the court, while the burden of proof required in s76 depends upon factual evidence and -

"...the emphasis in Section 76 on police behaviour and the reluctance of judges to include under this provision unreliability due solely to internal factors (e.g. drug withdrawal, disturbed mental state)...". (Gudjonsson (ibid) p:277).

Even so, as said above, Case Law does not always help to clarify matters, rather it muddies them further by not making clear the importance of an AA and the corresponding importance of the Codes of Practice under the Pace Act. This is a most unsatisfactory state of affairs which will not be remedied until the Case Law itself develops accordingly.

**Section: 76 Confessions, and Section: 78 - Exclusion of Unfair Evidence**

The burden of these two Section concerns oppression. There is a further growing body of Case Law showing that a large number of confessions have been excluded under s76 because the police were seen to have acted in an oppressive manner (see Birch 1989, Palmer and Hart 1996, Gudjonsson 1992). The following provide relevant sections of s76 -
76 (1)(2)(a)(b):

(1) In any proceedings a confession made by an accused person may be given in evidence against him in so far as it is relevant to any matter in issue in the proceedings and is not excluded by the court in pursuance of this section.

(2) If, in any proceedings where the prosecution proposes to give in evidence a confession made by an accused person, it is represented to the court that the confession was or may have been obtained -

(a) by oppression of the person who made it; or

(b) in consequence of anything said or done which was likely, in the circumstances existing at the time, to render unreliable any confession which might be made by him in consequence thereof, the court shall not allow the confession to be given in evidence against him except in so far as the prosecution proves to the court beyond reasonable doubt that the confession (notwithstanding that it may be true) was not obtained as aforesaid.

All told there are 8 sub-sections to s76, but they need not be reproduced here, except to state that sub-section (8) defines oppression to includes torture, inhuman or degrading treatment, and the use or threat of violence (whether or not amounting to torture).

Section 76(1) states and emphasises that confessions may be used in court. That much is clear. But what does oppression mean and how, and under what circumstances can a confession be excluded under sub-section 2(a)(b)? Birch states that -
"A clear overlap can be seen to exist between the oppression hurdle and the unreliability test, because oppression is likely to consist of something said or done which is conducive to unreliability. Few confessions obtained by oppression would be admissible if reliability were the only test. Such justification as there is for the overlap is provided by the philosophy behind the Act, which qualifies the basic theory that the rule of exclusion is concerned only to ensure reliability of confession evidence, and not to discipline police officers or uphold the suspect's rights when under interrogation, with the proposition that where oppression was, or may have been, used then automatic exclusion must follow in order to "mark the seriousness" of the misconduct. In the context of the Act, the marriage of section 76(2)(a)'s embodiment of this secondary principle to subsection (2)(b)'s more general guarantee of reliability announces an important philosophical truth: some basic minimum standards are not negotiable, and courts cannot entertain arguments based on the reliability of evidence obtained in an oppressive way without descending to the level of the oppressor....a great deal depends on the interpretation of the concept of oppression....If too wide a definition of oppression is adopted, the reliability debate will be too frequently short circuited. Oppression...at common law, where it was defined loosely and in general terms as:

"....that which tends to sap, and has sapped, that free will which must exist before a confession is voluntary."......The 1984 Act affords no clear guidance......". (Birch, 1989 pp:100-101)

that the interrogation had induced hallucinations but the Court of Appeal considered this was not oppression as the police questions were not designed to cause such delusions. In the Fulling case (1989) the Court ignored the definition of oppression in 76(8) and suggested its dictionary meaning of -

"exercise of power in a burdensome, harsh or wrongful manner; unjust or cruel treatment of subjects, inferiors etc., the imposition of unreasonable or or unjust burdens." (quoted by Birch 1989, p:102).

Zander (op.cit) states that the Fulling definition of oppression requires that police impropriety must involve -


Birch suggests that the definition of oppression should include -

"...the denial of access to legal advice or some other fundamental right...". (p:103).

Birch goes on to give an example of a case when a man confessed because he was put in an unheated cell and denied legal advice - the police claimed this resulted because of a misunderstanding, and the Court of Appeal did not find misconduct on the part of the police. It seems likely therefore that the mental vulnerability of a suspect might be irrelevant to the question of oppression unless the conduct of the police was intended to exploit the suspect's vulnerability.

However, in the case of R v Paris, Abdullahi and Miller (1993) the Court of Appeal's Judgement was severely critical of the police and Miller's solicitor. Miller confessed after 13 hours of interrogation. Of particular interest is the
importance the Court placed on Miller’s mental vulnerability, as the following extracts from the *R v Paris, Abdullahi and Miller* judgement reveals -

“Having considered the tenor and length of these interviews taken as a whole we are of opinion that they would have been oppressive and confessions obtained in consequence of them would have been unreliable, even with a suspect of normal mental capacity. In fact, there was evidence on the voir dire from Dr. Gudjonsson, called on behalf of Miller, that he was on the borderline of mental handicap with an IQ of 75, a mental age of 11 and a reading age of eight”.


Or again as the following quotation shows -

“The officers... were not questioning him so much as shouting at him what they wanted him so say. Short of physical violence, it is hard to conceive of a more hostile and intimidating approach by officers to a suspect... We have no doubt that this was oppression within the meaning of section 76(2)... First, the police officers adopted techniques of interrogation which were wholly contrary to the spirit and in many instances the letter of the Codes laid down under the Act. In our view, those responsible for police training and discipline must take all necessary steps to see that guidelines are followed... Secondly, the solicitor who sat in on the interview seems to have done that and little else... it is of the first importance that a solicitor fulfilling the exacting duty of assisting a suspect during interviews should follow the (Law Society) guidelines and discharge his functions responsibly and courageously”. (quoted in Justice, 1995, p:8)
While Justice goes on to state that -

"The judgement set a new standard for 'oppressive' behaviour under PACE and also for the conduct and role of solicitors representing in police stations".

(Justice, 1995 p:8)

However, the authors of Justice (ibid) remain unconvinced that police practices have changed much since the above Court of Appeal Judgement. They cite many examples of similar breaches of the PACE Act and Codes since then.

The legal issues surrounding Sections 76 and 78 are complicated but need to be stated because legally the presence of an AA is required to prevent unreliable evidence being admitted, at least according to Code C of the Codes of Practice. Briefly, Section 76 (2)(b) is concerned with the reliability of evidence because it can lead to a false confession, whilst Section 78 (1) is concerned with the exclusion of unfair evidence which could include evidence submitted when the AA was not present.

Without going into too much detail about the various sections, briefly Section 76(2)(b) does not require such a level of impropriety on the part of the police as 76(2)(a). Accordingly, it seems that most cases involving defendants with mental vulnerability rely on s76(2)(b) which deals with reliability of evidence. The difficulties the Court of Appeal has in deciding whether to admit evidence in circumstances which might render it unreliable remain confused. There is agreement with Birch (1989) who describes in detail the disarray surrounding the Case Law concerning these Sections, pointing out that the Court of Appeal by consistently failing to distinguish between the differing principles contained in these
Sections denies guidance to the lower courts. However, for the purposes here, a close look at several cases under s76(2)(b) reveals that the absence of an AA, is not always seen by the Court of Appeal as crucial to a test of unreliability, if other breaches of the Act and the Codes are proved. Palmer and Hart (1996) conclude that -

"The confessions of mentally disordered or mentally handicapped defendants have been excluded under s 76(2)(b) for reasons other than the fact an interview was conducted in the absence of an appropriate adult. For example, in some cases the decision to exclude a confession has been based on the fact that the defendant, in spite of requesting legal advice, was interviewed without a legal representative being present (a breach of s 58 of the Act). In others, the breach has arisen from a failure to follow other aspects of the Codes of Practice......There is no reference in these reports to the existence of an appropriate adult, yet if one was not present (which seems likely from the facts) there would have been a further breach. Whilst the mental state of the accused was a factor considered by the courts when determining the reliability of the confessions, the breach of a safeguard specifically directed at providing protection for this vulnerable group does not appear to have been addressed. A failure by those representing the defendant to raise such a breach undermines their potential effectiveness". (Palmer and Hart 1996, pp:18-19)

The above comment suggests that the courts see solicitors or legal representatives as being the most important safeguard for protecting a suspect’s rights, even if they are mentally disordered. However, Sir Louis Blom-Cooper (personal communication 1997) has said that in his view the Court of Appeal decisions are wrong; he maintains that the attendance of the Appropriate Adult is more important than that
of a solicitor. In this one must agree with Sir Louis, the solicitor and the AA occupy qualitatively different roles, where the solicitor has a conflict of interest if and when he is asked to protect all the legal rights of a mentally disordered suspect. In contrast the AA, if doing the job properly, will have no such conflict of interest. But more importantly, Sir Louis' comment raises the question; does the Appropriate Adult matter? And the answer must be yes, at least if the AA does the job properly. All this is of no surprise, but sadly the Court of Appeal has not always seen things that way.

In terms of Section 78 which provides an additional discretionary provision for the exclusion of unfair evidence this Section states -

78(1) In any proceedings the court may refuse to allow evidence on which the prosecution proposes to rely to be given if it appears to the court that, having regard to all the circumstances, including the circumstances in which the evidence was obtained, the admission of the evidence would have such an adverse effect on the fairness of the proceedings that the court ought not to admit it.

(2) Nothing in this section shall prejudice any rule of law requiring a court to exclude evidence.

Only one Court of Appeal case at the time of writing (1997) seems to have been successful within the test of s78, and that is R v Brine (1992). The appeal was successful because the trial Judge had accepted medical evidence that Brine's confession was unreliable. The Court of Appeal decided that as there was no evidence of police misconduct the Judge should have excluded his confession under s78. However, Palmer and Hart (op.cit) point out that -
“...had it been raised at trial that Brine’s condition warranted the presence of an appropriate adult, his confession might have been excluded at first instance since the trial judge might have considered the failure to call an appropriate adult to be a sufficient act of impropriety which, together with Brine’s mental state, would have led him to exclude the confession under either s 76(2)(b) or s 78”. (p:19)

It seems that the confusion and contradictions Birch (op.cit) argues are inescapable -

“When the duty to exclude in section 76 and the power to do so in section 78 are couched in such similar terms, it is almost inevitable that mistakes will be made by invoking principles relevant to one section while considering another.” (Birch 1989, p:113).

One case in particular exemplifies the confusions surrounding these Sections of the Act. It is found in R v McKenzie (1993). At first sight the decision seems to provide protection for the mentally handicapped suspect, so much so, that Palmer and Hart (op.cit) declare that the decision in McKenzie provides, “an additional safeguard beyond those contained in PACE and the Codes of Practice.”. (p:21).

That may well be true, yet they do not mention that the McKenzie case failed despite having ample opportunity for doing otherwise to define the role of the AA within s76. What Palmer and Hart are referring is the Practice Note issued in R v McKenzie (1993) which states that -

“(1) The prosecution case depends wholly upon confessions;
(2) the defendant suffers from a significant degree of mental handicap and
(3) the confessions are unconvincing to a point where a jury properly directed could not properly convict upon them, then the judge should withdraw the case from the jury."

(quoted in Palmer and Hart 1996, p:21, see p:20 R v McKenzie transcript)

Palmer and Hart (ibid) suggest that those who suffer from “a significant degree of mental disorder” should have been included in the above set of classifications. It should be remembered that Note 1G of the Codes of Practice (op.cit) recognises that both conditions (mental handicap and mental illness) are different but are treated as the same in the Codes. What is important about this Judgement (see the Practice Note above) is that the McKenzie case finally provided special rules for the consideration of the admissibility of confessions from mentally vulnerable suspects, thus, formerly recognising that false confessions can and do occur, with a duty being placed upon the Judge to withdraw the case from the jury at any stage if those conditions apply.

However, as mentioned previously, the McKenzie judgement failed to resolve the position of the AA (see page 16 of transcript). That the Court of Appeal considered the Judge to be entitled to reject the submission that the absence of an AA made McKenzie’s confession unreliable (within s76(2)(b)) reveals the difficulties for mentally vulnerable defendants when relying on this Section. Yet two previous Court of Appeal cases: DPP v Blake 1989 and R v Everett 1988 emphasised the importance of the AA. In the case of DDP v Blake the Court of Appeal found that the defendant’s estranged father was, ...”not an “appropriate adult” and ruled the confession inadmissible under s.76(2)(b) (Sheppard 1995). The Court of Appeal in R v Everett 1988 -
"...held that the test applied under s 76(2)(b) is an objective one...the fact that the police believed that Everett, who was aged 42 but had a mental age of 8, was of average mental ability, was irrelevant in determining whether or not to admit the confession evidence. A court must have regard to the defendant's state of mind as it actually was at the time the confession was made. The court also took the view that an interview with a mentally disordered or mentally handicapped suspect which takes place in the absence of an appropriate adult, is "something done" for the purposes of the sub-section".

(Palmer and Hart 1996, p:17)

Moreover, Birch (1991) is correct when she declares that it is difficult to see if the police do not ensure the attendance of an AA at a mentally disordered suspect's interview that this does not come within the meaning of "anything....done" (i.e. an omission) in s76. Surely, the relevance of "the circumstances existing at the time" is that the vulnerability of the suspect requires an AA to ensure that the questions addressed to the suspect are understood along with all the other requirements outlined in the Code. Therefore the absence of an AA is a breach of the Code and should mean that any confession made in those circumstances is likely, "to render unreliable any confession which might be made by him in consequence thereof" (within the definition of s76(2)(b)). Yet the Court of Appeal in the McKenzie case was not persuaded that the lack of an AA had a detrimental effect on the reliability of his confessions. But an AA may have helped McKenzie to distinguish between his "feelings" of guilt and whether he knew that he had committed these crimes (see page 16 of transcript).

However, Palmer and Hart (1996) are confident from their review of the Case Law that the Courts deal well with breaches of the PACE Act and Codes. They are more
concerned about the failure of the Court of Appeal to criticise the *effectiveness* of AAs. They cite as an example the case of a mother acting as an AA for her 13 year old daughter. The mother suffered from paranoid delusions, but the court decided that as her paranoia was directed at others she was capable of acting as the AA for her daughter. This is probably a poor example of an 'inappropriate' AA, for if everyone considered to be suffering from a degree of paranoia were excluded from acting as an AA or from any other criminal justice work, there would be few people left who would be appropriate. This is not to say that there are no 'inappropriate' AA's. The AA who gave evidence for the prosecution in the Rosemary West trial is an obvious example of an AA, through lack of training, failing to understand that her lack of legal privilege may place her in an invidious position (*The Independent* 1995; Pearse and Gudjonsson 1996). The question lies in the nature of psychiatric diagnoses generally (Bean 1983 and 1986). Palmer and Hart (op.cit) criticise the implications of the Court allowing a person described as 'paranoid' to act as an AA and other cases where the court has questioned the ability of the AA. They state that-

"...where an appropriate adult is present *and capable* of performing the role contained in Code C 11.16, provided he or she is not estranged from the suspect the courts will not enquire into the *effectiveness* of their presence. In these circumstances, any failure to *perform* the role within the limited definition provided by Code C 11.16 seems to be a matter with which the courts are not yet concerned." (p:23). (emphasis in the original)

It is not clear from the above statements what Palmer and Hart mean by 'effectiveness'. What test of effectiveness would they suggest? Should the test be whether the mentally vulnerable suspect was released, or 'diverted' somewhere
else? What Palmer and Hart (ibid) complain about is that according to the interviews they conducted for their study, they were told that AA’s fail to give advice (but they do not say what sort of advice) or that they, ‘‘...rarely intervene in interviews, even when the interrogation is robust’’. (P:23). Such complaints as these could also be directed to solicitors, who may not always act in the best interests of their client (see McConville and Hodgson 1993, Baldwin J. 1993). Indeed the judge in the Rosemary West case severely criticised the effectiveness of the AA for acting for the prosecution. Clearly this woman, the AA that is, did not understand the nature of the AA role, particularly that relating to the issue of confidentiality (this and other aspects of the AA role is discussed in following chapters).

Moreover, judging by the Court of Appeal’s findings in the R v Howard James Law-Thompson (1997) the court did not consider that the presence of an AA would have affected in any way or made any difference to the suspect’s confession, although the court considered that the person the police called to act in the AA role was appropriate (see page13 of transcript). This judgement reveals that in this case at least, the Court of Appeal did not view the AA protection in any way relevant, the absence of the AA did not make any difference to the reliability of the confession.

However, many of the criticisms that Palmer and Hart (1996) and others (see Pearse and Gudjonsson 1996) direct toward the AA, could be remedied by training (see nal Chapter 7). Moreover, that from the review of Court of Appeal judgements, based on the safeguards contained in Sections 76, 77, and 78 of the PACE Act outlined above, they seem to leave room for concern. After all, the AA procedure can hardly be said to have a long and tested history upon which to test such matter as their ‘effectiveness’, simply because the AA protection is rarely implemented.
The Court of Appeal and their deliberations have been in existence much longer, yet seem unable to clarify the safeguards for mentally vulnerable suspects. They do not say whether the absence of the AA protection should always be seen, no matter what other conditions apply, as - “something done” within sub-section 76(2)(b). The Court of Appeal judgements outlined above reveal that as far as the AA protection is concerned, the law is equivocal. Indeed the most recent case of Law-Thompson 1997 (ibid) is very worrying. Not only does Section 76,77 and 78 fail this mentally disordered suspect, but so does article 6 of the European Convention on Human Rights. The following extract reveals what this Court of Appeal thought about the AA protection, when explaining why they refused Sir Louis Blom-Cooper’s submission to have evidence excluded under s78(1) which provides the court with additional discretion.

"...but Sir Louis submits that when a mentally disordered defendant has been interviewed without an appropriate adult then, regardless of the circumstances, the discretion can only be exercised in one way, namely by excluding the evidence. He invited us to find support for that rather startling proposition in article 6 of the European Convention on Human Rights,.....”.

(see page 8 of transcript)

Thus, the Court of Appeal judgement in this case viewed the suggestion that a confession recorded in the absence of an AA should be excluded, as a “startling proposition”. Clearly this court attached no great import to this breach of the Codes. Such judgements do not give any guidance to the lower courts or to the police about the role and function of the AA. Indeed that judgement suggests that, if all other provisions in the Codes have been implemented then the absence of the
AA does not matter. Sir Louis Blom-Cooper however, submitted that the AA protection does matter.

But Palmer and Hart (1996) (see also Pearse and Gudjonsson 1996) are concerned that the AA (whether capable or not) might confer reliability upon police procedures, particularly if the police comply with all other provisions in the Codes; such ideal conditions could then be used by the prosecution. Birch (op.cit.) made this point several years previously in 1989 when she said that -

"Full compliance with the procedural rules, on the other hand, may provide evidence of reliability for the prosecution." (p:100).

However, if the case of Law-Thompson (ibid) is anything to go by, the issue about the AA conferring some spurious reliability for the prosecution, or providing reliable protection for a vulnerable suspect and thereby ensuring probable reliability for the defence, remains unanswered. Palmer and Hart (ibid) and Pearse and Gudjonsson (ibid) are, it is suggested, not correct in this. Rather than the Courts viewing the AA protection as conferring reliability to the proceedings, it is more important that the Crown Prosecution Service should see the presence of an AA as a marker which states that this case is, or should be looked at with more care, as the suspect is seen as mentally vulnerable. Perhaps the fact that Palmer is a solicitor and Gudjonsson a psychologist may have something to do with the way in which they arrive at their conclusions.
Conclusion.

When considering the Statutes relating to the position of mentally disordered suspects and the Case Law relating to the confessions of these vulnerable people, there is much less certainty and clarity than one would have expected. Constantly there is failure to give clear guidelines and definitions about the role and function of the AA, and for that reason the AA seems to be regarded as of less importance than one would have thought. This is surprising but might go some way to explain why lawyers and others appear to know so little about the AA procedure. One can but hope that a few strident Case Law judgements by the Court of Appeal will remedy this and make the AA more prominent than hitherto.

"The Judge was fully persuaded that the infliction of pain upon the weak and sickly was the only means of preventing weakness and sickliness from spreading....".

Samuel Butler ('Erewhon') 1872
CHAPTER 4

RESEARCH METHODS.

Aims.

There are four main aims of this research. They are as follows:

(1) to determine the manner in which the Appropriate Adults are used in selected police stations, and to make comparisons. The method for this aim was the study of custody records.

(2) to determine who acts as the AA when the Appropriate Adults are used, the method here is the same as for aim 1.

(3) to determine the role of the custody officers and other personnel concerned with vulnerable suspects including that of police surgeons. The method for this aim was through formal and informal interviews.

(4) to determine the policy implications of existing practices and point to future developments.

As the methodology mainly involves the study of police custody records, taken together these four aims would, it is considered, provide data which covered the full extent of information available on the custody records. For example, there is no data available on the impact the AA had on police interviews, nor on the manner in which the AA interrupted interviews if at all. That type of data would only be available through an observational study or listening to tape recordings of the interviews.
These main aims can be broken down into sub-aims.

(1) Main Aim: to determine the procedures that take place when the AA is used in selected police stations and make comparisons.
Sub-aims are:
(a) to determine the number of AA’s used in the various police stations;
(b) to determine selected socio/demographic features of the suspects when the AA is used, including the mental health classification given on the custody records;
(c) to determine the reason in terms of the offence for the suspect’s detention in the police station, and determine the outcome of that detention;
(d) to determine how many suspects should have had an AA called, to determine their socio/demographic features, their mental health and criminal characteristics and compare these to those suspects who had an AA called;
(e) to compare the police stations in terms of a, b, c and d above.

(2) Main Aim: to determine who acts as the AA when an Appropriate Adult is used.
Sub-aims are:
(a) to determine existing relationships between the suspect and the AA;
(b) to determine the procedures used when an AA is called;
(c) to determine what the AA did when called;
(d) to determine what others such as police surgeons and legal advisers did when the AA was called;

(e) to determine links, if at all, between the use of the AA and other legal requirements relating to mental disorder, especially s136 of the Mental Health Act 1983.

3. Main Aim: to determine what part the custody officer plays in the process which results in calling an AA.

Sub aims:

(a) to determine the level of training the custody officers receive and their experience in calling an AA, with particular reference to determine how they expect AA's to behave during the interviews;

(b) to determine the custody officer's relationship with the police surgeons in respect of the AA;

(c) to determine the custody officer's relationships with the legal advisers in respect of the AA;

(d) to compare custody officers in different police stations in respect of a, b and c, above.

4 Main Aim: to determine the policy implications of existing practices and point to future developments;

Sub aims: None.
RESEARCH METHOD

Overview.

The original method was to take data from custody records in selected police stations in three, possibly four police areas. They were to be Nottinghamshire, Leicestershire, and Greater Manchester. Unfortunately, Nottinghamshire and Leicestershire police authorities refused to give permission to carry out the research, but Greater Manchester did. Derbyshire, Lincolnshire and South Yorkshire were then approached requesting permission to conduct the research, and permission was granted by all of them. As a result of these negotiations with the respective police representatives it was agreed that the following police stations would be used for data collection purposes:

Derbyshire - The main police station in Derby covering an inner city area.
Lincolnshire - Grantham and Skegness police stations; one covering a typical market town, the other a seaside resort with a transient population in summer.
South Yorkshire - A central police station in Sheffield covering an inner city area.

The selection of the above police stations, which of course means essentially selection by the police themselves, was based on the criteria that they were designated police stations i.e. they had the PACE recording facilities for interviewing suspects, and custody records were stored in these police stations.

Invitations were made initially by the Greater Manchester police asking that the research be carried out in two Manchester police stations within the inner and outer conurbations. The Manchester police were concerned and interested in the research as they wanted to establish more details about how the AA procedure worked within
their area. Unfortunately, it was not possible to include Greater Manchester in the research, mainly because of time and travelling constraints. Accordingly it was decided to look elsewhere. It was considered that it would be wrong to include London because it was thought that Metropolitan practices differed from the rest of the country. The final police areas selected were in Lincolnshire, Derbyshire and South Yorkshire. The police stations from which the records were taken were thought sufficient to provide a reasonable selection of the police areas in the East Midlands and that of the population generally.

There were two main methodologies used; that of a semi-structured schedule and that involving custody records. In the former, the semi-structured schedule was given to all the custody officers in the four police stations, there were only 26 such posts and it was relatively easy to obtain a complete population. This schedule was concerned with the way they, the custody officers' made decisions about requesting an AA, but the open ended nature of the schedule allowed the officers to range over a wider set of matters, which they did and which proved valuable.

In retrospect, and with the benefit of hindsight provided by the research and results, a similar schedule should have been given to the police surgeons. At the time it was not realised how important this occupational group was. That only became apparent when the data was analysed. Had the police surgeons been included, a wider and richer set of data would have been available.

The second main methodology was the analysis of custody records, it was decided that the research method would rely predominantly on this form of data collection. There were a number of reasons why this method was selected, one of the most important being of a pragmatic nature. For example, an observational study was rejected as such studies often rely on data recorded over a 24 hour period and or, over a number months. They are usually carried out by several researchers.
Therefore, as a lone researcher, an observational study would have been impossible to undertake especially as it would have involved a study in a number of police stations.

There was one major practical advantage in studying custody records: namely that records are immediate to hand and very productive, i.e. they often contain much descriptive information. There will be a great deal to discuss about this throughout the research, but clearly there are strengths and weaknesses of this approach. For example, it is recognised that using custody records poses certain methodological problems not the least that it involves conducting research on what is recorded, which may not be the same as that which occurred. Nonetheless there are additional advantages.

The first advantage is that this method would be expected to allow a wide sweep of the position to be taken, that is, a broad base of data covering one year’s records would reveal important trends and gives an overall view of the actions of key personnel. The second advantage is that records would be expected to give insights into what was seen to be important by those required to make decisions. For example, it was considered that the language and terminology used by the custody officers would indicate a level of seriousness felt about a vulnerable suspect. In fact this was borne out by the study. Also, the use of formal language such as 'mentally disordered' was it was expected be able to suggest that the suspect may already be known to the police officer, having been diagnosed as such by a professional at some earlier stage or the custody officer had been informed that the suspect was mentally disordered. This was found to be so but less formal descriptions of disturbed behaviour such as 'appears a bit simple' or 'is a sandwich short of a picnic' appeared all too frequently and were interpreted as conveying a lesser sense of urgency. Interestingly, such language often indicated that the custody officer considered the suspect to be suffering from learning difficulties rather than mental
illness; and as the research progressed it was clear that the police had developed a classificatory system reflecting the nature of, and the seriousness of the suspect’s condition.

It was also considered that the case records would likely show how language and terminology used by custody officers on the custody records, whether compassionate or disparaging, conveyed a level of awareness or understanding about mental disorder. Perhaps they would also show expressions of frustration with other professionals. Again, this was borne out by the study. For example, it was often noted on the records that the social services, relatives or friends failed to attend the police station within a reasonable amount of time, a factor which incidentally sometimes resulted in a different outcome for the suspect. By that is meant, that a decision would then be made to release a detainee from custody instead of waiting for a social worker to act as an Appropriate Adult or conduct a mental health assessment. However, what was also interesting was that such frustrations were rarely fully expressed on the custody records, nor during the interviews, about the more established professionals such as the police surgeon, perhaps because the latter almost always attended the police station promptly, and the police are heavily dependent upon their professional services. These frustrations appeared more often when the police were discussing matters informally with the researcher.

Also, it was known that custody records contain information received from others, such as telephone conversations with relatives, or as a result of meetings with friends of the suspect, social workers, doctors or other health professionals. It was considered important to obtain such information and to see whether it would reveal stereotypical assumptions about the mentally disordered. Occasionally, such information was recorded, but more often about female suspects than male, and then paradoxically by social workers or health professionals over the telephone to
custody sergeants. The health and social problems of female detainees were discussed, especially intimate matters such as, 'recently undergone a hysterectomy operation' or 'has had an abortion' or 'her children have been taken into care'. Apart from the fact that such information is confidential, questions have to be asked about the relevance of such information to the suspect’s offence where the woman has been arrested for say, a public order offence or shoplifting. Incidentally similar comments were made in research that looks at how sexism is reproduced in the media (Soothill, 1993) or on studies of social inquiry reports or pre-sentence reports compiled by probation officers (Raynor and Gelsthorpe, 1995).

Moreover, it was expected that custody records would sometimes read like a pre-sentence report, and the police surgeons' assessments sometimes read like a charge sheet compiled by the police or the Crown Prosecution Service (these reports are accepted as important evidence in determining decision making by criminal justice professionals and often criticised in research). If so, then it is suggested custody records should also be accepted as valid research data. By that is meant, accepted because of the way they contain data and information about decision making.

Thus, although the use of custody records presents severe limitations as a research methodology, they have a number of distinct advantages, especially as in this research one of the aims was to determine how and in what circumstances the police make decisions to call an Appropriate Adult. It was thought that such decisions would be noted in the custody records and to use these records would be entirely reasonable, and perhaps the only way of obtaining that type of data.

But the main advantage is, if only to put an earlier point in a slightly different way, that such a method allows a number of different police areas to be covered over a fairly long period of time. Whatever disadvantages in using custody records, they are made up for by this one major advantage. For as was said above, to undertake
an observational study is time consuming, expensive and labour intensive: in this respect studying custody records is more efficient. Moreover, it was considered that research into a topic where little research had been conducted hitherto requires a method that covers a wide sweep of the argument rather than a detailed study of a small population providing this.

The Population Studied

Accordingly, records were examined covering a 12 month period from 1st January 1992 to 31st December 1992. This period was chosen because it was thought to avoid distortion as a result of seasonal variations. One of the police stations was Skegness which has a highly volatile seasonal trade in the summer and has a quiet period in the winter months. The period was also chosen because it was thought it would provide information about the most recent police practices.

However, in Derby police station records covering the first six months of 1990 were also examined (i.e. prior to the 1991 Revised PACE Codes of Practice). This was done in order to compare the data with that from the records for the first six months of 1992. It was decided to examine only the first 6 months of the 1992 records in Sheffield, because by then almost 21,000 records had been examined and it was clear that the data was showing similar practices as that found in the other police stations. It was considered that this figure represented a large enough population upon which to make useful inferences or assumptions.

It was decided not to include juveniles in the study. At the beginning of the data collection which began in Skegness, juveniles were included. This turned out to be an error. It was clear after several weeks of data collection that almost all the data concerned juveniles and this data was dominating the research. It was also clear
that although the legal justification for linking juveniles and the mentally disordered was the same, i.e. both groups were regarded as not being fully responsible for their actions, yet they are widely different in the ways in which an AA is called and expected to operate. The decision to call an AA for juveniles is relatively clear cut: age is the determining factor and criterion to use. Also for juveniles it is usually relatively easy to determine who the AA should be, parents, guardians or social workers. This is not so for the mentally disordered. There is nothing clear cut about who are, and who are not mentally disordered, identification is difficult and so too are the decisions about who the AA should be. This makes the two groups qualitatively different.

Having decided to exclude juveniles, the research was then wholly directed towards mentally disordered adult suspects. This was often seen as a little puzzling to the police, for very early in the data gathering it was clear from the custody records and clear from the interviews with police officers, that the Appropriate Adult protection was seen by the police to be for juveniles only. This misplaced and misunderstood view posed all sorts of methodological problems, especially when the data was collected using the semi-structured schedule. In spite of what was said, some custody officers clung tenaciously to the view that the research was about juveniles.

As stated above the methods have been to examine the custody records at four police stations. In addition, key figures such as police custody sergeants, were interviewed to discover how they use Appropriate Adults and to determine policy matters.

Data from the custody records and the interviews was transferred to the research questionnaires (see appendix). In the four police stations custody records of detainees were hand written and filed numerically; this, of course, makes data extraction difficult and time consuming, as sometimes the records were hardly
Data was transcribed from the custody record onto a structured schedule, i.e. the research questionnaire.

This posed problems of reliability, for judgements had to be made about what the records meant and how they should be interpreted. In several instances the records showed that someone had been in attendance at the interview, and that someone had acted in a way commensurate to that of being an Appropriate Adult. Yet no formal acknowledgement of the use of an AA was made, except rarely. Accordingly, a decision had to be made and a set of criteria devised to include those representative as AA's and the data on that record to be included to meet the problems of reliability. An AA was said to have been used when the following criteria were satisfied:

1. When the need for an Appropriate Adult had been recorded on the custody record and an AA had attended the police station.

2. When it was considered a person had acted in the role of the AA even though it had not been described officially as the AA on the custody record, e.g. when a relative or social worker attended the police station and remained until the detainee was charged or released.

In addition, data was recorded in circumstances when there was evidence of mental disorder or some degree of vulnerability. These occurred:

3. When the suspect had not been given an AA but when the records suggested that an AA should have been called.

4. When the custody records revealed that the custody officer considered the offender to be mentally disordered in some way but nothing more
appeared to have been done - or at least nothing further was stated on the record.

(5) When a person other than the custody officer considered the detained person to have been or was currently suffering from mental disorder, (in some cases to be otherwise vulnerable such as being deaf and dumb or unable to read or write).

(6) Whenever the Police Surgeon considered the detained person to be mentally disordered and advised accordingly.

(7) When the Police Surgeon was called to see the detained person and although there were no records that the detained person was deemed to be mentally disordered the circumstances were such as to suggest the Police Surgeon thought this to be so e.g. when the Police Surgeon visited frequently and gave the impression he was concerned about the suspect's mental health.

(8) In cases where the detained person was recorded as being in the police station which was being used as a 'place of safety' under Section 136 of the Mental Health Act 1983.

This second group were included whenever the custody record revealed concern by the custody officer or other key professionals, such as the police surgeon or solicitor, about the mental vulnerability of the suspect, irrespective of whether an AA had been called. However, it needs to be said that a large number of custody records were excluded because they did not fit the criteria outlined above, usually
because the information on the record was either illegible or so ambiguous as to permit almost any interpretation to be given.

**Methodological Problems.**

One of the major difficulties with this research, as with all research, is a definitional one: in this case, what was an Appropriate Adult? How could an Appropriate Adult be identified in the records and how was it possible to determine whether a person was acting as an Appropriate Adult at a police station? Custody records in Skegness and Grantham police stations made the task slightly easier as there was a separate form in the record showing whether an AA had been used or not. This was not so elsewhere. Derby records contained a box indicating the use of an AA, but Sheffield's custody records did not. That meant a decision had to be made according to the information derived from the custody records. However, even recording the use of an AA on the records in Lincolnshire did not always solve the problem. Sometimes those custody records showed that an Appropriate Adult had been used when there had not been one, and conversely sometimes the records did not show the use of an Appropriate Adult when it seemed clear from the record that someone probably acted in that role during the police interview.

Moreover, as has been said above yet bears repeating, all the police officers interviewed formally and informally in the four police stations viewed the Appropriate Adult procedure to be for children only: perhaps this explains the lack of clarity in the police records.

Also these records showed considerable confusion about the use of an Appropriate Adult, seeing an AA to be synonymous with a social work/psychiatric examination.
usually under Section 136 of the Mental Health Act 1983, (this is the section where a mentally disordered person can be detained in a 'place of safety', usually a police station, in order to be interviewed by a social worker and psychiatrist to determine psychiatric outcome) or often the presence of the social worker or psychiatrist at a police station was seen by the police as equivalent to having an Appropriate Adult present during a police interview. This often made it difficult to determine the nature of the interviews being undertaken: hence in some cases it is less certain that an Appropriate Adult was used. (This point will be examined in some detail later).

Paradoxically, it was sometimes easier to identify detainees suspected by the custody officer or others as mentally disordered and/or vulnerable. Often the records contained detailed graphic descriptions of bizarre behaviour recorded by the custody officer(s), or an 'at risk' form might be included in the record giving a warning that the detained person was a 'suicide risk' or 'mentally ill' or 'violent'. Or sometimes the records contained just a few words indicating the custody officer's concern about the suspect's mental health. In these cases the police surgeon was always called by the custody officer to attend those suspects. Or sometimes the police surgeon was called at the request of the detained person; but then sometimes the reason for the request was recorded, sometimes not.

The police surgeon always recorded his diagnosis or assessment of the suspect's condition on the custody record. (There was only one female police surgeon and that was in Sheffield. The male gender will therefore be used throughout).

 Apparently police surgeons also make additional medical notes which remain confidential and were not available for these research purposes.

All custody records that revealed the custody officer's or any other person's concern, or information about the detained person's mental health or vulnerability were transcribed by the researcher. Moreover, the police surgeon's assessments or that of
other health professionals assessment were also recorded. On average, between 150-300 records were completed during a day.

A further difficulty with the records besides determining what had probably happened, was a simple practical one, that of deciphering the custody officers' and sometimes the police surgeons' handwriting. Often the suspects were detained for more than 24 hours, consequently, the custody records were compiled by several custody officers which added to the difficulty.

Other difficulties encountered during the research was the environment in which the data had to be examined. In all the police stations except Sheffield the records were stored in the custody area, which was invariably busy and noisy with prisoners being processed etc. The main problem was finding a space in order to read the custody records. Although the police officers in all the police stations were co-operative and helpful and interested in the research, some days the gathering of data had to be abandoned. It is difficult to determine how much the working environment affected concentration and judgement when recording the data. The gathering of data in Sheffield posed no such problem as the records were stored in an administration area, although again space was a problem, sometimes it meant having to move several times in one day.

Other difficulties encountered concerned the problems of being a female researcher in a predominately male environment. There was only one female custody sergeant seen during the research. First encounters with male custody sergeants often resulted in stereotypical assumptions, i.e. a new filing clerk or secretary had been recruited. However, once it was found to be otherwise, attitudes ranged from genuine friendliness and helpfulness to patronising toleration.
The Population Studied.

Initially, the selection of the police stations depended upon permission from the Chief Constables. However, the resulting police stations reflect a reasonable representative sample of the population, in as much as they include inner city police stations with high ethnic populations, a seaside town with a transient population during the summer months and a market town with a relatively static population. Over 21,000 records were studied and 448 case histories recorded. This makes it the largest research study undertaken on the use of the AA in terms of the number of custody records studied. It is reasonable to assume that the population is large enough to warrant certain inferences being drawn, although of course, claims are not being made to suggest that the population or police stations include a representative sample from England and Wales generally.

Validity.

Questions of validity and reliability inevitably arise and the research method and conclusions must be justified. As a single researcher, interviewing and recording data from the custody records, at least it may be argued that equivalence was established. There were no problems therefore of inter-rater reliability.

The size of the population recorded, indicates an 'on the face of it' type of validity, together with 35 recorded interviews with custody sergeants and other officers and informal discussions with numerous other officers. In other ways tests of validity could be established when comparing the style of recording in the four police stations. Although the custody records differed in as much as a 'box' reserved for the AA was missing from Sheffield's records, the custody records were in many respects very similar. Moreover, the type of information required to be reported under the PACE Act e.g. reason for arrest and detention, rights read, requests for
solicitor, reviews, times and dates etc., ensured some measure of standardisation. That the extent of detailed information differed from record to record and throughout the police stations, had of course, everything to do with individual custody officers' idiosyncrasies, than real differences in recording practices. For example, some officers used terminology that was very descriptive and even derogatory, while others used more simple language that conveyed similar practices.

There is extensive research about custody officers implementing PACE procedures. Particularly relevant to this research are views on how custody records are 'constructed'. McConville at al (1991) recognise the pressures custody officers contend with in charge rooms (often observed during this research e.g. drunk, violent and abusive suspects and cells full) makes it difficult to comply always and fully with PACE requirements and recording such on the custody record. In these circumstances researchers are not surprised when discrepancies are found between the information given to the suspect, e.g. right to free legal advice, and what was written on the custody record - what McConville et al calls 'creative accounting' takes place. (McConville et al 1991).

Thus, bearing in mind all the problems associated with using the information on custody records, it is argued here that, by and large, the blanket conformity to custody record keeping or 'construction', did engender a level of confidence and that, despite the obvious, and not so obvious discrepancies in the records, the discrepancies were consistent in all the police stations.

Moreover, this research was concerned with looking for markers on the record that would alert the researcher to the fact that this suspect was thought to be vulnerable by someone during his detention. And if so, was an AA then called? It was found, over time, that consistent descriptions, or information given by others, or simply a
note to the effect that the police surgeon had been called almost always meant that a suspect was seen to be vulnerable in some way.

Added to the uniformity of the custody officers' recording, was the police surgeons' recorded assessment of the suspect's mental and/or physical health. Approximately two or three police surgeons were on call at any one time in the police stations. Their assessments almost always included 'orientation' questions i.e. does the suspect know 'time and place', invariably with a diagnosis that the suspects were 'not psychotic at present' (very few suspects were judged by the police surgeons to be in need of psychiatric help). The assessments almost always ended with 'fit to be detained and interviewed' - and sometimes 'fit to be charged'. The uniformity of the police surgeons' assessments added to the confidence that whatever the records revealed at least they were consistent.

As stated earlier, all the police officers encountered during the data gathering were helpful and interested in the research. The data collection took several months to complete in each police station, consequently, friendly relationships were established with many custody officers. This often led to officers volunteering information about past or present prisoners whom they suspected as being mentally disordered. However, when these custody records were analysed a few did not contain information that would have indicated that that person was vulnerable in some way. Consequently, it must be assumed that a number of mentally disordered or vulnerable suspects was greater than recorded as many have not been identified as such on the custody records, even though in some cases the custody officer was aware of their past psychiatric history or present vulnerability.
Reliability.

Clearly, inter-rater reliability did not apply. The records were examined by a single researcher and therefore no tests were required for more than one research worker. It is test - re-test reliability that is the most worrying.

It has been mentioned above that there are problems about test - re-test reliability. Here the aim is to look more closely at that to determine to what extent this form of reliability may or may not compromise the data. The problems concern the analysis of the records approximately one year after they had been written. It is difficult to determine how much bias, or how much the researcher had been influenced by the working environment when gathering the data that now influences the analysis.

It is possible that some case histories now reveal important issues that were not seen to be important at the time the record was transcribed. For example, should a drug addict who stated he was 'withdrawing' be classified as vulnerable for the purposes of this research? And should the confusion that surrounds detentions under Section 136 of the Mental Health Act 1983 be relevant?

There were other problems with test re-test reliability. The records were examined over approximately two years, and it is highly likely that the research worker's perceptions changed during that time. Certainly, as mentioned above and will also be discussed later, the experience in reading records resulted in greater and increasing levels of awareness and understanding about what was going on. However, as the results show in later chapters it is comforting to realise that there was a remarkable evenness about the use of the Appropriate Adults in the various police stations. This led to some certainty that a measure of test re-test reliability was maintained.
The questions posed above and many more besides, occupied most of the two years spent gathering the data. It is probable that throughout those years attitudes and assumptions change about what is being measured. However, a fairly well established criteria for selection of data was agreed at the beginning of the research which was always adhered to. The research did not include interviews with suspects, that at least excludes the possibility of further bias that could have influenced the analysis and conclusions.

A retrospective study poses other methodological problems, not least in this case in relying on the accuracy of custody records. Yet, as said above there were advantages compared to an observational study which would probably only take place in one police station, and relies ultimately upon assessments by the observer, at least this method has allowed a wide sweep of the situation.

Some final points need to be raised in defence of the reliability and validity of the research method. Although the research relies heavily upon the notes made by custody sergeants' about suspects' mental disorder or vulnerability, nevertheless, other research suggests that police officers are well able to identify people with mental disorder (Bean et al 1991). Moreover, the data gathering included interviews, mainly with police officers but also occasionally, informal interviews with social workers, community psychiatric nurses and solicitors. What they said tended to support what the records stated. This added a feeling of confidence that the data was of a sufficiently high quality to be of value.

Whilst attempts have been made to argue that an acceptable level of reliability and validity has been obtained it is recognised that probably all research fails to provide conclusive evidence. Here, as has been said above, there is an 'on the face of it' type of validity which comes from seeing similarities in a number of police stations over a period of time. This suggests that the data was probably sound.
Evaluating the Research Method.

On the whole, it can be argued that the method chosen is vindicated, in as much as is shown above, the results of the data in the four police stations were consistent. Moreover, the following can be added which increases its level of credibility:

1. Getting In:

Gaining permission from the Chief Constables of Derbyshire, Lincolnshire and South Yorkshire to carry out the research was crucial to the success of the study. Most important was access to the police stations. The credibility of the research was helped because of the Chief Constables' support. That is, once the custody officers knew that the Chief Constable's support was available and forthcoming their co-operation increased. It has to be said that the Chief Constable's support did not impress some officers, but it did get the research worker into the police station nonetheless.

2. Personal Relationships:

Relationships that developed between the researcher and police officers during the months spent gathering data was based on trust. An indication of trust between the researcher and police officers was revealed when police officers in all the police stations presented information about mentally disordered suspects that it is suspected would not ordinarily be available to the researcher. Moreover, sometimes the information revealed that police officers had blatantly disregarded the PACE Codes of Practice. One example of this was when the custody sergeant informed the researcher that a suspect who had been arrested the previous evening
for a very serious offence (the suspect was described in derogatory terms) had been interviewed several times without an AA. The sergeant informed the Inspector and the interrogating officers that the suspect was vulnerable, but was told that they could not call an AA now after several interrogations had taken place because, "what would the Defence think about that"!

That such spoken and written information was revealed during the weeks and months spent in the police stations conveyed conflicting messages. On the one hand, officers were aware that breaches of the Code of Practice had taken place, but were clearly willing to reveal this knowing full well what the research was about. Yet, because so many police officers were open about obvious transgressions of the PACE Act, it seemed that the failure to call an AA for many vulnerable suspects was by and large not cynically operated by the majority of police officers. This is not meant to exonerate the police, rather it is said in an attempt to understand the interactions and decision making.

It is interesting to speculate on this point, for it is difficult to know why police officers should impart information to a researcher about breaches of the Codes of Practice, by other officers, especially as the police are in McConville's terms well known adherents of a 'cover your back' type of culture (McConville et al 1991). Perhaps explanations for such behaviour lie in the way police officers interact with known criminals whom they use as informants (Fielding N. 1995). Thus, as many police officers operate within a grey area of policing methods, and furthermore operate using wide discretion in their dealings with the public on a daily basis, then such indiscreet revelations about police practices are seen as of little consequence and thereby easier to understand.

This is supported by McConville et al (1991) who relate that they too received admissions from police officers that they had, "..'bent', the rules, 'gilded the lily' or
acted unlawfully in a variety of situations" (p.177). McConville et al (ibid) state that this apparent disinhibited behaviour on behalf of police officers reflects the premise that the law is, "...very much a police product.". McConville et al point out that much law reform has legitimated unlawful police practice, as the following shows -

"The police are constantly striving to push out and extend the boundaries of 'legal' behaviour and they do this by their practice. They were not dissuaded from interrogating individuals by occasional judicial rebukes but continued custodial interrogations until these were legitimated by the judges (Judges' Rules, 1912)....They did not stop searching people's houses illegally, until they were given judicial sanction... and Parliamentary approval (PACE Act, ss.8-22). The same is true of detention purely for the purpose of imposing interrogation conditions likely to secure a confession...PACE s.37)." (McConville et al 1991,p:177).

There is no doubt, that the above may very well explain police illegal practices and further why police officers readily admit to researchers to 'bending the rules'.

Senior police officers have often defended and justified illegal practices by their officers that they are forced into such action because they are deprived of legal powers to 'fight crime'. The notion then that much law reform has, or does legitimate unlawful police practice, is understandable.

To some extent, the behaviour of these officers cannot be explained solely within the above analysis. Perhaps a combination of explanations is closer to the point. Or, perhaps the simple explanation is much more mundane, that is to say the officers did not think these cases were sufficiently important to worry about, as there is an assumption that the majority of the crimes of the mentally disordered are low level
nuisance offences "nothing jobs that are going nowhere" (Evans and Rawstorne, 1995).

However, the explanation given by Irving and McKenzie (1989) regarding the behaviour of the officers involved in the Confait case is interesting in this respect. They state that the Fisher Inquiry Report (1977) revealed that -

"....the officers were not fully conversant with the Judges' Rules and operated mostly on their view of common practice, they did not break the rules as they saw them." (Irving and McKenzie, 1989, p.222)

This corresponds closely to the assessment made at the beginning of this discussion, i.e. that the officers encountered during this research were not acting cynically when failing to call an Appropriate Adult for a vulnerable suspect. It is interesting to note however, that Irving and McKenzie (1989) predicted that if a more effective rule system had been in place at the time of the Confait case (presumably meaning the requirements of the PACE Codes of Practice, i.e. a custody officer and custody records, an AA and a solicitor amongst other protections) then those officers would have adhered to the rules.(p.222) It seems ironical, now that the PACE Act and the Codes of Practice have been in place for 11 years, that many police officers, including senior officers, are still not conversant with the rules and operate the rules according to "common practice". To be fair to Irving and McKenzie, they did state that their analysis was optimistic. (p:220 ibid.).

To end this brief discussion on police culture and rule breaking, the following argument put forward by Irving and McKenzie (1989) is relevant and worth reproducing:
"On balance we wish to abandon our previous notions of police deviance and the conservatism of the craft culture in the context of legislative design. In its place and for the purpose of further work on the rule systems controlling and organising police behaviour, we prefer an ergonomic approach to law and rule systems which recognises the complex heterogeneity of the police work-group especially with respect to attitudes to the law and ethics. Given that police work will continue to embrace diverse roles the idea of grass roots deviance in policing begins to look naive. It also seems naive under current conditions to expect heterogeneity to decline markedly. (Irving and Mckenzie 1989, pp:245-246)

Surely, in an attempt to explain causation, in this case issues about rule breaking, one fact remains clear:

"Only in the light of rules and by the standards they provide can we intelligibly evaluate behaviour.". (Bean 1983, p.85)

However, for whatever the reasons, covert or overt, the point remains: the researcher received full co-operation and support from police officers in all the police stations.

3. Mistakes:
Because the Chief Constable of Lincolnshire was the first to give permission for the research to go ahead, the Skegness police station was the first police station chosen from which to collect the data. Upon reflection, Skegness should perhaps not have been included in the research.

Much time was wasted in Skegness recording only data that included juveniles, because it was originally decided to include all detainees who had had an AA called. A more effective pilot study would have revealed the juvenile issue and the
importance of the police surgeon in decision making. Another disadvantage of Skegness, this time a practical one, was the distance and the time taken to get there. Because travelling between Skegness and Nottingham took so long, it was often impossible to work for any more than four hours in any one day. Sometimes the working day was limited further; when the cells were full, when the custody area was chaotic and when suspects were shouting abuse!

Also, as has been mentioned earlier, it was probably a mistake not to interview police surgeons.

Personal Observations: 'Living with the Research':

Undoubtedly the weeks and months spent in the police stations was valuable experience which revealed insights into police practices and culture. Yet, despite the full co-operation and support from most of the officers, the police stations and particularly the custody areas where most of the time was spent, remained intimidating and stressful places in which to work.

The custody areas in all the police stations included in this research can only be described as 'slums'. Thus, the working environment for custody officers and other professionals who visit the police stations daily is depressing and uncomfortable, not to mention the suspects. The custody area environment is designed for one thing, to confine persons suspected of committing an offence. That police stations are also used as 'a place of safety' for the mentally ill is really nothing more than a euphemism considering the environment.

However, in one police station the custody records were stored in the administration section of the police station. Visits to the custody area was needed only for
interviews with police officers. Yet despite the relative comfort of the administration section, the use of a desk in a room where three female clerks worked, stressful working conditions remained. The other rooms in the administration section were occupied by senior police officers, whose conversations with each other included the usual type of 'canteen culture' language. It was impossible not to overhear these senior officers conversations because the partitions between the rooms provided inadequate sound proofing, and besides most officers spoke in a loud tone. Moreover, it was obvious that they knew that their language could be overheard by the female clerks.

When these women were asked why they did not complain about having to put up with such language, coming daily from the rooms on either side of them, their answers were that they said they could not afford to lose their jobs. My impression about the behaviour of these senior officers corresponds well with John Braithwaite's argument about the behaviour of superiors towards inferiors. (Braithwaite, 1989). The lack of respect, or the lack of shame about their behaviour on the part of the officers firmly placed these women low in the social hierarchy. The women did not want me to make a complaint, as their wages were vital to their family's financial security (all the women were married with children and husbands in work).

Upon reflection, the environment of the most chaotic custody area on a bad day, was preferable to the atmosphere in the administration section. The degradation ceremonies that suspects undergo in the custody areas, although intimidating and sometimes fraught with stress and emotion, varies from barely controlled violence and aggression between the suspect and the police, to routinised banal processing, on to comical farce, such as the prisoner who became so impatient waiting to be taken to a cell that he decided to take himself off and closed the door of the cell after him! Yet, there are checks and balances in the custody areas and even if they are
not always enforced, many suspects now know they have rights which can be exercised. Paradoxically, the women such as those described above feel unable to exercise their particular rights.

Theory Behind the Research.

Some form of analysis is needed when confronted with the recorded quantitative data and the hundreds of case histories taken from the custody records, plus the formal and informal interviews with the police officers. A number of theoretical options were considered, but in the end none were seen to be sufficiently comprehensive to be accepted as prominent. Moreover, it needs to be emphasised that there was little earlier research on AA's so that to impose a fixed theoretical structure might be damaging. What was known was that the research covered activities in the police station, involved a number of professionals, and fitted into that area of criminology commonly referred to as 'the mentally disordered offender'. There had been no detailed report on the extent or use of the AA and nothing on what AA's were supposed to do. In almost every respect this research was entering a new field, largely uncharted and with little precedent upon which to draw.

As said above, this research was conducted from the outset as an exploratory and descriptive study, and to repeat the point there was no adequate or obvious theory to drive the research along. The research questionnaire was constructed by a priori hypotheses with no major theoretical basis, but within theories of the 'middle range'. In other words, the theoretical model was to a large extent guided by the empirical data (Bean, 1970 p.180). Thus, theories of the 'middle range' rely more heavily on the data itself, out of which a more theoretical perspective develops. The advantages of 'middle range' theories allow a more integrated approach. For example, a view may be adopted as a result of the examination of the data about
how the 'social construction' of the custody records reflects wider social, economic and political imperatives.

This is not to say the approach was entirely atheoretical. McConville et al (1991) use what they call an integrated approach described thus;

"....our approach is an integrated one, exploring 'the interpenetration of the micro-structures with the macro and vice versa'....We need to recognise the complexity of the micro-social world, the dynamic way in which cases reflect external 'realities' and the way that cases are social constructions which further broad socio-political objectives." (sic) (McConville et al. 1991 p.11)

McConville et al’s methodological models (ibid) and arguments come closest to the theoretical models and arguments employed in this research. McConville et al declare that no one else could have written their account of the research. Why this is so is clear -

"The account, and the data upon which it relies are not separate from ourselves, the methods and strategies adopted, the choices and selections made and the meanings and interpretation adopted or imposed. Research, like the world of its subjects, is a process of construction. In describing the 'realities' presented by police and prosecution, we set up another 'reality'. The fact that researchers do not and cannot have unmediated access to the 'truth' is not a strength or a weakness of the research and is not a deficiency in our method: it is an epistemological reality."

(McConville et al 1991, p.13)

The above quotation encompasses much of the thinking regarding the arguments and discussion resulting from this research. Thus, the results and the accounts of the case histories reveals that no one form of analysis is obvious, the issues are too
complex. For example, attempting to understand why some vulnerable suspects were denied the protection of an Appropriate Adult in terms of legal requirements or adherence to the Code of Practice, reveals that a legalistic positivist account is too simplistic. That of course, leads to an interesting question: would a change in legislation, policy or police practice, necessarily ensure the desired end? Probably not according to the data here. But even so, more is required than an understanding of the legal arguments.

One possibility is to produce a theoretical model which takes account of other actors and social contingencies that influence police decisions. For example, the evidence presented in this research indicates the importance of the role of the police surgeon and the effect his assessment had on the decision to call an AA. Thus, an analysis could be made within the theory of professional dominance, the means by which professional groups gain and maintain control of their work, knowledge and expertise. Nowhere is this dominance more evident than with the medical profession (Friedson 1970). To approach this research or argue within the theory of professional dominance is relevant, but again is inadequate.

It was clear at the outset that whilst professional dominance was a factor, it was not the only one, and to see the research in these terms might miss the point. How much professional dominance or deference played a part in the custody officers’ decision making remains unclear. The ambivalence expressed by many officers about the role and function of police surgeons suggests, not so much a deference towards the police surgeons, more a pragmatism, by that is meant that professional dominance was allowed but not deeply felt. As will be examined later the police surgeon's assessment is clearly used by the custody officer so that the medical examination is instrumental in two important ways. First, the police surgeon's assessment that the suspect is 'fit to be detained' and 'fit to be interviewed' is needed
in order to process speedily the detained person, and second - and more importantly, in order to 'cover their backs'. (McConville et al, op.cit)

Alternatively, it would have been possible to have approached this research in terms which emphasised police decisions about the mentally disordered. This would have been a fairly straightforward approach as the police officers are required to identify the suspects as mentally disordered before calling an AA. However, in contrast the police are much more concerned with gaining a confession and the interrogation conducted in the police station is crucial to police investigative procedures McConville et al (ibid). The police themselves declare that the interrogation is to arrive at the 'truth', a homily often repeated during this research. With this in mind, how much priority should we expect the police to give to the recognition of, and the responsibility for, mentally disordered and/or vulnerable detained suspects?

Recognition by the police of the mentally disordered is therefore only part of the exercise: there remains questions about calling the AA after mental disorder or vulnerability had been recognised, finding out what the AA did, and showing too the interactions between the AA and other actors involved in the police station, in respect of the latter there is little research available.

Presumably, labelling theory or group interaction would have been an approach valid to this research's analysis. Philip Bean describes 'group interaction' as -

"Group interaction does not involve questions about the nature of mental illness, nor about those who decide and assign labels, but is a study concerned with the interplay of groups and the study of the emergence of new categories of moral and legal rules. Labelling theory deals with those who directly enforce the rules, group interaction deals with the emergence of legal rules. (Bean, 1980 p.178)
Group interaction and interactionism and to some extent labelling theory helps inform the analysis of this research, but it does not dominate it. Indeed, interactionism which, "...stresses the ambiguity and uncertainty of information, and indeed of all social life." (ibid.) fits neatly into this analysis, i.e. an empirical study with little theoretical input. But more is required than accepting the data as ambiguous and uncertain.

That a reliance on empirical data to determine the boundaries of this analysis might produce a too close focus on police subculture at the expense of structural considerations, is a valid criticism. Moreover, an interactionist analysis of rule breaking inevitably leads to a view that changes in the legislation will result in changes in police practice. Or, that recommendations to define clearly the role and function of the Appropriate Adult, will automatically protect the rights of vulnerable detainees. Again, this is not what is required. Before making suggestions about changes it is necessary to know first how the system works, and that is what this research is about.

In many ways, the use or the failure to use the Appropriate Adult protection for mentally disordered suspects in the police station, brings into focus the attitudes and assumptions of those at the sharp end towards vulnerable people. The actions of those at that end e.g. the arresting officers, the custody officers, police surgeons, social workers, and psychiatrists etc. all reflect the wider social structure's attitude towards the mentally disturbed.

For example, this ambivalence towards the mentally disordered suspect can be seen most clearly in cases of miscarriages of justice and in Court of Appeal decisions about the admissibility of confessions made without the presence of an AA. (see R v McKenzie transcript ). Therefore, it is argued that such an analysis, dependent as it
is on empirical input, does not neglect or ignore the wider social structures, but it
does centre on empirical input.

On balance then, it was decided to adopt a 'middle range' approach where the data
drives the theory and not *vice versa*, but with a strong influence from McConville *et al* (1991) and their so called 'integrated approach'. This attempts to understand socio-legal phenomena on the basis that researchers do not have unmediated access
to the truth; that is to say interpretation is not a weakness of the research but an
CHAPTER 5

RESULTS.

The purpose of this Chapter is to realise Aims 1 and 2 as listed in Chapter 4. They are:

1. To determine the manner in which AA's are used in selected police stations, and to make comparisons.

2. To determine who acts as the AA when an Appropriate Adult is used.

Each Aim has its own sub-aims which will be dealt with accordingly. For the first Aim the sub-aim is -

(a) To determine the numbers of AA's used in the various police stations.

Table I shows the number of AA's called. These were recorded when the custody record stated clearly that an AA had been called and attended the police station.

Table I The Number of Appropriate Adults called between 1st January - 31st December 1992 according to the number of records examined.

<table>
<thead>
<tr>
<th>Police Station</th>
<th>Number of Records Searched</th>
<th>Number of Appropriate Adult's Identified and Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skegness</td>
<td>4,122</td>
<td>7 (0.16%)</td>
</tr>
<tr>
<td>Grantham</td>
<td>4,800</td>
<td>8 (0.17%)</td>
</tr>
<tr>
<td>Derby (1990)*</td>
<td>3,200</td>
<td>10 (0.30%)</td>
</tr>
<tr>
<td>Derby (1992)**</td>
<td>5,200</td>
<td>6 (0.11%)</td>
</tr>
<tr>
<td>Sheffield</td>
<td>3,483</td>
<td>7 (0.20%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>20,805</td>
<td>38 (0.16%)</td>
</tr>
</tbody>
</table>

* Derby records covered the period 1st January - 30th June 1990

Table I is extraordinary in at least two respects. The small number of instances when an AA was used, 38 in all or 0.16% of the total, is the major finding of this study. It is
that finding from which all other discussions flow, namely that the AA is rarely used. It should be remembered that the provisions for an AA are not those about which some civil rights advocates might suggest should happen but they are a requirement of the PACE Act and they impose on the police a duty to invoke the AA procedure when certain conditions are fulfilled.

Bearing in mind that the most conservative estimates of mentally disordered suspects going through police stations is 2 %, then on that basis the AA should have been used 416 times (2% of 20,805). A less conservative estimate puts the figure at 20% in which case the AA should have been used 4,161 times. In fact when the project was started it was expected that the AA would have been used about 500 times. Imagine the surprise when it was found to be used so infrequently. In this respect that data in Table I shows how vastly under used the AA seems to be. Clearly, one of the immediate tasks arising out of Table I is to explain why the AA is rarely used, and try to see how if appropriate, it can be used more frequently.

The second feature in which Table 1 is extraordinary is that there is a measure of uniformity about the results over the four police areas. The range is from 0.16% - 0.30% with Skegness being the lowest and Derby in 1992 being the highest. However, if the Derby 1990 and the Derby 1992 figures are combined the percentage drops to 0.18%, almost identical to the others, in which case the range is then from 0.16% - 0.20%. This would suggest that there has been a standard approach to the use of the AA or rather lack of use which, given the low numbers, and if these four police stations are representative of England and Wales generally, one can say that AA's are rarely considered for mentally
disordered suspects. (Much higher numbers would have been recorded for juveniles. As far as could be seen the AA was almost always implemented for juveniles, however as stated previously juveniles were excluded from this research).

It is possible to identify a number of instances when records show that the suspect was regarded as mentally disordered yet no AA was called. Data on this is provided in Table II.

Table II  
The number of Appropriate Adults called and the number of Suspects thought to require an Appropriate Adult according to the custody records

<table>
<thead>
<tr>
<th>Police Station</th>
<th>Number of Appropriate Adults Called</th>
<th>Number of Suspects thought to require an Appropriate Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Column A</td>
</tr>
<tr>
<td>Skegness</td>
<td>7</td>
<td>31</td>
</tr>
<tr>
<td>Grantham</td>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td>Derby (1990)</td>
<td>10</td>
<td>37</td>
</tr>
<tr>
<td>Derby (1992)</td>
<td>6</td>
<td>93</td>
</tr>
<tr>
<td>Sheffield</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>38</td>
<td>197</td>
</tr>
</tbody>
</table>

Using a chi-squared test for the last 2 columns then the chi-squared = 34.86 df. = 4 p < 0.001 Significant.

The differences between the last two columns in Table II (columns A and B) requires some explanation. In column A there was a more certain record of mental disorder for the detained suspects whereas in Column B it was less clear. Column B, for example, records the detained suspects simply as being 'suicidal' 'depressed', having 'self-inflicted injuries', registered heroin addicts' when experiencing withdrawal symptoms, or when the suspects
had psychotropic medication in their property, "claustrophobic" emotional and disturbed behaviour, "violent and aggressive" disturbed behaviour, "slow reactions", "vague", "difficult to communicate with", and a history of past psychiatric treatment. In Column A the data is more certain, the suspect was described as mentally disordered, or mentally ill. Incidentally, the terms used in Column B are some of the most common diagnostic classifications recorded by the custody officer and/or the Police Surgeon. To repeat the point: what these records show is that for both columns there was some recognition that mental disorder existed amongst the detained suspects but little was done to bring in an Appropriate Adult.

This data was collected for a number of reasons not the least that it shows that the police, or at least as far as it was shown on the custody records that someone, usually the custody officer, recognised mental disorder in a number of suspects. As shown in Table II the first column, column A, shows there were 197 such suspects and the second column, column B shows 251. Had the AA been called for these additional suspects the over all figure would have risen to 2.3% with a range from 1.3% in Skegness to 3.7% in Derby (1992). This would have certainly increased the aggregate figure but the over-all figure would still have remained low. The question is: do these figures represent an accurate level of mentally disordered suspects in the police station, or were the police under recording? Or is something else happening? Anecdotal evidence suggests that the police were under recording for as it is pointed out elsewhere in this thesis there were times when it was discovered that the police knew a suspect to be mentally disordered but this was not shown on the custody record.
Looking further into the data in Table II and in column A and B a chi-squared test shows there are significantly wide differences between the various police stations (chi-squared = 34.8, df. = 4 p < 0.001). It is the Sheffield and Skegness police stations that contribute most to the chi-squared value; there is a similarity amongst the others. It is difficult to know how to interpret this data in a general way except to say that using the criteria to distinguish the two groups as provided here, the police in Skegness were more certain than the others about how they interpreted mental disorder, whilst those in Sheffield were much less certain and, as the chi-squared result shows, significantly so.

Detained Suspects and their Appropriate Adults

As the number of suspects who had an AA was small there is little point at this stage in examining that data by trying to draw out statistical inferences. Better to let the data speak for itself. There is also important additional information from the custody records for most of the suspects. Accordingly, case histories will be presented to supplement the data on the following Tables. The plan therefore is to look at each police station in turn presenting the data on the use of AA's in tabular form. There will be two Tables for each police station; one on the use of the AA, the other on the mental health classification for the suspects in those police stations. There will be a short commentary on each Table in turn. This will be followed by selected case histories from the four police stations but without additional commentary at this stage.
To begin with Skegness (A). Table III sets out the data on the use of the AA and Table IV on the mental health classification.

A. Skegness

Table III Use of Appropriate Adults in Skegness Police Station

<table>
<thead>
<tr>
<th>Code of Detained Person</th>
<th>Gender</th>
<th>Reason for Detention</th>
<th>Police Recognition of Mental Disorder</th>
<th>Information from PS* or Other Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>S001</td>
<td>M</td>
<td>Assault</td>
<td>Yes</td>
<td>PS not Called</td>
</tr>
<tr>
<td>S002</td>
<td>M</td>
<td>Warrant</td>
<td>Yes</td>
<td>PS not Called</td>
</tr>
<tr>
<td>S003</td>
<td>M</td>
<td>Rape</td>
<td>Yes</td>
<td>Seen by PS</td>
</tr>
<tr>
<td>S004</td>
<td>M</td>
<td>Theft</td>
<td>No</td>
<td>Information on Mental Disorder from Probation Office</td>
</tr>
<tr>
<td>S005</td>
<td>M</td>
<td>Public Order and Assault</td>
<td>Yes</td>
<td>PS not Called</td>
</tr>
<tr>
<td>S006</td>
<td>M</td>
<td>Begging</td>
<td>Yes</td>
<td>PS not Called</td>
</tr>
<tr>
<td>S007</td>
<td>M</td>
<td>Warrant original offence was possession of indecent photographs</td>
<td>No</td>
<td>Information on Mental Disorder from Solicitor seen by a Psychiatrist PS not Called.</td>
</tr>
</tbody>
</table>

* PS - police surgeon

There are two interesting observations that can be made from Table III. First in the column on 'police recognition of mental disorder' in 5 out of the 7 cases it was the custody officer who recognised that the detained person was suffering from mental disorder or was vulnerable in some way and therefore in need of an Appropriate Adult. Information concerning the other two suspects was given by a probation officer and the other by a solicitor, and the custody officer acted upon this information.
Second, as shown in the final column other key personnel such as the Police Surgeon was called to assess only one detained person. Given the importance of the Police Surgeon as a gatekeeper, a point which will be dealt with more fully later in this chapter, and a decision maker on matters relating to the mentally disordered suspects in the police station, the use or rather the lack of use of the Police Surgeon here is important. One can only speculate why this is so, perhaps because here the custody officers felt confident in their own assessment of the mentally disordered. Or perhaps the fact that these persons were classified as 'mentally handicapped' or 'mentally retarded' and as this was probably seen as a condition that would not respond to medical treatment the custody officers therefore saw no reason to seek a medical opinion from the police surgeon.

Turning now to Table IV: this data has been listed under what has been called the 'mental health classification' i.e. it uses the key terms listed on the records which described the detained suspect’s mental condition. Included too are the occupations of the AA, or in some cases the relationship of the AA to the suspect. The final column gives an assessment by the research worker of the level of certainty about the use of the AA. This column is not unimportant. The custody records were not always clear as to whether an AA had been used. But on 19 custody records the words Appropriate Adult was written (see Table XIII which shows these records). Sometimes they said that someone had been called to the police station but not described as acting as an AA, nor was it clear that these people had attended the interview. In Table IV there was one instance where it was not clear that a formal AA procedure was operating, but it has been included because it seemed to indicate that an AA had been called.
### Table IV: Mental Health Classification for Suspects in Skegness Police Station and the Use of an Appropriate Adult

<table>
<thead>
<tr>
<th>Mental Health Classification and DP's Code</th>
<th>Appropriate Adult</th>
<th>Formal Use of Appropriate Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Mentally Retarded'</td>
<td>Mother</td>
<td>Yes</td>
</tr>
<tr>
<td>'Blind'</td>
<td>Nurse</td>
<td>Yes</td>
</tr>
<tr>
<td>'Medication in DP’s Property Mentally Sub-Normal'</td>
<td>Approved Social Worker</td>
<td>Yes</td>
</tr>
<tr>
<td>'Learning Difficulties'</td>
<td>Probation Officer</td>
<td>Yes</td>
</tr>
<tr>
<td>'Mentally Retarded'</td>
<td>Approved Social Worker</td>
<td>Yes</td>
</tr>
<tr>
<td>'Mentally Sub-Normal'</td>
<td>Warden of Home</td>
<td>Yes</td>
</tr>
<tr>
<td>'Suicidal'</td>
<td>Approved Social Worker</td>
<td>Not Clear</td>
</tr>
</tbody>
</table>

Case Histories.

The case histories provided below give a selection of the cases as recorded on the custody records.

S001: the custody sergeant stated, “the prisoner is 26 but has a mental age of lesser years, needs to be interviewed with a parent”.

S002: the custody sergeant contacted a local home for the Blind. They sent a District Nurse to act as an Appropriate Adult. The detained person was arrested on a warrant from Grimsby Crown Court which was not backed for Bail. The custody officer also contacted the suspect’s own G.P. by telephone who - “confirmed it is the day for him to have his medication”. The medication was not identified, but it was probably a major tranquilliser or depot injection. Nor was it indicated that any medication was administered while in custody. The suspect was transported to Grimsby. There was no indication that the
nurse/Appropriate Adult accompanied him there. This suspect was aged over 70 years; there was no information concerning the original offence.

S003: the Police Surgeon was contacted by telephone by the custody sergeant to gain information about the medication in the suspect’s property which was identified as largactil and heminevrin tablets. The Police Surgeon informed the custody sergeant that - “these tablets are only prescribed to persons who are suffering from severe mental problems”.

Thus, this information alerted the custody officer who contacted the EDT (Emergency Duty Team) to send a social worker to act as an Appropriate Adult. But due to the lateness of the hour (00.55a.m.) it was agreed to conduct the PACE interview the next day. An approved social worker finally attended the police station at 15.00p.m. the next day and an interview was conducted in the presence of a solicitor which lasted for 30 minutes. This detained person was arrested on suspicion of rape, but was released from custody because of insufficient evidence to charge. The police surgeon attended the police station but did not examine the suspect. He attended only to authorise the administration of the medication. This suspect was detained in custody for approximately 18 hours.

S004: this suspect’s probation officer informed the custody sergeant that her client had ‘learning difficulties’; and that she must be present to act as the Appropriate Adult when interviewed. A few days later this suspect was subsequently breached by this probation officer and was arrested at the probation service’s office. Strangely enough on this occasion it was not thought necessary for the suspect to have the special protection of an Appropriate Adult! As stated later this case highlights the conflict of interest that may arise when a professional, involved with the suspect/client takes on this dual role.
S007: this suspect told his solicitor that he had attempted suicide twice recently with sleeping pills; he had amitriptyline tablets in his property. The custody sergeant called the police surgeon on the telephone who stated that the medication was "not controlled and 2 tablets may be given safely". The tablets were given at 12.00 pm, the suspect had been in custody since 10.20 am. The next day the solicitor arrived at 10.22 a.m. and an approved social worker arrived at 12.47 p.m. There was no information on the custody record about who called the social worker except this statement which said - "seen by social worker under Mental Health Act"; however, a Section 136 was not officially recorded. At 13.14 p.m. a psychiatrist attended the police station - "at the request of social services". No mental health assessment was recorded; but the suspect went to court and was given a conditional discharge for 12 months, and "handed over to Mr (name of social worker)".

Conclusions from the Case Histories.

The case histories presented above illustrate a variety of practices, but most of all a lack of awareness of the likely conflicts of interest that take place inside and outside the police station. Case S004 for example shows that the probation officer acted as an AA when the suspect was being interviewed in the police station but did not consider using an AA when that same suspect was breached by that same probation officer and brought back to Court on a Breach of Probation. The case histories also give examples of the muddles that existed surrounding the use of Section 136 of the Mental Health Act 1983. This point will be dealt with again later.
B. Grantham

Table V shows the same type of data as in Table III and Table VI shows the same type of data as in Table IV.

### Table V Use of Appropriate Adults in Grantham Police Station

<table>
<thead>
<tr>
<th>Code of Detained Person</th>
<th>Gender</th>
<th>Reason for Detention</th>
<th>Police Recognition of Mental Disorder</th>
<th>Information from PS or other Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>G001</td>
<td>F</td>
<td>Assault</td>
<td>Yes</td>
<td>PS not Called</td>
</tr>
<tr>
<td>G002</td>
<td>M</td>
<td>Robbery</td>
<td>No</td>
<td>Information from suspect and others</td>
</tr>
<tr>
<td>G003</td>
<td>M</td>
<td>Disorderly Conduct and Criminal damage</td>
<td>Yes</td>
<td>PS not Called</td>
</tr>
<tr>
<td>G004</td>
<td>M</td>
<td>Theft</td>
<td>Yes</td>
<td>PS not Called</td>
</tr>
<tr>
<td>G005</td>
<td>M</td>
<td>Taking a vehicle without Consent and Mental Health Act</td>
<td>No</td>
<td>Information from Others</td>
</tr>
</tbody>
</table>

PS - police surgeon

Table V shows the number of times an AA was used in Grantham was 5 but in one case the suspect (G004) was arrested on four separate occasions. In all these arrests except one a member of the suspect's family was called to act as the Appropriate Adult; the police were well aware of this suspect's 'learning difficulties' and social problems. Various relatives acted as the AA for the suspect including father, uncle and sister.
Table VI  Mental Health Classification for Offenders in Grantham Police Station
and the Use of Appropriate Adult

<table>
<thead>
<tr>
<th>Mental Health Classification and DP's Code and Gender</th>
<th>Appropriate Adult</th>
<th>Formal Use of Appropriate Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>G001(F) 'Unable to Read or Write'</td>
<td>Social Worker</td>
<td>Yes</td>
</tr>
<tr>
<td>G002(M) 'Suicidal'</td>
<td>CPN</td>
<td>Yes</td>
</tr>
<tr>
<td>G003(M) 'Violent and Aggressive'</td>
<td>Father</td>
<td>Yes</td>
</tr>
<tr>
<td>G004(M) 'Low Intelligence'</td>
<td>Relatives</td>
<td>Yes</td>
</tr>
<tr>
<td>G005(M) 'Volatile State'</td>
<td>CPN</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(F) - female (M) male

Case Histories.

Again, the case histories are a selected group of the suspects from Grantham.

G001: classified in the case record as 'unable to read or write'.

G002: this suspect informed the police on arrival at the Police Station that he had recently been released from a local psychiatric hospital and he wanted to commit suicide - thus all information recorded about this suspect’s mental disorder came from the suspect, community psychiatric nurse (CPN), Police Surgeon, Solicitor and Psychiatrist.

G003: the custody officer recorded the suspect as acting ‘very violent and aggressive’.

Prior to this the custody sergeant had written ‘father and mother to be informed due to state of health’; the suspect was aged 35 years. Here the custody officer and probably the arresting officers recognised that the suspect was vulnerable.
G004: this was the suspect detained on four separate occasions.

G005: the custody officer called the CPN after receiving information about the suspect’s so-called ‘learning difficulties’ from his parents. The CPN who was called for this suspect was the same person who was called to act as the Appropriate Adult for G002. This CPN was often noted in the custody records as being someone to call to assess a suspect’s mental health. The Grantham Police had to rely on the services of this CPN because at the time of the research no ASWs were employed locally. For G005, this suspect was detained for TWOC (taking a vehicle without consent) and for the so-called ‘Mental Health Act’. The suspect’s parents informed the police that their son had taken their car, he had been drinking and was in an ‘aggressive’ state. The parents had also informed the police about their son’s mental health history - but this was not clearly recorded on the custody record. The suspect’s parents informed the police that they did not want to press charges. The custody officer called a CPN (community psychiatric nurse) first. It was not clear if the CPN was acting in the dual role of Appropriate Adult and/or carrying out a mental health assessment as a nurse.
### C. Derby 1990

#### Table VII The Use of the Appropriate Adult in Derby Police Station 1990

<table>
<thead>
<tr>
<th>Code of Detained Person</th>
<th>Gender</th>
<th>Reason for Detention</th>
<th>Police Recognition of Mental Disorder</th>
<th>Information from PS* or Other Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>D001</td>
<td>F</td>
<td>Arson</td>
<td>Yes</td>
<td>PS called but did not Attend</td>
</tr>
<tr>
<td>D002</td>
<td>F</td>
<td>GBH</td>
<td>Yes</td>
<td>PS not Called</td>
</tr>
<tr>
<td>D003</td>
<td>F</td>
<td>Theft</td>
<td>No</td>
<td>PS Called</td>
</tr>
<tr>
<td>D004</td>
<td>F</td>
<td>Abduction</td>
<td>No</td>
<td>PS called. Info from Solicitors</td>
</tr>
<tr>
<td>D005</td>
<td>F</td>
<td>Damage to Window</td>
<td>Yes</td>
<td>PS Called**</td>
</tr>
<tr>
<td>D006</td>
<td>M</td>
<td>Theft</td>
<td>No</td>
<td>Information from Suspect &amp; PS</td>
</tr>
<tr>
<td>D007</td>
<td>M</td>
<td>Criminal Damage</td>
<td>Yes</td>
<td>SW Priest &amp; Psych Called***</td>
</tr>
<tr>
<td>D008</td>
<td>M</td>
<td>Theft</td>
<td>Yes</td>
<td>PS Called</td>
</tr>
<tr>
<td>D009</td>
<td>M</td>
<td>Offensive Weapon</td>
<td>Yes</td>
<td>Information from PS &amp; Soc. Serv.</td>
</tr>
<tr>
<td>D010</td>
<td>M</td>
<td>Deception</td>
<td>Yes</td>
<td>SW Called</td>
</tr>
</tbody>
</table>

* PS - police surgeon  
** D005 the police surgeon was called because the social services refused to attend.  
*** D007 this suspect was eventually admitted to hospital on s35 of the MHA 1983, however PACE interviews were also conducted.

The procedures at Grantham did not differ markedly from that of Skegness, they were in the same police authority. The position for Derby however is different. Table VII reveals some differences between Derby and that for Skegness and Grantham. In 7 out of 10 cases in Derby the custody officers recognised mental disorder or vulnerability in the suspect. However, in those 7 cases the Derby custody officers also called the Social Services or the police surgeon to assess the suspect. This suggests a slightly different approach, or perhaps the Derby custody officers' were seemingly less confident in their ability to recognise mental disorder than those in Skegness and Grantham; or it may be that the mental health problems presented by those suspects in Derby are more complicated than those in Skegness and Grantham. This point will be referred to later.
Table VIII on the mental health classification, it is same as used for Skegness and Grantham.

Table VIII  Mental Health Classification for Suspects in Derby Police Station and the use of Appropriate Adults

<table>
<thead>
<tr>
<th>Mental Health Classification and DP’s Code</th>
<th>Appropriate Adult</th>
<th>Formal Use of Appropriate Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>D001 (F) 'Not Mentally Stable'</td>
<td>DSW</td>
<td>No</td>
</tr>
<tr>
<td>D002(F) 'Slightly Mentally Retarded'</td>
<td>SW</td>
<td>Yes</td>
</tr>
<tr>
<td>D003(F) 'No Direct Observation'</td>
<td>SW</td>
<td>No</td>
</tr>
<tr>
<td>D004(F) 'No Direct Observation'</td>
<td>Solicitor</td>
<td>No</td>
</tr>
<tr>
<td>D005(F) 'Very Vague'</td>
<td>Matron</td>
<td>No</td>
</tr>
<tr>
<td>D006(M) 'No Direct Observation'</td>
<td>Solicitor’s Clerk</td>
<td>No</td>
</tr>
<tr>
<td>D007(M) 'Emotionally Disturbed'</td>
<td>ASW</td>
<td>No</td>
</tr>
<tr>
<td>D008(M) 'Mentally Retarded'</td>
<td>DSW</td>
<td>No</td>
</tr>
<tr>
<td>D009(M) 'Not Fully Mentally Fit'</td>
<td>Mother</td>
<td>No</td>
</tr>
<tr>
<td>D010(M) 'Possible Mental Problem'</td>
<td>DSW</td>
<td>Yes</td>
</tr>
</tbody>
</table>

DSW - duty social worker  
ASW - approved social worker  
SW - social worker

The most important point to note for Table VIII is the small number of instances where it was certain an Appropriate Adult was formally used. To try to explain the differences some comments on the cases are needed.
Case Histories.

The same pattern is followed here as for the others.

Suspect D001 was described by the custody officer as follows: "on arrival this woman does not appear to be mentally stable". The custody sergeant called the Police Surgeon but in the meantime the suspect suffered an epileptic fit and was taken to hospital; the Police Surgeon decided not to attend. The suspect returned to the police station a few hours later after being declared 'fit'. The custody sergeant tried for one and half hours to contact the Police Surgeon and finally gave up and authorised the administration of medication to the suspect (Epilim, Itegretol and Frisium). It was not clear whether the sergeant only wanted the Police Surgeon to administer the medication or to carry out a mental health assessment. However, a social worker attended the police station and an interview with the suspect took place in the presence of the social worker. Again, the police seemed uncertain about this diagnosis. Nor was it clear whether the social worker was called to act in the dual role of Appropriate Adult or carry out a mental health assessment. The suspect was eventually released 'into the care of the social worker - insufficient evidence to charge'.

D002: the suspect was the client of a Social Worker who attended the police station as an Appropriate Adult. For D003 the custody sergeant was alerted to this suspect's possible mental disorder when he was informed by the suspect that she lived in a mental health hostel. Although the Social Worker who attended the interview probably acted in the role of the Appropriate Adult, the custody officer described her as acting "as a friend during interview". For D004 the custody officer was informed by the duty solicitor over the telephone that he knew this suspect and that she "does have a mental problem". The
Police Surgeon attended and advised - “I consider she can be interviewed in the presence of her solicitor only”. Clearly, the solicitor was seen here as acting in the role of the Appropriate Adult. This was probably fairly common practice until the 1991 PACE Codes of Practice excluded the solicitor acting in the dual role of legal adviser and Appropriate Adult, but the practice clearly continues.

D005: the custody sergeant recorded - “authorised matron to sit in on interview”. Although it was not stated that the Matron was formally acting in the role of the Appropriate Adult she was the only person present during the interview besides the interviewing officer - a solicitor was not present. It clearly states in the PACE Codes of Practice Review that an Appropriate Adult cannot be someone employed by the police. Yet the Matron (who is often the wife of a police officer) was employed by the police on this occasion.

D006: the custody officer recorded that he found the suspect lying on the floor of the cell complaining of “feeling faint and suffers from blackouts”. The Police Surgeon attended and diagnosed a physical problem and an undiagnosed neurological disorder. The assessment continued - “I have advised (name of solicitor’s clerk) that someone representing him should be present during the interview and that if for any reason he feels unwell the interview should be terminated”. Again, the solicitor (in this case a solicitor’s clerk) acted it is suspected, as the Appropriate Adult for this offender.

D007: This is a very complicated case. This suspect was in custody approximately 16 hours before being admitted to Hospital under Section 35 of the Mental Health Act 1983.
he was assessed by the Police Surgeon, an ASW, a priest and a psychiatrist. He was interviewed twice, before and after the psychiatrist’s assessment. The social worker attended both interviews but again his role was ambiguous - certainly carrying out a mental health assessment - but probably also acting as the Appropriate Adult.

D008: The custody sergeant recognised that this suspect was vulnerable immediately and called the EDT (first) then the Police Surgeon. The social worker arrived four hours after the first request (much to the frustration of the police sergeant). In the meantime the Police Surgeon assessed the suspect as “mentally impaired and not psychotic. Not sectionable - appears harmless...not fit to charge...could be returned home....fit to be detained until S.W. arrives”. The suspect was interviewed ‘informally’ with the social worker present.

D0010: the custody sergeant recognised immediately that the suspect was vulnerable and needed “someone to look after his interests until a doctor certifies he is fit to understand them”. The sergeant called the EDT “to provide social worker for joint assessment with Police Surgeon and to look after the interests of the person who is clearly not fully competent”. Clearly, the custody officer expected the social worker to carry out a mental health assessment and act as the Appropriate Adult too, - although the term was not used. The Police Surgeon declared him ‘fit to be interviewed and fit to be detained’. The suspect was interviewed with the social worker and a solicitor present.
Conclusion on the case histories.

These case histories highlight again the ever present confusion about the AA, see D004 where the police surgeon said "I consider she can be interviewed in the presence of her solicitor only", as if the solicitor could be the AA, but one wonders knew what an AA was anyway. Then in D005 the matron, employed by the police, illegally acted as an AA, and in D006 the same problem existed as in D004 where the police surgeon misunderstood what an AA was for.

C. Derby 1992

The records in Derby were also examined for 6 months between January 1 and June 30 1992. This period was selected in order to cover the 1991 Revised Codes of Practice and compare this with the other period. The results are given in Table IX.

Table IX Use of Appropriate Adults in Derby Police Station

<table>
<thead>
<tr>
<th>Code of Detained Person</th>
<th>Gender</th>
<th>Reason for Detention</th>
<th>Police Recognition of Mental Disorder</th>
<th>Information from PS or other Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0011</td>
<td>F</td>
<td>Criminal Damage</td>
<td>Yes</td>
<td>PS not Called</td>
</tr>
<tr>
<td>D0012</td>
<td>F</td>
<td>Theft</td>
<td>No</td>
<td>Solicitor Present**</td>
</tr>
<tr>
<td>D0013</td>
<td>F</td>
<td>Theft</td>
<td>Yes</td>
<td>PS Called</td>
</tr>
<tr>
<td>D0014</td>
<td>M</td>
<td>Breach of Peace</td>
<td>Yes</td>
<td>PS not Called</td>
</tr>
<tr>
<td>D0015</td>
<td>M</td>
<td>Theft</td>
<td>Yes</td>
<td>PS Called</td>
</tr>
<tr>
<td>D0016</td>
<td>M</td>
<td>Criminal Damage</td>
<td>Yes</td>
<td>PS Called</td>
</tr>
</tbody>
</table>

** The PACE interview had been stopped by the solicitor because the suspect had become "agitated and upset". The custody officer then decided to call an AA.
Table X  Mental Health Classification for Offenders in Derby Police Station and the use of the Appropriate Adult

<table>
<thead>
<tr>
<th>Mental Health Classification and DP's Code</th>
<th>Appropriate Adult</th>
<th>Formal Use of Appropriate Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0011(F) 'Limited Intelligence'</td>
<td>SW</td>
<td>Yes</td>
</tr>
<tr>
<td>D0012(F) 'No Direct Observation'</td>
<td>Probation Officer</td>
<td>Yes</td>
</tr>
<tr>
<td>D0013(F) 'Agitated and Distressed'</td>
<td>ASW</td>
<td>No</td>
</tr>
<tr>
<td>D0014(M) 'Deaf and Dumb'</td>
<td>Brother</td>
<td>Yes</td>
</tr>
<tr>
<td>D0015(M) 'Slow in Comprehension'</td>
<td>Hostel Worker</td>
<td>No</td>
</tr>
<tr>
<td>D0016(M) 'Mentally Confused'</td>
<td>SW</td>
<td>No</td>
</tr>
</tbody>
</table>

SW - social worker

Case Histories.

Again, the same practice is followed as before.

D0011: in this case listed above the custody officer recognised immediately that this suspect “was of limited intelligence”. the custody sergeant questioned the suspect further about her school - “when asked about her previous school, she said “she went to a school for the disabled. She said she could not read and could only write her name”. (she was 23 years old). The sergeant then called the social services after questioning the suspect about her relatives, but she lived in a local hostel and only had an uncle but did not know his address; the duty solicitor was also called. The PACE interview took place with the social worker and solicitor present, and the suspect’s rights were given again in the social worker’s presence. She was released without charge.
D0012: this detained person had requested that her probation officer be informed of her arrest. Although the probation officer talked on the telephone with the custody officer about her client she declined to attend the police station. There was no reference to the suspect's mental state until the solicitor stopped the interview and reported his concern for the welfare of his client to the custody officer. The custody sergeant then decided that the suspect needed an Appropriate Adult, and he contacted the probation service again. This time the probation officer agreed to attend. The PACE interview took place with the probation officer presumably acting as the Appropriate Adult and the solicitor was present. The suspect was charged with theft and bailed. It is interesting to note that initially the above suspect was not considered to be 'at risk' at the police station by her probation officer, who apparently must have been aware of her mental difficulties. Again, it was left to the solicitor to protect his client's rights and welfare - and prompt the custody officer into gaining the attendance of the probation officer/Appropriate Adult.

D0013: This case history has been included in the research as an example of the ambiguities surrounding the role of the Appropriate Adult. This suspect was arrested on 2 charges of theft of petrol. The arresting officers informed the custody sergeant that the suspect had a social worker and was presently an outpatient at a local psychiatric hospital. The custody officer recorded, ".....DP clearly became agitated and became distressed over 'everyone ganging up to give her grief'.....". The custody officer called the Police Surgeon and the emergency duty team. Then the sergeant called a, -".....West Indian Community Worker.....A person who would be concerned for DP welfare". This person promised to telephone the suspect but no call was recorded from this person. Although this person did not call or attend as an Appropriate Adult, it does reveal that the custody
officer intended that the suspect not only had a mental health assessment but also the protection of an Appropriate Adult. A social worker and the Police Surgeon attended and the Police Surgeon declared the suspect ‘fit to be detained’ but he contacted a psychiatrist who had been treating the suspect. The psychiatrist recorded the following, “Informed = ASW (name of suspect) appeared much calmer and talking rationally. She described the events leading to her arrest. She agreed to cooperate with treatment at home and I am going to organise this after discussing with CPN”. It was recorded that the social worker remained with the suspect after the psychiatrist had left. A solicitor was called and a PACE interview took place - but there was no record that the social worker was present during the interview to act as the Appropriate Adult. The suspect was bailed.

D0014: this suspect was arrested in his home for Breach of the Peace. The arresting officers’ were informed that the suspect was deaf and dumb and the custody officer described him “....in a very agitated state produced by a combination of alcohol and emotional state through being unable to express himself....managed to calm him down.... The suspect’s brother accompanied the suspect to the police station and it was recorded that the brother acted as the Appropriate Adult. The time was then 22.50, the suspect was released into the care of his brother the next morning at 06.55. PACE rights and the ‘reason for detention’ was given to this suspect’s brother but no interview took place. Presumably the suspect was kept in cells overnight.

D0015: this suspect was arrested for theft of petrol. The custody sergeant recorded - “...appears slow in comprehension and slurred in speech. Officers informed me that he is a schizophrenic who is taking medication”. The custody officer called a solicitor and the
Police Surgeon and contacted the hostel where the suspect lived; he was informed that the suspect “is on injections for his illness”. The Police Surgeon assessed the suspect and recorded - “long history of schizophrenia on depot medication. Sectioned 2 years ago for 6 months. Now been out of hospital sometime, lives in a hostel. Not fit for interview”. A person, presumably a social worker, arrived from the hostel and spoke with the Police Surgeon and the suspect. The Police Surgeon assessed the suspect again, and recorded that “...not fit to be charged, safe to be released into the control of the hostel”. The suspect was then released into the care of the social worker.

D0016: this case is another example of diversion recommended by the Police Surgeon. The suspect was arrested for criminal damage and the custody officer was in no doubt that the suspect was “obviously mentally confused”. The custody officer advised the suspect of “his rights and contacted a solicitor and the Police Surgeon and recorded - “Detention authorised for assessment by Doctor then evidence by questioning”. Clearly, at this point the custody officer intended that an interview would take place. The sergeant also telephoned the suspect’s father who informed the police that his son had a long history of schizophrenia, however, the suspect’s father was not invited to attend as the Appropriate Adult. The Police Surgeon recorded the following assessment - “Affable and co-operative. Won’t admit to taking medication. Says he hasn’t seen Dr.... for a long time. Says also he was aware of his actions and the police should charge him if necessary. He denies hearing voices and he appears to be guarded in what he says. I do not feel that he is certifiable at the present time but I feel definite accommodation with some supervision is required for him. (Name of Social Worker) EDT to attend with a view to arranging this. Fit to be detained pro term”. A social worker and solicitor found a hostel place for the
suspect and the custody officer decided to release the suspect without charge "due to his mental state".

**Conclusion on the case histories.**

There can be no better illustrations of the indecision and the lack of understanding of the AA's role than in D0013, or the equal lack of understanding by the probation service in D002. These case histories add to the point made time and time again throughout this thesis, that although a requirement of PACE, there was little to suggest that those whose task it was to operate the legislation were conversant with it.

A number of other comments can be made about the case histories. First, D002 with the possible exception of D010, these were the only formal implementations of the Appropriate Adult procedure. In all the other cases there was some doubt. The common feature of the other cases however was that they involved a mental health assessment by the police surgeon and other health professionals - these assessments usually concluding that the suspects were 'fit to be detained and fit to be interviewed'. In essence then the police surgeon viewed the AA's role as a medical decision - clearly revealed in the way they felt able to recommend whether social workers or solicitors be present during the police interviews. This assumption was shared by many custody officers. In almost every case the police surgeon suggested the need for someone to attend the interview after he had recorded the suspect 'fit to be interviewed'. The police surgeon recommended for D004 and D006 that they only be interviewed in the presence of solicitors. In the other cases social workers were usually recommended; although for D009 all attempts failed to
ensure the presence of a social worker for this suspect (much to the custody sergeant's frustration). Finally, the suspect's mother attended the interview.

Then case history D0013, this case history shows the difficulties in deciding how to categorise various events and the role of those involved. For example: clearly, an assessment under the Mental Health Act 1983 did take place - but a formal Section 136 was not recorded. Thus the legal status of the suspect is in doubt; the custody officer recorded his effort to gain the attendance of someone 'who would be concerned for her welfare', and although the social worker was presumably still at the police station she was not recorded as present during the interview.

Thirdly, D0015 and D0016, both were diagnosed as schizophrenic and diverted from the Criminal Justice System. These case studies show examples of more ambiguities surrounding the AA. Both were diverted by the police and the police surgeon into the care of a relative, or in this case a social worker. Is the social worker acting as an AA even though no interview took place? It is difficult to know.
D. Sheffield

The following Table shows the use of an Appropriate Adult for detained persons at Sheffield police station. The records covered the period 1 January - 30 June 1992.

Table XI  Use of Appropriate Adult at Sheffield Police Station

<table>
<thead>
<tr>
<th>Code of Detained Person</th>
<th>Gender</th>
<th>Reason for Detention</th>
<th>Police Recognition of Mental Disorder</th>
<th>Information from Police Surgeon or other person</th>
</tr>
</thead>
<tbody>
<tr>
<td>SH001</td>
<td>M</td>
<td>Threats to Kill</td>
<td>Yes</td>
<td>PS &amp; Psych Called</td>
</tr>
<tr>
<td>SH002</td>
<td>M</td>
<td>Assault</td>
<td>Yes</td>
<td>PS Called</td>
</tr>
<tr>
<td>SH003</td>
<td>M</td>
<td>Theft</td>
<td>Yes</td>
<td>PS not Called</td>
</tr>
<tr>
<td>SH004</td>
<td>M</td>
<td>Assault</td>
<td>Yes</td>
<td>PS not Called</td>
</tr>
<tr>
<td>SH005</td>
<td>F</td>
<td>Theft</td>
<td>Yes</td>
<td>PS Called</td>
</tr>
<tr>
<td>SH006</td>
<td>F</td>
<td>Theft</td>
<td>No</td>
<td>PS Called info. from drug project</td>
</tr>
<tr>
<td>SH007</td>
<td>F</td>
<td>Theft</td>
<td>Yes</td>
<td>PS &amp; Psych Called</td>
</tr>
</tbody>
</table>

Table XII  Mental Health Classification for Offenders in Sheffield Police Station and the Use of Appropriate Adults

<table>
<thead>
<tr>
<th>Mental Health Classification and DP's Code</th>
<th>Appropriate Adult</th>
<th>Formal Use of Appropriate Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>SH001 'Mentally Retarded'</td>
<td>SW</td>
<td>No</td>
</tr>
<tr>
<td>SH002 'Epileptic'</td>
<td>Father</td>
<td>No</td>
</tr>
<tr>
<td>SH003 'Mentally Sub-Normal'</td>
<td>Father</td>
<td>Yes</td>
</tr>
<tr>
<td>SH004 'Deaf and Dumb'</td>
<td>Interpreter</td>
<td>Yes</td>
</tr>
<tr>
<td>SH005 'Deaf and Dumb' 'Violent Aggressive'</td>
<td>Interpreter</td>
<td>Yes</td>
</tr>
<tr>
<td>SH006 'No Direct Observation'</td>
<td>Probation Officer</td>
<td>Yes</td>
</tr>
<tr>
<td>SH007 'Mental Disorder'</td>
<td>Volunteer</td>
<td>No</td>
</tr>
</tbody>
</table>
Case Histories

Again, the same pattern as before.

SH002: this case raises several issues firstly, it was clear that this suspect’s father was only allowed to stay with his son because he was injuring himself; therefore, the father probably acted in the role of the Appropriate Adult by default. Secondly, the Police Surgeon was called because of the suspect’s self-inflicted injuries - not to carry out a mental health assessment because the suspect was epileptic, but to declare the suspect ‘fit to be detained’. The police rightly do not consider suspects’ identified as epileptic as suffering from mental disorder. However, several cases of suspects identified as epileptic and presenting difficult and disturbed behaviour have been recorded in the research as persons at risk. The question of epilepsy and the use of the Appropriate Adult, which is far beyond the remit of the study, needs to be explored further.

SH004 and SH005: both suspects were identified as being deaf and dumb and an interpreter was called on both occasions.

Conclusions on case histories.

Only 3 case histories have been inserted for Sheffield but these show that vulnerability extends beyond mental disorder, it means in SH004 and SH005 being described as ‘deaf and dumb’. In SH004 and SH005 a volunteer attended as an AA. He belonged to the Sheffield Volunteer Appropriate Adult Scheme, a scheme originally created by the Youth Justice Team to act as AA’s for juveniles. Occasionally, these volunteers acted as AA’s for adults. The Sheffield AA Scheme is discussed in the following Chapter.
Summary and Conclusions.

Aim 1.

The data shows that the AA was rarely used, on only 38 occasions. There were however, a further 448 suspects who were recorded as mentally vulnerable, who it was considered should also have had an AA called. There were no differences in the use of the AA between the various police stations. The case histories recorded for many of the 38 suspects show too often a basic misunderstanding about the role and function of the AA.

On Aim 2 the next two sub aims are:

(b) to determine the socio-demographic characteristics of the suspect when the AA is used, including the mental health classification given on the custody records;

(c) to determine the reason for the suspects’ detention in the police station (for the alleged offence) and determine the outcome of that detention.

These two sub aims can be taken together as they tend to overlap. First, the gender of the AA's: Table XIII sets out the details.

Table XIII  Gender of the AA's in Relationship to the various Police Stations

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skegness</td>
<td>6</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Grantham</td>
<td>7</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Derby 1990</td>
<td>4</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Derby 1992</td>
<td>2</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Sheffield</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>14</td>
<td>38</td>
</tr>
</tbody>
</table>
There were 24 males and 14 females who acted as AA's and as shown in Table XIII above.
6 of these females were from Derby (in 1990). Relating this data to the occupational
informations shown in Table XIV below i.e. the listed occupations or relationships to the AA,
the female AA's came from as wide an occupational group as the males indeed many of the
males were also social workers. Again, relating the gender of the AA's to the various
occupational groups in the Table below, and dichotomising the occupational categories in
to 'social workers' and 'others' a 2 x 2 Table can be produced vis.

<table>
<thead>
<tr>
<th></th>
<th>S.W.</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>14</td>
<td>10</td>
<td>24</td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>19</td>
<td>38</td>
</tr>
</tbody>
</table>

Using a chi squared test: $\chi^2 = 1.8 \text{ df.} = 1 \ p < 0.2 \text{ not significant.}$ This suggests that there
were no differences between the gender of the AA's and their likelihood of being social
workers.
Table XV gives the details of the so called occupational groupings of the 38 AA's for the four police stations.

Table XV  Occupational Groupings of the AA's for the Four Police Stations

<table>
<thead>
<tr>
<th></th>
<th>Skegness</th>
<th>Grantham</th>
<th>Derby 1990</th>
<th>Derby 1992</th>
<th>Sheffield</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family member</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Social Worker</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>Probation Officer</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Other Social Worker</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>CPN's</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Solicitors/Clerks</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7</strong></td>
<td><strong>8</strong></td>
<td><strong>10</strong></td>
<td><strong>6</strong></td>
<td><strong>7</strong></td>
<td><strong>38</strong></td>
</tr>
</tbody>
</table>

Those in the 'Other category includes 1 matron from Derby and 2 interpreters and 1 AA volunteer from Sheffield.

Table XV Above shows that social workers were more often used as AA's, 14 (29%) than for any other occupational group. However, if we include in the social work occupational group the warden from a hostel, a hostel worker and the probation officers then this figure increases to 19 in all (or 50%). The next highest group are 'family members' of which there are 10 or (26%). As noted on the commentary on the case histories it is interesting to note that a matron was used, certainly employed by the police in that police station and should not therefore have been permitted to act as an AA. Also, there were two interpreters acting as AA's and one solicitor and one was a solicitor's clerk.
Looking at the alleged offences of the suspects for which an AA has been called (where the suspect was charged with more than one offence the most serious have been listed) the data is set out below.

Table XVI  Showing Offences of Suspects Who Had an AA Called

<table>
<thead>
<tr>
<th>Offence</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Violence</td>
<td>4*</td>
</tr>
<tr>
<td>Violence</td>
<td>5</td>
</tr>
<tr>
<td>Theft</td>
<td>17**</td>
</tr>
<tr>
<td>Robbery</td>
<td>1</td>
</tr>
<tr>
<td>Criminal damage</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>7+</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>38</td>
</tr>
</tbody>
</table>

* Includes 1 rape, 1 arson, 1 GBH and 1 threat to kill.
** Includes 1 TWOC, and 1 deception.
+ Includes 1 abduction and 1 begging.

As expected theft accounts for the largest number of offences (17 or 45%) but there were 4 serious violence offences and 5 less serious, all for assault. Clearly, in the few cases when an AA was called it was for the widest range of offences, that is to say, not confined to the serious or the petty as perhaps could have happened. This strongly suggests that the determining factor to call an AA was not the suspect's offence but the suspect's condition - which is as it should be. (However, recent commentators and anecdote (1997) suggest that the police are now calling AA's more often for serious offenders who may or may not be borderline in terms of their mental vulnerability, one example is the case of Frederick West).
The police were not responsible for recognising and identifying mental vulnerability in all the cases when the AA was called. There were 9 cases when a solicitor or a probation officer alerted the custody officer to the suspect's mental disorder. If the groups are again dichotomised into those recognised by the police and those recognised by others and tested against the type of offence categorised as 'theft' and 'others' and put in a 2 x 2 table, the result are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Theft</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police recognition</td>
<td>12</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>Others recognition</td>
<td>17</td>
<td>4</td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
<td>9</td>
<td>38</td>
</tr>
</tbody>
</table>

Chi-squared = 0.84 df.=1  p < 0.4 not significant. The numbers in the 2 x 2 Table are small but even so the results show that there is a similarity about them which again suggests those identifying mental vulnerability are doing so not on the basis of the offence but on the way they perceive the offender.

Looking next at the so called mental health classification. Classifying offenders in this way is difficult because the categories used in the custody records rarely give detailed information necessary to make sophisticated classifications. It must always be a matter for debate where to put individual suspects. Even so the following three categories have been identified (a) learning difficulties which includes offenders listed on the custody records as being mentally retarded and mentally sub normal, (b) mental illness which includes offenders listed as exhibiting suicidal behaviour, and (c) a category called 'other' which simply takes the remainder. On this basis then, the data is as follows:
Table XVII -
Number of Suspects who had an AA called and their Types of Mental Disorder

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Difficulties</td>
<td>16 (42%)</td>
</tr>
<tr>
<td>Mentally Ill</td>
<td>11 (29%)</td>
</tr>
<tr>
<td>Others</td>
<td>11 (29%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>38 (100%)</strong></td>
</tr>
</tbody>
</table>

Those defined as 'mentally ill' and 'other' in Table XVII included a wide range of behaviour and mental health classifications - admittedly this classification is crude, but even so the results suggest that mental disorder which by definition includes a wide range of behaviour was identified in those suspects who had an AA called for them. The category of 'learning difficulties' seem however to dominate (42%). One wonders how, if at all, this figure would stand against a national profile of offenders having an AA. That is to say, whether the police nationally tend to call an AA for offenders with learning difficulties more often than for offenders with other types of mental disorder.

It is interesting to try and understand why this was so in the police stations covered here. This data shows that a set of proceedings seems to operate which if not so in every case did so in many. That is, those suspects identified as mentally ill tended to be referred to the police surgeon for a mental health assessment. Sometimes the police surgeon called a psychiatrist and a social worker thereby making a formal mental health assessment under the Mental Health Act which sometimes led to a section being made or diversion. However, for the majority of those suspects who were recognised as mentally ill the police surgeon alone declared the suspect fit to be detained and fit to be interviewed. The criteria for fitness for detention and interview seemed to be that these suspects were not
'sectionable' under the Mental Health Act. The PACE interview then proceeded but the AA was not called. But the criteria for a suspect needing an AA is not whether they are fit to be detained or fit to be interviewed - if that were the case there would be no role for them at all. Just because these suspects were not 'sectionable' under the MHA does not mean that their mental vulnerability ceased. This is the nub of the findings. Those suspects who were recognised by the custody officer as having a learning disability tend not to have a police surgeon called, perhaps believing that their condition is 'fixed' i.e. that nothing in the medical sense can be done about it.

However, these considerations should be set against those in the following Chapter, where to anticipate what is being said there these same custody officers said that they could not distinguish between suspects with learning difficulties (mental handicap) and those suffering from mental illness. Clearly, what these custody officers said and what happened does not always correspond. Yet, the impression gained from the interviews with the custody officers revealed that while they may be able to distinguish between mental illness and learning disabilities in suspects it is the labels that they are unsure about; and their lack of confidence is in being able to communicate or articulate their recognition of mentally disorder to the police surgeon or other health professionals.

To summarise: the results of these two sub aims show that most of the AA's were male, half were in social work or related occupations, although 'family members' were used often. AA's were used for suspects who had committed the widest range of offences and the suspects themselves were more likely to have learning difficulties.
Moving now to the next sub aim:

Sub aim (d) is, to determine how many suspects should have had an AA called, to determine their socio-demographic features their mental health and criminal characteristics and compare these to those suspects who had an AA called.

On the custody records there was evidence to suggest that the police and occasionally someone else such as the police surgeon, were aware that some suspects were mentally disordered but for these no AA was called. As shown in Table II above there were 448 such suspects, 197 in column A (where there was more certain evidence of mental disorder) and 251 in column B (where the evidence was less clear). This data was collected because it was considered that it might help explain why the AA was not used, and it was thought to be just as important to explain why this was so as it was to explain why the AA was used. It was thought that an examination of this data might show or suggest or perhaps point to some of the processes which operate in the police station when dealing with the mentally vulnerable. Perhaps something was being offered to these 448 suspects which was not being offered to those when an AA was called? Or, perhaps something else was happening? As was said in the literature review there had been no research conducted on these matters when this research began. This meant that the hypotheses were formulated on an a priori basis with only a suspicion that something was afoot.

The data from Derby police station was selected for closer examination. This station was selected because the data covered two years 1990 and 1992, it had the largest number of
suspects in columns A and B and contributed least to the chi-squared value in the 2 x 2 table above i.e. there was a similarity about the Derby data.

To look first to look at the socio-demographic features consider first the question of gender. In Derby in 1990 out of the 37 suspects recorded there were 30 males and 7 females, and for 1992 there were 79 males and 14 females. This compares with the gender differences of those suspects who had an AA, where there were 24 males and 14 females.

The data is presented in the following Table.

Table XVIII  Gender of Suspects who had an AA and those from Derby who did Not

<table>
<thead>
<tr>
<th></th>
<th>Approp.Adult</th>
<th>Derby 1990</th>
<th>Derby 1992</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>24</td>
<td>30</td>
<td>79</td>
<td>133</td>
</tr>
<tr>
<td>Female</td>
<td>14</td>
<td>7</td>
<td>14</td>
<td>35</td>
</tr>
<tr>
<td>Total</td>
<td>38</td>
<td>37</td>
<td>93</td>
<td>168</td>
</tr>
</tbody>
</table>

Chi-squared = 7.5 df. = 2  p < 0.04 Significant.

The data in the table above just reaches a level of significance but this is almost wholly due to the females who had an AA called. In other respects there is a strong measure of similarity.

Looking next at the type of offences, the data is set out in the Table XIX below. The same categories of offences have been used as for those suspects who had an AA in Table XVI.

It should be noted however, that in Derby 1992 in the category of 'Other' there were a number of drug offenders - drug offenders had not featured earlier in the 1990 data.
Table X1X  Offence Categories of Suspects who had an AA called and for those in Derby who did Not in 1990 and 1992.

<table>
<thead>
<tr>
<th>Offence Category</th>
<th>Appropriate Adult</th>
<th>Derby 1990</th>
<th>Derby 1992</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Violence</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Violence</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Theft</td>
<td>17</td>
<td>13</td>
<td>18</td>
<td>48</td>
</tr>
<tr>
<td>Robbery</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Criminal Damage</td>
<td>4</td>
<td>8</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>4</td>
<td>26</td>
<td>37</td>
</tr>
<tr>
<td>s.136</td>
<td>0</td>
<td>7</td>
<td>28</td>
<td>35</td>
</tr>
<tr>
<td>Total</td>
<td>38</td>
<td>37</td>
<td>91</td>
<td>166</td>
</tr>
</tbody>
</table>

Because the numbers in some of the cells are small the offences have been re-grouped into 3 categories, violence, theft and robbery and Others. Those concerned with s.136 of the Mental Health Act 1983 have not been included in this Table. No such suspects were included in this category who had an AA, and to do so here would distort the data.
Table XX Re-Grouped Offence Categories for Suspects who had an AA called and for those in Derby in 1990 and 1992 who did Not.

<table>
<thead>
<tr>
<th></th>
<th>Approp. Adult</th>
<th>Derby 1990</th>
<th>Derby 1992</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violence</td>
<td>9</td>
<td>3</td>
<td>11</td>
<td>23</td>
</tr>
<tr>
<td>Theft</td>
<td>18</td>
<td>15</td>
<td>18</td>
<td>51</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>12</td>
<td>34</td>
<td>57</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>38</strong></td>
<td><strong>30</strong></td>
<td><strong>63</strong></td>
<td><strong>131</strong></td>
</tr>
</tbody>
</table>

The first point to note is that, referring to Table II, it will be remembered that the last 2 columns A and B were significantly different. It will also be remembered that using a chi-squared test, then $\chi^2 = 34.86$ df. = 4 $p < 0.001$, with the Sheffield data contributing most to the chi-squared value. It was suggested then that in the four police stations those writing the custody records may be working on the basis of different levels of confidence in their ability to recognise and describe mental vulnerability, with Sheffield being the outsiders and Derby not.

The second point is that once the data has been re-grouped then a chi-squared test shows there are no significant differences between the offence categories and whether an AA was called or not. ($\chi^2 = 6.72$ df. = 4 $p < 0.2$ not significant). This suggests a measure of similarity between the categories. That is, the offence seems not to be the determining factor.

Looking next at the 'mental health classification' an altogether different picture emerges, if we consider the 93 cases in Derby (1990 and 1992) and compare these to the 38 cases...
when an AA was called and make comparisons according to the mental health classification then the difference is striking. Indeed, so much so, that in what follows is another crucial finding of the research. For the 93 cases in Derby all except one was defined as suffering from mental illness (comments on the custody records as: 'schizophrenic' 'depression', 'floridly psychotic', 'paranoia', were common place). The exceptional case was when one suspect was defined as 'slow', but even he was also described as suffering from dementia.

The other important determining factor was for all these suspects the police surgeon was called, that is except for two suspects one insisted on having his own G.P. and the other where the police surgeon was called but was not available (this was a singularly rare event) the suspect's father was invited to attend the police station but declined, the suspect was interviewed with a solicitor present. When the police surgeon was called he invariably declared the suspects as 'fit to be detained and fit to be interviewed', sometimes adding 'not sectionable' and sometimes even 'fit to be charged'.

Interpreting the data suggests that the first course of action for the custody officer was to call the police surgeon, and in doing so fulfilled one requirement of the Codes of Practice. The second requirement of course, was not fulfilled that is, to call the AA. Once the police surgeon assessed those suspects and declared them 'fit to be detained and fit to be interviewed', the custody officer permitted the PACE interview to proceed on the basis of the police surgeon's assessment only.
Summary and Conclusion.

The data shows that there is a clear division between those suspects where an AA is called and those not, and that shows itself best in the mental health classification. Appropriate Adults are not, it seems, less likely to be called for the 'mentally ill' than for the 'mentally handicapped'. In contrast the police surgeons are rarely called for the 'mentally handicapped' but almost always for the 'mentally ill'. When this occurs the 'mentally ill' are then likely to be pronounced 'fit to be detained and fit to be interviewed' and are processed into the Criminal Justice System.

Sub aim (e): to determine links if at all, between the use of the AA and other legal requirements relating to mental disorder, especially Section 136 of the Mental Health Act 1983.

The Mental Health Act (1983) under Section 136 makes provisions for mentally disordered persons found in a public place to be escorted to a place of safety, more often than not that place of safety is a police station. This power can be used whether or not the person is suspected of committing a criminal offence. The power to arrest under this Section is contained in Section 26 and Schedule 2 of the PACE Act and applies the persons who have been brought to the police station as a place of safety. Paragraph 3.10 of Code C. states that when a person is brought to the police station on a place of safety a mental health assessment should take place by an Approved Social Worker (ASW) and a Registered
Medical Practitioner (usually a psychiatrist) in order to make suitable arrangements for his or her treatment and care.

All Section 136 detention were recorded during this research. The custody records almost always showed that the 'reason for arrest and detention' was written as 'a place of safety' or 'for own protection'. Only once or twice was 'Section 136' written on the custody records. In fact, no custody officer who was interviewed knew that a 'place of safety' meant a Section 136 under the Mental Health Act 1983. In contrast, all the custody officers knew that the person on a 'place of safety' order needed to see a doctor and a social worker.

Invariably, suspects were brought to the police station on a 'place of safety/offence' as the 'reason for detention'. Presumably this gave the police the option of transferring the suspect into the Mental Health System or the Criminal Justice System.

The data for Derby 1990 and 1992 was used, there were 35 suspects on a 'place of safety' order, 7 in 1990 and 28 in 1992. Invariably custody officers called the police surgeon first when a person was brought to the police station on what was stated on the record as a 'place of safety'. Only occasionally did the custody officer call an ASW as well. A psychiatrist was called in 16 of these cases and an ASW was called for 20, but the psychiatrist and the ASW were not always called together for the same cases.

What is interesting is that even those cases in which a person is brought into the police station on a 'place of safety' the police surgeon also pronounced those persons as 'fit to be detained and fit to be interviewed'. One wonders what that means in this context? If one looks at those incidents when a psychiatrist attended as well, 10 were admitted to hospital
under Section 2 of the Mental Health Act 1983 - sometimes the police expressed
amazement and frustration when an order under the Mental Health Act was not made.
Even so, what this means is that the police surgeon is again the gatekeeper who is relied
upon to keep the processing of suspects/patients moving out of the police station - into the
Mental Health System or the Criminal Justice System.

There seems to be little understanding on the part of the police about what a Section 136
means. Suspects were routinely sent to the police station in the same way as for offenders,
the police surgeon assessed them and came to similar conclusions, quite forgetting that he,
as a Registered Medical Practitioner, could make an assessment under the Mental Health
Act alongside an ASW ‘to determine the patient’s treatment and care’. One could add
parenthetically that this whole area cries out for research to be conducted aimed solely at
determining whether the procedures found here are to be found nationally, and if so, in
what way could they be improved, if only to fit the requirements of the 1983 Mental Health
Act.
The Table below gives information when the custody record contained the words Appropriate Adult.

Table XIII Showing the Circumstances When the Formal Use of the Appropriate Adult Scheme was Implemented and the Outcome

<table>
<thead>
<tr>
<th>Code &amp; MHC*</th>
<th>Offence</th>
<th>A.A.</th>
<th>P.S. or Other**</th>
<th>Formal</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>S001(M) 'Mentally Retarded'</td>
<td>Assault</td>
<td>Mother</td>
<td>No</td>
<td>Yes</td>
<td>Bailed</td>
</tr>
<tr>
<td>S002(M) 'Blind'</td>
<td>Warrant</td>
<td>Nurse</td>
<td>No</td>
<td>Yes</td>
<td>Escorted to Grimsby</td>
</tr>
<tr>
<td>S003(M) 'Mentally Sub-Normal'</td>
<td>Rape</td>
<td>ASW</td>
<td>No</td>
<td>Yes</td>
<td>Released - No Evidence to Charge</td>
</tr>
<tr>
<td>S004(M) 'Learning Difficulties'</td>
<td>Theft</td>
<td>Probation Officer</td>
<td>No</td>
<td>Yes</td>
<td>Bailed</td>
</tr>
<tr>
<td>S005(M) 'Mentally Retarded'</td>
<td>POA</td>
<td>ASW</td>
<td>No</td>
<td>Yes</td>
<td>Bailed and Fined</td>
</tr>
<tr>
<td>S006(F) 'Mentally Retarded'</td>
<td>Begging</td>
<td>Warden</td>
<td>No</td>
<td>Yes</td>
<td>Released into Care of Warden</td>
</tr>
<tr>
<td>G001(M) 'Unable to Read &amp; Write'</td>
<td>Assault</td>
<td>S.W.</td>
<td>No</td>
<td>Yes</td>
<td>Bailed</td>
</tr>
<tr>
<td>G002(M) 'Suicidal'</td>
<td>Robbery</td>
<td>CPN</td>
<td>Yes***</td>
<td>Yes</td>
<td>RIC Prison</td>
</tr>
<tr>
<td>G003(M) 'Violent &amp; Aggressive'</td>
<td>Criminal Damage</td>
<td>Father</td>
<td>No</td>
<td>Yes</td>
<td>Summons</td>
</tr>
<tr>
<td>G004(M) 'Low Intelligence'</td>
<td>Theft</td>
<td>Relatives</td>
<td>No</td>
<td>Yes</td>
<td>Bailed</td>
</tr>
<tr>
<td>D002(F) 'Slightly Mentally Retarded'</td>
<td>GBI</td>
<td>S.W.</td>
<td>No</td>
<td>Yes</td>
<td>Bailed</td>
</tr>
<tr>
<td>D0010(M) 'Possible Mental Problem'</td>
<td>Deception</td>
<td>DSW</td>
<td>Yes++</td>
<td>Yes</td>
<td>Summons</td>
</tr>
<tr>
<td>D0101(F) 'Limited Intelligence'</td>
<td>Criminal Damage</td>
<td>S.W.</td>
<td>No</td>
<td>Yes</td>
<td>Released without Charge</td>
</tr>
<tr>
<td>D0012(F) 'No Direct Observation'</td>
<td>Theft</td>
<td>Probation Officer</td>
<td>No</td>
<td>Yes</td>
<td>Bailed</td>
</tr>
<tr>
<td>D0014(M) 'Deaf &amp; Dumb 'Very Agitated'</td>
<td>BOP</td>
<td>Brother</td>
<td>No</td>
<td>Yes</td>
<td>Released No Charge</td>
</tr>
<tr>
<td>S1003(M) 'Mentally Sub-Normal'</td>
<td>Theft</td>
<td>Father</td>
<td>No</td>
<td>Yes</td>
<td>Bailed</td>
</tr>
<tr>
<td>S1004(M) 'Deaf &amp; Dumb'</td>
<td>Assault</td>
<td>Interpreter</td>
<td>No</td>
<td>Yes</td>
<td>Summons</td>
</tr>
<tr>
<td>S1005(F) 'Deaf &amp; Dumb Violent Aggressive'</td>
<td>Theft</td>
<td>Interpreter</td>
<td>No</td>
<td>Yes</td>
<td>Verbal Caution</td>
</tr>
<tr>
<td>S1006(F) 'No Direct Observation'</td>
<td>Theft</td>
<td>Probation Officer</td>
<td>Yes+++</td>
<td>Yes</td>
<td>Bailed</td>
</tr>
</tbody>
</table>

* MHC = Indicates the mental health classification the custody officer recorded on the custody record.
** PS or Other = Indicates whether the Police Surgeon or a psychiatrist was called to assess the suspect.
*** G002 has been recorded as a formal A.A. because although the Police Surgeon was called and assessed the suspect the custody officer had already recorded the need for an Appropriate Adult.
+ G004 this suspect was recorded 4 times.
++ The Police Surgeon recommended that an Appropriate Adult be called for this suspect.
+++ The Police Surgeon recommended that an Appropriate Adult be called.
Chapter 6

Additional Results:

The Role of the Custody Officer, Police Surgeon and Legal Adviser.

The purpose of the Chapter is to realise Aim 3: which is to determine the role of custody officers and other personnel concerned with vulnerable suspects including that of police surgeons. Before looking more closely at that a brief introduction is required setting out the reasons by which this aim was introduced.

Introduction.

The custody officer is the pivot on which the AA procedure stands or falls. Besides having the responsibility for calling the AA and the police surgeon, the custody sergeant’s responsibilities, defined in the PACE Act include taking responsibility for the care and control of the detainee (s39), ascertaining whether the reason for detention is necessary (s37) and once the original grounds for detention no longer exist immediately releasing the detainee (s34). Custody officers rarely if ever examine the reason for detention, the procedure is seen simply as a formality. Indeed, during the research conducted for this study, the police in Sheffield used a rubber stamp, literally, for completing the section on the custody record that indicates the reason for detention, which was to ‘obtain evidence by questioning’.

Moreover, during this research there was only one occasion when a custody officer refused to accept the detention of a suspect.

Most of the research undertaken in police stations (see Chapter 2) mention the problems the custody officer has to deal with particularly in busy police stations. The custody officer’s overriding priority is to get through what is called the ‘paper
work' involving booking suspects in, and then getting them out as quickly as possible. The process is often like a production line. In some police stations the pressures were observed and were seen to build up because of the numbers of suspects waiting to be documented. Indeed, at times it was all too apparent why or how requests for solicitors or an AA (other than a juvenile) might be postponed or perhaps forgotten. There is no doubt that the custody officer has a difficult job, particularly in terms of the work load, over which he has no control.

The exigencies that the custody officer faces on a daily basis act against him (or her) fully implementing the Codes, particularly obtaining an AA for a mentally vulnerable suspect. That so few AA's were/are used is itself important. With reference to the research conducted for this study the aim is to take the matter further and do more than determine how the custody officers operate in the custody area in relation to the AA. The question is, what part did they play in the proceedings and did custody officers fail to identify suspects because they were unable to identify those who were vulnerable? Or, was there something else?

**Aims and Methods.**

The purpose therefore is Aim 3 of the list of Aims provided in Chapter 4. That is: to determine what part the custody officer and others play in the process which results in calling an AA. The Sub Aims are:

(a) to determine the level of training the custody officers receive and their experience in calling an AA, with particular reference to determine how they expect AA's to behave during the interviews,
(b) to determine the custody officers' relationship with the police surgeons in respect of the AA,
(c) to determine the custody officers' relationships with the legal advisers in respect of the AA,
(d) to compare custody officers in different police stations in respect of a, b, and c, above.

The method was to interview all the custody officers who were working in the four police stations using a semi-structured schedule (copy in Appendix). It is believed that those custody officers interviewed were acting as custody officers in the police stations when the relevant custody records were compiled. The custody officers were encouraged to talk freely and give their views on matters relating to the AA, whether directly concerned with the questions on the schedule or not. In this way it was hoped to provide data which would prove additionally valuable. And to anticipate some of the results, that additional data turned out to give a wider dimension than would have been provided otherwise.

Results.

(a) The Custody Officers.
There were 26 custody officers in the four police stations and all agreed to be interviewed. There were 6 from Grantham, 6 from Skegness, 6 Sheffield, and 8 from Derby. Only one of the custody officers was a woman (from Derby). As expected there were wide variations in the length of police service and as custody officers, some were long serving in both respects, others were relatively new to the post.
(b) Training and the Police Service.

When asked about their training in matters relating to the AA and mental health, none said they had received any training about the AA, 4 said they had received some training about mental health. One said that he had gone on a one day course about mental health, another said the subject of mental health was touched upon during the sergeants' course but that was about all. One particular custody sergeant from Derby seemed to sum up matters when he said, he would like mental health training in order to feel more confident and be able to communicate more fully with health professionals. This officer explained that he recognised mental vulnerability in suspects by 'the look in the eyes' (this was a remark often heard from officers in all the police stations) but he felt embarrassed relaying this suspicion to a police surgeon. He said he did not have the language or vocabulary to be able to communicate his suspicions to the police surgeon or other mental health professionals. Such explanations might account for some of the reasons why many mentally vulnerable suspects are not identified in police stations. Another, again from Derby, put things more forcefully. He said the lack of training has meant the passing down of good/bad habits from one custody sergeant to another, but more importantly had led to a lack of support from senior officers. He said the training manuals were derisory, patronising and childish. For that reason he thought they should be disregarded and presumably new ones written. The researcher was shown these training manuals and it was difficult not to agree with the officer that they were written in simplistic language that was patronising.

The 'lack of support from senior officers' came up often in the interviews. The custody officers often said that they tried to deal with mentally disordered suspects in what they thought was the correct way, sometimes they had insisted on calling an AA. In doing so they had encountered reluctance from senior officers, and sometimes also from the interviewing officers, the former fearing that the defence and prosecution would complain if they heard that the suspect had needed an AA.
The implications of this is obvious but is important nonetheless: decisions made by the custody officer have to be seen in the light of his structural position within the police organisation. That is to say custody officers do not make decisions as if they were independent of the police force in which they work. That the decision to call an AA was or has been vetoed by senior officers is an important finding which was not anticipated nor considered when the Codes of Practice were debated in Parliament. Indeed, no one considered this to be a possibility.

In terms of the training police officers did, or did not receive, custody officers said this led to a lack of confidence and they were unsure about who was, or who was not mentally disordered. Translated into practical details 7 out of 22 (or about one third) there were 4 who did not answer the question said they could not distinguish between mental illness and mental handicap. However, it was clear they had their own classificatory system which roughly corresponded to the legal classification. (A 'nutter' for the mentally ill or a 'sandwich short of a picnic' for the mentally handicapped). It has to be noted however that this crude classificatory system was not shared by everyone, especially those custody officers experiencing mental disorder within their families. Not surprisingly their views were more sympathetic.

(c) Dealing with Appropriate Adults.

Three of the 26 custody officers said they had no experience of the AA, 2 were from Sheffield, 1 from Grantham. At one level this is quite surprising but less so when the data presented earlier is considered. And even when one looks closely at the 23 who had experience, 9 of these were restricted to dealing with juveniles, i.e. no experience with adults, leaving about half having no experience of dealing with an AA for adults. Again, this is considered to be an important finding. As has been mentioned on a number of occasions, some custody officers and officers of higher and lower ranks when interviewed assumed that the research on AA's would be for
juveniles, and for that reason those with no adult experience of AA's showed little overt concern. Throughout the interviews the emphasis had to be constantly repeated that the schedule related to mentally disordered adults.

At the risk of being too repetitive the assumption that AA's are for juveniles only is deeply ingrained. It is fostered in police stations such as Sheffield where 5 out of the 6 custody officers there dealt only with juveniles. Perhaps this can be explained by the rather bizarre situation that has taken place in Sheffield which no doubt promoted the idea further with the link with juveniles. Initially there was an AA scheme operating with volunteers in the early 1990's run by the local Social Services department and developed by the Youth Justice Team, whose volunteers occasionally acted as an AA for adults. This scheme was then put out to tender and Dr Barnardo's was awarded the contract. They promptly closed it down for adults but retained the juvenile connection. Perhaps this is why Sheffield custody officers saw things that way.

When social workers acted in the role of the AA the custody officers' views were somewhat predictable i.e. that social workers do not attend the police station within a reasonable time and are unreliable etc., but then somewhat contradictorily those same custody sergeants would add that they are satisfied with the work social services provide. However, for 2 AA volunteers that were used in Sheffield there was even greater satisfaction expressed: these 2 men apparently attended the police station quickly and were said to have a good rapport with the custody officers. In fact, when questioned more closely, one of these custody officers' gave reasons for being satisfied which were not those which ought to have been expressed. That is, this custody officers approval was based on the view that (a) there had been no voiced criticism from the interviewing officers about these volunteers, (b) that these volunteers helped the 'wheels run smoothly' and (c) and following from (b) above that these volunteers 'do not interfere'. What this example shows is that AA's who
become too close to the police begin to lose their independence. The AA has a set of interests which if not oppositional to the police are certainly not identical.

The custody officer quoted above was from Sheffield. It is interesting in this respect when asked when an AA should ever interrupt the questioning during an interview, 6 custody officers said the AA should not and 4 of these were from Sheffield. It is difficult to explain why this should be so. One can only speculate again that where schemes are run for juveniles as in Sheffield and custody officers’ experience of AA’s is for juveniles only then parents and others who act as AA’s are expected to acquiesce to police authority. It reinforces the point however that AA’s must retain a measure of independence if they are to be seen as effective, even if that means being disruptive by police standards.

(d) Indicators determining whether to use an AA.

The custody sergeants were asked to select the indicators that would determine their decisions to call an AA. They were offered the following:

1. The subject is overtly mentally disordered.
2. The subject has a known history of mental disorder.
3. The subject has a known history of learning difficulties.
4. The subject has had an AA called on a previous occasion.
5. The subject is under age
6. The police surgeon and/or solicitor or other person suggest that an AA is needed for the subject.
7. Other (specify)
8. Combination of the above (specify).

Almost all gave 'combination of above' as the reason for calling an AA, but 2 indicators tended to be selected most frequently, they were 'subject is under age' and 'subject has a known history of mental disorder'. What is interesting about this is
that it does appear that, leaving aside the indicator 'subject under age' the police are heavily influenced by previous psychiatric history. In the light of their earlier uncertainty about distinguishing between mental illness and mental handicap perhaps the information on previous history produces a more secure platform about which to make decisions. This is not to say that the other indicators were disregarded, merely that the two noted above were selected more frequently.

One particular custody sergeant produced a register of detainee's personal details which included photographs kept by his police station on mentally disordered adults, which was used he said to identify mentally disordered suspects. The custody sergeant acknowledged that this was unlawful; listed below the photographs were a set of derogatory comments. Irrespective of the legality of the exercise it adds to the suggestion that previous history is the most important characteristic when making decisions about the suspect. This was borne out by the custody officer in Skegness who claimed to know all the local families in which there were mentally disordered suspects and saw this knowledge as invaluable when deciding about an AA. Custody officers can obtain information about a suspect's previous mental health history as well as, of course, criminal history from the Police National Computer (PNC).

Summary.
The data shows that custody officers tended to be uncertain about their role in respect of the AA and largely unaware of their duties in this matter. They were certainly lacking in confidence about their ability to identify mentally disordered suspects believing that training in this area was long overdue. Perhaps the best summary comes from a custody officer in Derby who said that being a custody sergeant was not a popular job, and if it could be seen as more specialised it would produce a rise in status that would attract the right type of police officer and inevitably, he said would have a positive effect on police culture.
The Role of the Police Surgeon

In this section the aim is to determine the custody officers’ relationship in respect of the police surgeon and the AA. The method used IS as above i.e. the same schedule was used which included questions relating to the police surgeon. Data from the custody records was used when appropriate. No formal interviews were made with the police surgeons although a number of informal discussions took place.

(a) Relationship between Custody Sergeants and Police Surgeons.

The general impressions gained during this study about the way police handled mentally disordered suspects, was that they placed considerable confidence in the assessment by the police surgeon, and in some police stations that of the community psychiatric nurse (CPN). Both were seen as able to assess vulnerable suspects, and consequently their assessments were seen as sufficient to protect suspects’ rights. In this sense it was clear that the police surgeon and the CPN’s became key figures in the process. The police, and occasionally a CPN were likely therefore to be called to make important decisions. Contrast this to the AA which for the police produced rather fewer benefits. To call an AA is to place an additional demand upon custody officers because it takes up more of their time, adds pressure on them to find additional accommodation and involves additional arrangements especially when the AA is less than co-operative. During this study, all custody sergeants complained about the difficulties getting parents and/or social workers to act as AA’s for juveniles, how much more so for mentally disordered adults?

Similar complaints were often expressed about gaining the attendance of an AA for mentally vulnerable suspects. The perception remains with many custody sergeants that social workers are particularly elusive. The data in this study shows that the average time taken before an AA attended the police station was 3 hours. The
range was between 1 and 18 hours. However, there were no such complaints about the availability of police surgeons. Custody officers often remarked that the police surgeon 'tends to help them' or 'tends to be on the side of the police'. What they meant by such remarks was that police surgeons generally hold similar views especially on law and order as the police.

(b) Police Surgeons' Assessments of Mental Disorder.

Judging by the comments made by police surgeons on the custody records and during interviews with them, their views of the suspects, the so called 'police property' as Reiner calls them (Reiner, 1992) that predictably flow through the police stations, are remarkably similar to those of the police. With reference to the 'street wise' mentally disordered offender, to paraphrase one police surgeon who remarked that, 'as most of his patients were low intelligence types who could look after themselves in the community, then so too could similar mentally vulnerable suspects cope during police detention and questioning'. Some police surgeons abandon the medical model of mental illness when it suits them. This was so when the mentally disordered suspect was considered to be dangerous or undeserving. For example, one custody record showed that a known psychotic suspect was also HIV positive, he was assessed by a CPN on the advice given over the telephone by a police surgeon, as being fit for detention and interview. In this case the CPN and the police surgeon abandoned this suspect because the alleged offence was indecent assault; they both agreed that despite his mental illness he was responsible for his actions. It was also clear from the custody records that police surgeons' assessments of mental illness were sometimes based upon information received over the telephone from hospital staff or a psychiatrist. Thus in many cases police surgeons ratify diagnoses of mental illness and mental handicap. Police surgeons assessments for fitness are value laden when the diagnosis becomes submerged within the 'mad v bad' or deserving/undeserving debate.
It is not suggested that the majority of police surgeons think this way about mentally disordered suspects, some police surgeons clearly saw many vulnerable suspects' problems emanating also from social causes. But it should be noted that many police surgeons had practised in these police stations for many years, and it would be unusual if they did not sympathise with the police, or adopt some of the police attitudes towards some suspects. Even researchers, e.g. particularly those who used an observational method, find it hard sometimes not to sympathise with the police. What this means is that the role of the custody officer and the role of the police surgeon are inextricably linked and that means both have a direct effect on the use of an AA.

(c) Calling a Police Surgeon and an AA.

Whether the duty to call an AA should become a formal joint responsibility between the police surgeon and the custody officer remains unanswered. Perhaps the best that can be hoped for is that police surgeons improve and define what they mean by fitness for detention and interview, and that the Code of Practice should clearly state that the police surgeon as well as the AA must be called whenever the custody officer is in any doubt about a suspect's mental vulnerability.

The question asked of the custody officers was 'would you call the police surgeon first for someone you suspected of suffering from mental disorder and/or handicap before contacting an AA?'. Almost all the custody sergeants said they would, 22 out of 26, with those from Grantham and Derby being unanimous. The next question was more revealing: 'would you then call an AA after the police surgeon had declared the subject to be fit to be interviewed?'. About half the custody sergeants said they would, the other half said they would ask the police surgeon's advice to see if the AA was needed.
Answers to the above questions tell a great deal about the link between the custody officer the police surgeon and the AA. Clearly the police surgeon is seen as the most important person when considerations about fitness for detention and interview is needed. In this the custody sergeants were complying with PACE. But even when that assessment was completed, many custody officers said they were still likely to seek the police surgeon's assessment about using an AA. In this respect to say that the police surgeon is a gatekeeper is to understate the point. As one custody sergeant said, "you would call a police surgeon for a professional opinion", and another said he would not call an AA if the police surgeon advised against it as he would, "not want to go against a police surgeon after the police surgeon said someone was fit to be detained and fit to be interviewed.". (The assumption here of course, wrongly, is that if a suspect is 'fit to be detained and fit to be interviewed' he or she does not require an AA).

Comments such as that by one of the custody officers reinforced the view that the police surgeon would, at least for him, be the final arbitrator as far as the AA was concerned. Not all saw things that way, one custody officer said he would only call the police surgeon if it was for a s136 (Mental Health Act 1983) 'Place of Safety Order', not for anyone charged with a criminal offence. Another saw the question in somewhat crude class terms believing that calling the surgeon was what he called a 'class thing', but added that the key decision to call an AA must be that of the custody sergeant. These variations suggest that there is no official policy about the use of the police surgeon in respect of the AA, or if there is, it was not known to these various custody officers. It seems that individual custody officers operate the AA procedure according to each individual suspect. One of the key questions for future research is to determine what will happen to the police surgeon if the AA is seen as more important? Will the police surgeon be called upon less often and will the AA take over some of his/her traditional roles? Presumably yes, in which case
the AA is in one sense a rival to the police surgeons' dominance. Particularly as volunteer AA schemes are of no cost to the police.

**The Role of the Legal Adviser**

Legal advisers were not interviewed formally, some were spoken to informally. But somewhat naturally custody officers had views about them. The data here is more sparse than that relating to the police surgeons as fewer questions were asked of the custody officer about legal advice.

The custody officers generally agreed that the legal adviser is there to ensure the best interests of the suspect by refereeing the rules. But again there was no consensus on what they should do. One custody officer thought that solicitors occasionally acted as an AA, but that raised the question of whether the solicitor should interrupt the interview if the question was unfair. (All custody officers were aware that solicitors were excluded from acting as AA's in the 1991 Revised Codes of Practice). The question is what is fair interviewing? What is proper interviewing? These questions were ignored by the RCCJ (1993) and in the Codes of Practice, indeed all the Code states is that -

"The solicitors only role in the police station is to protect and advance the legal rights of his client." (Revised Code C. 1995, Note for Guidance 6D)

To set the role of the legal adviser within the context of the AA: no one knows what is proper for interviewing officers to do. The Police Central Planning and Training Unit provides training and issue guide books on correct interviewing techniques (CPTU 1992). But research on police interviewing techniques suggests that there is no relationship between skill and training, with interviewing officers poorly
prepared, needlessly confrontational, no proper caution given, exhibiting mostly inept and repetitive interview techniques (Baldwin 1993 (a)). Baldwin (ibid) and McConville and Hodgson 1993 found that the vast majority of legal advisers were passive during the interviews. Baldwin (1993 (b)) states that even when the interviews were unfair because of serious arguments, or the officers losing control of the interview and becoming petty and confrontational, the legal adviser still did not interfere. When solicitors did intervene in the interviews, which was very exceptional, Baldwin (1993 (b)) declares that they tended to facilitate and help the police (see also McConville and Hodgson 1993). Clearly, there is a difference between what is permitted and what is proper interviewing, these are questions that were not addressed by the RCCJ (1993) or anyone, not even it seems, by many legal advisers.

Even so, there are important legal dimensions to the presence of a solicitor during the interview, the most important being the admissibility of evidence gained from the suspect’s answers to questions. There is also the legal conception that the presence of a legal adviser places the suspect on “even terms” with the police, that is, to provide an important balance of power. One custody officer said he thought an AA should not interrupt an interview if a solicitor was present. He gave as reasons for this that the solicitor might let an interview run on in order to reveal that the suspect was mentally disordered or reveal other matters which might be important in a trial. But other custody officers thought differently.

The RCCJ (1993) recommended that the Law Society should implement training, education and supervision of legal advisers who attend police stations (RCCJ, para 63). Accordingly, the Law Society has introduced training requirements for unqualified legal advisers. The training kit includes guidance on how to recognise suspects who may be mentally vulnerable. As yet the Law Society has not published an evaluation of the training accreditation package. However, some
commentators seem confident that legal advisers who work in the Duty Solicitor scheme are now capable of acting in the dual role of legal adviser and the AA (Pearse and Gudjonsson 1996). Solicitors were banned along with anyone employed by the police to act as the AA in the 1991 Revised Codes of Practice. Pearse and Gudjonsson (ibid) say that the decision to exclude solicitors in the 1991 Code was never fully explained.

Again, there is no standard view by the custody officers. But there is a conflict of interest between the two roles. The conflict of interest is obvious in that a solicitor may, when acting in the best interest of his/her client advise silence, while the AA is supposed, amongst other things to facilitate communication. This basic conflict of interest is even more important since the Criminal Justice and Public Order Act 1994 brought about changes to the right of silence. Given the criticisms about the poor performance of legal advisers, it is unrealistic to suggest that legal protection has improved dramatically at police stations, it is even more incredible to believe that the majority of legal advisers would be capable of taking on the additional role of the AA. Even more astonishing is Pearse and Gudjonsson's suggestion that legal advisers could be trained in mental health "recognition and management", similar to that of section 12 doctors.

There is nothing to prevent anyone, even legal advisers, taking on training in mental health, indeed perhaps a good start in such training should be undertaken by police surgeons, who rarely it seems have any forensic training. Information received from police surgeons during this study revealed that police surgeons are deterred from gaining forensic qualification because of the cost involved. Moreover, Chief Constables do not demand that police surgeons gain forensic training because if they did they would have difficulty in recruiting any (personal correspondence, 1993). The only credible argument that Pearse and Gudjonsson (ibid) put forward in favour of legal advisers acting as AA’s is that they have legal privilege. The issue of the
lack of privilege or confidentiality between the AA and the vulnerable suspect is a difficult issue that needs clarification, and is discussed in the next and final Chapters. Indeed, several duty solicitors who attended the four police stations, when asked about their views on this dual role were adamant in that they saw their role to protect suspects rights within a legal framework and that they had no interest in mental health issues. They said that the AA was there for welfare reasons, issues that they did not want to get involved in.

Summary and Conclusion.

Information gained from the custody officers shows that they had little experience in dealing with the AA for adults. Custody officers too have little confidence in their ability to recognise mental disorder and saw the suspect's previous history as the main indicator. The majority of custody officers saw the police surgeon as the key figure in determining whether an AA should be called. There were also no clear views from the custody officers about what a legal adviser should do in relation to the AA.

The following chapter looks at the use of a volunteer AA scheme. Would the availability of trained AA volunteers increase the use of the AA, and would the role of the police surgeon diminish? Would custody officers use volunteer AA's - and do they protect mentally vulnerable suspects?. These are some of the questions that are discussed.
CHAPTER 7

A VOLUNTEER APPROPRIATE ADULT SCHEME: A CASE STUDY.

One clear implication of this research is to see how if, at all, a fully operationalized AA scheme could be introduced, and decide if such a scheme could work. The answer to that can only be in terms of a piecemeal approach when local schemes are introduced and evaluated. It was fortunate and propitious that during the writing of this thesis the author was offered the opportunity to evaluate a volunteer AA scheme in Southampton and was thereby afforded a unique opportunity to answer some of those questions.

What is presented is a description and findings of the evaluation, not as a separate empirical study but as a way of seeking to ask and provide answers to some of the questions raised thus far about who should be the AA, what should they do, and will they be used?

Briefly, by way of background Southampton MIND applied for, and was granted funding from the Mental Health Foundation (MHF) to implement a volunteer AA scheme. (The MHF agreed to the funding of the AA scheme for two years - from April 1994 to April 1996). The MHF agreed to the funding with the understanding that an evaluation of the scheme would be carried out an independent researcher. The evaluation was funded by the Mental Health Foundation for two years. The
The MIND volunteer AA scheme began in April 1994 and the evaluation began in November 1994.

The Hampshire police had agreed to co-operate with the scheme and four designated police stations were chosen to take part in the scheme. One police station was situated in central Southampton, the second and third police stations were in the suburbs of the city and the fourth police station was in the New Forest area. These police stations were designated stations which means that suspects are taken to these stations because they have the equipment to record PACE interviews. A reasonable representative sample of the population is reflected in the geographical positions of these police stations, that is, inner and outer city and the rural area of the New Forest whose population increases during the Summer with holiday makers. The level of crime and subsequently the rate of arrests and detentions reflected these geographical areas. Consequently the level of demand for AA’s varied between the four police stations.

The MIND volunteer AA scheme was slow to start; this had much to do with the inexperience of the Co-ordinator, who was employed by Southampton MIND to organise the scheme. The Co-ordinator had personal difficulties interacting with the police in the four police stations. The Co-ordinator was young and this was her first experience of police practices and culture. The police station, particularly the custody areas, is intimidating and the police are in total control of the situation. Therefore, it took several months before the Co-ordinator and the custody sergeants particularly, began to trust each other. Gradually the Co-ordinator came to
understand that the co-operation of the police is essential to the successful operation of an AA scheme, and an adversarial approach with the police does not gain co-operation. However, given the personal difficulties between the Co-ordinator and the custody officers, the senior officers in charge of these police stations realised that it was in their interest to ensure that the AA scheme was successful. Therefore, a key point to the successful operation of a volunteer AA scheme is a good working relationship between the custody officers and the AA scheme’s organiser - based on the knowledge that the success of the scheme benefits both.

It was agreed that the evaluation would not follow the traditional method of non-participant observation, but that the evaluator would advise the Co-ordinator and the scheme’s Steering Committee when appropriate. The most important aim of the evaluation was to oversee the development of a training programme for AA volunteers. However, the first serious disagreement between the Co-ordinator and the AA scheme’s Steering Committee soon emerged. It was apparent that the MIND scheme viewed the AA role as primarily a 'diversion from custody' procedure. The failure to understand the role and function of the AA was not surprising given the findings of the evaluator’s previous study on the use of AA’s (see chapters 5 and 6). Moreover, the funding for the scheme came from the Mental Health Foundation’s funding for 'diversion from custody' projects. The original idea for setting up a volunteer AA scheme came from Southampton’s Mentally Disordered Offenders Scheme (Mendos) whose function was to divert mentally disordered offenders away from the criminal justice system. A Mendos social worker had been visiting Southampton Central police station for several
months to advise the police about mentally vulnerable suspects. It was this social worker who suggested to Southampton MIND to apply for funding from the MHF to set up a volunteer AA scheme. Therefore, from the beginning there was the mistaken belief that the AA’s function was to divert suspects out of the criminal justice system. Moreover, the MHF, by agreeing to fund the MIND AA scheme, also misunderstood the role and function of the AA. Thus, given the initial misunderstanding by Southampton MIND and the local mental health services, including Mendos, about the role of the AA, combined with MIND’s fundamental principles about the treatment of people with mental disorder, the legal requirements of the role and function of the AA contained in the PACE Act were disregarded, or seen as secondary to the main purpose of diversion.

Eventually the Co-ordinator and the Steering Committee accepted advice from the evaluator, that administrative and training procedures must reflect the role and function of the AA, as it is defined in the Codes of Practice. By the time the evaluation began, preliminary organisation of the AA scheme had been operating for several months.

The first problem encountered concerned the manner in which the volunteer AA’s were encouraged to pass information obtained during the PACE interviews to other agencies, for example, Mendos and the local Department of Psychiatry and social services. This information was contained in a referral form that had been devised by the Co-ordinator and the Steering Committee. The referral forms included relevant and important information about the suspect, besides the usual data of
name, age, ethnicity, type of accommodation etc., further important information was recorded such as: reason for arrest, reason for calling the AA, which meant defining the suspect's vulnerability, the police surgeon's assessment, whether the suspect was known to a mental health agency, whether the solicitor was present during the interview and the outcome of the interview, but what caused concern was the inclusion of information about any confession made during the PACE interview.

Advice was sought from a Chief Constable and Sir Louis Blom-Cooper QC who confirmed that the circulation of confession evidence to these agencies probably breached the rules of disclosure and was therefore unlawful. In effect any confession or other evidence is subject to the rules of disclosure and should not be written about or discussed before any court hearing. The assumption by Southampton MIND and Mendos that mentally disordered suspects' information and confession evidence should be distributed around all these agencies reflected the perception that the AA's primary function was to divert vulnerable suspects from the criminal justice system. However, the idea of the 'diversion' of mentally vulnerable suspects was not completely abandoned by the MIND AA scheme. It was agreed that, with the suspect's permission, the AA could pass on the suspect's details to Mendos or other mental health agencies, and the AA could inform the suspect about housing, or drugs/alcohol services if requested.

In hindsight, the initial misunderstanding surrounding the AA role was to be expected, as the problems were largely the result of all concerned to promote a 'diversion scheme'. After all, the funding from the MHF came from the 'diversion
from custody' fund which was intended to be used for 'diversionary' projects. Moreover, as this study, and other research reviewed in chapter 2 reveals, the AA procedure for vulnerable adults had rarely been operated, therefore, there was little understanding at that time about the AA role, use and function. Combined with the lack of a clear understanding of the AA role, was the MIND organisation's philosophy relating to the treatment of mentally disordered people. Thus, initially there was a conflict of interest between MIND's political and philosophical imperatives, the misunderstanding that the AA scheme should be a 'diversion scheme', and the requirement to ensure that the AA procedure adhered to the PACE Act and the Codes of Practice. Consequently, given the initial problems outlined above, the evaluation could not remain a formal objective assessment of the scheme, because of the input from the evaluator.

The debate with the MIND AA scheme about diversion issues has important implications for other volunteer schemes. The point needs to be made that, whatever type of organisation implements a volunteer AA scheme, that is, whoever 'owns' the scheme must abide by the requirements, first and foremost, of the PACE Act and the Codes of Practice.

Subsequently, the MIND AA referrals forms were changed, removing any reference to confessions, and the exclusion of the names and addresses of victims, witnesses and relatives from the forms. Also, it was agreed that the referral forms would be passed only to the Co-ordinator. The evaluator also had access to the referral forms in order to quantify the data for inclusion in the reports to the MHF. The referral
forms were changed several times because of suggestions by the evaluator usually to include further questions such as: the custody officer informing the AA about their responsibilities, that the AA has the right to speak to the suspect in private before the interview, and that the suspect’s rights and caution should be repeated to the suspect in the presence of the AA. All in all, the revised referral form, which would be completed by the AA during their time in the police station, contained information on all the AA procedures defined in the Codes, and much valuable information about the suspect.

Initially, the Co-ordinator had no experience of the procedures that takes place in custody areas, no blue-print to work from, or anyone but the Mendos social worker to shadow in the police station. There was no training manual on the role of the AA available, the only guidelines available were those contained in the Codes of Practice, and they are limited and unclear. Thus, the Southampton MIND AA scheme evolved over the two years.

Therefore, besides the practical problems dealing with recruiting suitable volunteers, the training programme had to be devised. It became very clear early on in the scheme’s organisation, just how complex and onerous the task was. Not only does the AA need to gain a knowledge of the Codes as they relate to the AA, but the volunteer also needs to understand the role of the police and all others who might become involved with the suspect during their detention and interrogation. However, before discussing the training programme that eventually evolved, a brief discussion about the volunteers who applied to act as AA’s follows.
The Volunteer Appropriate Adult

The following discussion includes a brief outline of the characteristics and background of the volunteers who attended the MIND AA training programmes.

As already mentioned in this study the PACE Act Code C. defines who may act as an AA for juveniles and mentally disordered or mentally handicapped adults. However, it is worth repeating who the Codes define as suitable to act as an AA.

For vulnerable adults the AA may be a relative or a guardian or someone experienced in dealing with vulnerable adults, or any adult over the age of 18 who is independent of the police. (Code C. 3.1, 3.2, and Notes for Guidance 3A,3B and 3C). While the guidance in Code C. remains the criteria for selection of AA’s further guidelines are needed as more and more organisations recruit and train AA volunteers. For example, the MIND Co-ordinator and the Steering Group recruited volunteers who had a history of mental disorder and/or volunteers who had a history of spent convictions.

The evaluator criticised the recruiting of such volunteers and this issue remained an area of contention throughout the evaluation. It was argued that the volunteers must be appropriate and pointed out several court cases when the judge criticised the inappropriate or inept AA’s (see chapter 3). Appropriate Adult schemes’ organisers have responsibilities and duties towards their volunteers. Conversely, AA schemes and individual AA’s must also be accountable to the suspect/client, and indeed may be required to give evidence in court about their conduct when acting as the AA. Furthermore, AA schemes must also be seen to be credible by the police, otherwise
they will not be used. The MIND AA scheme operated a formal application and interview procedure with prospective AA volunteers. The application form included a question which explains, that because of the nature of the AA work the Rehabilitation of Offenders Act 1974 does not apply, thus volunteers must declare previous criminal convictions. Although the evaluator was not made aware of any formal decision about the recruiting of volunteers with spent convictions and/or mental health problems, however, a police check is carried out on accepted volunteers, which places part of the decision about recruiting volunteers with the police. Although several senior police officers voiced their concern about being partly responsible for the ‘appropriateness’ of volunteer AA’s, it was argued that the courts have already criticised the police for using inappropriate AA’s.

Thus, while no formal decision about recruiting volunteers with previous criminal convictions or people with a history of mental disorder was agreed, it became evident throughout the evaluation that these volunteers were being excluded. Obviously, the question about recruiting mental health service users as AA’s, or for any work within the MIND organisation, lies at the heart of MIND’s philosophical approach to mental health issues generally. However, organisations such MIND, MENCAP, Sane and the National Schizophrenia Fellowship (NSF) for example, each with their distinctive approach to mental health issues, who are, or may be operating AA schemes need to be aware that they are also accountable to the suspect/client, and possibly to the courts.
Characteristics of the AA Volunteers

Initially the evaluator was not optimistic that the required numbers of volunteers would be available with the necessary qualities to take on such important work. It was assumed that, unlike Victim Support which relies on an army of volunteers around the country, the same sympathy would not be forthcoming for suspects of crime, even those who were mentally vulnerable. However, despite an initial slow response to the advertisements for volunteers, information about AA volunteers spread and the Co-ordinator found innovative ways of recruiting. One example was via computer systems in local government and social services.

The volunteers ages ranged between 25 - 70 year with an average age of 39 years. All the volunteers were employed, except for a retired male, who had 38 years experience working in the NHS with vulnerable groups. All the volunteers had, or were currently involved in voluntary work, some in the field of mental disorder and/or learning disabilities or related work. Several volunteers’ employment was directly related to working with vulnerable people in the community. Most of the volunteers were employed in the voluntary sector, local social services, county councils, NHS or commerce, with one volunteer retired and one was a student studying for a post-graduate degree in criminology. Consequently, the impression was that people who have experience of working within the mental health field, are likely to volunteer for an AA scheme. Many of these volunteers were committed to and had experience in helping mentally vulnerable people.
Because of their employment commitments most volunteers were only able to offer their services during evenings and/or some week-ends. Although requests for AA's did come during the evenings from the police, the data showed that the majority of requests came within the normal working day, i.e. between 9 a.m. and 5 p.m. Consequently, the Co-ordinator had to take on a disproportionate number of referrals herself. However, the MIND AA' s scheme's recruiting showed that there is a pool of interested, concerned and experienced individuals who are willing to volunteer as AA's. As with all volunteer schemes, volunteers come and go, so there is always the problem of keeping volunteers interested and committed to the work. As with all organisations there will always be a problem of 'wastage' but if experience of Victim Support schemes is anything to go by, there seems to be a small group of volunteers who will remain committed to their work.

All the volunteers were interviewed throughout the evaluation. These were informal interviews. It was decided not to use structured questionnaires, although certain questions or subjects were always introduced into the conversation. The interviews were tape recorded and notes were taken. The interviews ranged around the following issues: reasons for volunteering, experience working with vulnerable people, their thoughts on the training sessions, their relationship with the police, solicitors, police surgeons etc., and their relationship with the suspect/client and generally their views about the role of the AA.

Interestingly, most of the volunteers stated that they volunteered because they thought the AA role was important and worthwhile. Many volunteers felt that they
had some skill or experience they could offer. Clearly, the AA role was seen as valuable 'real work'. Over the course of the evaluation several volunteers who were students, usually studying for degrees in social sciences, were interviewed, these students saw the AA work as useful for them in their future employment. Clearly, social science students could be used as a recruitment pool, indeed volunteer AA work could become part of an applied social work course, for example. Other volunteers said they were interested in the AA work because they had either had personal experience of the mental health services, or they had a relative who suffered from mental disorder.

Training for Volunteer AA's

Throughout the two years of the evaluation several training sessions were implemented however, the final training sessions that the original Co-ordinator organised were the culmination of the two year period funded by the MHF. These final training sessions were also the final ones the evaluator observed. Thus, the following discussion about the training sessions reflects the experiences gained by the Co-ordinator, the volunteers and input from the evaluator over the two year period. However, the training sessions could not be completed without valuable input from two police officers. These police officers conducted several training sessions with the volunteers with skill and expertise. Moreover, at least one training session should be held in a police station with access to the custody area. It
is imperative that any volunteer AA scheme must have the support and input from the police.

The final training session was held over 8 weeks during the evenings, and occasionally over the week-end. The MIND Co-ordinator was present at every training session and conducted several training sessions alone or with the police sergeants. Besides the Co-ordinator and the police, other trainers conducted several sessions, they included: an approved social worker (ASW), a community psychiatric nurse (CPN), a worker from Mencap, a solicitor, two mental health service users, and ‘assertiveness’ trainers.

Obviously, the quality of trainers will depend upon the resources available for ‘buying in’ experts in the field of, for example, mental health. However, police input and resources will probably be readily available to AA schemes, without resource implications. Although AA volunteer schemes must remain independent of the police, including any independent individual who acts as an AA, nevertheless, police expertise and support should remain an essential part of AA training.

However, having said that, the police input in AA volunteer training is essential, it should be pointed out that the two sergeants involved with the MIND scheme stated that they had not received any training concerning AA’s, this is not surprising as this study and other research cited in previous chapters (e.g. Evans and Rawstorne 1995 and Palmer and Hart 1996) reveals the lack of police training on issues concerning the AA. Indeed all custody officers interviewed during this study complained that they had never received any specific training on the PACE Act or
the Codes, all the custody sergeants received was a booklet explaining the Codes. All the custody officers treated this booklet with contempt because it was written in simplistic language which the officers felt was patronising. Thus, the police officers who took part in the AA training, like the MIND Co-ordinator, developed the AA training programme from their experiences and interpretation of the PACE Act and Code C. as it relates to AA’s. The sergeants were aware of the problems associated with them training AA’s. That is, they were sensitive to the inherent conflict of interest their role as police officers and trainers of AA volunteers places them in. The officers were concerned not to be dogmatic about what the AA should do, as they felt, and many would agree, that the AA role as it is defined the Code is ambiguous. However, the training these officers provided on the first and subsequent training sessions concerned the role of the police in the detention and questioning of suspects in the police station - areas where they were or should be expert.

The most important part of AA training, alongside the AA role itself, is the recognition and a clear understanding of the roles of all others who attend police stations and may become involved with the suspect in the police station. The AA needs to understand the boundaries and extent of the duties and responsibilities of, for example: the custody officer, the interviewing officer(s), the police surgeon, the legal adviser, the duty inspector and of course, the position of themselves as AA’s in relation to these professionals and the suspect.
Obviously, devising a training programme for volunteers, coming from a variety of backgrounds and acquired knowledge about the criminal justice system generally, and mental disorder particularly, will be a difficult task. The problem is not only about what should be included in AA training but the amount of time and effort volunteers are willing to commit to training. Clearly, the impression gained from the Southampton MIND AA volunteers was a high level of commitment and a willingness to devote time and effort to training. Very soon into the training, the volunteers soon realised, if they were not already aware, the importance of the work they were committing themselves to.

It was important to gain the volunteers’ views about the training. Generally, the volunteers’ views differed little in agreeing that the training programme was very good i.e., a good basic training. All the volunteers agreed that on-going developmental training in such areas as: mental health, drugs, alcohol, and the law was needed. Those volunteers who had no relevant experience of the criminal justice system or the mental health system, stated that they were ‘overwhelmed’ with the amount of information contained in the training sessions. Even those volunteers with experience in these areas realised that there was much to learn about the AA role - and what goes on in the police station. Indeed, all the volunteers stated that they would have liked more time during the training sessions, which usually meant they wanted more in-depth information and discussion on most of the areas the training covered. The general demand for more training clearly demonstrated that the volunteer training needed to be on-going developmental training. However, all the volunteers commented that after they had ‘shadowed’
experienced volunteers several times then, 'everything came together'. Although academic training is essential, clearly the role of the AA needs to be learned by observation and exposure to the police stations, particularly the custody areas. All volunteers, even those volunteers who had worked in the criminal justice system, often stated that despite their training and experiences nothing could prepare them for the intimidating environment of the police station. Although most volunteers said that they gained confidence after several call outs the police station's environment became less intimidating - but never totally disappearing. The volunteers are able to attend de-briefing or feedback sessions in groups or one to one with the Co-ordinator.

Overall, the impression gained from all the volunteers throughout the evaluation is that the training, while it may be overwhelming in terms of the amount of information required, is seen as essential basic training. Indeed the call for more on-going developmental training by the volunteers reveals the need for more information, knowledge and skills. Moreover, all the volunteers recognised how important it was for the police to be involved in the training, and called for more visits to police stations and opportunities to observe police procedures.

Without exception all the volunteers described their feelings of shock when confronted with the police culture that pervades the custody areas in the police stations. It is worth repeating the point that, no amount of training can prepare a volunteer for the daunting experience of the police station, even for those who have previous knowledge or experience of police practices, as one volunteer stated, "...it
takes getting used to - close contact with the police”. Yet despite their initial apprehension and anxieties, all volunteers stated that they were able to perform their duties as an AA to the best of their abilities. Indeed, a large part of the volunteers’ time in the police station is taken up with reminding the custody officer and the interviewing officers about the Codes, for example, the requirement to inform the AA about their duties, and repeating the caution to the suspect in the presence of the AA.

Through the course of a number of visits to the police stations the volunteers get to know, particularly the custody sergeants, those who were most sympathetic or not towards the mentally disordered suspects. One volunteer described custody officers attitudes towards vulnerable suspects thus, “....some are sympathetic...some not....some are abrasive...some would be frightening - most are good...”.

Consequently, some volunteers stated that they developed a rapport with some custody officers. However, the volunteers are aware of the inherent conflicts of interests between their role, the police and the suspect. While some volunteers are able to develop relationships with some police officers, based on trust and mutual respect, other volunteers prefer to maintain a professional distance. Clearly, volunteers views about police officers and vice versa are subjective and much depends upon personalities and experiences. However, that is not to pronounce subjective views invalid, especially when several volunteers disclose similar findings or views about some police officers.
Other problems expressed by the volunteers concerned the police, particularly custody officers' expectations of the AA's role and expertise. For example, volunteers stated that they were frequently asked by custody officers to give their opinion on the suspect's mental disorder, in effect to diagnose. Also legal advice and knowledge of the Mental Health Act was often sought. As one volunteer put it - "the expectation of the police is that you are a catch all". Other expectations by the police of the volunteer AA's included requests to give suspects a lift home, or indeed find them somewhere to stay etc. While all volunteers agreed that after the post interview procedures, their responsibility towards the suspect ended, yet most volunteers stated that they found it very difficult in some cases to 'abandon' the suspect. However, as previously mentioned, the volunteers were able, with the suspect's consent, to refer vulnerable suspects onto mental health agencies.

Interestingly, several volunteers stated that in some cases bail was settled on the understanding that the suspect agreed to being referred onto Mendos or another agency for treatment. In such cases, the volunteers were involved in what could be described as a 'diversion from custody' exercise.

But the volunteers described other cases where the suspect was released or bailed but was nevertheless seen to be in immediate need of care or support, despite being diagnosed as 'not sectionable', the volunteers were concerned for these suspects, because there was little or no help available from statutory agencies. The increasing use of volunteer AA's in police stations will highlight areas where community care is failing many mentally disordered individuals. Many of the case histories revealed by the volunteers were similar to those already described
throughout this study. The volunteers agreed that it was likely that the police will continue to make demands and have expectations of them above and beyond the AA role. However, the volunteers’ primary anxieties about carrying out the role of the AA, concerned their contact with the police. This included coping with the police culture, the custody area environment, the police’s attitude to them as either a help or hindrance and their expectations of the AA beyond the AA role.

The volunteers’ views about legal advisers and police surgeons revolved around their concern about whether they are called to see the suspect. Many volunteers thought that custody officers were deciding not to always call the police surgeon when calling the AA, but relying on the AA to make decisions about the need for the police surgeon. Several volunteers dealt with this problem by deciding that they would always insist that the police surgeon be called if they were at all concerned about the suspect and/or if the suspect was taking any medication. Some volunteers expressed concern about police surgeons’ criteria for assessment of fitness for detention and interview, in that they felt that some suspects should have been ‘sectioned’ or at least not recommended fit for the interview. The volunteers soon came to realise that the majority of police surgeons’ assessments declare the suspect fit for detention and interview, and thus their confidence in police surgeons may decline, as one volunteer put it after requesting a police surgeon and then having to wait several hours declared - ‘why did I bother?’ What the volunteers were expressing here, is their frustration with a legal and mental health system that fails many mentally vulnerable people. The volunteers want something done, and cannot understand a system that seems incapable of dealing with mentally
vulnerable people that no one seems to care for - the 'unloved' and the 'not nice'.
(Prins 1994).

All the volunteers stated that they would try to call the duty solicitor if one had not already been called by the custody officer. Moreover, the volunteers maintained that they would try and persuade a reluctant suspect to have a legal adviser called, especially if the alleged offence was serious. No volunteer recorded any occasions when they had to override the wishes of the suspect when requesting the presence of a solicitor. Several volunteers expressed surprise that some legal advisers were not more active during the interview. Volunteers agreed that about half the solicitors were either active or passive during the interview. One volunteer stated that while he had never interrupted an interview himself, 'just a look at the solicitor is all that is needed'. The AA volunteers views about legal advisers behaviour during the interview, suggests that not much improvement has occurred since the critical research discussed in this study, (see Baldwin 1993, Brown 1989, McConville and Hodgson 1993).

However, while the quality and competence of many legal advisers may leave much to be desired, nevertheless, the AA should not be used as a surrogate legal adviser. The risk is that when trained volunteers become known and trusted by custody officers, they usually arrive at the police station quickly, the custody officer then leaves decisions about the police surgeon and the solicitor up to the AA. But the AA must always bear in mind that they may be required to give evidence in court about the validity of evidence. While the PACE Act and the Codes requires the
police to inform suspects about their right to free legal advice, the Codes do not place an obligation upon the police to ensure the presence of a solicitor for any suspect, least of all for a mentally vulnerable suspect. The onus then for agreeing to call a solicitor falls upon the suspect and/or the AA. Thus, as trained AA volunteers become more confident and competent, they may not always call a legal adviser, especially if the suspect also declines to see a solicitor. The Appropriate Adults Working Group 1995 recommended that -

"Bearing in mind that the appropriate adult is not in a position to give legal advice, and may not be aware of its importance, the Group further recommends (10) that a solicitor should always be called, in cases where a suspect has been arrested in respect of an alleged offence and identified as requiring an appropriate adult." (p:8. emphasis in original).

As volunteer AA schemes become more established they should not wait for recommendations like that outlined above to be included in a future Revised Code of Practice, but decide on their own guidelines in such matters as calling the police surgeon and the legal adviser, if this can be done with the agreement of the local police, so much the better.
Volunteers' Views About the Suspect/Client

All the volunteers stated, that in their opinion, all the suspects for whom they were called to the police station for needed the services of an AA. This is an important finding, especially as the volunteers come from different backgrounds and wide differences in knowledge and experiences of mentally disordered people and/or the police and police practices.

However, all the volunteers agreed that their main concerns were with the police - their attitudes and culture - not with the suspect. No volunteer expressed anxieties about their personal safety when talking with the suspect alone. Moreover, some volunteers felt that at times the police were over cautious in their behaviour towards some vulnerable suspects. Some volunteers stated that on occasions when the suspect was upset or volatile the AA was able to calm the suspect and the situation. Volunteers thought that their ability to 'defuse' situations had much to do with the fact that they were not authority figures. However, to be fair to the police, they are responsible for the safety of all people who visit the custody area, and the AA is another lay person they are liable for.

Several volunteers stated that occasionally suspects expressed their gratitude to them for their help. This was appreciated by the AA's, as some volunteers expressed a wish to know whether they had 'done o.k.'. Occasionally some volunteers were called for suspects whom they had previously acted as the AA for, they were concerned that these suspects might become dependent upon. However,
the most often expressed concern between the AA and the suspect was the requirement that AA's must not talk privately with the suspect about the alleged offence. The difficulty here involved trying to explain this to mentally vulnerable suspects, who often only wanted to talk about the offence. Interestingly, it was evident that some suspects are being informed about the AA’s from other suspects. Consequently, some suspects, especially repeat offenders, will come to understand the AA procedure and might well demand an AA on future occasions.

All the volunteers stated that it seemed very important to the suspect that they were volunteers - not professionals. Moreover, most volunteers agreed that the AA role should remain voluntary. Although, some volunteers added that if the role was professionalised then vulnerable suspects, 'would get to know who they are i.e. for them'. Some volunteers talked about the occasion when they were called for suspects who were accused of committing serious sexual offences, sometimes when children were involved. One volunteer stated that he was surprised about how well he coped with just such a suspect. Overall, the volunteers were pleased that they were able to cope in such difficult situations and act in the best interests of the suspect - whatever he or she was accused of. The interviews with the volunteers revealed their awareness about the many inherent contradictions and difficulties about the AA role. But it was apparent that the volunteers considered that all the suspects they had been called for needed an AA. The volunteers found that despite the stress and the intimidating police culture they found the role satisfying, and were able to persevere and act in the best interests of the suspects.
Hampshire, and many other police forces are now implementing mental health training for police officers, together with a recognition by the police of the importance of the AA procedure for mentally vulnerable adults. Thus, despite initial problems between the Co-ordinator, volunteers, custody sergeants and interviewing officers, a change in attitude toward the AA volunteers in Southampton evolved over the two year evaluation. The change in police officers’ attitude towards the AA volunteers has been recorded during interviews with custody officers and volunteers over the period of the evaluation. Much of the change in attitude, particularly by custody sergeants, is related to the understanding that the AA procedure is gaining in importance for the police, particularly being recognised as ensuring reliable evidence for successful prosecutions. The chapter on socio/legal issues revealed the substantial case law that is now growing where the position of the AA is discussed. While the case law remains somewhat equivocal on the status of the AA, each case is different, and the courts clearly take the view that all circumstances surrounding a case of a mentally vulnerable suspect must be scrutinised, but at least the role of the AA is being debated in the courts. Moreover, the AA volunteers are seen by the police as reliable and efficient and attend the police stations within a reasonable time compared to other professionals such as police surgeons and solicitors, as one custody sergeant observed, ‘the scheme makes life easier, they’re quicker than social workers and police surgeons’. Thus, as previously mentioned, custody sergeants are pragmatic, they are likely to use volunteer AA’s because they are available.
The attitudes of interviewing officers were gained from the return of approximately 150 postal questionnaires which represented a 95 per-cent response rate. The views about the MIND AA’s and other AA’s may be summarised thus: the volunteer AA’s were seem as on the whole helpful to the suspect and the interview procedures in that they facilitated communication, but some volunteers were seen as obstructive. Social workers acting as AA’s were usually viewed as reasonable, but many complained about the length of time they took to arrive at the police station. Parents acting for juveniles, on the other hand, were viewed by the interviewing officers as being the greatest hindrance to the interview procedures. The complaints about parents acting as AA’s, were either that they intimidated their children into ‘confessing’ or told the juvenile not to say anything, these views replicated other research findings, particularly Evans 1993, and Evans and Rawstorne 1996. In general, the interviewing officers’ comments either betray their ignorance of the role of the AA, or they reflect an increasing awareness of the need for the AA for mentally vulnerable adults. In summary, the interviewing officers’ observations occasionally reveal a sound understanding about the AA role, but generally they tend to be ambiguous, perhaps suggesting patchy training or at best a misconception about the AA role.

Many issues surrounding the role of the AA remain contentious, not least being the issue of confidentiality between the suspect and the AA. Moreover, while the AA remains the only added protection for vulnerable adults during their detention and interrogation in the police station, they may also be held, or seen to be held liable
for the validity of any evidence obtained during the interview, and may well be called as a witness for the prosecution.

Moreover, it is clear that the role of the AA is complex and stressful. The analysis of the MIND AA training programme reveals that volunteers need to acquire knowledge and skills that many professionals take years to train for. Therefore, future questions about volunteer AA’s is likely, that is, should trained AA’s remain voluntary? The majority of the Southampton MIND AA’s seem to think that the role should remain voluntary, particularly as their status seems to make their services more acceptable to the suspect. As one volunteer stated -

"There has to be an element of ordinariness about the role of the volunteer AA....if professionalised then they will be used instead of police surgeons and solicitors".

Whatever the future is for schemes like the Southampton MIND AA scheme, it looks certain that the AA protection for mentally vulnerable adults will remain a requirement of the PACE Act and the Codes of Practice. How effective trained volunteer AA’s are, or will be, depends upon all players who work in, and attend the police stations in various capacities, it is they who need to insist that the police adhere to the Codes. Changes to the Codes of Practice will help, particularly relating to a requirement to call the police surgeon and a solicitor whenever an AA is needed.
The PACE Act 1984 and the Codes of Practice were in place by 1986, additionally the Codes were revised in 1991 and 1995, but only over the last few years has the AA procedure been implemented to any degree. Even so, the provision of AA schemes remains patchy around the country. A national AA scheme is needed, something similar to the Victim Support model. A nation-wide network is needed, because the Royal Commission on Criminal Procedure 1981 was correct, when they stated that there would never by enough qualified professionals to run a comprehensive system. Indeed, if vulnerable witnesses and victims are included amongst the groups of vulnerable people who are obliged to attend police stations and take part in interviews (Sanders et al 1996) then the demand for AA’s will continue to increase.

After almost half a century since the first post war miscarriage of justice, the case of Timothy Evans (Brabin Report 1966; and Nemitz and Bean, 1997), we are still trying to implement safeguards for mentally vulnerable suspects. While the AA protection may not be the perfect solution, it remains the only added protection for mentally vulnerable suspects who are detained and interrogated in the police station. But the AA does not work in a vacuum - for the AA to be really effective then all the other players involved in the detention and interviewing of mentally vulnerable suspects must also play their part.

There are obviously resource implications for on-going training programmes and time constraints, especially for co-ordinators, who will probably always need to be available to act as AA’s if a volunteer is not available, particularly during the
working day when the majority of calls for AA's are more likely. While police co-operation and help with the training should not be a problem, the organisation of other training personnel requires time and resources. The funding of all volunteer organisations is obviously fundamental, but the AA procedure is surely somewhat different from the majority of charity organisations, in that the AA procedure is a requirement of the PACE Act. Therefore, if the way forward for developing and implementing the AA role is through the use of trained AA volunteers, then the question of who's responsibility for funding such schemes becomes paramount.

The Southampton MIND Scheme has shown that a volunteer AA scheme can work. Support and guidance is now needed from the Home Office to implement a national volunteer AA scheme. Formal action by the Home Office, would at last indicate, that the role and function of the Appropriate Adult for detained mentally vulnerable suspects in the police station, does matter.
CHAPTER 8

A Summary and Discussion of the Main Findings.

In this Chapter the purpose is to realise Aim 4: to determine the policy implications of existing practices and point to future development.

In order to realise that aim first, a summary of some of the main findings is required, and an examination of them as they apply to the AA and the AA procedures. This will then be followed by a discussion of some of the implications, specifically relating to the workings of the criminal justice system.

Summary of the Main Findings.

To summarise; the research findings show that out of the study of 20,805 custody records only 38 record the attendance of an AA, giving a range between 0.1% - 0.3%. However, a further 448 records revealed that the suspect was mentally vulnerable but an AA was not called. This is a conservative estimate; only those custody records that showed either the police surgeon being called for the suspects and/or when an account of disturbed behaviour was recorded by the custody officer were included in this estimate. There were many more custody records that documented some misgivings by the custody officer or other professionals present at the police station, or from information received over the telephone about the
suspect's mental health, but these records were excluded. The decision to exclude these records was taken because of the uncertainty of the situation summarised on the custody record. However, the 448 records of those detainees whose mental vulnerability was evident from information recorded on the custody record, gives a percentage range of between 0.7% - 4% of the suspect population in the four police stations, were identified as mentally disordered in some way. This range of percentage of mentally disordered suspects identified in the four police stations, corresponds with other research discussed in Chapter 2. It is interesting to note that, given the range of research methods discussed in Chapter 2, this retrospective study of custody records finds similar numbers of suspects defined and recorded by the custody officer, as mentally vulnerable. Therefore, the implications of this study, combined with the body of literature reviewed in Chapter 2, reveals that the AA protection for many mentally vulnerable suspects is not working. This is regarded as one of the main and certainly one of the most important findings of the research. Accordingly, the safeguards that the PACE Act introduced to protect vulnerable suspects and prevent unreliable evidence are largely disregarded by the police.

Some understanding about why some vulnerable suspects had an AA called and others did not may be gleaned from the case histories. The qualitative data recorded from the case histories reveals that it was not always clear if the person attending the police station, i.e. a social worker, a relative or 'other' person, was acting in the role of an AA. However, out of the 38 recorded accounts of the presence of an AA, 19 records contained the term 'Appropriate Adult', which
suggests a formal implementation of the AA procedure. Out of the 19 formal AA records only 3 record the involvement of the police surgeon. Of the 38 AA’s 19 were either social workers, probation officers or community psychiatric nurses; 10 were relatives and 9 are classified as ‘others’ - which includes interpreters, solicitors, a warden, nurse, matron and a volunteer.

While some of the above people who acted in the role of the AA conform to the definition in the Codes as suitable AA’s, others were evidently not. The Codes clearly state that anyone employed by the police may not act as an AA, thus the matron who seemed to be acting in the role of the AA ought not to have done so. Matrons are employed by the police and they are usually wives of police officers to look after the welfare of female prisoners during their detention.

Briefly, an overview of the results show there were a small number of instances when the AA was called. When they were called it was invariably because the suspect was recognised as being mentally handicapped (learning difficulties) or having other disabilities such as being blind or 'deaf and dumb'. More often than not the custody officer did not call a police surgeon for these suspects which suggests that they, the custody officers, had a certain level of confidence in their ability to identify such disabilities. The police surgeon was not seen to be needed for these suspects because the custody officers probably assumed that their mental or physical disabilities were 'fixed'; by that is meant not seen to be in need of medical attention or a mental health assessment. But clearly these people were vulnerable and hence the AA was called.
However, for those suspects who were recorded as being recognised as mentally disordered - more often mentally ill - the police surgeon was invariably called and almost always declared these suspects 'fit to be detained and fit to be interviewed'. The criteria used, can it is suggested only be on the basis that the police surgeon did not consider these suspects sectionable under the MHA 1983. This impression is supported and was advanced by the numerous times a police surgeon's assessment on the custody record concluded that the suspect was 'not sectionable'.

What then happened to these mentally disordered suspects after having been seen by the police surgeon? The answer is quite simple: they were interviewed without an AA and often without a solicitor either. It is of course, highly likely that despite the police surgeon's assessment the suspect's vulnerability did not disappear. They were simply 'not sectionable' in the police surgeon's view but should still have been afforded the protection of the AA.

The requirement to call an AA is not on the basis of being 'unfit to be detained and interviewed', if that were the case there would be no reason for the AA at all. The AA is there to fulfil the requirement of non-discrimination which is not a medical but a moral matter (this point was made in Chapter 1 about the AA fulfilling a moral vacuum). As far as the custody officers were concerned they believed that they had fulfilled their duty towards these suspects by calling the police surgeon. Even if this were so, they were not fulfilling the requirements of the Codes of Practice which, if only to repeat a point, says 'if the custody officer has any suspicion............then that person shall be treated as mentally disordered and the
custody officer must call the police surgeon and the AA'. The custody officers were fulfilling one part of the Code but not the other.

Translating this into a more sociological framework, one can see the custody officers' dilemma. Faced with a suspect who is mentally disordered the semi professional seeks guidance and authority from the professional, and a professional known to be sympathetic to police culture and values. Those criteria for 'fitness for detention and interview' are somewhat loose. One can only assume that a great number of people who are mentally vulnerable are being processed through police stations on that basis. It is also reasonable to assume that some will enter the Criminal Justice System by way of a gatekeeper who offers the mantle of expertise which has been gratefully accepted because that gatekeeper 'oils the wheels of the system' and helps the police to keep things moving. One can begin to see why there are so many mentally disordered offenders within the Criminal Justice System; the problem starts in the police station, and whilst the mental disorder may be identified there, nothing is done about it. In the same way the AA is forgotten or not seen relevant once the police surgeon's assessment has been made.

What then is likely to happen if the AA system develops using trained volunteers? The previous chapter indicated that if a pool of trained volunteers, willing to attend the police station at any time are available, they will be used. And what will the effect of this have on the police surgeon? It is suspected that the police surgeon's role and influence will thereby diminish. After all, volunteers cost the police nothing, whereas police surgeons are expensive. Given that there are ad hoc
volunteer AA's schemes operating around the country, training is essential. The previous chapter indicated that a basic AA training programme can be developed, but clear guidelines are still needed from the Home Office about the role and function of the AA.

The Custody Officer, the Police Station and Section 136.

The recognition of mental disorder in detained suspects by the custody sergeant, or by others who attend police stations in various roles, is obviously fundamental to the initiation of the AA protection. This study has described custody sergeants' descriptions of mental disorder or learning difficulties in these suspects. The data shows that when the custody officer seemed confident of his recognition of mental vulnerability, an examination of the suspect by the police surgeon was not thought necessary - but the AA was called. However, when the police surgeon was called for a suspect, the role of the AA (especially if that person was a social worker or a psychiatric community nurse) becomes confused with a mental health assessment and possible diversion, either into the mental health system or out of the criminal justice system, but the AA is rarely called. Was he or she acting within the requirements of the Mental Health Act (MHA) 1983, or in the role of the AA? What often happened was that the social worker assessed the suspect with the police surgeon alone, or separately, then if the suspect was assessed as fit for detention and interview the PACE interview would proceed without the presence of an AA. Even if the social worker stays to act as the AA after a mental health assessment, it is
debatabile if he or she should be seen as suitable, in that the social worker would be seen by the suspect as someone in authority over him or her, as only a few minutes previously the social worker would have had the power to compulsorily admit the suspect under a Section of the MHA.

Further confusion arises when a mentally vulnerable suspect is brought to the police station on a s136 of the Mental Health Act 1983, this was usually recorded as 'a place of safety' on the custody record. Sometimes the reason for arrest of a mentally vulnerable suspect was recorded as a 'place of safety' and also for an offence. The Mental Health Act 1983 (MHA) makes provision for mentally disordered persons, found in a public place, to be escorted by the police to a 'place of safety'. The 'place of safety' is usually the police station. The person can be detained in a place of safety for 72 hours.¹

This power can be used whether or not the person is suspected of committing a criminal offence. The power to arrest under this Section is contained in s26 and Schedule 2 of the PACE Act and applies to persons who have been brought to the police station as a 'place of safety'.

All Section 136 detentions were recorded during this study. The custody records almost always noted that the reason for arrest and detention was: as a 'place of safety', or 'for own protection', or 'place of safety' with an offence, usually a 'breach of the peace', or 'criminal damage'. Only once or twice was the term Section 136 written on custody records as the reason for arrest and detention. No
custody officers interviewed during the study understood that a 'place of safety' meant a Section 136 under the MHA 1983. However, all the custody officers knew that the detained person needed to see a doctor and a social worker.

Invariably, custody officers call the police surgeon first when a person is brought to the police station on a 'place of safety', or a 'place of safety/offence' arrest. Only occasionally did the custody sergeant call a social worker or the Emergency Duty Team (EDT) as well as the police surgeon. Also included with the data on s136's is information on suspects who were originally arrested for an offence but were subsequently seen to need a psychiatric assessment. Because of the confusion surrounding the processing of s136 detentions, too often disturbed people have to wait an unacceptable length of time in a police cell before being seen by a social worker and a psychiatrist. However, the police surgeon usually attends the police station promptly, except occasionally when, for example, the police surgeon had previously examined the person and/or knew that the social worker and the psychiatrist were unable to attend the police station for several hours. While the police are urged to divert mentally vulnerable suspects away from the criminal justice system (Home Office Circulars 66/90 and 12/95) the mental health system is not always willing or able to accommodate all the mentally disordered offenders that might benefit from diversion.

Furthermore, there remains the issue about the need for an AA when persons are detained at a police station on s136 - and for an offence. The need for an AA is also clear when, a PACE interview takes place, then as often occurs, if the suspect is
seen to be mentally disordered they wait many hours in a police cell before being assessed by a psychiatrist and sometimes a social worker. Conversely, persons brought into the police station on a s136 but when assessed are declared 'not sectionable', are then interviewed if an alleged offence is involved - but are interviewed without an AA. Although suspects brought to the police station as 'a place of safety' might not be 'sectionable' under the requirements of the MHA 1983, they are nevertheless, vulnerable within the guidelines contained in the PACE Act Code C. which urges the custody officer to err on the side of caution if a detainee is suspected of being mentally vulnerable then an AA must be called.

The police powers in the use of Section 136 have often been criticised. The criticism particularly concerns the seemingly over-representation of black suspects being detained under this Section of the MHA 1983 see (Bean et al 1991, Bean and Mounser 1993, Rogers and Faulkner, 1987). This research also showed that the police are good at identifying people suffering from mental disorder, so much so, that over 90 per cent of those studied by Roger and Faulkner (1987) and Bean et al (1991) were subsequently confirmed by psychiatrists to be mentally ill. Philip Bean suggests that the reason why the police are "reasonably efficient as diagnosticians of mental disorder is because of their experience in dealing with bizarre and odd behaviour". (Bean and Mounser 1993, p:47). It should be borne in mind that the research conducted on the police's use of s136 powers (ibid) was carried out in the Metropolitan area. There does not seem to be any corresponding research on the police use of s136 outside of London. The Department of Health statistics indicate that s136 is rarely used outside of London (Hoggett 1990).
However, official mental health statistics need to be viewed with caution because they are likely to be inaccurate because of the system of collating and recording mental health statistics (see Nemitz and Bean 1995). Therefore, the data on s136, gathered during the course of this study, although only a by-product of the main purpose of the study, nevertheless, reveals the confusion that often surrounds the s136 procedure by the police and other mental health professionals.

The Mental Health Act Commission (MHAC), amongst others often criticise the use of police stations as places of safety particularly, and the detention of mentally disordered people generally (see the MHAC's Fifth Biennial Report 1991-1993). However, the point ought to be made that, often the police do not have any choice in this matter as many psychiatric hospital's policy is not to accept people brought in by the police on s136. (Nemitz and Bean 1995).

The Mental Health Act Commission’s Report (op.cit.) also makes reference to the legal rights of people detained in police stations as a 'place of safety'. These rights are defined in the PACE Act Codes of Practice (op.cit.). The MHAC’s Report also refers to the need to call an AA for suspects thought to be mentally disordered, the Report states -

"The Police and Criminal Evidence Act makes provision for arrested suspects thought to be mentally disordered. An "appropriate adult" (e.g. a relative or mental health worker) should be asked to attend the police station and an examination by a police surgeon should be arranged. Assessments with
a view to sectioning can, of course, take place on persons detained other than under Section 136”. (MHAC Report 1991-1993, p:56)

The above statement is confusing regarding the role and function of the AA. Is the MHAC stating that an AA should be present during every psychiatric assessment for suspects detained in police stations, and for persons detained on s136? The MHAC needs to clarify this area, for example, if the AA is a mental health worker such as an approved social worker (ASW) he or she should not act in both roles at the same time. One of the major findings of this study has shown that it is precisely when psychiatric assessments take place that the need for an AA is overlooked. If the MHAC interprets the role of the AA to be present at all psychiatric assessments, which includes the police surgeon, and ASW and/or a psychiatrist, then the Commission should clarify the function of the AA during psychiatric assessments, that is, is the role the same as that during a PACE interview? Further, whose duty is it to call an AA when a psychiatric assessment is to take place? It is likely that the MHAC interprets the role of the AA during psychiatric assessments in police stations to help divert suspects from the criminal justice system.

Indeed, the role of the AA has become confused with the debate about diverting mentally disordered offenders from the criminal justice system. (NACRO 1993). The diversion of mentally disordered suspects and the role that the AA might play in such a process in the police station has only added to the confusion that is already present about the role and function of the AA. That the AA should be involved in diverting a suspect from the criminal justice system not only widens the role as it is
defined in the Code, it places responsibilities on the AA that only a social worker would likely be able to accomplish. Issues of diversion of mentally disordered suspects introduces further conflicts of interest when it is confused with, or seen to be part of the role of the AA.

**Other Professionals, Psychiatrists and Social Workers.**

This study has shown that there is not only confusion surrounding the role and function of the AA, but there is a failure to implement the AA protection for many mentally vulnerable suspects. Often the confusion is exacerbated when a psychiatric assessment takes place, especially when the assessment is carried out by the police surgeon alone or, as sometimes occurs the police surgeon and a psychiatrist assess the detainee in the absence of a social worker, then if a PACE interview proceeds the AA procedure is disregarded. Indeed, the police could hardly be blamed for not thinking an AA is necessary (if they think about the AA at all) after a suspect has been examined by a police surgeon and a psychiatrist. Thus, the inclusion of a discussion about the use of police powers under s136 and the use of the police station as a ‘place of safety’ for mentally vulnerable suspects, is further complicated with the presumption that it is a good thing to ‘divert’ mentally vulnerable suspects somewhere other than prison. What is revealed is confusion, ignorance, lack of training and the will to implement the safeguards contained in the MHA 1983 and the PACE Act 1984 by the police and mental health professionals. Given the problems surrounding the detention and treatment of mentally vulnerable
suspects generally, it is hardly surprising that similar confusion and contradictions abound over the use of the AA.

But what is clear, is that when mentally vulnerable people are detained in police stations as a 'place of safety' within guidelines defined by the MHA 1983, they are also detained within the PACE Act Codes of Practice, and therefore technically should be afforded the protection of the AA. However, as mentioned above, just what an AA's contribution would be during a psychiatric assessment, remains unclear. Moreover, it is doubtful, given the confusion that already exists with psychiatric assessments in police stations, that the presence of an AA would only add to the general chaos.

The data from this study also suggests that when professionals, such as social workers or probation officers act in the role of the AA, there is the possibility of a conflict of interest, especially when the suspect is also the social worker's client, not only if the case comes before the court, but if the social worker has information about the suspected offence, then it is doubtful if the social worker/AA acts in the best interest of his/her client/suspect. Indeed, even if the social worker excludes him or herself from acting as the AA because of a conflict of interest, such an action would likely be seen by the police to infer guilt.

As already stated, one of the major findings of this research was the lack of understanding about the AA role which was expressed by many police officers, including custody sergeants. For example, the immediate assumption stated in
every police station, was that the AA procedure was for juveniles only. Many custody officers also assumed that the need for an AA was a medical decision. This assumption is confirmed in several case histories, especially those where the police surgeon recommends the need for an AA (Palmer and Hart 1996, and Robertson et al 1996, also record confusion concerning whose responsibility it is to call an AA). However, during formal and informal interviews with custody officers throughout the course of this study, they invariably declared that they would still call an AA even when the police surgeon assessed a vulnerable suspect as ‘fit to be detained and fit to be interviewed’, yet the data does not confirm these statements. Also, from the interviews with custody sergeants and other officers, it was clear that their perception of the role and function of the AA was often equivocal. For example, many officers felt that an AA should never interrupt an interview, or if they do, only for welfare reasons, such as for food/drink or the lavatory. The confusion or lack of understanding about the role and function of the AA was not confined to the custody sergeant however. Professionals such as social workers also revealed a lack of knowledge about the role, and a reluctance to act as an AA. (Interestingly, the assumptions about the role and function of the AA and the confusion about whose responsibility it is to call an AA when a police surgeon is involved, were found again during the evaluation of the Southampton MIND AA Scheme, see previous chapter for a discussion of this research). The Appropriate Adult Review Group (1995) recommended that -

"The Forensic Medical Examiner should not be regarded, as a matter of course, as being competent to declare a suspect's need, or otherwise, for an appropriate adult." (para 18. p:3) (emphasis in the original)
Summary of the Findings as they relate to the Role of the Appropriate Adult.

In order to answer the above question, it is necessary to digress and state first what the Codes of Practice say who should be the AA and what the AA should do. It was not part of the empirical study to ask this question, so the answer must be gleaned from what the Code says.

Code C of the PACE Act’s Codes of Practice defines the role of the AA and who can act in the role. The definition outlined below are taken from the Revised Code 1995. Once the custody officer has any doubt about the mental vulnerability of a suspect then the AA must be informed and asked to attend the police station for the suspect (C.39). For the purposes of the mentally disordered or mentally handicapped suspect the AA is defined as -

"(i) a relative, guardian or other person responsible for his care or custody;
(ii) someone who has experience of dealing with mentally disordered or mentally handicapped people but who is not a police officer or employed by the police (such as an approved social worker as defined by the Mental Health Act 1983 or a specialist social worker);
or
(iii) failing either of the above, some other responsible adult aged 18 or over who is not a police officer or employed by the police.

Note for Guidance 1E states that it may be better to have someone who is trained in mental health rather than a relative lacking these qualifications, but specialist mental health training (Approved Social Worker (ASW) does not include training in learning disabilities). However, the Note goes on to state that if the suspect prefers a relative, or objects to the AA, then the suspect’s wishes should be respected if practicable.
Who is appropriate to act as an AA is a fundamental question as some of the Court of Appeal cases outlined earlier reveals (see DPP v Blake). In this case the juvenile’s father was present at the interview, but the lack of empathy between the suspect and her parent entitled the Magistrates to conclude that an estranged parent was not an AA within the spirit of the Code. In relation to juveniles, another factor plays a vital part in the interaction between the juvenile and the parent who acts as the AA, that is, whether the parent is pro-police or anti-police. The latter type were described as obstructive and usually insisted upon the right of silence. But the pro-police parent were the types who either deferred to police authority or because of their lack of empathy with their child bullied them into confessing. However, a lack of empathy could also exist between an adult suspect and his/her social worker or mental health professional, which was often observed during the course of this study. It is suggested that the test in R v Blake should also apply to mentally vulnerable adults and their AA.

Moreover, the appropriateness of the AA involves not only a lack of empathy between the suspect and the AA, but also the mental capacity of the AA. Such a situation is described by Gudjonsson and MacKeith (1994) when they assessed a mentally handicapped and highly suggestible man who had confessed to a double murder in the presence of a solicitor and an AA. However, Gudjonsson and MacKeith (ibid) found that the AA, who was a relative was also of borderline intelligence. The police had not asked her whether she could read or write, or apparently considered this AA was in any way inappropriate. This and other cases raise important issues about who is competent to act in the role of the AA.

The AA is clearly seen as having a very important role in the protection of mentally vulnerable suspects during their detention and interrogation in the police station. This is confirmed when examining Code C in relation to the role of the AA. The AA is envisaged as being with the suspect at every stage of the detention. The
AA’s involvement with the suspect includes: if the suspect has been informed of his/her rights or has been cautioned then they must be repeated in front of the AA (C 3.11). Robertson et al (1996) state that when they acted as AA’s during the course of their research (see Chapter 2) they felt embarrassed because the suspects had understood their rights because some of them had already called a legal adviser, but the authors do not mention whether these suspects understood the caution, this is important now that the right of silence has been amended. However, Robertson et al (ibid) point out that if the suspect has not requested a legal adviser then as the Code states, the AA can request a solicitor (C 3.13). The suspect must not be interviewed nor asked to sign a written statement in the absence of an AA (C 11.14) unless an urgent interview is necessary defined in C 11.1 and Annex C. However, the Note for Guidance in Annex C states that owing to the potential unreliability of this “particularly vulnerable” group this provision “should be applied only in exceptional cases of need.” (Annex C Note for Guidance Cl). Indeed, even if the police have good reason for delaying informing someone of a suspect’s arrest, the AA must still be informed and asked to attend the police station (C Annex B.B1).²

Clearly, the AA’s general role is intended to be one of an interpreter: to explain to the suspect the purpose of the various procedures, ensure that the suspect understands them, and that the police do not discriminate against a vulnerable suspect. But as already discussed so far, the AA is also intended to ensure, or minimise the risk of unreliable evidence (see Note for Guidance 11B Chapters 3 and 6). Indeed, if as the Codes indicate, that the presence of the AA is to ensure reliability of evidence, this requirement gives added impetus to the decision to exclude the solicitor from acting as the AA. Not only should the AA facilitate communication between the police and the suspect, which would be compromised if the solicitor advised silence furthermore, the solicitor has no duty to the criminal justice system to aid in obtaining reliable testimony, whereas it seems the AA does. However, as can be seen from the Court of Appeal Judgements outlined earlier,
particularly the cases of McKenzie and Law-Thompson, the question of reliability and the absence or presence of the AA, is a moveable feast. The question is: does the court recognise the presence of the AA during the interrogation as conferring reliability upon that testimony - whatever circumstances prevail? The answer must be no.

The reliability of the testimony of mentally vulnerable suspects depends upon whether all the protective procedures are adhered to by the police. The presence of the AA throughout all the procedures in the police station, is to ensure ‘fair play’ including the interrogation where the communication of evidence between the suspect and the police is paramount, evidence gathered in such conditions should be reliable in order to be used at a later stage in a trial. Thus, all the police procedures are important, but the interrogation is obviously the occasion when the suspect is most at risk. The Code defines the role of the AA thus -

"Where the appropriate adult is present at an interview, he shall be informed that he is not expected to act simply as an observer; and also that the purposes of his presence are, first, to advise the person being questioned and to observe whether or not the interview is being conducted properly and fairly, and secondly to facilitate communication with the person being interviewed."

(Code C. 11.16)

The definition of the role of the AA is limited in scope, but even so, the task is onerous, above all the role is not passive but active. The role is to act much like a referee between the police and suspect which demands a knowledge of police procedure, the PACE Act and the Codes, also an understanding of the role of other professionals such as the solicitor, the police surgeon and other mental health professionals is needed. In order to be able to interrupt, or object to questions during the interrogation demands not only knowledge but confidence. To request
the presence of the solicitor or the police surgeon also means prior knowledge of the
Codes and the importance of these professionals. Clearly, the Codes of Practice
confer rights and responsibilities upon the AA that are demanding. However, given
the importance that the Codes of Practice place upon the AA role, an area that
remains even more contentious than many of the others involving the role of the
AA, is the issue of confidentiality.

Only one professional group has legal privilege and that belongs to legal advisers.
Some professional groups claim confidentiality e.g. doctors, social workers, priests
or journalists, but only legal advisers are afforded it by statute. These other groups
claim privilege but they could be compelled by the courts to divulge information
given to them in confidence by an accused. Indeed there is a case of a social worker
while acting as an AA receiveing an admission of murder from a suspect. The
social worker was informed by a senior social worker to breach confidentiality and
inform the police (personal correspondence 1995). Even if a social worker does not
inform the police about an admission from a client but just exclude herself or
himself from acting in the role of the AA, such an action would more or less inform
the police that the suspect was guilty. Although there is no legal obligation for
ordinary citizens to inform the police about a crime, there is considered to be a civic
duty to do so. Such a duty is recognised by professional social work organisations.

But of course, there is always the matter of public interest that the court must take
into consideration in such cases. For example, compelling a priest to tell a court
about a suspect’s confession told during the Sacrament of the Confessional, would
probably not be seen in the public’s interest, as most people whether religious or
not, would agree that a priest answers to a higher court. However, the case of a
journalist claiming privilege might be seen in a different light - being either
avaricious or guarding a scoop. Probation officers hear admissions from their
clients - some may decide to inform the police particularly if they think someone is
in danger. But many probation officers might not divulge admissions of guilt from their clients, because for probation officers to be effective, much depends upon the relationship that builds between them and their clients. There are other forms of confidentiality that exist between the police and their informers. This is a secretive area of criminal justice, and necessarily so. But the police use children as informers and when they do, the child is interviewed in the presence of an AA. It is not known if the AA in these cases understands the implications of their role, not only the lack of confidentiality, but the obvious danger informers and the AA of children who are informers, places themselves in. In such cases, although the police protect their informer's identity, the court, or the defence counsel, would have the right to force informers to give their evidence in court, and this would include in the case of a child informer, the AA.

The lack of confidentiality between the AA and the vulnerable suspect needs to be clarified. The Appropriate Adult Review Group (1995) recommended that either the AA be afforded legal privilege or that they should never be compelled to give evidence in court. Sir Louis Blom-Cooper (personal correspondence 1997) thinks that AA's should be given legal privilege. Indeed, if legal privilege was granted to the AA, this would enhance the status of the role within the police station and the courts. Breaches of the Code involving the AA might then be taken more seriously - conversely the accountability and the effectiveness of the AA would be scrutinised. All in all, the role and function of the AA might then be defined, formalised, and above all to be seen to matter for all mentally vulnerable suspects. For the role of the AA is justified not because the suspect is unfit to be detained or unfit to be questioned. The role of the AA is to protect the suspect from the special disadvantages they face in being required to participate in detention and interrogation, not only in the legal sense of ensuring reliability of evidence, but also in the moral sense of respecting the non-discriminatory principle on behalf of mentally vulnerable suspects. When custody officers disregard calling an AA
because the police surgeon has decided that a mentally vulnerable suspect is fit to be detained and interviewed, or the Court of Appeal decides that the absence of an AA for a mentally disordered suspect did not matter because other circumstances prevailed, and when the legal adviser fails to act in the best interests of a mentally vulnerable client, when any, or all these, so called safeguards for mentally disordered and mentally handicapped suspects are disregarded, then so too is the moral non-discriminatory principle abandoned that these legal safeguards were supposedly designed to guard against.

This study has shown that the Appropriate Adult procedure is a piece of legislation that is not working and suggests why that should be so. The previous Chapter suggested how the situation could be ameliorated and goes some way to provide answers to some of the questions posed above.

The findings of this study, including the research discussed in the literature review, shows that there is a clear need for more training for custody officers in the recognition of mental disorder and learning disabilities and implementing the Codes of Practice in relation to the AA procedure. Indeed, all custody officers interviewed during this study stated that they would undergo training in mental health issues if it was available. Moreover, if there was available a group of trained individuals willing to act as AA's, the custody officers said they would use them whenever there was doubt about a suspect's mental ability. The evaluation of the Southampton MIND volunteer scheme discussed in the previous chapter argued that where trained volunteers are available they will be used. While the need for training for custody sergeants and the availability and training for AA's is an obvious implication of this study but the problems about how vulnerable suspects are treated in police stations is more complex than matters of training, or indeed clearer Codes of Practice or legislation, might suggest. The problems are endemic, that is, the attitudes and perceptions that prevail about the mentally vulnerable in
society generally, are reproduced in the police station to a greater degree of discrimination - with possible enormous consequences for these suspects. But the use of AA volunteers in the police station introduces ordinary people into the custody area - which is perhaps one of the most intimidating areas where police culture flourishes - which might engender changes in attitudes towards mentally vulnerable suspects. Indeed, more volunteers, especially AA volunteers in the police station can only help to promote changes in police culture. At least the volunteer AA schemes are a start in this direction.

Moreover, as the AA is used more often this may well generate research that will reveal how effective AA’s are in terms of how mentally vulnerable suspects proceed through the criminal justice system, and what part other professionals play in that process. Particularly relevant here is the effect an increase in the use of AA’s will have on the Crown Prosecution Service. The use of an AA is a marker which should indicate that this case should be looked at more closely. Further research would be particularly important here. Indeed, the increased use of the AA would open other areas of research that would add to our understanding about how and under what circumstances should mentally vulnerable suspects be treated in police stations - and the wider community.

Notes.

1 The MHA 1983 states that -
"If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons remove that person to a place of safety....A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved social worker and of making any necessary arrangements for this treatment or care.". (Jones, 1991 p:218)

2 For the conditions necessary before an urgent interview can take place is if the delay would be likely -
“(a) to lead to interference with or harm to evidence connected with an offence or interference with or physical harm to other people; or (b) to lead to the alerting of other people suspected of having committed an offence but not yet arrested for it; or (c) to hinder the recovery of property obtained in consequence of the commission of an offence.”. (C 11.1) of Code C.)
Chapter 9

A Broader Context.

In this Chapter the purpose is to extend the focus and the realisation of Aim 4: i.e. to determine the policy implications of existing practices and point to future development, by developing an understanding of how the provision of the AA fits within the general schema of special defences of the mentally disordered offender. The intention is to suggest that the role and function of the AA is an extension of those special defences provided for the mentally disordered offender before, during or after the trial stage. Obviously, the AA procedure comes before the trial, but whether implemented or not it could influence the outcome of those special defences. Moreover, by placing the AA protection within these special defences, which are, of course grounded in those older arguments about justice versus treatment, this suggests why the AA role has been neglected.

The Place of the Appropriate Adult within the Special Defences for the Mentally Disordered Offender.

Introduction.

Modern lawyers have inherited from the neo-classicists that where a person caused an actus reus and had the appropriate mens rea he will be held liable. Since our common law system is constructed on the premise that individuals should not be convicted of an offence unless they deliberately choose to do something wrong, those regarded as unable to choose require special provisions (Verdun-Jones S.
Accordingly, where these provisions are introduced, and they apply also to children, they are likely to be varied, aimed at different groups and at a number of different legal outcomes.

One group requiring special provisions are the mentally disordered - another are children (hence the justification for including adults and juveniles together in Code C. of the PACE Act Codes of Practice). Mental disorder itself intersects with the criminal justice system in complex and changing relationships with varying tests for the consequences of those intersections (Morris N. 1983). Three major areas exist; the competency of a mentally disordered person to be tried for a criminal offence, the responsibility for conduct, so that where the mental disorder is shown to be present that person can no longer be adjudged as criminal, and the task of sentencing mentally disordered criminals. These by no means exhaust the list, although they are the focal points of much public anxiety and professional consideration, and are required to promote that difficult balance between individual autonomy and State authority in relation to criminal behaviour and mental disorder. (ibid. 1983). These three relationships between mental disorder and the criminal law are what Norval Morris calls, "‘triability’, ‘responsibility’ and ‘punishability’", (ibid, 1983, p:1).

Are those three relationships or intersections applicable in the police station when a mentally vulnerable suspect is detained and interrogated? Can, or should these concepts apply in the police station? The answer must be yes, but why is it relevant to the role of the AA?
'Triability'

'Triability' concerns the competency of a person to stand trial. It is generally accepted that persons must be able to understand that they are accused of a crime, and have the ability to defend themselves when cross examined and be able to question witnesses. If a person is found 'unfit to plead' then the only justification it seems for detaining that person is in order to ensure that he/she may become fit or competent to stand trial. For those for whom it is unlikely that they will achieve competency the justification for incarceration in secure psychiatric hospitals is for 'treatment'(and 'punishment', depending upon which side of the justice versus treatment debate one favours). The arguments have ranged around such concepts as 'not guilty by reason of insanity' or 'guilty but insane'. However, we have more or less solved these dilemmas by introducing the plea of 'diminished responsibility', with the hospital order, with or without restrictions, or the sentencing of the, "partly mad and the partly bad", (Verdun-Jones, 1989).

The custody officer who is concerned about the competency of a suspect to be detained and interrogated should call the police surgeon to determine if the suspect is fit for detention and interview. Indeed, this research showed that generally this is what the custody officer does (that the AA should be called as well was largely ignored because the medical model dominates). Whatever criteria the police surgeons operate it seems they are concerned with whether the suspect is 'sectionable' or not, whether this assessment involves competency to stand trial during detention and interrogation is questionable. If found 'sectionable' they are
diverted for treatment either voluntarily or on a Section of the Mental Health Act 1983, that is, with or without restrictions much like the hospital order. This research showed that the majority of mentally vulnerable suspects were classified as competent i.e. fit for detention and interview. While the assessment for fitness for detention and interrogation as far as the police surgeon is concerned is a matter of clinical judgement, the tests for competency to stand trial or any insanity defence are likely to be scrutinised by the court, and are central to the debates between law and psychiatry since the McNaughtan Rules. Thus, one could argue that until recently the gatekeeping medical model operated by police surgeons has largely been ignored and as such has produced injustices for many mentally vulnerable suspects as far as the AA protection is concerned.

While the AA stands closest to the first two of those major intersections defined above, i.e. that concerned with the competency of a mentally disordered person to be tried for a criminal offence, and responsibility for conduct, it differs in a number of respects, not the least in that a lower level of proof is required. All that is necessary to invoke an AA is for a custody officer to believe that a suspect is mentally vulnerable in some way and he or she must then call an AA. Why then is the AA neglected? The explanation as stated above, could be that when the medical model dominates in the police station as elsewhere, rights tend to be neglected, in this case the right to the AA protection.

The relevance of the role of the AA within the special defences becomes clearer when the other major intersection, that of responsibility, is considered. What
does the concept of responsibility mean and why is it relevant to the role of the AA? Benn and Peters (1959) make reference to F.H. Bradley's concept of responsibility which contains four main conditions which are set out below -

"(a) Self-sameness. There must be continuity of personal identity.

(b) The deed must issue from the will of the agent. By this he means that the agent must not be forced to do it. Compulsion he defines as 'the production, in the body or mind of an animate being, of a result which is not related to a consequence to its will.

(c) The doer must be supposed to be intelligent. He must know the particular circumstances of the case. If a person takes somebody else's hat from a cloakroom, thinking that the hat in question is his own and having no prior knowledge that there was a hat in the cloakroom exactly like his own, it would be unreasonable to say that he was responsible for stealing somebody else's hat. (These two criteria (b) and (c) are as old as Aristotle and comply with the main criteria which he suggested for saying that an action is voluntary).

(d) The doer must be a moral agent. He must be familiar with the general rules of what is required from his society. It is interesting to notice that these last two criteria are very similar to those of the McNaghten Rules, (sic) where in the case of people pleading guilty but insane, it must be shown that they suffer from a defect of reason of such a kind that they do not know what they are doing or do not know that what they are doing is wrong.”.

Bradley's fourth condition quoted above has particular relevance. Essentially, the role and function of the AA by trying to redress that defect in responsibility and by helping the vulnerable suspect to become a 'moral agent' conforms with Bradley's fourth condition. This point is expanded further when linked to the concept of informed consent, and is discussed below.

The AA Stands Between the Law and Psychiatry.

The AA stands between two control systems - the law and psychiatry or the mental health system and the criminal justice system. The place, or the role and function of the AA, raises again the old tensions between law and psychiatry. A central point, a point often made throughout this thesis, is that the decision to call an AA is not a medical decision. Whether a suspect is fit or unfit to be detained and questioned is separate from the decision to call an AA. Thus, it is argued here that the AA protection can be seen as an additional intersection between criminal behaviour and mental disorder, that is, it is part of those special defences for suspects not held responsible for their actions.

It is not the intention here to describe and discuss the insanity defences pre and post the 1959 and 1983 Mental Health Acts, except to make the point that the debates and the subsequent legislation oscillate between treatment and justice, that is, first giving priority to psychiatric experts - the medical model of mental disorder and then moving towards punishment and legal definitions of mental
disorder that emphasise the seriousness of the offence i.e. the due process justice model. Fundamentally the arguments concern the nature of mental disorder and how those ascribed or diagnosed as being mentally disordered should be punished or treated when they commit crime.

At present in England and Wales we seem to be in a position where we operate a mixture of both models (Peay, 1993) at one and the same time. The police station is where the mixture of both models i.e. due process and the medical model collide and is crucial to understanding why the AA procedure is confused

**The position of the AA within Therapeutic Law and the Concept of Consent.**

An analogy was made in Chapter 1 between the concept of consent and the role of the AA. It was argued that just as the concept of consent contained in the 1983 MHA was a moral commitment so the AA was created to fill a similar moral vacuum. The intention here is to expand and explain that analogy further and place the AA protection within that of the special provisions for the mentally disordered offender. The AA special provision takes place in the police station, but can also be implemented whenever and wherever a formal interview takes place between a mentally vulnerable person and the police or a psychiatrist. An example here are the Advocacy Schemes operating in the Special Hospitals where the emphasis is on empowering the patient. The role and function of the AA is
also about empowerment, to ensure that the suspect’s rights are respected and to resist harassment or pressure that produces false confessions.

The special provisions for the mentally disordered run through the legal system from the court’s use of the insanity defence(s) to the hospital order, which attempts to meet the problems of how to deal with people who are not fully responsible. This is why the debate about the responsibility of the mentally disordered must always be argued within a legal, moral and political framework and not within medicine or psychiatry. Although medicine and psychiatry may have something to say about responsibility they are not the sole contributors, for example, a psychotic person may not be responsible for his/her actions but some persons who are mentally disordered clearly are.

It was stated above that the AA stands between the law and psychiatry, or justice versus treatment, and as such encompasses the tensions between those two control systems. It is argued too that the confusion that surrounds the role and function of the AA, that this research found, is generated by, and emanates from within that tension. And within that tension lies two Mental Health Acts. The 1959 MHA reflected what Philip Bean calls, therapeutic law (Bean 1980) but the concept of consent was enshrined in the 1983 MHA which meant something else (Bean 1986). The place and the role and function of the AA lies between these two concepts, that is, the AA is intended to produce a system, or symbolise that which approximates to formal law and order to reduce arbitrary decisions and miscarriages of justice. Indeed, the modern version of the AA contained in the
PACE Act 1984 was created at the time when the new Mental Health Act (MHA, 1983) emphasised a return to legalism, a legalism that is exemplified by the concept of informed consent. Thus, it is argued that this is why the duty to implement the special provision of the AA falls upon the custody sergeant, not the police surgeon, and is therefore at least in the first instance, not a medical decision. Moreover, to place the AA protection within a legalistic framework, ensures, or should guarantee that the AA should be called for all mentally disordered suspects whether or not the alleged offence was serious. This is why it is argued that while the police insist upon interrogating mentally vulnerable suspects for petty offences, then the AA special protection should be implemented. The following discussion argues why this is so.

Therapeutic Law.

Therapeutic law, as the term implies, concerns essentially psychiatric decision making and as such can be seen in contrast to formal law in several ways (Bean, 1980). The concept has four main features, they are: *parens patriae*, professional discretion, rule enforcers are not accountable, and purposive law which involves choices between values. Essentially, ‘therapeutic law’ is about needs which are always open to moral interpretation. *Parens patriae* within the concept of therapeutic law is defined as -
"Under parens patriae the state looks after its people, particularly those who are members of vulnerable groups unable to look after themselves. Historically, it was children or the insane (or both) who qualified for parens patriae considerations, as they are regarded as being unable to look after themselves."

(Bean, 1980 p:47).

Clearly, some would see the concept of parens patriae as defined above as relevant to the role of the AA. The argument would be that parens patriae is about paternalism and see the AA simply in terms of welfare. However, to see the role of the AA in these terms is to miss the point about why the role was created. There would be no role for the AA at all within the concept of paternalism, or within any of the features of ‘therapeutic law’ because ‘therapeutic law’ involves discretion. This is to say it means that someone knows best about the welfare or treatment of the suspect/patient, and in so doing denies vulnerable suspects the right to become ‘moral agents’ in Bradley’s terms. Those who argue that the place of the AA lies within a welfare model (or even a medical one) are abandoning the non-discrimination principle, a principle that the concept of consent implies in the 1983 MHA.
Consent.

The concept of consent included in the 1983 MHA was a return to 'legalism' (Bean, 1986). Consent was ignored in the 1959 MHA, but the 1983 MHA Act reflected a change in attitude towards the mentally disordered that was

"...part of a change worldwide which seeks to reduce the paternalism of an earlier age, to identify the rights of the individual patient, and to reduce (albeit marginally) the power and prestige of the psychiatric experts".

(Bean, 1986, p:14).

The concept of consent enshrined in the 1983 Act was a way of reducing the control of the treatment providers and allowing patients some exercise of choice and freedom, in this case about treatment, other controls of course were not affected. The concept of informed consent when applied to the detained patient involves awareness i.e. being conscious of self, and even those in F.H. Bradley's term 'not self same', it also includes information, the quality of that information and how it is given and consent must not involve coercion. In effect the concept of informed consent recognises the integrity of the patient and the ability to make decisions.

When the concept of consent as outlined above is applied and transferred to the mentally vulnerable suspect in the police station together with the role and function of the AA, there can be no doubt that the AA when viewed as such, is therefore part of those special defences that apply to the mentally disordered who
commit crime. It then becomes clear why the role of the AA as defined in the Code should be present during all procedures in the police station. The AA protection recognises the integrity of the mentally vulnerable suspect, provides the information necessary to help understanding, and resists coercion in order to empower the suspect to become a 'moral agent'. This is why the AA cannot or should not be accused of paternalism or be confused with issues about welfare, treatment or diversion.

This research revealed that the AA is rarely used, this has much to do with the confusion surrounding the role i.e. that the AA is only for children, while decisions about mentally vulnerable adult suspects were confined to the police surgeon, thereby ensuring that as far as adults were concerned the medical model dominated. The tension between law and psychiatry collides in the police station with potentially serious consequences for many suspects, Norval Morris states that in this view -

"...that injustice and inefficiency invariably flow from any blending of the criminal law and mental health law powers of the state; each is sufficient unto itself to achieve a just balance between freedom and authority, each has its own interested constituency - mixed together only the likelihood of injustice is added.". (Morris, 1983, p:14).

Of course, Norval Morris is talking out the abolition of the insanity defence in favour of diminished responsibility, in the above quotation. But the relevance of
his statement is applicable to what goes on in the police station when the AA should be involved and indeed includes those suspects arrested on s136 of the MHA (this was discussed in the previous chapter).

In effect, the results of this research have proved the points so eloquently expressed in the above passage, that is, injustice and inefficiency developed precisely because the custody sergeants confused the requirement to call the AA with a mental health assessment. The medical model dominated at the expense of the legal requirement to call an AA.

The justification for linking the role and function of the AA to the special defences for the mentally disordered and the concept of consent is because the creation of the AA, as defined in the Code, took place at a time when the debate emphasised a moral and political view about enlarging freedom, a liberal framework of enlarging freedom; these principles need to be reasserted.

Even so when considering the elaborate and necessary legal rules, and the enormous legal interest shown in defences such as the McNaughtan Rules, one could have expected similar levels of interest when the suspect is being questioned in the police station. But for reasons which are difficult to identify this has not been so. Legal theorists have shown little interest, and practising lawyers likewise. Perhaps the police station is seen as outside their remit, if only because they cannot control what goes on there, or perhaps they think that injustices can be corrected at the trial stage. Nor have treatment officials shown interest, often
being more concerned with finding ways to divert mentally disordered offenders out of the criminal justice system than with what goes on during detention and interrogation. Whatever the reasons the national statistics present a daunting picture on the extent of the problem. No one knows the numbers of mentally disordered suspects passing through the police stations in England and Wales each year but estimates vary from 2% to 20% (see particularly Brown D. 1989 and 1997, Brown D. et al 1992, Gudjonsson G. et al 1993 in Chapter 2). Put in the context of the current crime statistics of England and Wales, or any modern Western Society, and it becomes an enormous figure.

It is not suggested that the role of the AA should be ascribed the same status as the special defences of insanity, unfitness to plead, or diminished responsibility, yet the role and function of the AA must lie within those special defences. Although none seems sufficient to prevent mentally disordered people being convicted of crime (Morris N. 1983) the principles that produced them have not been abandoned. The role of the AA is part of those principles that formed the debate about how and under what circumstances mentally vulnerable people should be treated in the criminal justice system. More specifically the AA is part of the change and debate that produced the 1983 MHA, in as much as the 1983 Act was about reducing paternalism and emphasising the rights of the individual patient.

When a suspect presenting with some form of mental vulnerability the custody officer's first action is to call the police surgeon. However, the custody sergeants may not be entirely culpable or responsible for the injustices. Home Office
Circulars (particularly Circular 66/90 which does not mention the AA) court diversion schemes, community psychiatric nurses attending police stations, all reflect the medical model of crime control. It is hardly surprising that custody officers feel that they need a medical opinion before they think of the AA - if indeed, by that time the AA is thought of at all.

Although the AA was described above as standing between law and psychiatry, it is argued that the emphasis of the role and function of the AA must remain within the justice model. Those who would relegate the role of the AA to something like that of a concerned friend, or to reside mainly within a welfare framework are missing the point, and in so doing deny the principles outlined above. The role is about empowering the suspect to become a ‘moral agent’ and to resist coercion i.e. therefore the emphasis must reside within a legal framework. Otherwise only confusion, injustice and inefficiency results.
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Kiszko S.I. (1992) (see Transcript no.2665/W3/91) (see also Fennell P. (1994) for a critique of this case and other miscarriages of justice)


'Today', 'Charged with Murder and Locked up Despite an Unshakeable Alibi',


Case List.


_R v Brine_ (1992) Crim. L.R 122

_R v Campbell_ (1995) 1 Cr App R 522 (Appendix)


_R v Fulling_ (1987) 85 Cr App R 136

_R v Kiszko_ (1992) (unreported) (Transcript no 2665/W3/91

_R v Lamont_ (1989) Crim.L.R. 813

_R v Law-Thompson_ (1997) (Unrevised Judgement 21.3.97) (Appendix)


APPENDIX

Research Questionnaires
**QUESTIONNAIRE: 'APPROPRIATE ADULT'**

**CUSTODY OFFICER**

<table>
<thead>
<tr>
<th>No</th>
<th>Question</th>
<th>Code</th>
<th>Col.No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>What is your rank</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sergeant</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Constable</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other (specify)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Have you any experience of the Appropriate Adult Scheme - (excluding juveniles)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>If yes to Q2 who was the last person for whom you called an AA (Appropriate Adult) for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Detained Persons suffering from:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NA 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Illness</td>
<td>1</td>
<td>3-4</td>
</tr>
<tr>
<td></td>
<td>Mental Handicap</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Learning difficulties</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unable to read or write</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physically handicapped eg (blind, deaf and/or dumb)</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Juveniles</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other (specify)</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>
4 What indications would determine your decisions to call an A.A is it:

| The subject is overtly mentally disordered | 1 | 4-5 |
| The subject has known history of mental disorder | 2 |
| The subject has known history of learning difficulties | 3 |
| The subject has had an A.A called on a previous occasion | 4 |
| The subject is under age | 5 |
| The Police Surgeon and/or Solicitor or other persons suggest that an A.A is needed for the subject | 6 |
| Other reasons (specify) | 7 |
| combination of above (specify) | 8 |

5 Who would you call upon first to act as the A.A for person suffering from (NOT persons detained under the Mental Health Act)

(a) Mental Illness -

| ASW | 1 |
| Duty Social Worker | 2 |
| Parent(s) | 3 |
| Any relative | 4 |
| VSS volunteer | 5 |
| Other (specify) | 6 |

(b) Mental Handicap (learning difficulties) -

| ASW | 1 |
| Duty social worker | 2 |
| Parent(s) | 3 |
| Any relative | 4 |
| VSS volunteer | 5 |
| Other (specify) | 6 |
6  Would you call the Police Surgeon first for a D/P you suspected of suffering from Mental disorder and/or handicap before contacting an A.A

   Yes  1
   No   2

7  If yes to Q6 in your last use of the AA did you call the Police Surgeon in order to determine if the subject was:

   Fit to be detained | NA  0 | 8
   Fit to be interviewed | 1
   Fit to be charged | 2
   Other reasons (specify) | 3

8  Would you then call an A.A after the Police Surgeon has declared the subject to be fit to be interviewed etc

   NA  0
   Yes  1
   No   2

   OR - Ask the police surgeon's advice if an A.A is needed 3

9  If No to Q8 why have you decided that an A.A would not be needed for the D/P you called the Police Surgeon for - would it be because the Police Surgeon has declared the D/P:

   Fit to be interviewed and Fit to be detained

   NA  0
   Yes  1
   No   2

   Other reasons (specify) | 3
<table>
<thead>
<tr>
<th>No</th>
<th>Questions</th>
<th>Code</th>
<th>Col.No</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Do you know the difference between Mental Illness and Mental Handicap or Learning difficulties?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Are you confident that you can identify a D/P suffering from mental disorder and/or learning difficulties from someone who is-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(a) Drunk  Yes 1</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>No 2</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>(b) Drugs user Yes 3</td>
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<td></td>
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<td></td>
<td>No 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(c) Under stress Yes 5</td>
<td></td>
<td></td>
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<td></td>
<td>No 6</td>
<td></td>
<td></td>
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<tr>
<td>12</td>
<td>Are there any behavioural characteristics that would alert you to the possibility that the D/P was suffering from mental disorder? eg-</td>
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<tr>
<td></td>
<td>Shyness 1</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>diffidence 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>aggression 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>belligerence 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>uncooperative 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>unable or unwilling to communicate 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>unable to read/write 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>lacking self care 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>fearful 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other (specify 11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Would you consider the D/Ps address important e.g. living in a hostel or NFA</td>
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<td></td>
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<tr>
<td></td>
<td>Yes 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Would you consider the type of school a D/P attended important?</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Yes 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
15 Would the type of offence alert you to the possibility of mental disorder eg.-

<table>
<thead>
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<th>Question</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
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<tr>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>5</td>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

16 What in your opinion what should the A.A do:

<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Protect D/Ps Rights</td>
</tr>
<tr>
<td>2</td>
<td>Protect D/Ps Welfare</td>
</tr>
<tr>
<td>3</td>
<td>Facilitate/assist in the conduct of the interview</td>
</tr>
<tr>
<td>4</td>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

17 In your opinion should an A.A ever interrupt an interview

<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
</tr>
</tbody>
</table>

18 Would you agree to any of the following conditions when the A.A should interrupt an interview -

<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The subject seems eager to please the interrogating officers</td>
</tr>
<tr>
<td>2</td>
<td>The subject seems eager to confess to a crime(s)</td>
</tr>
<tr>
<td>3</td>
<td>The subject is confused (not due to drugs/alcohol)</td>
</tr>
<tr>
<td>4</td>
<td>The subject is upset</td>
</tr>
<tr>
<td>5</td>
<td>The interview is over-long</td>
</tr>
<tr>
<td>6</td>
<td>The subject needs food/drink lavatory etc.</td>
</tr>
<tr>
<td>7</td>
<td>Other conditions (specify)</td>
</tr>
<tr>
<td>No</td>
<td>Question</td>
</tr>
<tr>
<td>----</td>
<td>--------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>19</td>
<td>Have you had any specific training in the subject of mental illness/mental disorder, mental handicap (people with learning difficulties)?</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>If yes to Q19 did you find the training useful in helping you identify persons with mental disorder/mental handicap etc?</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>If No to Q19 would you attend a training course on mental health if it was offered?</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>If NO to Q21 please specify any reasons why you do not consider training in mental health issues necessary for Police Officers in general and Custody Officers in particular? eg.:-</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>It is the Police Surgeon's responsibility to identify people who are mentally disordered and/or handicapped</td>
</tr>
<tr>
<td></td>
<td>Custody Sergeants have long experience in dealing with the public and thus are able to identify people suffering from mental disorder</td>
</tr>
<tr>
<td></td>
<td>All police officers are able to identify people suffering from mental disorder</td>
</tr>
<tr>
<td></td>
<td>Other reasons (specify)---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Question</td>
<td>Code</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>What is the name of Police Station</td>
<td>Man A 1</td>
</tr>
<tr>
<td></td>
<td>Man B 2</td>
</tr>
<tr>
<td></td>
<td>Man C... 3</td>
</tr>
<tr>
<td></td>
<td>Linc A 4</td>
</tr>
<tr>
<td></td>
<td>Linc B 5</td>
</tr>
<tr>
<td></td>
<td>Derby A 6</td>
</tr>
<tr>
<td></td>
<td>Derby B 7</td>
</tr>
<tr>
<td>What is the date of visit</td>
<td></td>
</tr>
<tr>
<td>What is the name of subject</td>
<td>Code</td>
</tr>
<tr>
<td>What is subject's sex</td>
<td>Male 1</td>
</tr>
<tr>
<td></td>
<td>Female 2</td>
</tr>
<tr>
<td>What is subjects age</td>
<td>Under 14 years</td>
</tr>
<tr>
<td></td>
<td>14 - 16</td>
</tr>
<tr>
<td></td>
<td>16 - 20</td>
</tr>
<tr>
<td></td>
<td>20 - 25</td>
</tr>
<tr>
<td></td>
<td>25 - 35</td>
</tr>
<tr>
<td></td>
<td>35 - 50</td>
</tr>
<tr>
<td></td>
<td>50 - 60</td>
</tr>
<tr>
<td></td>
<td>60 - 70</td>
</tr>
<tr>
<td></td>
<td>Over 70 years</td>
</tr>
<tr>
<td>Has an A.A. been called</td>
<td>Yes 1</td>
</tr>
<tr>
<td></td>
<td>No 2</td>
</tr>
<tr>
<td>f yes, who was called?</td>
<td>N/A 0</td>
</tr>
<tr>
<td></td>
<td>ASW 1</td>
</tr>
<tr>
<td></td>
<td>Duty S.W. 2</td>
</tr>
<tr>
<td></td>
<td>Relative 3</td>
</tr>
<tr>
<td></td>
<td>Other (specify) 4</td>
</tr>
<tr>
<td>f relative called who was it</td>
<td>N/A 0</td>
</tr>
<tr>
<td></td>
<td>Mother 1</td>
</tr>
<tr>
<td></td>
<td>Father 2</td>
</tr>
<tr>
<td></td>
<td>Sibling 3</td>
</tr>
<tr>
<td></td>
<td>Other (specify) 4</td>
</tr>
<tr>
<td>Question</td>
<td>Code</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Has an A.A been called previously for this subject</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>N.K.</td>
<td>3</td>
</tr>
</tbody>
</table>

If yes why was this A.A called, was it—

<table>
<thead>
<tr>
<th>Reason</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>By arrangement between police and social services</td>
<td>1</td>
</tr>
<tr>
<td>A list of available ASW's</td>
<td>2</td>
</tr>
<tr>
<td>Was A.A. only person available</td>
<td>3</td>
</tr>
<tr>
<td>The subject was a juvenile</td>
<td>4</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>5</td>
</tr>
</tbody>
</table>

Was the A.A who was called for this subject defined as Appropriate Adult on the custody record

<table>
<thead>
<tr>
<th>Response</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>

If NO to Q 11 what was the A.A defined as on the custody record;

<table>
<thead>
<tr>
<th>Definition</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>N.A</td>
<td>0</td>
</tr>
<tr>
<td>The nominated person</td>
<td>1</td>
</tr>
<tr>
<td>Not defined</td>
<td>2</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>3</td>
</tr>
</tbody>
</table>

Did the A.A who was called for this subject and NOT defined as the Appropriate Adult on the custody record, SIGN the custody record in the section reserved for the Appropriate Adult's signature

<table>
<thead>
<tr>
<th>Response</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>N.A</td>
<td>0</td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>

as the Police Surgeon called for his subject

<table>
<thead>
<tr>
<th>Response</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>

as a Psychiatrist called for his subject

<table>
<thead>
<tr>
<th>Response</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Question</td>
<td>Code</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>If yes to Q 15 was an ASW also called for this subject</td>
<td></td>
</tr>
<tr>
<td>N.A 0</td>
<td></td>
</tr>
<tr>
<td>Yes 1</td>
<td></td>
</tr>
<tr>
<td>No 2</td>
<td></td>
</tr>
<tr>
<td>If NO to Q16 what reason was given why no ASW was called/or attended</td>
<td></td>
</tr>
<tr>
<td>N.A 0</td>
<td></td>
</tr>
<tr>
<td>No ASW was available</td>
<td>1</td>
</tr>
<tr>
<td>No reason recorded</td>
<td>2</td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
</tr>
<tr>
<td>Why was the subject arrested and brought to the Police Station.</td>
<td></td>
</tr>
<tr>
<td>Suspicion of:</td>
<td></td>
</tr>
<tr>
<td>Theft</td>
<td>1</td>
</tr>
<tr>
<td>Burglary</td>
<td>2</td>
</tr>
<tr>
<td>Criminal damage</td>
<td>3</td>
</tr>
<tr>
<td>Indecent exposure</td>
<td>4</td>
</tr>
<tr>
<td>Common assault</td>
<td>5</td>
</tr>
<tr>
<td>ABH</td>
<td>6</td>
</tr>
<tr>
<td>arson</td>
<td>7</td>
</tr>
<tr>
<td>drunk/disorderly</td>
<td>8</td>
</tr>
<tr>
<td>drugs related offence</td>
<td>9</td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
</tr>
<tr>
<td>Combinations of above</td>
<td></td>
</tr>
<tr>
<td>Was subject brought to the Police Station under the 1983 Mental Health Act (as 'place of safety')</td>
<td></td>
</tr>
<tr>
<td>N.A 0</td>
<td></td>
</tr>
<tr>
<td>Yes 1</td>
<td></td>
</tr>
<tr>
<td>No 2</td>
<td></td>
</tr>
<tr>
<td>If yes to Q 19 was Section 136 as fined under the 1983 MHA formally used</td>
<td></td>
</tr>
<tr>
<td>N.A 0</td>
<td></td>
</tr>
<tr>
<td>Yes 1</td>
<td></td>
</tr>
<tr>
<td>No 2</td>
<td></td>
</tr>
<tr>
<td>when A.A called was the subject charged with an offence</td>
<td></td>
</tr>
<tr>
<td>N/A 0</td>
<td></td>
</tr>
<tr>
<td>Yes 1</td>
<td></td>
</tr>
<tr>
<td>No 2</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Code</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Was subject read his/her rights in presence of A.A.</td>
<td>N/A</td>
</tr>
<tr>
<td>Was subject read his/her rights in presence of A.A.</td>
<td>Yes</td>
</tr>
<tr>
<td>Was subject read his/her rights in presence of A.A.</td>
<td>No</td>
</tr>
<tr>
<td>Was subject read his/her rights in presence of A.A.</td>
<td>N.K</td>
</tr>
<tr>
<td>What was subject charged with?</td>
<td>N/A</td>
</tr>
<tr>
<td>What was subject charged with?</td>
<td>Theft</td>
</tr>
<tr>
<td>What was subject charged with?</td>
<td>Indecent Exposure</td>
</tr>
<tr>
<td>What was subject charged with?</td>
<td>burglary</td>
</tr>
<tr>
<td>What was subject charged with?</td>
<td>arson</td>
</tr>
<tr>
<td>What was subject charged with?</td>
<td>assault</td>
</tr>
<tr>
<td>What was subject charged with?</td>
<td>Criminal damage</td>
</tr>
<tr>
<td>What was subject charged with?</td>
<td>ABH</td>
</tr>
<tr>
<td>What was subject charged with?</td>
<td>Drunk/disorderly</td>
</tr>
<tr>
<td>What was subject charged with?</td>
<td>Drugs related offence</td>
</tr>
<tr>
<td>What was subject charged with?</td>
<td>Other (specify)</td>
</tr>
<tr>
<td>Combination of above</td>
<td></td>
</tr>
<tr>
<td>Does the subject have previous Convictions/Charges?</td>
<td>N.A</td>
</tr>
<tr>
<td>Does the subject have previous Convictions/Charges?</td>
<td>Yes</td>
</tr>
<tr>
<td>Does the subject have previous Convictions/Charges?</td>
<td>No</td>
</tr>
<tr>
<td>Does the subject have previous Convictions/Charges?</td>
<td>N.K</td>
</tr>
<tr>
<td>If yes to Q 24 how many?</td>
<td>N.A</td>
</tr>
<tr>
<td>If yes to Q 24 how many?</td>
<td>1</td>
</tr>
<tr>
<td>If yes to Q 24 how many?</td>
<td>2-3</td>
</tr>
<tr>
<td>If yes to Q 24 how many?</td>
<td>4-5</td>
</tr>
<tr>
<td>If yes to Q 24 how many?</td>
<td>6-7</td>
</tr>
<tr>
<td>If yes to Q 24 how many?</td>
<td>8-9</td>
</tr>
<tr>
<td>If yes to Q 24 how many?</td>
<td>10+ specify</td>
</tr>
<tr>
<td>If yes to Q 24 how many?</td>
<td></td>
</tr>
<tr>
<td>Specify last 3 categories of given sentences</td>
<td></td>
</tr>
<tr>
<td>Specify last 3 categories of given sentences</td>
<td>N.K</td>
</tr>
<tr>
<td>When A.A. was called was subject diverted into Mental Health System</td>
<td>Yes</td>
</tr>
<tr>
<td>When A.A. was called was subject diverted into Mental Health System</td>
<td>No</td>
</tr>
<tr>
<td>Question</td>
<td>Code</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Was subject with A.A. present assessed at police stn under the 1983 Mental Health Act</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>N.K.</td>
<td>3</td>
</tr>
</tbody>
</table>

| If subject was assessed under the 1983 MHA at Section was s/he admitted to hospital under |     |        |
| N/A                                                                     | 0    | 31     |
| Section 2                                                               | 1    |        |
| Section 3                                                               | 2    |        |
| Section 4                                                               | 3    |        |
| Voluntary                                                               | 4    |        |
| Other (specify)                                                         | 5    |        |
| N.K                                                                     | 6    |        |

| Was subject assessed under the MHA but NOT admitted to hospital          |     |        |
| N/A                                                                     | 0    | 32     |
| Yes                                                                     | 1    |        |

| If yes to Q29 what happened to subject- was s/he                          |     |        |
| N/A                                                                     | 0    | 33     |
| Discharged                                                              | 1    |        |
| cautioned                                                               | 2    |        |
| Conditional discharge                                                  | 3    |        |
| Bailed                                                                  | 4    |        |
| Summons                                                                 | 5    |        |
| Other (specify)                                                        | 6    |        |

| Was the subject described as Mentally ill                              |     |        |
| Yes                                                                     | 1    | 33     |
| No                                                                      | 2    |        |

| Was the subject described as Mentally Handicapped                       |     |        |
| Yes                                                                     | 1    | 34     |
| No                                                                      | 2    |        |

<p>| Was the subject described as Mentally ill and/or Mentally Handicapped but NO A.A called |     |        |
| N.A                                                                     | 0    | 35     |
| Yes                                                                     | 1    |        |
| No                                                                      | 2    |        |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Code</th>
<th>Col1 No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the subject described as Mentally ill and/or Mentally Handicapped but NO Police Surgeon called</td>
<td>N.A 0</td>
<td>36</td>
</tr>
<tr>
<td>If yes to Q33/34 was an A.A called on a previous occasion for this subject?</td>
<td>N/A 0</td>
<td>37</td>
</tr>
<tr>
<td>If the subject was described as Mentally ill or mentally handicapped and NO A.A called was s/he still assessed under the 1983 MHA</td>
<td>N.A 0</td>
<td>38</td>
</tr>
<tr>
<td>f YES to Q36 was subject admitted to hospital under</td>
<td>N/A 0</td>
<td>39</td>
</tr>
<tr>
<td>Section 2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Section 3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Section 4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Voluntary</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>f the subject described as mentally ill and/or mentally handicapped and NO A.A was called, and assessment was made under the MHA was s/he charged with an offence?</td>
<td>N/A 0</td>
<td>40</td>
</tr>
<tr>
<td>Yes 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Code</td>
<td>Col No</td>
</tr>
<tr>
<td>----------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>If YES to Q38 what offence was the subject charged with</td>
<td>N/A</td>
<td>40-41</td>
</tr>
<tr>
<td>Theft</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Indecent exposure</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Burglary</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Arson</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Assault</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Criminal damage</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>ABH</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Drug related offence</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Other - specify</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Combination of above</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>If NO to Q38 was the subject released</td>
<td>N/A</td>
<td>42-43</td>
</tr>
<tr>
<td>Unconditionally</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Conditional discharge</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Bailed</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Summons</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>What reason if any is given why if the subject is described as mentally ill and/or mentally handicapped but NO A.A called and NO assessment made under the 1983 MHA-</td>
<td>N.A</td>
<td>44-45</td>
</tr>
<tr>
<td>No explanation given</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Not aware of A.A. scheme</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>No A.A. available</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Other - specify</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>If A.A called how long did s/he take to arrive at police station</td>
<td>ASW</td>
<td>46</td>
</tr>
<tr>
<td>Within one hour</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>1 - 2 hours</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2 - 4 hours</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td>4</td>
<td></td>
</tr>
<tr>
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