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Collaborative guidance for TEWV staff and Police: Working with Police and Criminal Justice System

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Contents

1 Introduction

1.1 Joint Guidance

This is joint guidance between Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) and the Police services that work in the Trust area. Namely North Yorkshire, Durham and Cleveland Police, henceforth known as 'Police', unless named due to specific differences in place between the forces. The purpose of this joint process is to ensure clear understanding between partners in all matters concerning Police and Criminal Justice responses with TEWV staff and services.

1.2 Right Care, Right Person (RCRP)

The guidance has been updated to reflect the national implementation of Right Care, Right Person (RCRP), the new threshold in terms of Police involvement and contact and the actions TEWV staff need to take if it is not at threshold or there is disagreement about threshold being met.

2 Who this guidance applies to

This process applies to all employees of the Trust, including contractors, employees of other organisations working within the Trust, seconded staff and volunteers. It applies to Police officers and Police staff in the relevant Police forces.

3 Purpose

The guidance provided within this process also aims to achieve the following:

- Ensure Trust staff understand the appropriate circumstances for requesting an emergency and/or priority response from Police.
- That Trust staff and Police Officers understand each other's powers, duty of care and responsibilities where Police Officers have been deployed to an incident.
- Ensure Trust staff know how to report a criminal incident both using Online Incident Reporting (Safeguard) and to the Police.
- That Police Officers are aware of the Trust's expectations once a crime has been recorded, as per national crime recording guidance.
- Trust staff are aware of the legal considerations and frameworks placed on Police and Criminal Justice partners and where this may impact on Trust staff expectations.
- Support mechanisms are provided to staff and patients who have been victims of a criminal act.
- Appropriate support is provided to Police in relation to their investigation process following the report of a criminal incident, and they know how to access this appropriately.

4 Related documents

This procedure refers to:

- Criminal incident reporting procedure
- Section 135(2) procedure
- Section 136 – removal of mentally disordered persons without warrant
- Section 17 leave for detained patients
- Missing patients procedure
- Prevent procedure
- Procedure for addressing verbal and physical aggression towards staff by patients, carers, and relatives
- Safe use of physical restraint techniques
- Safeguarding adults policy
- Safeguarding children policy
- Human Rights, Equality Diversity and Inclusion Policy Equality

5 Procedure

5.1 Reasons for calling the Police

Police may be called by TEWV for various reasons. This may be due to crime on TEWV property, a crime against staff or patients, due to concern for a person's safety, safeguarding matters or due to emergency need for assistance. This section explains the RCRP threshold, when it is met, and the actions required if it is not met. This process will cover all of these areas, although detailed Police involvement around Safeguarding and Public Protection are found within specific Safeguarding Trust/Police guidance.

5.2 Before calling the Police

Before TEWV staff consider involving the Police, they must familiarise themselves with this process and decide whether the threshold for Police involvement is met. This may be obvious, for example a crime has taken place and the police need to investigate. It may be about a situation on a ward where staff have worked within their legal framework (e.g. Mental Health Act or Mental Capacity Act), duty of care and responsibilities, and now need Police assistance as it is no longer safe for staff or patients and there is an immediate risk, or likely to be an immediate risk, of serious

harm. Making sure that staff have a good understanding of this document will ensure key considerations about involving Police, exit strategy, potential higher use of force and lawful basis are all fully considered before contact.

5.3 Right Care, Right Person (RCRP)

5.3.1 Trust staff must be familiar with RCRP

Staff must be familiar with RCRP and what this means when requesting Police support. RCRP is a nationally agreed approach with partnership agreement to be locally implemented. You can see the partnership agreement framework here: National Partnership Agreement: Right Care, Right Person (RCRP).

5.3.2 Partnership Agreement

The Partnership Agreement states: Right Care, Right Person is an approach designed to ensure that people of all ages, who have health and/or social care needs, are responded to by the right person, with the right skills, training, and experience to best meet their needs.

5.3.3 Threshold for police response

At the centre of the RCRP approach is a threshold to assist police in making decisions about when it is appropriate for them to respond to incidents, including those which relate to people with mental health needs.

The threshold for a police response to a mental health-related incident is:

- **To investigate a crime that has occurred or is occurring; or**
- **To protect people, when there is a real and immediate risk to the life of a person.**
- **Or of a person being subject to, or at risk of, serious harm.**

5.3.4 Consider threshold before contacting Police

Staff must consider this threshold and be familiar with this before making contact with Police. It should be noted when Police refer to ‘mental health’ that this is an all-encompassing term which will include, disability, neurodiversity, learning disability, etc. It also includes generally what health services may refer to as Mental Disorder.

5.3.5 Detail of threshold

More detail is provided below, along with some examples, although this is not an exhaustive list. This is to assist staff in understanding the risk threshold and the terms used within:

- **Real and Immediate risk to Life**

  Is there a real chance / risk in the immediacy of time of the person or another dying, or at least putting their life or that of another person at risk? Are they heading to a bridge or cliff? Are they tying a ligature and saying goodbye? Do they have petrol and are pouring this over themselves and others? Perhaps someone has a knife to their throat or they have a firearm and are saying that they will kill themselves and others, etc.

- **Serious Harm**

  The legal overview for Harm in RCRP is under the human rights act duty of care - Police can owe duties under the Human Rights Act 1998 to protect individuals from harm caused by others or harm caused by the person themselves. The police owe responsibility to take all reasonable measures to assist where there is either:

  - a real and immediate risk to the life of a person (European Convention on Human Rights (ECHR) Article 2)

  - a real and immediate risk of that person being subject to serious harm or other inhumane treatment (ECHR Article 3)

The risks of harm where a duty can arise generally comes from the criminal acts of a third party – but not always. A duty to act would only arise if a threat included all of the following:

1. For a duty to arise under Article 2 the threat must be of death. A threat of injury, even serious, is not enough to create a risk of death.

2. Threats or risks that do not qualify under Article 2 may still qualify under Article 3. A duty may arise under Article 3 where there is a threat of serious injury, inhumane or degrading treatment. For example, a serious sexual assault would qualify as conduct breaching Article 3, even if no injury resulted from the attack.

3. For both Articles 2 and 3, the threat or risk must be real and immediate. That means the threat must be present and continuing. Threats are not defined as real and immediate if they are conditional on other events happening or are said to occur at some point in the non-immediate future.

4. The threat has to be against a specific and identifiable person or group of persons. Generalised threats do not give rise to a duty.

5.3.6 Other emergency services

Some incidents, depending on the circumstances, may need ambulance and fire service response also, or exclusively. See Section 8 below for more detail.

5.3.7 Constant review

Important note: If the threshold is not felt met, the incident should remain under constant review, and if the situation changes and/or risks escalate, it can be referred to Police at any time, even if it has been declined initially.

6 Contacting the Police

6.1.1 How to contact the Police

There are currently several ways to contact Police, depending on the reason for contact.

- **Emergency – call 999** – this is the national number to be called in an emergency for Police. This means a serious offence is in progress or has just been committed, or someone is in immediate danger or harm. It's worth noting that people who are deaf or hard of hearing can use a 18000 textphone or can pre-register to be able to text 999. There is also a procedure in place for silent 999 calls if speaking could put someone in further danger. This includes pressing 55 when asked to speak and following call-handler instructions.

- **Non-emergency – call 101** – this is a national non-emergency number to be called for Police. You will be asked about which Police force you require. The number is used for non-emergency enquires and reports where Police attendance is not time critical.

- **Online reports** – If you don't need Police response on the same day, this is the preferred option. To access, go to the relevant force's website and submit an online report. You will be asked a number of questions.

This is for non-emergency reports and, in TEWV, **must not** be used to report patients missing or where risk to self/others is evident.

It can be used to report a crime. See below for relevant links:

Durham Police - **Report a crime | Durham Constabulary**
North Yorkshire Police - **Report | North Yorkshire Police**
Cleveland Police - **Report a crime | Cleveland Police**

- **Lone working Community staff** - may require Police response in an emergency via their lone-working devices. They can still be used and activated within a community base or setting. It may prove essential in getting a Police response, as long as a relevant alert is recorded (by pressing the alert button on the back of the lone-working device) and GPS is in place. A call should still be made to the Police if this is possible or necessary. RCRP will not change this process.

6.1.2 THRIVE

All calls where 'mental health' is a component will now go through the RCRP threshold after THRIVE. Staff will be asked a series of questions, including the threshold questions to ascertain if their call meets the threshold for Police deployment or if it will be declined. The reporting agency hold risk, duty of care and will be required to action. All calls to Police are recorded and will be subject to THRIVE assessment at source in the Police control room. THRIVE is a risk-assessment tool used by the Police and is used to assess risk supported by the National Decision Making Model and Code of Ethics. North Yorkshire Police use THRIVE+ - the + relates to the force considering whether the incident should be passed to a more appropriate organisation. THRIVE(+) will assist the Police in understanding the situation, risk and threat, and help them decide what level of grading it needs and the response. Grading will be either Grade 1 (within 10 minutes, variable in rural areas and depending on nearest resource availability), or Grade 2 (within an hour), or a follow-up call if reporting a non-urgent matter via telephone.

6.1.3 Sufficient detail sharing

It is essential when calling the Police that good information sharing occurs to ensure the call handler has enough information to complete a good assessment. Staff should note that, depending on policing areas, not all call handlers/takers are Police officers, many are Police staff. Staff should ensure articulation of risk clearly and why they are of the opinion that the threshold for Police involvement is met. This articulation of the risk concern and the sharing of sufficient detailed information of the concern is essential. Below are some considerations. In an emergency call, it may also be appropriate to stay on the line so any officers making their way to the scene can ask further questions and clarify the situation, particularly with incidents that are evolving or where weapons are involved.

6.1.4 Call protocols

Information must be given to the Police call handler in a clear and concise way. DO NOT USE acronyms or jargon, medical language or ambiguous words. Be clear and descriptive on what is

happening now, and what the risk concern is. The call handler will be gathering information from the source using the THRIVE tool to assess, hence will need the information outlined below:

- Who you are and where you are calling from? Give the exact address and location, type of setting, your role and job title. Make it clear if you or any patients involved are from a Community Team, even if in a hospital setting. This is important as what can be done by individual teams will be different due to training, legislation, etc. This is particularly relevant for Community Teams based on hospital sites (see Section 5.3 for further guidance).
- RCRP - Is a crime occurring or has one occurred?
- RCRP – Is there real and immediate risk to life of a person?
- RCRP – Is a person being subject to, or at risk of, serious harm?
- What is occurring? Who is it involving? What is their capability of causing harm? What is their intent? Are they contained? Can they be contained?
- Who is at risk of being harmed? Are there weapons and is the threat imminent? Can it be contained/managed?
- What have you done to manage the risk, and has this occurred before? How was it managed? Are there limitations to what can be done? If so, why?
- Who are the people involved? Are they patients, visitors, staff, public, etc.? Are they detained, informal, visiting? Any relevant information to support?
- What would the specific Police role be and why are they needed? What is the exit plan once the Police have supported?

6.1.5 Recording information

TEWV staff should ensure that when making any call to Police they record the log number and any collar numbers of officers who do then attend the incident. Staff should also record what information was shared in detail, as well as the agreed actions by Police and the further actions needed by TEWV. These are also required for the TEWV incident report, Inphase.

6.2 Information sharing

6.2.1 Consent / lawful basis

Both Police and TEWV need a lawful basis to share information with each other. In TEWV the best lawful basis is always consent, and consent should always be considered in the first instance. Only when consent has not been given, or when it hasn't been possible to get consent or seeking consent under the circumstances is not appropriate, i.e. it would impact on the investigation (e.g. destruction of evidence), can you rely upon another basis such as public interest (i.e. serious crime/imminent risk of serious harm or Court Order etc.). Where information is disclosed on the basis of consent, the request should be processed in line with the relevant data protection legislation (Data Protection Act 2018, UK General Data Protection Regulation). Police will follow their appropriate legal frameworks when considering lawful basis of a disclosure.

As above, there will be instances when seeking consent is not appropriate. Where this is the case, Police and TEWV are limited to sharing what is necessary and proportionate, in order to mitigate the risk and/or in TEWV to ensure that a serious crime is being investigated. There may be other occasions when TEWV staff need to also consider contacting Police to share information. This may be if you have been provided information in respect of a patients that you are concerned about, for example:

- They have been involved in an incident and hurt someone.
- They have committed a crime.
- They have been victim of crime and don't want to tell Police.
- They have witnessed a crime.
- They are concerned about their safety and scared to tell Police.
- They have been driving whilst under the influence of alcohol or drugs.
- They are making threats to harm/kill another person - sometimes these persons are identified (i.e. 'my mother'), or sometimes generic (i.e. 'someone').

TEWV staff would need to consider before sharing information in the above situations/examples (in the absence of consent or a Court Order) whether consent applies, or whether there is a current and imminent risk. The risk that has been identified should be balanced against that patients right to medical confidentiality. Where the identified risk outweighs the duty of confidentiality, then information limited to that which is necessary and proportionate can be shared. Ultimately it is for the appropriate clinician/clinical team/MDT to make the decision around risk, but the Disclosure or Legal team may assist you. TEWV Staff should also consult with the Confidentiality NHS Code of Practice and Supplementary guidance on public interest disclosure, which assist in deciding lawful basis. Confidentiality: NHS Code of Practice - GOV.UK

Police will also have to work through legal considerations to share information. They will not be able to share unverified intelligence or anything that may put someone at risk or jeopardise court/criminal proceedings.

6.2.2 Caldicott Principles

Staff should be aware of their common law, legislative, professional and Trust obligations in balancing confidentiality with necessary information sharing, when working with Police and the Criminal Justice System. The seven principles of Caldicott should be remembered:

Principle 1: Justify the purpose(s).

Principle 2: Don't use personal confidential data unless it is absolutely necessary.

Principle 3: Use the minimum necessary personal confidential data.

Principle 4: Access to personal confidential data should be on a strict need-to-know basis.

Principle 5: Everyone with access to personal confidential data should be aware of their responsibilities.

Principle 6: Comply with the law.

Principle 7: The duty to share information can be as important as the duty to protect patient confidentiality.

Considering all of above and the RCRP threshold, if staff believe there is a real and immediate risk to life or someone currently at, or at risk of, serious harm, then it is essential that all necessary information that will evidence this is shared with Police at the earliest opportunity. This may include any professional judgement clinical opinion as well as information from CITO healthcare records. It is essential that all information shared is also fully recorded in the CITO progress notes, evidencing why the risk threshold has been met and the request for Police to support. The Police control room record calls and the call handlers will record on the relevant Police system the information and decision making.

6.3 Incidents Requiring Emergency Police Response at TEWV Wards.

6.3.1 Background

In response to the serious nature of Police being called to inpatient mental health/learning disability settings and significant incidents that have occurred nationally, a nationally agreed multi-agency document was published in January 2017. This “Memorandum of Understanding (MoU) – the Police use of Restraint in mental health and learning disability settings” was agreed among multiple national partners, including the College of Policing, the National Police Chief Council, NHS England, and the Department of Health. It outlined the agreed principles and these will form the body of this guidance. RCRP will not change this area. The threshold has been in place for some time, with the national MoU and legal position.

Incidents of this nature should be escalated to Senior Managers in TEWV in real time for information and oversight due to serious nature of Police attendance at wards. In the Police it will be escalated to the Force Incident Manager (FIM) for information. Response supervisory command and control should occur.

6.3.2 Trust staff training in Violence and Aggression

TEWV inpatient staff are trained in verbal and physical skills to prevent and manage behaviour that challenges, as well as aggression and violence. Community staff are only trained in

breakaway techniques, and in any call to the Police this must be made clear. Incidents of violence and aggression in TEWV community bases may therefore need Police response more than wards. Wards support and de-escalate patients who may present with such behaviours, however there are rare and exceptional occasions where their resources are not sufficient to manage a situation and keep everyone within the incident safe. It is on these occasions that Police may be called to assist to bring the situation safely under control, due to their enhanced skill set and the tactical options available to them.

6.3.3 Police tactical options

At the same time, it must be acknowledged that involving the Police and their array of tactical options opens up a potential higher use of force, with an increased propensity for injury to the person. Police tactical options are always a decision to be made by the Police. This cannot be "requested" by TEWV staff. Decision making about this use of force will always need to undergo a robust risk assessment and may involve the FIM, as use of any force, particularly higher-level force, must be lawfully justified by the officers using this. It may also need senior agreement/authorisation from the FIM. TEWV staff therefore must be aware that a decision to call Police, which could result in greater force being used, must be justifiable and there are no other options available at that time.

6.3.4 Categories prompting Police response

The National Memorandum of Understanding outlines five examples in which a Police response would be appropriate within ward environments. The information shared with Police by clinical staff is assessed using the THRIVE model in order to make a decision about Police involvement and attendance. Each incident will be assessed on its own individual circumstances, and Police will make the decision about how to respond accordingly. The following five scenarios are presented as a guide to when a Police response would be appropriate:

a) **An immediate risk to life and limb**. For example, patient has a weapon in their hand and threatens to harm someone with this. If the patient has left the weapon in their room and staff can safely take possession of this, Police would not be required for emergency attendance.
b) **Immediate risk of serious harm**. For example, a patient is needing restraint and seclusion due to violence being shown. During restraint a number of staff have been injured, causing serious injury requiring treatment in the Emergency Department. Due to this, staff would need Police support to bring the situation safely under control and help seclude the patients.
c) **Serious damage to property**. For example, a patient has caused damage to ward infrastructure, including windows broken, chairs and tables damaged, appliances broken. They continue to damage ward property with debris flying around room, making it unsafe for staff.
d) **Offensive weapons**. For example, a patient has advised staff they have a knife in their possession to protect themselves against staff, as they feel staff may harm them by giving them medication or other treatment. Patient has a known history of possessing offensive weapons or sharply pointed implements.

e) **Hostages**. For example, a patient has locked the door to a room with a staff member/other person inside and is threatening to harm them if anyone tries to enter the room. Patient is saying they will allow them out if they are released from ward. No indications about weapons.

6.3.5 Restrictions on Police support in Clinical interventions

The guidance makes it very clear that Police should not be called for clinical interventions, such as:

- Administration of treatment without consent (e.g. medication etc.)
- To transfer patients from one service to another, or to accident and emergency departments, unless exceptional or aggravating factors apply.
- To transfer someone to seclusion, unless exceptional or aggravating factors apply. (E.g. someone has caused serious injury to a staff member/s who needs hospital treatment and staff cannot safely transfer them without support).

TEWV must ensure that, in environments where restrictive interventions are required, there are arrangements to convene sufficiently skilled staff to appropriately mitigate the risks – including from other wards. This often can be a 'response team', which consists of staff members responding to an alarm activation from each ward on the site, to attend such incidents and support. This is not a specialist-trained team such as the Prison service may have.

6.3.6 Seclusion considerations

Seclusion-entry support is not mentioned specifically in the guidance. TEWV staff must try to be proactive and stop situations reaching the stage where Police are required if possible, e.g. entering and stopping someone from pulling down wires or damaging the room to make a weapon if safe to do so. However, there are some situations that may need a Police response and action. This is always a Police decision. Each situation should be judged on its own merits, risks and circumstances, and be subject to a THRIVE assessment. It should still fit into one of the above categories mentioned. Here are some specific areas to clarify:

- Police cannot be called to support in seclusion entry just because there is a threat to physically assault someone on entry. This should be managed clinically, and the situation should be escalated to senior managers accordingly, with relevant plans formulated. If the situation should become unmanageable, it may then fall into category (b) described in Section 5.5 above.

- If someone has weapons in seclusion and is threatening to harm others, particularly those that enter, again this situation should be managed clinically. Negotiation would be an option to consider, as it would clearly be unsafe to enter, as long as there isn't any urgency due to risk to that person in the room or you are unable to see the person. Staff

could continue to negotiate with the person to get them to hand over the weapons, monitoring the situation.

- If someone has an item with which they are threatening to harm themselves, then a request to the Police to support entry under 999 may be required while staff try to negotiate and monitor. It will very much depend on the circumstances. If anything can be done to prevent further harm, this should be carried out. For example, if someone has live wires exposed and is saying they will electrocute themselves, then if the electricity to the room can be isolated this should be expedited. If someone has something sharp and it is pointed at their neck, then a 999 call for Police as well as for an ambulance may be required.

- If someone is systematically dismantling the seclusion room and there is serious risk of room integrity being compromised, then this may require a call to the Police to support. This is circumstances-specific and escalation within clinical management, along with input from the Police, will be necessary for the safest resolution for all.

6.3.7 Exceptional requirement for Police attendance

It is the responsibility of TEWV to ensure the application of Human Rights, Health and Safety, and Mental Health/Capacity legislation in the first instance. Where a therapeutic intervention has been attempted, staff have been injured and there are no further staff to call upon, Police may be required because of the ongoing risk to staff safety and therefore lessened ability to ensure the safety of the intervention, however officers must also work within the appropriate legal frameworks.

It should be acknowledged that Police Officers should only be contacted and deployed in exceptional circumstances. TEWV staff should not use Police attendance as a preventative or controlling measure, or to manage a clinical-management issue. In these circumstances, there should always be other clinical strategies and direction in place to manage situations and/or occurrences. The Police will then be assured that any call for attendance from the Trust is one requiring immediate deployment to a situation that staff are unable to manage safely without their assistance.

No assumptions should be made by Police call handlers or officers that incidents involving patients or within wards will always be a matter for healthcare alone, and that offences committed by patients cannot and should not be investigated or prosecuted as detailed in the National Strategy for Policing and Mental health by the National Police Chiefs Council (NPCC) (2019). Following an incident, officers will record crimes in accordance with National Crime Recording Standard (NCRS) guidelines. Staff should give statements and Police should ensure they are fully considered. Only in exceptional circumstances would someone be arrested and removed from the ward. More often than not crimes can be investigated ‘slow time’. This means there isn’t the same timescale as there would be if someone had been arrested and would be subject to strict timescales for evidence gathering and charge. See Section 10 for crimes and investigation. If this

does occur, the ward should liaise with the Liaison and Diversion team in custody to consider any necessary information sharing and support that might be required.

6.3.8 Necessity for review

Any emergency Police deployment to the wards MUST be subject to joint review. The level of the review will depend upon the incident and the nature of the Police involvement/intervention required. A TEWV online incident report must be completed on Inphase, and the TEWV Clinical Police Liaison Lead (CPLL) must be notified via email. The Police will also notify their Mental Health leads. The review may be a paper review with the CPLL and Police, a local after action review (AAR) led by the clinical team/independent person or a serious incident (SI) review led by the Trust Clinical Risk and Investigations team. All incidents that involve Police should be subject to a joint review. Any reviews being led by TEWV need to involve Police and this can be coordinated via the CPLL. Any reviews undertaken of incidents within the Police should include TEWV and can be co-ordinated via the CPLL. The reviews will also highlight emerging trends and themes and feed the learning across the Trust.

6.4 Responsibilities and Expectations for TEWV Staff and Police Officers during Emergency Attendance at TEWV Wards

6.4.1 Initial actions

In every incident where Police are in attendance at a TEWV premises, the Officer in Charge (OIC) will make contact with the TEWV nurse in charge of the situation. This may be a Staff Nurse, Clinical Lead, Ward Manager or Senior Manager, but must be the person with the best overview and understanding of the person and situation. There must be a clearly identified person in command and control from both police and TEWV.

Police on attendance at wards will initiate Body Worn Cameras (BWC) to record events.

TEWV staff members should ensure they provide the Police with all the necessary information they require to manage and mitigate the imminent risk that has resulted in their attendance. It must be sufficient information so that Police can assess, deploy necessary resources and manage the risk. They should include any complicating factors relating to the presentation or that could be affected by any Police interventions (i.e. physical and mental health information). This may include, but is not an exhaustive list:

- Current legal status under the Mental Health Act (detained/informal) or if the person is a community patient at a base/hospital.
- Any communication or sensory needs/difficulties (see 6.9.3)
- Current clinical presentation.

- Current physical health/medical presentation, as well as any known underlying physical health or medical conditions.
- The risks posed to the patient and others.
- Previous history of violent/assaultive behaviour towards others.
- Previous history of self-harming behaviour.
- Recommended ways of engaging with and/or approaching the individual.
- Physical health conditions that may put a person at risk during an intervention.

6.4.2 Incident management

There should be an understanding that, by contacting the Police, they will take over the management of an incident but the clinical responsibility for the patient remains with TEWV. Hence, where practical, any intervention should be discussed and plans made jointly, including the exit strategy for the Police once the situation is under control, so that the Trust's staff can monitor the physical health and wellbeing of the person throughout.

However, it should be noted that in some circumstances it will not always be practicable to agree such strategies before Police intervention. This would be where there is an actual occurrence of serious harm being caused or there is an immediate/imminent risk of serious harm being caused. The Trust's staff should always ensure they support Police in keeping a patient safe and monitoring and managing their physical health and wellbeing once able and safe to do so. As mentioned, Police will lead the intervention when TEWV staff cannot manage the risk, as defined in Section 5. Once the risk is managed/reduced, the responsibility passes back to TEWV. There may be rare and complex situations that require the involvement of both agencies. For example, if Police are exhausted from lengthy restraints and unable to safely bring the situation to a conclusion (Exit seclusion etc.), staff could support in this or attempt TEWV approved physical intervention techniques. This will be planned with the two leads from TEWV/Police and the risks acknowledged due to differing training techniques in a joint approach. This would only be undertaken in a situation that is unmanageable by one agency alone.

6.4.3 Consideration for forward planning

Where there is predictable and recognised serious risk that Police support may be required due to the patient's risk profile, historical information and/or offending history, there should be consideration of joint planning in advance, working with the hospital/Mental Health Liaison

Officers. This ensures that all are aware of the risks, and what may need to occur in the event of an incident.

6.5 Police Support with Mental Health Assessment in the Community

6.5.1 Mitigation considerations

There may be exceptional occasions in the community where Police support is required to undertake an assessment of a person's mental health, due to the significant risk they are posing to the assessor/s. This may be a crisis assessment, or Mental Health Act (MHA) Assessment, or a community appointment. Any request must be made to the Police control room and will be subject to the THRIVE assessment process to review risks before deployment of Police is considered.

Requests for Police support would go via the control room (101) and would be THRIVE-assessed for consideration on whether it is suitable for Police to attend. RCRP threshold will be applied, unless a Section 135 warrant is to be obtained and therefore where the legal power is clear. It will be about establishing if risk can be mitigated in any other way or if risk to TEWV staff is real and immediate risk to life, or they are at risk of serious harm.

Where there is a concern around the risk and potential imminent harm at an assessment/appointment, the Trust's staff will attempt to minimise and manage the risk by whatever means available to them. This may mean undertaking the assessment in a public area, with two staff, using hospital security for support, etc.

6.5.2 Police supporting assessments

If these actions have been taken and the risk remains real and immediate or there is a risk of serious harm to staff, or if it is not possible to mitigate the risks, a discussion should take place with Police at the earliest opportunity. This will be completed as far in advance as possible to ensure Police have adequate time to look at risk information and make plans to support clinicians should this be agreed. Clear, detailed and accurate information should be given about current and imminent risk, and what specifically is required from the Police.

Everyone involved in a clinical assessment should be alert to the need to provide support to colleagues, especially where there is a risk of the patient causing physical harm. TEWV staff carrying out assessments should be aware involving the Police to support is a last resort and they should consider the circumstances in which the Police should be asked to provide assistance to ensure the safety of everyone involved. Whether the Police can lawfully become involved to support such a scenario is a Police decision based on the information they receive from the clinicians

Some examples (but not an exhaustive list) where Police support may be required/requested:

- Section 135 (1) and (2) warrants – as Police required to execute warrant.

- Recall of a Section 41 restricted patient as recalled by Ministry of Justice, if risk is known to be high to the public.

- MAPPA high risk cases or ongoing serious investigation cases.

- Where there is clear current evidence of imminent risk of serious harm to others.

6.6 Concern for welfare

6.6.1 Overview

The RCRP will be applied to all requests for a police response to a concern for welfare made by TEWV staff, all partner agencies and the public. This may mean that the public are redirected to TEWV if it is felt that mental health was the main concern and the incident does not otherwise meet the RCRP threshold for a police response.

There is sometimes confusion regarding what a welfare check is and when is someone missing. The Police definitions of these terms are:

Welfare check – Location is known or suspected and RCRP threshold is met.

Missing – Whereabouts **cannot** be established and RCRP threshold is met.

There is no national definition of what is involved in a “concern for welfare”. In its broadest sense it means checking someone is currently safe (not injured or deceased) and is well (doesn’t appear to be obviously suffering from ill health and in need of immediate healthcare). This is not an automatic role for Police.

6.6.2 Police powers

When a call is made to Police to ‘check’ on a person’s welfare by other services, police powers are limited.

Police officers have a power to force entry to premises, but only where there is a requirement to “save life or limb” – a general concern for someone’s welfare is not sufficient to satisfy this test (Syed v DPP).

Police are not clinical professionals and hence not always best placed to make such checks. For those concerns that have come to TEWV as first agency, or for those who are our patients and we have concerns such as they have failed to attend an appointment or have made contact with the care team and there are further concerns etc., and it is not at the RCRP threshold, TEWV Staff have the duty of care and must act on the concern for welfare. We may have also individuals that attend TEWV sites asking for help. TEWV will need to action these unless at the RCRP threshold for Police or another agency is needed.

Some examples of actions staff may need to undertake:

- Can TEWV make contact via phone, check with other involved persons, or cold-call an address if there are concerns?
- Is it someone who has hung up the telephone out of frustration for example and we have tried to call back? Remember to disable “withheld number”, as many will not answer the phone to a “withheld number”. This can be done by dialling 1470 before entering the number to be called.
- Can TEWV staff arrange to go to the address and see the person?
- Constantly reviewing the risk and whether it has escalated at any time to the RCRP threshold during or following actions. The incident may then be about calling Police or perhaps another agency, e.g. the ambulance service.

There are occasions when a concern for welfare needs Police (as per threshold), or may need ambulance or TEWV staff to act. Please see the guidance below.

6.6.3 Ambulance Called for Concern for Welfare

If the welfare concern relates to a person who is in need of urgent medical care and treatment, an Ambulance call should be made on: 999.

Examples:

- Where there is concern about a person calling TEWV services - if they have taken an overdose and are not answering the phone.
- If a person has not attended an appointment and we are concerned they may be injured or seriously ill at home.
- Where the location is known and emergency physical care is needed.

Ambulance services can request Police support if needed and have the same legal powers in a home address as Police under the Mental Capacity Act. If ambulance services do not respond in a timely manner, this is not a Police role. It must be escalated within the ambulance service as to the concern and delay. Ambulance services can also call upon the fire service in some areas to assist in forcing entry to an address, and they have legal powers around this.

6.6.4 Police Called for Concern for Welfare

The Right Care, Right Person (RCRP) threshold is met where there is a real and immediate risk to life, or the individual is currently at, or at risk of, serious harm. The Police are not trained clinicians, but they have skills to ensure public safety. Some examples of where Police may be called:

- Where the person is in a public area, but they are planning on harming self or others and the threat/risk is real and immediate.
- Where there is immediate risk with weapons to the life of the person or others.
- Where there are risks/concerns for others and wider public protection (E.g. where a person is threatening to set a fire or has taken a hostage etc.)
- Where risk is as such at a home address where it is evident RCRP threshold has been met and forced entry is required to save life and limb, a Police power derived from Section 17 Police and criminal evidence act 1984.

6.6.5 Concerns for a Staff Member's Welfare

There may be occasions where colleagues or a manager are concerned about the safety of a staff member. The Trust manager should ensure they make appropriate and relevant enquires and use Trust support processes where there is concern for staff welfare that is not evidently a real and immediate risk or person at risk of serious harm. This may include visiting the home address, speaking to next of kin etc. This may be done in conjunction with other Human Resources processes such as Counselling, Occupational Health, etc.

There may be many different scenarios of concerns for staff welfare, but it could include the following:

- The person is off work due to sickness, but they are unable to be contacted on numerous occasions by various means and family members are expressing concern.
- A person is due in on shift and does not turn up. They are not responding to repeated attempts by telephone and in person to contact them and there are concerns for the person's safety.
- A person contacts the ward/team member and during discussion there are concerns for their immediate safety.
- An activation of lone-working device, but nothing indicating immediate need for support, but the staff member is unable to be reached on their escalation contacts.

6.6.6 Initial actions by TEWV

If it is the scenario that there has been no contact and concerns present, but not yet at the threshold requiring Police or ambulance, then it would be appropriate to do the following before ringing the Police if then appropriate:

- This would include – ring the person, their family, friends (personal contacts), attend their home address, speak to neighbours if applicable, leave a note with a timescale to make

contact before you will be ringing police. Look through windows, the letterbox, and all around the property if able to access and it is safe to do so.

- Make a note of the how property looks. Has the heating been on? Is there condensation on the windows? Are the windows open? Is there mail behind the door? Differences can then be noted if a second visit occurs or reported to Police.
- Discuss the concerns with a senior manager and decide the best course of action.
- If the person is not located, consideration could be given to reporting them as missing.

6.6.7 Urgent escalation

If there is concern that the person is at real and immediate risk to their life or they are currently at, or at risk of, serious harm, this may then be escalated to appropriate emergency services. This may be Police or, if it is felt the person is in need of emergency medical care and treatment, the ambulance. Ensure all relevant information is communicated and ask that they feed back to you as the reporter or the senior manager. Emphasise the sensitive nature of the situation.

6.7 Communication and Escalation – Concern for Welfare

6.7.1 Documenting decisions / considerations

Whatever the concern for welfare, record keeping of the decision making is essential. CITO healthcare records (or notes kept for staff record) should be updated to reflect the decision making, actions taken, rationale on reporting to Police / ambulance, information shared, reports to Police / ambulance service, and evidence of risk threshold. It should record the log number / reference number and if accepted by Police or the actions agreed to be taken by another agency. This does not mean TEWV do not act any further, but that another agency may be leading on concern for welfare, with it coming back to TEWV for the mental health assessment / follow up afterwards, so this needs to be planned. With agreed contact for police / ambulance service to feed back to.

If the concern for welfare is felt to reach the RCRP Police threshold but Police disagree and this is declined, this needs to be documented fully in the CITO healthcare record accordingly, and the escalation process must be followed in a timely manner. Escalating to a Manager / Associate Director / Group Director (or on-call equivalent) and they then discussing with their equivalent in Police - Police Control Room supervision / FIM – Silver commander on duty. It must be clear when contacting that the caller is following the escalation process and wishes to escalate a disagreement on the incident. The log number must be quoted. All actions must be documented in the CITO healthcare record.

6.8 Crimes and Mental Health

6.8.1 Overview

Justice does not stop at the hospital gate. The Police service can have a role to play within care facilities for patients detained under mental health law. The NPCC Mental Health and Policing National Strategy outlines the following:

- Where someone with a mental health problem offends, it is not usually the case that they have done so directly because of their mental illness.
- It is both possible and necessary to prosecute some suspects for offences committed whilst mentally ill. This remains true where a person is so unwell that they are detained under the Mental Health Act. Whether someone should be prosecuted is a different matter. All cases should be assessed on their individual merits.
- 'Capacity' is not the legal issue to be determined during criminal investigation. Some offenders who 'lack capacity' and insight are nonetheless prosecuted, where this is appropriate.
- Mental illness may or may not affect the mens rea (the guilty mind) element of criminal conduct - all cases should be taken on their individual merits and the various forms of mens rea borne in mind.
- The NICE Guidelines on Violence (2015) outline that only 8% of people who offend whilst mentally ill lack all insight into their actions.
- Prosecution should not occur purely for the purposes of accessing relevant kinds of mental health care - for example, medium or high secure care. It should be necessary on its own terms as a criminal justice intervention.
- Only the criminal courts in England and Wales have powers under Part III of the MHA and they can only make use of those opportunities (remands for assessment, psychiatric reports etc.) if someone is charged before the court.

6.8.2 Are criminal charges required?

In weighing up whether or not criminal charges are required in a given circumstance, generally the more serious the alleged offence, the less relevant someone's mental health problems to the Police or CPS decision to prosecute. Decisions should reflect the full set of evidential and public-interest test requirements in the Code for Crown Prosecutors. **The investigative starting point is one of neutrality - all cases turn on their individual merits.**

6.8.3 Capacity

There is often a discussion around a person having 'capacity' for the offences. But, as College of Policing guidance and the Crown Prosecution (CPS) guidance both state, 'Capacity' isn't a factor that should be considered in an investigation.

The College of Policing Approved Professional Practice (APP) guidance states:

'Investigating officers should recognise that the law presumes all suspects to be sane and to be legally accountable for their action, unless the contrary is proved in court. This is an underlying principle of the criminal justice system (as outlined in the M'Naughten rules on insanity).'

⚠ **The M'Naughten rule is a test for criminal insanity. It states:**

'at the time of the committing of the act, the party accused was labouring under such a defect of reason, from a disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.' (Queen v. M'Naughten, 8 Eng. Rep. 718 [1843]).

All available information should be considered during any criminal investigation before deciding on the outcome (whether determined by the police or by the Crown Prosecution Service). When deciding on whether or not it may be appropriate to charge a mentally ill or vulnerable person with an offence, investigators should consider (as a guide) that the more serious the offence, the more appropriate it is likely to be to consider prosecution for the crime involved. This level of additional consideration is supported by Home Office circular 66/1990.

6.9 Crime Investigation on Wards

6.9.1 Reporting potential crimes

It is the decision of the victim in most cases on whether they wish to report an incident to Police, unless there is an overriding public-interest reason to make the report regardless. There is a need for commitment from staff making a report and they should realise this means engaging fully in the process, making a statement, and being willing to attend court should this be required.

The incident may not always lead to court as there are a multitude of avenues and options along the way for consideration. Certainly, some low-level concerns around behaviour may be dealt with jointly with Police and the Trust in the form of an acceptable behaviour agreement. E.g. this may be in response to concerns about a visitor's behaviour, or a patient that is verbally hostile in appointments or to reception staff.

Where staff or patients report an incident to Police, it should be considered fully by Police from a point of neutrality. There are occasions of patients making allegations against staff and this needs to be investigated. Agencies safeguarding polices will cover this in more detail.

The matter will be reported as per Section 6.3. Staff must ensure that they make it clear they wish to make a statement and report this as an offence. The process for this differs in each police force.

There will be occasions when no action can be taken against the patient responsible, for example in cases where acute mental illness is present, considering severity and permanence of mental disorder i.e. severe learning disability/severe dementia where the patient cannot speak or understand language and will not recover. Criminal offences by such patients can and should still be reported, but a criminal investigation will not take place. In these instances team managers must support victims on how best to reduce ongoing risks around individuals likely to commit criminal acts.

6.9.2 Responsibilities for TEWV staff/teams

staff must ensure the following are done in a timely manner, to prevent delays or jeopardy to investigations:

- **Statement**: Staff should ensure they make themselves available at the time allocated to give a statement. TEWV staff should be aware this isn't making the call, or discussing the event, this is making a full, detailed written account with an officer, that you will be asked to sign.
- **Forensic Evidence**: Ensure we secure any necessary forensic evidence (this may mean that areas are locked off and kept forensically secure until Police advise otherwise, or that we ensure we keep clothing that's been spat on, or property that has been damaged, or photo evidence etc.) Seek advice from Police in the call if unsure.
- **Evidence Gathering**: Ensure CCTV is secured in a timely manner so any footage is preserved as evidence. Another option for repeat offenders is also the Community Impact Statement, which TEWV can look to complete for those repeat 'offenders' causing significant impact on ward areas.
- **Fitness for Interview: This must be assessed (NB not Capacity as mentioned in section 6.8.3. This does not come into Crime investigation). Assessment is undertaken by the Responsible/Approved Clinician in charge of the person's care (Nurse Consultant or Psychiatrist), or on-call equivalent if required as a matter of extreme urgency due to the situation (E.g. being arrested).**
- **Information Disclosure**: It is not usually required to have any further information pre-charge, but if a request for this is made, this must go via the TEWV Legal team to ensure that this is carried out on a lawful basis, to protect any evidence in the case. This will be done in a timely manner, depending on the severity of the offence, the nature of it, and the request.

6.9.3 Voluntary interviews with patients

If possible, patients do not need to be removed from the ward for a voluntary attender interview (VA). This can be undertaken in a suitably quiet area of the ward to allow nearby support for the person if needed. Staff on these occasions will support Police to organise the interview. The patient can be supported to contact a legal representative to attend the ward. The patient will likely also require an appropriate adult (AA). The Police will need to bring necessary equipment to be able to undertake the interview on the ward. The interview is a legal process and cannot be interrupted by anyone not in the key roles: AA or solicitor, unless during an emergency.

If Police request to interview a patient and they are not arrested and taken to a Police station. TEWV staff are responsible for the following:

- **Arrange provision of appropriate adult**
- **Subject to patients wishes, arrange attendance of legal representative**
- **Arrange provision of interview supporter – if deemed appropriate or requested**
- **Arrange a qualified interpreter if the patient's first language is not English and they are not fully conversant in English**

6.10 Appropriate Adults and Interview Supporter Roles

6.10.1 Appropriate Adults

The Police and Criminal Evidence Act 1984 (PACE) set out the rules and safeguards for policing in England and Wales, including the role of the appropriate adult (AA). The principle intention of the AA safeguard was to reduce the risk of miscarriages of justice as a result of evidence being obtained from vulnerable suspects which, by virtue of their vulnerability, led to unsafe and unjust convictions. Where the suspect is a child or vulnerable person, PACE requires the presence of an AA for many procedures.

The role of the appropriate adult is to safeguard the interests, rights, entitlements and welfare of children and vulnerable people who are suspected of a criminal offence, by ensuring that they are treated in a fair and just manner and are able to participate effectively. This is a key role in legal proceedings, not just an advocate. The AA role is filled by many different types of people, including:

- Parents or other family members.
- Friends or Carers.
- Social Workers (Statutory duty only for Children).
- Charity workers.
- Specialist Appropriate Adults.

6.10.2 Who can be an Appropriate Adult?

In TEWV, the stance is only staff trained to act in this role can undertake this role, due to ensuring they are not acting outside of professional remit/training. It must be someone not involved in the incident, or ideally working within the environment where the incident has occurred. If you need further advice or support about the role, contact can be made with the Clinical Police Liaison Lead to see if anyone within the Trust can support.

In Custody, Police have Appropriate Adult schemes that support those arrested and taken to Custody. This is organised via the Custody Sergeant.

Only suspects require consideration and potentially an AA role. Victims who are our patients may require someone to act in the interview supporter role, while they provide a statement.

6.10.3 Interview Supporters

It should be noted that interview supporters are not the same as ‘appropriate adults’. Appropriate adults have not been required in witness interviews since the revised edition of the Codes of

Practice to the Police and Criminal Evidence Act 1984 came into force on 1st April 2003 ('witness statements' are no longer included among in the list of circumstances in which an appropriate adult is needed during interviews with suspected offenders in Code C paragraph 11.15).

It may be decided by the clinical team that it would be helpful if a patient has some additional support if they are a witness or victim. The interview supporter ideally should be known to the witness and can be present during the interview to provide emotional support. Where this is appropriate and practical, the views of the witness should be established prior to the interview as to whether they wish another person to be present and, if so, who this should be.

Other witnesses in the case, including those giving evidence of an earlier complaint, cannot act as interview supporters. Interpreters and intermediaries should also not act as supporters. These different functions should not be vested in one person.

6.11 Police Custody

6.11.1 Decision on whether to arrest

There may be occasions where someone needs to be arrested from the ward to enable the crime to be investigated. Before such action is taken, the Police, Responsible Clinician and any other relevant healthcare professionals should discuss the appropriateness of removal to Police custody and determine agreed outcomes and levels of support required from the Trust. This should be a rare occasion; however, it is acknowledged that in serious cases, a patient is likely to be arrested and taken into Police custody from the ward. It may also be appropriate to arrest an informal patient where the necessary measures to manage the risk and behaviour are not available, as they are not liable to be detained. The ultimate decision to do so lies with the arresting officer, ensuring the '**necessity test**' for the legal power of arrest is passed. If arrest does occur, there should be an agreed plan of whom is responsible for the persons health and wellbeing during this time, and if staff are supporting within the custody environment.

A necessity test is the threshold that Police must ensure they have met before someone can be arrested. A Police Officer has a power to arrest for any offence, and arrest is not a punitive measure. It is based on a necessity and is normally a last resort. There are set criteria the officer must ensure are met.

6.11.2 Other service users

There may be individuals who are not TEWV inpatients but are TEWV community patients, or who have no current TEWV involvement, who nonetheless end up in Police custody. The Liaison and Diversion teams (L & D) that work in those areas can then undertake any necessary triage/assessment and may also refer to other mental health services. They will provide advice and support to the healthcare provider in custody on fitness for interview and detention, and support Custody Sergeants. They will provide a report for court, and/or CPS if this is also required. If a person is arrested from a ward and taken to Police Custody, the L & D team can offer support to the individual and ensure any relevant information is made available to police. The ward clinical

team must ensure they contact the L & D team in the relevant Custody suite to provide handover of relevant information. If they are returning to the ward, the L & D team shall hand back over to the ward team.

For inpatients attending court, L & D can assist the clinical team to submit a court report, thus ensuring relevant information is made available to the courts. L & D can also assist in facilitating secure entry and facilities within the court or request patients attend via video link from the ward if appropriate.

The Liaison and Diversion team intervention may include referring to Crisis services for further assessment if indicated, Mental Health Act assessments being called, referral to other community-based services, and follow up in the community post release. Local Processes for this are followed. In relation to serious crimes and concerns relating to mental health, this differs from area to area due to commissioning arrangements.

6.12 Role of the Crown Prosecution Service (CPS)

6.12.1 CPS overview

The Crown Prosecution Service (CPS) prosecutes criminal cases that have been investigated by the Police and other investigative organisations in England and Wales. The CPS is independent and makes decisions independently of the Police and Government. Their duty is to make sure that the right person is prosecuted for the right offence, and to bring offenders to justice wherever possible.

The CPS function and role is to:

- Decide which cases should be prosecuted.
- Determine the appropriate charges in more serious or complex cases and advise the police during the early stages of investigations.
- Prepare cases and present them at court.
- Provide information, assistance and support to victims and prosecution witnesses.

Prosecutors must be fair, objective and independent. When deciding whether to prosecute a criminal case, our lawyers must follow the **Code for Crown Prosecutors**. This means that to charge someone with a criminal offence, prosecutors must be satisfied that there is sufficient evidence to provide a realistic prospect of conviction, and that prosecuting is in the public interest.

6.12.2 Requests for further information

In relation to mental health cases, CPS may require further information. The decision maker should consider the information available and decide whether a decision to prosecute can be made or whether further information should be sought. That the suspect's mental health condition

or disorder has been raised as an issue is not in and of itself a basis for seeking further information. The basis for doing so should be founded in the two-stage test for prosecution in the Code for Crown Prosecutors: is there sufficient evidence for a realistic prospect of conviction? If so, is a prosecution required in the public interest? Therefore asking: is there sufficient information available to address the evidential and public-interest stages?

A request for further information should therefore articulate whether it is related to an assessment of the evidence in the case, or the public interest, or both, and how. Precision is needed to inform any further investigation of this issue. A request for evidence as to capacity for instance, lacks precision. Whilst this term appears elsewhere in mental health law and in some criminal offences, it is not a term which makes clear whether it is focused on the evidence (the mental element of a crime or a potential defence) or the public interest. A prosecution does not have to prove as part of the evidence the suspect's capacity. It implies that a prosecution would not proceed if the suspect lacks capacity. As will be discussed below, this may be the case but it may not be. (CPS Legal Guidance – Mental health suspects and defendants with mental health conditions or disorders 2019)

There may be occasions that a crime cannot be progressed due to not passing the tests set out by CPS. A detailed rationale will always be provided.

6.13 Outcomes and Sanctions

6.13.1 Overview

There are a range of criminal justice outcomes and disposals. Both Police and courts have options in sanctions and disposals, depending on the circumstances. This depends on the nature and severity of the offence, and the individual's previous offending history. This may range from verbal warnings, cautions and community resolutions, as well as specific (e.g. youths) out of court disposals/pathways. Court disposals can be anything from absolute discharge, conditional discharge and fines, to suspended and full prison sentences etc.

There may also be restrictive orders/conditions that may be put in place temporarily or longer term, from bail conditions, Community Protection Notices (CPN), Criminal Behaviour Orders (CBO), to injunctions and restraining orders.

6.13.2 Options

Courts have specific disposals relating to mental health within the Mental Health Act, as detail below:

- Section 35: Remand for Court (The Crown Court or a magistrates' court).
- Section 36: Remand for Treatment (The Crown Court).
- Section 37: Hospital Order (Either the Crown Court or a magistrate's court).

- Section 37/41: Hospital Order with Restrictions (Crown Court).
- Section 38: An interim Hospital Order (Crown Court).
- Section 45A: Restriction direction (Crown Court).

There are also options during remand and sentence for secure transfer, with Prison Transfer sections of the Mental Health Act:

- Section 47: Transfer direction sentenced prisoner (from prison).
- Section 47/49: Transfer sentenced prisoner with restrictions.
- Section 48: Transfer direction remanded prisoner.
- Section 48/49: Transfer direction remanded prisoner with restrictions.

Courts also have an option, as part of a suspended sentence or community order, of imposing a Mental Health Treatment Requirement (MHTR) order, but these must be discussed and agreed with the treating clinical team before this can be put in place. It would need to be supported at court by a named professional report with details of why this is suitable and how it may help in the offending behaviours of an individual.

6.14 Monitoring Investigation Process and Outcomes

6.14.1 Security Management Specialist & Police Liaison Support

TEWV staff must ensure they have completed a TEWV online incident report for all incidents involving Police. The Police involvement section of the incident report must be completed as fully as possible and should be checked again by the authorising manager before sign off. This enables us to ensure we work with Police around these incident outcomes.

The Trust's Security Management Specialist will liaise with the Police and appropriate members of staff during the investigation process where required, and where necessary act as a Single Point of Contact (SPOC) for the Police along with the Trust's Legal Team where required.

Where required, the Security Management Specialist will arrange Police contact with members of Trust staff during their investigations and will be able to update those concerned on the progress and outcomes of the investigation. Where Trust support is required for staff to give statements and information to inform Police investigations into the matter, the Security Management Specialist will liaise with the Officer in Charge and appropriate Clinical teams to ensure such support is afforded, along with the Trust's Legal Team.

The Police/Mental Health Liaison Officers and harm-reduction teams will work closely with the Clinical Police Liaison Lead around crime investigation and complex offenders to ensure robust multi-agency planning.

The Police Liaison Officers keep in regular contact with ward/team managers with updates of case progressions, and support victims when required in the process. The victim can receive ongoing support with the case from Witness Care Units and victim support services where required.

6.15 Debrief, Reviews and Escalation

6.15.1 Basis

As mentioned in Section 6.3, all incidents of emergency attendance must be reviewed. This review can be paper based, a more detailed after action review or a serious incident review, depending on the nature of the incident. Following any incident, an immediate hot debrief should be considered, involving Police and TEWV staff if appropriate. See organisational guidance on conducting debriefs. The National Memorandum for Police restraint within inpatient areas requires a review is undertaken. This will involve the TEWV Clinical Police Liaison Lead and Police Mental Health leads in the discussion and may require a more formalised SI or AAR review. Hence the respective leads must be notified of these incidents.

6.15.2 Process

There is clear partnership working between Police and TEWV, but this does not mean that we will always agree. A good basis to partnership working is being able to professionally challenge each other where appropriate, and have open and honest discussions, and look to learn together and improve the services we offer.

Dependent on the seriousness of the incident being debriefed, this may require the involvement of senior managers (TEWV & Police) to allow any issues to be escalated appropriately. Should disputes arise during “live incidents”, the TEWV escalation process will be followed, in conjunction with the Police Command structure.

The Local Police and Partner group will review data, trends and themes and ensure that this is being monitored and any actions taken where necessary.

Right Care, Right Person (RCRP) implementation is being monitored closely both by the multi-agency groups, which will continue following implementation in each area, and also internally. The incident forms will be used to look at data, as well as concerns fed directly to the Clinical Police Liaison Lead for review in slow time. Trends, themes and learning will be fed back across the Trust. A senior meeting in-Trust will continue to provide senior oversights to review implementation.

6.16 Training and Further Information

6.16.1 Available resources

Both TEWV and Police are delivering training on RCRP and how it will work. TEWV also has a web page with further detail:

Right Care Right Person | TEWV Intranet

There is also a need for multi-agency training to understand each other and how we work together around scenarios. RESPOND is multi-agency training with police, ambulance staff, nurses, doctors, AMHPs (Approved Mental Health Professionals) and patients, which was developed in response to the crisis care concordat. We identified the need to strengthen our collaboration with all the agencies involved in the crisis pathway to make the experience for patients the best it can be.

It is a one-day training package designed to increase knowledge and skills of the crisis pathway. In the training, a group of professionals work together through a simulated scenario of a service user in crisis.

7 Definitions

Term	Definition
RCRP	• Right Care Right Person
THRIVE	• Threat, Harm, Risk, Investigation, Vulnerability, Engagement
FIM	• Force Incident Manager
CPS	• Crown Prosecution Service
CCTV	• Closed Circuit Television
MHA	• Mental Health Act
MDT	• Multi Discipline Team
NPCC	• National Police Chiefs Council

NCRS	• National Crime Recording Standards
VA	• Voluntary Attender
CPN	• Community Protection Notices
CBO	• Criminal Behaviour Orders
MHTR	• Mental Health Treatment Requirement
SPOC	• Single Point Of Contact
SI	• Serious Incident
AAR	• After Action Review
AMHP	• Approved Mental Health Professional
MoU	• Memorandum of Understanding
Hot debrief explanation	• **Capture key observations quickly** before they are forgotten. • **Identify immediate lessons learned** and any urgent actions required. • **Support staff wellbeing** by allowing them to share experiences and concerns. • **Provide clarity** on what went well and what could be improved for future responses.

8 How this procedure will be implemented

- This procedure will be published on the Intranet and Trust website.
- Line managers will disseminate this procedure to all Trust employees through a line management briefing.

8.1 Implementation action plan

Activity	Expected outcome	Timescale	Responsibility	Means of verification/ measurement
Not applicable				

8.2 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Not applicable			

9 How the implementation of this procedure will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	**# of declined police responses later escalated and accepted (indicator of threshold articulation/quality)**	**Frequency** = Monthly **Method** = Individual cases brought to attention of LSMS / weekly review of Inphase incidents by H&S **Responsible** = LSMS	Health Safety Security & Fire (HSSF) Group bi-monthly meeting
2	**Incident handling reviews**	**Frequency** = Following serious incidents **Method = AAR** **Responsible** = Manager leading AAR supported by LSMS	Shared AAR with concerned parties including Police where appropriate
3	**Police feedback**	**Frequency = Bi-monthly** **Method** = LSMS/Police liaison meetings **Responsible** = LSMS	Issues / learning brought to the HSSF meeting for action or noting

10 References

- College of Policing – Approved Professional Practice Guidance
- CPS Legal Guidance – Mental Health Suspects and Defendants with Mental Health Conditions or Disorders (2019)
- The Memorandum of Understanding – the Police use of Restraint in Mental Health and Learning Disability (2019)
- National Strategy for Policing and Mental Health by the National Police Chiefs Council (NPCC, 2019).
- DoH Confidentiality code of practice and supplementary public interest guidance (2003) Confidentiality: NHS Code of Practice - GOV.UK
- Right Care, Right Person National Partnership Agreement - National Partnership Agreement: Right Care, Right Person (RCRP) - GOV.UK
- Human Rights Act 1998

11 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	13 May 2026
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This document replaces	Not Applicable – new document
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Change record

Version	Date	Amendment details	Status
v1	13 May 2026	New document	Approved

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Security management
Title	Collaborative Guidance for TEWV staff and Police
Type	Guidance
Geographical area covered	Trust wide
Aims and objectives	The guidance provided within this process also aims to achieve the following: • Ensure Trust staff understand the appropriate circumstances for requesting an emergency and/or priority response from Police. • That Trust staff and Police Officers understand each other's powers, duty of care and responsibilities where Police Officers have been deployed to an incident. • Ensure Trust staff know how to report a criminal incident both using Online Incident Reporting (Safeguard) and to the Police. • That Police Officers are aware of the Trust's expectations once a crime has been recorded, as per national crime recording guidance. • Trust staff are aware of the legal considerations and frameworks placed on Police and Criminal Justice partners and where this may impact on Trust staff expectations. • Support mechanisms are provided to staff and service users who have been victims of a criminal act. • Appropriate support is provided to Police in relation to their investigation process following the report of a criminal incident, and they know how to access this appropriately.
Start date of Equality Analysis Screening	January 2025
End date of Equality Analysis Screening	11/12/2025

Section 2	Impacts
Who does the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	Patients, carers, families, staff and Police forces within geographical area – Durham, Cleveland and North Yorkshire
Will the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men and women) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO** • **Human Rights Implications NO** (Human Rights - easy read)
Describe any negative impacts / Human Rights Implications	There are occasions when some patients will subject staff to abuse. This can often include racist abuse. Staff are encouraged to report these incidents to Police. On most occasions positive action can be taken against the patients that carry out these abuses. However, there are certain patient cohorts that are unaware of their conduct due to severe mental illness, such as dementia. This can have a negative impact on staff as these incidents of abuse cannot be stopped or punitive action cannot be taken.
Describe any positive impacts / Human Rights Implications	This guidance supports all patients and staff regardless of protected characteristics, to receive fair and equitable service from Police or TEWV around any issues of a nature contained within the document.

Section 3	Research and involvement
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	See references section
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Yes
If you answered Yes above, describe the engagement and involvement that has taken place	Meetings with TEWV management teams. Liaised with three partner Police forces. Conducted Trust wide staff consultation.
If you answered No above, describe future plans that you may have to engage and involve people from different groups	

Section 4	Training needs
As part of this equality impact assessment have any training needs/service needs been identified?	No
Describe any training needs for Trust staff	Not applicable
Describe any training needs for patients	Not applicable
Describe any training needs for contractors or other outside agencies	Not applicable

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 2 – Approval checklist

Title of document being reviewed:	Yes / No / Not applicable	Comments
1. Title		
Is the title clear and unambiguous?	Y	
Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2. Rationale		
Are reasons for development of the document stated?	Y	
3. Development Process		
Are people involved in the development identified?	Y	
Has relevant expertise has been sought/used?	Y	
Is there evidence of consultation with stakeholders and users?	Y	
Have any related documents or documents that are impacted by this change been identified and updated?	Y	Criminal incident reporting procedure reviewed and updated.
4. Content		
Is the objective of the document clear?	Y	
Is the target population clear and unambiguous?	Y	
Are the intended outcomes described?	Y	
Are the statements clear and unambiguous?	Y	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Y	
Are key references cited?	Y	

Are supporting documents referenced?	Y	
6. Training		
Have training needs been considered?	Y	
Are training needs included in the document?	N	Not applicable
7. Implementation and monitoring		
Does the document identify how it will be implemented and monitored?	Y	
8. Equality analysis		
Has an equality analysis been completed for the document?	Y	
Have Equality and Diversity reviewed and approved the equality analysis?	Y	
9. Approval		
Does the document identify which committee/group will approve it?	Y	HSSF / EFM DMT + approved by Police
10. Publication		
Has the policy been reviewed for harm?	Y	No harm
Does the document identify whether it is private or public?	Y	Public
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	Not applicable	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Y	
Do all pictures and tables have meaningful alternative text?	Y	
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	Y	