NHS
Worcestershire
Health and Care
NHS Trust

Operational Protocol for the Multi Agency Management of Places of Safety under S135(1) and (2) and S136 Mental Health Act 1983 (Revised 2007, Revised Policing and Crime Act 2017)

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Guideline / Policy on a Page – Summary of Key Points

PART A

- To provide specific guidance in relation to the usage and management of the designated health based place of safety in Worcestershire.

PART B

- To provide a policy framework to support compliance in relation to Section 135(1) and Section 136 of the Mental Health Act 1983;
- To set out a multi-agency approach to delivering good care for patients detained under the above powers;
- To provide a clear and supportive framework to help guide staff providing assessment and care;

PART A

Supplementary Local Policy Guidance for Worcestershire

1.0 Introduction

1.1 Part A of this document has been written to complement the 'Operational Protocol for the Multi-Agency Management of Places of Safety Under S135(1) and (2) and S136 Mental Health Act 1983 (Revised 2007, Revised Policing and Crime Act 2017'. Part B, which follows this section on page 11 is the formal policy of Warwickshire Police, West Mercia Police and West Midlands Ambulance Service.

1.2 Worcestershire Health and Care NHS Trust has not completely adopted the Warwickshire / West Mercia protocol because it does not fully recognise local practice issues, however our organisation recognises the protocol as an appropriate framework to support practice in this area. The aim of guidance in Part A is to provide clarity where the police protocol contrasts with operational practice in Worcestershire. Furthermore this guidance has also been written to provide active support for our staff in Worcestershire and it is particularly aimed at Approved Mental Health Professionals, Section 12(2) doctors and other mental health staff.

2.0 Version History

Version	Circulation Date	Job Title of Person/Name of Group circulated to	Brief Summary of Change
1.0	December 2017	West Mercia Police, West Midlands Ambulance Service, Medical Team Worcestershire Hosptials Acute Trust Multi-Agency Mental Health Act Steering Group AMHP Service Clinical Directors – Adult Mental Health CAMHS, Community Care and Learning Disability management. Standard distribution list for all clinical policies. Members of the Core Circulation List: Head of Education & Clinical Development	This is fresh policy guidance written to complement an associated Operational Protocol produced by the Warwickshire and West Mercia Police Alliance. The document does draw on an earlier protocol last revised in 2015. No amendments.

		Safeguarding Services Manager Audit, Research & Clinical Effectiveness Manager Lead for Allied Health Professionals Chief Pharmacist Nurse Consultant Infection Prevention Control Head of Quality Governance Author's SDU Medical Lead Author's Clinical Director All SDU Leads Trust's Medical Director Director of Nursing Deputy Director of Nursing All Quality Leads	
2.0	27.02.18	Clinical Policies Group	Minor amendment to change the order of the content within policy – Approved by Group
2.0	28.03.18	Quality & Safety Committee	Ratified

Glossary	
AMHP	Approved Mental Health Professional

3.0 Accessibility

3.1 Interpreting and Translation services are provided for Worcestershire Health and Care NHS Trust including:

- Face to face interpreting;
- Instant telephone interpreting;
- Document translation; and
- British Sign Language interpreting.

Please refer to the intranet page: http://nww.hacw.nhs.uk/a-z/services/translation-services/ for full details of the service, how to book and associated costs.

4.0 Training and Development

4.1 Worcestershire Health and Care NHS Trust recognises the importance of ensuring that its workforce has every opportunity to access relevant training. The Trust is committed to the provision of training and development opportunities that are in support of service needs and meet responsibilities for the provision of mandatory and statutory training.

4.2 All staff employed by the Trust are required to attend the mandatory and statutory training that is relevant to their role and to ensure they meet their own continuous professional development.

5.0 Co-production of Health and Care – Statement of Intent

5.1 The Trust expects that all healthcare professionals will provide clinical care in line with best practice. In offering and delivering that care, healthcare professionals are expected to respect the individual needs, views and wishes of the patients they care for, and recognise and work with the essential knowledge that patients bring. It is expected that they will work in partnership with patients, agreeing a plan of care that utilises the abilities and resources of patients and that builds upon these strengths. It is important that patients are offered information on the treatment options being proposed in a way that suits their individual needs, and that the health care professional acts as a facilitator to empower patients to make decisions and choices that are right for themselves. It is also important that the healthcare professional recognises and utilises the resources available through colleagues and other organisations that can support patient health.

6.0 Operational Guidance

6.1 Oversight

6.1.1 Worcestershire Health and Care NHS Trust acknowledges the key points highlighted in the police alliance protocol (section 4.0). In Worcestershire services are committed to providing multi-agency oversight. This will be provided via the Mental Health Partnership Group, which will meet on a quarterly basis, rather than bi-monthly (as in other areas of the alliance).

6.1.2 Clinical staff in Worcestershire recognise the need to complete timely assessments for people detained under Section 135(1) or Section 136 of the Mental Health Act. This policy guidance has been written to compliment the overarching operational policy and to provide clarity in relation to local practice expectations.

6.2 Timescales

6.2.1 The AMHP should arrive at the place of safety within 70 minutes of the patient arriving at either the Crisis Assessment Suite or custody. The assessment should commence as soon as possible thereafter. The AMHP will take responsibility for arranging appropriate doctor(s) to carry out an assessment with a view to commencing an interview as soon as reasonably practical. There is an expectation the AMHP will start the process of arranging an appropriate doctor(s) immediately after reviewing the circumstances of the case. Please note there are no doctors employed specifically to respond to Sec.136 assessments in Worcestershire. Therefore this policy does not identify target times for the arrival of Registered Medical Practitioners.

6.3 The Designated Place of Safety

6.3.1 In Worcestershire the expectation is that the Crisis Assessment Suite at the Elgar Unit will act as the place of safety for the overwhelming majority of assessments. An AMHP (in some cases supported by a mental health nurse) will oversee arrangements in the Suite. This includes managing the safety and welfare of patients in the unit and there is an expectation that all agencies work within a spirit of cooperation and mutual support.

6.3.2 Once an AMHP arrives, a joint risk assessment must be completed with the police. If the AMHP is satisfied the patient can be safely managed and supported by health staff, then they should seek to stand police officers down. In circumstances when police officers are retained on the unit, this decision should be reviewed every two hours. If subsequently felt safe and appropriate for officers to be stood down, then this should be arranged. The safety and welfare of patients and staff must be the primary concern.

6.3.3 The AMHP must complete the relevant sections of the multi-agency monitoring form and ensure this is passed on for recording purposes.

6.4 Use of the Place of Safety for Children or Young People

6.4.1 Professionals involved in admitting a child or young person to the Place of Safety should, at this time, give active consideration to closing the Place of Safety to further admissions. In these circumstances, contingency arrangements should be pursued whereby any further admissions are directed to the Family Room at the Hadley Unit, Newtown Hospital. Should the Crisis Assessment Suite be occupied an adult patient at the same time a child or young person is detained, active consideration should be given to transferring that person to Hadley Unit. It is recognised that making arrangements with regard to contingencies is complicated and challenging. It is expected that all agencies should seek to focus on the safety and best interests of all those involved. Where

difficulties are experienced in enacting contingency arrangements this will need to be reported to the Multi-Agency Partnership Group.

6.4.2 It is recognised that specific guidance in relation to making contingency arrangements cannot cover every potential scenario. Therefore professional judgement will be needed from those involved in the process. Multi-agency working and good communication will be critical to making appropriate arrangements. Professionals should consider the following factors:

- At the point a child or young person is admitted to the Suite, the involved professionals should consider whether or not action to close the unit to further admissions is necessary. Likewise, if the Suite is occupied by an adult and services are informed a child or young person has been detained under S136, the professionals will need to consider whether or not a contingency arrangement is needed;
- This policy regards the Crisis Assessment Suite as an appropriate environment for an assessment to be carried out with a child or young person. There is an inherent preference for a child or young person to be assessed on the Suite rather than the Family Room at the Hadley Unit;
- In circumstances where an adult patient is already on the Suite, it is possible to consider moving that person to the alternative place of safety at the Hadley Unit. When exploring this, professionals will need to consider the safety and appropriateness of moving a detainee. This will need to be considered in terms of the stage the said adult is at in their assessment and any risks associated with them moving from the Suite to the Hadley Unit and in particular the risk of them absconding;
- When professionals are considering the simultaneous assessment of an adult and a child or young person being carried out on the Suite, they will need to consider the following; the particular age and vulnerability of the child, the likely length of stay required on the Suite (if known), the presentation or likely presentation of the adult also accommodated on the Suite, any information known about the history of both parties (particularly in relation to child protection issues, aggression and/or harm to others) and the support that would be available to each party;
- Involved professionals will need to be aware that the Hadley Unit are not able to provide support staff in relation any person detained in the family room under s136 powers;
- During this process it will be necessary to brief the appropriate manager in each agency and if the Crisis Assessment Suite is closed to further admissions the police control room will need to be informed of any contingency arrangements.

6.5 Practical Considerations with Regard to the Place of Safety

6.5.1 Life sustaining emergency medical equipment including a defibrillator is provided at the adjacent Hadley Ward. Staff will respond urgently from the ward if alarms are sounded and they will bring the necessary equipment with them.

6.5.2 The Place of Safety is cleaned on a regular basis. That said, those staff using the Suite are responsible for ensuring the unit is left in an appropriate state. All professionals must recognise that this is an area for service users and that it remains open for admissions on a 24 hour basis.

6.5.3 In circumstances where blood, bodily fluids or any other potential infection control risks are identified, those in the Suite must seek to clean this up with due consideration to infection control. It would be expected that the Band 2 or 3 Nursing Assistant would take the lead with this and they are able to seek guidance from staff on the Hadley Unit. After the initial clean, this needs to be reported to the facilities team to request a deep clean and the affected room(s) should not be used until this has taken place.

6.6 Extension of Detention Powers

6.6.1 As a result of changes to the Mental Health Act, the time a patient can lawfully be detained has reduced from 72 hours to 24 hours. This is effective from the 11th December 2017.

6.6.2 There is provision for the period of detention to be extended for a further 12 hours when '*the extension is necessary because the condition of the of the person detained is such that it would not be practicable for the assessment of the person for the purpose of the Section 135 or Section 136 to be carried out before the end of the period of 24 hours'* (Mental Health Act 1983 as amended 2017). The wording of this change indicates that the unavailability of a hospital bed to transfer the patient would not be a legitimate reason to warrant an extension to the detention period.

6.6.3 A process has been agreed to guide staff managing this change and to ensure appropriate management occurs.

6.6.4 If after between 12 and 16 hours of detention an assessment has not been convened and the involved AMHP believes it will not be possible to complete an assessment and discharge the patient within the available 24 hours - they must:

- Request the period of detention is extended by: In working hours contacting the patch consultant responsible for that patient, or out of hours contacting the 'on-call consultant'. For a patient from out area, the consultant covering Holt Ward or providing cross cover will provide this support (these doctors have been identified by the Trust as 'the registered medical practitioner who is responsible for the examination of the person detained');
- A personal examination by the doctor is not necessarily needed;
- The decision of the consultant must be recorded on the patients electronic record by the place of safety staff and the new time until which the patient can remain detained must also be recorded;
- This must be shared with the patient, recorded and updated on the patients legal rights leaflet;

- In a custody environment it will be the duty inspector that is authorised to grant the extension.

6.7 Managing cases when assessments are at risk of not been completed before the end of the legal detention powers (either 24 hours or up to 36 hours if extended)

6.7.1 It is acknowledged by Worcestershire Health and Care NHS Trust that new timeframes adopted in statute are a positive development in terms of improving the quality of service experienced by people subject to Section 135(1) or Section 136 powers. It is also recognised that in a minority of cases, making appropriate arrangements for on going care will be challenging and this will require staff to manage a complex process within the new limited statutory timeframe. The emphasis for Worcestershire Health and Care NHS Trust is adherence with the law and also to fulfil our responsibility in terms of the duty of care we have to patients.

6.7.2 In circumstances when the AMHP believes the period of detention is at risk of reaching the expiry period of 24 hours (or the extended period of 36 hours) - the following process should be followed:

- Approximately four to six hours before the period of detention is due to end, a manager must be informed. In the daytime this would include: the AMHP Lead, CRT manager or 'out of hours' the level 2 'on-call' manager. The managers role will be to provide non-clinical practice direction - for example this could include agreeing for the release of a surge bed or other required resource;
- Three hours before the expiry time, the AMHP and any other involved professionals should consider what the most appropriate plan should be. A non-exhaustive list of options to consider is set out below:

    - Negotiating with the patient for them to remain at the place of safety to allow the assessment process to be completed. This discussion must be recorded along with confirmation that the patient has been made aware they are agreeing to remain on a voluntary basis;
    - If the patient is unable to engage in such a discussion, the AMHP must consider assessing their mental capacity with a view to the said patient remaining in their best interests for a limited period. This would apply where significant concerns exist about the patients safety if they were to leave the unit;
    - In the case of a child under 16, competence should be assessed and if the child lacks the ability to make a decision to remain in the unit, then parental permission should be sought or a decision made in the interests of their welfare or safety to retain them on the unit until discharge can be arranged. For sixteen and seventeen year olds an assessment under the Mental Capacity Act could be considered, with a view to considering making a Best Interests Decision, if appropriate for that patient to remain on the unit at least for a limited period;
    - If a patient with capacity refuses to remain in the unit, they must be allowed to leave in all but extreme circumstances. It is incumbent on involved professionals to seek an alternative plan. This might include arranging to visit the patient at home to complete the assessment process;
    - Staff must record that they have considered the issue of capacity and reached a conclusion that the patient has capacity to make the decision to leave. When staff

have reached the conclusion that a patient has capacity because there is no reason to assume otherwise, this also must be recorded;

- If a patient leaves the unit and staff have significant concerns about their welfare or the welfare of others, this must be discussed both with the police and the patient should remain open to the service until satisfactory arrangements have been considered for their on-going care.
- In all cases contemporaneous record keeping must be made on the electronic patient record;
- The Trust recognises that staff are being asked to make difficult decisions in a challenging environment with limitations on the legal powers available to them. The Trust also will support decisions made by staff with reference to this protocol, particularly when they are able to evidence a clear focus on the safety and welfare of the patient and that of others. In cases where there is a conflict between adherence with statutory timeframes and a duty of care to a patient – Worcestershire Health and Care NHS Trust will support staff seeking to achieve an appropriate and proportionate balance, even when this risks a potential extension of the detention period beyond the statutory timeframes. In such cases every effort must be made to strike an appropriate balance and decisions must be recorded.

6.8 Drugs and Alcohol

6.8.1 Statutory guidance in the Mental Health Act Code of Practice (2015) highlights that 'where patients are subject to the short-term effects of alcohol or drugs (whether prescribed or self-administered) which make interviewing them difficult, the AMHP should wait until the effects have abated before interviewing the patient'. In Worcestershire the expectation is that AMHPs, assessing colleagues and partners always seek, wherever possible to complete interviews at a point the patient is most able to meaningfully engage in the process.

7.0 Statement of Agency Approval

7.1 This policy guidance has been produced in consultation with multi-agency partners with support and input from the Mental Health Partnership Group. Following consultation, approval has been received from the appropriate Trust governance structure.

7.2 The appendix draws on statutory guidance and the principles of good practice. It is the intention of the Mental Health Partnership Group that the policy provides a foundation to support high quality practice which is dedicated to the needs of service users.

Operational Protocol for the Multi Agency Management of Places of Safety under S135(1) and (2) and S136 Mental Health Act 1983 (Revised 2007, Revised Policing and Crime Act 2017)

Implementation Date: 11th December 2017

Next Review Date: December 2018

Contents

PART B

1. Introduction

1.1 The health and social care community of Warwickshire and West Mercia Police alliance 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 the alliance supporting the Governments' Mental Health Crisis Concordat.

1.2 This document covers:

- Place of Safety procedures under s135 and s136 MHA
- Mental health assessments in private premises, with or without a warrant under s135(1) MHA
- Search and recovery of patients who are AWOL including use of warrants under s135(2) MHA
- Transfer and transportation

1.4 This protocol has been developed jointly with WMAS and NHS trusts across the alliance area. Use of this protocol will ensure compliance with relevant legislation, national guidance and other sources of standards for the NHS and the Police.

2. Executive Summary of Intentions

- To ensure efficient, effective and dignified assessment arrangements for ALL patients who need to be taken to a Place of Safety.
- To ensure effective assessment by police officers and / or the ambulance service to ensure transport 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 a **police station** as a place of safety.
- The use of a police station as a place of safety for persons aged 18 and over is limited to specific circumstances set out in The Mental Health Act 1983 (Police Stations as Places of Safety) Regulations 2017. These specify that a police station may only be considered as a place of safety if:

  (i) the behaviour of the person poses an imminent risk of serious injury or death to themselves or another person;

  (ii) because of that risk, no other place of safety in the relevant police area can reasonably be expected to detain them, and

  (iii) so far as reasonably practicable, a healthcare professional will be present at the police station and available to them

  The **authority of an officer of at least the rank of inspector** must be given for the use of a police station in such circumstances – unless the person making the decision is themselves of such a rank or higher.

- To ensure effective multi - agency oversight for Place of Safety arrangements across the alliance.
- To work across organisational boundaries in achieving these intentions.

3. Equality Impact Assessment

3.1 This generic protocol is based on an agreement between agencies 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 the alliance for which the power of detention has been used. It includes the particular health provision made available at 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 organisations responsibility to ensure support for the other(s), throughout the period of detention (including transportation) 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.

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 the specific circumstances set out in The Mental Health Act 1983 (Police Stations as Places of Safety) Regulations 2017 apply 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.

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 transportation 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 available, street triage programmes may assist in an initial assessment to determine any MH disorder. 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, a police officer is now required by the new section 136(1C) to consult – if it is practicable to do so in the circumstances of the case – a health professional (as specified in the legislation or the regulations) before deciding whether or not to exercise powers to keep a person at or remove a person to a place of safety under section 136(1). The professionals that the officer can consult include: An approved mental health professional, A registered nurse, A registered medical practitioner, An occupational therapist, A paramedic. Where available, street triage may be considered as a liaison prior to detention. The police officer retains ultimate responsibility for the decision to use – or not use – their section 136(1) powers, having considered the advice given to them as part of the consultation. The police officer should ensure that consultation – including who was consulted and the advice they gave –is recorded. The officer's judgment as to whether it is practicable to consult is likely to be informed by a number of potential factors. These will include:

- whether a local process for undertaking the necessary consultation is readily in place
- the likely time taken to obtain the necessary consultation
- whether the person is likely to remain co-operative and present during the time taken to undertake a consultation
- whether it is safe to undertake a consultation or whether the behaviour of the person requires intervention in the interests of safety

5.4 The new section 136C enables a police officer to search a person detained under section 135, 136(2) or 136(4) if the officer has reasonable grounds to believe that the person detained may be a danger to themselves or others and is concealing something on them which could be used to physically injure themselves or others. The new powers do not include any restrictions around age or any other characteristic of the person to be searched, although the extent of any search is limited. The purpose of using these powers is to enable a police officer to take the necessary steps to ensure the safety of the person detained and the safety of others. They remedy a gap in police search

powers in some limited situations. These powers should be used to support policing and health agencies to effectively provide the care and support required by a person detained under section 135 or 136. They do not require a person to be searched. A search conducted by the officer under new section 136(C) is limited to actions reasonably required to discover an item that the officer believes that the person has or may be concealing. The officer may only remove outer clothing and they may search that person's mouth. The new power does not permit the officer to conduct an intimate search. The new section 136(C) powers do not alter the applicability of other existing powers – including powers under section 32 or section 54 of the Police and Criminal Evidence Act 1984, and the general powers of health professionals to search patients in hospitals – which may apply in some circumstances. The applicability of other such powers does not prevent the new search powers under section 136C from applying.

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 Ambulance Service transportation 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 transportation 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 defined by The Mental Health Act 1983 (Police Stations as Places of Safety) Regulations 2017. 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.

5.11 A child or young person should not be taken to a police station as a place of safety under ss135/6 MHA.

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 24 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.

6. Initial Transportation

6.1 It will be the responsibility of police officers to request an ambulance for transportation following detention under s136. It will be the responsibility of an AMP 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 transportation requirements should the individual be subsequently transferred.

6.2 Transportation 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 give advice on the use of emergency pharmacological intervention. 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 transportation, police officers and paramedics will act in consideration with the advice given.

6.7 Any problems in securing arrangements for transportation 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 transportation.

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 transportation 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 is required to ensure that any person receives appropriate clinical attention, by calling an ambulance.

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.

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 if the Mental Health Act assessment is 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 24hrs maximum assessment period.

7.13 Anyone removed to ED and accepted there for assessment/treatment, should be informed of their rights whilst detained.

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.

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 PoS monitoring form (See Appendix D), 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 7.7, 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.

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. 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 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.

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.

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 C).**

8.9 Disputes in the implementation of this protocol or risk assessment conclusions will be referred to the 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 LPA 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.

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.

The use of a police station as a place of safety for persons aged 18 and over is limited to specific circumstances set out in The Mental Health Act 1983 (Police Stations as Places of Safety) Regulations 2017. These specify that a police station may only be considered as a place of safety if:

(i) the behaviour of the person poses an imminent risk of serious injury or death to themselves or another person;

(ii) because of that risk, no other place of safety in the relevant police area can reasonably be expected to detain them, and

(iii) so far as reasonably practicable, a healthcare professional will be present at the police station and available to them

The **authority of an officer of at least the rank of inspector** must be given for the use of a police station in such circumstances – unless the person making the decision is themselves of such a rank or higher. 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 B, should lead to immediate transfer to an ED being ordered.

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**.

9.3 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.

9.4 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 MAG. The overall timescale for detention is a total of 24 hours unless there is an authorised extension up to 36 hrs due to the patient's condition.

9.5 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/LPA 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.

9.6 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.

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.

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 Community Treatment Order 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 Community Treatment Order (CTO) 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.

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. Any interpreter will be arranged by the Place of Safety Staff. (If the place of safety is at the police station the custody officer will explore this when the individual is being booked into custody)

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.

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 transportation 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 transportation 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.

11.2 Where the person is detained at the PoS, 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 24 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.

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.

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 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 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 24 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 24 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
- **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
PoS Senior nurse in charge
Police Duty Inspector

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

18hrs: 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
PoS Operations Manager
Police Duty Superintendent

Further contact will be made with the AMHP at least **every 2hrs** 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 AMHP or by someone authorised by either of them to do so. Even where authority is delegated, the police officer or AMHP retain responsibility for transportation.

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, although the person remains in the legal custody of the police officer or AMHP

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 transportation 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 transportation 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.

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.

15.4 Where the Police are unable to attend to assist with the transportation of a resisting patient from the Place of Safety to an off-site psychiatric ward or hospital the AMHP or PoS Lead Nurse will contact the Clinical-on-Call Manager to authorise the use of Private Transport.

15.5 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; 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.

15.6 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.

15.7 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 transportation for repatriation is in the most appropriate way.

15.7 This should represent a roughly equitable division of responsibility between agencies. Frequency of transportation 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 B.

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 24hrs period. If they absent themselves after arrival at a PoS, they may be retaken with a 24hrs period after their arrival at the first PoS to which they were taken.

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 'INITIAL 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. Where an individual's re-detention necessitates forcing entry to a premises, the criteria for securing a warrant under s135(2) are different to those under s135(1). There are two important differences to be borne in mind:

- Police officers may apply for this warrant, alone if need be.
- There IS a need to demonstrate that access has already been attempted or that refused access is apprehended.

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 24hrs from the point of arrival at the first place of safety.

ASSESSMENT ON PRIVATE PREMISES

There are two important considerations for any AMHP planning a Mental Health Act assessment on private premises with regard to police support:

1. Do I need police support during the assessment?
2. Do I need a warrant under the MHA?

POLICE SUPPORT

Police support should be requested for all assessments where the reason for officers' attendance is consistent with their statutory functions (protection of life, prevention of crime, to prevent a breach of the Queen's Peace, etc.) That said, careful consideration should be given to the legal powers which the police (and the AMHP) have available to safely manage any assessment conducted in private premises.

The police have no legal power without warrant to do anything except:

- Arrest following an attempted or substantive criminal offence;
- Arrest to prevent a breach of the peace or its continuance.

Accordingly, there is no police power to prevent anything that does not constitute an attempted or substantive criminal offence, or a breach of the peace: NO power to prevent the individual from:

- completely denying access (unless another person may grant it);
- moving to a room which can be locked (bathroom / cupboard);
- picking up knives, cutlery or other (improvised) weapons;
- boiling kettles or picking up hot-drinks;
- accessing areas where there are windows / balconies;
- leaving the premises.

NB: There should be no automatic assumption where such an individual leaves a premises that s136 can automatically be used. The police officer must be separately satisfied that the criteria for s136 are met.

The fact that the police are present, does not in itself ensure that the police have the powers to guarantee a safe outcome for all concerned. This should give rise to consideration of whether or not to apply for a warrant under s135(1) MHA.

Where there is an anticipated likelihood of resistance, aggression, violence or escape from the person being assessed, the powers afforded by a warrant under s135(1) significantly improve the abilities of the officers to proactively deliver a safe conclusion without allowing matters to escalate to the point where a service user is arrested for any reason and / or that an attending professional or anyone else is injured.

Where either an AMHP or a police duty sergeant / inspector remains dissatisfied about any aspect about the preparation for an assessment on private premises, they should refer the matter to the MAG for consideration.

WARRANTS UNDER s135 (1) MENTAL HEALTH ACT

Where a warrant is obtained, it ensures that the police officer who executes it has two powers:

- Power to enter the premises, by force, if need be; AND
- Power to remove the individual to a Place of Safety, if thought fit.

The criteria to be satisfied to secure a warrant are that the individual to be assessed:

- is or has been neglected
- is or has been ill-treated
- is or has been kept otherwise than under proper control; OR
- that they are living alone and are unable to care for themselves.

Only one other thing needs to be shown: that where a warrant is being applied for despite no attempt to enter having yet been made; or where it is known that access to the premises can be lawfully secured, the reasons for still applying must be documented.

Accordingly, there is NO requirement to demonstrate:

- That access to the premises has already been attempted;
- That refused access to the premises is apprehended;
- That there is a specific risk of violence, aggression or resistance;
- That the power to remove the individual to a Place of Safety WILL be used; that it might be needed, is sufficient.

Where the AMHP anticipates that there will be aggression and resistance which requires police support, they should anticipate the sergeant requesting confirmation of a warrant being sought. Where the AMHP does not intend to apply for a warrant, they should bear in mind the risks and threats inherent in that approach. use of low-level, reasonable force where they have done so in order to safely execute warrants on private premises, for example to briefly control the movements of others in order that the warrant may be executed efficiently. Legal advice to the police service has upheld the contention that these cases would apply to the execution of either type of warrant, under s135 and therefore provide additional reasons to consider applying for a warrant.

INTER-AGENCY DECISION MAKING

The AMHP co-ordinating the assessment should ensure discussion with the police duty sergeant, prior to making requests for police support and in order to discuss whether a warrant is sought. This should include requests for police information about anticipated risks - it may be that following confirmation of certain information, the AMHP is willing

WARRANTS UNDER s135 (2) MENTAL HEALTH ACT

Where a warrant is obtained, it ensures that the police officer who executes it has two powers:

- Power to enter the premises, by force.
- Power to remove the individual to the place where they are liable to be detained or recalled.

The criteria to be satisfied to secure a warrant are that the individual to be assessed:

- That the person liable to detention is believed to be on the premises AND;
- That admission to the premises has been refused or is apprehended.

Only one other thing need be borne in mind: that where a warrant is being executed by a police officer, it is suggested good practice for the police to be accompanied by someone from the hospital or care team with responsibility for the patient.

Several common misconceptions:

- Police officers CAN apply for these warrants on their own, if need be;
- Police officers CAN execute these warrants on their own, if need be;
- Other professionals, authorised under the MHA, may apply for a warrant under s135 (2).
- It is not a requirement that the police be accompanied, but it is suggested good practice wherever possible.

NB: It is often worth ensuring copies of supporting legal material for the attention of Magistrates, such as this protocol. Magistrates are not always fully aware of the criteria for

granting warrants under s135 or the differences between the two warrants available under this section.

INTER-AGENCY DECISION MAKING

Where the police undertaking AWOL enquiries, learn of the presence of a patient and the need for a warrant, wherever possible, dialogue should occur with the relevant professional (the AMHP), to arrange NHS support to the police during the process of applying for and executing the warrant. Duty sergeants should ensure this liaison occurs and that the fullest possible information supports the risk assessment process after securing the warrant.

18. Monitoring

18.1 The Police will ensure provision of the MHA PoS Monitoring form and the POS Lead will ensure collation of completed MHA PoS monitoring forms and ensure that they are sent to the appropriate professionals for each agency. These will ensure the basis of overseeing the use of s135/6 powers in the area. They are legally required and of critical importance. Analysis will be subject to Home Office Annual Data Return (ADR) requirements for Police.

18.2 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.

18.3 Analysis will be as per the Athena Question Set and may also 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 transportation to the PoS undertaken?
- How was transportation 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. Body Worn Video (BWV) & Mental Health

19.1 Guidance on the generic use of BWV can be found within the Alliance Procedure for Body Worn Video implemented in April 2017. The following documents & guidance have also been referred to:

College of Policing Guidance (Body-Worn Video 2014)

IPCC Positional Statement

19.2 There are seven key principles for the overt use of BWV which underpins this guidance which can be found within the CoP guidance document. The use of BWV in relation to Mental Health incidents is no different. Of note are the following principles:

- The use of BWV by the police is lawful. (1)
- The operational use of BWV must be proportionate, legitimate & necessary. (4)
- Use of BWV will be incident specific. (5)

19.3 The operation of BWV is something for the officer to justify. Officers have a common law power to do so where they judge it reasonable and proportionate.

19.4 Generally BWV should not be used in private dwellings but this can be done **where justified**, but not just as a routine record of proceedings.

19.5 It should be considered only where officers reasonably believe they will be making written records of events, because of the use or potential use of police powers.

19.6 **NHS PREMISES**

- Nothing prevents staff asking for videos to be turned off, but where officers feel this cannot be done, the reasons why should be explained.
- Depending on the legal situation in hand, nothing prevents the AMHP or NHS staff preferring that officers leave a situation rather than it be recorded, if the officers are not prepared to turn it off.
- If the incident involves continued circumstances which justify the use of it (such as the use of restraint), then the recording can continue for as long as officers remain.

19.7 Discussion has to be held if police are asked about it. Any footage in any incident which is not required for a criminal investigation or prosecution will remain securely stored in a police data warehouse until data protection policies see it deleted.

****Can an AMHP, the patient or anyone else (like NHS ward staff) demand that the camera be turned off?** No, they can't.******

Appendix A – References

This protocol is developed in compliance with the following legislation:

- Mental Health Act 1983 (Revised 2007)
- Mental Health Act 1983 (Police Stations as Places of Safety) Regulations 2017
- Police and Crime Act 2017
- 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

Appendix B – Red Flag Criteria

RED FLAG CRITERIA

Police Officer / Paramedic triggers for condition requiring

Treatment or Assessment in an Emergency Department

Dangerous Mechanism:

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 including:

- Loss of consciousness
- Facial swelling
- Bleeding from the nose or ears
- Deep cuts
- Suspected broken bones

Actual (Current) 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

ONLY AT REQUEST OF PARAMEDICS / TECHNICIANS / ACCESSED VIA EOC

Where immediate management of RED FLAG conditions necessitates the intervention or skills of an advanced practitioner or where without medical oversight the journey would involve too much risk, either to the patient, the paramedics or the police officer.

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

Transportation to the nearest ED:

Should NOT be undertaken in a police vehicle **UNDER ANY CIRCUMSTANCES**

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 Services to outline the **MEDICAL ASPECTS.**

When a clinician deems in their opinion a patient requires assessment at hospital this overrides all other situations and the patient MUST be conveyed to hospital

Appendix C – Risk Assessment Tool

DYNAMIC RISK ASSESSMENT RATING (*please circle appropriate answer)*

To be completed by Multi-professional team when Ambulance Staff / Police, are asked to assist in conveying a patient to hospital / unit. A copy to be handed to Ambulance Personnel / Police Officer.

Risk Factor	High Risk	Medium Risk	Low
Detention under the Mental Health Act 1983	An application has been, or is being completed. Patient is presenting a moderate to high risk to themselves or others. Patient has known history of violence / unpredictable behaviour. Patient actively resisting admission and physically able to do so.	An application has been, or is being completed. Patient is considered to present a potential moderate to high risk to themselves or others. Patient passively refusing admission. This can be the case for older people who may be distressed.	NO
Informal or informal admission	NO	NO	Patient accepting of situation, no evidence of presenting a risk to themselves or others
Substance misuse?	Dependent on illicit drugs or substances	Known History	No Known History
Alcohol misuse?	Alcohol dependent	Known History	No Known History
Suspected risk of suicide or self harm?	YES	NO	NO
Involved in a violent and / or racial incident immediately prior to assessment	YES – serious incident	Yes – minor incident	NO
Out of character; e.g. unusual behaviour prior to assessment; disappeared with no prior indication etc.	YES	NO	NO
Family / relationship problems or recent history of family conflict or abuse	YES	Maybe	NO
Recent or ongoing victim of bullying or harassment e.g. racial, sexual etc.	YES	Maybe	NO
Transportation Category **(See Appendix 3)**	**CATEGORY 4 Transportation**	**CATEGORY 3 Transportation** / **CATEGORY 2 Transportation**	**CATEGORY 1 Transportation**

ADDITIONAL INFORMATION

Following Multi-agency discussion, please use this space to add additional information on any other risk identified or to expand on the risk rating above

Completed by……. Signature……..

Appendix D – s135/s136 PoS Monitoring Form

Section 135/136 Place of Safety Monitoring Form

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. The 24 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:		Under 18?	Yes / No	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:					
Consulted MHP?	Yes / No	Time:			
Restraint used?	Yes / No	Details:			
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					
Method of transport:	☐ Ambulance			Ambulance call sign:	
	☐ Other health vehicle			☐ Police vehicle	
	☐ Other (please state):				
Time ambulance called:				Time ambulance arrived:	
Restraint used in transport?	Yes / No	Type:			
If ambulance not used, why?	☐ Amb not available within 30 mins			☐ Amb redirected to higher priority call	
	☐ Amb not available within 60 mins			☐ Amb crew refuse to convey	
	☐ Police/Amb risk Assessment (Behaviour)			☐ Ambulance not requested	
	☐ Already at PoS			☐ Other	
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):	
	☐ Private Home				
Time/date of arrival:					
Restraint used?	Yes / No	Type:			
If Police custody used reason for using:	☐ PoS no capacity			☐ PoS - refused admission (Other than capacity)	
	☐ Arrested for substantive offence			☐ Too violent for PoS	
	☐ Other (state reason):				
Section E - To be completed if police station used as PoS - by detaining officer					
Rationale:					
Police station:				Time/date of arrival:	
Custody record no:					
Transfer to:				Time/date of transfer:	
Transfer authorised by:					
Ambulance transfer?	Yes / No			Ambulance call sign:	
If transfer not used, why?					

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Section F - To be completed if A&E used as PoS - by detaining officer			
Emergency dept:		Time/date of arrival:	
If A and E used reason for using:	☐ Medical reason		☐ Intoxication
	☐ PoS no capacity		☐ Child and Young Person
	☐ PoS - refused admission (other than capacity - state reason):		☐ Other (state reason):
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	Already known to MH Services?	Yes / No
Details:		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 ☒):	☐ 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 other risks identified to be shared at handover:			

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			
24 hours starts (same as arrival time at first PoS - section D):			
Name of AMHP:			
Time/date AMHP arrival:		Time taken to arrive:	
Rights offered?	Yes / No	By:	
Rights Leaflet given?	Yes / No	By:	
Any criminal investigation?	Yes / No	Police contact no:	
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		
Does the person have a learning disability?	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:			
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?			

This form should go with police to all PoS settings involved in patient care.
The PoS/lead AMHP should collate all completed forms and forward to the local Harm Assessment Unit as agreed by local protocols for monitoring purposes

Appendix E

Equality Impact Analysis Screening Form

Title of Activity	Place of Safety Protocol - Supplementary Local Policy Guidance for Worcestershire		
Date form completed	31.1.18	Name of lead for this activity	David Palfreyman

Analysis undertaken by:			
Name(s)	Job role	Department	Contact email
David Palfreyman	AMHP Lead	AMH and LD SDU	dpalfreyman@nhs.net
Karen Hyde	ASWP - CRT	AMH and LD SDU	Karen.Hyde3@nhs.net
Helen Reynolds	MHA Manager	Mental Health Act Team	Helen.Reynolds2@nhs.net

What is the aim or objective of this activity?	Assurance over equality impact
Who will this activity impact on? *E.g. staff, patients, carers, visitors etc…*	Staff acting as AMHPs, Section 12(2), multi-agency partners including the acute trust, police and paramedics. Patients detained under with Section 135(1) or Section 136 of the Mental Health Act.

Potential impacts on different equality groups:

Equality Group	Potential for **positive** impact	Neutral impact	Potential for **negative** impact	Please provide details of **how** you believe there is a potential positive, negative or neutral impact (and what evidence you have gathered)
Age	✠	❑	❑	Specific contingency arrangements are set out to ensure children and young people receive the most appropriate care and support.
Disability	✠	❑	❑	Specific guidance set out in this policy with the explicit intention of ensuring good care is provided by those experiencing mental disorder. Environment facilities support the care of people with disabilities, which can be accommodated with necessary health care support delivered on a ground floor unit.
Gender Reassignment	❑	✠	❑	All patients to be treated individually and supported appropriate regardless of gender or gender reassignment.

Equality Group	Potential for **positive** impact	Neutral impact	Potential for **negative** impact	Please provide details of **how** you believe there is a potential positive, negative or neutral impact (and what evidence you have gathered)
Marriage & civil partnerships	❑	✠	❑	No relevant issues identified with expectations for patients consistent regardless of status.
Pregnancy & maternity	❑	✠	❑	Medical screening available to detained patients and any care deemed necessary can be delivered or arrangement as required.
Race	❑	✠	❑	No particularly issues noted with professionals maintaining responsibility towards patients through this process regardless of race or cultural background.
Religion & belief	❑	✠	❑	No relevant need for any additional action or steps noted beyond general support and sensitivity to religion or belief.
Sex	❑	✠	❑	No issues noted in the contents of the policy requiring specific action.
Sexual Orientation	❑	✠	❑	As indicated above, no particular action needed from review of policy in relation to sexual orientation.
Additional Impacts *(What other groups might this activity impact on? e.g. carers, homeless, travelling communities etc.)*	❑	✠	❑	None identified.

Level of impact

If a potential negative or disproportionate impact has been identified from this activity:

	Yes	No
Could this impact be considered direct or indirect discrimination?		*X*
If yes, how will you address this?		

If the impact could be discriminatory, please contact the Inclusion Team to discuss actions

	High	Medium	Low
What level do you consider the potential negative impact to be?			*X*

If the negative impact is high, a full equality impact analysis will be required

Action Plan

How could you minimise or remove any negative impact identified, even if this is rated low?
No action required,
Future Review Date: *March 2021*

Once completed, please attach this form to the relevant proposal, strategy, policy etc and submit for approval via normal channels