Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

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

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Version History

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Contents

1. Introduction

1.1 Overview

There are occasions where it has been felt to be necessary to request police assistance in managing potential or actual violent and aggressive situations in inpatient mental health and learning disability units.

To date there has been little guidance on the circumstances in which it is appropriate to seek police support and when it is reasonable for the police to respond to requests.

In January 2017 a multi-agency memorandum of understanding was published by the College of Policing in partnership with mental health organisations such as the Royal College of Psychiatrists, the Royal College of Nursing and Mind. The document was developed in partnership with mental health providers and NHS England. The memorandum of understanding outlines the police use of restraint in mental Health and learning disability settings.

A requirement of the memorandum is for local agencies to develop 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.

1.2 Basic Principles

The Police Use of Restraint in Mental Health & Learning Disability Settings document sets out to provide guidance on 2 main issues:

- Police being over-relied upon to enter clinical settings and undertake restrictive practices which fall within the scope of what we would all agree are predictable risks associated with being a mental healthcare provider.
- Police not recognising the need to support healthcare professionals in addressing unexpected risks that are beyond their ability to cope, where control is lost and safety is compromised.

In summary the document states that:

- The provision of healthcare and the undertaking of restrictive practices associated with healthcare is the legal responsibility of the healthcare provider who must ensure compliance with health & safety legislation as well as human rights laws in the way they undertake this difficult work. Specifically, this includes the requirement to mitigate foreseeable risks.
- It is the role of the police to investigate allegations of crime; and to assist in restoring safety where unpredictable risks have seriously compromised the safety of staff and patients. The officers' role is to restore the circumstances of safety that allow staff to retake control at the earliest point and to then determine whether a criminal inquiry is required.
- Where it is alleged that safety is seriously compromised, for whatever reason, the restoration of safety is the key priority – if there are any discussions to be had about whether the call for the police is appropriate OR whether the police response was appropriate, these are discussions for after the safety of all has been ensured.

2. Scope

2.1 Mental Health and Learning Disability Inpatient Hospital Settings

This protocol will include the following settings:

- Adult Acute Inpatient areas

- Older Adult Inpatient areas, both functional and organic
- Psychiatric Intensive Care areas
- Specialist inpatient areas including Mother and Baby and Eating Disorders units
- Medium Secure inpatient areas
- Low Secure inpatient areas
- Rehabilitation inpatient areas
- Learning Disability areas registered as hospitals
- AWP managed mental health Places of Safety

In these settings it is sometimes necessary for mental healthcare staff to deliver care that 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 service users. Whilst all efforts are made to avoid physical restraint, on occasion patients are restrained to ensure their own and other peoples' safety.

2.2 Acute Hospital Environments

This protocol will not include general Acute Hospital Environments, even where AWP provides mental health liaison services. The protocol will not cover community services even where they are delivered on AWP hospital sites.

3. Procedure

3.1 Before Requesting a Police Response

In the majority of situations inpatient areas should not require police assistance to manage incidents where service users may pose a risk of violence and aggression or require a restrictive intervention, including restraint, seclusion and search.

Inpatient areas must make use of appropriate interventions and techniques to prevent situations where police assistance might be requested. The implementation of Safewards interventions supports inpatient areas to reduce conflict and containment.

All inpatient areas, (excluding stand-alone community rehabilitation not on a hospital site), must identify and record an allocated response team to respond to all types of incident. All areas must have an appropriate alarm system to alert response teams. This will include cross-ward support arrangements on multi-ward sites including the Long Fox Unit, Southmead, Callington Road, Fountain Way, Sandalwood Court and The Victoria Centre. This will not include cross site support at Green Lane Hospital for the Daisy Unit due to the differences in model to manage violence and aggression in the different service user populations.

Care plans should be in place, including positive behaviour support plans, to ensure primary, secondary and tertiary interventions are identified and planned for each service user who has an identified risk of disturbed/challenging behaviour. Plans should include interventions to manage de-escalation, summoning additional staff, transporting or escorting of patients and use of restraint; seclusion; and rapid tranquillisation.

Care plans must be must be considered and implemented before police are requested.

Making a request for police assistance should be an exceptional circumstance.

Inpatient staff must ensure they adhere to the Trust Recognition, Prevention and Management of Violence and Aggression Policy, Use of Medication to Manage Disturbed, (Violent), Behaviour on Mental Health Units Policy and Tertiary Interventions Policy

3.2 Requesting a Police Response

Police assistance should only be requested where unpredictable risks have seriously compromised the safety of staff and service users.

Examples of where a police response could be requested are:

- An immediate risk to life and limb
- Immediate risk of serious harm
- Serious damage to property
- Offensive weapons
- Hostages

Further examples of these can be found in Appendix A.

AWP staff do not have access to mechanical restraints; however mechanical restraints can be used by transport services contracted by AWP to transport service users.

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.

Police response should be requested using (9)999 as all requests should only be made in exceptional circumstances and in an emergency.

3.3 Police Response

When so deployed police officers must work within an appropriate legal framework (see Appendix B). For example, the police should not be expected to assist health staff in responding to a service user who is presenting with behavioural or clinical management issues, (including their transfer from one service to another), unless those exceptional or aggravating factors apply.

No assumption should be made by the police that any incident involving any service user will always be a matter for healthcare staff alone; or that offences committed by a service user 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 nurse in charge has concerns about the appropriateness of the police response, they should escalate that to the duty inspector and to the locality senior management team.

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 service users and staff. All staff should be encouraged to ‘speak up and speak out’ during incidents, where concerned.

Step 1: Establish RVP

At the time AWP staff request the Police to attend they must identify a suitable rendezvous point (RVP). This is where the most senior police officer present can meet with the Nurse in Charge 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: Communication

When Police are asked to attend an inpatient area the Nurse in Charge will act as the key communication link. The Nurse in Charge should use the SBAR format for communication:

S=Situation (a concise statement of the problem)

B=Background (pertinent and brief information related to the situation)

A=Assessment (analysis and considerations of options — what you found/think)

R=Recommendation (action requested/recommended — what you want)

The communication must include any specific risks associated with the service user (e.g. the service user's legal status; whether they have already been restrained by AWP staff; whether rapid tranquilisation has been administered and the effect this has had; highlighting any dangers and relevant health related issues).

Step 3: Establishing Roles

It is important to establish what the police are being asked to do. If further deployment is necessary both the Nurse in Charge and the 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 AWP staff will remain responsible for the service user's health and safety. This will require active monitoring of the service user's physical health using NEWS.

AWP staff must alert Police officers regarding any concerns as to the patient's welfare during any period of restraint.

Step 4: Police Handover

Police will regain control of the ward/service user/situation using appropriate tactics. If police restraint is used, police will hand-over the service user to AWP staff as soon as control is regained.

There should be sufficiently trained AWP staff to enable this to happen (unless exceptional circumstances, e.g. 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 service user 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 service user's mental state at the time of the offence.

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

3.4 Following a Police Response

Any decision to call the police should be properly evaluated and consistently applied, in line with local protocol.

All incidents which require a Police response should be reported by all agencies using organisational incident reporting systems.

Localities should work with the Police to jointly review all incidents where a Police response has been requested. This may, on occasion form part of a Root Cause Analysis, (RCA).

If the threshold for, (RCA), is not met then a local review should be undertaken organised by the locality Senior Management Team in order to ensure shared learning.

Should an incident occur where statutory review is required all agencies will participate with whichever statutory organisation undertakes this, e.g. HSE, CQC, etc.

Reporting of incidents should include any concerns by either AWP or the Police as to the appropriateness of any request for them to attend.

Reviews of reported incidents should review any decision by the Police not to attend an incident, after being requested to do so.

Data from incident reporting should be reviewed by local Crisis Care Concordat groups.

4. Roles and Responsibilities

4.1 Inpatient Managers

All inpatient areas must undertake an annual Health and Safety Risk Assessment as per Trust Policy for Violence and Aggression and Physical Security Assessments.

Inpatient managers should ensure that where possible staffing arrangements are reviewed and provided to manage increased risks of violence and aggression. Assessments should include staffing requirements and contingency planning.

Inpatient managers must ensure staff complete appropriate identified training in the management of violence and aggression and that rostering arrangements ensure that there are always appropriately trained staff available to manage foreseeable incidents.

All inpatient areas have emergency resuscitation equipment in line with Trust Resuscitation Policy.

AWP managers will initiate and implement any formal joint post incident review, where necessary, including Root Cause Analysis processes.

4.2 AWP Nursing and Quality Directorate

Safer Staffing levels suggested by the Nursing and Quality Directorate and approved by the Trust Board should take account of the risk of violence and aggression and the need to provide proactive approaches to reducing the need for restrictive practices.

Safer Staffing levels are reviewed every 6 months and adjusted according to identified needs.

Flexibility in staffing levels, including skill mix, is included within Safer Staffing processes, allowing for staffing to be increased or decreased and skill mixes to be changed according to the clinical needs of the wards at any time.

4.3 Inpatient Multi-disciplinary Teams

AWP staff are responsible for all clinical interventions (e.g. taking of fluid samples, injections, etc.) with or without consent and in accordance with the law e.g. Mental Health Act status:

> Take steps that are reasonably practicable to safeguard other service users and other staff during incidents to which this protocol relates.
>
> Those restrictive interventions allied to mental health care; for example –

- The transfer of service users to a seclusion area.
- Transfer of service users; within or between mental health units or Accident & Emergency.
- Administration of treatment without consent (Part IV MHA / Mental Capacity Act).
- Undertaking searches of service users.

AWP staff are responsible for maintaining physical observations in the event of any restrictive practice including use of restraint, seclusion or rapid tranquilisation.

AWP staff must retake control of any restraint from the police as soon as it is safe to do so.

AWP staff will initiate and implement any informal joint post incident review, where necessary.

Staff must ensure attending police are fully aware of any physical health issues that may affect safety prior, during or post incident.

Ward staff must allocate a lead member of staff to co-ordinate the incident and instruct and inform attending police.

There will be occasions where there are exceptional circumstances which are not specifically addressed within this protocol. The principles outlines here will be applied to all exceptional factors.

4.4 The Police

The Police 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 National Partnership Protocol.

The police must provide an effective response to reports of serious crime, including incidents involving weapons, barricades or hostages as per appendix 1 to assist in the prevention of immediate risks to life and limb, immediate risk of serious harm to persons or serious damage to property.

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.

5. Reporting and Review

5.1 Crisis Care Concordat

It is expected that the memorandum of understanding will be part of the mental health Crisis Care Concordat local action plans in both England and Wales.

The implementation of this protocol will be monitored through Crisis Care Concordat meetings across the AWP geography.

6. Appendix A

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.

Appendix B

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 of the multi-agency memorandum of understanding, and Section 3.2 of this protocol.

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, (R, (on the application of Hicks and Ors) v Commissioner of Police of the Metropolis (2014) EWCA Civ 3), 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.

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.