Coventry & Warwickshire

Mental Health Act

Joint Agency Management Group

Operational Protocol for the Multi-Agency Management of Places of Safety under S135(1) and (2) and S136 Mental Health Act 1983 (Revised 2007)

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1. Introduction

1.1 The health and social care community of Coventry and Warwickshire Clinical Commissioning Groups Arden Cluster, West Midlands Police, Warwickshire Police, West Mercia Police, British Transport Police, West Midlands Ambulance, UHCW, Coventry & Warwickshire Partnership Trust, George Elliot Hospital, Warwick Hospital, Hospital of St Cross, Coventry City Council and Warwickshire County Council are working together to improve provision to patients in contact with the criminal justice system. This document forms part of the wider plan to improve partnership arrangements between the health and social care community across Coventry and Warwickshire supporting the Governments' Mental Health Crisis Concordat.

1.2 This document provides an outline operational protocol for the application of the Mental Health Act under sections S135 & S136 of the Mental Health Act 1983 (MHA).

1.3 This protocol will support the provision of multi-agency services to individuals who are likely to be patients under (S135 / 6) MHA.

1.4 This protocol has been developed jointly by all partner agencies (as listed in signatures section) based upon a previous generic protocol developed by NHS West Midlands and West Midlands Police. Use of this protocol will ensure compliance with relevant legislation, national guidance and other sources of standards for the NHS and the Police, see [References - Appendix A].

2. Executive Summary of Intentions

- To ensure efficient, effective and dignified assessment arrangements for ALL detainees who need to be removed to a Place of Safety.
- To ensure effective assessment by police officers and / or the ambulance service to ensure removal to the most appropriate location.
- To ensure the use of a dedicated psychiatric Place of Safety on the majority of occasions, exemplifying best practice.
- Providing prompt assessment (including how soon the doctor and AMHP should attend) and, where appropriate, admission to hospital for further assessment or treatment.
- Securing the attendance of police officers at health-based places of safety, where appropriate, for the patient's health or safety or the protection of others.
- The safe, timely and appropriate transport of the person to and between places of safety (bearing in mind that hospital or ambulance transport will usually be preferable to police transport, which should only be used exceptionally, such as in cases of extreme urgency or where there is an immediate risk of violence).
- Deciding whether it is appropriate to transfer the person from the place of safety to which they have been taken to another place of safety.
- Ensuring that people who are intoxicated can be safely managed in any place of safety or an emergency department, and receive an assessment of both their physical and mental health needs. Intoxication should not be used as a basis for excluding people from particular places of safety, except in the circumstances outlined in the policy such as where the patient's current behaviour clearly indicates that there may be a risk to their own safety, or that of the staff, which cannot be safely managed in the health-based place of safety.

- Ensuring that people who are behaving, or have behaved, violently can be safely managed in a place of safety taking into account the needs of the person and the safety of staff and others.
- Arranging access to a hospital emergency department for assessment for people who need it, and having an agreed list of circumstances when this will be necessary, such as where a person is self-harming, has a high body temperature or physical injury
- To ensure that no person under 18 is taken to police custody as a place of safety
- To ensure the use of Police Stations only in exceptional circumstances and where it is medically safe to do so
- To ensure effective multi-agency oversight for Place of Safety arrangements within Coventry and Warwickshire
- To work across organisational boundaries in achieving these intentions

3. Equality Impact Assessment

3.1 This generic protocol is based on an agreement between those agencies listed above who will review standards set by commissioners in respect of current legislation, regulations and 'best practice evidence'.

3.2 The Equality Impact Assessment will be conducted with reference to the population of Coventry and Warwickshire for which the power of detention has been used. It includes the particular health provision made available at the Caludon Centre and other Places of Safety.

4. Oversight

4.1 This protocol relates to individuals who are detained by the police under ss135 / 6 Mental Health Act (MHA) for removal to a Place of Safety (PoS).

4.2 All parties have agreed that those detained are a JOINT management responsibility from the first point of contact with the police to the completion of the assessment process (including admission if necessary). It is every organisation's responsibility to ensure support for the other(s), throughout the period of detention (including conveyance) in accordance with the legislation and guidance.

4.3 A senior professional in each agency will be responsible for the oversight, implementation and on-going strategic management of this protocol. A formal annual review of the operation of this protocol will occur involving those professionals from all partner organisations listed on page 21. This will be carried out under the auspices of the Joint Policy Steering Group.

4.4 Each partner will designate a manager from each organisation (Police Inspector, Social Care and NHS equivalent) as responsible for on-going operational, day-to-day oversight of the protocol, as well as being the day to day point of contact to resolve challenges with operational implementation of this protocol. Problem solving, where it cannot occur at the time, will be managed in a regular and minuted forum (at least bi-monthly). This will involve attendance by key staff including the designated PoS Manager, police inspector, senior AMHPs, ambulance representative and other representatives as required. It will be referred to in this protocol as the 'multi-agency group' or 'MAG'.

4.5 People who are intoxicated should be safely managed in any place of safety or an emergency department, and receive an assessment of both their physical and mental health needs. Intoxication should not be used as a basis for excluding people from particular places of safety. The assessment may be delayed, for example, when it is unclear whether a person under the influence of drugs and alcohol also has a mental

disorder. In addition to this there may be circumstances when the need to administer emergency sedation makes the subsequent assessment implausible, until the effects of the medication, drugs and/or alcohol have subsided. If it is not realistic to wait because of the patient's disturbed behaviour and the urgency of the case, the assessment will have to be based on whatever information the AMHP can obtain from reliable sources.

4.6 There will be joint consideration on the location of individuals who are detained whilst presenting with drug, alcohol or physical aggression. For those displaying physical aggression, they will not automatically be removed to a police station unless risk assessment evidences that the individual poses an 'unmanageably high risk' and it is considered medically safe to do so. The nurse in charge of the Place of Safety suite retains the decision as to whether to allow the detainee access to the suite.

4.7 Where a person is removed to custody as a place of safety the custody sergeant will retain the decision around detention.

4.8 It is envisaged that NHS professionals will be robustly supported by police officers wherever a health-setting is used and where those individuals present a 'manageably high risk'. Risk is inherent in the joint operation of detentions under ss135 / 6 and must be managed. Police supervisors in particular should ensure this as the police are legally responsible for the prevention of crime. This includes risk of assault to NHS professionals.

4.9 Where assessments occur on private premises without a S135 warrant issued by a Magistrate, there are no powers to remove an individual to a Place of Safety and this protocol does not apply.

4.10 Careful planning should be undertaken by any AMHP who is responsible for coordinating an assessment on private premises, especially where there is a possible risk of resistance or aggression. There is often confusion amongst professionals about the powers available to act and a lack of clear communication. The number of professionals and agencies involved dictates that effective planning and communication is key. For further guidance please see the Joint Standing Operating Procedures for Searching for and Removing Patients from Private Premises under Section 135 Mental Health Act 1983.

5. Detention under S135 / S136

5.1 Only police officers may detain someone under ss135/6 MHA and remove them to a Place of Safety. Following an initial decision to detain, an ambulance should be requested for conveyance to a PoS (it should have been organised in advance by the AMHP if detention is likely to arise following execution of a warrant under s135). This is not only important in terms of the patient's dignity, it is also important in terms of the skills of ambulance service staff in assessing whether other medical risks may be masked by mental ill-health and / or drugs and alcohol, requiring urgent medical assessment in an Emergency Department (ED).

5.2 When considering the use of police powers to detain people under the Act, less restrictive alternatives to detention should be considered. Health and/or social care professionals may be able to identify alternative options. For example, with the person's consent, the police, or any other qualified person may convene a mental health assessment without using section 135 or section 136 powers, by requesting that a section 12-approved doctor attend in order to assess the person and make any arrangements for their on-going care. Where appropriate, and depending on specific circumstances, consultation with carers may help, particularly in the case of children and young people. Health and social care professionals, and the police, should have regard to the principles of the Mental Capacity Act 2005.

5.3 When deciding that detention may be necessary, the police may also benefit from seeking advice before using section 136 powers in cases where they are unsure that the circumstances are sufficiently serious for using these powers. Advice can be obtained from the patients' clinical team, place of safety and liaison and diversion or street triage (where available).

5.4 The patient should be searched under s32 PACE. Any items which are considered to pose a risk of harm to others may be seized and they should be retained by the police officers until handed to the Place of Safety staff, ED staff, or to the Custody Officer at the police station. NHS staff should note that this search is limited to a physical 'pat-down', to searches of pockets and bags. The individual can only be requested to remove their hat, outer coat and / or gloves – it will not be a strip or intimate search, as defined by Police and Criminal Evidence Act (PACE).

S32(1) PACE

5.5 Identification of which PoS to be used should be reached in accordance with this policy and the Joint standing operating procedures on conveying mentally disordered patients. Police officers bear legal responsibility for the health and safety of their detainees until formal, agreed handover to NHS staff.

5.6 Where an ambulance is unavailable, police officers should still make their initial assessment in accordance with the West Midlands Ambulance Service conveyance policy. Under such circumstances, police officers may contact relevant health professionals for advice and information exchange.

5.7 Where police officers take a decision to expedite conveyance themselves, this should be in cases of extreme urgency or where it is necessary in order to safely manage a risk of violence. It will not normally be an exceptional circumstance to convey in a police car if the ambulance is delayed and there is no immediate threat to life) If a patient is presenting with a RED FLAG trigger condition (see Appendix C) an ambulance MUST be used.

5.8 The guiding principle of this protocol is that unless there are extreme circumstances and the risk is unmanageable, individuals will be removed to health-based, psychiatric Places of Safety. Health-based places of safety should ensure that they have arrangements in place to cope with periods of peak demand, for example using other suitable parts of a hospital, neighbouring health-based places of safety, or alternative places of safety. Unless they are detained whilst presenting with a RED FLAG, these are outlined in Appendix C and are agreed as criteria for removal to an ED.

5.9 In the event that none of the RED FLAG criteria are met and the health based PoS is not available other safe places can be considered and if unavailable the individual should only be removed to the police station in exceptional circumstances, which may include extreme violence. A police station should not be used as the automatic second choice if there is no local health based place of safety immediately available. Other safe places to be considered could include family home, relatives home, and residential placements with the agreement of the owner/manager. There is nothing that precludes other areas of a psychiatric hospital (such as a ward) being used as a temporary place of safety, provided that it is a suitable place and it is appropriate to use that place in the individual case.

5.10 Intoxication (whether through drugs or alcohol) should not be used as a basis for exclusion from places of safety, except in circumstances set out in the local policy,

where there may be too high a risk to the safety of the individual or staff. Health based places of safety should not be conducting tests to determine intoxication as a reason for exclusion, and

5.11 A child or young person should not be taken to a place of safety in a police station. If this occurs, consideration should also be given to using a different part of a police station or other place under the supervision of a police officer and not a police custody suite and immediate escalation should occur as in paragraph 9.2

5.12 A person is defined as 'arriving' at a Place of Safety when their care has been accepted by the NHS professionals managing that location or by the custody officer at a police station. Disputes into acceptance should be referred to the Local Multi Agency Group (MAG) if they cannot be resolved by operational supervisors at the time.

5.13 The 72 hour time limit on detention under s136 commences at the point of arrival at the first Place of Safety, this includes first arrival at Accident & Emergency, if used.

5.14 Advance notification of an impending s135/6 arrival will be given to the staff who manage the PoS from the Police Service or those professionals authorised by the police to do so as soon as it is possible to do so:

- For the Caludon Centre Coventry and Warwickshire, the advance number is 024 7696 8080.
- For Accident & Emergency Department, University Hospitals Coventry & Warwickshire (UHCW) the advance number is 024 7696 4000.
- For the police station, advance notification will be given via Operations Centres.
- The direct telephone number for use by Social Care and NHS Staff of local custody offices are:
  - **West Midlands Police** is **0345 113 5000 or 101**
  - **Warwickshire Police** is **01926 415 000 or 101**

6. Initial Conveyance

6.1 It will be the responsibility of police officers to request an ambulance for conveyance following detention under s136. It will be the responsibility of an AHMP to arrange an ambulance for assessments under s135. The ambulance service is the preferred method of transport to convey that individual from the location of detention to the PoS and to undertake any further conveyance requirements should the individual be subsequently transferred.

6.2 Conveyance following detention under s136 should be instigated by Police Officers via an emergency call to ambulance control.

6.3 It is the responsibility of the ambulance crews to consider the presentation of the patient detained by the police. Where paramedics or technicians believe that the patient has a RED FLAG presentation (see Appendix C), they should advise that the persons is removed to an Emergency Department.

6.4 Where it is considered that the safety either of the patient, the ambulance staff or the police officers would be at risk during transfer, ambulance crews should give consideration to requesting an authorised medical practitioner to advice on the use of emergency pharmacological intervention. West Midlands Ambulance Service have available to them a number of 'Pre-assessment Drs' who can be called by paramedics to assess the need for Emergency Treatment including rapid tranquilisation. Such treatment is given via a best interest decision under the Mental Capacity Act. Please

refer to the guidance on the use of the Mental Capacity Act 2005 in the Management of Mentally Disordered People in the Community.

6.5 Particular consideration should involve whether there is a need for on-going physical restraint by two or more police officers and therefore a risk of positional asphyxia or excited delirium. Whether or not pharmacological interventions are immediately appropriate, would depend on the advice of an authorised medical practitioner (for example anti-psychotics or lorazepam) ***The decision to use emergency medication for behavioural management can only be given in accordance with the Mental Capacity Act 2005 and is the responsibility of the person who is administering the medication***.

6.6 Where an authorised medical practitioner has been deployed prior to conveyance, police officers and paramedics will act in consideration with the advice given.

6.7 Any problems in securing arrangements for conveyance should be escalated to appropriate managers for discussion with ambulance managers and referred to the MAG if not resolved. This will allow on-going monitoring of the frequency of ambulance or police conveyance. The Exceptional Circumstances Monitoring Form (see Appendix I) should be completed and forwarded to the relevant Operational Manager to aid discussion at the MAG.

6.8 People taken to a health-based place of safety should be transported there by an ambulance or other health transport arranged by the police who should, in the case of section 136, also escort them in order to facilitate hand-over to healthcare staff.

6.9 Where police officers take a decision to expedite conveyance themselves, this should be in cases of extreme urgency or where it is necessary in order to safely manage a risk of violence. It will not normally be an exceptional circumstance to convey in a police car if the ambulance is delayed and there is no immediate threat to life) If a patient is presenting with a RED FLAG trigger condition (see Appendix C) an ambulance **MUST** be used.

7. Removal or Transfer to an Emergency Department

7.1 It is not the intention of this protocol, to promote the use of Emergency Departments (ED) as a Place of Safety although it is a safe place.

7.2 However, a minority of people detained by the police under ss135 / 6 MHA present with physical healthcare requirements in addition to their suspected mental disorder, which could only be addressed in an ED.

7.3 Individuals brought to the attention of the police because of disturbed or agitated behaviour may be at risk of coming to harm by virtue of undiagnosed or untreated medical or psychiatric emergencies.

7.4 Where such concerns exist or cannot be ruled out by police officers, the police officer be required to ensure that any person receives appropriate clinical attention, by calling an ambulance.

PACE CoP Code C; para 9.5 and Annex H.

7.5 Police officers will ensure staff are made aware of whether the person is detained under s136 or under arrest for a criminal offence on arrival at ED. Either way, the police officer(s) will remain with the patient throughout the assessment process in ED, to a conclusion or until transfer to a PoS and they should commence the monitoring form (See Appendix E).

7.6 It is the responsibility of the duty sergeant to ensure sufficient officers are deployed to manage risk in support of ED staff, especially so where the RED FLAGS involved, include agitated or disturbed behaviour.

7.7 In addition, police officers will ensure the following information is supplied to ED staff:

- Name and address of the individual detained;
- Name and address of the individual's next of kin or nearest relative;
- Circumstances in which the individual was found and detained;
- Whether restraint has been used on the individual detained
- Whether the detainee has been to any other Place of Safety prior to arrival;
- Confirmation that the individual has been searched by the police;
- Whether any article or contraband has been retained by the police;
- Whether they are also suspected of any criminal offence of which the police will consider taking action.
- Whether the police hold any information regarding the possibility that the individual presents a risk of violence or escape.

Subject to DPA, schedules 2 and 3.(Data Protection Act)

7.8 Ambulance staff will provide appropriate medical information on whether restraint has been used; drugs have been administered and any other observed symptomology which will subsequently need to be known.

7.9 This protocol ensures only detainees presenting with RED FLAG are removed to Emergency Departments for medical management. By necessity, this will involve initial psychiatric assessment and consideration of capacity and consent issues. This may involve liaison between ED Doctors and the Liaison or Duty psychiatrist.

7.10 Informing an AMHP should not be delayed pending transfer to a Place of Safety, as it would not necessarily be known upon arrival at ED how long the patient will remain there.

7.11 The AMHP should liaise with ED to co-ordinate the timing of any Mental Health Act assessment, dependent on the overall circumstances. It may be that this occurs in ED, for example if the patient would need to remain there for some time, because of their medical or physical healthcare needs; or that it the Mental Health Act assessment delayed for a short-period because it is known that the person will be safely transferred to a PoS and the assessment can be better conducted there.

7.12 Anytime spent at ED needs to be included in the overall 72hrs maximum assessment period.

s136(2) MHA.

7.13 Anyone removed to ED and accepted there for assessment/treatment, should be informed of their rights whilst detained. This will be done verbally and by the provision of the 'rights leaflet' (see Appendix F)

s132(1) MHA.

7.14 If it is possible for the ED staff to manage the physical healthcare requirements, rule out a medical emergency and confirm the person is considered 'fit for discharge' then the

person may be considered for transfer to a Place of Safety for conclusion of the mental health assessment.

s136(3) MHA.

7.15 If the patient is discharged from ED but remains in detention under s136 for MH assessment elsewhere, it will be the responsibility of the ED staff to ensure the transmission of relevant medical information which may be required by PoS staff, police custody officers or the Forensic Medical Examiner (FME) and the AMHP. This should not be done verbally, via the detaining officers.

8. Removal (or Transfer) to a place of Safety

8.1 The police will remain with the detainee upon arrival at the PoS for at least the duration of the 'handover period'. This period of time will include completion of the MHA monitoring form (See Appendix E), research by the officers of the individual's background, for sharing of information and for a joint risk assessment.

8.2 In the psychiatric setting, the 'handover period' should include a sufficient period of time for the PoS to coordinate their staff and for a police officer to provide a comprehensive briefing of relevant information. It should last no more than one hour.

8.3 The police service will be able to inform NHS staff of the information listed in para 4.8, where this information is known or easily able to be established:

8.4 `intoxication (whether through drugs or alcohol) should not be used as a basis for exclusion from places of safety, except in circumstances set out in the local policy, where there may be too high a risk to the safety of the individual or staff. Health based places of safety should not be conducting tests to determine intoxication as a reason for exclusion, and

8.5 Following acceptance of the individual at the PoS, the subsequent legal detention may be maintained by health/social care staff as well as by police officers. This will NOT occur in ED – the police will remain throughout and pending transfer to the PoS or to police custody.

s136(2) MHA.

8.6 Following acceptance at a health PoS, the rights of the detainee should be explained by hospital staff. The explanation of these rights should not be delayed where removal is to Accident & Emergency.

s132(1) MHA and MHA CoP; para 10.46.

8.7 Healthcare staff, including ambulance staff, should take responsibility for the person as soon as possible, including preventing the person from absconding before the assessment can be carried out. The police officer(s) should not be expected to remain until the assessment is completed; the officer should be able to leave when the situation is agreed to be safe for the patient and healthcare staff. Police officers and PoS staff will undertake a risk assessment to agree on whether the police officers may leave the patient with PoS staff or whether they remain until risks reduce or until the MHA assessment is concluded.

8.8 There should be identified, objective reasons based on risks and threats for police officers to remain after arrival in psychiatric PoS, utilizing the risk assessment tool (Appendix D).

8.9 Disputes in the implementation of this protocol or risk assessment conclusions will be referred to duty Sergeant and the duty PoS Manager. Where the disagreement CANNOT be resolved through further discussion or by the involvement of the duty Inspector or on-call manager, compromise will be reached in the following way:

- NHS Managers will have the right to insist upon police support and it will be given;
- Police supervising officers will have the right to insist on the level of that support.

8.10 Risk assessment should be regularly subject to joint-review and the police should be released, recalled or reinforced, where risks alter.

The following escalation procedure should be followed to conclude the assessment or release of police officers in a timely fashion:

- 2hrs: contact the AMHP co-ordinating the assessment, review with place of safety manager and police sergeant
- 4hrs: re-contact the AMHP co-ordinating the assessment, review with Duty inspector and place of safety manager
- 8hrs: inform the duty FIM or LPY supt / re-contact the AMHP/ contact NHS Manager/Social Care Manager
- Every further 2hrs: have the duty FIM re-contact NHS Manager to oversee and conclude the process, if possible.

8.11 Operational staff will comply with this compromise. Should operational staff from any agency remain unsatisfied and resolution has not been agreed informally, the incident can be referred to the MAG, via the Exceptional Circumstances Monitoring Form (Appendix I)

8.12 To maintain confidence in the support arrangements, the MAG will ensure effective communication and feedback to all operational staff regarding the difficulties that are referred to them.

9. **Removal or Transfer to a Police Station**

9.1 Detention at a police station should only be considered in exceptional circumstances, for example it may be necessary to do so because the person's behaviour would pose an unmanageably high risk to other patients, staff or other users if the person were to be detained in a healthcare setting. A police station should not be used as the automatic second choice if there is no local health based place of safety immediately available

Detention at a police station should only be accepted by the custody sergeant where it is considered medically safe to do so. Any conditions referred to or the 'RED FLAGS' in Appendix C, should lead to immediate transfer to an ED being ordered.

PACE CoP Code C; para 9.5 and Annex H.

9.2 The health based place of safety should be used as the place of safety for those under 18. A person under 18 should not be removed to a police station as a place of safety

If a person under 18 is detained then the following escalation process must be followed immediately and the person should be transferred to a health based place of safety as soon as it is safe to do so. See 14.

Where detention at the Police Station is accepted, the custody sergeant will immediately inform both an RMP (the FME) and an AMHP.

- IMMEDIATELY: inform the duty FIM/LPU Supt who will contact Senior NHS Manager and Social Care Manager

- Every further 2hrs: have the inspector re-contact NHS Manager and to oversee and conclude the process, if possible.

9.3 It is especially important for custody officers to consider those factors listed above and below, if conveyance to the police station has NOT occurred with the involvement of paramedics. Confirmation should also be sought from the arresting officer as to whether the police station is the first place of safety to which the person has been removed and whether or not any paramedics / technicians, doctors or other medical staff have been involved in any management decisions thus far.

9.4 Where detention at the Police Station is accepted, the custody sergeant will immediately inform both an RMP (the FME) and an AMHP.

9.5 An appropriate adult should be requested to support the detained person whilst they remain in police detention: nothing in law prevents the AMHP undertaking this function, although if an AMHP is being asked by the police to undertake this role it should be clearly explained. Where the AMHPs arrival will be significantly delayed for any reason, consideration should be given to securing another appropriate adult.

9.6 The custody officer must ensure that anyone detained receives appropriate clinical attention from an Approved Healthcare Professional. The AHP may be an FME or custody nurse but it may be necessary to call an ambulance.

PACE CoP Code C; paras 3.6, 3.8, 3.9, 3.16, 9.5 and Annex H.

9.7 There will be no delay in notifying the AMHP pending the arrival of an FME, AHP or any other RMP.

9.8 Although the Act provides a limit of 72 hours for detention under section 136, when a police station is used as a place of safety in the absence of a health-based place of safety being available, an assessment should be made as quickly as possible and made a priority by the doctor and AMHP. Alternatively, a transfer to a more appropriate place of safety should be made as soon as one becomes available unless it is clearly in the best interests of the person not to move them. Wherever practicable, detention in a police station under section 136 should not exceed a maximum period of 24 hours.

9.9 Detaining officers will still be responsible for initial completion of the MHA monitoring form and for attaching it to the custody record. This form will follow the patient if they are transferred to a health PoS or to ED.

9.10 The custody sergeant will ensure confirmation of information which should subsequently be shared with NHS professionals, either in police custody during MHA assessment or upon transfer to a health-setting. This information is listed in para 5.3, above.

PACE CoP Code C; para 9.4.

9.11 If a person is excluded from a place of safety in a hospital and taken to a police station as a place of safety a record should be made of the decision, of who made the decision, and the reason it was made. Where an individual is removed to a police station as a PoS, the reason they cannot be accommodated at the main PoS should be recorded on the MHA monitoring form and the matter be referred to the local monitoring group. This will allow focus on the proportion of instances that each venue is utilised.

9.12 Where an individual's assessment is entirely managed in police custody, MHA assessment should occur, unless delayed on medical advice, within 3 hours. Assessment taking longer than 3 hours should be referred to the MOG.

9.13 The custody officer will adhere to the following escalation procedure to conclude the assessment or release in a timely fashion:

- 2hrs contact the AMHP co-ordinating the assessment.
- 4hrs: re-contact the AMHP co-ordinating the assessment.
- 6hrs: inform the duty inspector / re-contact the AMHP/contact NHS Manager/Social Care Manager
- 15hrs: inform the duty FIM/LPU Supt who will contact Senior NHS Manager and Social Care Manager
- Every further 2hrs: have the inspector re-contact NHS Manager to oversee and conclude the process, if possible.

9.14 The above timescales should be adhered to if the person is detainable under the act but there are delays in obtaining a bed. It should be urgently considered whether a transfer to hospital based place of safety should be expedited.

MHA CoP; para 10.33.

10. Mental Health Act Assessment Considerations

10.1 Medical examination by doctors

10.1.1 In most circumstances, the assessment will involve 2 doctors, at least one of whom will be approved under Section 12 of the Act. The detained person will be seen by both the AMHP and doctor(s). Wherever possible this will be a joint assessment.

10.1.2 Where practicable and where this does not contribute to any unreasonable delay, at least one of the medical recommendations should come from a doctor who has previous acquaintance with the patient, preferably who has treated the patient previously.

MHA CoP; para 4.73.

10.1.3 Although it is preferable for the MHA assessment to occur with the AMHP and relevant RMPs together, there will be occasions where this does not occur.

If a doctor assesses the person and concludes that the person is not suffering from a mental disorder then the person must be discharged, even if not seen by an AMHP.

If the doctor sees the person first and concludes that they have a mental disorder and that compulsory admission to hospital is not necessary, but that they may still need treatment or care (whether in or out of hospital), the person should still be seen by an AMHP. The AMHP should consult the doctor about any arrangements that might need to be made for the person's treatment or care.

10.2 Is the person on supervised community treatments or AWOL?

10.2.1 It should also be borne in mind that a person who is removed to a place of safety may already be on supervised community treatment (SCT) or conditional discharge or may be on leave of absence from detention in hospital and that their recall to hospital may need to be considered. If it becomes apparent that this is the case, the professionals assessing the patient should make an effort to contact the patient's responsible clinician as soon as possible.

10.3 The role of the AMHP includes:-

- To undertake a mental health act assessment when requested and in accordance with this protocol.
- Coordinating the Mental Health Act assessment
- Contacting the nearest relatives
- Interviewing the person in accordance with the MHA Code of Practice
- Ascertaining whether there is a psychiatric history
- Considering any possible alternatives to admission to hospital if appropriate
- Making arrangements for compulsory admission to hospital if appropriate
- With the doctor coordinating any other care or treatment if required where compulsory admission to hospital is not required
- Fully recording the process in accordance with their local authority policy and process.

10.4 Assessment requirements

10.4.1 The same care should be taken in examining and interviewing people in places of safety as in any other assessment. No assumptions should be made because a detention to a place of safety has taken place and the guidance in Chapter 4 of the MHA Code of Practice applies in these circumstances as in any others.

MHA CoP; para 10.26 and chapter 4

10.5 Communication and the need for interpreters

10.5.1 The doctor and AMHP will consider whether the services of an interpreter are required or whether the person has special needs due to sensory impairment or learning disability. (If the place of safety is at the police station the custody officer will explore this when the individual is being booked into custody)

MHA CoP; para 2.4.

10.6 Timescales

10.6.1 The AMHP should make contact with the place of safety manager/custody officer?ED nurse in charge within 1 hour of referral and the assessment should commence within 2 hours. The assessment will normally be completed and detention concluded within 4 hours of the individual being detained at the place of safety. This time standard may not be achievable when the assessment is complex or the person is under the influence of alcohol or drugs.

MHA CoP; para 4.55

10.7 Completion of the assessment

10.7.1 Informal admission

If the person agrees to be informally admitted to hospital the doctor will make all the necessary arrangements for admission. If conveyance to the hospital where the person is to be admitted is required this will be done in accordance with Conclusion of Assessment paragraph 15.4 in this document.

10.7.2 Formal / Compulsory admission

If a detained person is assessed to have a mental disorder requiring hospital admission and refuses informal admission, Section 2 or 3 of the Mental Health Act 1983 may be used to effect compulsory admission. It should not be necessary or appropriate to use Section 4.

The AMHP will not be able to complete the assessment until a bed has been identified; the Act requires admission to a specific hospital. It is the responsibility of the assessing doctor to locate an available bed where required. The AMHP cannot refuse to undertake / complete the assessment because a bed is unavailable.

If the person is admitted to hospital compulsorily the doctor will make all the necessary arrangements for admission. If conveyance to the hospital where the person is to be admitted is required this will be done in accordance with Conclusion of Assessment paragraph 15.4 in this document.

10.7.3 `As soon as practicable after the assessment and interview, the person should be discharged, informally admitted, further detained under the Act, or other arrangements made for the person's treatment or care in the community. The person may continue to be detained whilst these arrangements are being made provided that the maximum period of detention is not exceeded

11. Learning Disabilities Assessments

11.1 Where the detained person appears to have a learning disability, it is desirable for a consultant psychiatrist in learning disabilities and an AMHP with experience of working with people with learning disabilities to make a joint assessment. This should not be used to cause any significant delay in the assessment process.

MHA CoP; para 10.29

11.2 Where the person is detained at the Caludon Centre the PoS Lead will request an RMP who is s12(2) approved and a specialist in Learning Disabilities to undertake a medical assessment. PoS staff will also ascertain whether the individual is known to the Trust's Learning Disability service so that any relevant information is shared at the earliest possible point.

11.3 On referring to the AMHP service the PoS Lead should advise that the person has learning disabilities.

11.4 The AMHP will seek specialist support and/or advice from their Council's Learning Disability Teams. This will ensure that if the person is known to their service that relevant information is shared at the earliest possible point. The AMHP may request for

a specialist worker to be present at the point of assessment to enable a thorough holistic assessment of the persons circumstances.

11.5 Whether or not Learning Disabilities specialists are involved in the MHA assessment the same timescales for completing the assessment should be adhered to. It will be the Learning Disabilities clinicians' responsibility, in conjunction with the AMHP, to ensure that any arrangements for the person's on-going treatment and on-going care are concluded in a timely manner and must be concluded within the 72 hour legal time frame.

11.6 As in all cases the MHA-PoS monitoring form will be completed enabling the number of Learning Disability assessments undertaken to be monitored by the MAG with particular consideration given to the efficacy of the partnership working in each case and other learning outcomes.

12. CAMHS Assessments

12.1 The health based place of safety should be used as the place of safety for those under 18. A person under 18 should not be removed to a police station as a place of safety. If this occurs, consideration should also be given to using a different part of a police station or other place under the supervision of a police officer and not a police custody suite and immediate escalation should occur as in 9.2.

12.2 This protocol applies equally to children and adolescents (under the age of 18) who may be detained under s136. If a child or adolescent is detained, the assessment should be undertaken, wherever possible, by a CAMHS consultant and / or an AMHP with knowledge and experience of caring for this age group.

MHA CoP; para 10.30

12.3 It is preferable that CAMHS assessments are undertaken by an RMP who is s12(2) approved and a specialist in that area of psychiatry. The Caludon Centre PoS Lead will make the referral to the CAMHS service for such an RMP to undertake the medical assessment.

Prior to any assessment of a child or adolescent, staff should liaise with CAMHS or if out of hours, the on-call CAMHS Consultant.

12.4 Decisions to delay for a specialist or s12(2) RMP should be balanced against the delays in assessment which would result and any reason for proceeding without resort to a s12(2) RMP or a CAMHS specialist, should be documented.

12.5 The Caludon Centre PoS Lead will ascertain whether the individual is known to CAMHS so that any relevant information is shared at the earliest possible point and if a specialist doctor is not available request specialist support and guidance for the assessment process. This will include a request for a specialist worker to be present at the point of assessment to enable a thorough holistic assessment of the person's circumstances.

12.6 Whether or not CAMHS specialists are involved in the MHA assessment the same timescales for completing the assessment should be adhered to. It will be the CAMHS clinicians' responsibility, in conjunction with the AMHP, to ensure that any arrangements for the person's on-going treatment and on-going care are concluded in a timely manner and must be concluded within the 72 hour legal time frame.

12.7 As in all cases the MHA PoS monitoring form will be completed enabling the number of CAMHS assessments undertaken to be monitored by the MAG with particular

consideration given to the efficacy of the partnership working in each case and other learning outcomes.

12.8 Following assessment, if it is decided that the individual should be detained in hospital, a bed in an appropriate health setting should be negotiated via the CAMHS Service.

12.9 The requirements of the Mental Health Act 2007 in relation to Age Appropriate Accommodation must be observed.

13. **Escalation Process**

13.1 The Royal College of Psychiatrists recommends a maximum period within which to conclude Mental Health Act assessments. Whilst the law allows 72 hrs to do so, assessment should occur and conclude in most cases within 4hrs / 6hrs wherever possible. This will be longer where individuals are detained whilst under the influence of drugs / alcohol or where physical healthcare issues prioritised in ED cause a delay in the commencement of MHA assessment.

13.2 For the purposes of this escalation process 'PoS Guardian' means –

Emergency Department	Senior ED nurse
Caludon PoS	Senior Mental Health nurse in charge
Police Station	Custody sergeant

13.3 Clear communication between the AMHP and the PoS Guardian should ensure that progress being made towards conclusion of assessment is understood in the particular circumstances. Ensuring that the PoS Guardian understands any reasons for delay is also key to preventing difficulties across the organisations.

13.4 Where delays are caused beyond this recommended minimum period or where there is a lack of communication to the PoS Guardian, the following escalation process will apply:

NB: These are MINIMUM requirements – each PoS Guardian is entitled to make contact more frequently where needed.

2hrs: PoS Guardian to contact the AMHP for a situation update.

Further contact will be made with the AMHP at least **every 2hrs** in the absence of any other communication.

12hrs: The fact of an on-going s136 detention should be brought to the attention of the appropriate managers, below, who should then work together to conclude the assessment or arrangements:

ED	Senior ED Nurse
Caludon PoS	Senior nurse in charge
Police	Duty Inspector
AMHP Manager Coventry	General Manager Social Care Governance
AMHP Manager Warwickshire	Social Care Coordinator

Further contact will be made with the AMHP at least every 2hrs in the absence of any other communication.

12hrs: The fact of an on-going s136 detention should be brought to the attention of the appropriate senior managers, below, who should then work together to conclude the assessment or admission / referral arrangements:

ED	Senior ED Nurse
Caludon PoS	Operations Manager
Police	Duty Inspector
AMHP Manager Coventry	General Manager Social Care Governance
AMHP Manager Warwickshire	Social Care Coordinator

Further contact will be made with the AMHP at least **every 2hrs** in the absence of any other communication.

48hrs: The fact of an on-going s136 detention should be brought to the attention of the appropriate service directors, below, who should then work together to conclude the assessment or admission / referral arrangements:

ED	Senior ED Nurse
Caludon PoS	Operations Manager
Police	Duty Superintendent
AMHP Manager Coventry	General Manager, MH SC Services
AMHP Manager Warwickshire	Service Manager MH Services

Further contact will be made with the AMHP at least **every hour** in the absence of any other communication.

13.5 Each signatory agency will always retain the right to refer a particular case to the MAG where they believe there were problems from which lessons should be learned, regardless of whether this escalation process resolved a particular difficulty.

13.6 **All** PoS detentions lasting longer than 24hrs will be referred to the MAG for review.

14. Transfer between Places of Safety

14.1 Initial management in an ED and / or Police Station should be for as short a period as possible and individuals should be transferred to the main PoS as soon as possible.

14.2 That stated, a transfer should not occur without the authority of an AMHP, a RMP or another health care professional who is competent to assess that the transfer will not put the individual's or others' health at risk.

14.3 Transfer can only be undertaken by a police officer or an AHMP or by someone authorised by either of them to do so. Even where authority is delegated, the police officer or AMHP retain responsibility for conveyance.

14.4 Neither should the transfer occur without the agreement of the receiving PoS that they are able to accept the individual.

14.5 Transfer of an individual should be undertaken by the Ambulance Service, organised via the Urgent Care Desk, **01785 270 320** although the person remains in the legal custody of the police officer or AMHP

MHA CoP; para 10.17.

15. **Conclusion of Assessment**

15.1 Where assessment concludes that the individual requires admission to hospital as a voluntary or detained MHA patient, the police should remain involved in assisting any necessary conveyance if they have remained involved thus far.

15.2 Where it has been agreed that the police should resume other duties, they should not become re-involved in supporting any conveyance unless the risk assessment has altered. Securing arrangements for admission to hospital remains the responsibility of the AMHP and should be obtained via the Ambulance Service (**01785 270 320**)

15.3 Once an individual is subject to an application for compulsory admission under the MHA, they are in legal custody of the AMHP (or the applicant). Where the Ambulance Service or the Police Service are requested to convey, authority to do so must be delegated to them by the AMHP and should be done in writing (see Appendix G).

s137(1) MHA.

15.4 There is no clearly prescribed process by which to determine which organisation bears responsibility for the repatriation of those individuals who are not subject to formal admission under the MHA. In recognition of the principle that the operation of s136 is a joint responsibility, the following compromise is outlined:

- The **police service** will bear responsibility for the repatriation or the costs of repatriation for all those individuals with whom they have remained involved during the assessment process (including those wholly assessed in the ED); AND those who are not deemed by the assessing RMPs as mentally disordered within the meaning of the MHA;

- The **NHS** will bear responsibility for the repatriation or the costs of repatriation for all those persons who are deemed by the assessing RMPs to be mentally disordered within the meaning of the MHA but with whom the police have not remained.

15.5 This compromise ensures that police officers repatriate and manage all those who pose risks and those in relation to whom the power was used in good faith but without utility.

15.6 It ensures that the NHS takes responsibility for those low risk individuals who are mentally disordered, albeit not subject to hospital admission following their s136 assessment and ensures that their conveyance for repatriation is in the most appropriate way.

15.7 This should represent a roughly equitable division of responsibility between agencies. Frequency of conveyance upon conclusions should be monitored.

16. Criminal Offences / s136 Mental Health Act

16.1 Where an individual is detained by the police in circumstances where they could *either* have been arrested for a criminal offence *or* detained under s136 MHA, they should be arrested and removed to a police station unless the offence is so trivial as to be safely set aside for the purposes of prioritising a mental health assessment. This might well occur where the offending was very low-level, possibly 'victimless' and / or where the behaviour is most likely to be related to their mental health condition.

16.2 It is ultimately up to the discretion of the arresting officer as to whether to prioritise the offence or s136, where both options exist.

16.3 For offences which are not trivial, including offences of violence against Social Care or NHS staff prior to or after arrival at the PoS, immediate consideration of the criminal justice process should be made. The individual may be arrested for the offence and transferred to custody to facilitate the investigation of the offence. Any mental health assessment must be considered alongside the criminal investigation in police custody and the assessment should not be delayed solely due to the transfer to police custody

16.4 Patients who assault Social Care or NHS staff, by definition, may pose an 'unmanageably high risk' and violence towards Social Care or NHS staff is always unacceptable.

16.5 However, following any arrest for an offence, an ambulance should still be called where the individual is presenting with any of the conditions outlined in Appendix C .

16.6 They should then be considered for removal to an ED prior to detention in police custody, subject to any advice given by the ambulance service.

16.7 There should be NO assumption by police officers or anyone else, that because someone was detained under s136 MHA at the point where they have offended, that they are automatically unable to be prosecuted because of their mental health condition. A thorough criminal investigation of the incident should occur on each occasion without prejudice or presumption and police supervisors should always be directly involved in overseeing this investigation.

16.8 All incidents of violence or damage towards within the Place of Safety staff or property should be referred to the MAG.

17. AWOL under ss135/6

17.1 Where a patient absents themselves from detention under either s135 or s136, the police and the AMHP will ensure a co-ordinated approach to recovering the patient.

17.2 Local procedures on patients going AWOL under the MHA should be referred to and initiated.

17.3 If an individual escapes detention under ss135/6 prior to arrival at the PoS, they may be retaken into custody in the subsequent 72hrs period. If they absent themselves after arrival at a PoS, they may be retaken with a 72hrs period after their arrival at the first PoS to which they were taken.

s138(3) MHA.

EXAMPLES:

- Detained at 3pm on DAY 1
- Escapes at 3:15pm on DAY 1, prior to arrival at a PoS
- They may be retaken into custody up until 3:15pm on DAY 4

- Detained at 10am on DAY 1
- Arrives at A&E at 10:15am because of physical injuries
- Escapes from A&E at 12:30pm on DAY 1

- They may be retaken into custody up until 10:15 on DAY 4

- Detained at 2am on DAY 1
- Arrives at the Police Station at 2:30am on DAY 1 because PoS is full
- Transferred to PoS at 10am on DAY 1.
- Escapes at 11:00am on DAY 2
- They may be retaken into custody up until 2:30am on DAY 4

17.4 There is NO power to force entry to premises in order to secure the re-detention of someone who is missing under the MHA and this extends to a person AWOL from detention under ss135 / 6. Where entry needs to be forced in order to re-detain a patient, this must be done under the terms of a warrant issued under s135(2) MHA see Joint Standing Operating Procedures for Searching for and Removing Patients from Private Premises under Section 135 Mental Health Act 1983.

17.5 Where a person is re-detained, police officers should then recommence the process of this protocol from Section 3, 'INTIAL DETENTION', calling an ambulance and re-risk assessing the appropriate place to which the patient should be removed. This may or may not be the same location to which they were previously heading or from which they have absconded.

17.6 The fact of the escape should be strongly considered when risk assessment decisions are then made about the appropriate PoS to be used and / or whether the police remain at that location pending assessment.

17.7 The overall time for assessment and conclusion of Place of Safety operations, including absences, is 72hrs from the point of arrival at the first place of safety.

18. **Monitoring**

18.1 The Police will ensure provision of the MHA PoS Monitoring form and the Caludon POS Lead will ensure collation of completed MHA PoS monitoring forms and ensure that they are sent to the Lead Professionals for each agency (see 13.4 above). These will ensure the basis of overseeing the use of s135/6 powers in the area. They are legally required and of critical importance. They will be analysed on behalf of both the Joint Agency Steering and Liaison Group for Mental Health Act Policies and Procedures and it's Warwickshire and Coventry sub-committees in accordance with it's terms of reference and to the PoS MAG which has specific oversight of the commission and operation of place of safety provision in Coventry and Warwickshire.

MHA CoP; para 10.42.

18.2 Data should be prepared and circulated on a bi-monthly basis for consideration to MAG and the Joint Agency Steering and Liaison Group for MHA Policies and Procedures. It should be further analysed and examined during the annual review.

18.3 Particular attention should be paid to demographic factors, such as:

- Age
- Gender
- Ethnicity

But also to:

- CAMHS / LD issues
- Average length of time from arrival at PoS to discharge or application for admission
- Examination of assessment times significantly above the average.

18.4 Analysis should include:

- How many were 'mentally disordered within the meaning of the MHA'?
- How many under the influence of drugs / alcohol?
- How many were physically aggressive on detention?
- How many and percentage of removals to A&E?
- How many and percentage of removals to Police Stations?
- How was conveyance to the PoS undertaken?
- How was conveyance upon conclusion undertaken?
- How many criminal offences were committed towards PoS staff / property or other agencies' professionals?
- What was the outcome of those criminal investigations?
- Any correlation between demographic factors and the above points?

19. Signatures

		Date	
NHS Coventry MH Commissioner			

		Date	
NHS Warwickshire MH Commissioner			

		Date	
CWPT Place of Safety Lead			

		Date	
UHCW ED Lead			

		Date	
George Eliot ED Lead			

		Date	
SWFT ED Lead			

		Date	
CCC AMHP Lead			

WCC AMHP Lead		**Date**	

CWPT CAMHS Lead		**Date**	

CWPT LD Services Lead		**Date**	

WMAS MH Lead		**Date**	

Coventry Police Lead		**Date**	

Warwickshire Police Lead		**Date**	

References

This protocol is developed in compliance with the following legislation:

- Mental Health Act 1983 (MHA)
- Code of Practice (CoP) to the MHA, revised 2015
- Police and Criminal Evidence Act 1984 (PACE).
- Code of Practice, Code C, to PACE, revised 2008
- Human Rights Act 1998
- Data Protection Act 1998

Due regard has been further given to the following guidance, case law and other specialist literature, relevant to the operation of MHA Places of Safety (PoS):

- Royal College of Psychiatry Standards on s136 (2008)
- Independent Police Complaints Commission of the use of police cells for detentions under s136 (2008)
- Academy of Medical Royal Colleges Report on Managing Urgent Mental Health Needs in the Acute Trust (2008)
- NICHE Guidelines on the Short-term Management of disturbed / violent behaviour (2005).
- NPIA Safer Detention Guidance, NPIA (2006)
- NPIA Guidance on Police Responses to People with Mental Ill Health or learning disabilities (forthcoming, 2010)
- Home Office Circular 17/2004
- Home Office Circular 66/1990
- R v Ashworth Hospital Authority (2005), House of Lords.

DETENTION UNDER s136 MENTAL HEALTH ACT 1983

1. INITIAL POLICE RISK ASSESSMENT & CALL '999' AMBULANCE

'RED FLAGS'? – is a pre-hospital medical practitioner required?

See Appendix C for RED FLAG criteria – utilise BASICS Doctor if necessary (Paramedic / Technician decision only).

2. CONFIRM RED FLAG RISK ASSESSMENT AND CONVEY TO:

1st Resort PoS for	1st Resort PoS	Last Resort PoS
s136 requiring **URGENT** hospital treatment or assessment arising from one or more **RED FLAG** criteria	NO **RED FLAG** criteria Transferred to ED if **RED FLAG** criteria develop whilst in the PoS	NO **RED FLAG** criteria where they pose: an unmanageably high risk (inc assault of PoS or ED staff)
2nd choice PoS? ←	Identified Alternatives	Exceptional use ONLY
EMERGENCY DEPARTMENT	**PLACE OF SAFETY**	**POLICE STATION DEPARTMENT**

COMPREHENSIVE HANDOVER BY THE POLICE TO THE NHS

Circumstances of detention, nominal details, risk- based intelligence, other relevant information from Computer Systems

DISCHARGE from s136	**TRANSFER to PoS**	**TRANSFER to PoS**	**DISCHARGE** from s136

REPEAT INFORMATION SHARING UPON TRANSFER

RISK ASSESSMENT OF WHETHER THE POLICE REMAIN

s136(2) MHA - see Appendix D for risk assessment criteria

WHEN UNRESOLVED: POLICE REMAIN & DISPUTE REFERRED

keep reassessing ⟷ ***keep reassessing***

Red Flag Criteria

RED FLAG CRITERIA

Police Officer / Paramedic triggers for conditions requiring Treatment or Assessment in an Emergency Department

Dangerous Mechanisms:

Blows to the body
Falls > 4 Feet
Injury from edged weapon or projectile
Throttling / strangulation
Hit by vehicle
Occupant of vehicle in a collision
Ejected from a moving vehicle
Evidence of drug ingestion or overdose

Serious Physical Injuries:

Noisy Breathing
Not rousable to verbal command
Head Injuries:

Loss of consciousness at any time
Facial swelling
Bleeding from nose or ears
Deep cuts
Suspected broken bones

Attempting self-harm:

Head banging
Use of edged weapon (to self-harm)
Ligatures
History of overdose or poisoning

Psychiatric Crisis

Delusions / Hallucinations / Mania

Possible Excited Delirium:

Two or more from:

- Serious physical resistance / abnormal strength
- High body temperature
- Removal of clothing
- Profuse sweating or hot skin
- Behavioural confusion / coherence
- Bizarre behaviour

BASICS Doctors:

ONLY AT THE REQUEST OF PARAMEDICS / TECHNICIANS – ACCESSED VIA EOC

Where immediate management of RED FLAG conditions necessitates the intervention or skills of a Doctor or where without medical oversight the journey would involve too much risk, ether to the patient, the paramedics or the police officers.

This should include situations where rapid tranquilisation is considered necessary, in accordance with **NICHE GUIDELINES 2005**.

Conveyance to the nearest ED:

Should NOT be undertaken in a police vehicle **UNDER ANY CIRCUMSTANCES** where a **RED FLAG** trigger is involved.

This includes remaining in ED until the person is medically fit for discharge to PoS, to Police Station or from s136 detention.

It is the responsibility of the Police to outline to ED the **LEGAL ASPECTS** of detention; it is the responsibility of the Ambulance Service to outline the **MEDICAL ASPECTS**.

Risk Assessment Tool, s136(2) MHA

POLICE SUPPORT WITHIN THE PLACE OF SAFETY		
LOW RISK	**MEDIUM RISK**	**HIGH RISK**
Current / recent indicators of risk	**Current / recent indicators of risk**	**Current / recent indicators of risk**
No currently present behavioural indicators (other than very mild substance use) **AND** no recent criminal / medical indicators that the individual is violent OR poses and escape risk OR is a threat to their own or anyone else's safety **OR**	Some currently presented behavioural indicators (including substance use) **AND / OR** some recent criminal / medical indicators that the individual may be violent OR poses an escape risk OR is a threat to their own or anyone else's safety **BUT**	Currently presented behavioural indicators (including significant substance intoxication) **OR** significant recent criminal or medical indicators that an individual is violent AND poses an escape risk OR is an imminent threat to their own or anyone else's safety OR
Previous indicators	**Previous indicators**	**Previous indicators**
Which are few in number AND historic OR irrelevant; **BUT** Excluding violence graver than ABH and not involving weapons, sexual violence or violence towards NHS staff or vulnerable people	Limited in number OR historic OR irrelevant; including violence graver than ABH or involving weapons, sexual violence, violence towards NHS staff or vulnerable people **OR** LOW RISK patients who have disengaged from treatment and where there are MEDIUM RISKS threats when disengaged.	Neither limited NOR historic NOR irrelevant; including violence graver than ABH or involving weapons, sexual violence, violence towards NHS staff or vulnerable people **OR** LOW or MEDIUM RISK patients who have disengaged from treatment and where there are MEDIUM RISKS threats when disengaged.
Police support is NOT required	**Police support MAY be required**	**Police support is VITAL**

- Where there is dispute within this framework, NHS professionals will have the **right to insist** upon police support where they believe they require it – police supervisors will have the **right to insist** on what that support should be. **Each agency will accommodate the other, through this compromise.**
- Where the police feel that the NHS have insisted upon support inappropriately or where the NHS feel the police have provided too much or too little support, this should be referred to the MAG for resolution and feedback should be provided by managers to ALL professionals involved.

Section 135/136 Place of Safety Monitoring Form Appendix E

This form is to be completed in the first Place of Safety (PoS) and should go with the detainee should they need to be moved to another more appropriate PoS. It is important that times and dates are recorded, as the 72 hour detention starts at the first PoS.

Section A - Individual's personal details - Detaining officer to complete			
Section used (please circle):	Section 135 / Section 136	Ethnicity:	
Detainee's full name:		Language:	
Date of birth:		Gender:	
Address:			
Tel no:			
Next of kin (NoK):		Relationship:	
NoK address:			
NoK tel no:			

Section B - Circumstances of detention - Detaining officer to complete			
Time/date of detention:		Location (when detained):	
Circumstances leading to detention:			
Detaining officer name:		Collar no:	Force:
Incident no:		Time AMHP contacted by police:	
PNC warning markers (GENIE/ FLINTS should also be checked):			

Section C - Transfer to place of safety - Detaining officer to complete			
Ambulance triage used?		Ambulance call sign:	
If triage not used, why?			
Ambulance transfer used?	Yes / No	Ambulance call sign:	
If transfer not used, why?			
Initial screening:	Drugs: Yes / No / Unknown	Alcohol: Yes / No / Unknown	

Section D - Place of safety used - Detaining officer to complete			
Initial PoS used:	☐ PoS (s.135/6) Suite - **Go to Section G**	☐ Police Custody - **Go to Section E**	
	☐ A&E - **Go to Section F**	☐ Other (please specify):	
Time/date of arrival:		PoS used:	
Reason for using specified PoS (in particular if police custody has been used, why is this?)			

Section E - To be completed if police station used as PoS - by detaining officer			
Police station:		Time/date of arrival:	
Custody record no:			
Appropriate adult (if applicable):			
Appropriate adult (relationship/tel no):			
Solicitor (if applicable):			
Transfer to:		Time/date of transfer:	
Transfer authorised by:			
Ambulance transfer?	Yes / No	Ambulance call sign:	
If transfer not used, why?			

Tick as applicable:

☐ Coventry and Warwickshire Partnership NHS Trust
☐ South Staffordshire and Shropshire Healthcare NHS Foundation Trust
☐ Warwickshire Police/West Mercia Police
☐ 2gether NHS Foundation Trust (Herefordshire)
☐ Worcestershire Health and Care NHS Trust
☐ West Midlands Police

Section F - To be completed if A&E used as PoS - by detaining officer			
Emergency dept:		Time/date of arrival:	
Transfer to:		Time/date of transfer:	
Transfer authorised by			Yes / No
Ambulance transfer?	Yes / No	Ambulance call sign:	
If transfer not used, why?			

If A&E used as an initial PoS police are to remain throughout (until detainee transferred to PoS suite)

Section G - Joint risk assessment (at PoS suite) - To be completed by detaining officer and PoS staff/AMHP			
Police PNC/FLINTS/GENIE checks completed?	Yes / No	Details:	
Already known to MH Services?	Yes / No	Details:	

Warning review to take place			
Police Risk Assessment (RA):	Low / Medium / High	AMHP/PoS RA:	Low / Medium / High
Police to remain beyond handover (please circle):		Yes - police to remain	No - police can leave
Reason for police to remain (if applicable):			
Time/date police left:		Individual assuming responsibility for detainee:	
Any police concerns for s.135/136 Monitoring Group:			

Please bring any police concerns to the attention of the Police Mental Health SPOC for your area.

Section H - Legal matters at PoS - To be completed by PoS staff/S12 doctor/AMHP			
72 hours starts (same as arrival time at first PoS - section D):		Name of AMHP:	
Time/date AMHP arrival:		Time taken to arrive:	
Rights explained?	Yes / No	By:	
Rights Leaflet given?	Yes / No	By:	

Section I - MHA assessment - To be completed by S12 doctor/AMHP			
Name of 1st RMP (S12 doctor):		Time/date assessment commenced:	
AMHP and 1st RMP present together?	Yes / No	If not, why?	
Mentally disordered within MHA?	Yes / No		
Name of 2nd RMP (S12 doctor):		Time/date assessment commenced:	
AMHP and 2nd RMP present together?	Yes / No	If not, why?	
Admission to hospital required?	Yes / No	If yes, hospital name:	
If yes, state section of MHA/voluntary:	☐ Voluntary	☐ Section 2	☐ Section 3
If no, time/date of release from s.135/136 and alternative management plan:			
Name of care co-ordinator (if applicable):			
Time/date MHA assessment concluded:		Time from arrival at first PoS, until release/section:	

Section J - Criminal offences at PoS/issues for s.135/136 monitoring group - To be completed by PoS staff			
Any criminal offence during detention at PoS?	Yes / No	Police recalled to PoS?	Yes / No
Police incident no:		Trust incident form no:	
Incident in brief:			
Any other issues for monitoring group?			

The original of this monitoring form should go with the police to all PoS settings involved in the patient care. The PoS lead/Lead AMHP should collate all completed forms for monitoring purposes. Police should copy this form at the point they are released and then scan and email this copy to their local Harm Assessment Unit (HAU).

Legal Rights Leaflet – s136 MHA

PATIENT INFORMATION	s136 Mental Health Act

ADMISSION OF MENTALLY DISORDERED PERSONS
FOUND IN A PLACE TO WHICH THE PUBLIC HAVE ACCESS

1. Patient's Name	
2. Name of Place of Safety	

WHY AM I IN HOSPITAL?

You have been brought to this hospital by a police officer because they are concerned that you may have a mental disorder and should be seen by a mental health professional.

You are being kept here under section 136 of the Mental Health Act 1983 so that you can be assessed to see if you need treatment.

HOW LONG WILL I BE HERE?

You can be kept here (or in another place where you will be safe) for up to 72hrs so that you can be seen by a doctor and an approved mental health professional.

An approved mental health professional is someone who has been specifically trained to help decided whether people need to be admitted to hospital.

If the doctor and the approved mental health professional agree that you need to remain in hospital, a second doctor may be asked to see you to confirm their decision.

During this time you must not leave unless you are told that you may. If you try to go, the staff can stop you, and if you leave you can be brought back.

If the doctors and the approved mental health professional have not seen you by the end of the 72 hours, you will be free to leave. You may decide you want to discuss staying on as a voluntary patient or discuss other health or social care assistances that may be available. But if you do want to leave, please talk to a member of staff first.

WHAT HAPPENS NEXT?

When the doctors and an approved mental health professional have seen you, they may say that you need to stay in hospital for longer. They will tell you why and for how long this is likely to be. You will be given another leaflet that explains what will happen.

If they decide that you do not have to stay, someone will talk to you about what other help you should have.

CAN I APPEAL?

No. Even if you do not agree that you need to be in hospital, you cannot appeal against the decision to keep you here under section 136.

WILL I BE GIVEN TREATMENT?

The hospital staff will tell you about any treatment they think you need. You have the right to refuse any treatment you do not want. Only in special circumstances, which would be explained to you, can you be given treatment you do not agree to.

LETTING YOUR NEAREST RELATIVE KNOW

A copy of this leaflet will be given to the person the Mental Health Act says is your nearest relative. There is a list of people in the Mental Health Act who are treated as your relatives. Normally, the person who comes highest in that list is your nearest relative. The hospital staff can give you a leaflet which explains this and what rights your nearest relative has in connection with your care and treatment.

In your case, we have been told that your nearest relative is:

If you do not want this person to receive a copy of the leaflet, please tell your nurse or another member of staff.

CHANGING YOUR NEAREST RELATIVE

If you do not think this person is suitable to be your nearest relative, you can apply to the County Court for someone else to be treated as your nearest relative instead. The hospital staff can give you a leaflet that explains this.

CODE OF PRACTICE

There is a Code of Practice that gives advice to the staff in the hospital about the Mental Health Act and treating people for mental disorder. The staff have to consider what the Code says when they take decisions about your care. You can ask to see a copy of the Code, if you want.

HOW DO I COMPLAIN?

If you want to complain about anything to do with your care and treatment in hospital, please speak to a member of staff. They may be able to sort the matter out. They can also give you information about the hospital's complaints procedure, which you can use to try to sort out your complaint locally. They can also tell you about any other people who can help you make a complaint, for example an independent mental health advocate (see below).

If you do not feel that the hospital complaints procedure can help you, you may complain to an independent Commission. This is called the **Care Quality Commission** and it monitors how the Mental Health Act is used, to make sure it is used correctly and that patients are cared for properly while they are in hospital. The hospital; staff can give you a leaflet explaining how to contact the Commission.

They can also contact the police on your behalf or provide you with a leaflet from the **Independent Police Complaints Commission** if you have any concerns about the police involvement in your detention under the Mental Health Act.

PLEASE ASK HOSPITAL STAFF FOR ANY OTHER INFORMATION.

AUTHORITY TO CONVEY

SS6 AND 137 Mental Health Act

I *(name of AMPH / Police Officer):*

……

BEING AN APPROVED MENTAL HEALTH PROFESSIONAL / POLICE OFFICER,

BASED AT *(professional address):*

……

AUTHORISE THE FOLLOWING PERSON:

……

TO DETAIN / CONVEY THE FOLLOWING PERSON:

INDIVIDUAL'S PERSONAL DETAILS			
Surname		First name	
Date of birth		Custody Number	
Address		Application under s2, 3 or 4 MHA	Yes / No
		Arrested under s136 MHA?	Yes / No
		Arrested under s135 MHA?	Yes / No

TO *(name of hospital):*

……

THIS PATIENT HAVING BEEN DETAINED UNDER THE MENTAL HEALTH ACT 1983

AND BEING LIABLE BY VIRTUE OF s6 or s137, TO BEING DETAINED & CONVEYED.

Signature: …… **Time / Date:** ……

Telephone Numbers

LOCATION	TELEPHONE NUMBER
EMERGENCY DEPARTMENTS	
University Hospitals Coventry & Warwickshire NHS Trust	**024 7696 4000**
George Eliot Hospital NHS Trust	**024 7635 1351**
South Warwickshire NHS Foundation Trust, Warwick Hospital	**01926 495 321**
PLACE OF SAFETY	
Caludon Centre	**024 7696 8080**
POLICE STATION	
Coventry Central PS Custody	**02476 539101**
Wilenhall PS Custody	**02476 539841**
Leamington PS Custody	**01926 684124**
Nuneaton PS Custody	**02476 483126**
COVENTRY CITY COUNCIL APPROVED MENTAL HEALTH PROFESSIONALS	
Office Hours	**02476 967900**
Out of Office Hours	**02476 967900**
WARWICKSHIRE COUNTY COUNCIL APPROVED MENTAL HEALTH PROFESSIONALS	
Warwickshire (Office Hours)	**01926 413956**
(Out of Hours)	**01926 406789**
WEST MIDLANDS AMBULANCE	
Ambulance Conveyance	**01785 270320**
PCT MENTAL HEALTH	
MHA PoS Monitoring form collation point	**024 7655 2225**
LEARNING DISABILITIES	
Tel: (office hours) Coventry	**024 7678 5950**
Tel **(out of hours) Coventry**	**024 7683 2222**
(office hours) Warwickshire	**01926 410 410**
(out of hours) Warwickshire	**01926 886 922**
CAMHS	
Coventry	**02476 961489**
Warwickshire	**01926 410 410**

REQUEST FOR INTER-AGENCY ASSISTANCE EXCEPTION MONITORING FORM

This form is designed to help monitor the request for inter-agency assistance relative to the management of Mentally Disordered Persons in the community. Partner agencies may wish to use this as their record of requesting assistance if they have no other pro forma or agreed mechanism for doing so. It should always be completed when a partner agency feels that the process is not working as designed in order that the Joint Agency Steering and Liaison Group for Mental Health Act Policies and Procedures can monitor the success of inter-agency working and make improvements where necessary.

Agency Requesting Assistance: Select

Assistance required of: Select

Reason and Nature of Request:

Request Granted/Denied - (Record Reason for denial)

Outcome - Result of inter-agency co-operation:

Print Name **Date** 05 May 2015

If this Exception Report is as a result of a Police Incident please include the Incident Reference Number within the text. If the report is compiled by a member of staff within Warwickshire Police when completed email to HAU [pvp@warwickshire.pnn.police.uk]
If the report is completed by any other partnership member please email to Jeanette Sutton jeanettesutton@warwickshire.gcsx.gov.uk

Out of Hours Process Notes CAMHS

Covering Note

This Out of Hours Emergency referring process is only in operation between the hours of 5pm to 9am Monday to Thursday, Weekends and Bank Holidays. At **ALL** other time the usual processes of referral are to be following through the standard admission protocols.

- ***Referring Agent to contact their appropriate Tier 4 NHS CAMHS Unit***

To ask for the Nurse in Charge at the appropriate Unit.

Parkview Clinic Telephone Number 0121 243 2020

PCT's

Dudley Walsall Sandwell Solihull Heart of Birmingham

Birmingham East and North South Birmingham Wolverhampton

Coventry Warwickshire Hereford Worcester

Darwin Unit Telephone Number 01782 427665 or 427666

PCT's

South Staffordshire North Staffordshire Stoke-on-Trent

Shropshire County Telford and Wrekin

CAMHS T4 Emergency Out of Hours Referral Process from 6/10/09

Community services contact CAMHS Tier 4 NHS Unit (Darwin Unit/Parkview Clinic)

The nurse in charge will have information about whether there is capacity to admit to tier 4.

NO

NHS Unit to provide feedback to the referrer highlighting the reasons for this and any management advice that may be appropriate

Nurse In Charge to email Pro-forma to SCT only

YES

Referral Gateway Pro-forma completed by the Nurse In Charge at the designated unit

NO

Does Pro-forma indicate whether admission is appropriate?

YES

NHS unit able to admit?

YES

Admit and inform Care Pathway Advisor next working day

YES

Email Pro-forma to

NO

Pro-forma emailed to Huntercombe Stafford with accompanying phone-call. Pro-forma also emailed to SCT. Details given to referrer of Huntercombe Hospitals Stafford contact information

Can Huntercombe Stafford admit?

NO

Huntercombe Stafford must advise the referrer and share the reason for none admission

Notification of an inability to admit will be sent to the co-ordinating commissioner (SCT) on the next working day. This is to include a rationale for not admitting

YES

Huntercombe Stafford to contact referrer and arrange admission. **NOTE: Transport is the responsibility of the originating referrer**

Notification of admission will be sent to the co-ordinating commissioner on the next working day of the admission and include date and time of admission, initial care plan and treatment plan

Reviewed by Care Pathway Advisor on next working

Important Note: ***Transport:*** *It is the responsibility of the originating referrer to arrange transport to the receiving Unit and to ensure that that this transport remains present until the formal admission process is complete.*

Process Details

- The Nurse in Charge (NHS) at the appropriate Unit will have information as to whether there is capacity within the designated Units to admit a young person through this Out of Hours Protocol. If there is **NO** capacity within the designated Tier 4 inpatient Units, the referrer will be informed. (***Important Note***: *At this point, it is the* ***originating referrer's responsibility*** *to make other arrangements for the care and management of the young person they have referred by contacting their local on-call arrangements. The Nurse in Charge (NHS) may be in a position to offer advice at this time, however does not take responsibility for the further management of this case.* Information on the referral (basic details) and outcome will then be forwarded to the SCT via the Referral Gateway Pro-forma. (It is recognised that this pro-forma will not be completed fully, however information on general demographics, referring PCT and reason for inability to admit will be supplied)

- When capacity is known to be available, the Nurse in Charge (NHS) will complete the designated Referral Gateway Pro-forma document to evaluate the suitability for a Tier 4 mental health placement.

- If the referral is NOT suitable for Tier 4 Mental Health Services following completion of the Referral Gateway Pro-forma, the Nurse in Charge (NHS) will inform the referrer of this outcome. (***Important Note***: *At this point, it is the* ***originating referrer's responsibility*** *to make other arrangements for the care and management of the young person they have referred by contacting there local on-call arrangements. The Nurse in Charge (NHS) may be in a position to offer advice at this time, however does not take responsibility for the further management of this case).* A completed Referral Gateway Pro-forma will be emailed to the SCT (camhs.wmsc@nhs.net) by the Nurse in Charge (NHS).

- If admission is deemed appropriate for Tier 4 inpatient services, the Nurse in Charge (NHS) makes an assessment as to whether their **OWN** NHS Unit is in a position to offer admission. If the answer is **yes**, arrangements can then be made to facilitate this as per the usual NHS internal process. The NHS unit will then email the Referral Gateway Pro-forma to SCT (camhs.wmsc@nhs.net) .

- If admission cannot be facilitated by the NHS Unit concerned and is appropriate, it is the Nurse in Charge's (NHS) responsibility to email the completed and signed Referral Gateway Pro-forma to the Huntercombe Stafford,(oohreferralsstafford@fshc.co.uk) **with an accompanying telephone call** to prepare and confirm receipt.

  (***Important Note***: *The Referral Gateway Pro-forma* ***must*** *be signed by the Nurse in Charge at the NHS Unit, any failure to do will render the Huntercombe Stafford unable to proceed with the referral as this signature acts as the authorisation on behalf of the SCT (WM) for them to do so)*

Once the Referral Gateway Pro-forma has been emailed and received by the Huntercombe Stafford the Nurse in Charge (NHS) can provide information re contact details to the originating referrer to enable liaison between the originating referrer and the Huntercombe Stafford team. (***Important Note***: *The Nurse in Charge (NHS) following this referral being deemed appropriate and faxed to the Huntercombe Stafford, has* ***no*** *further role in the management process of the referral.*

- On receipt of the Referral Gateway Pro-forma, the Huntercombe Stafford will liaise with the referrer and complete their own assessment on the suitability of the referral for the Services offered at the Huntercombe Stafford site. If the referral is deemed appropriate, admission will be arranged. An initial care plan will be emailed with notification of the admission to the SCT (WM) by the next working day.

- If the Huntercombe Stafford is unable to admit, it is the responsibility of the Huntercombe Stafford to feed this information back to the originating referrer. (***Important Note***: *At this point, it is the* ***originating referrer's responsibility*** *to make other arrangements for the care and management of the young person they have referred by contacting their local on-call arrangements. The Huntercombe Stafford may be in a position to offer advice at this time, however do not take responsibility for the further management of this case).*

- The Huntercombe Stafford will feedback to the SCT(WM) on the next working day the reasons for their inability to admit. Via Secure E-mail.

Additional information for Nurse in Charge (NHS)

Ethic monitoring reference guide.

Section	Group	Code
White	British	A
	Irish	B
	Other White Background	C
Mixed	White & Black Caribbean	D
	White & Black African	E
	White & Asian	F
	Any other mixed background	G
Asian /Asian British	Indian	H