# Memorandum of Understanding –

# The Police Use of Restraint in Mental Health & Learning Disability Settings

## Contents

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Finally, thanks must go to three individuals who have been instrumental in this MoU being conceived and now coming to fruition. Commander Christine Jones, NPCC Lead for Mental Health, instigated the work and there is no doubt that without her determination and leadership this MoU would not be in place. Lord Carlile of Berriew QC CBE, for agreeing to Chair the MH ERG and performing the role with diligence and at times extreme patience. Inspector Michael Brown, Mental Health Co-ordinator for the College of Policing, who has worked tirelessly on developing the MoU and producing the final document in, at times, challenging circumstances.

# Executive Summary

This Memorandum of Understanding (MoU) provides clarity on the role of the police service in responding to incidents within mental health and learning disability settings. The intention is to outline when and how the responsibilities of the police service fit in to the established roles and responsibilities of care providers. This MoU is one of the objectives in the national Crisis Care Concordat (CCC) action plan and it builds upon *Positive and Proactive Care (2014)*[1] which relates to work undertaken by the Department of Health to reduce restraint and restrictive practices in mental health care. All areas must now ensure their local CCC action plans incorporates the approach outlined within the MoU and this is to ensure that people are treated with dignity and respect in a therapeutic environment[2].

Ensuring effective and appropriate responses to mental health related incidents is "core police business"[3]. This remains true even where healthcare providers are responsible for the health, safety and wellbeing of their staff and patients. It is acknowledged that health providers manage the vast majority of incidents of violence and aggression and that both health providers and police see police involvement as an exceptional event.

Health providers have a duty to undertake, implement and review risk assessments for all the services they provide. The police do not have specific powers to restrain a patient for the purposes of medical treatment regardless of whether the treatment is in the patient's best interests however, research by Mind in 2013 revealed there is significant variance in the extent to which healthcare providers call the police for support around restraint and restrictive practices[4].

Physical restraint can be humiliating, terrifying, dangerous and even life-threatening. It can trigger psychological trauma, especially for people with previous experience of physical or sexual abuse. When police officers are involved this can be even more frightening. People have told us about their shock and fear when police come onto a ward and how this can exacerbate a person's distress and make the situation even more charged. This is especially true for communities which may have a negative experience of policing and where there is a history of deaths in custody. Going through this has a lasting impact and can set back a person's recovery.

People who talked to us wanted mental health staff to be proactive and use their therapeutic skills to de-escalate situations and only call on the police when absolutely necessary. They wanted the police to be better trained in understanding mental health and to hear directly from people with mental health problems, people who are through the other side of crisis and can share their insights. Whoever is involved in responding to an incident, everyone was clear on the importance of communication and trying to de-escalate the situation from the outset and throughout.

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[1] Positive and Proactive Care (2014)

[2] Crisis Care Concordat (2014)

[3] Independent Commission in to Policing and Mental Health in London (2013).

[4] Physical Restraint in Crisis (2013), p16.

Each situation where the police are called for emergency assistance should be properly assessed on its merits. There will be no assumption that police cannot be involved because the patient is either detained under the Mental Health Act (MHA) or in hospital. The police role is the prevention of crime and protection of persons and property from criminal acts.

Police services and health providers should develop or review existing protocols to take account of this MoU. There should be timely joint reviews of incidents where the police use force or where the police did not attend an incident despite the agreed local protocol being properly used.

Health providers should review the prevention and management of violence and aggression training they provide for their staff and review all the incidents in 2016 where the police have been called for emergency assistance. Any dispute about pre-incident issues are matters for review after safety has been restored.

The MoU represents two years of work by a large number of health, service-user and policing agencies, independently chaired by Lord Carlile CBE QC. It has been endorsed by the National Police Chiefs' Council, Mind, the Royal College of Psychiatrists, the Royal College of Nursing and the Faculty of Forensic and Legal Medicine with a view to other organisations providing their formal support in due course.

# Foreword

## Police attendance and / or use of restraint in mental health, learning disability and settings.

The police service and the health service exist to deliver distinct public service functions which occasionally overlap and require joint working. It is vital to patient, staff and public safety that individual professionals and organisations understand how these functions work when responsibilities overlap in difficult circumstances which may include physical restraint.

This document relates to the first of two phases of a national initiative aimed at setting a clear direction on the following;

- **Phase one** aims to provide clarity on police attendance at mental health and learning disability inpatient settings and health based Places of Safety, and the use of compulsion and restraint in such settings.
- **Phase two** will address restraint related actions outside those settings.

Both phases aim to improve clarity and understanding as to *how* police officers should exercise their professional judgement in support of colleagues from healthcare professions – and *when* they should be called upon to do so. The overall aim is to ensure the health and safety of patients, professionals and the public.

The Independent report of the Mental Health taskforce (2015)[5] commissioned by the NHS describes the current state of mental health inpatient care, and includes:

- Admissions to inpatient care have remained stable for the past three years for adults but -
- The severity of need and the number of people being detained under the Mental Health Act continues to increase, suggesting opportunities to intervene earlier are being missed.
- The number of adult inpatient psychiatric beds reduced by 39 per cent overall in the years between 1998 and 2012.
- Bed occupancy has risen for the fourth consecutive year to 94 per cent.
- Many acute wards are not always safe, therapeutic or conducive to recovery.
- Pressure on beds has been exacerbated by a lack of early intervention and crisis care.
- The position in Wales is similar to that in England.

On occasions, mental health care involves the use of restraint. Detention under the Mental Health Act 1983 removes the liberty of individuals, and can lead to decisions about medical treatment being taken by others, without the consent of patients. Whilst all efforts are made to avoid physical restraint, on occasion patients are restrained to ensure their own and other peoples' safety.

The risks associated with restraint are significant. The police service and healthcare providers have experienced incidents in which patients under restraint have died. Where agencies find themselves working in close partnership in fast-moving situations in which there may be danger, the potential for unclear communication, conflict between organisations' guidelines and different restraint practices have the potential to increase the difficulty in ensuring a safe and effective outcome.

This document aims to improve patient and staff safety by ensuring the best response to patient safety incidents, based on a clear and common

[5] Five Year Forward View for Mental Health, NHS England (2015).

understanding of their role, the role of others and an assessment of risk and other factors. The document outlines an approach to the assessment of incidents involving risk and instils the need for clear operational leadership during joint incidents. The overall aim is to ensure clear communication and understanding that services should work closely and effectively.

**The evidence is clear; any use of restraint or other force involves increased levels of risk and no period of time spent under restraint (especially prone restraint) is inherently safe.**

This Memorandum of Understanding (MoU), was instigated by the National Police Chiefs Council (NPCC) Business Area for Mental Health. It has been chaired independently, and led by a core group comprised of the Department of Health, representatives from the Royal College of Psychiatrists, Metropolitan Police Service, Home Office and NHS England, NHS Protect and which was co-ordinated by the College of Policing. Furthermore over 40 agencies / organisations were formed into the Mental Health & Restraint Expert Reference Group (MHRERG – see appendix six) to act in an advisory capacity.

The MoU aims to synthesise positive practice and provide guidance for every mental health provider and police service in England and Wales. It describes the situations when it may be appropriate for police to be involved in restraining patients, and the legal framework within which the police and health providers should work.

This guidance will be part of the mental health Crisis Care Concordat local action plans in both England and Wales.

## Who is this for and what does it do?

This document is aimed at –

- All operational police officers who may respond to requests for support from in-patient mental health and learning disability services and health based Places of Safety
- All healthcare staff who work in these settings, to understand the various parameters within which police officers operate.
- Strategic Leads from all relevant organisations

The document covers –

- What the NHS are committed to doing
- What the police are committed to doing
- How to manage the uncertainties which often emerge.

It applies to all patients regardless of whether they are detained under the Mental Health Act 1983.

**Lord Carlile of Berriew** CBE QC

Chair of the Mental Health and Restraint Expert Reference Group

**Commander Christine Jones** QPM

Metropolitan Police
NPCC Lead on Mental Health

# Local Operating Protocols

All health providers and police services in England and Wales should agree or review existing local protocols across relevant policing and health areas, to maximise clear communication and cooperation and achieve a consistency of response to mental health and learning disability inpatient settings and health based places of safety. These protocols should form part of the local Crisis Care Concordat action plans.

As a minimum these protocols should cover the following issues, and include –

### Joint protocol commitments –

- Staffing in both health and policing to be able to discharge their respective legal responsibilities.
- Set up agreed processes to allow information exchange between police & health before police enter health facility (See appendix three).
- Effective information exchange between police & health in order to aid assessment of risks that may present to staff, in line with section 115 of the Crime and Disorder Act 1998 (Disclosure of Information).
- Escalation procedures in each agency to problem solve, both at the operational and strategic levels.
- Provision for the joint review of individual cases of police use of restraint in mental health settings, where necessary – including any informal debrief immediately required after an incident or a more formal serious incident (SI) or near miss review, where required.
- In Wales the National Untoward Incidents Steering Group and Community of Practice provides the forum for review.
- Using the National Decision-Making Model (NDM) to identify the most appropriate actions and tactics (see appendix four).
- Oversight of the effectiveness of local arrangements and any need for local (joint) training.
- Data monitoring and reporting processes.

### Health provider commitments –

- All clinical interventions (e.g. taking of fluid samples, injections, etc.) with or without consent and in accordance with the law e.g. MHA status.
- Local risk assessment for the purposes of staffing requirements and contingency planning.
- Take steps that are reasonably practicable to safeguard other patients and other staff during incidents to which this MoU relates.
- Those restrictive interventions allied to psychiatric care; for example –
  - The transfer of patients to a seclusion area.
  - Transfer of patients; within or between mental health units or Accident & Emergency.
  - Administration of treatment without consent (Part IV MHA / Mental Capacity Act).
- Maintaining physical observations in the event of any restraint.
- Retaking control of any restraint as soon as it is safe to do so.
- Initiating and implementing a joint post incident review, where necessary.
- Ensuring attending police are fully aware of any physical health issues that may affect safety prior, during or post incident.
- Allocating a lead member of staff to co-ordinate the incident and instruct and inform attending police.
- These examples are subject to the existence of any exceptional factors – see the "overarching ethos", p9.

## Police commitments –

- Investigation of any allegations of criminal conduct should take into account NHS Protect / NPCC's national partnership protocol for managing risk and investigating crime in mental health settings (publication expected in early 2017).
- Response to serious crime, including incidents involving weapons, barricades or hostages – see examples, below.
- Through effective response, prevention of immediate risks to life and limb, immediate risk of serious harm to persons or serious damage to property.
- Any action under the direction of court under Part III of MHA – for example, detention or conveyance connected to s55 MHA.
- Police officers should *not* arrest patients for a criminal offence if they have no intention of investigating criminal matters in order to provide an apparently legal basis to justify the use of force in connection with treatment or care.

## The Over-Arching Ethos

- **Each situation should be properly judged on its individual merits –**

- Police officers should NOT be called to undertake restrictive practices, connected to ***purely*** clinical interventions (e.g. taking of fluid samples, injections, etc.) **unless exceptional factors apply**.

  These could include, but are not restricted to –

  1. An effort by healthcare staff to undertake a restrictive intervention (restraint, manual handling, threatened or actual use of force or other therapeutic intervention that involves the threatened or actual use of force) without police support has led to injury to staff which compromises their ability to continue safely; OR

  2. No other support from healthcare colleagues is available or appropriate in a sufficiently timely manner to ensure safety of all those affected.

- The police service should ensure an appropriate response to allegations of crime and to requests for <u>immediate</u> support in connection with risks of serious injury or damage, where healthcare providers' internal mechanisms have been unsuccessful and safety is then compromised.

- **Any dispute about pre-incident issues are matter for review <u>after</u> safety has been ensured.**

# Examples Requiring a Police Response

## An immediate risk to life and limb

A patient has returned from authorised s17 leave and is in possession of a large knife. If the patient produces this weapon and threatens harm to staff an immediate police response will be necessary. If that patient left the weapon unattended in their room and staff can safely take possession of it, immediate police attendance would not be proportionate.

## Immediate risk of serious harm

A patient is exhibiting disturbed behaviour on a ward after returning from leave believed to be under the influence of drugs. Nursing staff have attempted to seclude the patient for their own and others' safety following one nurse being punched causing grievous injury which requires assessment in an Emergency Department. Nurses are now asking for police support to complete the seclusion because of the further risk of serious harm to staff. A police response would be appropriate.

## Serious damage to property

A patient in an inpatient unit has caused damage to ward infrastructure including a kitchen area where they have broken chairs, tables, windows and appliances, the floor is covered in debris and the patient continues to cause damage and throw the debris around the room. A police response would be appropriate.

## Offensive weapons

A patient has told staff upon return from leave that they have a knife on them for their own protection because they believe that nursing staff will harm them by giving them more drugs. It is known the patient has a history of possessing offensive weapons or sharply pointed implements. A police response would be appropriate.

## Hostages

A patient has closed the door to their own room whilst a nurse is inside and is shouting, threatening to harm the nurse if anyone enters the room. The patient is asking to be allowed out of the unit as a condition of releasing the nurse and state they will harm them unless this is agreed to. There is no indication one way or the other as to whether the patient has a weapon and the noise from within the room suggests that furniture has been piled against the door to block entry. A police response would be appropriate.

## Thinking through the examples

- Good local relationships between providers and the police should be developed to help prevent violent situations arising through single and inter-agency work on early intervention techniques and regular inter-agency dialogue.
- Where a restrictive intervention is required, healthcare organisations should have arrangements to convene sufficient appropriate staff to mitigate foreseeable risks – this can include cross-ward support arrangements.
- From both a Health & Safety and Human Rights law perspective the application of the Mental Health Act to patients is a matter for healthcare providers in the first instance.
- Where a therapeutic intervention has been attempted and staff have been injured and are unable to gather wider healthcare support, police officers may be requested to assist because of the ongoing risk to staff safety and their diminished ability to ensure the safety of that intervention. When so deployed police officers must work within an appropriate legal framework (see appendix one). For example, the police should not be expected to assist health staff in responding to a patient who is presenting behavioural or clinical management issues

(including their transfer from one service to another), unless those exceptional or aggravating factors apply.

- There should always be plans, led by the health provider, to manage de-escalation, summoning additional staff, transporting or escorting of patients and health staff use of restraint; rapid tranquillisation must be considered before police are requested.
- A health focused incident response plan should be in place to enable staff to safely assess and confidently manage foreseeable risk situations, making a request for the police an exceptional circumstance. (See appendix three.)
- Any decision to call the police should be properly evaluated and consistently applied, in line with local protocol.

## Police contact handling

- No assumption should be made by the police that any incident involving any patient will always be a matter for healthcare staff alone; or that offences committed by a patient cannot or should not be investigated or prosecuted.
- Where the senior police officer at an incident has concerns about the appropriateness of police involvement, they should exercise their professional judgement on the legal powers available to them (see appendix one) in that context and refer the matter to the duty officer.
- Where the senior nurse has concerns about the appropriateness of the police response, they should escalate that to the duty inspector and to their own managers.

## Post-incident

- Each organisation should ensure accessible mechanisms to allow for a subsequent joint-review.
- All police and health services should record details of incidents, report according to local policies and commit to joint review and to shared, ongoing organisational learning.
- This should include any concerns by the police as to the appropriateness of any request for them to attend.
- It should review any decision by the police not to attend an incident, after being requested to do so.
- Collate data for reporting and analytical purposes.

**What constitutes a reasonable 'mitigation of foreseeable risk' may vary across England and Wales. This MoU encourages healthcare providers, with their police partners, to identify and mitigate those variations to help meet commitments.**

# Restraint and Restrictive Practices

The importance of de-escalation and other verbal skills in managing violence and aggression by **all** agencies cannot be overstated. Appropriate preventative strategies are known to be effective in preventing / lessening incidents of violence and aggression and the corresponding need to consider the use of any force.

All staff using restraint to deal with violence and aggression from people suffering from mental health issues or physical illness, should be aware of potential additional problems, (e.g., medication, obesity, co-morbidity of drug and alcohol problems; Acute Behavioural Disorder[6] or ABD[7]). These factors can raise the risks of restraint[8].

The long lasting impact and distress caused to patients, staff and relatives can be substantial. For these reasons, wherever possible, every effort must be made to utilise methods of dealing with violence and aggression that does not involve the use of restraint. It must be remembered that any period of restraint can be dangerous. Prolonged periods of restraint can be especially dangerous (particularly where this occurs on the ground) and features significantly in restraint-related deaths. It is, therefore, important to reduce the time a person is restrained to a minimum.

- No restraint position can ever be totally safe or free of risk.
- All take-down techniques carry additional risks.
- Prone and supine restraint positions both carry (different) risks. It is wrong to consider either one to be safer without fully understanding the practical application.
- Take-down techniques have been used when they were not entirely appropriate. When used, the person should be brought to the standing position as soon as possible.
- Care must be taken to avoid anything that impacts on the patient's airway, breathing or circulation. The mouth and/or nose must never be covered and pressure should not be applied to the neck region, rib cage and/or abdomen.
- The person must be effectively monitored in accordance with the NHS patient safety alert of December 2014[9].
- Any member of police or health staff who observes a safety concern should speak up and never assume that other colleagues have picked it up.

However *any person* has the common law right to use reasonable force to protect themselves and others from life threatening situations. Furthermore, appropriate training of staff will increase an organisations capacity and capability to deal with potentially violent situations. Effective training will enable staff to be more self-sufficient and will result in fewer requests for additional health staff and police attendance. The Department of Health is leading work to develop national standards for the prevention and management of violence and aggression.

## Clinical oversight –

It is important to consider all aspects of medical oversight during restraint. This should include a discussion about specific roles and responsibilities. This must include an understanding of –

- What should the healthcare staff do during and after restraint?

[6] See Appendix Five for explanation of how this term is being used in the context of this MoU.

[7] RCEM / FFLM Guidance on Acute Behavioural Disorder (2016).

[8] FFLM Guidance on the Management of ABD in Police Custody (2016).

[9] Patient Safety Alert: the importance of vital signs during and after restrictive interventions or manual restraint, NHS England (2015).

- What is the minimum requirement for observations during the restraint and who should do this?

- In certain circumstances, restraint should be treated the same way as any other medical intervention. Restrictive interventions are deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently. This is usually to take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and end or reduce significantly the danger to the patient or others.

- Restrictive interventions must not be used to punish or for the purpose of inflicting pain, suffering or humiliation. The most common reasons for needing to consider the use of restrictive interventions are –

  - physical assault by the patient
  - dangerous, threatening or destructive behaviours
  - self-harm or risk of physical injury by accident
  - extreme and prolonged over-activity that is likely to lead to physical exhaustion, or
  - attempts to escape or abscond (where the patient is detained under the Act or
  - deprived of their liberty under the MCA)

- How quickly can/do healthcare staff get to the scene of a restraint and what should happen before their arrival and upon their arrival?

After any form of manual restraint is used on a patient, health staff should monitor[10] the patient's physical and psychological health for as long as is clinically necessary[11].

Both police and health staff may have access to manual and mechanical restraint options. For health staff mechanical restraint is defined in NICE NG10 as "a method of physical intervention involving the use of authorised equipment for example handcuffs or restraining belts, applied in a skilled manner by designated healthcare professionals. Its purpose is to safely immobilise or restrict movement of part(s) of the body of the service user."

Police officers have a range of manual and mechanical restraint options available to them and receive appropriate training in their use. These include handcuffs, body and leg restraints, plus use of irritant sprays, electro-conductive devices or other equipment. All of these options will be considered by police officers called to deal with violent patients and will be deployed in line with the National Decision model (see appendix four).

It is vital that any joint agency use of restraint is supported by shared information, clear and highly effective communication between the staff involved to ensure the safety of patients and staff. All staff should be encouraged to 'speak up and speak out' during incidents, where concerned.

[10] Violence and Aggression: short-term management in mental health, health and community settings, para 1.4.33. National Institute of Health and Care Excellence, NG10, (2015).

[11] Patient Safety Alert: the importance of vital signs during and after restrictive interventions or manual restraint, NHS England (2015).

# Learning the Lessons

There should be overarching scrutiny and review jointly conducted by health providers, police and other relevant partners and this should align with the existing requirements for agencies set out below. The review should include the perspective of the patient concerned (where they have agreed to share it), or in the case of a fatality, that of the family.

The three key levels should in all cases be led by the mental health service provider and are as follows:

## Local (level 1)

*In the event of a near miss, no injury incident, non-RIDDOR (*Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013) *reportable injury –*

A local review, led by the mental health service provider with appropriate police or other agency inclusion. This organisational learning should at the very minimum be shared locally and with all the agencies involved in the incident. This should inform local procedures, arrangements and processes. Opportunities to share learning via local health professional and police professional groups should be encouraged as open and transparent learning.

## Serious Incident Review (level 2)

*In the event of a serious incident as defined by the NHS*[12] *Serious Incident Framework (England) and Patient Safety Wales (Wales), notifications that fall within RIDDOR or repeated level 1 failures –*

The mental health service provider should review in accordance with the NHS Serious Incident[13] or Patient Safety Wales Frameworks[14].

This review is to be led by the service provider with appropriate police or other agency inclusion. Notification should be in accordance with RIDDOR and the relevant NHS Serious Incident Patient Safety Framework.

Organisational learning will be captured and disseminated as part of the Serious Incident Review Process; this should also be fed back to CCG / LHB commissioners allowing incidents to be taken in to consideration during any subsequent commissioning / contractual discussions, as appropriate.

## Statutory Enforcement (level 3)

*In the event of a fatality, an incident requiring investigation by, for example, the CQC (England) and HIW (Wales), falling within HSE investigation criteria or a complaint made to an enforcing authority –*

This will generally take the form of an investigation by the HSE and/or CQC/HIW. The police will lead if the investigation is one of murder, manslaughter or corporate homicide. The IPCC must be informed of any incident involving death or serious injury in police custody or following police contact if it may be possible that custody or contact contributed in any way, directly or indirectly. Formal, statutory level 3 investigations will generate national learning outcomes via statutory body guidance, HM Coroners inquests (Reg 28, PFD notices), changes in local or national guidance and reports such as the IPCC learning reports[15].

[12] Private healthcare organisations, providing services on behalf of the NHS or independently, may have similar policy frameworks.

[13] NHS Serious Incident framework, NHS England (2015).

[14] Patient Safety Wales, downloaded 07/01/2017.

[15] Learning the Lessons reports, IPCC.

The relevant lead agency such as the NHS and Police will often also issue national learning, guidance and changes in practice following serious incident investigations at this level. These investigations will also need to adhere to the following which define investigation criteria, responsibilities and information sharing agreements:

- MoU between CQC, the HSE and Local Authorities in England.
- MoU between HIW and HSE in Wales.
- Work-related deaths: liaison with police, prosecuting authorities, local authorities and other interested authorised including consideration of individual and corporate manslaughter or homicide**.**

All mental health services and the police, should maximise learning opportunities and ensure lessons to improve understanding, guidance, practices, processes are exploited. This process should involve people who use mental health services. Health commissioners have a key role to play in ensuring the learning translates into the provision of effective, safe and progressive services.

Procedures should be established (or reviewed) to ensure joint organisation learning where incidents in mental health or learning disability inpatient units or mental health place of safety locations require the involvement of the police or other state agencies. Where appropriate, all the relevant agencies should be involved in the organisational learning review process to maximise evidence-based learning to prevent recurrences.

## The Next Steps

This document is a Memorandum of Understanding between National Police Chiefs' Council, Mind, the Royal College of Psychiatrists, the Royal College of Nursing and the Faculty of Forensic and Legal Medicine. The work has been coordinated and is fully supported by the College of Policing and will be published on their website.

The list of organisations who have formally supported the MoU, as well as those who advised on its development, will be listed on the College of Policing website.

All CCC areas are now required to ensure effective local arrangements on these issues, given this MoUs status under the national Crisis Care Concordat action plan.

Any future events which generate learning may cause the MoU to be reviewed and, if necessary, updated with the agreement of the signatories.

The MHRERG will now commence Phase 2 of its work exploring how the use of restraint by police is reduced in incidents involving mental health conditions in non-mental health settings and public places.

# Appendix One – THE LAW

## Over-arching frameworks –

All Health and Police Services are governed by the over-arching requirements of both Human Rights and Health & Safety Law. Whatever local protocols and practice look like, they must be capable of justification against those obligations. The legal advice in support of this protocol outlines that the primary responsibility for the Health & Safety of patients, as well as the protection of their human rights, rests with healthcare providers. However, police services also carry obligations around the investigation and prosecution of criminal offences and the protection of life and serious damage to property.

The nature of the interface and the overlap between challenging behaviours and criminal conduct is such that there will not always be an obvious distinction or absolutely clarity between challenging behaviours and criminal conduct. Ultimately, there needs to be an appreciation by all professionals that 'grey areas' exist about those circumstances that should 'obviously' be a responsibility for one organisation and not involve the other. In situations of ambiguity where safety is compromised, it should be borne in mind that police officers acting in pursuance of an objective under the Mental Health Act 1983, will be protected from liabilities under s139 MHA as long as they have done so in good faith, with reasonable care, which will involve careful assessment of the risks of acting versus not acting, in a particular situation. Healthcare professionals should also bear in mind that officers will in such circumstances not usually be under an obligation, strictly speaking and may have legitimate reasons for reluctance to become involved with interventions under the Mental Health Act.

The following provisions are of particular relevance to this guidance –

**Human Rights Act 1998**

- **Article 2** – the right to life.
- **Article 3** – the right not to suffer inhumane and degrading treatment.
- **Article 5** – the right to liberty and security.
- **Article 8** – the right to privacy for family life.

**Health & Safety at Work Act 1974**

- **Section 2** - employers should ensure, so far as is reasonably practicable, the health, safety and welfare at work of all employees.
- **Section 3** – employers should conduct their undertakings in such a way as to ensure, so far as is reasonably practicable, that persons not in their employment who may be affected are not thereby exposed to risks to their health and safety.
- **Section 7** – employees should take reasonable care of their own health and safety and that of others who may be affected by their acts or omissions at work; and cooperate by following any requirement imposed on them by their employer.

**Management of Health and Safety at Work Regulations 1999**

- **Regulation 3** – every employer shall make a suitable and sufficient assessment of the risks to the health and safety of his employees to which they are exposed whilst they are at work; and the risks to the health and safety of persons not in their employment arising out of or in connection with the conduct of the undertaking. (Need to be foreseeable risks, and you are not expected to eliminate all risks, but protect people as far as is reasonably practicable).
- **Regulation 5** – employers need to introduce preventative and protective measures to control the risks identified by the risk assessment.

## Police powers –

There are very few police powers which are, in fact, exclusively reserved to the office of constable. Many legal authorities perhaps considered to be police powers are those of all citizens, including healthcare professionals.

**The Police and Criminal Evidence Act 1984 –**

- **Section 24 PACE** – this provision is the power for constables to arrest individuals for an offence.
- **Section 117 PACE –** where any provision of PACE confers a power upon a constable and does not provide that the power may only be exercised with the consent of a person other than a police officer, the officer may use reasonable force, if necessary, in the exercise of the power.

**Code G (2012) of the Codes of Practice to PACE –**

Where an offence is alleged or has occurred, it does not automatically follow that police officers may arrest that person - it remains subject to the 'necessity test'.

Grounds of necessity include –

- To ascertain the person's name or address.
- To prevent the person –
  - causing physical injury to himself or any other person
  - suffering physical injury
  - causing loss of or damage to property
  - committing an offence against public decency
  - causing an unlawful obstruction of the highway.
- To protect a child or other vulnerable person from the person in question
- To allow the prompt and effective investigation of the offence or of the conduct of the person in question;
- To prevent any prosecution for the offence being hindered by the disappearance of the person in question.

**Detention in police custody -**

Many of those grounds of necessity would apply to situations under consideration in this guidance and it is relevant to consider what happens after arrest: constables must remove any arrest person to police custody and bring them before the custody officer (also usually known as the custody sergeant). The custody officer must then assess, under s37 PACE, whether there is sufficient evidence to charge the person with the offence for which they have been arrested.

Where such evidence exists, they must charge the person; where it does not they may only detain them in custody where this is necessary to secure and preserve evidence or obtain evidence by questioning. They must also, at all times have regard to the health of the person under arrest and ensure their wellbeing – anyone whose health is at risk in custody must be examined and potentially transferred to hospital.

Once the grounds for detention in police custody cease to apply, s34 of PACE directs the custody officer to bring that person's detention to an end. This is an assessment based upon the evidence for a criminal prosecution and is not based on any other consideration, including difficulties in securing transfers of MHA patients to more restrictive settings. In addressing the question of whether any patient has allegedly offended, these considerations around arrest and detention should be borne in mind.

## Mental Health Act 1983 –

Where a patient is detained in hospital under the main provisions of either Part II or Part III MHA, they are liable to treatment decisions to be taken without their consent, under Part IV of the Act. This covers various circumstances in which treatment may be administered, including administration of medication or a decision to seclude or transfer a patient, as part of an overall approach to their care and covers emergency situations.

- **Section 19 MHA** – covers the transfer of patients from one healthcare facility to another.
- **Part IV MHA** – includes various sections between 56-64 which pertain to the administration of treatment without consent. They imply the use of reasonable force in the least restrictive way, where this is necessary to achieving the purpose of those provisions.
- **The application of restrictive practices is the responsibility of healthcare professionals where this is connected to these objectives under the MHA.**
- Police officers' involvement in such situations should be connected to some 'exceptional' factor, as defined on page 9.

## Other Legal Provisions –

All citizens may rely upon the following statutory and common law provisions to intervene in a situation to keep themselves or others safe from harm. It will be a matter of risk assessment, competence and degree as to whether any intervention should be undertaken by health or policing professionals under these frameworks –

### Common Law –

- The common law is based on the precedents which have been established by the courts and is not set against the background of Acts of Parliament. There are therefore no 'sections' to which to refer, as mentioned above for PACE.
- **Doctrine of necessity** – Baroness Hale said in the Court of Appeal in 2003 that "the common law doctrine of necessity … has two aspects. There is a general power to take such steps as are reasonably necessary and proportionate to protect others from the immediate risk of significant harm. This applies whether or not the patient lacks capacity to make decisions for himself …" (*Munjaz v Mersey Care NHS Trust and S v Airedale NHS Trust* [2003] EWCA Civ 1036, at para. 46).
- **Breach of the Peace** – this fourteenth century common law provision has now been affected by modern human rights legislation and has limitations that need to be understood. A Breach of the Peace is any situation in which harm is caused to a person or to their property in their presence. In 2014, the Court of Appeal ruled[16] that arresting someone to prevent a Breach of the Peace was only lawful where officers intended to take that person before a Magistrate. (This is subject to an appeal to the Supreme Court; the MH ERG will keep this under review during 2016/7.)

### Section 3 of the Criminal Law Act 1967 –

A person may use such force as is reasonable in the circumstances in the prevention of crime, or in effecting or assisting in the lawful arrest of offenders or suspected offenders or of persons unlawfully at large.

[16] *R (on the application of Hicks and Ors) v Commissioner of Police of the Metropolis (2014) EWCA Civ 3*

This is part of the law of self-defence and the defence of others and may be relied upon by anyone.

**Mental Capacity Act 2005 –**

Where a person thought to be suffering from an impairment or disturbance of the mind of brain lacks capacity concerning a particular decision another person may do the least restrictive thing in their best interests. Section 5 of the MCA will provide a defence to that individual from legal liabilities that would otherwise occur as long as they have taken steps in accordance with the Act to assess capacity and acted in accordance with the general principles of the MCA.

Where an action may extends to restraint of the person who lacks capacity, by the threatened or actual use of force, this may only be justified under section 6 MCA where the intended restraint is proportionate both to the risk of harm and to the likelihood of that harm. If restraint extends to such a degree that it amounts to an urgent deprivation of liberty, it may only occur subject to the criteria in section 4B MCA which requires that action to be a life-sustaining intervention or a vital act to prevent a serious deterioration in that person's condition.

# Appendix Two – GOOD PRACTICE CASE STUDIES

*These case studies highlight good practice when the police were called upon and communication was clear.*

**CASE STUDY ONE**

An adult female patient is detained under the MHA in a psychiatric intensive care unit. The patient damages a window on the ward and secures several pieces of glass as weapons, barricading herself in a room. Nurses and other staff secure the immediate area, moving other patients away and begin to try to de-escalate the incident. The patient remains inside, threatening to harm staff who enter the room and the decision is taken to call the police.

**The request here is to ask the police to assist in preventing crime and protecting life.**

Staff continue to negotiate without success and officers arrive. The police sergeant in charge discusses the background of the patient and the incident with the nurse in charge. The lead nurse asks police officers to take over negotiations to see if the approach of other professionals can de-escalate the incident and requests the police consider reasonable force to enter the room, remove the weapons and move the patient a short-distance down the corridor should negotiations fail. Nurses offer to then take back control of the situation and seclude the patient.

**The legislative power to consider here is to use s3 of the Criminal Law Act to prevent crime.**

Officers try and fail to de-escalate the situation. They then enter the room using protective equipment, restrain the patient and remove the weapons. When this has been achieved they move her to the adjacent room where nurses are ready to take over. Having done so, the officers disengage and resume their other duties, leaving the sergeant to discuss the post-incident issues.

**Nursing staff restrain the patient for medication under the MHA and leave her in a seclusion room under supervision.**

Ten minutes later, the nurse undertaking observations identifies the patient has removed another piece of glass from her vagina and is now using it to self-harm, indicating she will attack staff who enter. The senior nurse again contacts the police.

**The legislative powers to consider here are s3 of the Criminal Law Act to prevent crime, the Mental Health Act, the Mental Capacity Act and the Common Law (self-defence).**

Because the patient is actively self-harming, the police make only limited efforts to negotiate before re-entering the room and use reasonable force to remove the weapon. Nursing staff then again take responsibility for the situation.

## CASE STUDY TWO

An adult male patient without any previously identified risk of assaultative behaviour declines to receive medication to treat his mental health conditions whilst detained under s3 of the Mental Health Act. A senior nurse convenes four members of staff to administer medication without consent under Part IV of the MHA. During the course of attempting to restrain the patient, one nurse is assaulted and his jaw is broken. He instantly disengages from the situation and is in considerable pain. A second member of staff disengages for her own safety and also to attend to her colleague's immediate first aid. She decides to ring 999 for police and ambulance to attend the ward.

**The request here is in connection with a serious assault and necessary for the prevention of further injury to staff or to the patient.**

Remaining staff also disengage from the restraint because they are unable to control the patient who has assaulted them, thankfully less seriously, by hitting them to the upper arm in an effort to push them away. They suffer pain and discomfort. Staff attempt to de-escalate the situation whilst calling 999 and discuss what to do next. The police arrive with paramedics and the police sergeant in charge asks what they are being asked to do whilst paramedics attend to the seriously injured nurse. Nursing staff ask officers to assist them in removing the patient to a seclusion room because three of them have been assaulted and cannot be confident of avoiding further assault without support. The nurses state the patient will need to receive medication before being left in seclusion under nursing observations.

**The legislative powers to consider here are s3 of the Criminal Law Act to prevent crime and Part IV of the MHA to administer treatment.**

Police officers spend a short amount of time talking to the patient who seems to have calmed somewhat and along with two nursing staff who remain involved move the patient using low-level manual restraint. This is to control his arms whilst moving him to the end of the ward where the seclusion room is situated. Once inside, nurses talk to the patient about receiving medication and he again becomes aggressive, insisting he doesn't want an injection. He attempts to leave the room, pushing officers away using his arms. Nurses have insufficient resources available to restrain him on their own and it was agreed that police officers would assist to prevent anyone suffering further serious injury.

**The legislative power to consider here is the MHA itself and police officers involvement in its application should only be agreed where the risk of not acting now outweighs the risks involved in any further delay to seek alternative solutions.**

## COULD POLICE INVOLVEMENT BE AVOIDED?

If nursing staff know a degree of resistance will be likely from a patient who requires medication in a few hours when insufficient nurses will be available, consideration should be given to escalating this to health care managers so this can be handled solely by nursing staff – it is what the law regards as a foreseeable risk.

# Appendix Three – POLICE ATTENDANCE PROTOCOL

**Once Police arrive at the mental health, learning disability and place of safety settings.**

In situations where police are called to attend healthcare premises to regain control of a patient who is suffering from mental ill health, similar procedures as outlined below should be included in local protocols and agreements between partners.

**Step 1 – Decide RVP**

At the time Healthcare staff request the police to attend, a suitable rendezvous point (RVP) should be agreed. This is where the most senior police officer present can meet with the most senior member of health staff before police deployment onto the ward takes place. Depending on the circumstances and urgency of the situation, an RVP may not be suitable.

**Step 2 – Incident explained**

Police and health staff meet at the RVP. Health staff will explain the incident, which should include any specific risks associated with the patient (e.g. the patient's legal status; whether the patient has already been restrained by healthcare staff; whether tranquilisation has been administered and the effect this has had; highlighting any dangers and relevant health related issues). An assessment of available/sufficiently trained staff should also be made.

**Step 3 – Police/Health roles established**

It is important to establish what the police are being asked to do. If further deployment is necessary both Health care/Police leads will work together to decide how best to resolve the incident. Police will consider the use of specialist officers/public order trained/hostage negotiator etc., where relevant. Throughout the incident health staff will remain responsible for the patient's health and safety. This will require active monitoring of the patient's vital signs. Health staff **must** alert police officers regarding any concerns as to the patient's welfare during any period of restraint. Emergency resuscitation/defibrillator equipment with trained healthcare staff should be immediately available at all times.

**Step 4 – Police handover**

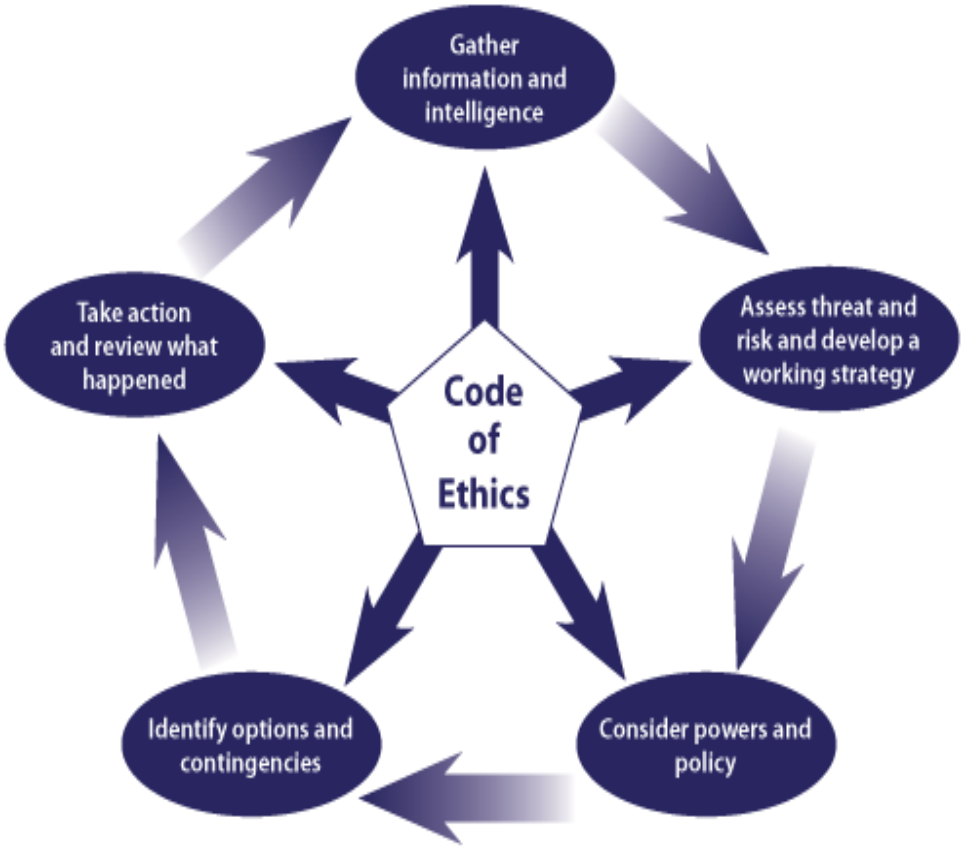
Police will regain control of the ward/patient/situation using appropriate tactics. If police restraint is used, police will hand-over the patient to healthcare staff as soon as control is regained. There should be sufficiently trained healthcare staff to enable this to happen (unless exceptional circumstances, e.g. health staff injured/unavailable).

**Step 5 – Determine need for Criminal Investigation**

If a criminal act is alleged or the police determine that a criminal offence has been committed, a police investigation should be instigated. If a patient is suspected to be responsible for a crime, it will be an exceptional set of circumstances where police will consider arresting and removing the patient from the health setting. The Police and Criminal Evidence Act 1984, Code G needs to be carefully considered. This does not mean a crime will not be investigated. The crime will be recorded by police and a statement obtained from relevant witnesses. A short statement/CPS approved pro-forma will also be obtained from a suitably qualified health practitioner in relation to the patient's mental state at the time of the offence.

There will be times where a patient has committed a criminal offence but police officers do not arrest the patient. This may have implications for health staff and management in relation to how that patient's treatment will continue. Issues around the ongoing safe management of the patient need to be carefully considered. If movement of the patient to an alternative hospital/ward is necessary, it is expected that health/care staff will manage this transfer, unless exceptional circumstances apply.

## Appendix Four – THE NATIONAL DECISION MODEL



# Appendix Five – TERMS AND ABBREVIATIONS

**ABD –** Acute Behavioural Disturbance / Disorder[17], formerly known as 'excited delirium'.

**Chemical restraint –** restraint involving the use of drugs under medical or nursing direction.

**Manual restraint –** any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person.

**Mechanical restraint –** restraint techniques which rely upon the use of equipment, for example handcuffs, soft-cuffs, emergency restraint belts.

**MCA –** Mental Capacity Act 2005

**MHA –** Mental Health Act 1983

**MHRERG** – The Mental Health & Restraint Expert Reference Group.

**MoU** – Memorandum of Understanding.

**Offensive weapon -** any article made or adapted for use for causing injury to the person, or intended by the person having it with him for such use by him, or by some other person.

**PACE –** Police and Criminal Evidence Act 1984

**Restrictive Practices** – this term is used generically within the document to mean any kind of restraint, manual handling, threatened or actual use of force or other therapeutic intervention.

**RIDDOR –** the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013

**Section 17 leave** – is authorised absence from hospital which has been granted by a patient's Responsible Clinician (RC). This will be leave of a specific duration and may or contain conditions, such as a supervision or residence requirement. The RC may also cancel leave before its originally authorised conclusion, where circumstances require.

**Therapeutic intervention** – used in this document describe practices which are a part of healthcare delivery for patients, distinguished from interventions which are for the purposes of preventing crime.

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[17] There is variance across policing and health organisations and individuals as to whether ABD, previously known as Excited Delirium, refers to 'Acute Behavioural *Disorder*' or to an 'Acute Behavioural *Disturbance*' -

Members of the ERG gave various views for a variety of reasons. This guidance does not attempt to settle that debate in terms of whether it is a formalised condition or a descriptive term – the views offered are acknowledged and it is used here merely in the sense of providing short terminology to reflect whatever behaviours or factors give rise to the question of whether such a condition exists, given that it is referenced in health guidance as well as by UK Coroner's Courts. It refers to individuals who exhibit a high state of psychological or mental arousal, agitation, tactile warmth and abnormally elevated temperature association with sweating, violence, aggression and hostility with insensitivity to pain. The significance is that all things taken together, this amounts to a medical emergency that requires immediate hospitalisation.

See RCEM / FFLM guidance on ABD (2016); FFLM Guidance on the Management of ABD in Police Custody (2016).

# Appendix Six – MHR ERG MEMBERS & ORGANISATIONS

Lord Carlile CBE QC *(Chair)*

*Group members in alphabetical order by surname –*

| | |
|---|---|
| Ghazala Afzal | The Chelsea Practice |
| Michaela Bartlett | Equality and Human Rights Commission |
| Eric Baskind | Liverpool John Moores University |
| Sue Beacock | Welsh Government |
| Zameer Bhunnoo | Health and Safety Executive |
| John Black | South Central Ambulance Service |
| Mike Boyne | Association of Ambulance Chief Executives |
| Michael Brown | College of Policing |
| Neil Buckingham | Bradford District Care NHS Foundation Trust |
| Cassandra Cameron | NHS Providers |
| Alison Cobb | Mind |
| Deborah Coles | Inquest |
| Jane Crane | Independent Police Complaints Commission |
| Guy Cross | Department of Health |
| Catherine Daglish | Equality and Human Rights Commission |
| John De Sousa | Home Office |
| Che Donald | Police Federation |
| Gary Firkins | South Staffs & Shropshire Healthcare NHS Foundation Trust |
| Claire Flannigan | Leeds & York Partnership NHS Foundation Trust |
| Andy Harding | Metropolitan Police Service |
| Jenny Holmes | Faculty of Forensic and Legal Medicine |
| Ian Hulatt | Royal College of Nursing |
| Christine Jones | Metropolitan Police Service |
| Viral Kantaria | Department of Health |
| Nick Kettle | Metropolitan Police Service |
| Mat Kinton | Care Quality Commission |
| James Lunn | College of Policing |

| | |
|---|---|
| Matilda MacAttram | Black Mental Health UK |
| Chris MacDonald | NHS Protect |
| Anne McDonald | Department of Health |
| Joanne McDonnell | NHS England |
| Claire Mallett | NHS Confederation |
| Andrew Masterman | NHS Protect |
| Catherine May | Equality and Human Rights Commission |
| Meng Aw-yong | Metropolitan Police Service |
| Chris Morrow | Metropolitan Police Service |
| Deborah Partington | Greater Manchester West Mental Health NHS FT |
| Jan Penny | Thames Valley Police |
| Paul Phillips | College of Policing |
| Sue Putman | South Central Ambulance Service |
| Ian Read | Metropolitan Police Service |
| David Rees | Police Liaison Unit, Welsh Government. |
| Tarek Rehmatulla | Independent Police Complaints Commission |
| Keith Rix | Faculty of Forensic and Legal Medicine. |
| Ashok Roy | Coventry & Warwickshire Partnership NHS Trust |
| Faisil Sethi | South London & Maudsley NHS Foundation Trust |
| Karen Stephens | Police Federation |
| Nicholas Sutcliffe | Metropolitan Police Service |
| Daniel Thorpe | Metropolitan Police Service |
| Robert Tunmore | NHS England |
| Peter Turner | West London Mental Health Trust |
| Nick Vamos | Crown Prosecution Service |
| Sue Warner | Metropolitan Police Service |
| Michael Wilks | Faculty of Forensic and Legal Medicine |
| Chris Witt | Home Office |
| Emily Wright | Care Quality Commission |